Federal Role in Rural Health

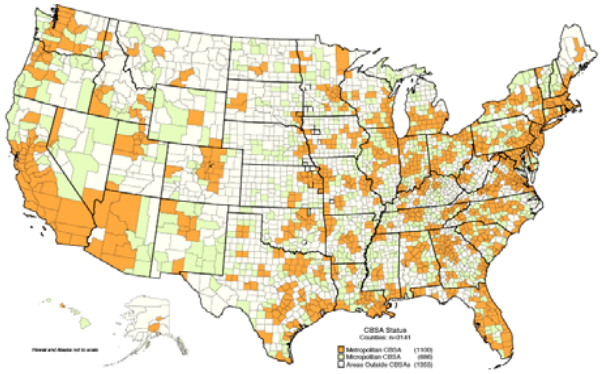
Tom Morris

Associate Administrator, HRSA

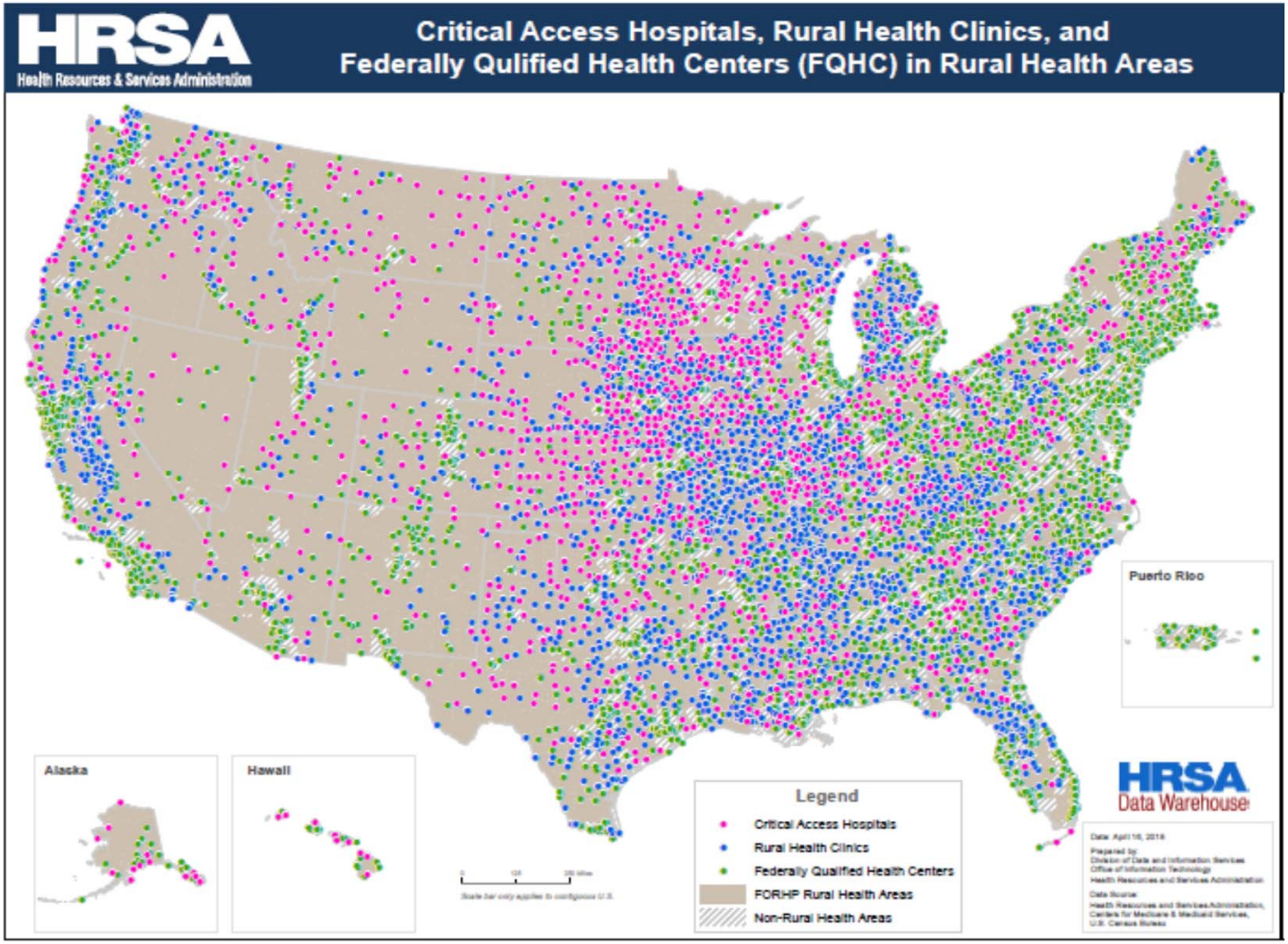
Federal Office of Rural Health Policy

Infrastructure & Workforce Investment

- Supporting Access via …
  - Enhanced Payments through Medicare and Medicaid
    - Special designations
      - CAH, RHC, Swing Beds, etc.
    - Pilots and Demonstrations
  - Workforce Training, Clinician Placement
    - (National Health Service Corps)
  - Access to Capital, Investments in Technology
    - Telehealth
    - Broadband
    - Electronic Health Records
  - Targeting Resources by Designating Shortage Areas (HPSA)



