

Rural Health Access for Older Adults

A summary of findings and recommendations from the California Commission on Aging

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May, 2009

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Introduction

Out of all the potential changes human beings may experience with age, increased health problems are a given. Time and hard work take their toll, and older adults experience a high degree of chronic illness, disability, and medication dependence. Despite these facts, one of the primary issues that impedes good health care for older adults in rural areas is poor access, whether from lack of transportation, the high cost of care, a lack of care management, or from the limited number of physicians caring for patients.

A variety of factors contribute to the difficulties that rural older adults can face in accessing prompt and appropriate medical care. Just getting to the doctor's office may present a significant obstacle for someone who no longer drives, has limited access to public transportation, or who lives far from the nearest provider. A shortage of support services can make it difficult for rural elders to receive the follow-up care they need in their homes. The cost of care, funding "silos" that focus on a service rather than the patient, and restrictive eligibility criteria for Medi-Cal and Medicare benefits mean that many individuals are excluded from the care they need.

These issues were among the barriers cited during three public hearings held by the California Commission on Aging in to examine older adults' ability to access health services in rural settings.

The California Commission on Aging is a citizens' advisory body created by statute to advise the Governor, State Legislature, and state departments

and agencies on programs and policies affecting older adults. As part of its 2007 strategic planning activities, the Commission identified three priority areas on which to focus its work through 2009. A series of public hearings would be held on each of the priority topics, including "Older Adult Health Access," "Aging in Place," and "Elder Abuse," from which the Commission would draw public input and develop policy recommendations.

The three public hearings on Older Adult Health Access were held in November 2006 and June and October of 2008. The hearing locations were Jackson in Amador County, Woodland in Yolo County, and Redding in Shasta County. The three locations reflect a variety of geographic settings and demographic issues affecting older adults' health. The following report summarizes the major concerns and recommendations raised in both expert testimony and in public comments at the three events.

The Issues: What prevents older adults from getting the medical care they need?

Access

In rural settings, transportation to and from medical appointments is a significant obstacle to care. Older adults no longer able to drive must find some form of transportation to the doctor, whether it be paratransit services, public transportation, a family member or friend. Paratransit and public transportation are not universally available throughout California; in many rural communities these services may be non-existent.

In many rural areas, access may be limited by a shortage of medical professionals, making lengthy travel necessary to receive even the most basic medical care. In rural communities many providers will accept few, if any, Medi-Cal patients due to low reimbursement rates and red tape associated with Medi-Cal participation. Many rural hospitals and clinics lack the most current diagnostic and treatment equipment, again requiring the elder to travel away from their home community to obtain medical care.

The number of physicians practicing in rural areas is limited by the high proportion of uninsured patients who depend upon Medi-Cal to cover the cost of their care. New medical school graduates are seldom in the position to open a practice, pay for staff and operations, and cover the costs of medical school loans and mal-practice insurance on the small salary that Medi-Cal reimbursements bring. In Amador County, the CCoA heard from a local hospital director who believes that allowing rural hospitals to directly employ physicians, as is done in

many other states, would provide support staff and shared overhead expenses to allow new physicians to set up sustainable practice in rural communities.

Many smaller communities lack sufficient long-term care services, sometimes requiring elders that need skilled nursing to be moved far from friends and family. For those rural long-term care facilities that do exist, the number of Medi-Cal beds is limited. Individuals with Medi-Cal coverage are often left out of the long-term care service loop just because of where they live. In an example offered at the Redding public hearing, a 54-bed rural long-term care facility would not make a Medi-Cal bed available to a dying patient unless fewer than 50 beds were occupied.

Support services at home

There are too few trained caregivers, home health programs and out-of-home respite options to meet current demand in either rural or urban areas. Funding for caregiver respite programs is limited, and home health visits may consist of only a few visits following hospitalization, rather than on-going care. The lack of care coordination and care management is a problem statewide, leaving family members to realize only after an elder is home from the hospital that they are unable to provide the level of care needed. Low pay for In-Home Supportive Service workers and eligibility limits for recipients make it difficult for many to secure reliable and consistent help at home.

