Rural Health Care

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United States population according to the 2018 data from the U. S. Census Bureau was approximately 327,167,434 people and 46,100,224 live in rural communities (RHIhub, 2018). 1 and 5 older Americans live in rural areas and in certain states over half their populations are in rural areas. The Older Population in Rural American 2012-2016 reflects that approximately 17.5 percent of the rural population was over the age of 65 compared to 13.8 percent that live in urban areas (Trevelyn, 2019). 2019 data from data.HRSA.gov there are approximately 1,351 Critical Access Hospitals, 4,386 Rural Health Clinics, 3,681 Federally Qualified Health Centers and 1,120 short term hospitals in rural areas (HRSA,2019). Over the next 25 years the population in rural areas over the age of 65 is expected to double, due to the longer life spans, the increased number of baby boomers reaching retirement age. Chronic disease has been identified as a burden on older adults that impacts both healthcare cost and the person's quality of life (RHIhub, 2018). Along with chronic conditions rural areas struggle with creating and maintaining access to quality health care. Rural population encounter barriers to healthcare that prevent them from obtaining the care that they require. In order for them to obtain quality healthcare they need to have sufficient access, necessary and appropriate healthcare services available to them. In some cases even with the access available there are other barriers such as the rural resident needs financial means to pay for service, transportation for the resident to obtain services, confidence in their ability to communicate with healthcare providers (patients that are not fluent in English, or poor health literacy), the belief that they will receive quality care and trust that they can use the services without compromised privacy (RHIhub, 2018).

According to National Conference of State Legislatures only 11% of the nation's physicians practice in a rural community, despite approximately 20% of the American population

live in rural areas. This is making rural areas underserved by providers, healthcare facilities and hospitals. A recent survey found that 41% or rural Medicare beneficiaries saw a physician's assistant or nurse practitioner for all 17% or some 24% of their primary care in 2012 (National Conference of State Legislature,2013). It is agreed that thousands of additional primary care providers are needed to meet the current demand in rural communities, during the coming decade, tens of thousands additional primary care providers will be needed to meet the growing population. It is important to obtain regular primary care more preventive services, make the patient more likely to adhere to their treatment plan and have lower rates of illness and premature death according to research (Starfield, 2015). Patient Protection and Protection and Affordable Care Act require most all citizens have insurance will increase the demand for healthcare services. Estimates are 8 to 9 million rural individuals will be eligible for coverage through Medicaid as a result of the expansion coverage for those with incomes up to 133% of federal poverty guidelines (Hinkley, 2012).

Rural Culture

Rural population have an emphasis on hard work, self- reliance, typically hard work with hands, toughness in minor or not so minor physical injuries are shrugged off. A high concern about privacy and confidentiality, it is custom not to acknowledge a patient in less they acknowledge you first (Porter, 2014).

Interprofessional Team

Chronic illness is a concern for healthcare in rural areas; they have an impact on the resident's quality of life, mortality and cost of their healthcare. National Center for Chronic Disease Prevention and Health Promotion has a webpage that provides teaching on chronic

illnesses, prevention strategies, economic and health cost. It provides information on how providers and communities can assist each other in order to help residents with chronic illnesses, where to look for funding assistance. A few of the chronic illnesses that elderly rural residents are diagnosed with are diabetes, heart disease, strokes, chronic respiratory diseases and arthritis to name few. The interprofessional team is comprised of hospitals, clinics, providers and community health workers and many more. Providing safe, effective patient care requires all members of the healthcare team, regardless of discipline, have expertise in their fields of study. Healthcare team members often fail to understand the educational preparation and practice of professionals of other disciplines (Perron, 2018). In order to provide proper care and improve patient health outcomes today's nurses have to collaborate effectively with members of the healthcare team from other disciplines. In essence this means working as a team leader and team member. Learning the language, norms, and special foci of other disciplines foster a more effective use of resources and knowledge. The six healthcare education associations in the United States developed the Interprofessional Education Collaborative: American Association Colleges of Nursing, American Association of Colleges of Pharmacy, American Association of Osteopathic Medicine, American Dental Education Association, Association of American Medical Colleges and Association of Public Health. Together these organizations worked together to define interprofessional collaboration and four core competencies: 1) interprofessional teamwork, 2) values and ethics for interprofessional practice, 3) roles and responsibilities for collaborative practice, and 4) interprofessional communication practices. Overview of these competencies is to embrace the values and ethics of interprofessional practice means working together while respecting the expertise of those in other disciplines. Being aware of the professional roles and responsibilities of all team members; effective communication with

