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Improving Rural Health: State Policy Options

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Health care in rural America presents challenges that states are addressing in a variety of ways. Many rural communities lack adequate access to primary and preventive services. More than three-quarters of the nation's rural counties are designated as health professional shortage areas.[1] In addition to the scarcity of primary care providers and services in rural areas, the people who live there also lack access to mental health and other behavioral health services, long-term care options for seniors, emergency medical services, and other essential services.

To address the barriers that impede access in rural areas, states have adopted strategies to provide high-quality, affordable and accessible primary care services to rural Americans. This report provides an overview of state policies and investments in five key areas:

1. Achieving Greater Access to Health Care Services and Overcoming Distance

In order to broaden access to health care coverage and services, states participate in Medicaid, create state-run health insurance programs, and provide affordable coverage options for people who cannot afford private insurance.[2] They also adopt a wide range of health care reforms and workforce policies to improve people's access to high-quality, efficient health care services and providers. Policymakers have also adopted varied strategies to overcome distance and connect rural Americans with high-quality primary care and emergency medical services.

Health Insurance Coverage

States play several roles related to health insurance, such as regulating and establishing health insurance policies, enacting health insurance coverage mandates, and—as a result of the Affordable Care Act of 2010 (ACA)—creating a health insurance exchange. Often called a marketplace, an exchange is designed to make purchasing insurance through qualified health plans easy. States may establish and operate their own exchanges, contract with another entity to run the exchange, partner with the federal government in operating the exchange, or defer to the federal government to operate it. Subsidies to purchase health insurance are available for people with incomes between 100 percent and 400 percent of federal poverty guidelines and tax credits will subsidize small businesses with fewer than 25 employees. Exchanges will offer insurance plans that contain essential health benefits, such as preventive care, ambulatory patient services, emergency services, and mental health and substance abuse services.

As a result of the ACA, states also will modify how they regulate the individual and small group markets in order to review and oversee proposed health insurance rate increases and ensure that policies meet new requirements, such as the prohibition against pre-existing condition exclusions.[3]

Health Insurance Coverage Options and Strategies

- Support policies that make health insurance more affordable for individuals and small businesses.
- Establish effective rate review systems to examine proposed rate increases and ensure that individual and group policies meet new requirements.
- Determine the state legislative oversight role with the state health insurance exchange. In New Jersey, for example, state legislators passed a resolution to create a Joint Legislative Task Force on Health Insurance Exchange Implementation to oversee the federally administered exchange in the state and develop recommendations for the exchange.[4]
- Consider the need for legislation to address health insurance marketplace issues, such as the concern about "churning" as people move between Medicaid and the exchange.

Medicaid

Medicaid, a federal-state partnership with shared authority and financing, is a public health coverage program for low-income children, their parents, the elderly and people with disabilities. In rural communities—where individuals have higher rates of poverty and disability and lower rates of employer-sponsored insurance—Medicaid represents an important source of coverage.[5] In 2010, 18 percent of rural residents were enrolled in Medicaid, compared to 15.5 percent of urban Americans.[6] Medicaid also offers a significant payment source for rural hospitals, physicians and providers of long-term services and supports.[7]

The ACA Medicaid expansion and state health insurance exchanges play a key role in extending affordable coverage options and reducing the number of uninsured Americans. States that opt to expand Medicaid under the ACA will extend Medicaid coverage to everyone with an income at or below 138 percent of the poverty level. According to the Kaiser Family Foundation, as of July 2013, 24 states were moving forward with expansion, 21 states were not moving forward, and six states reported having ongoing debate about whether to expand or not.[8] For states that do expand Medicaid, the federal government will cover 100 percent of the medical costs of the newly-eligible population through 2016; the federal share decreases to 90 percent by 2020.

Medicaid Options and Strategies

- Discuss the pros and cons of adopting the ACA Medicaid expansion, with an emphasis on the effect the expansion will have on rural Americans.
- Support policies that create strong outreach and enrollment programs for Medicaid, the Children's Health Insurance Program and the state health insurance exchange or marketplace.
- Identify opportunities to use outcome-based performance measures and incentives in Medicaid contracts with managed care organizations.
- Consider policies that strengthen the Medicaid provider network, such as enhanced reimbursement for primary care services.

Payment and Delivery Reforms

In 2011, states spent nearly 17 percent of their general funds on Medicaid, second only to elementary and secondary education.[9] In response, states across the nation are adopting payment and care delivery innovations to reduce costs while improving health outcomes or results. For example, states encourage high-value care through coordinated care models, such as patient-centered medical homes and Accountable Care Organizations (ACOs).

- Medical homes provide comprehensive, patient-centered preventive and primary care through a team of providers and across health care settings. Health homes offer an important tool for improving care and results, while also reducing costs related to poor coordination and lack of communication

among disparate providers.

- ACOs are groups of physicians, hospitals and other health care providers who work together to provide high-quality, coordinated care. ACOs contract with public and private health care payers and oversee all aspects of care for a specific population. Providers share costs and assume financial risk; as a result, they have an incentive to coordinate care, control costs and improve results.