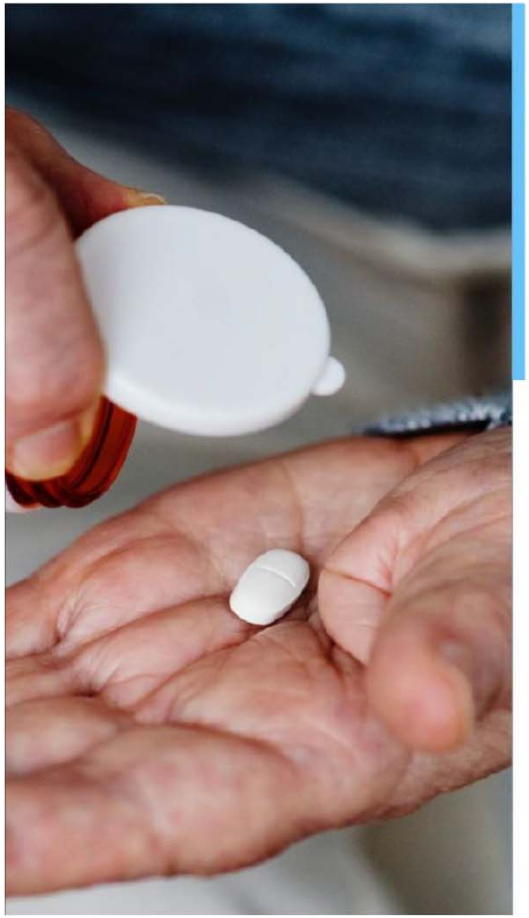
Key Federally Supported Parts of the Rural Health Safety Net



Disparities in Rural America

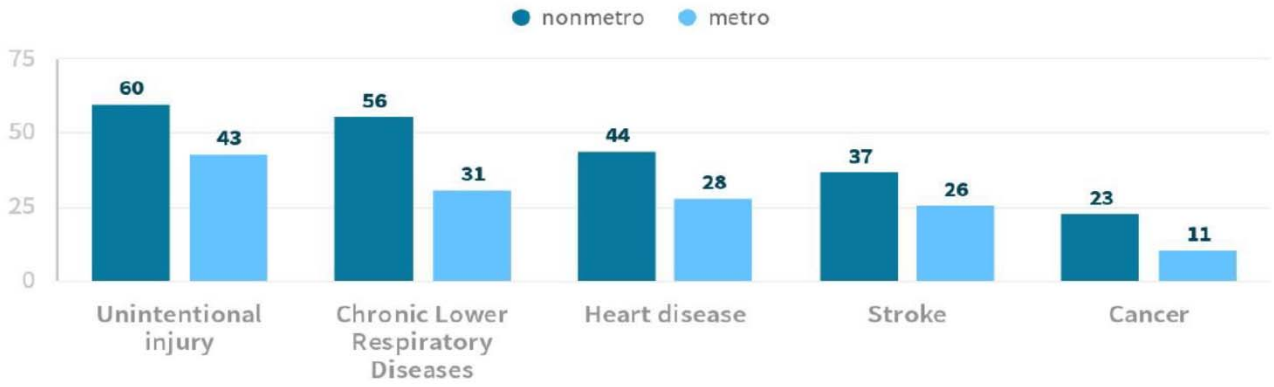
- Rural populations are more likely than urban populations to be:
  - Living in poverty
  - Unhealthy, Older
  - Uninsured or underinsured, Medically underserved
- Add to that social determinants:
  - Transportation issues
  - Housing
  - Income
  - Distance to facilities
  - Disparities w/in rural communities (tribal, racial etc)

Disparities in Rural America



Percentage of deaths that are potentially preventable are higher in rural counties

United States, 2015



Moy E, Garcia MC, Bastian B, et al. Leading Causes of Death in Nonmetropolitan and Metropolitan Areas — United States, 1999–2014. MMWR Surveill Summ 2017;66(No. SS-1):1–8. DOI: http://dx.doi.org/10.15585/mmwr.ss6601a1

Federal Office of Rural Health Policy

State and Hospital Programs

State Offices of Rural Health, Flex and Small Rural Hospital Improvement Programs, Rural QI TA, Small Rural Hospital Transitions

