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Access and Capacity to Care for Medicare Beneficiaries in Rural Health Clinics

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Key Findings

- Over half of Rural Health Clinics (RHCs) have night or weekend hours (or both).
- The majority (87%) of RHCs accept walk-in appointments, and two-thirds have language interpretation available at their clinic.
- Over half of RHC respondents reported that the nearest clinic was less than 10 miles away, and two-thirds reported that the nearest hospital was less than 10 miles away.
- Most RHCs had a medical doctor or nurse practitioner (or both), but only one-quarter had a care coordinator and less than one in five had a social worker and/or case worker.

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Purpose

Access to timely, high-quality health care is essential for health, but rural areas face particular barriers to access, including for primary care. However, there is limited information on access to primary care for Medicare beneficiaries in rural areas, specifically care received in Rural Health Clinics (RHCs), which are safety net clinics designed to increase access to care for rural residents. This policy brief presents findings from an online survey of RHCs describing clinic data and characteristics related to health care access and capacity for Medicare beneficiaries in rural areas.

Background and Policy Context

Rural areas have struggled with access to health care for decades.[1-4] Reasons for this are multifaceted, but include challenges with transportation and long distances between patients and facilities; difficulty recruiting and retaining health care workforce; financial challenges related to providing care in low-volume settings; and historically lower incomes and higher uninsurance rates among rural residents.[5-8] Access to care is particularly important for Medicare beneficiaries, who are older adults and/or have certain disabilities or complex health issues.[9] In rural areas, where residents are older, on average, than urban areas, and have poorer health outcomes,[10-11] programs and policies to improve access to care for Medicare beneficiaries can have a marked impact on population health.

Lack of access to care in rural areas is due, in part, to workforce issues within these communities. Over 4,700 out of 7,578 Primary Medical Health Professional Shortage Areas are located in rural communities.[12] Primary care providers, (including physicians and non-physician practitioners), specialists, and nurses are all in high demand in rural areas, and workforce availability can impact access to care as well as health outcomes.[13-14]

In an effort to improve access to care, RHCs were created in 1977 to address a scarcity of providers serving Medicare beneficiaries in rural areas. The federal government created RHCs to serve as a source of primary care and preventive services for underserved rural areas.[15] The creation of RHCs has helped to fill the large gaps in care between rural and urban areas, though provider shortages and other barriers to accessing care remain.[13, 16]

In this brief, we use data from a survey of RHC staff to bet-

ter understand how they are addressing issues related to access and capacity for rural Medicare beneficiaries and where gaps remain.

Approach

Data from this study come from a survey of 111 RHC staff from 27 states across the U.S. We conducted an online survey in collaboration with the National Association of Rural Health Clinics (NARHC). Respondents included clinic managers/administrators, practice supervisors, nurse managers, CEOs, medical directors, and physicians. The survey was fielded between March and April of 2019 using an invitation on an online forum. Participation was entirely voluntary, but was encouraged by NARHC.

After data collection was completed, we compiled the data and analyzed counts of responses to questions related to access to care. The majority of survey questions asked participants about accessibility to RHCs, particularly the physical access to the RHC, the availability of appointments, and the flexibility of services. Most items analyzed for this study were closed-ended questions (e.g., yes/no or multiple choice). Using the responses to these questions, we calculated percentages for each question. Percentages reflect data with different denominators as we used all available data for each measure and not all respondents answered every question. As this survey included RHCs that voluntarily chose to participate, data cannot be considered representative of all RHCs, but instead provide a perspective of RHCs willing and able to respond to a request for information on this topic.

Means were calculated for responses related to the percentage of the RHC population who are Medicare beneficiaries and for next appointment availability for new and established Medicare beneficiaries. Medians were also calculated for next appointment availability for new and established Medicare beneficiaries. For responses to next appointment availability for new Medicare beneficiaries, an outlier of 210 days was excluded from calculations of the mean as it was far outside of the range of other participants' responses.

