2021 NORTH CAROLINA RURAL HEALTH SNAPSHOT

Compiled by participating members of the North Carolina Rural Health Leadership Alliance.

Foundation for Health Leadership & Innovation
NC RURAL HEALTH LEADERSHIP ALLIANCE
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01

EXECUTIVE SUMMARY

Dear Friends,

I am excited to introduce the NC Rural Health Leadership Alliance's (NCRHLA) inaugural issue of the *North Carolina Rural Health Snapshot*. A program of the Foundation for Health Leadership & Innovation, NCRHLA connects all organizations interested in strengthening rural health in North Carolina. NCRHLA was founded on the idea that collaboration and a forward-looking, equity-focused approach is required to improve rural health in our state. NCRHLA serves as a hub, a single organizer whose role it is to convene, foster, share, advocate, and offer a unified voice that promotes better rural health for our communities. We are proud of the work of our NCRHLA members and hope this publication will be a useful tool as we work together.

Ensuring that all people have equal access to high-quality health care to help them live healthy and productive lives is a core goal of every state health system. In North Carolina, where you live matters, particularly if you have a low income and are a member of a historically marginalized population. There is a wide gulf in access to and quality of care between those living in rural areas and the rest of the state.

The *2021 North Carolina Rural Health Snapshot* identifies opportunities for North Carolina to improve how our public health system serves our rural population. Overall, the report finds that there are often two North Carolinas when it comes to health care — divided by geography. Wide state differences in health care for rural populations are particularly pronounced in the areas of affordable access to care, preventive care, dental disease, maternal health, food security, and premature death.

Moreover, greater pronounced and persistent racial disparities in health coverage, chronic health conditions, mental health, and mortality exist for Black, Indigenous, and people of color (BIPOC) households in these rural areas because of structural inequities across multiple sectors and health care systems. The COVID pandemic shed a bright light on disparities that have existed for generations. As state health reforms take hold and additional resources become available, state legislators and local care delivery systems have a real opportunity to address these inequities. By doing so, we will not only help reduce these disparities, but we will improve the public health system's performance for everyone in North Carolina, regardless of geography and racial and ethnic demographics.

A special thanks to the organizations who represent NCRHLA, to those who provided data and support in the development of this report, and to our NCRHLA Chair Emily Roland of the North Carolina Healthcare Association, and Vice Chair Patrick Woodie of the NC Rural Center, for their steady leadership throughout this past year.

Best regards,
Kelly Calabria, President & CEO
Foundation for Health Leadership & Innovation

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ABOUT NCRHLA

THE NC RURAL HEALTH LEADERSHIP ALLIANCE SUPPORTS PARTNERSHIPS AND STRATEGIES THAT IMPROVE HEALTH OUTCOMES IN RURAL NORTH CAROLINA.

VISION

NCRHLA is committed to magnifying the voice of rural and underserved North Carolinians to improve health for all.

MISSION

The mission of NCRHLA is to address rural health issues in the state of North Carolina and find solutions that will improve health.

The North Carolina Rural Health Leadership Alliance is a collaborative network of associations, organizations, and individuals representing healthcare, education, economic development, local government, and a variety of rural stakeholders invested in supporting rural health. It is committed to amplifying the voice of North Carolina's rural communities with the intention of improving the health and well-being of all citizens.

Though members of the alliance began convening in the 1990s, NCRHLA was formally established in 2014. The alliance is sponsored by the Foundation for Health Leadership & Innovation in Cary, North Carolina and is funded by the National Rural Health Association (NRHA) and alliance membership dues. The alliance is currently recognized by the NRHA as North Carolina's state rural health association.

GUIDING PRINCIPLES

- We believe in the value, strengths, and assets of our rural communities.
- We strive for NCRHLA to be at the forefront of rural health.
- We endeavor to build the rural voice at the local, regional, state and national levels.
- We promote shared and coordinated resources; including, but not limited to, time, knowledge, expertise, and funding.
- We seek to collaborate across our individual organizational missions and visions to achieve the greatest good for rural communities.
- We promote authentic community engagement and involvement, across all demographic and geographic groups representing rural North Carolina.
- We serve as a space for innovative approaches and collective action that seek to advance rural North Carolina.
- We engage in proactive advocacy for policies and positions that promote whole-person, whole-community health for rural North Carolinians.

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NCRHLA MEMBERS

THE NC RURAL HEALTH LEADERSHIP ALLIANCE IS COMPROMISED OF RURAL HEALTH AND COMMUNITY LEADERS FROM A VARIETY OF PARTNER ORGANIZATIONS.

INDIVIDUALS

Dr. Parissa Ballard
Karen Burns, MSW
Timothy Van Cooke
Dawn Daly-Mack, RN
Robyn Seamon
Dr. Timothy Tolson

ORGANIZATIONS

American Board of Family Medicine

Association of Regional Councils of Government

Blue Cross Blue Shield NC Foundation

Blue Ridge Health

Campaign for Tobacco Free Kids

Campbell University

Care Share Health Alliance

Center for Rural Health Innovation

Community Care of North Carolina, Inc.

The Conservation Fund

The Duke Endowment

Durham County Health Department

East Carolina University

East Carolina University Brody School of Medicine

Eastern Area Health Education Center

Federal Office of Rural Health Policy

Foundation for Health Leadership & Innovation

Kate B. Reynolds Charitable Trust

Kintegra Health

Mission Health

National Rural Health Association

NC Coalition on Aging

NC Pediatric Society

NC Rural Center

North Carolina Academy of Family Physicians

North Carolina AgroMedicine Institute

North Carolina Alliance for Health

North Carolina Area Health Education Centers (AHEC)

North Carolina Academy of Family Physicians

North Carolina Association of Free & Charitable Clinics

North Carolina Community Health Center Association

North Carolina Community Foundation

North Carolina Dental Society

North Carolina Department of Commerce - Appalachian Regional Commission

North Carolina Department of Health & Human Services - Office of Rural Health

North Carolina Department of Health & Human Services - Oral Health Section

North Carolina Healthcare Foundation

North Carolina Institute of Medicine

North Carolina Medical Society Foundation

North Carolina Nurses Association

North Carolina PACE Association

North Carolina State University Institute for Emerging Issues

North Carolina Rural Economic Development Center

Roanoke Chowan Community Health Center

Rural Health Group NC

University of North Carolina - Asheville

University of North Carolina Cecil G. Sheps Center for Health Services Research

University of North Carolina Center for Health Promotion and Disease Prevention

University of North Carolina - Chapel Hill

University of North Carolina - Greensboro

University of North Carolina School of Medicine

Vidant Health

Western Carolina Medical Society

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COVID-19 IMPACTS

No health report would be complete without recognizing the profound impact the COVID-19 pandemic has had on North Carolina's rural communities.