Community Based Programs

Black Lung, Delta, Opioids, Care Coordination, Network Development and Planning, Quality Improvement, Outreach

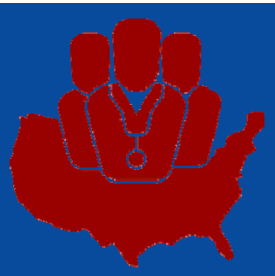
Telehealth Programs

Telehealth Resource Centers, Network Grants, Licensure Portability, Rural Child Poverty, Rural Veterans Health Access

Policy and Research

Rural Health Research Centers, Rural Health Value, Rural Policy Analysis, RHC Policy and Clinical Assessment

HRSA and Rural Health



Nearly 26 million people receive primary medical, dental, or behavioral health care from a health center.

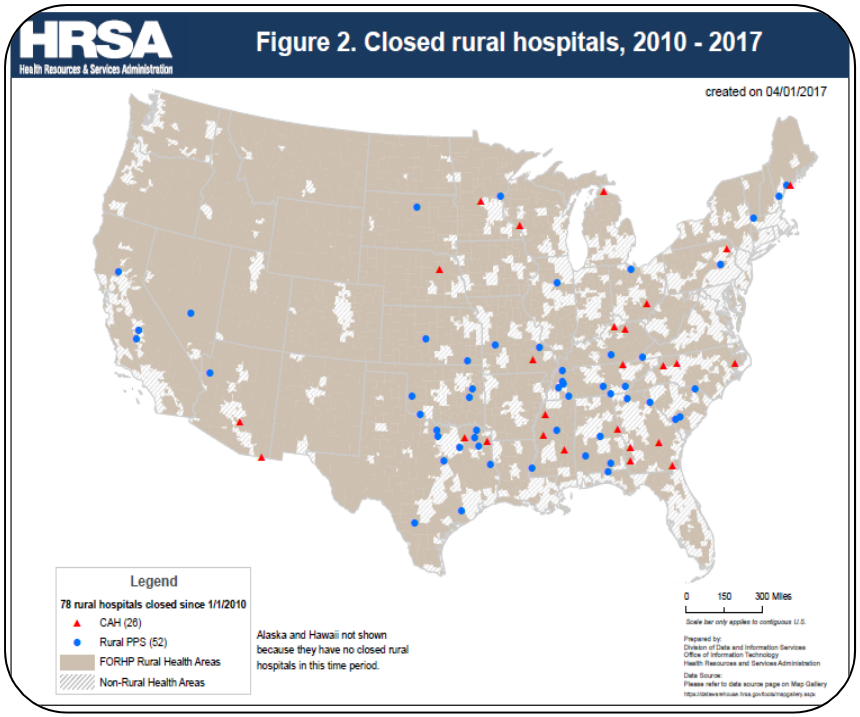
One in 2 people diagnosed with HIV receives care through the Ryan White HIV/AIDS Program.

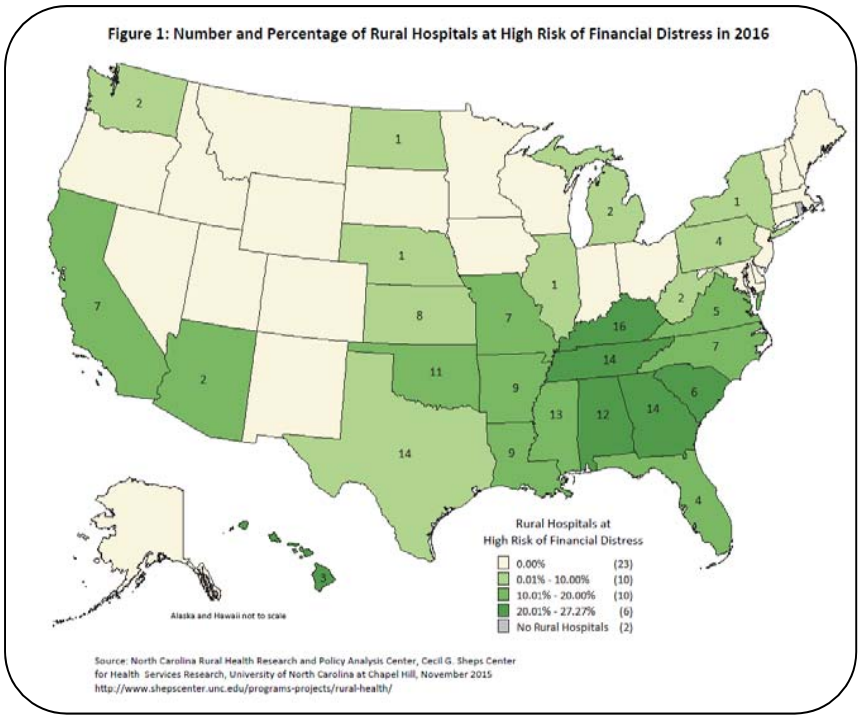
Eleven million people living in health professional shortage areas receive primary medical, dental or mental health care from a National Health Service Corps clinician in the past year.

