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Rural Culture Competency in Health Care White Paper

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ABSTRACT

Cultural competency has been identified as a critical consideration in addressing health disparities. Although information on culture exists for a variety of populations, little exists specific to individuals living in a rural environment based solely on their geographical location and not on other additional defining characteristics (e.g., race, ethnicity, age, etc.). Following a search for information specific to rural culture, along with new data collection, this white paper offers the position that there is a unique rural culture and that cultural competency from a rural perspective is an important part of effective health care delivery in rural areas. Four overall themes were identified, including three primary rural cultural attributes: (a) the use of informal resources, (b) the importance of relationships and building trust, and (c) the degree and impact of social connectedness. Other factors are also often present but may play out differently or be present to a greater or lesser degree depending on the community and, therefore should be explored as potential considerations.

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INTRODUCTION: WHY EXPLORE RURAL CULTURE?

Cultural competency has been identified as an essential consideration in addressing health disparities. While much information is available on the culture of various populations, little guidance exists to help providers know how to be culturally competent in their interactions with rural individuals. Much of the available information in this area relates to working with specific populations such as racial/ethnic groups who live in rural communities or specific disciplines like rural nursing or rural child welfare. There is a pronounced information gap relating to culture based on the rural way of life.

The REACH Healthcare Foundation (REACH) has been interested in this topic, having worked with rural communities for many years, in various ways. One key area is through the Rural Health Initiative (RHI), which focuses on increasing rural capacity through network building and leadership development. The work done through RHI has underscored the fact that rural health disparities do exist and that interventions and approaches often need to be tailored to apply to rural settings.

The experience of REACH program officers in the field also supports the fact that there is a specific rural culture that needs to be addressed. Program officers who have worked with rural community partners and spent time in rural counties over the years have found that REACH's existing Cultural Competency Initiative, which is not specifically tailored to urban or rural settings, has not worked well in the rural environment. They witnessed a difficulty in engaging the full spectrum of the rural population and realized that specifically addressing the unique aspects of rural culture was a key part of the solution.

With the belief that rural cultural competency could help with engagement and outreach, Carla Gibson, Senior Program Officer at REACH, searched for materials and experts focused on rural culture competency, but she could not find an existing framework broadly targeted to rural communities as a whole or that specifically addressed the particulars of rural cultural competency. It was at this point that REACH decided that a more strategic, focused approach was needed.

Knowing that the University of Kansas School of Social Welfare (KU) was working with rural communities and that one of the authors, Cheryl Holmes, M.P.A., was serving on the REACH RHI technical assistance team, Gibson approached KU to discuss this issue. Holmes and Michelle Levy, M.A., confirmed that through their work with various rural communities, they also heard from various stakeholders that something different was needed to successfully engage rural communities. However, when looking to the literature for guidance, their experience was similar to that of Gibson: they found that information readily available on this subject was limited. It became clear that content was needed to address the delivery of rural culturally competent services but, before this could be done, there was a need to more clearly document exactly what rural culture was. Thus, REACH provided a grant to the authors to conduct a review of the literature to document current knowledge around rural culture and cultural competency, identify specific existing information gaps and, based on new

conversations with providers and consumers, supplement the existing formal knowledge base on this subject.

Given that the work was in preliminary stages, an exploratory framework was used which centered around two primary questions:

1) Are there ways in which rural culture or a rural way of life may uniquely affect the delivery and accessing of health and social services?

2) If so, what might providers and funders consider in order to competently serve a rural community?

The results of this exploration are presented as this white paper. While it addresses what was learned related to these questions, it also raises additional questions yet unanswered. Our hope is the content will offer thought-provoking considerations that further the capacity to deliver services and funding in a way which is respectful and responsive to rural communities and which encourages others to join in the conversation. Therefore, this document not only contains highlights from the literature and the small exploratory study conducted with the funding, but it also shares lessons learned and concludes with ideas for next steps.

WHAT INFORMATION CURRENTLY EXISTS RELEVANT TO RURAL CULTURE?

Rural Health Disparities and Outcomes

To appreciate the need for rural cultural competency, it is useful to first examine what is known about health in these communities. Unfortunately, discussions on the health of rural residents are frequently hampered by various factors including differing definitions of "rural" as well as a lack of sufficient rural data and related analyses (Hall, Kaufman, & Ricketts, 2006; National Advisory Committee on Rural Health and Human Services [NACRHHS], 2011). One prominent exception is *Health Disparities: A Rural-Urban Chartbook* (Bennett, Olatosi, & Probst, 2008, p. i-ii) from which the following highlights were extracted:

- Residents in any rural county were more likely to report fair to poor health status than were residents of urban counties (19.5% versus 15.6%).
- Rural residents were more likely to be obese than were urban residents (27.4% versus 23.9%).
- Rural residents were more likely to be uninsured than urban residents (17.8% versus 15.3%).
- Rural adults were more likely than urban adults to report having deferred care because of cost (15.1% versus 13.1%).

