Nebraska Rural Health Advisory Commission's

Rural Health Recommendations

As authorized in the
Nebraska Rural Health Systems and Professional Incentive Act

December 2021

Nebraska Rural Health Advisory Commission
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Name / Location	Appointment Designation
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Background and Purpose

The passage of the Rural Health Systems and Professional Incentive Act in 1991 authorized the Rural Health Advisory Commission (RHAC) to advise the Department of Health and Human Services – Division of Public Health, the Legislature, the Governor, the University of Nebraska, and the citizens of Nebraska regarding all aspects of rural health care and to advise the Office of Rural Health regarding the administration of the Rural Health Systems and Professional Incentive Act. (NE Revised Statutes Section 71-5655). According to policy, these recommendations should address the problems related to the delivery of rural health care, the education and training of health professionals, the regulation of rural health providers and institutions, and other factors that impact rural health care. The recommendations must be prepared annually and submitted to all appropriate government agencies and bodies, including the Governor, the State Legislature, and the Department of Health and Human Services. The purpose of this report is to identify some of the major rural health issues and propose recommendations to address them.

Current Status of Rural Health: A Brief Overview

Prior to the COVID-19 pandemic, the rural health system was facing several challenges in many areas of the state. For example, there were shortages of health professionals, including primary care physicians, virtually all types of mental health professionals, dentists, nurses, physical and occupational therapists, and many types of ancillary staff. Although federal and state health professional incentive programs have helped to mitigate this problem, these investments are spread across several health professions, and some are not eligible. In addition, over half of the critical access hospitals either had negative or low positive margins due to lower revenue streams from declining populations, the prevalence of high deductible health plans, and patient bypass decisions while their costs continued to increase (e.g., investments in electronic medical records).

There is considerable evidence that the rural health system is fragmented and uncoordinated which has been magnified by nursing home closures and an EMS system that relies mainly on a dwindling supply of volunteers to meet an increasing demand for services. Limited public transportations options have also severely affected the ability of many older and disabled patients from obtaining services in a timely manner. Rural local health departments have fewer resources (i.e., funding and staff) than their urban counterparts even though rural populations tend to have poorer health behaviors and outcomes.

There were also many challenging behavioral health issues (mental health and substance use) that impacted nearly all rural areas. For example, there has been a shortage of behavioral health professionals in rural Nebraska for many years. The shortages include psychiatrists, psychologists, licensed mental health practitioners, advanced practice registered nurses practicing in psychiatry mental health, alcohol and drug abuse counselors, and others. Currently, out of the 90 rural counties, the RHAC has fully designated 81 counties and nine counties have been partially designated as mental health shortage areas. In addition to the shortage of behavioral health professionals, there are many other factors that limit the provision of these services, including the lack of care coordination between behavioral health professionals and primary care physicians, social exclusion factors, stigma labels, and lack of anonymity. Many

providers screen for mental health disorders but have no available resources to refer patients when symptomatic patients are identified. As a result, some patients are not referred to a behavioral health professional before their problems become more severe. Finally, some primary care physicians lack the training and expertise to treat patients effectively or efficiently in need of behavioral health services.

Although the rural health delivery system faced many challenges prior to the COVID-19 pandemic, this crisis highlighted and exacerbated many of these issues. For example, the pandemic has created considerable stress for health care and public health workers, leading to significant burnout conditions. A recent study found that in a survey of 21,000 health care workers 38 percent self-reported experiencing anxiety or depression, 43 percent suffered from work overload, and 49 percent had burnout. The stress scores were higher for nursing assistants, medical assistants, social workers, nurses, respiratory therapists, and nursing assistants (Berg, 2021). In addition, some rural health professionals have refused to get vaccinated and are likely to lose their jobs because of the federal mandates. The net result is that there are fewer health professionals working in rural areas where workers were already in short supply.

While some hospitals have benefitted from the recent federal programs such as the Provider Relief Fund or the American Rescue Plan, the subsidies from these programs have a very narrow scope and duration and vary widely from hospital to hospital. These relief funds do not enhance primary care settings as the funds are directed to hospital services for delivery of care to the inpatient and outpatient service settings. These funds, then do not assist primary care in the delivery of care in the clinic setting. Currently, many patients continue to delay their care for safety reasons and the COVID-19 surges have created crisis conditions in terms of the number of beds that are available to care for patients with chronic conditions. It is not uncommon for rural patients with serious COVID complications to be transferred to another state because of the existing limited capacity in Nebraska. When the federal funds expire, it is likely that the number of small rural hospitals with negative margins will increase which may lead to a larger number of closures in future years.

