

Fall 10-1-2016

A CASE STUDY OF INDIVIDUAL AND ORGANIZATIONAL STAKEHOLDER PERSPECTIVES ON STATE FACTORS IMPACTING ACCESS TO RURAL HEALTH CARE SERVICES IN IDAHO

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**A CASE STUDY OF INDIVIDUAL AND ORGANIZATIONAL STAKEHOLDER
PERSPECTIVES ON STATE FACTORS IMPACTING ACCESS TO RURAL
HEALTH CARE SERVICES IN IDAHO**

BY

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DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

Doctor of Philosophy

Nursing

The University of New Mexico
Albuquerque, New Mexico

December, 2016

ACKNOWLEDGMENTS

First and foremost, I would like to acknowledge Dr. Dorinda Welle, my dissertation committee chair. Dr. Welle was incredibly encouraging and informative and I will be forever grateful for her guidance throughout this journey. She always seemed to sense when I was about at my wit's end and would send a reassuring e-mail accompanied by a picture of a beautiful chicken, just what I needed to make me smile and continue my efforts. Thank you, Dr. Welle, for everything.

I also wish to acknowledge the other members of my committee, Dr. Nancy Ridenour, Dr. Shana Judge, and Dr. Keith Mueller. All of them provided very thoughtful assistance and support. I feel very fortunate to have worked with such a group of inspiring scholars. Former committee chair, Dr. Sally Cohen, was also a huge part of this project and I am grateful for her mentoring and friendship.

Lastly, I would like to thank my family, without whom none of this would have been possible. My parents instilled in me an appreciation for life-long learning. I was very fortunate to have such loving parents who made me feel as if I could accomplish anything I set out to do. My husband, Jeff Prengaman, never once complained about all the time I spent looking at the computer instead of him. Without his unwavering love and support I am certain I would never have undertaken or completed this study. I hope that my sons, Matt and Joe, have learned from watching this process that anything is possible if you continue to persevere; even if it does take much longer than anticipated. My grandson, Tyson, has inspired me every day throughout this process and is due a lot of grandma time. I love you all. Thank you for supporting me throughout this long journey.

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ABSTRACT

The purpose of this case study was to describe individual and organizational perspectives on the state factors and political context impacting access to rural health care services in Idaho. Approximately 50 million Americans, roughly 20% of the United States population, live in rural areas (U.S. Census Bureau, 2012). For over 100 years, U.S. rural residents have experienced health disparities and health care access barriers (De Alessi & Pam, 2011). Rural residents evidence greater health risks, fewer health care providers, poorer health outcomes, and greater mortality than most urban residents (Jones, Parker,

Ahearn, Mishra, & Variyam, 2009). Since many rural health care policies are implemented at the state level, state-level factors, such as health care delivery systems and the political context of health care, influence policy outcomes and rural health care access (Gray & Hanson, 2004; Jacobs & Callaghan, 2013). Although state-level rural health care access barriers are well documented, these have not been studied qualitatively in relation to state political context.

This case study employed narrative and thematic analyses to identify state-level factors and the political context that diverse stakeholders and interest groups perceive to impact rural health care access in Idaho. The study was developed from the analysis of twenty stakeholder interview transcripts and seven stakeholder group websites and the documents made publicly available on these websites. Stakeholders identified six state factors significantly impacting access to health care services in rural Idaho: the economy, rural/frontier geographic features, rural patient population, rural health care system, interest groups/policy voices, and the primary care provider shortage. Surprisingly, stakeholders only noted physicians as a solution to the workforce shortage, failing to mention nurse practitioners. Interest group websites and their associated documents illuminated four state factors related to the political context in Idaho: a narrative of state sovereignty, a narrative of medical sovereignty, the financial viability of health care in Idaho, and relationships of dependence and competition among key stakeholders. This case study poses questions to the profession of nursing about its priorities in developing an independent, compelling narrative to advance access to rural health care in and beyond Idaho.

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CHAPTER 1

Introduction

This chapter introduces the dissertation study. It starts with the “Statement of the Problem” and continues with further elaboration of the problem by reviewing rural health demographics, characteristics and related health outcomes, and the Affordable Care Act’s (ACA’s) potential impact on rural health care. It concludes with the research questions that this study addresses.

Statement of the Problem

According to the 2010 U.S. census, 50 million Americans live in rural areas (U.S. Census Bureau, 2012). If they were to form their own nation, the population would be greater than 90% of the world’s nations’ populations (United Health, 2011). In 1908, President Theodore Roosevelt formed the Country Life Commission to examine why rural America was socially, intellectually, and economically lagging behind urban America (De Alessi & Pam, 2011). “Health in the open country” was identified as one of the “deficiencies of country life” with differential access, numbers of physicians per capita, and costs of rural health care identified as concerns (De Alessi & Pam, 2011). Over 105 years later, all of these issues persist.

One of the first difficulties encountered when examining rural health issues is determining exactly what is rural. The U.S. Department of Health and Human Services (DHHS) reports that there are two major definitions of rural used by the Federal government (DHHS, 2013). The first, developed by the Census Bureau, identifies urbanized areas (UAs) as those with populations of 50,000 or more and urban clusters (UCs) as those with populations of between 2,500 and 50,000. Any area not designated as

UA or UC is considered rural (U.S. DHHS, 2013). The federal Office of Management and Budget (OMB) follows county boundaries and makes designations of metropolitan or micropolitan (OMB, 2013). Counties containing at least one city with a population of 50,000 or more are deemed metropolitan while counties with city populations between 10,000 and 50,000 are designated micropolitan; any counties with city populations outside of those ranges are considered rural (OMB, 2013). The U.S. Department of Agriculture uses a third classification system consisting of rural-urban continuum (RUC) codes which are based on counties' size, degree of urbanization, or proximity to metropolitan areas (USDA, 2013a). In addition, there are rural-urban commuting area (RUCA) codes that are increasingly used to identify rural and urban areas. RUCA codes combine the Census Bureau's definitions and commuting information to designate census tracts as urban or rural (Rural Assistance Center, 2013). These classification systems, along with a host of others, are used throughout the literature regarding rural topics. Many researchers fail to identify which definition of rural they use. The use of different rural designations can impact research, policy, and funding results (Hart, Salsberg, Phillips, & Lishner, 2002). For this study I purposely did not select one definition, choosing instead to allow participants to use their own definition of rural.

Rural populations have historically experienced disparities in access to health care services compared to those in other locales. Rural residents' high rates of poverty and uninsured status, combined with shortages of health care professionals and facilities, contribute to these disparities (Bailey, 2009; Bennett, Olatosi, & Probst, 2008). Rural residents typically pay more out of pocket for their health insurance and care than their urban counterparts (Ziller & Lenardson, 2009). Due to a low overall volume and a high

rate of under or uninsured patients, many rural hospitals and health care professionals struggle to remain financially viable (Coyne, Fry, Murphy, Smith, & Short, 2012; Holmes & Pink, 2012). The recession that began in December 2007 has compounded the difficulties experienced by rural residents, hospitals, and health care professionals (NBC News, 2008).

The ACA will increase the number of people with health insurance. By 2019 approximately 8 million additional rural residents are expected to be insured through Medicaid and state insurance exchange plans (United Health, 2011). From September 2013 to February 2015, even with 22 states not having expanded Medicaid, 6.5 million Americans who were previously uninsured became insured through Medicaid (Rand Corporation, 2015). The increase in insured residents may create a particular challenge in rural areas where there are fewer health care professionals available to address the heightened demand for health care services. In addition to increasing the number of people with health care insurance, the ACA also calls for more effective, coordinated, and prevention-based health care (Semansky, Willging, Ley & Rylko-Bauer, 2012). Rural practice characteristics, small patient volumes, and high unit costs may make health care system changes more difficult in rural settings (MacKinney, Mueller, & McBride, 2011).

Building on these themes, recent evidence reveals that where people live has a great impact on the health care they receive (Goodman, Brownlee, Chang, & Fisher, 2010). Rural residents have greater health risks, fewer health care providers, poorer health outcomes, and greater mortality than their urban counterparts (Bailey, 2009; Jones, Parker, Ahearn, Mishra, & Variyam, 2009; United Health, 2011). Rural residents also make less money, are less educated, and are more likely to be uninsured than urban

residents (Jones, Parker, Ahearn, Mishra, & Variyam, 2009; Kaiser Family Foundation, 2012b; Lenardson, Ziller, Coburn, & Anderson, 2009; National Rural Health Association [NRHA], 2010; United Health, 2011).

The majority of the literature pertaining to rural health compares health outcomes or determinants between rural and urban settings. While we know that rural areas are demonstrated to generally have poorer health outcomes when compared to urban areas, we also know that rural areas are not monolithic, as noted in the paucity of literature that describes intrarural variances (James, 2014). There is extensive literature that documents variations between U.S. geographic regions in health care service provision, determinants of health, health care professional distribution, and health outcomes (Cullen, Cummins, & Fuchs, 2012; Des Jarlais, Nugent, Solberg, Feelemyer, Mermin, & Holtzman, 2015; Gessert, Haller, & Johnson, 2013; McDonald, Carlson, & Izrael, 2012; Rosenkrantz, Hughes, & Duszak, 2015; Sargen, Hoffstad, Wiebe, & Margolis, 2012; Semrad, Tancredi, Baldwin, Green, & Fenton, 2011). Rural areas are dispersed throughout the geographic regions in the U.S. in which the variations are demonstrated, further supporting that all rural areas do not share the same health care challenges.

Implementation of the ACA has the potential to improve access to care for rural residents. Yet, addressing the challenges of access to care in rural areas entails more than enacting a new law. Issues of rural access to care are multifaceted and encompass political, social, and economic aspects of rural life. Moreover, factors that affect access to rural health care services will vary in each state. This includes, but is not limited to: political culture, partisanship, employers who offer insurance coverage, supply of health care personnel, the medical profession's influence, social determinants of health, and

scope-of-practice laws and regulations for nurses and others on the frontlines of care in rural areas. Much of the analyses of state factors are largely quantitative and rely on surveys of state officials or state-level data. How stakeholders identify relevant state factors, or how they understand the impact of or address state factors does not appear to be addressed. Further exploration of these factors may inform potential solutions.

In summary, ongoing economic challenges, persistent shortages of health care professionals, a pending influx of newly insured individuals and families, a transitioning health care system with states responsible for implementing many provisions in the ACA, and variation among states in the many political, health care system, socioeconomic, and policy factors all affect access to care. Thus, this is a critical time to study the factors that impede and facilitate access to rural health care services.

Rural Health Characteristics and Related Outcomes

Life in rural areas can present many health challenges. Among them are high rates of certain conditions including poverty, lack of health insurance due to the economic structure of most rural locales, and shortages of health care personnel. These challenges can result in poor health outcomes and steep health care costs for individuals, employers, and the government (Bailey, 2009; NRHA, 2007).

Morbidity and Mortality

Rural populations experience significant health disparities. Diabetes, heart disease, cancer and stroke are responsible for 75% of all health care spending, and rural residents experience higher rates of these diseases than the general population (Bailey, 2009; NRHA, 2007; NRHA, 2010; Pam, 2012). They also suffer higher rates of arthritis, asthma, dental problems, obesity, and mental health disorders than their urban

counterparts (Bailey, 2009; Bennett, Olatosi, & Probst, 2008; Jones, Parker, Ahearn, Mishra, & Variyam, 2009; Kaplan, Brown, Andrilla & Hart, 2009; NRHA, 2007; United Health, 2011). Rural residents have more chronic conditions and poorer overall health than urban residents. (Bennett, Olatosi, & Probst, 2008; NRHA, 2007; United Health, 2011).

Rural adults are more likely to smoke, be physically inactive, have poor nutrition, and abuse alcohol or other substances than urban adults (Jones, Parker, Ahearn, Mishra, & Variyam, 2009; Kaplan, Brown, Andrilla & Hart, 2009; Pam, 2012; United Health, 2011). In addition, rural youth have higher incidences of tobacco and alcohol use than urban youth (Bailey, 2009; Bennett, Olatosi, & Probst, 2008; NRHA, 2007; United Health, 2011).

Mortality gaps exist between rural and urban populations (James, 2014; Jones, Parker, Ahearn, Mishra, & Variyam, 2009). In the 19th and early 20th century, urban residents experienced greater mortality than their rural counterparts (James, 2014). This was generally attributed to poor sanitation and close living quarters in urban settings. Public health advancements contributed to extensive improvements in urban health between 1900 and 1940, resulting in roughly equal mortality rates for urban and rural populations (James, 2014). Recent literature demonstrates lower life expectancies among rural residents compared to those for urban residents, with the disparities widening over forty years (Singh & Siahpush, 2014).

Rural residents are at significantly greater risk of death from gunshot, unintentional injuries, diabetes, and suicide than their urban counterparts (Kaplan, Brown, Andrilla & Hart, 2009; NRHA, 2007; United Health, 2011). Higher fatality rates

in rural areas for infants, young adults, middle-aged adults, and victims of motor vehicle accidents than rates for their urban counterparts serve as stark evidence that living in a rural area places certain people's lives at risk (Johnson, 2006a; Kaplan, Brown, Andrilla & Hart, 2009). Evidence regarding the quality of care in rural versus urban locales is mixed and difficult to assess due to the use of varying quality measures and potential confounding factors (James, Li, & Ward, 2007; NRHA, 2007; United Health, 2011; Vartak, Ward, & Vaughn, 2010).

Poverty

The U.S. Secretary of the Department of Health and Human Services (DHHS) is required to update the federal poverty guidelines at least annually. U.S. poverty guidelines are used to determine eligibility for many federal programs. For 2013, the poverty guideline for all states, except Alaska and Hawaii, is an annual income of \$23,550 for a family of four (DHHS, 2013b).

Proportionately more rural residents live below the poverty level than those in urban areas (NRHA, 2007). Because of lower incomes, rural families pay a higher percentage of their household income for health care than do urban families (Jones, Parker, Ahearn, Mishra, & Variyam, 2009). Rural residents in all age groups have higher rates of poverty than those who live in urban areas (Johnson, 2006). In 2012, the poverty rate for children in rural America was 18% compared to 13% for children in urban America (Voices for America's Children, 2013). Rural child poverty rates are higher than those for every racial and ethnic group of urban children (Johnson, 2006). Rising costs to patients make poverty a significant factor when considering access to health care services.

Insurance Coverage

Having health insurance is an important factor in accessing health care. Uninsured people have poorer health outcomes and higher mortality than those with coverage (Institute of Medicine, 2009; Kaiser Commission, 2012b). Rural residents are more apt to be uninsured than urban residents (Kaiser Family Foundation, 2012b; Lenardson, Ziller, Coburn, & Anderson, 2009; NRHA, 2010; United Health, 2011).

Underinsured individuals frequently suffer the same financial barriers in accessing health care as the uninsured (Ziller & Lenardson, 2009). Many rural workers are employed in low-skilled service jobs, work for small businesses, are self-employed, work part time, or are seasonal employees and are thus less likely to have insurance available through their employment (Bailey, 2009; NRHA, 2010; United Health, 2011). More rural residents purchase individual insurance policies than do their urban counterparts. Such policies tend to be expensive and lack coverage for many services. Rural residents are also more apt to be underinsured, with high costs for health care to income ratios (Ziller & Lenardson, 2009).

Proportionately more rural than urban residents are covered by public health assistance programs and their numbers continue to grow (Bailey, 2009; Burman, Mawhorter, & Vanden Heede, 2006; United Health, 2011). Since 1987 the number of rural residents under age 65 dependent upon public health assistance programs for access to health care increased by over 120% (Bailey, 2009).

Having insurance, however, does not guarantee access to care, especially in rural areas. Other barriers to care, such as shortages of primary care practitioners, specialists,

pharmacists, dentists, nurses, mental health professionals, as well as insufficient public transportation, and a lack of hospitals and clinics result in many insured individuals being unable to access needed services and care (Aylward, et al., 2012; Bailey, 2009; Chan, Hart, & Goodman, 2006; United Health, 2011).

Access to Health Professionals

Rural and urban areas have different challenges regarding the health care workforce. Rural residents are often concerned about lack of access to a full range of health care services and availability of any health care facilities or practitioners (Johnson, 2006a). Rural residents are also more likely to be underserved and have difficulty accessing needed treatment than urban residents. Moreover, access to health care resources declines as population density declines and geographic isolation increases (Aylward, et al., 2012; Jones, Parker, Ahearn, Mishra, & Variyam, 2009).

Rural residents face shortages of primary care providers and specialists including pharmacists, dentists, mental health professionals, and nurses (Aylward, et al., 2012; Bailey, 2009; United Health, 2011). Rural residents typically must travel further than their urban counterparts to access care, particularly for specialty care (Chan, Hart, & Goodman, 2006). The average number of miles a rural resident has to travel to receive specialty care is 60 miles (United Health, 2011). The rural ratio of primary care physicians per 100,000 is less than half that of urban areas (Sanders, 2013; United Health, 2011). These ratios are not anticipated to improve as only 3% of recent medical students planned to practice in rural areas and only 2% plan to go into primary care (Bailey, 2009). The rural ratio of registered nurses per 100,000 is less, at 852.7, than the urban ratio at 934.8 (HRSA, 2013). Nursing vacancies in rural hospitals are more

common and can take up to 60% longer to fill than nursing vacancies in urban hospitals (Fitzgerald & Townsend, 2012; Skillman, Palazzo, Keepnews, & Hart, 2006; Sullivan Havens, Warshawsky, & Vasey, 2012). In an effort to improve access to health care providers there are several federally funded programs that provide monetary incentives, often in the form of student loan repayment, to health care providers who are willing to practice in rural or underserved areas (Idaho Department of Health and Welfare, nd.).

The Affordable Care Act's Potential Impact on Rural Health

The U.S. health care system is currently undergoing great change. With the 2010 enactment of the ACA and the 2012 and 2015 Supreme Court rulings upholding the individual mandate and subsidies, approximately 28 million more Americans are expected to be insured when the law is fully implemented than in 2010 (Buettgens, Holahan, & Carroll, 2011; U.S. Department of Health & Human Services, 2013a). Recent reports estimate 20 million people have obtained health insurance due to the ACA thus far (U.S. Department of Health & Human Services, 2016). Having health insurance does not guarantee access to health care, therefore, as state policymakers implement the ACA's provisions for expanded health insurance coverage, they also face the question of how to provide quality health care to the many newly insured. This may be particularly challenging in rural areas that already face unique difficulties with access to health care.

More extensive use of non-physician health care professionals, such as advanced practice nurses (APRNs), may help to adequately meet the increased demand for health care services (Cassidy, 2012). APRNs are registered nurses with masters or doctoral nursing education, state licensure, and national certification in a specific aspect of care. APRNs practice as nurse practitioners (NPs), certified nurse midwives (CNMs), and

certified registered nurse anesthetists (CRNAs). They are educated to assess, diagnose, and manage patient problems, order tests, and prescribe medications (National Council of State Boards of Nursing, 2008). The medical profession, by leveraging its professional sovereignty, has played a role in limiting APRNs' ability, despite their education, to function as independent providers (Starr, 1982). The ACA, by increasing the number of insured individuals and thus creating increased demand for providers, may facilitate greater use of APRNs, however the success of this effort may depend not just on favorable Nurse Practice Acts, but on APRNs' political voice (American Association of Nurse Practitioners, nd).

The Institute of Medicine, in its landmark 2011 report, *The Future of Nursing: Leading Change, Advancing Health*, recommended that, as part of an effort to adequately meet the increased demand for health care, all nurses should practice to the full extent of their training and education (IOM, 2011). State legislation and regulations regarding advanced practice nurse scope-of-practice and reimbursement vary widely from state to state and even within states (Cassidy, 2012). In some states APRNs are permitted to practice independently, while in other states, or geographic areas of states, APRNs are required to be supervised by a physician or are not allowed to prescribe medications (Safriet, 2011). State payment policies regarding reimbursement differ across practice locations and insurance payers. APRNs may be reimbursed at 65%, 75%, or 85% of physician rates for the same care by Medicaid, Medicare, or other payers depending upon state-level reimbursement policies (Safriet, 2011).

Medicaid is the largest component of state spending and continues to grow. It accounted for 22% of total state expenditures in 2010, 23.7% in 2011, and 23.9% in 2012

(National Association of State Budget Officers, 2013). In fiscal year 2015, Medicaid accounted for 27.4% of all state spending when including federal funds, but remained stable at 15.8% of state only funds (National Association of State Budget Officers, 2015). Even without Medicaid expansion, due to other provisions of the ACA, by 2022 Medicaid coverage is anticipated to increase by 5.7 million people compared to projected levels of enrollment without the ACA (Holahan, Buettgens, Carroll, & Dorn, 2012). For many newly insured individuals, health care costs will decrease as their entire health care costs will no longer be “out of pocket” expenses, insurance companies’ rating practices will be regulated, limits on annual or lifetime benefits will be prohibited, and consumer cost sharing will be capped (DHHS, 2012).

An aspect of the ACA aimed at reducing health care expenditures is its emphasis on primary and preventative care, with requirements for coverage of many preventative services. Many clinicians, public health officials, and other policymakers hope that, with greater numbers of Americans having health insurance, more will access primary care and preventive services, and fewer will use more expensive emergency room care, thus lowering health care costs for individuals, employers, and governmental programs (DHHS, 2012). Nonetheless, with fewer primary care providers per capita than urban areas, rural health care systems may have difficulty meeting any increased demand for primary care and preventive services.

Improvements in efficiency and care coordination are other key components of the ACA (Kaiser Family Foundation, 2013; MacKinney, Mueller, & McBride, 2011; Sanders, 2013). The ACA includes incentivized payment plans that encourage innovative health care system redesigns, such as accountable care organizations (ACO), to improve

health care quality and control health care spending (Coburn, Lundblad, MacKinney, McBride, & Mueller, 2010; Kaiser Family Foundation, 2013; MacKinney, Mueller, & McBride, 2011). Rural practice characteristics identified as unique challenges to ACO participation include low patient volumes, rural provider autonomy, historically efficient rural practice, lack of leadership experience, and regulatory barriers (MacKinney, Mueller, & McBride, 2011).

Each state is implementing the federally enacted ACA differently based upon political, socioeconomic, and health care system variances. State legislators and appointed officials are determining whether or not to adopt state run health insurance exchanges or default to a federally run exchange. They are also deciding whether or not to expand Medicaid. State-level implementation decisions impact a state's health care spending, the number of residents who acquire insurance, and, ultimately, access to health care. As of March, 2015, 29 states including the District of Columbia have implemented Medicaid expansion, 16 states are not proceeding with Medicaid expansion, and 6 states are still debating whether or not to move forward with the expansion (Kaiser Family Foundation, 2015). In states opting not to expand Medicaid nearly 4 million adults below 100% of the FPL are ineligible for subsidies (Kaiser Family Foundation, 2015).

Health policy analysts have extensively examined provisions of the ACA and its implementation (Bates, Blash, Chapman, Dower, & O'Neil, 2011; Carey, 2010; Cassidy, 2012; Center on Budget and Policy Priorities, 2012). In contrast, less is known about how implementation varies across states, the broad range of factors that affect each state's politics and policies of ACA implementation, and what this state variation may mean for

rural health care access. An in-depth analysis of state-level factors affecting health care reform and its implementation could provide insight into how the new law may affect access to care for rural residents, many of whom struggle with accessing care.

Conclusion

Rural residents often experience significant health disparities and access challenges that are different than those urban residents encounter. The challenges that rural life present in accessing health care can result in poor health outcomes and high health care costs for patients, employers, and government programs. In addition to the ongoing difficulties with access, rural populations and state health policymakers now face the challenges of health care reform.

Along with the challenges of implementing health care reform come great opportunities. As state policymakers, practitioners, and health care providers implement the ACA, state-level policies have the potential to improve rural health care access. But it is unclear how a given state's political, health care delivery system, and socioeconomic factors might impact rural health care access. Analyzing these factors and their relationships to each other in a specific state may be useful to policymakers and practitioners who have long strived to improve rural access to care. It might also illuminate potential policy solutions for other states. Such knowledge is especially important at this critical period of health policy when states are being given considerable responsibility for ACA implementation.

Research Questions

The purpose of this study is to explore the politics of policymaking and the state factors that affect access to rural health care services as state and federal authorities,

employers, and clinicians launch full implementation of the ACA. Findings from this study address the following questions:

- 1) How do policy stakeholders describe the politics of policymaking for access to rural health care services?
- 2) How do state factors, such as health care delivery systems, and political and socioeconomic issues, affect access to rural health care services?

Rural health care access has been an ongoing concern in the United States for over 100 years (DeAlessi & Pam, 2011). Many rural health care access policies are implemented at the state level. State-level factors, such as health care delivery systems, and political and socioeconomic issues, influence policy outcomes and, potentially, rural health care access (Gray & Hanson, 2004; Jacobs & Callaghan, 2013). Insight into stakeholder, organizational, and governmental perspectives on these factors may illuminate potential policy solutions to the longstanding issue of rural health care access. Such knowledge is particularly crucial during ACA implementation as states face great opportunities and significant challenges.

CHAPTER 2

Review of the Literature

This chapter provides an explanation of the framework that guided this study and a review of pertinent literature. Specifically, it discusses the Framework for Applying Health Services Research in Evaluating Health Policy (Aday, Begley, Lairson, and Balkrishnan, 2004) and the literature regarding state-level socioeconomic; health care delivery systems, including availability, access, quality, organization, nursing, and financing; and political factors that may influence state-level health policies and access to rural health care. This chapter concludes with identification of the gaps in knowledge that this study addresses and how such knowledge might illuminate policy solutions for improving access to rural health care.

Framework

The Framework for Applying Health Services Research in Evaluating Health Policy is a comprehensive model used in assessing health policy variances (Aday, Begley, Lairson, and Balkrishnan, 2004). The framework applies the criteria of effectiveness, efficiency, and equity to the evaluation of structure, process, and outcomes components of health policy. The framework also acknowledges the relationships among individual and social determinants of health.

Structure, as identified in the framework, includes the availability, organization and financing of health care. The population being served and its physical, social, and economic environments are also included under structure. Process is described as the interactions among patients and providers during health care, as well as the interactions between patients and environmental and behavioral variables that contribute to health

risks. Outcomes are identified in the framework as the health and well-being of patients and populations that result from health policies. Horizontal and vertical arrows throughout the framework demonstrate the interactive relationships between structure, process and outcomes and their components (Aday, Begley, Lairson, & Balkrishnan, 2004; see Appendix A).

The framework is designed for application at both the micro and or macro levels. Micro refers to the clinical level while macro refers to the population level. The definitions of effectiveness, efficiency and equity differ depending upon the level of application. At the macro, population level, effectiveness is defined as “improving the health of populations and communities through medical and/or nonmedical services” (Aday, Begley, Larison, & Balkrishnan, 2004. p.17). Efficiency at the macro level is defined as “combining inputs to produce maximum health improvements given available resources” (Aday, Begley, Larison, & Balkrishnan, 2004. p.17). Equity at the macro level is defined as “minimizing the disparities in the distribution of health across groups” (Aday, Begley, Lairson, & Balkrishnan, 2004. p.17).

This framework has been used in health services research and policy analysis for evaluation of community child health services, health needs of homeless populations, and mental health services, among other issues (Davidson, Anderson, Wyn, & Brown, 2004; Halfon & Hochstein, 2002; Morgan, et al., 2009). The Institute of Medicine has also used the framework in several of its health policy research projects (Institute of Medicine, 2002a, 2002b, 2003a, 2003b). Aday and her colleagues developed this framework to discover and explore relevant health policy factors and the relationships between those factors that may impact the health of individuals and populations (Aday, Begley, Larison,

& Balkrishnan, 2004). The framework can be applied to health policy analysis and exploration of potential impacts at the federal, state, or local levels. A concern with conceptual frameworks is that they may limit inductive exploration of a phenomenon of interest (Baxter & Jack, 2008). Because this study uses a case study strategy, where an inductive approach is desired, the framework is employed as a general guide for design, and not for prescriptive category determination or analysis.

Socioeconomic factors

Socioeconomic factors may influence state-level health policies and access to rural health care. Socioeconomic factors are included in the Aday framework under the environment category. Socioeconomic factors that affect states' public policies include population size and composition, migration and urbanization, physical characteristics including natural resources, state economic activities, and wealth (Gray & Hanson, 2004). Many rural areas demonstrate unique socioeconomic characteristics which may influence state-level policy and access to health care.

A state's population characteristics partly determine policies. With the size of populations in some densely populated states equaling the size of many nations, their policies must allow for grand scale policies in domains such as education, transportation, housing, and health. Other states, including many rural ones, are large in size with small and dispersed populations. These states may incur much greater costs per capita for infrastructures such as highways. Changes in a state's population can also impact public policies. A rapid influx of residents may strain educational or housing resources while a decrease in population will result in lower tax revenue. Thus, a state's population size, distribution, and growth impact its policies (Gray & Hanson, 2004).

Sections of rural areas are growing, particularly those close to an urban or micropolitan center. Historically, rural areas' growth was tied to a higher birthrate. Rural birthrates are no longer statistically higher than urban birthrates (Johnson, 2006b). Improved technology and infrastructure have made rural communities more accessible to businesses and families. Employers are drawn to the lower labor, land, and housing costs. Rural areas where recreation, retirement and service industries dominate are growing while those where farming dominates are stagnant or shrinking (Johnson, 2006b). The overall result of changes in the rural demographics has been a rural population that consists of more elderly, minority, and unemployed individuals (Sharp, 2010).

Composition of states' populations vary widely and impact public policies. States with high percentages of elderly or very young may have greater demand for public policy providing services for those groups. States with large numbers of residents at or below poverty level have a greater strain on their social programs. The numbers of immigrants or minorities residing in a state may also impact public policy. Diverse populations may have differing opinions regarding public policy and, depending upon how politically active these groups are, may influence policy makers' actions (Gray & Hanson, 2004).

U.S. rural populations are becoming more diverse, especially as migrant farm workers relocate to the Midwest and northern states (National Center for Farmworker Health, 2013). Although the U.S. rural population is 64% White non-Hispanic compared to 78% of the urban population, the Hispanic population growth in rural areas is the fastest growing of any racial or ethnic group (Housing Assistance Council, 2012). The western immigration stream, which flows into the western U.S. from the south, is the

most heavily used (National Center for Farmworker Health, 2013). African American and Native American rural populations are also gradually increasing. Immigration has accounted for 31% of the rural population growth since 1990 (Johnson, 2006b).

Despite the increasing racial and ethnic heterogeneity of rural areas in population demographics and economic diversity, some long-standing rural population characteristics persist. Rural residents are older, less educated, and have lower incomes than the general population (Jones, Parker, Ahearn, Mishra, & Variyam, 2009). Rural populations still consist of more elderly and children than urban populations and greater numbers of people who are under and unemployed, uninsured, and poverty stricken than urban populations (Bailey, 2009; Hart, Salsberg, Phillips, & Lishner, 2002; Johnson, 2006; Koven & Mausoff, 2002; Mason, 2004; NRHA, 2007; O'Hare, 2009; Semansky, Willging, Ley, & Rylko-Bauer, 2012).

However, the intersection of racial and ethnic demographics and rural locale highlights important differences in health and health disparities in a state. There is very little research available that examines intrarural differences, however a couple of studies were identified that illuminated the complexities and variances among rural areas in the U.S. (James, 2014; Murray, Kulkarni, Michaud, Tomijima, Bulzacchelli, Iandiorio, & Ezzati, 2006). These studies demonstrate variances among rural populations and may provide insights regarding characteristics applicable to the rural state in which this study was completed, beyond those documented as generally existing in rural areas.

One study, published in 2006, split the entire U.S. population into eight groups, coined "eight Americas", based on county location, county per capita income, homicide rate, and population density (Murray, Kulkarni, Michaud, Tomijima, Bulzacchelli,

Iandiorio, & Ezzati, 2006). The “eight Americas” identified in the study, in order of life expectancy, are: Asian, northland low-income rural white, middle America, low-income whites in Appalachia and the Mississippi Valley, western Native American, black middle America, southern low-income rural black, and high-risk urban black. The gap in life expectancy between the Asians in “America 1” and the high-risk urban blacks in “America 8” was 20.7 years in 2001 (Murray, Kulkarni, Michaud, Tomijima, Bulzacchelli, Iandiorio, & Ezzati, 2006). Thus, the disparities in life expectancy are not tied directly to rural versus urban location. The largest contributors to mortality disparities across the “eight Americas” identified in the study were chronic diseases and injuries (Murray, Kulkarni, Michaud, Tomijima, Bulzacchelli, Iandiorio, & Ezzati, 2006). The majority of the residents in the rural state in which this case study was completed would fall within the northland low-income rural white category of “America 2”, which was found to have a comparatively long life expectancy (Murray, Kulkarni, Michaud, Tomijima, Bulzacchelli, Iandiorio, & Ezzati, 2006).

A more recent study examined U.S. mortality data from 1968 to 2007 (James, 2014). The study compared mortality between counties categorized according to the rural-urban continuum (RUC) codes, rather than simply urban versus rural (James, 2014). The RUC codes classify counties as metropolitan (RUC 1-3) or non-metropolitan (RUC 4-9), based on total population, and further distinguish non-metropolitan areas with similar populations as being adjacent (RUC 4, 6, and 8) to or not adjacent (RUC 5, 7, and 9) to a metropolitan area (U.S. Department of Agriculture, 2013). James compared the counties’ in each RUC code category for mortality disparities versus the urban rates and examined a multitude of variables for mortality predictability (James, 2014). The

mortality disparity was not found to be equally dispersed across all rural areas. Counties in the RUC 6 and RUC 7 categories, both with populations of less than 20,000, with RUC 6 being adjacent to a metropolitan area and RUC 7 not being adjacent, had the greatest and second greatest mortality disparities, respectively. RUC category 4 counties, adjacent to a metropolitan area, and RUC category 5 counties, not adjacent to a metropolitan area, both with populations greater than 20,000, had mortality rates better than the rural average (James, 2014). Perhaps most surprising, RUC category 9, containing the most remote rural counties of all, with fewer than 2,500 residents, had the smallest mortality disparity of all non-metropolitan county categories (James, 2014). James' study further identified significant differences in determinants of mortality across RUC categories and geographic regions. Poverty was the only variable that predicted mortality across all rural categories (James, 2014). In RUC 6 counties, over 50% of which were located in the South, race and poverty were found to be more significant predictors of mortality than in other categories, while health care utilization and infrastructure variables were less so (James, 2014).