Over 61 million pregnant women and children in the U.S. are supported by the Maternal and Child Health Block Grant.

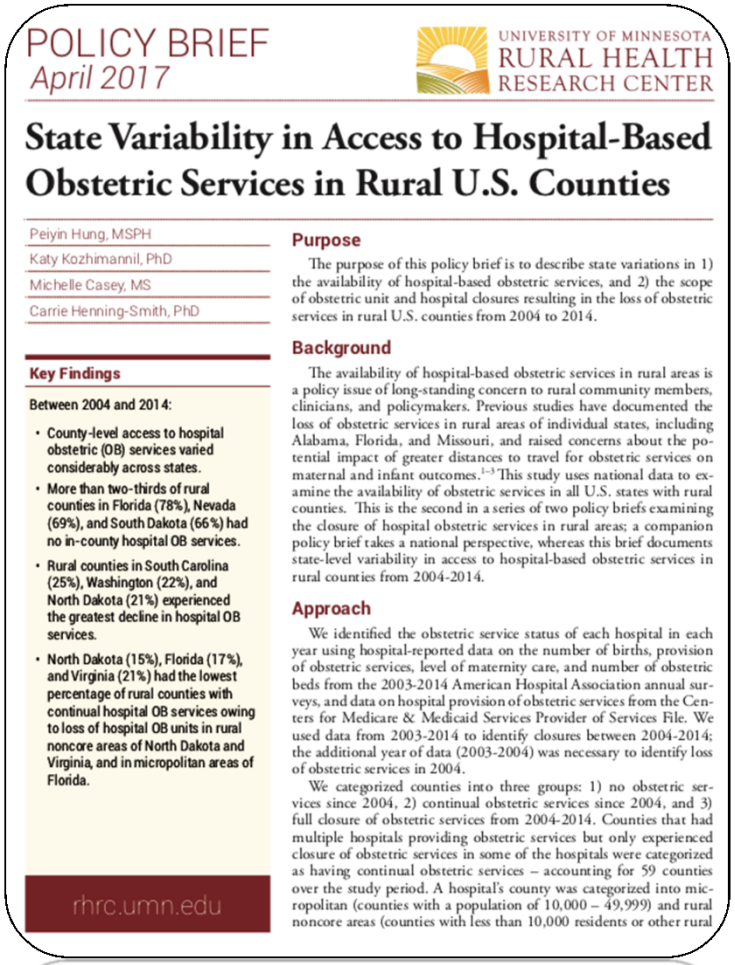
More than **160,000 parents and children** participate in the Federal Home Visiting Program.

Key Challenge: Rural Hospital Viability





Key Challenge: Obstetric Access



POLICY BRIEF
April 2017

UNIVERSITY OF MINNESOTA
RURAL HEALTH
RESEARCH CENTER

State Variability in Access to Hospital-Based Obstetric Services in Rural U.S. Counties

Peiyin Hung, MSPH
Katy Kozhimannil, PhD
Michelle Casey, MS
Carrie Henning-Smith, PhD

Key Findings

Between 2004 and 2014:

- County-level access to hospital obstetric (OB) services varied considerably across states.
- More than two-thirds of rural counties in Florida (78%), Nevada (69%), and South Dakota (66%) had no in-county hospital OB services.
- Rural counties in South Carolina (25%), Washington (22%), and North Dakota (21%) experienced the greatest decline in hospital OB services.
- North Dakota (15%), Florida (17%), and Virginia (21%) had the lowest percentage of rural counties with continual hospital OB services owing to loss of hospital OB units in rural noncore areas of North Dakota and Virginia, and in micropolitan areas of Florida.

rhrc.umn.edu

Purpose

The purpose of this policy brief is to describe state variations in 1) the availability of hospital-based obstetric services, and 2) the scope of obstetric unit and hospital closures resulting in the loss of obstetric services in rural U.S. counties from 2004 to 2014.

