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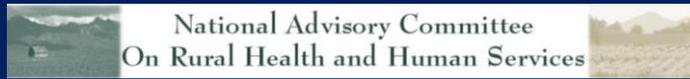
Your *First* **STOP** for  
*Rural Health*  
**INFORMATION**



## NACRHHS Policy Brief on Understanding the Impact of Suicide in Rural America

# Housekeeping

- Q & A to follow – Submit questions using Q&A area
- Slides are available at <https://www.ruralhealthinfo.org/webinars/suicide-impact-rural-america>
- Technical difficulties please call 866-229-3239



# Understanding the Impact of Suicide in Rural America

*Policy Brief Webinar*

April 24, 2018

National Advisory Committee on Rural Health and Human Services

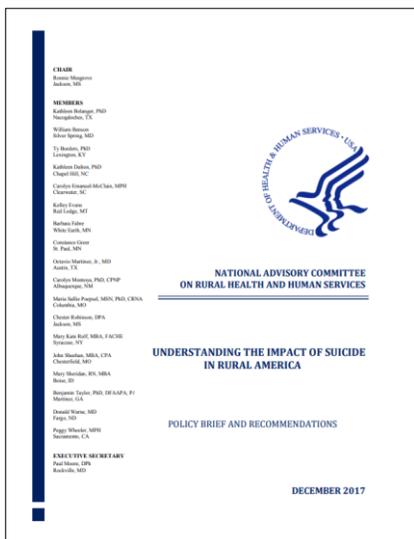
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## Background on the Committee

- A federally chartered independent citizens' panel comprised of 21 members with knowledge and expertise in rural health and human services.
- The Committee was chartered in 1987 to advise the Secretary of the U.S. Department of Health and Human Services (HHS) on ways to address health care challenges in rural America.

National Advisory Committee on Rural Health and Human Services

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The Committee convenes twice a year to:

- Examine important issues that affect the health and well-being of rural Americans;
- Provide policy recommendations to advise the Secretary of HHS on how the Department and its programs can better address these issues.

Link to Committee's Policy Briefs:

<https://www.hrsa.gov/advisory-committees/rural-health/publications/index.html>

## Webinar Speakers



**Ronnie Musgrove**

*Chair* | National Advisory Committee on Rural Health and Human Services  
*Former Governor of Mississippi* | State of Mississippi



**Holly Hedegaard, MD, MSPH**

*Injury Epidemiologist* | National Center for Health Statistics  
Centers for Disease Control and Prevention



**Kathleen Belanger, PhD, MSW**

*Member* | National Advisory Committee on Rural Health and Human Services  
*Professor Emeritus* | Stephen F. Austin State University's School of Social Work

## Notes on Terminology, Pt. I<sup>1</sup>

- ***Suicide***: Death caused by self-directed injurious behavior with an intent to die as a result of the behavior.
- ***Suicide attempt***: A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.
- ***Suicidal ideation***: Thinking about, considering, or planning suicide.

<sup>1</sup> Definitions provided by the Centers for Disease Control and Prevention. Retrieved from <https://www.cdc.gov/violenceprevention/suicide/definitions.html>.

## Notes on Terminology, Pt. II<sup>2</sup>

- For language to report a suicide death:
  - ❑ Refrain from saying “successful/unsuccessful suicide,” or “commit/committed suicide”
  - ❑ Instead, use phrases such as “**took his/her/their own life**,” “**ended his/her/their own life**,” or “**died by suicide**”
- For language that touches upon a “suicide attempt”:
  - ❑ Avoid using the phrase “failed suicide”
  - ❑ Instead, use “**made an attempt on his/her/their life**” or “**non-fatal attempt**”
- For language to describe suicide rates:
  - ❑ In place of “epidemic,” “outbreak,” or “skyrocketing”
  - ❑ Use words such as “**higher**,” “**increasing**,” or “**concerning**”

<sup>2</sup> For more information about suicide terminology, refer to pp. 21-23 in Crosby, Alex E., LaVonne Ortega, and Cindi Melanson. “Self-directed violence surveillance: Uniform definitions and recommended data elements, version 1.0” Centers for Disease Control and Prevention, 2011. Retrieved from <https://www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf>.

## Why Suicide?

- With more than 44,000 suicide deaths in 2015, suicide was the 10th leading cause of mortality in the U.S. and the 2nd leading cause of death among youth and young adults.
- At the 2017 Spring Meeting, the Committee expressed a collective concern regarding the persistent and widening increases in suicide rates among rural areas.



