URBAN INSTITUTE

Advancing Rural Health Equity through Partnerships, Data, and Finance

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HRSA
Health Resources & Services Administration

Promoting Rural Health Equity through Data and Partnerships Convening

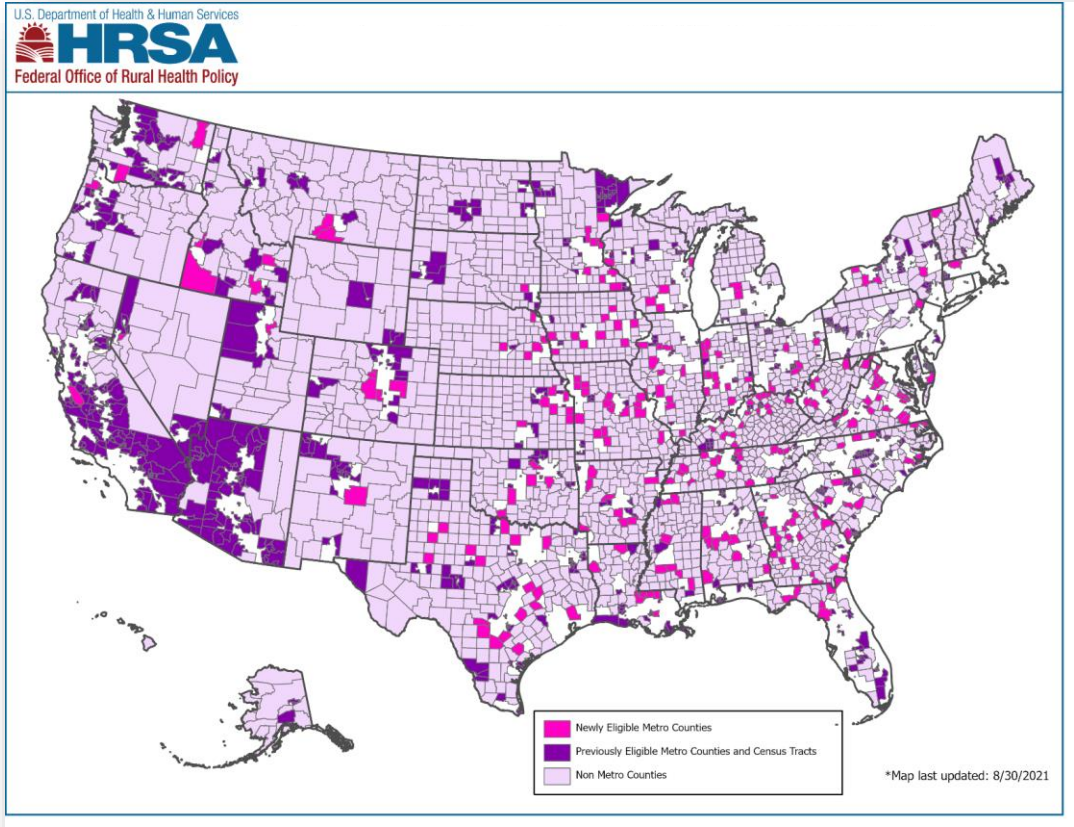
October 18th, 2023

Tom Morris
Associate Administrator
Federal Office of Rural Health Policy (FORHP)