While many of the healthcare challenges created and exacerbated by COVID-19 affect all Americans, those living in rural communities throughout our state face particular risks and challenges that have created a landscape where our rural citizens continue to be disproportionately affected by COVID-19.

In rural areas, not only is there a greater proportion of older adults dealing with higher rates of chronic health conditions, but access to quality healthcare remains a challenge for rural residents, even with the expanded adoption of telehealth.

Additionally, rural North Carolina holds a high share of workers in essential jobs (e.g., agriculture, food processing) with a limited capability to undertake these jobs from home, making telework and social distancing much harder to implement.

And finally, with each new COVID-19 case that requires medical attention and/or hospitalization, our local rural hospitals and clinics are at risk of having their local resources overwhelmed. Many of these facilities were already teetering on the edge of financial safety before the pandemic, facing a shortage of care providers, hospital beds, and equipment.

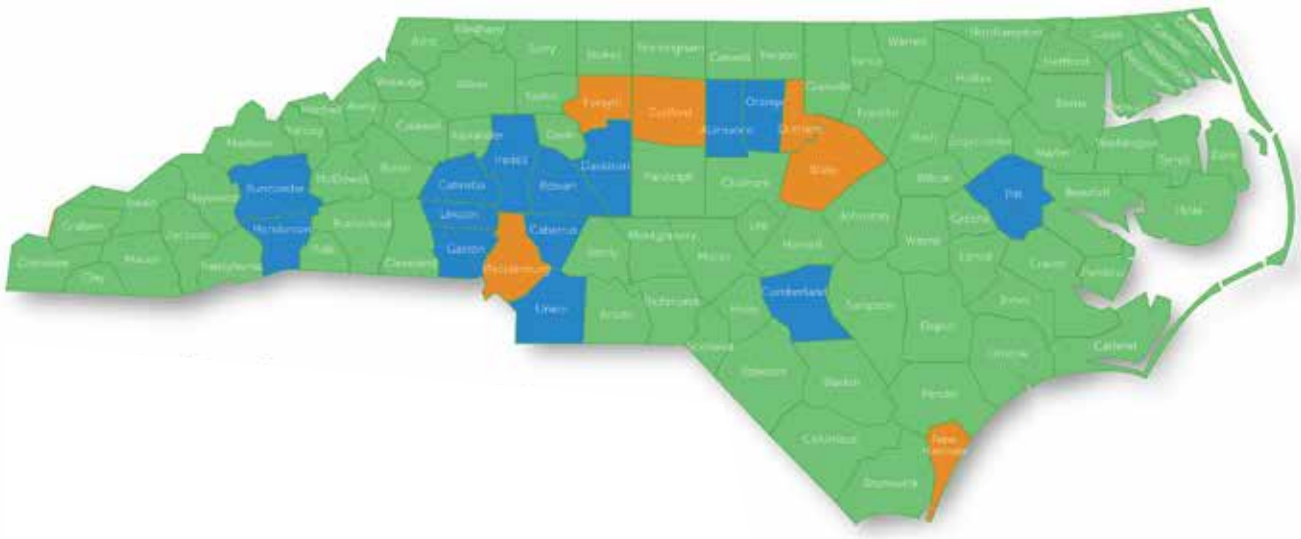
It is our hope that public and private organizations will come together to slow the spread of COVID-19, support local health departments, get our citizens vaccinated as quickly as possible, and address all underlying inequities in access to health and well-being for rural North Carolinians.

80

NORTH CAROLINA'S COUNTIES DESIGNATED AS RURAL

05

NC COUNTY MAP



RURAL COUNTY

County with an average population density of 250 people per square mile or less = 80 counties

REGIONAL CITY & SUBURBAN COUNTY

Counties with an average population density between 250 and 750 people per square mile = 14 counties

URBAN COUNTY

Counties with an average population density that exceeds 750 people per square mile = 6 counties

