

# SNAPSHOT OF RURAL HEALTH IN COLORADO

2014 EDITION

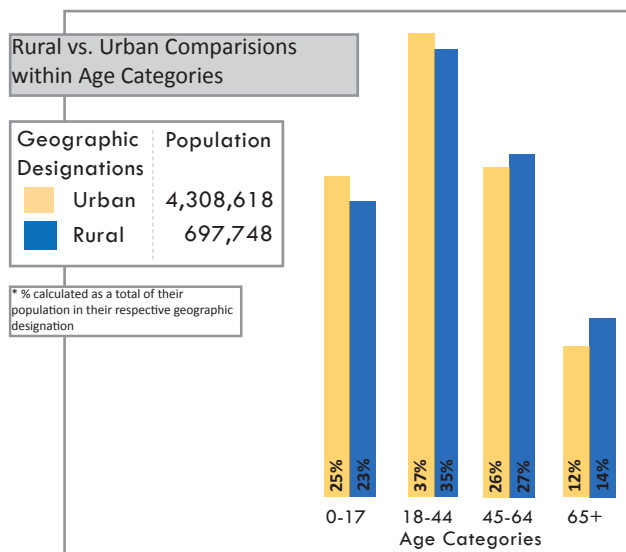
The Colorado Rural Health Center (CRHC) is Colorado's nonprofit State Office of Rural Health. CRHC works with federal, state and local partners to offer services and resources to rural healthcare providers, facilities and communities. CRHC has maintained its mission to enhance healthcare services in Colorado by providing information, education, linkages, tools and energy toward addressing rural healthcare issues since 1991.

*The Snapshot of Rural Health is prepared as a resource to highlight and advance interest in rural health issues in Colorado. A strong statewide healthcare infrastructure must include an awareness of, and attention to, healthcare in rural Colorado.*

## DEMOGRAPHICS OF RURAL COLORADO

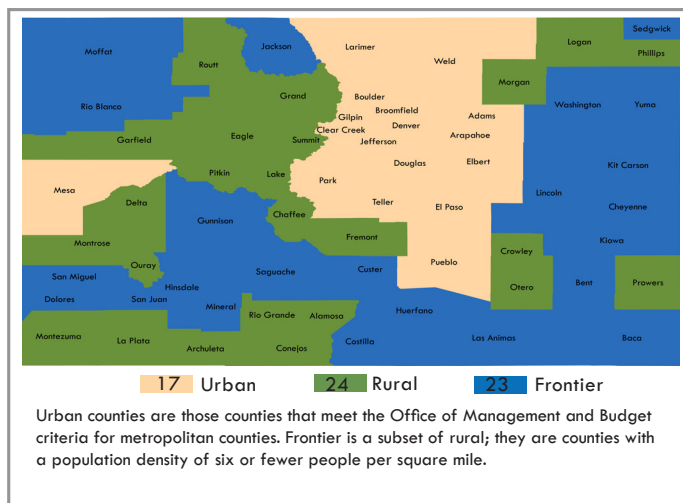
### RURAL STATE

- 73% of Colorado's 64 counties are rural; 17 are urban, 24 are rural and 23 are frontier.
- 77% of Colorado's land mass, or approximately 79,884 square miles, is rural (see map for designations).
- The average rural county covers nearly 1,700 square miles. Las Animas is the largest county with approximately 4,773 square miles, nearly four times the size of Rhode Island.



### POPULATION

- 16% of the population, or 697,748 people, reside in rural counties. Five rural counties have less than one person per square mile.
- The median age in a rural county is between 45-64, versus 18-44 in urban counties.
- By 2018, the age group most projected to grow in rural counties is the 65 and over population.



