Rural Health Capital Resources Council Meeting

HOSTED BY FORHP & NOSORH

MONDAY, JUNE 12TH

Tom Morris

Administrator for Rural Health Policy
HRSA

SPEAKER

Tammy Norville, CEO
NOSORH

Kirby Lecy, Manager of Healthy Communities Initiatives
Massachusetts Dept. of Health, Office of Rural Health

SPEAKERS

State Offices of Rural Health, WELCOME and THANK YOU!

NOSORH Vision, Mission & Values

VISION

NOSORH grows connections, tools, and education to support and build vital healthy rural communities.

MISSION

NOSORH promotes the capacity of State Offices of Rural Health (SORH) and their stakeholders to improve health care in rural America through leadership development, advocacy, education, and partnerships.

VALUES

- Health equity for all rural Americans
- Collaboration & active partnership development
- Trust in member capacity to make a difference
- Leadership & innovation
- Creativity in planning, programming, partnering & positioning of SORH
- Inclusiveness through transparent decision-making within the organization
- Accountability to funding agencies, partners, & members

More simply, we…

Connect, leverage and resource partnerships and communities to improve rural health!

Thanks to the Federal Office of Rural Health Policy

Provide leadership development at national, regional, state, and local levels to increase the impact of SORH.

RHC COVID-19 Work

- Testing
- Testing & Mitigation
- Vaccine Confidence Grant Program
- Vaccine Distribution

Institutes

- Grant Writing
- Data
- Rural Primary Care Institute
- Rural Health Leadership Institute
- Community Development Course

Wide variety of partners

- Support of rural health equity community collaboratives with ASTHO
- Tiered technical assistance support with SORH for primary care providers
- Other: broadband, economic development, graduate medical education

National Rural Health Day

- One day each year when we focus on what's positive in rural places!
- Shout out about your efforts.
- Honor your staff, grantees, communities, and partners!

- Free resources
- Community Star stories
- Key messages
- …and more!

All of this work is accomplished with partners - the State Offices of Rural Health and their stakeholders… more on State Offices of Rural Health

NOSORH | National Organization of State Offices of Rural Health

SORH: Your partners to grow communication, education, collaboration and innovation in rural health

- State Office of Rural Health in every state
- Unique funding structure (3:1 match requirement)
- SORH are statewide organizations designed to work at the local level, linking federal and state resources to rural and frontier community need

State Offices of Rural Health

A true part of the state:

- 37 are in state government
- 10 are within academic institutions
- 3 are independent non-profits

SORH funding or 3 core functions:

- Information Dissemination
- Rural Health Coordination
- Technical Assistance

- Other funding:
- Small Hospital Improvement Program
- Rural Hospital Flexibility Program
- CDC health equity

Massachusetts State Office of Rural Health (SORH)

Building **partnerships** for better health in rural communities.

Although SORHs have individual work, we all collectively create opportunities and build containers for collaborative work. Today, I'd like to highlight how our work supports the following areas – as a way to demonstrate how capital partners like all of you could think about the potential in partnership with a SORH.

How we facilitate partnerships & networks for us and our funding partners.

How we build capacity of our partners and communities to better access and navigate systems.

How we balance our work to support both immediate needs and long-term strategies.

How we access and interpret data to identify areas of need.

THE MDPH RURAL DEFINTION

Rural towns have a very low population density and large geographic spread which creates isolation.

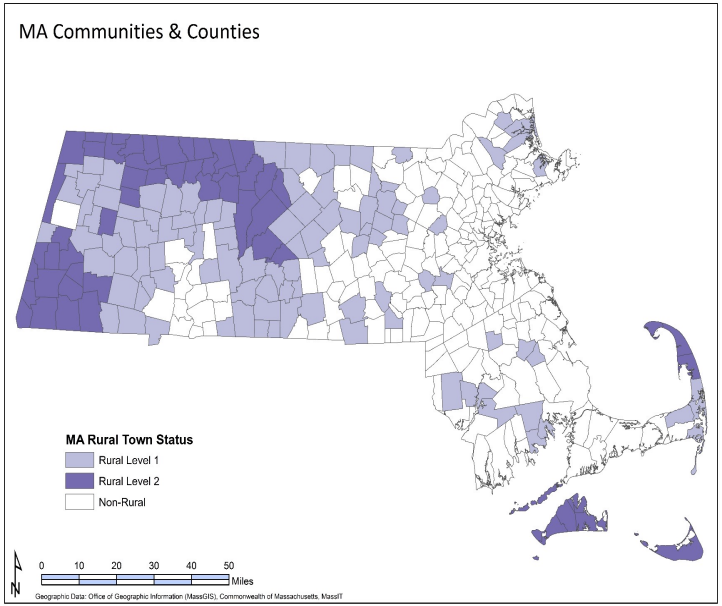
160 of Massachusetts' 351 towns are designated Rural.

10% of Residents live in the 53% of land mass designated rural.

The MDPH Rural Definition has two levels of rurality

RURAL LEVEL 2 TOWNS are less populated, more remote, and isolated from urban core areas.

RURAL LEVEL 1 TOWNS have more population than level 2 and are closer to urban core areas.

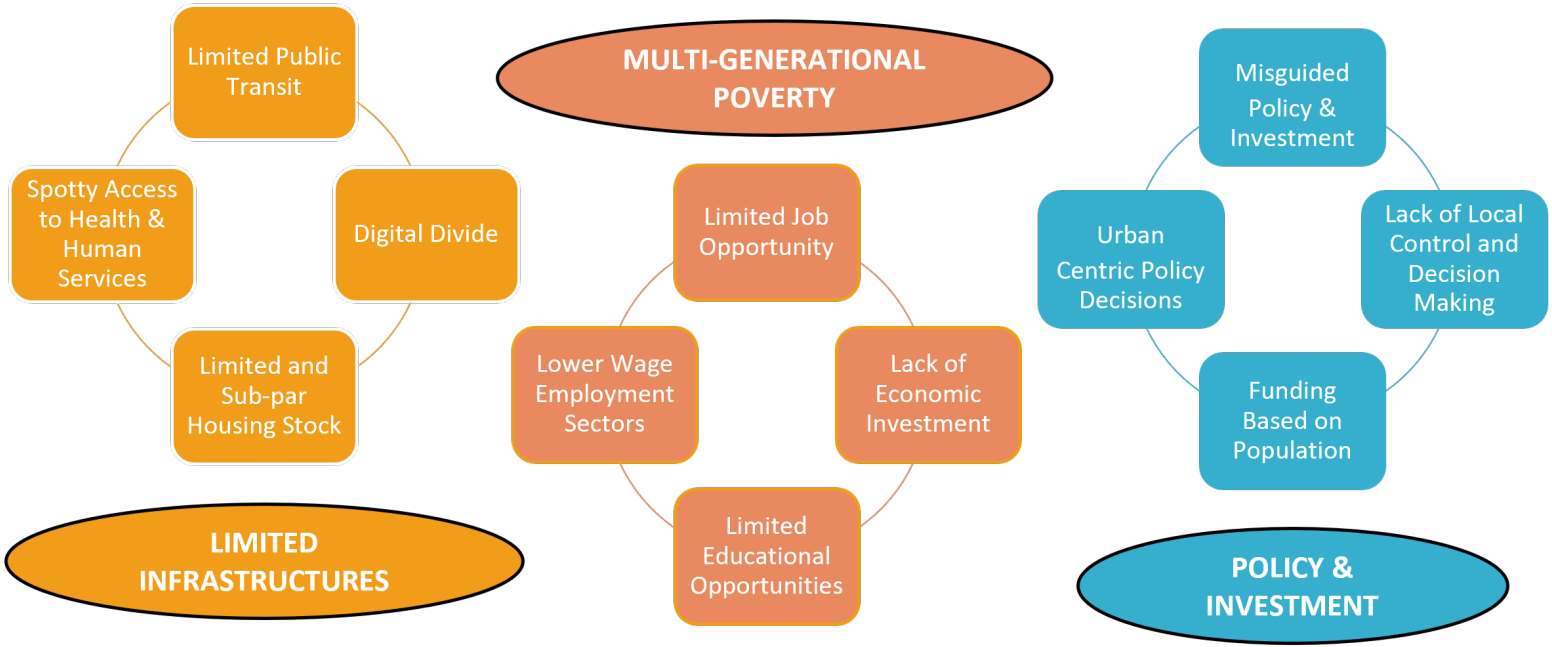


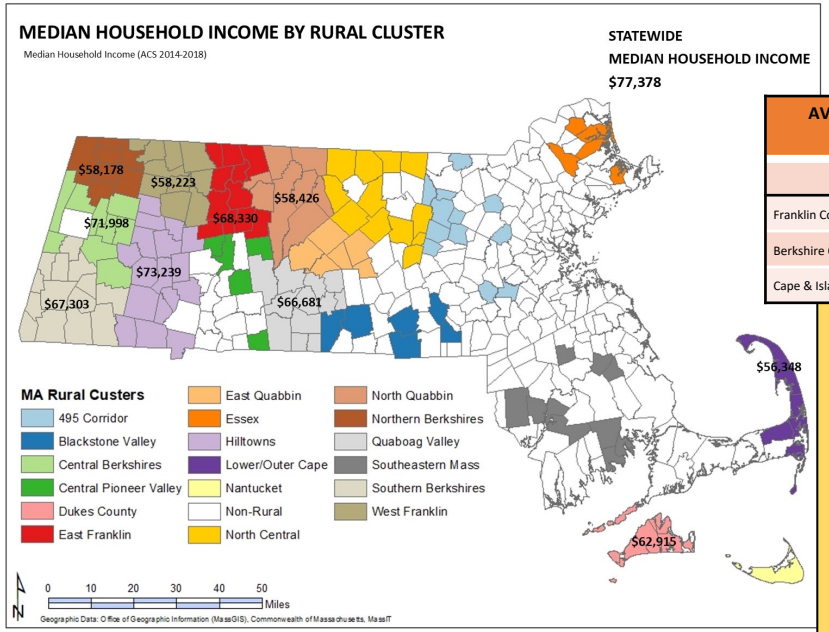
*There is no geographic definition for the "suburbs" or "metropolitan areas" within the federal classifications used by MA State Office of Rural Health.

Source: MA State Office of Rural Health.