NC RURAL CENTER

RURAL NORTH CAROLINA DEMOGRAPHICS

07

POPULATION

4,088,127
RURAL POPULATION

18%
RURAL POPULATION 65+ YRS

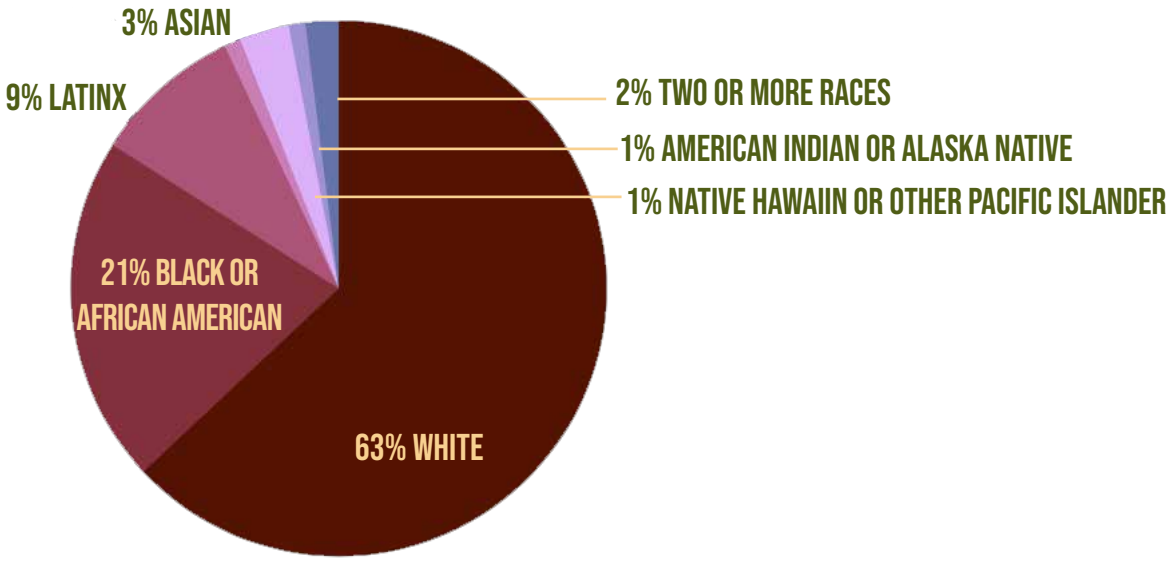
SOCIAL AND ECONOMIC FACTORS

Individuals with low incomes and long work hours may have less time to prepare meals at home and less time to participate in physical activities. Their stress levels or history of trauma may make them more likely to use substances like alcohol or tobacco. Advertisers of unhealthy foods or products target low-income communities and people of color. People with higher levels of education may have more knowledge and access to information about safe sexual practices, healthy eating, and the dangers of tobacco use.*

PHYSICAL ENVIRONMENT

People living in rural areas and low-income communities may be far from a grocery store that sells healthy foods. Their communities may lack formal facilities for exercise, or the roads and public spaces may not be safe to move around in.

NORTH CAROLINA OVERALL DEMOGRAPHICS



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POPULATION

According to the U.S. Office of Rural Health, almost a quarter of all veterans in the U.S. (4.7 million) return from active military careers to reside in rural communities. Active-duty military personnel and veterans have a significant presence in North Carolina, meaning that more North Carolina adults are veterans than the national average: 7.9% versus 6.9% nationwide. In 2019, nearly 642,000 veterans lived in North Carolina according to the most recent American Community Survey estimates. Of those, 46 percent live in rural areas.

While veterans may enjoy the benefits of rural living, they may also experience rural health care challenges that are intensified by combat-related injuries and illnesses.

CHALLENGES FOR RURAL VETERANS

LIMITED ACCESS TO PHYSICAL & BEHAVIORAL HEALTH CARE

Just like any rural resident, it may be difficult for rural veterans and their caregivers to access health care due to rural delivery challenges, including hospital closings; fewer housing, education, employment and transportation options; geographic and distance barriers; limited broadband for telehealth; and the inherent difficulty of safely aging in place in rural America.

HEALTH CARE COVERAGE GAP

Veteran populations may fall into the health insurance coverage gap, as they may be ineligible for VA health care coverage and may not qualify for TriCare.

INCREASED RISK OF SUICIDE

Men 45+, American Indians, whites, and rural residents all face higher rates of suicide than their respective demographic counterparts. The suicide rate among all veterans is 1.5 times that of the non-veteran population. Veterans face unique mental health, financial, and insurance coverage challenges that contribute to the increased rate within the population.

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EDUCATION

$9,377
NC PER PUPIL SPENDING

45
NC RANK AMONG 50 STATES FOR PER PUPIL SPENDING

NORTH CAROLINA SPENDS
$3,000
BELOW NATIONAL AVERAGE PER STUDENT

NATIONALLY, THE MOST RECENT DATA INDICATES AN AVERAGE OF $12,612 IS SPENT ANNUALLY ON PUBLIC EDUCATION PER STUDENT.

HOWEVER, SIGNIFICANT VARIATION EXISTS ACROSS STATES, AS DEMONSTRATED BY NORTH CAROLINA, WHICH SPENDS ABOUT $3,000 BELOW THE NATIONAL AVERAGE.

56.8%
READING AT A PROFICIENT LEVEL OR ABOVE BASED ON THIRD GRADE END OF GRADE EXAMS

SOME FACTORS THAT INFLUENCE STATE EDUCATION SPENDING TOTALS INCLUDE COST-OF-LIVING, CLASS SIZES, AND STUDENT DEMOGRAPHICS

53%
RURAL RESIDENTS WITH POST-SECONDARY EDUCATION, COMPARED TO 67% OF URBAN RESIDENTS

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EDUCATION

ADVERSE CHILDHOOD EVENTS

Adverse childhood experiences (ACEs) — such as exposure to trauma, violence, or neglect during childhood — increase the likelihood of poor physical and mental health as a child grows up. Research has shown that exposure to adverse experiences can impact children's neurobiological development, negatively affecting their learning, language, behavior, and physical and mental health.

23.6%

OF NC CHILDREN 0-17 HAVE EXPERIENCED TWO OR MORE ADVERSE CHILDHOOD EXPERIENCES

A two-year estimate of the percentage of children ages 0-17 who experienced two or more of the following:

- Economic hardship
- Being treated or judged unfairly due to race/ethnicity
- Parental divorce or separation
- Witness to domestic violence
- A parent who served jail time
- Death of a parent
- Victim or witness to neighborhood violence
- Living with someone who had an alcohol or drug problem
- Living with someone who was mentally ill, suicidal or severely depressed

