The Opportunity of Rural Health: Challenges and Options for Change

North Dakota Healthcare Financial Management Association (HFMA)

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Minot, ND

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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

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Today’s Objectives/Questions

• How do we define “rural health”?

• What is the relationship between the “rural” community and “rural” health?

• What are the primary rural health issues and conditions?

• What is the environment for rural hospitals?

• What does the Center for Rural Health do to assist rural communities?

• What are some options for positive change?

Ultimately Our Values Guide Our Perceptions Toward Health, Health Care, and Public Policy

“It is not what we have that will make us a great nation. It is how we decide to use it.”

Theodore Roosevelt

“Vision is the art of seeing things invisible”

Jonathan Swift?

“Americans can always be relied upon to do the right thing... after they have exhausted all the other possibilities”

Sir Winston Churchill
How Do We Define Rural Health

What is Rural Health?

- Rural health focuses on population health and improving health status
  - Morbidity and mortality, care quality measurement and improvement, access to care and services, availability of care and services, cost of care, ability to afford care, health promotion and disease prevention, care coordination, financing, health system performance and viability – “drivers” of health policy

- Rural health relies on infrastructure: facilities, providers, services, and programs available to the public (all with quality, access, and cost implications)
  - HRSA (ORHP, SORH, Flex, NHSC) – Federal bureaucracy orientation
  - Infrastructure improvement- health orgs, systems, payment structures
  - More and more health networks – independence with collaboration
  - Delivery systems: CAH, clinics, public health, EMS, nursing homes/aging services, home health, mental health, dental, pharmacy, and others
What is Rural Health?

- Rural health is not urban health in a rural or frontier area
  - Demographics and economic conditions make it distinct
  - Rural population that is older, poorer, less insured, and has a higher level of morbidity for a number of health conditions
  - Rural culture, relationships, how we do things are distinct

- Rural health need effective health policy, and health policy needs to rely on competent research
  - Policy process that is reflective of rural health needs
  - Policy advocacy that tends to be bipartisan
  - Variety of advocacy groups
  - Rural health research community

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
- Health outcomes should be comparable
- Quality of care on par with urban
- Availability of technology

Rural health is very community focused – interdependence frame

- Integral part of what a community is and how people see themselves
- Community engagement – public input is fundamental
- 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
What is the relationship between the “rural” community and “rural” health?

Rural Community and Rural Health

- Communities are comprised of key sectors that have economic, social, and cultural components – together they comprise the town
  - Health (with human services)
  - Business (can have one or two dominant business types – ag, oil – economic impact of health and health care)
  - Education (school consolidation and sport coop changing some of the community identity)
  - Government – city, county, special districts – role of park board with health care
  - Faith (social and cultural connections – access to health)

- Viable health systems need viable communities – strong education, business, faith, government and business, like those sectors need a strong health system (e.g. health access for employees, general health improvement, health care is large employer adding to business and schools)
Rural Community Health Equity Model

Environmental Conditions
- Demographics
- Economics
- Policy
- Health Status
- Workforce
- Finance
- Technology
- Health System Change
- Rural Community Culture & Dynamics

Impact on Community or Health Organization
- Threat to survival
- Growth/Decline
- Identity
- Perception toward change
- Perception toward opportunity
- How we respond

Community Action
- What do people think, want, or need?
  - Assessments
  - Forums-Discussions
  - Interviews
- Community Ownership (not health system ownership)
  - Collaboration
  - Inclusion
  - Participation
  - Interdependence
- Community Capacity
  - Skills and knowledge
  - Leadership development
  - Planning and advocacy
  - Manage change – non reactive

Source: Brad Gibbens, Deputy Director
UND Center for Rural Health

What are the rural health issues and conditions?
What are Some Important Rural Health Issues? (Version I)

- Access to and availability of care
- Financial concerns facing rural hospitals and health systems
- Health workforce
- Quality of Care
- Health Information Technology
- Networks – rural hospitals, urban hospitals, clinics, others
- Emergency Medical Services – EMS, ambulance, quick response units
- Community and Economic Development
- Health System Reform

Sources: 2008 Flex Rural Health Plan, 2009 Environmental Scan, and community presentation feedback surveys 2008-2014

What are Some Important Rural Health Issues? (Version II)

- Health care workforce shortages (28 of 39)
- Obesity and physical inactivity (16 of 39)
- Mental health (inc. substance abuse) (15)
- Chronic disease management (12)
- Higher costs of health care for consumers (11)
- Financial viability of the hospital (10)
- Aging population services (9)
- Excessive drinking (7)
- Uninsured adults (6)
- Maintaining EMS (6)
- Emphasis on wellness, education, & prevention (6)
- Access to needed equipment/facility update (6)
- Marketing and promotion of hospital services (5)
- Violence, traffic safety, elevated rate of adult smoking, lack of community collaboration, and cancer tied with (3) – lack of day care/housing (2)

Source: CHNA conducted 2011-2013 (39 of 41 ND hospitals)
What is the Environment for Rural Hospitals?