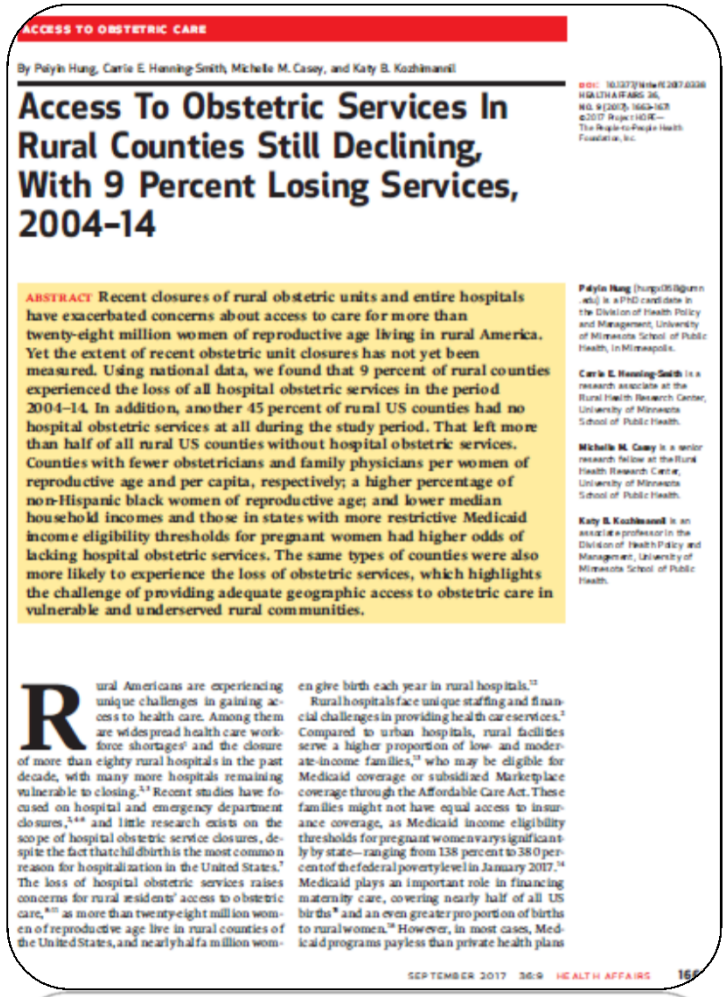
Background

The availability of hospital-based obstetric services in rural areas is a policy issue of long-standing concern to rural community members, clinicians, and policymakers. Previous studies have documented the loss of obstetric services in rural areas of individual states, including Alabama, Florida, and Missouri, and raised concerns about the potential impact of greater distances to travel for obstetric services on maternal and infant outcomes.[1–3] This study uses national data to examine the availability of obstetric services in all U.S. states with rural counties. This is the second in a series of two policy briefs examining the closure of hospital obstetric services in rural areas; a companion policy brief takes a national perspective, whereas this brief documents state-level variability in access to hospital-based obstetric services in rural counties from 2004-2014.

Approach

We identified the obstetric service status of each hospital in each year using hospital-reported data on the number of births, provision of obstetric services, level of maternity care, and number of obstetric beds from the 2003-2014 American Hospital Association annual surveys, and data on hospital provision of obstetric services from the Centers for Medicare & Medicaid Services Provider of Services File. We used data from 2003-2014 to identify closures between 2004-2014; the additional year of data (2003-2004) was necessary to identify loss of obstetric services in 2004.

We categorized counties into three groups: 1) no obstetric services since 2004, 2) continual obstetric services since 2004, and 3) full closure of obstetric services from 2004-2014. Counties that had multiple hospitals providing obstetric services but only experienced closure of obstetric services in some of the hospitals were categorized as having continual obstetric services – accounting for 59 counties over the study period. A hospital's county was categorized into micropolitan (counties with a population of 10,000 – 49,999) and rural noncore areas (counties with less than 10,000 residents or other rural



ACCESS TO OBSTETRIC CARE

By Peiyin Hung, Carrie E. Henning-Smith, Michelle M. Casey, and Katy B. Kozhimannil

Access To Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004–14

ABSTRACT Recent closures of rural obstetric units and entire hospitals have exacerbated concerns about access to care for more than twenty-eight million women of reproductive age living in rural America. Yet the extent of recent obstetric unit closures has not yet been measured. Using national data, we found that 9 percent of rural counties experienced the loss of all hospital obstetric services in the period 2004–14. In addition, another 45 percent of rural US counties had no hospital obstetric services at all during the study period. That left more than half of all rural US counties without hospital obstetric services. Counties with fewer obstetricians and family physicians per women of reproductive age and per capita, respectively; a higher percentage of non-Hispanic black women of reproductive age; and lower median household incomes and those in states with more restrictive Medicaid income eligibility thresholds for pregnant women had higher odds of lacking hospital obstetric services. The same types of counties were also more likely to experience the loss of obstetric services, which highlights the challenge of providing adequate geographic access to obstetric care in vulnerable and underserved rural communities.

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Carrie E. Henning-Smith is a research associate at the Rural Health Research Center, University of Minnesota School of Public Health.

Michelle M. Casey is a senior research fellow at the Rural Health Research Center, University of Minnesota School of Public Health.

Katy B. Kozhimannil is an associate professor in the Division of Health Policy and Management, University of Minnesota School of Public Health.