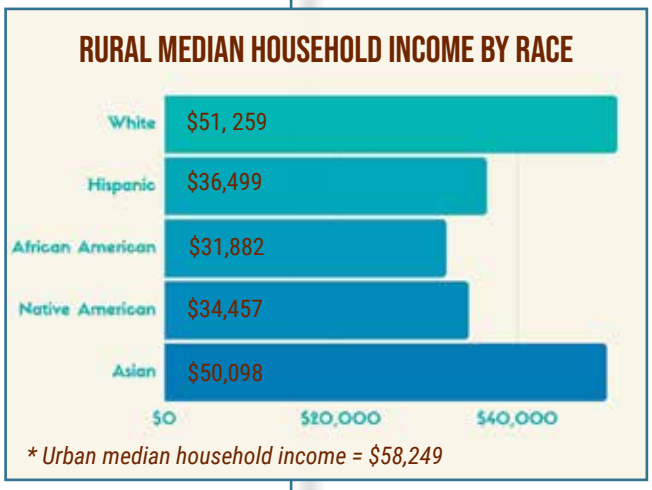
INCOME & POVERTY

RURAL FAMILIES ARE RENT-BURDENED

42%

ARE SPENDING > 30% OF HOUSEHOLD INCOME ON RENT

RURAL	VS.	URBAN
41%	Individuals living at or below 200% of the federal poverty line	**32.5%**



"People who live in homes that cost a large portion of their income — or where there is overcrowding or poor maintenance — are exposed to a variety of health risk factors. In many areas of North Carolina, there are insufficient affordable, quality housing options for low-income people and their families."

North Carolina Department of Health and Human Services, North Carolina Early Childhood Action Plan, Februrary 2019

At least 1 of 4 households experience severe housing problems (HNC 2030)

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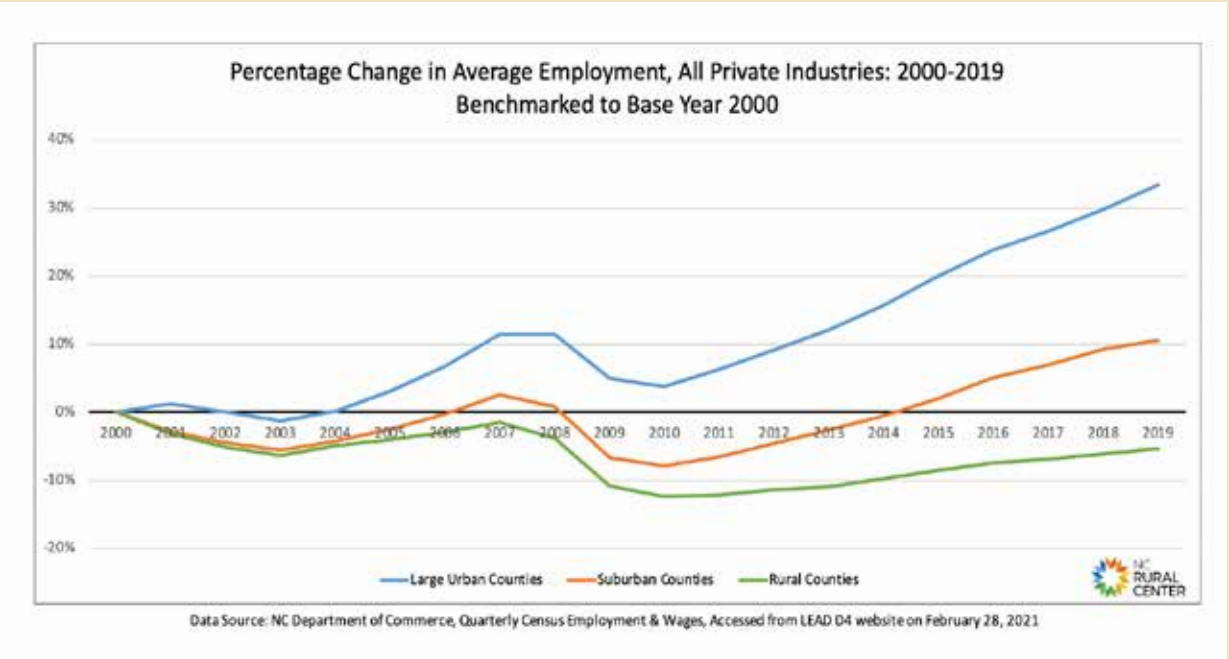
INCOME & POVERTY

EMPLOYMENT CHANGE OVER TIME



Data Source: NC Department of Commerce, Quarterly Census Employment & Wages, Accessed from LEAD D4 website on February 28, 2021

From Healthy North Carolina 2030: "Though unemployment is not an orthodox measure of health, economic well-being is inextricably linked to health outcomes...Loss of income poses clear financial barriers to accessing resources that protect and improve health...Beyond the financial strain, unemployment is correlated with adverse health outcomes related to stress. Treated as a stress-inducing event, the experience of unemployment increases vulnerability to stroke, heart attack, heart disease, and arthritis. Those laid off are more likely to have fair or poor health, have higher admissions to hospitals, and have a greater need for medical attention and medication."

* *The graph above does not account for pandemic-related employment changes.*

FOOD ACCESS

14.4%
OF NORTH CAROLINIANS IN BOTH RURAL AND URBAN AREAS ARE FOOD INSECURE

Some rural residents and households are food insecure, meaning they cannot always rely on access to enough affordable and nutritious food, increasing the risk of poor health outcomes. According to the 2017 United States Department of Agriculture Economic Research Service (USDA-ERS) publication Food Insecurity, Chronic Disease, and Health Among Working-Age Adults, food insecurity is strongly associated with chronic disease and poor health, both of which disproportionately affect rural populations.

Rural shoppers may rely on more expensive and less nutritious food, such as the types available at gas station convenience stores or face a long drive to a town with a grocery store that stocks fresh and nutritious foods.

18.8%
OF RURAL NORTH CAROLINIANS ENROLLED IN SNAP (VERSUS 11.8% OF URBAN RESIDENTS)

7%
OF NORTH CAROLINIANS ARE LIVING IN A FOOD DESERT

Access to healthy and affordable food can be a challenge for rural residents. Many rural areas lack food retailers and are considered food deserts (i.e., areas with limited supplies of fresh, affordable foods). In rural areas, access to food may be limited by financial constraints or other factors, such as transportation challenges.