patients, families and other healthcare professionals; and developing relationships to plan, implement and evaluate safe care all contribute to the health of the patient and the community. Future of interprofessional collaboration for nurses, healthcare professionals and patients is to improve patient health outcomes, decrease in preventable errors, reduction in healthcare cost, and improved relationships with other disciplines. The enhanced communication among the disciplines can lower the workload for all healthcare professionals by decreasing duplicate effort and increase knowledge (Jakubowski, 2018).

Telehealth uses secure video and audio technology to connect providers in smaller health care facilities with specialist in larger areas. In rural areas the residents are usually 100s of miles away from the care they require. Low budgets and low census in community hospitals usually leave them without specialist for instance cardiologist, neurologist or neonatologists on their staff and if they do they often lack sufficient coverage. Local providers don't get the chance to learn from specialist about complicated care. Likewise social workers, crisis workers and care managers for chronic diseases are also not available in rural communities in turn requiring the resident to travel hours for basic care. Telehealth can change these situations and benefit the community and the providers. It helps the patient to receive the care they need locally without the cost and risk of transfers to an urban area, the local hospital benefits by retaining volume of patients and revenue. Community benefits from evidence based best practice care and it make healthcare overall better. Telehealth gives the providers and specialist real-time updates on medical conditions and care. Telehealth can help smaller facilities to meet federal standards such as stewardship programs meant to ensure appropriate use of antibiotics. Telehealth makes sense to both clinical and financial perspective when you have financial risk since the savings aren't escaping to third party insurers. Payment policies and reimbursement models need to catch up

with this major advancement in health care technology and delivery which works best in pre-paid, capitation, model vs fee- for volume scenario. Washington D.C. is discussing about creating parity payment so the care providers can be paid the same for digital visits as for an in person visit. At this point only limited telehealth services are being covered by the federal government and other payers (Harrison, 2019).

Cultural Competency & Strategies

Cultural competency can be defined as a willingness to make changes to though and behavior to addresses biases, capacity of people to increase their knowledge and understanding of cultural differences. Using the National Standards for culturally and Linguistically Appropriate Services in healthcare, these standards are there to assist the healthcare organization and its staff to develop and implement programs that are appropriate for different cultures, languages and populations. Addressing communications barriers, language and cultural barriers while providing an environment where people with diverse cultural backgrounds can feel comfortable discussing their cultural health beliefs and practices while negotiating health treatments that are available to them (RHIhub,2018). Integration strategy is care coordination that facilitates patient's transition across a care setting and ensures the patient's individual health needs are met. Taking place by partnering with patients to develop plans that respect their preference as well as communicating with community partners, a community partner may be within the same system but are more often at external agencies like health care providers, home health care, community

organizations and health care insurance providers. Studies have shown that care coordination can improve treatment and reduce hospital use (Ghaffari, Wells, Creel, Sianez 2018). A care pattern in which a patient sees multiple providers across different specialties shows not only a significant need for but a challenge to coordinate the care delivery. When care coordination fails it leads to medication conflicts, hospital readmissions, duplicate testing and a huge gap in preventive care (Chang, Wanner, Kovalsky, Smith, Rhodes, 2018). Care coordination strategies are designed to be able to predict and prevent gaps in healthcare, navigate services to achieve a desired health outcome, quality and cost effective outcomes along with relaying data among patients, providers and insurers.