STRUCTURAL BARRIERS IMPACTING RURAL COMMUNITIES

Structural barriers are obstacles that collectively affect a group disproportionately and perpetuate or maintain stark disparities in outcomes. Understanding these factors helps us to interpret data and inform the actions we take.



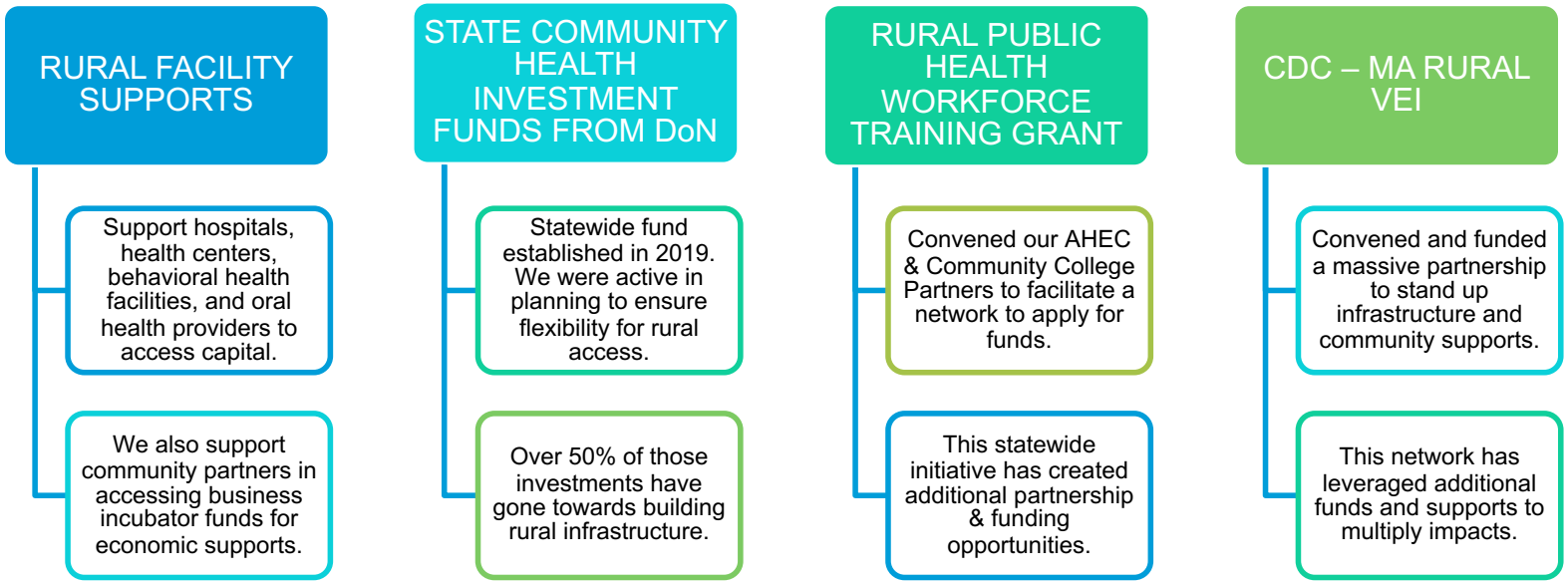


AVERAGE WEEKLY WAGE BY WORKFORCE DEVELOPMENT REGIONS

RURAL REGIONS		URBAN REGIONS	
Franklin County	$868	Lowell	$1,355
Berkshire County	$881	Metro North	$1,597
Cape & Islands	$912	Boston	$1,878

Rural residents are more likely to rely on 'fixed income' sources. The portion of rural households with Social Security is 13% higher at 31.2% and those living on retirement income are 19% higher.

How Have We Supported/Leveraged Our SORH Networks and Relationships with Outside Investment?



VACCINE EQUITY INITIATIVE: RURAL CBO INVESTMENTS

Supporting rural communities to meet ***immediate COVID-19 mitigation needs*** and implement long-range strategies to ensure ***resiliency*** from factors that created poor outcomes during the COVID-19 pandemic.

1. **Direct Funding**
2. **Technical Assistance**
3. **Resource Navigation**
4. **Peer Learning Network**

Funding to 12 CBOs in 14 Rural Regions. Covers 128 Rural Towns (80 % of rural towns)

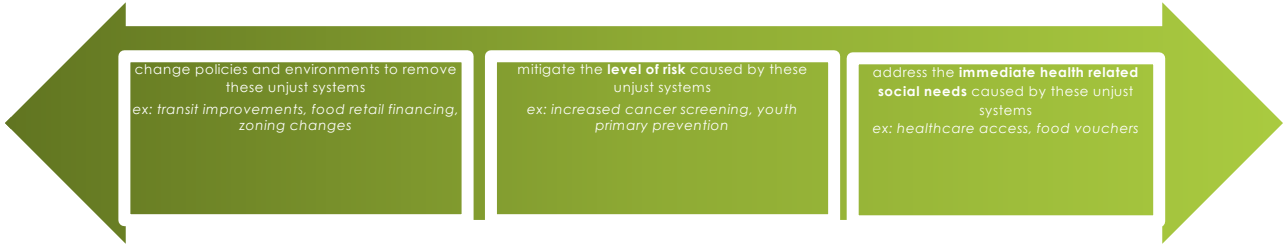
CBO PARTNER ENGAGEMENT

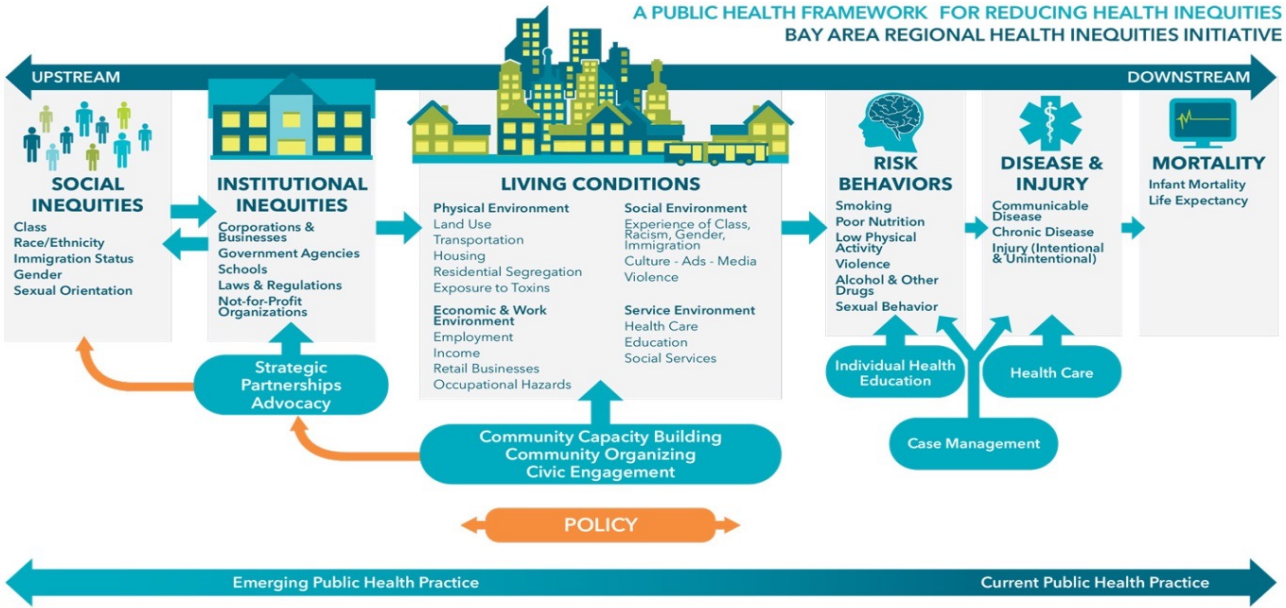
925 Partners activated since **JAN 2022**

Over 800 instances of technical assistance

NUMBER OF PARTNERS ENGAGED BY TYPE

Academic Institutions	11
Community Based and Civic Organizations	39
Corporation - Industry or Private Sector	18
Correctional facilities and institutions organizations	7
Council, community group, coalition	91
Faith Based Organizations	28
Federal agency (other than CDC)	1
Healthcare providers	55
Health-related organizations	16
Local governmental agencies	341
Local Health Department	78
Mental or behavioral health	26
Nongovernmental organizations	24
Rural health clinics and critical access hospitals	4
Schools / School Districts	62
Social services providers and organizations	78
State Health Department	1
Tribal Organizations	2
Other	18





Source: Framework adapted from the Bay Area Regional Health Inequities Initiative White paper on "The Groundwater Approach: Building a practical understanding of structural racism" by Bayard Love and Deena Hayes-Greene of the Racial Equity Institute

State Offices of Rural Health are…

Able to convene partners and understand needs, barriers, and opportunities.

Understand the unique rural prospects for investment.

Engaged in work with immense muti-sector partnerships. Each state has their own unique mix of partners.

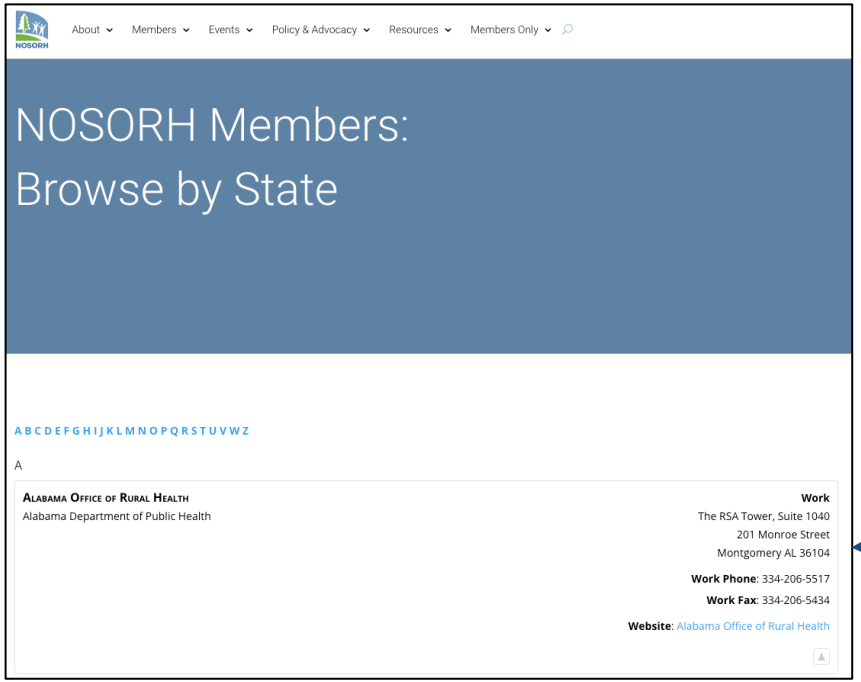
Able to disseminate information to their networks about key programs and initiatives.

