Rural Health: Access to Care and Services

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Abstract

Lack of access to quality health care has been a long-standing risk for rural Americans. Multiple factors are emerging that may increase this risk in the future. The National Association for Home Care continuously keeps rural access on the radar and supports legislation that will preserve home care access to vulnerable rural areas. Of special interest are the rural elderly. Rural residents older than the age of 65 years represent a large portion of the nation's home care recipients. Although people older than 65 years are living longer, healthier lives, they frequently require quality health care to make that possible. This population is also more likely to have complex medical issues requiring health care interventions. A review of current literature shows that there are many emerging trends posing a significant risk to the future of home care in rural America. This article discusses resources as well as initiatives undertaken to identify successful rural care delivery models.

Keywords

rural, access, disparities, models, resources, hospice, home care

Literature Review

A review of current literature substantiates the increasing vulnerability of rural home care in our current economy. Although many of the problems are not new, soaring expenses and tighter reimbursement threaten to further jeopardize access to home care in our high-risk rural areas.

Access to rural home care services presents a health care vulnerability that is well-documented. In a national survey of health care leaders and stakeholders in rural areas, access to quality health services was identified as the top ranking rural health priority (Hutchison, Hawes, & Williams, 2005). With the recent downturn in our economy, populations in rural areas may be at even greater risk for less than adequate access to home care services.

Rural Disparities in Health

The U.S. Census Bureau reports that 22% of our nation's elderly reside in rural areas (Hutchison et al., 2005). Studies show that the rural elderly are more likely than the urban elderly to have multiple chronic conditions, engage in less preventative medical treatment, and have an increased likelihood of being institutionalized due to an inability to care for themselves at home (Hutchison et al., 2005). Rural residents also are more likely to be considered low income. Maintaining independence in rural areas is often more difficult because of lack of services and support. Home care services have proven to be valuable in encouraging independence and self-management, fostering an environment in which people can avoid the expense and discomfort of institutionalization but are less available for rural elderly than for their urban counterparts (McAuley, Spector, & Van Nostrand, 2009; Rashba & Pavelock, 2006). This is especially important for rural Americans who tend to equate self-reliance and autonomy with quality of life.

Governmental Resource: The Office of Rural Health Policy

The U.S. Department of Health and Human Services has many divisions, subdivisions, and branches. The Office of Rural Health Policy (ORHP) was established in 1987 as part of the initiative to improve the health care to and of individuals living in rural locations. Its emphasis was on access in particular to rural hospitals and to rural health care (Health Resources and Services Administration, n.d.).

The ORHP is housed within the Health Resources and Services Administration of the Department of Health and Human Services. One of its key functions is communication and information sharing. The ORHP is expected to reach out to and collaborate with Federal, state, and local governments, the Tribal Nations and private organizations that include including associations, foundations, providers, and community

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leaders. The overriding goal of the ORHP is to increase access and improve quality of rural health care, which is supported by its major program thrusts, that is, maintaining a national information clearinghouse, coordinating activities related to rural health care, and providing rural-specific grant programs. Its outreach includes its 21 member National Advisory Committee on Rural Health and Human Services (NACRHHS). The NACRHHS was revamped in 2003 and since the revamping, committee members have expanded their work and activities to include field site visits, where committee members learn about the site through presentations by staff onsite. These become part of the committee's annual report and have included key rural health concerns, such as access to mental health, oral health, program development, health care financing, and workforce development.

The 2009 *Annual Report* by the NACRHHS focused on three key rural health care areas, these were its ongoing focus on workforce and community development, creating viable patient-centered medical homes, and serving at-risk children. Site visits were conducted that were relevant to each of these three areas, for the purpose of information gathering and identification of concerns, such as funding, access, and existing programs that might be simulated for a broadened impact in these areas (ORHP, n.d.).

One example, Program for All-Inclusive Care of Elders (PACE), is modeled after a San Francisco service care delivery model for elderly/seniors within the Chinatown community. The initial project began more than 20 years before the model was given a permanent provider status with The Centers for Medicare and Medicaid Services. The Balanced Budget Act of 1997 provided an impetus for the expansion of PACE models. There have been several "demonstration project" initiatives. The PACE is an example of a viable long-term care model of a medical home for those older than the age of 55 years. PACE organizations serve nursing home-eligible patients with the idea of keeping them in a home-based setting (Gingerich, 2003, p. 1).