Examination of RUC codes for Idaho's 44 counties revealed that the greatest number of Idaho counties, eleven, fall within the RUC category 6 (U.S. Department of Agriculture, 2013), the category with the greatest mortality disparity identified in James' study (James, 2014). The RUC categories 3, metropolitan, and 7, less than 20,000 people and not adjacent to a metropolitan area, each contain seven Idaho counties (U.S. Department of Agriculture, 2013). Furthermore, six Idaho counties fall within the RUC category 9, the most remote of rural categories.

Physical aspects of a state also impact its public policies. A state's physical location and geography impacts its access to natural resources. For example, states located in desert areas have greater needs for public policies addressing water access issues than those in coastal areas (Gray & Hanson, 2004). A state's physical characteristics also influence the cost of infrastructure such as roads and can impact where its residents reside (Gray & Hanson, 2004).

A state's location and size also influences its economy. Many states include recreational areas frequented by tourists, which boosts their services industry, but may strain their highway system. States may benefit from their location along an international border and reap enhanced international trade, while others suffer increased demand for public services from young migrant families. Such differences in location and size produce differences in public policy priorities among states (Gray & Hanson, 2004).

As rural recreational areas expand in number and population, the influx of people creates a strain on infrastructures, such as housing, transportation, and health care systems. These challenges are particularly significant in recreational areas where infrastructure systems must be capable of meeting the demands of seasonal peaks that are well beyond the area's baseline needs (Johnson, 2006b). Service level, seasonal and part-time work, which are prevalent in such rural recreational areas, also create economic challenges (Bailey, 2009; Johnson, 2006b; NRHA, 2010; United Health, 2011).

Individual wealth has a great impact on states' public policies. Those states with higher rates of individual wealth have a greater tax base with which to provide public services. Those with lower per capita incomes will have more demands for their public services yet fewer resources (Gray & Hanson, 2004). Corporate wealth may also impact

public policies. States compete for businesses, and their accompanying jobs and economic development, with favorable corporate tax rates. Since the 1980s corporate income tax has accounted for a decreasing percentage of states' general revenue while individual income tax has contributed a greater percentage. In 2002, corporate income tax contributed just over 3% of general revenue and individual income tax accounted for approximately 20% of general state revenues (Gray & Hanson, 2004). Debate remains over whether or not job creation and economic development offset corporate state tax breaks.

With populations consisting of more elderly, racial and ethnic minority, and unemployed individuals, declining economic activities, and shrinking individual wealth, rural poverty is an issue. Rural poverty rates are higher than urban rates for every age group (O'Hare, 2009). Rural residents have lower incomes and are more dependent on assistance programs such as food stamps, Medicaid, and Medicare (Jones, Parker, Ahearn, Mishra, & Variyam, 2009; Kaplan, Brown, Andrilla, & Hart, 2009; NRHA, 2007).

Farming is no longer the dominant rural industry; only 6.5% of the rural workforce is engaged in farming, while 12.4% is in manufacturing (Johnson, 2006b; Mason, 2004). However, recent globalization has detracted from rural manufacturing employment opportunities (Johnson, 2006). Much of the rural economy is tied to small business, self-employment and seasonal work which are typically low paying and less apt to offer insurance coverage (Bailey, 2009; Johnson, 2006b; NRHA, 2010; United Health, 2011).

Rural communities proximal to a metropolitan center or recreational area are experiencing population growth while more isolated rural communities are experiencing population decline (Johnson, 2006b; Sharp, 2010). Overall, rural populations are becoming more diverse, yet they still consist of more elderly and children, more under and unemployed, more uninsured, and more poverty-stricken individuals than urban populations (Bailey, 2009; Hart, Salsberg, Phillips, & Lishner, 2002; Johnson, 2006a; Jones, Parker, Ahearn, Mishra, & Variyam, 2009; Koven & Mausoff, 2002; Mason, 2004; NRHA, 2007; O'Hare, 2009; Semansky, Willging, Ley, & Rylko-Bauer, 2012). These socioeconomic factors experienced by many rural localities affect state-level health policy and may impact access to rural health care.

Health Care Delivery Systems Factors

Health care delivery systems factors may influence a given state's health policies and rural health care access. The Framework for Applying Health Services Research in Evaluating Health Policy identifies availability, organization, and financing as important health care delivery systems factors when evaluating health policy (Aday, Begley, Lairson, & Balkrishnan, 2004). In addition to the factors in the framework, this section covers access and quality, and a major component of the health care workforce for all these factors - nursing. Access, which differs from availability, incorporates those aspects beyond simple numbers of providers in a given area that may influence a population's ability to obtain health care. As discussed below, rural health care delivery systems pose specific challenges for access. Furthermore, nursing, a profession that comprises the greatest number of rural health care professionals (Fitzgerald & Townsend, 2012), figures

prominently in rural health care access. The factors may be interrelated and are not necessarily mutually exclusive.

Availability

Availability is usually defined by the number and distribution of health care clinicians, including general and specialty physicians, and nurses. Rural locations experience unique challenges because availability of all health care resources decline as geographic isolation increases and population density decreases (Aylward, et al., 2012).

Health Professional Shortage Areas (HPSAs) are more prevalent in rural than in urban areas (Bailey, 2009; NRHA, 2007; O'Hare, 2009; Semansky, Willging, Ley, & Rylko-Bauer, 2012). Over one-third of rural residents live in HPSAs and 82% of rural counties are designated as Medically Underserved Areas (MUAs) (Bailey, 2009).

HPSAs are determined by the U.S. Health Resources and Services Administration (HRSA) within DHHS, according to criteria originally set forth in the Public Health Service Act of 1980 (Center for Rural Health, 2013). HPSA designation is reserved for areas with a population-to-primary care physician ratio of greater than or equal to 3,500:1, or greater than 3,000:1 and an unusually high need for primary care services, as evidenced by greater than 100 births per 1,000 women per year or greater than 20% of area residents living below the federal poverty level (FPL) (Center for Rural Health, 2013). Rural and frontier locales have 2,157 HPSAs compared to 910 HPSAs in urban settings (NRHA, 2007).

MUAs are also determined by the HRSA. MUA designation is based on an Index of Medical Underservice (IMU) score of ≤ 62.0 (HRSA, nd). IMU scores are calculated by summing the percent of an area's population living below the poverty level, the

percent of an area's population aged 65 or over, the area's infant mortality rate, and the area's ratio of primary care physicians per thousand (HRSA, nd).

Primary care HPSA designations are based solely on physician numbers, which account for 25% of the calculation to determine MUA status. Yet, rural areas experience shortages of a wide array of health care and social service providers including nurse practitioners, pharmacists, physician assistants, dentists, registered nurses, social workers, and counselors (Bailey, 2009; Hart, Salsberg, Phillips, & Lishner, 2002; Semansky, Willging, Ley, & Rylko-Bauer, 2012). Dentists and mental health professionals are particularly scarce (NRHA, 2007; Semansky, Willging, Ley, & Rylko-Bauer, 2012). Small rural counties have one-sixth as many specialists per 100,000 residents as metropolitan counties (Johnson, 2006a). Only 9% of physicians practice in rural areas, where approximately 20% of the nation's population resides (Johnson, 2006a).

The distribution of registered nurses approximates that of the general U.S. population with just under 20% of registered nurses working in rural areas (HRSA, 2013). Likewise, the distribution of NPs in the U.S. mirrors the percent of U.S. population living in rural areas, with approximately 20% of nurse practitioners practicing in rural settings, a trend that has been slowly, but steadily increasing over the past 30 years (Aylward, et al., 2012; Bailey, 2009; Kaplan, Brown, Andrilla, & Hart, 2009; Presley, 2010).

The ACA requires new designation rules for both MUAs and HPSAs (Federal Register, 2013). What the new designation rules to be determined by HRSA will be and how they may affect access to rural health care remains to be seen. MUA and HPSA designations are intricate to eligibility for many funding sources and, thus, any changes in

how these designations are determined may potentially significantly alter rural health care access, structure, and financing (Center for Rural Health, 2013; NRHA, 2007).

Health care workforce supply data do not look promising for the near future. The largest age group of practicing registered nurses is 50 to 54 year olds with 45% of registered nurses 50 years of age or older (American Nurses Association, 2010). In addition, only 3% of medical students report that they intend to practice in a small town or rural location, many rural health care providers are nearing retirement age, and the ACA may further strain rural health care resources (Bailey, 2009; Semansky, Willging, Ley, & Rylko-Bauer, 2012).

Federal policies aimed at increasing the availability of health care professionals are under the jurisdiction of several federal agencies, especially HRSA, and have not been tailored to address rural health care system needs (HRSA, 2012). The majority of HRSA grants are only eligible to educational institutions or individual health care providers (HRSA, 2012). This requirement, coupled with decreasing interest in primary health care and rural placement, limits the application of these programs among many rural health care systems (HRSA, 2012; Rural Policy Research Institute, 2006). Recently, HRSA's Office of Rural Health Policy (ORHP) has worked under the "Improving Rural Health Care Initiative" to coordinate the HRSA programs to enhance their utilization among rural health care systems (HRSA, 2012).

The vast majority of literature regarding health care provider availability focuses on physicians. Paul Starr, winner of the 1984 Pulitzer Prize for general non-fiction, produced a comprehensive case study of the rise of the medical profession's authority and its impact. Since the early 1900s, the medical profession in the United States has

controlled the number of available health care providers via restrictive licensing laws and limited medical school seats. The medical profession, with its “professional sovereignty” established in the late 19th and early 20th centuries, has exhibited significant control over both the health care market and the various organizations that govern health care (Starr, 1982). The medical profession’s control waned somewhat since the 1980s with larger health care corporations and insurance companies’ widespread efforts to limit physician autonomy, often in the guise of taming health care costs. As the ACA is implemented, the medical profession’s authority may further be impacted, which may further impact the availability of health care providers. In spite of these more recent constraints on physician autonomy, medical sovereignty remains a political force with significant influence over the public’s understanding of health and health care (Starr 1982).

Rural populations experience more pronounced shortages of health care professionals than urban populations. Challenges experienced by rural health care systems include attracting health care professionals to practice where salaries are lower, demands may be greater, and opportunity for spousal employment and family education may be limited (HRSA, 2012). Decreased availability of health care professionals may impact rural health care access, particularly as demand for services rises with the ACA and aging baby boomers.

Access

Small rural and remote locales have access to a limited scope of services. Rural residents are forced to incur additional financial and travel time costs that may delay or prohibit access to care (Jones, Parker, Ahearn, Mishra, & Variyam, 2009). The travel time and financial costs associated with accessing health care providers can be significant

for rural patients (Lally, 2009). Those most particularly impacted are the elderly and poor. Such costs may cause patients to reduce their health care usage (Jones, Parker, Ahearn, Mishra, & Variyam, 2009). The delays associated with travel time are particularly problematic in an acute, urgent situation (Johnson, 2006a).

Among certain populations, rural and urban health care access is similar. Medicare beneficiaries' use of health care services, while varying significantly between regions, does not substantially differ between rural and urban locales. These similarities among rural and urban Medicare beneficiaries are found both in amount of service received and in satisfaction with access to care (Stensland, Akamigbo, Glass, & Zablinki, 2013). However, this parity is among Medicare beneficiaries and not necessarily present in the uninsured rural population.

Lack of insurance impacts health care access. There are higher rates of individuals lacking insurance in rural areas than in urban areas (Bailey, 2009; NRHA, 2007; O'Hare, 2009; Semansky, Willging, Ley, & Rylko-Bauer, 2012). The consequences of being uninsured are far reaching. Lack of health insurance is associated with higher mortality. Having insurance correlates with decreased emergency room visits and hospitalizations (Kaiser Commission, 2009; Kaiser Commission, 2012b). Hospitalizations for rural uninsured individuals are more apt to be for preventable conditions than hospitalizations for urban individuals who lack insurance (Zhang, Mueller, & Chen, 2008). Individuals who lack insurance suffer poorer health outcomes (IOM, 2009). Children without insurance are much less likely to have a regular care provider, receive well-child visits, or see a dentist than insured children (Kaiser Commission, 2009). When one or more family member lacks insurance the entire family's financial well being, health status, access to

and use of health services, and psycho-social stressors are all impacted (IOM, 2009). Health care professionals report that a patient's lack of insurance may alter their care (Burman, Mawhorter, & Vanden Heede, 2006). The ramifications go beyond those individuals who lack insurance; families, communities, providers, employers, and society at large are affected (Burman, Mawhorter, & Vanden Heede, 2006; IOM, 2009).

Scope-of-practice laws and regulations for non-physician providers also may affect access (American Nurses Association, 2010; Skillman, Kaplan, Fordyce, McMenamini, & Doescher, 2012). As discussed below in the section on political factors, states' practice and reimbursement regulations may impact access to health care, particularly in rural settings (National Nursing Centers Consortium [NNCC], 2011; Sanders, 2013; Skillman, Kaplan, Fordyce, McMenamini, P., & Doescher, 2012).

Rural residents are more apt than their urban counterparts to report that their access to health care is limited by costs they might have to incur (Jones, Parker, Ahearn, Mishra, & Variyam, 2009). Out of pocket costs, limited clinic hours, lack of transportation, privacy concerns, geographic distance, cultural practices, and complexity of the health care system are all barriers to accessing health care cited by rural residents (Johnson, 2006a; NRHA, 2007; Pieh-Holder, Callahan, & Young, 2012; Riddell, Ford-Gilboe, & Leipert, 2009).

Access to health care is typically measured by physician-to-population ratios (DeAlessi & Pam, 2011; IOM, 1993; Stensland, Akamigbo, Glass & Zabinski, 2013). These measurements are problematic for several reasons. Firstly, they address availability of physicians rather than access to care. Secondly, many rural health care providers are not physicians. Registered nurses, certified nurse midwives, nurse anesthetists,

pharmacists, and paramedics also provide care in rural settings. In 2011, nurse practitioners accounted for 19% of the primary care workforce, and were more apt to choose rural practice settings than physicians (Sanders, 2013). Twenty percent of NPs practice in a rural setting, which is more than double the percent of physicians who do so (Presley, 2010). Thirdly, an increase in physician numbers does not correlate with a more even dispersion of physicians or improved health outcomes (Mullan, 2013).

Multiple studies or reports identify dimensions of access, yet do not include a definition of access (Johnson, 2006; Mason, 2004; MedPac, 2003; MedPac, 2013; Pieh-Holder, Callahan, & Young, 2012). Some studies identify factors that affect access to health care, such as cost to patients, hours of operation, travel time, insurance coverage, disease prevalence, health literacy, cultural competence, and type and quality of service (Johnson, 2006a; Jones, Parker, Ahearn, Mishra, & Variyam, 2009; Kaiser Commission, 2012a; Mason, 2004; NRHA, 2010; Pieh-Holder, Callahan, & Young, 2012). The one explicit definition of access identified in the literature is from a 1993 Institute of Medicine (IOM) report on access in the United States in which access is defined as “the timely use of personal health services to achieve the best possible health outcomes” (IOM, 1993, p. 33). Over 20 years later, this definition is still useful.

The Rural Policy Research Institute (RUPRI) provides a comprehensive description, albeit not a definition, of rural access appropriate to the current health care reform context (RUPRI, 2012). RUPRI argues that the key aspects of rural accessibility should include primary care, emergency medical services, and public health (RUPRI, 2012). Their vision for true rural accessibility includes team-based care that encompasses

preventive services, provided as proximately as possible, but with regional coordination and portable health information (RUPRI, 2012).

Rural populations experience significant challenges to accessing health care. The ACA's emphasis on expanding insurance coverage, community-based prevention, wellness, public health, and improved quality may serve to address some rural access challenges (Pam, 2012). How state-level health care systems factors may influence rural health care access as health care reform is implemented remains to be seen.

Quality

In addition to availability and access, quality is another health care systems factor which figures prominently in rural health care access discussions. Rural health care may be of lower quality than that received in urban settings. Rural populations receive fewer preventive services, including blood pressure checks and cholesterol screenings than their urban counterparts, despite the fact that they are older (Bailey, 2009). They also have fewer routine physical exams and cancer screenings such as mammographies, colonoscopies, or Pap smears (Kaplan, Brown, Andrilla, & Hart, 2009; Ziller & Lenardson, 2009). It remains to be seen if increased insurance coverage will impact these disparities in care.

Rural patients suffering heart attacks or strokes have higher mortality rates than their urban counterparts (DeSai, Bekelis, Zhao, Ball, & Erkmen, 2013; NRHA, 2007). Rural locations experience higher fatality rates for infants, young adults, and middle aged adults (Johnson, 2006a). Rural veterans with HIV receive appropriate treatment in a less timely manner than their urban counterparts, and rural patients suffering from lung cancer undergo more invasive surgical treatment than urban patients with the same condition

(Ohl, et al., 2013; Stitzenberg, Shah, Snyder, & Scott, 2012). Rural locations have significantly fewer specialist physicians than urban areas (Johnson, 2006a). Less access to specialists may contribute to these differences.

Even when rural residents are able to access care, it may be of inadequate quality, however, research findings are mixed. For example, research reveals that Medicare patients suffering acute myocardial infarctions and receiving treatment in rural facilities are less likely to receive recommended treatments and are more apt to die within 30 days than those receiving treatment in urban facilities (NRHA, 2007). However, this increased mortality may be related to other factors and does not hold true in all rural locations as research demonstrates that, when controlling for confounding variables, mortality with myocardial infarctions in Iowa rural hospitals is not higher than that in urban hospitals (James, LI, & Ward, 2007).

In a 2010 study, CAHs were noted to have higher mortality rates, even when controlling for patient, community and hospital characteristics, than non-CAHs (Joynt, Orav, & Jha, 2013). However, these results were challenged by another study comparing small rural hospitals' patient safety outcomes with those of small urban hospitals, which revealed poorer outcomes among the small urban hospitals (Vartak, Ward, & Vaughn, 2010). While rural hospitals have made improvements in attending to community health needs, their collection, tracking, and communication of clinical and health information is not on par with that of urban hospitals (Zhang, Mueller, & Chen, 2009). A study performed by United Health, which examined 33 million opportunities for evidence-based care in approximately 300 hospital referral regions across the U.S., revealed that

rural area physicians' care quality scores were lower than urban area physicians' in 75% of hospital referral regions (United Health, 2011).

In summary, quality of rural health care may be unequal to that received in urban locations. Rural care is characterized by poorer health outcomes and less preventive care, however, there is conflicting evidence regarding overall quality comparisons (Joynt, Orav, & Jha, 2013; NRHA, 2007; United Health, 2011). Perhaps with further exploration, potential health policy solutions to these disparities could be identified.

Organization

Organization of health care delivery systems varies among states and may also impact rural health care access. The number and distribution of private and for-profit facilities, non-profit institutions, community health clinics, as well as managed care organizations (MCOs), accountable care organizations (ACOs), and insurance plans in a state may all influence state-level health policies and rural health care access.

The typical rural health care model is to provide primary and emergency care locally and refer to regional centers for specialty care (Jones, Parker, Ahearn, Mishra, & Variyam, 2009). Community health centers (CHCs) or rural health clinics (RHCs) and critical access hospitals (CAHs) typically serve as the cornerstones to rural health care organization (Holmes & Pink, 2011; Kaiser Commission, 2012a). CHCs and RHCs generally provide a large portion of the primary care and CAHs provide much of the emergency care (Holmes & Pink, 2011; Kaiser Commission, 2012a).

Community- based care takes place in settings such as schools, homes, stores or community centers, and is fundamental to improving access (IOM, 2011). Patients receiving community-based care can avoid the expenses and time requirements

associated with traveling to a practitioner or facility in a distant location, such as a major city. Community-based care traditionally focuses on primary care, including health promotion, education, and prevention (IOM, 2011). Community-based care improves population outcomes with programs as varied as the Visiting Nurse Service of New York (VNSNY), the U.S. Department of Veteran Affairs, and the Living Independently for Elders program (IOM, 2011). VNSNY has documented both social and health outcome improvements. The Department of Veteran Affairs' shift from acute care programs to community-based services significantly improved access for many veterans while lowering the cost per patient and improving health. The Living Independently for Elders program data reveals lower rates of falls, fewer pressure ulcers, decreased preventable hospitalizations and emergency room visits (IOM, 2011). Increasing community-based care is a key component of the ACA (DHHS, 2012).

Over 1,200 CHCs, also known as Federally Qualified Health Centers (FQHCs), exist nationwide and are located in all 50 states. Additionally, 8,000 CHC care delivery sites are located in medically underserved areas (MUAs), many of which are rural (Kaiser Commission, 2012a). Approximately half of CHC patients are rural residents (Sanders, 2013; United Health, 2011). In addition to MUA location requirements, CHCs must provide comprehensive primary care services, use a sliding fee scale, and have a governing board with a majority of patient members (Pieh-Holder, Callahan, & Young, 2012). Counties without a CHC have significantly higher rates of emergency room usage among the uninsured than counties with a CHC (Sanders, 2013).

Nearly 4,000 rural health clinics (RHCs) exist nationwide. They must be located in rural underserved areas and use at least one nurse practitioner or physician's assistant

as a provider (Rural Assistance Center, 2012). Unlike CHCs, RHCs are not required to care for the poor or uninsured, however, poor, uninsured, self-pay, and Medicaid patients made up 45% of their total volume in 2000 (Zhang, Mueller, Chen, & Conway, 2006).

Indian Health Services (IHS) facilities also provide primary care in some rural locations. There are 340 IHS clinics, approximately half of which are located in rural areas (United Health, 2011). The ACA includes a permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), a law initially enacted in 1976 but unfunded since 2000. Permanent authorization of the IHCIA provides for multiple health programs aimed at improving the health status of American Indians and Native Alaskans (IHS, 2010).

Local public health departments historically provided primary care in rural areas. Although public health department activities and funding vary widely across the country, budgetary cutbacks have resulted in very few providing primary care in rural areas. Most public health agencies are focused on providing services such as tracking reportable diseases, monitoring public water supplies, and inspecting restaurants (United Health, 2011). Whether or not this trend will reverse with ACA implementation, and public health agencies again become more involved in the direct administration of primary care, is as yet unknown.

There are more than 1,300 CAHs nationwide. Almost 80% of all small rural hospitals are CAHs (Holmes & Pink, 2011). CAHs are generally government- operated or private non-profit organizations. They must conform to limits on numbers of beds and average lengths of stay. They must also be located at least 35 miles from another hospital, or at least 15 miles over treacherous terrain or on secondary roads unless they were

designated by an approved state plan as essential (Holmes & Pink, 2011; Morrison, 2012). CAHs are vital to rural communities. In addition to providing needed medical services CAHs serve as important economic stimulators. They help attract retirees and businesses and are frequently the largest employer in a rural area (Coyne, Fry, Murphy, Smith, & Short, 2012).

In summary, rural health care delivery systems are generally organized differently than urban health care systems. Demographic, geographic, financial, and health care professional distribution factors shape the rural health care delivery system organization. Rural health care delivery systems may undergo changes in organization as the ACA is implemented. The influences these changes may have on access to health care in a rural state are unclear.

Nursing

Non-physicians play a significant role in provision of health care in rural areas and are commonly used by CHCs, IHS, and RHCs (Sanders, 2013). Nurses comprise the largest group of rural health care professionals and make up almost half of the health care workforce (Fitzgerald & Townsend, 2012). Rural areas' nurse shortages are even more acute than those in urban areas. Nursing vacancies in rural areas occur more frequently and traditionally take much longer to fill than those in urban areas. Rural areas also have lower nurse-to-population ratios (Fitzgerald & Townsend, 2012; Skillman, Palazzo, Keepnews, & Hart, 2006; Sullivan Havens, Warshawsky, & Vasey, 2012).

Rural nursing practice differs from that of urban nurses. In acute care facilities, rural nurses are often required to fill a variety of roles that in an urban setting are typically filled by other health care providers such as respiratory therapists or social

workers (Fitzgerald & Townsend, 2012). Unlike their urban counterparts, who typically specialize in one area of practice, rural nurses may practice in the emergency department, delivery room, and post operative unit (Fitzgerald & Townsend, 2012). Frequently, they perform their wider range of duties with little support and restricted resources (Place, MacLeod, John, Adamack, & Lindsey, 2012). Because rural hospitals employ a larger percentage of unlicensed patient care personnel than urban hospitals, registered nurses are often responsible for supervisory and administrative duties in addition to their patient care activities (Fitzgerald & Townsend, 2012).

Rural nurses practice in many settings other than acute care facilities including long term care facilities, home health, schools, public health departments, CHCs, and RHCs (Place, MacLeod, John, Adamack, & Lindsey, 2012). Nurses play a pivotal role in rural communities. With patients comprised of nurses' friends, neighbors, and colleagues they frequently play an integral role in the community and contribute significantly to rural social capital (Lauder, Reel, Farmer, & Griggs, 2006; Sullivan Havens, Warshawsky, & Vasey, 2012).

Advanced Practice Registered Nurses (APRNs) frequently practice in underserved areas (American Nurses Association, 2010) and are frequently used by safety net facilities such as CHCs and RHCs (Mullan, 2013). APRNs, such as nurse practitioners or certified nurse midwives, frequently serve as primary care providers in rural communities (NNCC, 2008). APRNs have been recognized as primary care providers under federal legislation since 1990, even though they have been a mainstay of care since the late 1970s (American Association of Nurse Practitioners, 2011). However, state governments determine Medicaid payment schedules for APRNs and many of them reimburse APRNs

at a lower rate than physicians and exclude APRNs from Medicaid managed care program provider panels (American Association of Nurse Practitioners, 2011). These disparities in reimbursement are in part a result of successful lobbying efforts by the American Medical Association, state-level physician groups, and other physician associations, and are not empirically justified (Naylor & Krutzman, 2010). Federal laws and states' variations in implementation of the laws regarding APRN reimbursement are complex and confusing and may be barriers to accessing care (American Nurses Association, 2011). Each year many patients go without health care because they cannot access a physician (American Nurses Association, 2011). This is particularly true for patients who lack insurance or have Medicaid coverage because increasing numbers of physicians are either refusing to treat them or are not located in the inner-city or rural communities where many of these patients live. APRNs traditionally treat patients other practitioners prefer not to, such as those with complex psycho-social difficulties, language or cultural differences, and chronic illnesses (American Nurses Association, 2010).

The distinctive aspects of rural nursing are documented throughout the literature (Fitzgerald & Townsend, 2012; Place, MacLeod, John, Adamack, & Lindsey, 2012; Sullivan Havens, Warshawsky, & Vasey, 2012). How recent health care reforms, especially those under the ACA, may influence rural nurse roles, and what impact any change in rural nurse roles may have on rural health care access is unknown.

Financing

Financing of health care varies greatly across states depending upon tax bases, population demographics, and rate of insured. These factors may also impact states' implementation of health policies and access to rural health care.

As previously discussed, rural populations have lower median incomes, which negatively impact a tax base (Bailey, 2009; Johnson, 2006a; NRHA, 2010; O'Hare, 2009; United Health, 2011). Rural population demographics such as high percentages of elderly and children, and more part-time, seasonal or self-employed individuals contribute to the fact that more rural individuals lack private health insurance and much of rural health is financed by Children's Health Insurance Program (CHIP), Medicaid and Medicare (Bailey, 2009; Johnson, 2006a; Kaiser Commission, 2012b; NRHA, 2010; O'Hare, 2009; United Health, 2011). Premiums for employer sponsored health insurance went up 97% between 2002 and 2012, 3 times as much as wages; those who do have private insurance are financing greater percentages of their health care costs (Kaiser Commission, 2012b).

Rural critical access hospitals (CAHs) qualify for special reimbursement at 101% of allowable Medicare costs (Holmes & Pink, 2011; United Health, 2011). Despite this preferential reimbursement, many rural hospitals continue to struggle financially due to low occupancy, high cost structure, and aging physical plants (Jones, Parker, Ahearn, Mishra, & Variyam, 2009; United Health, 2011). As recent unemployment rates rose, so did the burden of uncompensated care experienced by many CAHs (Coyne, Fry, Murphy, Smith, & Short, 2012). The June 2013 Medicare Payment Advisory Commission (Medpac) report reveals that some measures taken to contain Medicare costs adversely impact hospitals that provide services to low-income patients, such as CAHs (Medpac,

2013). Medicare and Medicaid provide approximately 60% of CAHs' revenue; therefore, any policy that lowers payments from either of those entities will significantly impact CAHs' bottom line (Bailey, 2009; Holmes & Pink, 2011). Recent evidence reveals that CAHs are undertaking financial improvement strategies that vary widely among facilities and between states (Holmes & Pink, 2011).

Community health clinics (CHCs) provide much of the non-urgent care in rural areas. CHCs rely heavily on public funding sources (Kaiser Commission, 2012a). Seventy-five percent of community health clinics' (CHC) patients lack insurance or are covered by Medicaid (Kaiser Commission, 2012a). Although CHCs receive significant revenues from Medicaid and public and private insurances, the majority of their funding comes from federal health center appropriations (Kaiser Commission, 2012a). The ACA included \$11 million in new funding aimed at expanding CHC capacity. However, with a greater than 25% cut in funding appropriations, the remaining monies were put toward existing CHC operations (Kaiser Commission, 2012a; Sanders, 2013).

Rural physicians receive 56% of their income from Medicare and Medicaid; more than urban physicians who report 45% of their income from those programs (United Health, 2011). States have flexibility on their payment models for RHCs and CHCs so policies impacting funding of those facilities and their providers vary greatly among states (HRSA, 2006).

Funding of health care provided by non-physicians varies widely between states, within a state depending upon the payer, and even among various federal agencies (American Nurses Association [ANA], 2010; HRSA, 2006; Safriet, 2011; Weiland, 2008). For example, nurse practitioners are eligible for the "Medicare Bonus" afforded

for primary care providers, but not for additional reimbursements provided to primary care providers through Medicaid (ANA, 2010). Insurer reimbursement policies vary widely. Thirty-three percent of HMOs and 40% of managed Medicaid companies recognize nurse practitioners as primary care providers. Of those, only 52% reimburse them at the same rate as physicians (Hansen-Turton, Ritter, Rothman, & Valdez, 2006). Forty one states are attempting various reforms of their CHIP and Medicaid payment models; some provide for nurse practitioner reimbursement while others do not (ANA, 2010).

The wide variation among state health care funding policies prompts confusion among patients and practitioners. Some practitioners and policymakers argue it is costly, both financially and in terms of access to care for many underserved populations, including rural. Barbara Safriet, renowned legal expert and contributor to the IOM's *The Future of Nursing: Leading Change, Advancing Health* report, which echoes many of the same concerns regarding the medical profession's dominance outlined by Starr over three decades ago, remarked in her analysis of the variations among advanced practice nurse regulations and reimbursement policies, "We all...pay a huge price for the consequences, measured in extra real dollars spent on health care, in lack of access to competent care..." and these policy variances are ultimately "exacerbating the current maldistribution and shortage of providers" (Safriet, 2011, p. 454).

In summary, financing of our nation's health care is undergoing transition with cost constraints and ACA implementation creating variation among state budget priorities and financial resources. Unique rural health care financing factors may further compound

health policies. The impact of these unique health care financing factors on access to rural health care is unknown.

Political Factors

Political factors, such as political culture, partisan control, gubernatorial power, and interest groups affect each step of the policy process, from agenda setting and policy formation through implementation and evaluation. Some of these factors play a role in influencing policies regarding access to rural health care. This section discusses federalism and political factors, their affect on state-level policies, and their potential impact on access to rural health care as the ACA is implemented.

Federalism

Federalism refers to the balance of power between various levels of government. First described in the *Federalist Papers* in 1787, James Madison wrote of the necessity for a balance of power that would enable the federal and state governments “to resist and frustrate the measures of each other” (Thompson & Fossett, 2008, p. 153). Federalism is a continually evolving concept. In the 1960’s described as a three-tiered cake with separate responsibilities and powers for the federal, state, and local governments, federalism, over the past several decades, has come to be more commonly viewed as a marble cake with responsibilities and powers for each level of government interspersed (Thompson & Fossett, 2008). As the ACA is implemented, the resistance and frustration identified by Madison is becoming increasingly apparent and intensified as some states make claims about their own sovereignty.

The ACA charges state governments with major roles in its implementation. Timothy Conlan and Paul Posner (2011) coined the term “hybrid federalism” in

describing health policy under the ACA as a combination of cooperative and coercive federalism (Conlan & Posner, 2011). Cooperative federalism refers to the various levels of government serving as partners and sharing responsibility for governance (U.S. Legal Definitions, 2013). An example related to the ACA would be the federal government enacting the law which allows state governments to establish and administrate the health insurance exchanges. Coercive federalism refers to the federal government imposing regulations that limit state governments' discretion regarding governance (Edwards & Lippucci, 1998). An example within the ACA is the ability for the federal government to establish and administer a health insurance exchange in any state that chooses not to establish one (Rigby & Haselwerdt, 2013). Many liberal-leaning state legislators and governors who support much of the ACA praise the flexibility afforded them while, in contrast, many conservative-leaning state legislators and governors see the ACA's directives as coercive.

Health insurance exchange implementation is a particularly poignant example of the struggles faced by state-level politicians who oppose the ACA yet support states' rights. Conservative legislators and governors are stuck between implementing a state-run health insurance exchange, a portion of the ACA that they ideologically oppose, and defaulting to a federal health insurance exchange, thereby granting the federal government greater control (Rigby & Haselwerdt, 2013). Although state legislatures technically lack the ability to nullify federal legislation, less explicit opposition has resulted in nullification-like results in the past, and may threaten to do so again (Rigby & Haselwerdt, 2013). Likewise, Medicaid expansion is proceeding in multiple states with

unified Republican governments, despite the fierce opposition to expansion among conservatives (Jacobs & Callaghan, 2013).