**How Many Opioid Overdoses Are Suicides?**

Research on drug addiction and suicide suggests much higher numbers.

"[Based on the literature that's available], it looks like it's anywhere between 25 and 45 percent of deaths by overdose that may be actual suicides," said [Dr. Maria Oquendo](#), immediate past president of the American Psychiatric Association.

Oquendo pointed to [one study](#) of overdoses from prescription opioids that found nearly 54 percent were unintentional. The rest were either suicide attempts or undetermined.

Several large studies show an increased risk of suicide among drug users addicted to opioids, especially women. In a [study](#) of about 5 million veterans, women were eight times as likely as others to be at risk for suicide, while men faced a twofold risk.

The opioid epidemic is occurring at the same time suicides have [hit a 30-year high](#), but Oquendo said few doctors look for a connection.

**Measuring Suicide Among Patients Addicted To Opioids**

Massachusetts, where Olinian lives, began formally [reporting](#) in May 2017 that some opioid overdose deaths are suicides. The state confirmed only about 2 percent of all overdose deaths as suicides, but [Dr. Monica Bhargal](#), head of the Massachusetts Department of Public Health, said it's difficult to determine a person's true intent.

"For one thing, medical examiners use different criteria for whether suicide was involved or not," Bhargal said, and the "tremendous amount of stigma surrounding both overdose deaths and suicide sometimes makes it extremely challenging to piece everything together and figure out unintentional and intentional."

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Several large studies show an increased risk of suicide among drug users addicted to opioids, especially women. In a [study](#) of about 5 million veterans, women were eight times as likely as others to be at risk for suicide, while men faced a twofold risk.

The opioid epidemic is occurring at the same time suicides have [hit a 30-year high](#), but Oquendo said few doctors look for a connection.

"They are not monitoring it," said Oquendo, who chairs the department of psychiatry at the University of Pennsylvania. "They are probably not assessing it in the kinds of depth they would need to prevent some of the deaths."

That's starting to change. A few hospitals in Boston, for example, aim to ask every patient admitted about substance use, as well as about whether they've considered hurting themselves.

"No one has answered the chicken and egg [problem]," said [Dr. Ezzam Mahabiah](#), a family physician who runs the Lynn Community Health Center in Lynn, Mass. Is it that patients "have mental health issues that lead to addiction, or did a life of addiction then trigger mental health problems?"

With so little data to go on, "it's so important to provide treatment that covers all those bases," Mahabiah said.

Source – Kaiser Health News: <https://khn.org/news/difficult-to-gauge-rate-of-suicide-among-deaths-from-opioid-overdoses/>

# National Rural-Urban Suicide Trends

Holly Hedegaard, MD, MSPH

Office of Analysis and Epidemiology  
National Center for Health Statistics

National Center for Health Statistics  
Office of Analysis and Epidemiology



## 10 Leading Causes of Death, United States, 2016

	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury	Malignant Neoplasms	Malignant Neoplasms	Heart Disease	Heart Disease
2	<b>Suicide</b>	<b>Suicide</b>	<b>Suicide</b>	Malignant Neoplasms	Heart Disease	Heart Disease	Malignant Neoplasms	Malignant Neoplasms
3	Malignant Neoplasms	Homicide	Homicide	Heart Disease	Unintentional Injury	Unintentional Injury	Chronic Lower Resp Disease	Unintentional Injury
4	Homicide	Malignant Neoplasms	Malignant Neoplasms	<b>Suicide</b>	<b>Suicide</b>	Chronic Lower Resp Disease	Cerebro-vascular	Chronic Lower Resp Disease
5	Congenital Anomalies	Heart Disease	Heart Disease	Homicide	Liver Disease	Diabetes Mellitus	Alzheimer's Disease	Cerebro-vascular
6	Heart Disease	Congenital Anomalies	Liver Disease	Liver Disease	Diabetes Mellitus	Liver Disease	Diabetes Mellitus	Alzheimer's Disease
7	Chronic Lower Resp Disease	Diabetes Mellitus	Diabetes Mellitus	Diabetes Mellitus	Cerebro-vascular	Cerebro-vascular	Unintentional Injury	Diabetes Mellitus
8	Cerebro-vascular	Chronic Lower Resp Disease	Cerebro-vascular	Cerebro-vascular	Chronic Lower Resp Disease	<b>Suicide</b>	Influenza & Pneumonia	Influenza & Pneumonia
9	Influenza & Pneumonia	Influenza & Pneumonia	HIV	HIV	Septicemia	Septicemia	Nephritis	Nephritis
10	Septicemia	Complicated Pregnancy	Complicated Pregnancy	Septicemia	Homicide	Nephritis	Septicemia	<b>Suicide</b>

