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Health Equity in Rural Communities: Overcoming Barriers to Care

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WHO WE ARE

- The National Rural Health Association (NRHA) is a national nonprofit membership organization with more than 21,000 members nationally.
- The association's mission is to provide leadership on rural health issues through advocacy, communications, education, and research.
- NRHA membership consists of a diverse collection of individuals and organization, all of whom share the common bond of an interest in rural health.

NON-PROFIT, NON-PARTISAN

- We work with everyone, regardless of party or affiliation.
- Our education and advocacy is focused on the needs of rural Americans, and we work with both sides of the aisle to make this happen.
- Rural health can create a bridge across parties.
- New NRHA Allies: The USDA and FCC
- New NRHA Focus: Social media and messaging growth

YOUR VOICE, LOUDER

- Through our Twitter, social media, and press expansion over the last two years, we reached more Washington insiders and policy influencers across the country than ever before.
- Because of our growing presence as thought leaders in the health care industry, we have had more interest in rural health issues, with major articles placed in Politico, the New York Times, and the Washington Post.
- Join us online! @NRHA_Advocacy

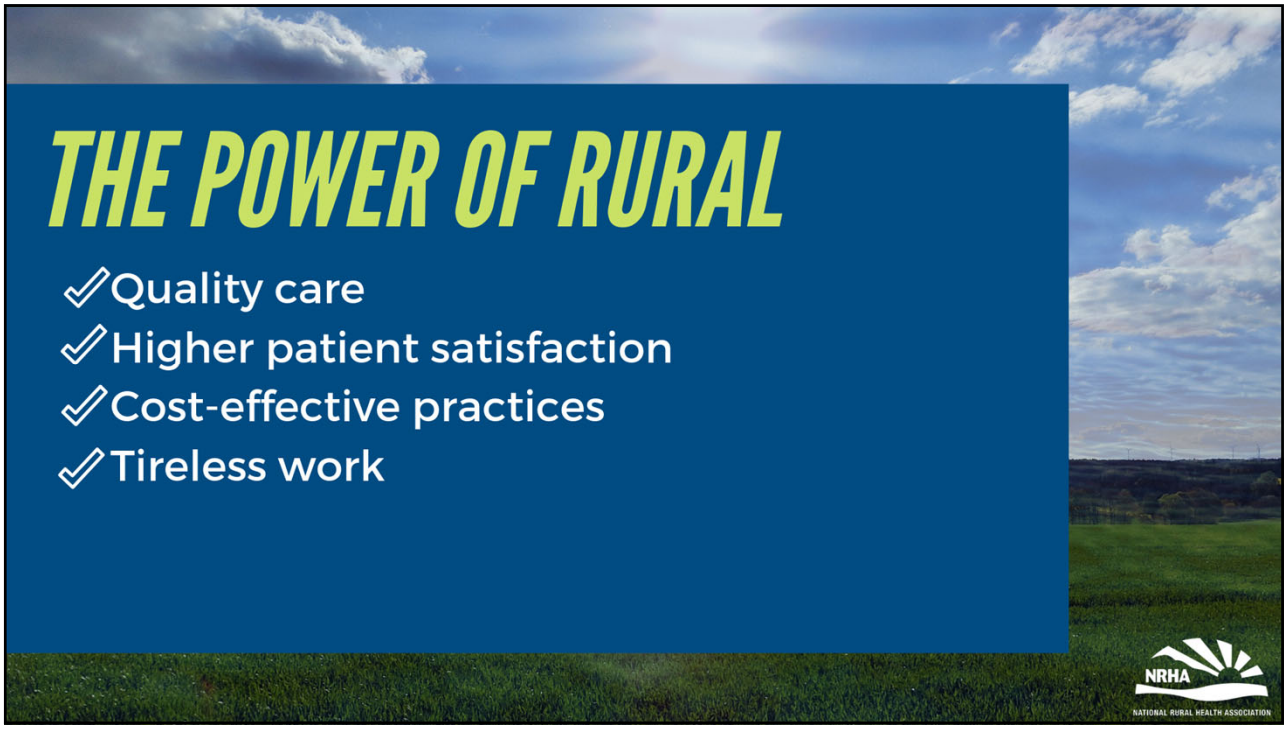
WHAT MATTERS MOST? HEALTH CARE

This election showed that health care is more important than ever before.

- 55% of registered voters said a "health care reform bill" should be a top priority for the next Congress. None of the other policy issues offered as a choice got such a significant response. Reducing the federal budget deficit came close with 51 percent saying it should be a top priority.
- 60% of Americans think insurance premiums will go up and those respondents will blame health insurance companies (40%), the Trump administration (34%) and the Obama administration (22%).

FOCUS ON PRE-EXISTING CONDITIONS

- July Kaiser Health Tracking Poll finds a candidate's position on protecting people with pre-existing health conditions is the top health care campaign issue for voters, among a list of issues provided.
- This issue cuts across voter demographics with most Democratic voters (74 percent), independent voters (64 percent), and voters living in battleground areas (61 percent), as well as half of Republican voters (49 percent) saying a candidate's position on continued protections for pre-existing health conditions is either the single most important factor or a very important factor in their 2018 vote.



RURAL MORTALITY RATES RISE

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A CDC MMWR STUDY FOUND THAT:

- **Rates of the five leading causes of death — heart disease, cancer, unintentional injuries, chronic respiratory disease, and stroke — are higher among rural Americans.**
- **Infant mortality rates are 20% higher than in large urban counties.**
- Mortality is tied to income and geography.
- Minorities, especially Native Americans die consistently prematurely nation-wide, but more pronounced in rural.