Opposition to the ACA is a battle being waged in large portion at the state level. Twenty-seven states filed legal action against the ACA, challenging its constitutionality (Heritage Foundation, 2011). Although the Supreme Court upheld the ACA individual mandate as constitutional many state-level politicians and policymakers continue efforts to discredit the ACA and overturn the law. Thus, the politics of health policy at the state level are particularly significant at this time of heightened national political polarization with unknown impacts on access to rural health care.

Political Culture

Political culture refers to attitudes, habits, and perspectives that shape an area's politics. Daniel Elazar proposed that U.S. political culture is shaped by the values of its earliest settlers and consists of three main subcultures: individualist, moralist, and traditionalist. He hypothesized that individualistic states prioritize the free market and prefer limited government; moralist states see government as a positive entity whose purpose is to advance the greater good; and traditionalist states do not favor the free market or government, yet want government to maintain existing hierarchies (Gray & Hanson, 2004).

Subsequent research has supported Elazar's classification of political culture in the U.S. (Gray & Hanson, 2004; Koven & Mausolff, 2002). Political culture may influence state health policies and access to rural health care. For example, based on Elazar's classification, individualistic and traditionalist states may be less apt to expand Medicaid while moralist states may be more likely to expand Medicaid as fully as

possible. However, each state must create and communicate its own narrative to structure the legitimacy of its particular frame for health politics (Mumby, 1987).

Partisan Control

Partisan control and competition can also impact state policies. When a large majority in a state is affiliated with one political party then policies aligned with that party's ideology can be implemented without much resistance. However, when political parties are more evenly represented, or competitive, then policies aligned with one party's ideology are more likely to be challenged. Thus, in states with more competitive political parties, more moderate policies tend to be implemented. States with competitive political parties spend more on social programs than states without competitive political parties (Gray & Hanson, 2004).

The Ranney Index is a tool that measures states' political party competitiveness. Developed in 1976, the Ranney Index is comprised of the percentage of votes for each party in gubernatorial races and percentage of seats won in the legislature, length of time each party controls governorship and legislature, and proportion of time that a divided government exists. Ranney Index scores range from 0, indicating complete Republican control, to 1, indicating complete Democratic control; a .5000 indicates a balance of power between the two parties (Gray & Hanson, 2004).

Political party competition may be particularly important as state lawmakers implement the ACA. In states with strong Republican control, resistance to the ACA remains intense and may stall its implementation. Republican-controlled legislatures may not implement Medicaid expansion as they are ideologically opposed to the ACA. Political party competition may likewise impact whether or not a state institutes a state

run health insurance exchange. A state's partisan control may not, however, entirely predict how the ACA will be implemented. Some Republican governors do not support Medicaid expansion, yet are proceeding with Medicaid expansion or receiving federal grants for Medicaid expansion preparation. Research exploring other potential factors that may influence states' future actions on Medicaid expansion has begun. Economic conditions, a state's historical record on health policies, and state institutional capacities may mitigate political party control and warrant further exploration (Jacobs & Callaghan, 2013). What affect these factors may have on rural health care access remains unknown.

Gubernatorial Power

Gubernatorial power is another political factor that may impact states' policies and access to rural health care. Gray and Hanson (2004) argue that gubernatorial power may be personal or institutional. Personal gubernatorial power is determined by several factors such as a governor's margin of victory, whether or not a governor has moved up the ranks of state government prior to being governor, whether a governor is eligible to run for reelection, and a governor's public approval ratings. Institutional gubernatorial power is determined by other variables. The number of state-wide officials elected, length and number of gubernatorial terms, number and range of political appointments a governor is allowed to make, budgetary control extended the governor, and the power of veto are factors that vary among states and may impact a governor's institutional power (Gray & Hanson, 2004).

In the context of rural health a governor is authorized to designate an area as medically underserved (MUA). Such designations are significant because they impact access to federal funds (De Alessi & Pam, 2011; Morrison, 2012). Thus, gubernatorial

power may affect rural health care access, via formal powers or informally through speaking out for or against “Obamacare”.

Interest Groups

Interest groups, and the politics among them, are another political factor that contribute to policy differences among states. Gray and Hanson define interest groups as individuals, organizations, public, or private entities that attempt to impact public policy (Gray & Hanson, 2004). Power and operations of interest groups are affected by five major variables: available resources and socio-economic diversity, political environment, governmental institutional capacity, intergovernmental and external influences, and the short-term state policy-making environment (Gray & Hanson, 2004).

Examples of interest group influence on state health policies abound in the literature (De Alessi & Pam, 2011; Gray & Hanson, 2004; IOM, 2011; Jacobs & Callaghan, 2013). Perhaps, the previous discussion regarding financing of health care systems helps to demonstrate why politics may play a significant role in state-level health policies (Holmes & Pink, 2011; Safreit, 2011) for where there is money at stake, politics are always at play. Exploration of interest groups and their organizational narratives may illuminate their perspectives on rural health care access (Mumby, 1987).

Scope-of-practice debate. One of the most contentious politically-influenced health policy debates among health care interest groups pertains to non-physician provider scope-of-practice, specifically those for advanced practice nurses. Physicians were the first clinicians in the U.S. to obtain legislative recognition of their practice, remain the only profession with professional sovereignty, and have expanded the reach of their influence well beyond medicine into state and national politics (Starr, 1982). By the

early 20th century every state enacted legislation designating a broad definition of medicine as the exclusive domain of physicians (Safriet, 2011; Starr, 1982). Organized medicine, especially the American Medical Association (AMA) and the American Academy of Family Physicians (AAFP), has consistently defended this broad domain and limited activities allowed by other health care professionals (Safriet, 2011; Starr, 1982). The issue gained renewed national attention with the Institute of Medicine's (IOM) 2011 report, *The Future of Nursing: Leading Change, Advancing Health*. Among the report's 4 major recommendations was one that called for nurses to practice to the full extent of their training and for scope-of-practice barriers to be removed (IOM, 2011). The IOM report indicated that full utilization of advance practice nurses may serve to address the anticipated surge of newly insured patients seeking primary care with the ACA, yet also noted the "political agendas" at play (IOM, 2011, p. 59).

Several national physician organizations responded quickly with their opposition to the IOM's report. The most antagonist tone was that of the American Academy of Family Physicians (AAFP) (AAFP, 2012). The AAFP opined that there is a physician shortage and argued against "allowing" nurse practitioners (NPs) to practice independently, noted that NPs' length of education and training is less than that required for a physician, and further stated:

We must not compromise quality for any American, and we don't have to...Physicians offer an unmatched service to patients and without their skills, patients would receive second-tier care. We must not downgrade Americans' care by offering them nurses instead of doctors (AAFP, 2012).

These comments by the AAFP, written in benevolent and protective terminology, leave no doubt about the physicians' group's opposition to nurse practitioners' autonomy.

Wide variation exists among state policies regarding licensure, scope-of-practice, and reimbursement of non-physician providers (Georgetown University, 2013; IOM, 2011; Sipe, Fullerton, & Schuiling, 2009). Evidence is lacking to confirm that states with more restrictive regulations for advance practice nurses have better care outcomes than states with less restrictive regulations. Research has demonstrated that advance practice nurses are capable of providing primary care at a level comparable to that of a physician and at a lower cost (Kitchenman, 2012; Weiland, 2008). The Veteran's Health Administration, the nation's largest health care system, uses advance practice nurses as primary care providers, as do many other innovative health systems, such as Intermountain Health Care, Geisinger, and Kaiser Permanente (ANA, 2010).

States' scope-of-practice policies for clinicians may have far reaching impacts on access to rural health care, particularly as the ACA is implemented. In states where NPs are granted authority to practice independently, evidence has shown that rural NPs experience more autonomy and use their statutory authority more fully than their urban counterparts (Judge, Boursaw, & Cohen, 2016). In a study in New Mexico rural NPs were also more likely than urban NPs to report that the care provided at their practice setting was always high quality, which may enhance job satisfaction and rural NP workforce stability (Judge, Boursaw, & Cohen, 2016). Evidence has also shown that NPs practicing in rural settings are more likely to practice in primary care than urban NPs (Kippenbrock, Lo, Odell, & Buron, 2015). If APRNs are legally allowed to practice as independent primary care providers then they may address the rural health professional

shortage that threatens to grow more significant with increased insured and aging residents. Nonetheless, many state nurse practice acts have limited scope-of-practice policies. Fourteen states require physician supervision or delegation for APRNs to practice; 25 states require APRNs to collaborate with physicians in order to practice; and 37 states require physician involvement for APRNs to write prescriptions (NNCC, 2011). Only eleven states have no requirements for physician involvement in APRN practice or prescription writing (NNCC, 2011).

As health care professionals adapt their practices with implementation of the ACA, the politically charged debate about scope-of-practice and other roles for APRNs may have an impact on access to rural health care. This debate will become especially crucial if APRN limited scope-of-practice policies impede people's access to needed care.

While national professional organizations, such as the ANA, AMA, and AAFP, debate scope-of-practice policies, licensure scope-of-practice is a state level responsibility. State legislatures and regulatory boards determine scope-of-practice for non-physicians, including advance practice nurses (Cassidy, 2012). The scope-of-practice issue is but one example of how political factors, such as interest group influence, vary among states and may impact state-level health policy and rural health care access.

Conclusion

Rural populations experience multiple challenges to accessing health care. There is a lack of available providers, higher numbers of people lacking insurance, lower average incomes, poorer health outcomes, and disparities in treatment quantity and, perhaps, quality. These challenges may be addressed through policy solutions.

Enhanced understanding of the state-level factors influencing rural health care access and the politics of policymaking may contribute to knowledge, both within and beyond nursing, and policy solution development. Many health care systems, political, and socioeconomic factors influence state-level policy. The majority of health policy is implemented at the state level. Despite this fact, a review of the literature regarding state factors that influence health policy reveals it predominantly consists of quantitatively driven statistics portrayed from the perspective of state leaders. Very little of the literature provides a ground level, in-depth viewpoint with diverse stakeholders' perspectives and narratives.

Previous nursing research has examined state-level case variation in health policies that support caregivers in the home (Ceccarelli, 2010). Other studies have examined factors impacting state-level policy in the domain of education (Doan & McFarlane, 2012; Manna & Harwood, 2011). However, there is a dearth of literature that examines the impact of state-level factors on rural health care access. In addition, there's no case study research on how stakeholders understand state factors in their particular state contexts.

The U.S. health care system, in attempt to improve quality and control skyrocketing costs to individuals, employers and governmental programs, is currently undergoing great transition. Expanded insurance coverage, improved coordination of care, patient-centered care, pay for performance, an emphasis on preventive care, and enhanced community-based health services are all key components of the ACA with the potential to impact rural health care access.

Health care professionals, including nurses, are reexamining how best to enhance access to care as our health care system transitions. This time of health care system upheaval, political polarization, and economic difficulty is an opportune time to explore the state-level factors and politics that influence rural health care access.

CHAPTER 3

Methodology

This study uses a case study strategy and employs qualitative content analysis to explore and describe state-level factors and the politics that impact rural health care access in Idaho. According to Robert Stake (2005):

“Case study is not a methodological choice but a choice of what is to be studied...As a form of research, case study is defined by interest in an individual case, not by the methods of inquiry used.”

This chapter will explain why the case study is the best approach for addressing the study’s main research questions. This chapter will also review details of this study’s methods including setting, sampling, recruitment, human subjects protection, data sources and collection, data analysis, and rigor.

Case Study

A case study is a comprehensive research strategy increasingly used for exploration of complex social phenomena in their natural context (Creswell, 2007; Hancock & Algozzine, 2006; Yin, 2003). Case study is a primary research approach within which varying research methods are frequently applied (Kohlbacher, 2005). Often case studies are presented using a considerable element of narrative in order to tell a story about a phenomenon and its context (Flyvberg, 2006). Integral to case study research is the assumption that examination of a phenomenon’s context is crucial to uncovering a deep understanding of the phenomenon of interest. Multiple sources of evidence are generally necessary to uncover the in-depth understanding sought through case study

research (Yin, 2012). Such triangulation contributes to thick description and may improve accuracy (Worlfram, Cox, & Hassard, 2005).

Case studies typically are used to research issues about which little is known (Gerring, 2004). In a case study, the phenomenon of interest is examined in its natural context, bounded by space and time (Baxter & Jack, 2008; Hancock & Algozzine, 2006; Yin, 2003). Thus, one of the primary reasons to choose a case study approach is if the contextual conditions are seen as particularly relevant (Baxter & Jack, 2008). Typically case studies involve "...naturally occurring situations without control of variables, collection of unstructured data and qualitative analysis" (Gomm, Hammersley, & Foster, 2000, p. 3). Case studies can be used to answer research questions regarding the how and why of contemporary events (Creswell, 2007; Hancock & Algozzine, 2006; Yin, 2003). They provide particularly rich descriptions that "bring to life the complexity of the many variables inherent in the phenomenon being studied" (Hancock & Algozzine, 2006, p. 16). The case study research strategy has been used effectively by nurses who conduct public policy research on issues such as state policies for informal care providers (Ceccarelli, 2010); politics of national child care policymaking (Cohen, 2001); the relationship between education and health policies in elementary schools (Seibold, 2006); and nursing workforce issues in Mexico (Squires, 2007).

Single-case case studies examine one bounded phenomenon of interest (Creswell, 2007; Gerring, 2004). Single-case case studies are frequently initiated not with the aim of proving a hypothesis, but rather to gain understanding (Flyvbjerg, 2006). The opportunity to intensely research a single unit is one of the primary strengths of the case study strategy (Gerring, 2004). A single-case case study typically involves the ability to

gather a larger amount and variety of data than with multiple-case case studies (Gomm, Hammersley, & Foster, 2000). Although limited generalizability is a common criticism of single-case case studies, some argue that there is more knowledge to be gained from the in-depth analysis of a case study than there is from “statistics applied to large groups” (Flyvbjerg, 2006, p. 236). This case study is specifically an intrinsic case study, which is undertaken when the aim is to understand the case, because “in all its particularity and ordinariness, the case itself is of interest” (Baxter & Jack, 2008, p. 548).

Identification of the unit of analysis is required for case study research (Baxter & Jack, 2008; Hancock & Algozzine, 2006; Yin, 2003). The definition of the unit of analysis delineates the “case” under study. This entails specifying boundaries regarding the people, geography, and time included in the case (Yin, 2003; Hancock & Algozzine, 2006; Baxter & Jack, 2008). Because of this case study’s focus on state-level policy impacts on rural health care access, the unit of analysis was a U.S. state. The geographic boundary and case selection criteria include that it be a predominantly rural state. Any case to be studied is “a complex entity located in a milieu or situation embedded in a number of contexts or backgrounds” (Stake, 2006, p. 449). Context was considered when determining the unit of analysis for this case study. As an overwhelmingly conservative rural state, which has consistently rejected the ACA and is the only state in the union to create its own health insurance exchange while opting out of Medicaid expansion, Idaho was chosen as the specific unit of analysis. Such context-sensitive treatment of case study sampling can enhance the richness of cases (Poulis, Poulis, & Plakoyiannaki, 2013). In this study the time boundary was from the enactment of the ACA in March, 2010, to the end of data collection for the study in January, 2016; with historical context provided.

Because no single source of data was sufficient for obtaining this information, this study collected and analyzed two major types of data to provide perspectives on state factors and politics affecting rural health care access: 1) Transcripts of semi-structured interviews that the researcher conducted with key policy stakeholder informants, and 2) Documents from both government and non-government entities and organizations such as professional associations and other pertinent interest groups variously engaged in rural health care policy. The organizations were chosen based on the categories of stakeholders who were interviewed. Stakeholder interviewees included clinicians, elected officials, state administrators, health care facility administrators, and interest group members and, thus, documents from organizations representing the professional interests of, and with membership from, these groups were chosen for inclusion in this case study. These documents were accessed via internet websites of governmental and non-governmental organizations. Documents included both the actual websites' content as well as reports and other resources accessible via the websites.

It should be noted that in the course of data analysis, it became apparent that this case study generated a substantial amount of narrative data, both from qualitative interviews and documents. Participants' accounts of state factors were situated in larger narratives about health politics, and website documents similarly described rural health care within larger narratives about health politics. Narrative analysis can be applied within any study that uses narrative data (Holloway & Freshwater, 2007). A strength of narrative data is its openness, which allows for unanticipated concepts to be illuminated (Overcash, 2003). In response to the narrative features of the qualitative interview and document data, this case study uses narrative analysis and thematic analysis to inform

naturalistic generalizations (Stake, 2005). The complex features of case study data support the use of qualitative content analysis methods (such as narrative analysis and thematic analysis) as an appropriate strategy for data analysis (Stake, 2005).

Methods

Setting

The setting for this study is the state of Idaho. This state was chosen because it meets the criterion of being a largely rural state, and has unique political and cultural contexts. It is the 14th largest state geographically, with a population of 1,567,582, and ranks 39th in the nation for density of population (U.S. Census Bureau, 2010). The vast majority of the state is comprised of counties with a population density below 10 per square mile (U.S. Census Bureau, 2010). As previously mentioned, consideration of context in case study sampling, boundaries, and unit of analysis selection is desired (Poulis, Poulis, & Plakoyiannaki, 2013). Idaho, with its conservative politics, frontier lifestyle, and consistent rejection of “Obamacare”, was seen as a potential unit of analysis for this case study which would yield a rich and complex story about the state-level factors and the politics that influence access to rural health care services.

Also, the researcher resides in Idaho and has practiced as a registered nurse (RN) and as a nurse practitioner (NP) in the state for over 20 years. Thus, the researcher has some knowledge of the challenges related to rural health care access and awareness of the key policy stakeholders in the state of Idaho. The researcher worked to minimize bias by employing several strategies described below in the methodological rigor section of this proposal.

Sampling

The qualitative interview sample was comprised of rural health care stakeholders in Idaho. Purposeful, snowball, and maximum variation qualitative interview sampling strategies were used. Purposeful sampling allows the researcher to choose participants that are informative about the phenomenon under study (Creswell, 2007).

Examination of websites and associated documents, from both government and non-government entities, such as professional associations, and other pertinent interest groups related to rural health and ACA implementation revealed potential interviewees knowledgeable about Idaho politics and policies and rural access to care.

Snowball sampling occurs when participants identify other potential participants who may be knowledgeable about the phenomenon of study (Creswell, 2007).

Participants were asked to suggest other potential participants who had knowledge on the topic of interest.

Maximum variation sampling consists of the selection of participants likely to reflect different perspectives (Creswell, 2007). This was achieved by recruiting four major types of participants: state policymakers, health care delivery organization representatives, clinicians, and interest group representatives. In addition to seeking participants of different roles, the researcher also strove for diversity in participants' geographic location, gender, culture, and race.

The document sample was comprised of publicly available records of both government and non-government entities and organizations, such as professional associations and other pertinent interest groups, variously engaged in rural health care policy. Purposeful and maximum variation document sampling strategies were employed.

The document sample was chosen to obtain diverse organizational perspectives and reflect the organizations associated with the categories of stakeholders interviewed: state policymakers, health care delivery organizations, clinicians, and interest groups. These documents were accessed via internet websites of governmental and non-governmental organizations. Documents included both the actual websites' content as well as reports and other resources accessible via the websites.

Case studies lack a specific predetermined adequate interview sample size (Yin, 2003). The study sample size was 20 interviewee participants and seven organizations' documents representing various individual and organizational stakeholders' perspectives.

Recruitment

Initial contact with potential interview participants was made electronically, via e-mail. The e-mail included a cover letter outlining the research study's aims and data collection logistics (See Appendix B). A copy of the informed consent form was included with the initial e-mail (See Appendix C). If no response was received to the initial e-mail after one week, the researcher sent a second, reminder e-mail (See Appendix D). If no response was received to the reminder e-mail within three days, the researcher attempted to contact the potential participant via telephone. If telephone contact was unsuccessful, the researcher left a message asking for a response by the end of the next business day. If there was no response by the end of the next business day then no further attempts to reach the potential participant were made.

If potential participants responded and indicated that they were willing to be interviewed, the researcher followed up via e-mail within one week to arrange an

interview time and location. Due to a desire for participants from various geographic locations, many of the interviews were done via telephone.

After completing the first interview, the researcher requested from the interviewee a list of other state policy stakeholders who may provide additional insights into the phenomenon of interest. Document review occurred concurrently throughout the recruitment process and revealed additional policy stakeholders actively engaged in access to rural health care policy discussions in Idaho who served as potential interviewees.

Four potential participants from each of the following four categories: state policymakers, health care delivery organizations, clinicians, and interest groups, were identified via the list obtained from the first interviewee, initial document review, and the researcher's knowledge of rural health stakeholders. In addition to selections from each of the four categories of participants, interviewees with a significant level of engagement in rural health policy and representative of diverse geographical, gender, cultural and racial groups were chosen. These four potential participants were contacted and invited to participate in the study.

Subsequent interviewees were chosen from concurrent document reviews and recommendations from interviewees, with the researcher attempting to maintain equal participation by individuals associate with the four categories of policy stakeholders previously identified, as well as geographic, gender, and racial or ethnic diversity.

Human Subjects Protection

All research activities have potential risks to participants. It is the investigator's responsibility to ensure that subjects are protected against such risks as much as possible.

Study approval was obtained from the University of New Mexico's Human Research Protection Office (HRPO). This study was noninvasive, meaning no biologic data was collected. This study did not involve patients as participants, and presented no more than minimal risks to participants. As such, it was appropriate for expedited HRPO review.

As previously noted, prospective interviewees received an informed consent form as an attachment to the initial e-mail inviting them to participate in the study. Because the study presented no more than minimal risk to participants, verbal consent was obtained from each interviewee. At the onset of each interview, the informed consent, which contains all required and appropriate elements of consent disclosure, was read verbatim. Any questions the interviewee had regarding the interview procedure or research study was addressed. The informed consent form stated that, by proceeding with the interview, the policy stakeholders were indicating their consent to participate in the study. Participation was voluntary and subjects were free to withdraw from the study or refuse to answer any questions without consequence at anytime during the research process.

Participants' confidentiality was protected to the fullest extent possible. Their identity or affiliation was not disclosed in data analysis or dissemination of findings, however, guarantee of anonymity was not made. In transcripts and in research reporting, all personal identifiers have been removed or changed to protect confidentiality.

Interviews were audio-recorded verbatim. The recording device was used solely for the purpose of recording interviews for the study. The recording device was stored in a locked cabinet located in the researcher's locked office at Boise State University. Once each interview had been transcribed, the researcher confirmed accuracy of the transcript

and then deleted the interview from the recording device. Hard copies of transcripts are stored in a locked cabinet located in the researcher's locked office at Boise State University. Electronic copies are stored in a password protected file on a secure server that meets all security protocol established by the State of Idaho and Boise State University. Only the researcher, members of the dissertation committee, and transcribers had access to raw data. Hard and electronic copies of the transcripts will be securely maintained for five years following completion of the study and will then be destroyed.

Data Sources and Collection

This study had two main sources of data: documents from government and non-government website sources; and transcripts of semi-structured qualitative interviews.

Documents. Government and non-government websites and associated documents were reviewed and analyzed. The websites and associated documents of state rural health stakeholder organizations were explored to discover the organizations' activities and communications related to politics and rural health care policy, as well as to gain further insight into contextual aspects of policy making in Idaho. Documents included those on the websites as well as reports and other resources accessible to the public via the websites.

Interviews. An interview guide was developed, utilizing the aforementioned framework as a guide, and piloted before data collection (See Appendix G). The interview guide was piloted with the Director of the Center for Health Policy at Boise State University. The reviewer's feedback, along with recommendations from dissertation committee members, was used in finalizing the interview guide. This guide

included semi-structured questions that were asked of each participant. Additional follow-up probes were used for clarification and to obtain more in-depth data.

Each participant was also asked a brief list of demographic questions at the end of their interview. The demographic data obtained was only used to document respondent diversity in geographic location, gender, and profession and not used as a source of data for analysis.

Five interviews were completed face-to-face. Fifteen interviews were conducted over the phone, when necessary due to distance or inability to coordinate personal meetings. Although telephone interviews are used less frequently in qualitative research than face-to-face interviews, they may enhance participant anonymity and openness, and their inferiority to face-to-face interviews has not been empirically demonstrated (Novick, 2008). Utilization of telephone interviews facilitated maximum variation by including participants from geographic areas that would otherwise be excluded due to travel time and cost constraints. Both face-to-face and telephone interviews were electronically recorded and transcribed verbatim. Consent obtained from each participant prior to data collection included permission to electronically audio-record the interview.

Data Analysis

Qualitative data analysis occurred throughout the study as an iterative process. By initiating data analysis early in the research process, researchers can identify gaps and weaknesses in data, strategize on how to improve data collection, and enhance the quality of data ((Basit, 2010; Liamputtong, 2009).

A non-linear approach to data analysis was used, moving back and forth between the two sources of data throughout the analysis process (Hancock & Algozzine, 2006).

Qualitative interview transcripts were analyzed for major thematic identification (Stake, 2005), which focused on state-level factors affecting rural health care access. The steps of thematic analysis included identifying the data content, reduction of redundancy, and grouping of the data into representative themes that describe the phenomenon of interest (Aguinaldo, 2012).

Once the narrative content of the organizational documents became apparent, narrative analysis was conducted on the organizational narratives evident in the documents and the individual narratives contained in the interviews; both were analyzed for narrative content and narrative type. Case study narrative data “approach the complexities and contradictions of real life” (Flyvbjerg, 2006, p. 237) and contribute to the “rich ambiguity” of a case study as useful and informative (Flyvbjerg, 2006, p. 237).

Computer software programs (e.g. NVivo, Atlas TI) are widely available to assist with data analysis. However licenses can be costly and may create distance between the researcher and the data (Creswell, 2007). I performed data analysis without the use of a computer program. Coding allowed the researcher to “communicate and connect with the data to facilitate the comprehension of the emerging phenomena” (Basit, 2003, p. 152). In addition to the cost savings, I aimed to maintain closeness with the data to ultimately facilitate a richer description of the case. In the process of hand coding, the narrative features of both sets of data emerged, presenting an additional opportunity for data analysis.

Each source of data was entered into a log (See Appendix E). The log included a number to track how many data sources were received and in what order, the type of data source, interview or document, and the category of the data source, e.g. state

policymaker, clinician. A duplicate, untouched copy of each piece of data was maintained and stored in a locked cabinet in the researcher's university office. Initially, the document or interview transcript was read in its entirety without any coding. Following the initial reading, the researcher created a summary sheet for each piece of data (See Appendix F). These sheets allowed for reflection and summarization, without which one may get lost in the detail of analysis (Miles & Huberman, 1994). For interviews, the summary sheet included log number, category of stakeholder participant, what, when, content summary, and reflective remarks. For documents, the summary sheet included context, significance, content summary, and reflective remarks. Each summary sheet was attached to the corresponding data source.

Initial coding occurred during the second reading of each data source. A preset list of categories can provide structure, however, it may also inhibit findings, and the data should, ultimately, determine the categories (Dey, 1993). Therefore, preliminary coding was done with both the substantive concepts of the framework in mind and consideration of who, what, where, why, and "so what" questions (Dey, 1993). While reading data the researcher was cognizant of the need to shift focus between levels of data, from a detailed line or word to the overall transcript, or section of a transcript, and back again (Day, 1993). Initial coding was performed by creating notes on the left margin of documents or interview transcripts as substantive statements were identified (Liamputtong, 2009). Margin notes were recorded on 3 x 5" index cards with the date created on the front, and specific data source information, such as the line in an interview transcript, was recorded on the back. The margin notes were examined for similarities and differences in order to categorize the initial codings (Basit, 2003). Like data were

grouped together in sub-categories and categories, and new groupings created for data that deviate from existing categories (Li & Seale, 2007; Liamputtong, 2009). Sub-categories and categories were recorded on 4 x 6" index cards along with the date. The 3 x 5" cards with the codings that fall within the sub-categories and categories were placed in an envelope and affixed to the corresponding 4 x 6" index cards. Categories and sub-categories were recorded on 4 x 6 index cards and examined for relationships and shared meanings among categories to identify general themes related to the phenomenon of interest, state-level factors and their political context that affect access to rural health care.

Codes, sub-categories, and categories were revised as more data was collected and analysis proceeded. A master list of codes, sub-categories, and categories was maintained and updated following each session of analysis. Dates recorded on the front of index cards aided in maintaining an accurate audit trail. Immediately following each analysis session the researcher recorded the thought processes which occurred during the data analysis, thus maintaining current analytic documentation (Patton, 2002).

Data analysis was regularly discussed with committee members. After analyzing the first several documents and interview transcripts, I shared preliminary results with two dissertation committee members who agreed to provide feedback in data analysis. Unmarked documents and interview transcripts were reviewed by two committee members for confirmation of substantive statements, coding and categorization. Committee members were also asked to provide feedback for subsequent data collection and analysis. Coding, categorization, thematic identification, and narrative analysis processes were reviewed with appropriate committee members for reliability.

Methodological Rigor

Rigor refers to strategies for enhancing the quality and credibility of research processes and results (Patton, 2002). In the history of science, objectivity has been upheld as the gold standard to which all researchers should aim (Patton, 2002). The ideal of objectivity is worth striving for; however, complete objectivity is not realistic or even possible as all researchers are impacted by their personal perspectives (Patton, 2002). Trustworthiness, credibility, dependability, confirmability, and authenticity are frequently used as criteria for qualitative research rigor (Creswell, 2007; Lincoln & Guba, 1985; Patton, 2002).

Several strategies for enhancing rigor were used in this study. Use of more than one data source is integral to strong case study research and requires a process of triangulation. Triangulation strengthens credibility by ensuring data are confirmed and complete (Houghton, Casey, Shaw, & Murphy, 2013). Confirmation of data occurs through comparison of data from various sources for corroboration while completeness of data is sought through gathering data from multiple perspectives and thus compiling as complete a description as possible of the phenomenon of interest (Creswell, 2007; Houghton, Casey, Shaw, & Murphy, 2013; Yin, 2003). In this study credibility was enhanced through recruitment of potential interviewees from policy stakeholders with diverse geographic, gender, and political demographics. This sample of potential participants included individuals with experiences, knowledge, and perspectives different than those of this researcher.

Peer review or debriefing can also be used to enhance credibility. Although no two qualitative analysts will interpret data exactly alike, there should be agreement on the

data codings and the rationale for those codings (Creswell, 2007; Houghton, Casey, Shaw, & Murphy, 2013; Yin, 2003). Two dissertation committee members performed reanalysis of the initial interview transcripts and documents to address reliability. The dissertation committee chair provided ongoing review and feedback regarding data analysis.

Maintenance of an audit trail, a meticulous recording of motivations and rationales for all methodological and interpretive decisions throughout the research process, is crucial to a rigorous case study (Houghton, Casey, Shaw, & Murphy, 2013; Rodgers & Cowles, 1993). A comprehensive audit trail allows an external observer to follow the entire research process, from beginning to end, and includes a clear explanation of how the conclusion was derived from the collected data (Houghton, Casey, Shaw, & Murphy, 2013; Rodgers & Cowles, 1993; Yin, 2003). Credibility of a study is also dependent on the researcher's self-awareness (Rodgers & Cowles, 1993). In this study, documentation of the researcher's thoughts and reactions throughout the research process served to enhance transparency and assisted the researcher in identifying and addressing potential sources of bias. A reflective diary and, as previously noted, a record of analytic decision-making was consistently maintained. All of the aforementioned strategies were used in an effort to strengthen the rigor of the study.

Summary

This study used a case study research strategy with thematic and narrative analysis to explore stakeholder and organizational perspectives on state-level factors that impact rural health care access in Idaho. The case study approach is appropriate when exploring a complex current phenomenon in its natural context. Multiple sources of data

were used as no one source would provide sufficient data for the rich description desired. Data included twenty semi-structured interviews with a diverse qualitative interview sample of policy stakeholders and a comprehensive sample of documents obtained from state government and non-governmental websites. Data analysis consisted of thematic analysis of state-level factors evidenced in interview transcripts and documents. The narrative analysis served as a process of integration of these two data sources. Rigor was enhanced via the use of multiple research tactics, including maintenance of an accurate audit trail.

Exploration of a single case state allowed for an in-depth examination of the context of politics and diverse stakeholder and organizational perspectives on state-level factors that impact rural health care access. As a “typical” rural state in many ways yet a unique context of political, health care system, socioeconomic, and policy variations in other ways, Idaho was an appropriate choice for a single case study as the ACA is being implemented.

CHAPTER 4

Interviews

In this chapter the following are discussed: the state factors identified by interviewees as most impactful on rural access to health care in Idaho, interviewees' perspectives on the ACA and its implementation in Idaho, and recommendations from interviewees regarding how best to enhance access to rural health care services in Idaho. Thematic analysis of the qualitative interviews identified six categories of state factors noted most commonly by interviewees as significantly impacting access to health care services in rural Idaho: the economy, rural/frontier geographic features, rural patient population, rural health care system, interest groups/policy voices, and the primary care provider shortage. While these categories were most commonly cited, individual interviewee perspectives on these factors vary widely, with politics informing these perspectives, frequently creating a competitive "us versus them" approach. This chapter presents the six primary factors, a brief description of Idaho's historical context regarding the ACA along with interviewees perspectives on the ACA's impact on rural health access, and interviewees' recommendations for improving access to health care services in rural Idaho.

The State Economy

The economy was identified by the majority of interviewees as having a significant impact on access to health care services in rural Idaho. Interviewees noted that Idaho has the highest percentage of minimum wage jobs in the nation and ranks near the bottom of income per capita.

One rural physician indicated that people avoid seeking health care because they fear the financial consequences. “Many patients, or prospective patients, would see their access to care being limited because it can often result in financial ruin such as bankruptcy.” Thus, rural individuals are seen as having to choose between their health and their financial stability.

Another interviewee stated that she saw the state economy as being more of a factor for rural individuals than for the general population. “For many people I think access is restricted, particularly in rural areas, by ability to pay.” This statement suggests that rural populations generally have lower incomes than non-rural populations and would, therefore, be more likely to have the economy influence their ability to access health care services. Thus, interviewees did recognize that rural Idahoans may find it difficult to afford health care which could influence their ability to access health care services.