Additionally, the *Chartbook* noted that rural residents tend to be on average older and experience poverty at a higher rate (Economic Research Service, 2012; Office of Rural Health Policy, 2011; UnitedHealth Center for Health Reform & Modernization, 2011) and are often sicker than their urban peers (Adams, Michel, Defrates, & Corbett, 2001).

Outcomes data from the three rural counties in REACH's service area (Cass and Lafayette in Missouri and Allen in Kansas) are consistent with the *Chartbook's* findings. All three counties fare worse than the national benchmark in premature death, poor or fair health, poor physical health days, percent of live births that are low birth weight, excessive alcohol consumption, and adult obesity (University of Wisconsin Population Health Institute, 2012).

There are multiple and complex factors affecting health outcomes, including low health insurance coverage rates and types, limited access to providers (both general and specialty care), transportation challenges, and stigma (Gale & Lambert, 2006; Institute of Medicine [IOM] Committee on the Future of Rural Health Care, 2005; Lenardson, Ziller, Coburn, & Anderson, 2009; Mohatt, Adams, Bradley, & Morris, 2005; NACRHHS, 2008; NACRHHS, 2010). While yet to be definitively linked to health outcomes, cultural competence has been identified as a critical component to professionalism and quality of care (Betancourt & Green, 2010). Specifically, a person's culture has a profound influence on how health and illness are defined, behavior related to seeking care, and views about what constitutes appropriate treatment (Like, Barrett, & Moon, 2008).

What Is Culture?

Before addressing rural culture specifically, it is helpful to briefly discuss the concept of *culture* generally. Culture involves norms that affect our behavior, interactions, beliefs, values, and skills, and affects how we view ourselves and our environment (Lum, 2003; Webb, 2001). It goes beyond the individual; culture is a way of life as a group, being passed on from one generation to the next, and can affect help-seeking behavior, communication styles, and how one relates with helping systems (Samantrai, 2004). Culture is an aspect of human life, including health and illness, and is not limited to ethnic and racial differences (DeSantis, 1994). The REACH Cultural Competency Initiative uses the Department of Health and Human Services Office of Minority Health's definition adapted from Cross, Bazron, Dennis, & Isaacs (1989): "'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups."

Is There a Rural Culture?

Keeping in mind this background information on rural health and the concept of culture in a general sense, we can now explore the specifics of rural culture and discuss how it fits within the health framework. Formal discussions of rural culture have often primarily focused on groups of different racial or ethnic backgrounds living in rural communities, with the emphasis on the racial or ethnic culture, rather than the broader rural culture. However, more

recently, the United States Department of Health and Human Service Office of Minority Health (2013) released its enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS), which is a framework for the delivery of culturally competent health care. The enhanced National CLAS Standards have adopted an expanded definition of culture that now includes *geographical* characteristics. Though the enhanced definition clearly recognizes that culture can vary based on geography, this concept has yet to be fully operationalized.

Within the academic context, there is an emerging, though limited, body of work focusing on the role of culture specific to the rural context in and of itself and acknowledging the variability and complexity within rural communities. Baffour asserted that "Rural communities have a distinctive culture… They are diverse in their needs and experiences" (2011, p. 6). Hartley noted that health data trends related to behavioral patterns suggests "a 'rural culture' health determinant" (2004, p. 1675). Others have acknowledged that rural culture can differ among locations and can affect health-seeking behaviors (Morgan & Reel, 2003; National Rural Health Association [NRHA], 2008; Slama, 2004b).

While common rural classifications are based on population or population density, "rurality" as a cultural concept is not community-bound – it is not solely defined by reference to geography or population size or density. Rather, it is based on social, structural, and behavioral norms or characteristics and represents a continuum based on the degree to which individuals internalize rural culture (Daley & Pierce, 2011; Slama, 2004a). This implies, therefore, that rural cultural competence should relate not only to practice in and with rural communities, but also to people identified with rural culture, irrespective of the community in which they currently reside (Daley & Avant, 2004).

What Is Rural Culture?

Though the literature on rural culture is limited and often not focused on rural culture broadly, when we piece together the existing available information, certain cultural features do emerge. Distinctive features or attributes that often are linked with rural culture, among others, include an importance of family, strong sense of independence, a connection to the land or place, conservatism, influence of faith, and use of informal networks (Bushy, 2009; Daly & Avant, 2004; Ginsberg, 2005; Health and Human Services Rural Task Force, 2002; Slama, 2004a). Other characteristics commonly associated with rural residents are a strong work ethic and a tendency to value social norms and traditional roles which can be difficult for those who do not fit in to them (Bushy, 2009). When discussing rural, the literature also references the "fishbowl" environment – situations where details about people's lives are more easily known and discussed by others (Slama, 2004a).