GENERAL HEALTH INFORMATION

HEALTHCARE COVERAGE

RURAL	VS.	URBAN
62%	Health Care Coverage Rates	68%

In 2018, private insurance rates were higher for urban populations (68 percent compared to 62 percent) whereas rural areas had higher rates of public health insurance relative to urban areas (42 percent compared to 33 percent). Additionally, Medicare and Medicaid are critically important to older Americans and people with disabilities. Moreover, the clinical infrastructure in many rural areas is more limited, with a focus on primary care and chronic disease management and less access to specialty care.35 There are also gaps in oral and mental health services (DHHS Rural Health Action Plan, page 10).

RURAL	VS.	URBAN
42%	Rate of public health insurance coverage	33%

MATERNAL HEALTH

One of the most important factors in an infant's health is their mother's health before and during pregnancy. Low birth weight, birth defects, and even infant death are tied to factors such as access to prenatal care, health risk factors, and health behaviors like smoking or drinking alcohol. Importantly, structural racism presents consistent barriers to healthy outcomes for women of color and their babies.

PREGNANCY-RELATED SERVICES

While almost 70% of all women in NC receive prenatal care in the first trimester, African-American and Hispanic women are less likely to receive prenatal care compared to their white counterparts.

Racial disparities also impact NC's infant mortality rate: African-American babies are more than twice as likely to die before their first birthday than white babies. -- *2021 North Carolina Child Health Report Card published by NC Child and the NC Institute of Medicine*

INFANT MORTALITY RATES

The overall Infant Mortality Rate is 6.8 in North Carolina, with that number rising to 7.5 across our rural counties.

Black infant mortality (12.2 per 1,000) is more than twice the rate of White, non-Hispanic infant mortality (5.0 per 1,000) in North Carolina.

In 2018, Pamlico county had the highest infant mortality rate in the state (22.2%)

TRAVEL TIMES TO RECEIVE CARE

The rural hospital closure crisis is continuing to intensify. According to the UNC Sheps Center, in 2019, the United States experienced the greatest number of closures in a single year since the beginning of the century.

At least 120 rural hospitals have closed since 2010, leaving communities without access to emergency care, increasing travel times for patients, and exacerbating social disparities in health outcomes.

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SEXUAL HEALTH

HIV Diagnoses

NC ranks 40th among all states with 13.9 new HIV diagnoses per 100,000 people.

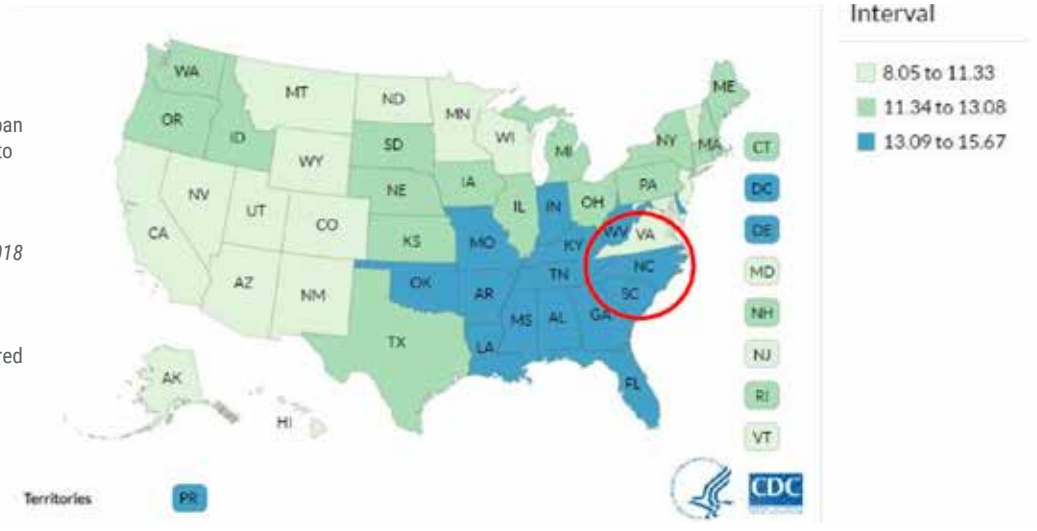
Teen Pregnancy

NC ranks 23rd among all states with 18.7 births to girls aged 15-19 per 1,000 people.

HPV-Associated Cancer Rates

Despite the availability of safe and effective vaccines, fewer adolescents in rural areas are getting the HPV vaccines compared to adolescents in urban areas, leaving them vulnerable to serious diseases.

According to the *Centers for Disease Control & Provention 2018 National Immunization Survey of Teen Data*, rural teens were 15 percentage points lower in receiving HPV vaccines compared to teens in urban areas.



