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Health Disparities Present New Challenges for Rural Hospitals in Aftermath of the Pandemic

By **Michael Topchik,** National Leader, *Chartis Center for Rural Health*

Even though the immediacy of the pandemic is receding, rural communities remain quite vulnerable. Four years ago, when our research team looked at health disparities and socioeconomic factors, the data revealed sizable differences between rural and urban communities. Rural communities at the time were older, less healthy, less affluent, and faced limited access to care. This reality was central to understanding the dynamics behind the erosion of the rural health safety net over of the course of the last 11 years.

Today, our analysis suggests that the socioeconomic disadvantages and health disparity gaps may be widening. What's particularly troubling is the variation we have uncovered within rural communities themselves. That is, rural communities with the most pronounced health disparities are also likely located in an area where the local rural hospital is in danger of closing. These communities are where we believe the rural health safety net is its weakest and residents are at greatest risk. Board members must recognize that the COVID-19 pandemic has not wiped away any of the factors that have been applying downward pressure on rural hospitals. In fact, the prolonged presence of the virus within rural communities due to vaccine hesitancy and resistance will likely exacerbate many of the factors that fueled the closure and rural hospital vulnerability crises (e.g., uncompensated care, recruitment, and retention). For rural hospital leadership teams and their boards, this is the start of a tricky "new normal," in which treating COVID patients alongside providing care for non-COVID patients becomes part of everyday hospital operations. In this new normal, health disparities and socioeconomic indicators take on new importance and better our understanding of the communities that rural hospitals serve.

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Disparity Gaps Emerge within Already Vulnerable Rural Communities

Since 2010, 138 rural hospitals have closed,[1] and another 453 are vulnerable to closure, according to our analysis. Even in places where hospitals remain open, we have found that services are rapidly disappearing. For example, more than 160 rural communities have lost access to obstetrics and 252 rural hospitals that offered chemotherapy in 2014 no longer offered the service by 2018.[2] Boards and senior leaders should consider some other emerging trends showing widening health disparities within rural communities.[3]

Rural communities continue to be older and less healthy, and struggle with access to primary care and mental health services. When compared to their urban counterparts, variation between rural and urban hospital service areas for metrics such as over 65, diabetes, access to primary care, and access to mental health services has remained statistically consistent since 2017, though some of the metric medians have worsened. The most worrisome revelation, however, is what we found relative to rural communities where the local hospital is vulnerable to closure (e.g., vulnerable hospital communities).

➜ Key Board Takeaways

- Utilize population health and health disparity data to define and assess local health dynamics.
- Consider how COVID-19 vaccine hesitancy/resistance may overlap with local prevalence for certain chronic health conditions.
- Investigate if people are seeking care elsewhere and for which services.
- Turn patient outmigration into opportunities to expand existing services or introduce new services.

1 The Cecil G. Sheps Center for Health Services Research, University of North Carolina, July 2021.
2 Michael Topchik et al., *Crises Collide: The COVID-19 Pandemic and the Stability of the Rural Health Safety Net*, The Chartis Group, 2021.
3 This section provides data from our newly published study: Michael Topchik et al., *Rural Communities at Risk: Widening Health Disparities Present New Challenges in Aftermath of Pandemic*, The Chartis Group, 2021.

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People served by a rural hospital vulnerable to closure struggle with access to care at a rate nearly three times that of their urban counterparts. Across several metrics, there are statistically significant gaps between communities with vulnerable hospitals and communities in which the rural hospital is not considered vulnerable. Urban communities have a much higher rate of primary care physicians to the population. Access to primary care is at the 63rd percentile for urban communities, compared to the rural community's median down at 33rd percentile. Within vulnerable hospital communities, however, that median drops lower still: to the 23rd percentile.

Insurance coverage rates are markedly lower in vulnerable hospital communities. In urban communities, the percentage of adults and children uninsured is at the 48th percentile and 40th percentile, respectively. In rural communities, these median percentiles rise to 53rd and 60th. But in vulnerable hospital communities, we found a higher percentage of adults and children without health insurance. For uninsured adults, the metric rose to the 73rd percentile, and to the 69th percentile for children.

In vulnerable hospital communities, the rate of premature death among adults is nearly 20 percentage points higher. When we looked at premature death among adults, we found that in urban settings the percentage of adults that die prematurely is ranked at the 40th percentile, whereas in rural communities the median percentile increases to the 61st percentile. In vulnerable hospital communities, however, the percentage of adults that die prematurely is ranked at the 77th percentile at the median.

While that is a lot of percentile rankings, the metrics—and this analysis—paint a very clear picture: People who reside in rural communities are vulnerable, and those who live in "vulnerable hospital communities" are at even greater risk due to 1) lower rates of insurance coverage, 2) less access to primary care and mental health services, and 3) higher rates of premature death.

Metric Snapshot: Percentage of Uninsured Adults

Since the implementation of the Affordable Care Act, it is estimated that more than 20 million Americans have gained health insurance.[4] Yet nearly 30 million non-elderly

4 Nicole Rapfogel, Emily Gee, and Maura Calsyn, "10 Ways the ACA has Improved Health Care in the Past Decade," Center for American Progress, March 23, 2020.

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individuals remain uninsured.[5] For rural hospitals, lack of insurance coverage represents a financial pitfall as Medicare only reimburses providers for 65 percent of unpaid out-of-pocket costs.

Where do we see the largest gaps in insurance coverage? Our research reveals that the percentage of adults under the age of 65 *lacking* health insurance is greatest in states such as Texas, Oklahoma, Mississippi, Florida, Georgia, South Carolina, and North Carolina. Of this group, Oklahoma is the only state that has adopted (though not yet implemented) Medicaid expansion, and that was in June 2020 via a voter approved ballot initiative. In Texas, which is the state with the most rural hospital closures and the most vulnerable hospitals, the percentage of uninsured adults is *greater than* 25 percent. While the specter of losing significant revenue to charity care looms large in Texas (and these other six states), this is an issue in every state, for every rural hospital and its leadership and board.

Health Disparities Can Inform the Strategic Planning Process

In the aftermath of the pandemic—even if the rural hospital you oversee is not vulnerable to closure—the board and senior leadership may need to reimagine strategies for addressing the rural hospital crisis and the widespread vulnerability of the communities they serve. Central to those ideas and plans will be a keen understanding of the underlying dynamics on the ground. This includes asking questions such as:

- What types of chronic conditions are prevalent in our community?
- How easily accessible is care?
- Are there barriers to care within our community for people of color?

A decade ago, it's not too likely that questions like these would be at the forefront of board conversations. The fact that they are today isn't just attributable to the breadth of the rural healthcare crisis but also to the power of data to bring greater clarity and better inform the strategic decision-making process. Across rural healthcare, we have moved beyond anecdotes and gut feelings when it comes to understanding market and patient trends. And now more than ever, rural hospital board members need to be able to ask more nuanced questions, push for data that either supports or

5 Jennifer Tolbert, Kendal Orgera, and Anthony Damico, "Key Facts About the Uninsured Population," Kaiser Family Foundation, November 2020.

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counters theories and assumptions, and hold people accountable for turning those insights into action. Every conversation about access to care in your community, for example, should evolve into a discussion about the potential for service expansion, introduction, or partnership.

The Governance Institute thanks Michael Topchik, National Leader, Chartis Center for Rural Health, for contributing this article. He can be reached at mtopchik@chartis.com.

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