The Landscape of Rural Health

Mid-South CAH Conference

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#ruralhealth
August 15, 2023

Brock Slabach, MPH, FACHE
Chief Operations Officer

Destination NRHA

Plan now to attend these 2023 events.

Rural Health Clinic Conference	Sept. 26-27, 2023	Kansas City, MO
Critical Access Hospital Conference	Sept. 27-29, 2023	Kansas City, MO
Rural Health Policy Institute	Feb. 13-15, 2024	Washington, DC
Annual Conference	May 7-10, 2024	New Orleans, LA
Rural Hospital Innovation Summit	May 7-10, 2024	New Orleans, LA

Visit ruralhealth.us

for details and discounts.

Why rural?

- Rural areas make up 80% of the land mass in USA
- Rural areas have roughly 17% of the US Population
- Rural areas provide the food, fuel and fiber to power our nation
- Access to high-quality health care is a requirement to keep these important resources available
- An exchange between urban and rural that must not be overlooked
- Historically, public policy has disadvantaged health care in rural communities

What We Fight for on Behalf of Rural

- Investing in a Strong Rural Health Safety Net
- Reducing Rural Healthcare Workforce Shortages
- Addressing Rural Declining Life Expectancy and Inequality

Carol M Highsmith/Library of Congress

Political Drivers of Health

The future of health equity begins and ends with the political determinants of health. --[Leslie Erdelack]

- Political drivers of health create the social drivers. Some examples:
  - Medicaid Expansion
  - GME Polices and specialties
  - Poor environmental conditions
  - Unsafe neighborhoods
  - Lack of healthy food options

- Defined: The Political determinants of health involve the systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either advance health equity or exacerbate health inequities.

  --Daniel E. Dawes (2020)

The real problem of humanity is the following, we have:

- paleolithic emotions
- medieval institutions
- godlike technology

Edward O. Wilson
https://www.nytimes.com/2019/12/05/opinion/digital-technology-brain.html

Stories and Data

Population Health Disparity

Rural v. Urban

Percentile Ranking

	Over 65	Diabetes	Median HSHLD Income	Access to Primary Care	Access to Mental Health
Rural	69	63	69	63	62
Urban	33	41	32	33	32

Oral Health Disparities in Rural

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Prevalence of Medicare Patients with 6 or more Chronic Conditions

The Prevalence of Medicare Fee-for-Service Beneficiaries 65 Years or Older With 6 or More Chronic Conditions, by County, 2012

Age-adjusted prevalence
Quintile classification

- 4.1%–10.3%
- 10.4%–12.9%
- 13.0%–14.9%
- 15.0%–17.2%
- 17.3%–32.3%
- Insufficient data

National age-adjusted prevalence is 15%.

Source: Centers for Medicare & Medicaid Services.