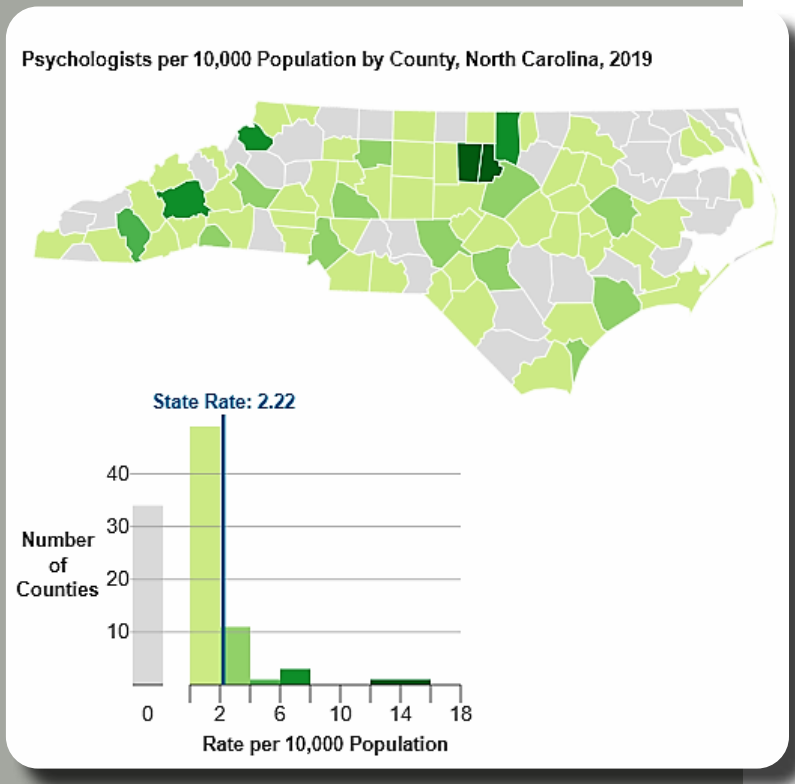
BEHAVIORAL HEALTH

34

COUNTIES WITH NO ACTIVE LICENSED PSYCHOLOGIST

NORTH CAROLINA RANKINGS

- 23rd out of all states for adults with mental illness who did not receive treatment (54.6%).
- 51st out of all states (and Washington, DC) for prevalence of untreated youth with depression (74.3%)
- 48th for youth with severe major depressive episode who received some consistent treatment (17%).
- 26th out of all states for mental health workforce availability.
- 94 of NC's 100 counties have a population or geographic mental health HPSA (94%)



** The term "mental health workforce" includes psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care..*

BEHAVIORAL HEALTH

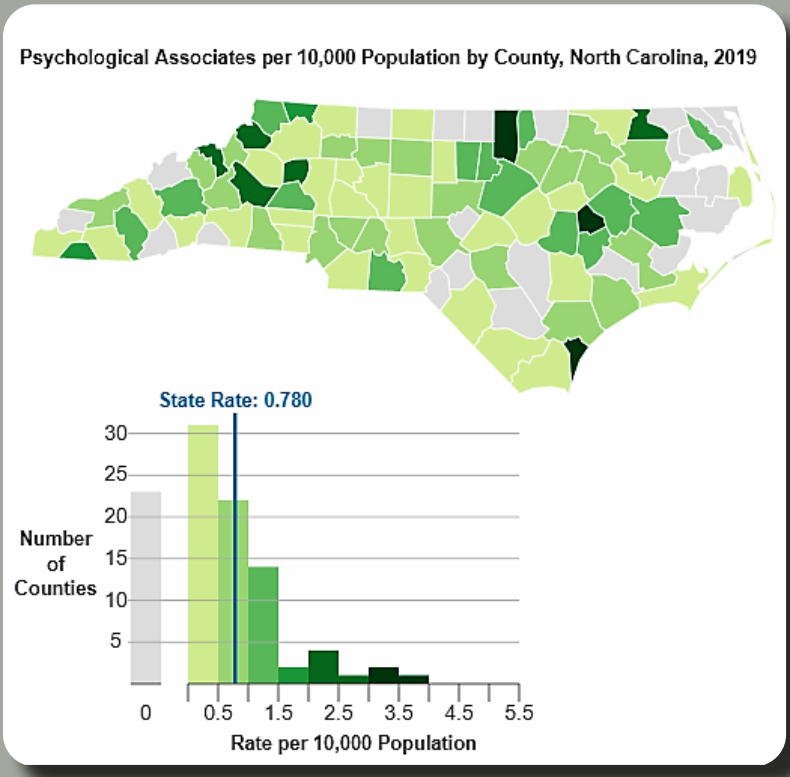
23

COUNTIES WITH NO ACTIVE LICENSED PSYCHOLOGIST ASSOCIATE

RURAL YOUTH ARE TWO TIMES MORE LIKELY TO COMMIT SUICIDE THAN THEIR URBAN COUNTERPARTS.

NORTH CAROLINA RANKINGS

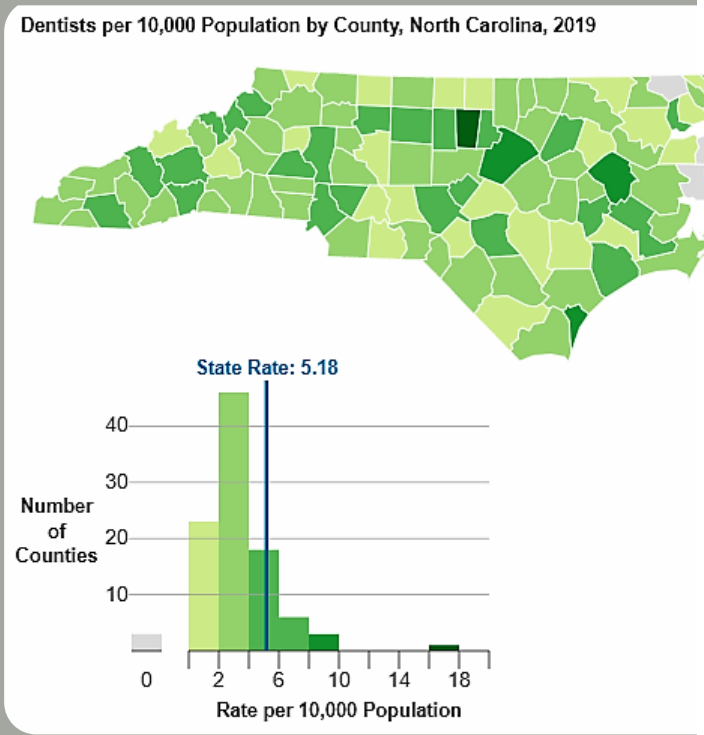
16th
among all states with a suicide rate of 13.8 per 100,000 people.



