

APPENDICES

EXECUTIVE SUMMARIES, PRESS RELEASES, RELEVANT STATUTES, AND WRITTEN TESTIMONY

1. Relevant State Statutes.
2. **NEWS** from the Office of Lieutenant Governor George H. Ryan — June 12, 1990; and Rural/Downstate Health Care Action Plan — Fact Sheet.
3. John Record, Assistant Dean for Rural and Alumni Affairs — SIU School of Medicine — January 30, 2006.
4. Reversing the Trend of Health Care Workforce Shortages in Rural Illinois — The National Center for RuralHealth Professions — University of Illinois — Rockford.
5. Barry S. Maram, Director — Illinois Department of Healthcare and Family Services — Springfield.
6. Addressing Illinois Critical Skill Shortages in Healthcare — Lori Clark, Senior Policy Advisor — Illinois Department of Commerce and Community Affairs — Springfield.
7. Ralph M. Schubert, Illinois Department of Human Services — Division of Community Health Prevention — January 30, 2006.
8. Governor Rod R. Blagojevich Press Release — May 4, 2006.
9. Health Issues Confronting Rural Illinois — Mary Jane Clark and Christopher D. Merrett, Ph.D. — Illinois Institute for Rural Affairs — Western Illinois University, Macomb — January 30, 2006.
10. Illinois Rural Downstate Health Act, Programs and Strategic Alliances Among Participating Agencies — Mary Jane Clark and Christopher D. Merrett, Ph.D. — Illinois Institute for Rural Affairs — Western Illinois University, Macomb; and Marcia Franklin — Illinois Department of Public Health — Center for Rural Health — March 2006.
11. Partners in Illinois Rural Health — Mary Jane Clark — Illinois Institute for Rural Affairs —Western Illinois University, Macomb; and Marcia Franklin — Illinois Department of Public Health — Center for Rural Health — March 2006.
12. Paul Schou, Executive Director — ICAHN: Illinois Critical Access Hospital Network —June 29, 2006.
13. The Economic Impact of the Critical Access Hospital Program on Illinois Communities — ICAHN: Illinois Critical Access Hospital Network, by Northwestern Illinois University, NIU Regional Development Institute — June 2006.
14. Matthew Hunsaker, MD — National Center for Rural Health Professions — University of Illinois, Rockford — August 29, 2006.

15. Reversing the Trend of Health Care Workforce Shortages in Rural Illinois — Michael Glasser, Associate Dean — The National Center for Rural Health Professions — University of Illinois, Rockford.
16. Harvey Davis, CEO — Franklin Hospital, Benton — August 29, 2006.
17. Focus on Rural Community Hospitals in Illinois, Illinois Hospital Association — Kathy Gayda, Director and Robert Hansen, Policy Information Analyst — August 2006.
18. Roger W. Hannan, MS, Executive Director — Farm Resource Center — John A. Logan College — August 29, 2006.
19. Betsy D. Mitchell, Legislative Consultant — Arthritis Foundation — Greater Chicago Chapter.
20. Kristen Lessen, Director — Healthy Communities Partnership — Abraham Lincoln Memorial Hospital, Lincoln.
21. Cheryl Boyd, Director — Family Counseling and Mental Health Center — A Division of Franklin-Williamson Human Services — John A. Logan College, Carterville — August 29, 2006.
22. Kathleen K. DeVine, CEO and President — St. Anthony's Hospital, Chicago.
23. Michael J. O'Grady, Jr., CEO and President — Norwegian American Hospital, Chicago.
24. Illinois Primary Health Care Association (IPHCA).
25. Illinois Primary Health Care Association (IPHCA). Community Health Centers: Providing Solutions to the Medically Underserved.
26. Daniel Yohanna, MD, President — Illinois Psychiatric Society.
27. Bob Gilligan, Executive Director — Catholic Conference of Illinois.
28. Susan Bauer, MA, MPH — Community Health Partnership of Illinois, Chicago — October 24, 2006.
29. A Proposal for the Expansion of the Rural Health Initiative — Rural Health Initiative Expansion — Southern Illinois University — School of Medicine.
30. Letter to Illinois State Senator Deanna Demuzio and Illinois Representative William Delgado — from Illinois Rural Health Association — November 10, 2006.

JOINT TASK FORCE ON
RURAL HEALTH AND MEDICALLY UNDERSERVED AREAS

RELEVANT STATE STATUTES

•PUBLIC HEALTH

- (410 ILCS 65/) ILLINOIS RURAL/DOWNSTATE HEALTH ACT
- (410 ILCS 66/) COMMUNITY HEALTH CENTER EXPANSION ACT
- (410 ILCS 100/) REDUCTION OF RACIAL AND ETHNIC HEALTH DISPARITIES ACT

•HIGHER EDUCATION

- (110 ILCS 935/) FAMILY PRACTICE RESIDENCY ACT
- (110 ILCS 905/) ALLIED HEALTH CARE PROFESSIONAL ASSISTANCE LAW
- (110 ILCS 978/) PODIATRIC SCHOLARSHIP AND RESIDENCE ACT

NEWS From the Office of LIEUTENANT GOVERNOR GEORGE H. RYAN



June 12, 1990

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RYAN, LAWMAKERS UNVEIL DOWNSTATE HEALTH CARE PACKAGE

SPRINGFIELD – Dramatic help for doctor- and hospital-poor downstate Illinois communities was outlined Tuesday in the health care action plan announced by Lieutenant Governor George Ryan and downstate lawmakers.

The Rural/Downstate Health Care Action Plan envisions modernization of existing hospitals, development of new clinics and improved dental and emergency medical services for communities throughout the region.

“Governor Thompson stated in his State of the State address that downstate was entitled to share in any initiatives on improved health care,” said Ryan. “We see this comprehensive, bipartisan proposal as the right answer to that call for balance.”

Ryan, chairman of the Illinois Rural Affairs Council, said Senate Bill 2277, sponsored by Sen. James Rea, D-Christopher, serves as an appropriate vehicle for proposals developed by the broad-based Rural Health Care Task Force. Negotiations already have begun to blend features of the bill and the task force’s proposals.

“Senator Rea and Representative (David) Phelps (D-Eldorado) are to be commended for advancing such a forward-looking community health care plan at so critical a time,” Ryan said. “Nine rural Illinois hospitals have closed since 1980, the most recent, Jarman Hospital, shutting down less than two weeks ago in Tuscola.”

(more)

While recent attention has been focused on crises in health care in Chicago and Cook County, Ryan and other downstate medical care advocates began meeting even earlier on the special problems of small cities and towns. Southern Illinois University and the Illinois State Medical Society were key contributors to the final plan.

“The initiative we bring you today is designed to attract doctors, nurses and other health professionals to rural counties that lack the most basic in modern health care services,” Ryan said. “It also provides funds for short- and long-term improvements, the kinds of services often taken for granted in metropolitan areas.”

Ryan made his remarks at an afternoon news conference at the State Capitol. He said the source of 416 million in first-year funding would have to be negotiated by the legislature and Governor Thompson in the closing weeks of the spring legislative session.

From the first-year pool, money would be provided for a wide spectrum of programs administered by the Illinois Department of Public Health and the SIU School of Medicine.

“The money would be in the right hands,” Ryan said. “There was no future for downstate medicine before SIU got involved. And Public Health, through our new Center for Rural Health, has an inside line on what rural Illinoisans want and need in the way of services.

“An exciting part of the plan also would have the SIU Medical School develop four primary care centers in rural communities,” Ryan added. “Basic care would be tailored to the needs of individual communities, and the centers serve as a conduit for the wealth of specialized expertise a major medical school can provide.”

(more)

The primary care centers would be established with \$1.8 million in state funds. Other program tentatively salted for funding include:
Allocation of \$3.7 million for recruitment efforts and incentives for future small-town dentists, nurses and other medical personnel. It would expand upon a loan-repayment program that has achieved some early success in bringing physicians to rural areas.

– A \$3 million program to provide for Illinois Department of Public Health 50 percent matching grants to 10 communities to improve existing outpatient clinics. Operators would be eligible for up to \$300,000 each to underwrite costs of supplies, modern equipment, patient transport systems and recruitment programs.

– A similar \$3 million program, also through Public Health, which inpatient facilities could tap for recruitment, building renovation, diversification of services and/or joint ventures.

– Allocation of \$2 million for 50 percent matching grants to rural counties or federations of counties for purchases and equipping of ambulances and training of emergency medical personnel.

– A total of \$3.8 million for personnel programs that include expansion of SIU's nursing specialties; expansion of southern Illinois dental centers and development of technical health personnel training.

“Survey after survey has shown that nothing is more important to people than accessible, affordable health care,” Ryan said. “With the planning that has gone into this report, and with the resources that stand behind it, I see no reason why Illinoisans in rural areas should remain second-class citizens where the health of their families is concerned.”

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RURAL/DOWNSTATE HEALTH CARE ACTION PLAN

FACT SHEET

FIVE TARGETED PROGRAMS TO IMPROVE RURAL HEALTH CARE ACCESS:

1. AMBULATORY CARE IMPROVEMENTS — \$5.8 million
2. INPATIENT CARE IMPROVEMENTS — \$4.8 million
3. EMERGENCY MEDICAL SYSTEMS DEVELOPMENT — \$2.0 million
4. HEALTH PERSONNEL SHORTAGES — \$3.8 million
5. RURAL HEALTH RESEARCH AND EVALUATION — \$1.0 million

Total first year funding is approximately \$16 million.

PROGRAM DESCRIPTION

1. AMBULATORY CARE IMPROVEMENTS — \$5.8 million

Illinois Department of Public Health will provide matching grants in approximately 10 communities per year improve access to primary care services through coverage of operational expenses, such as, medical supplies and equipment, patient transport systems, health provider recruitment. Each grant not to exceed \$30,000. — \$3.0 million

Southern Illinois University Medical School will develop four primary care centers in selected small rural community service areas which will link health care personnel with Medical School resources to insure comprehensive patient care. — \$1.8 million

Southern Illinois University Medical School will receive additional funding to stabilize its five family practice residency programs currently providing indigent care. — \$1.0 million

2. INPATIENT CARE IMPROVEMENTS — \$4.8 million

Illinois Department of Public Health will provide grants ranging from \$300,000 to \$500,000 to rural hospitals for renovation of facilities, recruitment of health personnel, diversification of services, joint venture arrangements. 50% local match required. — \$3.0 million

Southern Illinois University working with local clinics and hospitals will take the lead role in developing Affiliated Obstetric Centers in rural areas of the state. — \$1.8 million

3. EMERGENCY MEDICAL SYSTEMS DEVELOPMENT — \$2.0 million

The Department of Public Health will provide 50% matching grants to rural counties and groups of counties to develop and improve emergency medical services — personnel training, medical and vehicle equipment. — \$2.0 million

4. HEALTH PERSONNEL SHORTAGES — \$3.8 million

Illinois Department of Public Health increases in nurse scholarships and loan repayments. — \$1.6 million

Illinois Department of Public Health mid-level practitioners scholarship program. — \$800,000

SIU Nursing School — Expansion of educational programs to develop nurse specialty programs and continuing education opportunities in rural areas. — \$650,000

Creation of a Health Care Provider Recruitment Center within the Center For Rural

RURAL HEALTH RESEARCH AND EVALUATION — \$1 million

SIU — Center For Rural Health and Social Services to coordinate and implement integrated-comprehensive health systems models. — \$300,000

SIU — Medical School — Center For Regional Health Delivery — Advisory Board operations and medical telecommunications study. — \$700,000

IDPH — Center For Rural Health research grants to universities to assess alternative health delivery models. — \$40,000

**TASK FORCE ON HEALTH CARE ACCESS IN RURAL AND UNDERSERVED AREAS
TESTIMONY PRESENTED ON JANUARY 30, 2006**

John Record

Assistant Dean for Rural and Alumni Affairs
SIU School of Medicine

“... to assist the people of central and southern Illinois in meeting their health care needs through education, patient care services, and research.... will realize this mission through collaboration and partnership with the region’s community health care organizations...”

From its inception in 1970, this mission statement has guided the activities of Southern Illinois University School of Medicine. With a primary emphasis on education, the School has graduated nearly 2000 medical students since the School’s first commencement in 1975. As one of the criteria for admission, students must be residents of Illinois. This requirement, based upon extensive research, is critical in maximizing the number of graduates that stay in the state to practice medicine. An additional strategy employed by the School to aid in the retention of our graduates is the family medicine preceptorship program. Over 160 community-based physicians from throughout downstate Illinois serve as teachers for third year medical students during their family medicine clerkship. Students may spend additional time with community physicians through various electives offered during the fourth year.

The MEDPREP program, established in 1972, provides assistance to educationally and economically disadvantaged students in preparing for and achieving success in health professions schools. This nationally recognized post baccalaureate program works with each student to devise an individualized curriculum plan that includes courses in the biological, quantitative and medical sciences as well as courses to enhance reading and writing skills. To date over 1,000 students have completed the MEDPREP program, 80% of whom are from racial or ethnic backgrounds that are underrepresented in medicine.

In addition to the undergraduate medical education programs, the School of Medicine and our affiliated community hospitals provide graduate medical education (GME) through fourteen residency programs and nine fellowship programs. These programs are based in Springfield, Carbondale, Decatur and Quincy. Besides providing training in a wide range of primary and specialty disciplines, these programs provide direct patient care services under faculty supervision to thousands of citizens of central and southern Illinois.

The provision of patient care services extends well beyond the primary clinical service sites just noted. SIU faculty hold regular clinics in rural communities throughout the region in the specialty areas of family medicine, internal medicine, neurology, pediatrics, psychiatry and surgery. While these services have traditionally required physicians and other providers to travel to these communities, telemedicine is now used whenever possible. Reimbursement, regulatory and infrastructure barriers currently limit a fuller use of telemedicine for the delivery of health care services. However, distance communication technologies are being used more and more extensively to deliver educational programming.

These highlights are intended to offer only a snapshot of how SIU School of Medicine meets its mission of education and clinical service. Perhaps more to the business of this task force is the School’s Rural Health Initiative (RHI) program that was created with the passage of the Rural/Downstate Health Act. This act was passed by the Illinois General Assembly and signed by the Governor in 1990 but was not funded until 1994. The central problem addressed by the act is found in Section 2, which states, in part, that “The General Assembly finds that citizens in the rural, downstate and designated shortage areas of this State are increasingly faced with problems in accessing necessary health care...It is therefore the intent of this General Assembly to create a program to respond to this problem.” The Act calls upon Southern Illinois University, the University of Illinois and the Illinois Department of Public Health to each devise strategies consistent with their respective missions and goals that address this problem.

At SIU, responsibility for creating a strategy to meet the goals of the Act was entrusted to its School of Medicine. The Rural/Downstate Health Act charged SIU with "...expanding its focus on rural health care... and "further encourage the regional outreach mission of its School of Medicine through the establishment of a dedicated administrative entity within the School with responsibility for rural health care planning and programming." Since 1994, the RHI program has resulted in collaborative partnerships and projects with 70 different community-based organizations, statewide not-for-profit entities and state agencies and universities. Central to the majority of these collaborations has been the goal of assisting local organizations expand their capacity to provide health care services.

In 2004, ten years after the first RHI project was started, we decided to gather updated information to help inform the future direction of the RHI. Beginning in fall 2004 and concluding in summer 2005 a series of focus group meetings were held with rural community leaders. Five communities were selected as host sites—Pittsfield, Carlinville, Effingham, Mt. Vernon and Carterville. These communities were chosen based upon geographic distribution, their location in the School of Medicine's primary service area and their representativeness of rural characteristics of the region. The participants in each focus group were selected to represent a cross section of community leaders from various sectors—health, education, business and labor included.

When viewed in the aggregate, the following is a brief summary of the broad themes that emerged from all of the discussions:

1. Regional Health Service Needs/Gaps-The rural areas of central and southern Illinois lack mental health services, especially for children. At present there is only one child and adolescent psychiatrist practicing in the region south of Springfield. A related need is treatment services for substance abuse particularly for methamphetamine use, again a problem that especially impacts our youth. Another distinct area of need is oral health services including dental hygiene. The other major regional gap is inadequate transportation. This impacts direct medical care as well as pharmacy and diagnostic services.
2. Health Problems-The specific health problems most frequently mentioned were cancer, heart disease, lung problems, asthma, diabetes and obesity.
3. Physician/provider needs-While primary care providers are at the core of rural health services, the need for specialty care is increasingly evident. Most frequently mentioned was the need for child and adolescent psychiatrists. Other medical specialists mentioned were adult psychiatrists, obstetricians, anesthesiologist, cardiologists, general surgeons, gastroenterologists and ophthalmologists. Other providers mentioned were dentists and optometrists.
4. Workforce education, training and retention issues-Related to physician needs, other health professionals are also needed. Most frequently mentioned were nurses and social workers, re-enforcing the need for a strong primary care system while recognizing the growing need for mental and behavioral health services. Focus group participants frequently mentioned the desire to see physicians "return home" after training.
5. Payment issues-The impact of the uninsured and underinsured individuals and families as well as those on Medicaid is especially grave for rural areas. With a higher proportion of people living in poverty, rural providers are more likely to receive lower reimbursement. Of particular note is the problem of coverage for dental services, especially for children.

In addition to identifying problems and needs, focus group participants were asked how the health and health care of rural areas might be improved and how SIU School of Medicine might assist in this endeavor. In general, participants acknowledged that SIU is seen as a leader in central and southern Illinois and that they want the School of Medicine to be an advocate for the health care concerns of the people and the communities of the region. Based upon the responses from the focus groups, the following should be areas of concentration for the School's regional development and assistance efforts:

1. Improvement of the health care infrastructure and capacity of local health care providers and organizations.
2. Increased access to mental and behavioral services, especially for children.
3. Increased access to specialized services for children.
4. Increased access to health information and services through enhanced telehealth capabilities.
5. Increased access to preventive and treatment services for the major health problems of the region including cancer, heart disease and chronic conditions.

Many of the health care needs of the rural and underserved areas of Illinois could be improved if the Rural/Downstate Health Act was adequately funded. We encourage this task force to use that important piece of legislation to address the concerns that you are hearing today and will continue to hear as you gather further testimony. The School of Medicine was pleased to partner with the Paul Simon Public Policy Institute at SIU in 2003 to conduct the health care summit for rural and underserved Illinois that led to the creation of this task force. We look forward to further similar collaborations with the Institute. Likewise, we are prepared to assist this task force in its important work and appreciate this opportunity to share information and ideas with you.



THE NATIONAL CENTER FOR
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Summary

Reversing the Trend of Health Care Workforce Shortages in Rural Illinois

Prepared for the Legislative Task Force for Rural Health and Medically Underserved

Introduction

The National Center for Rural Health Professions (NCRHP). NCRHP at the University of Illinois-Rockford develops and supports innovative, evidence-based, and collaborative initiatives for addressing health issues among rural and underserved populations. The goals of NCRHP are: (1) to reduce health disparities and meet the health care needs of rural residents through education, research and community outreach, and (2) expand and implement recruitment, retention, and health care delivery initiatives that will positively impact the health and well-being of rural residents and their communities. The Center has attracted grant funding from the National Institutes of Health and cultivated partnerships with state and national organizations to study health disparity issues in rural and underserved populations.

The Rural Medical Education Program (RMED). RMED is the flagship program of NCRHP and is highly successful. RMED admits and prepares medical students from the state of Illinois who will, upon completion of residency training, locate and practice in rural Illinois as primary care physicians.

The RMED teaching model. RMED partners with rural Illinois communities to cultivate pre-professional students for medicine through unique processes of selection, training and mentoring. Students are recruited from rural communities who, in the screening process, express an affinity for returning to a rural community to practice medicine.

While completing requirements for a doctorate in medicine at the University of Illinois College of Medicine, RMED students train in additional areas pertinent to the practice of medicine in a rural environment, such as mental health, community problem solving, and community service. The final year of medical school includes 16 weeks of “service learning” in a rural physician’s office. Service learning places the student in a rural community as part of the educational process. The student lives in the community and gets “real-world” experience as part of an interdisciplinary team of health professionals in a rural hospital.

Successful outcomes. RMED leads the nation in accomplishing the goal of physician replacement in rural communities. RMED now has 132 graduates. Of those, 67 are currently completing their training in residency programs. Of the fully-trained physicians, 92 percent are practicing in Illinois communities and 74 percent are in rural primary care.

Background

Illinois Rural/Downstate Health Act of 1990. Fifteen years ago health care, academic, and civic leaders from across the state came together with legislators to design innovative solutions to rural health access problems. The product of those efforts is the Illinois Rural/Downstate Health Act. This Act invested resources directly into higher education for the purpose of reversing shortage trends. It provided pioneering legislation that created an opportunity to address rural health—directly—in an environment where funding dollars were tight and growing concerns were emerging about the quality and capacity of the rural health workforce. Those challenges are not unlike the challenges we face today.

Relevant Milestones in Rural Illinois Health Care

- 1990 The Illinois Rural/Downstate Health Act was initiated.
- 1993 Partial program funding was appropriated for the Illinois Rural/Downstate Health Act.
- 1996 Partial program funding was appropriated for the Illinois Rural/Downstate Health Act.
- 2000 The Illinois Board of Higher Education granted temporary ‘Center’ status to the Center for Rural Health Professions at the University of Illinois-Rockford.
- 2003 The Health Care Summit for Rural and Underserved Areas was hosted by the Public Policy Institute at SIU and spearheaded by the late U.S. Senator Paul Simon.
- 2005 The Legislative Task Force on Rural Health and Medically Underserved Areas was created by the passing of HJR 5.
- 2006 The Legislative Task Force conducts a series of public hearings.
- 2006 The Illinois Board of Higher Education granted permanent “National Center” status to the National Center for Rural Health Professions. This action provides formal recognition and endorsement from IBHE for the mission and activities of NCRHP.
- 2006 A commitment of resources was made by the University of Illinois Board of Trustees toward the construction of home offices for the National Center on the Rockford campus.

The Illinois Workforce Shortage

While 20 percent of Americans live in rural areas, only 9 percent of the nation’s doctor’s practice in rural areas. Illinois is no exception. Of Illinois’ 78 rural counties, 64 are underserved for primary care health services.

- **Physicians.** By 2010, approximately 485 additional physicians will be needed in rural Illinois to meet growing demand and to replace retiring physicians.
- **Nurses.** By 2010, Illinois’ supply of registered nurses will fall short by 4,265—nearly half of which will be required in rural communities.
- **Dentists.** At this time, children in 82 of Illinois’ 84 rural counties do not have access to a pediatric dentist who participates in Medicaid. Of 494 rural Illinois dentists surveyed in 2004, 29 percent reported they will reach or exceed age 65 within the next ten years. This means that, in the midst of Illinois’ existing shortage crisis, at least 141 additional dentists will be leaving the workforce.
- **Pharmacists.** Between 2006 and 2010, about 400 additional pharmacists will be needed in rural Illinois to meet growing demand and to replace retiring pharmacists.

These challenges left unchecked undermine the individual and collective health of small communities. Families that fail to receive primary care services often enter the health care system critically ill—and the most expensive to treat—through emergency department services.

NCRHP–SIU Relationship

The Illinois Rural/Downstate Health Act of 1990 called for the two state-supported medical schools to develop programs to improve health care for rural Illinois. Medical education efforts by both Southern Illinois University School of Medicine (SIU) and the University of Illinois College of Medicine at Rockford (NCRHP) have helped to reduce physician maldistribution and improve community-level health services.

During this period a spirit of cooperation has allowed each institution to advance successful innovations for reducing health disparities in Illinois.

SIU and NCRHP have established a history of productive collaborations, each having engaged the Center for Rural Health of the Illinois Department of Public Health and other public and private organizations around the state. Pilot funding from the Illinois Rural/Downstate Health Act allowed the University of Illinois, Southern Illinois University, and the Center for Rural Health to initiate programs to improve rural health. Each partner has demonstrated successes but in the absence of expansion of the Illinois Rural/Downstate Health Act, its goals have not been realized as originally intended. Expansion of the Illinois Rural/Downstate Health Act will enable each to continue developing programs to address the State's healthcare needs of today and as they evolve in the future.

Steps to Reverse the Trend

Many rural Illinois communities are struggling to make ends meet when it comes to rural health. Aging providers, rising insurance costs, and decreased reimbursements have pressured rural physicians and hospitals into a crisis situation. The University of Illinois at Rockford has been partnering with rural communities to face these challenges and continues to develop new partnerships and programs to increase access, improve quality, and ensure an adequate health professions workforce in rural communities.

Steps for rebuilding Illinois' rural health infrastructure and ensuring future capacity include:

- #1 Expand successful student recruiting methods to all disciplines.
- #2 Expand rural health professions education using the RMED teaching model.
- #3 Enhance rural health workforce retention efforts.
- #4 Establish and maintain a consistent database measuring the Illinois rural health workforce.

Request

Appropriation related to the Illinois Rural/Downstate Health Act has provided funding for the RMED program. However, funding has not yet been appropriated to expand the Center's programs to build the rural Illinois health professions workforce. Permanent core funding at the level of \$1.4 million annually is needed to implement comprehensive recruitment, training, and retention programs for all the health professions.

Summary

NCRHP is ready to adapt the RMED model to the other professions currently facing critical shortages. It is time to plan for adequate numbers of rurally oriented professionals to be selected, enrolled and graduated from Illinois' publicly funded institutions of higher education.

If the rural health care workforce is to be adequate for the growing health care demands of the next ten years, it must be through a partnership of the legislature, public academic institutions, and rural communities. Healthy rural hospitals require adequate staffing to provide quality care and sustainability.

This document is a legislative summary of the larger document "Reversing the Trend of Health Care Workforce Shortages in Rural Illinois." For the full report, please contact the National Center for Rural Health Professions, (815) 395-5779.

NCRHP—10/30/06

**ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SPRINGFIELD, ILLINOIS — JANUARY 30, 2006**

Barry S. Maram, *Director*

- I am happy to be here today to discuss what HFS staff does everyday to provide services to rural and underserved communities.
- At the Department of Healthcare and Family Services, it is our mission to provide families with the services they need to improve their lives.
- As part of that mission, we are particularly concerned with reaching underserved communities. We understand that those who live in rural and underserved areas can too often fall through the cracks, due to geographic, language and other barriers.
- I'd like to take a few minutes to give an overview of the Department's operations. HFS administers three major programs: Medicaid, Child Support Enforcement and Energy Assistance.
- In our Medical programs we are committed to providing adequate access to quality healthcare at a reasonable cost to the 2 million Illinoisans we serve. We work in partnership with providers, hospitals and health clinics in underserved areas to achieve this goal.
- Governor Blagojevich continues to make access to affordable healthcare a top priority. At a time when states across the nation have made cuts to their Medicaid programs and left families without healthcare coverage, Illinois has added over 400,000 more Illinoisans since January 2003.
- In fact, Illinois has been recognized by the Kaiser Foundation two years in a row as being first in the nation in providing healthcare coverage to parents, and 2nd in the nation in providing healthcare coverage to children.
- In addition, Illinois recently expanded eligibility to our FamilyCare program. Effective January 1, 2006, parents and guardians up to 185% of the federal poverty level can get healthcare coverage through FamilyCare. That's just over \$35,000 per year for a family of four.
- While we currently cover over 1 million children in Illinois, there are still an estimated 250,000 children in Illinois who don't have health insurance, many of them in rural, underserved areas of the state. In Henderson, Pike, Jasper and Franklin counties over 11% of children do not have health insurance. In Alexander and Pulaski counties it's 15%.
- That's why the General Assembly passed Governor Blagojevich's All Kids program, which makes Illinois the only state in the nation to make sure every child has access to affordable, comprehensive health insurance.
- HFS also administers the Supportive Living Facility (SLF) program. SLFs offer an affordable long-term care alternative to nursing homes for frail, low-income seniors who need some help with daily activities but don't need skilled nursing care.
- Knowing that seniors do better when they are able to stay in their community, even when they can no longer stay at home, we have encouraged development of SLFs in sites throughout Illinois. There are currently 54 SLFs in operation, and 22 of them are in rural communities.
- An additional 39 rural SLFs have been approved and will become operational in the next few years.

- When the federal government passed the Medicare Part D drug benefit, Illinois created the Illinois Cares Rx program, the nation's most comprehensive Medicare drug wraparound program.
- Most recently, when a federal glitch resulted in many low-income seniors being denied coverage or charged large copays and deductibles for their drugs, Illinois stepped forward to provide emergency coverage to make sure no senior had to leave the pharmacy without the lifesaving prescriptions they need.
- While we're proud of Illinois' record of protecting and expanding eligibility to those who need healthcare, we know that the real success of these programs lies in our ability to make sure eligible families actually enroll and access the healthcare coverage they need.
- There are several ways that HFS, under the leadership of Governor Blagojevich, is working to promote access to healthcare coverage in rural and underserved areas.
- For example, when Governor Blagojevich announced the IL Cares Rx program, he sent a caravan across the state to make sure seniors had help understanding the new prescription drug program. The IL Cares Rx caravan held 69 events and reached 7,820 seniors in rural areas.
- There is at least one KidCare Application Agent in all but two counties. Many of the state's rural counties have at least two KCAAs and most local health Departments also serve as KCAAs. We continue to look for new KCAA partners to help identify and enroll eligible families into our programs.
- HFS has implemented an online application for KidCare and FamilyCare, so families can apply for healthcare coverage without going to a DHS or KCAA office. Pre-registrations for the new All Kids program are also being taken over the web and over the phone.
- HFS strives to make sure that, once enrolled, beneficiaries have access to providers. Our dental administrator and transportation prior approval vendor both have contractual obligations to recruit providers to enroll with HFS.
- Beginning in July, we will move to a Primary Care/Case Management (PCCM) model in which most enrollees in our All Kids and FamilyCare programs will be assigned to a primary care physician. The PCCM administrator will be required to recruit providers to enroll with HFS to ensure that every enrollee has a medical home.
- We also make sure enrollees can get to their providers. HFS pays for non-emergency medical transportation for most of our enrollees. Since transportation providers in rural areas often have to drive long distances to transport patients to their appointments, we negotiate special rates to compensate them for unloaded miles and wait times that would normally go uncompensated.
- Recognizing that Advance Practice Nurses are critical healthcare providers, particularly in rural areas, HFS began allowing all Advance Practice Nurses (APNs) to enroll with the Department to be paid directly for their services on January 1, 2006.
- In addition, APNs now receive 100% of the physician rate and are eligible to receive the same Maternal and Child Health add-ons enjoyed by their physician counterparts.
- It is hoped that this will encourage participation by APNs in the Medical Assistance Program and provide access to clients in otherwise underserved areas, both rural and urban alike.
- HFS also makes grants to local health departments to start or expand dental clinics in underserved areas. Current grantees are Saline County, Hancock County, Bureau County, Edgar County, and the Southern Seven counties.

- The Department currently runs two long-standing programs that provide targeted assistance to rural hospitals. The Rural Critical Hospital Adjustment Payments were established in 1997 to target additional funds to rural hospitals, and currently provide a total of \$13.6 million to 89 rural hospitals.
- In 2003, the Rural Adjustment Program was implemented to provide additional funds to help close the cost coverage gap for hospital providers in rural areas, who have been deemed by the IL Department of Public Health as critical to the provision of healthcare in Illinois. RAP initially served 22 rural hospitals, but service has expanded to providing \$7 million in annual assistance to 53 hospitals.
- In 2004, the Department received approval from the federal Department of Health and Human Services for its hospital assessment program. This program provided additional payments to hospitals throughout the state in order to maintain and expand Medicaid, especially in important service areas. Several payments were specifically designed to assist rural hospitals, providing them with over \$59 million in extra funding. The Department is currently seeking approval for a new hospital assessment program. If approved by the federal government, it would provide over \$86 million per year in assistance to rural hospitals, for a period of three years.
- As I mentioned, HFS also administers the Child Support Enforcement and Energy Assistance programs. The Division of Child Support has 20 satellite offices serving rural communities in Illinois, and places staff in downstate DHS offices to help custodial parents get the child support they are entitled to.
- The Division of Child Support Enforcement has also developed a partnership with the Wabash Area Development, Inc. Head Start program in Enfield, IL and the Southern Illinois University's Head Start program in Carbondale, IL to help parents of children in these head start programs establish and collect child support obligations.
- Our Energy Assistance programs provide grants to low-income households to assist with the cost of energy bills, and also provide weatherization services to approximately 7,000 low-income households annually. Our Office of Energy Assistance partners with 35 community organizations that serve as local administering agencies to enroll people in all areas of the state into the LIHEAP program.
- HFS is a major participant in the Keep Warm Illinois campaign, a multi-agency effort to help families reduce the adverse impact of higher home heating costs this winter. The initiative aims to help families lower their heating bills by conserving energy and weatherizing their homes. We are currently coordinating energy saving workshops statewide.
- HFS clients live throughout the state and we strive to ensure they have access to the services they need regardless of where they live. We look forward to working with you as we continue to reach out to individuals in rural and underserved areas who are eligible for but not yet enrolled in our programs.

ADDRESSING ILLINOIS CRITICAL SKILL SHORTAGES IN HEALTHCARE

ILLINOIS DEPARTMENT OF COMMERCE & ECONOMIC OPPORTUNITY — Springfield, Illinois

Lori Clark, *Senior Policy Advisor*

Thank you for the opportunity to appear today to discuss an innovative, proactive and visionary initiative launched by Governor Rod Blagojevich in the Fall of 2003 as part of his Opportunity Returns Program. Opportunity Returns is the Governor's plan for restoring economic opportunity to the State of Illinois. Recognizing that the Illinois economy is actually a collection of regional economies, with distinct identities, opportunities and challenges, Opportunity Returns is a significant change in the state's approach to economic and workforce development. The Illinois Critical Skill Shortages Initiative (CSSI), administered by Director Jack Lavin and the Department of Commerce and Economic Opportunity (DCEO) Bureau of Workforce Development, is using an innovative method to build a more dynamic workforce in the 21st century. CSSI is being implemented based on the 10 Economic Development Regions designated by the Governor for Opportunity Returns.

It is first helpful to understand how the Critical Skill Shortages Initiative is being undertaken. CSSI has been implemented in two phases. During the planning phase, DCEO awarded a total of \$3 million in federal Workforce Investment Act (WIA) funds to consortia of key stakeholders convened by the Local Workforce Investment Boards in each of the 10 regions. The Regional CSSI Consortia are comprised of representatives of the Local Workforce Investment Boards, education, including K-12, community colleges and universities, training agencies, regional employers, business and industry associations, economic development organizations, one-stop partners, organized labor and others. The planning grant funds were used to undertake an informed and logical approach to identifying key critical skill shortages in each region.

First, data-driven research was conducted to identify the key industry sectors, such as healthcare or manufacturing, that drive the economy of the region. Then, specific occupations were identified that either were currently experiencing shortages or were projected to have long-term shortages. These critical skill occupations, such as Registered Nurses or front-line production workers, had to be "good jobs" in the sense that they provide a self-sufficiency wage and benefits. After identifying specific occupations, the Consortia then had to understand the "root causes" of the shortages, such as lack of career awareness, lack of educational or training capacity, lack of qualified faculty, or high turnover. Once the root causes were well understood and validated by industry, the Consortia were asked to develop regional solutions to pool and voluntarily redirect both public and private resources to address the causes of the shortages. At the end of the planning process and after the regional options were exhausted, the Consortia applied to DCEO for funding under CSSI Phase II to fill "gaps" in the regionally-funded solutions. DCEO is making up to \$15 million in Workforce Investment Act training funds available over a two to three year period to award, on a competitive basis, to consortia that produce the best regionally funded plans and have the best developed requests for supplemental funding.

Not surprisingly, the CSSI Consortia in all 10 Economic Development Regions targeted healthcare and occupations within that sector. Nurses, both Registered Nurses and Licensed Practical Nurses, were targeted as the top priority in every region, although there are many other allied health occupations in short supply (e.g., medical records technicians, medical laboratory technicians, radiology technologists/technicians, physical, occupational and respiratory therapists, etc.). After reviewing the planning documents related to healthcare, several things became apparent.

First, we needed to develop a consistent methodology to quantify the magnitude of the short and long-term shortages of nurses in each of the regions. This involved analyzing not only demand expressed by the industry, but supply data as well – how many nurses were being produced annually in each region. One of the root causes for the nursing shortage cited in many of the regional reports was related to nurse mobility. The regions were producing more nurses than were staying to work in the region following graduation and State licensure. Nurse mobility appeared to be more acute in the more rural regions of the state where most nursing school graduates historically have been young, single, no children/

dependents and female, and frequently would leave the rural areas to secure better-paying employment in urban areas. We now believe that we have a good picture of not only the supply and demand of nurses in each region and the state, but an understanding of nurse mobility as well. This also allows us to track how each of the projects being funded in the regions helps to contribute toward reducing the shortages in the targeted occupations.

Secondly, although the healthcare shortages in the State's more rural regions are numerically much smaller than our urban regions, the impact is frequently more severe in the rural areas. Some areas reported that people who lived in certain counties had no access to specialized healthcare (e.g., cardiology, neurosurgeons, etc.) unless they drove to an urban center.

Third, the magnitude of the shortages in healthcare occupations cannot be dealt with by the public or private sector alone – it requires public-private partnerships and the active involvement of business, government, education, and economic and workforce development in identifying and funding innovative solutions to address the root causes of the shortages. An important innovation in CSSI is that we require the regions to develop sustainability plans to maximize the initial investments being made. This will help ensure that the regions can continue to sustain the workforce pipeline, using public and private resources, once the CSSI investments are over.

Fourth, given that the healthcare industry is one of the most regulated industries, it is important that we be mindful of the impact of state legislation, regulatory policies and accreditation requirements so that they do not create unnecessary barriers to expanding the number of nurses in Illinois. Quick government approval to accredit programs with alternative delivery modes, such as on-line instruction, that are working in other states, realistic nursing program faculty requirements, reasonable time limits for the licensure of nurses trained in other states, and foreign-trained nurse licensure issues have the potential to create bureaucratic obstacles that may limit our ability to expand the number of nurses working in Illinois.

Fifth, in response to many of the same root causes of the shortages identified in the regions, such as lack of career awareness, it became apparent that some issues necessitated statewide solutions. It would not be cost effective or efficient to have each of the 10 Economic Development Regions undertake the development of career awareness materials when it is possible to develop career awareness materials that are consistent among all regions and can be cost-effectively implemented by the regions.

Sixth, we were able to validate the fact that “one size will not fit all.” There are differences between the Economic Development Regions, and frequently even between the rural and urban areas within the regions. Although the root causes may appear to be similar, the solutions may be quite different depending on the regional capabilities. We must allow for innovative solutions that can be tailored to meet the needs of the different regions, while ensuring that the appropriate accountability is in place and that “best practices” are tracked, documented and dispersed to others within the state that might benefit. Pilot testing various solutions will be instrumental to diffusing successful innovations throughout the state.

Finally, our workforce development efforts must be seamless and transparent to our customers. We must begin at the earliest level in the K-12 educational system to make sure that students are aware of the career opportunities that are available in the various target industry sectors, as well as the prerequisite educational requirements for these occupations in demand. There is an increasing emphasis on a strong foundation in science and mathematics, regardless of which industry sector a student may be interested in pursuing, along with strong interpersonal skills such as teambuilding and problem-solving.

DCEO Director Lavin, as Co-Chair of the Illinois Workforce Investment Board (IWIB), recognized that these statewide issues had workforce and economic development implications. With the approval of the IWIB, a Healthcare Task Force was established in 2004 and chaired by Janet Payne, Director of Personnel for Provena United Samaritan Medical Center. The Task Force also included representatives of healthcare associations, state regulatory, education and workforce development agencies, community colleges, employers and labor unions. The Task Force presented a report on its findings and recommendations to the IWIB in December, 2004. A copy of this report can be found on www.commerce.state.il.us.

We have recognized that we must build strong and sustainable public-private partnerships to develop and maintain a steady “supply chain” or “workforce pipeline” that will provide qualified workers to meet the

needs of healthcare employers so that Illinois' citizens, urban and rural, have access to qualified healthcare professionals to meet their needs. We also have made great strides in coordinating activities among our state agency partners, notably the Illinois Community College Board and the Board of Higher Education.

I would like to summarize some of the innovative pilot projects that are being funded in various regions through the Critical Skill Shortages Initiative or through Healthcare Education Innovation Grants awarded by DCEO.

As I mentioned previously, it is important to begin to prepare students in the K-12 educational system for future careers. The CSSI process determined that there was a lack of awareness of the great variety of healthcare professions among our youth, their parents and even career advisors. Through a Healthcare Education Innovation Grant, in cooperation with the Illinois State Board of Education, we launched a pilot project to expand career development opportunities for K-12 students by developing and marketing a curricular framework complete with instructional materials and instructional strategies. The pilot sites have established a three-tiered program based on national health science career cluster materials. The first tier is for the Elementary School and it focuses on health career activities developed by the national Consortium on Health Science and Technology Education. In the second tier, for Middle School, students are introduced to career opportunities in five healthcare areas – therapeutic services, diagnostic services, health informatics, support services, and biotechnology research and development. In the third tier, High School, educational programs are expanded to include rigorous academic and healthcare curricula in all five pathways in the national cluster model. At this tier, it is possible for students to obtain post-secondary credits while still in high school. Students are provided the same stringent career and academic preparation regardless of whether they aspire to be a physician, a registered nurse, a biochemist or a medical information technologist.

Another issue is related to the capacity of our community colleges to accommodate the demand for slots in their Associate Degree Nurses Programs (ADNs). Many colleges have long waiting lists of students interested in entering a nursing program. However, the colleges are limited in their ability to expand the number of slots in these programs for several reasons. One of the major factors is the cost associated with nursing and allied health programs. These programs are frequently the most expensive course offerings of community colleges and there currently is no mechanism to fund program expansion upfront. In addition, many colleges reported problems finding Master Degreeed Nurses willing to serve as faculty to allow for more education slots for nursing students or to replace retiring nursing faculty. Under CSSI in the West Central Region, primarily a rural region, in partnership with hospitals, Bachelor Degree Nurses working in the region are being identified to ascertain if they would be interested in pursuing their education toward a Masters Degree in Nursing. CSSI grant funds will pay the students' tuition for this continuing education, so long as they agree to serve as faculty for a period of time at a nurse training program within the region. Another example can be found in the Southeast Region where three healthcare institutions are paying the full salary of a Master Degreeed Nurse to serve as faculty for three years at a community college in the region.

Another obstacle to the capacity of Associate Degree Nursing programs is the fact that there are large waiting lists of qualified students to be admitted to the program. CSSI has allowed for several regions to expand their existing program capacity, frequently in rural areas that do not have an adequate number of clinical slots during the regular school day, by opening up night and weekend clinical slots.

Another innovative approach is being undertaken to expand current capacity by using technology. Three community colleges (Truman College, Kankakee Community College and Triton College) are partnering with us to develop an On-Line Hybrid Associate Degree Nursing Program. This initiative will modify existing nursing programs to add asynchronous, on-line component and pilot test with hospitals providing weekend clinical sites. This should expand the access of nursing programs to adult, working students, including incumbent workers in healthcare facilities. It also has the potential to be expanded to community college districts throughout the state.

In conjunction with Illinois Eastern Community Colleges, a Healthcare Education Innovation Grant was awarded to launch a Rural Healthcare Workplace Program. This program is developing new models to upgrade incumbent workers, such as Certified Nurses Assistants, in rural hospitals and nursing homes to

become License Practical Nurses or Registered Nurses. This “grow your own” strategy holds great potential for rural areas. For this program, we have partnered with healthcare employers in the region, including Richland Memorial Hospital, Crawford Memorial Hospital, Wabash General Hospital, Clay County Hospital and United Methodist Village.

Another innovative approach to “grow your own” is through the use of healthcare “bridge” programs. These programs frequently include integrated English as a Second Language, adult education and technical preparation, as well as career planning. These programs will bridge students, that may include lower-level incumbent workers, dislocated workers, or the under-employed or unemployed, so that they are adequately prepared to enter programs for occupations in the following areas: Registered Nurse; Certified Nursing Assistant; Phlebotomist; Surgical Technician; and, Health Information Technology. Bridge programs currently are underway at City Colleges of Chicago, College of Lake County, Harper College, McHenry County College, Oakton Community College, Prairie State College and Waubesa Community College.

The Associate Degree Nursing Programs are very academically challenging. To help retain students in these programs, it often is necessary to provide support services, including tutoring, mentoring, childcare, and transportation assistance. CSSI funds are being used in most regions of the state to provide some or all of these services to eligible nursing students. Let me put a face to how important these services are to students. CSSI is providing funds to support a Mentor/Tutoring Program for Associate Degree Nursing students at Frontier Community College in Southern Illinois. The goals of the Mentor/Tutor are to foster caring and supportive relationships, assist the nursing student to develop their own vision and plan for the future, provide professional guidance and provide academic help. Kim Belangee, RN/BSN, Frontier Community College’s Mentor/Tutor has focused on these principles. Kim uses a combination approach in her Mentor/Tutor sessions. Reading lists and calendars are prepared for each module the students cover in class. Practice tests are created using NCLEX (the difficult national nurse licensure test) review books. This allows students to target areas of weakness prior to the actual test. One of the students, Jean Ann Fox, reports, “I started the Fall semester without a mentor. I studied really hard but the highest grade I could get was a C. I wasn’t happy with that. It took me a while, but I got approved for the mentoring program about 8 weeks into the semester. After meeting with my mentor, Kim Belangee, I started making A’s and B’s. I couldn’t believe the difference it made. She taught me how to focus and techniques on how to study effectively. She also made practice tests that prepared me for the real test. The practice tests she made were great and helped lessen the anxiety for the real test. She also taught me several test taking techniques that helped me focus while taking the test. I can’t say enough about how much having Kim for a mentor has improved not only my grades but also the quality of my study time. She has truly been a blessing to me.” The Frontier mentoring program currently has five students enrolled for the Fall of 2005 – the pass rate for these students is 100%.

Other CSSI-funded programs are aimed at reducing the high turnover rate of nurses in healthcare facilities. Several programs are being implemented to provide front-line nurse supervisors with supervisory and leadership training that will allow them to better manage the work environment, help reduce stress among the front-line workers and provide better patient care. Another program provides stress management and coping skills training for front-line direct care nurses.

CSSI also is funding Nurse Refresher Programs in several regions to allow for nurses who have left the workforce to raise families or to care for elderly parents to enter a rigorous academic program to refresh their technical skills so that they will be prepared to take the tests needed for relicensure to practice. So far, the demand for these programs has exceeded our expectations, and several regions have increased the number of Nurse Refresher courses being offered.

I hope that these examples give you an idea of the types of innovative approaches being undertaken through public-private partnerships throughout the state. We have many more initiatives underway. In fact, in April of this year, we will be conducting the first-ever Healthcare Forum to discuss innovative approaches to workforce development being implemented throughout the state, enabling peer-to-peer exchange among the healthcare provider, workforce development and education communities, and sharing best practices for replication. Under Governor Blagojevich and Director Lavin, we have made great strides in addressing shortages of critical healthcare workers and creating high-skill, high-wage career opportunities for our citizens. I would be happy to answer any questions you might have.

Testimony on the Health of Rural and Underserved Women and Children

Presented to The Joint Task Force on Rural Health

January 30, 2006

By

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Senator Demuzio, Representative Delgado and members of the Commission:

Thank you for this opportunity to present some information for your consideration about the health status of women of child-bearing age and children in rural areas and underserved populations across the state. I will also present some information on the service providers who comprise the health care safety net and the health services that the Illinois Department of Human Services provides through grants to safety-net providers and other organizations.

I would like to highlight a few well-known indicators of the health status of women and children: early initiation of prenatal care, low birth weight, infant mortality and teen births. These fundamental indicators are the object of many interventions overseen by the Office of Family Health within the Illinois Department of Human Services. There are health problems facing these population groups -- perhaps most notably childhood overweight and mental health -- that I have not included for both brevity and the amount of time available for preparation. I hope and expect that other witnesses will address these concerns.

Maternal and Child Health Status Indicators

Overall, 82 percent of the women who give birth in Illinois each year initiate prenatal care during the first trimester of pregnancy. Early initiation of care is important for maintenance of maternal health and prompt identification and treatment of conditions that could adversely affect the health of both the mother and her newborn. Illinois has been making slow but steady progress on this indicator over the last several years.

When this indicator is examined among various racial and ethnic groups, a pattern of disparity emerges. While nearly 85 percent of Caucasian women and nearly 81 percent of Asian women begin prenatal care in the first trimester of pregnancy, the same is true of only 76 percent of Hispanic women and 71 percent of African-American women.

A different pattern emerges in Illinois' rural counties (which the Center for Rural Health in the Illinois Department of Public Health defines as counties with a total population under 60,000). In these 79 counties, the proportion of women who begin prenatal care in the first trimester of pregnancy is 85 percent, compared to nearly 82 percent in the other 22 "metropolitan" counties. The pattern of initiation of prenatal care is more favorable in rural areas of the state.

Infant who weigh less than five-and-a-half pounds at birth are at increased risk for a number of serious health problems or of dying before reaching their first birthday. The risk increases as birth weight decreases. Overall, 8.3 percent of the infants born in Illinois have a low birth weight.

A similar pattern of disparity is seen in the incidence of low birth weight. The rate among African American infants -- 14.4 percent -- is slightly more than twice the

rate among Caucasian infants (6.9 percent). The rate among Asian infants (8.2 percent) is close to the overall average. The rate is lowest among Hispanic infants (6.4 percent).