Testimony offered during the Commission hearings outlined the difficulties that support service providers have in reaching clients in rural communities. A point raised in both the Amador and Yolo hearings was that serving clients in distant underserved communities makes services more costly to deliver. When the onus shifts to the client to get to the service provider, rather than receiving service at home, access becomes almost impossible for the chronically ill homebound elder.

In much of rural California, assisted and group living facilities are also in short supply; expansion of social institutions such as adult foster care, adult day health programs and assisted living would help to address the shortage. In Redding, the Commission heard from the medical director of a remotely-located tribal health facility, where assisted living was unavailable but desperately needed.

Funding

Limits on funding for older adult health care was discussed at every hearing, with a number of speakers noting that public funding for health services is restrictive and tied too closely to specific programs. Reimbursement for Medi-

Cal providers does not cover the cost of care, resulting in few physicians willing to take Medi-Cal patients, regardless of where they live or the location of their practice. Likewise, eligibility for Medi-Cal and other social service program support is restrictive, leaving many low-income seniors ineligible for care, yet unable to pay for it on their own.

Recommendations

The CCoA heard testimony supportive of policy recommendations in four areas.

1. Increase the number of health care providers in underserved communities

The shortage of providers can be addressed in a variety of ways. Outside of California, many states authorize Nurse Practitioners (NP) to operate as independent health care providers. The advanced training these registered nurses receive equips them to provide primary care services over a range of acute and outpatient settings. California law is inconsistent on the NP's scope of practice, allowing some to take on greater responsibilities than others. A consistent approach that grants increased responsibilities for NPs could increase primary care options in underserved areas.

An additional solution to the health workforce shortage could come from enabling former military health personnel to practice in needy communities. A recent California Health Care Foundation study of the issue found that military medical personnel often have duties that don't always fit into current civilian medical positions. By realigning qualification and licensing standards, these experienced and well-trained individuals could bolster the state's health care workforce.

Physicians in underserved areas serve a high number of uninsured patients. This factor means these physicians earn less than physicians treating fully insured patients because of California's low Medi-Cal reimbursement rates. The situation is the same for dentists in these communities, with only 40% of California dentists willing to accept Medi-Cal patients. Reimbursement rate increases that target underserved communities could encourage more providers to open their doors to Medi-Cal recipients, as would a reduced administrative burden on these providers.

Amending California's Corporate Practice of Medicine law could be a significant step toward ending the physician shortage in underserved communities.

Currently doctors who want to practice in these areas often find the costs of setting up practice while paying off medical school loans unsustainable. Again, low Medi-Cal reimbursement rates make it nearly impossible for practitioners to pay for staff, utilities, rent, and malpractice insurance. Amending the law to permit rural hospitals to employ staff physicians would address the overhead and insurance issues, enabling rural doctors to focus on patient care.

Eliminating Medicare reimbursement disparities for rural areas could help improve physician recruitment, a solution that has been proposed to improve health care equity on a national basis as well. Another suggested approach to bring more physicians to rural areas might be the development of incentive programs beyond current student loan reimbursement programs.

2. Make health care technology more available in underserved areas

A health access concern that is unique to rural areas is the absence of specialized care. Medical specialists, such as cardiologists, osteopaths, oncologists, etc., usually practice in population centers where they can be reached by the greatest number of patients. For patients in the most remote reaches of California, traveling six or more hours to San Francisco, Los Angeles or Sacramento to see a specialist is not uncommon. Technology has the power to change outcomes for these patients by bringing specialized care into rural communities. The use of telemedicine and telepharmacy, to provide consultations with specialists, advanced diagnostic techniques and medication advice in rural clinics, could vastly improve the level of care available locally.

Older adults in rural areas can also benefit from home monitoring systems that enable medical professionals and long-distance caregivers to track an elder's vital statistics and activity levels throughout the day. Technology to assist frail older adults with difficult medication regimens should be more widely available in underserved communities. Medication dispensers that release the appropriate medication at the appropriate time, remind the elder to take the pills, and alert a contact person if the medication is not taken, could do much to help isolated elders stay well.