States are adopting payment policies that offer incentives for quality and efficiency and/or disincentives for ineffective care or uncontrolled costs. Rather than paying providers for each individual service or procedure, bundled payments provide a single payment for all services associated with an episode of care. By bundling payments, providers have incentives to provide efficient and appropriate services, coordinate care among all health care providers, and achieve positive health outcomes.

In addition to delivery reforms, states also are implementing federal and state payment policies that increase reimbursement for primary care providers and care coordination services. As an incentive to support primary care providers who accept Medicaid enrollees, the ACA provides increased payments for certain Medicaid services provided by qualified primary care providers.

Payment and Delivery Options and Strategies

- Support policies that promote medical homes for Medicaid or Children's Health Insurance Program beneficiaries. As of April 2013, 43 states had policies that promoted the medical home model for these beneficiaries.[10]
- Adopt payment policies that offer incentives for quality and efficiency and/or disincentives for ineffective care or uncontrolled costs.
- Examine the current payment and delivery system and identify opportunities for improving access, quality and efficiency. Some states have appointed commissions or task forces to make recommendations and guide implementation of new payment systems.
- Examine state oversight of ACOs that accept risk. Some states require HMO licensure, while others require a special license or certificate.

Health Centers

Health centers offer a consistent source of primary health care to people living in underserved communities. Community health centers provide preventive and primary care services to more than 21 million patients annually, and particularly those in "safety net" populations.[11] Health center patients are more likely to be poor, uninsured or publicly insured, and a member of a racial and ethnic minority.[12] As compared with those seeking care in other settings, health center patients are more likely to have common chronic conditions, such as depression, diabetes, asthma and hypertension—and the percentage of chronically ill patients is growing rapidly. Between 2000 and 2010, the percentage of health center patients with diabetes and hypertension increased by 154 percent and 147 percent, respectively.[13]

Despite the challenges of providing care to a population that is both sicker and poorer than the overall population, health centers offer improved access to high-quality primary care, successfully reduce health disparities and achieve improved health outcomes for their patients.[14, 15] As a result, creating or expanding health centers in rural communities is a common strategy to improve access. Many states support health centers through general fund appropriations or tobacco tax settlements. Thirty-three states and the District of Columbia allocated a total of $354 million in direct state funding to health centers in 2011.

Creating or expanding health centers—including community health centers, migrant health centers, health centers for the homeless and public housing primary care centers—in rural communities is another strategy for enhancing access to high-quality primary care services. Compared to the uninsured who do not use a health center, uninsured patients who do use one are twice as likely to get the care they need rather than delaying care because of cost or other reasons.[16] States support health centers in various ways, including funding health centers, offering financial incentives for providers who work in health centers, or encouraging health plans to contract with health centers.

Health Center Options and Strategies

- Gather information on health center resources, successes and challenges. Primary care associations and primary care offices, as well as local health center staff, can provide resources and data about health center services, funding, patient demographics, workforce trends and health outcomes, among other things.
- Examine current state funding and policies that support health center development and expansion. In addition to direct state funding for health centers, states can support health centers by encouraging or requiring contracted health plans to include health centers in their networks.
- Support workforce development policies that provide incentives for providers who practice in underserved, rural communities. Several states offer financial incentives, such as scholarships, tuition assistance or loan repayment, to encourage health professions students to pursue a career in primary care, often with requirements for practicing in health centers or other facilities in underserved communities.

Rural Health Clinics

The Rural Health Clinic (RHC) program aims to increase primary care services for Medicaid and Medicare patients in rural communities. To qualify as a RHC, clinics must operate in a rural and designated shortage area and they must provide certain services and meet other requirements, such as employing a physician assistant or nurse practitioner. Qualified RHCs can be public, private or non-profit entities. They receive enhanced reimbursement

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rates for providing primary care services to patients enrolled in Medicare or Medicaid. In 2012, there were 3,950 certified Rural Health Clinics throughout the country.[17]

Rural Health Clinic Options and Strategies

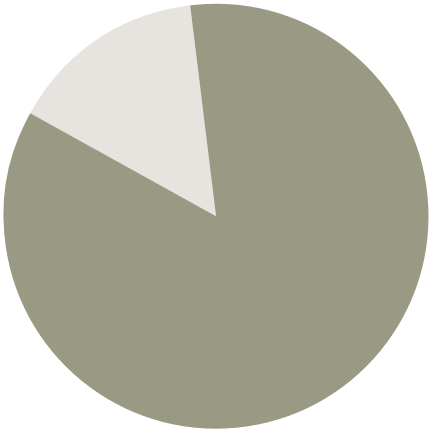
- Consider working with physicians, nurse practitioners and physician assistants to determine whether they would benefit from applying to become a Medicare-certified Rural Health Clinic, which enables these providers to get enhanced Medicare and Medicaid reimbursement. Information about this process can be obtained from the state office of rural health or from the regional offices of the Centers for Medicare and Medicaid Services (CMS).

