In addressing rural health inequities, definitions matter

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People in rural communities experience disproportionately higher rates of cardiovascular disease, stroke, cancer, diabetes and respiratory illness. On top of these grim statistics, the Centers for Disease Control and Prevention reports that the death rate from unintentional injuries in rural areas is 50% higher than in urban centers.

“Our nation seems to expect that health outcomes will be worse—a lot worse—for people living in small towns, farming and ranching communities, and other places far from city lights and suburban sprawl,” AMA President Bruce A. Scott, MD, wrote in an AMA Leadership Viewpoints column published this spring. “Rather than accept this status quo, the AMA is working on multiple fronts to reduce these inequities, promote greater access to care, and significantly improve the health of people regardless of zip code.”

Dr. Scott, a Louisville, Kentucky-based otolaryngologist, notes that “there is no single solution to the complex issues confronting rural health care,” but adds that the answer starts with ensuring access to care and strengthening the physician workforce.

There are well-intentioned programs that seek to help deliver these two basic rural health care goals, but these initiatives—particularly those aiming to bolster the rural health workforce—can be stymied by perplexing bureaucratic issues stemming from the variable and ambiguous definitions for “rural health care.”

A recently published AMA issue brief (PDF) raises awareness of the variety of ways rural communities are defined and offers solutions to rural health needs via improved medical education.

The brief notes that AMA has longstanding policy opposing any changes to rural referral center designations that may adversely affect the access to or quality of medical services provided by such centers. But it also lists the various government agencies that have varying definitions for “rural,” including the:

- U.S. Census Bureau.
- Office of Management and Budget.
- Centers for Medicare & Medicaid Services (CMS).
- National Center for Health Statistics.
- U.S. Department of Agriculture Economic Research Service.
- Health Resources and Services Administration.

Rather than concrete definitions, the brief notes that definitions are sometimes based on what “feels” rural and may rely more on stereotypes and “are not necessarily aligned to empirical data.”

“Definitions used to gather data are also not necessarily consistent or easily constructed,” the AMA brief says.

“Despite variations in definitions, there is robust evidence of health inequities in rural communities, and therefore, attention to these issues is necessary,” the brief adds. “Appropriate methods for determining rurality depend upon the desired focus areas and outcomes, and even small changes to how ‘rural’ is defined may have a large impact on services and funding to many individuals.”

Time for a defining moment

The brief notes that the Accreditation Council for Graduate Medical Education uses CMS guidelines in determining if a program qualifies for rural track designation, and the Rural Training Track (RTT) Collaborative has proposed requiring an area be designated as rural if it is identified as such by any two federally accepted definitions.

“When one definition of rural does not entirely overlap with other definitions, challenges may occur—for instance, due to lack of eligibility for necessary resources or alternatively by classifying well-resourced suburban areas as rural,” the brief says.

It cites a *Journal of Graduate Medical Education* article that notes the growing importance of this issue.

There remains “confusion around the terms ‘RTT’ and ‘rural program’ due to the lack of definition in the accreditation process and in federal and state statute,” the article says. “Medical students want to know, developing programs want to know, and communities and legislators want to know: ‘What is a rural program?’”

