BMJ

BMJ 2013;347:f5093 doi: 10.1136/bmj.f5093 (Published 27 August 2013)

FEATURE

RURAL HEALTHCARE

What healthcare reform means for rural America

The implications of the Affordable Care Act are very different beyond the cities, where much of it was devised. **Bob Roehr** investigates

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All healthcare is local, to adapt a phrase made famous by the late speaker of the House of Representatives, Tip O'Neill. The local character of healthcare has become even more apparent under reforms prompted by the Affordable Care Act (ACA), particularly in rural America, where political and ideological perspectives are often not sympathetic to an expanded role for government, as envisioned in that legislation.

The problems of rural healthcare are not just a scaled down version of those seen in urban and suburban areas, says Tom Morris, associate administrator for rural health policy at the US Department of Health and Human Services. In rural areas, people are more likely to be on a low income and uninsured; they are also less likely to have employer sponsored insurance coverage.

These people also tend to be older, sicker, and have less access to specialized care. They are more dependent on federal programs and would be even more dependent if they knew they were eligible for those programs and enrolled in them.

Providers in rural areas also tend to operate on smaller profit margins, largely because of the types of services they provide—basic healthcare rather than more profitable specialized care. Patient density is insufficient to support expensive technologies and specialized skills. Healthcare reform will have to be tailored to local conditions in rural areas.

The political framework

The political environment poses challenges to expanding healthcare coverage in rural areas. This is partly because of the stigma that some attach to such programs. The belief is that they are "a handout . . . making people dependent," says Art Kaufman, vice chancellor for community health at the University of New Mexico.

In his state, "30% of the population who is uninsured, doesn't know about the availability" of Medicaid or that they would probably qualify for help in obtaining health insurance under planned reform, he said.

The 50 counties with the highest rates of uninsured people (27-38.1%) are mainly rural, according to a new analysis by the Center for American Progress,[1] a liberal think tank with strong ties to the Obama administration. Texas and Florida are epicenters of being uninsured—31 and nine counties, respectively, are among those with the worst coverage. They include both rural areas and large population centers around Houston, Dallas, and south Florida.

Many of the elected representatives from these counties actively oppose Obamacare in Washington and are trying to repeal it. Often their state counterparts have chosen not to create state health insurance exchanges as envisioned by that legislation. They are leaving it up to the feds, but federal efforts are lagging and many question how well equipped national officials are to understand and meet local needs.

Polling data show support for many of the concepts underlying health reform, but also that the country is evenly split over the packaging of those elements as Obamacare. Lisa Miller, a health advocate and former member of the Maine House of Representatives, says, "The more we can start calling these products something else besides Obamacare, the ACA or whatever, the better off we are going to be."

There are about 4000 rural public health clinics certified by Medicare across the country. Clinics that cater to the needs of underserved rural and urban populations received a substantial increase in funding over the past decade. This increase, along with the creation of the Medicare Part D prescription drug benefit, were the two major domestic health initiatives of the George W Bush administration.

Some rural hospitals depend on public payers for 70-80% of their revenue, says Morris. "That means any change in policy in Medicare and Medicaid tends to have a disproportionate impact on rural providers." And the impact has a ripple effect because the hospital is often the largest employer in a rural community.

Policy makers have to think about the diversity of infrastructure and delivery system that is out there. For Morris, "Just because it worked in urban and suburban areas doesn't mean it can be downsized and work just as well in rural areas."

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Training and support

Physicians and healthcare workers are usually trained at academic health centers and hospitals in larger cities. Only a small part of that training occurs at ambulatory care and outpatient facilities, the settings where most care is delivered. Training at rural clinics is virtually non-existent. Physicians tend to remain close to where they train, so the shortage of healthcare workers in rural areas is not surprising.

Kaufman faults the emphasis on hospital training because hospitals provide just "15% of what makes communities healthy, which is why it [focusing training largely in this setting] has such little impact."

But rural providers must shoulder part of the blame as well, adds Miller. "Rural clinicians have got to bite the bullet and decide that teaching and training is a part of their responsibility."

The Department of Health and Human Services is supporting 23 rural healthcare training programs for physicians. "About 70% of the graduates of those residency programs stay in rural areas," said Morris. It hopes to expand the program to five more institutions in each of the next two years.

It is also trying to reduce regulatory burdens, including scope of practice restrictions, so that "nurse practitioners and physician assistants could do more in the settings they are in."

Nebraska has created a pipeline program that introduces rural primary school students to biological sciences, gives them priority admission to college and medical school, provides rural medicine training tracks and residencies, and subsidizes loan repayment for those who choose to practice in underserved rural areas. The decade long process is starting to produce results.