Can provide resource navigation or technical support for your programs.

Always looking to learn from models that have worked in other rural areas.

Top 5 focus areas

- Rural infrastructure and leadership development (facility improvements, technology upgrades, rural network development, board & staff development/training)
- Building community and county connections – public health departments – CBO to address food, housing, transportation and other SDOH
- Workforce – community health workers, mobile integrated health, nursing, first responders
- Rural specific data to address health equity (tribal impact equity and opportunity zones, hiring analyses)
- Transportation and mobile services



Find your State Office of Rural Health!

nosorh.org/nosorh-members/nosorh-members-browse-by-state/

Contact Information

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Session Introductions

Kristin Juliar, Consultant
NOSORH

SPEAKER

SESSION ONE: RURAL REVITALIZATION THROUGH PARTNERSHIPS

Cara James

President & CEO
Grantmakers in Health

SPEAKER

SESSION ONE: RURAL REVITALIZATION THROUGH PARTNERSHIPS

Andrew Crosson

CEO
Invest Appalachia

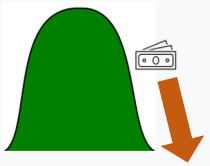
SPEAKER

A Systems Approach to Rural Community Investment

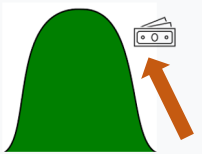
Invest
APPALACHIA

Community Investment: Making Money “Flow Uphill”

- Traditional investment flows to its easiest and most profitable uses – the path of least resistance.



- Community investment is meant to get capital to underserved communities; it is designed to make money “flow uphill”

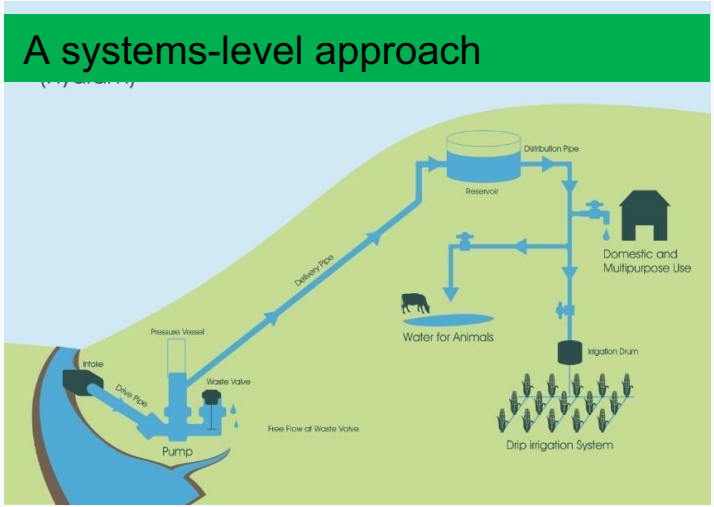


Making Money “Flow Uphill” Takes a System

- This doesn’t work on a transactional basis (one project at a time)

vs

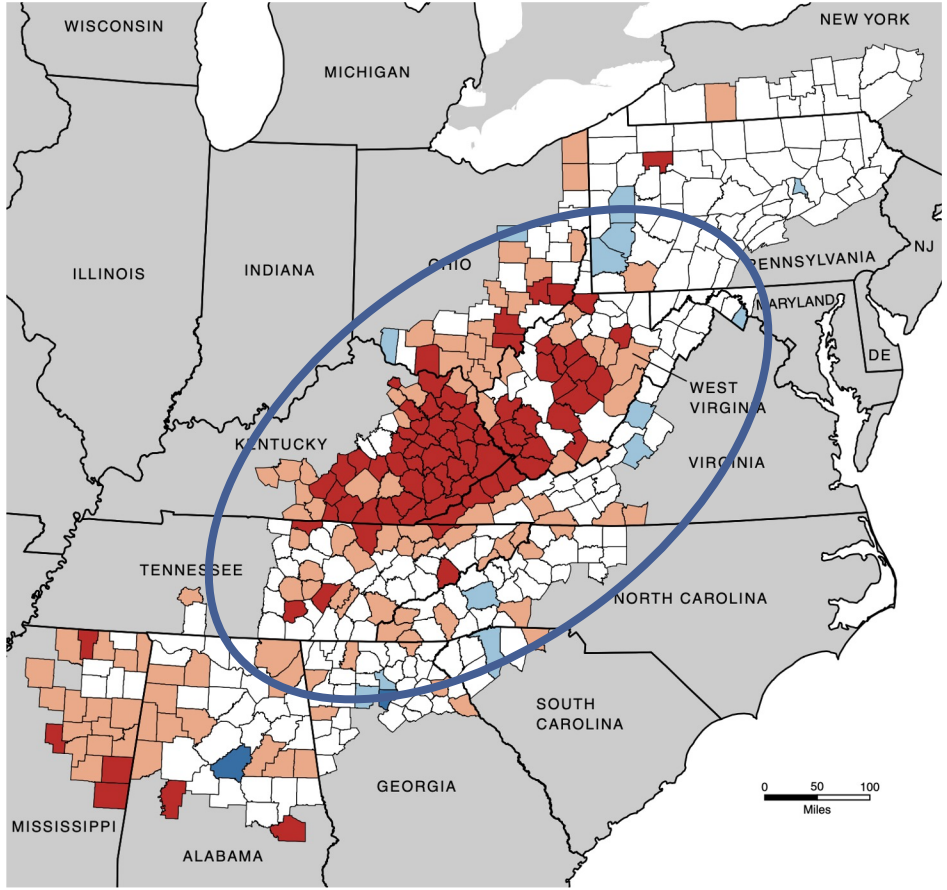
- Like irrigation moving water, a whole system is required:
  - Sources – the capital
  - “Pump” – the power
  - “Plumbing” – the vehicles/infrastructure
  - Distribution network – partners
  - Viable end uses - projects



A Region in Transition

Invest Appalachia's service area targets Appalachian counties in KY, WV, NC, OH, TN, & VA.

Appalachian Regional Commission map (right) reflects FY2021 economic status of target counties.



Appalachia's Investment Ecosystem Journey

Phases and Key Elements

Story themes

Every community investment ecosystem story is unique, but the principles and strategies that contributed to success in Appalachia can serve other communities as they develop their own ecosystems:

SELF-DETERMINATION: The ecosystem was built from the ground up by and for people and organizations in Central Appalachia, reflecting the collectively held vision, values, and priorities of the region.

EQUITY AT THE CENTER: Centering equity, inclusivity, and justice in our vision, as well as the ecosystem's process, structure, and goals, maintained accountability to grassroots constituents and influenced institutional partners to embrace a commitment to equity.

SHARED ANALYSIS: We developed a common analysis and framework around shared priorities, allowing each partner organization to see itself as part of the whole and to understand its role in advancing the collective vision.

COLLECTIVE IMPACT NETWORKS: Informal relationships developed around shared analyses and goals were strategically transformed into formal networks with clear roles and the ability to take collective action to advance regional investment pipelines in specific sectors.

CROSS-SECTOR PARTNERSHIPS: Cross-sector networks were critical to building a coordinated enabling ecosystem that could align resources, capital, and capacity.

TECHNICAL CAPACITY: Providing training and tools for community development finance, impact investing, and sector development at the local level helped build the infrastructure for community investment.

COMMUNITY CAPACITY: Recognizing that effective infrastructure must be rooted in community involvement, we engaged local leaders to help design and iterate solutions based on their lived experience and knowledge.

Impact Goals and Framework

Investing for a Just, Inclusive, & Resilient Appalachian Economy

Equity, Justice, & Inclusivity

- Address structural barriers to capital & opportunity
- Prioritize investment for people of color, women, displaced workers, & at-risk populations
- Drive capital to low-income communities that need it
- Nurture regenerative systems & practices

Community Wealth & Local Power-Building

- Increase quality careers & living wage jobs
- Support local business, community control & collective ownership structures
- Improve quality of life and ability to thrive in place
- Strengthen place-based capacity & local leadership

Sustainability & Climate Resilience

- Mitigate & adapt to longitudinal climate impacts through "whole of community" approach to resilience
- Harness innovative solutions to conserve and steward natural resources to support non-extractive growth that repairs environmental damage and benefits residents
- Support a democratized & just energy transition

UN SDG Alignment:

Goals

- Deconstruct outdated stereotypes of Appalachia and **empower the region to write its own next chapter**
- Develop robust impact tracking systems while utilizing trust-based philanthropic practices to **reduce reporting capacity burdens on grantees and borrowers**

Measuring Impact & Shifting Narratives

- **Narrative shift:** through storytelling, interviews, multimedia production, and partner voices
- **Core cross-sector metrics:** Quality jobs created, investment $ leveraged, % increased revenue, BIPOC-led & women-led projects, etc.
- **Core sector-specific metrics:**
  - Clean energy
  - Community health
  - Food & agriculture
  - Placemaking

Four Priority Sectors Driving Inclusive Prosperity

Clean Energy

~20% of Portfolio

Opportunities for Impact

Renewable energy, energy efficiency, green buildings, clean manufacturing, climate adaptation, mine land reclamation/redevelopment, workforce development, community ownership

Placemaking

~35% of Portfolio

Opportunities for Impact

Downtown redevelopment, asset-based tourism, outdoor recreation, commercial real estate, small business development, community amenities, arts and culture enterprises

Community Health

~35% of Portfolio

Opportunities for Impact

Workforce and affordable housing, community health facilities, health care provider access, addiction treatment & recovery, built environment, childcare and early childhood education