A rural clinician indicated that she sees the economy as having a significant impact on access to health care services, and echoed the sentiments of interviewees who felt that economic strife disproportionately impacts rural populations.

The economy has a huge impact, especially in rural areas. The less money there is in the state economy, the less you’re going to see funded in smaller rural areas. Traditionally it goes to bigger urban centers. A local business recently went bankrupt, approximately 350 people were laid off and most had to leave to find other work so that really drains the other businesses, the entire local economy suffers.

These remarks suggest that rural programs may be the first to lose funding when the government makes budget cuts. In addition, the loss of even one employer in a small rural town is noted to have significant ramifications.

One health care facility administrator opined that when the costs of health care are considered, those incurred by the patients are too frequently not acknowledged.

We have a real tendency in health care to, when we think about the cost of doing things, to think about what's on the bill, but we tend to forget that there's an economic cost to health care that we don't particularly measure. What's it costing them, that elderly person for example, that has to get in a car and drive two hours to the specialist they need, sit around, have an hour appointment, get back in the car and drive another two hours.

These remarks indicate that health care expenses, which are generally calculated according to the particular charges for services, do not accurately reflect the total cost of accessing health care from the rural patient perspective.

Multiple interviewees, when questioned regarding any impact the economy may have on access to health care services in rural Idaho, addressed the question in terms of the providers' finances.

There are some amazingly dedicated rural health providers, but retaining them in rural areas, because of the differences in compensation and pay and the burden that's on fewer numbers of providers, is a challenge to getting access in those rural areas.

This interviewee, a state administrator, demonstrated a concern reported by many: that the financial strains experienced by rural providers are a significant factor influencing access to health care in rural Idaho.

Even efforts aimed at improving impoverished residents' ability to receive health care were viewed through the lens of what those efforts would mean for physician reimbursement.

If we expanded Medicaid we could help alleviate a lot of our access issues.

Maybe not within the first six months, but over time we could attract more physicians to our state, we would be able to pay the physicians more.

This comment, by an interest group staff person, indicated that the ability to increase physician compensation was a primary reason to advocate for Medicaid expansion.

One remark in response to a question regarding the economy's impact on access to health care services in rural Idaho was unique. "I don't think it has really any impact. I can't see that being a force." This rural clinician was the only interviewee to express the opinion that the economy does not influence access to health care services in rural Idaho.

Multiple interviewees acknowledged that financial status may limit some individuals' ability to access health care services in rural Idaho, and that some may even choose to forego care in order to avoid financial difficulties. The costs in terms of time and travel, which many patients in rural Idaho experience, were also recognized by several interviewees. Other interviewees indicated lean government budgets and business failures, that frequently accompany economic downturns, are felt most greatly by small rural communities. The majority of the comments regarding the economy's impact on

rural access to health care, however, focused on the costs incurred by the “system” or providers, rather than by individual patients.

The politics surrounding the economy as a factor that influences access to health care services in rural Idaho are driven by questions of whose finances take precedence, the physicians’, the health care facilities’, or the patients’? If the rural physicians’ reimbursements were enhanced, would there be more physicians available to serve the rural population? If the rural CAHs’ reimbursements were increased, would these hospitals provide more services to those in the rural population who do not have insurance coverage? If Medicaid was expanded, would more of the rural patient population have coverage and thus improve the income of rural physicians and facilities? Where should scarce resources be applied for the greatest impact on access to rural health care services? These are the questions raised when considering the interviewees’ perspectives regarding the economy and its impact on access to health care services in rural Idaho.

Rural/frontier geographic features

Idaho’s terrain, road structure, and geographic isolation were identified by several interviewees as factors negatively impacting access to health care services in rural Idaho.

The geography is a problem. Just in terms of the ways the state is set up in terms of the road system, where things are located, the mountainous regions, and the difficulty getting around in those places.

This interviewee, an interest group staff person, recognized the topography of the land, with its many mountains, and the state roadway infrastructure as potential impediments to

accessing health care services in rural Idaho. A rural clinician saw Idaho's climate as an additional factor that can limit access.

There are actual geographic barriers to accessing care such as proximity to the geographic location; if you're on the wrong side of a mountain range in Idaho during a snow storm you may or may not be able to access care even if you had the payment.

This comment acknowledges that the combination of Idaho's mountainous terrain and the severe weather experienced in much of the state can limit access to health care services. An elected official who represents a rural district suggested that there are multiple areas in Idaho that are remotely located and from which it is difficult to access health care services, "Geographic isolation is a real barrier to health care in significant areas of the state."

These remarks regarding Idaho's geography, topography, roads, population density, and climate indicate that there are multiple physical features of the state that contribute to logistical difficulties for patients attempting to access health care services in rural Idaho.

Even the natural features of Idaho are seen through a political lens by some, as evidenced by this rural clinician's comments.

While Idaho has done much with little, I do worry that it may be under appreciated with regard to the challenges that rural Idaho would face in distinction from other states such as Iowa, for example, which has 82 critical access hospitals, is flatter than Idaho, and experiences less snowfall.

This remark was made in reference to the geographic aspects of Idaho that should be considered by the federal government when considering which facilities should continue to receive enhanced reimbursement. Thus, the politics regarding the geographic features of rural/frontier Idaho, at least for some, center around how those characteristics should be taken into account when funding for various services is being determined.

Rural patient population in Idaho

Several characteristics of the rural patient population in Idaho were identified by interviewees as having a considerable impact on access to health care services in rural Idaho. The demographics of Idaho's rural population, such as a growing number of senior citizens, a high poverty rate, and a high percentage of Medicare and Medicaid recipients in the rural patient population were cited by interviewees as considerable factors. The low population of many frontier and rural areas in Idaho was also identified as a factor influencing access to health care services in rural Idaho. According to one interviewee,

The number one factor influencing access to health care services in rural Idaho is low population. It takes a certain threshold of population to sustain a primary care practice, and an even larger one to sustain a CAH and Idaho has large areas where the population density falls below those thresholds.

These remarks on population density, made by a health care facility administrator, described the financial barriers to economic survival experienced by rural health primary care practices and CAHs.

Beliefs regarding privacy among Idaho's rural patient population were also reported as impacting access to health care services in rural Idaho.

There's a lot of farmers and ranchers, and logging industry, that kind of thing, and they're kind of the rough and tumble, go out and settle the west, do it yourself kind. If there's a problem you pull up your boot straps and you just fix it and get it done kind of attitude. I like to call it rugged individualism. There's a lot of folks who just simply wouldn't take help for issues because the attitude was we'll just fix it yourself.

This comment, made by a rural nurse practitioner, indicates that some rural people may be socialized to avoid seeking assistance, which may serve as a barrier to access. Another rural clinician suggested that the familiarity rural patients have with local providers may serve as a barrier to their accessing care.

You wouldn't seek treatment for a personal health problem because you know the doctor and you know that you're going to end up running into him in the local grocery store.

These interviewees, both rural clinicians, reported that seeking treatment for a health condition may be viewed by some in the rural communities as a weakness, as an inability to care for oneself, or a violation of privacy.

Seeking mental health care services may be particularly stigmatized in rural communities, according to one of the same rural clinicians, and further impact access.

If you have a mental health issue, or if somebody sees you go into the mental health clinic in town, well that would be a really bad thing. So people just wouldn't seek help and then it would, unfortunately, sometimes end badly, or they wouldn't receive the care that they needed or the help they needed.

While the small populations in rural towns across Idaho were generally described as positive and supportive, in the context of health care seeking, familiarity was actually seen as a detriment.

Rural clinicians also noted that the rural patient population's beliefs about health care made some aspects of being a provider more difficult. "Idaho has some attitudes around things, like immunizations, that make it difficult to achieve goals like those Healthy People 2020 goals for preventative services." There was a general consensus among interviewees that the rural patient population in Idaho does not regularly seek out preventative care services, however, there was some disagreement over whether this was simply due to the "rugged individualism" attitudes, lack of privacy in a small community, or financial constraints.

Several interviewees commented on the racial and ethnic homogeneity of rural Idaho. Some saw this as a positive, while others viewed the general homogeneity as a barrier to access for minority rural populations. This Caucasian rural physician saw the homogeneity as contributing to patient trust.

We are very homogenous here. We all have the same cultural, ethnic, and racial backgrounds for the most part and so there is a lot more trust than if you go to another place where you are one race and then your provider is of another race and the medical assistant is of another race or cultural background. There is a lot more distrust in that situation, I think, cause people like to hang out with people who look and act the same way they do.

This rural physician views that as an advantage for the vast majority of Caucasian patients in rural Idaho, but evidence reveals that minority patients, who are frequently in

racial or ethnic-discordant relationships with their health care providers, rate their relationships and the general health care system less positively than their white counterparts (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004).

Certainly not all interviewees saw the racial and ethnic homogeneity of rural Idaho in a positive light. One state administrator noted the difficulties experienced by minority populations when attempting to access health care services in the state.

Idaho has been homogenous for so long. What I have witnessed are the Hispanic and refugee populations getting relegated to a back burner, so they have difficulty getting their questions answered, finding out how to navigate the system. There needs to be more education, it needs to be made easier with more translators, more people who are culturally educated and sensitive to the needs of minorities and the different demographic populations moving into Idaho. We've seen that with health insurance, and it's the same thing in accessing health care, if there aren't translators then they would not be able to work with anybody to access services.

These comments suggest that because approximately 93% of Idaho's population reports being Caucasian (U.S. Census Bureau, 2015), the rural health care system may not be accustomed to tailoring services to a variety of patient populations or to considering the cultural aspects of care.

Multiple interviewees described abuse by entitlement program recipients and a lack of patient accountability among rural patients in Idaho. One CAH administrator saw patients as being too dependent on providers.

I just think people need to be more aware of their own care and not rely on the doctors for keeping track of their medications. We need to hold these patients accountable for some of their care. And it's getting harder and harder, you got 15 minutes to see a patient. I'm frustrated with some things. It's just when they come into the ER and say, 'Well, my doctor knows what's wrong with me.' You need to know what's wrong with yourself and what meds you're on. We, as a facility, need to educate these patients, but they also need to be more receptive.

These remarks illuminate the difficulties experienced by a provider during a provider-patient encounter without acknowledgement of the patient perspective. The administrator emphasizes that patients need to take responsibility to know more about their health conditions and treatments received, and adjust to the system that now allows only 15 minutes for a patient visit.

Another rural clinician reported that she was concerned with what she saw as rural patients' inappropriate and overuse of Medicaid.

We ought to start holding the patients a little bit more responsible for taking care of themselves and not having them rely so much on, you know, you have a stubbed toe and you come into the ER because you got that, the welfare card.

That's not to discriminate against anybody, but you gotta be a little bit more wiser on how you use the money that you don't earn.

Similar comments were made by several other interviewees who voiced that patients should be more accountable and knowledgeable regarding their conditions, their medications, and their care. These remarks convey some resentment toward Medicaid patients and may suggest that some providers expect all patients to be more accountable

and attribute a lack of responsiveness from low income patients to be negligence when it may be due to the circumstances of being low income. Alternatively, providers may hold greater expectations for those patients who receive assistance to know the appropriate level of care to seek than for those with private insurance.

One interviewee, a CAH administrator, described the lack of rural patient “ambition” as a substantial problem.

Provider shortage is an issue, but what is really frustrating is lack of patient ambition. We try to get patients involved in self care, not smoking/drinking, child care, all of that stuff and they just don’t want to participate. It’s pretty frustrating when the ambition level from these patients, these people, is just not there. We were doing a lot of community education seminars and stuff, and notified the public, but we quit because nobody showed up. So that makes me take a different look on what the public is, they’re just not holding themselves accountable for their own care.

This administrator’s comments indicate that patients are to blame for their lack of knowledge regarding health and self care. Furthermore, the terminology “these people” and “we” suggests a perceived distance between the patients who lack ambition and the interviewee and an “us” versus “them” mentality.

There were multiple factors identified by interviewees that fell within the theme of rural population characteristics in Idaho. These included low population density, which makes it difficult for individual providers or facilities to survive financially; a “rugged individualism” attitude which may cause rural individuals to avoid health care; lack of privacy, which may dissuade rural people from seeking care; financial constraints, which

limit rural individuals' ability to access care; population racial and ethnic homogeneity, which may impact the access and quality of care for ethnically or racially diverse patients; and rural patients' abuse of "the system" or lack of personal responsibility, which is viewed by some interviewees as a factor that also contributes to difficulties with access to health care services in rural Idaho. Some of the population characteristics noted by interviewees appear contradictory. For example, "rugged individualism" suggests taking care of oneself as a value, and conflicts with the reported abuse of entitlement programs and a lack of personal responsibility. In addition, some saw the homogeneity of Idaho's rural population as a benefit that contributes to trustful relationships between providers and patients, while others saw it as a barrier for rural minority patients.

Rural health care system in Idaho

Multiple interviewees identified aspects of the rural health care system in Idaho as contributing to difficulties with accessing care. Competition among various providers, volatile volumes that do not support overhead costs, acquisitions of rural facilities by regional corporations, and reimbursement issues were all identified as factors which influence access to health care services in rural Idaho.

Numerous interviewees commented on the competition that exists between critical access hospitals (CAHs) and community health centers (CHCs). One rural physician described the competition that exists and indicated that a collaborative business model between the two entities would be beneficial.

Unfortunately, in our state we've seen a lot of competitive posturing between the CAHs and the CHCs and not a lot of proactive partnerships. Partnerships between these two is going to be lifesaving to those communities because the preferential

payment that CHCs enjoy with Medicare and Medicaid are significantly greater than what CAHs get paid to see the same patients. Putting together a business model where everyone is being seen, the uninsured have a place to go that's appropriate, you can bring folks in to discuss preventative care and the payment systems are much more respectful of what it takes to deliver care through the CHCs so that's a great model and the opportunity for CAHs and CHCs to work together needs to be heightened.

While it is clear that such a partnership would benefit the CAHs, it is not clear what the CHCs would gain from such a business model. Perhaps the CHCs would gain patients if the CAHs referred all non-emergent care to the CHCs during business hours.

An elected official echoed these concerns about the competition between provider entities.

Sometimes we don't see CHCs or primary practices collaborating to provide the in-patient medical service coverage, but instead they're either incidentally, because of 3rd party payer systems, competing for out-patient lives and out-patient visits, while not necessarily cooperating to contribute to the other levels of care such as ER coverage or in-patient coverage services.

These comments speak to the difficulty rural providers and facilities face attempting to provide services and remain financially viable. Providers are competing for the out-patient services, which are more lucrative, yet one could argue that the in-patient and emergency services are those most vital to rural patient populations. Interestingly, none of the interviewees affiliated with CHCs acknowledged any competition between CAHs and CHCs.

Multiple comments, both positive and negative, centered on the critical access hospitals. One CAH administrator verbalized concerns about the facilities' survival. "Quite frankly, I think the government is trying to do away with us (CAHs)." This comment reflects concerns about the federal government's continued financing of CAHs at a sustainable level. Others mentioned that multiple CAHs have been, or are in the process of being, purchased by one of the three large regional medical centers in the state.

The other interesting part, for rural areas, is what I call consortium 2020. St.

Luke's is buying up hospitals everywhere and so now you have a hospital in this rural town that is part of that fork of hospitals. Does it still serve the community?

Is it listening to the community?

This rural physician identifies concerns that the acquisitions of rural hospitals by regional medical centers may negatively affect responsiveness and service to rural residents.

Another rural physician saw potential benefits from the acquisitions, but was unsure as to their final impact.

Now with the big buyouts at St. Al's and St. Luke's referrals are easier. You can just call them up and they will refer you to one, whatever specialist they have on at that time. It's easier, but I am not quite sure if that's better. I'm not sure if it will improve coordination. It may be more fractionation with more people involved that can do their little subsets, they only do this little part.

These remarks suggest that acquisitions may improve access to specialists for the rural provider, but may not result in improved access or quality of care for rural residents.

Indeed, in the 1980's as community hospitals began to buy individual physician practices, these acquisitions served to ease individual physicians' financial strain, yet

came with the price of decreased economic autonomy for physicians (Starr, 1982). This same trend opened up a diverse set of new, less generously paid roles for nurses as members of “clinical teams”, further challenging physician clinical autonomy (Starr, 1982). Many of these same community hospitals, now facing their own financial strain 25 years later, are agreeing to acquisition by regional health care hospitals in a kind of extended clinical food chain, resulting in the increased corporatization of health care.

One interviewee, an administrator at a critical access hospital, shared his career history, which illustrates many of these changes within our health care system. He began working in the seventies as a “back office person” in a solo medical practice where he “did not have a specific job description”, but rather did “whatever needed to be done”. He checked patients in, got their vital signs, filed lab results in charts, and assisted with minor procedures. After several years the solo practice was bought by the community hospital, he was “moved upstairs to the laboratory”, and became a lab tech. His account describes how, on a local level, the acquisition of one private medical practice removed some roles while opening others, both for the solo practice as a whole and for its individual employees.

While working as a lab tech for approximately 20 years, he returned to school and obtained a nursing degree. He began his nursing practice in the critical access hospital (CAH) where he now serves as the lead nursing administrator. His daily duties now include addressing what he describes as the challenges of rural provider recruitment, decreasing resources, and “expanding competition” from the local Federally Qualified Health Clinic (FQHC), “all of those issues of trying to get staff and physicians and those types of things to provide medical care to the people of our region.”

His language hints at how health care has become bureaucratized in a short three decades. The term “filled” was used repeatedly as he relayed his career in rural health. Initially, he “filled” a variety of roles in the solo practice, where he filled exam rooms with patients. Now he struggles to “fill physician vacancies”; rural facilities cannot “fill” their workforce needs and try to “fill” the provider gaps with nurse practitioners and physician assistants.

Multiple interviewees highlighted rural physician recruitment as a major factor influencing access to rural health care services in Idaho. Mr. X explained, “It’s hard to recruit physicians to this area. They have to be looking for the kind of lifestyle that is afforded in this area, an outdoor lifestyle.” Most resident physicians end up practicing close to where they train, in urban areas near the large teaching hospitals in urban centers (Rosenblatt & Hart, 2000). Likewise, over 90% of residency programs are in urban locales (Chen, Andrilla, Doescher, & Morris, 2010). Thus, the challenges of recruiting a young physician from the known urban lifestyle to the unknown rural lifestyle are many (Chen, Andrilla, Doescher, & Morris, 2010).

Typically, family practice physicians are most appropriate for rural service, where a wide spectrum of care, from labor and delivery to end-of-life, is needed (Marfatia, 2008). Unfortunately, family practice physicians are dwindling in number nationally, and are therefore even more difficult to recruit to rural practice (Chen, Andrilla, Doescher, & Morris, 2010). As Starr demonstrates, the U.S. health care system rewards greater specialization. Medical training is geared to specialization, with medical schools producing greater number of specialists and fewer general practitioners; and reimbursement encourages specialization, with incomes for specialists being much

greater than that of generalists (Starr, 1982; Chen, Andrilla, Doescher, & Morris, 2010). This CAH administrator echoes Starr's assertions, "Typically, family practice [is] not the highest paid profession in health care so we always struggle with getting physicians to this area."

He wonders how long it will be before one of the "bigger organizations" buys the CAH out. "We are not part of any of those at this point, although we have actually considered or looked at joining with some of those hospitals, but have not done so at this point." The *horizontal integration* described by Starr, with declining numbers of freestanding institutions and the rise of multi-institutional systems, is clearly occurring in Idaho. As Starr points out, with this change in ownership comes a shift in control away from local boards to regional or national health care companies.

In this context of implementing the ACA, multiple interviewees described similar concerns about CAHs viability and highlighted the crucial role that CAHs play in Idaho's rural communities.

Idaho has done a very good job with the resources it's had. Idaho has 27 CAHs, however, I think we're under threat. While perhaps not every single CAH must remain open, or is fiscally responsible to keep open, it's certainly the case that when you cut with a wide swath you may in fact not have an understanding of the key role that CAHs frankly play in a state like Idaho.

This comment is similar to many made by interviewees that see the CAHs as integral to the sustainability of rural communities. Some saw the existence of the CAH in a community as a crucial feature for people considering a move to rural Idaho. "Without a

hospital, people aren't going to move to a community, which means the schools are going to fail, everyone's going to fail."

Others recognized the financial contributions made by the CAH to the community's economy. "The CAH is frequently the largest employer in the community. If the CAH goes away then the community will not survive." These remarks demonstrate that many see the CAH as the economic hub of the community.

Some interviewees, particularly those employed by a CAH, described the financial strains experienced by CAHs. Two CAH administrators explained the financial difficulties of a CAH as an imbalance between costs and income.

The same 12 hour shift is going to cost a CAH the same amount of money if not more because you're asking someone to go out of their way and they're not going to accept less, nor should they, yet they're to come out and serve maybe 8 patients in a 12 hour period, or they might serve 25. The volumes are so volatile in the CAHs that you've got to pay the doctors the same wages and yet the volumes are so sporadic that you don't necessarily have the revenue stream to support those wages.

Clearly, in this administrator's opinion, CAHs are at a distinct disadvantage when it comes to being financially self-sustaining in the rural context.

A second CAH administrator similarly described his CAH's financial woes.

We have all of the overhead costs, but we don't have the volumes so we work at a very big disadvantage. The CHCs come in and skim patients off the top, contract for auxiliary services in other places and don't give back to the community. We can't compete with them.

This administrator explained that the competition from the CHCs further compounds the financial difficulties related to low patient volumes. His comments suggest that the competition from the CHC, and the resulting loss of revenue from out-patient and auxiliary services, may be the difference between financial sustainability and collapse for CAHs.

Others interviewees indicated that CAHs may be contributing to the difficulties of rural health care access in Idaho. One rural physician questioned the CAHs' priorities.

Most health care in rural areas is centered around the CAH and that actually becomes a problem because the hospital has its own interests and the hospital gets paid for having people in the hospital. One rural hospital in Idaho had hospice and home health, both great services for the community, but the hospital board dropped them because they weren't money makers. So the hospital is an interest group and they have their own definition of who they represent. You know, are they a public hospital or a private hospital? Are they a full for profit hospital?

His comments imply that the CAHs' greatest concern may be their own economic interest rather than provision of needed services to the community.

That same rural physician remarked on the employment practices of his local CAH and questioned their appropriateness.

At the local CAH on weekends there are 4 people working in the hospital, 3 nurses and 1 doctor. The radiology technician and the lab technician are on call and come in if necessary for a total of 6 employees on the weekends. Monday mornings, 40 people walk into the hospital to work and I don't understand that. So

that's part of the cost of health care. We're going to have to look at those questions; pretty, pretty tough questions.

Suggesting that the CAH may not be operating on as lean a budget as possible and that a large portion of their employees may not be required for patient care provision, this interviewee provided a contrast to others' descriptions of CAHs as saviors of the rural economy.

The qualitative interviews revealed many aspects unique to Idaho's rural health care system that influence access to care. The competition, rather than collaboration, between the CAHs and CHCs was seen as significant factor. The struggle to maintain financial viability, with an imbalance between overhead costs and revenue, for both rural facilities and individual providers, was also recognized as an issue that impact access to care in rural Idaho. Acquisition of community hospitals by regional medical centers was seen by some as a potential answer to the financial woes of community facilities, yet concerns were raised by others regarding the impact of those acquisitions. CAHs were described as crucial to the sustainability of rural communities, yet some interviewees questioned whether CAHs' budgets were examined closely enough and whether or not the CAHs were more concerned with their own sustainability instead of the communities' health care needs.

Primary care provider shortage

This state factor was mentioned as having a significant impact on access to health care services in rural Idaho by the vast majority interviewee. Of particular significance, the overwhelming majority of interviewees framed this factor as a primary care physician

shortage. Only three interviewees also mentioned a shortage of nurse practitioners or physician assistants as having a significant impact on rural access.

Some interviewees attributed the shortage of rural primary care providers to the greater demands presented in rural practice settings. One rural physician said, “Rural primary care practice is demanding. Rural doctors round on their own patients, deliver their own babies, they’re on 24/7.” This description of the wide range of services typically provided by a rural primary care physician, and a lack of multiple colleagues with whom to share coverage, resembles the typical physician workload in the 19th century, before medical sovereignty consolidated.

Another rural physician made similar remarks regarding the range of care provided by rural primary care physicians, yet also recognized that this is no longer always the case.

The vast majority of babies born in Idaho are delivered by family doctors and they also provide most of the geriatric care. It used to be that all family docs were expected to do OB, we did it in residency and when we got out of residency. Now there are not only fewer going into family practice, but many of them are opting out of OB, which wasn’t even an option when I became a family doctor.

His comments illuminate the complexities of rural provider shortages. The issue is not necessarily simply a matter of numbers of primary care physicians, but what services those physicians are willing to provide, which have consequences for rural women.

Other interviewees remarked that rural physicians’ income does not reflect the increased range of services they provide. “Rural physicians get less compensation, but experience greater 24/7 demands.” This comment, by an interest group administrator,

suggests that lower compensation may contribute to the rural physician shortage. What the interviewee does not specify is who it is that gets more compensation than the rural physicians.

One health care facility administrator, faulted Idaho's legislature for not funding competitive physician loan repayment programs. "Idaho's loan repayments don't compete well with those of nearby states like Wyoming or Montana." This comment underscores the fact that Idaho must compete with other surrounding rural states when attempting to address its rural physician shortage.

One administrator saw Idaho's political environment as a factor which may be contributing to the rural physician shortage.

Neighboring states are very proactive around the ACA, bringing millions or billions of ACA money into the state. Medicaid expansion is a huge swing to the bottom line as it reduces charity care. So it's one thing to be a rural provider in some of these neighboring states that are doing well, but it's another to be one in Idaho, a relatively poor state where now the state is not accepting the largest piece of Medicaid. We're finding that the federal government is starting to worry less and less about states like Idaho. And that's gonna make our physician recruitment that much harder.

This administrator's comments indicate that Idaho's politics have the potential to negatively impact the state's already difficult provider recruitment efforts. These comments also highlight the competitive nature of provider recruitment among rural states. Furthermore, these remarks suggest that the federal government may ignore those states that refuse to expand Medicaid and lead to greater isolation.

Several interviewees identified retention of rural physicians as an issue. A CAH administrator indicated that retention, rather than recruitment is a major issue. “We’re investing a lot of money in their education and now we need to invest the money in their retention.” A rural nurse practitioner reported a similar perspective. “Younger doctors don’t want to practice in rural settings. They give incentives of paying off their loans, but as soon as that’s done the doctors leave.” As a result, rural communities may not experience much continuity of care, with physicians staying just long enough to get their loans repaid before moving on.

Interviewees also indicated that the rural physician shortage impacts the type and quality of care provided in rural areas. One rural physician stated:

Access to preventive care begins with the primary care provider and rural areas in Idaho struggle to recruit primary care doctors so that limits the level of preventive care accessed in rural Idaho.

Thus, a lack of primary care providers is viewed by some as contributing to inadequate levels of preventive care provision in rural Idaho which may contribute to poorer health outcomes for rural populations. Although this interviewee did use the term “primary care provider”, he specifically identified the recruitment of primary care doctors as what limits the preventive care access.

A majority of interviewees recognized the rural primary care provider shortage as a factor that impacts access to health care services in rural Idaho, only 3 interviewees mentioned the shortage of rural NPs or PAs. Rural physician practice was described as less lucrative and more demanding, with longer hours and a broader range of services, than urban practice. These characteristics of rural practice were identified by interviewees

as barriers to both physician recruitment and retention in rural Idaho. However, some noted that the broad range of rural physician practice has narrowed, with the exclusion of women's health/OB services from training and family practice. Interviewees emphasized the stiff competition Idaho faces, not only with urban areas, but with other rural states, when attempting to recruit rural physicians. Idaho's physician loan reimbursement rates and the state's political climate were also raised as potential impacts on rural physician recruitment in Idaho. Interviewees gave numerous examples of the potential effect of the primary care provider shortage on the quality and type of health care provided to Idaho's rural residents.

Additional Factor: Nurse Practitioners

Interviewees, as previously mentioned, identified the primary care provider shortage as a factor that influences access to health care in rural Idaho, but only very few interviewees specifically mentioned NPs or PAs when discussing the provider shortage. I anticipated nurse practitioners being identified as more central to access to health care services in rural Idaho, where the Nurse Practice Act allows for NP independent practice. The qualitative interview specifically asked interviewees about their views regarding the use of nurse practitioners or physician assistants as primary care providers in rural Idaho. Because so few interviewees independently mentioned NPs in their comments regarding the rural provider shortage, inclusion of this specific question allowed insight into the varied perspectives on nurse practitioners and physicians assistants and their roles in rural health care in Idaho.

Physicians, health care facility administrators, and interest group staff referred to nurse practitioners and physician assistants as "mid-levels" and generally indicated that,

while these practitioners can be helpful, they lack the qualifications to serve as rural primary care providers.

If a mid-level doesn't know when they're in over their head then that's dangerous. If they don't know their limits and don't ask for help then by the time they get to a physician the patient has been completely mis-managed. They should have a limited role. Most of them do a good job with urgent care or very straight forward cases, but we see a lot of complex, chronic care patients with lots of co-morbidities that are more difficult.

This rural physician suggested that NPs or PAs can cause harm unless their role is limited to acute, non-complex care and emphasized the need for NPs/PAs to depend on physicians for "help". Another rural physician expressed similar views regarding the capabilities of NPs and PAs.

NPs and PAs can't handle the complexity of many patients nor be as efficient as primary care physicians. Patients of NPs and PAs will get referred to specialists a lot more because they get overwhelmed and send slightly complex patients out.

While these physician's comments echo those of the previous interviewee, there does seem to be some contradiction over whether NPs and PAs do not know their limits and do not refer to a physician quickly enough, or if they refer too quickly and too often. Even more substantial is the physicians' apparent challenge to the Nurse Practice Act which recognizes NPs as qualified and legally authorized to practice independently in Idaho.

Several interviewees commented on the need for a physician to direct patient care. One rural physician stated, "NPs and PAs are imperative as extenders to the physicians,

but without the physicians there to ground and lead the team, then it's somewhat dangerous." Another rural physician expressed similar a similar view, "In one respect they can improve access to care, but if they're not part of a physician-led team it can lead to higher costs with unnecessary referrals to specialists." These remarks by rural physicians suggest that the NPs' and PAs' purpose is to expand the number of patients who can be seen in a clinic yet not to function independently, contrary to the independent scope of practice for NPs that Idaho law authorizes. Repeatedly the notion of NPs and PAs as "dangerous" is presented, but here it is also suggested that the physician will serve to protect the patients from that danger by "grounding" and "leading" the team.

An interest group administrator shared a similar opinion regarding the role of NPs or PAs in relation to physicians.

NPs and PAs need to work on a care team led by a physician. They can be utilized as part of a rural health care team with a physician as leader, or quarterback. (We) Need to expand the number of rural NPs and PAs, but they need a physician referral base and to practice within the team approach.

The sports metaphor applied by this interviewee and several others is interesting. The quarterback is the offensive leader of a football team, calls the plays, and generally runs the offensive aspect of the game. Questions that arise when considering the sports metaphor include: Is health care a game? Who is the opponent?

Some interviewees cited differences in training as the rationale for NPs and PAs not to function outside of a team approach.

In terms of training, the difference in hours between a physician and NP is about 30,000 hours. We need patients to be seen, but NPs and PAs have to know their role, it has to be well defined.

This rural physician has clearly read the American Academy of Family Physicians literature referenced in chapter 2 of this study, which touts this same 30,000 hour figure to argue against NPs' independent practice authority (AAFP, 2012). In this comment, the terms "know their role" suggests NPs and PAs should "know their place", a gendered phrase that warns against acting in a non-subordinate way.

Another rural physician also mentioned the superior training received by physicians. "NPs and PAs are great assistants, great workforce multipliers. By themselves, however, the training is not nearly as good as the physicians'." This interviewee echoes the belief that the role of NPs and PAs is to serve as a physician's extender or multiplier, expanding physicians' reach and billing abilities.

Not all physicians who were interviewed spoke about NPs or PAs being dangerous or needing to be led by a physician.

I think they're a very integral part of rural health and I think that, for instance, probably 98% of every single preventative service that is offered to our population should strictly be done through mid-level providers.

Although this comment was more positive than most, the physician still referred to NPs and PAs as "mid-level providers" and suggested that the role they are allowed to fill needs to be confined to preventive services, seen as more "soft" than the physicians' role.

A different perspective was offered by two interviewees who provided specific reasons why they did not see NPs or PAs as part of the solution to rural health care access.

NPs and PAs are great if they have a very definite role. NPs and PAs don't really want the obligation required to take over primary care, they don't want to be in a code. I've seen NPs and PAs utilized more in medium-sized towns where they can work 9 to 5, 3 days per week and make enough money. But that's not continuity of care.

This statement assumes that NPs or PAs are not interested in providing all aspects of rural care and, furthermore, are not willing to work as hard as rural physicians.

Another interviewee, an interest group staff person, argued that NPs being able to practice independently in Idaho has not improved the rural primary care provider shortage.

Independently licensed NPs in Idaho haven't seemed to have helped the maldistribution of providers. NPs are just as likely to subspecialize and locate in urban areas as their physician counterparts.

On the one hand, NPs were described as a lesser, "mid-level" provider, yet on the other hand, NPs were compared with "their physician counterparts" when discussing their interest in specialization and willingness to practice in a rural locale, suggesting the ambivalent views many held about NPs and PAs.

Not surprisingly, NPs who were interviewed shared a different perspective. They reported reimbursement regulations and poor physician attitudes as reasons more NPs do not practice independently in rural areas. In addition, one rural NP explained that, despite

being licensed to practice independently in Idaho, NPs must have physicians sign off on their documentation in CAHs and CHCs.

NPs, who can practice independently in Idaho, are required to have all their charts and orders signed off on by a MD in a critical access facility or RHC (Rural Health Clinics). Medicare and Medicaid rules are the reason NPs have to have physicians co-sign everything, they overrule state law.

Thus, even federal regulations and state legislation with varying NP licensure laws reflect an ambivalence at the policy level about NPs' independent practice.