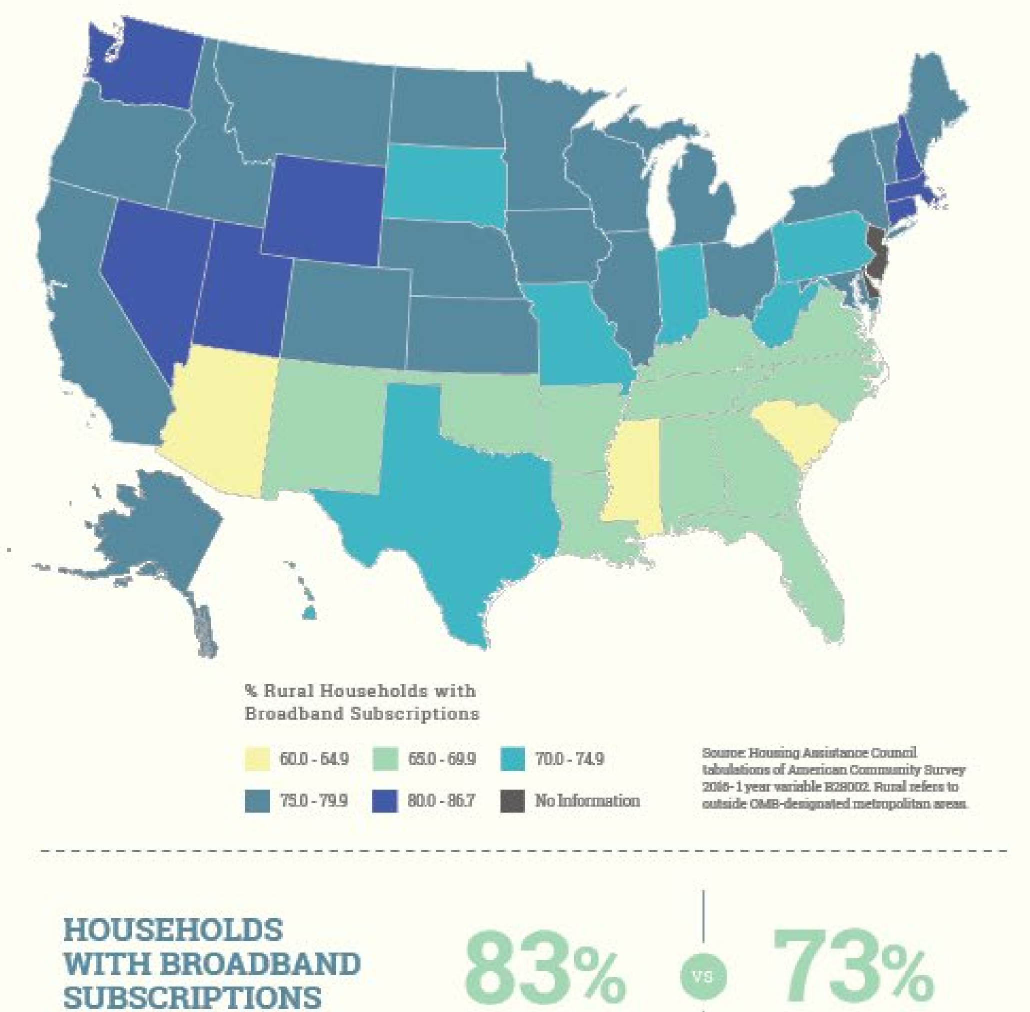
The Geography of Food Stamps

SNAP Enrollment as Percent of County Population

Source: Daily Yonder, 2018

The Digital Divide in Rural America

RURAL HOUSEHOLDS WITH BROADBAND SUBSCRIPTIONS



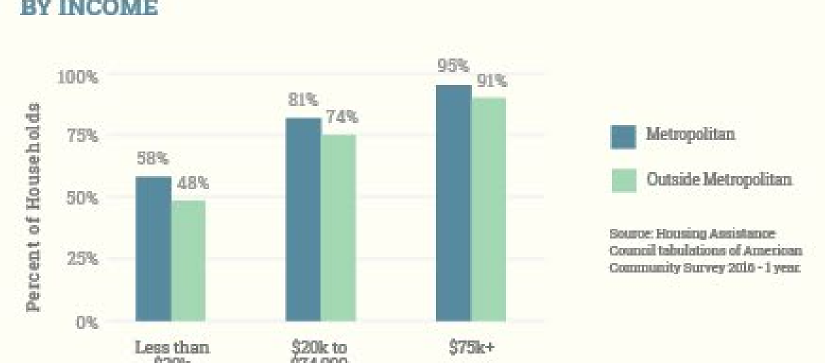
HOUSEHOLDS WITH BROADBAND SUBSCRIPTIONS

83% METROPOLITAN vs **73%** OUTSIDE METROPOLITAN

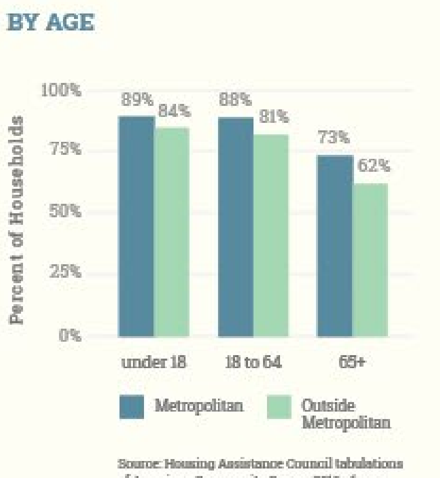
Source: Housing Assistance Council tabulations of American Community Survey 2016 - 1 year.

BROADBAND SUBSCRIPTIONS

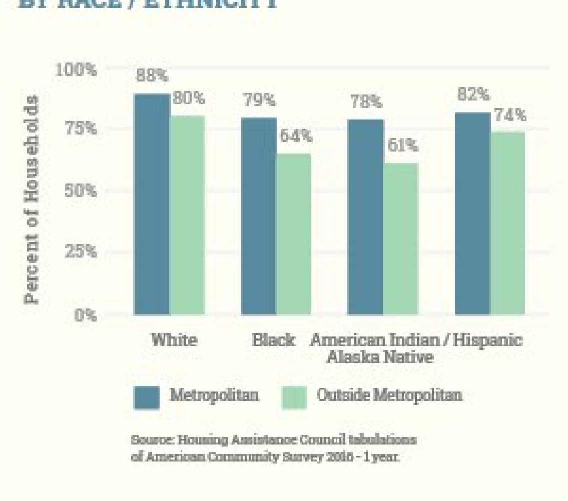
BY INCOME



BY AGE



BY RACE / ETHNICITY



Rural Hospital Closures

152 Closures since 2010

Closure Year
2005 2023

	Number of Closures
Complete	100
to Other	88
to REH	7

NC RHRP
NC Rural Health Research Program

UNC
THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

© 2023 Mapbox © OpenStreetMap

Complete Hospital Closure: Health care is no longer provided at this facility.
Converted to Rural Emergency Hospital (REH): Facility no longer provides inpatient care, but provides emergency and outpatient care.
Converted to Other: Facility no longer provides inpatient care, but provides some health care (e.g., urgent care, primary care, emergency care, long-term care).

2023: 5 in TX, 2 in IL, 1 in GA, 1 in PA,1 in MS (Holly Springs) and 1 in MI

Source: UNC Sheps Center for Rural Health

Recap of Rural Hospital Closures

- From 2005 through 2022, 186 rural hospitals closed (100 complete closures and 86 converted closures).
- Between 1990 and 2020, rural counties that experienced a within-county hospital closure became more economically unequal, with higher unemployment, lower per capita income, and lower median household incomes compared with rural counties overall.
- In the 2010s, two-thirds of all rural closures nationally were in the South, home to over half of Black people in the U.S., and where most states have not expanded Medicaid.
- In 2019, the typical rural hospital received nearly three-fourths of its revenue from outpatient services, with inpatient services comprising an increasingly smaller percentage of patient revenue since 2011.

Rural Health Research Gateway, June, 2023

America’s Rural Hospital Vulnerability Crisis

453 rural hospitals across America are vulnerable to closure.

Highest concentration of vulnerable hospitals in **states resisting Medicaid expansion** (e.g., TX, TN, MS, FL).

States with **most vulnerable** have also experienced **high number of closures** since 2010 (e.g., TX, TN).

WA OR CA ID NV MT WY UT CO AZ NM ND SD NE KS OK TX MN IA MO AR LA WI IL MI IN OH KY TN MS AL GA FL SC NC VA WV PA NY VT NH ME MA RI CT NJ DE MD AK HI