CHALLENGES IN RURAL HEALTH

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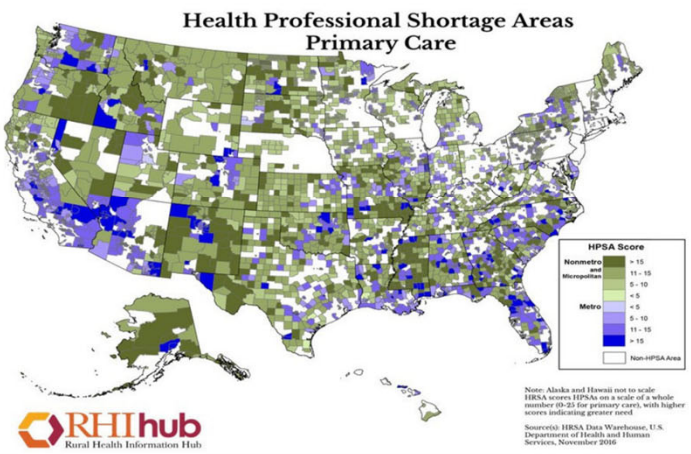
WORKFORCE SHORTAGES

- 77% of rural counties are Health Professional Shortage Areas. 9% have no physician at all.
- 4,300 areas are dental health shortage areas; and
- 3,500 areas are short of mental health shortage areas.



CHALLENGES IN RURAL HEALTH

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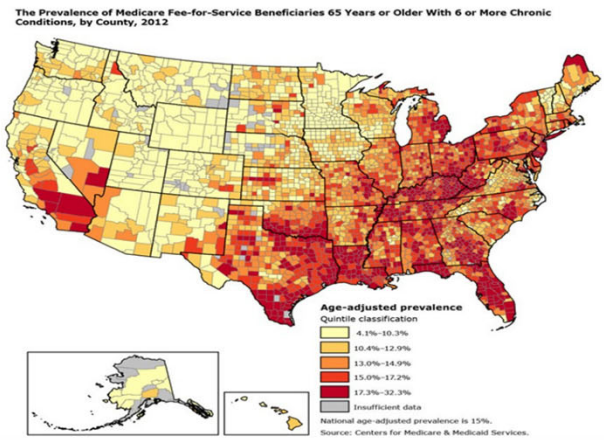
VULNERABLE POPULATIONS

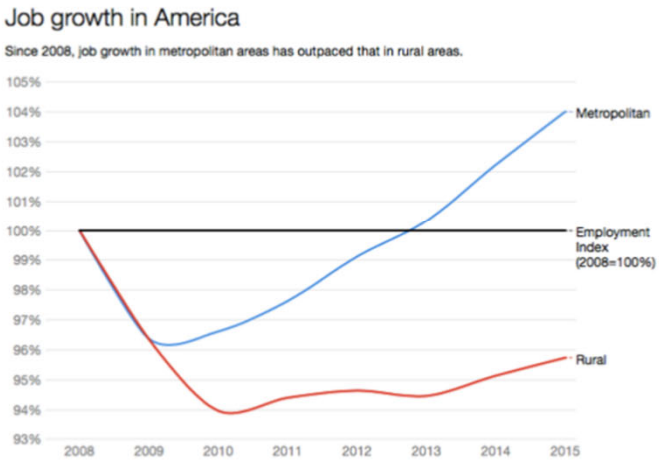
- Rural Americans are on average older, sicker, and poorer than their urban counterparts.
- Rural hospitals serve more Medicare patients (46% rural vs. 40.9% urban), thus across-the-board Medicare cuts do not have across the board impacts.



CHALLENGES IN RURAL HEALTH

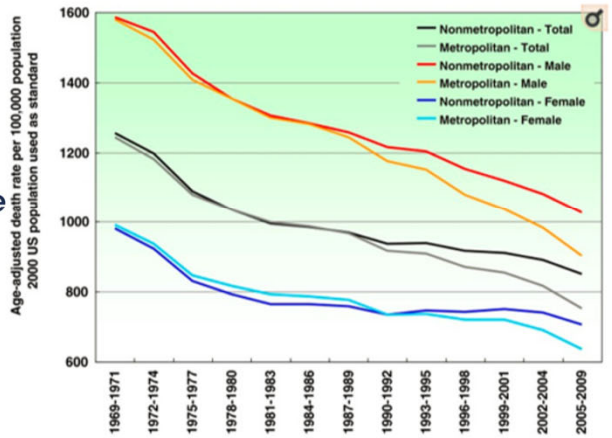
CHRONIC POVERTY

- A higher proportion of rural residents are covered by Medicaid (21% vs. 16%).
- Even though 20% of Americans live in rural areas, these communities make up just 3% of job growth since the Great Recession.



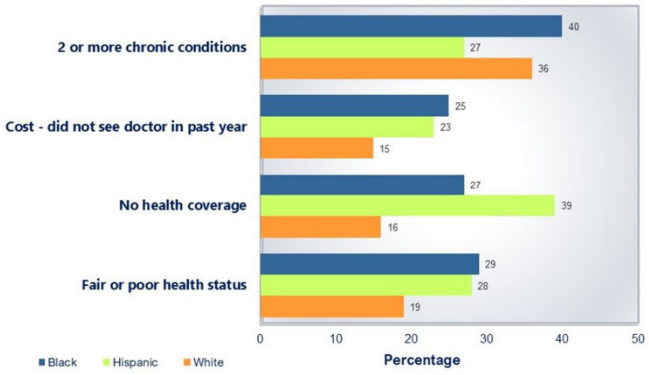
THE GAP BETWEEN URBAN AND RURAL GROWS

- In rural areas there are significantly higher rates of chronic diseases, and while these diseases may be curable, in rural America they are often left untreated, leading to higher mortality rates and lower life expectancy.
- As rates of cancer deaths drop nationally, CDC research shows that rural Americans are still dying from cancers that should be curable.