Food & Agriculture

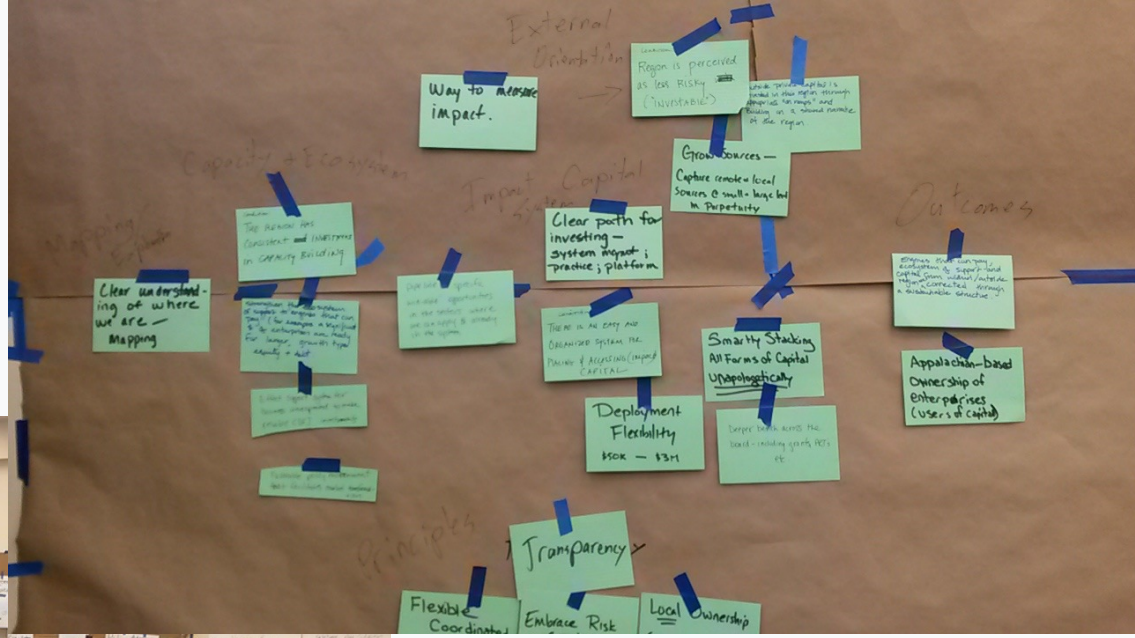
~10% of Portfolio

Opportunities for Impact

Family farms/farmer livelihoods, local retail, health food access, craft food & beverage aggregation/distribution infrastructure, value-added processing, agroforestry & forest farming, working lands conservation

Includes Cross-Sector Projects and Additional Industries that Meet Impact Criteria

System Mapping & Gap Analysis



Pipeline

Mapping Barriers and Bottlenecks in the Process from Idea to Investment

Identify and develop projects and investments that together add up to the realization of the community's strategic priorities.

Spot opportunities

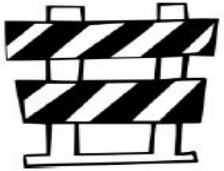
Frame the projects

Select project participants

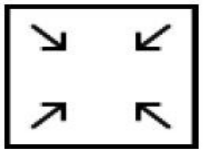
Assemble capital, including identification and blending of sources

Leverage public resources

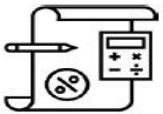
Overcome barriers to investment



Align deals and projects with vision and priorities



Structure and underwrite investments



Invest Appalachia's market research and stakeholder-led design process identified a blend of

70% repayable capital and 30% subsidy/credit enhancement

as the balance necessary to create truly transformative investments and effectively impact underserved communities.

Invest APPALACHIA

INVEST APPALACHIA'S BLENDED CAPITAL APPROACH

Social Capital
Investment Ecosystem

Appalachia's regionally networked ecosystem of place-based capacity, anchor organizations, and collaborations supporting community identified priorities, aligned sector strategies, impact data & storytelling, and regionally defined narratives.

Intermediary Capital
Loans & TA from Regional Partners

Partnership-based pipeline integrates opportunities from partners, coordinates strategies, leverages community & technical capacity, accelerates existing place-based industry sector clusters.

Catalytic (Philanthropic) Capital
$17M Grant Pool - IA 501(c)3

Philanthropic grant pool providing a mix of flexible capital tools including TA, credit enhancements, and other tools to accelerate and offset risk for equitable and innovative community projects.

Investment Capital
$40M IA Fund - LLC Affiliate

Impact investment fund providing patient, flexible, and often subordinated loan capital to underserved communities.

Managed by LOCUS Capital, Inc

Blended Capital Approach
Flexible, Partnership-First, Risk-Sharing

Aligning IA and Partner Capital Sources to Meet Community Priorities

Stacking Capital to Fit the Opportunity

Creating a Deal Structure That Works for the Project

Community Accountability & Stakeholder Governance at every level

- Representative Board of Directors
- Regionally Rooted Staff
- Stakeholder Investment Committee
- Grassroots Community Advisory Council

First Close: Invest Appalachia Fund

Total 1st Close Commitments: $18.95 Million

(Final Close of up to $21M additional - November 2023)

6 Initial Investors:

- Robert Wood Johnson Foundation
- UnitedHealth Group
- Appalachian Regional Commission
- Cassiopeia Foundation
- Laughing Gull Foundation
- Sugarbush Valley Impact Investing

Featured: *Impact Alpha*, *Philanthropy News Digest*, *Wall Street Journal*, *Yahoo News*, and others

Opportunities for Philanthropy

1. **Support place-based capacity: trainings and new tools for individuals and organizations**
2. **Support "systems quarterback" roles and "social capital infrastructure" (new and existing)**
3. **Fund TA and predevelopment needs**
4. **Make impact investments that recognize need for deeply concessionary terms**
5. **Provide "Catalytic Capital": grants as hyper-flexible and risk-absorbing credit enhancement tools**

Strategy Session I.
Key Questions — Idea Sprint

How can we scale up successful partnership investment models? What resources do we have, what resources do we need?

- What is a solution-focused approach to building partnerships that addresses real rural needs?
- How can the organizations here today help make partnership investment models happen?
- What is one thing we can do within our own organizations to expand the table and make sure that all relevant stakeholders are included?

SESSION TWO: RURAL HEALTH & RURAL REVITALIZATION

John Pender

Senior Economist
USDA Economic Research Service

SPEAKER

USDA
United States Department of Agriculture

Linkages Between Rural Community Capitals and Healthcare Provision: Findings of a Survey of Small Rural Towns in Three U.S. Regions

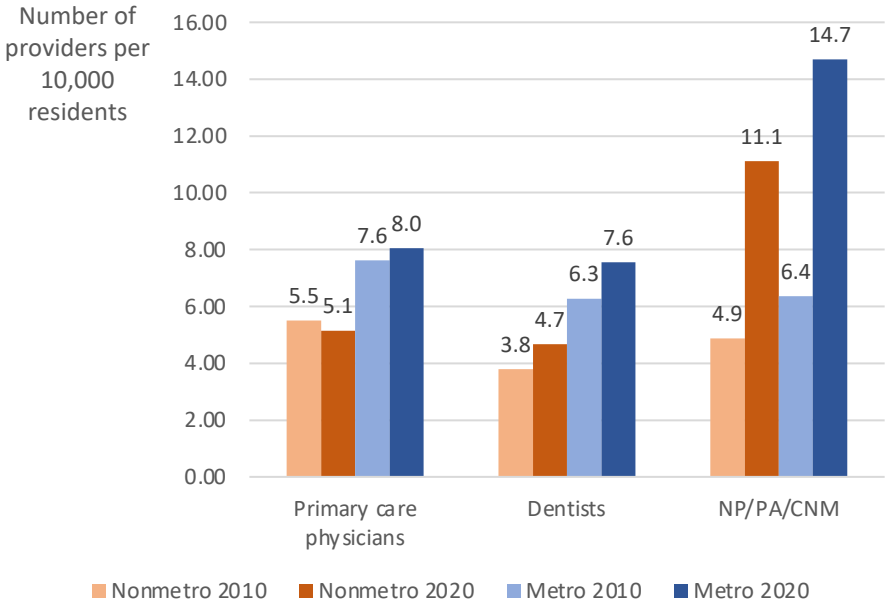
John Pender
USDA Economic Research Service
Presented at Rural Health Capital Resources Council Meeting
Rockville, MD
June 12, 2023

Background/Motivation for Study

- Access to health care services is limited in many rural areas, resulting in poorer health outcomes
- Health care services are increasingly important to rural economies; often one of the largest and most rapidly growing employers
- Little research has investigated how rural communities and their assets/investments affect recruitment & retention of health care providers
- With ERS support and leadership, Iowa State University completed a survey in 2015 of community leaders, health facility administrators, and health care professionals in 150 rural small towns in 9 states representing 3 regions (Lower Mississippi Delta, Southern Great Plains, and Upper Midwest)

Nonmetro areas lag in access to healthcare professionals and are falling further behind.

- In 2021, 30% of nonmetro population lived in primary care HPSAs, compared to 13% of metro population
- In both 2010 and 2020, the number of healthcare professionals per capita was greater in metro areas
- Between 2010 and 2020
  - The number of primary care physicians per capita declined 6% in nonmetro areas while it increased 5% in metro areas
  - The number of dentists and NP/PA/CNMs increased in both nonmetro and metro areas, but by more in metro areas



Note: Metro and nonmetro areas are as classified by the Office of Management and Budget in 2013. "NP/PA/CNM" refers to a combined category of healthcare professionals that includes nurse practitioners, physician assistants, and certified nurse midwives.
Source: USDA, Economic Research Service analysis of Area Health Resource File data (Health Resources and Services Administration, 2022).