Consistent with the differences in initiation of prenatal care, the low birth weight rate in rural counties -- 7.3 percent -- is somewhat lower than the rate in metropolitan counties (8.4 percent).

Illinois' infant mortality rate has been declining steadily -- if not consistently -- for the last three decades. There was a slight increase in the rate in 2003, due to an increase of 76 infant deaths and 1,838 more live births that year when compared to 2002. There was similar increase in 1995, which was followed by a decline in the rate the next year.

Here again there is a pattern of disparity among sub-groups of the population. The mortality rate among African-American infants -- 15.6 deaths per 1,000 live births -- is more than two-and-a-half times higher than the rate among either Caucasian or Hispanic infants (6.1 deaths and 6.2 deaths per 1,000 live births, respectively).

The infant mortality rate in rural counties (6.4 deaths per 1,000 live births) is noticeably lower than the rate in metropolitan counties (7.7 deaths per 1,000 live births).

The disparity in health status that I have noted among racial and ethnic groups is mirrored when these indicators are considered by income. Eligibility for Medicaid or participation in the Department's WIC and Family Case Management programs may be used as a proxy for income, since participants must have an income below 200 percent of the federal poverty standard to be eligible for services. Women from low-income families are much less likely than other women to initiate prenatal care in the first trimester of pregnancy (74 percent and 91 percent, respectively). Their infants are more

likely to have a low birth weight (9.3 percent versus 7.2 percent) and to die before reaching one year of age (7.6 deaths per 1,000 live births, versus 6.9).

Similar patterns are seen in the number of teen births and the proportion of all births that occur to teen-aged mothers. After a steady, ten-year decline in the number of births to teen-aged mothers, there were 149 births to teen-aged mothers in 2004, when compared to 2003. At the same time, the overall number of live births declined by 1,728. As a result, the proportion of births to teen-aged mothers increased from 9.7 percent in 2003 to 9.9 percent in 2004. This number and proportion are still well below those observed ten years earlier. In 1995, there were 24,046 births to teens, and these births represented 12.9 percent of all live births.

In 2003, the proportion of African-American infants born to teen mothers was more than two-and-a-half times greater than the rate among Caucasian infants (20.5 percent versus 7.8 percent). Hispanic infants are also more likely than Caucasian infants to be born to a teen-aged mother (12.8 percent versus 7.8 percent). Asian infants are the least likely to be born to a teen-aged mother (1.6 percent). Infants born in rural counties are somewhat more likely to be born to a teen-aged mother than infants in metropolitan counties (10.7 percent versus 9.6 percent).

The co-occurrence of these risk factors is well known. More than half of the state's African-American population lives in Chicago; Cook County has the largest African-American population of any county in the nation. Also, Chicago has the third-largest Hispanic population among major metropolitan cities. Caucasians account for 89 percent of the total population outside of Cook and the "collar" counties.

Because of the absolute size of the Caucasian population in Illinois, the absolute number of Caucasians living in poverty is greater than the number of African-Americans or individuals of Hispanic ethnicity. When looking at the proportion of individuals of a specific racial or ethnic group living in poverty, however, disparities become apparent: 26.3 percent of Blacks and 15.1 percent of Hispanics (any race) had incomes below the poverty level, compared to 7.9 percent of Whites. The American Community Survey found that 15.8 percent of all children under age 18 lived below poverty in 2003. Approximately 34.7 percent of Black children, 19.6 percent of Hispanic children and 10.1 percent of White children below 18-years-of-age live below poverty.

To summarize this information about health status and population, there are significant disparities in maternal and child health status among racial and ethnic groups, with notably unfavorable patterns among African-Americans, persons of Hispanic descent, low-income families and residents of Illinois' urban counties. These four population groups tend to overlap. With the exception of births to teens, reproductive health indicators are somewhat more favorable in rural counties.

Distribution of Physicians and Health Provider Shortage Areas

There are some surprises in the distribution of primary care physicians across the state. There is one primary care physician (defined as either "family practice" or "general practice" by the American Medical Association) for every 4,565 persons (of all ages) among metropolitan counties. Within these counties, the ratio ranges from a low of 1:2,260 in Adams County to a high of 1:8,813 in Kendall County. The ratio in Cook

County is 1:4,754; in DuPage County, the ratio is 1:3,021.

Surprisingly, the overall ratio in rural counties, 1:3,876, is more favorable than it is in metropolitan counties. However, the range is wider, from a low of 1:1,573 in Ford County to a high of 1:16,990 in Clark County. The ratio exceeded 1:10,000 in eight counties.

The Illinois Department of Public Health's Center for Rural Health has designated all or part of 92 of Illinois' 102 counties as primary health care professional shortage areas (HPSA). This includes all of 22 and parts of 7 counties that have been designated HPSA's for the entire population, all of 55 and parts of 4 counties that have been designated HPSA's for low-income populations, and parts of four counties that have been designated as HPSA's for the entire, the low-income or the homeless population. Within the City of Chicago, 31 community areas have been designated as primary care health professional shortage areas. Further, all of 28 counties and one or more townships in 55 more counties have been designated medically under-served areas or to have medically under-served populations. Within the City of Chicago, 15 community areas have been designated as fully medically under-served areas, 26 have been designated as partially medically under-served areas or to have a medically under-served population. Maps illustrating the counties, communities in suburban Cook County and Community Areas in the City of Chicago that have been designated as Medically Underserved Areas or Healthcare Provider Shortage Areas for primary care, dental care and mental health care are appended to this needs assessment. Access to care due to a limited supply of health care providers remains a problem for both rural Illinois and inner-city Chicago.

Health Care Safety Net

The Illinois Department of Human Services provides grants to support maternal and child health services through, among other types of organizations, local health departments and federally-funded Community Health Centers. Together, these organizations may be considered a large part of the health care safety net for preventive and primary care and play an essential role in the improvement of maternal and child health in Illinois.

Local health departments were first established in Illinois by “AN ACT to authorize the organization of public health districts and for the establishment and maintenance of a health department for the same” (70 ILCS 905/1, effective July 1, 1917). As of July 1, 2004, there were 95 local health departments serving 99.6 percent of the states' population.

The Illinois Primary Health Care Association reports there are 155 Community Health Centers, Federally Qualified Health Centers or Healthy Schools Health Communities grantees in Illinois. Many of these centers provide primary medical care, dental care services, mental health/substance abuse services, obstetrical and gynecological care, or other professional services to low-income and uninsured women and children.

Health Services

The Illinois Department of Human Services provides grants for four state-wide programs to address the problems of infant mortality, child development and teen pregnancy. The Family Planning program provides comprehensive reproductive health

care and contraceptive services to enable women to choose the number and spacing of their children. Unfortunately, the program only has enough resources to serve only one of every five women who need publicly-subsidized reproductive health care. The Family Case Management program assists low-income families with a pregnant woman or an infant to obtain the health care and other human services they need for a successful pregnancy and healthy infant growth and development. The Special Supplemental Nutrition Program for Women, Infants and Children, better known by the acronym, "WIC," provides supplemental foods and nutrition education to low-income families with a pregnant woman or a child under five years of age. Together, these two programs serve more than forty percent of all of the children born in Illinois each year and nearly 90 percent of newborns in low-income families. The Teen Parent Services program provides low-income teen parents with the support and assistance they need to finish school, gain employment and succeed in making the transition from welfare to work.

The Department also has several initiatives targeted to high-need areas of the state. The Chicago Healthy Start Initiative and the Targeted, Intensive Prenatal Case Management project, which recently expanded to new areas with the additional funds appropriated by the General Assembly, works with women who have medical or social risk factors associated with low birth weight in order to reduce the risk of an adverse pregnancy outcome. Through the Closing the Gap initiative, the Department is working with a wide array of service providers and taking steps through media campaigns and peer education to reduce the risk of premature birth and Sudden Infant Death Syndrome in the Austin, Englewood, West Englewood and Auburn-Gresham Community Areas in the City of Chicago. The Department also supports a network of more than 50 Healthy

Families Illinois projects to reduce the incidence of child abuse and neglect by providing family support and parenting education through home visits to at-risk parents.

The Department has several initiatives directed to children and adolescents to improve access to health care services, prevent teen pregnancy and reduce the rate of child abuse and neglect among teen parents. The Department supports a network of 38 school-based health centers in urban, suburban, metropolitan and rural parts of the state. The centers are an important source of primary health care (including sports physicals and mental health services); some centers also provide oral health care. While most centers serve high schools, there centers that serve elementary or middle schools. Each center has a local advisory board that specifies the types of services provided by each center.

There are 55 "primary" teen pregnancy prevention programs across the state, so designated because they target teens who are not yet parents. These programs implement at least two of five evidence-based strategies for the prevention of teen pregnancy, including sexuality education youth development, parental involvement, male involvement and public awareness. These projects are located in communities with high numbers and rates of teen pregnancy.

Similar to Healthy Families Illinois, the Parents Too Soon program provides support and education to first-time teen parents to help develop their parenting skills, them finish school and make a successful transition to adulthood. There are 21 Parents Too Soon programs located in urban, suburban, metropolitan and rural communities throughout the state.

More information about each of these programs may be found on the attached fact sheets. I have concentrated today on the Department's programs to address infant mortality and teen pregnancy and briefly touched on two programs that address the prevention of child abuse and neglect. The Division of Community Health and Prevention is also concerned with early childhood, school health, childhood overweight, positive youth development, substance abuse prevention, prevention of HIV, AIDS and sexually transmitted infections, domestic violence, diabetes and other health problems. The Division is equally concerned about disparities in the occurrence of these health problems in rural and minority problems.

Summary

The Department's maternal and child health programs are effective. Six consecutive annual evaluations have demonstrated that the rates of very-low birth weight, low birth weight, infant mortality and Medicaid expenditures during the first year of life are substantially lower among infants born to Medicaid-eligible women who participated in the WIC and Family Case Management programs than they are among Medicaid-eligible infants born to women who did not participate in either program during pregnancy. This integrated strategy has contributed to the reduction of the state's infant mortality rate and saved millions of dollars in Medicaid expenditures. A graph illustrating the decline in the state's infant mortality rate is attached.

Similarly, the state's efforts to prevent both initial and repeat teen pregnancies have contributed to a sustained reduction in the number of teen births during the last ten

years. The number and rate of teen births reached their second lowest level in state history. The number of teen births has declined by 41 percent in the last 40 years, and is 45 percent below the peak of 32,440 births to teen mothers in 1966. Similarly, the proportion of infants born to teen mothers is at the second-lowest level in the last 40 years and 48 percent lower than the peak of 19 percent in 1973. A graph illustrating the trend in over the last 10 years is attached.

Remaining Challenges

The challenge of reducing the racial and ethnic disparities in health status may be illustrated by the disparity in infant mortality rates between African-American and Caucasian infants. In 2002, this disparity reached its highest level in the last 10 years, when an African-American infant was 2.9 times more likely than a Caucasian infant to die before its first birthday. This gap has consistently exceeded 2.5-fold for the last 10 years.

Professor Helen Wallace of the San Diego University, San Diego School of Public Health once wrote, "*The infant mortality rate is the most sensitive index of the status of economic and social development of any country.*" If Professor Wallace is correct, the disparity in Illinois' infant mortality indicates that more must be done to improve the state's economic and social conditions. The people of Illinois must not permit these disparities to continue.

A Note About The Data

The data presented earlier about initiation of prenatal care, low birth weight, infant mortality and teen births by race and geographic area (metropolitan and rural counties) was from the year 2003. The data about initiation of prenatal care, low birth weight and infant mortality by income was from the year 2001. The data on physician to population ratios is from the American Medical Association for the year 2002.

Attachments

1. Maps illustrating Medically Underserved Areas, Primary Care Healthcare Provider Shortage Areas, Dental Health Healthcare Provider Shortage Areas and Mental Health Healthcare Provider Shortage Areas.
2. Fact Sheets for the Chicago Healthy Start Initiative, Closing the Gap, Family Case Management, Family Planning, Healthy Families Illinois, Parents Too Soon, Primary Teen Pregnancy Prevention School-Based Health Center, Special Supplemental Nutrition Program for Women, Infants and Children, Targeted Intensive Prenatal Case Management and Teen Parent Services programs.
3. Graphs illustrating recent trends in infant mortality, teen births and infant mortality rates by race and origin.

Chicago Healthy Start Program Fact Sheet

Office of Family Health
Division of Community Health & Prevention
Illinois Department of Human Services

Program Description

Target: Pregnant women or mothers parenting a child under the age of two. Women must reside in the Chicago Community Areas of Near North, Near South, Near West, Douglas, Grand Boulevard or West Town

Purpose: To reduce the infant mortality rate (the number of babies who die before reaching one year of age) and related health problems for both mother and baby.

Services: Assistance in getting well child care, immunization, family planning, smoking cessation, prenatal care, social services, WIC, transportation, health education and GED classes, screening for perinatal depression.

Delivery Method: Services are provided through one of four Chicago Healthy Start Family Centers. These centers are operated by Erie Family Health Center, Winfield-Moody Health Center, West Side Future and Henry Booth House.

Program Data

	SFY03	SFY04	SFY05	SFY06
Grant Amount (Numbers in 000's)	\$1,367.5	\$1,374.9	\$1,374.9	\$1,374.9
Number of Grantees	4	4	4	4
Number Served	1,405	1,469	1,643	
Number served may not increase year to year due to women staying in inter-conceptual care for 2 years.				

Program Effectiveness

The Chicago Healthy Start Initiative contributed to a 71 percent drop in the number of infant deaths and a 50 percent reduction in the infant mortality rate in its target area between 1991 and 2002. At the same time, the number of infant deaths in the City of Chicago declined by 55 percent and the infant mortality rate declined by 43 percent.

The initiative has also narrowed the gap between African-American and Caucasian infant mortality by one-third within the communities served by the program. The differences between the mortality rates among these two races is reported as a ratio: white rate/black rate per 1,000 live births. During 1991-93 the average ratio was 2.4:1. During 1997-99 the average ratio was a 33 percent decrease.

The Closing the Gap Initiative Program Fact Sheet

Office of Family Health
Division of Community Health & Prevention
Illinois Department of Human Services

Program Description

Target: The Closing the Gap initiative targets African American women of reproductive age residing in 4 community areas in Chicago. The communities are targeted to improve health systems and distribution of health information to these women who may be pregnant, at high risk for a premature delivery or whose infants may die from low birth weight or SIDS. Targeted areas include Austin and Englewood on the West side and West Englewood and Auburn-Gresham on the South side.

Purpose: The purpose of the initiative is to promote development of community-based health systems with goals to:

- reduce the number of very low birth weight infants born in the project area;
- reduce the number of African-American infants who die from Sudden Infant Death Syndrome (SIDS) in the project area;
- create a better integrated city, state, federal and privately funded system of health services in the project area.

Services: There are no direct services. The program strategies include:

- Public information campaign
- Peer counselors to change community norms on prenatal care and infant sleeping arrangements
- Coordinating other federal, state, and city-funded infant mortality projects
- Blending state and federal funds to finance prenatal and interconceptional case management

Effectiveness: The Department's process evaluation will focus on adherence to the work plan and program model. The outcome evaluation will determine whether the project has decreased the incidence of prematurity and SIDS deaths among program participants. The matched birth and death certificate files will measure and compare changes of infant mortality rates within the targeted areas.

Family Case Management Program Program Fact Sheet

Office of Family Health
Division of Community Health & Prevention
Illinois Department of Human Services

Program Description

- Target:** Low income families (below 200% of the federal poverty level) with a pregnant woman, an infant or a child with a high-risk condition
- Purpose:** The program's goals are to help women have healthy babies and to reduce the rates of infant mortality and very low birth weight.
- Services:** The program conducts outreach activities to inform expectant women and new mothers of available services and then assists them with obtaining prenatal and well-child care. The program works with community agencies to address barriers to accessing medical services, such as child care, transportation, housing, food, mental health needs and substance abuse services.

Delivery Method: Services are provided statewide through local health departments, federally qualified health centers and community-based organizations. Home visits by a public health nurse are provided to the families of infants with medical problems.

Program Data

	SFY03	SFY04	SFY05	SFY06
Grant Amount (Numbers in 000's)	\$44,658.5	\$44,658.5	\$44,174.0	\$44,479.0
Number of Grantees	121	121	117	116
Number Served	366,675	370,290	371,487	

Program Effectiveness

Family Case Management has contributed to the overall reduction in the state's infant mortality and has reduced expenditures for medical assistance during the first year of life. Program outcomes are more effective in the integrated system of Family Case Management and WIC. Together these programs served 43 percent of all pregnant women and more than 83 percent of all Medicaid-eligible women. The proportion participating in both programs experience better birth outcomes. The rate of premature birth is more than 67 percent lower; low birth weight is more than 41 percent lower; infant mortality is more than 72 percent lower and health care expenditures during the first year of life are more than 36 percent lower.

Family Planning Program
Program Fact Sheet
Office of Family Health
Division of Community Health & Prevention
Illinois Department of Human Services

Program Description

Target: Low-income women and adolescents of reproductive age

Purpose: Family Planning Program services are provided to enable individuals the information and means to exercise personal choice in determining the number and spacing of their children through the provision of effective family planning medical services, methods and education (including abstinence).

Services: Family Planning Services are confidential and include:

- physical exams, including *medical screening* for cancer (breast, cervical, colorectal), pregnancy, and testing & treatment of sexually transmitted diseases;
- *medical education at clinics* on the prevention of sexually transmitted diseases, infertility, birth control, preconceptional health, counseling on pregnancy options and emergency contraception;
- *community education services*, including workshop programs for schools and other community groups, consultation and training for professionals and educational outreach for parents and teens; and
- *special services*, not available at all sites, for sterilization (tubal ligation and vasectomy), limited services for males, and special clinic services for teens.

Delivery Method:

Services are delivered from 114 clinic sites operated by 54 delegate agencies, which includes health departments, Planned Parenthood agencies, hospital-based clinics, federally qualified health centers and other community-based organizations.

Program Data

	SFY03	SFY04	SFY05	SFY06
Grant Amount (Numbers in 000's)	\$11,172.0	\$10,945.0	\$11,140.0	
Number of Grantees	55	54	54	54
Number Served*	149,710	150,050	151,223	
*Note: Data is for Calendar Year.				

Program Effectiveness

The program has been successful in meeting its goals for serving high-risk populations. In SFY05, the program served 42,186 adolescents, nearly reaching the goal of 93% by serving 45,450 persons; and 133,306 of low-income adults, exceeding the goal of _____% by serving 128,775 persons. The program averted 31,491 pregnancies in SFY05.

Healthy Families Illinois

Program Fact Sheet

Office of Family Health
 Division of Community Health & Prevention
 Illinois Department of Human Services

Program Description

Target: Families with newborns who are at risk of child abuse or neglect. Some programs may target more specific populations (e.g., first-time teen parents).

Purpose: Healthy Families Illinois seeks to prevent child abuse and neglect and to promote healthy development by helping to build strong parent-child relationships.

Services: Participants receive information and referrals to:

- Improve family functioning, through:
 1. Development of improved problem-solving skills
 2. Identification and improved access to family support systems
 3. Development of self-sufficiency goals for teenage parents including completion of high school, or its equivalent, and the delay of subsequent births.
- Promote healthy child growth and development
- Promote positive parent/child relationship

Delivery Method: Services are provided through intensive home visits, commencing bi-weekly during the first pregnancy or weekly within three months of the birth of the first child. After six to nine months of weekly home visits, the frequency of contact may be reduced based upon the needs of the family. Home visitation may continue at least quarterly through the first five years of the child's life.

Program Data

	SFY02	SFY03	SFY04	SFY05
Grant Amount (Numbers in 000's)	\$9,062.6	\$9,455.6	\$9,455.6	\$9,455.6
Number of Grantees	53	52	52	52
Number Served	3,800	3,645	3,850	4,644

Program Effectiveness

SFY '05

- Nearly 100% of children who turned three months during the fiscal year received their first home visit prior to the three-month birth date.
- Over 90 percent of HFI participants were connected with other needed services, including Medicaid, Family Case Management, WIC and Early Intervention Services.

**Parents Too Soon (PTS)
Program Fact Sheet**

Office of Family Health
Division of Community Health & Prevention
Illinois Department of Human Services

Program Description

- Target: New and expectant teen parents in several communities
- Purpose: To provide support and assistance to teens who became parents
- Services: Services focus on nurturing relationships between mother and child, improving the health and emotional development of the teen and her child, delaying subsequent pregnancies, and completing school. The Department's grantee is the Ounce of Prevention Fund, which oversees 21 community-based sites.

Delivery Method Weekly home visits and peer group meetings

Program Data

	SFY02	SFY03	SFY04	SFY05
Grant Amount (Numbers in 000's)	\$4,672.1	\$4,390.8	\$3,900.6	\$3,900.6
Number of Grantees	1	1	1	1
Number Served	3,200	4,521	3,560	3,965

Program Effectiveness: SFY05

- 3.2% subsequent birth rate
- 98.5% completed parenting skills instruction

By 12 months of age

- 89.6% received three well child visits
- 88.1% fully immunized
- 96.8% screened for developmental delay

School Health Centers Program Fact Sheet

Office of Family Health
Division of Community Health & Prevention
Illinois Department of Human Services

Program Description

Target: The students enrolled in an individual school if the center is school-based or students attending one or several schools within the district if the center is school-linked. All students must have parental permission to receive services unless otherwise allowed by law.

Purpose: The purpose of the school health center is to improve the overall physical and emotional health of students by promoting healthy lifestyles and by providing easily accessible preventive and acute health care when it is needed.

Services: Routine medical care, physical exams for school or sports, laboratory services, sexually transmitted disease testing and treatment, immunizations, gynecological exams, family planning, pregnancy testing, nutrition services, drug and substance abuse counseling, mental health counseling, transportation, health education (including nutrition, substance abuse prevention and sex education and the promotion of abstinence), and referrals to other services as necessary.

Delivery Method: Services are provided by licensed professional medical staff as required by the Illinois Standards for School-Based/Linked Health Centers. DHS provides grant funds to non-profit agencies to provide the services.

Program Data

	SFY03	SFY04	SFY05	SFY06
Grant Amount (Numbers in 000's)	\$3,956.0	\$3,956.0	\$3,987.0	\$4,108.0
Number of Grantees	34	37	38 operational 3 planning	41
Number Served	26,400	26,700	28,800	

Program Effectiveness: SFY05

- Of the total grantee school population (127,298), 64.3 percent of the students received services in the health centers.
- There were 225462 students seen in 59,486 medical encounters for an average of 2.34 visits per student.
- Health education in the classroom by the center's health staff reached 32,320 students.
- Grantees increased the amount billed to 3rd party payers for reimbursement by \$1,042,750.

**Targeted Intensive Prenatal Case Management
Program Fact Sheet**

Office of Family Health
Division of Community Health & Prevention
Illinois Department of Human Services

Program Description

- Target:** Pregnant women who are at risk for having a premature birth and/or a low birth-weight baby and reside in seven targeted counties in downstate Illinois (Will, St. Clair, Peoria, Macon, East St. Louis, Vermilion and Winnebago); 12 communities in suburban Cook County (Bellwood, Maywood, Harvey, Riverdale, Markham, Hazelcrest, Homewood, Matteson, Dalton, Chicago Heights, Calumet City, Country Club Hills); and 15 community areas in Chicago (North Lawndale, East/West Garfield, Humboldt Park, Roseland, Burnside, Auburn-Gresham, Austin, South Shore, South Chicago, Woodlawn, Avalon Park, Calumet Heights, Washington Heights and Morgan Park). 14 of these communities were added in SFY'06.
- Purpose:** The program works to ensure the probability that participants will deliver infants weighing 5.5 pounds or more.
- Services:** The program helps pregnant women receive prenatal care and other needed medical and social services, including WIC.
- Delivery Method:** Registered nurses and social workers work with the pregnant women in the program. These case managers visit eligible participants twice each month to ensure that they are getting the services they need.

Program Data

	SFY03	SFY04	SFY05	SFY06
Grant Amount (Number in 000's)	\$2,438.0	\$2,438.0	\$3,085.7	\$4,949.4
Number of Grantees	10	10	10	13
Number Served	2,935	3,018	3,062	

Program Effectiveness

The low birth weight rate among participating women was 16 percent in SFY02 and 12 percent in SFY03. The program is reaching its intended target population. The three most common reasons why participants became eligible for the program were the presence of diseases that affect pregnancy (24 percent), having several closely spaced pregnancies (12 percent) and a prior pre-term birth (11 percent).

Teen Pregnancy Prevention - Primary Program Fact Sheet

Office of Family Health
Division of Community Health & Prevention
Illinois Department of Human Services

Program Description

- Target:** Adolescent boys and girls in selected high need areas of the state.
- Purpose:** To reduce first-time teenage pregnancy, sexually transmitted diseases and HIV/AIDS infection, improve access to health services and increase the role of the schools in improving adolescent health.
- Services:** Based on a community needs assessment, providers use three or more of the following strategies:
 sexuality education, family planning information and referral
 youth development
 parental involvement
 male involvement
 public awareness

Delivery Method Services are planned by community-based organizations, public, private, or not-for-profit agencies via either in a classroom or community settings and/or after school program.

Program Data

	SFY02	SFY03	SFY04	SFY05
Grant Amount (Numbers in 000's)	\$1,212.3	\$1,780.6	\$2,393.3	\$2,393.3
Number of Grantees	44	49	55	55
Number Served	95,850	124,200	119,660*	97,541*

* The SFY05 number of teens served is an unduplicated count. This unduplicated number of teens reach does NOT include the public awareness program component. ONLY sexuality education, youth development, parental involvement and male involvement in school and after-school education and activities are included in the number served.

Program Effectiveness

<u>Year</u>	<u>Percent teen births</u>
2004	9.9%

Teen Parent Services (TPS) Program Fact Sheet

Office of Family Health
Division of Community Health & Prevention
Illinois Department of Human Services

Program Description

- Target:** Pregnant or parenting low income teens who are age 20 or younger and do not have a high school diploma (or its equivalent). Participation is mandatory for teen parents on TANF.
- Purpose:** To increase below-post-secondary school completion, reduce subsequent pregnancy, improve parenting skills, increase the rate of the immunizations, well baby visits and screening for developmental delay of the teen parent's children
- Services:** Intensive and holistic case management; information, service referral, coordination and follow-up for social and medical services; payment of education and work related fees/expenses. Conducts life-skills and parenting workshops and other workshops of interest.

Delivery Method Family assessment of strengths, barriers, family issues, educational and career goals and development are outlined in a plan which includes long and short-term goals and activities required to accomplish goals.

Program Data

	SFY02	SFY03	SFY 04	SFY05
Grant Amount (Numbers in 000's)	\$4,450.5	\$4,815.0	\$4,800.0	\$5,550.0
Number of Grantees	77	82	85	88
Number Served	7,825	7,170*	8,210	8,649
*decrease due to an increase in the number of teens staying in the program and in school				

Program Effectiveness:

SFY05 TPS Outcomes
<ul style="list-style-type: none"> • 67.5% teens completed high school or obtained GED • 85% in an educational activity • 1.3% had a subsequent birth • 71.9% received research based parenting skills instruction <p><u>Children 12 months of age:</u></p> <ul style="list-style-type: none"> • 91% received three well child visits by age one • 88% were fully immunized • 87.9% were screened for developmental delay by age one

WIC (Special Supplemental Nutrition Program for Women, Infants and Children) Program Fact Sheet

Office of Family Health
Division of Community Health & Prevention
Illinois Department of Human Services

Program Description:

- Target:** Income-eligible pregnant, breastfeeding and postpartum women, as well as children up to 5 years of age, who have a medical or nutritional risk
- Purpose:** To improve the health and nutritional status of women, infants and children; to reduce the incidence of infant mortality, premature births and low birth weight; to aid in the development of children; and, to make referrals to other health care and social service providers
- Services:** The WIC program serves approximately 40 percent of Illinois live births. The program provides health screening, nutrition education and counseling, breastfeeding promotion and support, supplemental foods and referrals to other health services.

Delivery Method: A client applies at the most convenient of approximately 220 clinic sites run by local health departments, not-for-profit health and social service agencies and federally qualified health centers. Health screening, nutrition education, breastfeeding promotion and support and coupons for supplemental foods are delivered on-site. Participants receive food prescriptions based on their nutritional needs. WIC foods include nutritionally appropriate foods and infant formula. Food products are obtained at grocery stores statewide or at WIC Food Centers in some areas of Chicago.

Program Data:

	SFY03	SFY04	SFY05	SFY06
Grant Amount (Numbers in 000's)	\$122,000.0	\$124,250.0	\$137,000.0	\$139,000.0
Number of Grantees	98	100	100	100
Number Served	503,425	508,250	516,500	518,000

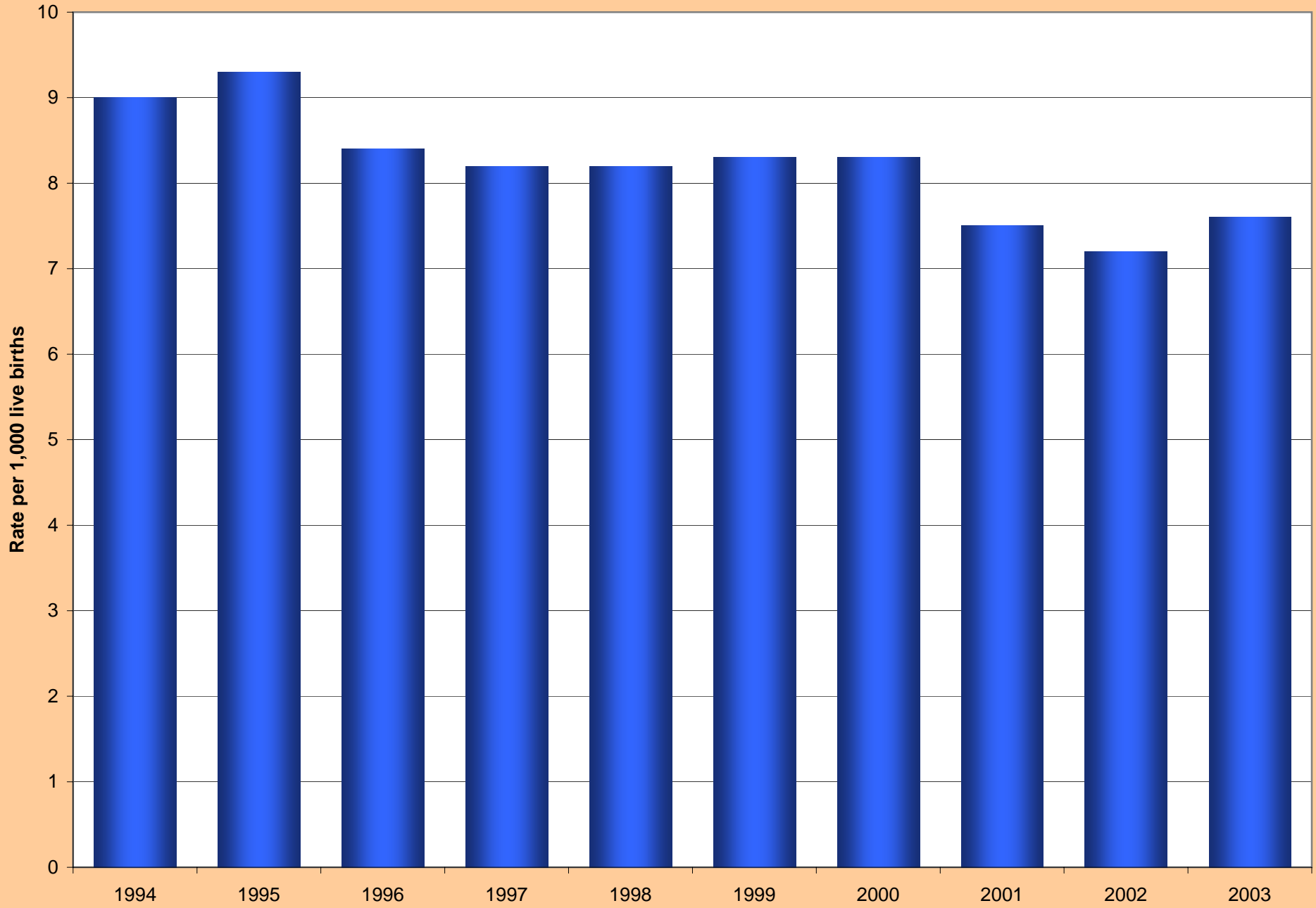
Program Effectiveness:

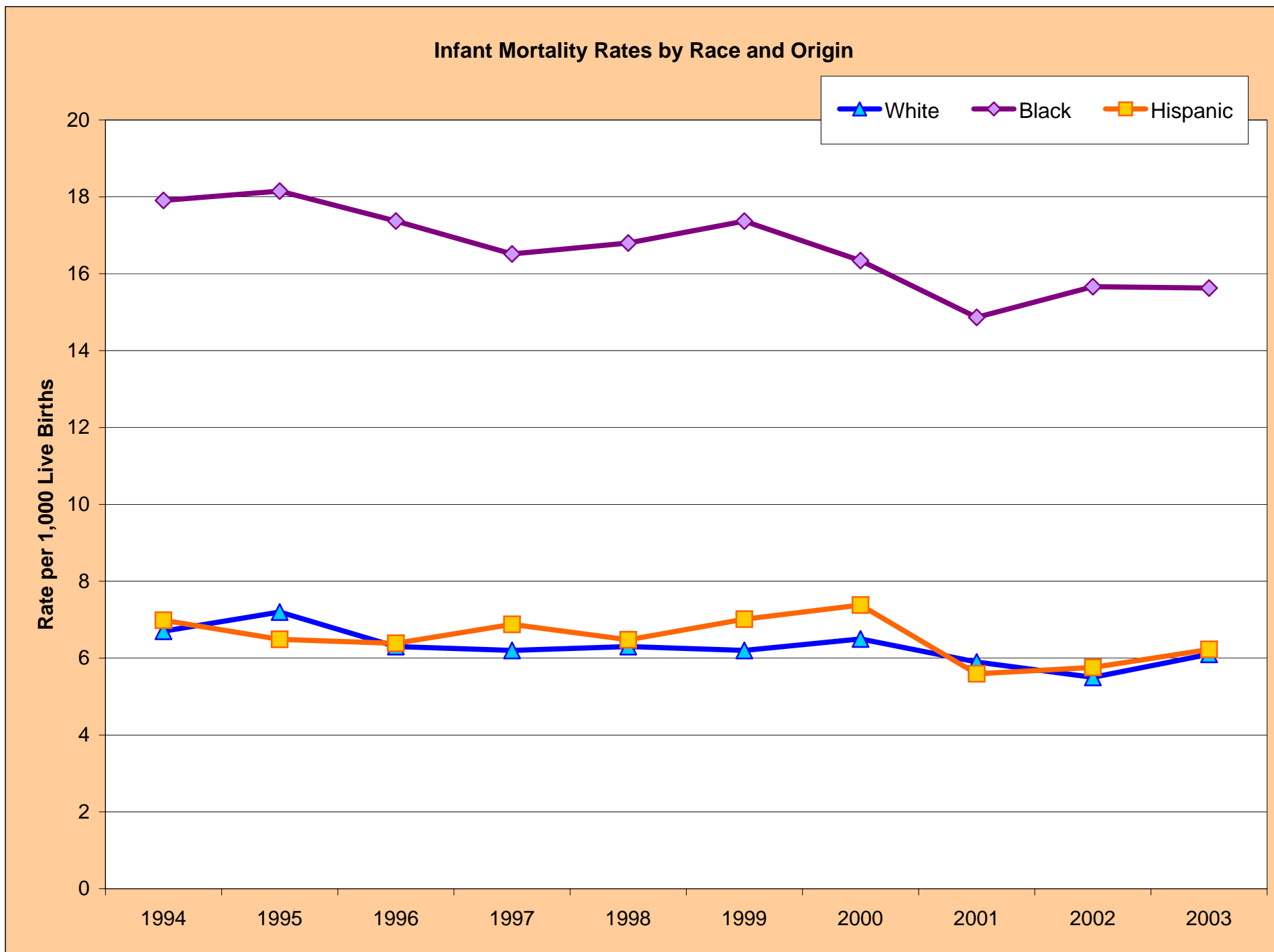
- The rate of infant death to WIC and FCM program participants was 5.8 per 1,000 and for non-participants was 16.2 per 1,000 in 2001 (most recent data to date)
- WIC has established a shared public health goal of 90 percent complete immunizations for participant children by age 2. In the last five years, this percentage has increased from 58 percent to 89.9 percent for 12-23 month olds and from 43 percent to 80.4 percent for 24-35 month olds. (2005 data)
- WIC encourages breastfeeding: the breastfeeding initiation rate has increased from 35 % in 1997 to 63% (2005 data)

Births to Teen Parents (Number and Percent)



Illinois' Infant Mortality Rate







FOR IMMEDIATE RELEASE

May 4, 2006

**Gov. Blagojevich thanks Illinois General Assembly for
 Swift Passage of Critical Nursing Legislation**

Measure will help stem nursing shortage; ensures adequate level of frontline healthcare providers as baby-boomers age; Legislation also creates a scholarship program to help retain forensic scientists at state DNA testing labs

SPRINGFIELD – Governor Rod R. Blagojevich today applauded the Illinois General Assembly for passing legislation that will allow Illinois to recruit, train and retain nurses that will be critically needed to help provide quality health care to Illinois patients, and to meet the growing health care needs of Illinois' aging baby boomer generation. The legislation, first outlined in the Governor's budget address, will increase the number of faculty available to train nurses, make it more affordable for nursing students to attend school, and improve working conditions for nurses through a new Center for Nursing. **Senate Bill 931**, sponsored by Senators Maggie Crotty (D – Oak Forest) and Carol Ronen (D – Chicago), and Representative Lou Lang (D – Skokie), passed final legislative action in the Senate today, after being unanimously passed in the House, and is now headed to the Governor's desk for his signature.

"Well-trained and committed nurses are essential in our ongoing effort to ensure access to health care for all Illinoisans. As the baby boomers grow older, we face the challenge of providing for their growing demands on the healthcare system," said Gov. Blagojevich. "Nurses are on the frontlines in providing care. It is time to train and develop a new generation of nurses so that patients can count on the high quality of care they're entitled to."

The number of potential caregivers, including nurses, is projected to decrease 4.2 percent between 2000 and 2020, while the number of those who need care is projected to increase by 31 percent. All told, by 2020 Illinois could be facing a shortage of over 21,000 nurses. According to region-by-region numbers put together by the Illinois Department of Commerce and Economic Opportunity (DCEO), the state currently has a nursing shortage of 7 percent (vacancies vs. jobs filled) and that shortage is projected to grow to almost 8,000 registered nurses and 1,200 licensed practical nurses (per year, projected through 2010).

"We've heard a lot in recent years about getting doctors to come to or stay in Illinois, but we haven't talked enough or done enough to encourage the nursing field," said Sen. Crotty. "However, without well educated and committed nurses, Illinois will still face a health care crisis. This legislation will enhance our ability to provide the quality of care Illinoisans deserve."

"With passage of SB 931, we have resolved one of the primary causes of our nursing shortage -- a lack of nursing faculty and training venues," said Sen. Ronen. "By providing grants to nursing schools, we can ensure that quality nurses are produced for the state of Illinois."

"Passage of this bill demonstrates that Illinois has made a firm commitment to the nursing profession," said Rep. Lang. "With this legislation, we are creating opportunities for nurse educators that this state desperately needs. Without the support of Governor Blagojevich and my colleagues in the General Assembly, Illinois would be facing a crisis in direct care of its residents."

“The Illinois Nurses Association is pleased to support Governor Blagojevich’s Nursing Initiative. His and the General Assembly’s support of nursing legislation these past two years demonstrates their understanding of the danger of the growing nursing shortage in Illinois,” said Kathleen M. Perry RN PhD, President, Illinois Nurses Association (INA). “The INA has worked hard to demonstrate that an investment in the nursing profession is an investment that will produce positive health dividends for the citizens of Illinois.”

“Nurses are leaving nursing every day to a different career that’s less demanding, less stressful, pays more and gives them their life back,” said Gail Van Kannegan, APN, NP, a family nurse practitioner at Quincy Medical Group and president of the Illinois Society for Advanced Practice Nursing. “Governor Blagojevich understands that increasing the enrollment in nursing schools is not as easy as opening up the doors. There needs to be space available and there needs to be qualified instructors to do the teaching. This legislation will allow those needs to be filled.”

The Governor’s proposal was developed after consultation with leaders in nursing education in Illinois. Administration officials met with teaching hospitals, accredited nursing schools and representatives of various nursing associations in the state. The legislation signed today will address the shortage of nurses in a number of ways:

Nursing Center – establishes a nursing center that will be responsible for assessing the current supply and demand for nurses in Illinois and developing a strategic plan to ensure that the state can train, recruit and retain the nurses that are needed. The newly created advisory board will work with nursing schools, hospitals, and nurses from varied geographic regions and specialties to make recommendations for long-term systemic changes that may be needed.

Nursing Educator Scholarships – creates a Nurse Educator Scholarship Program, to be administered by the IL Student Assistance Center (ISAC). The Program awards scholarships for nursing education students to cover tuition, fees and living expenses for training as nurse educators. In exchange, the newly trained educators must commit to teaching at an Illinois nursing school for at least five years.

Changes to Existing Nursing Scholarships – amends the existing nursing education scholarship law to allow merit, in addition to financial need, to be taken into consideration when determining recipients of the nursing scholarship. Students who have both financial need and the proven ability to meet the rigorous academic standards needed to complete nursing programs are more likely to complete their education and work in the nursing field.

Nurse Educator Loan Repayment Program – creates the IL Nurse Educator Loan Repayment Program through ISAC. The program allows current nurse educators to receive \$5,000 in student loan forgiveness a year, for up to four years. For every year of student loan forgiveness they receive, they must agree to continue working as a nurse educator. To be eligible, a nurse educator must be a resident of Illinois and have worked for at least a year teaching in a nursing program in Illinois. This program will be up and running next year.

Competitive Grant for Nursing Schools – establishes a competitive grant for nursing schools to increase the number of nurses graduating from Illinois nursing programs. The grants can be used for a number of purposes, including but not limited to: student retention programs, increasing faculty, increasing clinical space, creation of an evening or weekend program, and tutoring programs for the national nursing licensing exam. The program will be administered by the IL Board of Higher Education.

Fellowships for Nursing School Faculty – establishes the Nurse Educator Fellowship Program, to be administered by the IL Board of Higher Education. The Program will award fellowships, on a competitive basis, to supplement the salaries of nursing school faculty.

The legislation also contains an initiative that is part of the Governor's comprehensive Prairie State DNA Institute plan to enable the state to do all forensic testing in its own labs. One of the biggest challenges the state faces when it comes to DNA testing is training and retaining enough forensic experts to work in its labs. The bill creates a scholarship program that would help cover the cost of graduate-level forensic science degrees at Illinois universities for students who agree to work in state labs for at least four years after graduation. Testing forensic samples at state facilities is both more efficient and more cost-effective, and allows for better quality assurance.

Since 2003, Governor Blagojevich has taken a broad array of actions to deal with the nursing shortage and improve the working conditions for Illinois nurses. They include:

Critical Skills Shortage Initiative (CSSI): The Governor made a commitment in his 2005 State of the State speech to address the shortage of health care workers through his Critical Skills Shortage Initiative (CSSI). Approximately \$10 million is being invested statewide to ensure that every region of the state has a well-trained and equipped workforce in the health care industry. Through an innovative approach that is currently being replicated by Indiana, Local Workforce Investment Boards, area employers, economic development professionals, educators and service providers are developing individualized strategies to address local employment needs and to get more health care professionals into the workforce.

Enhancing the Nursing Education Scholarship Program: The Nursing Education Scholarship Program has increased its effectiveness with additional funding included in the reauthorization of the Nursing Practice Act, signed by Gov. Blagojevich in 2004. The Act increased the percentage of license fees that are transferred into the scholarship program. In 2006, there will be \$1.2 million – an increase of \$450,000 – to provide approximately 150 students with financial assistance to pursue an associate degree in nursing, an associate degree in applied sciences in nursing, a hospital-based diploma in nursing, a baccalaureate degree in nursing, a graduate degree in nursing, or a certificate in practical nursing.

Streamlining the license process: Through a coordinated effort by the Governor's Office, the Department of Financial and Professional Regulation (IDFPR) and the Illinois State Police (ISP), 800 nurse-licensing applications were reviewed and approved since the Governor's announcement in the State of the State address. Since 2001, Illinois has required nursing professionals to submit to a background check as part of the application process. A backlog of more than 1,800 applications had built up since the law was enacted. Both IDFPR and ISP have developed comprehensive guidelines for dealing with licensed fingerprint vendors to ensure that backlogs do not recur in the future.

Keeping nurses in Illinois: A new law enables advanced practice nurses to be licensed in more than one specialty without having multiple graduate degrees as long as they have the educational and clinical experience to be nationally certified. This encourages highly trained advanced practice nurses to stay in Illinois by making it easier for them to advance in their careers.

Establishing a first-in-the-nation externship program: Nurses who are licensed under the laws of another state or territory of the U.S., primarily from Puerto Rico, who wish to practice in Illinois and are preparing to take the National Council Licensure Examination, are now allowed to work under the direct supervision of a registered professional nurse licensed in Illinois while they are enrolled in a course which prepares them for the licensure exam and acclimates them to nursing and health care delivery in our state. This increases diversity within the nursing profession and prepares nurses educated in a U.S. territory for practice in Illinois.

Health Issues Confronting Rural Illinois

**Testimony by the Illinois Institute for Rural Affairs
Western Illinois University
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Presented To:

Joint Task Force on Rural Health
Springfield, Illinois

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ACRONYMS

EMS	Emergency Medical Services
GRAC	Governor's Rural Affairs Council
HPSA	Health Professional Shortage Area
ICCS	Illinois Coalition for Community Service
IDPH	Illinois Department of Public Health
IFB	Illinois Farm Bureau
IIRA	Illinois Institute for Rural Affairs
IPLAN	Illinois Project for Local Assessment of Needs
IRHA	Illinois Rural Health Association
IRLP	Illinois Rural Life Panel
MAPPING	Management and Planning Programs Involving Non-metropolitan Groups
RCDI	Rural Community Development Initiative
RETAC	Rural Economic Technical Assistance Center
USDA	United States Department of Agriculture
WIU	Western Illinois University

INTRODUCTION

Residents of rural Illinois struggle to gain access to health care services, especially when compared to residents of metro areas. This written testimony describes overall demographic trends in Illinois, which then provides the context for explaining the impediments to rural health care. One of the policy points of this testimony is that there is a direct and mutually reinforcing connection between the quality of rural health care and the economic health of rural regions in Illinois. In other words, it is imperative to discuss rural health in the context of a holistic approach to rural community economic development. For example, hospitals are one of the major employers in rural counties and must have a thriving economic base for continued survival. The reverse of this is also true in rural areas-the closing of such an institution can have a dramatic effect on the economic vitality of a community. The Illinois Institute for Rural Affairs (IIRA) at Western Illinois University (WIU) has delivered outreach services and conducted research in rural community health. Our testimony is based on this experience. More information about the IIRA and its rural health programming can be found in Appendix A and Appendix B.

PART I. DEMOGRAPHIC TRENDS IN RURAL ILLINOIS

Population Trends

The 2000 Census provides valuable information for examining demographic trends, which ultimately affect the health care system. Key demographic trends affecting rural health include:

1. The rural population in Illinois rose only slightly (1.1%) between 1990 and 2000, which is very low when compared with rural population growth rates in neighboring states (7.6 %). Metro counties in Illinois increased 10.1% compared with a 9.9% increase in adjacent states. This means that there is a growing gap between rural and urban population growth rates in Illinois.
2. The youth population (less than 18 years) declined 3.9% in rural Illinois compared with an increase of 2.5% in adjacent states, between 1990 and 2000. Metro counties in Illinois grew 12.8% compared with an 8.7% increase in surrounding states. This means that there is a growing concentrating of elderly in rural Illinois counties.
3. Some rural areas are losing elderly population. Rural Illinois counties lost 1.6% of their elderly compared with a gain of 4.0% in surrounding states. Illinois metro counties gained 6.1% compared with a gain of 8.5% in adjacent states. In many cases, the elderly must leave their homes to find appropriate housing options.
4. Within Illinois, the rural counties that have experienced continued declines during the past 20 years are mainly in western, southeastern, and southwestern Illinois.

Rural areas still have a large number of elderly residents. The very young and the elderly with chronic conditions are the major users of health care services in rural regions. But recent research shows a decline number of pharmacies, health care agencies, and specialists (Walzer et al 2002). If this trend is not reversed, rural residents will have to relocate to metro areas to access services.

