

Advancing Health in Rural America: Maximizing Nursing's Impact

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This Fact Sheet provides a link between the evidence-based nursing solutions in the *IOM Future of Nursing: Leading Change, Advancing Health* report and health care challenges facing Americans in rural areas. It outlines the challenges of providing access to quality, affordable care in rural areas, followed by examples of initial progress in additional support to key programs. However, nurses are limited in their full contributions in these programs because of practice barriers. Ample evidence shows that nurses can provide accessible, quality care to meet the complex care needs in rural areas. The changes in policy, outlined in the *Future of Nursing* report, will expand nurses' contributions to improve rural health.

Nearly one in four Americans—70 million people—live in rural areas. On average, they are older, poorer, more likely to be uninsured, and suffer from higher rates of chronic health conditions than others. For many rural residents, health care services are distant, and many rural areas continue to face a significant shortage of health care providers, particularly in the field of primary care.

In the past decade, federal programs such as the National Health Service Corps (NHSC), Area Health Education Centers (AHEC), and Federally Qualified Health Centers (FQHCs) have increased efforts to improve access and lower costs for rural health care. As a key component of these initiatives, registered nurses and advanced practice registered nurses (APRNs) are delivering essential health care services as primary providers and care managers in rural areas.

Despite ample evidence validating the quality of care provided by nurses, significant barriers continue to prevent

nurses from making their full potential contributions to rural health. This Fact Sheet highlights essential steps to breaking down these barriers.

Rural Health Challenges

Virtually every state in the country has counties that are classified as rural areas. Although nearly 25 percent of Americans live in rural areas, only about 10 percent of physicians practice there.

Rural residents are less likely to have employer-provided health care coverage, and the rural poor are less likely to be covered by Medicaid benefits than their urban counterparts. Per capita income is \$7,417 lower than in urban areas, and rural Americans are more likely to live below the poverty level. Increases in health care costs have disproportionately affected those in rural areas because of this lower income level overall. The disparity in income is even greater for minorities living in rural areas. (See table 1.)

Table 1
A National Rural Health Snapshot

	Rural	Urban
Percentage of U.S. population**	nearly 25%	75% +
Percentage of U.S. physicians**	10%	90%
Population aged 65 and older	18%	15%
Population below the poverty level	14%	11%
Average per capita income	\$19K	\$26K
Population covered by private insurance	64%	69%
Population who are Medicare beneficiaries	23%	20%
Medicare beneficiaries without drug coverage	45%	31%
Medicare spends per capita compared to U.S. average	85%	106%
Medicare hospital payment-to-cost ratio	90%	100%
Percentage of poor covered by Medicaid	45%	49%

Source: Statistics used with permission from *Eye on Health* by the Rural Wisconsin Health Cooperative, from the article "Rural Health Can Lead the Way" by former NRHA President Tim Size, Executive Director of the Rural Wisconsin Health Cooperative. <http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care>.

People living in rural areas face a shortage of health care providers, limiting access to health care. Rural areas are more than twice as likely as urban areas to be designated by the federal government as Health Professional Shortage Areas (HPSAs): There are 2,157 HPSAs in rural areas, compared with 910 in urban areas.¹

Twenty percent of nonmetropolitan counties lack mental health services compared with 5 percent of metropolitan counties. Additionally, rural areas tend to be home to more older adults, who generally need more health care services, especially for chronic disease management and long-term care.

Addressing Rural Health Needs

Sparse population centers, geographic obstacles, lower income levels, and a high percentage of older people with complex care needs make providing access to quality affordable care in rural areas a significant challenge. However, there has been progress in recent years in identifying and prioritizing needs, expanding proven initiatives, and developing promising new models.

In its 2004 report *Quality through Collaboration: the Future of Rural Health*,² the Institute of Medicine (IOM) outlined the unique challenges in providing rural health care. Specifically, the report notes that rural communities have been at the margins of the health care quality movement. Implementation of the recommendations from this report laid a foundation for increased awareness of the needs of rural residents and expanded focus on quality. Major federal rural health initiatives received increased support thanks at least in part to these recommendations.

The National Health Service Corps (NHSC) program addresses long-standing primary care health professional shortages by providing physicians, APRNs, and other health professionals with scholarships and repayments of student loans in return for at least two years' service in communities facing shortages.

Nurses play a crucial role in the NHSC; by law, at least 10 percent of NHSC support must go to eligible nurse practitioners or nurse midwives.³ An estimated 8,100 NHSC clinicians are caring for almost 9 million people in rural and other underserved areas across the country. Seventy-five percent of NHSC members report that they plan to stay at the site where they currently are working after their obligation is fulfilled.