0 | 1%—9% | 10%—15% | 16%—20% | 21%—25% | 26%—30% | 31%—40% | 41%+

Percentage of State Rural Hospitals Determined to be Vulnerable

Source: The Chartis Center for Rural Health,

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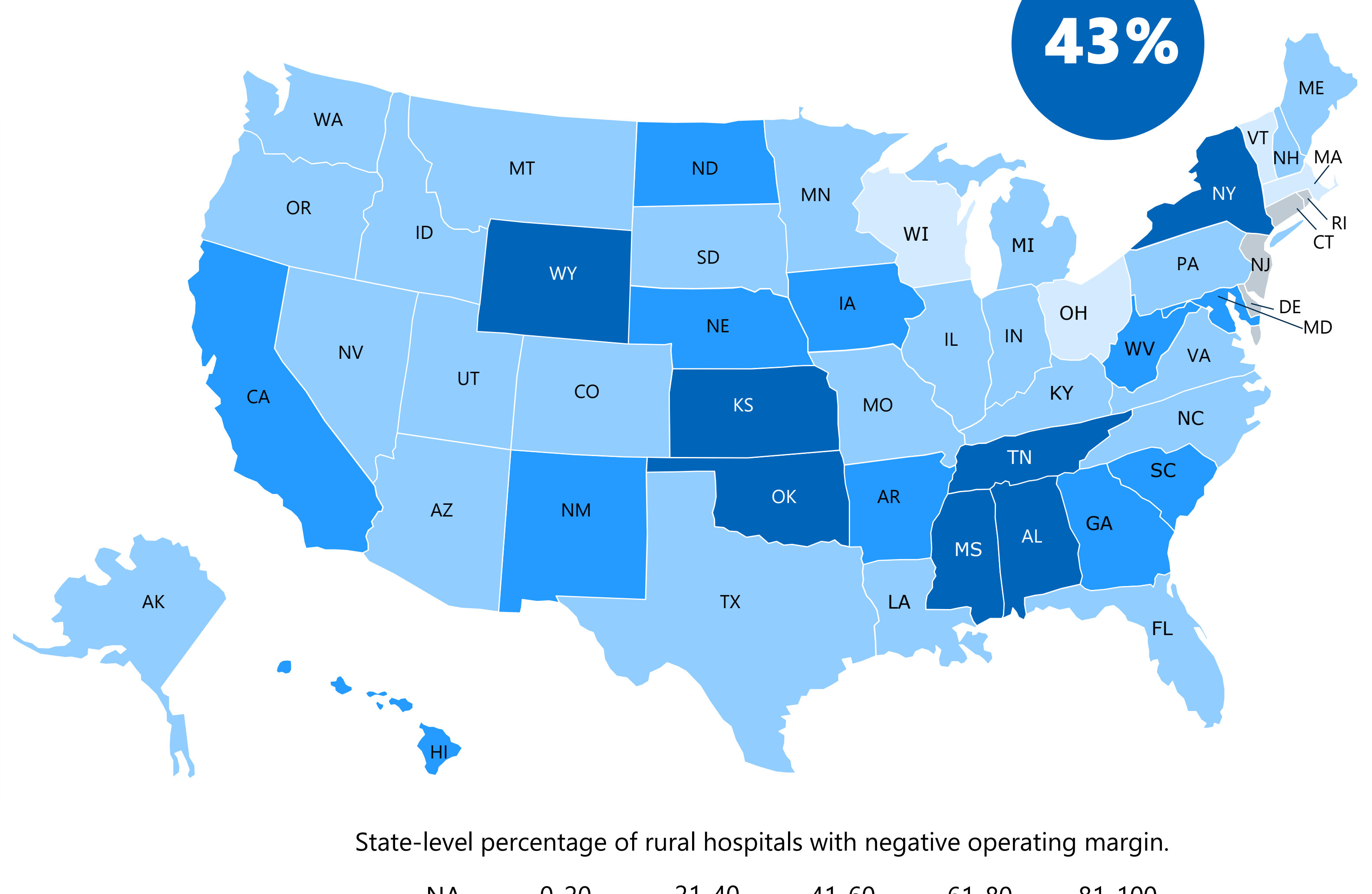
Rural Hospital Operating Margin

Overall, **43% of America's rural** hospitals are operating in the red.**

Higher utilization and **suspension of sequester** helped **boost** hospital operating margins.

In the **12 non-expansion states**, **51%** of rural hospitals are operating **in the red**.*



State-level percentage of rural hospitals with negative operating margin.

NA | 0-20 | 21-40 | 41-60 | 61-80 | 81-100

Source: The Chartis Center for Rural Health,

*South Dakota counted as a non-expansion state as it has not implemented as of 1/24/23.

**CMS Healthcare Cost Report Information System (HCRIS) Q4 2022. Operating margin is computed in accordance with Flex Monitoring Team guidance. Outliers are excluded. Hospitals for which data are unavailable are excluded. Reported Covid-19 PHE Funds (Worksheet G-3 line 24,50) excluded from operating margin. Adjustments made to operating margin to reflect full 2% sequester.

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USDA/NRHA Rural Hospital TA Program

- Rural Hospitals that are current borrowers from USDA are eligible for full-range of services:
  - Strategic, Financial, Operational Assessment (SFOA)
  - Target services, for example:
    - Revenue Cycle
    - 340B
    - Cost Report Review
- Rural Hospital that are not current USDA borrowers:
  - Debt capacity/Market Analysis
- TA is free-of-charge to hospital
- Contact Brock Slabach or Tommy Barnhart at NRHA

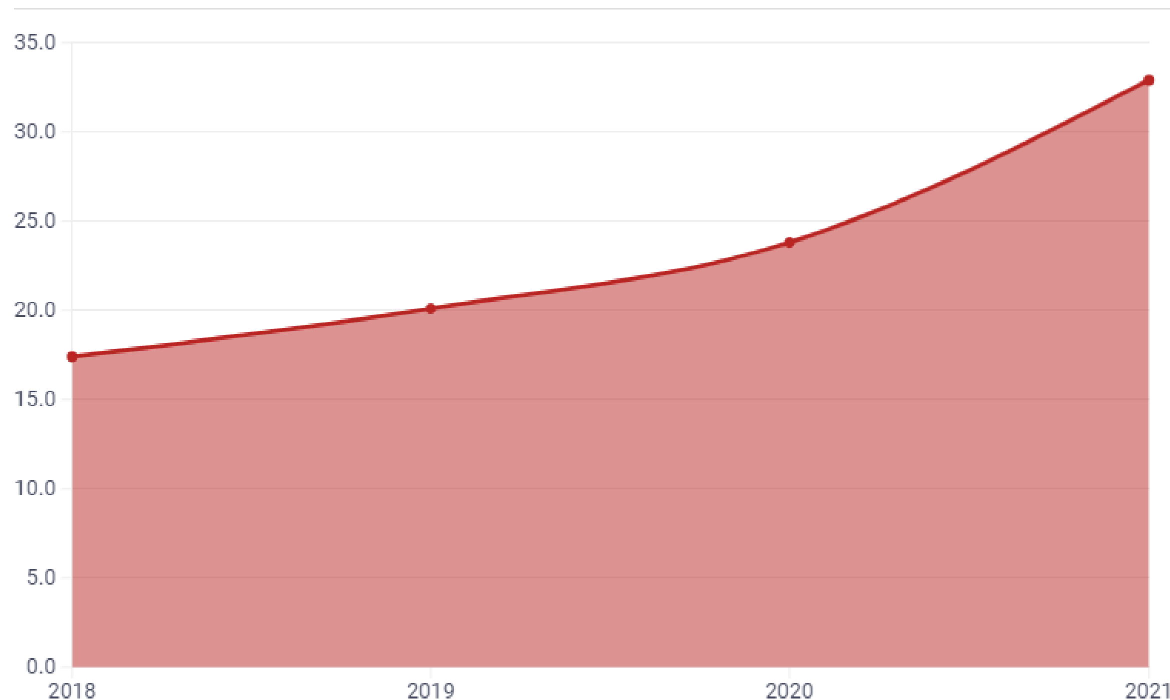
“Rural hospitals and the rural economy rise and fall together”

