Roanoke Amaranth Community Health Group, Inc: A Case Study

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Introduction

When William Spivey viewed the medical future of his community in the early 1970s, he saw "the handwriting on the wall," he said. Physicians in Northampton County were getting older, and younger physicians were not moving into the county to replace them. In western Northampton County, only two practicing physicians, both in their 60s, saw a limited number of patients. Mr. Spivey and other community leaders, such as Melvin Broadnax, Jasper Eley and Jack Faison, saw the need to work together to secure medical care for the future of their county.

A group of nine community leaders formed the Board of the Citizen's Health Assistance Program, or CHAP, and in 1974, began to devise a strategy that would attract physicians to Northampton County. The County Commissioners, the primary local government body in rural North Carolina, gave full support to the idea. This support enabled county employees, such as the directors of the social services, economic development and health departments, to work with CHAP. The program's board concluded that the county needed a private nonprofit, community-oriented primary health care clinic.

This case study traces the history of the health group's formation and provides an assessment of its current operations, largely from the providers' perspective. The first physician to be employed by CHAP, Joseph Berry, and its first administrator, William Remmes, named the community-oriented practice Roanoke Amaranth to convey the hope they had for the health group's future. Roanoke comes from the region's association with the nearby Roanoke River, whose waters have long supported the nearby communities; the amaranth plant, an organic grain, was said by the ancient Greeks to possess healing properties, and the combination of the health group's initials, RA, spell the name of the sun god of the ancient Egyptians. This combination of water, food and sun, said Mr. Remmes, provides the basic elements of life, and he and Dr. Berry hoped it would serve as the foundation of their practice. Their unorthodox name has now become synonymous with health care in their corner of eastern North Carolina.

Profile of Northampton and Halifax counties, North Carolina

Northampton County, a 538-square-mile county on the border with Virginia in northeastern North Carolina, is typical of the 23 counties in the state's coastal plain. The counties have sizable minority populations, above-average poverty rates, and high rates of illiteracy. The population of Northampton County shrunk by about 4 percent between 1970 and 1987, when the county population stood at 22,247. In 1984, the county's per capita income was $6,892, and its poverty rate was 28.4 percent in 1983. Blacks make up about 60 percent of its population and a disproportionate share of its poor. Almost 15 percent of all households in 1980 were headed by women, and of those households, 47.5 percent lived in poverty. Educational levels are also low: 40 percent of the population older than 25 had completed less than nine years of school in 1980 and only 36 percent had earned a high school diploma. About 15.5 percent of its homes were without full plumbing facilities.

Roanoke Amaranth began as an effort to bring needed medical services to Northampton County, but the practice moved into Halifax County when it realized the needs for increased medical services in its neighbor to the southwest. Although Halifax County also is predominantly rural, it contains a small city, Roanoke Rapids (population 15,747 in 1987), and had a total county population of 56,586 in 1987. Halifax County covers 724 square miles and, although larger and more populous than Northampton County, it shares many characteristics with its neighbor. The county poverty rate stood at 31 percent in 1983, and per capita income was $7,865 in 1984. In 1980, almost half of all households headed by women in the county lived in poverty. In 1980, about 36 percent of its population older than 25 had completed less than nine years of school and only about 43 percent had completed high school. About 15.5 percent of its homes were without plumbing in 1980. The county's infant mortality rate averaged 15 for every thousand births between 1982 and 1986.

For both counties, the levels of poverty, education and substandard housing have been and remain above the state average. The state's poverty rate in 1983 was 14.7 percent, and per capita income in 1984 was $10,853. About 25 percent of the state's population older than 25 had not completed nine years of school in 1980. Less than 4 percent of North Carolina homes were without full plumbing facilities in 1980.

The Start of the Community Health Group

Providing quality medical care to an impoverished rural population would prove a difficult challenge for any community. CHAP focused its efforts and moved decisively to attract top-rate physicians and professionals to their region. CHAP worked with the N.C. Office of Rural Health Services (ORHS, now known as the Office of Health Resources Development) to formulate their community clinic. Typically, the state office helps local groups organize community-oriented health care clinics that are initially staffed by physician assistants and family nurse practitioners who receive backup help from practicing physicians in the community. But in the case of Northampton, where physicians were near retirement and could not provide the sort of backup required by physician extenders, the Office of Rural Health Services decided to break with their past pattern and recruit primary care physicians for the community health group.

One of the first and most important programs of the Office of Rural Health Services was to give matching grants and comprehensive technical assistance to communities selected for the development of a community health center. Northampton County was one of the first ten sites chosen in 1973, the year the Office of Rural Health Services was established. The commitment from the office to the community lasts several years. The first year involves program development, community management training, facility development, and staff recruitment and training. Typically, ORHS provides community grants for capital financing that is matched with community funds on a 5 to 1 basis. As a means of establishing broad community support for the health center, the state requires that the local funds be raised through contributions from a minimum of 750 households. State money also can help pay for operational expenses, equipment and furnishings. To date, the Office of Rural Health Services/Office of Health Resources Development has worked with 49 community health centers.