Rural Hospital Environmental Considerations

- ND CAHs are complex and serve as a “Hub” service system for health and some human service functions for rural communities

- ND CAHs serve a more vulnerable population – population health is a major concern for rural North Dakota

- ND CAHs make a significant economic contribution to their communities and service areas

- ND CAHs face many financial concerns
CAHs are Service “Hub” providers

• 33 of 36 CAHs (92%) own and/or operate another health business
  o 83% (30 CAHs) operate 57 primary care clinics (43 RHCs)
  o Of the state’s 52 RHCs 43 are owned by CAHs (82%)
  o One CAH shares an administrator with the FQHC
  o 39% (14 CAHs) own/operate a nursing home
  o 28% (10 CAHs) have both a clinic and nursing home
  o 28% (10 CAHs) own senior apartments
  o 25% (9) own/operate ambulances
  o 22% (8) operate assisted living
  o 17% (6) operate basic care
  o 8% (3) offer home care services

• Policy makers – stress the equity frame and the interdependence frame

CAHs Serve a More Vulnerable Population

• 63% of people 65 and older live in rural ND (about 42% of CAH inpatient base is Medicare)

• About 368,000 ND are rural (outside the MSAs) – about 356,000 are urban – (USDA Economic Research Service, September 2014)

• 46% of ND veterans are rural compared to about 30% nationwide

• 11.1% of rural ND live in poverty; 11.2% of urban ND (rural much higher in 1999, 1989, and 1979)

• Health disparities
  o Rural ND higher rates for health behaviors: smoking, binge drinking, drinking and driving, not wearing a seat belt, not exercising
  o Rural ND higher rates for general health conditions: disability, overweight/obesity, having only fair or poor health, and number of days with poor health
  o Rural ND higher rates for specific health conditions: high cholesterol, high blood pressure, arthritis, cardiovascular disease, and diabetes (2010 CDC BRFSS)

• Policy makers – stress the equity frame
CAH CEOs Perceptions of Issues – 2014 Survey

- 34 Issues, Top 10
  - Access to mental or behavioral health services for inpatient and outpatient (Mean = 4.1 on 5.0 scale)
  - Access to mental or behavioral health services for substance abuse
  - Hospital reimbursement – 3rd party payer
  - Hospital reimbursement – Medicaid
  - Impact of the uninsured
  - Impact of the underinsured
  - Primary care workforce supply
  - Hospital reimbursement – Medicare
  - Nursing workforce supply
  - Ancillary workforce supply

ND CAHs Make a Significant Economic Impact

- 50% of CAHs have local tax support (2014 survey) – 36% in 2011 and 11% in 2005 - $30,000 to $550,000/yr (10 over 100,000 a year)
- 9 sales tax and 5 mill levy (4 did not identify)
- 85% have a hospital foundation (Source 2014 CRH CAH/PPS Hospital Survey)
- ND CAHs have, on average, about a $6.4 million (wage and benefits) impact on their community – primary/direct and secondary/indirect – 1.5% multiplier
- ND CAHs produce, on average, about 224 jobs (direct/indirect) to local economy
- Statewide CAHs contribute about $230 million to economy and 8,000 rural jobs (Source: CRH Rural Hospital Flexibility Program, CAH Four Key Factors)
- 1 rural physician can have an impact of about $2.4 million ($1.5 million revenues and about $900,000 in payroll for clinic and hospital)
- 1 rural physician can generate about 4 clinic jobs and 13 hospital jobs (Source: Rural Health Works)
CAHs Face Many Financial Concerns

- Nationally, from 2013 thru September 2014, 24 rural hospitals closed
- ND CAHs operating margins (-1.67); nationally +0.68 (2011 data)
- In 2010, ND CAHs OM were (-0.67)
- SD CAHs operating margins (+2.76)
- MN CAHs operating margins (+2.88)
- ND CAHs total margins (-0.02); nationally +2.33 (2011 data)
- In 2010 ND CAHs TM was (+0.15)
- SD CAHs total margin (+3.17)
- MN CAHs total margin (+3.45)
- ND CAHs ranks 4th in oldest physical plant
- ND CAHs ranks 20th in days cash on hand
- CAHs in ND increasing local tax support and hospital foundations
- (source: Flex Monitoring Team Data Summary Report No. 13, April 2014)

What Does the Center for Rural Health do to Assist Rural Communities?
CRH Assistance to Rural Communities