### INCOME AND POVERTY

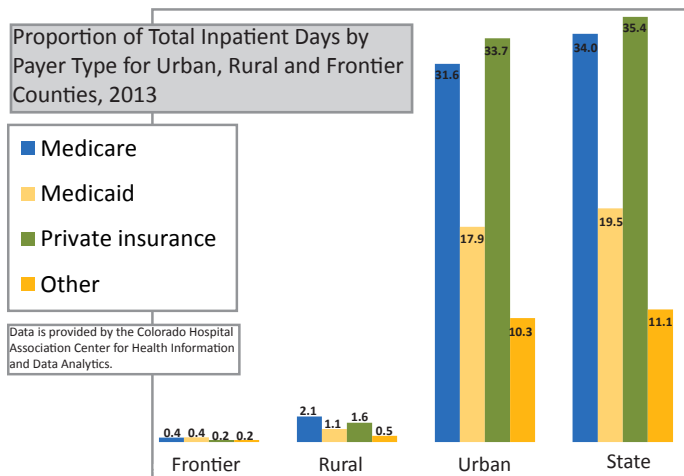
- The income gap between rural and urban counties persists. The median household income in rural counties is 26.5% less than the median household income in urban (\$45,307 compared to \$61,642).
- 9.8% of families living in rural counties live below the Federal Poverty Level (FPL). In urban counties, 8.9% of families live below the FPL. For a family or household of four, the 2014 poverty guideline is \$23,850.
- 24.5% of children residing in rural counties live in poverty, as compared to 15.8% of urban children. 36.4% of rural children are eligible for free or reduced priced school meals.

## RURAL HEALTH FACILITIES

The facilities that make up the rural health safety net are essential to the health and well-being of rural communities. Critical Access Hospitals, Rural Health Clinics, Federally Qualified Health Centers, community safety net clinics, public health departments, mental health centers, rural hospitals, long-term care centers, and medical and dental practices are the backbone of the rural health infrastructure.

### CRITICAL ACCESS HOSPITALS

Congress created the Critical Access Hospital (CAH) program in 1997 to support the fragile rural health infrastructure and stop the closer of hospitals across the country. CAHs receive cost-based reimbursement from Medicare. This reimbursement is intended to improve their financial performance and reduce closures. CAHs must be located in rural areas, must have 25 beds or fewer and must be over 35 miles from another hospital or 15 miles from another hospital in mountainous terrain or areas with only secondary roads. They may also be deemed a necessary provider by the state. There are 29 CAHs in Colorado.



### RURAL HEALTH CLINICS

Rural Health Clinic (RHC) criteria was established by Congress in 1977 to support and encourage access to primary healthcare services for rural residents. Therefore, a RHC is a federal designation that applies to a primary care clinic located in a non-urbanized area. RHCs must employ an advanced practice nurse, a physician assistant or a certified nurse midwife at least 50% of the time the clinic is open. Clinics receive cost-based reimbursement for services rendered to Medicare and Medicaid patients. There are 51 RHCs in Colorado.

13 counties in Colorado do not have a hospital, and two counties do not have a hospital, a Rural Health Clinic or a Federally Qualified Health Center.

### FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers (FQHCs) or Community Health Clinics (CHCs) receive grants under Section 330 of the Public Service Act. To receive enhanced reimbursements from Medicare and Medicaid, FQHCs must serve an underserved area or population (may be located in a rural or urban area), offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program and have a governing board of directors. There are 52 rural FQHCs in Colorado.

## WORKFORCE

The rural health provider workforce shortage is complicated. In order to reduce the provider shortage, it is critical that policymakers and program implementers better understand the nature and complexity of workforce issues.

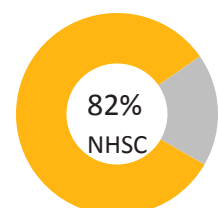
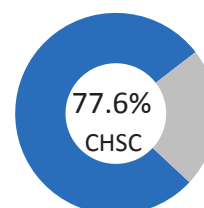
The Health Professional Shortage Area (HPSA) and the Medically Underserved Area (MUA) are two key federal designations that help identify areas of the country with health provider access issues and areas in need of assistance with healthcare delivery. Nearly all counties in Colorado are either totally or partially designated as a shortage or underserved area.

- Six counties in Colorado do not have a licensed dentist or dental hygienist.
- One county does not have a licensed physician, and one county does not have an advanced practicing nurse or a physician assistant.
- 12 counties do not have a licensed psychologist or a licensed clinical social worker.