With the help of the Office of Rural Health Services, CHAP was able to interview and recruit physicians through the National Health Service Corps, a federal program that sponsors the medical education of students who agree to practice in underserved communities. Burnie Patterson, a community development specialist from ORHS, contacted two physicians, Drs. Joseph Berry and Gerald Devine, who were volunteers with the Corps. Before

coming to Northampton County, Dr. Berry was working in New York and, although he intended to practice in an underserved community, he had not decided between serving in an inner-city urban neighborhood or an isolated rural community, the two types of communities most likely to have physician shortages. Dr. Devine, a native New Yorker who like Dr. Berry was an internist, was looking to get away from big-city medicine.

When Drs. Berry and Devine arrived in July 1976, Northampton was poor and had an agriculture-based economy, factors common to rural communities that have difficulty recruiting physicians. In addition to going to an underserved and poor region, this physician team was not typical of other medical practices in the Southeast in another important aspect. Dr. Berry, who is black, and Dr. Devine, who is white, established the first integrated practice in rural North Carolina. During their recruiting process, leaders of CHAP had made a unprecedented decision to establish an integrated practice. "People used to come from throughout the county just to see whether it was true, whether a black man and a white man were really working together," said Melvin Broadnax, the first and only chairman of the Board of Directors of the Roanoke Amaranth Community Health Group.

CHAP agreed to build a medical clinic and in turn lease that building to Roanoke Amaranth. That medical building had not been completed when Drs. Berry and Devine began their practice in the summer of 1976 and design problems with the construction of the building further delayed its opening. For about four months, while construction of the medical building was finalized, the two physicians hired staff and practiced in a temporary clinic set up in a trailer near the construction site.

To publicize their new health care clinic, members of CHAP spent their Sundays at church. They handed out information on their clinic after services and asked ministers to take a few minutes of the sermon to talk about the importance of health care and about the county's new clinic. "This way we reached all the people and informed them about Roanoke Amaranth," Mr. Broadnax said. In addition, attending the dozens of churches in the county prevented one community group from claiming all the credit for beginning Roanoke Amaranth. It broadened the credit and the pride for the new health group's formation.

"Then Dr. Berry and Dr. Devine set out to educate the people about health care," Mr. Broadnax said. "When they first came, someone told me I

had to get those doctors out of the county because before they came, no one (in the county) knew how sick they really were," Mr. Broadnax said laughing. The lack of doctors had meant that diseases were going undiagnosed and untreated. The presence of the Roanoke Amaranth health group increased people's knowledge of their own health. "We understand why we tick now," Mr. Broadnax said.

The CHAP structure remains and its continuity is represented by Jasper Eley, an original CHAP board member and its current president. Roanoke Amaranth still leases the buildings of the Jackson complex from CHAP. "We've been very happy with the services Roanoke Amaranth offers," Mr. Eley said. Residents have continued their support for the program and shown their satisfaction by contributing to the fund-raiser Roanoke Amaranth held in the summer of 1989 to build their new senior citizens' complex, Hampton Woods. The Roanoke Amaranth program represents a product of a community effort, augmented by state support. The health group has benefited from a continuously active board and a resident population that sees the health center as a permanent, community-centered project.

Services Offered by the Health Group

The Roanoke Amaranth Community Health Group operates three clinics under its name and a single board: the medical complex in Jackson, which also houses the administration of the group and its emergency services, and is located next to a pharmacy and a dentist's office; a full-service clinic in Weldon; and its obstetrics and gynecology office, which opened in 1987 across the street from Halifax Memorial Hospital in Roanoke Rapids. Roanoke Amaranth also shares coverage with nearby independent clinics, which are Twin County Rural Health Center in Hollister, the Lake Gaston Medical Center in Littleton, and Rich Square Medical Center in Rich Square. (Please see map in Appendix.) With the technical assistance of the Office of Health Resources Development, the six clinics are in the process of being merged into a single system under the name Rural Health Group, Inc. All of the physicians will work for Rural Health Group, Inc., and the clinics, which will retain their individual boards of directors, will contract with the Rural Health Group for the services of the physicians. A single Board of Directors of Rural Health Group Inc., with representatives of the individual clinic boards,

will decide general policy for the six medical centers, while the administrator and medical director will handle the day-to-day operations.

In the summer of 1989, there were 10 physicians and five physician extenders associated with the six-center practice, which was also recruiting physicians to fill two open positions. The health group provides the full spectrum of primary health care services--pediatrics, obstetrics and gynecology, family medicine, internal medicine, geriatrics, family planning, minor surgery, and health education. Dental care is offered at the Twin County center. Other support and ancillary services also are provided to patients. Doctors admit patients to and perform rounds at Halifax Memorial Hospital in Roanoke Rapids, 20 miles east of Jackson on U.S. Highway 158, a 25- to 30-minute drive from Jackson.

When the practice began, Northampton County had one of the highest infant mortality rates in the nation, according to the Robert Wood Johnson Foundation of Princeton, NJ. In addition, the county had the highest rates in the state for acute myocardial infarction, cancer mortality and severe hypertension. Today, chronic conditions such as hypertension, diabetes and heart disease still plague residents of the county, although these rates have decreased. The practice also has identified mental illness, substance abuse and other social illnesses as high prevalence problems, which are emphasized in clinical and educational programs.