Another rural NP reported that physicians want to have NPs to increase their revenue, but not to see patients independently.

More NPs would practice in rural settings if they (physicians) were more accepting of independent NPs. The doctors like us to work for them, not as competitors, so we NPs sometimes have a bit of a fight on our hands. I had one of my patients report that when he'd been seen in the emergency department, when he reported I was his primary care provider, the emergency room doctor told my patient that about the only person I'm good to see is one with a runny nose, a bloody nose, or a hang nail, and that he should see a real doctor.

The interviewee relayed this story as an example of a physician directly undermining the relationship she had with a patient by degrading her qualifications. She also indicated that the literature regarding Patient Centered Medical Homes authorizes this type of attitude toward NPs.

The PCMH literature doesn't make me very excited. It's very heavily doctors that don't want to be involved unless they can be the boss. As a NP I sure love being called "second tier" in the PCMH literature, and "mid-level" is my next favorite.

Despite what she sees as a very negative vision of NPs by rural physicians, she does believe that NPs help improve rural access in Idaho.

NPs, and PAs with supervising physicians, provide access to more people because it's hard to recruit physicians to rural areas because the pay's just not there. A NP or PA providing primary care just provides access that might otherwise not be there.

This comment highlights a key policy difference between NPs and PAs: NPs can practice independently, but PAs are required by law to practice under the license of a supervisory physician. One interviewee, a CAH administrator, also noted this difference and its effect in rural health care settings.

We should separate out nurse practitioners from physician assistants. Nurse practitioners are fully trained and capable of providing a full spectrum of primary care services, whereas physician assistants have to operate under the license of a physician so they are not as valuable in rural care settings where they are required to have a physician quote unquote "supervise" them. Nurse practitioners should be more widely utilized and they could answer a lot of the access issues here in Idaho.

In this administrator's opinion, NPs, with their ability to practice independently, have greater potential to improve access to health care services in rural Idaho than do PAs.

One interviewee spoke about the use of NPs from two different perspectives, that of a hospital administrator and as a patient.

I know politically that there are at times difficulties between primary and specialty care providers, and MDs accepting and acknowledging the importance of the mid-levels, the NPs and PAs in the community. We're doing a lot of work to educate and share ideas and it goes back to the premise that we're all better together than we are alone, we all need each other because there are just opportunities for all. Quite frankly, I hear from patients that they don't care if they go to a doctor, they don't care who they see, they want to go someplace where they can build a relationship and not have it be [about getting] you in and out in 10 minutes. I go to a nurse practitioner here and what I've found is that I can go in there and it can be the most off the wall things and she'll stop and say, "Oh, you know that's a really good question" and she'll go on to explain here's probably why and then say let's think about that. You know I'm not in there 2 ½ - 3 hours, I'm in there maybe 10 minutes longer than a normal visit with my doctor, but it's not big business medicine, it's a relationship that I have with her and I walk out of there feeling ok. You know what? She's gonna help me heal or she's gonna shoot me an email, you know, and let me know, hey I did a little research and this is what you're thinking. It's a different kind of relationship. It's the kind of relationship I think more of us would like to have with our providers.

This interviewee conveyed that, as an administrator, she is aware of the conflicts and controversies regarding NPs, but as a patient she is also aware of the positive aspects of NP care and their positive differences from physicians.

A state administrator also recognized the role that NPs and PAs play in providing care to rural populations in Idaho.

They are one of our most valuable resources in rural Idaho, and one of the rural health clinic requirements is that you must have a PA or NP on staff seeing patients at least fifty percent of the time that the clinic is open. So they are essential to our workforce in rural Idaho, absolutely critical to our workforce.

This state administrator's use of terminology such as "most valuable", "essential", and "absolutely critical" when describing NPs and PAs suggest that these providers are highly valued.

In the state factors part of the interview, only three of 20 interviewees spontaneously identified NPs or PAs as an integral part of the rural primary care provider shortage in Idaho. Prior to data collection I had anticipated that, in a state where they are licensed to practice independently, NPs would be a recognized as a substantial aspect of rural health care in Idaho. Analysis of the qualitative interview transcripts revealed that NPs are not widely seen as the answer to rural health care provider shortages, but may be viewed as useful within health care teams if they follow a physician's lead and perform within a limited role. Some interviewees, especially physicians, noted the inferiority of NP training versus that of physicians, stated that they were not qualified to see complex patients, and suggested NPs and PAs may even be "dangerous". Some interviewees did, however, describe how NPs, as independent providers, could play a greater role in addressing the primary care provider shortage than PAs who are required to practice under a physician's license. NPs indicated that they saw themselves as capable of providing a wide range of primary care services; however, they felt that federal

regulations and physician attitudes served as barriers to their independent practice. The interviewee who spoke from her perspective as a patient who is treated by a NP suggested that patients may see NPs not in terms of their hours of training, or as “better or worse” than a physician, but rather as a health care provider with whom they can have the type of engaged, patient-centered relationship that they desire.

Additional Factor: Affordable Care Act (ACA)

The qualitative interviews also contained questions about how the ACA and the politics of Medicaid expansion may influence access to health care service in rural Idaho. Similar to the topic of NPs, the ACA and Medicaid expansion were not spontaneously identified as state factors, but were addressed via specific questions contained in the qualitative interview.

Idaho has consistently opposed the ACA. The vast majority of Idaho’s population and politicians are conservative and staunch supporters of state sovereignty. So much so, in fact, that Idaho’s legislature took steps to guard against any federal health care reform even before the ACA was passed by Congress. On March 17, 2010, Governor Otter signed the Idaho Health Freedom Act, which says, according to the Governor, “...that the citizens of our state won’t be subject to another federal mandate or turn over another part of their life to government control” (State of Idaho, 2010).

Both the Governor and the Idaho Attorney General officially voiced their opposition to the ACA as Idaho became one of 26 states to challenge the constitutionality of the Affordable Care Act in a lawsuit filed on March 23, 2010 (Kaiser Family Foundation, 2012a). The predominantly Republican state legislature passed a bill in the 2011 session which served to nullify “Obamacare”, however, the Governor vetoed it,

opting instead to issue an executive order prohibiting state agencies from implementing “Obamacare” (State of Idaho, 2011). The Governor, while stating “No one has opposed Obamacare more vehemently than me”, never the less chose to veto the bill in order to maintain the ability to develop a state-run health insurance exchange, and avoid “further control over Idahoans” in a federally-run insurance exchange, should the Supreme Court uphold “Obamacare” (State of Idaho, 2011).

After the Supreme Court upheld the individual mandate and the health insurance subsidies of the ACA and a Governor-appointed task force recommended that a state-run health insurance exchange be set up, the Governor supported the establishment of a state-run exchange. There was significant opposition by many conservative legislators, one even going so far as to liken a state-run health insurance exchange to the Holocaust (Spokesman-Review, 2013). By the time legislation to establish a state-run exchange was passed, there was inadequate time available to get the exchange up and running before the first ACA open enrollment. Therefore, Idaho used the federal exchange for the initial open enrollment and then transitioned to its state-run exchange in time for the second open enrollment in 2015.

Ultimately, Idaho became the only state in the union to build its own health insurance exchange yet opt out of Medicaid expansion (Norris, 2016). In 2015, there were 54,000 Idahoans denied coverage through the state-run exchange because their incomes were too low to qualify for health insurance premium subsidy via the ACA and yet, because Idaho has not expanded Medicaid, ineligible for Medicaid (Spokesman-Review, 2016). Several health care task forces, convened by the Governor over the past several years, all recommended expanding Medicaid. However, no bill on Medicaid

expansion in the Idaho legislature has ever made it to the floor for vote (The Idaho Statesman, 2016).

Several interviewees expressed frustration over failures to legislate Medicaid expansion as part of the ACA implementation in Idaho. One interest group administrator reported,

We've had three shots at the legislative assembly and failed every time to get them to seriously consider Medicaid expansion. Idaho you know has its single party system. The numbers of Democrats is so small that the Republicans can substantially ignore them. You know this anti-federal, the "Obama is evil" vibe, to where we're just being senseless and we're actually causing harm. It's interesting on Medicaid expansion we have 78,000 people that you could help, but you're choosing not to. That's a much more difficult proposition because they (Republicans) are used to not helping them.

These comments reframe the "anti-Obama" stance in the Idaho legislature as an active choice to deny access to affordable care for the most vulnerable in Idaho.

That same administrator, while continuing to lament the conservative political environment in Idaho, questioned how much health care professionals are contributing to the problem by not actively advocating for change.

At the end of the last legislative session a reporter was interviewing the governor and asked how he graded the legislature this session and he gave them an "A" in education funding, a B- in transportation, etc., and we were just noting that in Idaho he doesn't even have to give a letter grade to how you do in health and social services. It's just fascinating because health care is the biggest component

of this state's, or any state's, economy. In health care we're having the conversation about to what degree are we contributing to that by not exercising the voice we should be exercising.

This administrator expressed clear frustration regarding the low ranking of health care in the hierarchy of state political priorities, contending that providers are not embracing their advocacy role as aggressively as they should.

The interviewees' responses to questions regarding the ACA and Medicaid expansion reflected a wide spectrum of political beliefs and contraindications. Those focused on the conservative ideology reflected a disdain for "government programs". One CAH administrator noted,

I don't believe in taking care of people through government programs, but if we had Medicaid expansion in this state it would have resulted in more people having the potential ability to access health care in rural areas.

In spite of her opposition to government programs, she acknowledged that Medicaid expansion could enhance rural health care access in Idaho.

Another CAH administrator focused on the "abuses" of entitlement programs, I think that the biggest policy change that's needed is a redesign of Medicaid. The service is so abused; people receiving it need to be educated and services, like use of the ER for non-urgent care, needs to be limited. I think those on Medicaid need to be more educated on what an emergency is as opposed to what can wait because I hear a lot of people coming in, "Well, I've got the card, I don't have to pay for it" when they're coming in for a cough. That's abusing the system. And

when I see at the grocery store somebody using their card to buy steaks most of us can't afford I think there needs to be limits put on that.

While this CAH administrator clearly believes Medicaid abuses are rampant, her remarks also demonstrate confusion regarding the Medicaid card versus the food stamp card.

The responses which focused on liberal ideology were more commonly directed toward the lack of Medicaid expansion in Idaho. One state administrator vehemently stated,

Three times in the past, every year,... the legislature has chosen not to expand Medicaid, so we are losing dollars, federal dollars into the state, we're losing the ability to increase medical services for people. People are dying because of it. We're losing money, we're losing health care jobs, we're losing health care services, and people are losing their lives. Every year for the past three years there have been work groups that have addressed this and the recommendations have been to expand Medicaid. It's fiscally responsible, it's morally responsible, it's ethically responsible, it's legislatively responsible. This is not a civil right or a civil liberty, it's a human right, to be able to be taken care of.

These remarks demonstrate the perspective that lack of Medicaid expansion has far reaching effects. The interviewee's passion and frustration regarding Idaho's lack of Medicaid expansion are evident. It is interesting to note that the loss of funding or money is a shared focus among interviewees regardless of political ideology.

Another interviewee, an elected official, echoed the concern about a lack of Medicaid expansion.

We can't get Medicaid expansion passed yet. And so the politics are profoundly effective simply because it's getting an ideology, a political ideology, against helping your citizens. And, so far the political ideology is winning.

Thus some interviewees asserted that Idaho's political environment itself is negatively impacting access to health care services in rural Idaho.

Interviewees also provided multiple viewpoints on what impact the ACA, irregardless of Medicaid expansion, has had on access to health care services. There were several interviewees who opined that the ACA had not enhanced access to health care services in rural Idaho. One CAH administrator complained about the stringent requirements of the ACA stating,

The ACA has made things worse. Rural providers, such as the CAH where I work, have to meet extreme compliance requirements and the increased numbers of patients isn't enough to offset the increased cost of compliance, such as additional FTEs (full time equivalent).

Citing the numerous new and "extreme" compliance requirements that accompanied the ACA, this administrator determined that the ACA is cost-prohibitive.

Another CAH administrator thought that the ACA had promised far more than it had delivered regarding increased access.

I think it's created a lot of complexity and here's an example: When the ACA was marketed and then became law people assumed that meant everybody was getting insurance. And what we know is that's not what that meant at all. It meant that the government would mandate that you have to have insurance or proof of insurance or you have to be insurable and get it and document it on your tax forms on an

annual basis. And so as far as I am concerned the ACA has done nothing to get people access to health care. It's created a lot of confusion with regard to who has coverage, how you get coverage, and then there's that whole big Medicaid gap.

It's a mess.

Contrasting the "marketing" of the ACA with "what it really meant", this administrator conveyed a sense of betrayal and disappointment, emphasizing the burden of the ACA mandate with no description of any resulting benefit.

Interviewees recognized the role that politics have played in Idahoans' support, or lack of support, for the ACA. An interest group administrator commented,

We've been in a lot of community groups where there's a lot of vitriol against Obamacare and how horrible it is, but then when you ask the obvious questions, like does anybody in the room have somebody in the family who is uninsured because they fall into the coverage gap? Everybody knows somebody. Or, has anybody in the room benefitted because now their kids can be covered under their group coverage to age 26? A lot of hands go up. Has anybody benefitted from the no preexisting condition elimination? Hands go up. That's Obamacare.

These remarks highlight the conflict experienced by community members who appreciate the individual benefits from the ACA but oppose or demonize the President's policy.

In an environment where reactions to the ACA are driven by ideology and intense emotions, some participants focused on the observed positive changes in their practices.

With the ACA I've seen a lot more new patients come in for a wellness exam so I was able to provide a lot of good health information and screenings. It's getting

more people access to good information about preventative health care so they can avoid issues 5 to 15 years down the road.

The majority of rural clinicians interviewed echoed these sentiments and indicated that they had seen a change in their practice, with more people accessing preventative care and seeking care for health issues sooner, since the ACA implementation. Their accounts imply that rural Idahoans, depicted in the media as absolutely against Obamacare, have sought out preventive and wellness care newly accessible to them through the ACA.

Overall, the interviewees' perspectives regarding the ACA were ambivalent. Almost every interviewee, regardless of ideology, reported both positive and negative aspects to the ACA. The table below, Table 1.1, demonstrates the complexity of interviewee perceptions on the ACA.

ACA Table

Interview #/Interviewee Category	Pro	Con
1/State administrator/Executive branch		Gov. Otter and our legislature are not supportive of the ACA
2/Interest group staff	The ACA is a step in the right direction	
3/Interest group staff	The most positive influence of the ACA would be Medicaid expansion if this state would choose to participate.	
4/		
5/Elected official	The ACA has increased payment to primary care and to rural health providers	Those positive influences were very marginal; it's not all that needs to be done.
6/Rural clinician	There's been a positive shift in more preventative care and people with problems coming in sooner than later.	
7/Rural clinician	Definitely a lot more preventative care	

8/Rural clinician		The ACA was helpful in the first year, but now they've become catastrophic plans because they're so expensive.
9/Rural clinician	It has definitely improved the amount of patients actually getting wellness care	
10/Administrator, h.c. delivery setting		Health care certainly isn't any cheaper. It's cheaper to afford the penalty than the insurance.
11/Administrator h.c. delivery setting	The ACA has made things worse. The increased compliance requirements are too expensive to maintain.	
12/Interest group member/Rural clinician	It has provided people with more access. I've seen more people coming in for primary and preventative care than they did before the ACA.	
13/Administrator h.c. delivery setting		With the ACA I think it's been harder to get acute care than in the past. You really, really have to be sick to get insurance companies to cover acute care now.
14/State administrator	Over 85,000 people have gotten health insurance through our state exchange so there's been a positive impact	
15/Elected official	Many more covered. Coverage for pre-existing and preventative care now.	
16/Interest group administrator	Definite shift from uninsured to commercially insured	
17/H.C. delivery setting administrator		The ACA has done nothing to get people access to health care. It's created a lot of complexity and confusion. It's a mess.
18/Interest group staff	The uninsured rate has come down a lot in Idaho under the ACA	
19/State administrator/Executive branch	Idaho's exchange has gotten a lot of people insurance. The SHIP grant came out of the	Lack of Medicaid expansion has created our gap population. Lack of expansion

	ACA.	has a huge effect throughout the state.
20/Interest group staff	There's definitely people who are getting coverage they never had before.	

Additional Factor: Interest groups/Policy voices

The qualitative interview included questions asking interviewees to identify those individuals or groups that they saw as having the most influence on policies that affect rural health care access in Idaho. There was also a question asking interviewees about rural health interest groups in Idaho. Interviewees had varied opinions regarding rural health care policy and rural health care interest groups. There was, however, some consensus regarding what groups have the greatest influence on policies that influence access to health care services in rural Idaho. A majority of interviewees indicated that the Idaho Hospital Association (IHA) and the Idaho Medical Association (IMA) are among those groups that have the greatest health policy influence. Several interviewees spoke to the power wielded by both individual physicians and physician groups. One rural physician provided an example of the priority placed on physician interests by the state legislature.

I remember several years ago there were only two things that didn't suffer funding cuts because the Idaho economy was down and those were roads and the family medicine residency programs. Universities saw their budgets cut by 7% that same year.

This comment implies that the legislature, even during times of economic strife, sees physician interests as paramount.

Another interviewee, an interest group staff person, also described the ability of physicians to impact policy implementation.

The IMA is able to take ideas and move them forward into policy. The IMA hires lobbyists. When physicians talk to their legislators they really listen, that's very powerful.

This remark also speaks to the strong voice and power asserted by both individual physicians and physician groups among the state legislature.

A rural nurse practitioner recognized the influence of physicians yet also felt nurse practitioner groups have played a role.

Individual physicians and the IMA have the greatest influence on policies that impact rural health care access in Idaho. The American Association of Nurse Practitioners (AANP) also has had an influence on Idaho's rural health care access behind the scenes.

Her comments suggest that the nurse practitioner organization asserts its influence in the shadows, outside of the public eye. She sees the AANP's role as less apparent than that of the IMA, but still impactful.

In comparison to the majority of interviewees who identified the IMA and IHA as most influential, four of 20 interviewees included the Governor or the state legislature on their list of most influential groups. The large regional medical centers (RMCs) were also listed by 4 interviewees, tied with the Governor and state legislature, as being among the groups with the most influence on policies that affect access to health care services in rural Idaho. One interviewee's comment demonstrates the perception that the large RMCs are influential. "The big hospitals, which we're not and most hospitals in Idaho are not,

those three have the most influence on policies that affect Idaho rural health care access.” This remark, made by a CAH administrator, also hints at the frustration felt by those who do not see themselves as wielding much impact on rural health care policy.

A rural provider was also one of the interviewees who listed the large RMCs among the most influential groups. “The large facilities have the most influence on policies that affect Idaho’s rural health care access.” An elected official expressed a similar perspective regarding the influence of the state’s RMCs. “The two main RMCs and the IMA have the most influence on policies impacting Idaho’s rural health care access.” Thus, it was not only those interviewees who were affiliated with smaller facilities who felt the RMCs wielded significant power.

Multiple interviewees commented on the lack of rural emphasis within the most influential groups. Although she listed the IMA, IHA, and the large RMCs as most influential on policies that affect access to health care services in Idaho, one administrator of an interest group questioned the importance of rural health within those groups.

Within the IMA or IHA I actually think rural health has a weak voice. IHA conversations are, I find, dominated by Luke’s, Al’s, and Kootenai. I’ve met with CEOs of CAHs and they feel a disconnect.

This remark suggests that although these entities may be among the most influential on rural health policies in Idaho, rural health may not be their priorities. A CAH administrator echoed this sentiment. “I can’t say that I feel there’s a strong, rural advocacy group in the state of Idaho. The IHA is much more focused on larger facilities throughout the state.”

Others noted that, because Idaho is predominantly rural, the statewide interest groups did represent rural priorities. “The IMA or IHA, while they may not necessarily have staff that are solely dedicated to rural, because so much of Idaho is rural, it is truly integrated with the work that they do.” This executive branch administrator’s opinion was that the IMA and IHA do adequately consider rural perspectives, despite the fact that they do not have aims specifically targeted to rural health issues.

Another elected official considered national advocacy groups as rural health interest groups.

There are a whole bunch of rural health care interest groups, but they don’t seem to be focused entirely, however, on the whole array of rural health issues. Many of the advocacy groups, such as the American Cancer Society, have some interests in rural health, but there doesn’t seem to be an umbrella organization that actually is able to organize all of those efforts.

While acknowledging that many of these organizations incorporate rural health in their national efforts, this elected official’s comments suggest the organizations’ narrow focus on single issues and fragmented approach to rural health may limit the impact of their efforts on rural access to health care services.

A significant number of interviewees expressed frustration about policies that impact access in rural Idaho being determined by stakeholders located in urban areas or those without real knowledge regarding rural realities. One CAH administrator explained:

Idaho as a state is very Boise-centric. The true understanding of rural Idaho gets lost in translation when it gets into the political workings of Boise. The true definition of rural is very different depending on who you’re talking to and what

their point of reference is. When I hear a physician in [suburban] Eagle talk about being rural I struggle with that concept.

In describing Boise as the center of power within the state this interviewee portrays the state capital as speaking its own language, one that “translates” rural realities into something unrecognizable. One CAH administrator voiced a similar opinion about those with the most influence on rural health care policies: “Those with the most influence on policies that affect rural access to health care in Idaho are probably not the people that really need to have the most influence.” This comment was made in reference to the strength of urban voices in statewide policymaking.

Rural providers from Northern Idaho voiced similar perspectives.

I don't think I have an opinion on (who has influence on policies impacting rural health care access in Idaho). I don't know that anybody up here has much influence on anything anyway statewide only by the simple fact that we're so far away from Boise.

This rural provider's comments convey her sense of irrelevance to state policies on rural health, and a near total concentration of political power at the state capital. Another rural clinician's comment reflects a similar frustration. “I know a lot of the decisions that are made in the southern part of the state have less benefit to those in the north.”

These providers' remarks indicate that geographic location impacts the ability to influence rural health care policy and that, from their perspective, influence on rural health care policy is limited to those in Boise, the non-rural portion of the state.

Several interviewees recognized the Idaho Rural Health Association (IRHA) as a rural health interest group, but indicated that it lacks significant influence. An interest group administrator noted:

The Idaho Rural Health Association is a very small organization with very limited bandwidth. I wish that wasn't so. We wish they were much more robust and much stronger, and they do a wonderful job with what they have, but what they have is one part-time person. Why is our rural health association and our public health association so small? Who's the voice for the rural health care stakeholders?

This participant's wish that the rural health advocacy groups had more "bandwidth" highlights the need for more capacity to convey/broadcast political influence and "voice".

In addition to identifying those groups with significant influence, several interviewees also identified specific groups who they see as particularly lacking a policy voice. "Groups like Latino health organizations, or women's health organizations, or Planned Parenthood, in Idaho it just seems that those voices are quiet or missing." This comment, by a health care facility administrator, reflects the silencing effect within the conservative political environment in Idaho on racial and ethnic minority groups or advocates for "liberal" causes like reproductive rights.

The Latino population was recognized by another interviewee as a stakeholder group not heard in Idaho.

Idaho just doesn't have a strong Latino voice. Surrounding states place a much greater emphasis on Latino health and are reaching out to them, but in Idaho it seems more like they're pretending the Latinos don't exist.

These comments reflect the opinion of several interviewees who see minority groups as not having the ability to impact policies that influence rural health care access in Idaho, or who imagine the state to be completely homogenous.

Interestingly, two rural clinicians and a CAH administrator, stated that they were unaware of any rural health care interest groups. “I really don’t have an opinion regarding any rural health care interest groups. I don’t know that there are any. I’m sure there are, but there’s none that I’m aware of.” It is unclear whether comments such as these indicate that rural health care interest groups are not well recognized in Idaho, even by rural health care professionals, or whether some interviewees are not aware of organizations beyond their own.

Many interviewees identified physicians and the IMA as having the greatest influence on policies that impact access to health care services in rural Idaho. Surprisingly, only a handful of interviewees named the Governor, state legislature, and the largest regional medical centers in the state as having the most influence. A lack of rural emphasis was noted among those groups with the greatest influence on policy impacting access to rural health care by interviewees. Frustration among the interviewees was also evident regarding the singular influence of urban stakeholders, and rural stakeholders’ lack of access to political influence over rural health policies.

Policy Recommendations

The qualitative interview included a question which asked what policy changes interviewees see as most crucial to optimizing access to health care services in rural Idaho. Interviewee responses were diverse, but all focused on financing; Medicaid expansion, health care payment system revision, and enhanced physician reimbursement

were the policy changes most often cited as crucial. Less than half of the interviewees indicated that Medicaid expansion or insurance coverage for all would have the greatest impact on optimizing access to health care services in rural Idaho. Less than one third of interviewees indicated that they believe the entire health care payment system in Idaho needs to be revamped, and several of these participants felt the State Health Initiative Program (SHIP) “is a good start”. One quarter of interviewees recommended policy changes aimed at addressing the primary care physician shortage through enhanced physician reimbursement or recruitment and retention efforts. Facilitating the use and reimbursement of telehealth was viewed by some interviewees as a crucial policy change that should be implemented in Idaho. Three interviewees indicated that policy changes to ensure the sustainability of CAHs was crucial to optimizing access to health care services in rural Idaho. A small minority of interviewees, who were NPs, included more equitable reimbursement for NPs on their lists of crucial policy changes. Several interviewees had specific, unique suggestions for policy changes that they see as crucial to optimizing access to health care services in rural Idaho.

The majority of interviewees indicated Medicaid expansion is a policy change that they see as crucial, signifying that they believe it will greatly enhance access to health care services in rural Idaho. “Medicaid expansion would alleviate a lot of access issues in rural Idaho.” Some interviewees recommended Medicaid expansion due to the health benefits that they believed people would experience. “Medicaid expansion would improve access to care in rural Idaho. People would come in to get their problems taken care of instead of waiting.” Others saw Medicaid expansion as a way to address the physician shortage. “Medicaid expansion would help with rural physician recruitment

and reimbursement.” The economic benefits of Medicaid expansion were central to some interviewees.

I hope Idaho will expand Medicaid. I think it needs to be done. Research has shown the state will actually save money in the long run; people are gonna be taken care of in a more reliable way. Medicaid expansion would also bring jobs and money into Idaho.

These comments, by an interest group staff member, emphasize the potential financial benefits to the state and its economy as a whole.

An elected official also emphasized the financial pluses of Medicaid expansion, but viewed them from a different perspective.

Medicaid expansion would benefit both rural hospitals and rural providers in Idaho because at least then there would be an ability to pay, even if it is Medicaid rates, which are the least desirable; it would be better than no reimbursement.

These comments suggest that Medicaid expansion, if enacted, could help to ease the financial strain experienced by providers and health care facilities in rural Idaho.

Although there were several different rationales provided for why Medicaid should be expanded in Idaho, overall it was the most common policy change recommended by interviewees. “Medicaid expansion would be overwhelmingly positive for Idaho” is how one state administrator expressed it, which summarizes this group of interviewees’ perspectives as a whole.

Several interviewees saw a restructuring of the health care payment system in Idaho as a policy change crucial to optimizing access to rural health care services, and offered several different opinions regarding how that should be achieved.

Some interviewees recommended that our health care system start focusing on, and paying for, more holistic health care rather than emphasizing acute care and procedures as it currently does.

So much of what providers do doesn't require a clinical environment, especially if you're trying to focus on healthy behaviors and preventing future morbidity. But that's not what we pay for, we pay for sutures. We have to get off the procedural treadmill.

This administrator suggests that an increase in community-based, preventive care could have positive outcomes, but recognizes that such changes will not be implemented until the health care payment system values such care. A rural provider had similar views, "Idaho needs to change our health care system to emphasize and fund public health and preventive health more." These interviewees recommended a change in paradigms, with a shift from episodic-based care to holistic, preventive care.

Other interviewees had similar recommendations and saw the SHIP program as a means to achieving these goals. One health care facility administrator stated,

You've got to deal with the payment side either before or simultaneously or health care reform can never happen. Idaho's having some really good conversations with the commercial payers too; it's all part of the SHIP, around what payment needs to look like in the future. Blue Cross of Idaho is the champion for that conversation. They're starting to put their money where their mouth is on this one. More than anything else, we've gotta stop paying for procedures and start paying for the health of a rural population, and nothing will change until that happens.

These remarks demonstrate a belief that a change from payment for volume to value-based payment would improve access to health care services in rural Idaho and emphasized the potential impact of the recently implemented SHIP program.

Other interviewees also mentioned SHIP in their recommendations. An elected official stated,

The payment and delivery system needs (to be) totally reformed and the SHIP is a road map. SHIP is aimed at developing networks of care based on PCMH with continuity, primary care, and tied into community services, and pays such that it is sustainable. It's difficult to measure costs saved, but with a control group without PCMH and a group where there are PCMH you can compare the costs.

This interviewee is hopeful that SHIP will facilitate wider implementation of the PCMH model, improve collaboration, and enhance reimbursements.

Multiple interviewees saw policy changes aimed at increasing the number of rural physicians as most crucial to optimizing access to health care services in rural Idaho. Again, there were several different perspectives on how to approach this aim. An interest group staff person suggested changes in reimbursement policies would ease rural physician shortages. "If we could improve rural physician reimbursement for Medicare and Medicaid patients it would help with rural physician recruitment." One rural physician simply stated, "Pay the primary care physicians here more. It's a money thing." While this physician believes that more physicians would be willing to practice in rural areas if they were able to make more money, one rural physician in the study disagreed.

We need to find a way to keep physicians in rural practice. The work is demanding and the lifestyle is difficult. It's not necessarily about just the money; it's the work-life balance.

Thus a strategy to ease the workload of rural physicians may attract and retain more of them in rural Idaho.

A state administrator indicated that she saw increased state support for medical school training as crucial.

We need more state-supported medical school seats and a policy that requires a return to practice in Idaho for all state-supported medical school seats going forward, not the current seats. That would help rural provider shortage and access.

Without the recommended policy change to require a return for practice, Idaho could be funding medical school seats with no return on its investment. However, the question remains whether this requirement would attract or discourage applicants.

Several interviewees cited enhanced loan repayment as the most crucial policy change.

Enhanced loan repayment, increased residencies, and a state coordinated physician recruitment effort under the State Department of Labor, these are policies we need in order to have adequate numbers of rural primary care physicians.

These remarks suggest that a government funded, multi-faceted approach to physician recruitment and retention is the ideal approach to improving access to health care services in rural Idaho.

State administrators, health care facility administrators and rural physicians were among the interviewees who included expansion of telemedicine on their lists of the policy changes most crucial to optimizing access to health care services in rural Idaho.

I'm hoping the legislature will pressure payers to pay for telehealth services.

They'll pay for them if people get on the road and drive if it's medically necessary, but if they stay home and receive the same care via technology they won't. Legislatively there's going to have to be some pressure to get people to realize the realities of our demographics and our terrain and the distances that people are being asked to travel. It's imperative that people be able to stay in their home town to continue to drive the economy of their local health care system which drives the local economy of their whole system.

These comments, by a health care facility administrator, indicate that the reason to support and reimburse for telehealth is the economic survival of the local health care facility and, ultimately, the community. Interestingly, there are multiple references to "driving": the patients "driving" for care, the patients remaining in the community to "drive" the local health care system economy, and the local health care system "driving" the economy of the entire community. Others saw the rationale a bit differently.

It's not good use of anybody's time to have to get in the care and drive 3 hours one way to deliver health care to a community when that exchange can happen very appropriately over secured technology.

This remark, made by a rural physician, reflects the rural provider's perspective and emphasizes the most efficient use of their time.

One interviewee, a health care facility administrator, who advocated for telemedicine, presented it as a patient preference.

Everybody seems to get comfortable with telepsych or tele mental health and they're less comfortable with tele-physician services and I do wonder how much of that is protectionist and how much of it is a real concern over clinical outcomes. I think we should be more cognizant of what patients need and want. These comments illuminate the political aspects of telemedicine, which the interviewee describes as "protectionist", alluding to the rural physicians' desire to protect their professional turf.

Several interviewees saw policy changes related to maintaining critical access points of care as most crucial to optimizing rural access in Idaho. Some focused strictly on CAHs while some included other facilities.

Increasing and sustaining safety net rural providers, such as Federally Qualified Health Clinics (FQHC) and Community Health Centers (CHC), and CAHs, is a crucial policy change that is needed.

This interest group representative's comments demonstrate the dependence of rural populations on safety net providers and facilities, but also convey a "protectionist" strategy.

NP interviewees cited enhanced NP reimbursement as a policy change that could optimize access to health care services in rural Idaho.

Reimbursing all primary care providers equally, rather than NPs at 85% of MD reimbursement is a policy change that could positively impact access in rural

Idaho because more NPs would open their own clinics so more people would have access.

These remarks parallel those made by several interviewees about physician reimbursement and sustaining CAHs, as each profession advocates for policies related to their particular sector of health care.

Two interviewees offered unique recommendations for policy changes they saw as most crucial. One CAH administrator stated,

The health policy change that is most crucial to access in rural Idaho is to get the government out of the private business competition and determining who's the winner in the private market. The government shouldn't be allowed to do that, they should stay out of that. If the government let the free market determine things then the insurance companies would compete and bring prices down and quality would go up.

This interviewee's remarks suggest that government intervention into the health care market has created the high cost of care and that a free market would result in lower costs and, ultimately, improved access.

The other unique response to what policy change would be most crucial came from a rural clinician, a NP, who saw insurance costs as prohibitive. "The most helpful policy change would be to lower the insurance premiums and deductibles and make health care truly affordable like it's suppose to be." It is interesting to note that it is the cost of insurance, rather than health care services themselves, that this provider sees as the issue.

Conclusion

Analysis of the qualitative interview transcripts provided important insights into the interviewee-identified state-level factors that influence access to health care services in rural Idaho and four additional topics that the study posed to interviewees: NPs and PAs, the ACA, interest groups/policy voices and rural access policy recommendations. The inquiry into the four topics allowed participants to speak out on topics that turned out to be the most controversial and that were not spontaneously raised in the interviewees' responses to state factors questions.