Employment Trends and Poverty

1. The unemployment rate (Census 2000) in non-metro Illinois counties was 5.9% compared with 5.2% for non-metro counties in surrounding states. Metro Illinois counties also exceeded their counterparts in surrounding states (6.1% versus 4.9%). In 2005, the unemployment rate was 5.5% in non-metro areas and 5.8% in metro Illinois. The closing of a rural business has a disproportionately large impact because it is more difficult for dislocated workers to find new jobs in rural communities. Increased unemployment also strains the health care system because fewer people may have health insurance.
2. Employment in services in rural Illinois increased 32.8% compared with a 41.7% increase in adjacent states. The growth in services was also less in rural Illinois but, percentage-wise was comparable with metro Illinois. Surrounding states are gaining elderly population in rural areas and providing increased employment in the service sector. The service sector encompasses a variety of occupations, including health care and other amenities a community might need to support the shifts in population.
3. Another trend identified by Walzer et al. (2002), is the migration of young families out of rural areas. Young families are migrating to find better-paying jobs in metro areas, thus lowering the rural tax base to provide services. This also provides a strain on rural health care systems as local health care dollars are also shifting to metro areas. It is becoming essential to examine creative solutions to retaining health care dollars in rural areas.
4. Forty-two of the 74 rural counties have at or above the state percentage of total poor persons (11.3%). Alexander, Jackson, and Pulaski Counties have the highest percentage of total poor persons for rural Illinois.
5. Thirty-two of the 74 rural counties are above the state average poverty rate (15.3%) for children age 0-17. Nine counties in rural Illinois report that 20% or more children are in poverty. Alexander, Pulaski, and Saline Counties have the highest child poverty rates.

Income and Wage Trends

1. Per capita income, in constant dollars, increased 15.4% in rural Illinois compared with 19.3% for counterparts in surrounding states.
2. The gap between the average wages paid in rural versus metro areas has widened from \$5,203 to \$8,178 in constant dollars since 1980.

Rural areas are characterized by low-wages across all sectors including health care. Rural providers are working longer hours with less compensation with far less resources than their urban counterparts. Professional coverage for these rural providers is also an issue, as well as retaining and replacing current providers. Income and wage trends in rural areas also influence allied health professionals. Most rural areas cannot compete with the metropolitan areas for salaries, amenities, professional support, and workload. More support data is in Appendix C.

PART II. RURAL HEALTH TRENDS

In rural Illinois, strides have been made to improve the overall infrastructure of our vulnerable system. The rural health agencies, organizations, universities, and key stakeholders work together to continue improving health care for rural residents. According to the Illinois Rural Health Association (IRHA) Membership Survey and the Illinois Farm Bureau (IFB) Survey, the key issues in rural health include access to primary health care, dental health, mental health, emergency medical services, the threat of methamphetamine drug use and related criminal activity, and the high numbers of under and uninsured. Other issues affecting rural health care include medical liability, lack of preventative services, recruitment and retention of health care professionals, the rising costs and demands of meeting the needs of an aging population.

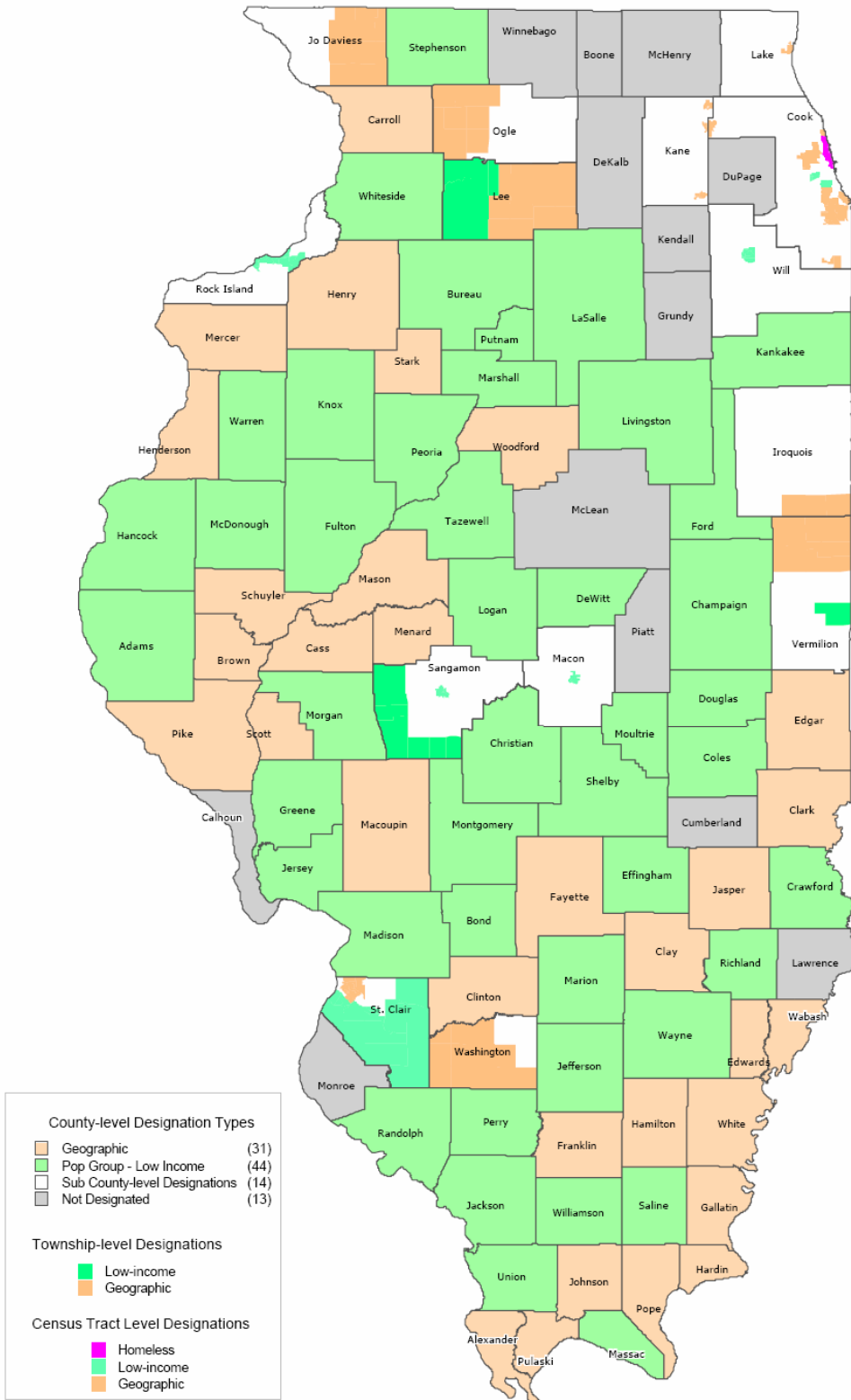
Rural leaders in Illinois were only slightly critical in rating health care on the 2003-2004 Rural Leaders Questionnaire. Concerns for rural leaders include transportation to health care services, local wages, housing concerns, and workforce issues. These findings reinforce the idea that rural health care access must be addressed through a holistic, multi-factor strategy that improves rural health issues in the context of economic development.

Access to Health Care

1. According to the Illinois Rural Life Panel (IRLP), 7.9% of participants did not have a primary care provider. Eight-two percent reported their primary care provider was a general physician. Few respondents used physician's assistants or nurse practitioners.
2. An estimated 4.6% of IRLP respondents indicated private or public transportation was an issue in receiving medical care.
3. In Illinois, 68 rural counties are designated as Health Professional Shortage Areas (HPSA) for primary care by the Illinois Department of Public Health (IDPH). Many counties have deficient services for Medicaid and low-income residents (Fig. 1).
4. According to the Rural Leaders Questionnaire conducted from 2003-2004, respondents indicated the quality of life in rural areas would be affected by access to health care. Data revealed this was particularly important for those over the age of 65. Rural leaders also indicated access to services for seniors would negatively affect their community.
5. The IRLP Survey revealed a statistically significant ($p = .05$ or less) difference between the satisfaction of older and younger respondents with basic medical care services. Younger respondents were less satisfied with medical services.
6. Transportation to clinics, hospitals, specialists, and other primary care providers is crucial when caring for low-income families, the elderly, and those with disabilities (IIRA 1999).

Ensuring quality health care in rural areas involves having access to transportation, investments in relevant technology, recruitment and retention of health care providers, adequate and timely reimbursement for services provided, and availability of specialists.

Figure 1. Federally Designated Primary Care HPSAs in Illinois, 2005



Source: Illinois Department of Public Health, Center for Rural Health

Underinsured/Uninsured

There is a chronic problem of people in rural Illinois having inadequate or no access to health insurance (Table 1):

1. According to the Illinois Rural Life Panel (IRLP) conducted in 2005, 6.2% of respondents indicated having no health insurance coverage, 5.7% indicated their spouse was not covered, and 11.5% indicated their children were not covered and their health care costs were paid out of pocket.
2. Participants in the IRLP indicated that the cost of health care services kept them from seeking medical care, preventive care, or prescription services (33.2%). Ultimately, this makes health care costs more expensive because patients then increasingly rely on expensive emergency services rather than the more cost effective preventative approach.

Many individuals without health insurance wait until emergency services are required to receive care. The individuals cannot afford the cost of regular health care, but the cost of treating them in the emergency department followed by hospitalization is far greater than routine medical care.

Table 1. Health Care Coverage and Utilization for Illinois: Metro vs. Non-metro Counties (Illinois Behavior Risk Factor Surveillance System 2003)

	Metro		Non-metro	
	Count	Percent	Count	Percent
Have Health Plan*				
Yes	3,065,798	91.1	1,311,687	89.3
No	299,363	8.9	157,919	10.7
When last had a health plan*				
Within past year	110,453	36.4	43,764	29.0
Greater than 1 year or never	193,191	63.6	106,917	71.0
Avoided doctor because of cost*				
Yes	259,192	7.7	129,235	9.1
No	3,107,927	92.3	1,297,241	90.9

*Individual county health surveys were performed between 1996 and 2000.

Metro counts do not include the Chicago area.

Source: Improving Local Health Care Access: Innovative Approaches to Meeting Rural Health Demands, 2003.

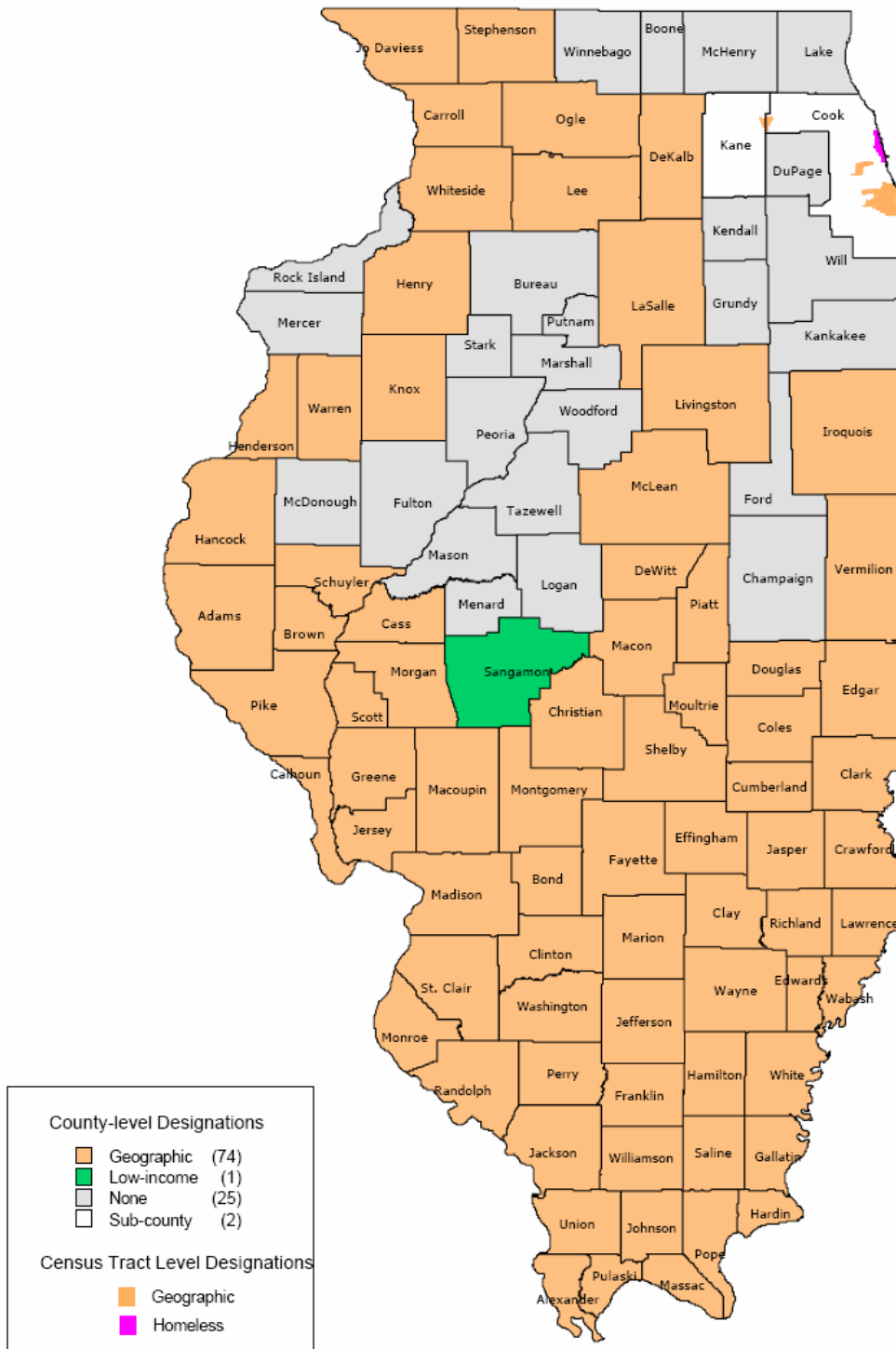
Dental Health

1. Rural dentists are retiring and are having difficulties finding replacements. Some dental health providers are cutting hours and only accepting private insurance. Those covered by Medicaid or KidCare have to travel to receive basic dental services (IFLOSS Coalition, 2002). The statewide oral health plan addresses the need to expand the dental work provided in rural areas (IFLOSS Coalition 2002).
2. In 2005, regional focus groups in west central Illinois prioritized areas of concern. Participants ranked oral health as the number one concern. The group identified gaps in services throughout the region. Even if low-income dental clinics are established throughout the region, recruiting a dentist to serve in the clinics is a difficult and expensive process.
3. In Illinois, the number of dental schools declined from 4 to 2, therefore decreasing the number of dentist available in the state. With a limited number of providers, already-full private pay practices, and the barriers to caring for the low-income populations, it will be difficult to recruit providers to rural areas to serve low-income and Medicaid patients.
4. An estimated 10.8% of Illinois Rural Life Panel respondents reported traveling over 31 miles one way to access a dentist.

Mental Health

1. There is a lack of mental health providers in rural areas, leaving family practice physicians responsible for treating mentally ill clients. In rural Illinois, 64 counties are designated as Mental Health HPSAs (IDPH). Family practice physicians do not have the time or resources to effectively treat severe mental illness. Many rural hospitals are also not equipped with the resources to treat mental health needs. Residents must travel and those with immediate needs are faced with months of waiting to access mental health services (Fig. 2).
2. According to the Illinois Rural Life Panel Survey conducted in 2005, 23% of respondents reported traveling over 31 miles one-way to receive mental health services.
3. Depression and anxiety are the most common mental illnesses, diagnosed in 28% of patients treated for heart disease and diabetes (SIU Carbondale, December 2003). Heart disease is the leading cause of death in Illinois.

Figure 2. Federally Designated Mental Health HPSAs in Illinois, 2005



Source: Illinois Department of Public Health, Center for Rural Health

Emergency Medical Services (EMS)

1. EMS is critical to the healthcare system. In rural areas, the volume of transports and reimbursements do not cover the cost to provide services (IRHA EMS Report 2005).
2. To fund EMS, 24 counties passed a referendum to raise local tax dollars. Of the 24 counties, 22 serve as a healthcare personnel shortage area. Creating an educational and community awareness campaign has been a valuable tool in passing a referendum.
3. Communities are spending money to support 911 services. If they do not support the local EMS providers, no one will respond to the 911 call.

Methamphetamine

1. According to the Illinois State Police, the number of methamphetamine laboratories has increased in Illinois in the last several years. Methamphetamine laboratories are infiltrating the rural landscape. Common ingredients are used to produce this highly addictive substance.
2. Rural Leaders are concerned about the increase in crime in rural areas and how this might impact their communities (Rural Leaders Questionnaire, 2003-2004).
3. In production of methamphetamine, waste products are toxic to the environment (IDPH fact sheet). Waste products are dumped in local playgrounds and in ditches. The long-term effects on the environment are not known.

Chronic Disease and Prevention

1. Colon cancer, breast cancer, cardiovascular disease, stroke, and diabetes are statewide concerns. According to the Centers for Disease Control and Prevention (2002), heart disease is the leading cause of death in Illinois. Overall, Illinois has the third highest rate of deaths due to breast cancer, and cancer accounted for 23% of the deaths in 1999. Rural areas are no exception to these chronic diseases. Investing in prevention and screening strategies will help decrease the burden of these chronic and costly diseases in rural areas.
2. Rural residents are being influenced to make health decisions based on recommendations by their physician or primary care provider (Straub, Clark and McLaughlin, 2001). Due to a large patient load and time constraints, primary care providers in rural areas do not have the time to devote to prevention strategies. Collaboration and partnering in rural areas will be an essential component of creating solutions to the rural health disparities.
3. Rural residents also lack access to health care specialist to receive additional treatment for some of their chronic disease conditions. According to 49.5% of Illinois Rural Life Panel Survey respondents (2005), they drive over 31 miles one-way to receive specialty care with 16.4% of participants reporting a drive of over 60 miles one-way.

III. IMPLICATIONS AND CONCLUSIONS

Several policy implications may become apparent from these data:

1. Telemedicine and other IT technologies are essential components in providing accessible, high quality care. This allows for access to specialists not otherwise available in rural areas. Rural communities need infrastructural improvements to continue to provide high-speed Internet access at affordable cost. These new technologies aid in the continuing education of health professionals, allowing rural communities to remain on the cutting edge in health care advances.
2. We need to examine elderly migration patterns and health care needs. As the population of baby boomers expanded in the 20th century, states built schools to accommodate. Now they are aging and it is imperative to examine creative solutions to the changing needs of rural residents.
3. Capacity building in rural areas is essential to implement creative and innovative approaches. It is critical for communities to build consensus on high-priority issues, pool resources, and develop a starting point for improvement. Improving local efficiencies through pooled resources will empower rural residents to take responsibility for planning of their healthcare needs. Appendix B in this testimony documents how the IIRA has improved the capacity for rural communities to deliver health care services.
4. State level resources are a key component in creating positive outcomes in rural communities. The state should foster an environment of applied research, publications and resources for best practices and innovative approaches, and support technical assistance for rural Illinois. Currently, key stakeholders are collaborating to provide necessary information and resources. This could be strengthened through additional financial support for the Illinois Rural/Downstate Health Act.
5. Rural Illinois does not respond in the same way to policies designed for larger metro areas. The Governor's Rural Affairs Council (GRAC), created in 1987, maintains a rural focus in state government and is a point of contact for rural elected officials and community leaders. The GRAC works with the IRHA and other partners throughout the state. The GRAC could play an increasing role in shaping health policy for rural Illinois.

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APPENDIX A

Background of Illinois Institute for Rural Affairs (IIRA) and Rural Health Issues

The IIRA is a statewide research-education-service organization dedicated to improving life in rural Illinois. It was funded in 1989 by the Illinois General Assembly through the Board of Higher Education and with a supplemental grant from the Office of Lt. Governor George H. Ryan. The main areas for which services are provided include community and economic development, education, transportation, health, housing, agribusiness, and public management. IIRA personnel study and advise on other issues as well, but usually those issues are strongly linked with the core areas listed above.

The main clientele served by IIRA include state and local public officials, business leaders, economic development practitioners, community leaders, and concerned citizens interested in improving their communities. IIRA serves the 74 non-metro counties in Illinois and cities with populations less than 25,000. Most of the services provided are demand-response, i.e. residents or leaders requesting information, technical assistance, or other services.

Dr. Norman Walzer, founding director, LaVonne A. Straub, and other stakeholders held focus groups on rural health issues throughout the state. From those initial meetings several key issues were addressed through the Illinois Rural/Downstate Health Act (410 ILCS 65/). The legislation provided a backbone for rural health infrastructure throughout the state. Since that time, rural health leaders have partnered to provide services and improve the overall infrastructure of healthcare systems. The focus groups on rural health paved the way for the IIRA.

The mission of the IIRA is to improve the quality of life for rural residents by partnering with public and private agencies on local development and enhancement efforts. The Illinois Institute for Rural Affairs is committed to continued partnerships on rural health issues. Our work is accomplished through public and private partnerships in rural areas to empower local residents to improve the quality of life.

IIRA programming and practices are based on the following principles and beliefs. These values underlie all of the efforts to improve the quality of life in rural areas.

- Community economic development encompasses more than job creation; it also includes health, education, public transportation, public management, housing, and telecommunications. IIRA addresses these issues in a holistic approach.
- The most successful solutions to local problems come from local initiatives. IIRA strives to empower residents and community leaders to make informed decisions rather than just recommending specific alternatives.
- Rural issues are broader than agriculture even though agriculture is important and must be included in efforts to strengthen the local economic base. IIRA programs address a multitude of community concerns to enhance the quality and ensure the vitality of community life.

- Long-term solutions to rural issues must recognize the sustainability of the region and not deplete existing resources. IIRA explicitly recognizes environmental issues in helping community leaders find solutions for local concerns.
- Communities in rural areas do not exist in isolation; they depend on economic prosperity at the metro, state, and national levels. IIRA understands these interrelationships and encourages partnerships among groups within and between communities.
- Successful community development enriches the lives of all residents regardless of race, creed, age, or economic status, including disadvantaged regions and underserved population segments. IIRA believes that broad-based participation in local decisions ultimately leads to a higher quality of life for all residents.

APPENDIX B

Rural Health Capacity Building by the IIRA

The IIRA has been involved in building the capacity of rural communities throughout the state. This is done through economic and community development strategies, but in the context of specialized areas. Health is an integral part of the Institute and provides outreach and technical assistance to rural communities through the MAPPING (Management and Planning Programs Involving Non-metropolitan Groups) the Future of Your Community's Health Program. For the sake of brevity, the name of this program is shortened to Community Health Mapping (CHM).

The CHM program is a decision-making process designed to promote grass roots initiatives for meeting local healthcare needs, ultimately empowering community residents to take more responsibility for their own health. Integrated with community and economic development strategies, this program builds consensus among local leaders, health care professionals, area health and human service agencies, and concerned citizens. CHM helps rural residents to understand the economic impact health care has on their community, envision a healthier environment, plan healthier futures, and begin to take action and responsibility for their own health.

Vision

The CHM program provides knowledge, information, and strategies for local health development to begin overcoming the rural disparities and improve the quality of life in rural Illinois. The process provides a health focused needs assessment in the areas of health care services, community health education, and environmental health.

Mission

MAPPING the Future of Your Community's Health program's mission is to work with communities to improve the quality of life in rural Illinois.

In many rural areas, a hospital may be the largest employer. The loss of such an institution lowers the quality of life and creates a financial strain on the community. Health care professionals and other local leaders need to understand the economic impact health has on the community and, likewise, how community and economic development can improve the overall health of the area. For example, a community may need to help improve substandard housing for residents suffering unnecessary episodes of lead poisoning. Through innovative approaches and collaborative efforts, real solutions to chronic problems may be possible. MAPPING the Future of Your Community's Health is a tool for health professionals and other community leaders to exchange ideas with local residents and initiate a workable plan for improving the community. CHM seeks to strengthen local health promotion through a holistic community development approach. Community assessment, visioning, and planning services are available to address a wide variety of subjects involving health care services, public health and health education, and community environmental health.

Program development began with support from the Illinois Department of Public Health—Center for Rural Health and the Federal Office of Rural Health Policy. The Health MAPPING program is now available to rural Illinois communities with support from the Illinois Department of Public Health—Center for Rural Health, Illinois Critical Access Hospital Network, and SIU School of Medicine.

Outcomes

When discussing capacity building and community planning, it is essential to discuss the outcomes. Communities are responsible for further pursuing goals and projects. IIRA provide technical assistance and resources from state agencies to assist them in implementing their health plan. Communities with a common vision can improve their overall health. The MAPPING the Future of Your Community's Health provides communities with the necessary tools to take concerns and issues and turn them into goals and projects.

Hamilton County

Hamilton County is working on developing an elder-friendly community. They identified the need to expand health care services in their area to include an Assisted Living Facility. At present, they have completed the background work for an Assisted Living Facility and a feasibility study through funding from the Illinois Delta Network Project. The CHM program has been able to provide technical assistance to the community for development of a survey tool to gather much needed information on their elderly population. They have results from an initial study and supplemented this information with a mail survey focused on marketing information and other valuable information on amenities for the Assisted Living Facility. The community has been working with the Blaire Corporation and is currently waiting for approval of the Supported Living Facilities to break ground.

The community has also worked together to provide additional elderly health programming and farm safety programs for the youth. The community has also developed a model for teen wellness programming. The community has also identified economic development as a target for improving the overall health of the community. The community has hired a part-time economic developer to focus on businesses and projects for the area.

Hamilton County conducted a Health MAPPING Update to revisit their initial goals, discuss progress, and determine their future direction. The community's high-priority goal areas included expanding healthcare services, improving communication among healthcare professionals, expanding/improving job opportunities for area residents, and developing adequate community infrastructure. One of the projects the community is working on is an emergent care clinic for area residents. After this project was determined, the community lost an area physician. This opened some space, but made physician recruitment the most important project to expand healthcare services.

Hancock County

Hancock County residents are working to increase awareness of health care services in their area. The Health MAPPING group completed their resource directory of health care services and support services, which is available in CD-ROM format. The directory was distributed to area providers and agencies; the Hancock County Health Department is working to provide this information via a website in the near future. The Hancock County Health Department also utilized the information identified in the Health MAPPING process to set their goal areas for their IPLAN process. Collaboration has increased within the community providing opportunities for successful health education programs and screenings.

Hancock County providers participated in the Burdick Interdisciplinary Fellowship program. Through efforts, IIRA was able to provide technical assistance to the fellows. The community completed a survey of healthcare needs for the elderly. The community has also used the fellowship to examine the possibilities of a low-income dental clinic. IIRA is providing technical assistance, as needed to the local health department and others for data needs.

IIRA staff conducted a survey for Memorial Hospital to determine the gaps and needs in healthcare services for area residents, as well as examine the perception and knowledge of area residents on the hospital, clinics, pharmacy, and durable medical equipment. The survey included questions from the local health department and mental health services.

Washington County

Washington County is working on reducing the mortality and morbidity rates of area residents due to cardiovascular disease. From the Health MAPPING program, the health department and hospital have collaborated to expand their heart healthy programs targeting women and children. They are also utilizing the information from the sessions to inform groups throughout the county on the importance of the health issues residents are facing.

The community also wanted to become an elder-friendly community, and therefore have utilized information from the Health MAPPING program to pursue an Assisted Living Facility for their community. Plans are moving forward.

Hoopeston

Hoopeston, Illinois has been in a transition phase due to a change in management at the hospital. The community's action plan had been on hold, because many of the key players on the committees were related to the hospital. They also lost the director of their chamber of commerce. The community is currently working on building collaboration throughout their community to tackle its health issues, providing welcome baskets for new community members and businesses, and developing business retention and expansion initiatives. The community has also seen the loss of another manufacturer, placing financial stress on the community, local business, and healthcare sector.

The community finished its business retention and expansion survey project this year and is working with the Rural Economic Technical Assistance Center (RETAC) to develop a plan. The community re-energized and the economic development group began meeting and discussing potential options. The group was considering a Peace Corp Fellow from WIU or ISU to work as a full-time economic developer to show the need to local government. The community is still trying to recover from many of the events in their recent past, but is attempting to move forward. A Peace Corp Fellow began an 11 month internship in the community in January of 2006. The community has begun a walking program through the hospital and is interested in developing additional health programming. We have also been able to provide resources to the local community for translated materials to help with the health needs of their Hispanic population.

Pleasant Hill

The community of Pleasant Hill, Illinois is working on several key initiatives to improve their local infrastructure, create jobs, maintain their school, and provide health education opportunities for residents through their health clinic. During the Health MAPPING process, health insurance was discussed as a barrier to receiving care at the local clinic. Since that time, the clinic has begun accepting another major health insurance provider utilized by area residents, as well as examining expanding clinic hours. After the Health MAPPING process, the community received additional funding to help keep the clinic open and provide capital improvements.

Through additional technical assistance, the clinic has been able to provide a resource to local residents to access health information. The clinic purchased a computer for area residents to use in the waiting area of the clinic to search information on health related illnesses and treatments available. This has been a valuable service to area residents.

Henderson County

Henderson County residents identified economic development as their high-priority goal to improving overall health of area residents. The community is interested in partnering at a regional level on projects and improving their economic infrastructure. The community is also working with others to have pharmacy services in the county and potentially expanded mental health services. They will be working with Warren County in the near future to determine areas of collaboration.

In February 2005, Henderson County was the recipient of an AmeriCorps VISTA volunteer through the Illinois Institute for Rural Affairs. This VISTA volunteer has agreed to spend one year in the county, devoting approximately two-thirds of their time assisting with Henderson County Economic Development projects and the other one-third working on Henderson County Health Department projects. Since February, the VISTA volunteer has been actively building relationships, gathering information about the county, and assessing county needs. The Health MAPPING program and partners were able to help fund this project.

Bushnell

The community of Bushnell, Illinois completed the MAPPING program in 2005. Following the completion of the visioning process, two community organizations, Bushnell Community Improvement Association and Bushnell Development Corporation, applied to participate in the USDA “Rural Community Development Initiative” (RCDI) grant program through IIRA and were accepted. Thus far, the Bushnell Community Improvement Association received financial assistance through the RCDI grant to conduct a financial feasibility pre-development study for building and opening an assisted living center. In addition, the Bushnell Community Improvement Association and Bushnell Development Corporation will begin the web site review and consultation process that will be provided through the RCDI grant. Through this process, the community organizations will work with a community web site consultant to develop an effective and functional community web site.

Warren County

The community of Warren County participated in the initial pilot of this type of program in 1995. The community had moved forward on some of the projects, but did not have the momentum in place to continue efforts. The community updated their health action plan in 2004. The community has been active in moving their action plan forward and is meeting on a quarterly basis to discuss the progress of each of the groups. Their high-priority goals included improving child care options, providing education to the elderly, compile a list of mental health and substance abuse resources, revive the healthcare services database, and develop a taskforce for renovating small older homes for the disabled and elderly. Through collaboration with the IDPH-Center for Rural Health, the community received a small grant to develop a healthcare services database for the county.

The community is researching after school programs and developed a youth and parent survey to gather information on what the service might include. The community developed a list of mental health and substance abuse resources and is interested in placing those in the healthcare database. The database group has been working on updating the work previously done and has been researching and applying for initial money to cover the cost of setting the database up in a web-format. The community has also organized a series of workshops for the elderly and has developed a taskforce to begin renovating homes for the elderly. The community is also working with the Illinois Coalition for Community Service (ICCS) and through that program had volunteers to help renovate homes in the Wyatt Earp area of Monmouth.

Alpha

Residents in Alpha, Illinois are interested in improving access to exercise for local residents through designating areas for exercise throughout the community (signs, bike path, walking) and improve communications and collaborate with the local health department to make more people aware of opportunities. The community has been researching options for exercise in the community, including signs to identify distance walked. The community is seeking funding for equipment to make available to area residents and is researching a walking program.

Through collaborative efforts with the IDPH-Center for Rural Health, this community was able to receive a grant to continue their efforts. The community began discussions with a Cardiac Rehab Unit to further assist them in efforts to improve access to exercise for local residents.

Mendota

Mendota residents focused on four areas which include creating a model for behavioral and physical health and wellness, developing small business and industry, becoming a premier recreational community, and becoming a model community for integration and unity. The community is interested in developing a walking/bike path, increasing/expanding mental health services, and continuing their community-wide wellness program. The community is also embracing the Hispanic population and looking at ways to better integrate their culture into Mendota.

Colchester

The community of Colchester combined participated in the MAPPING the Future of Your Community Program with an expanded health focus. Through the process, health was one of their high-priority areas. The community is interested in re-opening the healthcare clinic. The community has brainstormed several possibilities and pursued several options. The Peace Corp Fellow's class through Western Illinois University provided the community with technical assistance by researching clinics in other communities similar to theirs. This provided valuable insight into the needs of providers to open a clinic in the area. Currently, the community is in need of a market analysis to determine the feasibility of a full-time provider in the community. A local healthcare provider is interested in possibilities of opening a satellite clinic in the community. The community is searching for and exploring possible grants to fund this type of project. Through collaborative efforts with the IDPH-Center for Rural Health, Colchester received a grant to work with the RETAC to conduct a market analysis of the proposed service area.

Greene County and Mercer County just completed a Health MAPPING process in 2005 and have just begun working on their high-priority goals.

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Metro and Non-metro Counties in Illinois, 1999

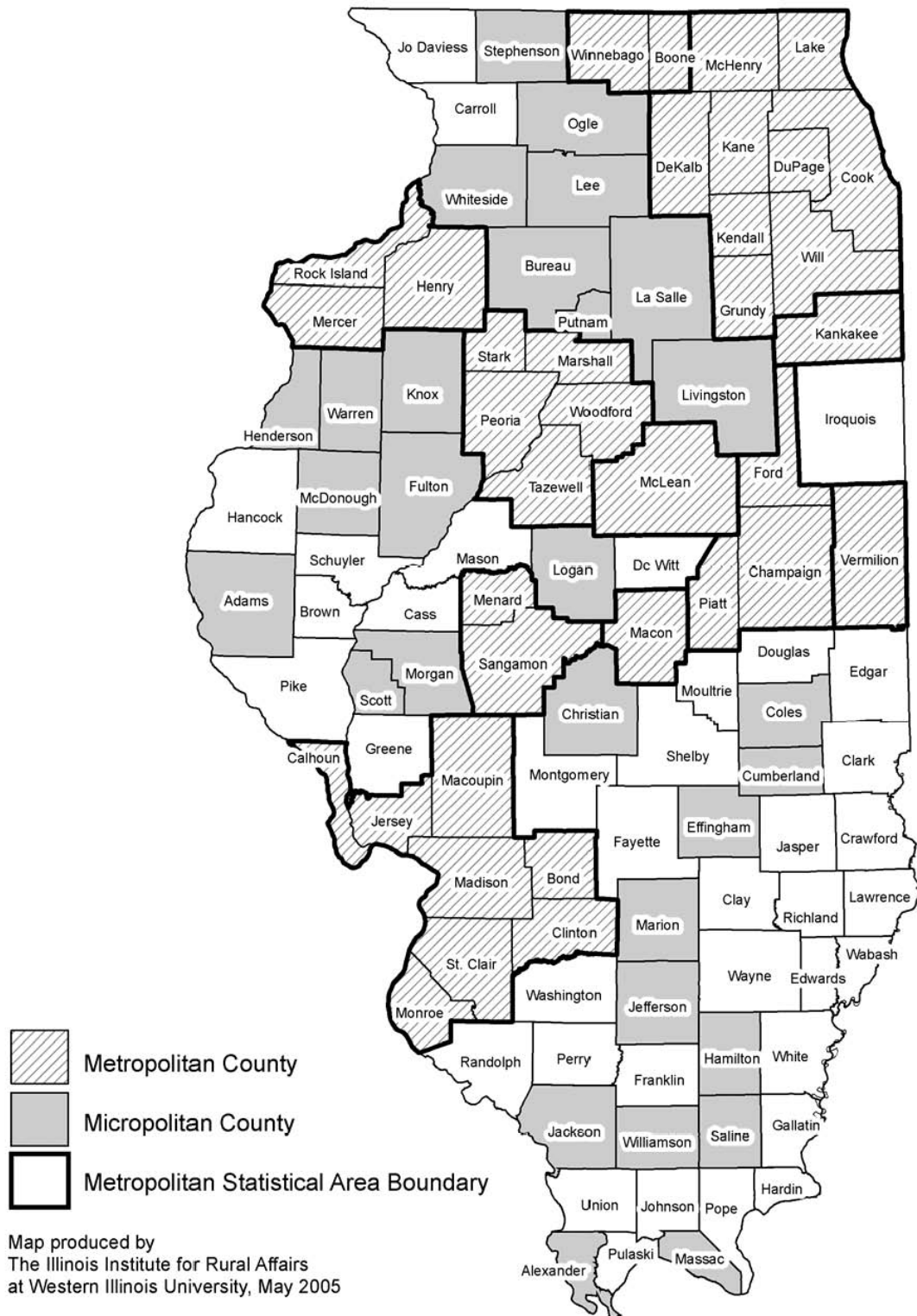


Metropolitan County
 Non-metropolitan County



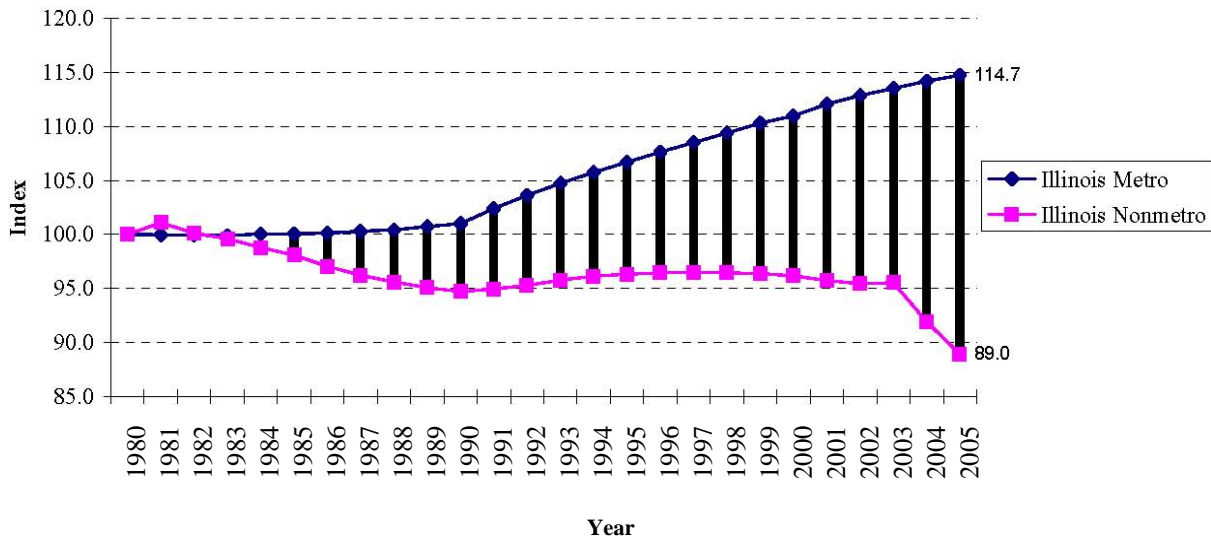
Source: United States Office of Management and Budget (OMB)
 June 30, 1999.
 Map produced by the Illinois Institute for Rural Affairs
 July 2006

Metro and Non-metro Counties in Illinois, 2003 Boundaries



Source: United States Office of Management and Budget (OMB), 2003.

1 Population Index, 1980-2005



	Census 1980	Census 1990	Census 2000	Estimate 2005	% Change	
					1980-2005	2000-2005
Illinois	11,426,518	11,430,602	12,419,293	12,653,545	10.7	1.9
Illinois Nonmetro (2003 def.)	1,773,350	1,680,018	1,705,887	1,577,451	-11.0	-7.5
Illinois Metro	9,653,168	9,750,584	10,713,406	11,076,094	14.7	3.4
Northern Illinois	8,250,111	8,366,258	9,285,986	9,621,441	16.6	3.6
Western Illinois	1,146,862	1,076,769	1,097,118	1,093,116	-4.7	-0.4
Eastern Illinois	798,652	777,580	805,406	808,699	1.3	0.4
Southern Illinois	1,230,893	1,209,995	1,230,783	1,130,289	-8.2	-8.2

¹ 1980, 1990, and 2000 are actual Census of Population figures, the other years are estimates that the Census Bureau calculates. NOTE: Metro and Nonmetro classifications based on the 2003 Office of Management and Budget classifications.

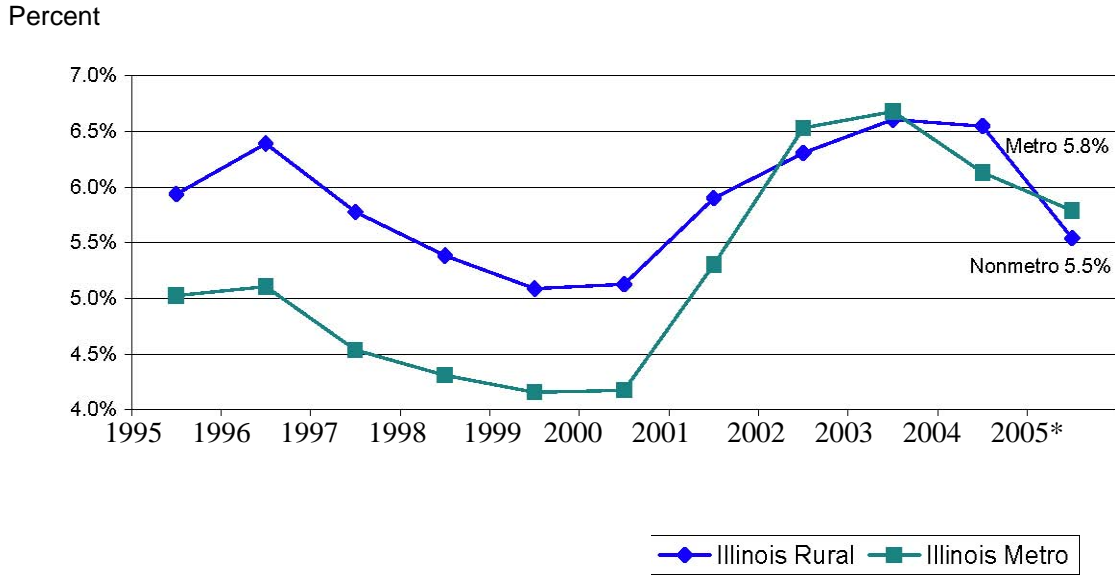
Source: U.S. Bureau of the Census. *County Population Estimates*. [Population Division of the Census] (Online)
 Available: http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=PEP&_submenuId=datasets_3&_lang=en.
 (Downloaded: July 26, 2006)

Population Change in Illinois, 1990-2005

County/Region	1990 Census	2000 Census	2005 Census	% Change		County/Region	1990 Census	2000 Census	2005 Census	% Change	
				1990-2000	2000-2005					1990-2000	2000-2005
Adams	66,090	68,277	67,040	3.3	-1.8	Lee	34,392	36,062	35,669	4.9	-1.1
Alexander	10,626	9,590	8,927	-9.7	-6.9	Livingston	39,301	39,678	39,186	1.0	-1.2
Bond	14,991	17,633	18,027	17.6	2.2	Logan	30,798	31,183	30,603	1.3	-1.9
Boone	30,806	41,786	50,483	35.6	20.8	McDonough	35,244	32,913	31,966	-6.6	-2.9
Brown	5,836	6,950	6,835	19.1	-1.7	McHenry	183,241	260,077	303,990	41.9	16.9
Bureau	35,688	35,503	35,330	-0.5	-0.5	McLean	129,180	150,433	159,013	16.5	5.7
Calhoun	5,322	5,084	5,163	-4.5	1.6	Macon	117,206	114,706	110,167	-2.1	-4.0
Carroll	16,805	16,674	16,086	-0.8	-3.5	Macoupin	47,679	49,019	49,111	2.8	0.2
Cass	13,437	13,695	13,898	1.9	1.5	Madison	249,238	258,941	264,309	3.9	2.1
Champaign	173,025	179,669	184,905	3.8	2.9	Marion	41,561	41,691	40,144	0.3	-3.7
Christian	34,418	35,372	35,176	2.8	-0.6	Marshall	12,846	13,180	13,217	2.6	0.3
Clark	15,921	17,008	16,976	6.8	-0.2	Mason	16,269	16,038	15,741	-1.4	-1.9
Clay	14,460	14,560	14,122	0.7	-3.0	Massac	14,752	15,161	15,348	2.8	1.2
Clinton	33,944	35,535	36,095	4.7	1.6	Menard	11,164	12,486	12,738	11.8	2.0
Coles	51,644	53,196	51,065	3.0	-4.0	Mercer	17,290	16,957	16,912	-1.9	-0.3
Cook	5,105,044	5,376,741	5,303,683	5.3	-1.4	Monroe	22,422	27,619	31,040	23.2	12.4
Crawford	19,464	20,452	19,898	5.1	-2.7	Montgomery	30,728	30,652	30,396	-0.2	-0.8
Cumberland	10,670	11,253	10,973	5.5	-2.5	Morgan	36,397	36,616	35,722	0.6	-2.4
De Kalb	77,932	88,969	97,665	14.2	9.8	Moultrie	13,930	14,287	14,510	2.6	1.6
De Witt	16,516	16,798	16,617	1.7	-1.1	Ogle	45,957	51,032	54,290	11.0	6.4
Douglas	19,464	19,922	19,950	2.4	0.1	Peoria	182,827	183,433	182,328	0.3	-0.6
Du Page	781,689	904,161	929,113	15.7	2.8	Perry	21,412	23,094	22,815	7.9	-1.2
Edgar	19,595	19,704	19,157	0.6	-2.8	Piatt	15,548	16,365	16,680	5.3	1.9
Edwards	7,440	6,971	6,784	-6.3	-2.7	Pike	17,577	17,384	17,099	-1.1	-1.6
Effingham	31,704	34,264	34,581	8.1	0.9	Pope	4,373	4,413	4,211	0.9	-4.6
Fayette	20,893	21,802	21,713	4.4	-0.4	Pulaski	7,523	7,348	6,794	-2.3	-7.5
Ford	14,275	14,241	14,157	-0.2	-0.6	Putnam	5,730	6,086	6,094	6.2	0.1
Franklin	40,319	39,018	39,723	-3.2	1.8	Randolph	34,583	33,893	33,122	-2.0	-2.3
Fulton	38,080	38,250	37,708	0.4	-1.4	Richland	16,545	16,149	15,798	-2.4	-2.2
Gallatin	6,909	6,445	6,152	-6.7	-4.5	Rock Island	148,723	149,374	147,808	0.4	-1.0
Greene	15,317	14,761	14,581	-3.6	-1.2	St. Clair	262,852	256,082	260,067	-2.6	1.6
Grundy	32,337	37,535	43,838	16.1	16.8	Saline	26,551	26,733	26,072	0.7	-2.5
Hamilton	8,499	8,621	8,301	1.4	-3.7	Sangamon	178,386	188,951	192,789	5.9	2.0
Hancock	21,373	20,121	19,153	-5.9	-4.8	Schuyler	7,498	7,189	7,073	-4.1	-1.6
Hardin	5,189	4,800	4,718	-7.5	-1.7	Scott	5,644	5,537	5,412	-1.9	-2.3
Henderson	8,096	8,213	7,972	1.4	-2.9	Shelby	22,261	22,893	22,322	2.8	-2.5
Henry	51,159	51,020	50,591	-0.3	-0.8	Stark	6,534	6,332	6,169	-3.1	-2.6
Iroquois	30,787	31,334	30,677	1.8	-2.1	Stephenson	48,052	48,979	47,965	1.9	-2.1
Jackson	61,067	59,612	57,954	-2.4	-2.8	Tazewell	123,692	128,485	129,999	3.9	1.2
Jasper	10,609	10,117	10,020	-4.6	-1.0	Union	17,619	18,293	18,202	3.8	-0.5
Jefferson	37,020	40,045	40,434	8.2	1.0	Vermilion	88,257	83,919	82,344	-4.9	-1.9
Jersey	20,539	21,668	22,456	5.5	3.6	Wabash	13,111	12,937	12,570	-1.3	-2.8
Jo Daviess	21,821	22,289	22,580	2.1	1.3	Warren	19,181	18,735	17,558	-2.3	-6.3
Johnson	11,347	12,878	13,169	13.5	2.3	Washington	14,965	15,148	14,922	1.2	-1.5
Kane	317,471	404,119	482,113	27.3	19.3	Wayne	17,241	17,151	16,796	-0.5	-2.1
Kankakee	96,255	103,833	107,972	7.9	4.0	White	16,522	15,371	15,284	-7.0	-0.6
Kendall	39,413	54,544	79,514	38.4	45.8	Whiteside	60,186	60,653	59,863	0.8	-1.3
Knox	56,393	55,836	53,309	-1.0	-4.5	Will	357,313	502,266	642,813	40.6	28.0
Lake	516,418	644,356	702,682	24.8	9.1	Williamson	57,733	61,296	63,617	6.2	3.8
La Salle	106,913	111,509	112,604	4.3	1.0	Winnebago	252,913	278,418	288,695	10.1	3.7
Lawrence	15,972	15,452	15,930	-3.3	3.1	Woodford	32,653	35,469	37,448	8.6	5.6
Statewide (102)	11,430,602	12,419,293	12,653,545	8.6	1.9						

Source: U.S. Bureau of the Census. County Population Estimates. [Population Division of the Census] (Online) Available: http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=PEP&_submenuId=datasets_3&_lang=en. (Downloaded: July 26, 2006)

Unemployment Rate, 1995-2005*

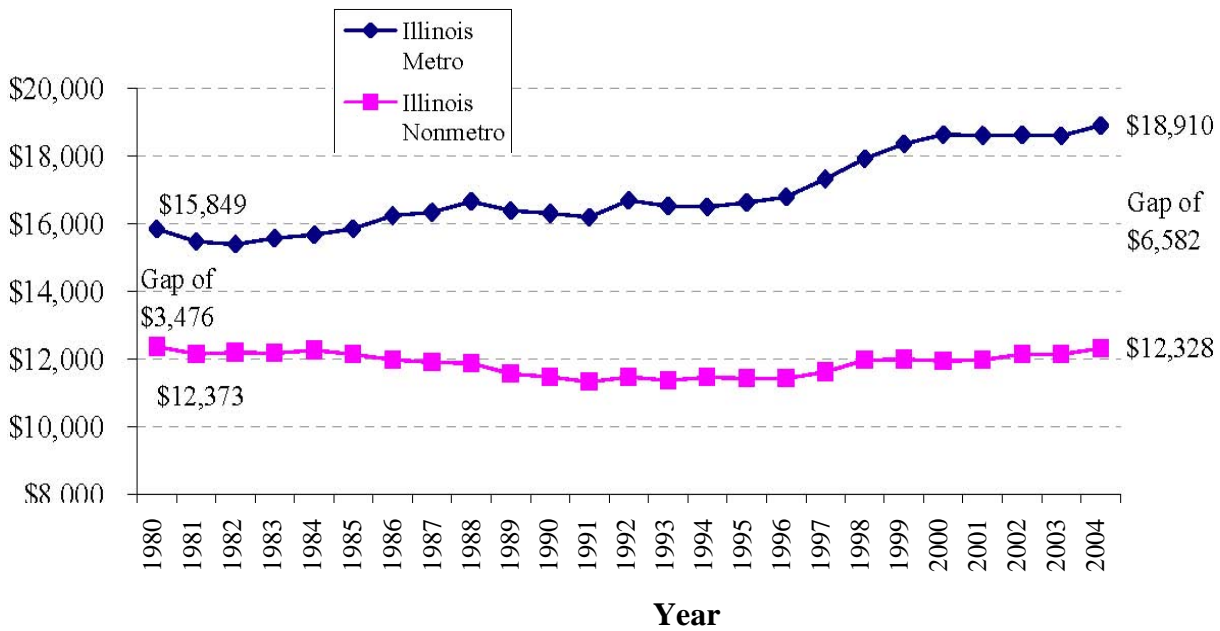


*2005 is an average of January through November of 2005.