These cultural traits are generalities that may or may not apply in all rural communities or among all individuals living in them. It is important to avoid stereotyping rural culture and using general assumptions that may not apply to particular rural contexts. As with other aspects of culture, such as race and ethnicity, the complexity and heterogeneity of rurality should be considered and respected.

The Interplay of Rural Context and Culture

Numerous environmental factors that exist in many rural communities can ultimately influence rural culture. Broadly speaking, rural residents often face structural barriers related to health care access due to a lack of general and specialty providers, transportation challenges, and limited employment opportunities (Ginsberg, 2011; NRHA, n.d.). Additional factors include the closing of hospitals and pharmacies, school consolidation, and population loss (Bard, Gardener, & Wieland, 2005; Johnson, 2012; Kaufman, B.G., Thomas, S.R., Randolph, R.K., Perry, J.R., Thompson, K.W. Holmes, G.M. & Pink, G.H., 2015; Todd, Ullrich, and Mueller, 2012). Contextually, the lack of anonymity and concerns about confidentiality can lead to a resistance to seeking help and create a heightened sensitivity (NRHA, 2008; New Freedom Commission on Mental Health [NFCMH], 2004; Slama, 2004a). Though stigma issues and a desire for privacy are not uniquely rural, they may be heightened in less densely populated areas, particularly in cases of mental health, unwanted pregnancy, sexually transmitted diseases, domestic violence, and alcohol/substance abuse (Bushy, 2009).

While the above factors may be generally common rural realities, rural communities are not homogenous. There are great differences in needs and resources depending on the geographical features (such as mountains, plains, islands, and deltas) and economic drivers (grain, cattle, oil, gas, coal, etc.). Even within Kansas and Missouri, there are variations. For example, there are vast difference in geography and the economy between rural western Kansas and rural southeast Kansas. The unique community issues can influence the culture and how people access health care.

Workforce Implications

Providers of health and human services working in rural communities come face to face with these realities. Many rural communities struggle with recruitment and retention of qualified providers. The small population creates dual and overlapping relationships as well as professional isolation (Cates, Gunderson, & Keim, 2012; Daley & Hickman, 2011). It can be difficult for rural professionals to step out of the role of provider even when outside of the office. Rural health providers often work as generalists, requiring them to see patients across the life span and with a wide range of symptoms and needs. Churches and other community institutions such as banks and schools play a critical role in the health of a community, and many services are provided informally (Bushy, 2009). Developing a stable, prepared and supported workforce is a critical component of the rural context that provides a foundation for culturally competent service delivery.

What Are the Gaps?

Based on the existing literature, there is a strong need for the inclusion of rurality as part of cultural competency. Despite the fact that roughly 19% of the U.S. population resides in an area defined as rural by the U.S. Census (2010), the notion of focusing on rural culture in a

systemic manner is relatively new. Although some literature, trainings, and guides are available on the subject, they tend to have a specific focus, such as on ethnic or racial groups living within rural communities or are directed at assisting practitioners in a specialized field of study, such as rural child welfare or nursing. A broader approach for acknowledging rurality as a category in and of itself, worthy of an integrated and systemic approach for serving rural populations, is lacking. The New Freedom Commission's rural subcommittee report noted that "Providers' cultural competence is a major issue for racial and ethnic minority populations seeking assistance, but 'rural cultural competence' receives little policy or training attention" (NFCMH, 2004, p. 13).

In developing our exploratory framework, we had to do so in the absence of an existing specific cultural competency model or approach relating to rurality. Thus, we looked to what we knew about developing cultural competence from other efforts designed to meet the needs of diverse populations. Current approaches for working with diverse racial and ethnic groups do not focus *exclusively* on specific elements that characterize those groups. This approach is considered outdated by experts since it can foster and reinforce biases and stereotypes that already exist (American Institutes for Research, 2002).

At the level of the individual practitioner, there is a need to develop self-awareness, knowledge, and practice skills in order to competently assess all sociocultural factors, including rurality, that may affect an individual consumer (Carrillo, Green, & Betancourt, 1999). At the institutional level, organizations must ensure that their policies, practices and leadership reinforce culturally competent service delivery without relying on "one size fits all" models that may not work well in certain rural communities and contexts. A competency-based approach to staff and organizational development is increasingly viewed as a core strategy for improving healthcare (IOM, Greiner, & Knebel, 2003).

ADDING LOCAL VOICE TO EXPLORE RURAL CULTURE

Given the lack of literature addressing rural cultural competency, we determined that it was essential to collect data directly from "front line" practitioners, policy makers and residents in order to answer our two primary questions. Thus, we conducted interviews with professionals from three Midwestern states and held a focus group with consumers. Before highlighting our findings, we describe the steps taken to create the questions and the process selected to collect the data as they are relevant to the lessons learned described later in this report.

