NIH Addresses Health Disparities in Rural Areas

The pandemic has increased awareness around rural health inequities via increased public communication and technological tools.

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During a time when digital technologies in health care has presented many benefits, the pandemic has enabled the opportunity for health agencies to break down existing red tape and social inequities in order to provide better access to health care in rural communities.
The dire needs for health care innovation in these communities are not new. During a Nov. 19 videocast, National Institute on Minority Health and Health Disparities Director Dr. Eliseo Perez-Stable explained how health disparities have been prevalent over the past few decades for approximately 60 million people living in rural areas.

“Rural residents have worse health outcomes compared to their urban counterparts — whether it be access to screening tests and prevention; risk behaviors such as drinking, smoking and physical inactivity; and then the outcome of obesity,” he said.

Those living in rural areas also have less access to health care and are more likely than their urban area counterparts to die from serious chronic conditions, such as heart disease and cancer, he added.

Some challenges in these areas have been exacerbated by the COVID-19 pandemic. Telehealth services, which has been shown to be a valuable tool in health care this year across the nation, are limited in rural areas due to insufficient broadband connectivity. Other challenges, like food security and availability of transportation, have presented further roadblocks.

“These are huge issues that are prevalent and common for all rural areas,” Perez-Stable said.

There is an apparent correlation between COVID-19 infection rates in rural communities and the lack of broadband in high-risk areas, noted National Institute of Allergies and Infectious Disease Associate Director for Scientific Management Dr. Marshall Bloom.

“[If] you're in a rural area, you have a higher rate of avoidable or excess death," Bloom said. "The pandemic on top of that, and you see the challenge we have moving forward and one that has us all quite concerned at this point."

While rural areas have been struggling during the pandemic, COVID-19 has also disproportionately impacted American Indian and Alaska Natives, Hispanic and Latinos, and Black subpopulations with higher hospitalization rates, Bloom said.
Out of those subpopulations, American Indians living in native reservations experienced most the most disproportionate COVID-19 death toll. Among the many unique health challenges, Bloom listed serious comorbidities (i.e. diabetes, poverty and obesity) and a lack of internet connectivity, among others.

Other challenges these communities face include the physical infrastructure and limited resources to support patients in intensive care units.

“Of the 2,000 rural hospitals that we have in rural America, about 1,700 of them have 50 beds or less, [while] 1,300 of them are 25 beds or less. So we're not talking about large facilities, and we're not talking about a lot of ICU capacity. A lot of these hospitals, they're able to offer ICU in one or two beds, so they have very limited inpatient resources,” said Tom Morris, associate administrator for rural health policy at the Health Resources and Services Administration (HRSA), during the videocast. “We already talked about the fact that the workforce is limited, but they're also financially vulnerable ... The pandemic has not made any of that easier, and we have many more rural hospitals that are at financial risk and have been for quite some time.”

Resources and tools that could help stabilize the negative effects of the pandemic and future emergencies include things like increased support for telehealth capabilities.

The Centers for Medicare and Medicaid Services, for instance, has relieved many of the regulatory barriers that previously existed to allow rural health clinics to provide telehealth services themselves and get reimbursed for providing those services.

“Before the pandemic, rural health clinics and community health centers could receive telehealth services, but they could not provide them,” said Morris. “So they were able to make a change that allowed them to do that.”

Ensuring that certain provisions are made after the emergency will be a very important next step, he added.

HRSA, which serves those who are uninsured, medically vulnerable and geographically isolated, also supported many providers transitioning to telehealth with educational resources and training services during COVID-19.
“We operate a national network of telehealth resource centers, and what they experienced was just a tremendous amount of increase in the number of calls and emails they were getting because basically the whole world had to move to virtual care in March and April and May. A lot of providers needed help doing that, so we received [CARES Act] funding to help our Telehealth Resource Centers do that,” Morris said.

The agency is also working on resources to support clinicians looking to gain appropriate accreditations to practice medicine via telehealth in multiple states.

“We're also getting ready to stand up a new web resource to help clinicians who want to be licensed in more than one state, to sort of speed that process along,” said Morris.

While the National Institutes of Health and other agencies are still looking to communicate these challenges effectively and deploy solutions across the country, there is still much work to be done. The Department of Health and Human Services recently highlighted in its recent Rural Action Plan plans to expand broadband services.