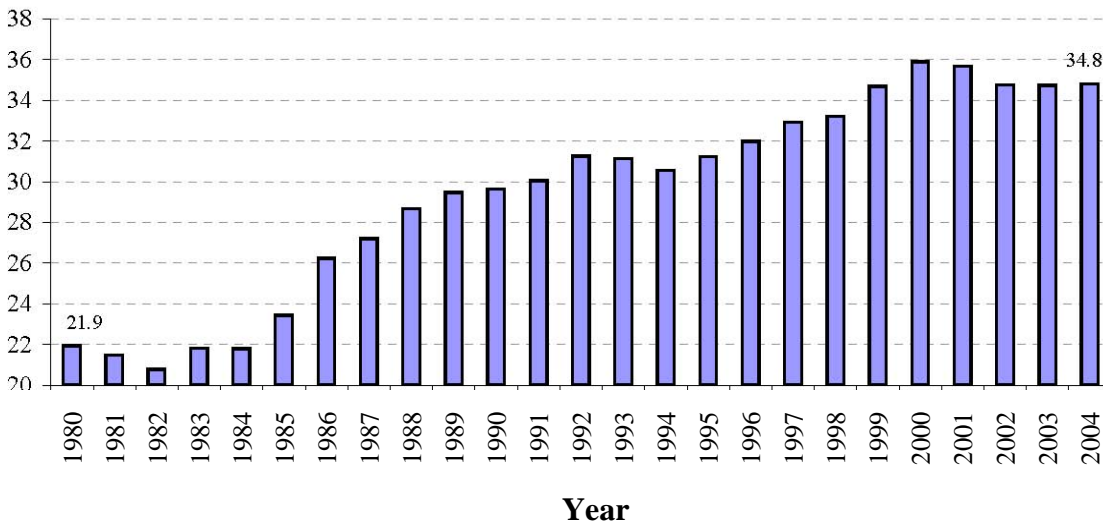
NOTE: Metro and Nonmetro classifications based on the 2003 Office of Management and Budget classifications.

Source: Local Area Unemployment Statistics (LAUS), Annual Averages for Counties, 1975-2003. Illinois Department of Employment Security. (Online) Available: <http://lmi.ides.state.il.us/laus/laushis.htm> downloaded: August 30, 2004; <http://lmi.ides.state.il.us/download/county-aa.xls> and <http://lmi.ides.state.il.us/laus/ytd/ytdcounty.htm> (downloaded: January 5, 2006).

Real Average Wage Per Job, 1980-2004



Metro/Nonmetro Gap



Note: The Consumer Price Index was used to adjust for inflation where 1980=100.0 and 2004=229.2.

Source: U.S. Dept. of Commerce, Economics and Statistics Administration, Bureau of Economic Analysis. Regional Economic Accounts. (Online) Available: <http://www.bea.doc.gov/bea/regional/reis> -- Date Downloaded: February 6, 2006. U.S. Bureau of Labor Statistics. Consumer Price Index, All Urban Consumers. (Online) Available: <http://www.bls.gov/cpi/home.htm> -- Date Downloaded: February 6, 2006.

Income and Poverty Estimates, 2002

Poor Related Children						Poor Related Children							
Total Poor Persons			0—17 Years Old			Media Household Income	Total Poor Persons			0—17 Years Old			Media Household Income
County	Number	%	Number	%	County		Number	%	Number	%			
Adams	7,743	11.8	2,380	14.8	\$36,390	Lee	2,974	8.9	830	10.3	\$41,495		
Alexander	2,198	24.8	772	32.9	25,058	Livingston	3,453	9.5	1,059	11.2	43,114		
Bond	1,867	11.9	457	12.3	37,782	Logan	3,034	11.4	787	12.5	39,260		
Boone	3,340	7.2	1,159	9	52,722	McDonough	4,927	17.6	980	17.9	31,748		
Brown	746	15.1	124	11.2	34,399	McHenry	11,998	4.2	3,587	4.4	68,455		
Bureau	3,005	8.6	901	10.9	41,284	McLean	12,667	8.7	3,420	9.5	49,944		
Calhoun	461	9.1	103	9.6	37,391	Macon	14,677	13.5	5,161	19.3	37,908		
Carroll	1,614	10	490	13.7	37,403	Macoupin	4,880	10.2	1,529	13.5	37,422		
Cass	1,450	10.6	477	13.9	35,449	Madison	26,169	10.1	8,894	14.2	42,504		
Champaign	22,055	12.8	5,456	14.2	39,337	Marion	6,029	15.1	2,116	21.4	33,895		
Christian	3,476	10.4	1,108	13.8	37,754	Marshall	1,020	7.9	293	10.2	42,315		
Clark	1,881	11.2	611	15.3	36,673	Mason	1,775	11.3	589	16	36,621		
Clay	1,741	12.4	511	15.3	31,962	Massac	1,938	13	622	18.3	33,190		
Clinton	2,472	7.3	659	7.9	45,877	Menard	994	8	323	10.5	48,847		
Coles	6,634	13.7	1,456	14.6	33,687	Mercer	1,382	8.2	435	11	42,992		
Cook	769,079	14.5	286,478	20.7	42,863	Monroe	1,201	4.1	294	4.1	59,376		
Crawford	2,237	12	634	15.1	34,904	Montgomery	3,586	12.9	1,080	16	34,239		
Cumberland	1,102	10.1	352	13.1	37,287	Morgan	3,915	11.8	1,172	15.4	37,182		
DeKalb	8,005	9.3	1,837	8.8	45,977	Moultrie	1,237	8.7	399	11.2	40,050		
De Witt	1,565	9.5	526	13.4	41,643	Ogle	4,152	7.9	1,248	9.3	46,114		
Douglas	1,698	8.6	652	12.5	41,642	Peoria	22,897	12.9	8,679	19.2	41,183		
DuPage	48,728	5.3	13,333	5.5	64,350	Perry	2,799	13.8	748	15.9	33,274		
Edgar	2,333	12.5	722	16.8	33,776	Piatt	1,020	6.2	267	7	47,891		
Edwards	694	10.1	209	13.8	34,422	Pike	2,193	13.4	640	16.8	32,278		
Effingham	3,008	8.7	1,023	11	41,222	Pope	626	15	149	18	30,160		
Fayette	2,832	14.2	860	17.7	32,262	Pulaski	1,492	21.8	547	29.9	25,640		
Ford	1,186	8.6	377	10.9	40,583	Putnam	432	7.1	133	9.6	45,754		
Franklin	5,985	15.4	1,949	22.4	29,982	Randolph	3,502	11.8	1,025	14.6	36,982		
Fulton	4,205	11.9	1,242	15.8	34,547	Richland	1,954	12.3	579	15.9	32,352		
Gallatin	992	16	296	22.1	27,861	Rock Island	16,141	11.2	5,665	16.4	38,746		
Greene	1,847	12.8	575	16.5	32,654	St. Clair	34,510	13.5	13,829	20.1	39,970		
Grundy	2,213	5.6	648	6.6	55,784	Saline	4,257	17	1,388	24.3	29,591		
Hamilton	1,070	13	300	16.2	31,641	Sangamon	18,969	9.9	6,702	14.4	44,865		
Hancock	1,971	10.3	623	14.2	37,704	Schuyler	674	9.7	176	11.5	36,753		
Hardin	788	17.3	202	22.6	28,246	Scott	558	10.2	153	11.9	37,013		
Henderson	865	10.8	247	14.5	36,519	Shelby	2,203	9.9	662	12.8	37,310		
Henry	4,171	8.3	1,323	11.1	41,804	Stark	580	9.5	192	12.9	37,077		
Iroquois	3,028	10	997	13.7	38,252	Stephenson	4,990	10.4	1,682	14.4	40,137		
Jackson	10,937	20.1	2,520	22.9	26,712	Tazewell	9,569	7.6	3,012	10.2	46,643		
Jasper	984	9.9	308	13.1	37,196	Union	2,472	13.7	762	18.7	32,323		
Jefferson	5,793	15.2	1,881	20.3	34,011	Vermilion	11,275	14.1	3,871	19.3	34,122		
Jersey	2,021	9.4	603	11.9	42,957	Wabash	1,419	11.3	407	14	36,282		
Jo Daviess	1,813	8.1	501	10.3	41,143	Warren	2,035	11.9	551	13.9	35,710		
Johnson	1,607	15.1	396	17	34,114	Washington	1,185	7.9	351	9.7	42,017		
Kane	32,278	7.1	12,124	9	59,721	Wayne	2,103	12.5	603	15.8	32,028		
Kankakee	12,078	11.8	4,434	16.1	41,364	White	1,954	13.2	556	18	31,458		
Kendall	2,583	3.9	784	4.3	69,760	Whiteside	5,427	9.2	1,702	12	39,591		
Knox	6,679	13.1	2,049	17.7	34,811	Will	36,024	6.2	12,448	7.4	63,067		
Lake	43,004	6.4	14,664	7.5	68,089	Williamson	8,415	13.8	2,680	19.5	33,697		
La Salle	10,915	9.9	3,483	12.9	41,749	Winnebago	33,203	11.8	12,249	16.8	42,872		
Lawrence	1,922	12.9	570	17.3	31,677	Woodford	2,079	5.9	598	6.5	52,779		
Illinois	1,411,869	11.3	494,208	15.3	44,946								

Source: U.S. Census Bureau, Housing and Household Economic Statistics Division, Small Area Estimates Branch. *Small Area Income and Poverty Estimates*. (Online) Available: <http://www.census.gov/cgi-bin/saie/saie.cgi#SA31>. Last Revised: August 30, 2005.

Please rate the following items using the scale provided. (1 = Poor and 5 = Excellent)

	Mean	Valid N
access to ambulance service at reasonable cost	___ 3.43	___ 216
local access to local health care (doctors, dentists, etc.)	___ 3.28	___ 219
adequacy and quality of drinking water	___ 3.15	___ 219
access to high speed Internet service at reasonable cost	___ 3.00	___ 217
ability to contact state government	___ 2.99	___ 217
services provided by local government	___ 2.90	___ 220
access to training to use Internet	___ 2.90	___ 214
ability of local schools to train students for jobs	___ 2.86	___ 219
local access to mental health services	___ 2.85	___ 213
ability to purchase local goods and services online	___ 2.83	___ 212
access to high quality local hospital services	___ 2.82	___ 218
adequacy of public services to meet family needs	___ 2.81	___ 217
facilities and services for the elderly	___ 2.81	___ 216
local access to specialized health care (MRI, CT scans, etc)	___ 2.80	___ 219
cooperation among local governments to provide services	___ 2.77	___ 215
adequacy of work training opportunities in region	___ 2.75	___ 216
condition of state highways	___ 2.73	___ 221
current status of efforts to use ag products in economic development	___ 2.67	___ 201
responsiveness of state agencies to local requests	___ 2.64	___ 211
availability of affordable child care	___ 2.63	___ 212
enough skilled trades in area to meet demand	___ 2.63	___ 220
condition of rural roads and bridges	___ 2.62	___ 218
ability to buy what I need locally	___ 2.60	___ 223
availability of affordable high quality housing	___ 2.57	___ 221
local wages paid for available jobs	___ 2.20	___ 150
adequacy of public transportation to get to health care, education, shopping, social service agencies	___ 2.06	___ 217
adequacy of school funding	___ 2.06	___ 83
current status of efforts to use alternative energy such as biodiesel	___ 2.05	___ 198
local job advancement possibilities	___ 2.03	___ 150
current status of efforts to use alternative energy such as wind energy	___ 2.02	___ 205
availability of local jobs for which you qualify	___ 1.95	___ 150
adequacy of public transportation to get to jobs	___ 1.78	___ 216

Source: Rural Leaders Questionnaire, 2003 and 2004, n=232

Rank Top 5 Most Important Conditions in Your Region

	Response	%	Cases
availability of local jobs for which you qualify	_____	61.5%	72
local wages paid for available jobs	_____	49.6%	58
local job advancement possibilities	_____	33.3%	39
ability to buy what I need locally	_____	31.6%	37
adequacy of public transportation to get to jobs	_____	21.4%	25
local access to local health care doctors, dentists, etc	_____	21.4%	25
condition of state highways	_____	20.5%	24
adequacy of school funding	_____	19.7%	23
ability of local schools to train students for jobs	_____	17.9%	21
adequacy of work training opportunities in region	_____	17.1%	20
availability of affordable high quality housing	_____	16.2%	19
adequacy and quality of drinking water	_____	16.2%	19
availability of affordable child care	_____	13.7%	16
condition of rural roads and bridges	_____	12.8%	15
access to high speed Internet service at reasonable cost	_____	12.8%	15
current status of efforts to use ag products in economic development	_____	12.8%	15
cooperation among local governments to provide services	_____	12.0%	14
access to high quality local hospital services	_____	10.3%	12
current status of efforts to use alternative energy such as wind energy	_____	10.3%	12
responsiveness of state agencies to local requests	_____	8.5%	10
current status of efforts to use alternative energy such as biodiesel	_____	8.5%	10
enough skilled trades in area to meet demand	_____	7.7%	9
services provided by local government	_____	6.8%	8
facilities and services for the elderly	_____	6.8%	8
adequacy of public transportation to get to health care, education, shopping	_____	6.0%	7
local access to specialized health care (MRI, CT scans, etc)	_____	6.0%	7
access to training to use Internet	_____	5.1%	6
local access to mental health services	_____	4.3%	5
access to ambulance service at reasonable cost	_____	4.3%	5
ability to purchase local goods and services online	_____	2.6%	3
ability to contact state government	_____	2.6%	3
adequacy of public services to meet family needs	_____	2.6%	3

Source: Rural Leaders Questionnaire, 2003 and 2004, n=232

**In the next 5 to 10 years,
How important will each of the following issues be?**

**1 = not important
5 = very important**

	Mean	Valid N
attract more high paying local jobs	___ 4.40	___ 222
improve course offerings in schools	___ 4.14	___ 217
prepare youth for better jobs	___ 4.11	___ 218
attract more retail businesses to downtown	___ 4.01	___ 222
preserve hospitals in rural communities	___ 3.97	___ 215
quicker response from state agencies	___ 3.93	___ 206
build more affordable housing	___ 3.84	___ 213
better coordination in providing public services	___ 3.76	___ 212
use technology (telemedicine) to deliver health care related services to rural residents	___ 3.71	___ 214
improve state highways	___ 3.68	___ 220
improve local telecommunication services	___ 3.67	___ 216
attract more skilled trades people to area	___ 3.67	___ 221
easier access to state government services (via Internet, etc)	___ 3.65	___ 209
attract more doctors to community	___ 3.63	___ 215
easier access to local government services (via Internet, etc.)	___ 3.60	___ 210
develop value-added agriculture initiatives	___ 3.60	___ 228
use technology to deliver government services to rural residents	___ 3.60	___ 213
provide/improve public transportation	___ 3.59	___ 219
develop commercial uses for waste products	___ 3.58	___ 137
reduce local property taxes	___ 3.56	___ 218
improve rural roads and bridges	___ 3.56	___ 218
biodiesel/biomass fuel and products	___ 3.55	___ 137
greater access to state government by citizens (via public hearings, etc)	___ 3.52	___ 216
provide/improve rail services	___ 3.30	___ 216
develop wind power/wind energy	___ 3.28	___ 229
provide/improve air services	___ 2.97	___ 217

Source: Rural Leaders Questionnaire, 2003 and 2004, n=232

**ILLINOIS RURAL DOWNSTATE HEALTH ACT
PROGRAMS AND STRATEGIC ALLIANCES
AMONG PARTICIPATING AGENCIES**

MARCH 2006

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ACRONYMS

IDPH	Illinois Department of Public Health
IRHA	Illinois Rural Health Association
CRH	Center for Rural Health
RDHI	Rural Downstate Health Initiative
RDHA	Rural Downstate Health Act
AHEC	Area Health Education Centers
FQHC	Federally Qualified Health Centers
SIU	Southern Illinois University
SHS	Shawnee Health Services
SIHF	Southern Illinois Healthcare Foundation
MCPHD	Macoupin County Public Health Department
IPLAN	Illinois Project for Local Assessment of Needs
UMWA	United Mine Workers of America Hospital
PACS	Picture Archiving and Communication System
CMN	Children's Miracle Network
MAPPING	Management and Planning Programs Involving Nonmetropolitan Groups
RMED	Rural Medical Education Program

I. INTRODUCTION TO THE RURAL DOWNSTATE HEALTH ACT — P.A. 86-1187; 87-1162

In 1990 the General Assembly passed SB2277 (Public Act 86-1187) amending the Rural Health Act to become the Rural Downstate Health Act. This change added Southern Illinois University and in 1993, P.A. 87-1162 added the University of Illinois to the Act. The Act gives the Illinois Department of Public Health’s (IDPH) Center for Rural Health authority to create grant programs for rural downstate communities, hospitals and all federally qualified health centers. It outlines responsibilities for the universities and directs the Center for Rural Health and the universities to collaborate in addressing health care disparities in Rural Illinois. Additionally, the Act created the Allied Health Care Professional Assistance Law to be administered by the IDPH. This report examines the role of the three agencies directed by the Act, as well as partner entities such as the Illinois Institute for Rural Affairs (IIRA) and the Illinois Rural Health Association (IRHA) and others (Fig.1).

II. THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH — CENTER FOR RURAL HEALTH

The Center for Rural Health (CRH) administers four programs identified in the RDHA:

- Allied Health Professional Scholarship Program
- Grants to Community-Based Organizations
- Grants to Community Health Centers
- Grants to Rural Hospitals

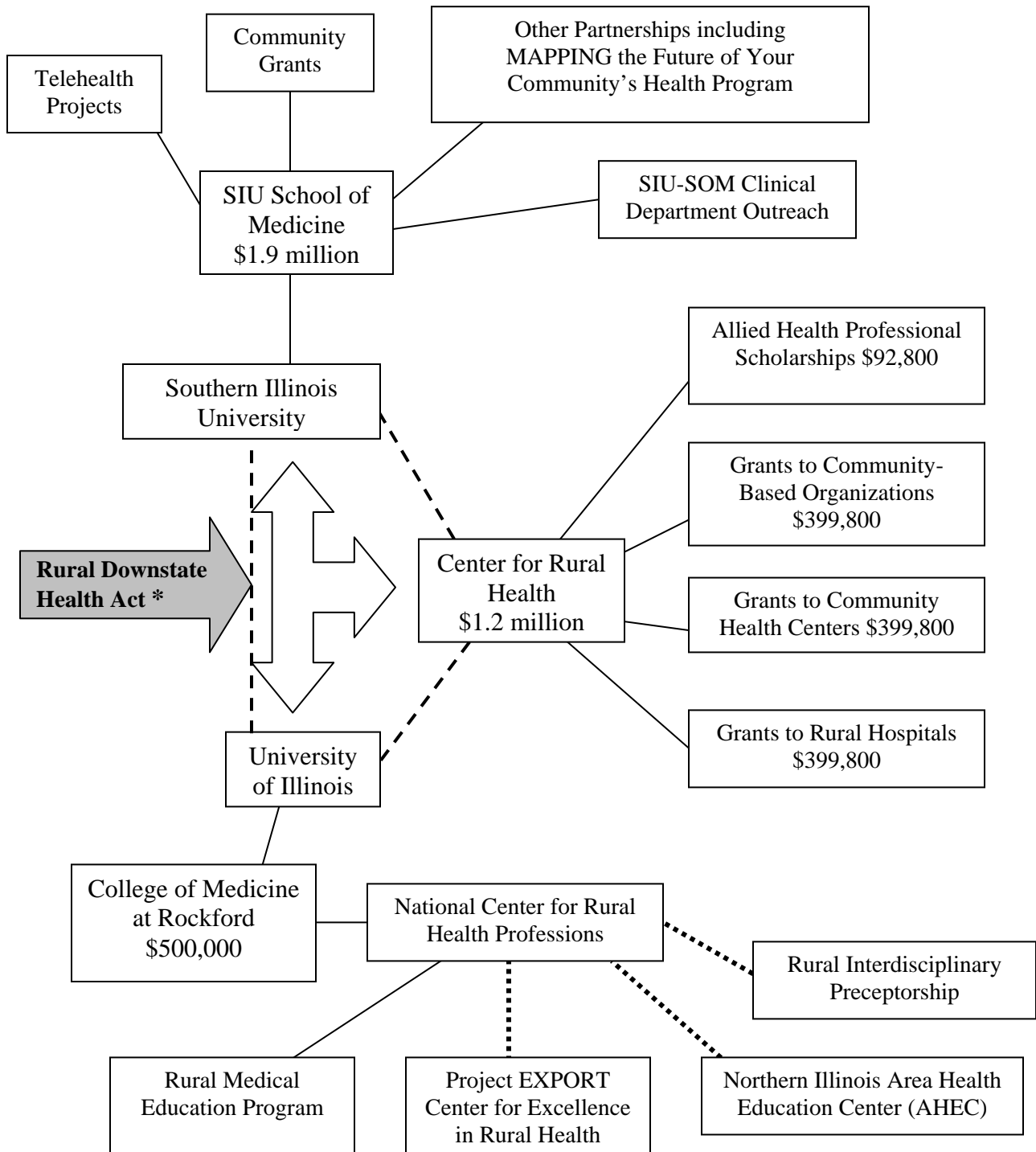
The RDHA funds are directly distributed to program grantees (Table 1, Fig. 2). The RDHA funds do not cover administrative costs to the CRH. State funding has declined since 2004. Total funding for the Center for Rural Health in 1994 was \$1,377,700.00, decreasing to \$1,292,200.00 in FY 2006 with an additional 2% reduction for set-aside.

Table 1. Rural Downstate Health Act Funds for the Center for Rural Health 1994 to 2006

Fiscal Year	Community Based Organizations	Rural Hospitals	Community Health Centers	Allied Health Professional Scholarships
1994	409,000	409,000	409,800	149,900
1995	409,000	409,000	409,800	149,900
1996	409,000	409,000	409,800	149,900
1997	409,000	409,000	409,800	149,900
1998	409,000	409,000	409,800	149,900
1999	409,000	409,000	409,800	149,900
2000	409,000	409,000,	409,800	149,900
2001	409,000	409,000	409,800	149,900
2002	409,000	409,000	409,800	149,900
2003	409,000	409,000	409,800	149,900
2004	400,820*	400,820*	400,820*	92,800*
2005	399,800*	399,800*	399,800*	92,800*
2006	399,800*	399,800*	399,800*	92,800*

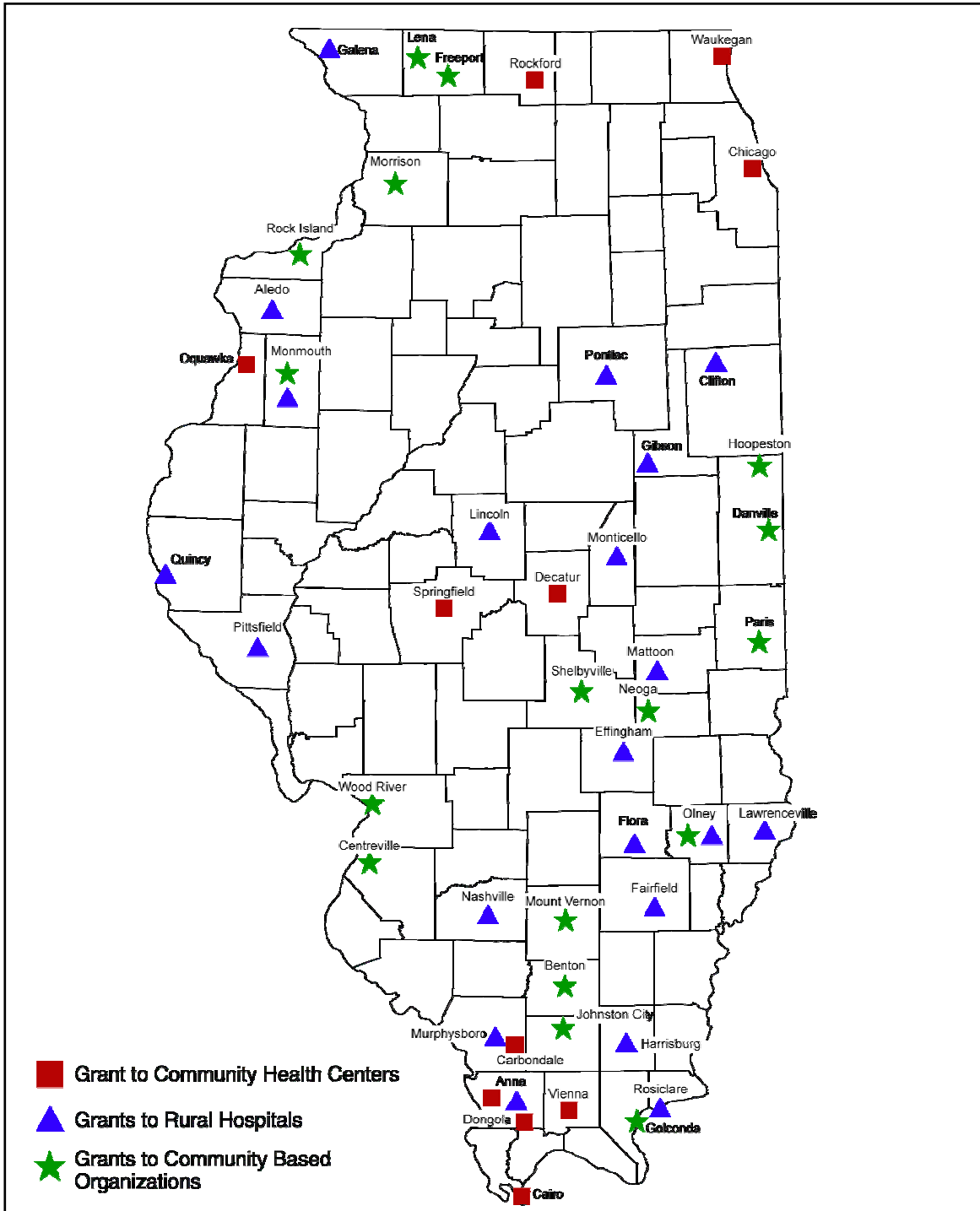
*Amount does not reflect an additional 2% reduction for set-aside.
Source: Illinois Department of Public Health-Center for Rural Health.

Figure 1. Inter-Agency Relationships within the Illinois Rural Downstate Health Act



* The charter members of the Illinois Rural Health Association were instrumental in the passage of the Rural Downstate Health Act.
 Note: The amounts indicate FY 2006 funding.

Figure 2. Rural Health Downstate Recipients from FY 1994 to FY 2006



Source: Created by the Illinois Institute for Rural Affairs from information provided by the Illinois Department of Public Health-Center for Rural Health, February 2006.

2.1 Allied Health Professional Scholarships

The goal of the program is to improve primary health care services for Illinois residents by providing scholarships to allied health care professionals who will agree to practice in areas of Illinois demonstrating the greatest need for more professional medical care. Since initial program funding in 1994 through the Allied Health Care Professional Assistance Law, 104 health professional students have received scholarships. This includes scholarships to 54 Nurse Practitioners, 47 Physicians Assistants, and 3 Certified Nurse Midwives.

Of those 104 students, 19 are still in school, 11 are working to complete their service obligation to the program, and 74 have completed the service obligation. Approximately 60 percent are working in rural underserved areas of Illinois.

2.2 Grants to Community-Based Organizations

Grants may be used to support projects that develop new services or enhance existing services to meet the primary health care needs of rural, downstate designated shortage areas.

Eligible applicants: local health departments; incorporated, not-for-profit organizations composed of local civic leaders and local citizens representative of the service area; governmental entities; hospital boards of directors. Table 2 provides information on the grant recipients from initial funding in FY 1994 to FY 2006.

Table 2. Grants to Community Based Organizations from FY 1994 to FY 2006

Applicant	City	County	Fiscal Years Funded
Neoga Community	Neoga	Cumberland	1994-1996
Rock Island County	Rock Island	Rock Island	1994-1999
Herrin Hospital	Johnston City	Williamson	1994-1998
Madison County/Wood River Hospital	Wood River	Madison	1994-1999
Hoopston Community Hospital	Hoopston	Vermilion	1994-1996
Community Memorial Hospital	Monmouth	Warren	1997 only
Touchette Hospital	Centreville	St. Clair	2000-2003
Northwest Adult Daycare	Lena	Stephenson	2000-2005
Vermilion Area Health Center.	Danville	Vermilion	2001 only
Whiteside County Health Dept.	Morrison	Whiteside	2000-2002
Edgar County Health Dept.	Paris	Edgar	2001-2006
Stephenson County Health Dept	Freeport	Stephenson	2001-2006
Jefferson County Health Dept	Mt. Vernon	Jefferson	2001-2006
Pope County Senior Center	Golconda	Pope	2001 only
Shelby Memorial Hospital	Shelbyville	Shelby	2006 --
Richland Memorial Hospital	Olney	Richland	2006 --
Franklin District Hospital	Benton	Franklin	2006 --

Source: Illinois Department of Public Health-Center for Rural Health.

2.3 Grants to Rural Hospitals

Grant funds can be used to develop or enhance primary health care services in the hospital's service area; to assist in strategic planning and staff training; facility modification and equipment acquisition; and personnel recruitment.

All Illinois hospitals located in rural designated shortage areas are eligible to apply for these grants. Hospitals which have received funding through the RDHA are listed in Table 3.

Table 3: Grants to Rural Hospitals from FY 1994 to FY 2006

Hospital	City	County	Fiscal Years Funded
John & Mary Kirby	Monticello	Piatt	1994-1999
Mercer County Hospital	Aledo	Mercer	1994-1996
St. Joseph Hospital	Murphysboro	Jackson	1994-1995
Fairfield Hospital	Fairfield	Wayne	1994 only
Galena-Stauss Hospital	Galena	JoDaviess	1994-1999
Harrisburg Hospital	Harrisburg	Saline	1994-1999
Central Community Hospital	Clifton	Iroquois	1996 only
John & Mary Kirby	Monticello	Piatt	1997-2002
Mercer County Hospital	Aledo	Mercer	1997-2002
Hardin County	Rosiclare	Hardin	1997-2002
Abraham Lincoln	Lincoln	Logan	2000-2005
Community Memorial	Monmouth	Warren	2000-2005
Union District	Anna	Union	2000-2005
Hardin County	Rosiclare	Hardin	2000-2005
Abraham Lincoln	Lincoln	Logan	2001 only
Gibson Area Hospital	Gibson City	Ford	2003 only
Washington County Hospital	Nashville	Washington	2003-2004
Sarah Bush Lincoln	Mattoon	Edgar	2003 --
Richland Memorial	Olney	Richland	2003 --
Lawrence County	Lawrenceville	Lawrence	2003 only
OSF St. James	Pontiac	Livingston	2003 only
Illini Community Hospital	Pittsfield	Pike	2003 --
Blessing Hospital	Quincy	Adams	2006 --
Clay County Hospital	Flora	Clay	2006 --
OSF St. James Hospital	Pontiac	Livingston	2006 --
St. Anthony's Hospital	Effingham	Effingham	2006 --

2.4 Grants to Community Health Centers

Grants may be used to help pay for the recruitment and retention of medical professionals, purchase of new equipment, operational expenses, facility construction and renovation, and outreach programs for medically underserved populations.

Eligible applicants for these grants: health centers funded through Section 329, 330 or 340 of the federal Public Service Act; federally qualified health centers, including look-alikes, as designated by the federal Public Health Service or by the Department; and not-for-profit organizations with an advisory board meeting the federally qualified health center (FQHC) requirements and having the goal to become an FQHC or look-alike. Community Health Center grant recipients are listed in Table 4.

Table 4. Grants to Community Health Centers from FY 1994 to FY 2006

Community Health Centers	City	County	Fiscal Years Funded
Community Health & Emergency Services	Cairo	Alexander	1994 only
Rural Health, Inc.	Vienna	Johnson	1994-1999
Shawnee Health Services	Carbondale	Jackson	1994-1999
Alivio Health Center	Chicago	Cook	1994-1999
Community Health Partnerships	Migrant programs (Chicago HQ)	Cook	1994 only
Rural Health, Inc.	Dongola	Union	1997-2000
Lake County Health Department	Waukegan	Lake	1997-1998
Roseland Health Center	Chicago	Cook	1997-2002
Lake County Health Department	Waukegan	Lake	2000 only
Crusaders Health Clinic	Rockford	Winnebago	2000-2005
Lawndale Christian Health Center	Chicago	Cook	2001-2006
Community Health Partnerships	Migrant programs (Chicago HQ)	Cook	2000-2005
Rural Health, Inc.	Anna	Union	2000-2005
Community Health Improvement Center	Decatur	Macon	2000-2005
Alivio Health Center	Chicago	Cook	2001-2006
Central Counties Health Center	Springfield	Sangamon	2006--
Community Health Improvement Center	Decatur	Macon	2006--
Henderson County Rural Health Center	Oquawka	Henderson	2006--
Erie Community Health Center	Chicago	Cook	2006--

Source: Illinois Department of Public Health-Center for Rural Health.

III. SOUTHERN ILLINOIS UNIVERSITY—SCHOOL OF MEDICINE

SIU has received RDHA funds to support their activities listed in Public Act 86-1187 since 1994. These funds resulted in the creation of the Rural Health Initiative (RHI) program at SIU School of Medicine. The purpose of the RHI program is to expand health care services in the region served by the School, and whenever possible, expand educational opportunities for health professions students. The RHI program is administered by the Office of External and Health Affairs. SIU's appropriation was \$512,100 in FY94. There were additional appropriations in FY95, FY97 and FY01 (\$100,000, \$400,000, and \$900,000 respectively). The current appropriation to SIU is \$1.9 million.

3.1 Community Grants and Partnerships, FY 1994 to FY 2006

Auburn: Assisted with development of primary care clinic. Provided physician staff from Departments of Internal Medicine and Pediatrics.

Beardstown: Provided funds for a health planner/educator to work with the Cass County Health Department.

Benton: Provided funds for a bone densitometer for Franklin Hospital.

Cairo: Funded development of specialty services clinic with Community Health and Emergency Services, Inc. and funded new medical specialist with Southernmost Illinois Community Health Improvement Corporation.

Carbondale: Funded expansion of rural health education program with Southern Illinois Healthcare.

Carbondale: Provided funds for equipment and staff support for Abundant Health Resource Clinic which serves the uninsured population in Jackson County.

Carlinville: Provided funds for the development of an outpatient physical rehabilitation facility for Carlinville Area Hospital.

Carrollton - Funded development of new outpatient clinic area at Thomas H. Boyd Memorial Medical Center.

Cartersville: Provided specialty pediatric service to Shawnee Health Service (SHS) through Department of Pediatrics. Assisted in the expansion of health and social services to senior citizens. Helped recruit additional physicians. Provided funds for the development of a health manpower plan. Provided funds to help develop school health centers in Marion and Carbondale.

Centreville: Developed Ob/Gyn resident service and training program with Southern Illinois Healthcare Foundation (SIHF). Provided specialty consultation services through Department of Obstetrics and Gynecology. Developed family medicine resident service and training program with SIHF. Developed medical student rotation with SIHF.

Franklin County: Provided technical assistance and secured grant funds through the Office of the Lt. Governor to start new school-based health programs at Benton and West Frankfort school districts. Provided RDHI funds for staff support.

Gallatin County: Provided technical assistance to Gallatin County School District to start a school-based clinic. Provided funding for Gallatin County School Health Clinic.

Golconda: Developed community health center clinic with Southern Seven health department.

Golden: Funded development of family practice clinic with Blessing Hospital. Provided support for a physician from Quincy Family Practice Center to staff the clinic. Funded development of electronic medical record system for East Adams Rural Health Clinic.

Hardin: Funded modular clinic to replace clinic destroyed by the flood of 1993.

Hardin and Pope Counties: Provided emergency funding to Hardin County hospital to retain services of only pediatrician in Hardin and Pope counties.

Harrisburg: Coordinated new obstetrical services in Harrisburg in conjunction with Memorial Hospital of Carbondale and the Carbondale Clinic. Provided specialty pediatric services through Department of Pediatrics. Developed video conference continuing education linkage with Department of Internal Medicine.

Hoopeston: Funded purchase of a new ambulance for Hoopeston Regional Medical Center.

Jacksonville: Funded geriatric outreach service and education program through the Department of Psychiatry.

Johnston City: Developed family practice clinic with Carbondale Family Practice Center.

Lawrenceville: Provided funding for new mammography unit at Lawrence County Memorial Hospital.

Lebanon: Developed family practice clinic with Belleville Family Practice Center.

Litchfield: Funded development of new dental clinic jointly sponsored by Montgomery and Macoupin County Public Health Departments.

Lincoln: Funded physician and administrative coordinator at Family Medical Group of Lincoln.

Livingston: Funded development of a rural health clinic with Community Memorial Hospital of Staunton.

Logan County: Funded nurse practitioner to staff mobile clinic operated by Rural Health Partnership.

Macoupin County: Funded health services transportation program for low income, elderly and disabled persons with Macoupin County Public Health Department (MCPHD). Provided nurse educator for a diabetes education program with MCPHD. Provided funds for the support of the Community Care Health Center with MCPHD.

Marion: Provided funds for medical equipment for Hands of Hope Family Clinic, a non-profit, volunteer-based clinic that provides free primary health care to qualified individuals and families living in Franklin, Johnson, Saline and Williamson counties. Provided family physician to staff the clinic. Provided funds to start and operate an oral health program. Provide physician assistant to staff the clinic.

Mattoon: Funded development of mobile preventive screening program for women living in Clark, Coles, Cumberland, Douglas, Jasper and Moultrie counties in conjunction with Sarah Bush Lincoln Health Center. Funded development of multi-county adult day care program.

McLeansboro: Funded the purchase of a new ultrasound unit at Hamilton Memorial Hospital. Funded contract to provide mental health services through the Family Resource Center.

Olney: Funded developmental phase of new assisted living facility with Richland Memorial Hospital. Funded expansion of services for Hospice of Southeastern Illinois and regional home care services in 13 county area.

Pike/Schuyler/Brown Counties: Funded emergency medical service equipment for Pike/Schuyler/Brown County Ambulance District.

Pittsfield: Provided facilitation and technical assistance to Pike County Health Department for IPLAN process.

Princeton: Provided funding to Bureau County Health and Wellness, a free clinic serving the working of Bureau County.

Quincy: Funded physician support through Quincy Family Practice Center.

Red Bud: Assisted Unity-St. Clement Health Services in developing a transportation program for low income, disabled and senior citizens of their service area.

Saline/Gallatin Counties: Funded development of a free clinic to serve the working poor of Saline and Gallatin Counties.

Sesser: Developed family practice clinic with the Carbondale Family Practice Center. Funded family physician to staff Sesser Family Practice Clinic.

Shelbyville: Funded the development of a rural health clinic with Shelby Community Hospital. Funded development of a women's health program. Funded specialty service unit construction at Shelby Community Hospital.

West Frankfort: Developed family practice clinic with Memorial Hospital of Carbondale. Provided physician support through Carbondale Family Practice Center.

West Frankfort: Supported development of At Home Health, a new home health agency serving Jefferson, Franklin, Salem and Williamson counties.

White Hall: Assisted in recruitment of a mid-level practitioner with Jersey Community Hospital.

3.2 Telehealth

Continuing Education — Developed linkage with Harrisburg Medical Center to provide weekly continuing medical education program.

Family Practice — Funded physician to develop new distance learning initiatives for students and residents in Department of Family and Community Medicine.

Regional Teleburn Network — Developed a telemedicine network connecting rural hospitals with SIU specialty physicians and the Regional Burn Center at Memorial Medical Center.

TeleHome Health Pilot Project — Funded development of in-home telehealth program with the Visiting Nurses Association of Central Illinois.

Teleradiology – Projects funded include:

- Teleradiology link between Herrin Hospital and UMWA Hospital in West Frankfort.
- Teleradiology project with Hamilton Memorial Hospital in McLeansboro.
- Teleradiology project with Washington County Hospital in Nashville.
- Teleradiology project with St. Joseph’s Hospital in Highland.
- Teleradiology project with Utlaut Health Services in Greenville.
- Teleradiology project with Community Memorial Hospital in Staunton.
- Teleradiology project with Lawrence County Memorial Hospital.
- Picture Archiving and Communication System (PACS) for Salem Township Hospital.

3.3 Other Projects

Center for Alzheimer Disease and Related Disorders — Provided funding for outreach program director to work with Primary Provider Network.

Center for Rural Health and Social Service Development — Provide funding support for various rural health research projects. Provided funding for technical assistance in conducting a series of rural health focus groups.

Children’s Miracle Network Clinic — Funded clinical coordinator to expand services of the CMN Clinic in 16 county central Illinois region.

Community Awareness Seminars — Funded community workshops organized by the Department of Behavioral and Social Sciences to increase awareness of common health problems associated with the development of children.

Hometown Housecalls — Supported health education program targeted at rural communities in central and southern Illinois.

Illinois Hospital Association — Provided funds to hire a graduate student in the Peace Corps Fellows program at Western Illinois University to develop a community health education program for rural Illinois hospitals.

Illinois Institute for Rural Affairs — Provide funding support for the MAPPING the Future of Your Community's Health program. The program has provided visioning and planning of health needs to 13 rural communities.

Illinois Practice Opportunity Web Site — Developed a web site for Illinois health organizations to post practice opportunities for physicians, physician assistants and advanced practice nurses.

Illinois Rural Health Association — Supported Illinois Rural Health Association's annual conferences and other Association activities.

Illinois Rural Life Panel Survey — Supported survey of rural Illinois citizens focusing on health care issues.

Medical Literacy Project — Supported development of patient education materials for use in physician offices.

Medprep — Supported clinical enrichment experiences for Medprep students at community health centers.

Needs Assessment Survey — Funded survey of the uninsured population of southernmost Illinois for four southern Illinois Community Health Centers.

Pearson Museum — Funded permanent rural health exhibit at the Pearson Museum.

Primary Care Video — Developed video program focusing on rural family physicians.

Rural Partners — Supported staff development of Rural Partners, a statewide community development consortium. (SIU 2006).

IV. UNIVERSITY OF ILLINOIS

The University of Illinois at Rockford has received RDHA funds to support their activities listed in Public Act 87-1162 since 1994. The Rural Medical Education Program (RMED) is a model for training rural family practice physicians. RMED is currently part of the National Center for Rural Health Professions at the University of Illinois-Rockford Campus. This program is funded at \$500,000 through the RDHA to support faculty, faculty development, recruitment, curriculum development, data collection and evaluation, dissemination, and operations. The RMED program typically enrolls 12-18 students to participate in additional training focused on rural medicine.

4.1 Outcomes of the RMED Program

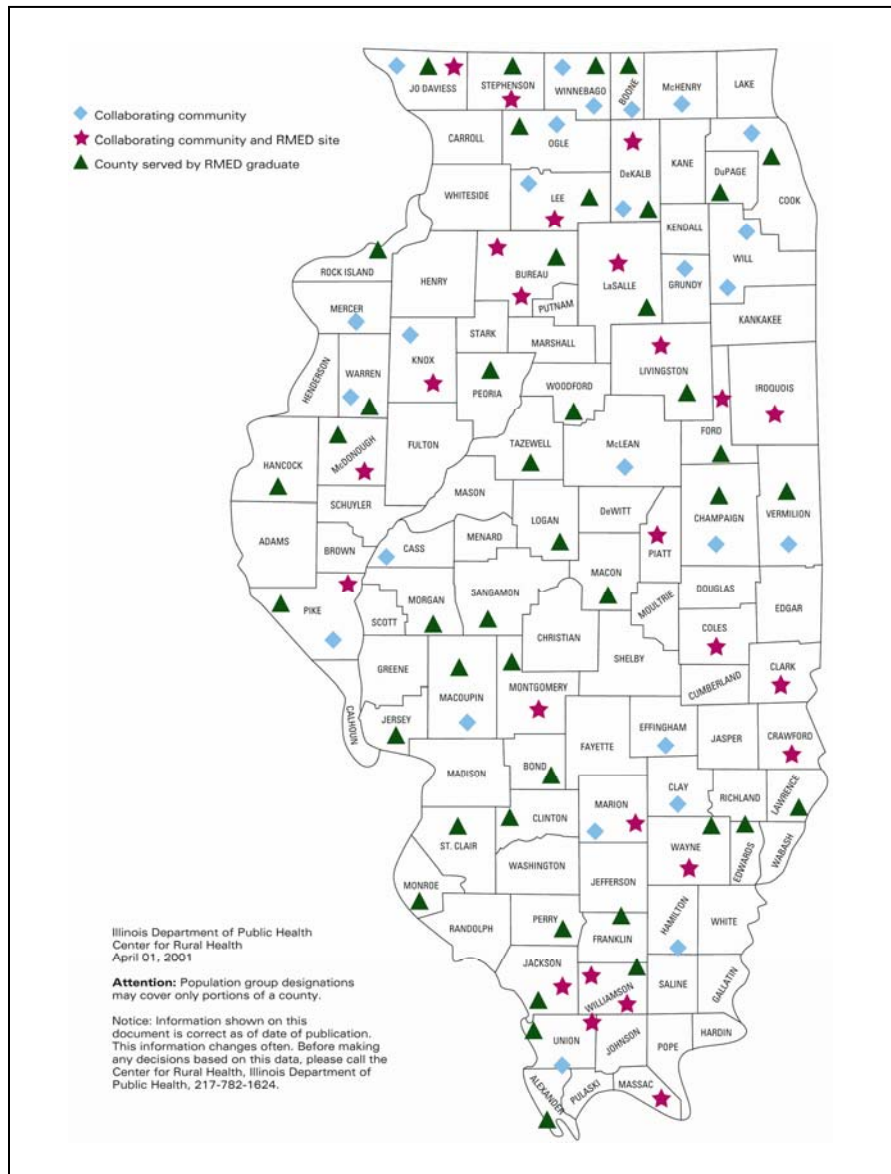
The first RMED class graduated in 1997. Since that time the RMED Program has had the following outcomes:

- Applications from candidates to the RMED Program have been received from.
- 90% of Illinois' counties.
- Students participating in the RMED Program come from 80% of Illinois' rural counties.
- To-date, there have been 187 RMED matriculants.

- There are 132 RMED Program graduates; 82 are currently in practice.
- 61 graduates (74%) are practicing in rural Illinois.
- Over 90% of graduates practice in communities of less than 20,000 people.
- There are 25 RMED collaborating hospitals, located from Galena to Metropolis.
- RMED students have completed 118 community-based projects designed to address local rural health needs.

Figure 3. provides additional information on the Illinois counties served, in some capacity, by the RMED Program.

Figure 3. Illinois Counties Served by the Rural Medical Education Program



Source: University of Illinois College of Medicine at Rockford, March 2006.

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PARTNERS IN ILLINOIS RURAL HEALTH

MARCH 2006

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Many agencies, organizations and individuals partner on rural health issues throughout the state of Illinois. The following list provides information on several of these agencies and their scope of work. This is not an exhaustive list of partners.