Rural Elderly Disparities

The term *elderly* historically refers to people older than the age of 65 years. The portrait of people of this age group is changing rapidly. As the population of older Americans grows, so does the diversity in their lifestyles and traits. With increasing frequency, older people are enjoying very active lifestyles. They are also more educated and informed, making them savvy health care consumers. This trend is creating a demand for health care to maintain optimal physical function in the presence of age related changes. People older than 65 years are increasingly likely to have several chronic illnesses and diseases with atypical presentations (American Geriatrics Society, n.d.). This results in a challenging consumer expectation for health care management that will promote independence and high levels of physical functioning. Nursing home utilization for people older than 65 remains at 5%; however, the age and severity of illness of people living in nursing homes is on the rise (American Geriatrics Society, n.d.).

We can expect the rural elderly to follow nationwide trends with some cultural differences. The rural elderly tend to value self-reliance even more than their metropolitan counterparts. The lifestyles that they enjoy often require them to maintain a higher level of physical fitness. Whereas yard work, chopping wood, caring for animals, and shoveling snow are things that older city dwellers may easily give up, rural residents are more likely to consider the ability to accomplish these tasks a vital part of their lifestyle and self-worth. In terms of health care, the rural elderly are often so self-reliant that they avoid visits to the doctor and try to take care of their health themselves.

Rural Disparities in Access to Home Care

The home care industry is changing. More small, rural agencies are finding it impossible to remain financially viable in the home care regulatory environment. This is resulting in the sale or divesture of community-based agencies to larger home care corporations that may not feel the same "home town" obligation to provide rural care. Rural areas are most likely to be served by small, hospital-based, nonprofit home care agencies (Hutchison et al., 2005). These agencies have much lower operating margins than urban agencies (Medicare Payment Advisory Commission, 2008). Because the census is smaller in rural agencies than is typical in urban agencies, there is an added barrier to rural agencies to cover regulatory and operational overhead expenses. These agencies are challenged to manage expenses and while maintaining service provision to patients in outlying areas. Often they are the only home care agency providing services to large geographical area, which increases travel and other operational expenses and decreases staff productivity. Hospital-based status is also a detriment to rural home care agencies as hospital-based home care agencies report significantly higher costs and lower operating margins than their free-standing counterparts (Medicare Payment Advisory Commission, 2008). This is often due to allocation of hospital overhead to the home care agency. Hospital-based agencies are further challenged because the hospital's operational and accounting practices do not support or accurately report the home care business model. These agencies are also rather obligated, by virtue of hospital ownership, to accept all referrals. Studies show that nonprofit agencies consistently have lower operating margins than for-profit agencies. Need citations for this.

Rural Disparities in Access to Hospice

Home-based hospice agencies face very similar challenges in providing services to rural residents. Vernig, Ma, Hartman,

Moscovice, and Carlin (2006) report that 332,000 elders nationwide live in rural areas in which hospice care is not provided and that 7% of all U.S. zip codes do not have hospice services available. This equates to 15,000 rural residents dying each year without access to hospice care (Vernig et al., 2006). The lack of hospice care results in inpatient stays or unsupported deaths at home. The U.S. General Accounting Office (2006) reports that, much like home health agencies, "small hospices face the paradoxical combination of higher costs and lower payments" (p. 1298).

Economy

Rising expenses and reimbursement cuts are prompting rural home care agencies to take action to remain in business. Decreasing Medicare reimbursement and increasing regulatory requirements have a significant impact on rural home care agencies that already struggle with lower profit margins. At the time the Perspective Payment System was implemented in 2000, rural home care agencies enjoyed a 10% rural add-on to Medicare payments. This add-on dropped to 5% in 2004 and was eliminated after 2006. The National Association for Home Care maintains a robust campaign in support of restoring reimbursement that will ensure rural access to home care. Because of this, many rural home care agencies are finding that they simply cannot afford to provide services to outlying areas. The expense associated with covering large service areas with limited staff can be daunting. The rising cost of mileage and travel time is glaring, but the loss of productivity while staff members are traveling further compounds the expense. The current economic environment promotes shrinking service areas and an increasing numbers of rural individuals without access to the home care services they need to remain independent.