Vision: Healthy Communities, Healthy People


Rural Basics: Defining It

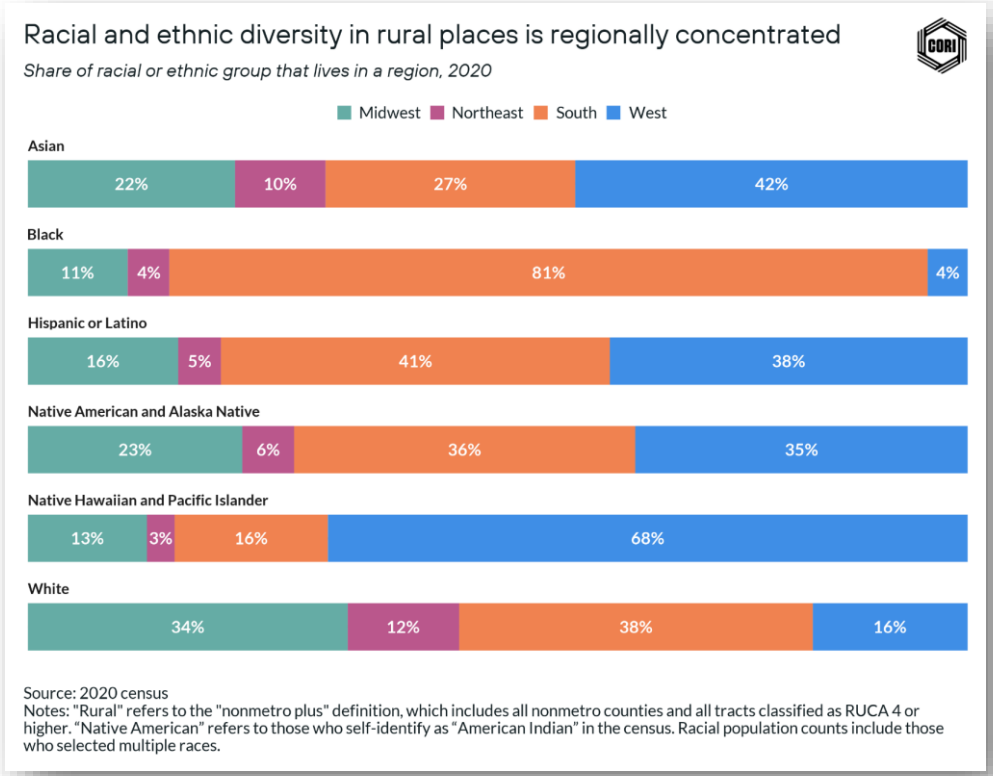
There are many different standards but common data points



Rural Population Demographics

Increasing Diversity

Rural Racial and Ethnic Diversity by U.S. Region



Center on Rural Innovation. "Who Lives in Rural America?"
https://ruralinnovation.us/blog/who-lives-in-rural-america-part-i/

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Rural Health Landscape

The Often-Cited Rural Health Concerns …

People in rural areas **live 3 fewer years** than people in urban areas, with **rural areas having higher death rates for heart disease and stroke.**

Rural women face higher maternal mortality rates

Rural residents face **higher rates of tobacco use, physical inactivity, obesity, diabetes and high blood pressure**

Rural populations face greater challenges with **mental and behavioral health** and have **limited access to mental health care.**

Rural hospitals are closing or facing the possibility of closing

+

Increasing shortages of clinicians

Long distances and lack of transportation make it difficult to access emergency, specialty and preventive care.

+

Rural populations are more likely to be **uninsured and have fewer affordable health insurance options** than in suburban and urban areas.

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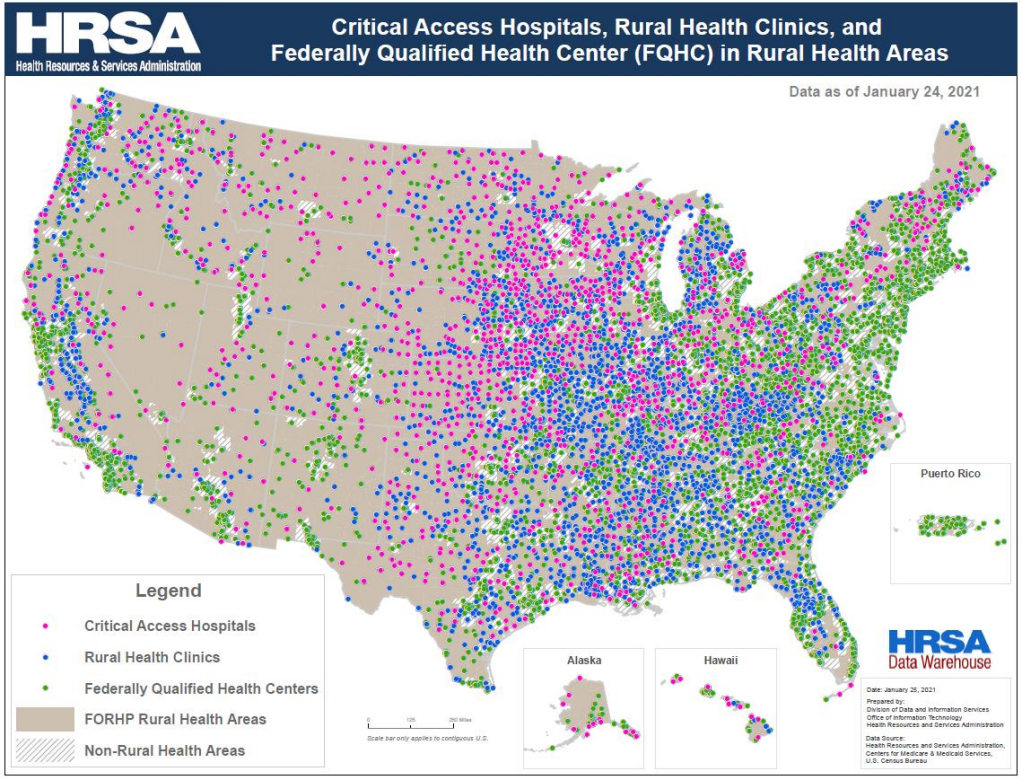
Rural Health Landscape