Rural Americans are experiencing unique challenges in gaining access to health care. Among them are widespread health care workforce shortages[1] and the closure of more than eighty rural hospitals in the past decade, with many more hospitals remaining vulnerable to closing.[2,3] Recent studies have focused on hospital and emergency department closures,[4–6] and little research exists on the scope of hospital obstetric service closures, despite the fact that childbirth is the most common reason for hospitalization in the United States.[7] The loss of hospital obstetric services raises concerns for rural residents' access to obstetric care,[8–10] as more than twenty-eight million women of reproductive age live in rural counties of the United States, and nearly half a million women give birth each year in rural hospitals.[11]

Rural hospitals face unique staffing and financial challenges in providing health care services.[2] Compared to urban hospitals, rural facilities serve a higher proportion of low- and moderate-income families,[12] who may be eligible for Medicaid coverage or subsidized Marketplace coverage through the Affordable Care Act. These families might not have equal access to insurance coverage, as Medicaid income eligibility thresholds for pregnant women vary significantly by state—ranging from 138 percent to 380 percent of the federal poverty level in January 2017.[13] Medicaid plays an important role in financing maternity care, covering nearly half of all US births[8] and an even greater proportion of births to rural women.[10] However, in most cases, Medicaid programs pay less than private health plans

Key Challenge: Workforce

Physicians	• MDs/DOs 5.5/10K non metro vs. 7.9/10K in metro
All Primary Care	• MD/DO/NP/PA 11.6/10K in non metro vs. 16.2/10K in metro
Dentists	• 3.6/10K non metro vs. 5.9/10K in metro
Dental Hygienists	• 4.5/10K in non metro vs. 5.0/10K in metro

http://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/09/RHRC_DB160_Larson.pdf

Key Challenge: Behavioral Health

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

	Counties without Psychiatrists (Percent)	Counties without Psychologists (Percent)	Counties without Social Workers (Percent)	Counties without Psychiatric Nurse Practitioners (Percent)	Counties without Counselors (Percent)	Total Counties without Behavioral Health Providers (Percent)
U.S (3135 counties)	1,606 (51%)	1,153 (37%)	641 (20%)	2,092 (67%)	430 (14%)	284 (9%)
Metropolitan (1164 counties)	315 (27%)	218 (19%)	102 (9%)	491 (42%)	67 (6%)	32 (3%)
Non-Metro (1971 counties)	1,291 (65%)	935 (47%)	539 (27%)	1,601 (81%)	363 (18%)	252 (13%)
Micropolitan (640 counties)	222 (35%)	124 (19%)	68 (11%)	387 (60%)	38 (6%)	31 (5%)
Non-core (1331 counties)	1,069 (80%)	811 (61%)	471 (35%)	1,214 (91%)	325 (24%)	221 (17%)

Data Sources: National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) data, October 2015, the U.S. Department of Agriculture Economic Research Service (ERS) Urban Influence Codes, 2013.

Source: WWAMI Rural Health Resource Center

Rural America and the Opioid Epidemic

Though opioid abuse and opioid-related death has been on the rise nationally, rural communities face unique challenges

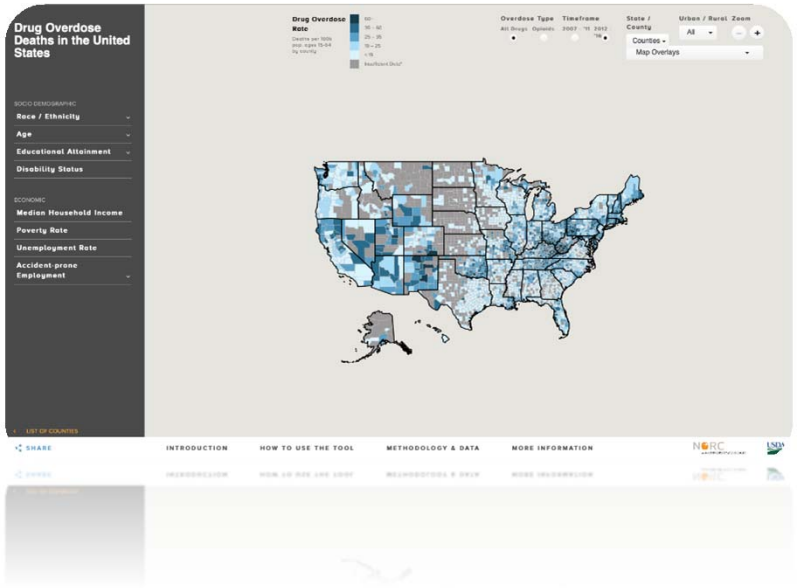
Rural Dimensions of the Opioid Crisis

- Opioid-related overdose deaths in rural areas increased more than 10% from 2015 to 2016
- Rural residents are most likely to be prescribed, and overdose on, prescription painkillers
- Rural residents with opioid use disorder tend to be younger, less wealthy and educated, un or uninsured
- More than 60% of rural counties lack a single physician that can prescribe buprenorphine, < 10% of opioid treatment programs in rural