Illinois Rural Health Association (IRHA)

<http://www.ilruralhealth.org>

- Membership driven
- Work to strengthen health care systems for rural residents and communities

Illinois Department of Public Health

<http://www.idph.state.il.us>

- Center for Rural Health
 - Serve as clearinghouse for rural health policy and information
 - Outreach grants for community health centers, rural hospitals, and community-based organizations
 - Provide information on rural health issues
 - Provide scholarships to health professional students.
 - Serve as the Office of Rural Health for Illinois
 - ▶ Administer federal programming as necessary
- Office of Health Promotion
- Office of Health Protection

Southern Illinois University

<http://www.siu.edu>

- Health professionals training with campuses in Carbondale, a School of Medicine in Springfield and Edwardsville. Edwardsville campus includes a School of Nursing, Pharmacy, and Dentistry (Alton)
- School of Medicine
 - Rural Health Initiative partners with community-based health care organizations, statewide associations, and other universities to improve access to health care services
 - Telehealth Networks and Programs work with university and community-based organizations to build health care capacity in downstate Illinois using advanced communication and information technologies
 - Clinical department outreach provide outreach services and programs in the specialty areas of Family Medicine, Internal Medicine, Pediatrics, Psychiatry, Surgery and Neurology including Alzheimer's disease and related disorders
 - Rural training programs through the Department of Family and Community Medicine Preceptorship program for medical students and rural residency sites
 - Continuing medical education programs for physicians and other providers located in downstate Illinois
- Center for Rural Health and Social Services at Carbondale
 - Conducts research
 - Tests new models of health care delivery

- Develops policy recommendations to improve the health of rural communities
 - community health and prevention programs
 - programs for persons with developmental disabilities, mental illness, or substance abuse problems
 - employment, training, and independent living programs for persons with disabilities
 - financial support, employment and training programs, and child care, and other family services for low-income families
- Paul Simon Public Policy Institute

Illinois Hospital Association-Small and Rural Constituency

<http://www.ihatoday.org>

- Provides insight into the small and rural hospitals in Illinois
- Gathers state information on individual hospitals
- Advocates for small and rural hospitals

Governor's Rural Affairs Council

[http:// www.ruralaffairsCouncil.il.gov](http://www.ruralaffairsCouncil.il.gov)

- Provides link between state and local governments
- Maintains rural emphasis in Illinois government

Illinois Critical Access Hospital Network

<http://www.icahn.org>

- Advocates for small rural hospitals in Illinois
- Provides educational opportunities for the Critical Access Hospitals
- Develops innovative strategies to assist the Critical Access Hospitals, such as the peer review program

Illinois Institute for Rural Affairs at Western Illinois University (WIU)

<http://www.iira.org>

- Conducts research on rural health through internal and external partnerships
- Provides information on rural trends to influence rural policy
- Conducts *MAPPING the Future of Your Community's Health* Program, a strategic planning program for rural communities
- Provides technical assistance to rural communities on health issues

University of Illinois

<http://www.ncrhp.uic.edu>

- Campuses at Rockford, Peoria and Champaign-Urbana
 - Trains health professionals
 - Some faculty provide research on health issues pertinent to rural populations and communities
- The National Center for Rural Health Professions at the University of Illinois College of Medicine at Rockford
 - Rural training program for primary care physicians through the Rural Medical Education (RMED) Program
 - Project EXPORT Center for Excellence in Rural Health

- Northern Illinois Area Health Education Center (AHEC)
- Rural Interdisciplinary Preceptorship
- Rockford faculty contributes to health research
- Provides research on healthcare workforce issues
- Conducts community health assessment and community-based participatory action research

Illinois Primary Health Care Association

<http://www.iphca.org>

- Advocate for primary health care in Illinois
- Member association for community health centers and federally qualified health centers in Illinois

**Illinois Health Education Consortium/
Area Health Education Centers (AHEC) Program**

<http://www.ihec.org>

- Provide interdisciplinary training for health professionals to increase opportunities for health profession students
- Programming for physician recruitment and retention
- Educating youth on health professions

Illinois State Medical Society

<http://www.isms.org>

- Advocate for the medical community

Illinois Farm Bureau (IFB)

<http://www.ilfb.org>

- IFB's mission is to improve the economic well-being of agriculture and enrich the quality of farm family life
- Seven areas of focus:
 - Operating the farm successfully
 - Service to members
 - Government and politics
 - Education and information
 - Involvement
 - Professional development
 - Operating IFB® professionally

Carle Foundation Hospital

<http://www.carle.com>

- RHC and satellites in rural areas

USDA Rural Development in Illinois

<http://www.rurdev.usda.gov/il/>

- Operates federal loan programs designed to strengthen rural businesses, finance new and improved rural housing, develop community facilities and support development of water and waste disposal systems, telecommunications and utilities
- Provide financing for over 35 programs that serve people in rural Illinois through guaranteed loans, direct loans and grants

Rural Partners

<http://www.ruralpartners.org>

- Membership driven organization
- Private/public partnership for rural community development

Farm Resource Center

<http://www.frci.org>

- Work with Illinois rural families providing mental health/behavioral health services

Illinois Foundation for Quality Health Care

<http://www.ifqhc.org>

- The Medicare contracted Quality Improvement Organization (QIO) for the state of Illinois. QIOs collaborate with Medicare consumers and each state's health care community to foster an environment in which every person receives the right care every time.

Illinois Children's Healthcare Foundation

<http://www.ilchf.org>

- Provides grants to communities to improve access for children
- Works with IRHA on mental health access

Illinois Public Health Association

<http://www.ipha.com>

- Provides leadership and networking opportunities

Illinois Dental Hygienists Association

<http://www.idha.net>

- Mission is to improve the public's total health
- Works to advance the art and science of dental hygiene by ensuring access to quality oral health care
- Increases awareness of the cost-effective benefits of prevention
- Promotes the highest standards of dental hygiene education
- Licensure, practice and research
- Represents and promotes the interest of dental hygienists

Local Health Departments

<http://www.idph.state.il.us>

<http://www.idph.state.il.us/local/alpha.htm> provides an alphabetical listing of county health departments

- Offers vaccinations
- Tests food, water, and drugs for safety
- Investigates infectious diseases
- Licensure for hospitals and nursing homes
- Collects health statistics to develop prevention programs
- Offers screening for diseases
- Has programs on women's health issues

Colleges of Nursing

<http://www.allnursingschools.com/find/Illinois/nursing-schools.php>

- Provides nursing education, research, scholarships, fellowships, and seminars to those interested in nursing careers
- Educates students to obtain a nursing degree at the AND, BSN, MS, and PhD level

Society for Advanced Practice Nursing

<http://www.illinoisadvancednurses.org>

- Has a diversified membership base
- Financial stability
- Presence in legislative and political issues
- Successful marketing campaign

Illinois Academy of Family Physicians

<http://www.iafp.com>

- Maintains high standards of family practice in medicine and surgery
- Educate physicians to help them provide care to the community they serve
- Develop effective communication for physicians, residents, and medical students
- Educate the people of Illinois that family physicians are the ideal primary health care providers

Illinois State University-Applied Social Research Unit

<http://www.asru.ilstu.edu/>

- Provides customized information collection, analysis, and recommendations to promote the effectiveness of public and private organizations.

EMS Providers

- EMS Providers are working with the Illinois Rural Health Association to maintain our rural health systems

Rural Hospitals

Rural Illinois Hospitals can be found at <http://www.ihatoday.org>

Association of Illinois Electric Cooperatives

- Provide information to cooperative members on health



June 29, 2006

ILLINOIS CRITICAL ACCESS HOSPITALS

There are 51 critical access hospitals (CAH) in Illinois as of December 31, 2005. Critical access hospitals are acute care hospitals with 25 inpatient beds offering a variety of outpatient services and are considered the smallest of hospitals located in rural areas. The 51 CAHs are the main source for primary and emergency hospital service for almost half of the 102 counties in Illinois. Critical access hospitals are located across Illinois from Galena to Metropolis and from Pittsfield to Mt. Carmel.

The critical access hospital program was created in 1997 and implemented in Illinois in 1999 as new federal reimbursement system for small rural hospitals. CAHs receive cost-based reimbursement plus one percent from Medicare, which has helped to stabilize their fragile financial stability. There are over 1279 CAHs nation-wide in rural communities. The CAHs have become the safety net for our small communities for access to emergency and primary care services, particularly for our elderly and disadvantaged patient. In addition, the CAHS are one of the top three major employers in their communities and a major economic contributor in those same communities.

ILLINOIS CRITICAL ACCESS HOSPITAL NETWORK

In 2003, a small group of newly approved critical access hospitals established a 501 © 3 not for profit corporation, Illinois Critical Access Hospital Network (ICAHN), for the purpose of sharing resources, networking, education, and development of shared service programs. ICAHN now has 50 CAH members and has worked collaboratively with multiple state health care partners to continue efforts to support our small rural hospitals and their communities. However, there are still many issues facing our CAHs and their future vulnerable.

Attached with these comments is a recent economic impact study conducted by Northern Illinois University for ICAHN and the Illinois Department of Public Health Center for Rural Health that documents the value of the Medicare reimbursement program to the CAHs. The economic impact study identifies that the CAHs are the primary access point for health care in their communities particularly for the elderly. Even though this federal reimbursement program has increased the financial viability of these very small hospitals, it does not solve all the problems of providing health care to the rural communities. The economic impact study detects the growing uninsured, lack of payment by Illinois Public Aid and the challenges of an elderly population base and increasing obesity and chronic diseases in the rural areas.

MAJOR ISSUES FOR CAHs

In November 2005, ICAHN and the Illinois Department of Public Health Center for Rural Health conducted a rural health state-wide planning session with over 21 state organizations representatives for the purpose of identifying current and future major issues. These issues are noted below:

- **Recruitment and Retention of Physicians and Health Professionals** — includes the difficulty of staying competitive with wages and health care benefits as well as the impact of high cost of malpractice insurance to encourage physicians and health professionals to locate in rural areas.

- **Reimbursement** — identifies the difficulty of CAHs not receiving Medicaid payments for six months or greater and the lack of substantial reimbursement by Medicaid. Many of the CAHs have a long term public aid unit attached to the hospital; have a rural health clinic and even a retail pharmacy, where all are impacted by the shortfall of Medicaid. In addition, CAHs are concerned about the affects of managed care programs where they are at a competitive disadvantage.
- **Rural Capacity** — defines the need to maintain positive relationships with secondary tertiary institutions. Often the larger hospitals compete for the insured patient and are not interested in coordination of patient care between the larger institution and the smaller hospital. Care can be fragmented.
- **Emergency Care Services** — identifies the growing difficulty of maintaining the local ambulance provider. Many of the small volunteer ambulance services are the only emergency care provider for the CAH. The decrease in ambulance services and volunteers will have a negative affect on our small communities. Also, there is a lack of public transportation for those individuals who do not require emergency transport but rather simply need transport to and from the nursing home or to the hospital. The local ambulance provider then provides the non emergency transport and a true emergency happens and a unit from another community has to respond. In addition, the reimbursement for emergency care services is not adequate to maintain equipment and provide training and retain personnel.
- **Health Care Policy** — notes the lack of understanding state-wide of small rural communities and the resources necessary to maintain and/or improve access to health care services.
- **Infrastructure** — identifies an increasing age of the rural facilities and difficulty of complying with building safety standards. The CAH reimbursement program has provided some capital improvement relief but continued support from policy makers for access to funding to make the building upgrade.
- **Health Information Technology** — notes the anticipated cost and resources that will be needed to meet the demands of technology which will place an extraordinary burden on these small rural hospitals both financially and human capacity.
- **Mental Health Services** — identifies there are almost no mental health inpatient and outpatient services for small rural communities for all ages. Patients presenting with mental health or drug induced emergencies to the rural emergency departments are able to receive the emergency treatment but have to then be transported to providers hundred miles or more away for any inpatient psychiatric care. There are limited mental health or drug outpatient facilities in the rural communities to provide any follow up care or provide treatment for those patients not needing hospitalization. There is very poor coordination of care for these mental health patients.
- **Obesity and Chronic Disease Management** — defines the growing rate of obesity in rural areas and chronic diseases such as chronic lung disease from high incidence of smokers and farming.

Contact Information

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Pat also serves as the Illinois CAH program coordinator for the Illinois Department of Public Health Center for Rural Health.

The Economic Impact of the Critical Access Hospital Program on Illinois Communities

EXECUTIVE SUMMARY

Illinois Critical Access Hospital Network



By Northern Illinois University

NIU Regional
Development Institute
NIU Outreach

June 2006

Funded by
the Illinois Department of Public Health Center for Rural Health
and the Medicare Rural Hospital Flexibility Grant Program

Executive Summary

The Economic Impact of the Critical Access Hospital Program on Rural Illinois Communities

Illinois has 51 small hospitals located throughout the state that are designated as Critical Access Hospitals (CAHs). The CAH Program was created by Congress in 1997 as a safety net to assure Medicare beneficiaries access to health care services in rural areas. It was designed to allow more flexible staffing options to respond to community needs, simplify billing methods, and create incentives to develop local integrated health delivery systems, including acute, primary, emergency, and long-term care. The Illinois Critical Access Hospital Network has contracted with Northern Illinois University to analyze the economic impact of the CAHs on their communities. This report presents the study findings.

The market areas served by CAHs are more than three times as rural as the state as a whole. The vast majority of these areas experienced net population loss between 2000 and 2005 and have more elderly, fewer young residents, and lower median incomes than the statewide averages. In two-thirds of the 33 rural CAH counties, hospitals are among the three largest employers in the county.

Two survey instruments were developed to capture information on the effect of CAH status on operating revenue, expenses, employment, patient loads, payor mix, capital expenditures, services, and relationships with other regional healthcare providers. Using input/output modeling and comparative analysis, 20 key findings were generated regarding current hospital operations and net changes in operation and services since CAH designation.

KEY FINDINGS

1. CAH status resulted in immediate and sustained improvements in revenues for almost every hospital that participated in the study, and in improved profitability for the majority of hospitals. However, despite these financial improvements, a number of hospitals reported an ongoing struggle with financial solvency.
2. Increases in Medicare reimbursement and in charges were the two main sources of revenue growth identified by respondents. Increased admissions were the third largest reason for improved revenue streams.
3. Changes in payor mix differed for CAH inpatients and outpatients. Following designation, inpatient changes included decreased reliance on Medicare and increased payments from the self-insured (self-payors). Outpatient changes included increases in both Medicare and Medicaid payments and a decrease in third party payments.
4. The patient revenues generated by this payor mix enabled a majority of CAHs to cover operating costs in 2005. However, only third party payors reimbursed at a rate for patient services that consistently exceeded expenses.
5. Overall, the greatest shortfall in reimbursement is by Medicaid, followed by Medicare and the self-insured. In most cases, the hospitals receive net revenue from third party payors, suggesting a fair amount of cross-subsidy among payor categories.
6. CAHs represent a significant employer in rural Illinois communities. CAH designation enabled the majority of hospitals to increase their staffing levels, primarily in direct care positions. Significant quality improvements were attributed to these additional positions.

Executive Summary

KEY FINDINGS *(continued)*

7. A number of hospitals were able to add clinics and needed patient and community services, expansions that account for much of the increase in direct patient care personnel.
8. The most significant change in service levels in hospitals that had been designated as CAH for at least two years was in outpatient admissions, which grew by an average of 50.9%. Increased admissions were explained, in part, as resulting from facility improvements and expansions and the hiring and retention of quality medical personnel that resulted from CAH designation.
9. Designation as a Critical Access Hospital allowed for the maintenance of patient and community services that were in financial jeopardy and the addition of specialty clinics and services that focused on the emerging healthcare needs of their community.
10. Many CAHs attributed improved services to the increased collaboration and communication with other regional providers that occurred since designation. These enhanced relationships allowed them to provide more services with existing resources.
11. CAH designation enabled many hospitals to address deferred capital improvements, including a number of life/safety projects and routine repairs. These increased capital investments in facility renovation and expansion, replacement of obsolete medical equipment, and the purchase of modern diagnostic and imaging equipment were credited with improving the ability of CAHs to deliver quality services to their communities.
12. COMPdata provided by five CAHs illustrate the breadth and versatility of the medical services these hospitals provide to their communities. In 2005, they treated an average of 108 different diagnoses for inpatients 65 and older and 91 diagnoses for those under 65. Moreover, there were only one or two cases reported for almost two-thirds of these diagnostic categories for both age groups.
13. The rural elderly are primary users of the CAHs. Individuals 65 and older represent 14.1% of the residents of the CAH counties, but made up 65.2% of all 2005 inpatient admissions for the five case study hospitals.
14. CAH designation has enabled small, rural Illinois hospitals to stabilize financially and maintain or expand quality healthcare services to their communities. The continued existence of these medical facilities has a significant local economic impact in revenues generated through hospital expenditures and through employee salaries.
15. The mature CAHs that provided financial data for this report experienced an annual increase of 9% in net revenue between 2000 and 2005, a robust growth rate when considering comparable rates of hospital output of 1.1% for the U.S. as a whole, -0.25% for the Great Lakes region and -0.6% for Illinois.
16. In two-thirds of the rural counties in which CAHs are located, the hospital is among the three largest employers in the county and is a major economic driver for the regional economy. In 2005, the combined net operating revenue for the 33 CAHs that reported FY05 financial data was \$528 million.
17. In addition to these direct economic impacts, another \$235 million was generated by the CAHs in business-to-business transactions and the expenditures by CAH employees on local goods and services (i.e. indirect and induced impacts). The total estimated economic impact of all Critical Access Hospitals on their host counties in 2005 was \$763,794,674.

Executive Summary

KEY FINDINGS *(continued)*

18. Construction projects undertaken by the participating hospitals, many of which were deferred until obtaining CAH status, generated additional economic benefit to their communities. In 2005, CAH facility renovations and expansions resulted in an estimated additional \$11.2 million in revenues to their counties and short-term employment for approximately 571 construction workers.
19. Future capital improvements planned for 2007 through 2011 will produce an estimated additional \$21.7 million in revenues and approximately 1,103 construction jobs.
20. Beyond financial stabilization and quality improvements, survey respondents identified benefits associated with CAH status as the ability to attract and retain qualified physicians and other healthcare personnel to these rural facilities and the opportunity to refocus their operations to improve efficiency.

Critical Access Hospitals throughout rural Illinois serve vital medical and economic purposes. In addition to providing a broad range of primary and emergency care and community services to medically vulnerable populations, particularly the elderly, CAHs are major contributors to the local economic base. Designation as a Critical Access Hospital and access to the financial benefits associated with that program have enabled many of these institutions not only to keep their doors open, but to update obsolete facilities and equipment and respond to the changing healthcare needs of their communities. The continued presence of the hospitals that participated in this study represents annual contributions of more than \$775 million to their local economies through expenditures and payroll.



**Joint Task Force
Rural Health and Medically Underserved Areas**

August 29, 2006

Presentation Remarks by:

Matthew Hunsaker, MD

National Center for Rural Health Professions
University of Illinois, Rockford

August 29, 2006

My name is Matt Hunsaker, I am a family physician by training and I have been involved in RURAL medicine in Illinois for a little over a decade now. I am a life-long resident of Illinois and before returning to the University of Illinois campus at Rockford in a leadership role, I was in full-time practice in Murphysboro, Illinois, west of Carbondale.

My partners and I delivered babies, treated geriatric patients and provided care for each milestone in between. I worked in a Community Health Center that was committed to treating all patients that presented to our practice. At times, we faced the difficult task of maximizing care with minimum resources. While in full-time practice in southern-Illinois, I was also the Medical Director of the Farmworkers Health Center for Migrant workers in Cobden Illinois and I had the first-hand opportunity to work with patients and families facing the most difficult barriers to health care: including cost, transportation and identity documentation. As part of my professional responsibilities at the University of Illinois, I continue to practice two days a week in primary care office in Dixon- a rural community in Lee County and I provide professional support to the Malta Clinic, a Rural Health Clinic. I have held faculty appointments to both public medical schools in Illinois and I am committed to improving both quality and access issues faced by rural communities.

I am pleased to have the opportunity to speak with you today about the concerning state of health in rural communities in rural Illinois. Many rural Illinois communities are struggling to make ends meet when it comes to rural health. Aging providers, rising insurance costs and decreased reimbursement have all pressured rural physicians and hospitals into a crisis situation. The University of Illinois has been partnering with rural communities to face these challenges and continues to develop new partnerships and programs to increase access, improve quality and ensure an adequate health professions workforce in rural communities. First with RMED and now with other innovative health professions programs, the National Center for Rural Health Professions or "NCRHP" at the University Of Illinois College Of Medicine at Rockford has been devoted to reducing

health disparities and improving access in rural communities across Illinois for more than 15 years. The concept of engaging rural communities to protect and promote health is not a new one to the College of Medicine at Rockford.

Each of you represents a specific district in Illinois. Each district is unique. Each has a unique demographic, economic and local history. Illinois is this diversity. It has been the job of each of us that work in rural health to ensure that of the 102 counties in Illinois, the 78 that are designated as rural be represented when health policy and health professions education is considered. The Rural Health Task Force is an important opportunity to enhance funding and address rural health issues and I am optimistic that the Task Force will raise the bar of health professions training programs in Illinois as a component of that plan.

Often at public hearings, I am surrounded by my friends from the agencies and associations that work cooperatively around the state to advocate for rural health. We each come from different areas of expertise and different institutions but our paths are inter-twined as we work to help rural health care survive in often difficult circumstances. In Illinois, the Center for Rural Health at the Illinois Department of Public Health has worked tirelessly to connect the willing partners in rural health. They have been a shining star in the Department of Public Health despite budget cuts and personnel reductions. I would certainly support both mention of and restoration of the Center for Rural Health in the Improvement Plan. It has been an integral part of the statewide team. We appreciate the opportunity to share our individual expertise from the NCRHP today, but acknowledging we are members of a cooperative rural team from many agencies.

It is a concerning statistic that 64 of the 78 rural counties in Illinois are underserved for primary care health services. Dental access is impossible in some communities and shortages in nursing and pharmacy threaten to affect quality. These challenges left unchecked undermine the individual and collective health of small communities. Families that fail to receive primary care services often enter the health care system, critically ill, and

the most expensive to treat, through emergency department services. Much of the reducible cost of health care hinges on early intervention provided in a doctor's office rather than episodic, disease-based, emergency salvage care. In Illinois we are struggling to meet the number of physicians required for primary care offices and in some communities this extends to provider shortages in emergency room coverage as well. As we consider rural health, we must ensure adequate workforce capacity in rural communities exists with physicians, nurses and other health professionals.

While 20 percent of Americans live in rural areas, only 9 percent of the nation's doctor's practice in rural areas and Illinois is no exception. The shortage of health care workers in Illinois is expected to rise sharply in the next ten years. Expected "baby-boomer" retirements and inadequate numbers of students in the rural oriented student pipeline will shrink the overall capacity of our health care systems. What Illinois does now to reverse this trend will determine its ability to meet demand in the future. By 2010, using a generous average retirement age of physicians of 75 years-old; 485 additional physicians will be needed in rural Illinois to replace retiring physicians. By 2010, Illinois supply of nurses will be 4,265 short, nearly half of those required in rural communities.

The lack of access to oral health care services for children has reached an all-time crisis level- a crisis made worse in rural areas due to a shortage and misdistribution of providers. Children in 82 of Illinois 84 rural counties do not have access to oral health care. Eighteen rural counties do not have a dentist that participates in Medicaid. The average population-per-dentist ratio in rural Illinois is 2,566-to-1 dentist compared to 1,397-to-1 in metro Illinois – a misdistribution of nearly two-to-one to the disadvantage of rural populations. Of 494 dentists in Illinois, 29 percent reported they will reach or exceed age 65 within the next ten years. This means that in the midst of Illinois' existing crisis, 141 dentists will be leaving the workforce. One-fifth of Illinois dentists graduated from Illinois Dental Schools that no longer even exist. Once there were four schools... Now, only two schools remain. We must ensure that consideration and special programming is instituted to recruit students from

rural communities for dentistry and promote rural dentist retention.

Pharmacies, particularly hospital pharmacies in rural areas, are facing difficult challenges recruiting graduates. The lack of availability of pharmacists leaves the small rural hospital struggling to meet its operational demands. The expansion of chain pharmacies may have increased urban convenience but it has engaged an increasing number of pharmacists. The complexities of modern therapeutics require the integration of appropriately trained pharmacists in the clinical management of patients. By 2010, 400 additional pharmacists will be needed in rural Illinois to meet demand.

I enumerate the shortages for the purpose of demonstrating the gravity of what we are discussing today. We need to ensure that rural students are both recruited and represented in the health professions or we have very little chance of sustaining rural health care. The aging health professions workforce, deemed by some to be the "Silver tsunami" is of paramount concern in Illinois strategic planning. We believe that the planning and steps we take today will protect the health future of rural Illinois.

Despite these concerns, there have been several **positive** milestones in the history of Illinois' rural health. Each positive milestone integrated with others before it, has "made the difference" to preserve Illinois' Rural Health Care Infrastructure. Integration of the agencies, programs, associations and consumers has held the infrastructure together—at times on extremely limited budgets. This is perhaps one of those times. The trend data we will share today comes with the reminder that each day 1 out of 4 people in a rural area gets up in the morning and is involved in some way in rural health care. We are talking not only about health care services, but economics. Rural health care is the glue that allows the elderly to remain on the farm longer, farmers and agribusiness professionals to live in rural communities, and economic development to occur in the largest portion of the state — rural Illinois.

Several milestones in rural health are of note: The Illinois Rural and Downstate Health Act and the

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programs it created; the Health Care Summit for Rural and Underserved Areas hosted by the Public Policy Institute at SIU, and spearheaded by the late Paul Simon and third the Health summits on Emergency Medicine, Mental Health and Professional liability hosted by Illinois Rural Health Association. Each time, stakeholders in rural medicine have been engaged in dialogue about protecting the future of rural health. Today, I would like to take a few moments and focus your thinking on Health Professions Workforce capacity as it pertains to rural areas. Specifically, I want to tell you about the ongoing work at the National Center for Rural Health Professions at the University of Illinois at Rockford.

Nearly fifteen years ago, representatives from the University Of Illinois College Of Medicine at Rockford, SIU and other “public trust” partners went before representatives of the legislature to discuss concerning access issues in rural health. At times the discussion was difficult and uncomfortable. They enumerated physician access as one of the biggest challenges. The two Public Medical Schools had to answer the difficult question, “Are we providing an appropriate medical work force for the State of Illinois? Rural workforce has been overlooked as an indicator of success for public medical and nursing schools. We cannot afford to overlook rural communities in Illinois.

ACCESS and Quality do matter to the people of this state. The discussions fifteen years ago partnered healthcare, academic and civic leaders from across the state with the legislature to begin to design innovative solutions for rural health access problems. The product of those efforts was known as the Illinois Rural and Downstate Health Act. It provided pioneering legislation that created an opportunity to address rural health –Directly- in an environment where funding dollars were tight and growing concerns about capacity and quality were beginning to emerge. Those challenges are not unlike the challenges we face today.

The Rural Downstate Health Act invested resources directly into higher education for the purpose of reversing shortage trends. I am pleased to tell you that the Downstate Health Act monies entrusted to the University of Illinois at Rockford have yielded a valuable return on investment for

the people of Illinois. I am pleased to report that what began as an effort to change the medical professional de-population of rural communities has continued to evolve into additional interdisciplinary programming to address disparities in the other non-physician health professions. The focus of this work is to provide tangible benefits to rural hospitals and the consumer in Illinois.

The Rural Medical Education Program has worked diligently to maximize the outcomes of the original investment in “rural programming” by partnering with communities to cultivate pre-professional students for medicine. The students are involved in a unique selection, training and mentoring processes called RMED. Students are recruited from rural communities who, in the screening process, express an affinity for returning to a rural community. They enroll in the University Of Illinois College Of Medicine and receive a doctorate in medicine upon completion. The RMED program is “add-on” to the medical curriculum that focuses on understanding the delivery of health care in rural communities. The curriculum has aspects on mental health, community problem solving, community service and many other pertinent topics not offered in a traditional medical curriculum. The final year of medical school for an RMED student includes 16-weeks of field work in a rural physician’s office. The student lives in the community and gets “real-world” experience in being a part of the interdisciplinary team in a rural hospital.

So far the partnership of involving rural communities has been a very successful one. We now have 132 graduates from the RMED program. Of those graduates, 67 are still in residency programs completing their training. Of the fully-trained physicians, 92 percent are practicing in Illinois communities and 74% are in Rural Primary care. These numbers lead the nation in accomplishing the goal of physician replacement in rural communities through this special program.

What is often called the “Rockford Model” in educational circles is more appropriately called the Illinois Model. We have “Academic-Community Partnerships” in more than 40 communities across the state. We have RMED teaching locations in 25 of those rural communities. We truly cover that

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state from one end to the other. The communities are as geographically diverse as Metropolis, Freeport, Galesburg, Marshall and Gibson City- with two new sites coming online in Centralia and Galena. The map I have included shows the wide geographic distribution of teaching sites around the state. We are cultivating physicians and programs that will provide sustainable capacity, access, and quality for Illinois.

RMED is truly a different type of program from traditional "HALO effect" of medical schools that often shows clustering of graduates in a sixty-mile radius around a teaching location. As you can see from the graduate distribution map, our graduates aren't clustered around the Rockford campus site, ignoring the rest of the state. The key is successful partnership with rural communities. Involving communities in protecting their future through a commitment to recruitment and education has strengthened local capacity. In places like Dixon, Illinois and Logan Primary Care in Herrin Illinois, RMED graduates have become the next generation of rural physicians where previously physician recruiting was difficult and huge shortages existed.

By working with local leaders, hospitals and professionals, the University of Illinois partnerships have lead to success in the physician workforce shortage program. The concepts and successes of RMED have been piloted in rural Illinois communities and shared nationally and internationally. Many of the strategies first piloted in RMED are exportable to health disparities reduction in both rural and urban underserved communities. Components of the RMED program have been replicated in Rural Florida, Alabama, and Wisconsin. The transfer of knowledge to international partners has been an exciting by-product of successful program implementation. The Rockford Campus hosted the World Health Organization's (WHO) first conference on medical education- a gathering of leaders from around the world. In September we hosted the First Rural Medicine Program Director's meeting for the National Rural Health Association.

In the calendar year 2005, the National Center for Rural Health Professions hosted a delegation from the Ministry of Health, Division of Rural Health from Beijing and maintains an ongoing relationship with

the Liaoning Province, China. These Chinese health leaders traveled out into rural communities in our state to visit rural teaching sites. They had the opportunity to visit rural Illinois communities and see successful academic-community partnerships in action. Health education leaders from South America, the Netherlands, and Malaysia all participated in rural Illinois Health activities as a part of the NCRHP this year. Activities this year have included work with colleagues from South America, Japan, Columbia and the Dominican Republic. Each international partner is interested in replication of a portion of the centers work in Illinois. The RMED program has provided additional capacity in rural Illinois and become a resource for others facing the task of providing quality care and access in rural communities nationally and around the globe.

We are certain that the RMED method can be adopted for other health disciplines where there are shortages. The information shared with you today provides a blueprint for increasing the capacity to educate health professionals who will be committed to rural Illinois' immediate and long-term health needs.

The statistics validate the reality that we have a health professions workforce problem in rural Illinois. Rural communities have asked the rural programming staff at the University of Illinois at Rockford to develop similar academic-community partnerships and programming for other "in-demand" health professionals. The evolution of the mission from a physician-based training program – RMED- to a National Center for Rural Health Professions has been a genesis of necessity. In communities where RMED graduates have located, they have provided professional expertise, enhanced access for patients, and improved overall capacity in a "graying-medical workforce." We are ready to adapt the RMED model to the other professions currently facing critical shortages.

As I mentioned at the beginning of my remarks, several of the milestones in Illinois Rural Health Care have addressed Workforce capacity as a concern. We believe it is time again to plan for adequate numbers of rurally oriented professionals to be selected, enrolled and graduated from Illinois'

publicly-funded institutions of higher education. Nationwide efforts by public health, professional societies and health policy experts has not provided adequate leverage to persuade suburban-born students to transplant to rural or underserved communities.

If the rural healthcare workforce is to be adequate for the growing capacity requirements of the next ten years, in must be a partnership of the legislature, public academic institutions and rural communities. Healthy rural hospitals require adequate staffing to provide quality care and sustainability.

The National Center for Rural Health Professions has not achieved its success as a lone outpost on the Rockford campus of the Medical School. We have had the cooperation and support of many of the agencies, the professional training programs of the UIC campus, the Center for Rural Health at IDPH, Illinois Critical Access Hospital Association, the Illinois Academy of Family Practice, the Illinois Hospital Association Small-rural constituency, the Illinois Rural Health Association, the Illinois Institute of Rural Affairs, NIU and others. We also owe a debt of gratitude to the 40 communities and hospitals around the state that represent the academic-community partnerships where we are working to improve health and educate our students.

The blueprint we have provided today is the product of cooperation, and innovation. It addresses the issues raised in the report of the Public Policy Institute led by Paul Simon in the monograph entitled "CHARTING A HEALTH CARE AGENDA" 2003. The monograph was a strategic plan for improving health care in rural and underserved Illinois. Included in the report are eighteen recommendations for rebuilding Illinois' rural health infrastructure and ensuring future

capacity. We are certain that the National Center for Rural Health Professions is capable of addressing 7 of the key eighteen recommendations as they pertain to workforce issues. The National Center participated in that historic summit, and the document we have given you today is a follow-up those important recommendations. We offer four specific suggestions as they pertain to rural health professions workforce concerns. They include:

- Successful student recruiting methods for all disciplines;
- Expanding rural health professions education using the RMED model;
- Enhance rural health workforce retention efforts; and
- Establish and maintain a consistent database measuring the Illinois rural health workforce.

The details are presented for your evaluation and review. We are certain that if we are provided the opportunity, and financial resources, the center can continue to reduce health care disparities in rural Illinois communities and protect the rural diversity that represents our state.

From Galena to Metropolis and from Beardstown to Marshall we continue to criss -cross the state in forwarding rural medicine with the work of the RMED, the NCRHP and our rural partners.

In closing, I appreciate the opportunity to update you on the progress of the Center since we last met at these hearings. Enhancement of the Rural Downstate Health Act is an excellent opportunity to improve training programs and fully realize the rural health workforce goals in Illinois. We look forward to working with our partners at IDPH Center for Rural Health and SIU College of Medicine as we work to reduce health disparities across the State.

Thank you.

Reversing the Trend of Health Care Workforce Shortages in Rural Illinois



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Executive Summary

Program: National Center for Rural Health Professions (NCRHP)

Location: University of Illinois-Rockford

IBHE Status: In June 2006, the Illinois Board of Higher Education granted NCRHP permanent National Center status. (The Center had been operating at temporary status the previous six years.)

Description: The goals of the NCRHP are: (1) to reduce health disparities and meet the health care needs of rural residents through education, research and community outreach; and (2) expand and implement recruitment, retention, and health care delivery initiatives that will positively impact the health and well-being of rural residents and their communities.

Of Illinois' 102 counties, 78 are designated as rural, and of these, 64 have been experiencing shortages of primary care health services for more than two decades. In response to the need, the Rural Medical Education (RMED) Program was established in 1993 to train physicians for rural practice. The RMED approach is based on recruiting medical students from Illinois' small towns and rural areas where they will return to set up practice following their training. RMED now leads the nation's rural medical education programs in returning physicians to rural practice, specifically in Illinois. To date, 70 percent of RMED graduates are practicing in rural Illinois communities as primary care physicians.

With the 2000 expansion of the University of Illinois College of Medicine-Rockford to the National Center for Rural Health Professions, the Center's mission expanded to address shortages in additional health professions. Within Illinois and nationally, health workforce shortages exist in nursing, pharmacy, dentistry, public health, mental health, and others, and are expected to worsen.

- By 2010, approximately 485 additional physicians will be needed in rural Illinois to meet growing demand and to replace retiring physicians.
- By 2010, Illinois' supply of registered nurses will fall short by 4,265—nearly half of which will be required in rural communities.
- At this time, children in 82 of Illinois' 84 rural counties do not have access to a pediatric dentist who participates in Medicaid.
- Between 2006 and 2010, about 400 additional pharmacists will be needed in rural Illinois to meet growing demand and to replace retiring pharmacists.

Funding has not yet been appropriated to expand the Center's programs to build rural Illinois' health professions workforce. In the meantime, the Center has attracted grant funding from the National Institutes of Health and cultivated partnerships with state and national organizations to address health disparity issues in rural and underserved populations. However, permanent core funding is still needed to implement a comprehensive recruitment and retention program for all the health professions.

Request: This request is for recurring State appropriation to provide core funding to continue and expand the Center's successful health professions recruitment and retention program.

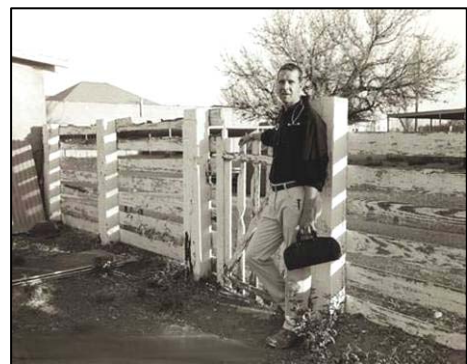
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Reversing the Trend of Health Care Workforce Shortages in Rural Illinois.

Attracting and keeping health professionals is a challenge for many rural communities. In 1993, Illinois legislators supported pioneering efforts to address a physician supply crisis. Those efforts have proven effective at graduating health professionals and have positively affected Illinois. Over the past 15 years the Illinois Rural Medical Education (RMED) Program has directed strategies at the re-supply of rural physicians. The program has achieved a 70 percent success rate in returning primary care physicians to rural Illinois communities—largely due to unique processes in selection, training, and mentoring students. RMED recruits students from rural communities who, in the screening process, express an affinity for returning to a rural community to practice. This method can be adapted for other health disciplines where there are similar shortages. This document provides a blueprint for increasing Illinois' capacity to educate health professionals who will be committed to rural Illinois' immediate and long-term health needs.



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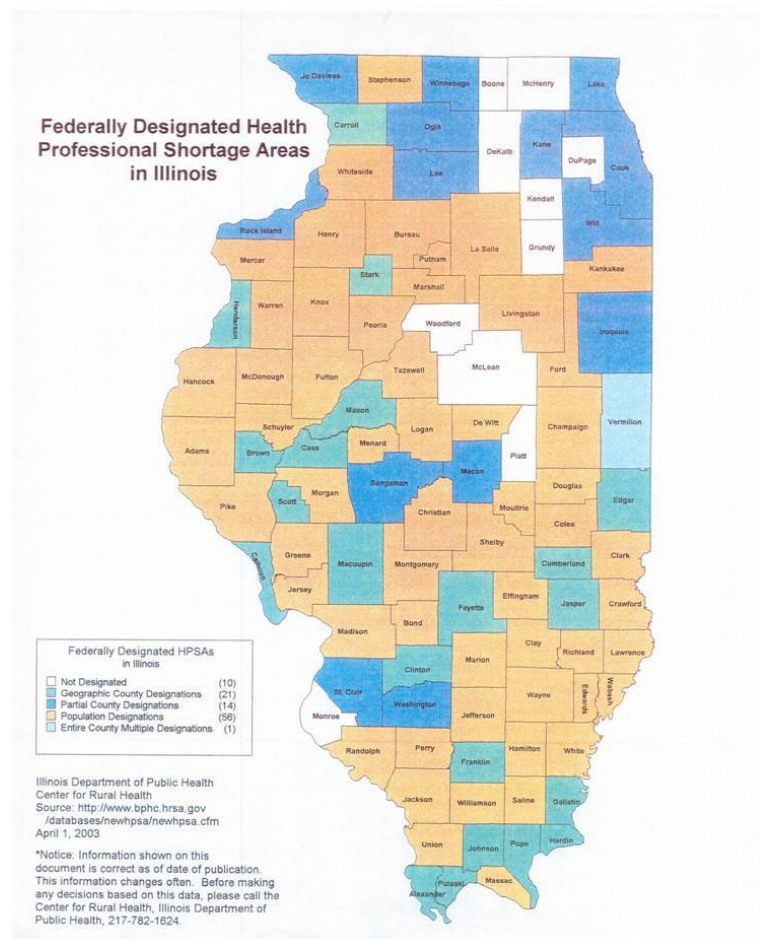


Illinois' rural health workforce supply crisis is expected to worsen in the coming decade.

While 20 percent of Americans live in rural areas, only 9 percent of the nation's doctors practice there.¹ Illinois is no exception. The shortage of health professionals in rural Illinois is expected to rise sharply in the next ten years. Expected "baby-boomer" retirements and inadequate numbers of students in the pipeline will shrink the capacity of our health care systems. What Illinois does now to reverse this trend will determine its ability to meet the demand for health care, which is expected to grow substantially in the next 8 to 12 years.

Physicians

- Eighty-eight Illinois counties have been designated full or partial physician shortage areas—85 percent of which are rural counties.²
- By 2010, approximately 485 additional physicians will be needed in rural Illinois to meet growing demand and to replace retiring physicians.³
- It takes at least eleven years from the time a high school graduate begins preparing for medical school to be fully qualified as a practicing physician. The training period varies for each health profession.



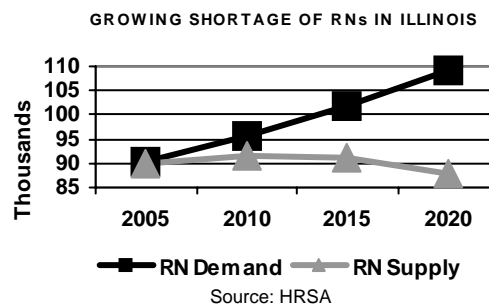
This means we need to start now to educate enough new health professionals to prevent a profound reduction in the availability of health care services.

Nurses

Quality health care requires adequate nursing staffs. Rural Illinois' nursing shortage will grow worse as rural health care needs increase.

- All of the 30 Illinois counties designated as nursing shortage areas in 2004 are rural counties.⁴
- By 2010, Illinois' supply of registered nurses will fall short by 4,265—nearly half of which will be required in rural communities.⁵
- Illinois' aging rural population will increase demand for health care services through 2020.
- Nationwide, the number of newly licensed nurses is projected to be 17 percent lower in 2020 than in 2002; losses from the nursing workforce due to death and retirement is projected to be 128 percent higher.⁵
- A shortage of nursing faculty is aggravating the problem by limiting the number of students in the nursing pipeline.⁶
- The practice of recruiting rural nurses to jobs in nearby urban areas will exacerbate rural shortages and will increase as urban hospitals offer employment incentives to fill their own nursing shortages.

Nursing Shortage Counties

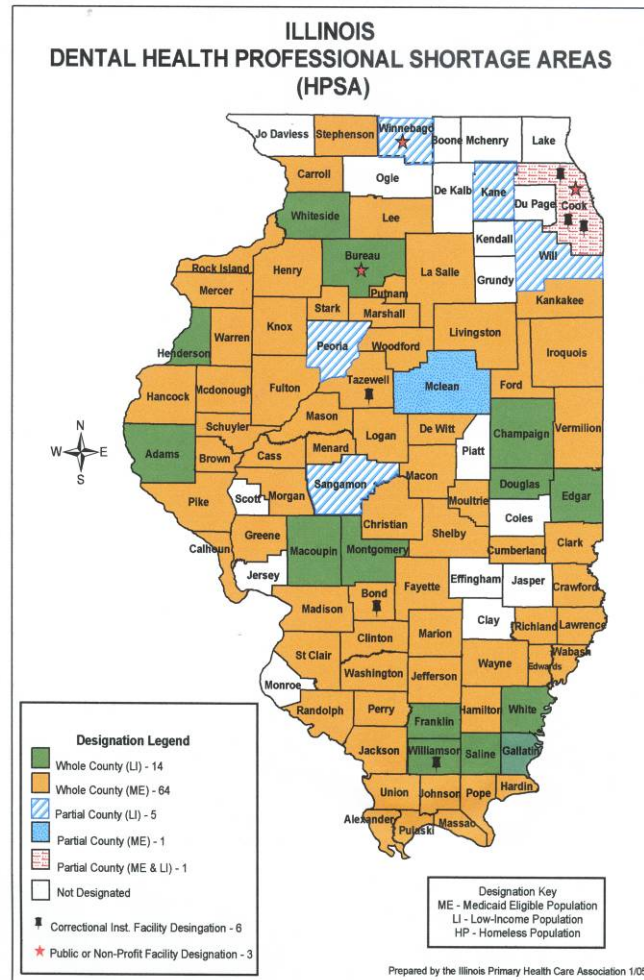


To moderate future nursing shortages, prompt intervention is needed to enhance and expand Illinois' nursing recruitment and education programs. To take advantage of the Governor's recent initiative to fund nursing education, rural recruitment and retention programs must be in place and ready to train qualified candidates.

Dentists

The lack of access to oral health for rural children has reached an all-time crisis level—a crisis made worse in rural areas due to the shortage and maldistribution of providers. Oral health is critical to our children’s general health and educational success. Cavities and other oral health problems lead to missed school days and ongoing dental problems.

- The average population-per-dentist ratio in rural Illinois is 2,566-to-1 compared to 1,397-to-1 in metro-Illinois areas—a maldistribution ratio of nearly two-to-one to the disadvantage of rural populations.
- Of 494 rural Illinois dentists surveyed in 2004, 29 percent reported they will reach or exceed age 65 within the next ten years.⁸ This means that, in the midst of Illinois’ existing shortage crisis, 141 additional dentists will be leaving the workforce.
- Children in 82 of Illinois’ 84 rural counties do not have access to a pediatric dentist who participates in Medicaid.⁹
- Eighteen rural Illinois counties do not have any dentist who participates in Medicaid.⁹
- Almost one-fifth of active rural dentists graduated from Illinois dental schools which are now closed. Until recently, Illinois had four dental schools. Now, only remain.⁹



Illinois must include programs for increasing the supply of dentists in underserved populations among its strategies for improving access to dental care for low-income children.

Pharmacists

Pharmaceutical care can increase the quality and years of healthy life and reduce health disparities among population groups. Unfortunately, a shortage of pharmacists exists in both rural Illinois hospitals and retail pharmacies. The lack of availability of pharmacists has left rural hospitals struggling to meet demand.

Through NIH funding and in collaboration with the University of Illinois-Chicago College of Pharmacy, NCRHP researchers are monitoring the effect recent changes in senior citizen pharmaceutical benefits will have on demand for rural pharmacists. Current research also examines the ability of small, independent rural pharmacies (as compared to the larger, urban-based chain drug stores) to survive the financial strains of smaller and longer-delayed reimbursements resulting from publicly supported drug programs.

- In response to a January 2005 survey, chain pharmacies representing more than 23,000 retail stores nationwide identified central and southern Illinois and several communities in northern Illinois as pharmacist shortage areas.¹⁰
- Between 2006 and 2010, about 400 additional pharmacists will be needed in rural Illinois to meet growing demand and to replace retiring pharmacists.^{11, 12}

Pharmacists play a vital role in health care delivery through collaboration with and referral to other health professionals. They dispense medication, provide community-based patient education, and promote safe and effective medication use. Effective pharmaceutical care decreases drug-related morbidity and mortality and improves the public health. Addressing the shortage of pharmacists will be an effective investment toward reducing health disparities among rural Illinois populations.

Illinois' demographic and environmental trends will increase demand.

As our rural population ages, demand for health care services will rise dramatically.

- In 2001, 20 percent of rural Americans were 60 years old or older, significantly higher than the 15 percent of seniors living in metropolitan communities.¹³
- The older population in America is expected to double between 2001 and 2050.¹⁴
- Adults 75 years of age and older visit physicians 3 to 4 times more frequently than the next highest service group, children under the age of 17.¹⁵

Illinois' health professional supply crisis will render it unprepared for future health challenges.

- Health workforce shortages have led to reduced staffing in health care facilities, placing patient safety and quality of care at risk.¹⁶
- Shortages of nurses, physicians, public health workers, and other health professionals will hinder Illinois' ability to manage mass casualty events such as natural disasters, flu epidemics, and bioterrorist attacks.¹⁷
- Illinois programs to extend health care and prescription coverage to at-risk populations should be accompanied by plans to increase the capacity of health care providers and pharmacists to meet the resulting increase in demand.

Current health trends will further strain fragile health care systems.

- Illinois is among the states with the highest incidence of diabetes—6 percent of all residents. Diabetes can lead to visual impairments, heart disease, and stroke—all of which require increased health and medical services to manage in order to reduce disabilities and costs.¹⁸
- Nationwide, the percentage of young people who are overweight has more than tripled since 1980. Illinois is no exception. The latest data show that 22.9 percent of Illinois adults are obese. Being overweight or obese increases the risk of high blood pressure, high cholesterol, diabetes, heart attack, stroke, respiratory problems, and some cancers—all of which require professional health intervention.¹⁸

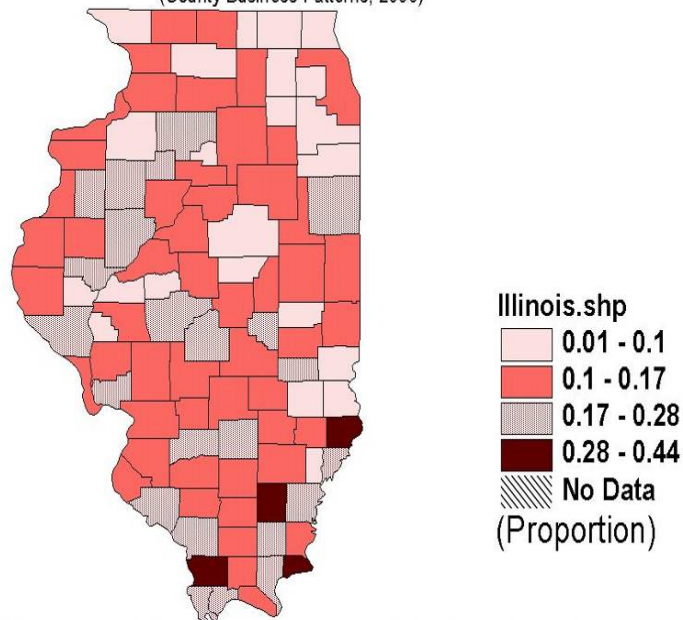
Investing in the rural health workforce yields positive returns in local economies.