A Patchwork of Providers …



Special Federal Designations

- Volume
- Payer Mix

Dominant Policy Focus

- Reimbursement as a Tool for Access
- Unique Payment Systems Also a Policy Challenge

Current Rural Issue: Disparities

Life Expectancy, Mortality and Avoidable Death Rates

Rural-urban disparities in preventable early deaths vary by cause

Persons living in rural counties are at higher risk of dying early from a preventable cause than their urban counterparts

*Provisional mortality data, NCHS https://www.cdc.gov/nchs/nvss/vsrr/provisional-tables.htm

Underlying determinants of preventable early death

Risk factors for early death are compounded in rural counties*

Rural counties

- Obesity
- Smoking
- Exposure to environmental hazards (ex. road conditions)
- Physical inactivity
- Occupational hazards and behaviors (ex. seatbelt use, helmet use, misuse of drugs)
- Poverty, low education, racial segregation, limited access to health care, inadequate social support

Metro counties

- Obesity
- Smoking
- Exposure to environmental hazards (ex. road conditions)
- Physical inactivity
- Occupational hazards and behaviors (ex. seatbelt use, helmet use, misuse of drugs)
- Poverty, low education, racial segregation, limited access to health care, inadequate social support

*America's Health Rankings analysis of CDC WONDER, Multiple Cause of Death Files, United Health Foundation, AmericasHealthRankings.org, accessed 2023

Source: M. Garcia, CDC Presentation May 2023, National Rural Health Association

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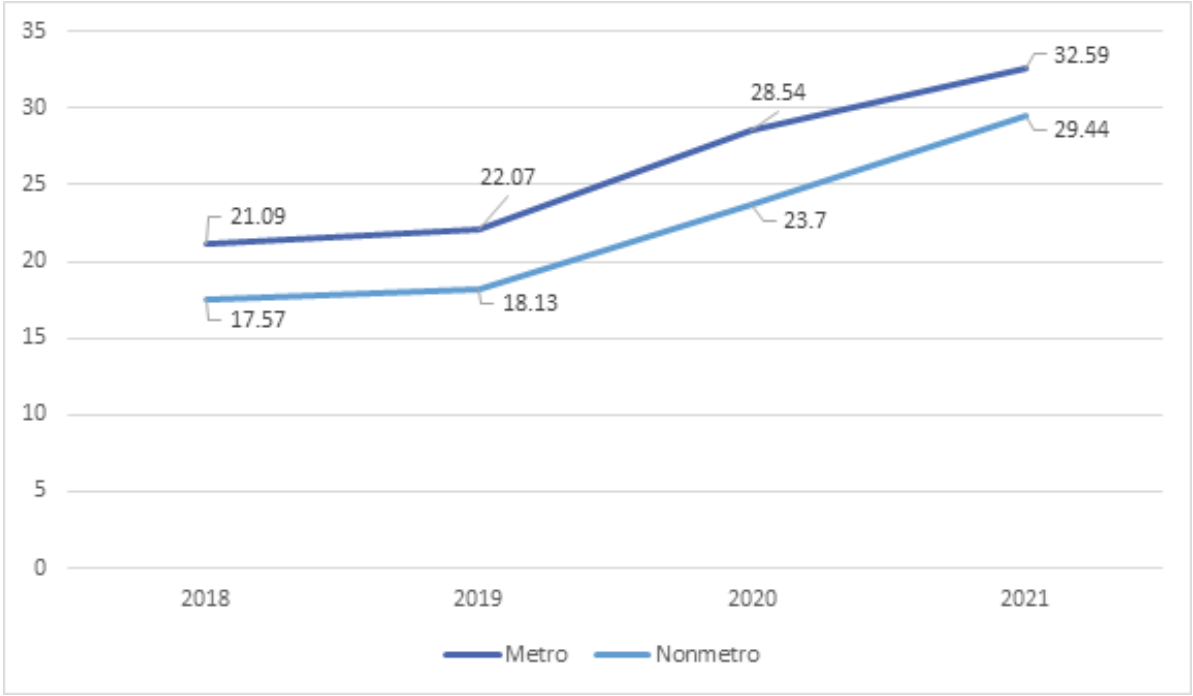
Current Rural Issue: The Opioid Crisis