School-Based Health Centers

School-Based Health Centers (SBHCs) increase access to primary care and preventive services among school-aged children and their families. SBHCs provide a wide range of services, including primary medical care, mental and behavioral health services, oral health, health education, substance abuse counseling and other services.[18] Research suggests that SBHCs have positive effects on health outcomes—particularly for children with asthma and other chronic conditions—and on student achievement and attendance. Funding for the nation's nearly 2,000 school health centers varies considerably, with many relying on a mix of public, private and non-profit funding. According to the National Assembly on School-Based Health Care (NASBHC), state-directed funding in 2011 totaled $89.6 million, an amount that has grown by 122 percent since 1996. The 2010 Affordable Care Act provided $200 million in 2010 through 2013 for construction of school health centers nationwide.

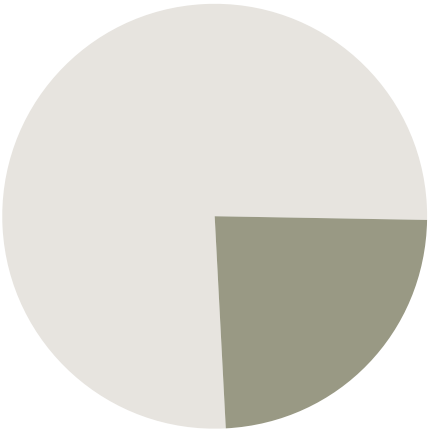
School-Based Health Center Options and Strategies

- Examine current state funding and policies that support health center and SBHC development and expansion. In addition to state direct funding, states can support health centers by encouraging or requiring contracted health plans to include health centers in their networks.
- Authorize and/or fund SBHC grant programs. Several states, including **Colorado**, **Texas**, **Nebraska** and **Michigan**, have passed legislation that authorizes SBHC grant programs. States can direct funds to SBHCs from various sources, including the general fund, assignment of taxes, and federal Maternal and Child Health Block Grant. States that fund SBHCs typically hold programs accountable by requiring them to meet operating standards, maintain SBHC certification, or submit performance data.[19]
- Enact Medicaid policies that support SBHCs. According to NASBHC, 10 of the 18 states that fund SBHCs had enacted Medicaid reimbursement policies in 2011. Examples of other Medicaid policies include: defining SBHCs as a provider type; waiving pre-authorization requirements for SBHCs; and requiring reimbursement from managed care organizations.[20]



85%

Percent of U.S. residents that can reach a Level 1 or Level 2 trauma center within one hour.



24%

Percent of rural U.S. residents that can reach a Level 1 or Level 2 trauma center within one hour.

Telehealth

Telehealth is defined as "the use of technology to deliver health care, health information or health education at a distance."[21] Telehealth enables patients or their providers to connect with providers located elsewhere through video conference, telephone or a home health monitoring device, or through "store-and-forward" technology that transmits data, images, sounds or video from one care site to another for evaluation. Home health monitoring devices, for example, enable chronically ill patients to transmit vital signs and health status remotely to their care providers to help manage their disease and receive medical care when needed. Telehealth also supports rural providers by facilitating continuing education, as well as communication and collaboration among medical providers in different locations. At least 42 states now provide some form of Medicaid reimbursement for telehealth services, and 15 states require private insurance plans to cover telehealth services.[22] In 2013, Missouri passed a law that requires parity in private insurance reimbursement of telehealth services.

Telehealth Options and Strategies

- Consider telehealth policies that expand access to primary care and other health services.
- Examine existing reimbursement and licensure policies for telehealth services. Several states have adopted reimbursement and/or portable licensure policies to remove practice barriers for health care practitioners who provide telehealth services.
- Examine opportunities to utilize telehealth to reduce costs and improve care for inmates. To address the rising costs and public safety risks associated with transporting and guarding inmates who travel for primary and specialty care, at least 31 states used telehealth in 2011 for some portion of correctional health care.[23]

Rural EMS

Emergency Medical Services are defined as "the initial stages of the emergency care continuum," and include emergency calls to 9-1-1, dispatch of emergency personnel, and triage, treatment and transport of patients.[24] Although rapid response is critical in emergency situations, rural residents typically do not experience swift transport to life-saving care. Nearly 85 percent of U.S. residents can reach a level one or level two trauma center within an hour, but only 24 percent of rural residents have access within that time frame. For patients with severe injuries, getting care at a Level I trauma center lowers the risk of death by 25 percent.

In addition to their traditional roles as first responders, some states and communities have discovered "community paramedicine," where EMS personnel perform a wide range of health care and social support activities in tandem with other providers in the patient's medical home. This enhances access to primary care services for rural patients and supports rural EMS by integrating it into the broader health care system by creating new pathways for reimbursement.

Rural EMS Options and Strategies

- Support policies that strengthen rural emergency medical services.
- Consider innovative strategies for strengthening the EMS workforce and addressing rural EMS needs. States have adopted varied strategies to recruit and retain EMS personnel, including financial incentives (e.g., loan repayment programs), improved access to training, and/or expanded EMS roles, such as community paramedicine.
- Consider adequacy and sustainability of current EMS funding sources. New funding sources or partnerships may be needed to support a sustainable, high-performing EMS system.
- Develop cohesive and integrated EMS and healthcare systems. Use of EMS providers for preventive and primary health care through a patient's medical home is one strategy for integrating EMS personnel into the larger healthcare system.