A viable health sector is a major component of a community's infrastructure. The health sector not only contributes to the medical health of the community, but also to its economic health. Attraction of new businesses to create jobs and economic growth can be difficult without the availability of quality health and medical services.¹⁹

- Among rural Illinoisans, health care jobs provided 9.2 percent of all local income in 2000.²⁰
- More than 16 percent of rural Illinoisans were employed in health care and related fields in 2000. (Figures do not include government hospitals.)²⁰
- The health care workforce impacts Illinois' local economies by generating employment and income in other sectors.
- Every doctor or dentist practicing in rural Illinois generates 1.94 additional jobs in the local area due to their business and household spending.²⁰
- For every nurse or protective care provider, 1.3 additional jobs are created.
- For every dollar earned by a doctor, dentist, or nurse, an additional \$1.59 is generated in the local economy.²⁰

Employment in Health Care*

(County Business Patterns, 2000)



* (health care & social assistance employment)/(total employment)

* excludes self-employed individuals and most government employees

* includes employees at government owned hospitals, such as a county hospital

Recommendations for rebuilding Illinois' rural health infrastructure and ensuring future capacity

#1 Expand successful student recruiting methods to all disciplines.

Rural medical education programs around the country have developed a formula for attracting students from rural and underserved communities who will, upon graduation, return to those communities to set up practice. With sufficient resources, this model can be adapted and expanded to attract promising candidates to the educational programs of all health professions.

To realize this goal, the following steps are needed.

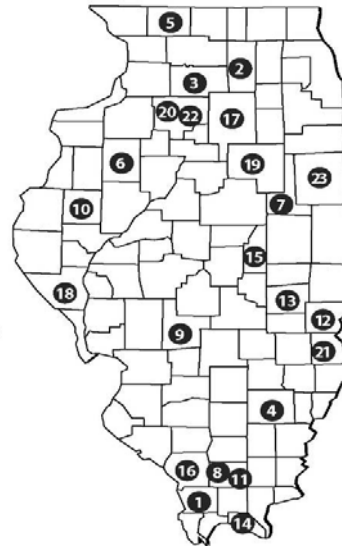
- Partner with Illinois high schools and community colleges to develop advanced curriculum resources for preparing students to enter health professions degree programs.
- Develop a comprehensive, statewide program to encourage student interest in Illinois' health professions shortage areas.
- Identify prospective students early and assist them and their families in the preparation and admission processes.

#2 Expand rural health professions education using the RMED teaching model.

In addition to fulfilling degree requirements, health professions students who specialize in rural health gain understanding of the ways they can interact with rural communities to affect health. The program involves students in designing and evaluating rural health programs in the context of the community's social, economic, cultural, and organizational structures. In addition to their regular curricular experience, RMED students spend four months working and learning in rural hospitals and offices alongside physicians and other rural health professionals. The 16-week "preceptorship" focuses on integration of the professional into the rural community. This experience bonds RMED students to rural communities and rural practice. The RMED model can be modified for interventions in other rural health shortage disciplines.

RMED COLLABORATING HOSPITALS

1. Anna
2. DeKalb
3. Dixon
4. Fairfield
5. Freeport
6. Galesburg
7. Gibson City
8. Herrin
9. Litchfield
10. Macomb
11. Marion
12. Marshall/
Terre Haute
13. Mattoon
14. Metropolis
15. Monticello
16. Murphysboro
17. Ottawa
18. Pittsfield
19. Pontiac
20. Princeton
21. Robinson
22. Spring Valley
23. Watseka



The return on investment in Illinois' rural health professions programming will provide for:

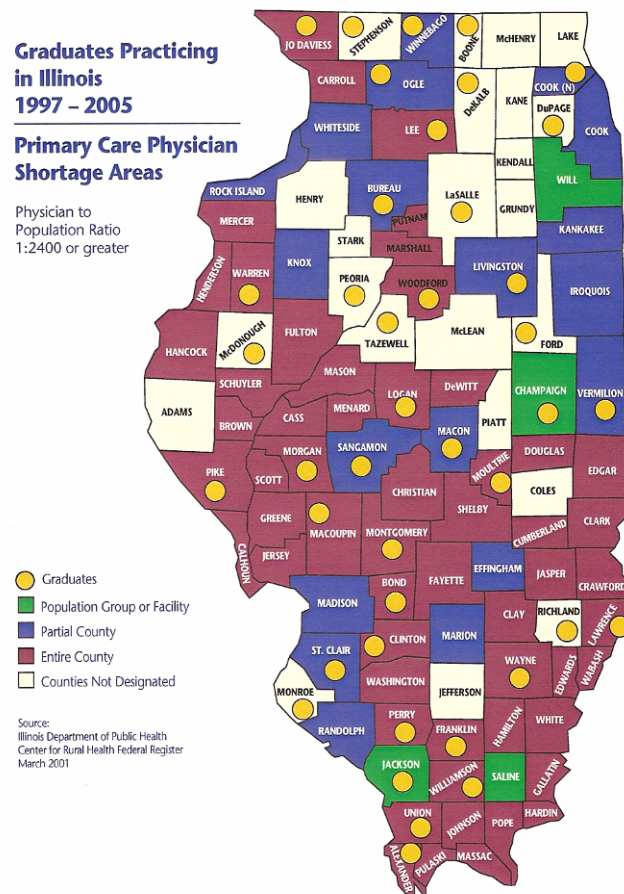
- development and enhancement of the rural health curriculum for each discipline;
- expansion of rural health teaching locations; and
- coordination of training experiences and integration of health professionals into the training network.

#3 Enhance rural health workforce retention efforts.

Efforts to match up physicians with their patients can improve distribution, retention, and the quality of medical care. Many communities suffer from temporary physicians who have not been trained in and for rural or underserved areas, who share few characteristics with rural peoples, who are costly to replace, and who often do not become a part of rural communities and economies.²¹

RMED leads the nation's rural medical education programs in returning physicians to rural practice, specifically in Illinois. Of RMED's 132 graduates, 49 are in residency training and 55 are in primary care practice in Illinois.

RMED's retention rates are improving both the quality and availability of health care in rural Illinois. Seventy percent of RMED graduates are practicing in rural Illinois communities as primary care physicians.



It's important to remember that health professions training is not a fast process. It requires commitment and support. In the case of physicians, it takes eleven years. Retention is a product of screening—getting the right students. Appropriate recruitment and enrollment, coupled with community engagement and curriculum, yield successful outcomes.

#4 Establish and maintain a consistent database measuring the Illinois rural health workforce.

Illinois has no comprehensive, up-to-date inventory of its health workforce. The inability to measure the supply of workers complicates the projection of future shortages. Current licensure data tends to overstate the workforce because license holders may practice in other states. Moreover, typical licensure counts do not define the role that a license holder plays, if any, in the delivery of health care services. In fact, many license holders are not actively engaged in their professions' delivery of patient care. A functional, ongoing tracking and evaluation system of Illinois' workforce will enable health and medical workforce administrators and educators to develop and prioritize appropriate programs and to better channel resources for meeting Illinois' immediate and long-term workforce needs.

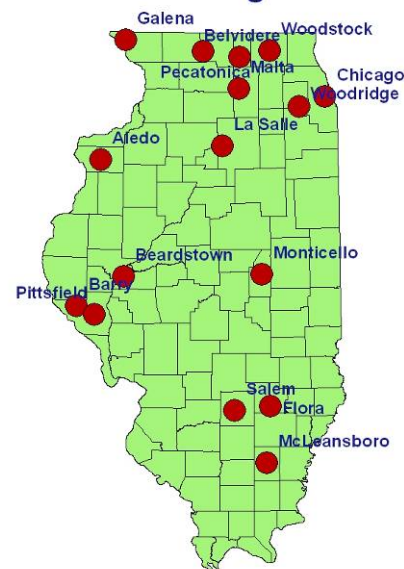
Health Disparities Reduction Initiatives

The mission of the National Center for Rural Health Professions is to promote the health of rural communities through partnerships in education, outreach, research and policy. The following examples of Center efforts focus on reducing health disparities among Illinois' rural and underserved populations. Health disparities occur when poor education, diseases, and environmental conditions disproportionately afflict members of specific population groups in comparison to the general population.

Research

Health clinics in twelve rural Illinois towns are partnering with Center researchers to compare the effectiveness of different levels of support on their patients' success in managing their diabetes. Illinois is among the states with the highest incidence of diabetes—six percent of all residents, nine percent in rural areas, 10.2 percent in Latino populations, and 13 percent among African Americans. The value of diabetes education is clearly documented. However, only 45 percent of persons with diabetes receive education. Research shows that diabetes patients who never receive education are at a four-fold higher risk of major complications. This study allows for comparisons between practice-based interventions versus those with patient-centered emphasis. Results will inform practitioners regarding effectiveness of monitoring and education to improve health outcomes of diabetes patients.

Clinic Sites Diabetes Self-Management Study



Education and Training

The Center is currently tracking the effectiveness of a summer program that gives rural Illinois high school students a chance to experience day-to-day activities of various health professionals. The objective is to encourage students from rural communities to consider careers in the health and medical professions. The third annual Health Careers Camp was held this summer on the campus of Northern Illinois University in De Kalb. Each year, between 30 and 50 students representing rural high schools around northern Illinois attend. Health professions students from Illinois colleges and universities serve as camp counselors.

The objective is to introduce rural students to the opportunities available in health professions, as well as educational and academic requirements, financial aid, and campus life. Students practice health care-related procedures with nurses, clinical laboratory technicians, speech/hearing specialists, nutritionists, and physical therapists. Camp sponsors and organizers hope to encourage rural Illinois students to pursue health professions education and then return to rural Illinois communities to set up practice.

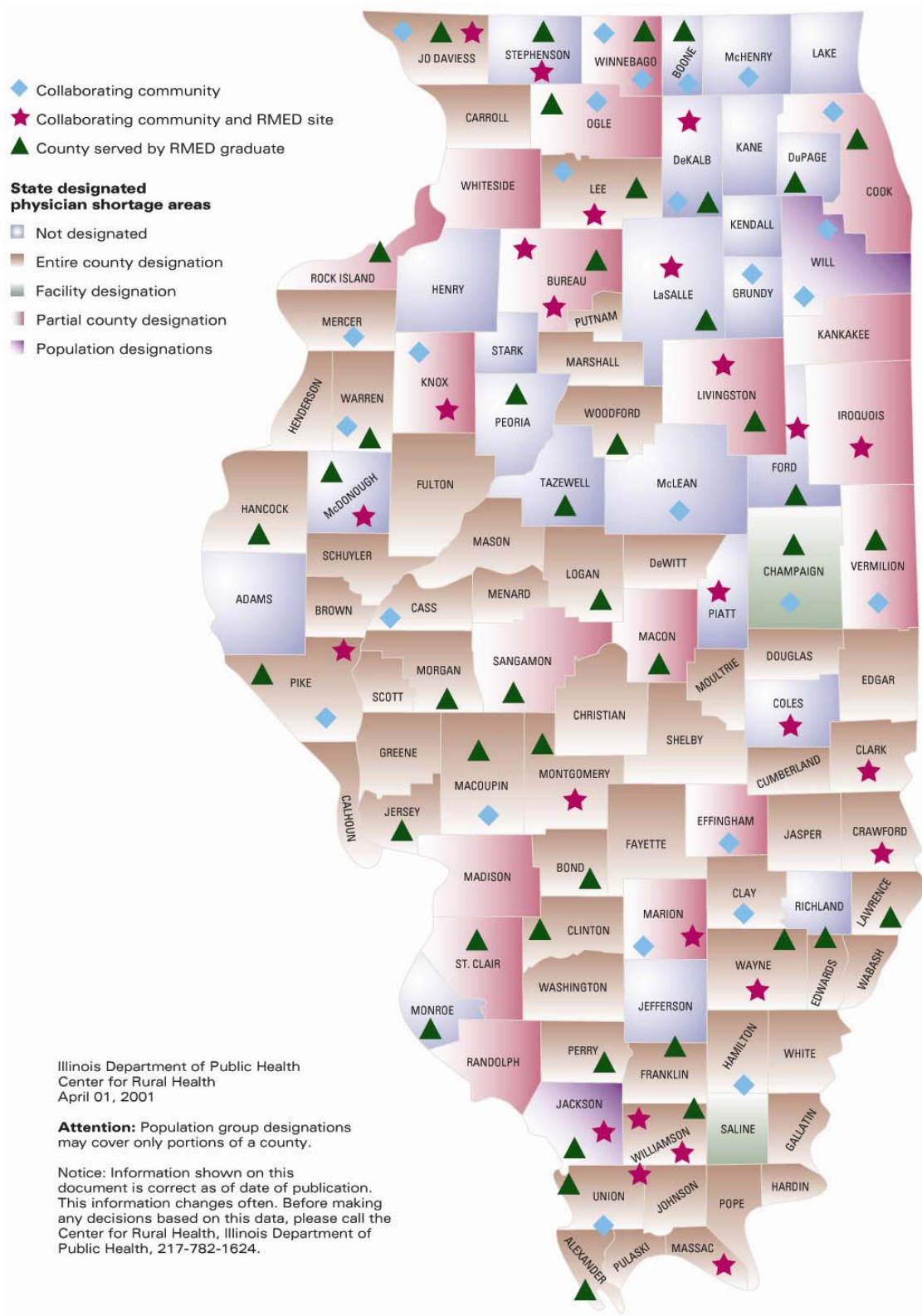
Outreach

The Center is applying a proven method of identifying health-related needs and building community problem-solving capacity in several rural Illinois Latino communities. The method follows the Community Based Participatory Action Research model (CBPAR), which involves coaching communities with underserved populations to build capacity at the grassroots level. CBPAR engages community members, organizations, and researchers in determining needs and implementing strategies to address those needs.

Current projects in Beardstown, Belvidere, Carbondale/Cobden, Champaign/Urbana, Danville, DeKalb/Sycamore, Effingham, Galesburg/Warren County, Rochelle, and Rockford are at varying stages of progression. The projects are made possible through National Institutes of Health funding and through partnerships with community organizations.



National Center Collaborating Communities



National Center for Rural Health Professions

Origin.

The University of Illinois College of Medicine at Rockford was one of two key academic partners in the 1990 Rural Downstate Health Initiative—legislation designed to improve access to health care services in rural downstate shortage areas. Toward fulfilling this charge, the U of I College of Medicine at Rockford initiated the Rural Medical Education Program (RMED). The evolution of RMED into an interdisciplinary center to address other health professions shortages was the genesis of the National Center for Rural Health Professions.

Scope.

The RMED program has become a national and international resource for reducing rural health disparities. Visitors from as far away as China, the Netherlands, Malaysia, and Japan have come to Rockford to learn about the RMED program. The University of Illinois College of Medicine hosted the World Health Organization's (WHO) first conference on medical education—a gathering of medical education leaders from around the world. Many of them come from countries facing similar rural health challenges.

Impact.

The impact of the Center has already been demonstrated at many levels. Nearly 70 percent of RMED graduates have returned to rural primary care practice in Illinois. The RMED Program has been used as a template for the development of other medical education programs, including those in Alabama, Florida, and Wisconsin. Adaptation and expansion of this model will help meet demands for other health professionals in rural Illinois.

Partnerships.

The Center partners with state, national, and international educational institutions to pioneer new models of recruitment, education, and retention. These models, piloted in local Illinois communities, have been exportable to communities across the nation and in other countries. Partnerships also enable the Center to implement interdisciplinary health team models to enhance the quality of care in Illinois and provide an academic resource for partners around the world.

Outlook.

In June 2006, the NCRHP's application for permanent "National Center" status was approved by the Illinois Board of Higher Education. Other promising developments for the rural health workforce include the recent commitment of resources by the University of Illinois Board of Trustees toward the construction of a home base for the National Center on the Rockford campus, and the commitment by the Governor of more resources toward nursing education.

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Methodology

Physician Data. Physician characteristics in rural Illinois counties were based on data in the American Medical Association (AMA) Masterfile. PT Williams, et al. [J Am Board Fam Pract. 1996 Mar-Apr;9 (2):94-99] examined the validity of the AMA Masterfile relative to other sources of information on physicians practicing in a particular location (professional group rosters, phone calls to physicians, contacting hospitals and mailings). The main finding related to the data provided is that incorrect omissions (undercounts) and incorrect inclusions (over counts) offset each other. The status of specialty and geographic location for family physicians in Ohio was verified in 91 percent of names not common to both the Masterfile information and professional family physician group rosters. In summary, the authors found that the family physician AMA Masterfile data was adequate for workforce projections and policy studies when the county data are aggregated. A similar study could be done in Illinois to assess the accuracy of the AMA Masterfile in assessing physician workforce information needed in rural areas.

Dentist Data. The information cited on dentists is from work others have done in Illinois related to dentist workforce issues. Specifically Gayle Beck at the Midwest Center for Workforce studies www.uic.edu/sph/irhwc has done several studies related to dental workforce issues. Dr. Lampis, Illinois Department of Public Health, Division of Oral Health, presented a talk in May 2005. As a part of the dental license renewal in 2004, background and practice characteristics were requested of dentists (53% response rate).

Nursing Data. The federal government Health Resource and Services Administration (HRSA) web site indicates that the Nursing Shortage County list was developed using data from the American Hospital Association Annual Survey database. It looks at the ratio of the number of full-time equivalent (FTE) nursing staff to adjusted average daily census. Nursing staff is defined as full and part-time registered nurses and full and part-time licensed practical or vocational nurses. Once the ratio for all hospital types was standardized, the data from all hospitals were aggregated to the county level. All counties with aggregated ratios that were less than 1.0 qualified as Nursing Shortage Counties. (source: <http://bhpr.hrsa.gov/nursing/shortage.htm#il>). A document titled "Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020" published in July 2002 by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, National Center For Health Workforce Analysis provided information for all of Illinois regarding projected nursing shortages. Available at: <http://bhpr.hrsa.gov/healthworkforce/reports/mrproject/default.htm>. An estimate for counties outside of Chicago metro area was approximated by dividing the state estimate in half since that would reflect population distribution in Illinois. Further study is needed to obtain exact information on retirements planned by nurses currently working in each rural county. A survey of nurse characteristics was last done in 2000. Only about one-third of nurses responded, which limits conclusions from the survey data that is available from earlier surveys.

Pharmacist Data. The projections regarding number of pharmacists needed was developed by adding up the projected number needed in each rural county then choosing <http://wic.ilworkinfo.com> labor market analysis—occupations, then Occupational Employment & Projections by county for pharmacists. An estimate of the projected number of pharmacists in each county between 2005 and 2010 can be derived by dividing the number needed from 2000–2010 by two. This document provides an estimate of total number needed in the next five years, but the site also breaks this down by the growth in demand and projected retirements.

**TESTIMONY TO
JOINT TASK FORCE ON RURAL HEALTH AND
MEDICALLY UNDERSERVED AREAS**

Harvey Davis, CEO
Franklin Hospital, Benton, Illinois
August 29, 2006

The **Illinois Hospital Association (IHA)** is submitting this testimony on behalf of IHA's Small and Rural Hospitals Constituency Section, which represents almost 90 small and rural hospitals across the state. We welcome the opportunity to discuss the critical health issues affecting rural and medically underserved areas that our state needs to address.

Rural Hospitals in Illinois: A brief overview

Illinois' rural hospitals, which serve 13 percent of the State's population, or 1.7 million residents in 66 counties, are relatively small. The typical rural hospital has fewer than 100 beds – but they serve a vital purpose. They are the centerpiece of many towns, serving as the foundation for health care delivery even as they struggle to overcome the effects of troubled local economies, large geographical distances with inadequate transportation, an aging population, and public policy inequities.

In addition to providing health care, rural hospitals are an essential part of the social and economic identity of rural communities, often serving as the primary economic engine of the community. Rural hospitals in Illinois employ more than 26,000 workers and pay more than \$1 billion a year in salaries and benefits, as well as purchasing \$935 million in goods and services annually. In more than 40 percent of Illinois' rural counties, a hospital is among the top three employers.

Our rural hospitals provide diverse services, beyond inpatient and outpatient care. Rural hospitals also provide home care, hospice services, adult day care, and home-delivered meals, just to name a few examples. Their emphasis on primary and preventive care is vital to rural residents, because access to specialized services may be limited or may require hours of travel.

For a more detailed overview of rural hospitals in Illinois, we have attached a fact sheet to this testimony.¹

Rural Hospitals Face Special Challenges

The citizens of rural Illinois tend to be both older and poorer than residents of metropolitan sections of our state. About half (46 percent) of patients in rural hospitals are over the age of 65, compared to one-third of urban hospital patients. This demographic difference has an impact on rural hospitals' patient population and reimbursement. For example, hospitalization rates for rural residents are higher than those for urban residents (142 per thousand in rural areas, 133 per thousand in urban areas). Rural hospitals treat fewer new mothers and infants, but have a higher proportion of patients with heart failure, pneumonia, chronic obstructive pulmonary disease, and other disorders associated with age or chronic conditions.

¹ "Focus on Rural Community Hospitals in Illinois," Illinois Hospital Association, August 2006.

Medicaid

The impact of rural demographics on hospital reimbursement is even more dramatic. Rural hospitals are more dependent on Medicaid, which, on average, does not pay the full cost of the services hospitals provide. In some Illinois hospitals, as many as 75 percent of the services provided are paid for by government. In the case of Medicaid, the combination of increased outpatient care and decreased Medicaid reimbursement poses a significant problem for Illinois rural hospitals.

All Illinois hospitals have seen a significant growth in demand for ambulatory services in the past decade. This growth has been especially dramatic in rural hospitals, in which inpatient utilization has dropped while the use of outpatient services has soared. Today more than half of rural hospitals' gross revenues (54 percent) come from outpatient services, compared with 36 percent in urban hospitals. Because outpatient services provide more than half of the gross revenue rural hospitals receive, and Medicaid pays hospitals less than 50 percent of outpatient costs, rural hospitals' dependence on outpatient revenues puts them at financial risk.

This dependence on Medicaid is further exacerbated by payment delays. Payment delays put tremendous pressure on hospitals as it forces them to delay payments to their vendors and suppliers or to borrow money to meet their financial obligations. Naturally, hospitals that engage in short-term borrowing must pay interest on those loans. Many rural hospitals are already hanging by a financial thread, even without facing the challenges of Medicaid underfunding and payment delays.

IHA welcomes the partnership with the General Assembly and the state on the Hospital Assessment Program now being reviewed by the federal Centers for Medicare and Medicaid Services (CMS). If approved by CMS, the program will bring \$100 million in new Medicaid funding for small and rural hospitals over the next three years. However, the assessment program is not a permanent solution to the unique financial problems faced by rural hospitals.

It is critical that the state, which has frozen the base rate for Medicaid for a dozen years, allocate sufficient funds to support Medicaid and to pay hospitals in a timely manner – without reducing the services covered and without reducing eligibility – so that rural hospitals can continue to serve the poor, disabled and elderly.

Serving the Uninsured/Underinsured, Charity Care

Hospitals are truly the health care safety net for the uninsured and working families. Providing care to these vulnerable populations is a major challenge, with some 1.8 million Illinoisans without insurance and hundreds of thousands more who are underinsured. Outside of the greater Chicago metropolitan area, there are more than half a million people without health insurance; in addition, there are nearly half a million Downstate residents who rely on Medicaid and Medicare for their coverage.²

Rural hospitals in Illinois contribute many benefits to their communities, including the provision of care to patients regardless of their ability to pay. In 2004, they provided nearly \$93 million in care for which they received no payment, or an average of almost \$1.4 million per rural hospital. The costs of providing this uncompensated care continues to grow – rising by 80 percent between 1994 and 2004 for rural hospitals – as their communities face economic challenges and as private employers reduce or eliminate coverage for their employees.

² “Real People, Real Stories: A Detailed Description of Illinois’ Uninsured,” The Gilead Outreach & Referral Center, March 2006.

Rural hospitals are proud of the quality health care services they provide their communities and the many benefits they perform, which would otherwise not be available to residents, such as free and reduced-cost preventive health screenings, health education programs, and meals for residents unable to prepare meals for themselves. Rural hospitals are led by board members from their communities who make decisions that respond directly to their communities' needs.

While there has been much debate and discussion in the General Assembly and other venues about the role and responsibility of hospitals to serve their communities, including the uninsured, IHA has serious concerns about proposals that would impose a rigid, one-size-fits-all approach on hospitals. Such an approach could jeopardize the financial viability of my hospital and rural hospitals that are currently carrying the burden of providing health care to the uninsured and underinsured.

Availability of/Access to Mental Health Services

Availability of and access to critically needed health services is another major concern for rural communities, especially in the areas of acute mental health and substance services. Statewide, there are only 16 rural hospitals offering any type of mental health or substance abuse services – with about half of these hospitals providing inpatient psychiatric services – serving large geographic areas. That means patients and their families must travel great distances to receive care in the hospital and to obtain follow-up care – (see attached map indicating locations of small and rural hospitals in Illinois providing services to mental health patients). If a patient with a mental illness or substance abuse disorder – both chronic conditions – does not have follow-up treatment, it is very likely he or she will relapse. Transportation is not available in many rural communities, compounding the challenges presented by the great travel distances between available providers.

At the same time, there are very few mental health professionals practicing in rural Illinois. For example, the only child psychiatrists practicing south of Springfield work at the state hospital in Choate, which is located in the southern most tip of the state. According to a report from the National Center for Rural Health Professions at the University of Illinois at Rockford, there are 59 rural, medically underserved counties in the state that do not have a psychiatrist.³

It's well known that Illinois has a large and growing problem with methamphetamines in rural communities. In their first year of operation, six Meth Response Teams established by the state reported handling 750 meth-related incidents, making 653 arrests and seizing nearly 213-thousand grams of drugs and materials used to manufacture methamphetamine. Unfortunately, there are very few treatment programs in the state with the expertise to adequately address the complex symptoms of persons addicted to and abusing this dangerous substance.

IHA believes the state needs to invest more funding to address these critical health issues. Without adequate financial support, rural hospitals do not have the means to provide these services. For example, the state's Medicaid base rates for hospital inpatient psychiatric and substance abuse services are significantly below the costs of those services. Medicaid rates for outpatient psychiatric services were reduced by 40 percent in 2002. Also, the Medicaid program reimburses physician services delivered via telemedicine for medical conditions but not for psychiatric conditions. That is a barrier to the use of a technological approach that could bring rural communities the benefit of a psychiatrist despite the fact that many rural hospitals in Illinois now have the capability to use telemedicine.

³ Kyle, M., C. Dankwa, and M. MacDowell, "Assessment of Mental Health Services in Rural Illinois," September 2005. Research supported through Project EXPORT Center for Excellence in Rural Health of the National Center for Rural Health Professions, University of Illinois at Rockford.

The state could also consider Medicaid reimbursements for advanced practice nurses (APNs) with a specialty in mental health, who can work with physicians. APNs working with a psychiatrist or physician can extend the reach of scarce health care professionals in rural areas.

Transportation/EMS/Ambulance Services

Another major challenge for rural hospitals in Illinois is the availability of transportation systems, directly affecting access to needed health care services – which was previously alluded to as a major issue in accessing mental health and substance abuse services.

Burdensome regulations on Emergency Medical Services and ambulance services can have an unintended impact, especially given the unique characteristics of rural areas, including a low population density that is widely dispersed across large geographic regions. Rural hospitals serve 13 percent of the state's population, with rural residents living in 66 different counties, or two-thirds of the state's land area.

Workforce Shortages

The evolving hospital marketplace and the characteristics of the rural environment have created other special challenges for Illinois rural hospitals. For example, rural hospitals face shortages of physicians and other health care workers. These workforce shortages loom, just as the rural population is aging and the demand for health care services is rising.

Because of “baby boomer” retirements of physicians and nurses, inadequate numbers of students in the education pipeline, and a shortage of nursing faculty, the shortage of health care professionals in rural areas of Illinois is expected to rise dramatically in the next ten years. By 2010, approximately 485 additional physicians will be needed in rural areas of the state to meeting growing demand and replace retiring physicians.⁴ It takes, on average, at least eleven years from the time a high school graduate begins preparing for medical school to be fully qualified as a practicing physician. At the same time, the state's supply of registered nurses is projected to fall short by 4,265 by 2010 – nearly half of which will be in rural areas of Illinois – and the supply of pharmacists is projected to be about 400 short by 2010 in rural areas. Shortages are also expected in allied health professions, such as therapists and dentists.

We need to work now to increase investments in the recruitment and education of many more new health care professionals in order to alleviate these workforce shortages and ensure the availability of health care services in rural areas of the state.

There are rural medical education programs around the country that attract students from rural and underserved communities, who return to their communities to practice after they graduate.

For example, the University of Illinois' National Center for Rural Health Education Professions in Rockford operates the Rural Medical Education Program, which identifies and recruits young people from rural areas for medical school. The program produces about 15 physician graduates a year, with nearly 70 percent of them returning to rural Illinois in primary practice. With additional financial support, such a program could be expanded to include not only physicians but other health care professions such as nursing, pharmacy, physical and occupational therapy, public health and social work.

⁴ “Reversing the Trend of Health Care Workforce Shortages in Rural Illinois,” The National Center for Rural Health Professions, University of Illinois, Rockford, December 2005.

Conclusion

The rural residents of Illinois rely extensively on community hospitals to meet their health care needs. Despite changing financial pressures and utilization patterns, most rural hospitals have remained viable for the past decade by changing their structures and focus. They have maintained inpatient services while increasing outpatient services and developing post-acute care services such as skilled nursing, home health and hospice care. This change has increased their value to the community, yet has left them more vulnerable to changes in reimbursement and other policies.

IHA commends the General Assembly for recognizing the challenges faced by rural hospitals and establishing the Joint Task Force on Rural Health and Medically Underserved Areas. We look forward to working with the Task Force and the General Assembly to find workable solutions to help resolve these issues.

Focus on Rural Community Hospitals in Illinois

Introduction

Illinois' rural hospitals serve a relatively small proportion of the state's population but a large geographic area. Although only 1.7 million people (13.2% of the population) live in rural areas, they are scattered across 234,082 square miles (62.8% of the state's land mass) and 66 counties. Sixty-seven hospitals, or 29.8% of all Illinois hospitals, are located in the rural areas of the state. Of these, 64 are community hospitals (i.e., non-federal, short-term hospitals that are open to the general public). The remaining three hospitals are non-community hospitals, including two state mental health facilities and one hospital operated by the Veterans' Administration. The data in the remainder of this report focus only on the 64 community hospitals located in rural Illinois. Rural hospitals represent 32.5% of all open Illinois community hospitals.

Rural Illinois community hospitals are most likely to be owned by general not-for-profit organizations; over forty (42.2) percent of rural hospitals are owned by such entities. Other types of organizations that own rural hospitals include governmental bodies (34.4%), churches (17.2%), and investor-owned organizations (6.3%). Rural hospitals are more likely than urban hospitals to be government-owned; only 4.9% of urban hospitals are government-owned.) Most government-owned rural hospitals are owned by hospital districts or authorities (72.7%); the others are county or city owned.

Hospital Capacity

Rural hospitals are typically smaller than urban hospitals. In both rural and urban settings, capacity has been decreasing since 1991.

- 12.3% of all staffed beds in Illinois are located in rural areas of the state.
- In 2004, the size of Illinois rural community hospitals ranged from 24 to 319 total staffed beds. On average there were 78 total beds in each facility. The average urban hospital, in comparison, had 234.4 total beds in 2004.
- Over forty (45.6) percent of rural hospitals have a long-term care type unit or facility. Rural hospitals are almost twice as likely as urban to have long-term care services; only 20.3% of urban hospitals have long-term care.
- In those rural hospitals that provide long-term care, this service represents a significant portion of the organization's capacity. Thirty nine percent of all beds in these hospitals are long-term care beds.
- For rural hospitals with a long-term care unit or facility, the number of total facility¹ staffed beds ranged from 45 to 319 in 2004, with an average of 104 beds. The number of hospital beds ranged from 23 to 299 with an average of 64 beds. The number of long-term care beds in these hospitals ranged from 10 to 115 and on average there were 41 long-term care beds in 2004.

¹ The term "total facility" in this report refers to the hospital and any long-term care type unit. "Hospital" refers to the hospital portion only of each facility.

- The number of hospital beds in rural hospitals has decreased by 30.9% since 1991, when the average rural hospital had 86 hospital beds. In 2004 the average hospital had 61 beds.
- More than eighty percent of rural hospitals (83.1%) have fewer than 100 hospital beds.
- Since 1991, 22 community hospitals have closed in Illinois. Of these, seven were rural hospitals.

Utilization

All Illinois hospitals have seen a significant growth in demand for ambulatory services in the past fifteen years. This growth has been especially dramatic in rural hospitals, in which inpatient utilization has dropped while the use of ambulatory services has soared.

- In 2004, rural hospitals were the site of 165,445 inpatient admissions, or 10.5% of all inpatient admissions in Illinois.
- Both rural and urban hospitals experienced steady declines in inpatient admissions during the early and mid-1990s. Admissions in urban hospitals began to increase again beginning in 1998, but rural hospital admissions have fluctuated since then. Compared to 1991, though, admissions to rural hospitals decreased by 12.0%, while urban hospitals showed a 5.3% increase in admissions.
- The average length of stay for patients in Illinois rural hospitals was 4.3 days in 2004, compared to an average of 4.9 days in urban hospitals. Since 1991 the average length of stay has decreased in both types of hospitals; in rural hospitals it decreased by 18.9%, and in urban hospitals by 28.1% between 1991 and 2004.
- Rural hospitals provided 708,020 days of inpatient care in 2004 (9.3% of the state's total inpatient days). The annual number of hospital inpatient days provided by rural hospitals decreased by 29.3% between 1991 and 2004, from 1,001,421 days provided in 1991.
- Since 1991, rural hospitals have had a consistently lower occupancy rate than urban hospitals. The average hospital occupancy rate for rural Illinois hospitals was 48.9% in 2004, compared to an occupancy rate of 66.8% in urban hospitals. Rural hospitals' occupancy rates dropped by 16.2% during the early to mid-1990s, but by 2004 had returned to its 1991 level.
- Rural community hospitals represent 33.3% of all community hospitals in the state, but only 8.4% of the births that took place in Illinois in 2004. Although the number of births in urban Illinois hospitals has fluctuated over the years, births in rural hospitals have declined in nearly every year since 1991, from 17,131 in that year to 14,713 in 2004, a decrease of 14.1%.

Ambulatory care has grown since 1991 in all Illinois hospitals, but particularly in rural hospitals, where it represents a large proportion of the care that is delivered.

- 146,108 surgeries were performed in rural hospitals in 2004, 12.7% of all surgeries performed in the state.
- The number of surgical operations performed in rural Illinois hospitals increased by 21.9% between 1991 and 2004. The number of surgeries performed in urban hospitals also increased during this time, but only by 8.5%.

- Since 1991 the mix of inpatient versus ambulatory surgery has changed substantially in rural Illinois hospitals. In 1991 only 58.8% of all surgeries in rural community hospitals were performed on an outpatient basis; in 2004 fully 73.5% of surgeries in rural hospitals were outpatient. During the same period, the proportion of surgeries performed on an outpatient basis in urban hospitals rose from 53.8% to 61.8%.
- In 2004, rural Illinois hospitals performed 107,353 ambulatory surgeries, an increase of 52.4% from 1991 to 2004, compared to a 21.6% decline in inpatient surgeries during the same period. Between 1991 and 2004 urban hospitals experienced a somewhat smaller increase in ambulatory surgeries (26.4%) and a smaller decrease (11.7%) in inpatient procedures.
- Illinois rural hospitals provided 4,294,500 total outpatient visits in 2004, including ambulatory surgery, emergency room visits, and other outpatient visits (such as visits to hospital-based clinics). This represents 15.0% of all outpatient visits in Illinois and is an increase of 94.7% since 1991, when there were 2,205,741 visits to rural hospitals. Urban hospitals also experienced a substantial growth in outpatient visits from 1991 to 2004, although it was not as dramatic; the number of outpatient visits to urban hospitals rose by 61.3% during this time.
- Rural hospitals experienced growth in all three types of outpatient care between 1991 and 2004, but the greatest growth was in outpatient clinic visits, which more than doubled (132.1%) during the period. In comparison, the number of clinic visits to urban hospitals grew by 75.4% from 1991 to 2004.
- There were 4,294,500 clinic visits to rural hospitals in 2004 compared to 1,540,037 in 1991. As noted above, ambulatory surgeries increased 52.4% during the period. Emergency room visits increased only slightly, from 665,704 in 1991 to 720,182 in 2004, an 8.2% change.

Rural Demographics and Health Care Needs

Illinois' rural residents are generally older and experience higher rates of hospitalization for conditions and diseases that are associated with age. Rural hospitals treat a larger proportion of patients with age-related conditions than do urban hospitals.

- Rural residents also experience somewhat higher rates of hospitalization overall (141.9 admissions/1,000 population, compared to 133.3 admissions/1,000 in urban areas), and particularly for certain chronic conditions or diseases associated with age (for example, heart disease, chronic obstructive pulmonary disease, and influenza/pneumonia).
- Rates of hospitalization for ambulatory care sensitive conditions are higher in rural areas as well, suggesting rural residents' access to primary care is limited.
- Demographic differences between rural Illinois and other areas of the state have an impact on the types of patients that rural and urban hospitals treat. Almost one-half (46%) of inpatients in rural hospitals were 65 years of age or older in 2004; only one-third of patients in urban hospitals were that old. Rural hospitals also cared for more patients in the oldest age group, where 12% of rural hospitals' patients were 85 or older, while only 76% of other hospitals' patients were that old.
- A greater proportion of cases in rural hospitals are patients with disorders associated with age and with chronic conditions. Urban hospitals treat a smaller proportion of cases with these diagnoses and a larger proportion of new mothers and their infants.

Workforce

Rural hospitals are often one of the leading employers in their communities. They employed 12.1% of the Illinois hospital workforce in 2004.

In 40.9% of Illinois' rural counties a hospital is among the top three employers in the county.

Of the 26,531 people employed by rural hospitals in 2004, 18,151 were full-time and 8,380 were part-time workers. The proportion of staff who work full-time was 31.6% in 2004, and this has remained essentially stable since 1991. Urban hospitals have an approximately equal proportion of part-time workers (33.6% in 2004).

Rural hospitals employed 22,300 FTEs in 2004, an increase of 17.4.0% since 1991. Between 1991 and 2004 the number of FTEs employed in urban hospitals remained essentially constant.

- Illinois rural hospitals employed 6,002 registered nurses (RNs) in 2004, an increase of 18.1% over 1991, when there were 5,056 RNs working in rural hospitals. With the exception of 2003's 3% increase, the number of RNs has been fairly constant since 1998.
- Of the RNs working in rural hospitals in 2004, 3,655 were full-time employees and 2,347 were part-time employees. Measured on a full time equivalent basis, the number of RNs in rural Illinois hospitals increased 15.3% since 1991 for a total of 4,827 full-time equivalent RNs in 2004. In 1991, 34.5% of RNs were part-time workers; in 2004, 46.4% of all RNs were part-time.
- In 2004 rural Illinois hospitals expended \$1.1 billion, or 50.6% of all expenditures, on labor costs. Payroll expenses accounted for 78.1%, and the cost of providing employee benefits for 21.9%, of labor expenses.
- Between 1991 and 2004, rural hospitals' labor expenses grew by 128.7%, compared to a growth of 85.4% in urban hospitals. The greatest growth was in the area of employee benefit expenses, which grew by 193.9% in rural hospitals (compared to 143.1% in urban hospitals).

Payer Mix

- As they are in urban hospitals, government payers are the primary payers in rural Illinois hospitals. In 2004, 60.1% of Illinois rural hospitals' gross patient revenue (and 54.0% of urban hospitals' gross patient revenue) was derived from government sources.
- The predominant government payer in both rural and urban hospitals is Medicare. In 2004 Medicare contributed 47.6% of rural hospitals' gross revenue and Medicaid contributed another 12.1% of gross revenue. Medicare contributed a smaller portion of revenue to urban hospitals – only 40.1%.
- As a percent of gross revenue in rural hospitals, Medicare decreased slightly (.7%) since 1991, offset by an increase in Medicaid (1.3%). The reverse occurred in urban hospitals where Medicare increased 1.5% as a percent of gross revenues while Medicaid decreased 1%.
- Of all discharges from rural Illinois hospitals in 2004, more than one-half (55.5%) were Medicare patients. In urban hospitals only 40.1% of discharges were Medicare patients.
- Medicaid discharges comprised 14.2% of all discharges from rural hospitals in 2004, compared to 18.6% in urban hospitals.

Illinois rural hospitals depend less on non-governmental payers than do urban hospitals.

- Third-party payers contributed less than one-third (31.3%) to rural hospitals' total gross patient revenue in 2004. In comparison, urban hospitals derived 40.1% of their gross revenue from third-party payers.
- Over five percent (5.5%) of rural hospitals' gross revenue was derived from self-pay, and 4.5% was from other non-government payers, in 2004, a decrease from other non-government payers of more than 50% since 2001.

Finances

Operating revenues in rural hospitals increased by approximately 138.3% between 1991 and 2004. Total expenses in rural hospitals increased slightly less (133.9%) during the same period.

- The total operating revenue for rural Illinois hospitals in 2004 was \$2,290,475,385. Total expenses were \$2,184,142,829, resulting in an aggregate operating gain of \$106.3 million.
- In 2004, the aggregate operating margin for rural Illinois hospitals was 4.6%. Almost one third (32.3%) of rural hospitals had negative operating margins in 2004.
- Rural Illinois hospitals derive more than one-half of their gross patient revenue from outpatient services.
- In rural hospitals, the proportion of gross revenue from outpatient services (53.8%) has grown by 64.5% since 1991, when 33.7% of gross revenue was derived from outpatient services. In urban hospitals the proportion of revenue derived from inpatient service still dominates, contributing 63.3% of urban hospitals' gross revenue in 2004.
- Uncompensated care has grown significantly in rural Illinois hospitals since 1991.
- Illinois rural hospitals provided \$194,335,200 in uncompensated care in 2004. Of that total, bad debt represented \$145,527,105 and charity care \$48,808,095.
- Bad debt expenses in rural hospitals rose by 287.3% between 1991 and 2004; in urban hospitals bad debt increased by 165.8% during the period. The amount of charity care rose by 467.5% in rural and 267.1% in urban hospitals.
- In 2004 the average patient margin for Illinois rural hospitals was 0.5%. Forty five (69.2%) had a negative patient margin, i.e., lost money in the delivery of patient care.

Notes:

1. Unless otherwise noted, all data are from 2004.
2. Data sources:
AHA/Health Forum Annual Survey of Hospitals, 1991-2004; IHA COMPdata;
IL Department of Commerce and Community Affairs; IL Statistical Abstract, 2004; US Census Bureau.
3. Prepared by the IHA Policy Information and Analysis Department.
For more information, contact:
Kathy Gayda, Director, Data & Policy Analysis or Robert Hansen, Policy Information Analyst.

August 2006

**Testimony Provided to
Special Task Force on Rural Health
And Underserved**

**By Roger W. Hannan, MS
Executive Director
Farm Resource Center**

**John A. Logan College
August 29, 2006**

Farm Resource Center

Roger W. Hannan, *Executive Director*

My name is Roger W. Hannan, I am the Executive Director of the Farm Resource Center. I appreciate this opportunity to provide testimony on behalf of the Farm Resource Center (FRC), a private not-for-profit agency that I helped establish in 1985 to provide outreach mental health crisis intervention and suicide prevention services to farm and rural families in Illinois. The Council on Accreditation for Services to Children and Families accredits FRC.

FRC currently provides services in 50 counties using our unique model of outreach. We are guided in our service delivery by the **APPLE PRINCIPLE**, which was developed by the Rural Family Issues Coalition, in 1986. **APPLE** is the acronym for Accessible, Personal, Professional, Linked, and Empathetic.

FRC is Accessible through our confidential toll free number 877-Need-FRC, and because our outreach workers provide our service in the consumer's home at their kitchen where they are empowered. FRC services are Personal because we work with the consumer to develop a plan of action they are willing to work on to resolve their crisis. FRC follows the social worker's code of ethics, is committed to the mental health confidentiality code, as well as being guided by accreditation standards for Professional conduct. FRC links consumers to appropriate resources including community mental health agencies. Finally, FRC is Empathetic because our outreach staff are recruited and hired in part based upon their ability to relate to the consumer groups they will be serving.

This past year I participated in a work group of the Illinois Rural Health Association, which looked at the question of access to mental health in rural Illinois. This work group conducted seven regional public forums to receive information from individuals from various walks of life. The results of these forums were produced in a report entitled **Mental Health in Rural Illinois: Recovery is the Goal**. This report verified what many of us have known for a long time, access to mental health services is a problem for rural citizens. It was learned that there are models of promising and evidence based-best practice programs that are having a positive impact on reducing access as an issue. I am proud to tell you that FRC is one of those programs.

A major problem that is encountered, however, is that the current focus on enhancing the Medicaid funding stream and other fee for service strategies leave these programs scrambling for the crumbs of funding that may be available after the traditional services are funded. Programs capable of reducing or eliminating access as an issue for rural mental health services will be difficult to put in place without specific funding being earmarked for that purpose. I truly believe that when we conquer the access problem we will reduce the overall cost of rural mental health care, but more importantly, we will enhance the quality of life for rural families. My personal bias is that we will soon realize that outreach should be a required component of every rural mental health program delivery system

I believe that funding could be done in a way that would allow the impact of earmarked funding to be measured. I would see this funding flowing through the Illinois Rural Downstate Health Act. I believe an initial amount of \$4 million dollars should be earmarked. I would suggest that stringent but not crippling requirements be placed on these funds. Programs eligible to apply for funding under this plan should be required to demonstrate how they would reduce the problem of access to mental health services in rural communities. Strict program evaluation strategies should be applied to assure compliance with this requirement and to provide the General Assembly with data that would support the ongoing funding of this initiative.

Thank you for the privilege of offering this testimony and I stand ready to respond to any questions you may have.

Arthritis Foundation, Greater Chicago Chapter

Betsy D. Mitchell, *Legislative Consultant*

Thank you for allowing me the opportunity to talk to you today about arthritis. I serve as the branch director for the Southern Illinois Branch Office of the Arthritis Foundation. While we live in the most beautiful part of the state, our area does have unmet needs in healthcare. As director of the Arthritis Foundation in this area, I talk with people daily who are frustrated by the lack of rheumatologists, the inability to pay for arthritis medication, and the challenges of living with a chronic illness such as arthritis.

The Southern Illinois Branch was established in 1982 and has a service area that covers the 20 southern most counties, a territory of 130 miles wide and 100 miles long, with an estimated population of 423,670 people. According to CDC statistics and estimates by the Arthritis Foundation, roughly 140,000 people in this area live with the pain of arthritis. In fact, recent studies show that southern Illinois has the highest prevalence of arthritis in the state of Illinois. The fact sheet before you gives you a broader view of the counties most affected by arthritis. As you can see, arthritis is an important health problem in Illinois, particularly in southern Illinois.

According to the U. S. Centers for Disease Control and Prevention (CDC) cost data, the estimated costs for arthritis (medical care and lost productivity) total \$86 billion. In Illinois, the total cost was estimated at \$3.8 billion. Illinois ranks seventh in the nation for percent of cases of arthritis at 4.35 percent.

In southern Illinois, we currently have only 2 rheumatologists to serve the needs of the population. Many people are unable to gain access to these two rheumatologists because the doctor's calendar is full. Those lucky enough to have good health insurance often travel out of state to find healthcare. Those without insurance do without health care. With arthritis, that can have irreversible consequences. For the children of southern Illinois who live with Juvenile Arthritis there is no pediatric rheumatologist. All have to travel to Chicago, St. Louis or Nashville for healthcare. Given the geographic distance between medical care and the small communities in southern Illinois, more funding is needed to bring programs and services to all southern Illinois communities.

Exercise is important for maintaining health and strong muscles, for preserving joint mobility and for maintaining flexibility. The Arthritis Foundation Aquatic Program, the Arthritis Foundation Exercise Program and the Arthritis Foundation Self Help Program are examples of services that the Arthritis Foundation can provide to help people with arthritis to help manage their disease. These programs comprise the Life Improvement Series of programs offered by the Arthritis Foundation, all of which have proven effective in reducing pain, reducing the number of doctor visits, and improving quality of life.

Recently, the Arthritis Prevention, Control and Cure Act (HB2380) was passed by the state legislature. To ease the burden of arthritis in this underserved area, it is imperative that funding of this bill is accomplished by the legislature. More proven public health interventions that are easily accessible and affordable need to be made available at the community level. Less than 1 percent of persons with arthritis who could benefit from such interventions receive them. The Illinois Department of Public Health's Illinois Arthritis Initiative, a partnership between the Arthritis Foundation and the Illinois Department of Public Health, is committed to decreasing the burden of arthritis in Illinois.