Rural areas track urban areas closely on mortality trends



Source: CDC WONDER File

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Current Rural Issues: Workforce

A history of gaps …

Primary Care

All Primary Care (MD, DO, NP, PA)

- Urban = 80.5/100,000
- Rural = 153.3/100,000 People

MD, DO

- Urban = 213.9/100,000

Note: Rural and urban defined as nonmetropolitan and metropolitan, respectively
Source: HRSA Area Health Resource File, 2020-2021 (2019 data)

Behavioral Health

U.S. Counties without Behavioral Health Providers by Urban Influence Category

	Counties without a Psychiatrist (Percent)	Counties without a Psychologist (Percent)	Counties without a Psychiatric Nurse Practitioner (Percent)	Counties without a Social Worker (Percent)	Counties without a Counselor (Percent)	Counties without any Behavioral Health Provider (Percent)
U.S. (3135 counties)	1699 (54.2)	1076 (34.3)	1711 (54.6)	487 (15.5)	404 (12.9)	241 (7.7)
Metropolitan (1164 counties)	316 (27.1)	183 (15.7)	360 (30.9)	62 (5.3)	50 (4.3)	25 (2.1)
Non-Metro (1971 counties)	1383 (70.2)	893 (45.3)	1351 (68.5)	425 (21.6)	354 (18.0)	216 (11.0)
Adjacent to metro (1023 counties)	653 (63.8)	377 (36.9)	651 (63.6)	145 (14.2)	112 (10.9)	60 (5.9)
Micro nonadjacent to metro (269 counties)	137 (50.9)	74 (27.5)	123 (45.7)	38 (14.1)	30 (11.2)	21 (7.8)
Noncore adjacent to metro (373 counties)	337 (90.3)	254 (68.1)	319 (85.5)	135 (36.2)	114 (30.6)	70 (18.8)
Noncore nonadjacent to metro or micro (306 counties)	256 (83.7)	188 (61.4)	258 (84.3)	107 (35.0)	98 (32.0)	65 (21.2)

Data Sources: Psychiatrists (2019) - Area Health Resource File (AHRF), 2020-2021, Psychologists and psychiatric nurse practitioners (July 2021), social workers, and counselors (January 2022) - National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) data, and the U.S. Department of Agriculture Economic Research Service (ERS) Urban Influence Codes, 2013.