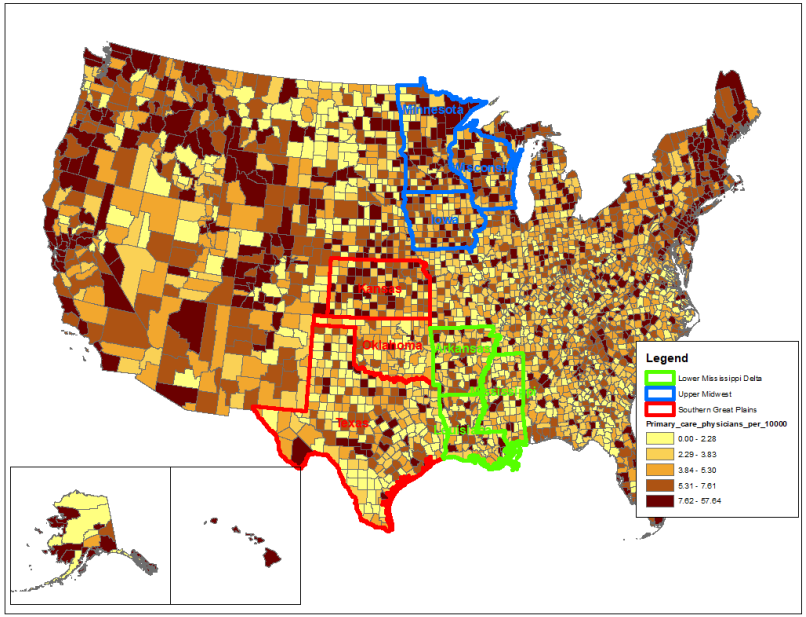
Research Questions

- How do the assets and investments of rural communities – broadly defined to reflect multiple types of community capitals – affect recruitment and retention of health care professionals?
- How does the importance of these factors vary across regions and types of providers?
- Does the importance of these factors differ between recruitment and retention?
- What can rural communities themselves do to help recruit and retain health care professionals?

Study Approach

- Semi-structured key informant telephone interviews with community leaders and health care administrators, and mail/web survey of health care providers in 150 towns in 9 states in 3 regions:
  - Lower Mississippi Delta (LMD - AR, LA, MS)
  - Southern Great Plains (SGP – KS, OK, TX)
  - Upper Midwest (UMW - IA, MN, WI)
- Regions selected to include
  - Areas of limited health care access (esp. LMD and SGP) and a contrasting region (UMW) with better access
  - Variations in community characteristics & assets (poverty, race, ethnicity, social capital, natural amenities, etc.)
  - Areas where growth in employment in health services is rapid and an important share of the economy

Study regions selected to represent variations in availability of healthcare professionals & other factors



Note: The categories represented in the map are quintiles of the distribution of primary care physicians per 10,000 residents in 2020.
Source: USDA, Economic Research Service using Area Health Resource File data.

- Upper Midwest (UMW) – IA, MN, WI
  - Above average access to healthcare professionals and health insurance
  - Above average nonmetro per capita income, below average poverty
- Lower Mississippi Delta (LMD) – AR, LA, MS – and Southern Great Plains (SGP) – KS, OK, TX
  - Below average access to most healthcare professionals, health insurance
  - Below average per capita income, above average poverty

Sample Selection

- Universe restricted to small rural towns (largest town in a Zip Code Tabulation Area (ZCTA))
  - With population at least 2,500 and less than 20,000
  - Without high commuting dependence on large urban areas (<30% dependence)
- This universe includes about 3.6 million people in 809 towns in the study states
- Strata:
  - Three regions (LMD, SGP, UMW)
  - Towns with/without a hospital (about 50% of each)
- Sample of ZCTAs selected using stratified random sampling
- Sample included 39 towns in LMD, 46 in SGP, 65 in UMW

Respondents

- Key informant interviews (in all 150 sample towns):
  - Community leaders (e.g., mayor, city manager, economic development official, Chamber of Commerce director) – up to 2 interviews
  - Health care facility (hospital or clinic) administrators, other healthcare representatives – up to 2 interviews
- Health care provider survey (in 132 towns with providers):
  - Primary care physicians
  - Dentists
  - Nurse practitioners, physician assistants, and nurse midwives
  - Maximum sample of 32 providers from any town

Key Informant Interviews - Respondents

- 341 respondents – 84 from LMD, 102 from SGP, 155 from UMW
- Responses from all 150 sample towns
- 1-4 key informants per town
- Most common respondents – mayor, city manager or clerk, hospital or clinic administrator, county health or economic development officials, Chamber of Commerce directors
- Most respondents reside in or near town, and had been there at least 5 years

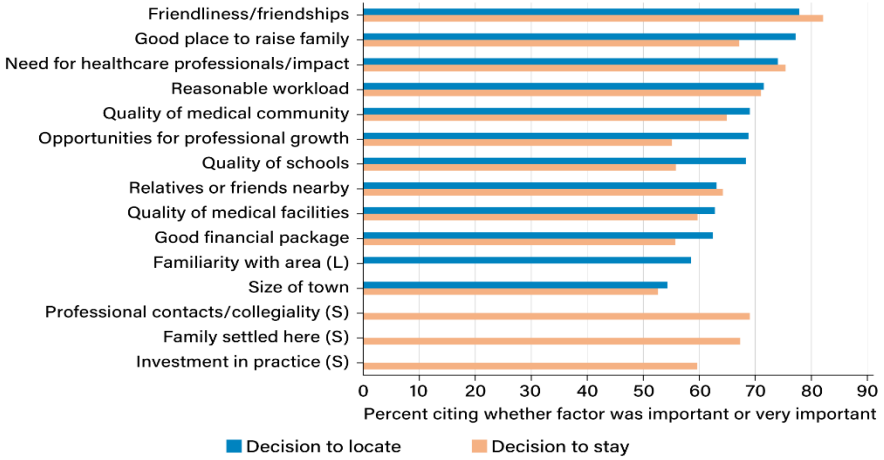
Provider Survey – Respondents

- 928 respondents - 130 from LMD, 231 from SGP, 567 from UMW
- Responses from all sample towns that have providers (132 towns)
- About 30 – 40 percent of respondents of each provider type (278 dentists, 275 NP/PA/MW, 375 physicians)
- Response rates:
  - Overall - 64%
  - 50% in LMD, 62% in SGP, 69% in UMW
  - 71% for dentists, 66% for NP/PA/MW, 59% for physicians
- After a low initial response rate (24%), we conducted a nonresponse follow-up effort using cash gifts ($40) to all non-respondents and initial respondents

Healthcare professionals most often cited social, human, and physical capital as important in their decisions to locate or stay in rural small towns.

- Many of the most cited factors reflect social capital
  - Friendliness/friendships
  - Professional contacts/collegiality
  - Relatives or friends nearby
  - Family settled here
  - Familiarity with area
- Human capital (quality of medical community), physical capital (quality of medical facilities), and multiple types of capital (good place to raise a family, quality of schools, size of town) also important to most professionals

Healthcare professionals cited friendliness and friendships as top factors in deciding whether to locate or stay in rural small towns



Note: **(L)**=factor only for initial location decision. **(S)**=factor only for decision to stay. All other factors are for both scenarios. Percentages are weighted to account for sampling probability. Standard errors of the percent responding that the factor is important are all less than 3.0 percent.

Source: USDA, Economic Research Service analysis of healthcare professional survey responses collected in 150 small rural towns in 9 States (Arkansas, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Oklahoma, Texas, Wisconsin) by Iowa State University's Survey and Behavioral Research Services, 2014–15.

Several factors were cited as important most often in the Upper Midwest region.

- Most factors were cited as important to a similar extent across regions
- But several factors were cited as important most often in the Upper Midwest region and least often in the Lower Mississippi Delta region

Region in which factor is most often cited as important

Factor with difference across regions	LMD	SGP	UMW
Good place to raise a family			X
Professional contacts/collegiality			X
Quality of medical community			X
Quality of schools			X
Quality of medical facilities			X
Size of town			X

Note: "LMD" = Lower Mississippi Delta; "SGP" = Southern Great Plains; "UMW" = Upper Midwest.
Source: USDA, Economic Research Service analysis of healthcare professional survey responses collected by Iowa State University's Survey and Behavioral Research Services, 2014–2015.

Many factors were cited as important most often by nurse practitioners/physician assistants/certified nurse midwives.

- Many factors were cited most often by NP/PA/CNMs
- Both NP/PA/CNMs and physicians cited need for service/impact as important more than dentists
- Dentists most often cited investment in practice and size of town as important

Professionals for which factor is most often cited as important

Factor with difference across healthcare professional type	Den-tist	NP/PA/ CNM	Physi-cian
Need for service, impact		X	X
Reasonable workload		X	
Professional contacts/collegiality		X	
Quality of medical community		X	
Professional growth opportunities		X	
Relatives or friends nearby		X	
Quality of medical facilities		X	
Investment in practice	X		
Good financial package		X	
Familiarity with the area		X	
Size of town	X		

Note: "NP/PA/CNM" = Nurse Practitioner/Physician Assistant/Certified Nurse Midwife.

Social and professional relationships often cited as the most important reason to locate and stay in the town.

The most important factors in initial location decision:

- Characteristics of community or family (62%)
  - Hometown, close to family & friends, familiar with area (36%)
  - Small town or rural life (12%)
  - Positive social aspects of town (11%)
  - Like the community/location (5%)
  - Spouse's career (4%)
  - Other (4%)
- Characteristics of medical community, facility, or job (41%)
  - Human or social capital characteristics (20%)
  - Economic aspects of job (16%)
  - Reasonable workload/work-life balance (4%)
  - Availability/quality of medical facilities (2%)
- Need for services/desire to help people (12%)

The most important factors in decision to stay (if considered leaving (42%)):

- Family considerations or characteristics of community (19%)
  - Family considerations: Stability for family, close to home or family, good place to raise a family, spouse's career, health issues in family (14%)
  - Like people of town, personal commitment to town (6%)
- Characteristics of medical community, practice, or job (22%)
  - Social or administrative considerations (12%)
    - Relationships with patients & colleagues (8%)
  - Economic factors – e.g., salary or financial package, investment in the practice, opportunity to buy practice, no better opportunities in area, loan repayment obligations (10%)
  - Human capital/workload considerations (4%)
- Other factors (6%)

Conclusions (1)

- Many factors affect healthcare professionals' decisions to locate and stay in rural small towns. Among the most important:
  - Social capital – the value of personal and professional relationships with family, friends, colleagues, and patients
  - Human capital – wealth imbedded in people's abilities, skills, and health, such as quality of the medical community
  - Physical capital – such as availability and quality of medical facilities
- Some important factors represent combinations of community capitals:
  - Good place to raise a family – social, human, physical, natural, cultural capital
  - Quality of schools – human, social, physical capital
  - Urban amenities – human, physical, cultural capital
- Some types of community capital were less often cited as important:
  - Financial wealth
  - Natural amenities
  - Cultural amenities

Conclusions (2)

- Some important factors are not community capitals themselves, but related to community capitals:
  - Need in the community – related to financial wealth, human capital
  - Workload concerns – related to human capital
  - Financial rewards offered to providers – related to financial wealth
  - Effects on spouse or partner – related to social capital
- Importance of some factors varies across regions and professional types
- Some factors were less often cited by key informants (e.g., community leaders, healthcare facility administrators) than healthcare professionals:
  - Need in the community/having an impact
  - Workload and on-call responsibilities
  - Impacts on spouse or partner

Implications

- Rural communities can have significant influence on recruiting and retaining healthcare professionals by investing in community capitals – especially social, human, and physical capital.
- Differences across regions and professional types in importance of some factors suggests importance of understanding regional and local contexts in efforts to recruit and retain healthcare professionals.
- Lack of awareness by community leaders and health facility administrators of some factors important to healthcare professionals may reduce the effectiveness of recruitment and retention efforts.