Technology

The goal of health communication and health information technology is to improve population health outcomes and health quality and achieve health equity. Health communication and health information technology are central to public health, healthcare, and the way society views health overall. Made up by ways and the context in which health professionals and public search for, understand and use health information, impacting their health actions and decisions. Providing new opportunities to connect with culturally diverse and hard to reach populations and by providing sounds principles in the design of programs and interventions that result in healthier behaviors. Health information technology is important to improve health care quality and safety, increasing the efficiency of healthcare and public health delivery, support care in the community

and at home, improve the public health information infrastructure and to build health knowledge and skills (HealthyPeople, 2020). Effective care coordination begins with effective sharing of health information across electronic medical records; progress in care coordination across separate health system could be achieved by improved interoperability among various electronic medical records systems. With mirroring calls for the establishment of a national standardized health information system, multiple providers verbalized a desire for unified health records that would accessible to any provider to see (Chang, Wanner, Kovalsky, Smith, Rhodes, 2018). Care coordination documentation is crucial to capturing the care process that includes assessment, development, implementation and evaluation of care based on the patient's own set of beliefs, values and preferences. The use of standardized terminology, a common data elements, reported outcomes by patients are needed the appropriate care of the patient and the evaluation of the patients responses. Health Information Technology provides a structure for documenting care coordination, electronic medical records contains personal health data and describes the patients' health status, care processes and patient health outcomes (Lamb, Newhouse, 2018).

Legal

Many legal issues with telehealth from cross state medical practice, malpractice insurance, reimbursement, online prescribing and informed consent. Telehealth presents a completely different way to care for patients so it is understandably to present some unique legal situations for providers. Top issue is state licensing, if you are licensed in one state are limited to only treating patients in that state. Interstate Medical Licensure Compact is promising for providers in a way the compact allows them to bypass the standard licensing process, reducing the cost and get the licensures quicker. There are 26 states and 1 territory apart of the compact as of January 2019. Second concern is malpractice insurance some healthcare providers assume

that telemedicine would raise their liability but it has shown that. Telehealth is shown to be used for low liability cases and routine follow ups along with switching from off hours or undocumented phone calls to billable telemedicine visits can improve documentation of patient care (Iafolla,2019).

Over the next decade the scope, speed and scale of adoption of health information technology will increase. Emerging technologies and social media promise to blur the line between expert and peer health information. Monitoring and evaluating the impact of this media that includes mobile health and public health will be a challenge. Other challenges will be assisting the health professional and public to accept and adapt to the changes in healthcare quality and efficiency due to the creative use of health information and health communication. Productive interactions, continual evaluation, access to evidence of the effectiveness of treatments and interventions will definitely change the doctor patient relationship. Will change the process of the way people receive; process and evaluate information. Capturing the scope and impact of these changes, the role of health care communication and health information technology in facilitating them will require a multidiscipline models and data systems, these types of systems will be critical to increase the collection of data to better understand the effects of health communication and health information technology on population and their health outcomes, quality of healthcare and health disparities (HealthyPeople2020). Three set of potential liabilities risk factors associated with care coordination for patients with multiple chronic conditions, the likely patient population, expanded professional responsibilities of care coordinating provider and the use of information systems and best practice guidelines. Patients with multiple chronic conditions are normally elderly and points to a lower liability risk since the elderly are less likely to sue their provider even though they are more likely to suffer medical

injury. If a suit is filed the elderly are less likely to generate high damage award because most awards are often dependent on life expectancy and earning potentials. Another element of concern is the provider's sense that expanding care coordination requires them to assume a broader scope of responsibility for patient's health outcomes and quality of care. Providers think that referring a patient to other provider limits the scope of their own responsibility but care coordination blurs that line by holding the coordination provider responsible for monitoring the care delivered by other providers to the patient. One more element is best practice guidelines or integrated electronic medical records, computerized reminders, and other forms of information of decision making. In theory the liability could he higher by holding coordinating provider to a standard of care set by ideal best practices and by making provider responsible for the information in medical records of multiple providers. Communication issues and inaccurate medical records, and other system problems are the main cause of medical errors in outpatient settings so better information can decrease the chance of a suit. A study of medical errors shows in primary care that informational and personal miscommunication was the root cause of two thirds of medical errors and more that 90% of these communications errors might be eliminated by computers and information systems (Hall, Peeples, Lord, 2015).

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