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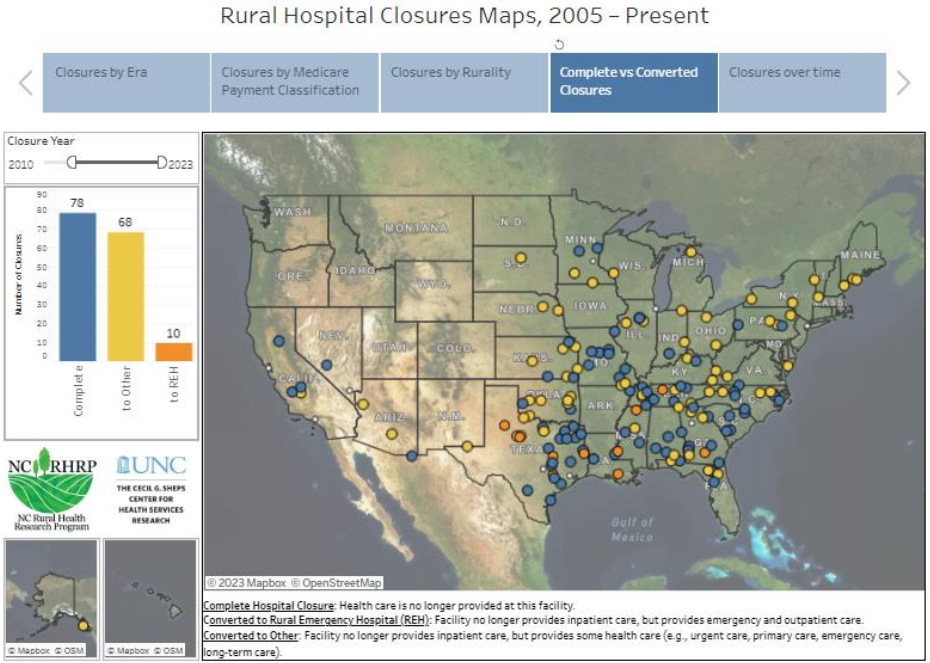
Current Rural Issue: Hospital Viability

Also a Health Equity Concern

156 Rural Hospital Closures since 2010



Additional Policy Options

- Rural Emergency Hospitals
- New Budget Proposals
  - At-Risk Assistance
  - Service Line Expansion/Bypass Reduction

https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

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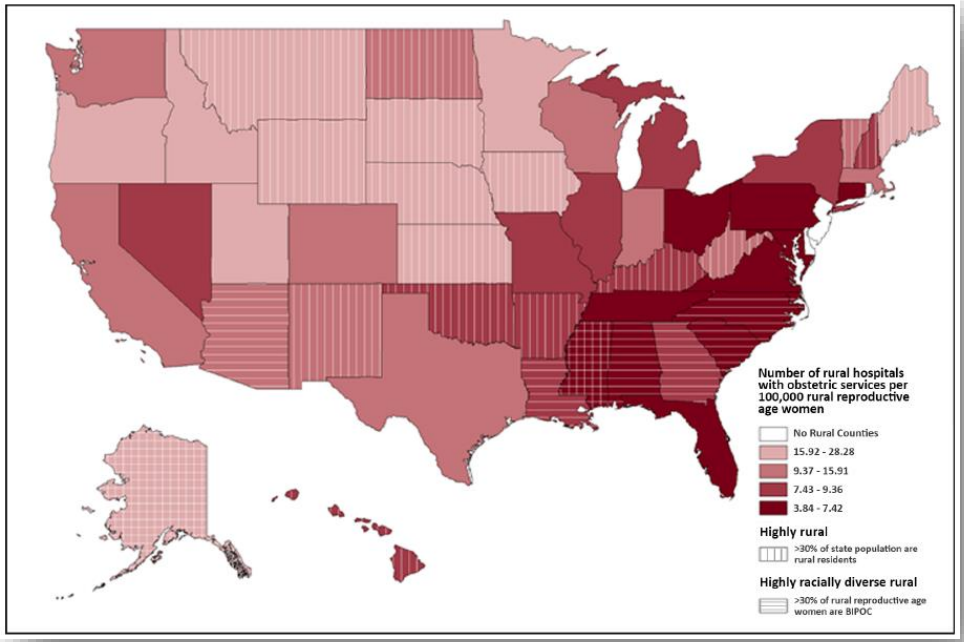
Current Rural Health Issue: Hospital Obstetrics

Access Gaps Increasing

- 56% of rural counties lack hospital-based OB services
- Loss of hospital-based OB services is most prominent in rural communities:
  - With a high proportion of Black residents
  - Where a majority of residents are Black or Indigenous and have elevated rates of premature death
- Opportunities:
  - Rural Maternal Obstetrics Management Strategies Program
  - Expanding Medicaid Post-Partum Coverage
  - Informing Service Viability Options