CHAPTER 5

Websites and Documents

To give context to the qualitative individual stakeholder interviews, publically available websites and their documents were reviewed. The websites and documents reviewed were chosen from organizations representing the professional interests of, and with membership comprised of, the diverse types of stakeholders who were interviewed. Content of the websites and associated publically available documents were analyzed for thematic and narrative content. A description of the websites and associated documents is provided.

The Governor's Website: www.gov.idaho.gov

The Governor's website is a primary source of Idaho's official state narrative. State sovereignty is a major theme identified throughout the Governor's portrayal of the official state narrative. On the homepage of this website the largest photo is of the Governor meeting with the Shoshone-Paiute Tribal Business Council, the first of many signals of the theme of sovereign government.

In the banner of the governor's website is a picture of the governor and his wife. Directly below the banner are tabs for "Our Governor", "Priorities", "Administration", "News & Media", "All About Idaho", and "Contact". The "Our Governor" tab provides access to a biography of the Governor, a description of his constitutional official duties as Governor, a link through which a message may be sent to him, and an explanation of the "Capital for a Day" program.

The Governor's biography applies a personal lens to the official state narrative, outlining his life story and multiple connections to rural Idaho. The photo which

accompanies the biography shows the Governor, wearing chaps and a cowboy hat and wielding a lasso rope, astride a horse, atop a mountain. His biography reports that the Governor was born in a farming community outside of Boise, and currently resides on a ranch.

The Capital for a Day program is described as a program that serves to promote connections between the state government and all of its citizens, many of which are rural. The Governor and members of his cabinet visit a rural community in a different county for one day each month.

"It is our job in State government to ensure people in communities all over Idaho have a real say in determining their own future. It shouldn't be the case that folks in Boise have a greater role in contributing their civic virtue to our statewide discussions than people in Moyie Springs or Malad, Ferdinand or Firth, Wallace or Wendell," Governor Otter said. "That's why I bring 'Capital for a Day' to a different rural town every month – to listen, learn, and solve some problems if we can." Governor Otter's goal is to visit all 44 counties twice in his two terms as Idaho's governor.

Here the official state narrative addresses Idaho's rural populace and acknowledges that rural people should have a voice in government.

The Priorities tab identifies enhancing economic opportunities, empowering Idahoans, and promoting responsible government as the Governor's priorities. Growing the state's economy through job creation and infrastructure development, with an emphasis on energy and transportation, is discussed in the "Enhancing Economic Opportunities" section of the website. Under "Empowering Idahoans" there are sections

on education, healthcare, and public safety. This is where the majority of health care-related information on the website is located. Here the Governor provides his viewpoint on improving access.

Improving affordability and access to quality healthcare is a pressing need, and it will take government and the private sector working together collaboratively and with a common purpose to bring about real changes. Reducing healthcare costs and improving accessibility to healthcare requires building public-private partnerships and addressing such specific needs as shortages of healthcare providers, incentives for preventative care, and more efficient and secure health information systems to better coordinate care. It takes fostering innovative, market-based solutions and engaging everyone – patients and physicians, hospitals and insurers, employers and employees – in a sustained effort to change healthcare in Idaho for the better.

Here the official state narrative speaks to a different audience, using the technical terminology of health care and policy to address health care stakeholders, including those in the private sector. The more technical terminology used suggests that stakeholders are being called to support a market-based solution, form public-private partnerships, and implement recommended changes.

At the end of the above quote is a link to “[Read more about Idaho's efforts to improve healthcare for our citizens...](#)”. The link leads to “Governor Otter’s Health Care Timeline” which runs from 2007 to 2014 and outlines various health care-related activities that occurred. It begins with the August, 2007, creation of the Idaho Healthcare Summit which was tasked with evaluating Idaho’s health care system and recommending

ways to make “health care more affordable and accessible to Idahoans”. The timeline provides descriptions of various working groups that were convened by the Governor to address health care issues in Idaho in the seven year period. These groups include: The Governor’s Select Committee on Health Care, The Behavioral Health Transformation Workgroup, The Idaho Health Professions Education Council, the Idaho Health Care Council, and the Insurance Exchange Workgroup. The Governor’s website includes a link to the Idaho Health Care Council’s web page where the Governor’s remarks provide further insight into his vision for health care access.

I want to ensure every Idahoan has access to quality healthcare that is affordable and is driven by patients and providers – not lawyers or government bureaucrats. Working together we are addressing issues such as shortages of healthcare providers, incentives for preventative care, and more efficient and secure health information systems to better coordinate care. We are leveraging one another's efforts and expertise in order to generate the best health delivery system possible in Idaho.

Here, again, the official state narrative is delivered in technical terminology aimed at the health care stakeholders.

The timeline also includes links to several of the Governor’s press releases regarding the following health care-related issues, most of which focus on federal policy: federal health care reform, an executive order prohibiting state agencies from implementing Obamacare, Medicaid reform, and insurance exchanges.

In a March 5, 2010, press release the Governor demonstrated his frustration over federal health care reform efforts and expressed his strong support of state sovereignty

while outlining the steps the state has taken to improve health care. The politics of the timing of this press release, which was disseminated shortly after the ACA was passed by the Senate, and right before it was passed by the House, may have contributed to the tone of this particular document.

It seems like Washington, D.C., is tilting at political windmills these days. The Obama administration and Congress are still promising to slay the fire-breathing dragon of healthcare costs. But the beast they are fighting is, to a large extent, the product of the government-installed cage in which it evolved.

“Fire-breathing dragons” and “beasts” evoke fearful images at a time when many Idahoans are leery of the potential impact of the pending ACA legislation. The official state narrative here appears to address politicians and all Idahoans, both urban and rural. The state narrative echoes the public outcry against “Obamacare” saturating conservative media and present throughout much of Idaho at the time.

The Governor’s press release continues:

For 35 years now the federal government has been essentially running healthcare in America, masking market signals and supplanting the judgment of patients and physicians with the determinations of politicians, bureaucrats and lawyers. It should be no surprise that healthcare became “health management,” people became statistics, and the fear of liability became the biggest expense of all.

This section of the press release describes the market, physicians, and patients as muted. The final phrase of this section, “...fear of liability became the biggest expense of all” seems to be referencing the cost of malpractice insurance which is purchased by physicians, but ultimately, it is implied, incurred by the patients.

Having described a failed system, the Governor's press release now focuses on "rescue":

Now the federal government is poised to rescue us from the disaster it created, promising "reform" that amounts to little more than increasing government's already dominant role in the healthcare system and further reducing the role of states like Idaho, not to mention individual patients and providers.

The public, policy makers and even patients contributed to the problem with their complacency. Having been lulled into a false sense of security by the promise of Medicaid and Medicare, we failed to insist on meaningful change and self-determination. But now the federal government has seized on healthcare reform as its mission in life, which means we should brace for still higher costs.

While the Governor's press release largely deems the federal government, and its "politicians, bureaucrats and lawyers" responsible for our nation's health care woes, he also blames "the public, policy makers and patients for "complacency" in adopting Medicaid and Medicare. The federal government's attempt to "reform" the health care system is identified as a threat to Idaho's sovereignty and a lost opportunity for the state to assert its "self-determination".

Continuing in the same press release, the Governor frames the official state narrative on health policy:

Largely missing from this discussion is the real work that Idaho and many other states are doing on their own to address healthcare needs, fulfilling their role as laboratories of the republic. That work includes controlling costs and improving access through a market-driven focus on preventive care, health promotion,

building public-private partnerships, and application of technology and professional development.

These remarks clearly demonstrate the animosity toward the federal government that is common among Idahoans and that characterizes the official state narrative. Here the Governor uses unique terminology, “laboratories of the republic”, to describe the role of state governments. The terminology suggests openness to experimentation with a variety of solutions; however, the Governor makes clear that experimenting with a federal solution is not acceptable.

In this next section of the same press release the official state narrative outlines multiple steps that the state has taken to address health care reform and further argues that such reform should rest in the capable hands of state, not federal, governments.

I convened the Idaho Healthcare Summit in 2007 to evaluate Idaho’s healthcare system and recommend ways to make healthcare more affordable. The Governor’s Select Committee on Health Care evaluated the recommendations, gathered additional data and provided its top recommendations for implementation in a report submitted to me in 2008.

The recommendations focused on expanding the statewide use of electronic medical records to provide better coordinated patient care; expanding the use of patient-centered medical homes that shift the focus of healthcare to primary and preventive care; expanding the number of already eligible children to register for the State Children’s Health Insurance Program; and expanding the number of residency opportunities to attract primary care and specialty physicians to our state. We are making great progress on all those fronts. And at the close of 2009 I

created the Governor's Health Policy Implementation Committee, consisting of people who are experts in these fields, to foster continuing advancement of the priority areas over the next couple of years.

All stakeholders, patients, providers, insurance companies, businesses, and higher education, may find something appealing in the official state narrative that includes costs, market-driven focus, health promotion, technology and professional development as aims of state-directed health care reform.

The Governor concludes by returning to an affirmation of state sovereignty over health care and health policy:

While there is still much more to be done, this much is clear: The federal government should not dictate our healthcare choices. The states, with public and private input, are capable of making changes to foster a better and more affordable healthcare system. We no longer can afford to be complacent and wait for the federal government to make things worse and take decisions out of our hands.

As Thomas Jefferson said, "A wise and frugal government, which shall leave men free to regulate their own pursuits of industry and improvement, and shall not take from the mouth of labor the bread it has earned – this is the sum of good government."

It is interesting to note that the press release closes with mention of a federal government figure's quote, weaving the acceptability of federal resources, but not federal sovereignty, into the official state narrative.

In his press release regarding his executive order of April 20, 2011, that prohibited state agencies from implementing Obamacare, Governor Otter explained why he had vetoed a bill that nullified the ACA and instead issued an executive order to forbid implementing it in its entirety.

The Legislature clearly wanted to send a message to the national government this session, expressing its frustration with Obamacare. I agree with the message and know the debate about Obamacare would be vastly different, if not completely unnecessary, if the national government adhered to the Tenth Amendment, Governor Otter wrote in a three-page letter to Secretary of State Ben Ysursa, explaining his veto of House Bill 298, which sought to entirely "nullify" the federal law's application in Idaho.

"I also agree with the Legislature and the sponsors of this bill that now is not the time to implement Obamacare. However, it is equally unacceptable to forego exploring viable state solutions to our healthcare needs and allowing the national government to assert more control over Idahoans," the Governor wrote. A copy of his letter can be found [here](#).

While Executive Order 2011-03 bars State agencies from implementing Obamacare, it does allow the Idaho departments of Insurance and Health and Welfare to continue developing a State health insurance exchange. The Governor said that would prevent the federal government from controlling the state's insurance market by administering an exchange of its own in Idaho.

"I had worked in the health insurance field for over 30 years and applaud the Governor for allowing Idaho to remain in control and giving our citizens the reins

for our own solution to healthcare reform”, Idaho Department of Health and Welfare Director Richard Armstrong said. "I am confident that Idaho's expertise and can-do attitude will design an exchange that provides better access for families and employers, while also preserving the health insurance marketplace.”

In this press release the official state narrative addresses multiple audiences including stakeholders, rural Idahoans, employers, and health insurance companies, and emphasizes the preservation of the health insurance marketplace as a primary mission of the state of Idaho.

The Governor issued a press release on June 28, 2011, regarding Medicaid reform which further demonstrates the emphasis he places on state sovereignty.

I recently joined 27 other Republican governors in signing a letter responding to the request for input. We agreed first and foremost that Obamacare should be repealed to allow states the opportunity – and the flexibility – to keep addressing our unique healthcare challenges.

We agreed that Medicaid should be reformed in a comprehensive and sustainable manner, not only to improve care for our nation's most vulnerable citizens, but also to address the inequities, inefficiencies, excess costs, fraud, waste and abuse that unfortunately are far too prevalent in Medicaid programs across the country.

Our shared goal is to establish and maintain a responsible safety net for our children's and grandchildren's generations without breaking our economy or putting those same generations and beyond even deeper in debt. And we are committed to doing it without giving up our self-determination or freedom.

These comments reveal the official state distaste for “Obamacare” and any intervention by the federal government that limits states’ rights.

In the website section on promoting responsible government, the Governor’s final identified priority, the official state narrative makes one last mention of health care and again laments the federal government’s actions.

From fighting the misguided efforts of D.C. bureaucrats to usurp state management of species under the Endangered Species Act, to speaking out early and often against the colossal expense and unprecedented extension of federal authority in the federal healthcare reform legislation, standing up for Idaho's rights to determine the best policies for our citizens remains one of my highest priorities.

Here the Governor explicitly identifies protecting state rights against an “unprecedented extension of federal authority” as one of his “highest priorities”. As “supreme authority within a territory” (Philpott, 2016), state sovereignty within the U.S. is defined in the Tenth Amendment, which states that “The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people (U.S. Constitution).”

A search of www.gov.idaho.gov website for “rural health” revealed no results. Searches of the website for the terms “Physician Shortage”, “Provider Shortage”, and “Nurse Shortage” revealed one additional link to a document containing health care-related information, the Governor’s 2016 State of the State and Budget Address.

That brings me to healthcare. First, from an education standpoint: I'm recommending that in the coming year we follow through on our plan for providing more physician training to meet Idaho's needs. Adding five more seats to our medical school partnership with the University of Washington will reach the Board of Education's 2009 goal of having 40 seats available for Idaho students. That's a great investment in our students and an important step toward addressing our community healthcare needs. But it also is a pipeline from which it takes years to realize benefits. There are quicker ways to address our shortage of primary care physicians. So I encourage you to keep funding our physician residency slots. And we must keep attracting healthcare professionals by providing medical loan reimbursement incentives for primary care doctors who agree to serve our rural communities. In the meantime, I'm asking the Board of Education to work with our medical community and higher education institutions to develop a new plan for addressing future demand for healthcare providers.

This section of the State of the State document is entirely physician focused. The official state narrative is silent on any other health care professionals that may be in short supply throughout rural Idaho, including nurse practitioners, social workers, and paramedics.

This silence is consequential as it excludes these providers as priorities for funding in the upcoming legislative session.

Review of the Governor's website and its associated documents reveals an emphasis on state rights and state self-determination as part of a broader argument for state sovereignty.

The Idaho Primary Care Association Website: www.idahopca.org

The Idaho Primary Care Association (IPCA) website home page reveals a large photo of a rural setting complete with a winding river in the foreground, beautiful lodge-style homes, and majestic mountains. As one of the primary recruiters of health care providers to rural Idaho, the website portrays a positive visual image aimed at enticing would be providers to rural Idaho. Perhaps the IPCA is implying that providers willing to make rural Idaho their home would be able to live in a beautiful lodge-style home set in a serene locale like that depicted on their website home page. It is interesting to note that there are no people present in the picture, just very large homes with snow peaked mountains in the background.

The IPCA reports its mission as "... to foster relationships between Idaho Community Health Centers (CHCs), community partners, and stakeholders to enable provision of safety net health care." Including the "provision of safety net health care" in their mission suggests that the IPCA views the health care of vulnerable populations in Idaho as a priority. The IPCA also describes itself as a "Leading state advocate for community-based health care programs." This description suggests that it is the programs, or facilities, that are the focus of IPCA's advocacy efforts.

IPCA programs noted on the home page include: Patient- Centered Medical Home (PCMH), Community Development, and Outreach & Enrollment. The IPCA serves as the regional coordinator for the Safety net Medical Home Initiative, a program begun in 2009 to promote PCMH model care. IPCA provides support to Community Health Centers (CHCs) wanting to become PCMHs. The IPCA explains the benefits of the PCMH in their website.

The patient-centered medical home (PCMH) is a model of primary care delivery. In PCMH practices, patients receive well-coordinated services and enhanced access to a clinical team. Clinicians practicing in PCMHs use decision support tools, measure their performance, engage patients in their own care and conduct quality improvement activities to address patients' needs. The PCMH model has the potential to improve clinical quality, improve patient experience and reduce health system costs.

The PCMH model is an evidence-based care model that the ACA supports (U.S.DHHS, 2014).

IPCA's Community Development program consists of how to start or expand a CHC and includes a link to the national CHC organization, the National Association of Community Health Centers (NACHC). IPCA's outreach and enrollment program consists of providing assistance with enrollment for health insurance through the Idaho Health Insurance Exchange.

Community health centers across the country are playing a critical part to help enroll the uninsured into healthcare coverage. Here in Idaho, Idaho's state insurance exchange (Your Health Idaho) has contracted with IPCA to engage health centers to provide enrollment assistance to all Idahoans. All Idaho health centers have enrollment counselors who have been trained and certified by the exchange. Each certified enrollment counselor is well-versed in the Affordable Care Act, coverage options available through the exchange, the exchange systems and the enrollment process.

Under a “Latest News” tab, there is a section titled “Idaho Lawmakers at turning point on health care for poor”, however, it is a link to a March 20, 2016, article in the Idaho Statesman regarding the then pending Idaho Primary Care Access Program (PCAP) legislation, House Bill 484, which subsequently never made it out of committee.

A search of the IPCA website for the terms “physician shortage”, “provider shortage”, and “nurse shortage” yielded no results. A search of the website for “rural health” resulted in 10 findings, ranging from 2009 to 2016. The two results from 2016 were employment opportunity announcements for an Executive Director position. The five from 2015 included a press release about National Rural Health Day, an announcement about CHC personnel being certified to assist individuals with health insurance enrollment via the state exchange, and three press releases about a rural community pharmacy opening. One result was a link to an Office of Rural Health Policy grant award from 2014. The two remaining “rural health” results consisted of one from 2009 on the Safety Net Medical Home Initiative and one labeled “data resources” that required member log-in to access.

Under the Employment Opportunities tab IPCA highlights the idyllic aspects of rural Idaho:

Beautiful, Wide-Open Spaces Whether your idea of play is outdoor adventure, spectacular mountains and rivers or enjoying an evening of music and plays, you are going to love living in Idaho. Idaho offers miles of whitewater rafting and kayaking, incredible world famous golf courses, world class hunting and fishing, and winter sports that are unequalled in the United States. Take a closer look and you'll be delighted and intrigued with this land of fun and adventure!

IPCA again highlights the rural leisure activities available in Idaho, once more beckoning to potential providers to make Idaho their “land of fun and adventure”.

Idaho Hospital Association Website: www.teamiha.org

On the Idaho Hospital Association’s (IHA) website there are nine tabs across the home page banner: “About IHA”, “Policy & Advocacy”, “Education”, “Annual Convention”, “Member Center”, “Publications & Resources”, “Hospital Careers”, “Quality & Patient Safety”, and “Member Highlights”. The majority of the home page is filled with a notification of their upcoming mid-year meeting. There are three advertisements featured on their home page. There is a member map and an announcement regarding their annual convention. A section titled “Idaho Health News Headlines” features links to recent health care-related articles from newspapers throughout the state. At the bottom of the home page, in small font, their mission is presented. The Idaho Hospital Association’s stated purpose incorporates hospitals’ viability, presumably financial viability, and service.

Its purpose shall be to provide leadership in health policy and advocacy and to provide comprehensive member services that strengthen Idaho hospitals' viability and capacity to best serve their communities.

Their mission statement highlights political advocacy and quietly advertises its “comprehensive member services” as an IHA priority. The aim of their advocacy efforts is identified as the enhancement of Idaho hospitals’ viability in order to “best serve their communities”.

The “About IHA” tab contains their bylaws, introductions of their board of directors and regional leadership councils, and a list of allied organizations. There is a

section containing their strategic plan, which requires member sign in to access. In addition, a list of IHA committees and special committees is provided. IHA committees include: executive, finance, nominating, hospital governance, and volunteers. The special committees include: Hospital finance, legislative policy, select committee on Medicaid managed care, and a bylaws committee.

The “Policy & Advocacy” tab on the home page contains a “State/legislative” section that includes a link to the most recent legislative session’s health care-related bills with brief descriptions and indications of IHA’s support, opposition, or undetermined status for each bill.

Clearly, the IHA is candid about its policy voice and supports those pieces of legislation that are viewed as favorable for hospitals. There are also links titled the American Hospital Association (AHA), Centers for Medicare and Medicaid Services (CMS), the Idaho legislature, contact legislators, legislative calendar, and IHA lobbyists. There are two lobbyists listed under the IHA lobbyist link; one is the IHA’s President/CEO and the other is their Vice President of Governmental Relations. Also incorporated under the “Policy & Advocacy” tab are links labeled “Federal/Congressional”, “The Bulletin”, and “Policy”. These links are not available for public review as they all require member sign in to access.

The advocacy link provides some clarification regarding IHA advocacy efforts: IHA brings hospital/health care leaders together to identify issues of mutual concern and to address these issues in a responsible manner that ensures quality health care for those we serve throughout Idaho.

Preventing or modifying improper legislation and unreasonable regulation, while supporting appropriate laws, is a major activity of IHA. Member hospitals are represented before elected officials and government agencies. The voice of IHA members is heard on a national level, as well, by way of American Hospital Association regional policy board and various council and committee representatives from this state. Key efforts include: State legislative and governmental agency input from the Association, federal legislative and agency input in cooperation with AHA, political action committee involvement via IHA/PAC, and liaison with allied health associations.

These remarks identify political advocacy on behalf of their member hospitals as a “major activity” of the IHA.

The “Member Center” tab includes a calendar of events, and sections labeled “Health reform” and “Membership directory” which are not accessible to non-members. Because the “Health reform” section is inaccessible to non-members, the IHA’s stance on the ACA is not publicly discernible from their website.

Under the IHA’s “Membership Services” section advocacy is emphasized. Advocacy for what or whom is not explicitly stated. “The voice of IHA members is heard through our [advocacy](#) efforts on the state and national level. Other member services are also available.” Other services described under the “Membership Services” section include consultation, data, education and information, and membership networking.

The “Publications & Resources” tab includes sections labeled “Member resources”, “The Bulletin”, and “News clippings”. The “News clippings” section contains

links to a variety of newspaper articles, ranging from an op-ed honoring a deceased volunteer at a chemotherapy center, to an article about Medicaid reimbursement.

The “Hospital Jobs” tab provides a link to IDHospitalJobs.com, a site where hospitals can seek employees and job seekers can locate employment opportunities. The “Member Highlights” tab is comprised of member hospitals’ general contact information. The “Quality & Patient Safety” tab indicates that section of the IHA website is currently under construction.

The IHA’s website suggests that the organization’s primary aim is to enhance health care services provided in Idaho communities by ensuring that member hospitals’ viability.

Idaho Rural Health Association website: www.idahorha.org

On the Idaho Rural Health Association’s (IRHA) website homepage appears a large font quote, “The recognized advocate for rural health issues in Idaho”. There is also a rural photo and a large font message thanking members for attending the annual IRHA legislative breakfast accompanied by a photo that is presumably of that event. There are tabs for the following: “Governor’s proclamation”, “Operation Diabetes”, “2015 Summit”, “Photo Contest”, “2015 Photo Contest Winners”, “Member Form”, “Events”, “Newsletter”, “Rural Health Links”, “About IRHA”, “Student Chapter By-Laws”, and “Contact Us”.

The “Governor’s proclamation” tab leads directly to an official document whereby the Governor declared November 19, 2015, National Rural Health Day. There is no such document for 2016. The “Operation Diabetes” tab contains a description of a pharmacy student program aimed at improving diabetics’ health outcomes.

The “2015 Summit” tab consists of a notification of the 2015 meeting with state legislators to discuss issues gathered from a member survey. The “Photo Contest” and “2015 Photo Contest Winners” tabs contain, respectively, entry instructions for the 2015 contest and a display of the winning photographs. Again, these sections all refer to 2015 and have no current 2016 remarks.

Under the “Member Form” tab a membership enrollment form is provided. The benefits of individual membership are outlined.

Thank you for your interest in membership in the Idaho Rural Health Association. You will not be disappointed in your decision to join the "recognized advocate for rural health issues in Idaho." These are just a few of the membership benefits you'll enjoy: subscription to quarterly newsletter focused on IRHA interests, access to "hot topic" policy issues and other resources on IRHA website, opportunities to network online and in person with colleagues, discounted registration at IRHA conference and other events, help promoting a rural forum or health fair in your community, NRHA Action and Media Alerts with legislative and regulatory information, one-time introductory subscription to NRHA's *Rural Roads* magazine.

By receiving member notification regarding any pending rural-related legislation, members may advocate with their legislators individually. This section does not describe the provision of any official IRHA lobbying or advocacy efforts as a membership benefit. Interestingly, the NRHA magazine is named after one of the state-level factors, “rural roads”, noted to negatively impact access to health care in rural Idaho.

The “Events” tab announces an upcoming teleconference board meeting. The “Newsletter” tab contains a link to quarterly newsletters from Fall 2008 through Winter 2016. The Winter 2016 newsletter includes a welcome to a new Resident Board Member, notes from the National Rural Health Association Policy Institute in Washington, D.C., information on the State Loan Repayment Program, and links to renew or initiate membership.

Under the “Rural Health Links” tab are links to various national and state health organizations. Health organizations with both rural and non-rural emphases are included.

The “About IRHA” tab includes the IRHA’s vision and mission, and an explanation of who the IRHA represents.

The Vision of the Idaho Rural Health Association is to be the recognized advocate for rural health issues in Idaho. The Mission of the Idaho Rural Health Association is to provide leadership on issues related to rural health in Idaho through advocacy, communication, and education. The IRHA represents a variety of individuals and organizations who are committed to the health and welfare of rural Idahoans. IRHA has a diverse membership, consisting of physicians, nurses, nutritionists, health care administrators, public health officials, government officials, researchers, educators, students, private individuals, and other health care professionals.

The information provided on the IRHA website suggests that the health of the rural population is their focus. There is not much detail provided regarding the range of their advocacy efforts.

Idaho Bureau of Rural Health and Primary Care Website:

www.healthandwelfare.idaho.gov/Health/RuralHealthandPrimaryCare/tabid/104/Default.aspx

Categories on the home page of the Idaho Bureau of Rural Health and Primary Care include: “Announcements”, “Upcoming Events”, “Rural Health Clinic (RHC) Certification”, “Free Medical Clinic Information”, “Workforce”, “Critical Access Hospitals”, “Shortage Designations”, “Grant Resources”, and “Meaningful Use/Health Information Technology”.

Announcements on the website declare that the Rural Physician Incentive Program (RPIP) and the Rural Health Care Access Program (RHCAP) eligible areas are now available:

The Rural Health Care Access Program (RHCAP) helps rural Idaho communities improve access to primary medical and dental health care through grants assistance. "Improving access to health care" includes removing barriers that prevent people from obtaining healthcare, strengthening healthcare systems, and developing partnerships to better serve communities. Grants of up to \$35,000 per year for a maximum of one year may be awarded to eligible entities serving areas designated as Health Professional Shortage Areas and Medically Underserved Areas. Applicants may submit grant proposals that improve access to healthcare in any of the three assistance categories: Telehealth projects, community development projects, other: loan repayment for primary/dental care providers, recruitment incentive, and/or reimbursement of relocation expenses for

primary/dental care providers. Applicants must be a non-profit organization registered with the Idaho Secretary of State or government organization.

Individuals may not apply for RHCAP funds.

The nature of this strategy for addressing rural provider shortages appears to be piecemeal, with \$35,000 grants available to organizations, which can be used for provider loan repayment or relocation costs, and larger amounts available to individual physicians for loan repayment, as is also described in this section of the Bureau's website:

The Rural Physician Incentive Program (RPIP) was successfully transitioned from the Office of the State Board of Education to the Bureau of Rural Health & Primary Care. RPIP provides loan repayment for qualifying physicians serving Health Professional Shortage Areas in Idaho. The program is focused on physicians providing primary care medicine, family medicine, internal medicine, and pediatrics. RPIP is funded by fees assessed to physicians attending the University of Washington and University of Utah medical schools in state-supported seats. Physicians may receive a maximum of \$100,000 over a four year period toward their academic debt. Preference is given to eligible physicians who paid into the RPIP fund, however, funding is not limited to these candidates. RPIP award decisions are made by the Health Care Access and Physician Incentive Grant Review Board.

The RPIP is described as a loan repayment program for physicians serving in provider shortage areas. Interestingly, the program is funded by medical students' fees. What is not clear is if these fees are incurred by individual medical students or if they are paid as part of the state support of those medical school seats.

Maps linked to the site indicate that 96.36% of Idaho is designated as a Health Professional Shortage Area (HPSA). A 2016 Quality Improvement Workshop for CAHs is also announced, with notification that travel costs are eligible for reimbursement and there is no registration fee for the workshop. An upcoming Spanish medical terminology for interpreters workshop, with available scholarships, is also among the announcements.

The opening of the State Loan Repayment Application (SLRP) cycle is announced, as is its expansion to now include registered nurses and social workers.

State Loan Repayment Program (SLRP): SLRP is a multi-discipline, state-based loan repayment program for nurses, clinicians, and physicians working in federally-designated Health Professional Shortage Areas. Loan repayment is provided through a federal grant, every award must be matched \$1 to \$1 with funds provided by the practitioner's employer. Participating sites must implement a sliding fee scale for low income and uninsured patients and accept Medicare and Medicaid. Loan repayment awards may range from \$5,000-\$25,000 per year for two years. A two-year service obligation is required and sites must submit biannual reports during the funding period. Participants currently receiving loan repayment and fulfilling a service obligation are not eligible. SLRP now includes Registered Nurses and Licensed Clinical Social Workers.

The fact that the SLRP now applies to registered nurses and social workers is demonstration of the wide variety of health care professional shortages that exist in rural Idaho beyond that of the physician.

The "Upcoming Events" section features the CAH Quality Improvement Workshop. The "Rural Health Clinic Certification" section describes certification

requirements and provides a link for locating a RHC. The “Free Medical Clinic Information” section offers a map of the 11 free clinics in Idaho, four of which are in Ada County.

In the “Workforce” section, the Bureau describes its efforts related to enhancing Idaho’s rural health care workforce.

Many Idaho communities experience healthcare workforce shortages, particularly in rural areas. Rural healthcare workforce shortages not only reduce healthcare access and increase stress on existing providers but also, contribute to overall higher costs. The Bureau of Rural Health & Primary Care works to strengthen workforce recruitment and retention efforts; provide educational workshops; and identify healthcare workforce shortage areas.

The “Workforce” section also contains links to statewide and national rural workforce studies and an Idaho Primary Care Needs Assessment document. Resources in this section include a power point presentation on clinician retention, information on the J-1 Visa Waiver and National Interest Waiver Programs which allow underserved communities to recruit and hire foreign trained primary care physicians as an “option of last resort”, and links to the National Health Service Corps (NHSC), the Nurse Education Loan Repayment Program, a national health care jobs site, and the previously outlined RHCAP and RPIP programs.

Under the “Critical Access Hospitals” section, the Bureau provides information on multiple federally funded programs that it administers. These include: Medicare rural Hospital Flexibility Program, the Medicare Beneficiary Quality Improvement Project

(MBQIP), and the Small Hospital Grant Program. A map of Idaho's CAH locations is also provided.

In the "Shortage Designations" section, the Bureau describes its role in developing and coordinating Health Professionals Shortage Area (HPSA) designation applications, as well as those for Medically Underserved Area/Population federal designations. The "Grant Resources" portion of the website offers information on applying for the RHCAP, RPIP, and SLRP program funds. The "Meaningful Use/Health Information Technology" section provides links to the Department of Health and Human Services' Office of the National Coordinator for Health Information Technology and the Centers for Medicare and Medicaid Services' (CMS) Electronic Health Records Incentives programs.

The information on the Idaho Bureau of Rural Health and Primary Care portrays both rural Idahoans and health care professionals as priorities. The resources provided are aimed at enhancing access to care for Idaho's rural populace, such as the list of free clinics throughout the state, and supporting health care professionals, such as the assistance with the logistics of applying for funds available to rural providers.

The Idaho Medical Association Website: www.idmed.org

The Idaho Medical Association's (IMA) website home page features the following

quote:

When you join the IMA you hire a powerful, professional staff to protect the viability of your practice. By protecting your practice from legal, legislative, and

regulatory intrusions, your IMA membership lets you focus on what's really important: Your patients.

This statement speaks directly to IMA physician members, positioning the members as employers of the “powerful” and “professional” IMA staff. The IMA professes to protect physicians’ practice from policy and legal “intrusion”, while explicitly identifying patients as “what’s really important”.

Also included on the home page is “The Economic Impact of Physicians in Idaho”. Here the IMA reports that for every physician practicing in Idaho 10 jobs are created. The IMA credits physician practices for a total of 27,095 jobs statewide.

Tabs on the IMA home page include “About Us”, “Membership”, “Resources”, “Calendar”, “Communication”, “Physician Finder”, and “Members Only”. The purpose of the IMA is provided within the “About Us” section, under an “IMA Mission Statement” tab.

The purposes of this Association are to promote the science and art of medicine, the protection of the public health, and the enhancement of the medical profession of the State of Idaho; and to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The IMA Mission Statement clearly incorporates priorities beyond the promotion of the medical profession, with protection of public health and promotion of the science and art of medicine figuring prominently in their mission statement. The IMA bylaws and policy sections are only accessible to IMA members.

In the “About Us” tab, the IMA reports a membership of 2,600 who all meet the “stringent membership requirements”. A history of the IMA is provided under a

subsection of the “About Us” tab. The following are some quotes from the reported history of the IMA.

The year was 1893. As Idaho approached a new century with the unbridled optimism that characterized the 1890's, its medical community was in disarray. "The state was overrun with quacks" engaging in dangerous medical practices, said historian of the time Sam Allison.

The IMA weaves the state's history within their own, echoing what Starr described as the medical profession's “rise to sovereignty” (Starr,1982). The website explains that in 1893, Idaho was run over by “quacks” because scientific medicine (now called evidence-based medicine) had not yet been consolidated, and physicians used any number of folk medicine practices.

The section on the history of the IMA continues with a description of the IMA's first meeting:

Boise physician Dr. Carol Lincoln Sweet, the father of Idaho organized medicine, stepped in to bring order from the medical chaos. He sent a letter to Idaho physicians inviting their attendance at a meeting in Boise on September 12 to organize, draw up laws to protect physicians, exchange ideas, and "enjoy the inspiration of fellowship."