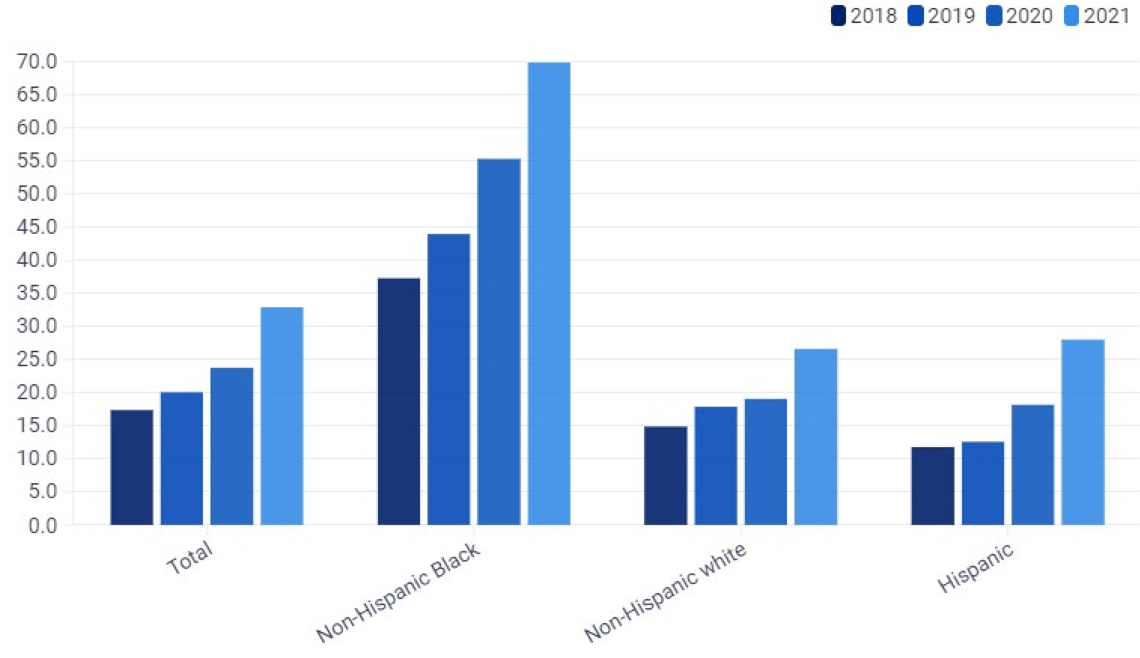
“Three years after a rural hospital community closes, it costs about $1000 in per capita income.”

- Mark Holmes, professor, University of North Carolina

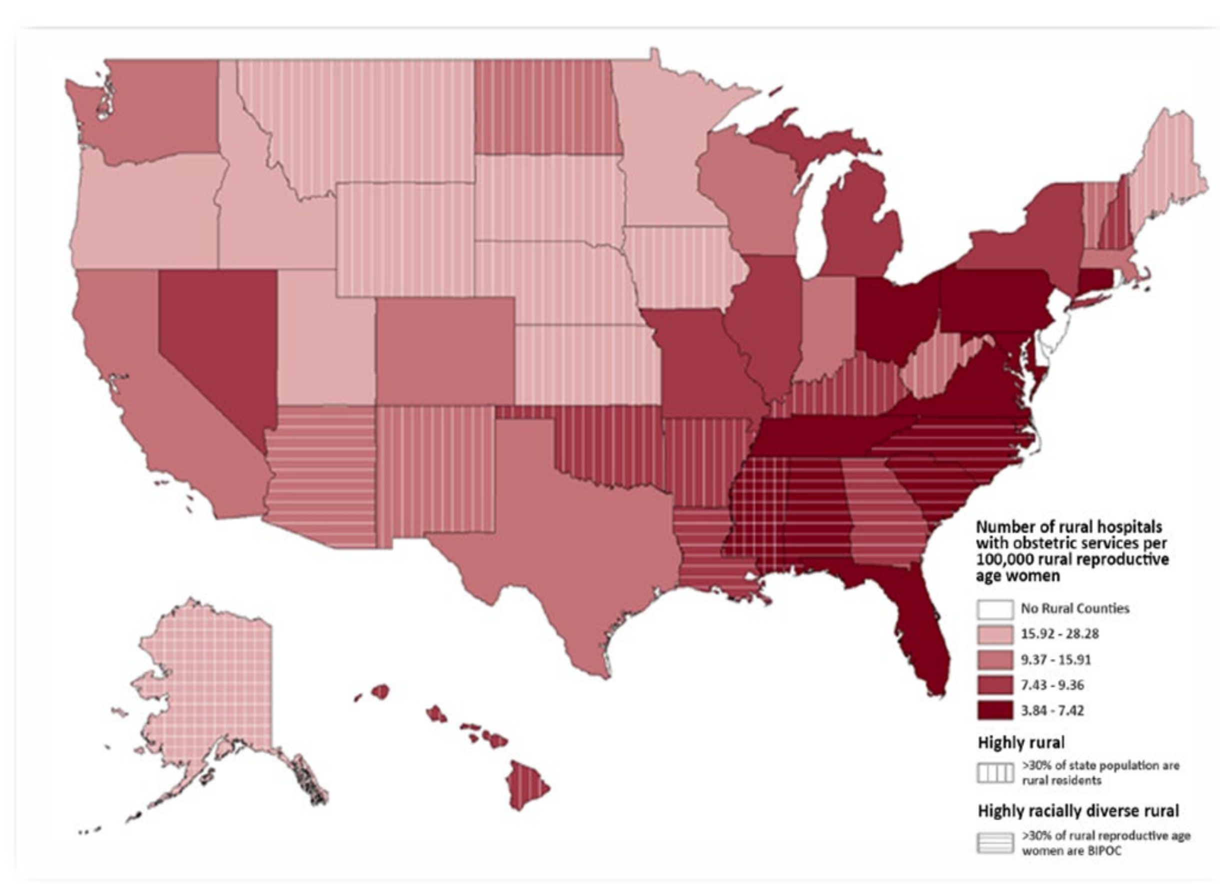
- On average, 14% of total employment in *rural areas is attributed to the health sector. Natl. Center for Rural Health* Works. (RHW)
- The average CAH creates 107 jobs and generates $4.8 million in payroll annually. (RHW)
- Health care often represent up to 20 percent of a rural community's employment and income. (RHW)
- Medical deserts form in rural communities where hospitals close.