Number of rural hospitals with Obstetric services

per 100,000 rural reproductive age women



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Assessing the Rural Health Patchwork

Understanding Differential Impact of Rural Gaps

January 2023

FINDINGS BRIEF

RURAL & MINORITY Health Research Center

Variations in Affordability of Health Care by Non-Metropolitan/Metropolitan and Race/Ethnicity Status across Eight Geographically Dispersed States

Whitney E. Zahnd, PhD; Radhika Ranganathan, MPhil, MSPH; Elizabeth L. Crouch, PhD; Peiyin Hung, PhD; Jan M. Eberth, PhD; Gabriel Benavidez, MPH

- Non-Hispanic White and non-Hispanic Black adults ages 18-64 living in non-metropolitan areas had lower health insurance rates compared to their metropolitan counterparts.
- Among non-metropolitan individuals, insurance coverage varied across racial/ethnic groups with Hispanic adults having the lowest health insurance rates.
- Non-Hispanic Black individuals reported higher levels of not seeing a doctor due to cost (18.3% metropolitan and 22.5% non-metropolitan) compared to their white counterparts (13.3% and 13.7%, respectively).
- Non-metropolitan individuals ages 18-64 were more likely to report forgoing medication due to cost (11.3%) than metropolitan individuals (9.4%).
- A larger proportion of non-metropolitan individuals reported having medical bills they were paying off over time (24.0%) than those living in metropolitan (20.8%).

INTRODUCTION

Access to and quality of healthcare services are key elements of the social determinants of health that facilitate mental and physical well-being. [1] Studies consistently show that rural residents—accounting for more than 59 million Americans— have less access to healthcare services than their urban counterparts in terms of availability (e.g., provider-population ratios) and accessibility (e.g., distance to care) as described by Penchansky's and Thomas's "5 As of Access".[2] Rural areas have fewer primary care providers and specialists (e.g., obstetrics, cancer care) per population compared to their urban counterparts. [3-5] Further, studies also show that rural populations live further from hospital-based care and specialists than urban.[6,7] Rural-urban disparities in access to care are exacerbated by race/ethnicity as rural minoritized populations, such as Black and American Indian/Alaska Natives, often have less access than their white rural peers.[7]

A comprehensive understanding of access to care inequities requires the investigation of not only availability and accessibility but also affordability. Affordability is often characterized as having health insurance coverage. Yet, affordability includes other aspects such as cost barriers to seeking care in the short-term and amassing medical debt in the long term both of which are less studied. Rural populations consistently report having higher rates of uninsurance.[8] Additionally, studies show that rural patients may be more likely to forgo care compared to their urban counterparts or experience long-term financial impacts (e.g., debt). [9,10] Though earlier studies examined racial/ethnic differences in some elements of affordability within rural communities few of these elements of

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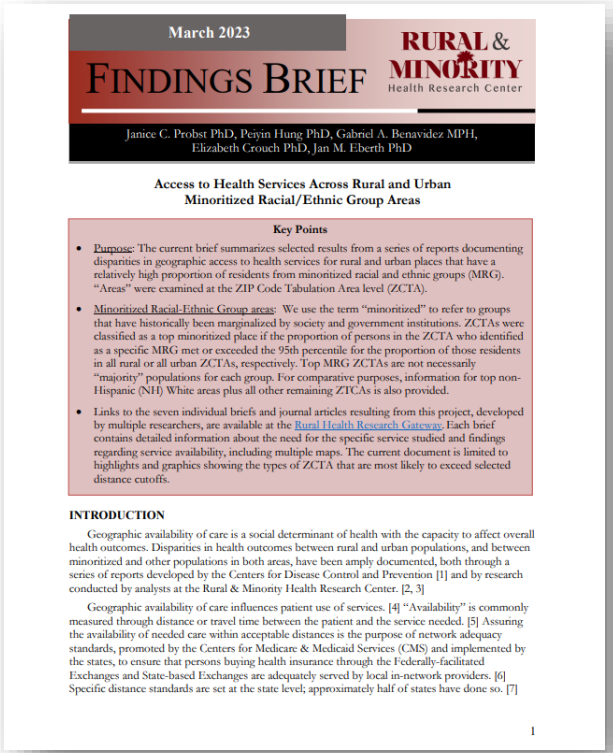

