The State of Rural Health: The Environment and Policy Implications

Presented to: Interim Health Care Committee
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Center for Rural Health

Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND

One of the country’s most experienced state rural health offices

UND Center of Excellence in Research, Scholarship, and Creative Activity

Home to seven national programs

Recipient of the UND Award for Departmental Excellence in Research

Focus on

– Educating and Informing
– Policy
– Research and Evaluation
– Working with Communities
– American Indians
– Health Workforce
– Hospitals and Facilities

ruralhealth.und.edu
CRH Assistance to Rural Communities

- **Community Engagement Tool Kit** – rural communities build capacity to address local issues.
- **Community Assessments** – inclusive of community surveys
  - Community Health Needs Assessment – about 85% of CAHs
  - Special Focus (e.g., assisted living, wellness centers, service expansion, other)
- **Community or organizational assessments and internal staff audits** – needs, marketing, morale.
- **Focus groups** – group interviews.
- **Key informant interviews** (one-on-one interviews).
- **Strategic planning** (organizational planning and community health planning)
- **Grant writing workshops**
- **Grant proposal development** - identify sources, proposal critiques and background searches
  - Rural Health Information Hub ([https://www.ruralhealthinfo.org/](https://www.ruralhealthinfo.org/))
- **Community forum and/or meeting facilitation**
- **Program Evaluation** – federally funded and/or private foundation funded programs.
- **Speakers Bureau** – annual meetings or special presentations (just ask!)
- **CAH Quality Network** – all 36 CAHs with a CAH Executive Steering Committee. (Stroke and cardiac)
- **Education** – annual conference, organizational presentations, research, information sharing.
- **Health Workforce** – R&R assistance, Scrub Camps, Scrub Academy, Workforce Data, Education

10 Key Factors to Understanding Rural Health in North Dakota

1. **Demographics** drive health conditions, services, demand, and supply.
2. **Networking, collaboration, and partnerships** are fundamental – hard to stand alone.
3. **Equity and interdependence** are ways to think about rural communities and rural health.
4. **You cannot focus on rural health without focusing on the community**
5. Rural health **providers** (hospitals, clinics, LTC, EMS) are **vulnerable**.
6. Rural health is more than just rural hospitals, primary care clinics, EMS, public health, and infrastructure, it is the **health of the population** too.
7. **Quality of care is high**.
8. **Health workforce** may be even more problematic in rural areas.
9. Rural health providers are **up to date with technology and tele-health**.
10. **Healthy policy** is critical to rural health.
Demographics

• Over 760,000 population
• ND is younger now, median age, but many rural counties where median is higher
  o 4th youngest state median is 35 years, younger than national median by 2 years.
  o 45 counties have a median age above the state (2017)
  o 27 counties have a median age of 45 or older
  o 11 counties have a median age of 50 and older. (McIntosh and Nelson at 52.6.
• Oil counties and urban counties continue to grow but most other rural counties marginal growth or even lose population.
• Demographics influence rural health care
  o Patient base
  o Employment base
  o Type and availability of services – market
  o Volunteer base
  o Distance to services, to work, to day care, to home.

Rural Health Providers (hospitals, clinics, LTC, EMS) are Vulnerable.

• Financial viability is difficult – operating margins, advent of Medicaid Expansion
  o 8 in 2014 and 19 in 2017 and 18 in 2018 with positive operating.
  o Inpatient still part of hospital but small part – CAHs in 2018, 359,000 clinic visits, 99,000 ED visits
• In ND, a rural hospital is not just a rural hospital. It is the Hub. For example,
  o 35 of 36 own another health related business and/or service
  o 34 (94%) own a clinic – 61 with 46 being RHC
  o 13 (36%) own a nursing home
  o 8 (22%) own assisted living
  o 8 (22%) own the ambulance
  o 5 (14%) own basic care.
• ND CAHs and local taxes – 15 use sale and/or property.
• About 85% have a hospital foundation.
• Workforce concerns contribute to facility vulnerability.
• Goal is not maintain the hospital for the sake of maintaining a hospital however it is to secure and stabilize access to health care, address disparities, and to improve health status.
• KEY POINT IN RURAL ND THE HOSPITAL IS MORE THAN A HOSPITAL. IF THE HOSPITAL CLOSES YOU LOSE ACCESS TO PRIMARY CARE, EMS, AND IN MANY CASES NURSING HOMES, AND OTHER ELDER CARE SERVICES. THE HOSPITAL IS THE SYSTEM OF CARE, the LINKPIN, IT IS INTERDEPENDENT.
Health of the Population: Rural Health Serves a More Vulnerable Population