The COVID-19 pandemic has also placed added stress on the mental health system because of the increasing demand for these services. According to a recent report from the Kaiser Family Foundation, the number of people in the U.S. who are experiencing mental distress rose significantly. From January to June of 2019, about one in ten adults reported symptoms of anxiety and depressive disorder as compared to about four in ten adults during the pandemic. This study also found that many adults are also reporting difficulty sleeping, increasing their consumption of alcohol and substance use, and worsening chronic conditions due to worry and stress over the COVID-19 virus (Panchal, et al., 2021). Mental health distress is more likely to impact young adults, individuals experiencing job loss, women with children, communities of color, and essential workers (Panchal, et al., 2021). Unfortunately, the limited capacity to care for patients with mental distress is diminishing. For example, a 2020 nationwide survey found that 52 percent of behavioral health organizations were experiencing an increase in the demand for services, but 54 percent of these organizations had to close programs and 65 percent had to cancel, reschedule, or turn away patients (National Council for Mental Wellbeing, 2021).

All these factors have affected the availability and accessibility of health care services which in turn has contributed to worsening personal health risk factors and health outcomes among rural residents. In comparison with urban areas, the population is older and declining in most counties. Incomes are consistently lower in rural areas and uninsured rate is significantly higher than the state average in many rural counties.

Rural residents face many of the same health problems as their urban counterparts, but they also encounter some vastly different challenges. When mortality rates were compared between large urban, small urban, and rural during the combined period 2015-2019, rural residents had substantially higher mortality rates for heart disease, unintentional injury overall, and motor vehicle crashes. These results are not surprising, given that heart disease is more likely to impact older populations and unintentional injuries and motor vehicle crashes reflect the fact that rural residents are more likely to work in higher risk occupations (e.g., agriculture) and more likely to drive on two-lane roads. The mortality rates were also slightly higher for colon cancer and suicide.

Rural residents were also at a greater risk of chronic disease because of specific individual risk factors. Based on the results of the Behavioral Risk Factor Surveillance System (BRFSS) from 2015 and 2019, rural residents as compared to urban populations were more likely to be obese, less likely to have their cholesterol checked in the past five years and be up to date on colon and breast cancer screening, more likely to use smokeless tobacco and engage in binge drinking, less likely to wear a seat belt and visit a dentist in the past year.

In summary, there are several factors that have limited the availability of and access to health services in rural health areas, including the inadequate supply of health professionals, low or negative hospital financial margins, the diminishing number of EMS volunteers, the limited capacity of rural local health departments, and the lack of coordination between the health care and behavioral health systems. Unfortunately, the COVID-19 pandemic has further exposed and exacerbated the limitations of the rural health system which in turn have negatively impacted health outcomes.

The Path Forward

Although some areas of the state have a very vibrant rural health system with an adequate supply of health professionals, financially viable hospitals, a relatively large service area with a network of multiple communities, the adoption and use of new technology such as telehealth, and strong collaborative partnerships, the RHAC believes that the current rural health system is unsustainable, and it must be redesigned to meet the current and future challenges.

Recommendation: It is the vision of the RHAC to participate in a building a sustainable rural health care system. This system would be patient-focused, containing entrance points for all aspects of patient care. It would include a coordinated health system, utilizing tertiary care centers, regional centers and local providers and facilities with an integrated access and transfer system to allow appropriate and efficient utilization of services. It is recognized by the RHAC, there are many divisions of opinion, silos of care and limitations in the present system.

In building a new integrated patient care system, it would take leadership from many arenas of care. The RHAC envisions a cohort of medical educational facilities (such as UNMC and CHI), Health Departments, Nursing Homes, Mental Health Representatives, Insurance personnel HHC, Professional organizations and select businesses to come together and develop this system. By starting with specific issues such as mental health, EMS, rural primary care etc. the system could be developed into a coordinated patient care structure of integrated patient centered care from tertiary to local provider utilizing a patient journey map of access and need.

The RHAC understands that many changes are needed to strengthen and transform the rural health system. However, it is a complex process and not all the challenges can be addressed simultaneously. To improve the health of individuals and populations, it is critical to build this system on a strong primary care foundation. However, it is equally as important to develop more effective collaborative partnerships with various health care partners and community organizations such as mental health centers and clinics, local public health departments, and EMS units. To begin this system redesign journey, the RHAC will work with several partners to focus on the following priority areas:

- Population health
- Mental health
- Workforce shortages
- EMS

Next Steps

To move this system redesign planning process forward, the RHAC has identified the following next steps:

- This project will be an agenda item for discussion at every RHAC meeting – the first priority area addressed will be workforce shortages.
- The RHAC will consider using consultants and/or facilitators to generate ideas and recommendations that have been successful in Nebraska and other states.
- The RHAC will explore various funding options to help them in the development and implementation of the plan.
- A draft of the redesign plan will be available by December 2022.

Conclusion

The rural health system in Nebraska is facing many challenges and must be redesigned to meet the health needs of rural populations and assure future sustainability. The RHAC recommends that this redesign planning process begin immediately. Although the RHAC will assume a lead role and coordinate the process, it should involve key rural stakeholders from within the state and selected consultants from outside of the state. While a strong primary care system should continue to be the foundation of the rural health system, the goal is to build a more integrated system that creates more effective partnerships with behavioral health, public health, EMS, and many others. Since the redesign process will involve several steps, the RHAC has identified four priority areas and steps to move this process forward.