The description of Dr. Sweet as the “father of Idaho organized medicine” highlights him as a parallel figure to the governor, governing the medical profession rather than the state government. The IMA history notes that originally the IMA protection efforts were aimed at physicians themselves, rather than patients or the public health.

The IMA describes their establishment of the Idaho State Board of Medicine to regulate themselves.

Early efforts of the organization focused on setting and maintaining standards for the practice of medicine in Idaho. From 1894 to 1897 it worked diligently to pass legislation creating a board of medical examiners. The IMA continued to lobby for stronger licensing procedures and finally succeeded in passing the Medical Practice Act of 1949, which established the Idaho State Board of Medicine. The IMA has historically taken a leadership role in public health and safety issues. Its proactive support for polio immunization, public water fluoridation, civil defense planning, cigarette warning labels, use of seat belts, child abuse reporting, motorcycle helmet use, day care licensing, cigarette taxes, minimum drinking age, and immunization of schoolchildren has positively impacted the quality of life and health of all Idahoans.

Here the IMA documents its long history of lobbying success. The policy examples provided are certainly among those most historically impactful on public health and do not include any specific to the promotion of the medical profession. The IMA narrative describes physicians' professional role as to defend the entire state's health.

The IMA further describes its role in procuring health insurance for Idahoans:

The IMA has been instrumental in bringing health insurance to the state, helping establish the North Idaho District and South Idaho Medical Service Bureaus, which have emerged as today's Regence BlueShield of Idaho and Blue Cross of Idaho. The IMA also guided physicians through a 1975 malpractice insurance

crisis, championing tort reform to help assure Idaho physicians have access to malpractice insurance.

These examples of IMA accomplishments are more reflective of their promotion of entities that benefit the medical profession. The Blue Cross and Blue Shield Association is currently the largest insurer in Idaho and contracts with 96% of the state's physicians (eHealth, 2015).

The IMA describes their advocacy efforts as being for both the benefit of the medical profession and for the quality of health care services for “all” Idahoans:

The IMA was born from the need of Idaho doctors to professionalize. From this beginning the Association has matured into a leading advocate for the practicing physician and for improving the quality of Idaho's health care. For more than a century, the Idaho Medical Association has supported and served the medical community and fostered high quality care for all Idahoans through its leadership in legislation, medical education, and public health.

As far as serving “all” Idahoans, no reference to minority groups could be found on the IMA website. There is, however, mention of the uninsured and medically indigent populations in a subsequent section of the IMA website.

Benefits and services that accompany IMA membership are reported on the website to include: Legislative representation, public relations, reimbursement assistance, audit consultation, physician advocacy, access to care, health insurance contract review, and professional involvement and commitment. A description of the extensive legislative representation provided to IMA members is provided.

The IMA provides state legislative and governmental liaison and monitors state and federal legislation affecting medicine. The IMA has input with state agencies, including the Department of Health and Welfare, and negotiates for Medicaid program improvements. The IMA closely monitors federal legislation affecting medicine by working with the AMA's Washington, DC, office. The IMA works directly with the Idaho Congressional Delegation on important issues and maintains a key contact system to facilitate open communication and support from the medical profession. IMPAC is the political action arm of the IMA, governed by a Board of Directors comprised of physicians from throughout the state.

Thus, the legislative representation provided to IMA members includes lobbying at both the federal and state levels, asserting influence through lobbyists, individual members, appointees to state agencies, and a Political Action Committee.

Another benefit outlined, physician advocacy, further highlights the organized policy voice enjoyed by members.

The IMA represents physician interests on many statewide committees as well as various ad hoc committees and task forces organized within government. By action of the House of Delegates, the IMA fosters meaningful physician input regarding healthcare issues at all levels of government.

These remarks illustrate how the medical profession's reach has extended far beyond that of medicine and into diverse arenas of political influence (Starr, 1982).

The IMA website includes a discussion regarding access to care which presents the IMA's desire to concurrently advocate for the medical profession and enhance access to health care for vulnerable populations in Idaho.

Access to care: The IMA takes a lead role on state committees, task forces, and coalitions seeking solutions for Idaho's uninsured and promoting access for the medically indigent. At the same time, the IMA addresses problems that impede access such as low reimbursement and uncompensated care.

Here the IMA describes advocating for access to health care for the indigent while simultaneously indentifying low reimbursement and uncompensated care as problems.

Under "Resources" on the website, there is a tab for medical student members. This section also illustrates the IMA's political voice and promotion of the profession into its next generation.

What an exciting time to be in medicine! With all of the current innovations in diagnosis, imaging and treatment, we are more advanced now than we ever have been and the future is sure to bring continued growth and progress! The political and legal environment that determines how we will practice medicine is also developing and changing. It is essential that we stay abreast of these changes so that we can provide for ourselves and our patients in the years to come. It's a lot to think about on top of our regular studies and obligations, but the Idaho Medical Association can help do just that. The IMA is a professional organization whose purpose is to "promote the science and art of medicine, the protection of the public health, and the enhancement of the medical profession in the State of Idaho." The IMA promotes student awareness and involvement. Spreading

understanding of the political and health policy changes that are occurring in the state (which is an indicator of the national atmosphere) are a priority. Providing an opportunity for interaction and debate pertaining to these issues among students is another IMA objective.

Here the IMA describes to future physicians the importance of remaining informed and allowing the IMA to represent them and their patients.

The IMA website emphasizes its longstanding role as protector of public health and its ability to influence policy.

Nurse Practitioners of Idaho Website: www.npidaho.org

The Nurse Practitioners of Idaho (NPI) website identifies their mission as “To represent, unify and provide a voice for Nurse Practitioners in Idaho”. Their mission clearly identifies advancement of the nurse practitioner profession as their priority. At the top of their home page there are “Legislation”, “Conference” and “Member Login” links. The legislation link specifically describes the organization’s advocacy for the nurse practitioner profession.

Advocacy has been a cornerstone of the NPI since its inception. Due to the hard-working efforts of NPI members, the Idaho State Nurse Practice Act was amended in 2004 to eliminate the requirement for supervision. This established a standard for collaborative practice with other healthcare providers for Idaho nurse practitioners under statute and rules regulated solely by the Board of Nursing. Today, the NPI is the voice of the profession at the local and state level, with the Idaho Legislature, Governor's office, regulatory agencies, the healthcare

community, businesses, and consumers. The NPI Advocacy Program represents and protects the interest of NPs, thereby advancing the profession and increasing visibility and viability of NPs. The NPI has an outstanding and highly effective Advocacy Program with a successful track record, and it continues to be a primary focus for the NPI. The NPI lobby team consists of the NPI professional staff, lobbyists and the Government Affairs Committee. Together with the NPI Board of Directors, Chapters and members, we identify key issues that impact NPs. Legislative initiatives and outreach programs are then developed to address these issues and expand opportunities for NPs. Our team works tirelessly to introduce, monitor and lobby for legislation with members of the Idaho Legislature, Congressional delegation, State agencies and key influencers and health care stakeholders to advance and advocate for the profession.

The NPI remarks demonstrate a focus on teamwork and collaboration through mentions of “collaborative practice with other healthcare providers”, working “together” across local and state levels, and a “team” that “works tirelessly”.

The NPI comments regarding legislation do not address any advocacy for patient populations or legislation related to improving rural access to health care services, however, under their “About” tab the NPI more broadly describes its advocacy efforts.

Active membership promotes establishing collegiality with all members of the health care team by supporting a voice for NP issues in the Legislature, participating within our communities to promote access to care for all, and maintaining excellence in provider skills, efficacy in practice and safety in patient care.

These comments suggest that the group's advocacy efforts extend beyond those of promoting the nurse practitioner profession to include enhancing health care access "for all" and advancing patient safety. Unfortunately the potentially meaningful power of community service or collegiality or the democratic process of surfacing issues of concern from members is not described.

In their "Membership" section, there is additional mention that NPI aims to enhance access to health care services.

Since 1999, when the official charter for Nurse Practitioners of Idaho (NPI) was signed, NPI has focused on meeting the needs of nurse practitioners across our state. The purposes of NPI are to advance, support and promote the role of nurse practitioners and to promote accessible, quality health care provided by nurse practitioners. This includes not only continuing educational opportunities, but also providing to our members current information that impacts their clinical practice. NPI promotes legislative changes that enhance NP practices within Idaho, which positively affects patient welfare. As a member of NPI you will be making a valuable investment in not only your career, but the health future of all Idahoans.

The relative youth of the NPI is quite striking. The NPI website displays no narrative of a founding father (or mother), no long line of professional ancestry, and no extensive history to convey permanence. On the NPI website potential members are told they will be "making a valuable investment not only in your career, but the health future of all Idahoans," serving as a reminder of the dual loyalties and ethical responsibilities of nurse practitioners to both profession and community.

Conclusion

Analysis of the websites and their associated documents illuminated four state factors related to the political context in Idaho that contribute to the case study: 1) State sovereignty narrative which describes power as concentrated within state government, competes for influence with the federal government, and depends in part on federal funding, 2) Medical sovereignty narrative which describes power and influence as concentrated in the medical profession, and competes for influence with state and federal governments in regards to shaping health care and health policy, 3) Financial viability of health care in Idaho, and 4) Relationships of both dependence and competition that exist among key stakeholders, for example, between patients and physicians, hospitals and physicians, rural communities and hospitals, and nurse practitioners and physicians. The websites and their associated documents demonstrate differences in the various organizations' use of the state sovereignty and medical sovereignty narratives, their perspectives on the relationships that exist among key stakeholders, their stances on the provider shortage, and their viewpoint on rural health care access in Idaho.

State Sovereignty Narrative

The press releases displayed throughout the Governor's website promote a state sovereignty narrative by rejecting federal sovereignty, depicting the two as incompatible. These press releases present federal health care policy as unacceptable, violating state sovereignty.

Review of the Governor's website and its associated documents reveals a narrative of state rights and state self-determination as part of a broader argument for

state sovereignty. His comments consistently demonstrate disdain for “intrusions” of the federal government, including “Obamacare”. Fiscal responsibility, by both individuals and the government, is also a strong theme in the official state narrative. “Abuse” and “fraud” are frequently mentioned in the Governor’s discussions of federal health care programs, including his June 28, 2011, press release regarding Medicaid reform. By highlighting responsibility, the Governor puts an ethical spin on state self-determination of health care policy.

The Governor’s website contains very few mentions of rural health or rural life. His biography portrays his connection to the rural lifestyle, serving to validate his qualifications to govern in Idaho, a predominantly rural state. The Capital for a Day program, where the Governor visits a rural community for one day each month, does demonstrate awareness of the need for state government officials to reach out to rural residents throughout the state. The Governor also specifically addressed rural health in his State of the State address when he called for continued funding of loan reimbursement incentives for physicians serving rural communities in Idaho.

Medical Sovereignty Narrative

The terminology used throughout the IMA website emphasizes the group’s power. In his foundational definition, Mumby (1987) describes official organizational narratives as functioning “ideologically to produce, maintain, and reproduce...power structures.” Much of the IMA’s medical sovereignty narrative is well-described by Paul Starr, who in 1982 published *The Social Transformation of American Medicine*, a study of the historical rise in power and authority by the medical profession (Starr, 1982). Starr documents how the medical profession not only developed extensive cultural and

scientific authority, but that members of the medical profession have been able to extend their power to the “control of markets, organizations, and governmental policy” (Starr, 1982, p. 580). The IMA website suggests that the economy, the viability of individual physicians’ practices, and the public’s health are dependent upon a strong medical profession. The terminology used on the IMA’s website when describing their role of “protecting” public health is potentially paternalistic.

Starr further asserts that “power, at the most rudimentary personal level, originates in dependence”, noting that “no one group has held so dominant a position...as the medical profession” (Starr, 1982, p. 576). According to Starr, the power enjoyed by the medical profession, as suggested throughout the IMA website, stems in part from the fact that most individuals must depend upon physicians’ scientific knowledge in matters related to their health (Starr, 1982).

By providing their extensive history on the website, the IMA is asserting the official medical profession narrative, a narrative of “medical sovereignty”, similar to the governor framing his biography as a means of asserting his right to govern. Just as the official Idaho state narrative is personified in the Governor’s biography, the IMA presents Dr. Sweet as the original sovereign medical leader, the “George Washington” of the IMA. Several references to the length of their existence further solidify the medical sovereignty narrative used throughout much of the IMA website.

On their website, the IMA further demonstrates a medical sovereignty narrative as both ethical and self-interested by describing the IMA’s establishment of the Idaho State Board of Medicine to regulate physicians. The terminology used in the IMA’s sovereignty narrative further demonstrates the policy power enjoyed by the medical

profession. The IMA “has input” and “works directly with” political representatives. The IMA narrative merges with the official state narrative regarding the need to “closely monitor” federal government actions. The IMA portrays itself as wary of the federal government as a potential intruder that may negatively impact physician practice viability.

The website demonstrates that the IMA not only plays a policy advocacy role but has assimilated itself within government, becoming indispensable to governing health care. The IMA narrative merges with the official state narrative yet again in the shared concern about federal policies that determine reimbursement rates, and positions the IMA as sitting at the table with state policy makers and even as state policy makers.

Despite the fact that it is a statewide organization with members from across rural Idaho, the IMA does not mention rural access issues. Thus, the voice of individual members, many of whom are rural residents, is not apparent.

While the IMA website is void of any overt political ideologies, there is a suggestion that the “political and legal environment” may threaten the ability of physicians to “provide for ourselves and our patients”. The implication is that if physicians are not able to contain state and federal government regulation then their practices, and thereby, their patients’ very health may be at stake. As the voice for a sovereign profession, the IMA describes itself as a reliable, trustworthy, and qualified voice for “spreading understanding of the political and health policy changes” to its member colleagues within the health care system and to the larger public, further illustrating the medical profession’s power as expanded well beyond that of the medical field (Starr, 1982).

The information publicly available on the IMA website emphasizes the group's ability and commitment to influence policy, and also reflects a wariness of government intervention into the medical profession. In some ways, the IMA's organizational power appears to be more lasting or longstanding than even that of the governor, who serves at the pleasure of the populace and for a limited term. Regardless of who becomes the next governor of Idaho, the IMA, with its extensive history, self-regulation, and impressive inroads into government, may seamlessly continue to assert their significant power and sovereignty to shape the health care system and health policy. Thus, while the IMA website and associated documents demonstrate use of both the state sovereignty and the medical profession sovereignty narratives, the use of the medical profession sovereignty dominates.

Financial Viability

The Governor's website contained multiple references to finances and financial viability. The Governor's website and associated documents suggested that the state government's financial viability was of utmost concern. The IMA website likewise demonstrated concerns related to financial viability. The IMA's concerns appeared to center around the financial viability of physician members' practices.

Several of the other websites and documents also referenced the theme of financial viability. The majority of the information available on the IPCA website pertains to business practices, the logistics of becoming a CHC, or the recruitment of providers or administrators for CHCs throughout the state. Terminology in their mission statement regarding "safety net health care" suggests that vulnerable populations are a priority, however, their documents do not describe advocacy for patient populations. The

IPCA does communicate a desire to enhance patients' involvement and satisfaction in their health care while simultaneously decreasing overall health care costs, using some terms from both "conservative" and "liberal" approaches to describing health care. The IPCA appears to focus on the financial viability of CHCs.

The IHA's website suggests that the organization's aim is to enhance health care services provided in Idaho communities by ensuring that member hospitals' policy voice is heard at state and federal levels. The IHA website and documents reveal that the IHA is concerned with maintaining member hospitals' financial viability. Similarly, comments throughout the IHA website imply that the IHA's advocacy efforts are applied both to advance the quality of health care for patients and to promote member hospital financial, and perhaps political, viability.

Compared to the IMA narrative which depicts physicians as "employers," the NPI website's emphasis on NPs as "investors" is less convincing, suggesting individual risk with individual resources. Mention of the future conveys the hope inherent in NPs' "investment" in their careers, but the hope portrayed in the NPI narrative differs sharply from the certainty of the long entrenched and ongoing power and sovereignty displayed in the IMA narrative. By and large, NPs remain one class of "employees" that Idaho physicians employ. This section and others of the NPI website hint at the financial vulnerability of NPs and demonstrate the NPI's concerns regarding NP financial viability.

Much of the information contained on the IRHA website is outdated, suggesting that their staff and resources may be limited. The IRHA is portrayed as very inclusive with no allegiance to any particular professional group. The IRHA states that it represents "a variety of individuals and organizations"; however, their description of

members is comprised of individuals and does not list any organizational members. The IRHA website does not contain any overt political opinions. The IRHA does not demonstrate any use of either the medical sovereignty or the state sovereignty narrative. The IRHA website demonstrates the financial vulnerability of non-profits and the difficulties they experience with operational costs such as staff and keeping their website current.

Relationships of Dependence and Competition

The Governor's website displays a relationship of dependence and competition between the state and federal governments. While the state government is dependent to some extent on federal funding, the Governor's website demonstrated the state's competition with the federal government in regards to self-determination and sovereignty.

The IMA website and documents also demonstrate relationships of dependence and competition. The IMA is dependent upon state and federal governmental funding while competing, both with the governments and with other providers, for control of the health care industry and their own self-regulation, maintaining their own professional sovereignty. Other organizations' websites and documents also revealed existing relationships of dependence and competition. The IPCA has a relationship of dependence with the federal government for funding. The IPCA competes with other rural states when recruiting providers and with CAHs for patients.

Nurse practitioners have relationships of dependence and competition with physicians. In some practice settings they are required to have physicians sign off on their documentation and orders. Nurse practitioners compete with physicians not only for

patients but also for legitimacy and recognition as primary health care providers. The NPI website does not explicitly speak to the relationship of dependence and competition that NPs have with physicians. However, the NPI website describes promoting “collegiality” with “all” health care team members and characterizes nurse practitioners as serving their communities: potential solutions to nurse practitioner and physician dependence and competition. This differs from the IMA narrative which highlights the physician’s role of professional and public guardian. Like the NPI, the IRHA struggles to be recognized and viewed as a legitimate player. The IRHA competes with other organizations to influence health policy that impacts access to rural health care in Idaho.

The IHA does appear to recognize the relationship of dependence that exists between rural communities and their hospitals. Remarks on the IHA website about “improper legislation and unreasonable regulation” imply a desire to limit government intrusion and a paternalistic perspective of serving to protect member hospitals from harmful government overreach. The IHA’s remarks demonstrate a disdain for government imposition. Thus, the IHA website and documents available to the public incorporate several features of the official state narrative portrayed on the Governor’s website.

The Idaho Bureau of Rural Health and Primary Care’s website and associated documents appears as unique among the others in this case study. The Bureau’s website demonstrates acceptance of the ACA and other federal health programs, acknowledgement of all health professionals as legitimate, and a concern for rural residents. The Bureau’s website describes efforts to improve access to health care

services in rural Idaho by providing information and assistance to rural Idahoans, health care providers, and rural health care facilities. The Bureau emphasizes the health care provider shortage throughout its website and demonstrates recognition of the broad groups of health care providers, beyond physicians, needed to serve Idaho's rural communities.

The Bureau does fall under the executive branch of state government, so it would be assumed to reflect the Governor's politics. However, the website does not use a state sovereignty narrative, and freely announces federally-funded programs of interest without politicizing them.

Summary

The review of the various organizations' websites and associated documents illuminated four factors informing the political context of rural health care access in Idaho. The disdain for the federal government and the ACA was evident throughout several of the organization's websites, while other organization's websites gave no indication of their opinion of federal programs. The use of one or both of the sovereignty narratives by the various organizations to consolidate or advance health policy influence, as well as the non-use of either of the sovereignty narratives and the possible ramifications for an organization's policy influence were interesting to note and provided perspectives on the political landscape of Idaho.

Chapter 6

Discussion

This case study, as most case studies, contains a large amount of description and can be, therefore, difficult to summarize. Flyvbjerg (2006) notes that critics of the case study approach frequently cite this as a weakness, however, I concur with those who have described the descriptive narrative as an indication of particular richness and summarization in case study a threat to nuance and intimate detail (Flyvbjerg, 2006). Contrary to attempting to summarize the case, I developed the case from the multifaceted, complex, and often contradictory stories as relayed from the participants and conveyed on the websites and their associated documents. In addition, consistent with a case study approach, I avoided tying the case to a particular theory, allowing instead for readers to draw their own conclusions and interpretations. As Eysenck 1976 has noted, “Sometimes we simply have to keep our eyes open and look carefully at individual cases – not in the hope of proving anything, but rather in the hope of learning something” (Eysenck, 1976). In this chapter, I will share my perspective on the learning that occurred from this single-case case study of access to rural health care in Idaho.

This chapter presents a discussion of findings by specific research questions from the two data sources followed by reflections on the relationships that were identified between the two sets of data. Commentary on the case study approach, as well as strengths and challenges of this study will also be discussed. Finally, implications for the profession of nursing, health policy, and future research will be identified and discussed.

The research questions posed when designing this study were:

- 1) How do policy stakeholders describe the politics of policymaking for access to rural health care services?
- 2) How do state factors, such as health care delivery systems, and political and socioeconomic issues, affect access to rural health care access?

Question 1: Politics of Policymaking

It was anticipated that participants would describe the politics of policymaking in their responses to questions posed specifically about politics. Surprisingly, there was as much, if not more, learned about the politics of policymaking from interviewees' responses to questions not directly pertaining to politics, and in the review of websites and their associated documents, as there was from the questions specifically addressing politics.

The first question on the qualitative interview which was anticipated to address the research question regarding the politics of policymaking for access to rural health care services was: "Who do you see as some of the individuals and groups with the most influence on policies affecting Idaho's rural health care access?" Counter-intuitively, state government policymakers, elected officials such as the Governor and the legislature, were not identified by interviewees as being most influential on policies that affect rural health care access in Idaho. Rather, the vast majority of interviewees named physicians, the Idaho Medical Association (IMA), and the Idaho Hospital Association (IHA) as most influential in the rural health policy arena. In addition to identifying those with the most political influence, the interviewees also identified who they saw as lacking influence on policies that affect rural health care access in Idaho. Multiple rural interviewees described frustration with what they saw as a lack of influence among rural residents in Idaho (the

majority of the state's patient population) and opined that power and influence are concentrated in the urban areas. Interviewees also identified racial or ethnic minorities as being relatively powerless to affect policy in Idaho.

Because the ACA has been such a controversial and highly politicized policy in Idaho, the interview questions, "How might the ACA influence rural health care access in Idaho" and "How might the politics of Medicaid expansion in Idaho impact rural health care access?" were anticipated to facilitate insight into the politics of policymaking in Idaho. The majority of interviewees' responses fell into one of two perspectives, as generally supportive of the ACA and Medicaid expansion or as generally opposed to the ACA and Medicaid expansion. Multiple interviewees portrayed the ACA as an example of government overreach, a program that fell short of its promises, creating a more complex and expensive health care system. Many of these same interviewees depicted Medicaid as a widely abused system that perpetuates a lack of individual responsibility. These interviewees indicated that the Medicaid program should not be expanded, but rather revised to increase patient accountability and limit costs.

Other interviewees expressed frustration that Idaho is not benefitting fully from the ACA without the optional Medicaid expansion. This group of interviewees outlined multiple advantages they believed could be realized from Medicaid expansion in Idaho. These interviewees portrayed conservative political ideology and widespread disdain for President Obama as the reasons Medicaid has not been expanded in the state. Some interviewees indicated that the political climate in Idaho itself affects not only Medicaid but generally exerts a negative effect on access to rural health care services in Idaho.

Interestingly, rural provider interviewees evidenced a common ground in their responses, regardless of their opinion of the ACA. The provider interviewees, both those who supported and those who opposed the ACA, reported that in their practices the ACA had resulted in larger numbers of patients seeking preventive care. They also expressed belief that Medicaid expansion would improve rural provider reimbursement if it were to be implemented.

The interview question asking interviewees about their thoughts regarding the use of NPs or PAs as primary care providers in rural Idaho prompted more participant description about the politics of health care policy than anticipated. Some interviewees, including, but not limited to physicians, described NPs and PAs as “dangerous”, portraying NPs in particular as incapable of handling a full spectrum of care, and arguing that “limits” need to be placed on NP’s scope. This was particularly surprising given that Idaho statute authorizes NPs to practice independently. Multiple interviewees described NPs or PAs as useful “workforce multipliers” but only if their role is clearly delineated and they are “led” by a physician.

NPs who were interviewed cited a lack of physician acceptance and poor federal reimbursement policies as contributing to a lack of practicing rural NPs in Idaho. Thus, multiple interviewees’ remarks advocating the limited use of NPs as primary care providers were counter to the Nursing practice act in Idaho that authorizes independent NP practice. Nurse practitioners have been a mainstay of care since the late 1970s and have been recognized as primary care providers under federal legislation since 1990 (American Association of Nurse Practitioners, 2011). Research has demonstrated that nurse practitioners are capable of providing primary care at a level comparable to that of

a physician and at a lower cost (Kitchenman, 2012). Despite these facts, the dominance of physician authority persists, as is demonstrated in the interviewees' comments.

Analysis of stakeholder groups' websites and their associated documents provided additional insights into organizational stakeholders' descriptions and perspectives of the politics of policymaking for access to rural health care services.

The Governor's website and its associated documents portray the federal government as nearly demonic, describing the need to repeal "Obamacare", and depicting the Medicare and Medicaid programs as examples of federal government overreach that have created a health care system "disaster" teeming with abuse and fraud. The Governor's website and associated documents promote a free market solution to health care system ails and describe the state government's health care-related actions as positive. The www.gov.idaho.gov website and its associated documents are silent on providers other than physicians, with little if any mention of NPs as primary care providers. Throughout the Governor's website and its documents remarks promoting the importance of state rights and state self-determination are prominent and abundant. The overarching political aim identified on the Governor's website and its associated documents is asserting and protecting state sovereignty in the face of federal intrusion and threat. The Idaho Primary Care Association's (IPCA) website and its associated documents contain no policy critiques of government health care programs. The IPCA expresses its support for the expansion of the Patient Centered Medical Home model, which is incorporated in the State Health Innovation Plan and championed in the ACA. The IPCA also describes its role in assisting individuals with health insurance enrollment

via Idaho's health insurance exchange, which was developed as part of the ACA implementation.

The Idaho Hospital Association's (IHA) website and associated documents portray the IHA as providing "leadership in health policy" and enhancing hospital "viability and capacity to serve". The IHA reports its advocacy efforts as twofold, to support its member hospitals and to ensure the provision of high quality health care. On its website the IHA displays its stance on health care-related legislation, supporting those favorable to hospitals. "Preventing or modifying improper legislation and unreasonable regulation, while supporting appropriate laws" is depicted as a "major activity" of the IHA.

The Idaho Rural Health Association (IRHA) is described on its website as an "advocate for rural health issues in Idaho". The IRHA reports that it provides notification of rural health issues to its members so that they can advocate as individuals, but there is no official lobbying by the IRHA described. The IRHA appears inclusive, portraying a diverse membership of individuals. The website mentions organizational memberships as well, but no organizations are identified. There are no explicitly political statements noted on the IRHA website or associated documents.

The Idaho Bureau of Rural Health and Primary Care describes its purpose as to improve the quality and access to health care for the rural populace in Idaho and to support rural health care providers. There are no political opinions displayed on the Bureau's website or associated documents. The Bureau does announce federal health care programs without critique.

The Idaho Medical Association's (IMA) website portrays the IMA staff as "powerful" and "professional" with an aim of protecting physician practice from "legal, legislative, and regulatory intrusions". The IMA advocacy efforts are displayed throughout the website and associated documents. The IMA has a government liaison, "monitors" legislation, has "input with government agencies", "works directly with" Congressional Representatives, fills a "lead role" on state committees, serves "spreading understanding of the political and health policy changes", and has a Political Action Committee comprised of physician members. Paternalistic and benevolent terminology abounds throughout the IMA's website. The IMA describes protecting the public health, bringing health insurance to Idaho, and boosting the state economy among its accomplishments. The IMA's creation of the State Board of Medicine is described on the IMA's website, demonstrating their self-regulatory status. There are no rural health care issues discussed on the IMA website or associated documents. A political theme that dominates the IMA website and associated documents is medical sovereignty: the medical profession's establishment of itself as an independent authority with the right to self-determination.

The Nurse Practitioners of Idaho (NPI) website describes the group's purpose as to "provide a voice and advocate for the nurse practitioner profession". The NPI website is void of any overt political commentary, but does "promote access to health care for all and safety in patient care". The NPI website and associated documents contain multiple remarks about "collegiality" with "all health care team members" and "teamwork". On their website the NPI reports that their organization "promotes legislative change to enhance NP practice and positively affect patient welfare". There is recognition of NPI's

role in the 2004 amendment of the Idaho State Nursing Practice Act to “eliminate the requirement for supervision”, however, there is no explicit challenge to the medical sovereignty narrative noted on the NPI website or its associated documents.

Question 2: State Factors

Interviewees identified multiple state-level factors that they viewed as having an impact on access to health care services in rural Idaho. The factors identified were not simple quantitative lists of discrete influences. They were very complex issues, each framed uniquely by participants’ narratives. While the state-level factors identified by interviewees generally fell into similar categories, they were viewed through different lenses by each interviewee and it is through these individual responses that the complexities of perspectives on state factors were truly illuminated.

The economy

The majority of interviewees identified the economy as a state-level factor that influences access to rural health care in Idaho. There were, however, multiple perspectives on how the economy impacts access. Some interviewees described the economy’s influence on government funding of health programs, indicating that rural areas were the first to suffer from budget cuts. Rural communities were also portrayed as suffering more significant effects from failing businesses during the recent economic downturn. Other interviewees expressed that lower wages in rural Idaho limit patients’ ability to access health care and that many rural patients have to choose between seeking health care and paying their bills. The costs incurred by rural residents were noted to be higher than those for urban dwellers due to travel expenses. Multiple interviewees indicated that the ailing economy poorly impacts rural health care facilities and providers,

which in turn threatens accessibility. These interviewees explained that rural facilities and providers see all patients, regardless of their ability to pay, and that a slow economy meant fewer patients could afford to pay for their care. The financial strains experienced by rural providers and facilities, due to volatile volumes and high overhead costs, were cited by multiple interviewees as an issue.

Geographic features

Geographic features were identified by interviewees as a state-level factor that impacts access to health care services in rural Idaho. The topography of the land, including its mountainous terrain, geographic isolation, extreme winter weather, and the state's roadway system were all characteristics in this category cited by interviewees as making access more difficult. These features of Idaho were portrayed as aspects that should be considered when government funding for health care programs is being determined. Interviewees described the geographic features of Idaho as contributing to patient costs: car maintenance, gasoline purchases, time commitments in terms of time away from home, family, and work, and potential need for temporary lodging while away from home. Thus, these geographic features were illuminated in interviewees' comments as not strictly physical barriers, but economic and social barriers as well.

Rural patient population characteristics

Many interviewees expressed characteristics of the rural patient population in Idaho as factors that influence access to health care services. Interviewees indicated that rural residents are not quick to seek care for a variety of reasons such as "rugged individualism", a belief that any problems should be handled without assistance, or concerns about privacy due to familiarity with providers and their staff. The racial and

ethnic homogeneity of Idaho were cited by several interviewees as a factor that impacts rural health care access. One provider thought such general homogeneity contributed to increased patient trust and comfort with providers who “look and act” like they do. Others indicated that the racial and ethnic homogeneity of providers in Idaho serves as a barrier to access for individuals of racial or ethnic minorities and may negatively impact the care they are provided.

Multiple interviewees portrayed the rural patient population in Idaho as abusers of Medicaid who lacked appropriate “personal responsibility” and “accountability” for their own health and use of health care. Particularly interesting was an interviewee’s remark that patients need to be more aware of their health conditions because it is more difficult for providers now that they only have 15 minutes to spend with a patient, suggesting that patients need to adjust to the 15 minute time limit imposed by the health care system.

Idaho’s rural health care system

Characteristics of the rural health care system in Idaho were also identified by interviewees as a factor that impacts access to health care services in rural Idaho. The competition between CAHs and CHCs, the financial fragility of CAHs, and the economic dependence between CAHs and their communities were all mentioned by interviewees as factors that negatively influence access to rural health care services. Interviewees reported that CAHs and CHCs compete for patients and funding. Interviewees expressed different opinions regarding the competition between the two entities, with some suggesting that CHCs “skim” patients away from CAHs and impact CAHs’ revenue and others opining that CHCs enhanced access. Some interviewees indicated that CAHs need more enhanced reimbursement while others thought that CAHs needed to be more

financially accountable. The recent trend of community hospitals being purchased by regional medical centers was noted by several interviewees as an influence on access. Some interviewees viewed this trend as having a positive impact while others saw it as a negative impact.

Primary care provider shortage

A large majority of interviewees identified a primary care provider shortage as a factor that affects access to care in rural Idaho. Most interviewees framed this issue as a physician shortage, with only three interviewees mentioning a NP or PA shortage as part of the issue. Increased demands on rural primary care providers were cited by interviewees as a factor contributing to the shortage. The wide range of services traditionally provided by rural primary care providers, ranging from deliveries to end-of-life care, as well as the fact that fewer physicians are interested in providing the full spectrum of care, were also mentioned as reasons for the shortage. Decreased reimbursement and compensation, with loan repayment programs that compare poorly with those of neighboring states were other aspects interviewees portrayed as contributing factors. Physician retention was identified as difficult in rural Idaho with physicians frequently leaving rural practice as soon as their loans are repaid. Finally, Idaho's political climate and lack of Medicaid expansion were depicted as hindering physician recruitment in the state and contributing to the primary care provider shortage. Interestingly, interviewees emphasized the availability of providers, specifically physicians, rather than the availability of services (Mueller & MacKinney, 2006).

Triangulation of Data Sets

Triangulation of data sources includes the use of more than one source of data as a strategy commonly used in case study research to enhance data credibility (Baxter & Jack, 2008). The two data sources used in this study, qualitative interviews and websites with their associated documents, provided individual stakeholder and organizational perspectives on the state factors and politics understood to impact access to rural health care services in Idaho. The data sources were triangulated through the data analysis and coding processes, identifying themes and categories in each data set, as well as commonalities across the data sets. The results of this triangulation process were then verified via inter-coder reliability checks, discussion with committee chairs, reflection, and double coding (Baxter & Jack, 2008).