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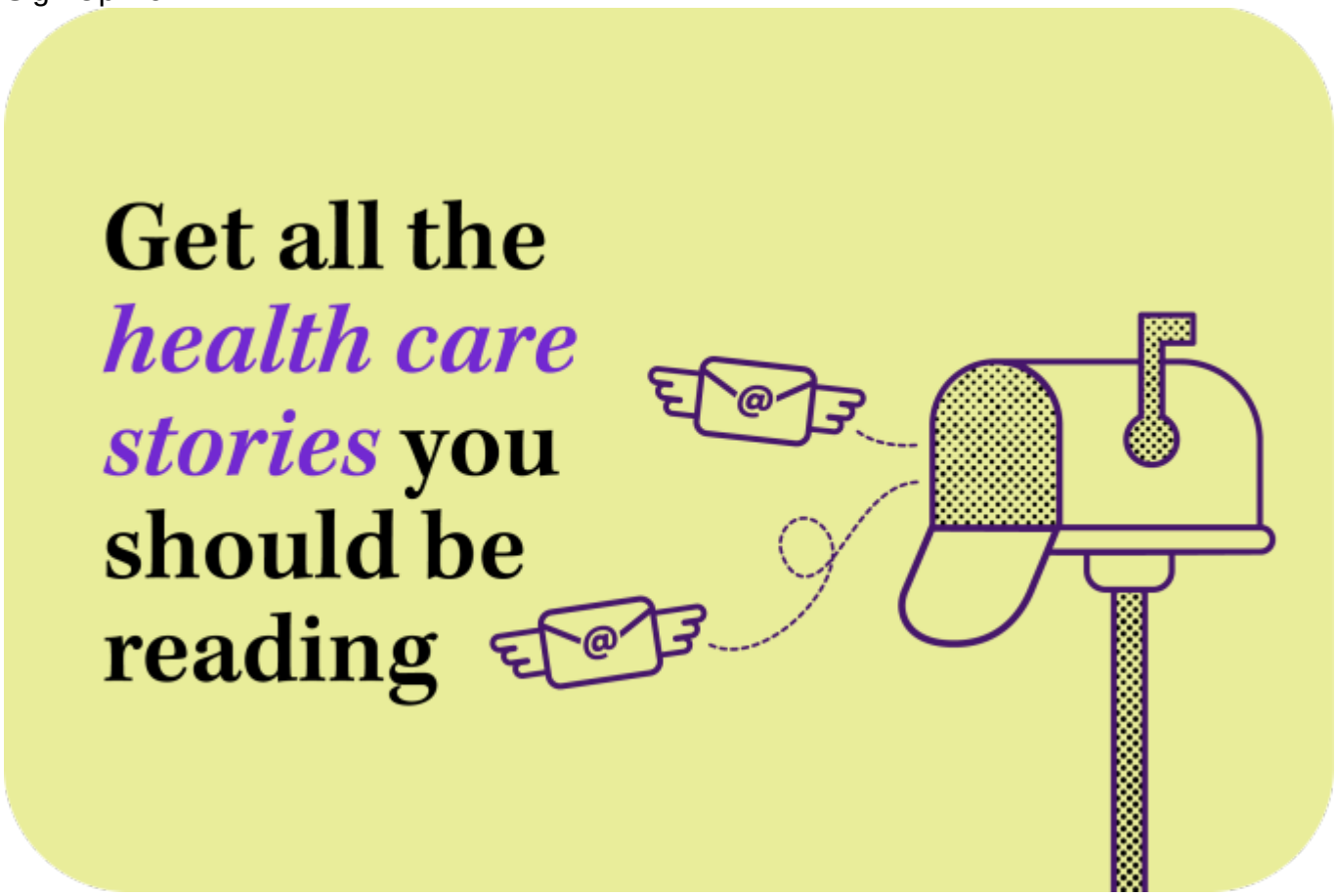

Put rurality in context

The AMA issue brief brings up an important explanation for why this issue is so complex.

“Rurality is still not a monolith, and each community must still be understood in its own context,” the brief explains.

It also suggests various ways to address the issue, including:

- Raising awareness about the complex, varying nature of how rurality is defined or designated.

- Customizing rural designations to be appropriate to the goals of any given program or population, staying attentive to the multifaceted nature of rural communities.
- Considering rural-specific physician workforce challenges, such as practice sustainability and physician professional support, when defining rurality within medical education.

The issue brief also lists several AMA policies that address rural health within medical education and sensitivity to definitions of rurality.

This includes policy on educational strategies to address the rural health physician shortage that was first adopted in 1990 and was most recently updated last year.

Provisions of the policy cited in the issue brief include encouraging:

- Medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements and to provide early and continuing exposure to those programs for medical students and residents.
- Medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
- State and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

The issue brief also cites a 2021 AMA Council on Medical Education report (PDF) on the issue.

“Investments are needed to increase the number of students from rural areas and other students committed to rural and family medicine who are enrolled in medical school and to increase resident exposure to rural practice opportunities,” the council report says.

“The current structure of medical education is predominately based in metropolitan areas and disproportionately exposes future physicians to medical practice in urban and suburban settings,” the report adds. “Opportunities to increase rural students’ exposure to careers in medicine should be explored to help expand rural physician pathways.”

Leading by example

Examples of how health systems are working on the issue include:

- The University of Iowa Carver College of Medicine established the Carver Rural Iowa Scholars Program that focuses on building pathways for rural physicians by enlisting medical students who are interested in practicing in small towns.
- The Lewistown Family Medicine Residency Program is a collaborative effort between Geisinger and the Family Practice Center, a large, physician-owned primary care group in

Central Pennsylvania.

- Through its Medicare Advantage Plan, Sanford Health's Sanford Health Plan has brought together physicians, nonphysician providers, pharmacy resources, care management, patient navigation and virtual services and has made notable improvements in patient outcomes.