March 2023

FINDINGS BRIEF

RURAL & MINORITY Health Research Center

Janice C. Probst PhD, Peiyin Hung PhD, Gabriel A. Benavidez MPH, Elizabeth Crouch PhD, Jan M. Eberth PhD

Access to Health Services Across Rural and Urban Minoritized Racial/Ethnic Group Areas

Key Points

- Purpose: The current brief summarizes selected results from a series of reports documenting disparities in geographic access to health services for rural and urban places that have a relatively high proportion of residents from minoritized racial and ethnic groups (MRG). "Areas" were examined at the ZIP Code Tabulation Area level (ZCTA).
- Minoritized Racial-Ethnic Group areas: We use the term "minoritized" to refer to groups that have historically been marginalized by society and government institutions. ZCTAs were classified as a top minoritized place if the proportion of persons in the ZCTA who identified as a specific MRG met or exceeded the 95th percentile for the proportion of those residents in all rural or all urban ZCTAs, respectively. Top MRG ZCTAs are not necessarily "majority" populations for each group. For comparative purposes, information for top non-Hispanic (NH) White areas plus all other remaining ZTCAs is also provided.
- Links to the seven individual briefs and journal articles resulting from this project, developed by multiple researchers, are available at the Rural Health Research Gateway. Each brief contains detailed information about the need for the specific service studied and findings regarding service availability, including multiple maps. The current document is limited to highlights and graphics showing the types of ZCTA that are most likely to exceed selected distance cutoffs.

INTRODUCTION

Geographic availability of care is a social determinant of health with the capacity to affect overall health outcomes. Disparities in health outcomes between rural and urban populations, and between minoritized and other populations in both areas, have been amply documented, both through a series of reports developed by the Centers for Disease Control and Prevention [1] and by research conducted by analysts at the Rural & Minority Health Research Center. [2, 3]

Geographic availability of care influences patient use of services. [4] "Availability" is commonly measured through distance or travel time between the patient and the service needed. [5] Assuring the availability of needed care within acceptable distances is the purpose of network adequacy standards, promoted by the Centers for Medicare & Medicaid Services (CMS) and implemented by the states, to ensure that persons buying health insurance through the Federally-facilitated Exchanges and State-based Exchanges are adequately served by local in-network providers. [6] Specific distance standards are set at the state level; approximately half of states have done so. [7]