Maternal Mortality Crisis





Maternity Deserts Nationwide

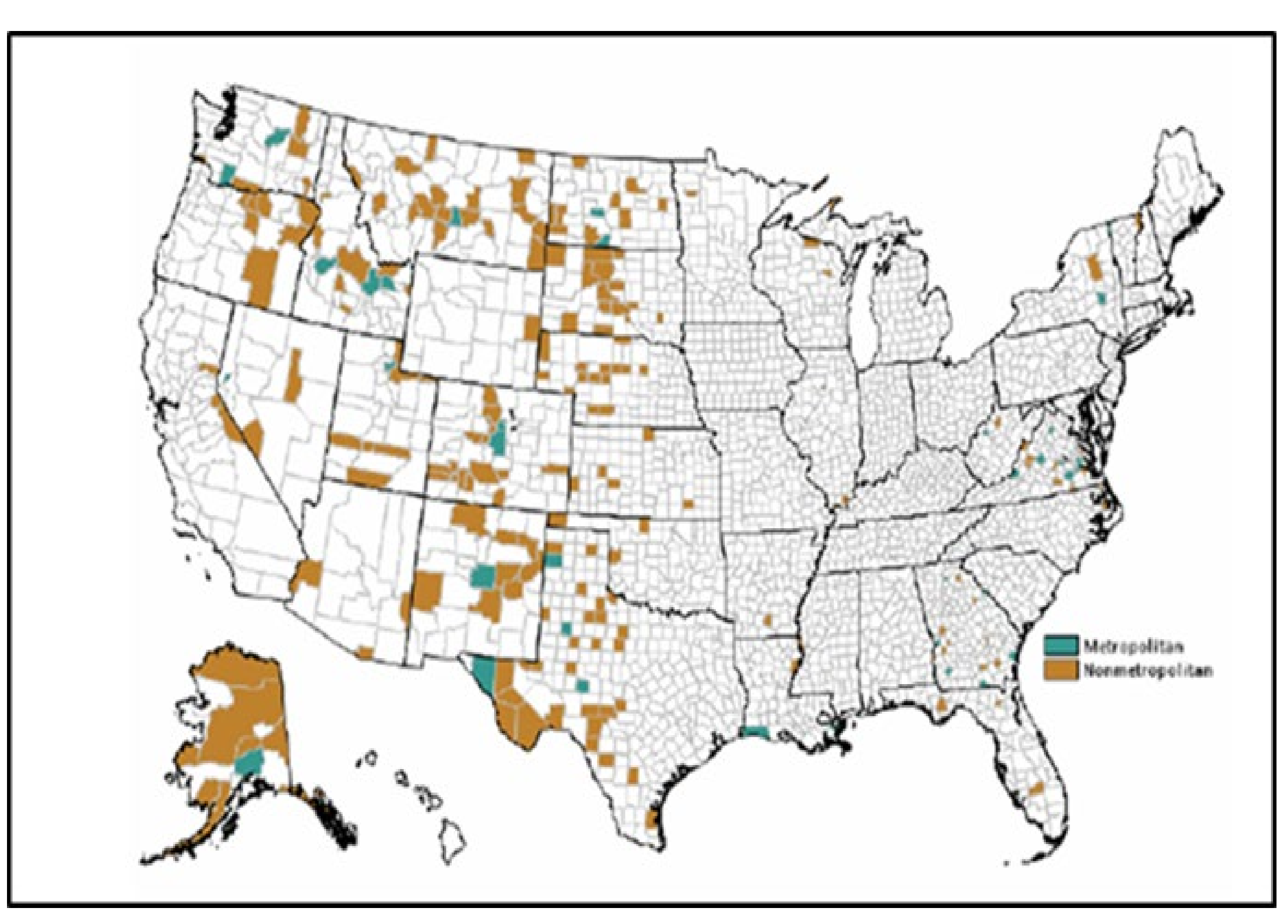


- 56% of rural counties lack hospital-based OB services
- Substantial state and regional variability
- Loss of hospital-based OB services is most prominent in rural communities:
  - With a high proportion of Black residents
  - Where a majority of residents are Black or Indigenous have elevated rates of premature death

- https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Hospital%20System%20Participation%20and%20Services.pdf

Infant Mortality by State

Rural Nursing Home Closures



- 10% of rural counties are nursing home deserts
- From 2008-2018, *400* rural counties experienced at least 1 nursing home closure

- https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf

Behavioral/Mental Health Workforce

U.S. Counties without Mental Health Providers by Urban Influence Category

	Metropolitan	Micropolitan	Non-Core
Counselors	6%	6%	24%
Social Workers	9%	11%	35%
Psychologists	19%	19%	61%
Psychiatrists	27%	35%	80%
Psych, NPs	42%	60%	91%

https://www.ruralhealthresearch.org/assets/411-1089/071817-behavioral-health-workforce-supply-webinar-ppt.pd

Rural/Urban Disparities in CVD Mortality

NRHA
Your voice. Louder.