## Overview

- Data source and rural/urban classification
- Temporal and geographic trends
- Rural/urban disparities in suicide

## National Vital Statistics System, Mortality Data (NVSS-M)

- Compiled from information on death certificates
- Includes all US resident deaths
- Includes demographic characteristics, cause of death, geographic information and other variables

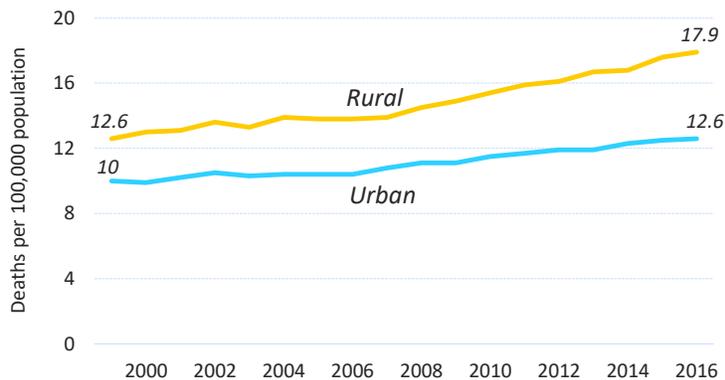
## Rural/Urban Classification

Group		Description
Metro (Urban)	Large Central Metro	Counties of 1 million or more population that: 1) contain the entire population of the largest principal city, or 2) are completely contained within the largest principal city, or 3) contain at least 250,000 residents of any principal city in the area
	Large Fringe Metro	Counties of 1 million or more population that do not qualify as large central
	Medium Metro	Counties of 250,000–999,999 population
	Small Metro	Counties of 50,000–249,999 population
Non-Metro (Rural)	Micropolitan	Counties in micropolitan statistical area
	Non-Core	Counties not in micropolitan statistical area

See: NCHS Urban–Rural Classification Scheme for Counties. Available from: [https://wonder.cdc.gov/wonder/help/CMF/sr02\\_154.pdf](https://wonder.cdc.gov/wonder/help/CMF/sr02_154.pdf).

## Rural/Urban Suicide Rates

United States, 1999-2016

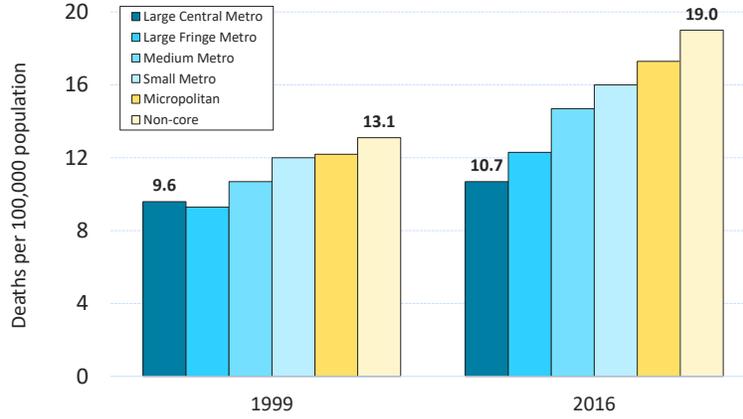


**Note:** Suicides are identified using International Classification of Diseases, 10<sup>th</sup> revision underlying cause of death codes U03, X60-X84 and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 standard population. Rurality of county of residence is based on 2006 classification scheme.