Interview and Focus Group Participants

An initial list of potential participants was developed by KU with suggestions provided by REACH staff and other local partners. During the interview process, some participants identified others to invite to the process. Interview participants were considered for inclusion based on a range of factors, including provider type, population density of community and location related

to REACH's service area (see Appendix B for more information about the methods). The focus group participants were selected by a community health professional living and working in one of the counties participating in REACH's Rural Health Initiative.

Over a two-month period of time during the summer of 2014, KU staff interviewed 15 individuals and conducted a focus group with seven consumers using questions and protocol approved by KU's Human Subjects Institutional Review Board (see Appendix C). Participants who completed an interview represented many perspectives: behavioral health, health department, social services, outreach, physical health, migrant workers, policy and research. Just under half of the participants were from a county in REACH's service area. From a population density perspective, the largest number of participants represented densely-settled rural counties (counties with 20-39.9 people per square mile).

Questions

The KU researchers drafted the first set of interview and focus group questions based on their work experience and the review of the literature. The questions were shared with REACH staff and a community health professional living and working in one of REACH's Rural Health Initiative counties. Significant feedback was received resulting in several iterations of the questions. Changes involved alterations to the specific language used, defining certain concepts, eliminating graphics, and reframing the questions to be broader. For example, given the exploratory nature of the interviews and focus group, semi-structured open-ended questions were ultimately used such as "Where do people in your community go to see a doctor or health care provider?" and "When do people go to see a doctor or provider?" with the intent of introducing the subject but maintaining flexibility so that it would not lead participants to provide overly narrow responses.

The feedback also shaped the process used. For example, the rural cultural attributes identified in the literature were prepared in a list format for the purpose of sharing with study participants and asking them to reflect on whether they thought any of the items might affect health and health seeking behavior. However, there was concern that seeing the list too early in the interview or focus group process might influence how study participants answered other open-ended questions. Therefore, the attributes list was prepared as a stand-alone document and shared with participants at the end of the session. Much learning, captured in the Lessons Learned section later in this paper, resulted from this step alone.

FINDINGS: LEARNING ABOUT RURAL CULTURAL COMPETENCY FROM CONSUMERS AND PROVIDERS

The interviews began with open-ended questions, designed to allow participants the opportunity to share their ideas and perspectives in an exploratory manner. At the end of the interview/focus group, in order to prompt attention to rural culture specifically, participants were given the list of attributes gleaned from the literature and asked to what extent the list

matched their experiences or perceptions specific to potential impact on health-seeking behavior. The list included the following attributes:

- Family relations
- Strong sense of independence
- A connection to the land or place: This is where I was born and raised
- Influence of faith
- Use of informal resources: Getting help outside of an agency (family, friends, neighbors, church members)
- Strong work ethic: I take pride in how hard I work
- Conservatism: I am careful about change
- Strong belief in traditional social values and roles
- Shared life experiences: I can count on people in my community who know what rural life is like
- Self-sufficiency: I am proud that I can take care of myself and my family
- Mindful of cost and distance: I think about how much something is going to cost and how far away it is before I act
- Responsive to/focused on immediate situation: I think about today and tomorrow and can't think a lot about the future
- Shared language, phrases, or descriptions (e.g., dinner is noon meal and supper is evening meal; pop versus soda)

The Four Themes

Responses to the interview and focus group questions, including reactions to the list, can be grouped into four themes. These themes and representative supporting statements from participants are summarized below.

Theme 1: There are three attributes that seem to be present as part of rural culture: (a) use of informal resources, (b) importance of relationships and building trust, and (c) degree and impact of social connectedness. Each can be a challenge or a facilitator to health.

(a) Use of informal resources

The use of informal resources was the factor most commonly agreed to be a part of rural culture. As one participant noted, having friends and neighbors helping each other is the "*key to everything*" in a rural community. Importance of family relations was another factor with general agreement. In fitting with both of these factors, several noted that in their rural communities residents are more likely to reach out to a pastor or family member for health advice or assistance, particularly in the case of mental health needs.

- *"Use of informal resources is important."*

- *"[Some might be interested in] holistic medical treatments like home remedies."*

- *"Our faith journey does influence how we allow our community to minister to us or minister to our medical needs."*

- *"[Farmers tend to be] independent, not comfortable with assistance but if somebody dies during harvest, the church and family will be there."*

<u>(b) Importance of relationships and building trust</u>

A second area within this theme is the role that relationships play in accessing health care and the need to build trust.