A common theme at the Woodland hearing was the ability of technology to bring training and educational opportunities to health care providers. Medical providers could gain access to new diagnostic and treatment techniques, such as

a congestive heart failure “tele-work” program offered by the University of California at Davis. Authorizing Medi-Cal reimbursement for telemedicine services will be important if physicians are to take advantage of the services once the technology is in place.

3. Coordination of services across agencies

Better coordination of care would improve the health of older adults throughout the state. By utilizing care managers to advise and advocate for elderly clients, patients could gain improved access to the full range of health care and social supports available in their areas. A multidisciplinary approach that combines health care and social programs, such as adult foster care and adult day health programs can also contribute to better care. Program expansion could be enhanced statewide through cost-sharing and collaborative partnering between the State and local governments, Veteran’s Administration and tribal governments.

Recognizing that dementia patients can stay longer in their homes (at a lower cost than nursing home care) when caregivers have access to support services is key. The State should consider non-traditional models of care, such as a mobile day care model pioneered in Georgia, where social day care programs are delivered to rural communities for one or two days per week, providing respite, counseling, care coordination and other supports in communities without the resources to offer their own respite service.

The development of caregiver assessment tools for use by home health care, family practitioners, senior centers and other community-based care providers could help these services better assist families with the planning of care and in coping with its challenges.

Elders with disabling conditions and those without family or social supports need better representation in order to gain access to home and community-based programs. Obtaining information on the services available in a community can also be daunting. More information distribution – through media, doctor’s offices, and other public venues -- is needed in order to increase awareness of available community services.

4. Person-centered approach

Advocates for improved older adult health access endorse a person-centered approach that provides the support and care access an individual requires across the full spectrum of services. An example would be providing long-term care

services based on the levels of support the individual requires, rather than on her/his diagnosis. Health care for older adults should include expanded preventive services and health education opportunities using a culturally appropriate, holistic and multidisciplinary approach.

Conclusion

Improving rural older adults' access to health care requires a combination of creativity, flexibility, and investment in the underserved areas of our state. As California's older adult population grows, keeping this group healthy will be essential in order to avoid the enormous cost burden that would come with a sudden jump in the numbers of elders with disabilities and in need of nursing home care.

Policy makers must seriously consider the alternative approaches offered in this report. Many of these ideas are not new: increasing Medi-Cal reimbursement rates and facilitating the employment of physicians in rural communities are long-identified goals that merit a public commitment of dollars and flexibility. Telemedicine is well-established in certain regions and better-accepted for some procedures than others, but the benefits the technology makes possible cannot be ignored. Collaborations between varying levels of governments, between programs and providers will be necessary if older adults in rural communities are to receive the care they both need and deserve.

Expert Witnesses

Woodland: David Soto, MA, Senior Program Manager, Area 4 Agency on Aging; Dawn Myers Purkey, MSW, Program Manager, Yolo Adult Day Health Center; Nancy Guenther, MST, Program Manager, California Department of Public Health, Injury Control Section; Teri Boughton, MHA, California HealthCare Foundation

Redding: Steven Burns, M.D., Medical Director, Karuk Tribal Health; Lynn Dorroh, Director, Hill Country Health and Wellness Center; Mona Johnston, Mercy Hospice, Mount Shasta; Mark Montgomery, PsyD, Shasta County Mental Health and Drug Department

Jackson: Laurie Webb, R.N., P.H.N., Director, Amador Senior Center; Nancy Slenger, M.S.W., home delivered health care services; Michelle Nevins, M.B.A., Executive Director, Del Oro Caregiver Resource Center; Pauline Campbell, R.N., M.S.N., Vice President, Sonora Regional Medical Center; Andrew Scharlach, Ph.D., School of Social Welfare, UC Berkeley; Steve Fowler, Technical Program Manager, California Telemedicine and eHealth Center