DISPARITIES WITHIN RURAL COMMUNITIES

- Though urban areas still have more diverse populations, the CDC found that rural communities have increasing racial diversity.
- The CDC also discovered that different health issues were mor prevalent among certain racial ethnicities.



RURAL HOSPITAL CLOSURES

- **As of the making of this presentation, 95 rural hospitals have closed since 2010, and nearly 700 are vulnerable.**
- The number of rural hospitals operating at a loss rose from 40% in 2017, to 44% in 2018, and has now risen to 46% at the start of 2019.
- Continued cuts in hospital payments have taken their toll, forcing far too many closures. The sequester and bad debt cuts have been the biggest culprits.

ALABAMA CLOSURES

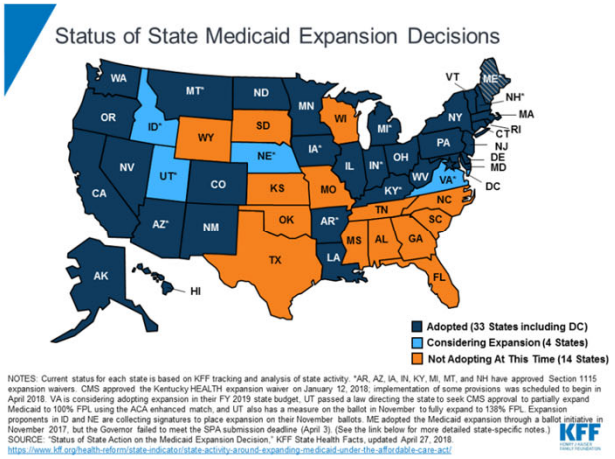
- 5 rural hospitals have closed in Alabama, 49 remain
  - Florala Memorial Hospital, Rural PPS, 22 beds
  - Elba General Hospital, MDH, 20 beds
  - Chilton Medical Center, Rural PPS, 27 beds
  - Southwest Alabama Medical Center, PPS, 27 beds
  - Randolph Medical Center, CAH, 12 beds
- 74% of Alabama hospitals operate at a loss
- Median profit operating margin is -4.4%

CAUSES OF CLOSURES

- Lower incomes and higher rates of uninsured people lead to higher levels of uncompensated care at rural hospitals. This is where bad debt cuts come in. (This is less of a problem for rural hospitals in states that expanded Medicaid.)
- Across the nation, rural hospitals absorb a combined $318 million in annual revenue cuts due to sequestration. For 29 rural hospitals, this was the difference between operating in the black and the red. The median rural hospital loses $71,000 annually from the sequester.
- Differences in the kind of care provided - the number of inpatient days has dropped drastically, but payment methods are still based on inpatient days.

MEDICAID EXPANSION

- Nonexpansion states have suffered a significant increase in hospital closures.
- States that expanded benefits, saw their rate of closures decline.
- Medicaid coverage is essential for many facilities, especially those that serve high levels of uninsured patients who cannot pay their bills.



NOTES: Current status for each state is based on KFF tracking and analysis of state activity. *AR, AZ, IA, IN, KY, MI, MT, and NH have approved Section 1115 expansion waivers. CMS approved the Kentucky HEALTH expansion waiver on January 12, 2018; implementation of some provisions was scheduled to begin in April 2018. VA is considering adopting expansion in their FY 2019 state budget, UT passed a law directing the state to seek CMS approval to partially expand Medicaid to 100% FPL using the ACA enhanced match, and UT also has a measure on the ballot in November to fully expand to 138% FPL. Expansion proponents in ID and NE are collecting signatures to place expansion on their November ballots. ME adopted the Medicaid expansion through a ballot initiative in November 2017, but the Governor failed to meet the SPA submission deadline (April 3). (See the link below for more detailed state-specific notes.)
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated April 27, 2018.
https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

RURAL HEALTH CLINICS SHUTTER

- **Rural Health Clinics (RHCs) are an integral part of rural healthcare infrastructure.**
- **They provide primary healthcare services in 45 states for over 7 million underserved rural residents.**
- **Since 2012, there have been 388 rural health clinic closures.**
- **The closures impacted over 3.86 million individuals living in rural and underserved areas.**

OBSTETRICS UNITS DISAPPEAR

- Between 2004 and 2014 more than 200 rural hospitals stopped providing labor and delivery services
- The most vulnerable are placed at greater risk: rural counties with higher percentages of African American women were more than 10 times as likely as rural counties with higher percentages of white women to have never had hospital-based obstetric services and more than 4 times as likely to have lost obstetric services between 2004-2014.

GEOGRAPHIC VARIANCE IN ACCESS

- We see geographic diversity in hospital operating margins, provider shortages, hospital closures, and other aspects of rural health care provision.
- While the Midwest has seen changes that impact their rural hospitals, southern communities with high poverty and racial disparities have been particularly hard hit by the closure crisis.
- While some policy changes can help every one of these rural areas, different policy solutions may be necessary to address the wide range of rural providers.

COMPARING HOSPITAL MARGINS

A 2016 report from the Sheps Center at the University of North Carolina studied the total margin of rural and urban hospitals by geographic census area. The total margin metric, as explained by the researchers, "measures the control of expenses relative to revenues, and expresses the profit a hospital makes as a proportion of revenue."