Abraham Lincoln Memorial Hospital — Lincoln, Illinois

Kristen Lessen, *Director*
Healthy Communities Partnership

I would like to thank the Task Force for the opportunity to speak today. My name is Kristin Lessen and I am employed by Abraham Lincoln Memorial Hospital, in Lincoln, Illinois, as the Director of the Healthy Communities Partnership. ALMH is a full-service critical access hospital that is an affiliate of Memorial Health System. ALMH has been recognized nationally as a clinically effective healthcare provider and is a JCAHO (Joint Commission on Accreditation of Healthcare Organizations)-accredited hospital.

Community health initiatives are crucial to Abraham Lincoln Memorial Hospital. In 1997 ALMH, along with other health and social service agencies, formed the Healthy Communities Partnership. The mission of the Partnership is to improve the health and quality of life of the people and communities we serve while striving to achieve our vision of creating the healthiest community in America. The 3 goals of the Partnership are to: provide education, support and alternative activities to promote healthy lifestyles; increase preventive healthcare and increase access to primary care. The Partnership is comprised of six community coalitions who have developed measurable objectives in order to meet our goals:

- Alcohol, Tobacco & Other Drugs
- Healthy Families
- Domestic Abuse & Violence
- Senior Issues
- Parish Nurses
- Rural Health

As indicated by the 2004 Illinois Behavioral Risk Factors Surveillance System, Logan County has a documented need for preventive healthcare:

- tobacco use in Logan County is 29.2% vs. Illinois' rate of 22.2%
- the rate of Logan County diabetics is 9.2% vs. 6.1% in Illinois
- 12.1% of Logan County residents have been told they have asthma vs. 8.4% for the State
- 26.4% have been told they have high blood pressure in Logan County
- 31.7% of Logan County have been told they have high cholesterol
- 20.8% of residents in Logan County have not seen a dentist in the past 2 years vs. 17.2% of the State; while 38% of Logan County residents do not have dental insurance

According to the Center on an Aging Society, the US population 65 years of age and older will double by 2030; while Logan County has a 3% higher than the State average of those aged 65 and older (19.3% vs. 16.2%).

The Partnership's Rural Health Task Force is the most visible of the coalitions and confronts the responsibility to address access to primary and preventive care. Rural Health currently consists of a 36' Mobile Health Unit that travels 5 days a week to 13 different locations providing primary and preventive healthcare. A Certified Family Nurse Practitioner and a Public Health Nurse staff the unit. HCP will be wheeling out a new unit (the HOPE Mobile) October 2, 2006, which will also include a dental hygienist and a volunteer dentist. HOPE is an acronym for Healthcare, Oral health, Prevention and Education...this new unit will be 40' long with 2 exam rooms in order to continue to provide current services and a dental room providing preventive oral health for disadvantaged youth. We will continue to travel 5 days a week and visit 12 different locations in Logan County. We serve all who come on board and never deny services.

The purchase of the HOPE Mobile was predominantly funded through the Illinois Children's Healthcare Foundation. Currently the Partnership receives funding from ILCHF, SIU School of Medicine's Rural Health Initiative, Abraham Lincoln Healthcare Foundation, Eaton Electrical, Inc., the Logan County Board, the Hilda Humphrey's Estate, fundraisers and revenue.

The Partnership was originally established through a three-year federal grant from HRSA (the Health Resources and Services Administration). Subsequent funding was granted by the Rural/Downstate Health Act through the Illinois Department of Public Health's Center for Rural Health and Southern Illinois University School of Medicine's Rural Health Initiative.

The Rural/Downstate Health Act was instrumental in the Partnership being able to continue to provide essential healthcare services following the completion of the Federal grant. We were fortunate to receive funding through the Rural/Downstate Health Act for six years. This funding enabled us to cultivate our Partnership to the level it is today – 38 organizations and 11 churches collaborating to improve the health and quality of life in Logan County. We would benefit from continued funding; however the level of funding made available to the Rural/Downstate Health Act reduces our odds of obtaining further monies. We recognize the need for funding that is found throughout the State and acknowledge how challenging it must be for grant reviewers to choose only a few organizations out of numerous applicants. Increased funding to the Rural/Downstate Health Act would not only benefit our Partnership, it would expand healthcare services to other rural communities throughout the State, consequently increasing the wellbeing of Illinois residents.

We are hopeful that the Partnership will become self sustainable with the revenue generated from the HOPE Mobile; however with Medicaid taking 142 days on average to reimburse providers, it will become crucial to supplement our income with additional funding prior to what could be considered "regular Medicaid payments". Many rural providers repudiate Medicaid clients due to the slow return in compensation.

In closing I would like to quote Abraham Lincoln who once said, "You cannot escape the responsibility of tomorrow by evading it today." ALMH, and by extension the Healthy Communities Partnership, are working to create a systems change by establishing and coordinating provisions for essential healthcare and quality of life needs.

John A. Logan College, Carterville, Illinois — August 20, 2006

Cheryl Boyd, *Director*
Family Counseling and Mental Health Center — A Division of Franklin-Williamson Human Services

As many of you are aware, in November of 2004, Illinois Centre Behavioral Health (ICBH) opened its doors in Marion, IL. ICBH is a cooperative venture between Franklin-Williamson Human Services and Shawnee Health Services, started with the purpose of expanding behavioral healthcare to persons in Southern Illinois. Because of that partnership, Franklin-Williamson Human Services went from having one FTE adult psychiatrist available to residents of Franklin and Williamson Counties to having 1.8 FTE adult psychiatrists, one full-time psychiatric physicians assistant and the first-ever Child and Adolescent psychiatrist, also working full-time.

While undoubtedly being great news and an admirable beginning to addressing the behavioral healthcare needs of the area, because: 1) The chances of being poor and uninsured in America are greatest for residents of remote rural counties, not adjacent to urban counties. 2) The chances of being uninsured continuously is greatest in remote rural areas. 3) The percentage of Medicaid recipients in remote rural counties is 50% higher than in other areas of the country. 4) Rural Residents are disproportionately affected by recessions and economic downturns. 5) The rural uninsured are in poorer health than their urban counterparts, we are still faced with a growing psychiatric crisis. After the collaboration between the organizations began, routine adult psychiatric assessments and follow up visits grew to 3,290 in FY 04, 4,230 in FY 05 and 6,940 in FY 06. Current caseloads for the psychiatrists and PA stand at a total of nearly 2,000.

Almost every person on that caseload needs to be followed by a therapist and or case manager, creating either waiting lists that are almost obscene (160 kids on a waiting list at Franklin-Williamson Human Services), or a caseload for a therapist that far exceeds what is a best practice standard (100-120 per therapists—should be 40-50).

Franklin-Williamson Human Services and Shawnee Health Services respectfully has the following recommendations for the Task Force:

- 1) Medicaid reimbursement rates should be set at a level that covers the cost of employing qualified professionals, i.e. therapists and case managers, thereby allowing community agencies to hire staff at a level that meets the communities' needs;
- 2) The Departments of Public and Mental Health should increase funding for FQHC's and community mental health agencies that are considering partnering to provide more seamless and comprehensive behavioral health services. Perhaps pilot projects throughout the state in rural areas could be established to assist in developing "centers of excellence" for such services. As a part of that effort, best practice standards and evidence-based practices of care could be incorporated into the overall design; and
- 3) The state Medicaid plan should provide for reimbursement for specialists that are involved in tele/health consultation. Currently 34 other states allow for Medicaid reimbursement in such instances. Tele/medicine is an excellent means by which specialists can provide consultation in rural areas, as well as, a time-saving resource for educating primary care physicians along psychiatric lines. Franklin-Williamson Human Services and Shawnee Health Services are currently working with SIU to bring tele/medicine resources to Illinois Centre Behavioral Health.

In conclusion, we would like to publicly thank Rep. John Bradley for his ongoing support of the Illinois Centre collaboration and with his continued assistance look forward to more comprehensive healthcare.

St. Anthony's Hospital, Chicago

Kathleen K. DeVine, *CEO and President*

St. Anthony's serves a very-defined community and it is generally defined as a community hospital. It has been an economic-stabilizing influence for the area. It is very racially diverse: heavily Latino and immigrant (1st, 2nd and 3rd generation) families, mostly working-class, whose access to healthcare has been diminishing greatly because of a lack of insurance – estimated in this community to be well over 50% uninsured.

St. Anthony's is probably the oldest hospital on the continent.

Although there has been general improvement in the availability of primary care, there is a horrible impact of diabetes and cancer (late-diagnosed, early morbidity, early mortality). Diabetes is the leading cause of death in this community, and of general disability. We're very concerned about having a system of care that addresses these health problems. Unfortunately, the way that healthcare is financed does not always contribute to that goal.

St. Anthony's is heavily-dependent on government funding. More than 50% of patients are Medicaid and 25% Medicare. On any given day, 10% of our patients are uninsured and for which the hospital receives no payment. Given the impetus of government programs to restrict payments, that means that our patient revenues makes the economics of that process very tough to manage. It's a regular challenge to simply make payroll, which is quite different than past times when the challenge was long-term capital investment.

St. Anthony's applauds the effort of the General Assembly with respect to the "Provider Tax," but the delay in approval by the federal government means that the hospital is really struggling with cash flow. There needs to be leadership in resolving these funding issues on a longer-term basis for the Medicaid program, beyond the "Provider Tax." The state cannot go back to the federal government every 2 years and then wait 1-1/2 years for approval. This is the time of the "Perfect Storm" of hospital finance, especially considering the current focus on "Charity Care," Medicaid funding issues, the rising number of uninsured, etc. St. Anthony's, and other similarly-situated hospitals, simply cannot do it any longer – We're really close to the breaking point. All it will take is for one more major hospital to close for there to be a domino effect.

St. Anthony's see well over 30,000 people each year in the emergency department, well over 30,000 in hospital-based clinics, delivery more than 2,000 babies, and taking care of 7,500 to 8,000 on an inpatient basis, many of whom are uninsured.

St. Anthony's has also had a series of patients who are uninsured who have no place else to go, so that we could not discharge them. One patient remained for 90 days, because there was nowhere else to go – no personal home, no relatives, no insurance, no nursing homes that would take them. Many patients are in the hospital for 30, 60, 90, or 120 days unnecessarily, simply for a lack of an appropriate discharge plan. St. Anthony's has stepped up its effort to partner with other community organizations to address this problem, including Cook County Health Systems and Rush/Presbyterian-St. Luke's Health & Hospital Systems, but there's a long way to go for a final solution. There have been meetings with local health authorities, including the City of Chicago, about this matter.

Norwegian American Hospital, Chicago

Michael J. O'Grady, Jr., *CEO and President*

The situation at Norwegian American Hospital (Chicago) is similar in most respects to St. Anthony's. It serves a similar inner-city community. The population is at great risk in terms of healthcare. The hospital remains committed to the community, but it is a tremendous challenge.

The patient population at Norwegian (based on pure volume of services) is 55% Medicaid and 12% is self-pay uninsured — 70% of patients account for about 55%-to-50% of the hospital's actual costs. This means that the hospital will not be able to collect enough to cover those costs. "Safety Net" hospitals [Norwegian American, St. Anthony's, St. Bernard, Loretto, Mercy, etc.], such as Norwegian American, are spending out whatever cash is accumulated. Every 2 weeks there is a \$1.4-to-\$1.5 million payroll, which means that other vendors are not being paid on a timely or adequate basis. Special payment terms have been worked out with many of those vendors, well beyond normal conditions. Norwegian is paying its vendors on a 60-day, 75-day schedule. Most are sympathetic to the hospital's circumstances, but they are facing related cash management issues. Meeting payroll is a very real concern.

In general, incentives are all wrong. The hospital will cover the cost of repeated, acute care interventions, at enormous costs, and yet not pay for regular visits to measure a diabetic's blood sugar. It does not make any sense at all to not cover this type of primary, preventive care for patients that will improve the lives of the patients before their conditions become more acute. The financial incentives are perverse, in terms of hospital payment methodologies. Norwegian is aware of hospitals in other parts of the country who have been implementing primary care programs, but it is not a widely adopted practice, especially for community hospitals that don't have the physical capacity or health manpower to administer such a program. If patients have no other alternative for that primary care, and they have to use the hospital for their routine medical care, and the hospital is not going to be paid in any event, it would be to the hospitals' advantage to implement such a program as a way of avoiding the higher cost of the acute interventions. Community hospitals do provide some outreach for prescription drug maintenance. It's an increasingly-difficult challenge to conduct outreach for a transient population like that being served by many of these hospitals.

Although "Safety Net" hospitals are reimbursed by Medicaid on an expedited basis, there are a significant number of employed physicians who are not being paid on a timely basis. For example, there are approximately \$1.5 million in unpaid radiologist invoices that are more than 90-days old.

As the State of Illinois is preparing to implement a statewide PCCM (Primary Care Case Management) program in 2007, the enrollment of primary care physicians is lagging way behind in terms of the coverage that will be required for the Medicaid population that is supposed to be covered. The Department of Healthcare & Family Services has been requesting hospitals' assistance in encouraging their practicing physicians to enroll in the PCCM program, so that there will not be disruption in patient care. Hospitals have not been actively involved with the state in the development of this program, but are now being asked to provide assistance. These physicians would be assured that they would maintain their patient caseload, and that enhanced reimbursements would be timelier under the ALL KIDS program.

Illinois Primary Health Care Association (IPHCA)

Philippe Largent, *Vice President, Government Affairs*

Established in 1982, IPHCA is the state's sole trade association for Community and Migrant Health Centers (CHC). IPHCA is a private, not for profit 501(c)(3) entity. The association employs approximately seventeen staff members with offices in Chicago and Springfield.

Services offered: Statewide Clinician Recruitment, Shared Services through IPHCA's Group Purchasing Organization (GPO), Primary Health Purchasing Alliance, financial and business consulting targeted to CHCs, community development services including MUA/MUP development, State and Federal advocacy, conference, networking and educational seminars targeted to CHC management. Management of statewide practice management system, INET. Collection and analysis of data to help define CHC impact and to plan future expansions.

IPHCA's Mission: Strive to improve the health status of medically underserved populations by fostering the provision of high-quality, comprehensive health care that is accessible, coordinated, community-directed, culturally sensitive, and linguistically competent. Ultimately, the Association works to increase access to high-quality, cost-effective primary health care services in urban and rural populations throughout the state, regardless of an individual's ability to pay.

ILLINOIS COMMUNITY HEALTH CENTERS: A QUICK GLANCE

Sometimes referred to as Federally Qualified Health Centers (FQHC), community health centers are not for profit (501 c 3), community based businesses. There are four health center organizations that are affiliated with public entities such as a county or local government (Will and Lake Counties, the Chicago Department of Public Health) or a public university (University of Illinois Chicago).

Health centers are required to serve Medically Underserved Areas (MUA) and/or Medically Underserved Populations (MUP) both of which are federal designations based upon levels of poverty, rates of infant mortality, and a demonstrated lack of health care providers.

Health centers are governed by a Board of Directors, which by federal law, must be composed of at least 51% users of the health center's services.

Health centers provide a wide range of services outside of a standard medical practice including patient translation services, transportation services, child care, case management, health education and prevention services, chronic disease management, and other ancillary services which have been identified by the CHC Board as a need within the community.

Health centers are required to provide access to the following services: Family medicine, internal medicine, pediatrics, OB/GYN, services offered by nurse practitioners, preventive health services including, prenatal and perinatal services, screenings for breast and cervical cancer, immunizations, disease screening, pediatric eye, ear, and dental screenings, voluntary family planning services, specialty referrals and referrals to other services such as substance abuse, case management, and patient education.

Health centers cannot deny services to a patient due to the patient's inability to pay for care.

The federal health centers program targets certain hard to reach or "special" populations by dedicating a certain percentage of federal spending to facilitate services to these groups of people. Special populations include the homeless, residents of Public Housing, and migrant/seasonal farm workers. In addition to standard health center grants, Illinois has a number of health care for the homeless, public housing and farm worker grants all funded through the federal government.

Health Center growth in Illinois has been dramatic: Since 1999 the federal government has funded 41 grants in Illinois to either create new health center organizations, or expand existing CHC health care access points or “sites”. They have also invested millions to expand service offerings (Oral and Behavioral health), and expand the capacity of existing centers to serve the uninsured.

State funded expansion grants through the Community Health Center Expansion Act, administered through the Illinois Department of Public Health, Center for Rural Health, have helped create or expand 29 CHC health care access sites statewide.

As a result of both the federal and state expansion efforts health centers have more than doubled the number of patients they serve annually since 2000 (400,000 in 2000 to 900,000 in 2005).

902,000	patients served
3,200,000	encounters or patient visits
315,000	uninsured patients served
366,000	Medicaid patients served
52,000	Medicare patients served
92.2%	of known patients served in 2005 had income 200% or below poverty level
254	Primary Care Clinical Sites (organizational members)

COST EFFECTIVENESS OF COMMUNITY HEALTH CENTERS

Savings to State of Illinois \$81.01 annually in medical costs.

The federal government saves \$1.42 in Medicaid expenditures for every \$1 it invests in Illinois' community health centers through the federal primary care grant program.

Increased usage of health centers and reduced utilization in emergency room care at Illinois hospitals could save \$343.02 million annually.

Illinois health centers provide services to their communities beyond the “traditional” health care needs. In 2004, Illinois community health centers injected more than \$332 million in operating expenditures into Illinois communities, resulting in an overall economic impact of more than \$524 million (according to an IMPLAN analysis using 1998 multiplier data).

In addition to the dramatic increase in economic output through operating expenditures, the 36 community health centers included in the sample provided direct employment to approximately 4,250 people in 2004 resulting in a payroll of more than \$199 million.

The indirect economic impact on Illinois communities in 2004 was close to \$273 million in labor income and approximately 5,750 jobs supported.

ILLINOIS COMMUNITY HEALTH CENTERS: CHALLENGES AND OPPORTUNITIES

Challenges

Growth in the uninsured population has slowed when compared to peak growth years (2002 and 2003) but health centers continue to serve large uninsured or “no pay” populations while the federal grant to serve that population has remained flat. The grant is not tied to any inflationary factor so it does not keep pace with regular medical inflation.

Medicaid

Medicaid represents the largest revenue source for Illinois' CHC network. As a result, CHCs are hyper sensitive to changes or potential reforms in Medicaid. Any reform efforts, including the transition into managed care, must take into account the state's CHC network and the impact reform may have on the ability of CHCs to serve both the Medicaid and uninsured population.

High volume of uninsured patients coupled with CHCs reliance on Medicaid patient revenue means timely and adequate Medicaid reimbursement is critical.

Dramatic changes in Medicaid eligibility or benefits offered could negatively impact health center revenues and their ability to treat uninsured population. Federal law requires CHCs to treat any patient regardless of their ability to pay. Changes in Medicaid which result in Medicaid beneficiaries becoming uninsured simply adds patients to the already large and growing health center uninsured population.

Given their location and their mission to provide high quality, affordable health care to anyone regardless of their ability to pay, Illinois health centers serve a large and diverse immigrant population, including the undocumented. IPHCA and our membership do not differentiate between U.S. citizens and non citizens when providing quality care and are supportive of efforts to maintain and where possible expand services to this population group.

The inability to make specialty referrals for uninsured patients is nearing a crisis level. A combination of poor and untimely Medicaid reimbursement, and sky rocketing medical liability costs fuels the exodus of providers, particularly in the southern part of the state and the refusal of specialists to treat uninsured patients.

Continued federal and state investment in health centers is critical to closing access “gaps” within Illinois. Federal and state budget shortfalls jeopardize ability to continue appropriate levels of investment.

Recruitment and retention of quality providers, particularly bilingual providers, continues to be a struggle. Combination of provider shortages in the market place and increased competition for highly sought after providers such as dentist and certain specialists make this matter of great concern to health centers and IPHCA.

Opportunities

State efforts to expand reach of health centers through state grant program has been successful. Scope of grant should be expanded to include both CHC expansion efforts and support for existing health center network perhaps based on volume of uninsured.

AllKids provides a real opportunity to move large segments of CHC patients from the “uninsured” column to the insured column. That removes pressure from the shrinking federal grant and allows more resources to be used to expand services.

Illinois health centers continue to make strides in their ability to demonstrate quality and cost effectiveness which positions them well for potential transition to pay for performance reimbursement model.

As a result of federal and state investment Illinois health centers have become one of the top providers of care to the state’s Medicaid population. Since 2000, Illinois CHC Medicaid patient volume has increased 94.2%. In 2005, our members served in excess of 350,000 Medicaid patients. Illinois CHC Medicaid volume creates unique opportunities for health centers to partner with state government in providing cost effective, high quality care to this population.

RECOMMENDATIONS

Support and fund five year, \$15 million increase for CHC Expansion Program administered by the Illinois Department of Public Health. Increased resources would be used to expand existing health center network, including the establishment of School based community health centers where appropriate, and provide grant funding to CHCs to assist in covering the cost of the uninsured. This proposal is similar to President Bush’s five year expansion effort at the federal level which is credited with a significant increase

in the numbers of patients served by health centers nationally while providing additional grant support to help offset the cost of treating greater numbers of uninsured.

Increase access to specialty and sub-specialty care for underserved populations through a combination of prompt payment, adjusted Medicaid reimbursement and incentives to specialty providers to serve underserved populations. The problem of accessing specialty care has reached a crisis point, particularly downstate where a combination of high malpractice costs and low/slow Medicaid payments has emptied the market place of specialists willing to provide care to the Medicaid or uninsured patient populations. Provide pilot funding to innovative efforts to increase access to specialty care, such as the Specialty Care Pool being developed in Lake County, Illinois.

Mandate timely Medicaid payments and stop politicizing issue. Both Republicans and Democrats have been guilty of balancing the budget on the backs of Medicaid providers. Politicizing the issue only drives out what few providers are left to serve the Medicaid population particularly downstate.

Illinois has an established program designed to recruit medical providers to serve in underserved areas. The state's program mirrors the National Health Service Corp., by providing candidates, who agree to serve a minimum of two years in an underserved community, with up to \$25,000 per year (\$12.5 in state funding and \$12.5 from the employer) in loan forgiveness or provide scholarships for health professional students. IPHCA recommends significantly increasing opportunities under the current loan forgiveness program. Loan forgiveness is the best way to assure underserved areas secure work commitments from Physicians, Nurse Practitioners, Dentists and other allied health professional. In fact we would favor the discontinuation of the scholarship program and transitioning those resources to loan forgiveness, perhaps to eliminate the employer share of the loan forgiveness; or use funds transitioned from the scholarships to retention bonuses targeted to candidates serving in the neediest of communities. At a minimum, the scholarship program needs to be revamped to avoid candidates skipping out on their commitments while benefiting from the scholarship.

Identify state and/or local revenue streams to support programs which promote access to care. Tobacco settlement dollars seem precarious. Other, more reliable revenue streams should be identified to support expanded efforts.

Stay committed to recent publicly financed efforts to increase access to care among low income populations such as AllKids, FamilyCare and recent Medicaid eligibility expansions. Allow Primary Care Case Management system to evolve and promote the concept of a "medical home" for the Medicaid/AllKids populations. Renew commitment to serve immigrant populations including persons who are undocumented.



**Community Health Centers:
Providing Solutions to the Medically Underserved**
Testimony provided to the Joint Task Force on Rural Health and Medically Underserved Areas

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**Background:
Illinois CHC Network**



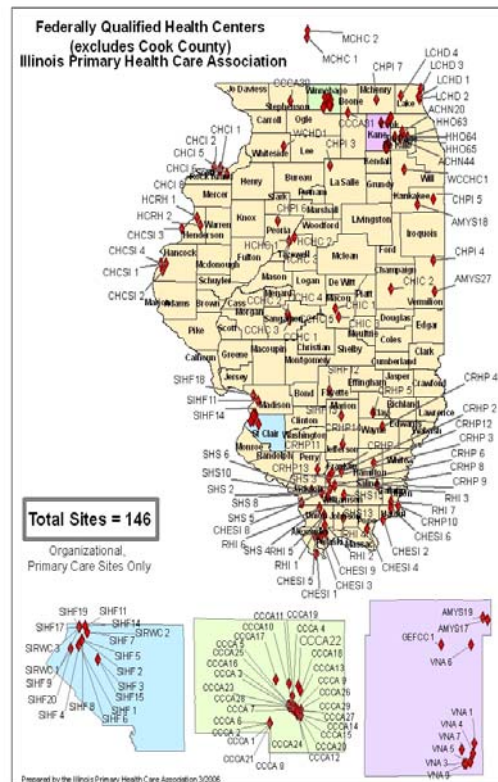
- Illinois Community Health Centers: A Quick Glance
 - Some times referred to as Federally Qualified Health Centers (FQHC), community health centers are not for profit (501 c 3), community based businesses. There are four health center organizations that are affiliated with public entities such as a county or local government (Will and Lake counties, the Chicago Department of Public Health) or a public university (University of Illinois Chicago).
 - Health centers are required to serve Medically Underserved Areas (MUA) and/or Medically Underserved Populations (MUP) both of which are federal designations based upon levels of poverty, rates of infant mortality, and a demonstrated lack of health care providers.
 - Health Centers are governed by a Board of Directors, which by federal law, must be composed of at least 51% users of the health center's services.
 - Health centers provide a wide range of services outside of a standard medical practice including patient translation services, transportation services, child care, case management, health education and prevention services, chronic disease management, and other ancillary services which have been identified by the CHC Board as a need within the community.
 - Health centers are required to provide access to the following services:
 - Family medicine, internal medicine, pediatrics, OB/GYN, services offered by nurse practitioners, preventive health services including, prenatal and perinatal services, screenings for breast and cervical cancer, immunizations, disease screening, pediatric eye, ear, and dental screenings, voluntary family planning services, specialty referrals and referrals to other services such as substance abuse, case management, and patient education.
 - Health centers cannot deny services to a patient due to the patient's inability to pay for care.
 - The federal health centers program targets certain hard to reach or "special" populations by dedicating a certain percentage of federal spending to facilitate services to these groups of people. Special populations include the homeless, residents of Public Housing, and migrant/seasonal farm workers. In addition to standard health center grants, Illinois has a number of health care for the homeless, public housing and farm worker grants all funded through the federal government.



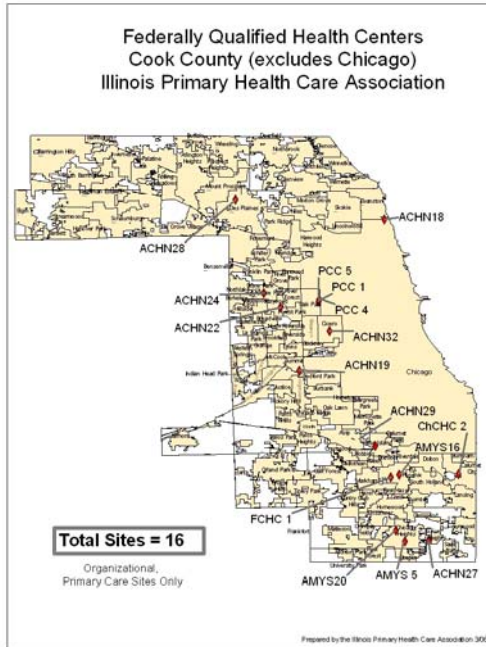
**Background:
Illinois CHC Network - Continued**

- Health Center growth in Illinois has been dramatic
 - Since 1999 the federal government has funded forty one (41) grants in Illinois to either create new health center organizations, or expand existing CHC health care access points or “sites”. They have also invested millions to expand service offerings (Oral and Behavioral health), and expand the capacity of existing centers to serve the uninsured.
 - State funded expansion grants through the Community Health Center Expansion Act, administered through the Illinois Department of Public Health, Center for Rural Health, have helped create or expand twenty nine (29) CHC health care access sites across the state. See attached breakdown of state funded CHC sites by year.
 - As a result of both the federal and state expansion efforts health centers have more than doubled the number of patients they serve annually since 2000 (400,000 in 2000 to 900,000 in 2005).

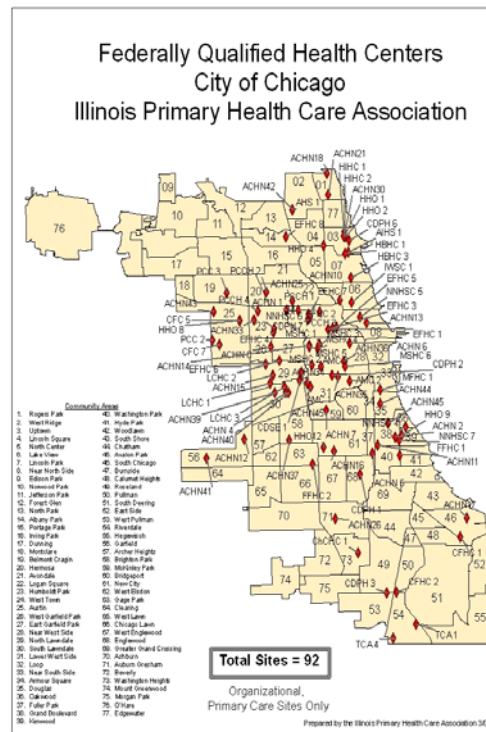
Illinois Community Health Centers: Illinois' CHC Locations



Illinois' CHC Locations - Continued



Illinois' CHC Locations - Continued



Illinois Community Health Centers: Patient Data
Selected 2005 Patient Demographics



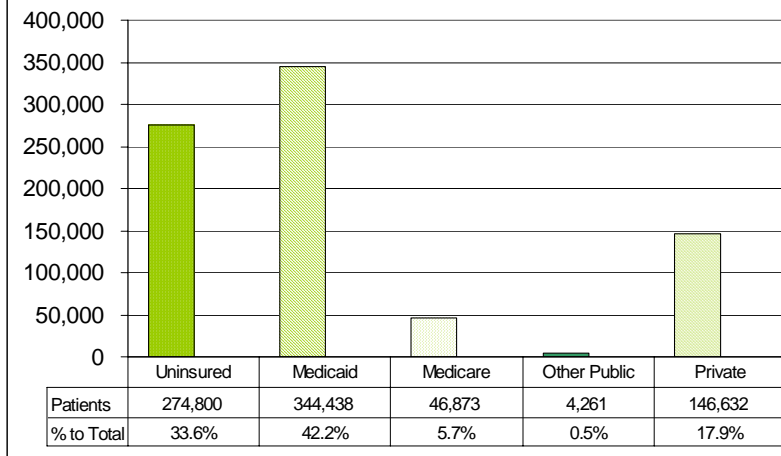
- 902,000 patients served
- 3.2 million encounters or patient visits
- 315,000 uninsured patients served
- 366,000 Medicaid patients served
- 52,000 Medicare patients served
- 92.2% of known patients served in 2005 had income 200% or below poverty level
- 254 Primary Care Clinical Sites (Organizational Members)

Note: Data represents IPHCA member Public Health Service Act, section 330 Community Health Center Grantees and FQHC Look-Alikes or may only include grantee data.

Illinois Community Health Centers: Patient Data



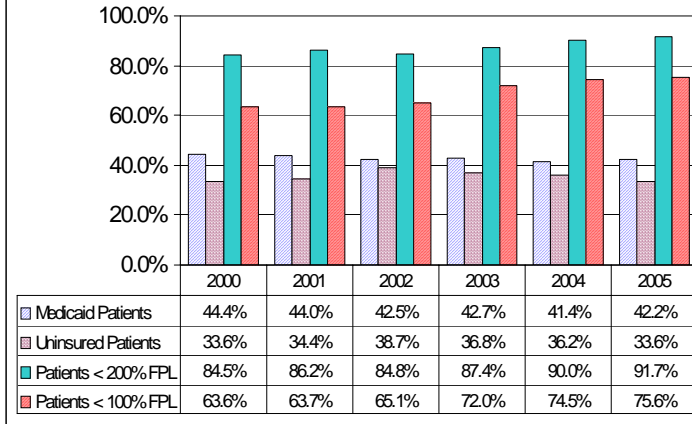
2005 Patients by Insurance Source
Illinois 330 Grantees



Illinois Community Health Centers: Patient Data



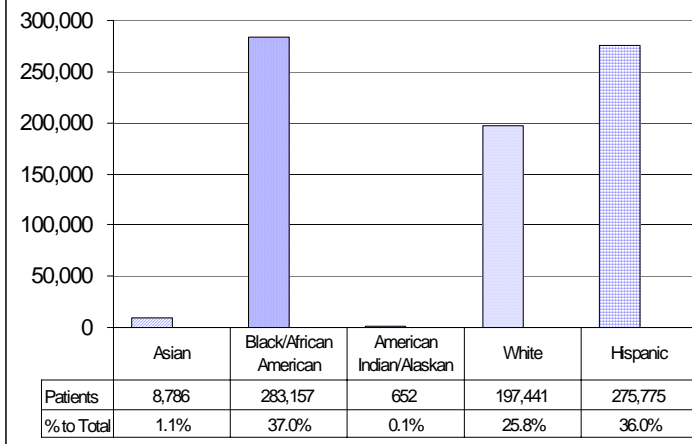
Selected Known Patient Volumes as a % to Total Illinois 330 Grantees



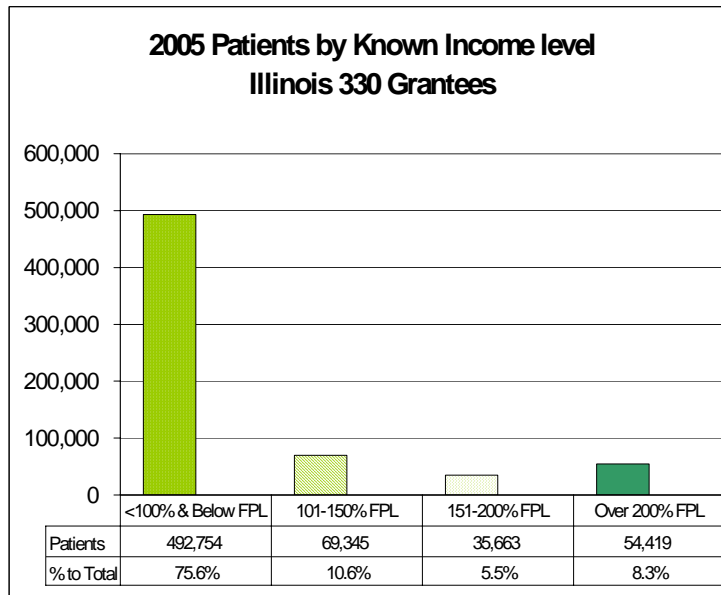
Illinois Community Health Centers: Patient Data



2005 Patients by Known Race/Ethnicity Illinois 330 Grantees



Illinois Community Health Centers: Patient Data

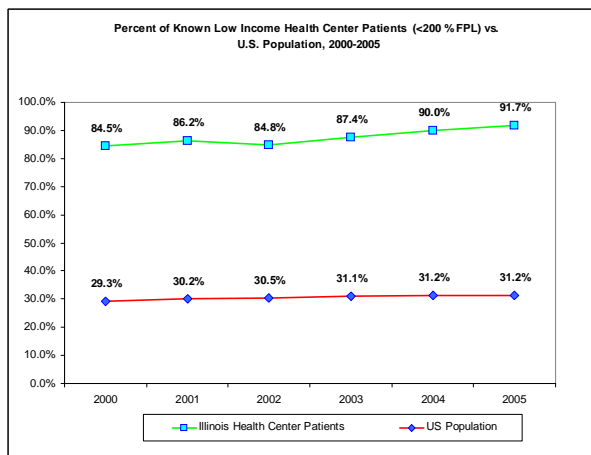


Illinois Community Health Centers: Patient Data



Illinois 330 Grantees
Percent of Known Illinois Low-Income Health Center Patients vs. National, 2000-2005

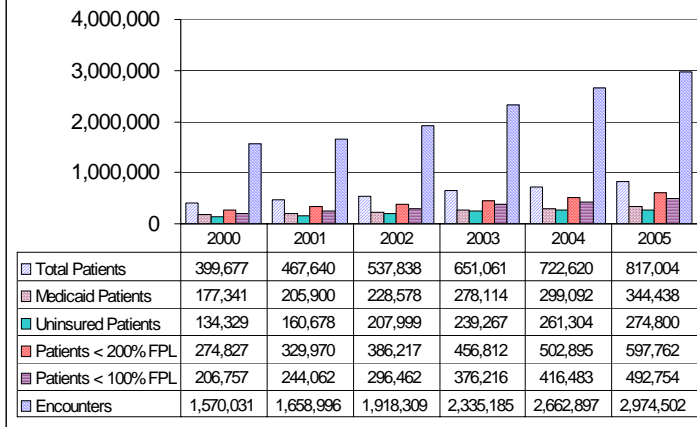
Nine out of every ten Illinois health center patients are considered poor, compared to less than a third of the U.S. population. In 2005, almost 92% of Illinois health center patients seen had incomes <200% Federal Poverty level.



Illinois Community Health Centers: Patient Data



**Selected Known Patient Volumes by Year
Illinois 330 Grantees**



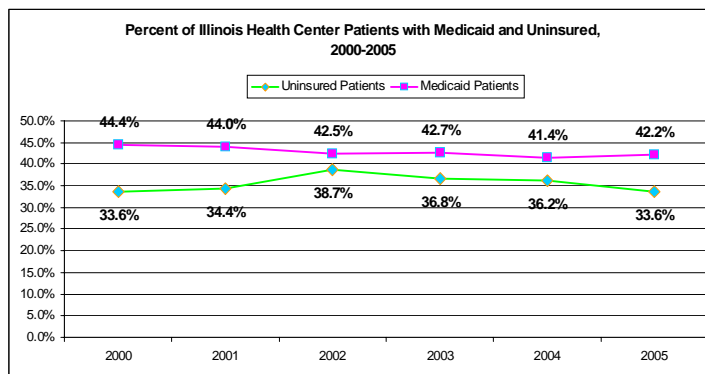
Illinois Community Health Centers: Patient Data



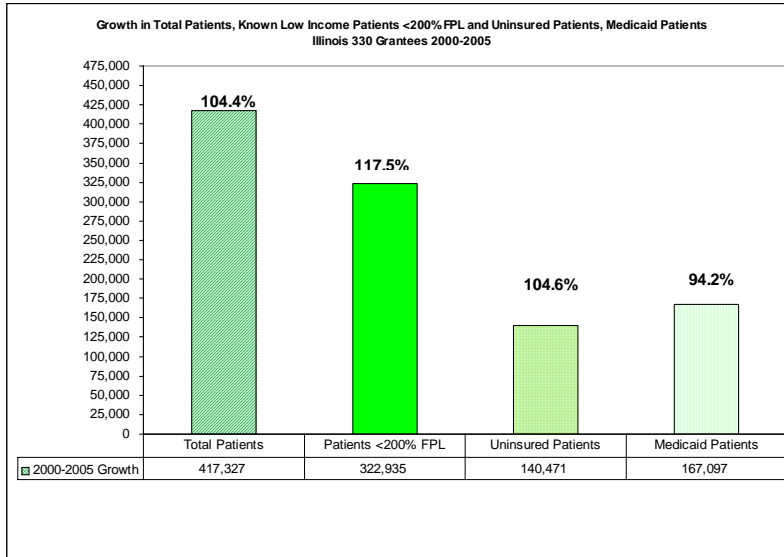
Illinois 330 Grantees

Percent of Illinois Health Center Patients with Medicaid and Uninsured, 2000-2005

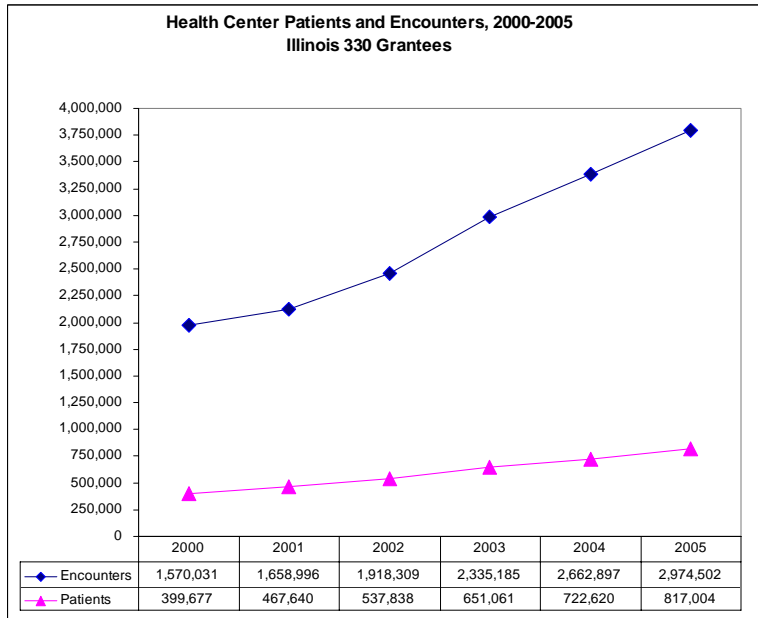
Three in seven Illinois health center patients have relied on Medicaid for insurance coverage over the last six years. In 2005, 33.6% of Illinois health center patients seen were uninsured.



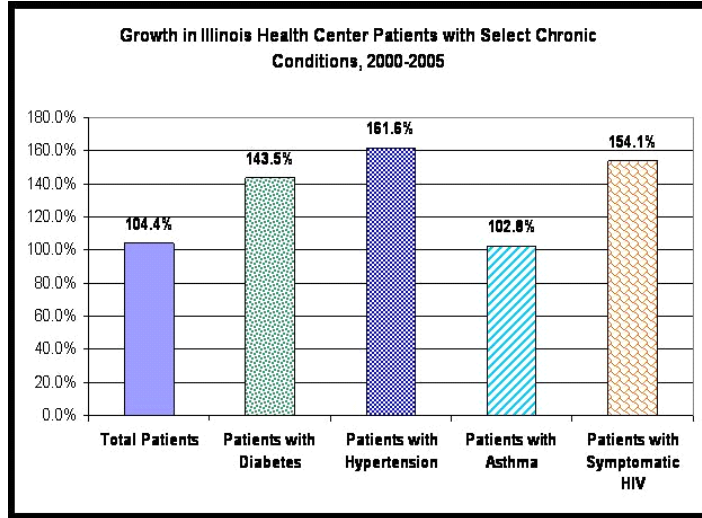
Illinois Community Health Centers: Patient Data



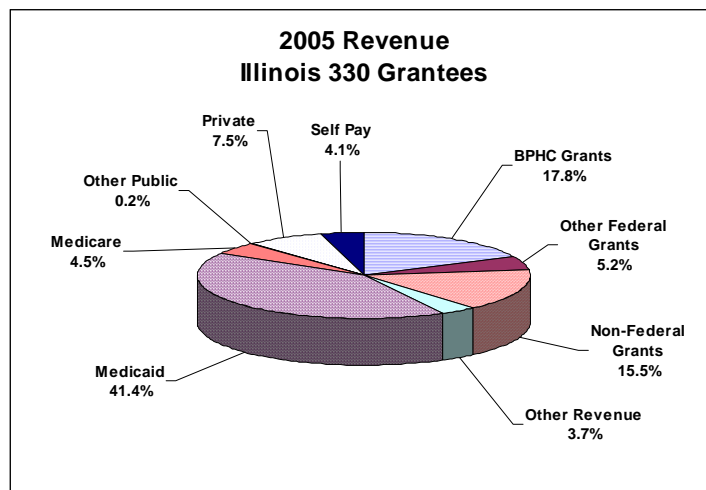
Illinois Community Health Centers: Patient Data



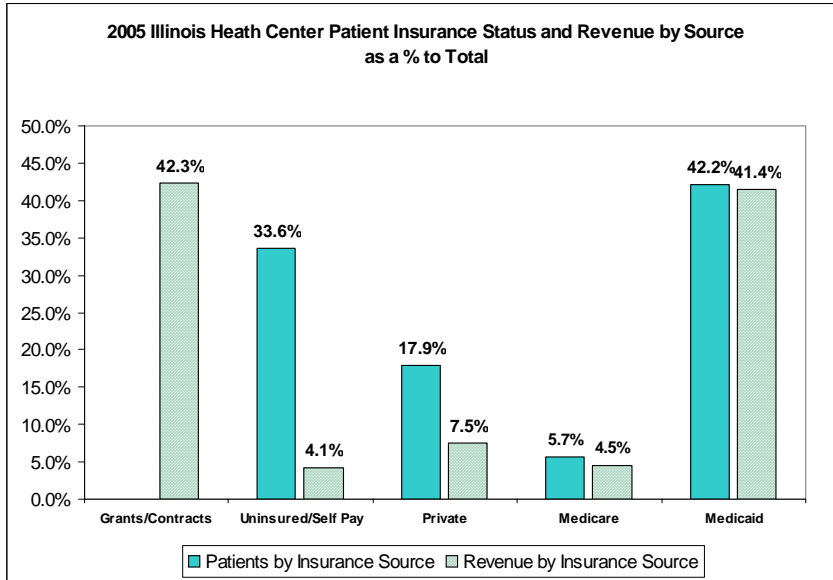
Illinois Community Health Centers: Patient Data



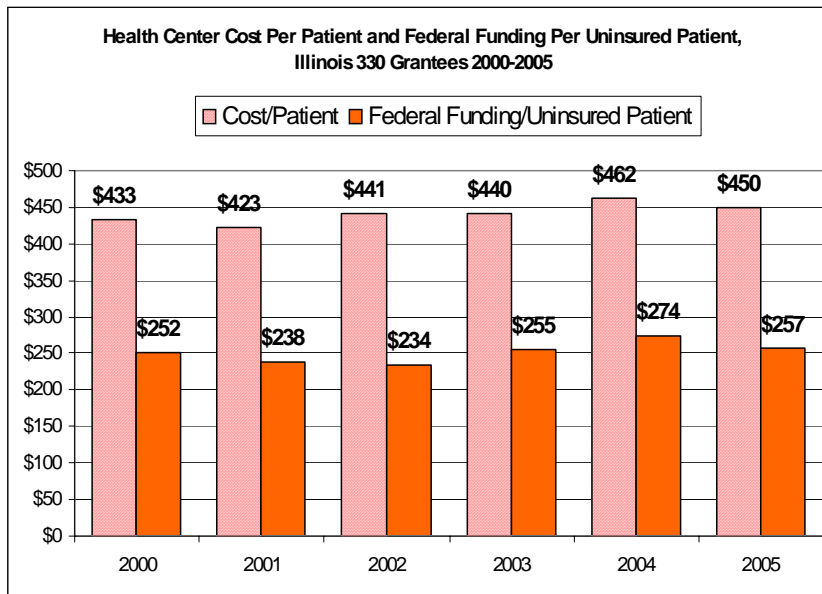
Illinois Community Health Centers: Revenue Sources and Cost Data



**Illinois Community Health Centers:
Revenue Sources and Cost Data**



**Illinois Community Health Centers:
Revenue Sources and Cost Data**



Illinois Community Health Centers: Cost Effective and Economic Engine



- Savings to State of Illinois \$81.0¹ annually in medical costs.
- The federal government saves \$1.42 in Medicaid expenditures for every \$1 it invests in Illinois' community health centers through the federal primary care grant program.
- Increased usage of health centers and reduced utilization in emergency room care at Illinois hospitals could save \$343.0² million annually.

1 2003 data from Illinois Department of Public Aid and assumes a 30% savings based upon the literature review on the impact of health center on state Medicaid spending.

2 "A Nation's Health at Risk II: A Front Row Seat in a Changing Health Care System", National Association of Community Health Centers, 2004, page 22

Illinois Community Health Centers: Cost Effective and Economic Engine



- Illinois health centers provide services to their communities beyond the "traditional" health care needs. In 2004, Illinois community health centers injected more than \$332 million in operating expenditures into Illinois communities, resulting in an overall economic impact of more than \$524 million (according to an IMPLAN analysis using 1998 multiplier data).
- In addition to the dramatic increase in economic output through operating expenditures, the 36 community health centers included in the sample provided direct employment to approximately 4,250 people in 2004 resulting in a payroll of more than \$199 million.
- The indirect economic impact on Illinois communities in 2004 was close to \$273 million in labor income and approximately 5,750 jobs supported.

Illinois Community Health Centers: Quality Providers of Care



- Reducing Racial & Ethnic Health Disparities: Estimating the Impact of High Health Center Penetration in Low-Income Communities
 - Study examined the relationship between health center penetration into medically underserved communities and the reduction of state level health disparities.
 - Results showed that greater levels of health center penetration (i.e., proportion of low-income individuals served) were associated with significant and positive reductions in minority health disparities.