ORAL HEALTH

ORAL HEALTH CARE ACCESS

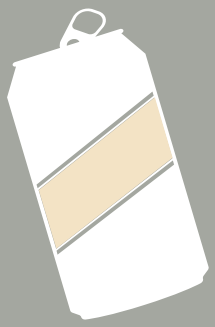
- As of September 2019, an estimated **2.4 million** North Carolinians struggled to get adequate dental care, according to the Health Resources & Services Administration of the U.S. Department of Health and Human Services.
- As of Nov. 2020, the U.S. Health Resource and Services Administration has either partially or fully designated **all 100 North Carolina counties** as a Dental Health Professional Shortage Area (dHPSA).
- Only 35.1% of dentists participate in Medicaid in North Carolina, making NC 37th out of all the states in dentist participation in Medicaid or CHIP.



FLOURIDATED WATER ACCESS

- 87.8% of the overall state population has fluoridated community water access.
- However, only 13% of population in Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain and Transylvania Counties have fluoridated community water access.

ORAL HEALTH



SUGAR-SWEETENED BEVERAGES

- 28.1% of rural residents (versus 20.1% of urban residents) drink regular soda or pop that contains sugar one or more times a day.
- 21.5% of rural residents (versus 19.8% of urban residents) drink one or more sugar-sweetened fruit drinks (such as Kool-aid and lemonade), sweet tea, and sports or energy drinks (such as Gatorade and Red Bull) daily.

TOBACCO USE

- Cigarette smoking is more prevalent in rural areas than in urban areas (26.9% of adults in nonmetro areas vs. 19.3% of adults in large metro areas), as well as smokeless tobacco use (8.1% of adults in nonmetro areas vs. 2.9% of adults in large metro areas), according to a 2019 report. Both can cause oral health problems.

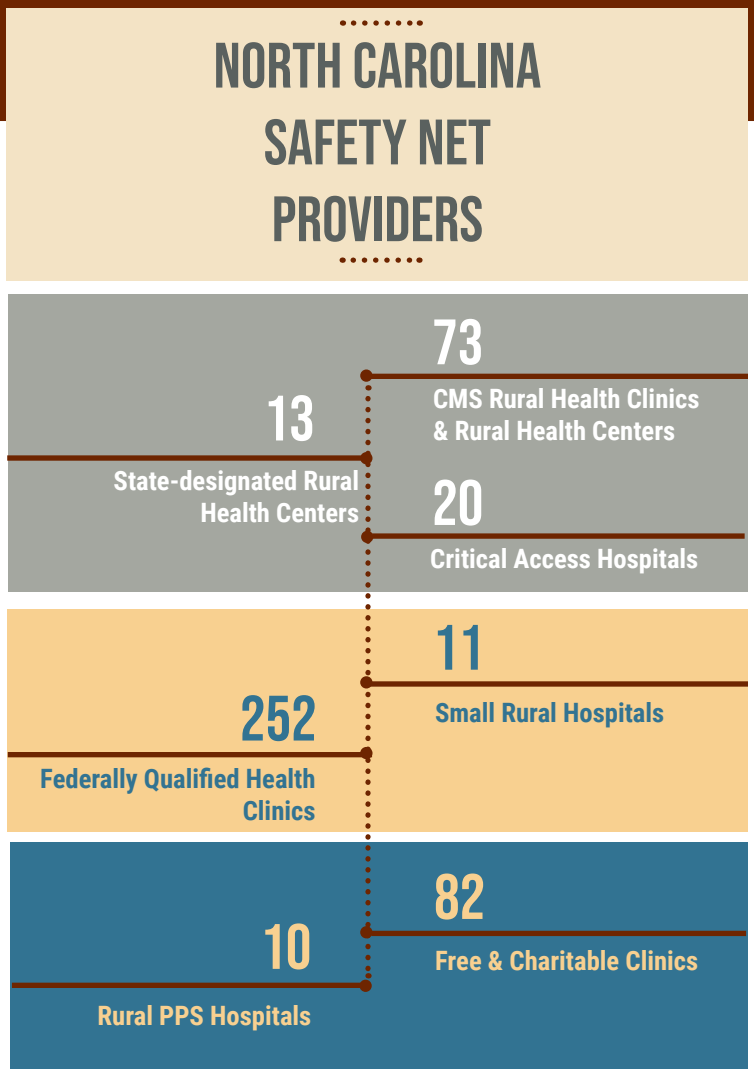
HEALTHCARE INFRASTRUCTURE

THE RURAL SAFETY NET

Safety net providers are "those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid and other vulnerable populations."

Core safety net providers are those who "either by legal mandate or explicitly adopted mission, offer care to patients regardless of ability to pay; and a substantial share of their patient mix are uninsured, Medicaid and other vulnerable patients.

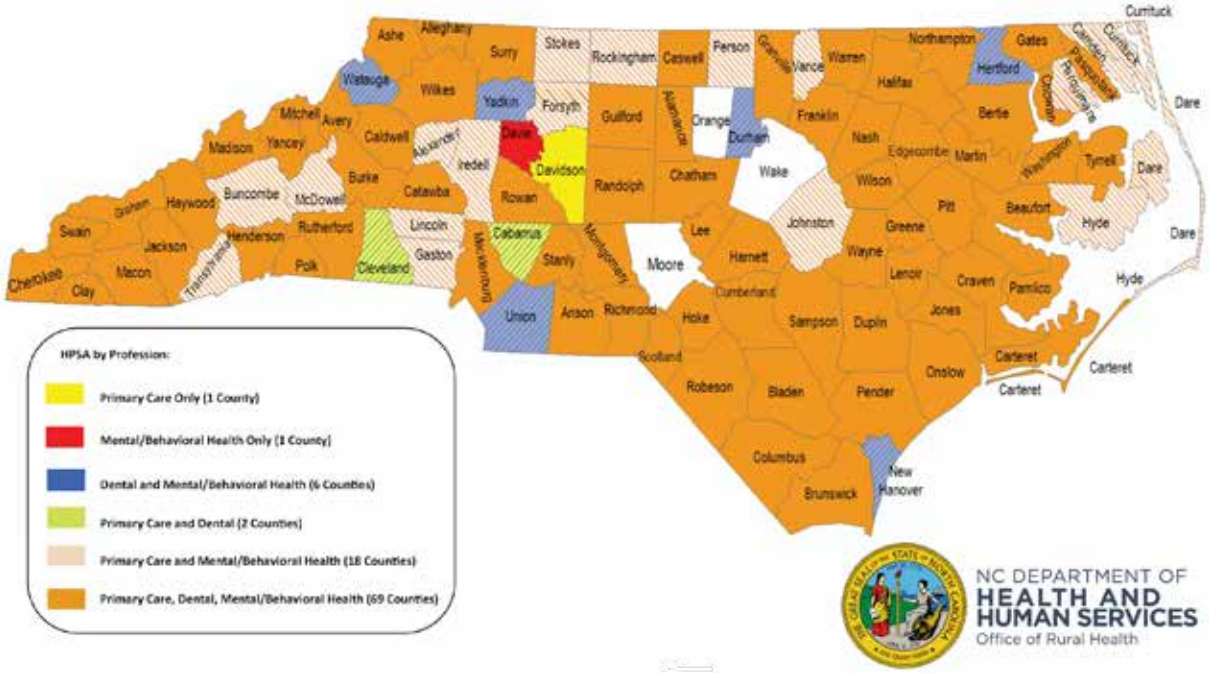
Source: Presentation to the NCIOM Legislative Health Policy Fellows Program by Pam Silberman, JD, DrPH, Professor, Dept. Health Policy and Management Gillings School of Global Public Health, April 23, 2018.