Staff Recruitment and Retention

Another challenge for rural home care agencies is obtaining adequate staffing to provide services. When staff members are not available, the result is often unnecessary and expensive inpatient stays or delays in service. Lower operating margins inhibit rural home care agencies from competing with the wages and benefits of other health care organizations in the area (National Association of Home Care & Hospice, n.d.). This staffing affects nursing, home health aide, and therapy staff. A lack of therapy staff compounds the problem by limiting access to reimbursement for therapy services under the current Medicare payment structure.

Service Delivery Opportunities

Be it hospital based or free standing, there are many issues that affect provision of home health services to rural populations. There are several creative service delivery opportunities that may improve access to rural areas. Health care clinics on wheels can provide screening and preventative health care services to rural residents efficiently, eliminating the expense and inconvenience of travel by residents as well as health care professionals. Tele-health home monitoring systems can significantly decrease the costs associated with providing home care services in rural areas and have been proven to improve patient outcomes. The tele-health model of care allows the patient to be monitored at home via phone lines or internet. This may decrease the expense of travel and personnel for the home care agency and improve access for rural residents. Although tele-health does not eliminate the need for home visits, it can decrease the frequency and duration of service and improve the patient's involvement in their plan of care. The expense of tele-health systems has been a challenge that is improving. Grant funding opportunities are available and standardized reimbursement is expected in the near future. As an added bonus, the autonomy associated with home monitoring may also be very appealing to country dwellers.

In Search of Models That Work

The National Rural Health Association has made one of its initiatives the identification and information sharing regarding rural health programs and projects that have worked to improve care to specific rural populations. This program, Models That Work, has developed specific criteria for consideration as a Model That Works. There are three criteria/elements that must be present for consideration, these are

1. Collaboration among rural providers such as public health, long-term care (at least two or more) in a rural community or region that includes at least one rural organization not in direct health care delivery (e.g., but not limited to schools, local government, faith organizations, business, social services).
2. Project activities and goals are focused on identified specific local needs, interests, and priorities that have been gathered through discussion with community members.
3. Projects purpose it to focus on the improvement of the health of the service area, with the activities focused on moving the health care system toward care that is safe, effective, efficient, patient/community-centered, timely, and equitable for individuals as well as the entire service area populations (NRHA, n.d.).

Included among the previously identified models that work are several Native American health delivery systems, such as Alaskan Tribal Health and the Hopi Regional Health. Other models that work have been identified through out the United States, in states as far north as Maine and as far south

as Texas. These initiatives assist health care providers in obtaining a better understanding of the diversity and wide ranging rural health disparities present in every corner of the United States and among all cultures.

Another far-reaching initiative that focuses on practice models is Rural Healthy People 2010—Models for Practice, is an effort that is housed at Texas A&M University, in the School of Rural Public Health's Southwest Rural Health Research Center in College Station, Texas. This specific project's research provides an overview of the 2010 Rural Healthy People initiatives as well as information on the top rural health concerns. Information gathered and shared by this research center includes specifics on successful practice models and a review of the literature that relates to rural health disparities and practice models (Rural Healthy People, n.d.).

The online database created and maintained by this Web site, allows providers to identify all practice models within their own state or region or the search can center on key rural priority areas, such as access, diagnosis, behavior, or other priority designations.

The Big Picture

Home care is cost effective and has proven patient outcomes that promote health, wellness, and independence. Improvements in health care reimbursement have yet to address the need to provide incentives for patients and health care providers to choose the most cost-effective level of care. If the health care system actually managed expenses across the continuum of care, home care would quickly be recognized as a core health care service, vital to preventing the expense of hospitalization, and institutionalization. The expense of providing home care services to vulnerable adults in high risk, low volume areas should be easy to justify when compared with the cost of hospitalization or inpatient skilled nursing care.

Current emphasis on improving the cost-effectiveness of our health care system with more responsible health care structure should reveal, home care as a vital, cost-effective component of the continuum of health care. Lack of access to home care in rural America will only serve to increase health care expenses and diminish quality of life and patient outcomes. Many professional organizations in the home care industry and in rural health continue to work diligently in supporting legislation that will assure adequate resources and access to home care for all rural residents.

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Bios

Julie A. Nelson, RN, BSN, MBA/HCM, CHCE, is nationally certified as a Home Care Executive. She has 11 years of experience in home care administration and 22 years of experience in health care. She completed her MBA in health care management through the University of Phoenix. She currently teaches for Axia of University of Phoenix Online. Julie also serves on the editorial board for *Home Health Care Management & Practice* and writes a regular column on technology in home care.

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