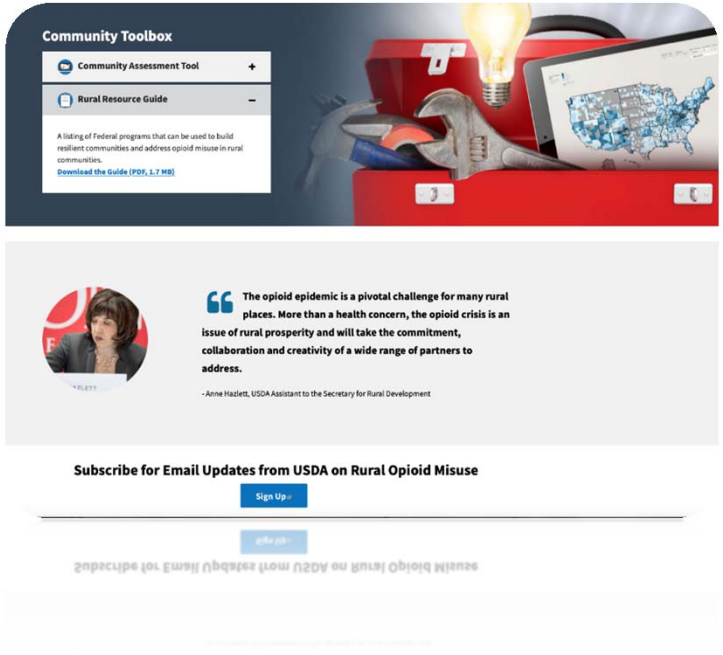
The Rural Community Opioids Response

- 2018 President's Budget and the 2018 Final Budget included a targeted focus for HRSA to address rural opioid crisis challenges
- Targeted key HRSA populations
  - Rural Underserved; People with HIV, pregnant women
- Multi-Pronged Approach
  - Prevention
  - Treatment
  - Recovery
  - Capacity Building
  - Workforce

USDA: A Key Rural Partner for Rural Opioid Challenges



NORC tool link: https://opioidmisusetool.norc.org/



USDA: https://www.usda.gov/topics/opioids

Resources

RHIhub
Rural Health Information Hub

www.ruralhealthinfo.org

Telehealth
Resource Centers

www.telehealthresourcecenter.org


National Advisory Committee on Rural Health and Human Services

Rural Health Insurance Market Challenges

Policy Brief and Recommendations

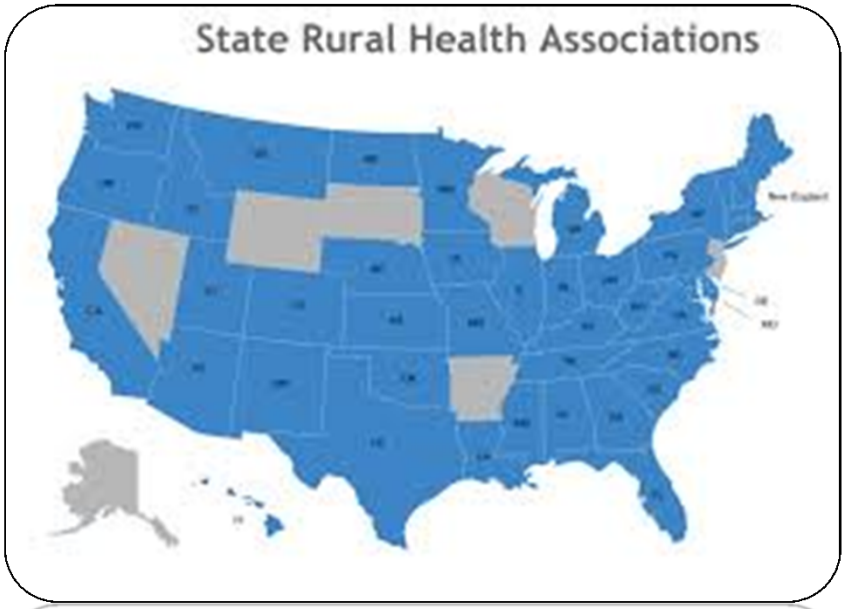
www.hrsa.gov/advisory-committees/rural-health/index.html