According to the practice's pediatricians, the most typical pediatric problems of Halifax and Northampton counties are: infectious diseases caused by living in close quarters in substandard housing; influenza; nutritional problems; trauma and accidents; child neglect and child abuse. Problems remain with neonatal care and with asthma and chronic lung disease, which seem tied to increased rural pollution from agricultural and industrial sources, physicians say.

In its newest project, the health group will expand its geriatric services and provide a comprehensive system of service to the region's growing elderly population. In Northampton County, more than 2,700 people, about 12 percent of the population of the county, were 64 years old or older in 1980, and that total was projected to increase by 26 percent by 1990. Burnie Patterson and the staff of the Office of Health Resources Development have provided intense technical assistance to Roanoke Amaranth in their planning and financing of the senior center. The health group has developed

a comprehensive system of geriatric care, Senior Care Spectrum, which has been recognized as a model for rural health groups practicing in communities with growing elderly populations. (Please see Appendix for service chart and map of project.)

Newest Project Expansion: Geriatric Care at Hampton Woods

Planning for the Senior Care Spectrum, known as Hampton Woods, began in 1984, and when the project is complete, it will offer varied housing and social opportunities for the growing number of elderly residents of the county. Similar to other rural communities, Northampton County has a high concentration of elderly residents. By 1990, 15 percent of its residents are expected to be aged 64 or older, an increase of 24 percent over its 1980 elderly population. In the past, older residents of Northampton County have been forced either to move at least 60 miles away to nursing home services or to travel long distances for specialized geriatric therapies. With the Senior Care Spectrum, elderly residents can receive the services they need without leaving their home community.

When complete, the Hampton Woods campus will contain a 60-bed nursing home, 18 home-for-the-aged beds, 20 apartments for low-income seniors, a senior center, a geriatric clinic, and 30 moderate-priced apartments. Fifteen apartments have been completed, and the senior center, which will serve social and medical needs for the county's elderly, has been built with money from the Regional L Council of Governments, the State Division of Aging, and community fund-raising. Construction is scheduled to be completed in 1989 on the nursing home and home-for-the-aged beds. Money for the entire $3 million project has come from the U.S. Department of Housing and Urban Development (Sections 202 and 232), the Z. Smith Reynolds Foundation, the Kate B. Reynolds Health Care Trust, the Local Initiative Support Corporation, the Consumer Cooperative Development Corporation, and other loans. The financial package was pulled together by the health group, with the help of the Office of Health Resources Development and its consultants.

The Senior Center and senior citizen housing will be located on the Hampton Woods campus, across the street from the Jackson medical center of the Roanoke Amaranth practice. Physicians and other health care professionals will be close-by to deliver specialized geriatric care to the

residents of the complex. In addition, a pharmacy, dentist's office, Emergency Medical Services, the county's Department of Health and Department of Social Services, and the regional mental health office are across the street from the Hampton Woods campus. (Please see map in Appendix for details.)

Jack Faison, an original member of the CHAP board, said the Roanoke Amaranth practice has served its patients well but needs expansion. "It's grown to the point where we now see the need for a nursing home and a senior citizens' complex," Mr. Faison said. Hampton Woods and its Senior Care Spectrum will further the health group's commitment and service to the two-county region, he added.

Health Connections: Aimed at the Youth of Northampton High Schools

Health Connections is a program targeted toward a different generation of residents living in Northampton County. The project, staffed by a physician's assistant and a counselor at the two county public high schools, provides free and confidential counseling to students on health-related issues ranging from dieting to drugs to dating.

Health Connections is located on the school campus and open to students anytime during the school day. Brochures and other information also are available to students. A consent form must be signed by a parent or guardian of the student once a year, and information on the service is provided for all students and their parents or guardians. Once a completed consent form is received by Health Connections, the student can receive unlimited health care advice or counseling without further notification of parents. Through this process, students can be assured that their counseling will be kept confidential, and parents will be fully informed on the services and information provided by Health Connections and its counselors.

Professionals at Health Connections help students to the extent of their training and refer students who need additional help to the proper professionals. Health Connections is a cooperative effort of the Roanoke Amaranth Community Health Group, the Northampton County Schools, and the Roanoke-Chowan Human Services Center. Technical and financial support for Health Connections has been provided by the North Carolina Foundation for Alternative Health Programs and the Kate B. Reynolds Health Care Trust.

Baby Love: Case Management of "Mom and Kid"

Although Roanoke Amaranth has branched out into providing more extensive services for the elderly and high school students, the practice retains its strong reputation for services to mothers and their young children. This tradition has been further strengthened in recent years by the addition of the Baby Love program, a state program of maternal and child health care management.

The Baby Love Program takes a case management approach to handling pregnant women who qualify for Medicaid. About 280 women have been served by the program, which started the fall of 1987 and serves women in Halifax County. A registered nurse in the Roanoke Rapids ob/gyn office and a social worker at the Twin County Rural Health Center administer the program with the help of a part-time Licensed Practical Nurse.

"It's an effort to make sure that pregnant women receive adequate prenatal care, enroll in WIC (the federal Women, Infants and Children nutrition program), and other services," William Remmes said. After the birth, the women and their babies are followed for at least 60 days, and in some cases up to one year, to make certain that the mothers and children sign up for the medical care and social services they are eligible to receive.