2. Bolstering the Rural Workforce

Today's primary care workforce is struggling to meet current demand for services, and the problem is especially acute in rural communities. The unmet needs are expected to intensify as a result of demographic changes, coverage expansions resulting from the Affordable Care Act, and a decline in the primary care physician workforce. To bolster the workforce and enhance access for rural Americans, states have implemented a wide range of strategies, including payment reforms that reward providers for coordinating care and meeting quality standards, financial incentives for practicing in rural areas, advancing the use of telehealth services, and expanded roles for non-physician providers.

Scope of Practice for Non-Physician Health Providers. One approach to meeting demand for primary care is a redefinition, and often expansion, of the scope and standards of practice for non-physician practitioners. Many states have taken steps to increase the procedures, treatments, actions, processes and authority that are permitted by law, regulation and licensure for non-physician primary care providers. Fifteen states allow nurse practitioners to diagnose, treat and prescribe medications without physician supervision. Another eight states allow nurse practitioners to independently diagnose and treat patients, but not to prescribe medications. The remaining 27 states require either direct or indirect physician supervision of nurse practitioners to diagnose, treat and prescribe.

Scope of Practice Options and Strategies

- Assess and consider scope of practice, licensure and prescriptive policies for non-physician workforce. To fill the gaps created by physician shortages in rural communities, many states have expanded the scopes of practice for certain non-physician providers, permitting them to independently provide a full range of primary care services commensurate with their education and training.
- Consider physician supervision requirements for nurse practitioners and physician assistants. Lawmakers may want to re-examine policies related to physician supervision for nurse practitioners and physician assistants, including policies that require direct or in-person supervision.
- Assess public reimbursement for services provided by non-physician health professionals. Many states have examined payment policies for non-physician providers practicing in rural areas. All 50 states pay for medical services provided by physician assistants under the supervision of a physician through Medicaid fee-for-service or Medicaid managed care programs.[25] Some legislators have adopted incentives for rural providers who practice in underserved areas.

Recruitment and Pipeline Programs

Several states support workforce initiatives aimed at exposing students in middle and high school to primary care careers. For example, **Colorado's** Recruiting and Retaining Youth of Color task force provides technical assistance to programs and organizations that address minority youth interested in health professions. Other strategies for expanding the primary care workforce pipeline provide training and career pathways for allied health professionals, as well as initiatives that utilize alternative health care providers. A number of states, such as **Alabama**, **Minnesota** and **Kansas** have also developed innovative programs to increase the training of physicians through targeted enrollment strategies and rural-focused admissions policies. There are also a growing number of rural training track residency programs (**Idaho**, **North Carolin**a and **Washington**, among others), which have a proven track record of producing physicians who choose to practice in rural communities.

Recruitment and Pipeline Options and Strategies

- Establish and fund recruitment and retention programs for the rural workforce. Policymakers can do this by supporting new or expanded residency programs and training and rotation opportunities in rural hospitals.
- Gather and analyze health workforce data. Legislators in several states have established work groups or advisory councils to study the role of primary care professionals and community health workers and make recommendations about workforce development, financing and sustainability.
- Create health workforce pipeline programs that recruit students from communities where providers are needed the most. Primary care providers from rural or underserved areas are more likely to live and practice in those areas; therefore, developing talent and generating interest within underserved communities can develop workforces where they are most needed.
- Support workforce development policies that provide incentives for providers who practice in health centers or other health facilities in underserved areas. Financial incentives, such as scholarships, tuition assistance or loan repayment, encourage health professions students to practice in health centers or other facilities in underserved communities.
- Provide state funding to create more teaching health centers (health centers that have primary care residency programs).

Scholarship/Student Loan Repayment Programs

States offer financial incentives to encourage health professions students to pursue a career in primary care and practice in a rural or undeserved area. State programs are funded through different public and private sources. The National Health Service Corps State Loan Repayment Program, for example, provides cost-sharing grants to support 30 states to operate their own state loan repayment program.[26] The programs target professions that

are most in-demand, and may include physicians, physician assistants, nurses, dentists, mental health professionals and others. Financial incentives include scholarships, tuition assistance, loan repayment and other incentives (e.g., tax credits) for providers who agree to practice in medically underserved areas. For example, **Alaska's** Supporting Health Care Access through Loan Repayment Program (SHARP), created in 2010, repays education loans for practitioners who agree to work in designated Health Professional Shortage Areas. **Mississippi's** Rural Physicians Scholarship Program, created by the legislature in 2007, provides rural students who wish to practice medicine in their home areas with financial support and mentoring opportunities.

Scholarship/Loan Repayment Options and Strategies

- Leverage federal and other loan and scholarship funds. Coordinating federal (e.g., National Health Service Corps), state, private foundation and other resources leverage state workforce funds to achieve optimal outcomes.
- Evaluate current primary care scholarship and incentive policies to ensure that they are meeting provider and community needs. Legislators may want to assess eligible provider types, program utilization, costs and retention of providers after they have met their service obligation.