HEALTH WORKFORCE & RECRUITMENT

Ideally, people have access to the type of care they need in their communities. However, 80 counties in North Carolina face shortages of primary care providers, with many counties also experiencing shortages of dental and/or behavioral health providers (Health Professional Shortage Areas or HPSAs).

NORTH CAROLINA COUNTIES DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS SFY 2020



HEALTH WORKFORCE & RECRUITMENT

3 counties with no dentists and only 25% of dentists practicing in rural areas

2 counties with no physicians and 21% of physicians in rural areas

34 counties with no psychologists and 15.5% of psychologists in rural areas

1 county with no nurse practitioners and 26% of nurse practitioners in rural areas

4 counties with no physician assistants and 25% of physician assistants in rural areas

26 counties with no OB-GYNs

9 maternity units across NC have closed since 2013, and a 10th is slated to close in 2021

HOSPITAL SUSTAINABILITY

The rural hospital closure crisis is continuing to intensify. According to the UNC Sheps Center, in 2019, the United States experienced the greatest number of closures in a single year since the beginning of the century.

% OUTPATIENT REVENUE AS TOTAL REVENUE

71%

Notably, most closures are occurring in areas where hospitals are needed most: "in communities of high health disparities, high poverty and high minority populations."

% RURAL HOSPITALS WITHOUT ICU BEDS

34%

At least 120 rural hospitals have closed since 2010, leaving communities without access to emergency care, increasing travel times for patients, and exacerbating social disparities in health outcomes.

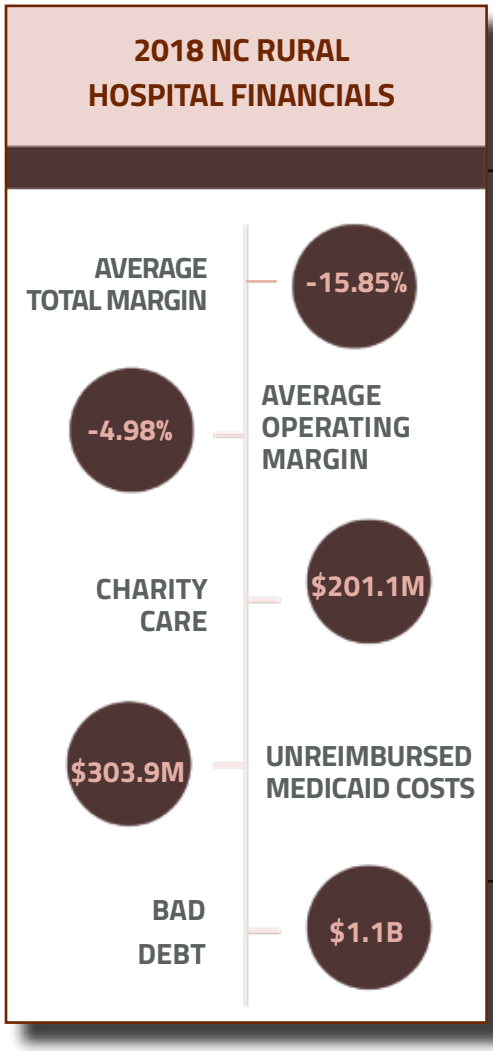
AVERAGE DAYS CASH ON HAND

117 (RURAL)
141 (NON-RURAL)

NORTH CAROLINA

# OF RURAL HOSPITALS	50
CLOSED HOSPITALS	5
# VULNERABLE HOSPITALS	15
MEDIAN OPERATING MARGIN	-0.2%
% NEGATIVE OPERATING MARGIN	51%

HOSPITAL SUSTAINABILITY



Total Margin is the percentage calculated by dividing net income by total revenues. The higher the Total Margin value, the more the hospital retains on each dollar of sales.

Operating Margin measures how much profit a hospital makes on a dollar of sale, after paying for variable costs of production. The higher the Operating Margin the more profitable a hospital is.

Charity Care refers to healthcare provided for free or at reduced prices to low income patients.

Bad Debt is a loss that a company incurs when credit that has been extended to customers becomes worthless, either because the debtor is bankrupt, has financial problems or because it cannot be collected.

SOURCES

For a complete list of data sources used to compile the 2021 North Carolina Rural Health Snapshot, please visit: https://foundationhli.org/2021-nc-rural-health-snapshot/.

Foundation for Health Leadership & Innovation

NC RURAL HEALTH LEADERSHIP ALLIANCE

SUPPORTING PARTNERSHIPS AND STRATEGIES THAT IMPROVE HEALTH OUTCOMES IN RURAL NORTH CAROLINA

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