1

https://www.ruralhealthresearch.org/centers/southcarolina/completed-projects

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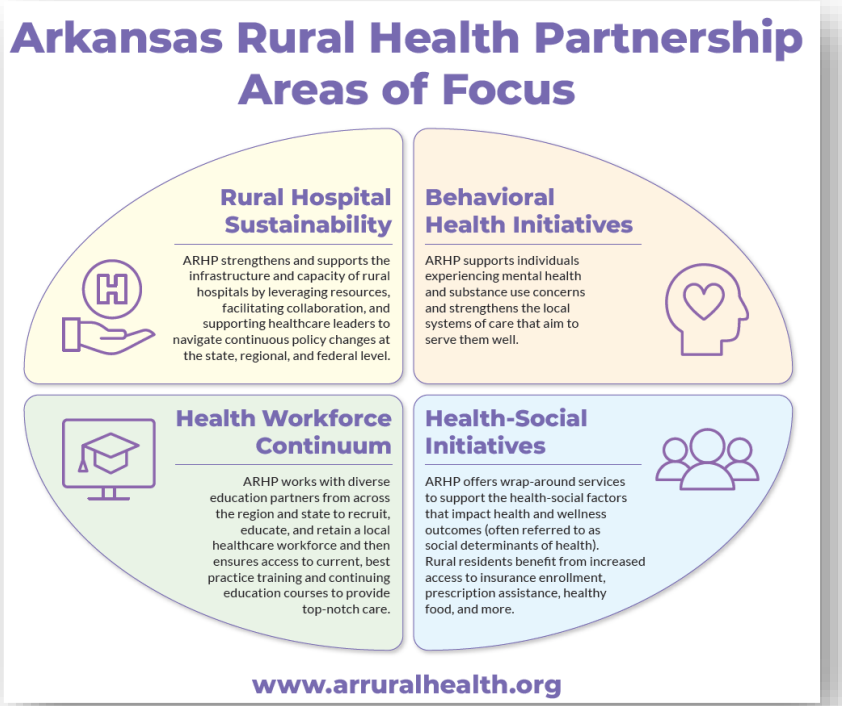
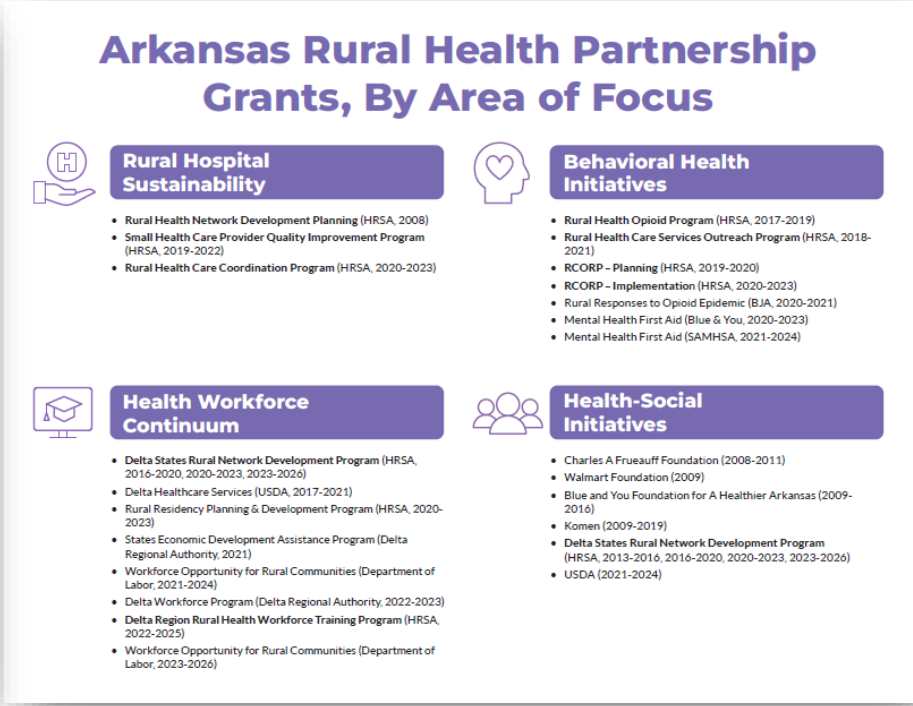
Promising Rural Practices

The Arkansas Rural Health Partnership





Promising Rural Practices

The Michigan Center for Rural Health

Blue Cross Blue Shield (BCBS) Foundation	▪ Private funder to support expansion of NMORC activity: Distribution of Naloxone
RCORP Psychostimulant & Behavioral Health	▪ Opportunity to impact the broader Substance Use Disorder issues in the NMORC region, including psychostimulant use & behavioral health access to care challenges.
RCORP – Implementation (I-IV)	▪ NMORC is fully staffed with RCORP I (FY 19) – Project Director, Project Associate (2), Medical Director ▪ RCORP II – Expansion to two additional counties, RCORP III – Expansion to three additional counties, RCORP IV – Expansion to four additional counties
RCORP -Planning	▪ RCORP –Planning allowed for a comprehensive assessment of needs and opportunities in a 16-county region of Northern MI. 23 Member organizations including all Hospitals, FQHCs, OTPs, LPHs, and CMHs in the region.
CDC Overdose to Action (OD2A)	▪ Prevention activities, opioid prescribing education, MAPs education & Academic Detailing
State Office of Rural Health (SORH)	▪ Provided staffing infrastructure to focus on SUD related activities ▪ SORH staff convened stakeholders, facilitated meetings in which Stakeholders "planned to plan" and wrote the RCORP – Planning NOFO

Contact Information

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