Midwest- MDH, SCH, and Rural PPS → 2.96%

Midwest- CAH → 3.43%

South- MDH, SCH, and Rural PPS → 1.43%

South- CAH → 0.19%

POVERTY RATES DIFFER

- According to the United States Department of Agriculture (USDA) Economic Research Service (ERS) "the nonmetro/metro poverty rate gap for the South has historically been the largest."
- From 2012-2016, the South had a nonmetro poverty rate of 21.3% — higher than the Midwest and Northeast
- From 2012-2016, 42.6% of the nation's nonmetro population lived in nonmetro Southern areas and 51.1% of the nation's nonmetro poor lived in the South.
- More simply, "nonmetro counties with a high incidence of poverty are mainly concentrated in the South."

HEALTH CARE JOBS

- USDA ERS also found more health care industry jobs in the Midwest - may be a factor in considering poverty rates.
- Between 2001 and 2015, rural counties with the most inpatient healthcare facility jobs per resident were concentrated in the Upper Midwest and Northern Great Plains.
- Regions with fewer inpatient healthcare jobs per resident included the West, the Southern Great Plains, and the South.

NATIONAL POLICY THAT FITS LOCAL NEEDS

NRHA believes a multifaceted approach is necessary to address the struggles of rural health care providers including hospitals.

1. Ensure rural providers reimbursement rates are sufficient to allow them to keep their doors open.

2. Support measures that reduce the cost of providing care including regulatory relief that reduces costs without negatively impacting patient care.

3. Support new models that allow communities to retain necessary access to care while right sizing their facilities to meet the community needs.

THE SAVE RURAL HOSPITALS ACT

- Two critical pieces of the puzzle: stabilization and innovation.
- The Save Rural Hospitals Act will stop the impending flood of rural hospital closures, provide access to care and regulatory relief, and create an innovative new delivery model.
- Any bill that we consider must encompass all of these aspects.

SAVE RURAL - STABILIZATION

- Elimination of Medicare Sequestration for rural hospitals (CAH, SCH, MDH, and subsection (d) facilities in rural census tracks and non-MSA counties);
- Reversal of "bad debt" reimbursement cuts (The Middle Class Tax Relief and Job Creation Act of 2012);
- Permanent extension of current Low-Volume and Medicare Dependent Hospital payment levels;
- Reinstatement of Sole Community Hospital "Hold Harmless" payments;
- Extension of Medicaid primary care payments;
- Elimination of Medicare and Medicaid DSH payment reductions;
- Establishment of Meaningful Use support payments for rural facilities struggling to maintain MU compliance; and
- Permanent extension of the rural ambulance and super-rural ambulance payment.

SAVE RURAL - INNOVATION - THE COH

- The Community Outpatient Hospital (COH) will ensure access to emergency care and allow hospitals the choice to offer outpatient care that meets the population health needs of their rural community.
- Eligibility: Critical Access Hospitals (CAH) and rural hospitals with 50 beds or less as of December 31, 2014 are eligible to become COH (this includes facilities as described that have closed within 5 years prior to enactment).
- Services: Emergency Services – a COH must provide emergency medical care and observation care (not to exceed an annual average of 24 hours), 24 hours a day, 7 days a week (must also have protocols in place for the timely transfer of patients who require a higher level of care or inpatient admission.)

EMERGENCY SERVICES ARE CRITICAL

- On average, rural trauma victims must travel twice as far as urban residents to the closest hospital.
- 60% of trauma deaths occur in rural America, even though only 20% of Americans living in rural areas.
- With nearly 700 hospitals on the brink of closure, patients may need to seek alternatives to 11.7 million rural hospitals visits as they lose ER access

SAVE RURAL - LOCAL NEEDS - THE COH

- Meeting the Needs of Rural Communities: Based upon a community needs assessment, a COH could provide medical services in addition to the Emergency services, but not limited to observation care, skilled nursing facility (SNF) care, infusion services, hemodialysis, home health, hospice, nursing home care, population health and telemedicine services.
- COHs are encouraged to provide primary care services though a FQHC (or FQHC look alike) or rural health clinic. These primary care services will ensure the community don't lose primary care and inappropriately use the emergency room.
- The COH will not operate any inpatient acute care beds, but can operate swing beds and observation beds.

SAVE RURAL - COH PAYMENTS

- The Medicare payment rate for services furnished at a COH (emergency care and outpatient services) will be 105% of reasonable cost.
- The bill also includes wrap around grants for population health to ensure sufficient payments to allow the COH to serve the needs of the community.
- Rural Hospital Grants: New grants are included for Rural EMS. Hospital based grants are available to assist rural hospitals with the change to value based payment models and for rural hospitals working on population health (included a grant program targeted at COHs).

OTHER SUPPORT FOR RURAL HOSPITALS

NEW OPPORTUNITIES AND SUPPORT FOR RURAL PROVIDERS IN THE FARM BILL

- Authorized assistance for a community facility to include the refinancing of a debt obligation of a rural hospital as an eligible loan or loan guarantee purpose if the assistance would help preserve access to health service in a rural community and meaningfully improve the financial position of the hospital.
- Emphasizes the necessity that USDA work with rural hospitals to improve their financial health as a part of a refinancing agreement.

OTHER SUPPORT FOR RURAL HOSPITALS

TECHNICAL ASSISTANCE AT USDA

- The Farm Bill encourage USDA to build on its current technical assistance efforts to improve the long-term operations of rural hospitals in order to continue providing vital services to rural communities.
- NRHA is working in partnership with the USDA on a new program to provide struggling rural hospitals with USDA loans with technical assistance.