- *"In smaller communities, patients like to know their provider. We need to be able to spend more time with the patient for this reason."*

- *"They put a lot of trust in their home town doctor…you've got to respect their hometown doctor."*

- *"Often times there is an implicit trust in the health care systems which is not the case in urban areas…doctors carry a lot of weight and they are put on a pedestal…that's helpful for the health system in that they can influence change quite a bit in rural areas...Rural people have more of a trusting relationship with the health system than people in urban areas."*

- *"Talking to your clients about what's important to you and your community…it's important with every client but even more so with rural."*

- *"Everyone knows each other and they talk to each other so it is important that you are consistent with the information that you share."*

- *"It's not easy to be trusted if you're coming from the outside…there is a 'wait and see' attitude. I don't blame them. There are a lot of providers who come in for 2-3 years and then leave...you need to build community and trust. You can do this by getting involved in social clubs. Also when you buy a house instead of rent, it shows your intention. Take time and make connections."*

While a provider's approach is arguably important in any setting, the lack of service options in many rural communities amplifies the significance of **good practice and engagement**:

- *"If I am treated rudely then I am done unless I have to go back because there is no choice. Otherwise I don't say anything; I just don't go back."*

- *"They need to understand that rural life lives by its own rules – different than urban. You go to the doctor when you have to, not before you have to. [A provider] may only get one shot so how you interact will make a difference in whether [the patients] come back. [Providers] need to understand how a rural community works. Talk in layman's terms to make patient feel comfortable to ask questions. The rural patient has lost time and money to see a provider and they can't easily get that back. To rush and be in and out is insulting to them…urban areas are more busy and rushed and people are conditioned for that. Rural pace is slower and needs time for relationship building."*

- *"Good customer service…in these areas [is important]. We are often the only provider of our type – the only behavioral health provider or the only primary health clinic. We have no competition so it's easy to become complacent…when that happens, people may either travel a distance to try to get care or they don't do it at all."*

(c) Degree and impact of social connectedness

The degree and impact of social connectedness is a defining feature of most, if not all, rural communities. While we did not ask specifically about social connectedness, it was an aspect of a rural way of life that came out spontaneously and clearly in both the interviews and focus group:

- *"There are so many connections among people and there are multiple layers of connections."*

- *"Everyone knows everyone."*

Social connectedness contributes to a **culture of helping** where it is accepted and expected that community members "take care of each other":

- *"It is slower paced and more friendly. There is less assumption that others are doing harm. Rather, it is that we will help each other."*

- *"In rural, there is a belief that we have to take care of our neighbors; that the government won't be there for us."*

This culture of helping reinforces the importance of **respect and relationships** when navigating rural communities:

- *"People in rural areas because they know each other, are way more courteous and careful in how they treat people…[some providers] don't pay enough attention to plain old-fashioned courtesy and that gets around really fast… the idea of courtesy is the standard in a rural community. Urban people may read that as though everybody is snoopy and in everyone's business, but the way I look at it is that everyone is concerned and somewhat protective of their neighbors."*

- *"Everyone knows each other and they talk to each other…a lot of people will talk to their friends and family; they get suggestions on what other people might try. This is big in a rural community."*

At the same time, social connectedness can be a barrier to health seeking by adding to **stigma**:

- *"This is a barrier with rural culture: there is a high value given to helping others but there is shame around asking for help…there's a feeling of 'I should grin and bear it and get through it on my own.'"*

It can also result in a **reluctance to share information**:

- *"Since everyone knows everyone else, some are resistant to seek out or to share information – they may hold back information. It may be that the provider is someone who goes to my church or is my neighbor, so I don't want to say that I have been drinking more than usual or that my spouse says that I am drinking too much."*

- *"Someone may have something that clearly needs medical attention but may not go because they will wonder 'what will my doctor think.' You have to appreciate that they are fiercely private and learn to navigate that."*

The need to maintain social connectedness and cohesion in a small community may also result in **non-direct or non-confrontational behavior** that impedes health services delivery and access:

- *"We need to understand that rural is a subculture… [patients] do not want to be confrontational and [don't want to] ask challenging questions. The doctor will say you need to do A, B, and C. The patient will nod their head and not confront or question anything. Then they will go home and not do it. They are then labeled as a difficult patient…we need to approach it more collaboratively…"*

- *"I would love to see providers more routinely do screenings. We need to ask the hard questions. A lot of time in smaller communities we want to be polite so we don't ask the questions."*

Theme 2: There are other rural cultural influences that are often present, although they may play out differently or be present to a greater or lesser degree. However, due to the possibility of their presence, they should be considered as potential considerations.

Overall, participants agreed that the items in the list shown above seemed to represent potential rural cultural influences, and that there is rural culture that can influence health. As one rural provider explained, *"Understand that culture is not just a racial issue but the way that people in a rural area talk, think and their habits."* In reviewing the list item by item, there was a diversity of opinions regarding the list of attributes beyond the **use of informal resources** and those that underscored the **importance of relationships and trust** discussed previously. Some participants felt strongly that a particular item was, in their experience, an element of rural culture while others would feel equally strongly that the same factor was not representative of rural culture, thus underscoring the complexity of this issue. Often it was noted that some of the factors seemed fitting for a segment of the rural population, such as farmers, an older generation or individuals with extended family in the area. For example, concerning the influence of **connection to the land**, it was noted that not everyone in a rural community has a connection to the land, particularly in communities where there has been significant immigration. In contrast, others agreed that there is a connection to the land in rural settings that not only impacts farmers (as one might assume) but also businesses and the whole community that are affected by the seasonal nature of farming (harvest, planting, etc.).