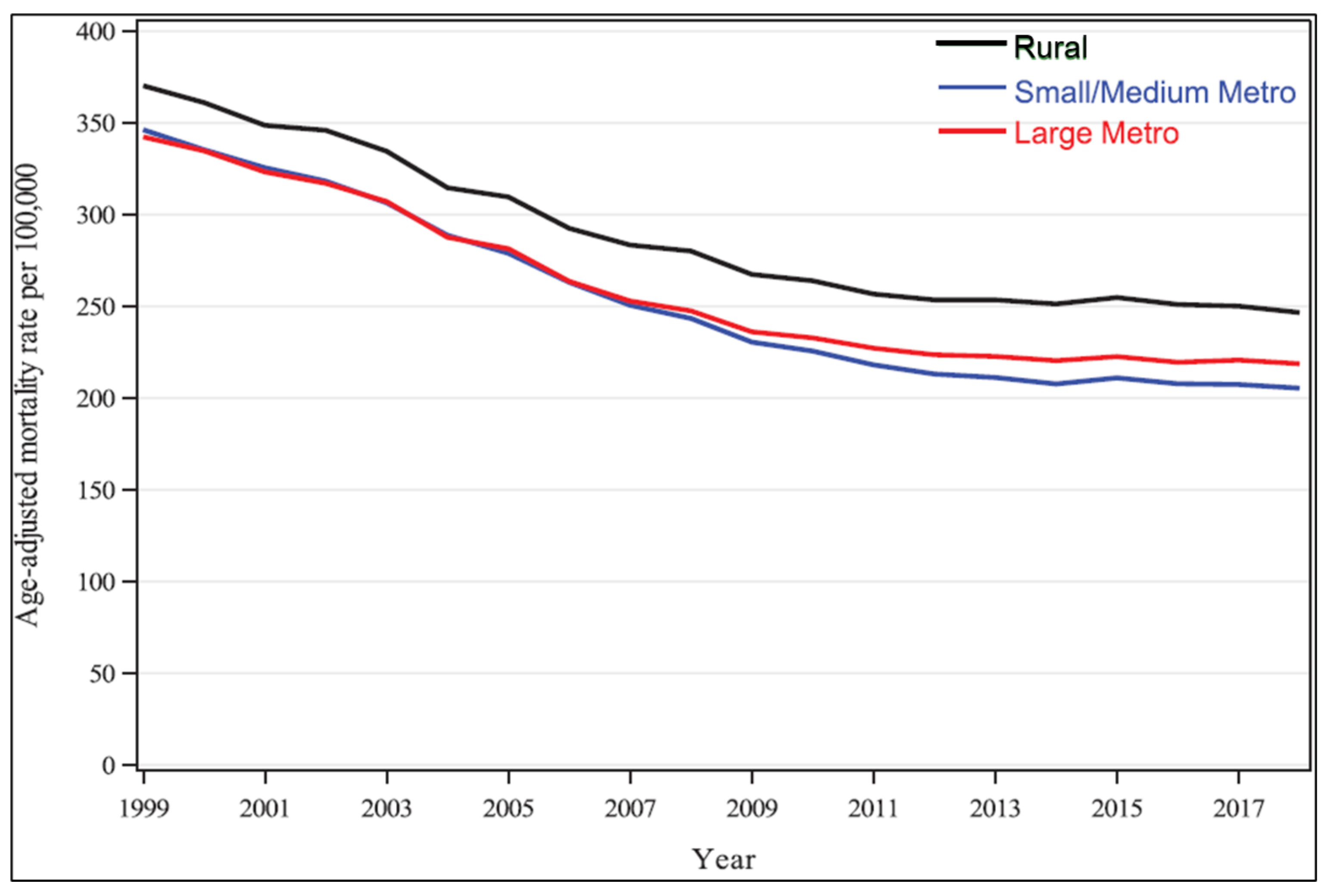


Figure 4. Trends in age-adjusted mortality rates per 100 000 population from total cardiovascular disease for both sexes stratified by urbanization status in the United States, 1999 to 2018.
Declines in cardiovascular mortality rate per 100 000 stratified by county-level urbanization between 1999 and 2018.

Goff DC, et al. Bending the Curve in Cardiovascular Disease Mortality: Bethesda + 40 and Beyond. Circulation. 2021 Feb 23;143(8):837-851.

Innovation

If you want to build a ship, don’t drum up men and women to gather wood, divide the work and give orders.

Instead, teach them to yearn for the vast and endless sea.

--Attributed to Antoine de Saint-Exupery

Payment Transition Plan: CMS & CMMI

Category 1 Fee for Service – No Link to Quality & Value	**Category 2** Fee for Service – Link to Quality & Value	**Category 3** APMs Built on Fee-for-Service Architecture	**Category 4** Population-Based Payment
	A Foundational Payments for Infrastructure & Operations	**A** APMs with Upside Gainsharing	**A** Condition-Specific Population-Based Payment
	B Pay for Reporting	**B** APMs with Upside Gainsharing/Downside Risk	**B** Comprehensive Population-Based Payment
	C Rewards for Performance		
	D Rewards and Penalties for Performance		

Goal: 100% of Medicare payments to providers are through a VBP approach

CMMI: AHEAD Model

CMMI signaling that it will release a new model for up to 8 states starting in 2025 that will include the following:

- Global Budget for hospitals (similar to PaRHM)
- Include a TCOC target/approach
- All-payer participation
- Include a primary care/provider incentive
- Directed toward safety-net providers (including rural)
- Address Mental health, SUD and SDOH
- Address Health Equity

Source: Rhode Island Health Care Cost Trends Steering Committee, January, 2023

CMMI: AHEAD Model

Tentative timeline for model release/implementation:

- Fall, 2023 release NOFO
- 2024 Select Model Participants
- 2025 Implement Model

Like the Pennsylvania model, AHEAD model requires state to organize and implement the features of this program.

Source: Rhode Island Health Care Cost Trends Steering Committee, January, 2023

New Payment Model

CMS Episode-Based Payment Model **request for information**.

- Comments due August 17 via regulations.gov.
- CMS looking to create new episode-based model. Current programs include Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model and Comprehensive Care for Joint Replacement Model (CJR)
- Questions around care delivery, clinical episodes, participants, and health equity.

Advocacy

CDC Office of Rural Health

- CDC Office of Rural Health is now official!
- Located in the new Public Health Infrastructure Center
- Staffing:
  - Diane Hall, Acting Director
  - Scott Miller, Senior Advisor for Rural Health
  - Kevin Matthews, Coordinator of Rural Public Health Research
- Initial steps: layout of mission, functions and structures
- Next step: develop a rural public health strategic plan
- Example of the political turning into policy

OPPS NPRM

CY 2024 Outpatient Prospective Payment System **proposed rule**.

- NRHA **summary**.
- Comments are due September 11 via regulations.gov.
- Overall, **2.8%** payment update, **4.4% for rural hospitals**.
  - Based on IPPS market basket increase minus productivity adjustment.
- Hospital price transparency –
  - Changes to required data elements
  - Machine Readable File (MRF) format – new CMS template/layout requirement.

OPPS NPRM

CY 2024 OPPS, cont.

- Indian Health Service hospitals can convert to REH and continue to receive all-inclusive rate for outpatient services.
- Last year, finalized policy to allow NPs, PAs, and Clinical Nurse Specialists (CNS) to provide direct supervision for cardiac rehab – clarifying that this may be furnished through telehealth thru Dec. 31, 2024.

MPFS NPRM

CY 2024 Medicare Physician Fee schedule (MPFS) **proposed rule**.

- NRHA **summary**.
- Comments are due September 11 via regulations.gov.
- Physicians facing **-3.3% payment cut** in 2024 due to statutory requirements and budget neutrality.
- Proposing new G codes to cover community health integration (incl. CHW services), SDOH risk assessments, and principal illness navigation.

MPFS NPRM

CY 2024 MPFS cont.

- Marriage & family therapists, mental health counselors can bill Medicare directly for services Jan. 1, 2024.
  - Addiction counselors that meet Mental Health Counselors (MHC) requirements can enroll in Medicare as MHC.
- HCPCS code for psychotherapy services furnished outside of a facility.
- Implementing telehealth flexibility extensions from Consolidated Appropriations Act of 2023.