- Community Engagement Tool Kit
- Community Assessments
  - Community Health Needs Assessment
  - Special Focus (e.g., assisted living, wellness centers, other)
- Focus groups
- Key informant interviews (one-on-one)
- Strategic planning (organizational planning and community health planning)
- Grant writing workshops
- Grant proposal critiques and background searches
  - Rural Assistance Center (www.raonline.org)
- Community forum and/or meeting facilitation
- Program Evaluation
- Speakers Bureau – annual meetings or special presentations (rural health, health policy, Native American, aging, community development/engagement, evaluation/program sustainability, HIT, quality improvement, TBI, network and system development, veterans, and other subjects – just ask!)
- CAH Quality Network
- Internal Personnel Audit (staff satisfaction with work environment)
- Education – statewide assessments (hospital and public health), presentations, research

What are Some Options for Positive Change? Rural Communities and Vision is the Art of Seeing Things Invisible
Rural Health Options

- Capacity Building – equity and interdependence
  - Community Engagement Tool Kit (January 2015)
    - Skill development to build local coalitions to address local health issues
    - Building partnerships and networks
    - Assessment and planning
    - Resource identification
    - How to write a grant
    - Evaluation and sustainability

- Grant Development – equity and interdependence
  - Grant writing workshops and proposal critiques
  - Medicare Rural Hospital Flexibility Grants and SHIP grants
  - Rural Health Outreach grants
  - Rural Network Development grants
  - Rural Network Planning grants

- Community Health Needs Assessment – equity and interdependence
  - NEW instrument – address hospital and public health needs

Rural Health Options

- Medicare Rural Hospital Flexibility Program
  - Since 1999, Flex has provided over $5 million in direct grants to ND CAHs (and another $3.5 million in Small Hospital Improvement Program-SHIP grants)
  - Impacted over 125 communities
  - 348 separate subcontracts with hospitals (about 9.6 contracts per CAH)
  - Help CAHs develop services, networks, staff and community education and/or training, board education, improve financial viability (Charge master review), quality improvement
  - Created CAH Quality Network – all 36 CAHs are members and work with the big 6 (regional CAH meetings)
  - Direct assistance:
    - 267 community and/or hospital meetings
    - 58 community needs assessments
    - 30 strategic planning sessions
    - 16 economic impact assessments
    - 11 Internal Personnel Audits
    - 34 Statewide workshops
### Center for Rural Health

**Rural Health Options**

- **Outreach Grants**
  - $200,000 a year for 3 years
  - 3 separate legal entities working together – MOU
  - Applicant rural and non-profit but can have urban and/or for-profit partner
  - Every other year
  - 23 grants funded in ND since 1991
  - 18 of 23 grants involved a rural hospital (78%)
  - 11 of 23 grants involved a collaboration of a rural hospital and rural public health (48%)
  - Other partners: 4 grants had ambulances, 3 grants community action agencies, 3 academic units, 2 tribal colleges, 2 economic/job development, 2 tertiary hospitals, 2 public schools, 1 pharmacy
  - Dickinson – 4 separate Outreach grants, Wishek 2
  - Subjects addressed – chronic disease, disease prevention, mental and/or behavioral health, EMS, community wellness, health insurance access, community health education, dementia, mobile health clinic, primary care clinic expansion, nursing education, public school nurse development, and other
  - 2014 applicants – advanced care planning, substance abuse, community access to Marketplace/Medicaid Expansion, care coordination for elderly

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**Health Workforce Data for the 3rd UNDSMHS Biennial Report – 2015**

(Sneak Peek!)
Table 10

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**Fig 62** Statewide Hospital Workforce Vacancy Rates*

North Dakota Hospital Workforce Survey: September 2014

*Note: These vacancy rates are not averages of hospital rates (means of means but are the rates using the overall category of vacancies and employed providers (essentially weighting these rates by FTE hospital employment count).*

Bar Staff Category Color Key
- Nursing Staff
- Laboratory Staff
- Radiology Staff
- Medical Records Staff
- Pharmacy Staff
- Other Staff
- Management Staff

![Vacancy Rate Chart](image)

**Fig 63** Statewide Hospital Workforce Employees and Vacancies by Position Type

North Dakota Hospital Workforce Survey: September 2014

Bar Staff Category Color Key
- Nursing Staff
- Laboratory Staff
- Radiology Staff
- Medical Records Staff
- Pharmacy Staff
- Other Staff
- Management Staff

![Employee and Vacancy Chart](image)
Conclusions

- Rural health is a significant sector in rural communities
- Rural health is unique or different from urban-based health
- 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
- 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
- Health workforce is a significant issue

Reminder!!

November 20th is National Rural Health Day
Questions??

Contact us for more information!

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