While pondering the list, many respondents mentioned that rural communities or regions can be very different from one another based on geography, demographics and other features. As one person noted, *"You know one rural community, you know one rural community."* **Belief in traditional values and roles, conservatism** and **influence of faith** were each viewed by many as a part of rural culture but also viewed as factors that are currently changing in many communities. In particular, it was noted that in some rural communities industry (e.g., farm work, meat packing) is driving an increased population and greater diversity, which is contributing to changes. Related to **shared language,** some felt, "Language is a barrier, and I don't mean Spanish or English. There is a rural dialect." Several indicated that **shared life experience** was a part of rural communities in that people had to rely on each other.

Many agreed that being **mindful of cost and distance** is a particular concern for rural residents in the context of accessing health care as exemplified by someone who noted that a person who lives in the country might think, "*Do we really need to take that 30 mile trip into town or can we wait this out?, whereas if you lived in town you would probably just go to the doctor."* On the other hand, others remarked that rural residents are accustomed to traveling and its costs. Regarding another factor on the list, **focused on the immediate situation,** some agreed this is common for rural residents. Others, however, felt it was more reflective of individuals in poverty regardless of geography. For example, one participant noted, *"Low-income, insecurity about the situation makes it day-to-day survival. It's not that they don't ever think about the future but they don't have the luxury to think about the future because working is the economic reality. There are so many unknowns – Is it going to rain? Is the crop going to make it? They have to respond to immediacy."*

A **strong sense of independence, strong work ethic** and **self-sufficiency** were felt by several to be factors in rural health:

- *"It seems like we have a farmer/rancher type person who is pretty independent. They don't necessarily go to the doctor, they just don't…they'll get cut and they'll sew themselves up and they'll take care of themselves. They have to be pretty hurt before they'll come in, or they'll have to be pretty sick or otherwise, they are not coming in."*

- *"There is a 'we can do it ourselves' and 'we can take care of our own.'"*

Others, however, felt these traits may not be held by all.

While there was a lack of consensus on these other rural cultural health influences, the presence of them in certain areas and for certain populations underscores the importance of a) considering them as factors for a given community until they can be determined not applicable for that area and b) the need for continued study and exploration of rural culture.

Theme 3: Structural challenges in rural health care delivery seem to complicate how people think about or frame cultural factors when it comes to seeking care.

Asked about where and when people in their community go to see a doctor or health care provider, every individual mentioned barriers that represent structural challenges. Most commonly, **affordability of care**, which included issues such as a lack of insurance or "good" insurance, high deductibles and copays, and the cost of driving to see a provider. In particular, poverty was mentioned, notably by many of those in REACH counties. The next most common barrier mentioned related to the broader category of accessibility challenges, specifically **distance and transportation** (e.g., time factors, reliable vehicle, etc.), along with office hours and lack of bilingual staff. Availability of services was the third most frequently noted theme, with issues including a **shortage of local providers**, including those who accept Medicaid, and a lack of choice in local providers.

Specific to the question of "when" care is sought, the majority agreed that rural health care tends to be more **crisis-oriented** rather than preventive/wellness-oriented. There were a few responses which described cultural factors that might account for this difference, such as a *"frontier spirit"* that contributes to a **reluctance to seek care**. Limited education and exposure to services were also mentioned as contributing to gaps in understanding health and abilities to navigate the system. Overall, however, respondents noted multiple obstacles beyond those of a cultural nature – such as taking time off work, having gas money, providers' hours or distance to services, among others – so that it is difficult to truly differentiate the impact of cultural factors amid the many other barriers to health care in a rural area. In fact, often it is the convergence of barriers for rural health consumers that impact health seeking as exemplified by these comments:

- *"Here you have to wait three months to have access to the service…she's working poor so she can't just jump in the car and go to [urban area] which is what people with resources would do."*

- *"Many people haven't grown up with the idea of prevention so it's their background plus whether they have health insurance. Many won't go unless they have a problem. Workers struggle with taking time off. Farmers will not take off unless there is a problem. Other barriers are distance and transportation especially if a specialist is needed."*

Theme 4: Understanding cultural factors can help providers more effectively connect with rural patients.