BARRIER TO CARE- DISTANCE AND TRANSPORTATION

- Distance and geography are consistent barriers to care.
- Lack of transportation for many elderly, injured, or poor is an additional issue.
- Ensuring that no rural individual is more than 30 minutes from emergency services remains a consistent concern - and one the government doesn't always seem to share.

THE 35-MILE RULE AND RECENT CHALLENGES

- In April 2018, CMS reinterpreted clear Congressional language, as well as its own long and consistent interpretation of the mileage requirements for CAHs
- Historically, the 35-mile requirement has been measured from a CAH to another hospital or like facility.
- For the first time, CMS deemed that an outpatient clinic (which has no emergency care, has limited operating hours and limited services) is considered a "like facility."
- NRHA fought back - and won.

THE STORY OF CURRY GENERAL HOSPITAL

- CGH is a small CAH along the rugged Southern Oregon Coast, known as the "jewel of rural hospitals in Oregon" for its exceptional care.
- It is 53.8 miles from the closest hospital, which is located in the state of California.
- Several years ago, that same out-of-state hospital, without consultation with Curry General Hospital, opened a provider-based clinic.
- The clinic is 28.3 miles from Curry General Hospital, has no Emergency Department and is only open 8 a.m. to 5 p.m. for scheduled appointments. Despite this, in April CMS threatened Curry Hospital's CAH designation.

WHAT'S NEXT?

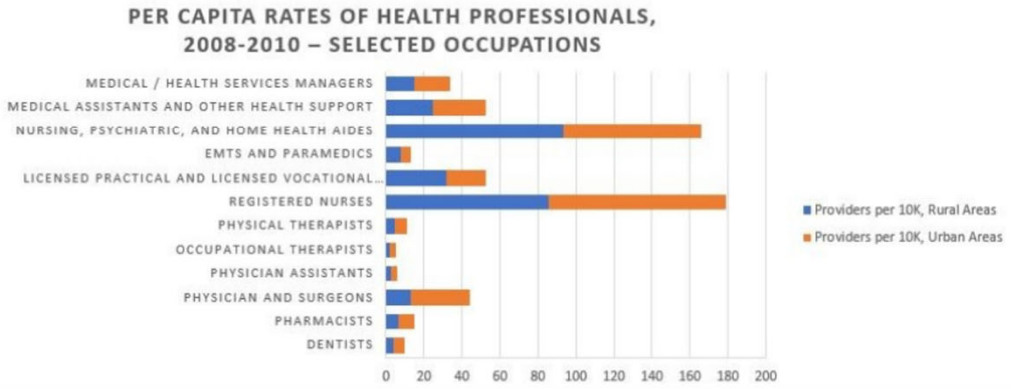
- After hiring a law firm, Curry Hospital was able to maintain its CAH designation by proving necessary provider status (under the guidelines of the State Health Plan). This solution will not work for many others and requires the hospital expend its limited resources on legal counsel.
- Looking to other parts of this question - what are the geographic challenges that make those 35 miles feel longer?

THE TRANSPORTATION CONCERN

- Rural health is a key part of infrastructure and the rural economy, and improving transportation is a key piece of this.
- Rural public transit is either non-existent or very limited and more than 90% requires a reservation.
- We need to identify strategies to assist individuals to ensure that they can access local and distant care.
- Share your local stories.

WORKFORCE SHORTAGES AND ACCESS

One of the most enduring characteristics of the rural health landscape is the uneven distribution and relative shortage of health care professionals.



WORKFORCE SHORTAGES SOLUTIONS

- Foster meaningful work by transforming hospitals into modern day organizations where all aspects of the work are going to be designed around patients and the needs of the hospital staff to care for and support them.
- Broaden the base of health care workers by creating strategies that attract and retain a diverse workforce of men and women, racial and ethnic minorities and immigrants.
- Build societal support for the public policies and resources needed to assist recruit and retain a qualified workforce, including adequate payment rates for hospital care and regulatory reform that reduces administrative burden

OBSTETRICS SHORTAGES AND CLOSURES

- Barrier to care for women of every color, though significantly more difficult for women of color and majority minority communities.
- 54% of rural counties have no hospital-based obstetrics services, and the most vulnerable communities
- When distance to maternity care is directly correlated with outcomes, this care shortage has a devastating effect.
- The loss of maternity care in rural America is the result of multiple factors including: workforce shortages, low birth volumes, and stingy Medicaid programs.

LEGISLATION TAKES STEPS FORWARD

- Improving Access to Maternity Care Act - creates Maternity Care HPSA's to help identify and adress shortage areas - became law in 2018
- Rural MOMS Act - being reintroduced in the Senate
  - Authorizes HHS Secretary, to "expand, intensify, and coordinate" activities that address maternal mortality and morbidity at CDC;
  - Creates Collaborative Improvement and Innovation Networks (CoIINs), to support women in rural areas as they work to find care, identify delivery models, provide training and guidance to rural health facilities
  - Helps develop the telehealth network and telehealth resource centers grant programs through HRSA to include obstetric care providers
  - Begins a demonstration program for grants for training of maternity care providers in rural areas and develops resident programs or fellowships to include rural obstetric tracks

USING TELEHEALTH TO FILL THE GAP

- Telehealth can fill gaps in service for some communities - but it must be supplemental, not replacing currently available services.
- Avera eCARE Consult in Sioux Falls, South Dakota, saved approximately $1.2 million in 2016 through programs that connected rural providers with almost 35 different medical specialties;
- University of Mississippi Medical Center's Center for Telehealth provided care for diabetic patients in the rural Mississippi Delta, saving 100 patients nearly $339,184.
- University of Maryland's Medical Center allowed 81% of telestroke patients were able to stay with their local hospitals in 2016 rather than traveling across the state for care.