**Source:** NCHS, National Vital Statistics System, Mortality (NVSS-M).

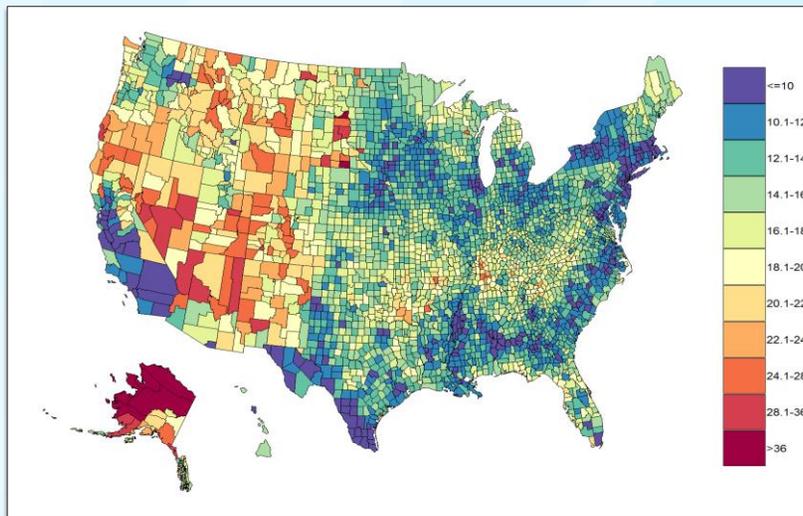
## Rural/Urban Suicide Rates

United States, 1999 and 2016

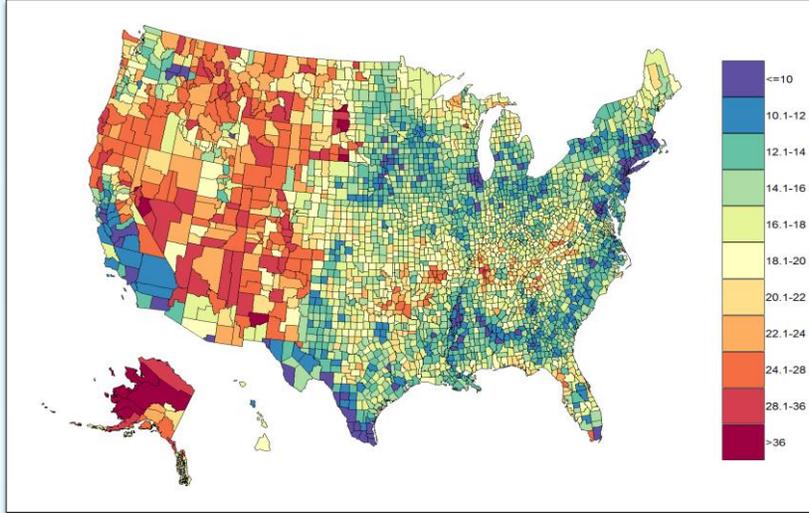


**Note:** Suicides are identified using International Classification of Diseases, 10<sup>th</sup> revision underlying cause of death codes U03, X60-X84 and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 standard population. Rurality of county of residence is based on 2006 classification scheme.  
**Source:** NCHS, National Vital Statistics System, Mortality (NVSS-M).

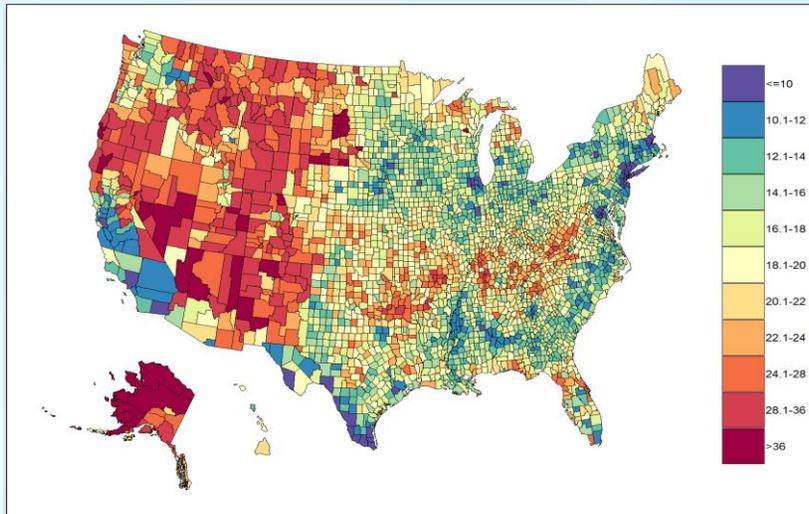
## Model-based Estimates of Suicide Rates, by County, 2005



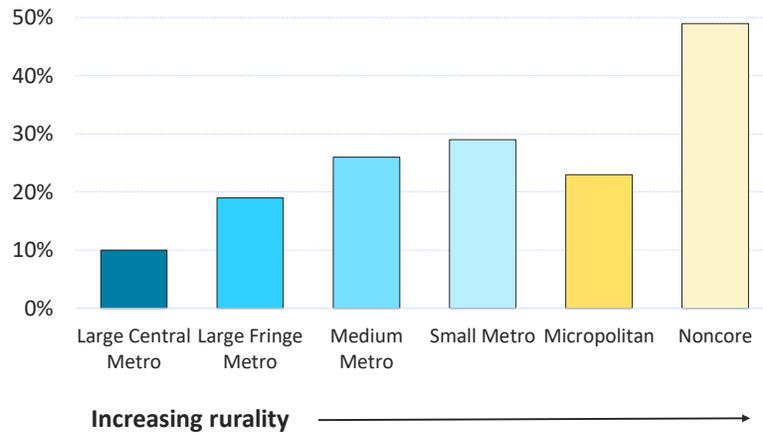
### Model-based Estimates of Suicide Rates, by County, 2010