We also examined data from an open-ended question asking respondents if there was anything unique about their clinic that they thought we should know. For these data, three members of the research team coded responses for themes independently and then met to discuss any instances of disagreement and come to consensus.

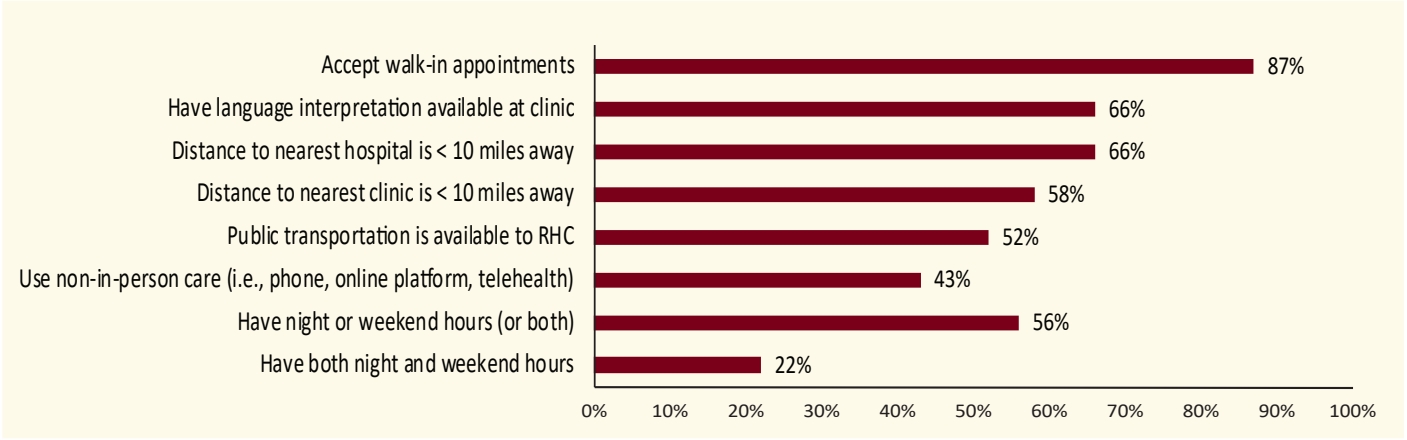
Results

Clinic Characteristics

On average, respondents reported that approximately 37% of their RHC patient population are Medicare beneficiaries. Distance to the nearest hospital or clinic was relatively close for the majority of RHC respondents, with 58% reporting that the nearest clinic was less than 10 miles away, and 66% reporting that the nearest hospital was less than 10 miles away (see Figure 1). Just over half (52%) of clinic staff noted that there was public transportation available to their RHC.

Though 87% of respondents said their RHCs accept walk-in appointments, other indicators related to appointment availability varied. For example, nearly two-thirds (65%) of respondents described having appointments available for existing Medicare beneficiaries within one day, and 37% described having appointments available for new Medicare beneficiaries within one day. The mean next appointment availability was 2 days for established Medicare beneficiaries, and 5 days for new beneficiaries, while the medians were 1 day for established beneficiaries and 3 days for new beneficiaries.

Figure 1: Percentage of RHCs with Access Characteristics



Only about half (56%) of RHCs reported having night or weekend hours, with just 22% having availability on nights and weekends. Less than half (43%) of RHCs reported using non-in-person care (online platforms, telephone, telehealth). Also, 66% of respondents noted that their RHCs have someone at their clinic who is available to assist patients with language interpretation needs.

Workforce

There was also variation in the workforce employed at RHCs (Figure 2). Most RHCs (86%) had a medical doctor or nurse practitioner (or both). Less than half, however, had a physician's assistant (47%), only one-quarter had a care coordinator (27%), and less than one in five had a social worker (15%) and/or case manager (13%). Very few RHCs (6%) employed a certified nurse midwife.

