



In Rural Kentucky, A Surprising Twist On The Health Debate

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By **FRANK BROWNING**

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HAZARD, Ky.— From a strip-mined bluff at the edge of this famous mountain town you can see one of the most concentrated and diverse sets of medical facilities in rural America: a general hospital, a psychiatric hospital, a university-based rural health care center and clinics for primary care, cancer, urology, cardiology, addiction and ear-nose-and throat problems.

Yet Hazard, which for 40 years was a coal boomtown, rests at the center of the worst life expectancy in America, according to a 2008 [report](#) by the American Human Development Project. Diabetes, asthma, lung cancer and emphysema, heart disease and life-long obesity are all problems encountered in the waiting rooms of these facilities.

Very little is likely to change under any of the current initiatives focusing on health care reform, say some experts like Dr. Forest Callico, former director of the Appalachian Regional Hospitals and a rural health advisor to both the Clinton and second Bush administrations. “It’s not all about the money,” says Callico. “We have to transform the way we take care of people.”

Bad as most health measures appear in lower Appalachia, Callico says, there are enduring models in places like Hazard that could prove instructive to rebuilding healthy communities across the nation, both rural and urban. He cites the work of two women who have dedicated much of the last 20 years to building community health programs in two adjoining counties, Perry -- where Hazard is -- and Harlan.

'We're out here dying'

Gerry Roll, who reached adulthood as a homeless, single mother, helped organize Hazard-Perry County Community Ministries, which despite its name has no religious mission. She wants to "create a community that values good health," a vision that goes well beyond the cluster of hospital resources perched on the hill above her offices. It requires building a system that addresses everything from exercise and diet to regular medical screening, and includes services that support good health.

“We’re out here dying and we’re showing up in the emergency room when we’re half dead, instead of saying, you know what, I live in this community. I want sidewalks,” she says. “I want ambulance services. I want grocery stores convenient, (so) that all of my neighbors can get there. I’d like to see some form of public

Videos: Profiles of Hazard, Ky. Residents

Gerry Roll



Beverly May



Annie Fox



Cathy Nance



transportation,” much needed by people without cars in steep mountain country.

She advocates a community boot-strap approach in which residents come together as health consumers and pressure the system to meet their specific needs. As an example of how the agency works, Roll cites the area’s leading health problem: Type II or adult onset diabetes, largely linked to bad diet and a lack of exercise.

“We’ll have a patient who sees the doctor and the doctor says you need to change your diet, and here’s a diet and (the doctor) will hand them a sheet of paper, and will tell them to exercise more, to walk or go to the gym, will tell them everything to do,” she says. “And the person will sit there and say yes, yes, I’ll do that, I’ll do that. They may not do any of that. They may not be able to get to the store. May not know how to prepare the food. They may not want to exercise. And there’s no one to encourage them to do that.”

So Community Ministries “lay health workers” go into patients’ homes once or twice a week, call them on the phone, drive them to the grocery or even organize regular walks with their neighbors—in short , taking an “interest in their life.”

The health workers are almost always local people. Frequently they are previous clients of community health outreach projects who first became volunteers and then were trained on the job. During visits, they evaluate patients’ living conditions to see if they qualify for housing and medical care under an array of federal programs, and then complete oral inventories of each client’s health history. Afterwards they bring the clients into one of the community clinics established in the two counties, and then when necessary refer them to private practitioners who offer limited free consultations in the evenings.

Plenty of government programs, little knowledge of how to use them

Family nurse-practitioner Beverly May works with Roll at the Little Flower Clinic down by the Kentucky River in one of Hazard’s poorer neighborhoods. It and two clinics in Harlan County serve some 2,500 homeless or poorly housed people. She tells the story of an itinerant Baptist preacher whom she calls Charlie to protect his privacy. He had come in for a regular health screening, which always includes a blood sugar test for diabetes.

“Charlie said, ‘Oh no, I don’t have diabetes, you don’t have to stick my finger.’” A tall, robust, courtly black man—a descendant of the segregated coal camps set up in the 1920s—Charlie was always well dressed, usually wearing a freshly pressed white shirt even with his overalls. He had no health insurance, but he was sure he was perfectly healthy.

May insisted on the test, and found he had a dangerously high blood sugar level. “It didn’t take much medication, it didn’t take much health care” to fix Charlie’s problem, she said, but by doing that “you have greatly reduced someone’s risk of getting kidney disease, blindness, heart disease down the line. So by a dramatic drop like that, we have changed his picture entirely for his future. We do that every day.”

May says her patients typically come in without having had any care for years – they may not have a job or insurance and can’t afford a doctor’s fee. Half the population of the two counties falls below the poverty line, and are covered by Medicaid or Medicare, but May says they frequently don’t know how to use those government programs for the poor and elderly.

Health care as a 'joint enterprise'

The approach taken by Roll and May is at the heart of a statewide commission examining health care reform in Kentucky. It’s led by Dr. Gilbert Friedell, a crusty 82-year-old who taught at Harvard and the University of Massachusetts Medical School, and ran the University of Kentucky’s Markey Cancer Center after spending 12 years directing the National Cancer Institute’s bladder cancer

project. He is a doctor's doctor. But he believes that too often doctors are a major problem in creating healthy communities. "Health care," Friedell argues, "has to be a joint enterprise between patients, families and physicians."