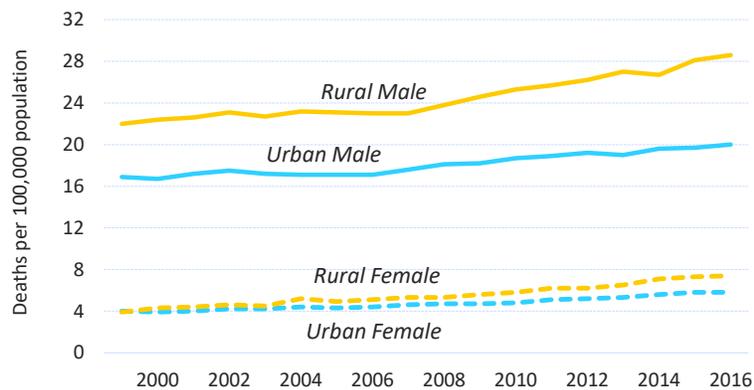
### Model-based Estimates of Suicide Rates, by County, 2015



### Percentage of counties with greater than 30% increase in model-based suicide rates from 2005 to 2015, by rural/urban classification

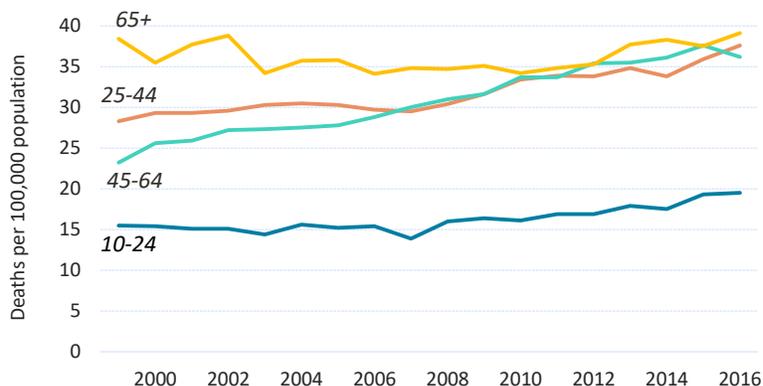


### Urban/Rural Suicide Rates: By Sex United States, 1999-2016



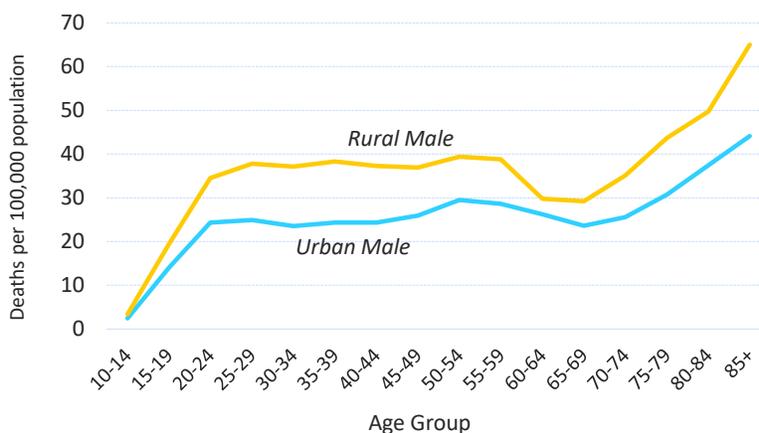
**Note:** Suicides are identified using International Classification of Diseases, 10<sup>th</sup> revision underlying cause of death codes U03, X60-X84 and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 standard population. Rurality of county of residence is based on 2006 classification scheme.  
**Source:** NCHS, National Vital Statistics System, Mortality (NVSS-M).