TELEHEALTH AND MENTAL HEALTH

- More than half of rural communities do not have a single mental or behavioral health provider.
- Stigma remains a challenge.
- As the opioid crisis continues - this could be a major key in solving the care challenges it has created.

TELEHEALTH AND MENTAL HEALTH

- CMMI awarded $7.7 million to a small telepsychiatry company between 2012 and 2015 to develop and implement a new care model integrating telepsychiatry into more than 80 clinics across Wyoming, Montana and Washington.
- Data was strong:
  - 96% of patients would recommend Telepsychiatry to friends and family;
  - 81% of participants preferred Telepsychiatry to in person psychiatry;
  - Significant cost savings and high adherence to medication;
  - Increased willingness to visit regular clinics and more likely to show up for the visits;
  - Reduction in stigma, as they felt that "no one knew they were seeking mental health care via their primary care provider."

CONNECTED CARE PILOT PROGRAM

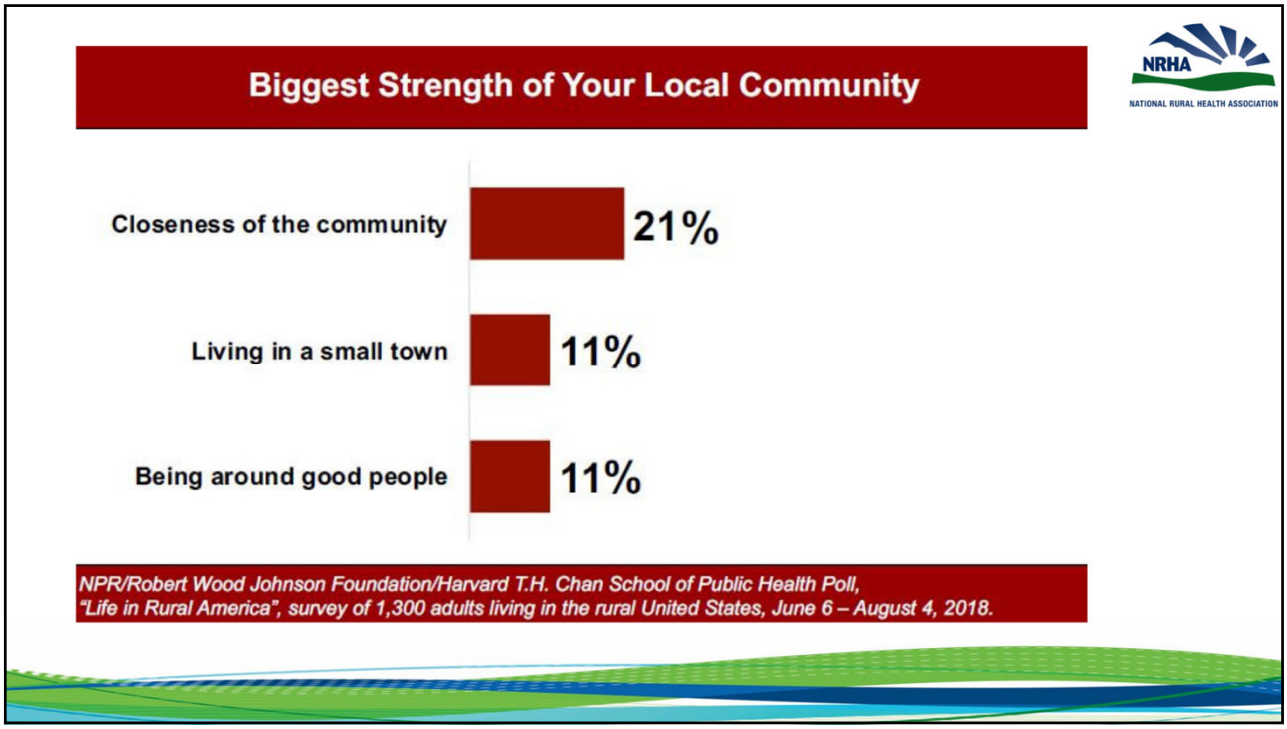
- FCC recently launched a new program to help improve broadband telehealth deployment - nonexistent rural broadband still a challenge.
- The program includes:
  - Budgeting for $100 million in USF support
  - Targeting support to connected care deployments that would benefit low-income patients, including those eligible for Medicaid or veterans receiving cost-free medical care
  - Supporting a limited number of projects over a two- or three-year period with controls in place to measure and verify the benefits, costs, and savings associated with connected care deployment

BARRIERS TO TELEHEALTH

- Medicare reimbursements for telehealth programs are limited by the Social Security Act, which restricts reimbursements by the type of service provided; the geographic locations of services; the type of institution delivering services; and the type of provider.
- The CONNECT for Health Act expands Medicare reimbursements for telehealth and remote patient monitoring programs and still includes provisions to control costs through the expansion.
  - HHS will be allowed to lift existing restrictions on coverage when quality and cost-effectiveness standards are met
  - Rural Health Clinics and FQHCs can serve as both originating and distant sites for care

THE POWER OF RURAL

- The resilience and strength of rural communities is astounding.
- Recent research from Harvard, NPR, and RWJF shows a confidence and a love for rural America - and a hope for the future.
- Providers are doing more with less, and patients are happy with their care... when the have access.
- The biggest challenge remains the economy - but health care can help.