- 63% of people 65 and older live in rural ND (about 39% of CAH inpatient base is Medicare)
- About 375,113 ND are rural or 49.5% (outside the MSAs) –about 384,964 are urban or 50.5%– (USDA Economic Resource Service) State population 760,077
- 46% of ND veterans are rural compared to about 30% nationwide
- 10.3% of rural ND live in poverty; 10.3% of urban ND (rural much higher in 1999, 1989, and 1979) (data 2017)
- 9.1% of rural ND not completed HS; 6.2% of urban ND. (2013-2017 data)
- 2.9% of rural ND is unemployed; 2.3% of urban ND.
- Per capita income in urban ND is just above rural ($53,480 vs.$51,039) (2017 data)
- 58% of people receiving Medicaid Expansion are rural ND. (Source: Maggie Anderson about 2016 or 2017).
- Distance, weather, transportation are factors contributing to health disparities.
- Health disparities
  - Rural ND higher rates for health behaviors: smoking, binge drinking, drinking and driving, not wearing a seat belt, not exercising
  - Rural ND higher rates for general health conditions: disability, overweight/obesity, having only fair or poor health, and number of days with poor health
  - Rural ND higher rates for specific health conditions: high cholesterol, high blood pressure, arthritis, cardiovascular disease, and diabetes (2010 CDC BRFSS)
Quality of Care

• Overall Quality of Care is positive in the state and in rural areas. Hospitals perform well.
• NRHA and Chariis identify Top CAHs – 9% of the top 100 are ND and 20% of the top 20
• Agency for Healthcare Research and Quality – ND “strong”
• Commonwealth Fund – 22nd out of 51-access, prevention, treatment, avoidable hospital use and cost, equity, and healthy lives
• HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems. - CAH and PPS
  o ND CAHs score better than national CAH average on inpatient quality -94% vs 85%
  o ND CAHs score better than national CAH average on outpatient quality -69% vs 60%
  o ND CAHs outperform ND PPS on some measures (2016 most recent data)
    ➢ Physicians always communicated well – 86% of ND CAH patients agreed; 78% of ND PPS patients agreed.
    ➢ Nurse always communicated well – 86% ND CAH patients; 75% ND PPS patients.
    ➢ Patients who gave their hospital a rating of 9 or 10 on a 10 point range – 79% ND CAH patients; 65% ND PPS patients (national average for all hospitals was 73%).
    ➢ On readmissions ND CAHs tied in its region (KS, NE, SD and ND) with NE for the lowest rate; however, ND PPS readmission rates were lower than the CAHs. (15.2% readmission rate in ND CAHs and 14.8% in ND PPS).

Health Workforce

• Others will speak in more detail from the UNDSMHS but a few key points
• Shortages but also mal-distribution
  o Population with 51 U and 49% R but 68% of primary care is urban and only 32% rural
  o CRH 2017 workforce survey (workforce) highest vacancy rates
    ➢ PPS highest vacancy was RN
    ➢ CAH highest vacancy was CNA and NP
• About 44% of all practicing physicians in ND completed either their medical degree or at least one residency in ND or both.
• 63% of Primary Care did so.
• About 65% of ND nurses are in the urban area.
• 57% of Nurses educated in ND.
• Rural Efforts to Address these Issues:
  ➢ Scrub Camps
    ✓ 96 camps (2009-2019); 570 communities; 7,485 students; 2,892 volunteers
  ➢ Scrub Academy
    ✓ From 2011-2019 512 students and 232 communities involved.
  ➢ AHEC (HOSA) – over 500 ND student members in 16 ND chapters.
  ➢ CRH Workforce specialist who has facilitated rural provider placements totaling about 45 since 2012 (12, NP, 11 MD, 10 PA, 3 RN, 1 dentist, 1 Pharmacist) so it is not just physicians
  ➢ ND Primary Care Week and Meet and Greet
  ➢ Numerous presentations to communities.
North Dakota is, as they say, “heavily wired”

Connects rural not only to tertiary but all over the world

All CAHs have an EMR or EHR. Provider order entry and quality reporting.

