The Rural Community: A Dynamic Condition for Health Reform

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OT511 Service Delivery System

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Connecting resources and knowledge to strengthen the health of people in rural communities.

Center for Rural Health

• Established in 1980, at the University of North Dakota School of Medicine and Health Sciences in Grand Forks, ND
• Seven core areas of focus:
  – Education, Training, & Resource Awareness
  – Community Development & Technical Assistance
  – Native American Health
  – Rural Health Workforce
  – Rural Health Research
  – Rural Health Policy
  – Program Evaluation
  – A UND Center of Excellence in Research, Scholarship, and Creative Activity
• Web site: http://ruralhealth.und.edu
Rural Health Issues

- Rural Health defined
- Social culture
- Demographics
- Economics
- Workforce
- Hospitals
- Quality
- Technology

What is Rural Health?

- Rural health focuses on population health and improving health status
  - Quality of care, access to care, cost of care – “drivers”

- Rural health relies on infrastructure: facilities, providers, services, and programs available to the public (all with quality, access, and cost implications)
  - Some are for-profit and some private or public non-profit entities
  - More and more health networks – independence with collaboration
  - Examples include: Community hospitals, clinics, public health, EMS, nursing homes/aging services, home health, mental health, dental, pharmacy, and others

- Rural health is not urban health in a rural or frontier area
What is Rural Health?

- Philosophy: rural people have the same right to expect healthy lives and access to care as do urban people – fairness frame
  - Access essential services locally or regionally
  - Access to specialty services through network arrangements
  - Quality of care on par with urban
  - Availability of technology

- Rural health is very community oriented – interdependence frame
  - Integral part of what a community is and how people see themselves
  - Sectors: Economic/business, public/government, education, faith/church, and health/human services
  - Direct services provided to the public and secondary impact for other sectors
  - Major employer

Rural Culture, Attitudes, and Behavior
**Comparative Rural and Urban Strengths and Weaknesses**

**Rural**
- Strong informal support network
- Fundraising
- Cohesive
- Established interdependence
- Collaboration

**Urban**
- More stable economy
- Availability of resources
- Availability of professionals
- Growing and diverse population
- Change is natural

**Weaknesses:**
- Skewed population demographics
- Fluctuating economy
- Resistance to change
- Shortage of professionals
- Lack of resources

**Implications of strengths and weaknesses on rural health systems**

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**Community Development Model**

**Environmental Impacts**
- Demographics
- Economic Conditions
- Political Process
- Workforce
- Finance
- Technology
- Health Organizations
- Culture and Attitude

**Community or Health Organization**
- Take Action
- No Action
- Delay Action

**Action**
- Assessment and Planning
- Community Forums
- Community Education
- Collaboration/Networking
- Regional Approach
- Community and Economic Development Integration
- Service Diversification
- Skill Development
- Advocacy

Source: Brad Gibbens, Associate Director
UND Center for Rural Health
Jonathan Swift once said:

“Vision is the art of seeing things invisible”

Rural Culture: Attitudes Towards Change

- Change is natural
- Resistance to change is natural
  - Threat to established order, way of life
  - Better an old problem than a new opportunity – history and norms
  - Community factors – population & economic conditions drive change
  - Community rivalry
- Agrarian Fatalism
  - Community orientation – it is inevitable, reactive
- Rural communities offer flexibility, adaptive behavior, and interdependence is a strength
Factors for Successful Community Building

- Community awareness of an issue
- Motivation from within the community
- Flexibility and adaptability
- Small geographical area
- Pre-existing social cohesion
- Ability to discuss, reach consensus, and cooperate
- Existing identifiable leadership
- Prior success with community building
- Widespread participation
- Minimal competition in pursuit of goals
- Benefits accrue to many residents
- Focus on the process and the product concurrently

Source: Fieldstone Alliance (http://www.fieldstonealliance.org/client/client_pages/tools_you_can_use/04-06-06_cmty_bldg_wmiw.cfm)

Factors for Successful Community Building

- Linkage to organizations outside the community
- Systematic gathering of information and analysis of community issues
- Training to gain community skill building
- Use of technical assistance
- Continual emergence of leaders, as needed
- Community control over decision making
- Sincerity of commitment
- Understanding of the community
- Relationship of trust
- Flexible and adaptive

Source: Fieldstone Alliance (http://www.fieldstonealliance.org/client/client_pages/tools_you_can_use/04-06-06_cmty_bldg_wmiw.cfm)
Strategies for Rural Health System Survival