The result has been healthier babies, says Jeanne Sumpter, who works with Baby Love in the Roanoke Rapids office of Roanoke Amaranth. "I haven't done any studies, but I see us getting better babies," she said. Coordination of services was clearly a problem, she said. "Before this, so many of our people got confused with the (welfare) system." Sumpter also happens to be married to one of the three pediatricians of the Roanoke Amaranth practice, Edwin Sumpter, who tells his wife that the young patients whose mothers were in Baby Love are a reflection of the success of the program.

Case management also provides the practice with a cost-efficient and effective way of serving many of their patients who qualify for public support but need help using the services. Care coordination includes home health care, some transportation (which Sumpter says is a "horrible" problem for rural patients), and intensive help in applying for services.

Staffing History of the Health Group

The present slate of services offered by the Roanoke Amaranth health group has grown steadily since its inception, as has the size of its professional staff. What began as a practice with two doctors in one trailer has grown to a network of six clinics with up to 12 primary care physicians. This growth has not been without pain, as the practice has experienced physician turnover and difficulty recruiting professionals to the region. However, the practice has been strengthened through grants from private and public sources. The practice has also relied heavily on the technical assistance offered by the N.C. Office of Health Resources Development, formerly known as the Office of Rural Health Services, throughout its fifteen years of practice.

In 1978, with the help of the Office of Rural Health Services, the practice received a $499,500 grant from the Robert Wood Johnson Foundation of Princeton, NJ, to become one of 13 demonstration projects in the Foundation's Rural Practice Project. The luxury of the grant's generous funding allowed Roanoke Amaranth to pursue its goals, Dr. Berry said. "We were trying to develop a community practice that was sensitive to individual and community needs," Dr. Berry said.

However, before that grant was received, the health program lost a physician. Gerald Devine stayed with the practice for almost two years before moving to open a practice in Lumberton, N.C. This left Joseph Berry as the sole physician for the Roanoke Amaranth clinic, and in 1978, he and a physician assistant were handling the clinic's 6,000 to 7,000 patient load. About one month after Dr. Devine left, however, in July 1978, Dr. Berry got administrative relief with the arrival of William Remmes, a former Peace Corps volunteer who was hired as the health group's first, and thus far only, full-time administrator. Mr. Remmes, who responded to a want ad in *The New York Times* placed by the Rural Practice Project, "brought added vision to the practice," Dr. Berry said.

In the Rural Practice Project, an administrator and medical director formed the leadership team for the model clinics. The Rural Practice Project gave Roanoke Amaranth funds to make up the losses it incurred during the project's five years. Dr. Berry says the grant gave the practice the financial security it needed to offer a comprehensive program of medicine to its patients. "It allowed us to be innovative in our practice," Dr. Berry said.

The clinical problems Dr. Berry and the practice focused on during the five years of the Robert Wood Johnson grant were cancer and heart disease rates in the county, which were above the rates in other regions of the state, according to state data. Dr. Berry also wanted to add physician assistants and family nurse practitioners to the staff because he felt they would be more holistic in their approach to patients than physicians alone and could give more time to individual patients.

In 1979, the group also received grants from the Kresge Foundation, the Z. Smith Reynolds Foundation, and the Kate B. Reynolds Health Care Trust to expand their Jackson office and establish a Weldon office, which opened in October 1980 and is located south of Roanoke Rapids about three miles from Halifax Memorial Hospital. Together, the Weldon and Jackson medical centers have served as the foundations for the growing medical practice.

In part the expansions of the health group were possible only after they found another physician to relieve Dr. Berry's workload. ORHS recruited Dr. Jane McCaleb, a family physician who joined the practice in August 1979. "And when people heard that a *white* woman was working with a black man, that was really something in this county," Mr. Broadnax said.

Dr. McCaleb, who now serves as Medical Director of the health group, said she chose Roanoke Amaranth in part because, "the practice was really into community medicine in a way that appealed to me." As a reflection of her dedication to primary care medicine, a sign in her office reads: "A general practitioner is a doctor who treats what you've got; a specialist is a doctor who finds you've got what he treats."

A native of Columbia, Mo., Dr. McCaleb went to medical school expressly to practice family medicine. When she graduated, she also had decided to find work in a rural community in the Southeast. After medical school, she joined the National Health Service Corps, which paid for two years of her medical education and then directed her to openings in rural communities with a physician shortage. Dr. McCaleb was attracted to North Carolina because of the Area Health Education Centers, a state program that provides continuing education to health care professionals in regional centers, and the Office of Rural Health Services, a unique state agency that gives technical assistance to rural primary health care centers, hospitals, and health care providers in the state.

When Dr. McCaleb joined the practice, she not only relieved Dr. Berry but also brought her family practice skills to the health group. Dr. McCaleb, who Dr. Berry said is a "brilliant physician," expanded the pediatric services of the practice and added obstetrics to their work. This allowed Dr. Berry to concentrate more on the chronic diseases that plagued the county's adult population.