Rural Health
Research Gateway

www.ruralhealthresearch.org

Potential Rural Partners

- State Offices of Rural Health
- State Rural Health Associations



NOSORH
National Organization of

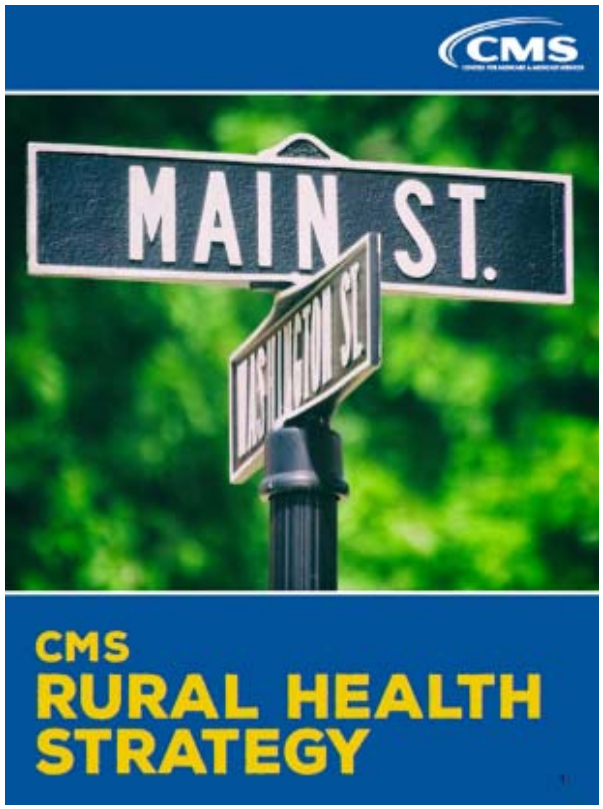
www.nosorh.org

www.ruralhealthweb.org/programs/state-rural-health-associations

CMS Rural Health Strategy

May 2018 - CMS launches Agency's first rural health strategy to improve access and quality of care for rural Americans.

go.cms.gov/ruralhealth

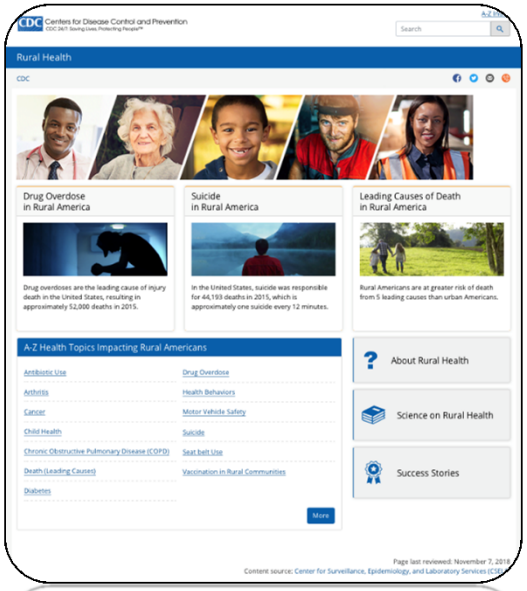


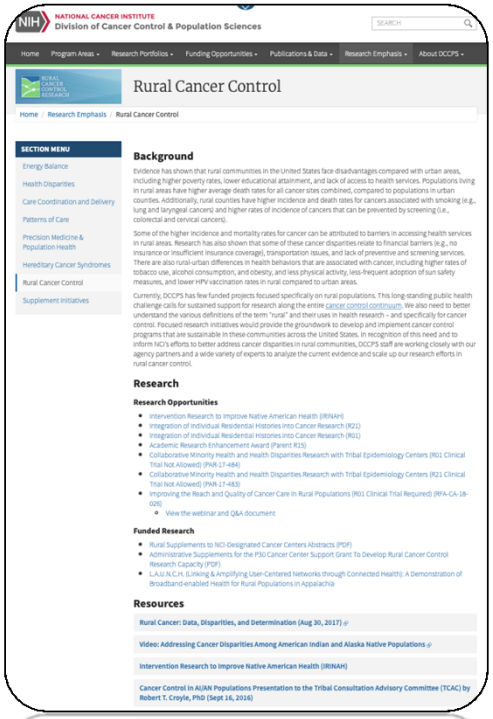
CMS Rural Health Strategy Objectives

1. Apply a rural lens to CMS programs and policies
2. Improve access to care through provider engagement and support
3. Advance telehealth and telemedicine
4. Empower patients in rural communities to make decisions about their health care
5. Leverage partnerships to achieve the goals of the CMS Rural Health Strategy

Other Federal Partners

- Centers for Disease Control and Prevention
  - https://www.cdc.gov/ruralhealth/index.html
  - https://www.cdc.gov/nchs/data-visualization/potentially-excess-deaths/





- National Cancer Institute
  - Rural Cancer Control Initiative
  - https://cancercontrol.cancer.gov/research-emphasis/rural.html
- HRSA Programs

Thank you

Tom Morris

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www.hrsa.gov/rural-health/index.html