• Community involvement and support
• Strategic Planning, reliable data, analysis, best practices
• Diversification and/or redefinition of services
• More inclusive, redefinition of community, regional perspective
• Use of external resources (SORH, Flex, RAC, IOM, HP2010/2020)
• Progressive healthcare leadership – youth, new community members
• Collaboration – provider-to-provider, community-to-community
• Emphasis on quality
• Advocacy and involvement

Source: UND Center for Rural Health, 2008

Rural Communities and Health Reform

• Many of the characteristics found in rural communities can be facilitators for health system change

• Many of our rural health issues are addressed in health reform

• Reform offers opportunity for change
Demographics

National Conditions

A glance at rural and urban America

<table>
<thead>
<tr>
<th></th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of U.S. population</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>Population aged 65 and older</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>Population that is white</td>
<td>83%</td>
<td>69%</td>
</tr>
<tr>
<td>Private insurance</td>
<td>64%</td>
<td>69%</td>
</tr>
<tr>
<td>Medicare beneficiaries</td>
<td>23%</td>
<td>20%</td>
</tr>
<tr>
<td>Medicare hospital payment</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: NRHA web page
Demographic Issues

- Revised population – 641,481 (July, 2009 Estimate) – increase of 3,600 from 2007 – significant increase from 2003
- From 2007-2008, 18 counties had population increase
- In 2008, 122 more people immigrated to ND than left (first increase in close to two decades)
- 1990-2000 47 of 53 counties lost population
- 1990-2000 48 of 53 counties saw a decline in number of youth
- Median age 1960 was 26.2 and in 2000 it was 36.2 – (estimated at 38.0 in 2008)
- From 2007-2008, births increased by 3.9% (330)

Economic and Demographic Impacts

A population that is:
- Smaller
- Older
- Poorer

Rural Health Impacts:
- Smaller markets
- Greater dependence on Medicare population
- Greater difficulty in recruiting and retaining health professionals
- Smaller tax base
- Greater number of people without health insurance or with limited insurance
- More chronic health conditions
North Dakota Frontier Counties

36 of 53 North Dakota Counties designated as Frontier (less than 6 persons per square mile) Based on 2000 Census

Combined Rural Counties that Equal Cass County 1990-2000

The combined population of the 35 pink counties (122,066) approximately equals the population of Cass County (123,138)
Projected Percent Change in Total Population in the Great Plains States by County: 2000 to 2020

Note: For purposes of this study, the Great Plains is defined as all counties in Colorado, Iowa, Kansas, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming.

Source: U.S. Census Bureau, Decennial Censuses; Individual state agencies providing population projections.

Projected Percent Change in Persons 65 and Older in the Great Plains States by County: 2000 to 2020

Note: For purposes of this study, the Great Plains is defined as all counties in Colorado, Iowa, Kansas, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming.

Source: U.S. Census Bureau, Decennial Censuses; Individual state agencies providing population projections.
Distribution of the Elderly: 2000
Percentage of Persons 65 Years and Older

The Elderly – 85 plus
Persons Age 85 and Older as a Percentage of Total Persons by State: 2000
Economics

Rural Economics and Health Care

- Health Sector as part of GDP (2007) – SD (8.7%); ND (8.6%); western states (18 states = 6.4%)
- Comparison: Agriculture as part of GDP (2007) – SD (6.0%) and ND (7.7%) – manufacturing (ND) about 10%
- Health care accounted for 44% of service industry (largest)
- Ag sector now about 8% (1979 was 18%); service sector now about 23% of GDP (1979 was about 9%)
- 8 of 10 largest private employers in ND are health related
- Health care accounts for about 10-15% of a rural communities economy
- Rural hospital and/or health center one of largest employer
- Multiplier effect – money and jobs
The Healthcare Economic Linkage

1. Employment Impacts
2. Attracting/Retaining Local Residents
3. Attracting/Retaining Business
4. Generating Investment Funds
5. Enhancing Local Leadership Capacity

Source: Cordes, 1996

Workforce
Common Workforce Issues

- Some shortages of providers, some elements of mal-distribution (where are they located) -- Supply
- Not limited to physician issues as we face shortages/mal-distribution with nursing, PA, NP, mental health, dental, pharmacy, and others -- Supply
- Aging provider base
- Adequate number of academic faculty -- Supply
- Viability of rural health institutions -- Demand
- Ability to recruit and retain providers in rural areas -- Demand
  - Attractive sites
  - Type of practice setting -- multi-physician setting, strong management
  - Salaries for family medicine and primary care
  - Exposure to rural practice in medical education and/or residency -- very important