Together, Drs. Berry and McCaleb served as the professional core for the practice during its early development. They were joined in August 1981 by Dr. Edwin Sumpter, a pediatrician, shortly after a family practice physician left after one year to start his own private practice. Dr. Sumpter, who was recruited through ORHS and is still with Roanoke Amaranth, spent 13 years in private practice in pediatrics in Rochester, NY, and six years at the University of Massachusetts School of Medicine as vice-chairman of the department of pediatrics before joining the health group. Dr. Sumpter, who practices in the Weldon office, says he misses teaching but has learned more in eight years of practicing in Halifax and Northampton counties than in his previous 19 years as a physician. Dr. Sumpter had been interested in rural health care since his medical school days and has spent time working in rural medicine as a volunteer in Haiti and in a Cambodian refugee camp in Thailand. He specifically looked to come to North Carolina because of the state's monetary and technical support of rural health centers.

As part of their operations in northeastern North Carolina, the Office of Rural Health Services had envisioned an expansion of the health group to include a network of clinics in other neighboring communities of the region. Under plans designed by the ORHS, Drs. Berry and McCaleb looked to expand into Littleton, a community in northwestern Halifax County. Two physicians, a husband and wife team, opened the Lake Gaston Medical Clinic, Inc., in Littleton, with the assistance of the ORHS. The Roanoke Amaranth physicians hoped a cooperative relationship would lead to shared coverage between the clinics' doctors.

But the Littleton expansion did not work out as well as Dr. Berry had hoped, he said, and the "chemistry" between the two groups of doctors was not good. From then on, he tried to shy away from expansions, Dr. Berry said. However, the extension of Roanoke Amaranth into a full-fledged network of associated clinics in the two counties continued. The two Littleton physicians left Lake Gaston, and as other rural clinics were set up in the two county

region, the Office of Rural Health Services sought to link Roanoke Amaranth with the professionals and patients of the other centers. These efforts led to the current six-clinic network that will soon become Rural Health Group, Inc., a single system of coordinated rural health care that offers an extended scope of care not often found in rural communities.

Physicians working for Rural Health Group, Inc., will be assigned to a home base medical center, where they will see most of their patients. For one day or one-half day, most physicians will be assigned to another medical center as a way of extending specialized care to as many patients as possible. For example, patients who cannot travel to the group's Roanoke Rapids ob/gyn clinic will be able to see an obstetrician on the designated day that specialist holds office hours in the Jackson or Littleton medical centers.

Although Drs. Berry, McCaleb and Sumpter have worked with the health group for more than eight years each, the practice has suffered from a problem common to rural health groups--high physician turnover. The physicians who have left the practice cite numerous reasons, ranging from the quality of the county schools to the lack of cultural activities to the physical isolation of rural life. A particularly significant departure, and one that bears a more in-depth description, was that of the practice's "founding father" Joseph Berry in 1985.

By 1985, the Roanoke Amaranth practice had become established in the county, and it became apparent to Dr. Berry that the health group would survive financially. "My professional interest started to wane," he said. The public schools were not as rigorous as he would have liked for his children, and after serving for four years on the Board of Education, Dr. Berry saw little hope for needed improvement. After nine years with Roanoke Amaranth, Dr. Berry and his family decided to settle in Albuquerque, NM, because of its multi-cultural history and society. Once they decided on Albuquerque, Berry went job hunting and decided to join the staff of the Lovelace Medical Center, where he is now chairman of the division of satellite operations.

Dr. Berry's departure pointed up the present conflict rural physicians must face between the promise of rural practice and its results. Don Madison, professor of medicine at the University of North Carolina at Chapel Hill School of Medicine, headed up the Rural Practice Project that included Roanoke Amaranth. He says the image of the long-serving country doctor in rural America is a myth. "There's always been high physician turnover in

rural communities," he said. The more important concern is that the practice remains in a community. "Whatever the turnover in these places," he said, "it's better for the communities that the practice is still there."

Physician recruitment will continue as an ongoing cooperative activity with Roanoke Amaranth and the Office of Health Resources Development, which conducts much of the health group's recruitment. The National Health Service Corps has provided a stream of physicians for the practice to recruit, but many physicians who came through the Corps have left as soon as their obligation expired. In addition, other physicians with the practice have remained for only one to three years.

"There is a constant feeling of financial instability and professional turnover," Dr. Sumpter said, but he added that he had no easy answers to the financial strains the rural practice struggles with each year. "I'm not sure the numbers will allow us to continue what we are doing," he said, referring to the financial side of the health group. The physicians should be able to practice without the constant worry of financial constraints, he said. "What we are doing should be endowed."

Financial History of the Health Group

Dr. Sumpter's frustration with financial constraints is not uncommon among rural practitioners. The Roanoke Amaranth Community Health Group has received generous private foundation grants as well as technical support from state government. Up until 1984, the group received only technical assistance, such as aid in recruiting physicians and securing private grant money, from the Office of Rural Health Services. However, that year, the practice sought to expand its services and needed financial help from the State. In addition, the practice received support from the Robert Wood Johnson Foundation. Despite this help, in recent years its budget has been strained due to the continuing shrinkage of money available for what they do--provide health care to a rural population with a disproportionate number of poor residents.