Thank you!
Questions? Comments?

For more information: john.pender@usda.gov

SESSION TWO: RURAL HEALTH & RURAL REVITALIZATION

Andrew Dumont

Lead Community Development Analyst
Federal Reserve Board

SPEAKER

Bank branch trends and community development investment patterns: Intersections with hospital closures

Presentation at the Rural Health Capital Resource Council Meeting

Andrew Dumont, Lead Community Development Analyst, Federal Reserve Board

June 12, 2023

Disclaimer

The information, analyses, and conclusion set forth are those of the presenter and do not necessarily indicate concurrence by the Board of Governors of the Federal Reserve System, the Federal Reserve Banks, or members of their staffs.

Key trends affecting rural areas

- Bank branch trends
  - Banks have been reducing their branch footprint for more than a decade, a trend that accelerated during the pandemic
  - Branch closures have affected metro areas more, but have also deeply affected certain rural areas, especially those with low incomes and large Black populations
  - Banking consolidation is leaving fewer rural areas with a bank headquarters
- The distribution of CD investments is uneven across rural areas
  - Rural census tracts receive fewer CRA small business loan dollars per 1,000 people than urban census tracts
  - Recent Federal investments in rural census tracts shows a clear regional pattern
  - Various measures of "capacity" show clear weaknesses in certain rural regions
  - Rural census tracts – especially those located in majority-minority and persistent poverty counties – receive more CDFI investments per 1,000 people than urban census tracts

Banking Trends:

2012-2022

The number of bank branches has declined significantly over the last decade

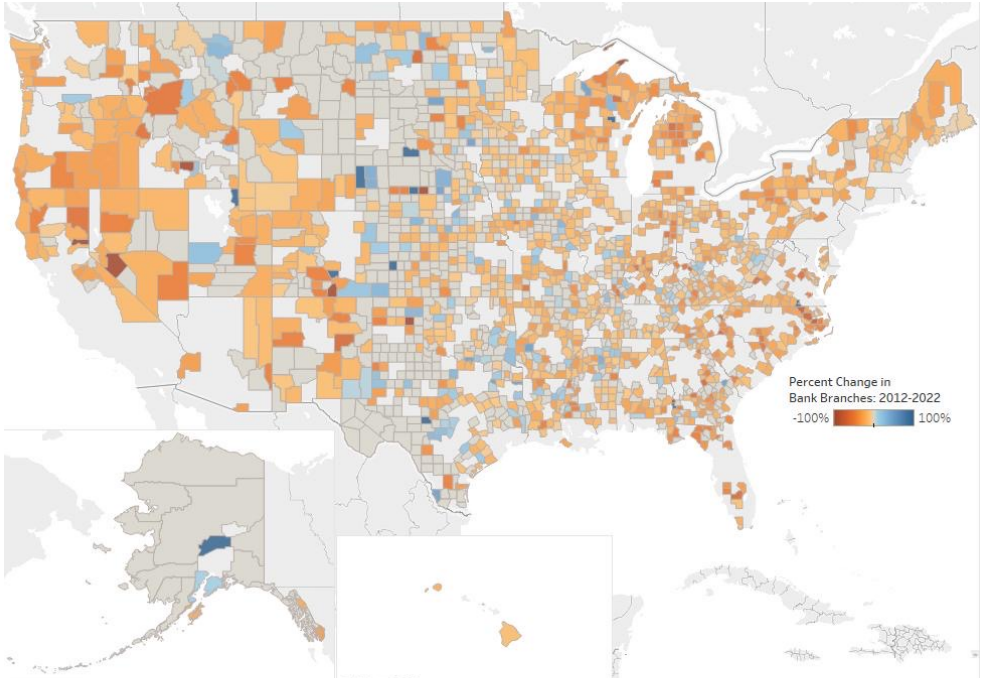
Change in number of bank branches, 2012-2022

	Areas that gained branches		Areas that lost branches		All Areas	
	Change	% Change	Change	% Change	Change	% Change
Metro	237	9%	(14,098)	(20%)	(13,861)	(19%)
Nonmetro	198	16%	(3,034)	(22%)	(2,836)	(15%)
Total	435	11%	(17,132)	(20%)	(16,697)	(18%)

Source: FDIC, Summary of Deposits data, limited to brick-and-mortar and full-service retail branches

The Northeast, Southeast, Midwest, and Western regions have been widely impacted

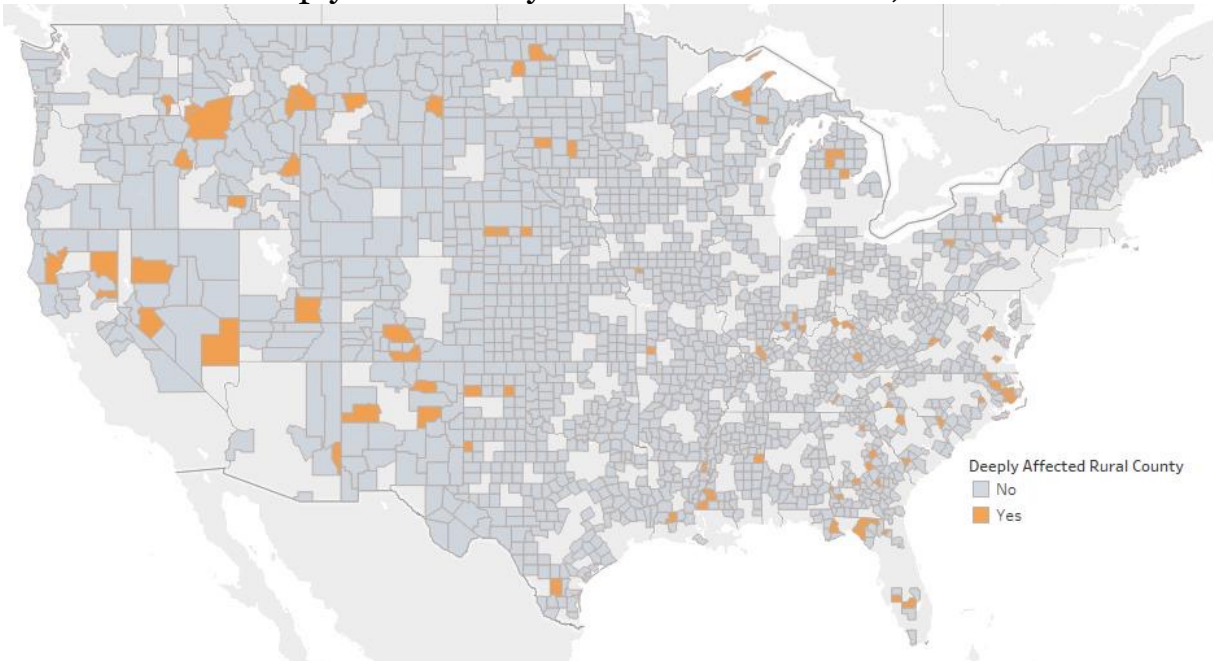
Percent change in bank branches, 2012-2022



Source: FDIC, Summary of Deposits data, limited to brick-and-mortar and full-service retail branches

Some rural counties in the South and West have been deeply affected by branch closures

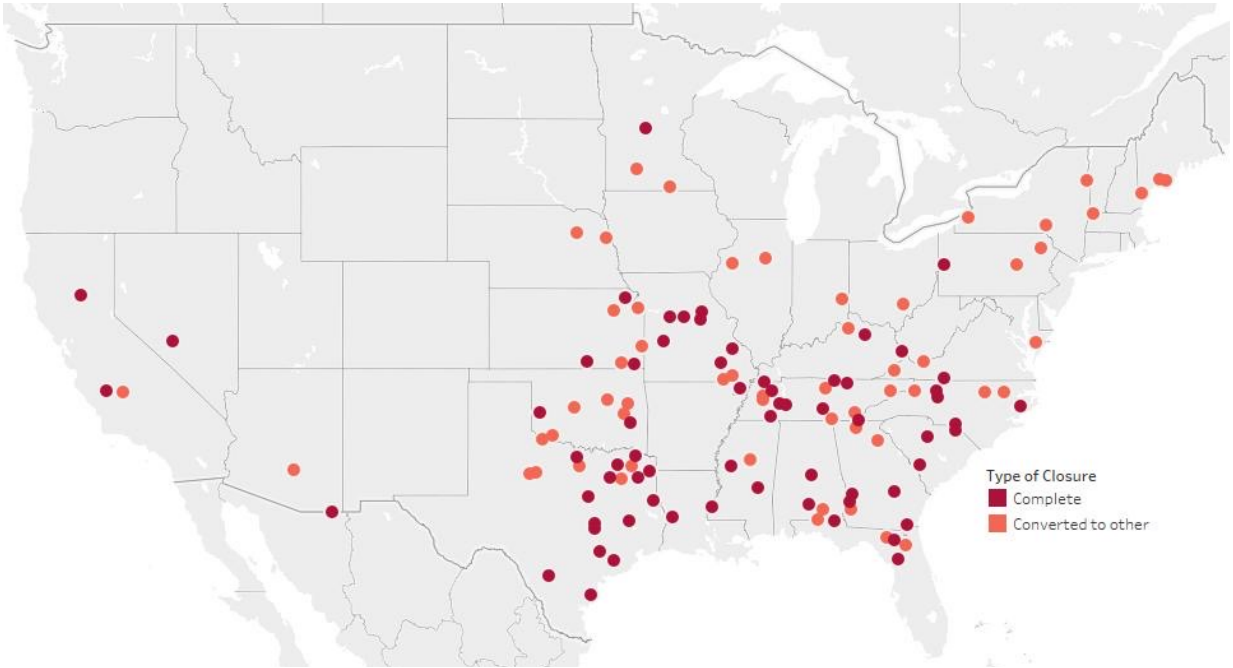
Rural counties deeply affected* by bank branch closures, 2012-2022