Community Health Workers

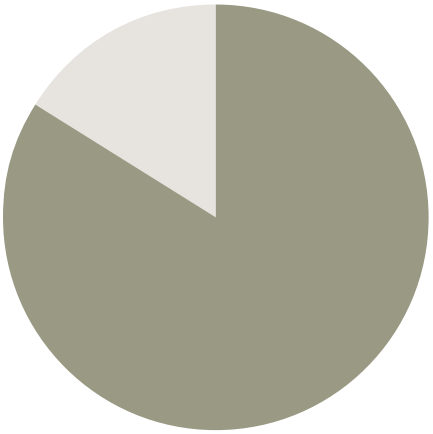
Known by different titles—including community health advisors, *promotores/promotoras de salud*, lay health workers—community health workers (CHWs) enhance access to primary care resources and promote adoption of healthy behaviors. They perform a variety of roles, including patient education, informal counseling and coaching, care coordination and basic services such as first aid and blood pressure screening, all in a familiar setting.[27] They work for pay or as volunteers and tailor their work to meet local community needs.[28] CHWs rely on a variety of funding sources, including time-limited grants, health centers, health plans and Medicaid.

Community Health Worker Options and Strategies

- Establish and fund CHW programs. Several states have adopted legislation that defines or recognizes community health workers, establishes standards or credentials, assesses training and certification needs, or directs a state agency to collect workforce data. CHWs can play a key role in promoting policies that help improve health outcomes and reduce avoidable readmissions, as well as contribute to the success of medical homes and accountable care organizations.
- Assess public reimbursement for services provided by community health workers and other non-physician health professionals.

3. Long-Term Services and Supports for Seniors and People with Disabilities

Rural seniors with unmet personal and health care needs may be prematurely forced into assisted living or nursing homes because they are unable to live independently in their own home or community. The shift to institutionalization not only restricts consumer choice and satisfaction, but it is a major cost driver for state Medicaid programs. Medicaid is the nation's largest payer for long-term care services. Older individuals and adults with disabilities represent about one-quarter of all Medicaid enrollees; however, they account for approximately 70 percent of all Medicaid spending. Containing costs and ensuring high-quality, accessible, Long-Term Services and Supports (LTSS) is a critical concern for state legislators.



84%

of people over age 50 want to remain in their homes as they age.

Home and Community-Based Services

States rely on Home and Community-Based Services (HCBS) to improve patient satisfaction and help reduce long-term care costs. Currently, the vast majority of Medicaid LTSS spending supports nursing home care, which is not only more expensive than care delivered in a home or community-based setting, but it is often not the setting of choice for seniors or people with disabilities. Eighty-four percent of individuals over age 50 want to remain in their homes as they age.

Despite their preferences, lack of home care services or providers and lack of awareness about HCBS options could lead seniors to be directed prematurely to nursing homes or other institutional facilities. For rural residents in particular, lack of providers and LTSS resources may mean that they have to move some distance to receive adequate services in an institutional setting. State policymakers have adopted a wide range of solutions to facilitate and invest in home and community-based services, including "balancing" policies that aim to serve more people with LTSS needs in their homes and communities, and allocating an increasing share of LTSS funds into HCBS over institutional care.

The ACA contains several provisions and enhanced federal funding that states can use to improve and expand HCBS. For example, by April 2013, 46 states had received federal grants

to transition Medicaid beneficiaries from institutions to home or community-based settings.[29] Other ACA provisions include a Balancing Incentive Payment Program that offers financial incentives to states that expand access to community-based LTSS, and enhanced federal funds for care coordination and case management for chronically ill Medicaid beneficiaries.

Home and Community-Based Services (HCBS) Options and Strategies

- Expand access to high-quality HCBS and supports in rural counties. Ensuring access to HCBS can encompass a wide array of funding, workforce, informational or other strategies designed to meet local and state needs.
- Track progress toward achieving quality, funding and other state-defined goals. To ensure that HCBS are accessible, affordable and high-quality, state policymakers can require the lead state agency to submit performance and quality data that demonstrate progress towards benchmarks and goals.
- Assess the current mix of spending on institutional and HCBS. An analysis of current investments may identify opportunities to invest in policies and programs that support consumers in their homes and communities.
- Engage rural stakeholders to address program design, implementation and ongoing oversight. States establish Medicaid subcommittees, task forces or workgroups with diverse representation to address program design and implementation.

Managed Long-Term Services and Supports

Long-Term Services and Supports (LTSS) include a wide range of home health and personal care services designed to meet the personal and health care needs of individuals living with disabilities, chronic diseases, complex medical needs, impaired mobility or impaired cognitive function. LTSS can help individuals live independently at home or they can support individuals who live in a nursing home or other institutional setting. As the largest payer of LTSS, Medicaid accounts for 41 percent of all LTSS spending in the United States, with the majority of state funds going to support unmanaged fee-for-service programs.[30] However, a growing number of states are implementing programs that offer risk-based contracts with managed care organizations that provide LTSS to seniors and people with disabilities. The number of states with managed Medicaid LTSS programs doubled from eight to 16 between 2004 and 2012. By 2012, 26 states are projected to have such programs.[31]