Kaufman also faults training programs for not embracing a broad team approach to healthcare and for taking a limited view of what contributes to health. "Social determinates—adequate housing, access to food, stress, social exclusion educational attainment, transportation—all have a huge impact on health," he said.

New Mexico

The cooperative agricultural extension program has served as a model for revamping healthcare education, training, and services in New Mexico. The programs embrace larger concepts of economic development, youth education, and community building as crucial to their core missions.

The primary role of health extension coordinators in New Mexico "is to link the community's health priorities with the [university's] health sciences center resources," Kaufman explains. "It moves the locus of control out of the health science center towards the community. It has been very successful."

One major concern is stigma associated with behavioral health problems. Patients in small towns are often hesitant to park near the provider's office because this can compromise privacy and lead to gossip. New Mexico has expanded basic behavioral health training to a greater number of medical and non-medical peer groups that regularly interact with patients.

It has also created "health hubs" that link providers with local hospitals, community groups, and education facilities to help alleviate providers' sense of isolation. Kaufman said these ties help to recruit and retain providers in rural areas.

Dental health ranks high among community concerns, partly because many insurance programs provide little or no dental coverage. In Maine, "The number one visit to ERs [emergency rooms], particularly among Medicaid [enrollees] was dental and oral health issues." Miller asked rhetorically, "How are you going to impact the ER visits" if insurance does not cover those health problems? "There is a lot of interplay between oral health, and primary care, in the ER. Right now the ACA is not addressing that."

Maine

Maine is the third most rural state and it has the highest median age in the nation, yet it recently ranked as the ninth healthiest state.[2] Miller attributes much of this success to policies that have supported broad access to primary care providers (1.5/1000 population *v* 1.2/1000 nationally) and high rates of enrollment in insurance plans, particularly Medicare and Medicaid.

However, Medicaid coverage has been rolled back since its peak in 2010, a decision made by conservative elected state officials. She said, "We will not be a Medicaid expansion state" under the ACA.

Maine is supporting a doubling of capacity for its osteopathic medical school, which emphasizes primary care, and a quarter of the state's rural primary care physicians have graduated there. It is also supporting the creation of the first allopathic medical school in the state.

Miller said that training programs for nurses and physician assistants are having trouble hiring faculty to expand those programs. Graduates are tending to settle in larger communities rather than serve more isolated areas.

Access to technology, including electronic health records, has become less of a barrier for rural providers as technology has become cheaper and easier to use.

Rural health has often led the way in areas such as telemedicine. A recent study from the University of California Davis Health System found a significant improvement in emergency department pediatric care when a video link consult was used, compared with a telephone consult or no consult.[3]

Incentives will probably be needed for small practices to invest in technology, training, and the transition of integrating tools such as electronic health records into their operations. Much of that adoption today is being driven by hospital purchase of small practices.

Hospitals have bought up about three quarters of the private practices in Maine. "The thing that I worry about is that rural health centers are not being bought up. And their salaries are much lower than the hospital based clinicians." Miller fears this will drain healthcare workers away from rural areas.

Payment reform

Miller sees payment reform—"tectonic change in reimbursement, mostly between primary care and specialty practice"—as "the ultimate access tool" for rural healthcare.

Kaufman notes that hospitals make money by filling beds through the ER; under current reimbursement methods they have little incentive to cut down on those ER visits. So he is not surprised that "some of our strongest partners, doing the most innovative work for prevention, are the managed care organizations, who save money by decreasing ER visits."

Keith Mueller concurs. The head of health management and policy at the University of Iowa College of Public Health says payment reform is crucial, "It needs to occur almost everywhere . . . but it may not always be the ACO [Accountable Care Organization] model." Key themes in reform are trying to "set up a payment system that rewards high value and moves providers to even higher levels of value." Any net savings in

the total cost of care would be shared between insurers and providers.

Competing interests: None declared.

Much of the substance of this article came from a forum sponsored by the Alliance for Health Reform: Rural Reality: More Coverage, Enough Care? A webcast and background materials can be accessed at: www.allhealth.org/briefing_detail.asp?bi=296.

1 Chu A, Posner C. The counties that need the Affordable Care Act the most. Center for American Progress, 2013. www.americanprogressaction.org/wp-content/uploads/2013/07/UninsuredCountriesACA-4.pdf.
2 United Health Foundation. America's health rankings. 2012. www.americashealthrankings.org/Rankings.
3 Dharmar M, Romano PS, Kuppermann N, Nesbitt TS, Cole SL, Andrada ER, et al. Impact of critical care telemedicine consultations on children in rural emergency departments. *Crit Care Med* 2013; published online 7 Aug.

Cite this as: *BMJ* 2013;347:f5093