In operation for about a year, the Friedell Committee, as it is known, has organized a series of working groups aimed at generating citizen activism on local health issues. One group is targeting a half dozen counties where citizens will be encouraged to challenge local boards of health on what they're doing to improve local health markers. Another is targeting three counties where diabetes is prevalent, urging local leaders to press their health services to develop a coherent plan of coordinated care—from monitoring to diet to exercise to long-term treatment. A third group is focusing on how well—or poorly—counties are following a new law to enroll every child in a state-mandated health care program.

The objective is not only to evaluate current health care assets and deficits, but, more importantly, to create "citizen tools" that can be employed across the state to hold doctors, hospitals and county health boards accountable.

Nationally, Friedell believes, the health reform debate has to be transformed.

"Currently the issues are framed as insurance or not insurance," he says. "Having insurance gives you financial access to a system, assuming there is a system. It gives you nothing more than that. And getting into the system, if there is one, doesn't tell you anything about the quality of care, the availability of services, the way the patients and families are treated."

Lowest life expectancy

Kentucky's Fifth Congressional District, which includes Harlan and Perry counties, has the lowest life expectancy of any district in America: 72.6 years for men and 76.4 for women. Many factors contribute to those numbers and they would be little changed, Friedell says, by either a government-run system or a requirement that all people have insurance. Substantive change, he says, will only arrive built on a basis of re-ordered health values founded on programs like the one Gerry Roll and her colleagues have tried to build in Hazard.

An hour away from Hazard, across the corkscrew roads of Pine Mountain, is Kentucky's second most famous coal town, Harlan—known for a half century of militant miners' activism. Coal's fortunes have declined sharply since the 1960s when more than 60 coal trains a day rumbled alongside the Cumberland River in downtown Harlan. In those days the United Mine Workers union established one of the region's landmark hospitals to deal with miners' growing health problems.

The UMW hospitals were long ago converted into non-profit hospitals known as the Appalachian Regional Hospital system. Today, the biggest health problem is diabetes and its associated cardiovascular problems. As in Perry County, half the population qualifies for Medicare or Medicaid. But simply qualifying for public insurance hasn't helped much, says Annie Fox, who about a decade ago helped organize a citizens' committee to address local health problems.

The group, Harlan Countians for a Healthy Community (HCHC), took the same approach as Gerry Roll's organization in Perry County—targeting everything from walking trails to clinical care to adolescent drug abuse prevention.

"As with so many issues," Fox says, "we have this myopic kind of vision of what health is, or what housing is, or what drug abuse is: well, hey, they're all utilized by the human body, and unless you deal with the whole issue, there's going to be tons of fallout. That's why it's important that you get people in decent housing that they can have a refrigerator, they can have potable water, they can have decent sanitation."

'We're planted where the need is'

It's been a rough road keeping HCHC alive with ever-changing financing mechanisms, but gradually Fox's group collaborated with community leaders to buy a house in a low-income neighborhood that has become part community center and part clinic. "We're planted where the need is," she says. "This is a very comfortable place for our clients. They say, 'Wow, I'd love to be able to have a home like this.' Part of our work is to help people realize that dream."

Cathy Nance lives in one of 10 houses maintained by HCHC. Perched on Pine Mountain, the highest in the area, the small home has anchored her once troubled life.

Outreach worker Tracy Grubbs recalls the time they were working for the county and Nance came into work right after open heart surgery, with "big staples in her chest." When Grubbs asked why she had come in, Nance said she had no place to live and couldn't afford to stop working.

"I had no choice," Nance says now. "I'm divorced and I didn't have no other way but to go back to work. And then [when I had] the kidney cancer, it was the same thing. But my health just kept declining and the doctor took me off work."

Unable to pay her rent, she was evicted from her apartment and moved in with friends. Then HCHC intervened. The program paid her rent on the house where she now lives until she qualified for Social Security disability, helped her buy new furniture using federal funds and filed requests with pharmaceutical companies for free medications. "If it hadn't been for Tracy and her program, it's no telling what would have happened to me," Nance says.

Bringing diabetes under control

Fox estimates HCHC's approach has saved Harlan's Appalachian Regional Hospital at least a half a million dollars a year in non-compensated emergency room visits and other care. Though no countywide health statistics are available, both the Hazard and Harlan clinics also report that they have brought their 2,500 patients' diabetes indicators down to very near the national norms.

Even so, that kind of success hasn't ensured that organizations like HCHC and Perry County Community Ministries would find secure funding. HCHC, which won national acclaim for its community-driven approach, was funded as a model research program through the University of Kentucky's Center for Rural Health. But the flow of dollars ended when the study was finished, which meant that Fox and her colleagues had to scramble to keep the program alive.

Currently, HCHC's services result from a collaboration: Fox and Hazard's Gerry Roll sat down to look at how they could gain access to longer-term state and federal support by joining forces. They creatively applied for money from a variety of sources – and even enlisted a Rotary Club's help.

The programs they run are the sort that former federal rural health advisor Forest Callico says will be essential to any national reform effort that takes actual care seriously. "The debate about health care transformation has always started with the assumption that it's all about the money. I think that people in my profession abdicated leadership in health care a long, long time ago to the economists and the attorneys," he says.

Financing alone will solve few of the problems of rural or urban health care, Callico says. He argues that the community initiatives stitched together like those in Harlan and Perry Counties provide solid bottom-up models for a profound shift in the overall health policy debate. "We can figure out from people who know each other saying, here's how we can make these moving parts actually work together in a systemic way."



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