Medicaid Long Term Services and Supports Options and Strategies

- Review or conduct an LTSS needs assessment in the state's rural counties to understand current resources and gaps. State and local data or reports—e.g., reports from state agencies or foundations, or state-specific data or "scorecards" from national resources—can identify the critical challenges that impede development or expansion of home and community-based services (HCBS).
- Develop recruitment and retention strategies to expand and support the LTSS workforce. Policymakers may choose to review workforce policies—e.g., reimbursement, loan repayment, provider scope of practice and telehealth policies—to support and retain long-term care workers and family caregivers in rural areas.
- Develop a comprehensive and unified LTSS budget and strategy. To reduce fragmentation and develop a comprehensive approach for funding LTSS, several states have created a single state agency that administers and funds institutional and HCBS through a unified or "global" budget.
- Develop information and consultation services to help consumers choose LTSS that meet their needs and preferences. Many states have developed resources and navigational tools to inform consumers and hospital discharge planners about LTSS.
- Ensure adequate oversight capacity. Effective information technology systems, as well as agency staff competency in contract monitoring, quality assurance and rate setting is crucial to managing LTSS programs.
- Examine opportunities available under the ACA, including enhanced federal funding, to improve access to community-based LTSS.
- Define, implement and measure quality. States can require annual quality reviews or other reporting requirements to ensure that managed health plans meet state quality standards and measures.

4. Developing Behavioral Health Capacity

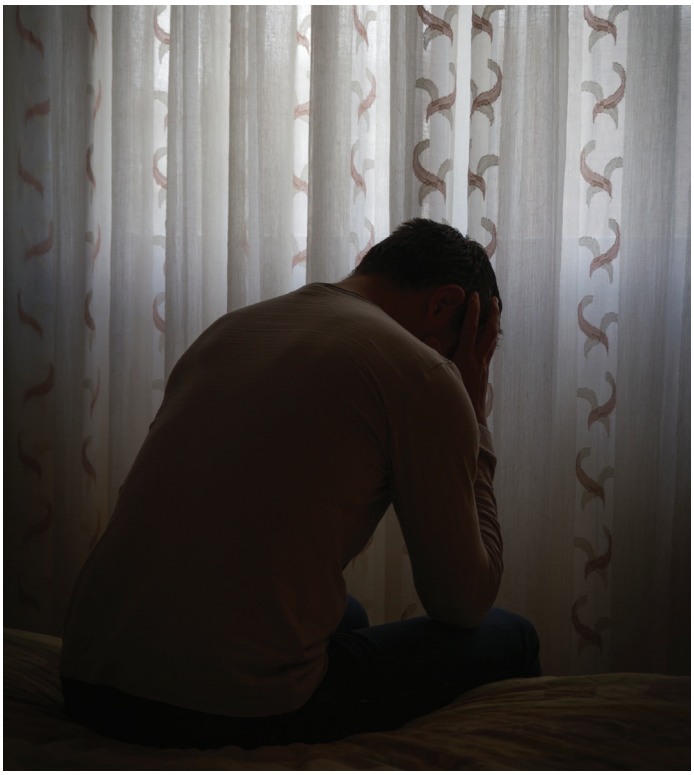
Rural Americans lack access to high-quality mental health and substance abuse services. To address the multiple barriers that impede access, legislators have adopted a multi-faceted approach to developing the workforce, removing access barriers and improving the quality of behavioral and substance abuse services in underserved, rural communities. For example, research indicates that telemental health is an important service that bridges the access barriers for rural residents requiring mental health services.

Substance Abuse

Substance abuse among rural youth and adults is comparable, and in some cases higher,[32] than in urban areas; however, rural communities have fewer resources to deal with the problem.[33] The substances—alcohol, prescription drugs, methamphetamine and other drugs—vary depending on factors such as age and geography.[34] Rural youth have higher rates of binge drinking and driving under the influence than urban youth.[35] Rural areas often lack the continuum of services needed to assess, diagnose, treat and evaluate substance abuse patients. Most treatment facilities are located in urban areas, and rural areas have fewer facilities that offer intensive services, such as inpatient and residential care. More than 80 percent of rural residents live in counties without a detoxification provider, and travel distances are a significant barrier.

Access to Mental Health Services

A 2011 study prepared for the National Institutes of Health concluded that the quality and availability of mental health services were lower among rural Americans and their treatment in a primary care setting was more likely to involve prescription medication rather than psychotherapy due to shortfalls of mental health professionals.[36] As a result, rural Americans with mental health needs enter care later, have more serious symptoms, and require more costly and intensive treatment.[37] The problem is exacerbated by provider shortages that disproportionately affect rural communities. To address these persistent and daunting challenges, states have adopted a wide range of policies aimed at addressing access, availability and quality of mental health resources in rural areas.



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Substance Abuse and Mental Health Options and Strategies

- Analyze substance abuse and mental health resources and unmet needs. Needs assessments or youth surveys can provide important information about current substance abuse patterns, adequacy and accessibility of resources for prevention and treatment, and workforce shortfalls.
- Consider primary care provider roles. Integrating substance abuse prevention and detection with mental health screening in primary care settings can be an effective strategy for educating and screening patients, and providing referrals.
- Consider legislation to reduce or deter prescription drug abuse, overdose and misuse. State policies include: so-called "doctor shopping" laws (that deter people from obtaining multiple prescriptions); immunity for individuals seeking medical assistance; controlling sale of over-the-counter ingredients and medications; requirements for physical examination before prescribing controlled substance; and prescription drug monitoring programs that report all filled prescriptions for controlled substances.
- Develop substance abuse and mental health rural workforce capacity.
- Ensure that state investments in mental health and substance abuse support evidence-based practices. Resources such as The Guide to Evidence-Based Practices identify best practices for treatment and prevention of mental health disorders.[38]
- Support community education and outreach programs that inform rural residents about behavioral health issues and resources.
- Consider innovative methods to support access to mental health treatment in rural areas, including use of telehealth or hotline programs.
- Examine existing reimbursement policies to identify barriers or options. States may want to examine existing mental health coverage laws to ensure that they do not create coverage or access barriers.
- Encourage programs that provide support for caregivers of family members who have mental illness to enable people to remain in a community-or home-based setting.