Solutions

- What Is Working
  - Community/health facility leadership
    - Community-Based Task Forces
    - Grow Your Own efforts including targeting elementary and secondary students -- CRH HOTT effort
    - Meetings with health education programs
    - Networking of providers -- surgical network
  - Federal Policy
    - Conrad State 30 Program
    - NHSC and loan repayment programs
    - Rural Health Clinic Act and Community Health Centers
    - Title VII and Title VIII
Solutions

- What Is Working
  - State Policy
    - State Loan Repayment
    - Better state data on workforce needs – Job Service
    - Greater awareness and support for health careers in state sponsored job fairs and searches

- Changes in Medical and Health education
  - UNDSMHS - 1 of only 30 (out of 125) – patient-centered learning
  - UNDSMHS 1 of only 30 – inter-professional health care course
  - All ND medical students have an educational experience in rural setting
  - UNDSMHS ranked 4th graduates pursuing family medicine (2008)
  - UNDSMHS ranked 5th in nation America’s best Graduate Schools
  - Approximately half of UNDSMHS graduates practice in ND
  - Development of AHEC
  - Health reform discussion also emphasizes need for inter-professional training
  - Expanding role of community colleges
Hospitals, Health Systems, and Rural Facilities

Issues facing Rural Hospitals and Health Systems

- ND CAH administrators in 2008
  - 3rd Party Payers 96% problem/moderate problem/significant problem
  - Nursing Workforce 89%
  - Medicare Reimbursement 86%
  - Ancillary Workforce 85%
  - Physician Workforce 82%
  - Impact of Uninsured 81%
  - Access to Technology 78%
  - Demographics 74%

  - Most Prevalent Significant Problems
    - Third Party Reimbursement 57%
    - Physician Workforce 46%
    - Demographics 35%
Issues facing Rural Hospitals and Health Systems

• Significant number of primary care clinics closing over last 15 years
  o 25-30 closed in large part to changes in RHC reimbursement and tertiary provider business decisions
  o Impact on rural community and ability to successfully self-manage (skill atrophy)
• EMS
  o Volunteer to paid professional
  o Some closures
  o New state efforts to manage change from ambulance to 1st Responder and to identify “Access Critical” ambulance units – core
• Home Health
  o Significant disruption and agency closure – federal reimbursement issues

How Rural Hospitals and Health Systems Respond

• New delivery structure – CAH, maybe in time FESC
• RHC and CHC common – more movement to CHC
• Diversification – services but cost reimbursement has issues
• Community Engagement and Development
  o Network development and collaboration
    o Significant increase through Flex grants of rural CAH network activity
    o Statewide CAH quality network
    o Increased role of tertiary providers in working with CAHs
• Proactive advocacy – ND Rural Health Association, NRHA, AHA
• Adaptation to new systems – technology, quality/performance
• Increased professionalism – e.g. EMS and paramedics, statewide quality network
Quality of Care

- IOM “Quality through Collaboration”
  - Health and Healthcare in Rural Communities
  - Quality Improvement
  - Human Resources
  - Finance
  - Information and Communication Technology
- Rapid movement to a quality and performance focus in health
- Linkage to reimbursement
- Significant discussion point for national health reform
Technology

- Increase in medical knowledge
- Perceived as key element in health system reform
- Chronic conditions
- HIT in a rural setting
  - Interest and financial ability
  - Healthcare settings
  - Population health
Rural Health Outreach Grants

- Network of 3 independent organizations
- Up to $150,000 (yr 1), $125,000 (yr 2), and $104,000 (yr 3)
- Focus on service development and implementation to address a shared/common health issue
- Very competitive – 300 applicants may fund 30-40/yr
  - Broad and comprehensive focus
    - Improve health system delivery, address specific health needs, improve health status, health is broadly defined and inclusive of human services
    - Relates to Healthy People 2010
    - Can lead to additional Outreach and/or Network Development
    - One ND network has had three Outreach grants on the same general subject area
**Rural Health Outreach Grants**

- **24 Funded Grants in North Dakota**
  - EMS
  - Mental Health
  - Wellness
  - Chronic disease management
  - Mobile health clinic
  - Discount medication access
  - Elder and Alzheimer’s care, education, and training
  - Diabetes education and training
  - Distance learning for nursing education
  - School nursing

**Network Development Grants**

- Formal network of 3 or more entities
- Up to $180,000/yr for up to 3 years
- Focus is on developing the formal organizational operations of the network
- Outreach is similar but more emphasis on the subject to be addressed while Network Development emphasizes building and strengthening a long term network
- Five funded in ND
Network Development Planning Grants

- Federal – 2002
- 1 year grants for planning purposes – up to $85,000
- 5 funded in ND
- Good first step toward Outreach and/or Network Development
- Doesn’t obligate applicant to apply for Outreach/ND, but very good way to support a local assessment

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