Mr. Remmes says stabilizing the practice's finances will remain a challenge for the community health group. Two years ago, 37 percent of the program's budget came from outside sources, such as private and government grants, he said, but in 1988-89 that figure had dropped to between 10 and 15 percent of their $1.4 million annual budget. The greater proportion

of patient income may give the impression that the program is more self-sufficient, but it actually represents a shift from preventative and health maintenance activities to more "remedial" medicine, treating and curing sicker patients. Such a drop is forcing the practice to juggle its budget and look for additional funding mechanisms.

One budget shortfall that could be avoided has resulted from inadequate reimbursement from the state's Medicaid fund. As a federally designated Rural Health Clinic, the Roanoke Amaranth health group is entitled to cost-based reimbursement for its Medicaid patients under the Rural Health Clinic Act, Public Law 95-210. Under a process called reconciliation, Medicaid annually compares the payments made to clinics with the amount of money the clinics were entitled to under its regulations. Some clinics are discovered to have been overcompensated while others, like Roanoke Amaranth, are owed additional moneys under programs like 95-210.

But because of bureaucratic delays, the reconciliation process under Medicaid has lagged despite the fact that Roanoke Amaranth submits its paperwork on time. In 1989, the practice was reimbursed for its 1986 reconciliation amount and is still owed its reconciliation payments for 1987 and 1988. Medicaid is frequently two to three years behind in these reconciliation payments, and this delay causes cash flow problems for the health group. The practice also is undercompensated for certain dental procedures performed for Medicaid patients. With the assistance of the Office of Health Resources Development, Mr. Remmes has moved closer to settling these problems. The Office has contacted the state's Medicaid office and has begun an inquiry that could lead to the fair compensation of the Roanoke Amaranth practice.

Dr. McCaleb said the practice also has suffered from inadequate physician productivity and unnecessary bad debt. "There's been a mindset that the money will always be there," she said. Charging for services rendered has been spotty for many patients whom physicians believed could not pay their bills. But Dr. McCaleb said the practice must now record those charges and, if needed, write them off as either bad debt or indigent care. "This way, at least we'll know how extensive the problem is," she said.

To increase physician productivity, each physician will be assigned goals as to the number of patient encounters and the amount of charges they have, Dr. McCaleb said. Physicians and administrators will be encouraged to

increase charges and the collection of fees, she said. "Both doctors and the administrator have resisted this," she said, "because we serve a lot of poor people....But if we close our doors (because of bankruptcy) we won't be doing them any good," she said.

Professional Challenges and Rewards: Rural Physicians Today

The uncertainty created by a budget crunch is not the only challenge facing rural physicians, Drs. Sumpter and McCaleb say. They agree that certain qualities must be present in a physician hoping to practice in rural communities.

"You need to be creative and innovative in a rural community-oriented practice," Dr. McCaleb said. Physicians working in a rural community have to be interested in all facets of primary care, she added, and must accept the challenges that arise when treating rural patients who are often limited by poverty, illiteracy, and inadequate transportation systems.

"You become an advocate for a health plan for patients with chronic diseases," she said. "You're not always the leader because you need specialists and consultants to help you care for your patients." As an example, Dr. McCaleb has recently kept in close contact with a heart patient's cardiologist at Duke University's Medical Center in Durham, NC, about 100 miles from Jackson. She serves as a liaison between the patient and the specialist and performs the role of both family physician and counselor. "You have to be willing to do more than medicine," Dr. McCaleb said. "For a lot of doctors, that's just not what being a physician is about."

Dr. Sumpter says his colleagues are often in emergencies where "the buck stops here." The physical isolation from colleagues in medicine can prove difficult for rural physicians, he says. "A tough part of the job is that you don't have the backup that you have in a big city," he said. Rural physicians are typically on their own when it comes to making critical decisions for their patients. "It gets lonely at two in the morning with a preemie when the nearest NICU (neonatal intensive care unit) is a hundred miles away," he said.

But despite the frustrations of rural health care, the providers and staff feel intense satisfaction and a sense of service that comes from knowing that physicians with Roanoke Amaranth have improved health care delivery in Halifax and Northampton counties. "We've made a difference here, no

doubt about it," Dr. Sumpter said. Neonatal mortality has decreased, he said, and quality of care for sick neonates has vastly improved. In the last few years, with the addition of two pediatricians, Dr. Sumpter has found the time to pursue an interest in developmental pediatrics and the problems of at-risk youth.

"The rewards are you can see that you made a difference," Dr. McCaleb said. In the early 1980s, Dr. McCaleb received state and national recognition for her efforts to reduce infant mortality in Northampton County. In 1979, the infant mortality rate in the county was 23.5 deaths for every 1,000 births. That rate, one of the highest infant mortality rates in the nation, was above that of many Third World nations. In 1982-86, that rate was down to 8.3 deaths per 1,000. Dr. McCaleb's efforts to reduce that rate included increasing the quality of prenatal care given to pregnant women, getting them on sound diets and on vitamins, giving the women information on symptoms of problems with pregnancy, and increasing the quality of facilities and training at Halifax Memorial Hospital.

"Getting that recognition was all well and good," she said, "but the problem should never have been allowed to get so bad." She said upgrading equipment and facilities at Halifax Memorial Hospital and sustaining the progress that was made in infant mortality and prenatal care remain continuous goals of the practice. "If you've done your job well (in primary care medicine), no one should notice," she said. "The miracle is not that the premature infant lived through a neonatal trauma, but that there was no trauma."