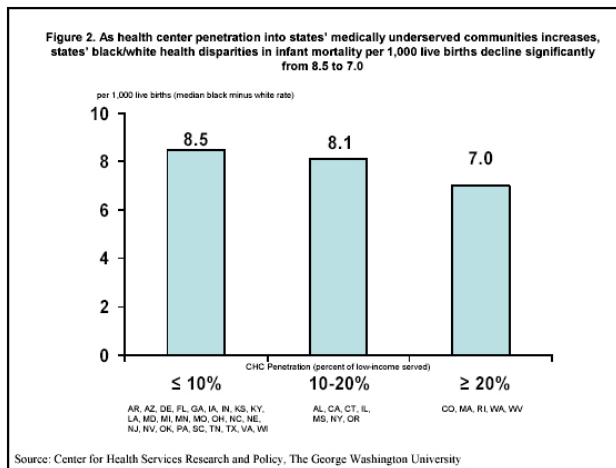
Peter Shin, PHD, MPH
 Karen Jones, MS
 Sara Rosenbaum, JD

Center for Health Services Research and Policy, The George Washington University Medical Center, School of Public Health and Health Services (September 2003)

Black/White Health Disparities in Infant Mortality



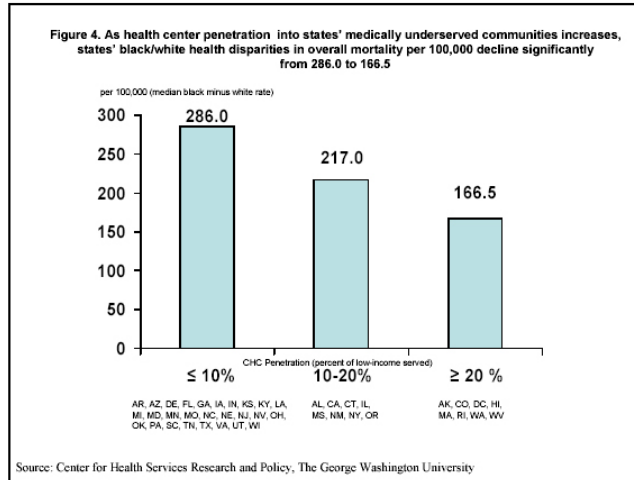
States' black/whites health disparities in infant mortality per 1,000 live births decline significantly from 8.5 to 7.0 as health center penetration into state's medically underserved communities increases.



Black/White Health Disparities in Overall Mortality



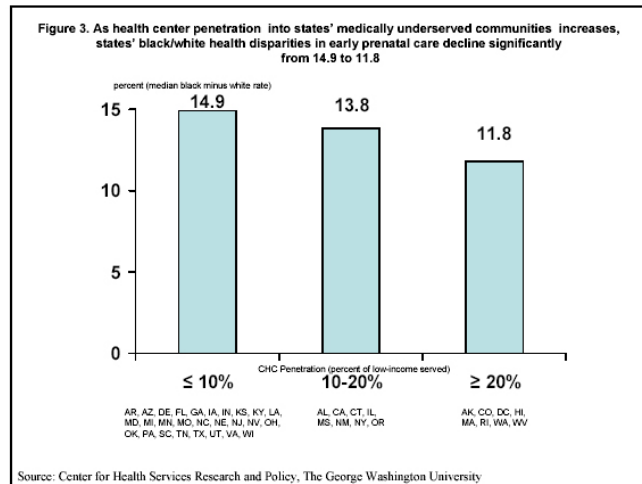
States' black/whites health disparities in overall mortality per 100,000 decline significantly from 286.0 to 166.5 as health center penetration into state's medically underserved communities increases.



Black/White Health Disparities in Early Prenatal Care



States' black/whites health disparities in early prenatal care decline significantly from 14.9 to 11.8 as health center penetration into state's medically underserved communities increases.

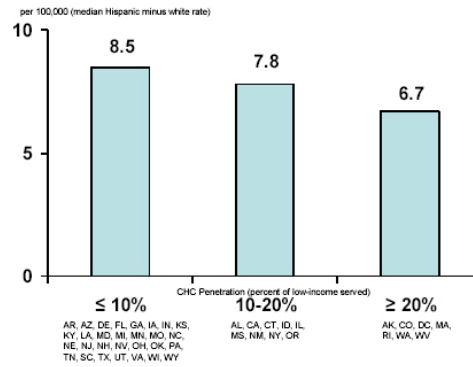


Hispanic/White Health Disparities in Tuberculosis



States' Hispanic/White health disparities in tuberculosis cases per 100,000 decline significantly from 8.5 to 6.7 as health center penetration into state's medically underserved communities increases.

Figure 6. As health center penetration into states' medically underserved communities increases, states' Hispanic/white health disparities in tuberculosis cases per 100,000 decline significantly from 8.5 to 6.7

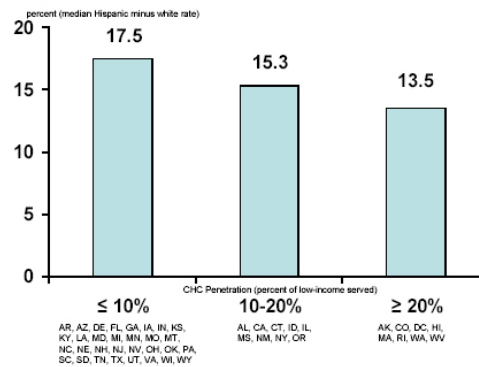


Hispanic/White Health Disparities in Early Prenatal Care



States' Hispanic/White health disparities in early prenatal care decline significantly from 17.5 to 13.5 as health center penetration into state's medically underserved communities increases.

Figure 5. As health center penetration into states' medically underserved communities increases, states' Hispanic/white health disparities in early prenatal care decline significantly from 17.5 to 13.5





Illinois Community Health Centers: Quality Providers of Care Continued

Making Progress in Chronic Disease Treatment, June 2006

- IPHCA analysis of Illinois Health Disparities Collaborative Data for the years 2003-2005. Data indicates Illinois health centers are making good progress in improving the health status of patients with chronic illnesses. The collaboratives, sponsored by the Health Resources and Services Administration (HRSA) and the Bureau of Primary Health Care (BPHC), both agencies within the U.S. Department of Health and Human Services, focuses on improved methods of treating people with chronic disease, adopting these new methods into treatment protocols within health centers and then tracking the patients progress against widely accepted treatment goals.



Illinois Community Health Centers: Challenges and Opportunities

- Challenges:
 - Growth in the uninsured population has slowed when compared to peak growth years (2002 and 2003) but health centers continue to serve large uninsured or “no pay” populations while the federal grant to serve that population has remained flat. The grant is not tied to any inflationary factor so it does not keep pace with regular medical inflation.
 - Medicaid:
 - Medicaid represents the largest revenue source for Illinois' CHC network. **As a result, CHCs are hyper sensitive to changes or potential reforms in Medicaid.** Any reform efforts, including the transition into managed care, must take into account the state's CHC network and the impact reform may have on the ability of CHCs to serve both the Medicaid and uninsured population.
 - High volume of uninsured patients coupled with CHCs reliance on Medicaid patient revenue means timely and adequate Medicaid reimbursement is critical.
 - Dramatic changes in Medicaid eligibility or benefits offered could negatively impact health center revenues and their ability to treat uninsured population. Federal law requires CHCs to treat any patient regardless of their ability to pay. Changes in Medicaid which result in Medicaid beneficiaries becoming uninsured simply adds patients to the already large and growing health center uninsured population.

Illinois Community Health Centers: Challenges and Opportunities



- Given their location and their mission to provide high quality, affordable health care to anyone regardless of their ability to pay, Illinois health centers serve a large and diverse immigrant population, including the undocumented. IPHCA and our membership do not differentiate between U.S. citizens and non citizens when providing quality care and are supportive of efforts to maintain and where possible expand services to this population group.
- The inability to make specialty referrals for uninsured patients is nearing a crisis level. A combination of poor and untimely Medicaid reimbursement, and sky rocketing medical liability costs fuels the exodus of providers, particularly in the southern part of the state and the refusal of specialists to treat uninsured patients.
- Continued federal and state investment in health centers is critical to closing access “gaps” within Illinois. Federal and state budget shortfall jeopardize ability to continue appropriate levels of investment.
- Recruitment and retention of quality providers, particularly bilingual providers continues to be a struggle. Combination of provider shortages in the market place and increased competition for highly sought after providers such as dentist and certain specialists make this matter of great concern to health centers and IPHCA.

Illinois Community Health Centers: Challenges and Opportunities



- Opportunities:
 - State efforts to expand reach of health centers through state grant program has been successful. Scope of grant should be expanded to include both CHC expansion efforts and support for existing health center network perhaps based on volume of uninsured.
 - AllKids provides a real opportunity to move large segments of CHC patients from the “uninsured” column to the insured column. That removes pressure from the shrinking federal grant and allows more resources to be used to expand services.
 - Illinois health centers continue to make strides in their ability to demonstrate quality and cost effectiveness which positions them well for potential transition to pay for performance reimbursement model.
 - As a result of federal and state investment Illinois health centers have become one of the top providers of care to the state's Medicaid population. Since 2000, Illinois CHC Medicaid patient volume has increased 94.2%. In 2005, our members served in excess of 350,000 Medicaid patients. Illinois CHC Medicaid volume creates unique opportunities for health centers to partner with state government in providing cost effective, high quality care to this population.

**Illinois Community Health Centers:
Recommendations to the Joint Task Force on Rural Health
and Medically Underserved Areas**



- Support and fund five year, \$15 million increase for CHC Expansion Program administered by the Illinois Department of Public Health. Increased resources would be used to expand existing health center network, **including the establishment of School based community health centers where appropriate**, and provide grant funding to CHCs to assist in covering the cost of the uninsured. This proposal is similar to President Bush's five year expansion effort at the federal level which is credited with a significant increase in the numbers of patients served by health centers nationally while providing additional grant support to help offset the cost of treating greater numbers of uninsured.
- Increase access to specialty and sub-specialty care for underserved populations through a combination of prompt payment, adjusted Medicaid reimbursement and incentives to specialty providers to serve underserved populations. The problem of accessing specialty care has reached a crisis point, particularly downstate where a combination of high malpractice costs and low/slow Medicaid payments has emptied the market place of specialists willing to provide care to the Medicaid or uninsured patient populations. Provide pilot funding to innovative efforts to increase access to specialty care, such as the Specialty Care Pool being developed in Lake county, Illinois.
 - Mandate timely Medicaid payments and stop politicizing issue. Both Republicans and Democrats have been guilty of balancing the budget on the backs of Medicaid providers. Politicizing the issue only drives out what few providers are left to serve the Medicaid population particularly downstate.
- Illinois has an established program designed to recruit medical providers to serve in underserved areas. The state's program mirrors the National Health Service Corp., by providing candidates, who agree to serve a minimum of two years in an underserved community, with up to \$25,000 per year (\$12.5 in state funding and \$12.5 from the employer) in loan forgiveness or provide scholarships for health professional students. IPHCA recommends significantly increasing opportunities under the current loan forgiveness program. Loan forgiveness is the best way to assure underserved areas secure work commitments from Physicians, Nurse Practitioners, Dentists and other allied health professional. In fact we would favor the discontinuation of the scholarship program and transitioning those resources to loan forgiveness, perhaps to eliminate the employer share of the loan forgiveness; or use funds transitioned from the scholarships to retention bonuses targeted to candidates serving in the neediest of communities. At a minimum, the scholarship program needs to be revamped to avoid candidates skipping out on their commitments while benefiting from the scholarship.

**Illinois Community Health Centers:
Recommendations to the Joint Task Force on Rural Health
and Medically Underserved Areas-Continued**



- Identify state and/or local revenue streams to support programs which promote access to care. Tobacco settlement dollars seem precarious. Other, more reliable revenue streams should be identified to support expanded efforts.
- Stay committed to recent publicly financed efforts to increase access to care among low income populations such as AllKids, FamilyCare and recent Medicaid eligibility expansions. Allow Primary Care Case Management system to evolve and promote the concept of a "medical home" for the Medicaid/AllKids populations. Renew commitment to serve immigrant populations including persons who are undocumented.

Illinois Primary Health Care Association: Who we are and what we do...



- Established in 1982, IPHCA is the state's sole trade association for Community and Migrant Health Centers (CHC). IPHCA is a private, not for profit 501 c3 entity. The association employs approximately seventeen staff members with offices in Chicago and Springfield.
- Services offered: Statewide Clinician Recruitment, Shared Services through IPHCA's Group Purchasing Organization (GPO), Primary Health Purchasing Alliance, financial and business consulting targeted to CHCs, community development services including MUA/MUP development, State and Federal advocacy, conference, networking and educational seminars targeted to CHC management. Management of statewide practice management system, INET. Collection and analysis of data to help define CHC impact and to plan future expansions.
- IPHCA's Mission:
IPHCA strives to improve the health status of medically underserved populations by fostering the provision of high-quality, comprehensive health care that is accessible, coordinated, community-directed, culturally sensitive, and linguistically competent. Ultimately, the Association works to increase access to high-quality, cost-effective primary health care services in urban and rural populations throughout the state, regardless of an individual's ability to pay.

Illinois Psychiatric Society

Daniel Yohanna, M.D., *President*

The Illinois Psychiatric Society is deeply concerned about access to psychiatric care for all citizens of Illinois. There is a shortage of psychiatrists in many areas of the state and particular shortage of psychiatrists specializing in treating children and adolescents. There are approximately 2,080 psychiatrists in Illinois. 50 out of 102 counties have no psychiatrist and many more have only one.

There are several models throughout the country to improve access to psychiatric care that need further exploration for the compatibility with Illinois. Most models may also need to be modified to work here. No one model will work everywhere in the country or throughout every county in the state. In a recent Mental Health Forum, PARTNERSHIPS AND SOLUTIONS, held in Chicago on October 18, 2006, the Illinois Psychiatric Society, along with the Illinois Hospital Association and the National Alliance for the Mentally Ill, explored solutions to (ensure) access to mental health care. This forum led to several work groups that will develop legislation to address the issues.

Models to improve access can be broadly divided into 4 categories:

- **Consultation**: Allows primary care physicians (internists, family practice doctors and pediatricians) access to psychiatrists for advice on diagnosis and treatment.
- **Education**: Provides education through a variety of means and incentives that can assist primary care physicians to use evidence-based practices.
- **Recruitment**: Provide incentives for psychiatrists to live and/or work in underserved areas.
- **Telepsychiatry**: Use video conferencing for consultation on patients. Medicaid does not reimburse for telepsychiatry, but does cover telemedicine.

Catholic Conference of Illinois

Bob Gilligan, *Executive Director*

There must be access and resources available to fulfill people's most essential needs, including healthcare. In rural Illinois, access to an adequate healthcare is of particular concern.

One significant challenge is the lack of adequate health insurance. Rural residents are more likely to earn lower wages or work in small business, and are less likely to have employer-sponsored health insurance. Farm families may be more likely to be insured than the rest of the rural populations, but this varies greatly according to the type of farm and economic situation. There are many farm families that have no insurance. Farmers who are self-employed are reliant on private insurance, which has grown increasingly expensive. It is a continuing struggle for farmers who are faced with these extremely high costs.

Access is also impacted by the lack of available transportation. Rural residents often have to travel great distances to physicians' offices and health care facilities, but the public transportation is not always available in cases where the person cannot drive their own vehicle. There can be significant delays in cases of emergencies.

The lack of available healthcare providers is a third issue, in part due to the limitations of the Medicaid program. Rural residents tend to be poorer and older. The Medicaid program is a predominant healthcare payer, but at low and slow rates of payment. The disproportion of Medicaid patients and lower utilization makes it extremely difficult for rural healthcare providers to sustain services. Rural physicians find that they can no longer accept Medicaid patients, or they must limit the number they can accept.

There is also limited access to mental health care. The challenges of rural life, especially farming, can cause mental distress and disability. There is a significant shortage of mental health professionals in rural areas, and the capacity of rural (family) physicians to provide such care is extremely limited.

Written Testimony

presented to:

**The Joint Task Force on Rural Health and Medically Underserved Areas
Chicago, Illinois — October 24, 2006**

by:

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INTRODUCTION

Migrant and seasonal farmworkers have been a designated Medically Underserved Population (MUP) since 1962 with the creation of the Migrant Health Program. Unfortunately, the economic, social and cultural barriers to health care for this marginalized population have substantially worsened over the last four decades. Farmworkers and their families are unable to access basic primary health care primarily due to their low-income status. Access to care is further complicated by a lack of health insurance (88%), including ineligibility for public health insurance programs such as Medicaid. Over 88% of migrant families earn incomes well below federal poverty guidelines. Farmworkers suffer rates of morbidity and mortality that far exceed local and national averages. Finally, cultural and linguistic barriers and lack of transportation create additional challenges for agricultural workers who are in need of essential primary health care.

For nearly 40 years, Community Health Partnership of Illinois (CHP), a statewide, federally funded migrant health program, has been addressing the health care needs of migrant and seasonal farmworkers through innovative programs and a service delivery model that builds on collaboration with the public and private health sectors, social service agencies, academic institutions, advocacy organizations, government and private funders, and, above all, the farmworkers we serve. CHP has successfully leveraged funding from various governmental entities, foundations, and private donor sources to help meet the need for affordable primary health care, including oral health and behavior health services, and to provide a range of supportive services that address the special needs of migrant farmworkers including occupational health and safety, HIV/STI prevention, early cancer detection and reproductive health, and peer-led health education and health advocacy through our nationally recognized and award winning *Promotores de Salud* program. In 2005, Community Health Partnership of Illinois serves 7,819 patients and provides 28,676 health care encounters to the migrant and seasonal farmworker population through our five medical clinics (Aurora, Woodstock, Momence, Mendota, Hoopeston), one dental clinic (Aurora), our school-based health and dental program (statewide) and our seasonal satellite clinic (Princeville).

HEALTH CARE NEEDS ASSESSMENT

Community Health Partnership of Illinois' target population includes the estimated 27,000 migrant and seasonal farmworkers and dependents that reside throughout northern and central Illinois. This estimate is based on the most recent US Department of Agriculture Census of Agriculture that calculates the number of hired farm workers by crop and county. We have also taken into consideration detailed

Agricultural Workplace Profiles maintained by each of our clinics, as well as the county by county Census of Agricultural Employers that is updated annually by the Illinois Migrant Legal Assistance Project. For more than twenty years, Community Health Partnership of Illinois also has contracted with the Illinois Migrant Education Program and the Illinois Migrant Head Start Project to provide all of the health and dental services for the 1,000 migrant children enrolled in these programs throughout the state of Illinois. The majority of migrant farmworkers reside in rural areas in the above-mentioned counties, although an increasing number are gravitating to mid-sized cities such as Aurora, Kankakee and Champaign. As a result of agricultural employers closing migrant labor camps, farmworkers now seek affordable housing in areas that have significant populations of Mexican migrants where they can feel a part of a local community.

Farm labor is arduous and dangerous, and characterized by long, unpredictable work schedules and sub-poverty wages. Most farmworkers do not benefit from the wage and hour protection, workplace health and safety laws, or paid sick leave and health insurance benefits that other workers in this nation enjoy. Most migrants still live in crowded, substandard housing.

Farmworkers and their families are unable to access basic primary health care primarily due to their low-income status. Access to care is further complicated by a lack of health insurance (88%), including ineligibility for public health insurance programs such as Medicaid. Over 88% of migrant families served by Community Health Partnership of Illinois earn incomes well below federal poverty guidelines. Farmworkers suffer rates of morbidity and mortality that far exceed local and national averages. Finally, cultural and linguistic barriers and lack of transportation create additional challenges for agricultural workers who are in need of essential primary health care.

Changes in immigration patterns and agricultural production have created dramatic shifts in the demographic profile of farmworkers. Most agricultural workers are recently arrived immigrants from rural areas in Mexico. An increasing percentage of these workers are unaccompanied men who come to Illinois in search of work and must leave behind their wives and children. Although more than half of Illinois' farmworkers are still migratory, expansion in the nursery and greenhouse industries has created a year-round demand for farm labor. This enables some migrant workers to provide a more stable living environment for themselves and their families, but also creates additional year-round demand for health care and social services.

•Service Gap Analysis

Access to essential primary health care for the migrant and seasonal farmworkers served by Community Health Partnership of Illinois is compromised by a number of factors including the lack of both public and private insurance coverage, inadequate public transportation in rural areas of Illinois, and a shortage of medical providers who have the linguistic and cultural competency to serve this population of predominantly Mexican agricultural workers and families. A substantial portion of this population are undocumented workers and therefore not only uninsured but essentially uninsurable. Sadly, since the introduction of so-called "immigration reform" legislation at the national level and the subsequent anti-immigrant backlash in response to the immigrant marches in the spring of 2006, migrant farmworkers and families are increasingly reluctant to seek out health care unless they are seriously ill or injured. In point of fact, we had a number of patients, including those who are US citizens, who have been illegally detained by local law enforcement in various areas of the state, which has led to patients being fearful to leave their homes for doctor appointments or even to pick up their medicines at local pharmacies. We are, therefore, observing a very tangible, negative effect on access to health care for this highly vulnerable population resulting from the growing anti-immigrant sentiment in rural Illinois.

Another factor that impacts access to care is the demographic shift in the migrant population. Over the last 20 years, we have seen a significant trend away from domestic migrant families traveling to Illinois in search of work toward an increasing number of young male workers, many of whom are unaccompanied

minors and recent immigrants from Mexico. Not surprisingly 35% of our user population is men between the ages of 18 and 64. These men are here primarily to provide for their families, and therefore are not willing to jeopardize their sole source of income to take time off from work for doctor appointments. There also may be a cultural factor that comes into play with adult male workers, for whom illness is often associated with personal weakness. As a result of these factors, minor health problems often go untreated until workers become seriously ill. It is, therefore, essential that Community Health Partnership's outreach activities bring health care enrollment, health assessments, education and intervention services directly to this segment of the population for targeted risks such as HIV and STIs, prostate cancer, and health conditions prevalent in this population such as diabetes and high blood pressure. These activities are vital to our goal of promoting health and well being within the community and making health care services fully accessible to the population we serve.

We also see significant geographic barriers and concomitant transportation difficulties in accessing care for this population. Migrant and seasonal farmworkers work 10 to 12 hours a day or longer during the harvesting season and typically live and work in very remote rural areas. In most cases, individual workers do not have their own vehicles and must rely on crew leaders to transport them. Additional trips not only place their jobs in jeopardy, but also cost them dearly as friends, co-workers or supervisors will only transport workers when they are paid to do so. Rural areas of Illinois have extremely limited public transportation options and where they do exist, they simply are not accessible to the agricultural work force.

In addition to the health care needs previously described in this section, there is substantial need for services that address some of the less obvious but nonetheless highly detrimental behaviors that affect the overall well being of the farmworker population. Community Health Partnership of Illinois has, over the last decade, documented increasing rates of domestic and intimate partner violence within the farmworker community, as well as high rates of substance, alcohol and tobacco use. This may be attributed to the fact that with the changing demographic profile of the farmworker population, more young men (according to the National Agricultural Worker Survey, 25% of the agricultural workforce are minors), are migrating to areas where they are strangers in every sense of the word, living and working in isolated, crowded and unfamiliar conditions in migrant labor camps and trailer parks without the support of their extended families. These living conditions place migrant men increasingly at risk for alcohol, drug and tobacco use, and the attendant problems of intimate partner violence, sexually transmitted infections and mental health problems. Community Health Partnership of Illinois continues to work closely with our community partners including local health departments and substance abuse and mental health centers to address these issues. However, absent any state or federal funding to support service expansion in the area of behavioral health, we are limited in the services we are able to provide directly to migrant workers who demonstrate great need but who, because of additional cultural and linguistic barriers, are extremely challenged in accessing these important services.

Finally, fully 88% of the farmworkers served by Community Health Partnership of Illinois are not only uninsured but in fact uninsurable. Few agricultural employers offers health insurance for their workers, and when they do, it is typically a very limited major medical policy for only the employee, not the employee's family, with no coverage for primary care, dental care, or prescription medicine. A substantial portion of this population also is undocumented and therefore not eligible for Medicaid or Medicare. Even when migrants are legal permanent residents or U. S. citizens, they often do not qualify for Medicaid because for at least part of the year they earn monthly incomes that exceed Medicaid eligibility guidelines. In recent years, Community Health Partnership of Illinois has helped a significant number of US born migrant children enroll in KidCare (SCHIP), which has provided some relief for families with children. We are hopeful that with the introduction of the All Kids insurance program, an increasing number of migrant children will be able to qualify for health care coverage, regardless of their immigration status.

•Mortality & Morbidity

Migrant farmworkers in Illinois suffer high rates of illness, injury and chronic disease. Hazardous working conditions, substandard and overcrowded housing, and migration itself can cause or complicate these health problems. There are significant health disparities in this population as well, as evidenced in excess rates of morbidity and mortality. A report released in 2005 by the Governor's special task force on Latino Workers revealed that workplace injuries and deaths among Latino workers, including agricultural workers, have increased substantially, in recent years, while those in the general population are on the decline. Agriculture is consistently rated by the US Department of Labor as one of the three most hazardous occupations in the country, along with mining and construction. The lack of adequate protective laws and enforcement places farmworkers — and their families — at high risk for environmental and occupational injuries and illnesses including acute and chronic health effects from exposures to pesticides and other agricultural chemicals.

There are also higher than expected rates of cardiovascular disease and diabetes within the migrant population. In fact, one in ten of CHP's migrant patients over the age of 40 are diabetic. In 2004, Community Health Partnership of Illinois was accepted into the National Health Disparities (Diabetes) Collaborative. For the last two years, we have been redesigning our health delivery system to target improvements in the health status of our patients who live with diabetes. Today, as a result of this focused effort, nearly 60% of our diabetic population of focus has met or exceeded the standards of controlled, well-managed diabetes, a phenomenal achievement for a migrant population in less than two years.

Obesity, particularly childhood obesity and its attendant health risks, has reached epidemic proportions in the migrant population. In collaboration with Southern Illinois University Dental Hygiene Program and the Illinois Department of Public Health, CHP gathered data on the health status of migrant children enrolled in summer Migrant Education Programs in 2005, which revealed that fully 50% of migrant children ages 6-9 and 70% of migrant children ages 10-15, were either clinically obese or at risk for obesity. CHP is currently piloting programs to encourage healthy eating habits and increase physical activity at home and at school to address this crisis.

Dental disease also continues to be rampant within this population, particularly for migrant farmworker adults, nearly 50% of whom demonstrated extensive decay or emergency dental needs in our last survey (2000). However, we have seen significant improvements in the oral health of migrant children as a result of three decades of providing school-based prevention services and treatment for migrant children in Head Start and Summer School programs. In fact, Community Health Partnership of Illinois was the only dental sealant program in the state of Illinois, and in fact one of the few in the country, to exceed the Healthy People 2010 goal of 50% of children having dental sealants (51%). However, there is a continuing need to address the issue of early childhood caries in very young migrant children, which CHP is addressing through expanded pediatric dental specialist clinics and peer-led education and community outreach and advocacy delivered by our *promotores de salud* to begin to reshape oral health knowledge, attitudes and behaviors of farmworker families and caregivers.

•Agricultural Environment

Illinois agricultural production has evolved substantially over the last several decades. With encroaching suburbanization into rural areas, housing developments have replaced farm fields that were previously planted with corn, soybeans and fresh market produce such as cantaloupe, broccoli and pumpkins. There is no question that more traditional forms of agricultural activity and the jobs that supported that activity have disappeared. But ironically this has also led to a surge in other kinds of agricultural production, particularly nursery products including trees, shrubs, annuals and sod, precipitated by the very same housing boom in rural areas and extended suburban areas. According to the Agricultural Employer Census created and maintained by our colleagues at the Illinois Migrant Legal Assistance Project, there are over 700 commercial nurseries operating in Illinois. This creates substantial opportunities for

employment for migrant and seasonal agricultural workers. Much of the work in the nursery industry takes place during a much longer season. The good news for Illinois migrant and seasonal farmworkers and families is that fewer workers are forced to migrate to make a living, thereby creating less need for workers to uproot their families to follow the harvest. However, farmworker families remaining in Illinois year-round also places additional demands for services on our limited health care resources.

•Health Service Delivery Model

Community Health Partnership of Illinois provides primary health care annually to more than 7,800 Latino migrant and seasonal farmworkers. After two decades as part of a migrant service agency, CHP was incorporated in 1991 as a health care focused, non-profit organization. We have over 35 years experience meeting the unique health care needs of farmworkers through outreach, health promotion, case management, advocacy and collaboration with a wide array of community partners. CHP's programs and staff have been honored with national, state and local awards for dedication, excellence and innovation.

CHP's philosophy of health care builds upon the language, beliefs and culture of the communities we serve. Our mission is to:

- Improve the health and well-being of migrant and seasonal farmworkers and their families by providing quality, accessible, affordable and culturally-compatible health care; and
- Enable the farmworker community to prevent and manage health problems and effectively utilize the health care system.

CHP serves the migrant farmworker population through a network of nurse-managed migrant health voucher clinics throughout northern and central Illinois. The centerpiece of our service delivery model is community outreach. CHP health teams visit migrant labor camps, farms and nurseries to enroll workers and families in our programs and provide health assessments and education. CHP's peer educators (*promotores de salud*) provide outreach, advocacy and health promotion in the community and create a vital link between our health care services and migrant workers and families residing in isolated rural areas.

CHP provides medical care through a network of contracted primary care physicians and nurse practitioners who provide care to our clients in their offices on referral, or on-site during evening health clinics. We also contract with local pharmacies and hospitals for prescription medicines and diagnostic services. Oral health services are provided at our Aurora Dental Clinic and through our school-based dental program. Medical specialty care is arranged for through referrals made by our primary care contracted physicians (See attached samples of provider contracts and list of contracted providers).

CHP also provides comprehensive health and dental services to migrant children enrolled in Migrant Education Summer School Programs and Migrant Head Start Centers throughout Illinois. CHP's award winning school-based dental program has invested in state of the art portable equipment and has dozens of dentists, hygienists and assistants that work for us each summer to staff this program.

As a nurse managed migrant voucher program that emphasizes case management and prevention, our bilingual, bicultural health care teams spend a great deal of time providing essential enabling services that are vital to assure that migrant and seasonal farmworkers are able to access health care services. Our Community Health Workers are highly experienced and trained to provide medical translation, health education, and enrollment in public benefit programs such as Medicaid, WIC and food stamps. These bilingual/bicultural clinic staff persons, along with our clinic nurses, provide outreach, health assessments, and early case-finding activities in migrant labor camps, at work sites, and in neighborhoods that are highly populated by migrant and seasonal farmworkers. We also provide or arrange for transportation of patients who are not able to transport themselves, particularly for medical specialist visits.

Oral health care services are delivered through various mechanisms. CHP received an oral health service expansion grant in 2001, which was used to open a three-chair dental clinic in Aurora, Illinois. In 2005 this clinic served over 500 patients and provided more than 2,100 visits. In addition, CHP provides comprehensive, school-based dental services to all migrant children enrolled in Migrant Education programs and Head Start Centers statewide using portable equipment and through contracts with local dentists that provide dental treatment for these children on an hourly basis in their offices. We also contract with a number of private practice dentists throughout our service areas to provide emergency dental services for those patients who are not able to access our Aurora dental clinic. This year we introduced limited dental services at our Momence Health Clinic. Our long-term goal is to expand oral health services to each of our four year-round health clinic sites. Finally, CHP's dental staffing is augmented by our relationship with the University of Illinois College of Dentistry as a community site for student clinical rotations.

Mental health and substance abuse counseling is provided through referral mechanisms to local community mental health centers and substance abuse and domestic violence programs. Fortunately, CHP service areas include communities that have a growing number of Latino residents; therefore, there are more bilingual services available than there have been in the past. However, accessing these services is still problematic for a patient who cannot take time from work during the day for appointments. CHP is finalizing a unique arrangement with a bilingual clinical social worker to provide on-site counseling services for us in Mendota. We also were selected for a domestic/intimate partner violence prevention program that will become operational in the spring of 2007, pending receipt of funding.

All of the services provided by CHP are made available to all of our eligible patients regardless of their ability to pay. Because nearly 90% of our patients earn incomes below 100% of federal poverty guidelines, the vast majority of our patient fees are voluntary co-payments. However, we have been very fortunate that the majority of our patients contribute to their health care by making that co-pay, although no one is ever refused care based upon inability to pay. Typically, our patients are asked to contribute \$10-15 per doctor visit or medication. CHP enrolls eligible patients into Pharmacy Assistance Programs (PAP) to lessen the burden of prescription medicines, particularly for those patients with chronic conditions.

•Disease/Care Management and System Improvement Program

In the fall of 2004, CHP was accepted into the National Health Disparities Collaborative (HDC) as part of the Diabetes Collaborative. We are very proud of the fact that CHP is the only exclusively nursed-managed migrant voucher program to be a part of the Collaborative. We also are very honored to have been asked to present at two different National Learning Sessions on the innovations that we have already implemented through our HDC activities. Since entering the Diabetes Collaborative, CHP has seen significant improvements in the self-management of our diabetic patients and in a number of other indicators including HgbA1c levels and percentage of diabetic patients receiving oral health care. Our collaborative team recently decided to expand our diabetes control activities with our population of focus to include cardiovascular risks. This project is currently being piloted at our Aurora clinic, but will eventually be adopted at all our clinics.

•Culturally and Linguistically Appropriate Services

The hallmark of CHP's health delivery system is providing services that are consistent with the culture and worldview of the patients we serve. All but five of CHP's valued staff members are bilingual and bicultural. CHP also has the good fortune of having a number of primary health care providers that are not only bilingual but also bicultural, including Dr. Jorge Brunelle, our Medical Director. We hear time and again from our patients that even when they have a choice of health centers, they much prefer coming to our clinic for services where they feel that they are treated with dignity and respect. We make every effort to make our patients feel welcome and to provide the highest caliber of health care possible.

Another major feature of our cultural and linguistic competency is our *promotores de salud* program. This program was honored last year with the first National Golden Lantern Award for outstanding achievement in a peer-led health education. Over the ten years that this program has been in operation, we have trained over 100 farmworker men and women to provide community health education and advocacy to address health concerns including workplace health and safety, oral health, reproductive health and cancer prevention, HIV and STI prevention, and, most recently, domestic and intimate partner violence prevention. These extraordinary men and women devote themselves tirelessly to promoting wellness in their communities and to increasing access to health care. The *promotores* serve as ambassadors for our program and have enabled us to build trusting relationships with farmworkers who live in very isolated, rural areas. The *promotores* program encourages farmworkers to be active participants in the wellness process and has proven to be a powerful mechanism for personal and community development around issues of health.

•Additional Note

Immigrant workers who are not involved in agricultural work are generally excluded from the federally-funded Migrant health program through which our clinics are funded, so it does not cover the workers at the Beardstown meat processing plant. These workers are not eligible for our program. They do receive (some) coverage through the Federal Migrant Education Program.

RECOMMENDATIONS

1. Revise Medicaid eligibility that currently excludes very low income seasonal workers, such as migrant farmworkers, whose annual income is below federal poverty guidelines but whose seasonal earnings during the growing season disqualify them from Medicaid. This could also be resolved by Illinois entering into an interstate compact with Texas to give presumptive eligibility to migrants from Texas who already are enrolled in Medicaid in their home base state.
2. Allow FQHCs that are serving rural underserved communities where there is no health center or rural health clinic in collaboration with contracted private providers to bill Medicaid at FQHC rates for medical and dental services provided off-site by contracted providers and specialists. Also allow FQHCs that provide medical and dental services to school settings using portable equipment to bill for those services at FQHC rates.
3. Expedite professional licensure for health professionals (RNs, dentists, physicians) trained outside of the US to increase the number of culturally and linguistically competent providers in underserved areas of Illinois.
4. Require local health departments to be open for patient services (immunizations, WIC, STD clinics, etc.) at least one evening per week to accommodate the needs of working poor families.

Executive Summary

A Proposal for the Expansion of the Rural Health Initiative

Rural Health Initiative Expansion
Southern Illinois University
School of Medicine

BACKGROUND

In 1990 the Illinois General Assembly passed and the Governor signed the Rural/Downstate Health Act. Initial funding, however, was delayed until 1994. The central problem addressed by the act was “that citizens in the rural, downstate and designated shortage areas of this State are increasingly faced with problems in accessing necessary health care.” The Act called upon SIU School of Medicine (SOM) to expand upon its focus on rural health care by establishing a dedicated administrative entity responsible for rural health care planning and programming. Known as the Rural Health Initiative (RHI), this program has resulted in collaborative partnerships and projects with over 70 different community-based organizations, statewide not-for-profit entities and state agencies and universities. Central to the majority of these collaborations has been the goal of assisting local organizations expand their capacity to provide health care services especially primary care.

PROGRAM EXPANSION

SIU School of Medicine seeks additional funding through the Rural/Downstate Health Act in order to expand programming in three targeted areas: 1. specialty services; 2. telehealth and; 3. transportation. The rationale for this expansion, in part, derives from the November 2003 health care summit, “Charting a Health Care Agenda: Strategies for Rural and Underserved Illinois”. The summit was organized by SIU’s Paul Simon Public Policy Institute and its School of Medicine. Health care leaders from throughout Illinois convened to discuss the state of health care in the rural and underserved areas. At the conclusion of the program, selected summit participants convened as a work group to discuss strategies for increasing health care access and services. The late Senator Paul Simon and J. Kevin Dorsey, M.D., Ph.D., Dean and Provost of SIU School of Medicine, moderated the session. Work group participants included representatives from health care organizations, academia, state agencies and members of the Illinois General Assembly. Included in the 18 recommendations issued by the work group were expansion of telecommunications technologies that enhance health professions education and health services delivery, design of a transportation system to improve access to health care services and addressing specialty service needs including mental health.

REQUEST

SIU School of Medicine requests an additional recurring State appropriation of \$2.1m through the Rural/Downstate Health Act for the expansion of the Rural Health Initiative.

A Proposal for the Expansion of the Rural Health Initiative

Rural Health Initiative Expansion
Southern Illinois University
School of Medicine

October 2006

BACKGROUND AND RATIONALE

The Rural/Downstate Health Act was passed by the Illinois General Assembly and signed into law by the Governor in 1990 as a means of addressing the critical health care needs of the state's rural and underserved people. This Act charged Southern Illinois University School of Medicine, the University of Illinois College of Medicine at Rockford and the Illinois Department of Public Health's Center for Rural Health with developing new and innovative strategies for responding to the problem of limited access to health care services in the rural and underserved portions of the state. Since funding was first appropriated under the Act in 1994, all three entities have developed productive collaborations with public and private organizations around the state. These collaborations have helped reduce physician maldistribution and have expanded the health delivery capacity of many community-based organizations in rural and underserved areas. Each entity has built a successful foundation of program development and implementation relative to their respective missions and goals. However, the individual and collective ability of all three organizations to fully realize the potential of the Act has been minimized by limited funding. Expansion of the Rural/Downstate Health Act will enable each to continue developing programs that respond to the state's healthcare needs of today.

At SIU, the goal was to build on the School of Medicine's mission "...to assist the people of central and southern Illinois in meeting their health care needs through education, patient care services and research..." and to..."realize this mission through collaboration and partnership with the region's community health care organizations..." Once funding was appropriated in 1994, the SOM established the Rural Health Initiative program. Since then, over 70 collaborative partnerships and projects have been developed through the RHI. The partners have included various community-based organizations including rural hospitals, community health centers, local health departments, "free" clinics, primary care clinics and school districts. Additional partners have included such diverse organizations as the Illinois Rural Health Association, Illinois Hospital Association, Illinois Institute for Rural Affairs and Rural Partners.

The principles that guided the original proposal that led to the drafting of the Rural/Downstate Health Act, as articulated by rural health researchers Roger Rosenblatt and Ira Moscovice, are still relevant today.

1. Planning for the development of health care services must be population-based with technical assistance offered as needed.
2. There are basic health services that need to be provided to everyone and are subsidized through state and federal expenditures.
3. The rural health system should be based on generalists, with referral linkages to specialist care.
4. All functions within a rural health care system should be integrated to avoid duplication.
5. The structure of the reimbursement system must reward rural health services.
6. Rural communities must have two-way cooperative arrangements with other rural and urban health care systems.

More recently, the September 2006 issue of *Academic Medicine*, the Journal of the Association of American Medical Colleges, contained the article "Beyond the Horizon: The Role of Academic Health Centers in Improving the Health of Rural Communities." While nationally focused, the article speaks clearly to the situation in Illinois. The article describes the following challenges facing rural America.

•HEALTH CHALLENGES— Individuals living in rural areas are more likely to engage in risky health behaviors and suffer work-related injuries, and face increased likelihood of physical limitations due to chronic health conditions than people living in urban or suburban areas.

•QUALITY OF CARE— While rural hospitals have fewer safety events than urban hospitals, rural patients are less likely to receive effective care or receive recommended preventive medicine interventions. This suggests that linking Academic Health Center (AHC) specialists with community-based generalists has the potential to enhance the quality of care for rural residents.

•HEALTH CARE FACILITIES— Rural hospitals are smaller and less complex and rely more on generalists than urban hospitals. Rural hospitals have fewer financial, information and personnel resources than urban hospitals, which can affect the scope of care provided by rural health care providers.

•SHIFTING DEMOGRAPHICS— Rural communities are becoming increasingly older and culturally diverse as rural economies shift away from their historical base in agriculture.

•INCOME AND EMPLOYMENT— The majority of the persistent poverty counties in the United States are located in rural areas, with more than 20% of their residents living at or below U.S. poverty standards.

The article goes on to describe the current and potential role of AHCs in addressing rural health needs. Two recent reports, *Rural Healthy People 2010* and an Institute of Medicine Report, *Quality Through Collaboration*, identify four priorities for improving rural health that fall within the purview of AHCs. These four priorities are: 1) increasing access to health care; 2) addressing specific and unique health concerns; 3) improving quality of care, with a strong focus on community-level interventions; and 4) improving community health.

The rationale for expanding the programs and projects of the Rural Health Initiative is further bolstered by the results of the November 2003 health care summit, "Charting a Health Care Agenda: Strategies for Rural and Underserved Illinois," and by a community health needs assessment conducted in 2004-2005. The health care summit was organized by the Paul Simon Public Policy Institute and the School of Medicine at SIU. Members of the Governor's staff responsible for economic development, workforce education, training and health and human services were consulted regarding the program. Experts in rural and underserved health care together with members of the Illinois General Assembly gathered in Springfield to share their knowledge and perspectives. At the conclusion of the summit a working group of nearly 40 statewide health care leaders was convened under the leadership of the late Senator Simon and J. Kevin Dorsey, M.D., Ph.D., Dean and Provost of SIU School of Medicine. The work group's charge was to suggest strategies to address the health care needs of the rural and underserved areas of Illinois. A list of 18 recommendations was developed that are reflective of the four priorities for improving rural health enumerated earlier in this proposal. The recommendations included: 1) expansion of telecommunications technologies that enhance health professions education and health service delivery; 2) design of a transportation system to improve access to health care services; and 3) addressing specialty service needs, especially mental health.

The health needs assessment was a series of focus group meetings with community leaders in five locations in central and southern Illinois. Participant responses were distilled to the following five areas of need: 1) improvement of the health care infrastructure and capacity of local health care providers and organizations; 2) increased access to mental and behavioral services, especially for children; 3) increased access to specialized services for children; 4) increased access to health information and services through enhanced telehealth capabilities; and 5) increase access to preventive and treatment services for the major health problems of the region including cancer, heart disease and chronic conditions.

Rural Health Initiative Expansion

Southern Illinois University School of Medicine seeks funding to expand the RHI program in three areas: 1. specialty services; 2. telehealth; and 3. transportation. New funding will allow the School to build upon the 70 plus community partnerships developed through the RHI to respond to the health care needs described previously in this proposal. As the downstate academic medical center whose mission is to assist the people of central and southern Illinois in meeting their health care needs, SIU relies upon partnerships with community groups and organizations to extend essential health care into the region. The existing RHI program follows that model having developed partnerships with such community organizations as Critical Access Hospitals, local health departments, community health centers, clinics for the working poor, local health consortiums and local school districts. Through these partnerships locally defined health priorities are addressed.

Expansion of the RHI will specifically support the School's goal of excellence in its academic programs and expansion/improvement of clinical practices that address the health care needs of the region. The academic goal – with its educational, research and service dimensions – will be advanced through the extension of new and existing health care partnerships because these partnerships provide additional opportunities for medical student/resident education, research on regional health care needs and conditions and improving clinical practice activities. The School's goal for expanding and improving clinical practices to enhance health care throughout central and southern Illinois specifically calls for improving the regional health care system through cooperative arrangements with community providers and groups.

This proposal also supports SIU's priorities for academic quality and, particularly, goals for public and private partnerships. Academic quality is advanced by providing additional opportunities for student training in rural and underserved locations and further exposing the School's medical students and residents to medical services provided in community settings, the very settings in which they are most likely to practice, and through incorporating information technology-based methods that will prefigure the technologies students and residents will use when they begin their professional careers. Since the RHI works with a cooperative public-private model, this proposal directly supports SIU's partnership priority and will expand its successful program in community-based health care.

Budget

•**SPECIALTY SERVICES** — While primary care remains the basis of the rural health care system, there is clear evidence that rural communities want and need improved access to specialty care. Priority will be given to mental health services, particularly for children and adolescents, cancer, pediatrics and chronic diseases. Expansion funding will allow the School to build on its clinical outreach network of nearly 30 communities throughout downstate Illinois. \$840,000

•**Telehealth** — To link health care organizations and resources through the Internet and such public/private networks as the Illinois Century Network, communities need basic information/communication technologies in their locations. Once in place, such technologies can improve access to care and the quality of care through such uses as primary/specialist case consultations, continuing education for health professionals and better health data management at the community level. Expansion funding will allow the School to build on its existing telehealth network which encompasses nearly 50 communities throughout downstate Illinois. \$840,000

•**TRANSPORTATION** — While the use of advanced telecommunications technologies are critical to improved access to care, it is still vital to strong community/university partnerships that Academic Health Center providers also deliver services in rural settings. Expansion funding will allow the School to build on the pilot projects being developed for a Rural Medical Transportation Network. \$420,000



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November 10, 2006

The Honorable Deanna Demuzio
Illinois Senate
M106 - Statehouse
Springfield, IL 62706

The Honorable William Delgado
Illinois House of Representative
264-S - Stratton Office Building
Springfield, IL 62706

Task Force Members: (Senators Dale Righter, James Clayborne, and Dan Rutherford;
Representatives Patty Bellock, Rich Brauer and John Bradley)

Dear Senator Demuzio, Co-Chair,
Dear Representative Delgado, Co-Chair,
Dear Task Force Members:

On behalf of the Illinois Rural Health Association (IRHA), we applaud the legislature for its creation of the Joint Task Force on Rural Health and Medically Underserved Areas. We are especially grateful for the leadership and energy that has characterized the Task Force's work. We are hopeful that the Task Force recommendations will result in funding for critical programs that build the infrastructure and workforce necessary for increasing access to health care services for the rural and the medically underserved throughout Illinois.

The IRHA was formed in 1989 to provide a statewide, public voice for individuals and organizations committed to improving the health status of rural Illinois residents. The association is a collaborative organization committed to strengthening health systems for rural residents and communities through education programs, legislative advocacy, public awareness and networking. In this capacity, we interface closely with the rural programs at both public medical schools in Illinois and work in concert with the Center for Rural Health at the Illinois Department of Public Health.

Nearly fifteen years ago, members of IRHA met with leaders from around the state to develop legislative hearings about rural/urban health disparities in Illinois. The resulting legislation was the Illinois Rural/Downstate Health Act. (410 ILCS 65/). Through this Act, critical programs supporting the development of health care infrastructure and workforce were created at the

Center for Rural Health, SIU School of Medicine, and the University of Illinois College of Medicine at Rockford. The original funding for the act was seen as a stopgap to address crisis shortages of primary care physicians and services in Illinois with the intention, yet to be realized, to progressively expand funding.

SIU School of Medicine and the University of Illinois College of Medicine at Rockford have both shared innovative programs with the Task Force that complement their original commitments to the Illinois Rural/Downstate Health Act (see enclosures). IRHA has reviewed them and endorses them as practical solutions with positive impact on rural health. We urge the Task Force to promote the expansion of these critical programs by making additional funding through the Rural/Downstate Health Act a major recommendation.

IRHA also urges the Task Force to increase funding to the Center for Rural Health at the Illinois Department of Public Health. The Center is estimated to be under-funded by \$3 million dollars to carry out the work to which they were originally committed. Original work tasked to the Center required eleven full time staff. Budget cuts resulting from Illinois' fiscal crisis now finds the Center with only four employees. They continually struggle to maintain the excellent work they have done in the past under the pressure of these staff reductions. They continue to administer multiple state and federal programs with finesse, but they desperately need restoration of their staffing levels. The programs that the Center administers help community health centers throughout both rural and metropolitan areas, targeting funding and services for those citizens most in need. Additional funding is critical to their ability to function effectively; the IRHA urges that the Task Force promote the expansion of these critical programs by making additional funding through the Rural/Downstate Health Act a major recommendation.

Increasing the annual appropriation to the Illinois Rural/Downstate Health Act is a sensible, prudent investment of state resources. The Act has been a successful legislative effort with partnerships by committed institutions that have yielded tangible results for the state of Illinois. The Center for Rural Health, SIU School of Medicine, and the University of Illinois College of Medicine at Rockford are careful stewards of the state's investment. Additional funding for these programs through the Illinois Rural/Downstate Health Act will be money well spent.

In closing, the IRHA is grateful for the opportunity to work with the legislature through the task force hearings and participate in advocacy for rural communities. As the Task Force begins to consider its summary work and report back to the legislature, we continue to offer our support and encouragement toward a meaningful report and recommendations. We believe that increased funding of the Illinois Rural/Downstate Health Act is a tangible step to reduce health disparities.

Thank you for your consideration of our recommendation in your important work.

Respectfully,

Patricia Bickoff, President
Illinois Rural Health Association

Enclosures (2)