Area Health Education Centers (AHECs) were developed by Congress in 1971 to recruit, train, and retain health professionals committed to underserved populations, including those in rural areas. Today, there are 56 AHECs with more than 235 centers operating in almost every state and the District of Columbia. Approximately 120 medical schools and 600 nursing and allied health schools work collaboratively with AHECs to improve health for underserved and underrepresented populations.⁴

Federally Qualified Health Centers (FQHCs) make up one of the largest systems of care for rural America, and are frequently the only source of primary and preventive services in their communities. Fifty-three percent of these community health centers (CHCs) are located in rural and frontier areas. These centers currently serve 7.9 million people, including one in seven of all U.S. rural residents. Nurses play a central role in these centers, providing both direct primary and preventive care.⁵ AHECs and CHCs work together to improve access to care among populations dependent on safety net providers.⁶

Essential Next Steps

In each of these federal initiatives, nurses provide access to high-quality care as managers, primary care providers, and educators. Yet, for rural residents to fully benefit from the services nurses can provide, nurses must be able to practice much more extensively.

The landmark 2010 IOM report *The Future of Nursing: Leading Change and Advancing Health*⁷ identifies evidence-based nursing strategies and solutions that build on the 2004 IOM report to further advance the health of rural

America. The report defines a blueprint for action and offers recommendations to maximize the full potential and vital role of nurses in designing and implementing a more effective and efficient health care system.

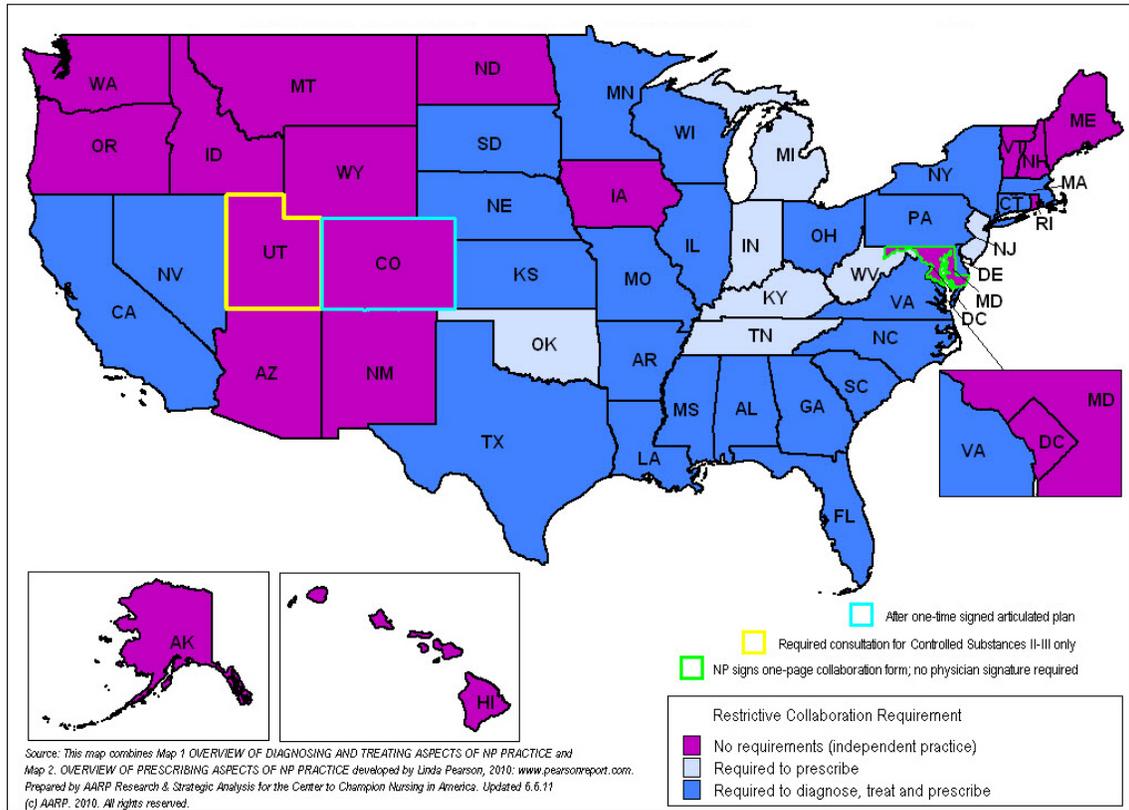
Specifically, the report recommends that nurses should practice to the full extent of their education and training.