### Rural Suicide Rates: Males, by Age Group United States, 1999-2016



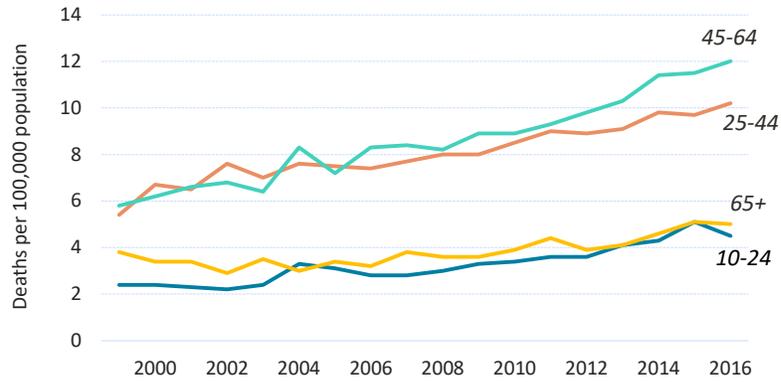
**Note:** Suicides are identified using International Classification of Diseases, 10<sup>th</sup> revision underlying cause of death codes U03, X60-X84 and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 standard population. Rurality of county of residence is based on 2006 classification scheme.  
**Source:** NCHS, National Vital Statistics System, Mortality (NVSS-M).

### Rural/Urban Suicide Rates: Males by Age United States, 2016



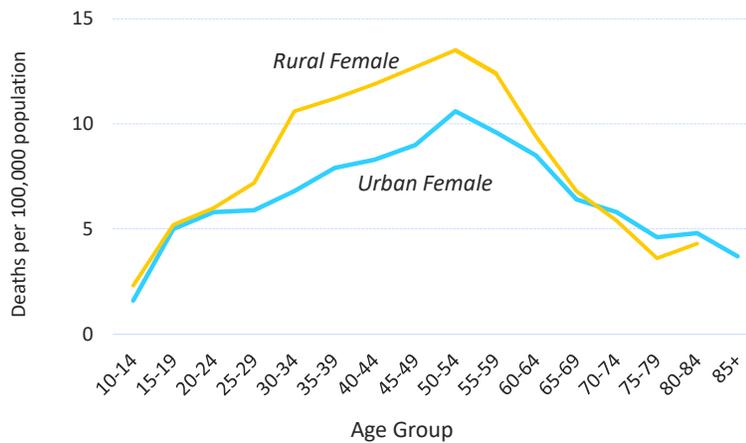
**Note:** Suicides are identified using International Classification of Diseases, 10<sup>th</sup> revision underlying cause of death codes U03, X60-X84 and Y87.0. Rurality of county of residence is based on 2006 classification scheme.  
**Source:** NCHS, National Vital Statistics System, Mortality (NVSS-M).

### Rural Suicide Rates: Females, by Age Group United States, 1999-2016



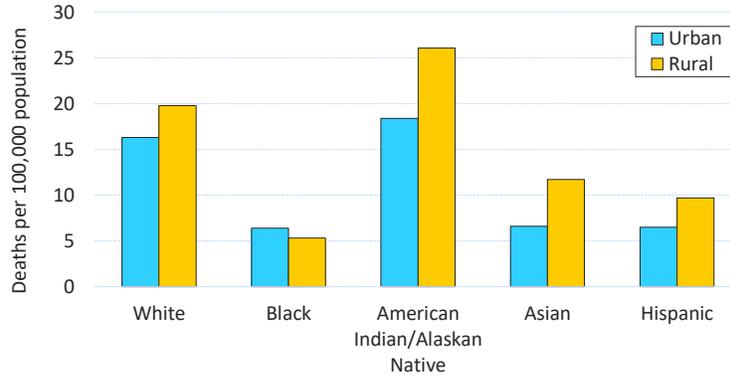
**Note:** Suicides are identified using International Classification of Diseases, 10<sup>th</sup> revision underlying cause of death codes U03, X60-X84 and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 standard population. Rurality of county of residence is based on 2006 classification scheme.  
**Source:** NCHS, National Vital Statistics System, Mortality (NVSS-M).