Source: FDIC, Summary of Deposits data, limited to brick-and-mortar and full-service retail branches.
* "Deeply affected counties" are defined as those that had 10 or fewer branches in 2012 and where 50% or more of those branches closed by 2022

The South has been most affected by hospital closures in recent years

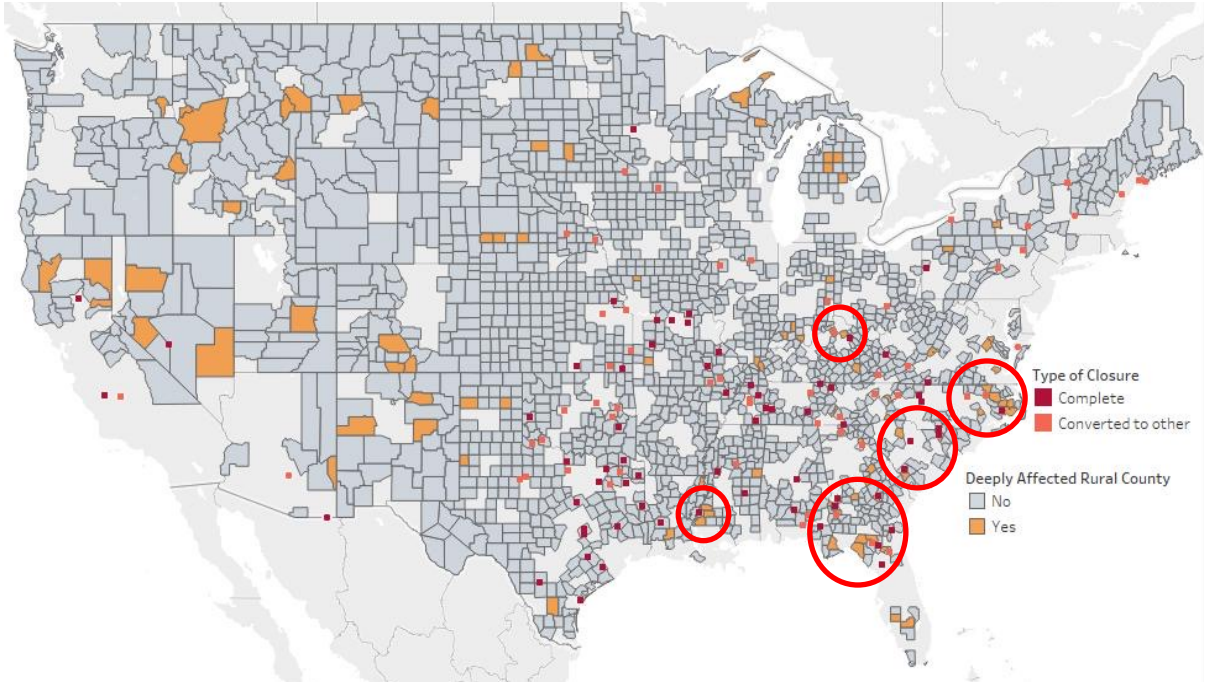
Hospital closures and conversions, June 2012 to June 2022



Source: UNC, The Cecil G. Sheps Center for Health Services Research

Certain rural areas, primarily in the Southeast, have been impacted by both types of closures

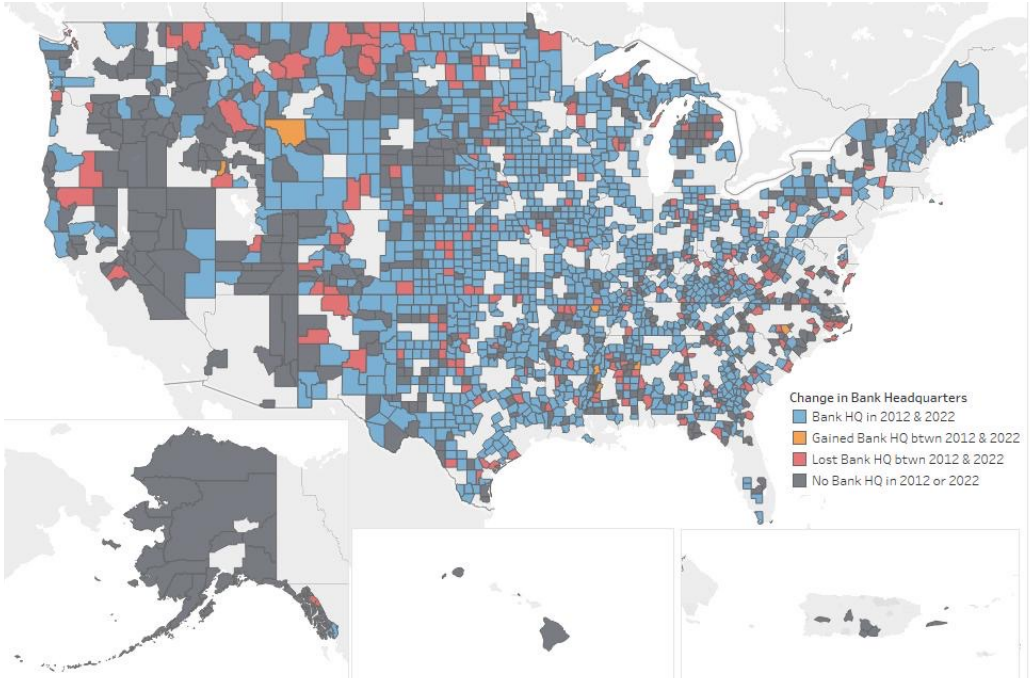
Deeply affected rural counties, with hospital closures & conversions, 2012-2022



Sources: UNC, The Cecil G. Sheps Center for Health Services Research; FDIC, Summary of Deposits data, limited to brick-and-mortar and full-service retail branches

Many rural areas lost the presence of a bank headquarters over the past decade

Change in the presence of a bank headquarters, 2012-2022

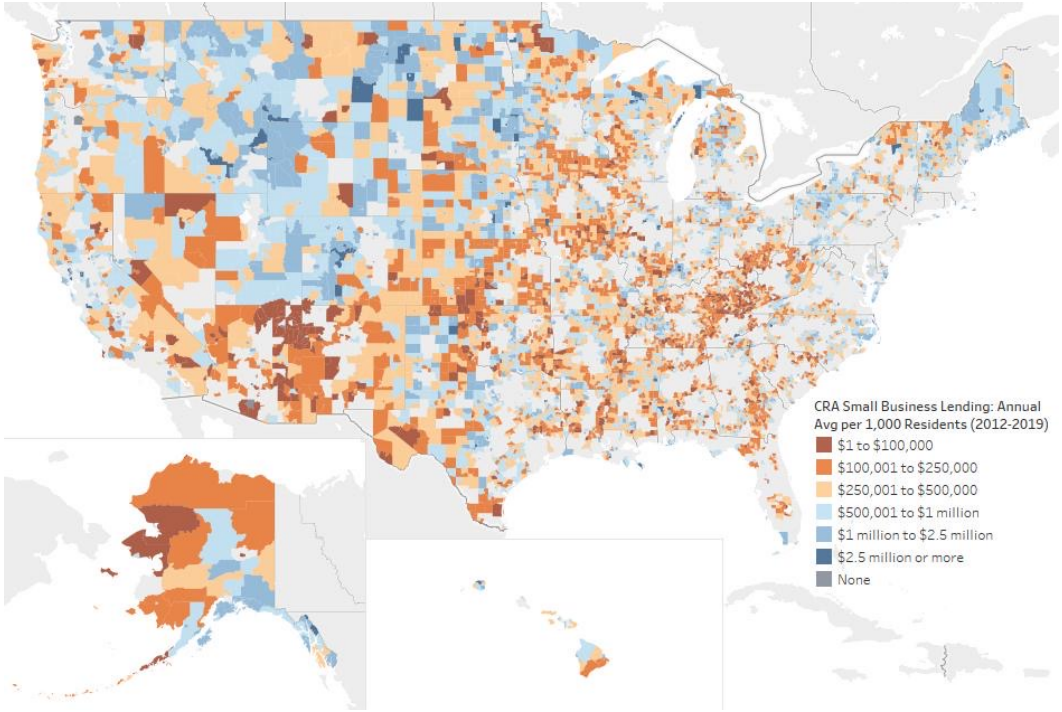


Sources: FDIC, Summary of Deposits data

Patterns in Community Development Investments and Capacity Indicators

Many of the areas most affected also receive relatively low levels of CRA small business loans

Annual average CRA small business lending per 1,000 people, 2012-2019



Source: St. Louis Fed's Community Investment Explorer

Majority-minority and persistent poverty rural communities receive fewer CRA small business loan dollars than comparable urban areas

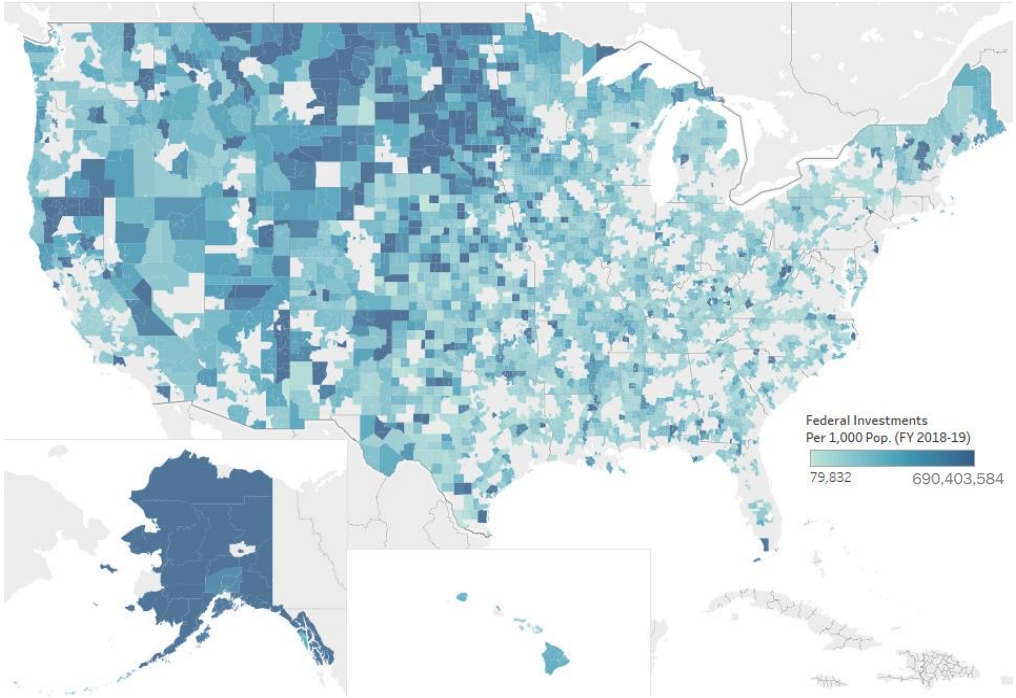
Annual Average CRA Small Business Lending per 1,000 people, 2012-2019