5. Prevention and Wellness

Chronic diseases drive U.S. health care spending, accounting for up to 78 percent of all health care costs. An estimated 96 percent of Medicare spending and 83 percent of Medicaid spending are for people with chronic diseases. Many chronic diseases can be prevented with regular health screenings and healthy behaviors, such as more physical activity, better diet and less tobacco use. Chronic disease, such as heart disease, cancer and stroke, are the leading cause of death in the United States.

Because chronic diseases are often preventable, state policymakers have adopted wellness and prevention legislation in several categories, including insurance-related strategies, public employee programs, wellness commissions and studies, and others. Federal initiatives such as the CDC's Community Transformation Grants and CMS' Partnership for Patients can help states and communities address prevention and wellness.

Prevention and Wellness Options and Strategies

- Establish commissions or studies. Between 2006 and 2009, six states created commissions or authorized studies to examine existing wellness programs or to recommend the creation of one.
- Promote health and wellness programs at schools, workplaces, healthcare and community-based settings. This includes adopting high-quality physical education (PE) and health education standards and/or nutrition education and standards in schools, child care facilities, worksites and hospitals.
- Ensure access to a full range of quality health services for individuals with chronic conditions.
- Encourage the creation of and participation in insurer and employer wellness programs.
- Consider current policies and investments that prevent tobacco use among youth and adults, protect individuals through smoke-free policies and provide access to smoking cessation for smokers.
- Encourage physicians to promote cessation to their patients who use tobacco.
- Support programs that focus on eliminating racial, ethnic and socio-economic-based health disparities.
- Support efforts to effectively educate the public about their health and prevention of chronic illness.
- Enact policies that support healthy choices and healthy environments. These include programs that increase access to fresh produce in schools, businesses and communities. Others can create and maintain safe neighborhoods for physical activity by improving access and conditions in parks and playgrounds; promoting dedicated lanes for bicycle and public transit; and promoting walk-to-school and work initiatives.

Conclusion

Rural communities face myriad barriers to high-quality primary care services and resources. While there is not a single solution, legislators have adopted a wide range of strategies to remove barriers and enhance access to care for rural Americans. Regardless of the policy, legislators have adopted common strategies to improve health care services for and the health of residents in rural communities.

- Assess the magnitude of the problem. Gathering data about unmet health care needs and workforce challenges can help legislators understand the most pressing problems and ensure that access, workforce, long-term care, and mental health/substance abuse policies support health and wellness for rural residents.
- Engage stakeholders to review policies, identify challenges and opportunities and develop effective programs.
- Align policies and investments to support programs that work. Legislators play an important role by ensuring that programs and state funds support approaches that have proven results.
- Look at the workforce differently. While strengthening the workforce involves strategies for increasing the quantity of providers in rural areas, states and localities are demonstrating that innovations in technology (i.e., telehealth) or redefined roles for primary care providers and care extenders can expand the reach of the current workforce and improve access to care.

Legislators can play an important role by ensuring that the state's primary care policies and investments meet the unique needs of rural communities and the workforce that supports them, and that the strategies have been evaluated and proven to be effective. ■