Loan repayment programs are important tools used to recruit providers to rural and urban underserved clinics. The National Health Service Corps (NHSC) and the Colorado Health Service Corps (CHSC) are vital programs for recruiting healthcare providers.

- On average, it takes one year to recruit a physician to a rural community, and recruitment for an advanced practice nurse or physician assistant is six months.

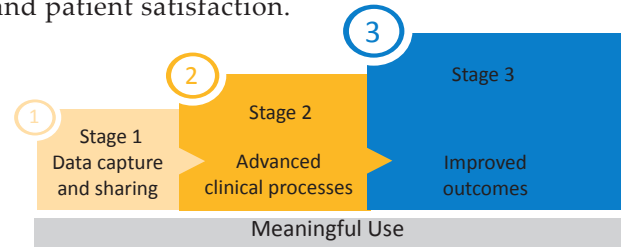
#### Retention After Service Obligation



## HEALTH INFORMATION TECHNOLOGY

Many of Colorado's rural health providers already use health information technology (IT). However, barriers in the adoption and use of health IT include resource limitations when purchasing new or upgrading existing systems, inadequate broadband and Internet access, staffing shortages that impact availability for training and implementation and insufficient health IT personnel to effectively implement and sustain health IT. Despite limited resources, rural clinics and hospitals are working to adopt and make meaningful use of electronic health records (EHRs) to improve clinical care coordination, quality and patient satisfaction.

- Nearly all RHCs have adopted an EHR or have begun planning to adopt one.
- All 29 CAHs have an EHR and are working to demonstrate meaningful use in the EHR incentive program.



## COVERAGE AND ACCESS

With so many new public and private health insurance programs included in the Affordable Care Act (ACA), more information is needed to fully understand the impact on rural patients and providers. This data will be invaluable to inform strategies moving forward to address dynamic rural health policy issue issues such as churning, network adequacy, the 90-day grace period, underinsurance and geographic ratings.

- Rural Coloradans have a higher rate of uninsurance (20.6%) compared to their urban counterparts (15.1%).
- Rural Coloradans experience interruptions in coverage (often called churn) at a rate slightly higher than urban (11.9% versus 10.8%).
- Even post-ACA implementation, rural residents do not have as many choices as urban residents in terms of premiums, issuers, plans and plan types.
- The annual out-of-pocket expenses reported by the underinsured are almost eight times greater than those of the adequately insured and the uninsured.
- High deductibles mean uncompensated care for rural providers.



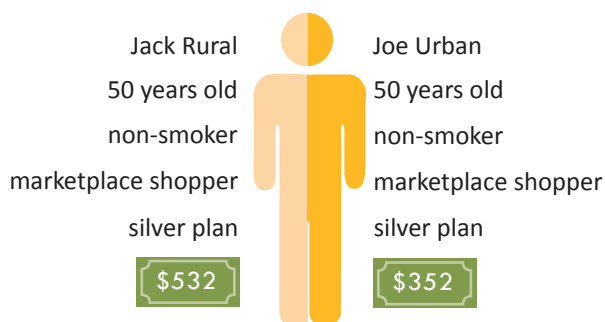
- The rural economy is largely based on self-employment and small business. Compared to urban residents, rural employees are more likely to work in establishments with 10 or fewer employees.
- Rural populations have historically faced higher premiums and less competition compared with urban populations, primarily due to lack of economies of scale and lack of competition among providers.

**43,869**  
lives changed  
in rural Colorado

Due to individuals enrolled in private health coverage through Connect for Health Colorado during the first open enrollment period and through the Medicaid expansion (during the same period) in rural and frontier counties.

- Of the Coloradans signed up for, private health insurance through Connect for Health Colorado during the first open enrollment period (ended March 31st), 17% were from rural.
- Of the Coloradans signed up for the Medicaid expansion, 15% were from rural (during the same period of time).