Frustrations about her job are the "huge amount of work," being on-call often, and the low reimbursements given to rural health care centers by federal programs. In addition, her patients struggle with the lack of transportation found in rural communities, literacy problems (many of her patients cannot read the prescriptions or directions she gives them), and poor nutrition. "If I could get them transportation and good food and get them to read, my life would be much easier," Dr. McCaleb says.

But their job has a lot to offer young physicians, Drs. McCaleb and Sumpter say. Despite what many medical students may think, working in rural medicine provides intense intellectual challenges not found in suburban or even urban primary care medicine. "There's an intellectual

fascination in a place like this," Dr. Sumpter said. "It's a zoo of fascinating combinations of diseases. I've seen everything in the pediatric textbook."

In general, medical students are not exposed to the challenges and rewards of rural primary medicine, or primary health care in general, Dr. McCaleb said. Students spend most of their training time in a tertiary care setting in a teaching hospital and therefore have little exposure to ambulatory care. This presents a problem when primary care practices, such as Roanoke Amaranth, attempt to recruit young medical students, many of whom have not been exposed to their brand of medicine. This and other factors impeding physician recruitment to rural communities pose one of the greatest challenges for rural practices similar to Roanoke Amaranth.

Prospects and Challenges

In the past, the Roanoke Amaranth Community Health Group has kept its professional staff strong by recruiting heavily through the National Health Service Corps. In addition, in past years, the Corps also boosted the rural clinics by paying the salaries of many of its Corps physicians. With this federal program's slow demise, it will grow even more difficult to recruit and retain physicians in the community. Federal appropriations for the Corps peaked at $95 million in 1982 when more than 6,000 scholarships were awarded to medical students. Funding in 1986 stood at $58.5 million and the number of scholarships had been cut to 42. "When I was in medical school, the (National Health Service) Corps was in its friendly phase," Dr. McCaleb said.

The departures of key personnel, such as that of Joseph Berry in 1985, leave critical holes in the fabric of a practice. Typically strained workloads become even more demanding when physicians leave. Yet with the new developments and expansions into geriatric care, the practice should be able to use its new services as an attractive selling point to a physician with an interest in geriatrics. The challenge of making certain that the Hampton Woods project is successfully inaugurated remains ahead of the health group.

In addition to changing physician attitudes about working in a rural practice, the Roanoke Amaranth group also must work to change patient attitudes about rural doctors. Many patients are still used to the style of the solo country doctor who did not have a hospital practice. The Roanoke Amaranth physicians are younger, work as part of a group and share on-call

responsibilities. In addition, they maintain hospital practices, which put demands on their time. Patients must come to appreciate the style of their physicians, Mr. Remmes said.

Dr. Sumpter also feels that there is a continuing need for health education among community residents. "Physicians can only treat those who come through the door," he said. This leads to a sort of self-selection of patients who realize that they or their children are sick and need help. Many other residents who require medical care don't realize their need, Dr. Sumpter said.

In their attempts to attract additional physicians and support staff, basic quality of life issues in the counties will continue to be obstacles for the practice. Rural schools possess intrinsic strengths and weaknesses. For example, class size is smaller in most rural classrooms, yet rural teachers are frequently more isolated from continuing education programs available to urban teachers, who tend to have more advanced degrees. The public schools in Northampton and Halifax counties are not supported by all of the county's residents. In Northampton County Public Schools, 80 percent of the 4,121 students were black and 20 percent were white in 1986-87. During the 1986-87 school year, almost 84 percent of the Halifax County Public Schools' 6,650 students were black, and 86 percent of the 1,300 students in the Weldon City Schools were black. In contrast, 90 percent of the 2,728 students in Roanoke Rapids City Schools were white that year. (Halifax County was one of 28 N.C. counties to maintain more than one school district in 1986-87.)

Administrator Remmes says race is an important aspect of adjusting to life in rural Northampton County. "Someone in an area like this has to accept living in a majority black community," he said. "There are challenges related to (race). Race in an issue in everything in this county."

In addition, poverty is an everyday issue in Halifax and Northampton counties. Its ill effects will continue to present challenges to physicians trying to care for a population that is disproportionately poor, undereducated and ill. Despite great progress in reducing the infant mortality rate in Northampton County, high-risk pregnancies continue to pose problems for Roanoke Amaranth's patients and their families. More than 60 percent of the children in Northampton and Halifax counties live under the poverty line. Children in the region also are more likely to live in households headed by single mothers and that receive public assistance. Dr. Sumpter says he sees many

patients who are third-generation welfare recipients who see no way out of the system.

Board chairman Melvin Broadnax, who also is mayor of the Town of Seaboard in Northampton County, says the county needs to increase its attention and commitment to economic development. Mr. Broadnax says the county should pursue peanut companies to locate a processing and packaging plant in Northampton, which is one of the state's top producers of peanuts. Increasing the number of jobs in the county will bring more wealth into the region and help increase the county's standard of living, he says.