### Rural/Urban Suicide Rates: Females by Age Group United States, 2016



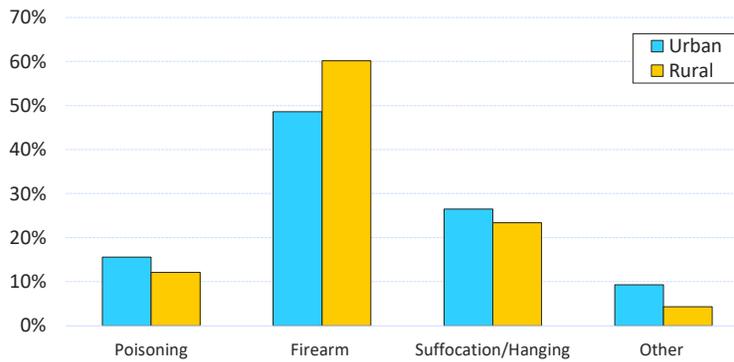
**Note:** Suicides are identified using International Classification of Diseases, 10<sup>th</sup> revision underlying cause of death codes U03, X60-X84 and Y87.0. Rurality of county of residence is based on 2006 classification scheme.  
**Source:** NCHS, National Vital Statistics System, Mortality (NVSS-M).

## Rural/Urban Suicide Rates: By Race/Ethnicity United States, 2016



**Note:** Suicides are identified using International Classification of Diseases, 10<sup>th</sup> revision underlying cause of death codes U03, X60-X84 and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 standard population. Rurality of county of residence is based on 2006 classification scheme. All groups other than Hispanic are non-Hispanic.  
**Source:** NCHS, National Vital Statistics System, Mortality (NVSS-M).

## Rural/Urban Suicides: Percent by Selected Means United States, 2016



**Note:** Suicides are identified using International Classification of Diseases, 10<sup>th</sup> revision underlying cause of death codes U03, X60-X84 and Y87.0. Rurality of county of residence is based on 2006 classification scheme. In 2015, there were 34,948 suicide deaths in urban counties and 9,245 suicide deaths in rural counties.  
**Source:** NCHS, National Vital Statistics System, Mortality (NVSS-M).

## Summary

- Increasing disparity between rural and urban suicide rates
- Suicide rates are highest for rural males
- Similar age patterns for rural and urban males; rural rates higher for all age groups
- Similar age patterns for rural and urban females; rural rates higher for ages 25-59
- Among race/ethnicity groups, rates are highest for rural American Indians/Alaskan Natives
- Compared to urban suicides, a higher percent of rural suicides involve use of a firearm (60% vs 49%)

## Contact Information

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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# Federal Efforts, Committee Findings and Policy Recommendations

**Kathleen Belanger, PhD, MSW**

*Member* | National Advisory Committee on Rural Health and Human Services  
*Professor Emeritus* | Stephen F. Austin State University's School of Social Work

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## Key HHS Agencies, Pt. I

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - ❑ **Mission:** To reduce the impact of substance abuse and mental illness on America's communities.
  - ❑ SAMHSA Programs:
    - Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Grant Program
    - Garrett Lee Smith Campus Suicide Prevention Program
    - Garrett Lee Smith Suicide Prevention Resource Center (SPRC)
    - National Strategy for Suicide Prevention
    - National Suicide Prevention Lifeline (1-800-253-TALK)
    - Tribal Training and Technical Assistance Center
    - Tribal Behavioral Health Grants

## Key HHS Agencies, Pt. II

- Indian Health Service (IHS)
  - ❑ **Mission:** To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.
  - ❑ IHS Programs:
    - Mental Health/Social Services (MH/SS) program
    - Substance Abuse and Suicide Prevention (SASP) program
      - ❖ Formerly known as the Methamphetamine and Suicide Prevention Initiative [MSPI]
- Other Agencies
  - ❑ Health Resources and Services Administration (HRSA)
  - ❑ National Institutes of Health/Mental Health (NIH/NIMH)
  - ❑ Centers for Disease Control and Prevention (CDC)