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End Notes

1. Alex McEllistrom Evenson, *Informing Rural Primary Care Workforce Policy: What Does the Evidence Tell Us?* (North Forks, ND: Rural Health Research Gateway, April 2011), http://www.ruralhealthresearch.org/pdf/primary_care_lit_review.pdf
2. Alan Weil et al., A State Policymakers' Guide to Federal Health Reform (Washington, D.C.: National Association for State Health Policy, November 2009), 6, http://www.nashp.org/sites/default/files/Policymakers%20Guide%20Part1.pdf.
3. Alan Weil and Raymon Sheppach, "New Roles for States in Health Reform Implementation," *Health Affairs* 29, no. 6 (2010): 1179, http://www.hsd.state.nm.us/pdf/hcr/Role%20of%20States%20in%20HC%20Reform%20(2).pdf.
4. NCSL, "Federal Health Reform: State Actions Newsletter," (Denver: NCSL, 2013), 1, http://www.ncsl.org/documents/health/ACANews61.pdf.
5. Keith J. Mueller et al., The Current and Future Role and Impact of Medicaid in Rural Health (Columbia, Mo: Rural Policy Research Institute, Sept. 2012), 2, http://www.rupri.org/Forms/HealthPanel_Medicaid_Sept2012.pdf.
6. Ibid.
7. Ibid, 3.
8. Henry J. Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision as of July 1, 2013," http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.
9. Kaiser Commission on Medicaid and the Uninsured, Medicaid: A Primer 2013 (Washington, D.C.: KCMU, 2013), 32, http://www.kff.org/medicaid/upload/7334-05.pdf.
10. National Academy for State Health Policy, "Medical Home and Patient-Centered Care," (Washington, D.C.: NASHP, 2013) http://www.nashp.org/med-home-map.
11. HHS, HRSA, "Health Center Data," http://bphc.hrsa.gov/healthcenterdatastatistics/index.html.
12. Ibid.
13. National Association of Community Health Centers, "A Sketch of Community Health Centers: Chart Book 2012" (Bethesda, MD: NACHC, 2012), http://www.nachc.com/client//Chartbook2012.pdf.
14. Michelle Proser, "Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care," *Journal of Ambulatory Care Management* 28(4):321-330.
15. Leiyu Shi et al., "Reducing Disparities in Access to Primary Care and Patient Satisfaction with Care: The Role of Health Centers," *Journal of Health Care for the Poor and Underserved*. 2013; 24(1):56-66.
16. Leiyu Shi et al., "Reducing Disparities in Access to Primary Care and Patient Satisfaction with Care: The Role of Health Centers," *Journal of Health Care for the Poor and Underserved*. 2013; 24(1):56-66.
17. The Henry J. Kaiser Family Foundation, "Number of Medicare Certified Rural Health Clinics," http://kff.org/other/state-indicator/total-rural-health-clinics/.
18. HHS, HRSA, "School-Based Health Centers," http://www.hrsa.gov/ourstories/schoolhealthcenters/.
19. National Assembly on School-Based Health Care, State Policies that Support School-Based Health Centers, (Washington, D.C.: NASBHC, 2012), http://www.sbh4all.org/atf/cf/%7BB241D183-DA6F-443F-9588-3230D027D8DB%7D/State%20Policy%20Survey%20-%20Executive%20Summary.pdf.
20. Ibid.
21. U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), "Telehealth," http://www.hrsa.gov/ruralhealth/about/telehealth/.
22. For a complete list of state telehealth reimbursement policies, visit http://www.ncsl.org/issues-research/health/state-coverage-for-telehealth-services.aspx.
23. See Laura's prison brief
24. National Academy of Sciences, *Emergency Medical Services: At the Crossroads* (Washington D.C.: The National Academies Press, 2007) http://www.iom.edu/Reports/2006/Emergency-Medical-Services-At-the-Crossroads.aspx.
25. American Academy of Physician Assistants, *Third-Party Reimbursement for Physician Assistants* (Alexandria, Va.: American Academy of Physician Assistants. 2007), http://www.aapa.org/uploadedFiles/content/Common/Files/RI_3rdParty_v4%20-%20052711%20UPDATED.pdf.
26. HHS, National Health Service Corps, "State Loan Repayment Program FAQs," http://nhsc.hrsa.gov/currentmembers/stateloanrepaymentprogram/faq/.
27. Lisa Sprague, *Community Health Workers: A Front Line for Health Care?* (Washington, D.C.: National Health Policy Forum, Sept. 17, 2012), http://www.nhpf.org/library/issue-briefs/IB846_CHW_09-17-12.pdf.
28. HHS, HRSA, *Community Health Workers Evidence-Based Models Toolbox* (Rockville, Md.: HRSA, 2011) http://www.hrsa.gov/ruralhealth/pdf/chwtoolkit.pdf.
29. Kaiser Commission on Medicaid and the Uninsured, "How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports Today? State Adoption of Six LTSS Options," April 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8079-02.pdf.
30. Sara Barth, "State Roadmap for Planning and Implementing Medicaid Managed Long-Term Services and Supports," (presentation at the National Health Policy Forum, December 2012), http://www.nhpf.org/uploads/Handouts/Barth-slides_10-05-12.pdf.
31. Ibid.
32. HHS, Substance Abuse and Mental Health Services Administration, *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Rockville, Md.: Office of Applied Studies, 2009) http://www.samhsa.gov/data/nsduh/2k8nsduh/2k8results.pdf.
33. Rural Assistance Center, "Substance Abuse," http://www.raconline.org/topics/substance-abuse/.
34. HHS, Substance Abuse and Mental Health Services Administration (SAMHSA), *Results from the 2011 National Survey on Drug Use and Health: National Findings* (Rockville, Md.: Office of Applied Studies, 2011) http://www.samhsa.gov/data/nsduh/2k11results/nsduhresults2011.pdf.
35. John A. Gale et al., Adolescent Alcohol Use: Do Risk and Protective Factors Explain Rural-Urban Differences? (Portland, ME.: Cutler Institute for Health and Social Policy, University of Southern Maine, March 2012), http://muskie.usm.maine.edu/Publications/WP48_Adolescent-Alcohol-Use-Rural-Urban.pdf.
36. Jacqueline S. Gray, *Rural Mental Health Research White Paper for National Institute of Mental Health*, (Grand Forks, ND.: Center for Rural Health, Sept. 2011), 12, http://ruralhealth.und.edu/pdf/j_gray_nimh_white_paper.pdf.
37. Ibid.
38. HHS, SAMHSA, "A Guide to Evidence-Based Practices on the Web," http://www.samhsa.gov/ebpwebguide/index.asp.