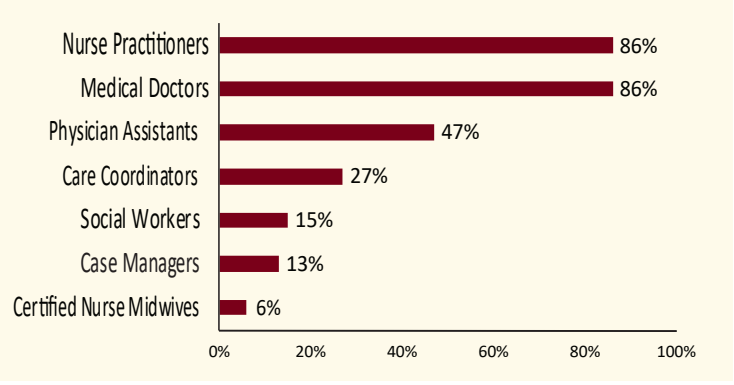
Uniqueness of RHCs

When respondents were asked to describe if there was anything unique about their clinic, three themes emerged: 1) RHC participation in an integrated health system; 2) examples of strategies to improve access; and 3) examples of a strong community connection. The integrated health care system structure among these RHCs varied from patient-centered medical homes (PCMHs), integration with behavioral health or clinical pharmacies, or participation in an Accountable Care Organization (ACO).

Respondents also highlighted strategies their clinics employed to improve access for rural Medicare beneficiaries. Examples included availability and flexibility characteristics, such as having one provider keep an empty schedule for acute visits, maintaining night and weekend hours, and providing home visits. Patient education and community outreach were also mentioned as unique approaches employed by RHCs.

Finally, many respondents noted their strong community connection as a distinctive RHC characteristic. Some mentioned they "love their patients" and that "they are a family" or "friendly." Others highlighted that their RHCs are well established locally (though not originally designated as an RHC), dating back as far as 1910. Others stressed that "patient care is [their] primary focus, not ROI [(return on investment)]" and that they were community owned.

Figure 2: Percentage of RHCs with Full-Time Employees



Discussion and Implications

Overall, in this study we identified multiple ways in which RHCs are addressing access and capacity to improve care and remove barriers for rural Medicare beneficiaries. Most RHCs surveyed were able to see both new and established Medicare beneficiaries relatively quickly, with appointments available within a day or two for established patients and 3-5 days for new patients. The majority of RHCs also accepted walk-in patients.

Similar to other studies on access to health care in rural areas, transportation emerged as a perennial problem in this study. Only half of the respondents in our survey have public transport available for their patients. Additionally, while some RHCs indicated the availability of night or weekend hours, overall, there was little flexibility through services like after-hours care or telehealth.

Incorporating telehealth practices not only for primary care, but also for specialty care, into the care practices at RHCs could improve access to care among the beneficiary population. However, payment restrictions on RHCs, including reimbursement rates for telehealth and originating site restrictions, may prevent growth in this area. Other clinical adaptations, including an increase in night or weekend hours or home visits, could be improved to allow for greater flexibility for patients to access care. However, adding those may stretch already resource-constrained clinics.

We also found that interpretation services at the RHCs participating in our survey were limited, which

may lead to access barriers for rural residents who are not conversant in English. Rural areas are becoming more racially and ethnically diverse, with Hispanic individuals making up the fastest growing segment of rural populations.[10] With greater diversity there may be changes to the needs of certain rural areas, and interpretation services may be one area that is overlooked for contributing to access of health care services.

RHCs provided limited access to care coordinators, social workers, and case managers, which could make it difficult for clinics and rural communities to address broader social determinants of health. A lack of coordination and communication could also influence a clinic's ability to successfully connect patients with specialty services[17] and more advanced care.

Future research should continue to explore the ways in which RHCs and other safety net clinics, beyond those represented in this survey, work to meet the health care access needs of the rural communities they serve, as well as the specific challenges they face. Results from this survey showed that while RHCs and rural communities may struggle with certain aspects of access to care, these challenges are common across the RHCs that participated in the survey. However, despite these barriers, there were a number of areas that the RHCs identified as common strengths. These characteristics point to the awareness that RHCs have about the importance of improving the health of the communities they serve despite the challenges they may face.

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