       Stakeholders (consumers and providers) were asked what, if anything, providers could do to more effectively connect with rural patients. Taken together, their responses suggest four approaches providers could take in this regard: (a) get to know the community, (b) be involved in the community and (c) be a health facilitator. The fourth area was related to recognizing and respecting the importance of relationships, which was covered in the first theme. As acknowledged by one rural practitioner, *"The default way of doing things may not work."*

<u>(a) Get to know the community</u>

- *"Understand the community that you're working in. [Providers] should go to restaurants or markets where the people are and show an interest in who they are. It takes some time."*

- *"In some rural clinics the environment is very unassuming… I think that it's important to understand the dynamics of the community where you are working and then you create an environment that fits with them."*

- *"It is important to get information on the population you are going to serve. We do a '101' with providers every year due to staff turnover."*

- *"…hire people from the community who have lived there a long time…who might have a better sense of what will work….ask their opinion and involve [them] in the decisions."*

- *"I think more than anything else is, at least in our area, is the issue of poverty…even as adults, they don't lose that mentality of poverty. So as a caregiver, I have to be aware of that, to know that how they react to things is still somewhat crisis oriented."*

<u>(b) Be involved in the community</u>

- *"Get out in the community. People want to know you before they will put their health in your hands."*

- *"We send the new doc to be on sidelines of football games. It's a visible way of serving the community and a way for that person to get involved...there are always ways in a small community of involving yourself."*

- *"Just engaging in the community and being a part of it. I don't think you have the luxury to disconnect yourself like you can in an urban area...if you want to improve patient outcomes and you care about the health of your patients. I think providers could go a long way by integrating themselves in the community."*

- *"It's important if they can for people in health and mental health to be on the chamber of commerce and be active in working for the general health of the community, and that means financially, too."*

- *"You just have to be a little more sensitive and have a little more perseverance. Sometimes very small communities can be . . . closed to new – what they perceive as outsiders coming in. So I think it is really important for the organization or the provider to understand that going in and understand that they are going to have to assimilate into the culture they are going to be working with rather than expecting the rural community to bond to them."*

(c) Be a "rural competent" health facilitator

- *"If someone drives an hour or 1 ½ hours to get there and then the intervention only takes 10 minutes, it is not going to go over very well – not a good use of time. We want to help them multi-task when they are in town. This is likely to help them do what you are asking them to do...ask them 'is there anything I can do to make things more convenient for you?' Meet them where they are (not geographically, but their needs)."*

- *"A doctor may say that an individual needs to get more exercise. They are likely to be hesitant to say 'now how would I do that' (not safe places to walk or paved areas to ride bikes). Providers need to understand their population and what is possible."*

LESSONS LEARNED: WHERE MIGHT WE GO FROM HERE?

Reviewing the four themes, we find:

1. There are three attributes that seem to be present as part of rural culture: use of informal resources, importance of relationships and building trust, and degree and impact of social connectedness. Each can be a challenge or a facilitator to health.

2. There are other rural cultural influences that are often present and, as such, attributed to rural culture. However, there was not consensus on what these factors were. Instead, it appears that they may play out differently and play out to a greater or lesser degree depending on the community and individual. However, it is wise to consider them as potential additional factors.

3. Structural challenges such as transportation, workforce and prevalence of poverty seem to complicate how people think about or frame cultural factors when it comes to seeking care or, at a minimum, strongly influence and may be intertwined with how and when care is sought.

4. Exploring and understanding cultural factors from a rural perspective in and of itself is important and can help providers more effectively connect with rural patients.

   Additional **lessons learned** and areas warrant further conversation and consideration including the following:

   • It can be difficult to discuss one's own culture in detail; this was true for many of the participants in this study. Some of the participants mentioned that when they were invited to participate in an interview/focus group about "rural cultural competency" they assumed that it would involve talking about the needs of a specific group (e.g., Latino) living in a rural community. Participants who naturally talked about culture based on a rural way of life were more the exception. For most, it appeared to be a new concept.

   • Even when asked directly about rural cultural competency, the topics of affordability, accessibility and availability naturally emerged. Taking a combined approach of addressing structural issues and increasing provider cultural competence may offer new ideas for improving rural health disparities.

   • Given that rural cultural influences vary among and within communities, more clearly defining and understanding rural cultural competency, including how it might be best promoted as a standard of service delivery within a particular community, is needed.

   • Exploring the pervasive social connections in rural communities is another opportunity for facilitating health. One provider noted that in rural communities *"schools, churches and bars are the three main social avenues outside family."* Finding leaders to engage from these community institutions may be yet another way to promote health. There are strengths within rural communities, particularly related to social connectedness, that have yet to be tapped.

As with cultural competency issues related to race and ethnicity, there is not an easy, quick fix. There is a need for further work and dialogue with individuals representing multiple perspectives including providers, health funders and residents.

A clear next step is to find an effective way to perform outreach and engagement in rural counties. A flexible approach is needed that provides resources and processes to connect with diverse groups within a single community but pays particular attention to marginalized and underserved groups. The process of identifying this framework not only will provide a method for engaging the full community in health but also will allow additional information to develop around the concept of rural culture.