Biggest Strength of Your Local Community
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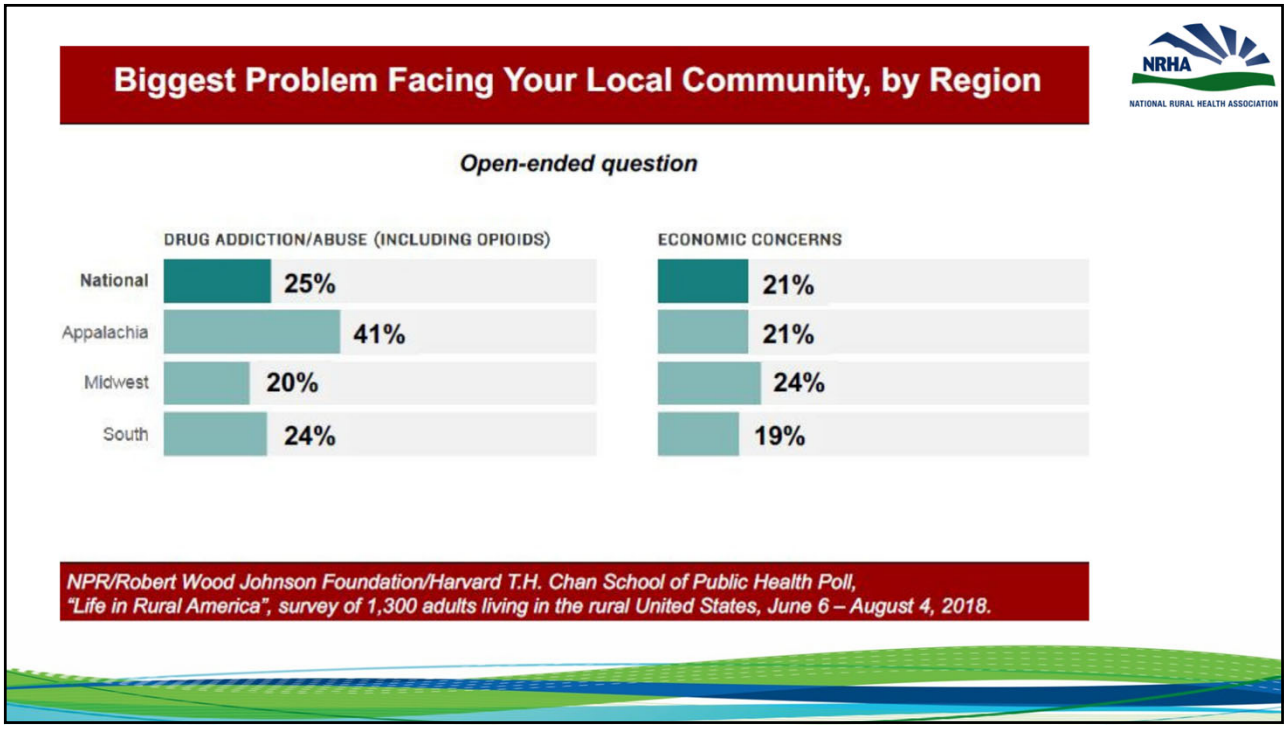
Closeness of the community
21%
Living in a small town
11%
Being around good people
11%
NPR/Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health Poll,
"Life in Rural America", survey of 1,300 adults living in the rural United States, June 6 – August 4, 2018.


Biggest Problem Facing Your Local Community, by Region
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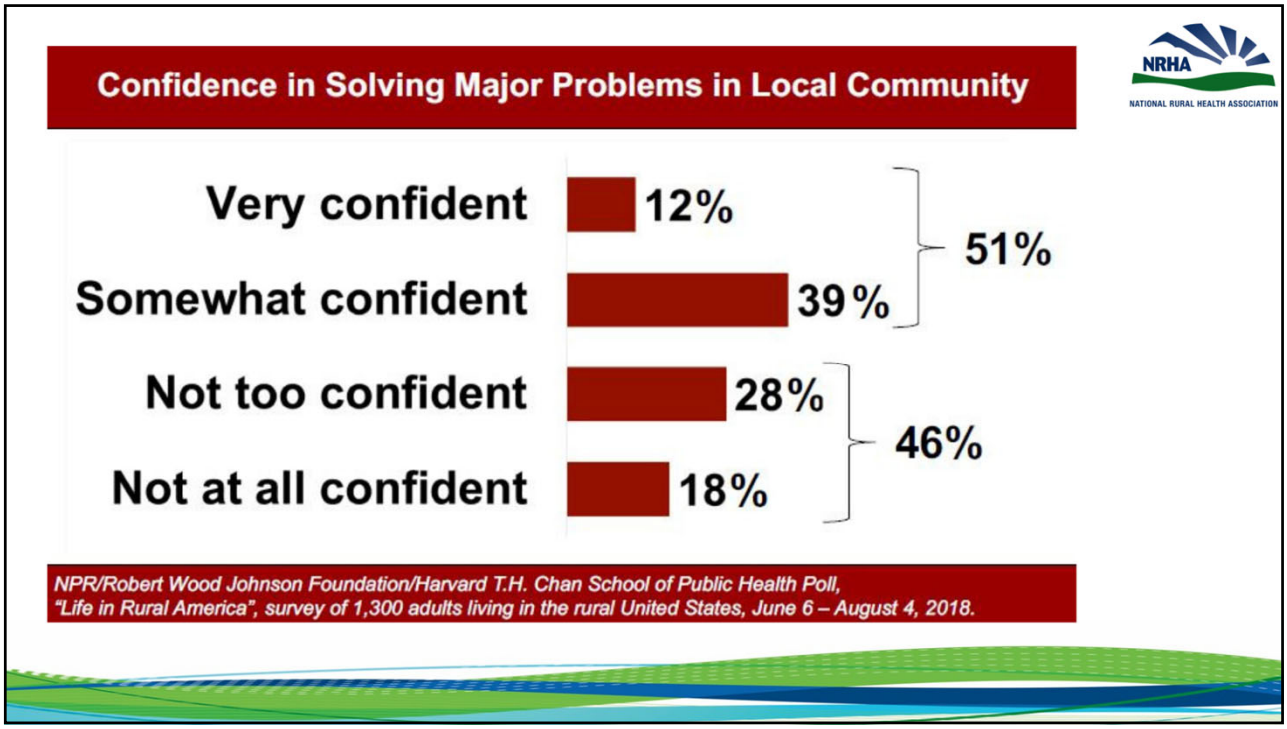
Open-ended question
DRUG ADDICTION/ABUSE (INCLUDING OPIOIDS)
ECONOMIC CONCERNS
National
25%
21%
Appalachia
41%
21%
Midwest
20%
24%
South
24%
19%
NPR/Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health Poll,
"Life in Rural America", survey of 1,300 adults living in the rural United States, June 6 – August 4, 2018.