	Census tracts located in…		
	Majority-Minority Counties	Persistent Poverty Counties	All Counties
Urban census tracts	$1,816,212	$849,757	$1,774,038
Rural census tracts	$554,002	$500,265	$710,762
All census tracts	$1,701,831	$755,410	$1,586,559

Source: St. Louis Fed's Community Investment Explorer

Affected areas received relatively low levels of Federal investments per capita in FY 2018-2019

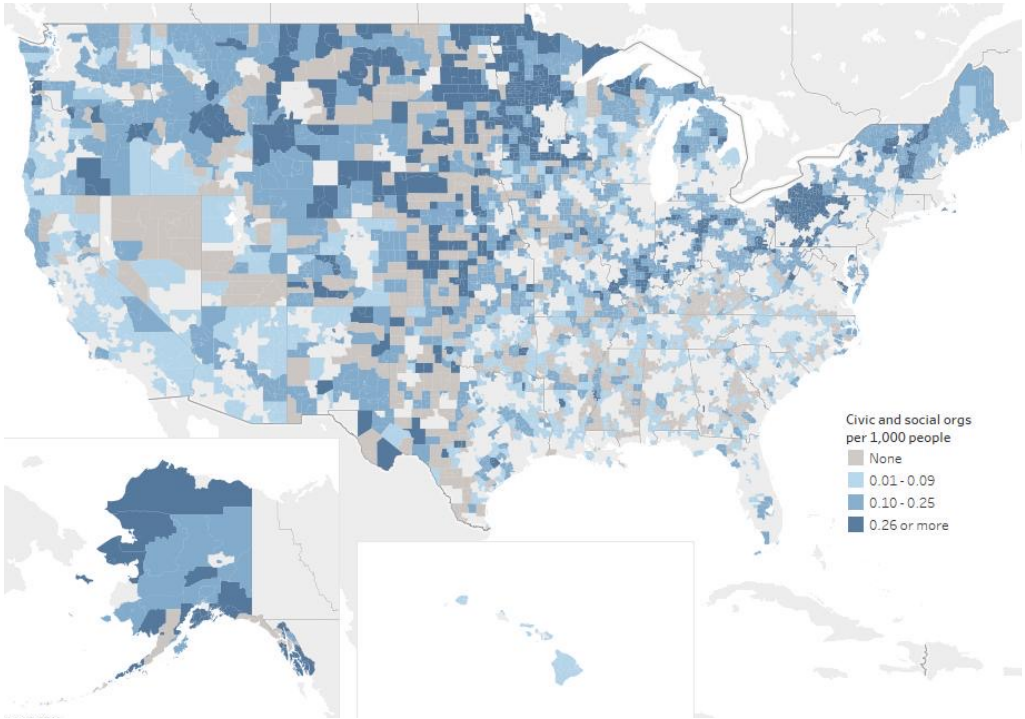
Federal investments per capita, FY 2018-2019



Source: Urban Institute, Reenvisioning Rural America

And have fewer civic and social organizations per 1,000 people than other regions

Number of civic and social organizations per 1,000 people, 2014



Source: Urban Institute, Reenvisioning Rural America

By one measure at least, persistent poverty rural communities have less capacity than other rural areas

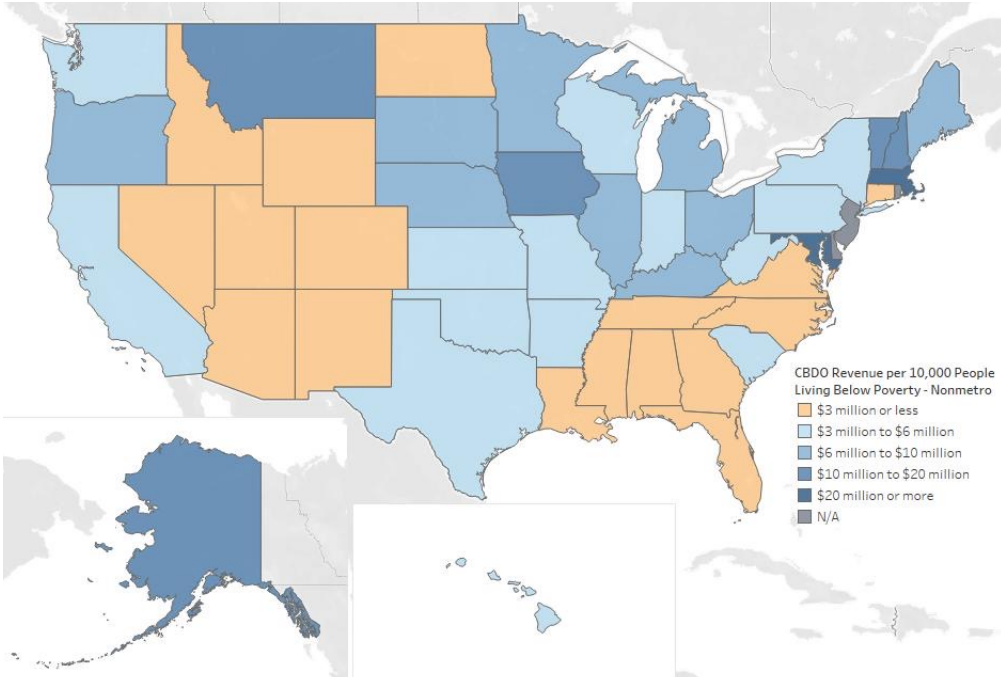
Percent of counties by the number of civic and social organizations per 1,000 people and by persistent poverty status, 2014

	Number of civic and social orgs in the county, per 1,000 people			
(Percent of counties)	None	0.01 - 0.09	0.10 – 0.25	0.26 or more
Persistent Poverty County	48	30	18	3
Not Persistent Poverty County	23	29	33	15
All counties that incl. a rural census tract	13	34	41	11

Source: Urban Institute, Reenvisioning Rural America database

Community-based development organizations serving affected regions have relatively low revenues

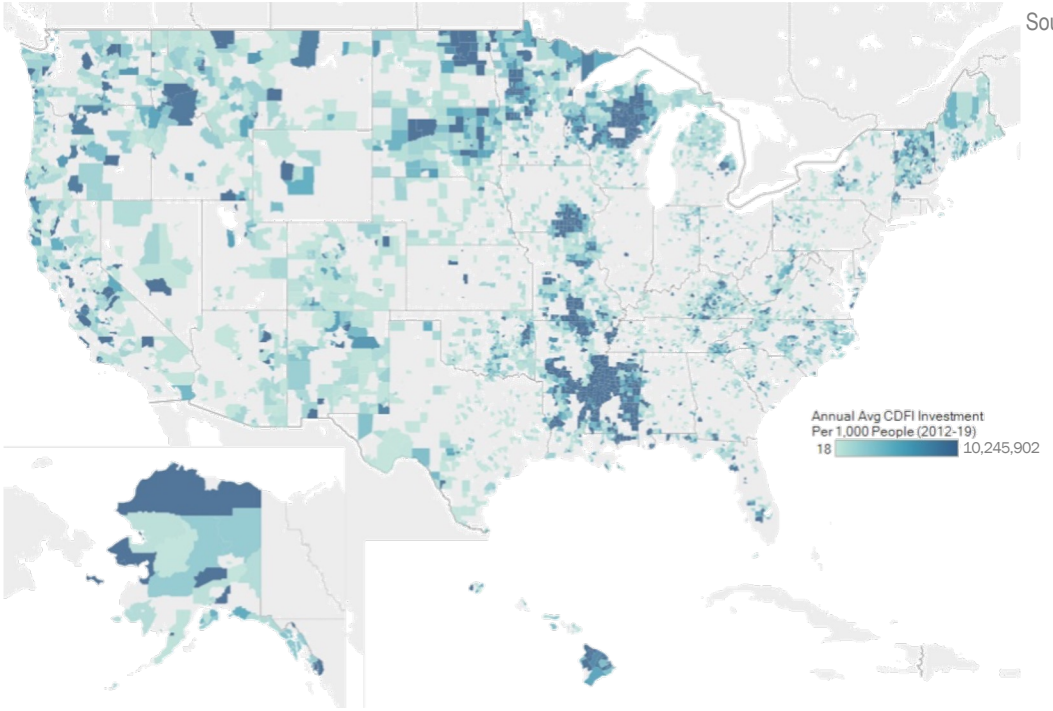
Total revenue of CBDOs, per 10,000 people living below poverty, 2018



Source: Urban Institute, Community-Based Development Organization Sector and Financial Datasets

Some of the affected areas do relatively well at attracting CDFI investments

Annual average CDFI investments per 1,000 people, 2012-2019



Source: St. Louis Fed's Community Investment Explorer

Thank you!

Andrew Dumont
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Strategy Session II.
Key Questions — Idea Sprint

What implications do data trends have for the communities we serve? What policies programs and projects should we be pursuing?

- How do the factors that John and Andrew discussed impact our work at the community level?
- What can our organizations do to support successful community strategies?
- How can we use data more effectively to make the case for funding rural projects and programs?

Afternoon Meet & Greet

Join the group for fellowship, beverages, and appetizers

LOCATION: WASHINGTON D.C. HILTON
1750 ROCKVILLE PIKE, MD 20852