### The Cost of Health Coverage per Month...

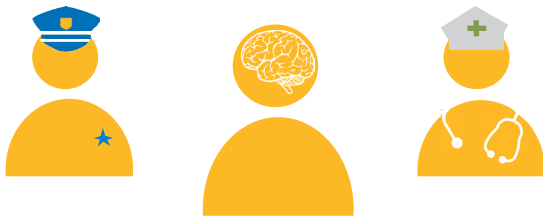


...the difference is \$180 in groceries.

## DISPARITIES

### BEHAVIORAL AND MENTAL HEALTH

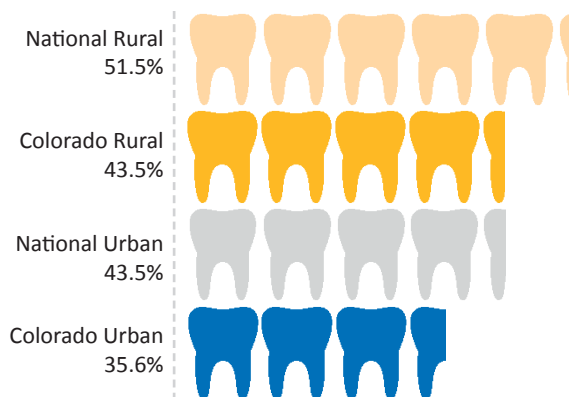
- More than 65% of rural Americans get their mental healthcare from their primary care provider.
- Suicide remains disproportionately higher for rural residents in Colorado. The regions of the state with a suicide rate significantly higher than the state average are the northwest and the central mountain regions (Health Statistics Regions 11, 17 and 13), as well as the urban HSA 17 (Mesa County).
- The mental health crisis responder for most rural Americans is a law enforcement officer.



### ORAL HEALTH

- The oral health landscape in Colorado is changing. While the dental provider shortage is not new, 2014 is the first year an oral health benefit is available for adults with Medicaid coverage.
- The rate of tooth loss due to decay for rural adults is 43.5% versus 35.6% for urban adults.
- Currently, 33.7% do not have a private practice dentist taking Medicaid as compared to 26.4% in urban. With the new adult oral health benefit in Medicaid, this number might shift.

#### Average Adult Tooth Loss Due to Decay

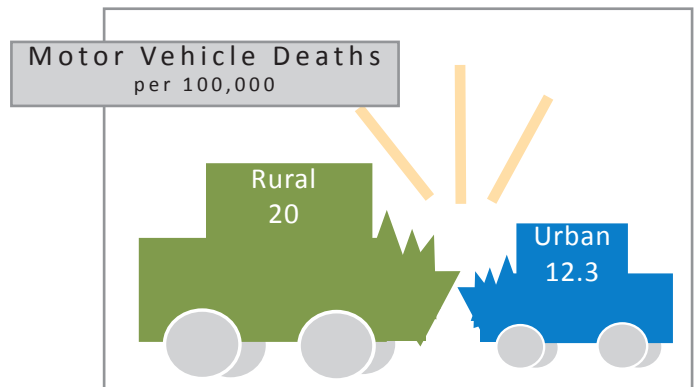


### EDUCATION

- Rural residents are less likely to have a high school diploma than their urban counterparts. 11.5% of rural adults do not have a high school diploma as compared to 7.3% of urban adults.
- Coloradans with higher levels of educational attainment have lower rates of obesity, physical inactivity and smoking.

### FOOD SECURITY

- Rural communities face limitations when it comes to accessing healthy food outlets.
- Nationally, one in nine (11.5%) rural households contain a Supplemental Nutrition Assistance Program (SNAP) recipient that is either 60 years old or older or a child under 18.
- Any changes to the SNAP funding are likely to disproportionately impact rural families and communities.



### VEHICLES AND TRANSPORTATION

- 14% of rural adults have low incomes and lack transportation compared to the state average of 8%. Transportation is important to access and secure basic needs.
- Higher rates of motor vehicle deaths are found in rural areas compared to urban (20 people per 100,000 versus 12.3 in urban).

### OTHER

- The rate (per 100,000 people) of unintentional injury death is also higher in rural areas (33, as opposed to 30 in urban counties).
- The rate of births to teens between the ages of 15 and 19 is 1.6 times higher in rural than urban.