Confidence in Solving Major Problems in Local Community
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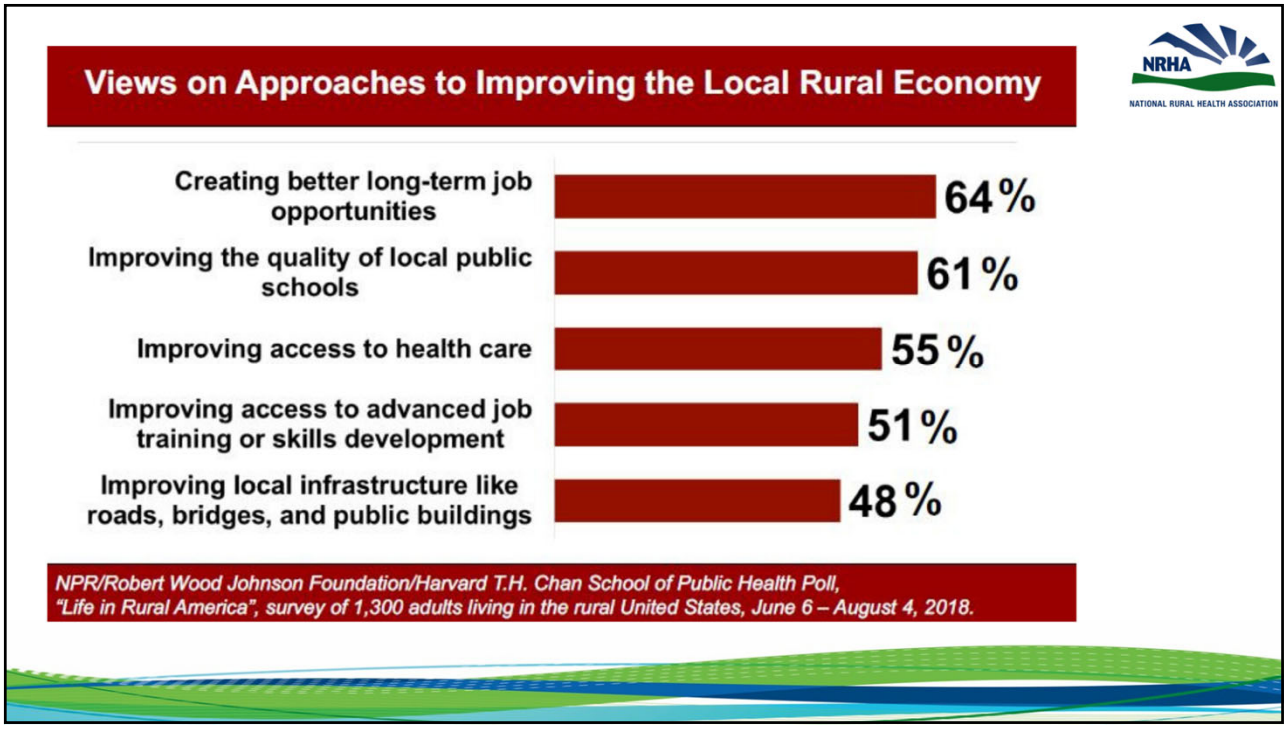
Very confident
12%
Somewhat confident
39%
51%
Not too confident
28%
Not at all confident
18%
46%
NPR/Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health Poll,
"Life in Rural America", survey of 1,300 adults living in the rural United States, June 6 – August 4, 2018.


Views on Approaches to Improving the Local Rural Economy
NRHA
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Creating better long-term job opportunities
64%
Improving the quality of local public schools
61%
Improving access to health care
55%
Improving access to advanced job training or skills development
51%
Improving local infrastructure like roads, bridges, and public buildings
48%
NPR/Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health Poll,
"Life in Rural America", survey of 1,300 adults living in the rural United States, June 6 – August 4, 2018.

INTERESTED IN RURAL HEALTH ADVOCACY?

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- 30th Annual Rural Health Policy Institute is less than two weeks away! February 5-7, Washington, DC
- Hear from policymakers and Washington insiders on what's new and next in rural health policy.
- Make your voice heard on Capitol Hill with a full day of advocacy.
- Learn from HRSA, FORHP, CDC, HHS, USDA, and the FCC about rural health disparities at the 2nd Annual Rural Health Disparities Summit hosted with AAFP.

QUESTIONS? WANT TO CONNECT WITH NRHA?

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