CONCLUSION

This study was designed to explore rural culture as it related to seeking, accessing and providing health care from a broader rural perspective. The information obtained from the literature and from individuals participating in interviews and a focus group suggests that the barriers and facilitators are multiple and complex. However, the results support the concept that a rural culture does exist when connected to their influence on health and accessing health care. And while there is variation as to the extent to which some of the factors commonly attributed to rural residents exist, three attributes stood out in this exploratory study as typically present: (a) the use of informal resources, (b) the importance of relationships and building trust and (c) the degree and impact of social connectedness. Given the disparities in health care that exist for rural populations, the results of this exploratory study suggest that opportunities do exist to more effectively connect with rural residents, including those groups that may not seek routine care. Focusing on engagement and outreach to individuals in trusted positions within the rural community and those who offer support through more informal ways may lead to more effective connections with rural residents overall and marginalized populations in particular. Exploring these suggestions and providing a framework in which to do so could yield important inroads to how better understanding of rural culture might facilitate health care delivery and access.

Appendix A: References

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<u>Appendix B: Exploratory Study Methodology</u>

Data Sources

Over a two-month period of time during the summer of 2014, KU staff interviewed 15 individuals and conducted a focus group with 7 consumers using questions and protocol approved by KU's Human Subjects Institutional Review Board.

Interviews and the focus group followed a semi-structured interview guide (Appendix C). Questions varied slightly between the focus group and interviews and some variation in interview questions were made depending on the perspective of the respondent. Overall, the questions were designed to explore where individuals go to receive services, challenges and facilitators to accessing services, and the extent to which rural culture may be a factor.

Study Participants

Respondents represented the following perspectives, with some respondents able to speak to more than one: behavioral health, health department, social services, outreach/connectors, physical health and diversity/migrant workers. Each category had at least two representatives. Some individuals served a specific location, some served a region and others had a statewide perspective. Over half lived in or served the rural counties in REACH's service area. Interviewees included front-line practitioners, administrators, policy-makers and researchers. The focus group consisted of individual consumers. Overall, respondents for the interviews and focus groups represented three Midwestern states.

In order to seek inclusion of respondents from different sized counties, researchers referred to the Kansas Department of Health and Environment's frontier through urban continuum when identifying potential respondents:

- Frontier: less than 6 people per square mile
- Rural: 6 to 19.9 people per square mile
- Densely-settled rural: 20-39.9 people per square mile
- Semi-urban: 40 to 149.9 people per square mile
- Urban: 150+ people per square mile

The largest percentage (40%) of interview respondents lived in densely-settled rural counties.

Data Analysis

Interviews and the focus group were digitally recorded and detailed notes also were taken. Audio-recordings were referenced and/or transcribed. Data were analyzed qualitatively using a modified grounded theory methodology in which researchers look for broad themes among responses.

Appendix C: Interview/Focus Group Protocol

RURAL CULTURAL AND COMMUNITY COMPETENCY:
Rural Provider Interview Questions

Our plan for today is to talk with you about how people in rural areas receive health care services when they are sick or want to stay well. We will not be asking any personal health questions and there is no right or wrong answer. So, let's begin!

1. Where do people in your area or community go to see a doctor or health care provider?

2. When are people in your area or community likely to see a doctor or health care provider?

    a. What are some of the barriers that prevent them from seeing a provider?

    b. What are things that help them or make them more likely to see a health care provider?

3. What might a provider need to do differently to be sensitive to a rural patient's needs?

4. What, if anything, can providers do to more effectively connect with rural patients?

    a. Are there ways that the office environment can support rural patients?

5. Now, let's talk about the rural areas or communities where you provide services. Are there any changes that could be made in these areas or communities to help people be healthier?

6. Now we would like to show you a list of items that are thought to sometimes affect health for people from rural areas. Are there things that should be taken off? Things that should be added?

    Rural cultural influences that might affect health:
    - Family relations
    - Strong sense of independence
    - A connection to the land or place: This is where I was born and raised
    - Influence of faith
    - Use of informal resources: Getting help outside of an agency (family, friends, neighbors, church members)
    - Strong work ethic: I take pride in how hard I work
    - Conservatism: I am careful about change
    - Strong belief in traditional social values and roles
    - Shared life experiences: I can count on people in my community who know what rural life is like

- Self-sufficiency: I am proud that I can take care of myself and my family
- Mindful of cost and distance: I think about how much something is going to cost and how far away it is before I act
- Responsive to/focused on immediate situation: I think about today and tomorrow and can't think a lot about the future
- Shared language, phrases, or descriptions (e.g., dinner is noon meal and supper is evening meal; pop versus soda)

7. What else would you like to tell us about how rural people receive health care services when they are sick or want to stay well?