MPFS NPRM

CY 2024 MPFS cont.

- RHCs/FQHCs:
  - Can bill for community health integration & principal illness navigation.
  - Remote physiologic monitoring and remote therapeutic monitoring in the general care management code.
  - General supervision for behavioral health services furnished incident to physician/NPP’s services.
- Minor changes to Medicare Shared Savings Program.

CMS Fix for 340B

OPPS Remedy for 340B-Acquired Drugs from CYs 2018 – 2022 **proposed rule**.

- NRHA **summary**.
- Comments are due **September 5** via regulations.gov.
- CMS policy in place from 2018 – 2022 struck down by SCOTUS last summer – paying hospitals ASP -22.5% for 340B drugs.
  - Have since reinstated Average Sales Price (ASP) +6% policy
  - This proposed rule is a remedy for the unlawful policy.

CMS Fix for 340B

OPPS 340B Remedy, cont.

- CMS is proposing:
  - **One-time lump sum payments** equal to the difference of what hospitals should have been paid vs. what they were paid.
  - **-0.5% payment adjustment** for the next 16 years.

Mental Health Parity NPRM

Requirements Related to the Mental Health Parity and Addiction Equity Act **proposed rule**

- Issued by Departments of Health & Human Services, Labor, and Treasury. Press release **here**.
- Comments due 60 days after publication in Federal Register.
- Amends regulations implementing the Mental Health Parity and Addiction Equity Act (MHPAEA).
- Overall, strengthening “no more restrictive” standard for mental health/SUD benefits.

CY2024 Medicare Advantage Policy and Technical Changes

- Prior authorization
  - Can only be used to confirm diagnosis, determine medical necessity
  - MA plans must comply with coverage and benefit conditions in traditional Medicare, national & local coverage determinations
  - When Medicare coverage criteria are not established, MA plans:
    - Must make publicly accessible coverage policies based upon widely used treatment guidelines or clinical literature
  - MA plans cannot revise its medical necessity determinations
  - 90-day transition period for ongoing course of treatment

CY2024 Medicare Advantage Policy and Technical Changes

- Network adequacy
  - MA plans must arrange for out-of-network medically necessary items and services that are not available in-network
- Behavioral health
  - Clinical psychologists and social workers now subject to time, distance, and minimum number requirements – can receive 10% credit
  - Did not finalize MOUD-waivered providers for network adequacy requirements
  - Primary care appointment wait times apply to behavioral health care
    - Emergency services: immediately
    - Not emergency but requires medical attention: within 7 business days
    - Routine/preventive: within 30 business days
  - Emergency medical services include mental health services. MA plans must cover emergency services without regard for prior authorization

CY2024 Medicare Advantage Policy and Technical Changes

- Targeting misleading marketing and advertising
  - MA ads must include specific plan name
  - Superlatives prohibited without supporting documentation
  - Prohibited from advertising benefits not available in a service area
  - Must provide annual notice that beneficiaries may opt out of business calls
  - Pre-enrollment checklist must include “effect on current coverage” item
  - Scope of appointments, business reply cards, and other contact mechanisms are valid for 12 months
  - Prohibited from using Medicare name, CMS/HHS logo in misleading way

CY2024 Medicare Advantage Policy and Technical Changes

- Health equity
  - Health Equity Index is added to the Star Ratings program to encourage MA plans to focus on improving care for enrollees with social risk factors.
  - MA plans must develop procedures to identify and offer digital health education to help enrollees access medically necessary telehealth benefits

Updates from Congress

Senate 340B RFI

- Bipartisan group of senators put out **request for information** on 340B.
- NRHA **draft response** available for review. Responses were due Friday, **July 28**.
- Questions include:
  - How can HRSA oversee the program?
  - Protecting contract pharmacies?
  - How to protect against duplicate discounts?
  - Accountability/integrity measures to protect program?
  - Ensuring savings are used for patient benefit?
- Largely basing answers off our **340B Reform Policy Principles**.

Bipartisan Rural Health Care Caucus

- **Relaunched** by Reps. Jill Tokuda (D-HI) and Diana Harshbarger (R-TN)
- An opportunity to host briefings and events to educate and inform Members of Congress and the public.
- Will allow Members to interact with patients, providers, and health advocates.
- Another great legislative vehicle to help move NRHA's rural health priorities.

FY 2024 Appropriations Request

- **CDC Office of Rural Health** - $10m
  - The office will enhance implementation of CDC's rural health portfolio, coordinate efforts across CDC programs, and develop a strategic plan for rural health

- **Increase funding for Rural Maternal and Obstetric Management Strategies** – $24.6m
  - To improve maternal health outcomes, NRHA is requesting an increase across all three RMOMS programs: RMOMS grantee program cohorts, Rural Obstetrics Networks Grants programs, and the Rural Maternal and Obstetric Care Training Demonstration

- **Rural Hospital infrastructure and sustainability**
  - USDA Technical Assistance Program - $5m
  - Financial and Community Sustainability for At-Risk Hospital Program - $10m
  - Rural Hospital Stabilization Pilot Program - $20m

FY 2024 Appropriations Request

- **Rural Residency Planning and Development Program-** $14.5m
  - Expand the number of rural residency training programs and increase the number of physicians choosing to practice in rural areas
- **Medicare Rural Hospital Flexibility Grant Program** - $73m
  - Used by states to implement new technologies, strategies, and plans in CAHS, in addition to technical assistance funds for REHs
- **Behavioral Health and SUD treatments**
  - Rural Communities Opioid Response Program - $165 million
  - Rural Health Clinic Behavioral Health Initiative - $10 million

ADVOCATE WITH US!

https://www.ruralhealth.us/advocate/rural-health-advocacy-campaigns

HELP Workforce Package Released

- HELP Chair Sanders released **HELP Workforce Package** that includes:
  - Appropriates Rural Residency Planning and Development Program.
  - 2,000 new GME Slots each year from FY 2024-FY 2028, 10% required to go to rural areas.
  - Creates Rural health Workforce Pathway Act.
  - Reauthorization and funding for Community Health Centers (CHCs), National Health Service Corps (NHSC), and Teaching Health Center Graduate Medical Education (THC GME) Program.
- Hearing was scheduled for July 26 but has been postponed.
- NRHA **letter** to Senate HELP Leadership.