It calls on Congress, the Centers for Medicare & Medicaid Services (CMS), and other federal agencies to remove scope-of-practice barriers for nurses. A full list of IOM recommendations is provided in the appendix. Key recommendations include—

- Expanding Medicare to include coverage of APRN services within the scope of practice of applicable state law.
- Authorizing APRNs to perform Medicare admission assessments and certification of patients for home health, hospice, and skilled nursing services.
- Changing CMS requirements for Medicare hospital participation to ensure that APRNs are eligible for clinical and admitting privileges.
- Increasing Medicaid reimbursement rates for APRNs providing primary care services.
- Urging states to amend unduly restrictive state APRN regulations.

Decades of research show that APRNs deliver care that is safe, effective, and efficient.⁸ No studies suggest that care is better in states that have more restrictive scope-of-practice regulations for APRNs than in those that do not. Yet most states continue to restrict the practice of APRNs beyond what is warranted by either their education or their training, as outlined in figure 1.⁹

Figure 1
Consumer Access and Barriers to Primary Care
Physician-Nurse Practitioner Restrictive Collaboration Requirements by State



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The 2010 IOM report also underscores the need for nurses to be full partners with physicians and other health care professionals in redesigning health care in the United States.

A leadership role for nurses in collaborative health care improvement efforts is a key recommendation. The report states that “private and public funders, health care organizations, nursing education programs, and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the health care team to conduct research and to redesign

and improve practice environments and health systems.”

Such interprofessional collaboration will be integral to a transformed rural health care system. The Arkansas Aging Initiative (see box),¹⁰ for example, illustrates the value of nurses as care managers meeting diverse needs of rural residents in a variety of settings.

Case Study: Arkansas Aging Initiative

A Statewide Program Uses Interprofessional Teams to Improve Access to Care for Older Arkansans

Patient centeredness, meticulous diagnostics, and wise counsel represent the kind of nursing that might provide a textbook definition of holistic care. This is not about making somebody live to be 100 or 110. This is about quality of life. You can make the end [of life] as great as the beginning. Amyleigh Overton-McCoy, PhD, GNP-BC, RN, is geriatric nurse practitioner and education director with the Arkansas Aging Initiative (AAI). The AAI has two direct service components. First, a team consisting of a geriatrician, an advanced practice registered nurse (APRN), and a social worker provides care at each of eight satellite centers on aging, which are owned and managed by local hospitals (and financially self-supporting through Medicare). The team follows its patients across settings—hospital, clinic, home, and nursing home—as needed. Second, an education component targets health professionals and students, older adults and their families, and the community at large. The AAI's director, Claudia J. Beverly, PhD, RN, FAAN, said that these two components are funded separately but go hand in hand in practice. Geriatricians offer in-depth assessment and manage complex problems. APRNs provide health promotion and disease prevention, analyze drug regimens, and manage chronic health problems. For patients with complex conditions, social workers make referrals and work with families on nursing home placement. Almost all older Arkansans can now access interprofessional geriatric care within an hour's drive of their home. Unpublished analyses of the areas around the centers show lower rates of emergency room use and hospitalization and higher rates of health care knowledge among elderly patients. Physicians at the eight sites report to Dr. Beverly, who is also director of the University of Arkansas for Medical Science's Hartford Center of Geriatric Nursing Excellence, which provides some funding to the AAI. She has hired a nurse with a doctorate and a geriatrician to act as associate directors. Developing teamwork has been a priority. "This is such a beautiful case study in how nursing and medicine can work together," she said, "and how, together, we can do good things."

Source: IOM, *The Future of Nursing: Leading Change and Advancing Health*, box 5-2. Washington, DC: Institute of Medicine, 2010.

Endnotes

¹ Health Resources and Services Administration Data Warehouse, <http://datawarehouse.hrsa.gov/default.aspx>.

² IOM, *Quality through Collaboration: The Future of Rural Health* (Washington, DC: Institute of Medicine, 2004).

³ National Health Service Corps, <http://www.hhs.gov/recovery/programs/nhsc/nhscfactsheet.html>.

⁴ National Area Health Education Centers, <http://www.nationalahec.org/About/AboutUs.asp>.

⁵ National Association of Community Health Centers, Inc., Fact Sheet #1108, accessed http://www.nachc.org/client/documents/Rural_Health_Fact_Sheet_Final1.pdf, June 8, 2011.

⁶ National Area Health Education Centers, <http://www.nationalahec.org>.

⁷ IOM, *The Future of Nursing: Leading Change and Advancing Health* (Washington, DC: Institute of Medicine, 2010).

⁸ *Ibid.*

⁹ Requirements for physician nurse collaboration, by state, as a barrier to access to primary care. Note: Collaboration refers to a mutually agreed upon relationship between nurse and physician.

¹⁰ IOM, *The Future of Nursing*, box 5-2, BOX 5-2 Case Study: Arkansas Aging Initiative, *A Statewide Program Uses Interprofessional Teams to Improve Access to Care for Older Arkansans*, pp 226-7.

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