Analysis of the various stakeholders' websites and their publically available documents identified description of many of the same state factors impacting rural health care access as those identified in the qualitative interviews. There was, for example, much emphasis placed on the economic aspects of health care and the provider shortage in the majority of websites and their associated documents. The need for more "personal responsibility" for health and health care usage, noted in several of the interviews, was also highlighted in the Governor's website and its associated documents. There were, however, also additional insights gained regarding state factors and the political aspects of policymaking that emerged from the websites and associated documents.

Analysis of the two data sets revealed two state factors that were unanticipated, the official narratives of state sovereignty and medical sovereignty. State sovereignty was depicted throughout the Governor's website and its associated documents and state

sovereignty arguments appeared in multiple interviews, especially evident in participants' comments that assumed ill intent by the federal government and its health care policies. The medical sovereignty narrative was displayed throughout the IMA and IHA websites and their associated documents and was, likewise, evident in multiple interviewees' narratives, particularly in comments that identified primary care providers as exclusively physicians and questioned the capabilities of NPs.

Most significantly, these two narratives portrayed in the Governor's and IMA's websites, those of state sovereignty and medical profession sovereignty respectively, were readily apparent in many, but not all, interviewees' comments. Many interviewees described the significant if not exclusive political influence exerted by the IMA and the IHA, and the lack of such influence among rural residents, state-level policy makers and interest groups. Concepts and language featured in the IMA website are apparent in the comments made by multiple interviewees who identified physicians and the IMA as those most qualified to provide primary care and most influential on policies that impact access to health care services in rural Idaho. The fact that so many of the interviewees see the provider shortage as strictly a physician shortage further demonstrates the political strength exerted by the medical profession and its reluctance to accept NPs as legitimate primary care providers. Likewise, interviewees' emphasis on physicians' financial strain when discussing the economy, and frequent calls for improved physician reimbursements as a crucial policy change, also demonstrate interviewee's use of the medical sovereignty narrative.

The use of a medical sovereignty narrative was further described in interviewees' comments that their rural communities' survival is dependent upon the survival of CAHs,

along with remarks that CAHs are under threat of extinction by the federal government. The importance of hospitals was also reflected in interviewees' recommendations for enhanced funding of CAHs.

Multiple interviewees reported having very little influence, even as rural health stakeholders, on policies that affect access to rural health care services in Idaho. Physicians, the IMA and the IHA, not Idaho's Governor or legislature, were identified by interviewees as those most influential on policies that affect access to rural health care services in Idaho, further underscoring the significance of medical sovereignty in Idaho politics.

On his website and in its associated documents, the Governor recognizes the need to improve affordability and access to quality health care in Idaho and appears to identify provider shortage and federal government bureaucracy as major contributing factors. Thus, the official state narrative highlights themes characteristic of the medical sovereignty narrative, such as the impact of the economy on physicians and Idaho's rural physician shortage, evidenced in the qualitative interviews, but prioritizes the theme of state sovereignty throughout.

Historically, the federal government has been generally viewed as supporting and upholding democracy and well regarded for recovering from the Great Depression, winning World War II, and establishing civil rights. In the 1970s and 1980s, the Vietnam War, the Watergate scandal, and the hostage crisis in Iran, however, dampened public esteem for the federal government and bolstered "states rights" efforts to shift power away from the federal government to state governments (Thompson & Fossett, 2008). However "state rights" has a long and controversial history in the US. Several Southern

states invoked “states rights” in their succession from the Union, as did Governor Wallace while resisting desegregation, therefore, some scholars have associated state sovereignty claims with racism (Price Foley, 2012). Such criticisms have been raised in response to states rights-based opposition to the ACA (Lazarus, 2012).

A state sovereignty narrative, characterized by portrayal of the federal government as an intrusive and potentially damaging force, whose powers should be minimized in favor of states’ self-determination, is evident in the Governor’s, IMA’s, and IHA’s websites and was also used by multiple interviewees. An interviewee depicted the removal of government intervention in the private health care business as the single most crucial policy change needed to optimize access to health care services in rural Idaho, echoing the sentiment in several websites and documents that the federal government is “intrusive” and “unreasonable”. While not commenting directly on the Governor’s, IMA or IHA websites, other interviewees critically commented on the contempt for the federal government that is openly exhibited in rural health stakeholder websites in Idaho. Several interviewees expressed frustration that the demonization of the President and delegitimizing of the federal government prevent Idaho from expanding Medicaid, a move they view as positive for the rural populace, providers, facilities, and the state’s economy as a whole.

On the Governor’s website, the state sovereignty narrative also evidences the same silence noted in the qualitative interviews regarding nurse practitioners or other primary care providers beyond physicians as a key component of the Idaho provider shortage and part of the potential solution to workforce development. In this regard, the state sovereignty narrative and the medical sovereignty narrative align.

Patient accountability is a key aspect of the state sovereignty narrative. Multiple providers and health care facility administrator interviewees indicated that patients should be held responsible for their lack of knowledge regarding health behaviors and health care, and for patient abuse of entitlement programs. The state narrative holds both patients and the federal government accountable, however, is relatively silent regarding the accountability of hospitals, insurance companies, workforce, or state policymakers.

Thus, the use of these two official narratives, state sovereignty and medical profession sovereignty, gleaned from the websites and documents, helps form the political context that is evident in the two sources of data. These narratives are frameworks for consolidating power, advancing policy agendas, and determining voice. In addition, upon reflection a third sovereign narrative was illuminated, that of the insurance industry and its free market, for-profit framework for health care. This narrative was not explicit in the interview data, however, it was displayed in a minority of the interviews as a criticism of for profit systems and widespread state government and medical profession's support for a "free market" solution to Idaho's health care woes.

Throughout the websites, associated documents, and interview data, the patient perspective is largely silent. While this researcher acknowledges that patients were not recruited as participants in this study, the silence reflects more than their absence. Both data sets evidence recommendations promoting the financial viability of various professional groups or health care facilities. A small minority of interviewees did not use the two sovereign narratives and these interviewees' comments demonstrate that they value patients beyond their role as income generators for providers and recognize that patients need to be heard and prioritized by rural health care policymakers.

Implications of this Case Study

The politics surrounding the rural patient population and the rural health care system in Idaho seem to be a politics of blame. Interviewees blamed CHCs for taking patients and revenues away from CAHs, threatening their financial survival. The federal government was also blamed for “wanting to do away” with CAHs. A similar theme is evident in several of the websites where the federal government or President Obama is blamed for existing health care system problems, abuse and fraud are cited as rampant among government assistance programs, and the “public, policy makers and even patients” are admonished for having “contributed to the problem with their complacency”. The medical sovereignty narrative blames NPs for asserting themselves as qualified primary care providers, citing their lack of knowledge of the “limits” on their scope of practice and blaming them for either referring too often or too seldom. With the political context being a politics of blame, the case study approach facilitated participants’ candor.

This case study has several implications for the profession of nursing. It was surprising how few interviewees identified nurse practitioners as part of the solution to addressing access issues in rural Idaho. Only a very few interviewees even mentioned nurse practitioners prior to being asked a question specifically about nurse practitioners. In Idaho, one of the first states to authorize independent practice by NPs, it was anticipated that NPs would have been a more integral component of interviewees’ responses regarding access to rural health care services.

This case study highlights how Idaho’s Nursing Practice Act appears to have some political similarities with the ACA. Both are policy that have become law and yet

continue to be challenged by those using the narratives of state sovereignty and medical sovereignty. These challenges, occurring in provider interactions, public discourse and (in the case of the ACA) courts of law, complicate and slow the implementation of both the ACA and Idaho's Nursing Practice Act, demonstrating the power wielded by some stakeholders to continue to influence policy even after it has been instituted into legislation. The IHA's self-declared "major activity" of "preventing or modifying improper legislation and unreasonable regulation, while supporting appropriate laws" demonstrates some stakeholders' recognition of their ability to have such influence.

Empirical evidence has long supported the quality and cost-effectiveness of care provided by NPs as well as patient satisfaction with that care (Blevins, 1995; Kitchenman, 2012; Marino, 2011; U.S. Congress, 1986; Weiland, 2008). Despite such evidence, Idaho's Nursing Practice Act remains politicized, with the medical sovereignty narrative challenging the Nursing Practice Act on a daily and systems basis, via everyday interactions between physicians and nurses, and in ongoing reimbursement policies that persist in devaluing NPs and the services they provide. As evidenced on the NPI website, NPs in Idaho appear to primarily focus their advocacy on the level of daily interactions with physicians, fostering collegiality and collaboration among "all" health care team members. Some NP organizations have, however, advocated at other levels, battling in individual states for equitable insurance laws and reimbursement rates, and requesting Federal Trade Commission comment on the competitive impact of statutory requirements for NPs to establish relationships with supervisory physicians (American Association of Nurse Practitioners, 2016; Gilman & Fairman, 2015).

Regardless of the evidence demonstrating independent NP practice as good policy and longstanding efforts by NPs to establish themselves as legitimate primary care providers, this case study suggests that there remains much resistance framed through the medical narrative. The medical profession has spent well over a century constructing and disseminating their sovereign narrative, all while amassing broader and more influence. This case study suggests that advanced practice nursing may lack an empowered, independent narrative with which to address the challenges NPs experience from the medical profession's assertions of sovereignty and state-level acceptance of medical sovereignty.

Power is frequently viewed as a masculine attribute and sits in direct opposition to caring (Manojlovich, 2007). Since the 19th century, nursing has been defined as a caring profession and, thereby, "women's work" (Manojlovich, 2007). Despite great advances in feminism and an influx of male nurses into the field, nursing continues to struggle for legitimacy as providers of health care. As has been well documented, the medical profession has established an expansive definition of medicine as its exclusive domain (Safriet, 2011; Starr, 1982). Historically, nursing's focus has been patient advocacy, particularly for vulnerable populations, health promotion, and holistic, preventive care (Dossey, 2005; Klainberg, nd). More recently advanced practice nursing has increasingly woven itself into the medical narrative, mimicking the medical profession's self-promotion approach and working to establish higher status for nurses as top "mid-level" in the medical hierarchy and under the medical umbrella. Advanced practice nursing faces the choice to proceed with no narrative of their own and continue their efforts for power and status within the medical narrative, or to construct a counter narrative that

defines advanced practice nursing on its own terms, through the foundationally different narrative of nursing (Nelson, 2001).

Nationally, the medical profession has extended its control beyond that of the practice of medicine to include nearly every aspect of health care (Starr, 1982), creating the assumption that health care and medicine are synonymous. This is, perhaps, where advanced practice nursing could begin to construct a new narrative of its own or build on the existing narrative about nursing. Rather than accepting the view of medicine as the umbrella under which all of health care, including nursing, falls, advanced practice nursing may consider a counter narrative which asserts health care as the holistic, overarching umbrella under which the multitude of health care services fall. A holistic view of health care now commonly incorporates prevention and promotion of physical, mental, and social well-being (Mehta, 2011). Multiple interviewees, both with conservative and liberal political leanings, remarked on the importance of preventive care, suggesting a growing recognition among many of a broadening understanding of what constitutes health care.

Such a counter narrative would build on the very foundation of nursing. The holistic view of health care aligns with nursing's focus on health promotion that began with Florence Nightingale (Dossey, 2005). Nursing's traditional holistic approach, coupled with its current emphasis on collaboration among all health care team members, is an appropriate starting point for construction of a more empowered and independent advanced practice nursing narrative.

In this case study many interviewees spoke critically about patients, placing blame on patients for not being knowledgeable enough about their health or illness,

implying that patients knowingly misuse the emergency department and give no thought to the costs. Nursing has traditionally been viewed as the most trustworthy of professions, consistently voted highest by the public among professions on honesty and ethics (Gallup, 2014). This case study highlights the opportunity to place trustworthiness at the center of the advanced practice nursing narrative. In constructing the language and content of this new narrative, nursing has the opportunity to partner with patients with the aim of consolidating power and voice for patients, rather than for the profession of nursing.

This case study has implications for imagining a new advanced practice nursing narrative where holistic health care is the umbrella under which a plethora of health care professionals reside: mental health counselors, nutritionists, exercise counselors, community health workers, home health aides, occupational therapists, senior center personnel, and others, all with their unique foci, but with overlap; all working in conjunction with patients to achieve the patient's health goals. With a new definition of what constitutes health care, determined in conjunction with patient groups, those diverse aspects of health care outside the scope of medicine could become more valued. Consolidating a narrative with the patients, nurses as policymakers may become channels for the patients' voices.

Advanced practice nursing can continue its efforts to establish an empowered voice within the medical narrative and submit ongoing evidence of the quality and cost-effectiveness of their care, but physicians, with their political influence that was well-evidenced in this study, will likely maintain their ability to direct policy and marginalize NPs. This case study poses questions to the profession of nursing about its priorities in

developing an independent narrative: do nursing priorities lie with self-promotion and positioning the profession as high as possible on the “mid-level” ladder within the medical narrative (achieving citizenship status within medical sovereignty), or do nursing priorities lie with elevating patient advocacy and the provision of holistic health care, beyond the scope of medicine, in collaboration with an inclusive team of providers according to the patient’s perspective?

Methodologic implications

Although some scholars remain ambivalent about the case study approach, suggesting that the practical (context dependent) knowledge produced via the case study approach is less valuable than the theoretical (context independent) knowledge produced by other approaches or that the case study contains a bias toward verification (Flyvbjerg, 2006). This case study challenges that critique and demonstrates that much of value can be learned from a single-case case study. The case study approach was particularly effective at providing an in-depth exploration of the complexities of state factors perceived to impact access to rural health care services and the politics of policymaking in Idaho. Because I was utilizing the case study approach, a description of the state factors and the politics from the participants’ perspective was my goal, not advancing a theory or trying to judge perspectives to determine which perspective was “right.” As a result, interviewees felt free to talk to me, despite the fact that Idaho is such a highly charged, political environment. As an indication of interviewees’ comfort with freely sharing their perspectives, multiple interviewees reported negative perspectives on the use of NPs as primary care providers despite my disclosure about my being a NP prior to beginning the interviews. The interviews appeared to provide an opportunity for diverse

stakeholders to describe their experiences in a manner that the political context in which they normally reside does not allow, as several interviewees commented they felt comfortable describing political differences that they would not normally discuss.

A diverse group of rural health care stakeholders were interviewed, representing assorted geographic, professional, and gender categories. Similarly, the websites and associated documents of diverse stakeholder groups were analyzed and contributed meaningful insights into the case study. A study incorporating only one of the data sets would have not allowed for the depth of description, nor would it have illuminated the two official narratives and their use by interviewees.

Rigor

Several strategies were applied to enhance the rigor of this study and the dependability of its descriptive findings. Inter-coder reliability, achieved when different coders reach similar results with the same data, is commonly used to ensure rigor of qualitative research (Baxter & Jack, 2008). Inter-coder reliability was established with the assistance of two committee members who performed independent analyses of the data and substantiated the results of my analysis. Double coding, another strategy aimed at enhancing rigor, was also used (Baxter & Jack, 2008). The data were analyzed, set aside for a period of time, and then reanalyzed and compared with the initial coding and analysis results.

Every research method sets the unachievable gold standard to “bracket out” (Denzin & Lincoln, 2005) or reflect on (Ortlipp, 2008) the biases of the researcher. Several strategies were employed in this case study. I disclosed to interviewees my position as a NP prior to initiating each interview, kept reflective notes throughout the

research process, discussed my personal views with my advisors, and sought affirmation of my data analysis through inter-rater reliability checks with two different veteran researchers.

The expectation that the case study would simply be described and not interpreted until the very end is the unachievable gold standard of case study method. Although I developed this case study very aware of the standard, the moments of interpretation that occurred throughout were recognized and valued. Remaining cognizant throughout the research process of the gold standard of description kept my focus on acknowledging the humanity of the participants and reporting the interviewees' stories in all of their complexities. A particular challenge was how best to describe the types of political power that presented throughout both sets of data as very "real", but could not be "seen". Ultimately, I decided upon using the terminologies "medical sovereignty" and "state sovereignty", which seemed to convey accurate descriptions of the political power portrayed.

When reporting the case study, additional steps were taken to protect the identity of participants. For example, even if all participants had identified a particular factor, or relayed a particular point, the findings were reported as being identified by a "majority" of participants. This was done to protect those participants who may have informed others of their participation and whose viewpoint would be disclosed if reported among a finding from "all participants."

Limitations

This case study has some important limitations to consider. A single-case case study, in particular, is frequently criticized as not contributing to scientific development

because of limited, if any, generalizability (Flyvbjerg, 2006). This single-case case study, set in Idaho, a rural, generally racially, ethnically, and politically homogenous state, may pose additional limitations than would a similar study conducted in a more diverse context.

This case study was developed from the analysis of twenty stakeholder interview transcripts and seven stakeholder groups' websites and their associated documents. Diversity in geographic location, gender, profession, and stakeholder category of interviewees was sought; however, completion of additional interviews may have provided additional insights. Oversampling stakeholders of African American, Asian, Native American, and Hispanic descent would have insured the inclusion of more diverse perspectives. In addition, rural patients were not included as participants in this study. Their perspective would have, undoubtedly, provided additional worthy insights into state factors and state politics. Likewise, diverse websites illustrative of the various stakeholder interviewee categories were chosen for analysis, however, the strength of the study overall could have been enhanced by inclusion of a larger number of websites.

The Indian Health Service system and the politics impacting Native Americans, a sub-population who reside throughout much of rural Idaho, were not specifically addressed. An interview question pertaining to this segment of Idaho's rural populace may have garnered additional perspectives on the research questions. Additionally, Native American stakeholders could have been purposively recruited to provide their perspectives and strengthen this study.

In addition, rural patients were not included as participants in this study. Their perspective would have, undoubtedly, provided additional worthy insights into state factors and state politics.

Future Investigations

This case study identified multiple opportunities for future research. Of primary import, rural patients' perspective needs explored, both on the state factors and politics of policymaking affecting access to rural health care, and on establishing a definition of health care with which to construct a health care narrative.

In Chapter 5, four state factors related to the political context in Idaho were identified: 1) State sovereignty narrative which describes power as concentrated within state government, competes for influence with the federal government, and depends in part on federal funding, 2) Medical sovereignty narrative which describes power and influence as concentrated in the medical profession, and competes for influence with state and federal governments in regards to shaping health care and health policy, 3) Financial viability of health care in Idaho, and 4) Relationships of both dependence and competition that exist among key stakeholders, for example, between patients and physicians, hospitals and physicians, rural communities and hospitals, and nurse practitioners and physicians. Upon further reflection on the first two unanticipated state factors, another potential narrative comes to light, that of the insurance industry. Although not explicitly explored in the interviews, there were comments regarding the "free market" and whether a hospital's "for profit" status influenced access and the care provided, which indicates this may be a topic of potential significance. The IMA, IHA, and the Governor's websites referenced and promoted "the free market" in health care.

Future exploration of the insurance industry, the features of its free market narrative, and its role in influential narratives shaping rural health policy would be enlightening.

Native Americans' perspectives were not included in this study. A case study on Native American access factors would be informative.

The NP-patient relationship also warrants further investigation. One interviewee shared her perspective as the patient of a NP and shed some light on what she gained from and why she valued the relationship. Further exploration of the NP-patient relationship, both from the patient and NP perspectives, could illuminate the complexities of the relationship and how it may or may not differ from a MD-patient relationship, or how the relationship may be influenced by the narrative on which an NP frames his practice.

Further investigation into the concept and politics of an advanced practice nursing narrative is needed. This case study predominantly illuminated how physicians and non-nursing stakeholders positioned advanced practice nurses within the medical narrative. How might future research inform an empowered, independent advanced practice nursing narrative?

Summary

The case study approach resists summarization, since, according to Kohlbacher, the case study itself is both the “process of inquiry” and the “product of that inquiry” (Kohlbacher, 2005). Therefore, I will not attempt to summarize this case study here, but rather provide a brief summary of my experience through completion of this case study. As a seasoned NP and a novice researcher, with a fair amount of exposure to policymaking within the state of Idaho, my expectations and curiosity entering into this

exploration were far and away exceeded. While I consider myself a qualitative researcher at heart, with an appreciation for the uniqueness of individual perspectives and realities, I did not anticipate the depth or complexities of experiences that would be revealed in this case study. The case study approach was very productive for illuminating stakeholders' perspectives on the politics of policymaking and the multitude of state-level factors as they impact access to health care services in rural Idaho. While I had not anticipated much of the complexities of the politics of policymaking, what surprised me the most was the emergence of the two sovereign narratives. I had expected that the elected officials would be viewed as most influential on policies and that interviewees may remark on the Republican Party's dominance, but I did not foresee the sovereign narratives. Their emergence took the development of this case study in a direction that was completely unanticipated as I completed this research.

Throughout this process I learned much about the value of case study research. In hindsight, it truly was, I believe, the ideal approach for facilitating open dialogue in a political context that is not known for such disclosure. I appreciated interviewees' willingness to share their experiences and thoughts, particularly those who did so with the acknowledgement that their perspectives were viewed as "outliers" in Idaho, but who felt that by sharing their views they might advance the perspective of others who are silent in Idaho's political arena.

Health care has been studied by a multitude of disciplines for decades in an effort to optimize patient care. My hope is that this case study has implications that can advance that aim.

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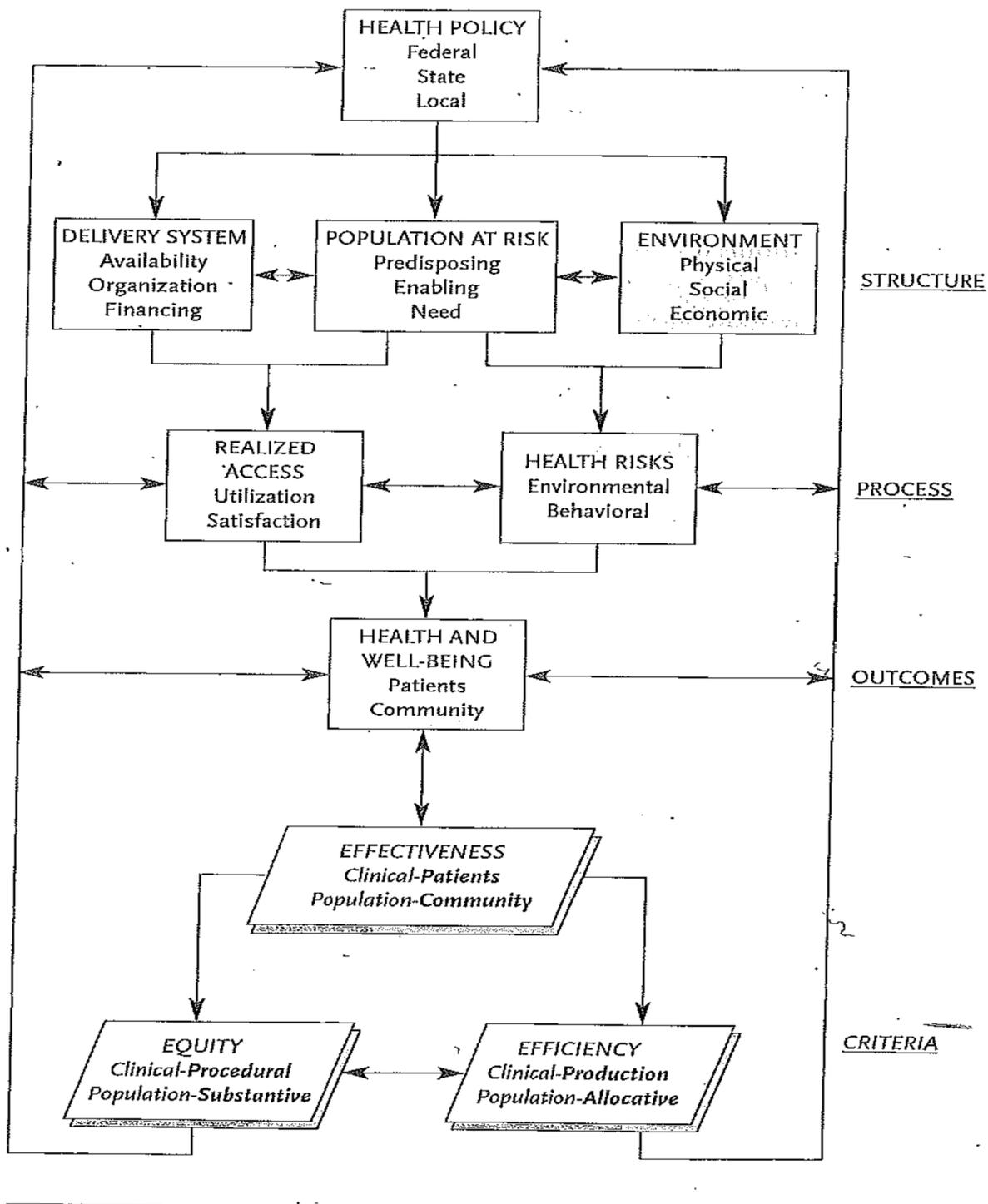
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Appendix A

Figure 1.4 Framework for Applying Health Services Research in Evaluating Health Policy



Appendix B

Invitation to Participate in the Study UNM Letterhead

Date

Inside Address

Dear.....:

Because of your knowledge regarding rural health care or rural health care policy, Molly Vaughan Prengaman would like to interview you as part of a study we are conducting on factors affecting access to rural health care services in Idaho. This research is part of Molly's work as a PhD student at the University of New Mexico College of Nursing. The purpose of the study is to explore the impact of state factors on access to rural health care services.

The interview will last approximately one hour. Ideally, it will be conducted in person; however, if time or travel constraints preclude meeting then Molly will conduct the interview by telephone. Molly will make every effort to accommodate your schedule and meet at a location and time convenient for you. Interviews will be audio-taped for subsequent transcription and data analysis. Every effort will be made to protect the information you give us. Identifying information will not be reported with interview responses. Information resulting from this study will be used for research purposes and may be published; however, you will not be identified by name.

Participation in the study is completely voluntary. Attached is a consent form. Molly will review it with you before the interview and address any questions you may have regarding the study or your participation. By proceeding with the interview, and responding to the interview questions, you will be indicating your consent to participate in this research study.

If you are interested in participating in this study, please contact Molly via e-mail at MPrengaman@salud.unm.edu or via telephone at 208-342-7162, and she will arrange a time and location for the interview. We look forward to learning about your perspectives on access to rural health care services in Idaho.

Sincerely,

Sally S. Cohen, PhD, RN, FAAN
Associate Professor
University of New Mexico
College of Nursing

Molly Vaughan Prengaman, RN, MS, FNP-BC
PhD Student
University of New Mexico
College of Nursing

Appendix C

University of New Mexico

Informed Consent Cover Letter for Interview

The Impact of State Factors on Access to Rural Health Care

Dr. Sally S. Cohen, from the University of New Mexico College of Nursing, Molly Vaughan Prengaman, PhD student at the University of New Mexico, and their associates are conducting a research study as part of Molly's PhD education. The purpose of the study is to explore the impact of state factors on access to rural health care services. You are being asked to participate in this study because of your knowledge regarding rural health care or rural health care policy.

Your participation will involve responding to interview questions posed by Molly Vaughan Prengaman. The interview should take about 60 minutes to complete. Your involvement in the study is voluntary, and you may choose not to participate. The interview includes questions such as "What do you see as the major factors influencing access to health care services in rural Idaho?" You can refuse to answer any of the questions at any time. There is no direct benefit to individuals agreeing to participate in this study. Your participation may help identify possible policy solutions to the ongoing issue of access to rural health care. If you choose to participate, you will receive a copy of the abstract upon completion of the study.

Interviews will be audio-taped for subsequent transcription and data analysis. The findings from this project will provide information on access to rural health care. Every effort will be made to protect the information you give us. Identifying information will not be reported with interview responses. Information resulting from this study will be used for research purposes and may be published; however, you will not be identified by name. Your name and other identifying information will be maintained in locked files in Molly Vaughan Prengaman's office, separate from the interview transcript, available only to Molly. All data will be kept for 5 years in a locked cabinet in Molly Vaughan Prengaman's office and then destroyed.

If you have any questions about this research project, please feel free to call Dr. Sally Cohen at (505) 272-8832 or Molly Vaughan Prengaman at (208)342-7162. If you have questions regarding your legal rights as a research subject, you may call the UNM Human Research Protections Office at (505) 272-1129.

By responding to the questions posed during the interview, you will be indicating that you have had an opportunity to ask questions, all questions have been answered to your satisfaction, and you are agreeing to participate in the above described research study.

Thank you for your consideration.

Sincerely,

Sally S. Cohen, PhD, RN, FAAN
Associate Professor, University of New Mexico, College of Nursing

Molly Vaughan Prengaman, RN, MS, FNP-BC
Doctoral Student, University of New Mexico, College of Nursing

Appendix D

Follow Up E-mail to Initial Invitation to Participate in Study

UNM Letterhead

Dear.....:

Approximately one week ago we invited you to participate in a study regarding state factors' impact on access to rural health care services in Idaho. This research is part of Molly Vaughan Prengaman's work as a PhD student at the University of New Mexico College of Nursing. The purpose of the study is to explore state factors' impact on access to rural health care services.

Please refer to my previous e-mail regarding details of the study. I am attaching another copy of the consent form to this e-mail. Participation in the study is completely voluntary. Molly will review it with you before the interview and address any questions you may have regarding the study or your participation. By proceeding with the interview, and responding to Molly's interview questions, you will be indicating your consent to participate in this research study.

If you are interested in participating in this study, please contact Molly within the next 3 business days at MPrengaman@salud.unm.edu or via telephone at 208-342-7162 so that she can arrange a time and location for the interview. We look forward to visiting with you and learning about your perspectives on rural health care access in Idaho.

Sincerely,

Sally S. Cohen, PhD, RN, FAAN
Associate Professor
University of New Mexico
College of Nursing

Molly Vaughan Prengaman, RN, MS, FNP-BC
PhD Student
University of New Mexico
College of Nursing

Appendix E**Interview Data Log & Key**

Data Number/Date Obtained/Name	Category of Data Source
I1/June 5, 2014/Sue Smith	State Policymaker
I2/June 7, 2014/Sally Jones	Clinician
I3/June 8, 2014/John Doe	Interest Group
I4/June 8, 2014/Jill Adams	State Policymaker

Appendix F

Interview Summary Sheet

Data Log Number/Category of Stakeholder: _____

Interview Type: Phone _____ Face-to-face _____

Date of Interview: _____

Date Transcription Completed: _____

Potential Interviewees Recommended: _____

Content summary:

Reflective remarks:

Document Summary Sheet

Context:

Significance:

Content summary:

Reflective remarks:

Appendix G

Interview Guide

Introduction: I am a registered nurse, nurse practitioner, Boise State University nursing faculty member, and a PhD student at the University of New Mexico College of Nursing. My focus of study is health policy, and my dissertation is on state factors' impact on access to rural health care services in Idaho. My dissertation includes interviewing individuals who are engaged in or have an interest in rural health care access in Idaho. Before we begin the interview, I am going to review the consent form with you. When I am finished reading it I will answer any questions you may have regarding the study. By proceeding with the interview you will be indicating that you agree to participate in this study and have this interview audio-recorded.

(Consent will be read verbatim and any questions addressed.)

Now that you have given verbal consent to participate in the study, let's move to the interview. I will ask you questions regarding access to rural health care services in Idaho. After the interview, I will ask you several demographic questions. The demographic information will not be utilized as part of my data analysis. I will only use it to document the diversity and general characteristics of interviewees.

1. Tell me about your role in rural health care.

Prompt: How long have you been in this position?

Prompt: Previously, what kind of work did you do?

2. What do you see as the major factors influencing access to health care services in rural Idaho?

Prompt: State policy factors?

Prompt: Federal or national policy issues?

Prompt: Health care systems factors?

3. Many rural health experts consider infrastructure and regional coordination as key to enhanced rural health care delivery systems. How do you think Idaho is faring in these regards?
4. Who do you see as some of the individuals and groups with the most influence on policies affecting Idaho's rural health care access? Explain.

Prompt: To what extent are the individuals' influences due to the authority vested in their position?

5. What, if any, impact do you think the economy has on Idaho's rural health care access?
6. How might the ACA influence rural health care access in Idaho?
7. How might the politics of Medicaid expansion in Idaho impact rural health care access?
8. Many rural health experts view primary care, preventive care, emergency medical services, and public health services as key components of an efficient rural health care system. How do you think Idaho is faring in providing its rural residents a) primary care b) preventive care c) emergency medical services d) public health services?

9. What are the rural health care interest groups in Idaho?

Prompt: What are the major alliances and divisions among rural health care interest groups in Idaho?

Prompt: How do these alliances and divisions influence rural health policy outcomes?

10. What are your thoughts regarding the use of nurse practitioners or physician assistants as providers for primary care in rural Idaho?

11. What do you envision as the future for access to health care services in rural Idaho?

Prompt: What do you envision as the future for rural health clinics/FQHCs and community health clinics?

12. Idaho's population is aging and becoming more diverse with a growing Latino population. How do you see these types of demographic changes influencing future policymaking for rural health care access?

13. Given the current transitional status of our health care system, what health policy changes do you believe are most crucial to optimizing rural health care access in Idaho?

Prompt: What do you see as your role in facilitating any necessary health policy changes?

14. Is there anything else you'd like to share regarding state-level factors that influence rural health care access in Idaho?

15. Is there anyone you'd recommend I interview for my study?

Demographics

We've completed the interview. These next questions will be excluded from the interview data and analysis, but will simply be used to document diversity among the participants. Response to these questions is completely voluntary.

1) Into which of the following age groups do you fall?

20s ____, 30s ____, 40s ____, 50s ____, 60s ____, 70s ____

2) Which of the following best describes your role? Tell me if more than one applies

Clinician ____, Elected official ____, State administrator/executive branch official ____, Interest group staff ____, Interest group member ____, Administrator in a health care delivery setting ____

3) In which geographic region of Idaho do you reside?

Southwest ____, North ____, Central ____, Southeast ____