Movement on PAHPA

- In late July: House Energy and Commerce and Senate HELP Committees both voted on PAHPA reauthorization legislation.
- House: **H.R. 4421**,The Preparing for All Hazards and Pathogens Reauthorization Act and **H.R. 4420**, The Pandemic and All-Hazards Preparedness and Response Act.
- Senate: **S. 2333**, The Pandemic and All-Hazards Preparedness and Response Act.
- NRHA's letters to **Energy and Commerce** and **HELP** about our PAHPA priorities.

New Legislation

- **S. 2477, Equitable Community Access to Pharmacist Services Act**
  - Introduced by Sens. Thune (R-SD) and Warner (D-VA).
  - House Companion by Reps. Smith (R-NE) and Matsui (D-CA).
  - Allows for Medicare reimbursement for certain services provided by pharmacists including tests, treatments, and vaccines for influenza, RSV, COVID-19, and Strep.
- **H.R. 4829, Physical Therapist Workforce and Patient Access Act**
  - Introduced by Reps. DeGette (D-CO) and Armstrong (R-ND).
  - Allows physical therapists to be eligible for National Health Service Corps.
- **H.R. 4605, Healthy Moms and Babies Act:**
  - Introduced in House by Reps. Carter (R-GA) and Bishop (D-GA).
  - Senate Companion by Sens. Grassley (R-IA) and Hassan (D-NH).
  - Improves maternal health coverage, supports care coordination, focuses on quality measures under Medicaid and CHIP.

New Legislation

- **H.R. 4713, Rural Hospital Technical Assistance Program Act**:
  - Introduced in the House by Reps. Derek Kilmer (D-WA), Ronny Jackson (R-TX), and Jodey Arrington (R-TX).
  - Makes an existing U.S. Department of Agriculture (USDA) program which provides technical assistance for rural hospitals permanent.
- **H.R. 4603, Rural Wellness Act:**
  - Introduced by Reps. Caraveo (D-CO) and Finstad (R-MN).
  - Prioritizes programs designed to increase access to behavioral and mental health treatment in rural communities in certain Rural Development grant programs.

Support the Rural Health Infrastructure

- NEW: S. 1571: Rural Hospital Closure Relief Act of 2023
  - Restore Necessary Provider status for CAH conversion
- Support the rural safety net hospitals
  - H.R. 833 Save America's Rural Hospitals Act
  - H.R. 1565 Critical Access Hospital Relief Act
    - repeals the 96-hour physician-certification requirement for inpatient CAH services
  - S. 803: Save Rural Hospitals Act of 2023
    - Establish a national minimum rate of 0.85 for the AWI reimbursement rate
  - S. 1110: Rural Hospital Support Act of 2023
    - make permanent the MDH program and enhanced LVA and MDHs and SCHs to choose an additional base year
  - S1673/HR1666: Ambulance Add-on

Support the Rural Health Infrastructure

- Modernize the RHC program
  - S. 198/H.R. 3730, Rural Health Clinic Burden Reduction Act
  - Developing RHC Quality Reporting Program with enhanced payment
- Ensure the 340B Drug Pricing Program remains a viable lifeline
  - H.R. 2534: PROTECT 340B Act of 2023
  - Evaluating other 340b reform proposals
- Extending authorization for CHC and NHSC.
  - H.R. 2559: Strengthening Community Care Act of 2023

Strengthen the Rural Health Workforce

- Expand the Medicare Graduate Medical Education (GME) program
  - S. 230/H.R. 83 Rural Physician Workforce Production Act
  - S. 665 Conrad State 30 and Physician Access Reauthorization Act
  - H.R. 751 Fair Access in Residency Act
- Support development and capacity of health care providers
  - H.R. 2761 Reintroduce Improving Care and Access to Nurses Act
- Support loan repayment programs
  - S. 940 Rural America Health Corps Act

Address Rural Health Equity

- Expand Access to Maternal Health Services
  - S. 948 Healthy Moms and Babies Act
  - H.R. 3305 Black Maternal Health Momnibus Act
- Permanently Expand Telehealth Provisions
  - S. 1636 Protecting Rural Telehealth Access Act
  - S. 1642 Reconnecting Rural America Act
  - Reintroduction of CONNECT for Health Act – Coming Soon!
    - Including in person payment parity for RHC and FQHC services
- Expand Access to Emergency Medical Services (EMS)
  - S. 1673/ H.R. 1666 Protecting Access to Ground Ambulance Medical Services Act

    3 percent increase in the rate for ground ambulance services that originate in rural areas. Super Rural Bonus 22.6 percent increase in the base rate for ground ambulance transports that originate in an area in the lowest 25th percentile of all rural areas
- Support Rural Public Health Capacity
  - Reauthorize and increase funding for new CDC Office of Rural Health

2023 Farm Bill

- Sent **Farm Bill requests letter** to House and Senate Agriculture Committee leadership
- Requests include:
  - Addressing hospital capital, capacity building grants/loans
  - Supporting Farm and Ranch Stress Assistance Network (FRSAN)
  - Developing farmer and agriculture worker crisis hotline
  - Supporting and increasing funding for nutrition programs like SNAP, Food Distribution Program on Indian Reservations, and Gus Schumacher Nutrition Incentive Program
  - Addressing childcare

CAH Issues

- 96-hour average length of stay
  - Longer waits for tertiary transfer
  - PAC placement more difficult due to staffing shortages
  - Increased Obs. Status by commercial insurance/Medicaid MCOs
  - Solutions:
    - Remove requirement altogether
    - Raise the average to 120 hours, for example
    - Other ideas?
- 72-hour qualifying length of stay for Swing Bed placement
  - Solution: Remove requirement altogether or lower the threshold to 36 hours, for example. Other?

Thank you.

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@bslabach
#ruralhealth

New 2023 Policy Papers Posted

- Emergency Preparedness for Rural Communities
- Center for Medicare and Medicaid Innovation Initiatives to Address Rural Health and Health Disparities
- Health Care's Role in Rural Economic Development:
  - Addressing Health Workforce Needs
  - How Broadband Can Improve Health Outcomes
  - How Work Support Programs Improve Health and Stimulate Rural Economies
- Integrating Z Coding for Social Determinants of Health and its Impact on Rural Areas

New 2023 Policy Papers Posted

- Obesity Prevention and Treatment in Rural America
- Obstetric Readiness in Rural Communities Lacking Hospital Labor and Delivery Units
- QI in Rural Health Care
- Retaining Rural Health Care Professionals: Strategies to Reduce Burnout
- Rural Reclassified Hospitals and RTPs
- Urban Bias in Rural Data Sets