Virtually all rural medical providers have EHR

EHR is part of how we are approaching quality improvement and measurement and thus it is essential to a “Volume to value” movement.

Telemedicine systems are in place connecting rural hospitals and clinics with tertiary.

Avera Health System in SD has e-Emergency in about 30 or so ND CAHs also e-Pharmacy and e-ICU and the other teriaries have their systems. In total, the 2017 CAH CEO survey found 95% of CAHs having tele-emergency and about two thirds had tele-radiology. About 60% were interested in exploring tele-stroke, and provider education via distance learning.

45 counties in the last count had tele-pharmacy

Tele-health is a tool, an important and vital tool BUT it is not a panacea.
Health Policy

- Federal and state health policy drives rural health – structure, services, payment, workforce virtually all facets.
- Profound change in how we think of health and health care – population health, quality, value, performance, health status improvement.
- Value-Based Payment Models
  - 7 ND CAHs in an ACO
  - About 63% of CAHs are in some form of care coordination payment system with BCBSND and their Blue Alliance- some are in a shared savings arrangement.
  - Care coordination training and health coaching – BCBSND, QHA, NDDH, and CRH
  - Medicaid operates Primary Care Payment methods and PC Case Management.
  - QHA involved with 27 clinics in a CMS PCP+ (advanced primary care medical home).
- Washington DC Policy on the horizon
  - Global budgets – Pennsylvania demonstration
  - COH (Community Outpatient Hospital) and Rural Emergency Care Hospital
  - 119 rural hospitals closed since 2010 (72% in non-Medicaid Expansion states).
  - Still looking for a payment methodology that is equitable to rural.

Health Issues According to Rural North Dakotans

- CHNA process in 2019-2021 used with rural hospitals and many public health units.
- 24 hospitals out of 36 (November 2019)
- Top 4-5 ranked community health issues -107 ranked (4.45 per CHNA)
- Thematic
  - Community environment (jobs livable wage, day care, young families, housing) 30 or 28%
  - Mental health – 25 or 23%
  - Behavioral health – 20 or 19%
  - Health system – 10 or 9%
  - Cost – 6 or 6%
  - Elderly – 6 or 6%
  - Wellness/fitness/obesity – 4 or 4%
- Most often identified as #1
  - Availability of mental health -7
  - Ability to retain primary care providers – 5
  - Attracting and retaining young families -3
  - Cost of health care insurance – 2
  - Not enough jobs with a livable wage -13
CAH CEOs Perceptions of Issues – 2017 Survey

• 22 Issues, Top 12
  o Access to mental health inpatient services (94.5% problem, moderate problem, severe problem)
  o Access to substance use disorder inpatient treatment services (92.7%)
  o Access to substance use disorder outpatient treatment services (91.4%)
  o Access to mental health outpatient services (86.2%)
  o Transportation of patients with mental health/substance use disorders to treatment services (80.5%)
  o Hospital reimbursement – Medicaid (69.4%)
  o Impact of the under-insured (69.4%)
  o Impact of the uninsured (68.6%)
  o Service area economic change (66.7%)
  o Hospital reimbursement – 3rd Party Payer (63.9%)
  o Service area population change (61.1%)
  o Hospital reimbursement – Medicare (50%)

Conclusions

• Rural health is a significant sector in rural communities.
• Rural health is unique or different from urban-based health culture, values, the way people relate to each other, high community identity.
• Rural health organizations, including rural hospitals, are complex organizations.
• ND recognize a wide variety of community health needs, some related to population health, and some more organizational and structural.
• The value-based payment evolution is inclusive of rural health
• Health workforce is a significant issue.
• Center for Rural Health works closely with rural communities, particularly to build local capacity.
• Rural health providers have used a number of grants to start local/regional initiatives – build collaborative arrangements.
• Health policy is critical.
• Ultimately, Rural Health is about Community.
Contact us for more information

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