National trends also will have an impact on isolated rural practitioners, Dr. McCaleb says. The Joint Commission on Accreditation of Healthcare Organizations, or JCAHO, is beginning to accredit ambulatory care facilities, including rural health care clinics that don't have facilities comparable to more sophisticated urban medical centers. Medicare and Medicaid reimbursement, which is lower for rural services than for urban services, is based on the unproven assumption that medical services are less costly per unit in rural America. Dr. McCaleb also foresees increased national emphasis on quality of care and on formulating a plan for national health insurance. Much of this newfound interest comes from business owners concerned about their escalating health insurance bills, she said. This collection of major national health care issues will have a greater impact on rural physicians than some local issues, Dr. McCaleb says.

The practice also faces the challenge of attracting more middle-income, self-paying patients to the practice. Because the Jackson clinic is located next to the Northampton County Department of Social Services, many residents associate the practice with the county's welfare system. Although the health program receives no public money from the county, its location links it to images of public medical care.

The departure of Dr. Berry, the "founding father" of Roanoke Amaranth, made 1985 a difficult transition year, Dr. McCaleb said, and she thinks 1989-90 will be similar. "We'll either get stronger or have to contract our practice," she said. The practice needs to plan for the future of the health program, improve its organizational management, and have all physicians "pull their own weight," she said.

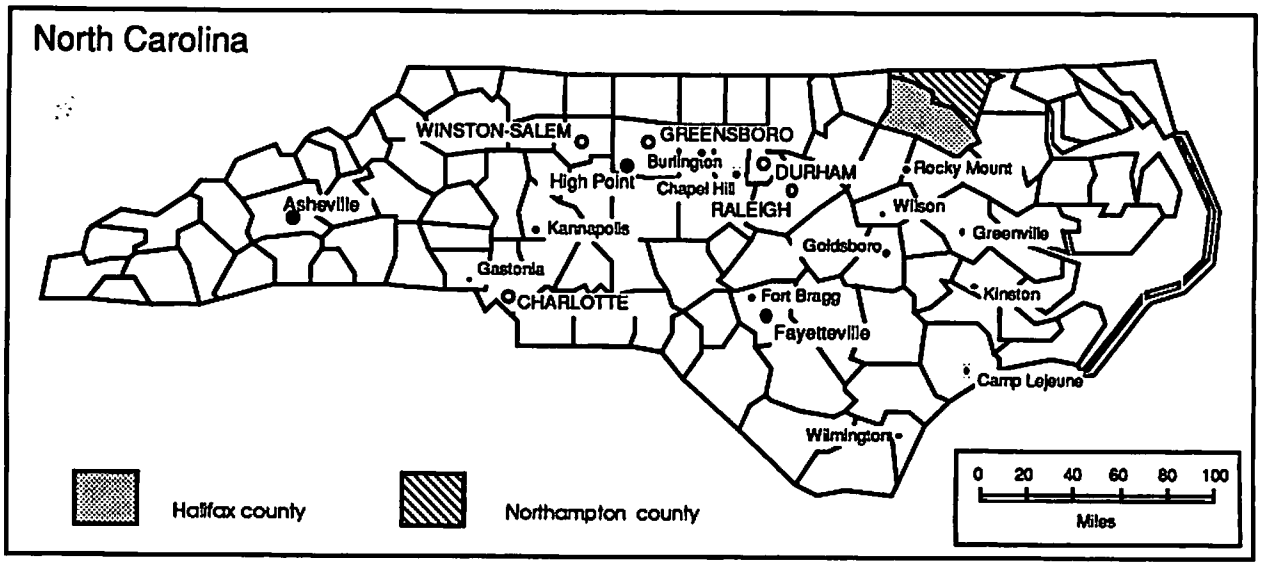
"If practice has to shrink, it won't be a failure. We have to realize there are things we are not able to do, and that's tough to admit," she said.

Eventually, the practice has to place increased emphasis on fiscal survival. "At that point, you have to make some tough choices about services," she said. "That's not easy to do when you see so much need."

Summary

The Roanoke Amaranth Community Health Group is a success, but that success continues to be fragile. The practice and its clinics are unique in that Roanoke Amaranth:

- has enjoyed substantial grant support;
- has the attention and expertise of a state agency;
- has found committed and talented physicians willing to work in an underserved and poor community;
- was able to overcome potentially damaging race relations;
- actively seeks out cooperative arrangements and has a goal of an "integrated" system of medical care; and,
- is seriously "community-oriented" both clinically and in its political and administrative outlook.



	Northampton Co.	Halifax Co.
Population (1987)	22,247	56,586
Racial mix (1987)	61% Nonwhite 39% White	50% Nonwhite 50% White
Poverty rate (1983 estimate)	28.51%	30.99%
Estimated Uninsured Population (1988)	22.0%	22.7%
Infant Mortality Rate 1982-86	8.27 per 1,000 births	15.09 per 1,000 births

FACTS on Roanoke Amaranth Community Health Group, Inc.

Utilization	July 88-June 89	22,924 clinic encounters 6,857 hospital encounters
Facilities	Three clinics:	Jackson, 5,200 sq. ft. Weldon, 3,000 sq. ft. OB/GYN Associates, 2,200 sq. ft.
Staffing	41 permanent employees, including eight physicians	
Budget	$1.3 million, 1988-89	