Agency	Program/Project Name	Funding History		
		FY 2016 Final	FY 2017 Annualized CR	FY 2018 Estimated
SAMHSA	<b>Suicide Prevention</b>	\$60,032,000	\$59,940,000	\$59,940,000
	<i>National Strategy for Suicide Prevention</i>	\$2,000,000	\$1,996,000	\$1,996,000
	<i>Suicide Lifeline (1-800-273-TALK)</i>	\$7,198,000	\$7,184,000	\$7,184,000
	<i>Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Grant Program</i>	\$35,427,000	\$35,382,000	\$35,382,000
	<i>Garrett Lee Smith Campus Suicide Prevention Program</i>	\$6,488,000	\$6,476,000	\$6,476,000
	<i>Garrett Lee Smith Suicide Prevention Resource Center</i>	\$5,988,000	\$5,977,000	\$5,977,000
	<i>Tribal Training and Technical Assistance Center</i>	\$2,931,000	\$2,925,000	\$2,925,000
	<b>Tribal Behavioral Health Grants</b>	\$15,000,000	\$14,971,000	\$14,971,000
	<b>Projected Total Dollars Spent</b>	<b>\$75,032,000</b>	<b>\$74,911,000</b>	<b>\$74,911,000</b>
	IHS	<b>Mental Health/Social Services (MH/SS)*</b>	\$82,100,000	\$81,944,000
<b>Substance Abuse and Suicide Prevention (SASP)</b>		\$15,475,000	\$15,475,000	\$15,475,000
<b>Generation Indigenous (Gen-I)</b>		\$10,000,000	\$10,000,000	\$10,000,000
<b>Projected Total Dollars Spent</b>		<b>\$107,575,000</b>	<b>\$107,419,000</b>	<b>\$108,129,000</b>
NIH	<b>Suicide Research</b>	\$41,041,913	\$43,319,800	\$33,641,800
	<b>Suicide Prevention Research</b>	\$27,488,875	\$29,014,500	\$22,532,400
	<b>Projected Total Dollars Spent</b>	<b>\$68,530,788</b>	<b>\$72,334,300</b>	<b>\$56,174,200</b>
CDC	<i>National Electronic Injury Surveillance System – All Injury Program</i>	\$51,959	\$51,959	\$51,959
	<i>Evaluating Innovative and Promising Strategies to Prevent Suicide Among Middle-Aged Men</i>	\$695,960	\$658,370	\$658,370
	<i>Injury Control Research Centers – Suicide-related projects**</i>	\$1,600,000	\$1,600,000	\$1,600,000
	<i>State of Suicide – Environmental Scan of Suicide Prevention Among States and Tribes</i>	\$299,942	\$276,341	\$277,129
	<i>Non-Fatal Suicide Attempts Project</i>	--	\$29,990	\$29,990
	<i>Building Capacity Among Governors to Address Suicide in Suicide Belt States</i>	--	\$150,000	--
	<i>Veteran Informed Plan for Suicide Prevention</i>	--	\$150,000	--
	<b>Projected Total Dollars Spent</b>	<b>\$2,647,861</b>	<b>\$2,916,660</b>	<b>\$2,617,448</b>

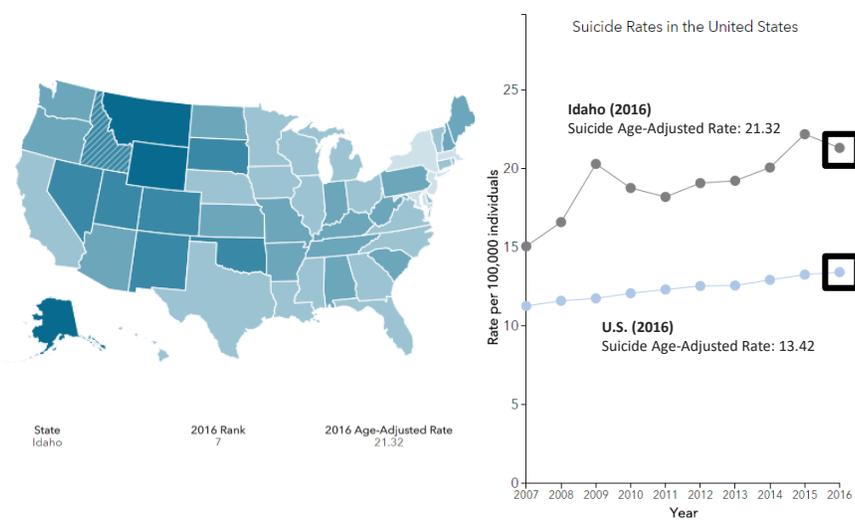
\* Provided funding for MH/SS displays the total amount; specific numbers for suicide-related funding were not available as MH/SS funds multiple services, not just suicide.

\*\* These projects are part of larger funded initiatives; the funding amount is estimated based on a percentage of suicide-related work.

# Takeaways from Idaho

National Advisory Committee on Rural Health and Human Services

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Source – American Foundation for Suicide Prevention: <https://afsp.org/about-suicide/suicide-statistics/>

National Advisory Committee on Rural Health and Human Services

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## Idaho Suicide Prevention Efforts, Pt. I

- **2001** – First Suicide Prevention Conference was initiated
  - 2001 – National Strategy for Suicide Prevention was released
- **2002** – Suicide Prevention Action Network (SPAN) of Idaho was created to develop and implement prevention activities statewide
  - 2002-2017 – SPAN Idaho regional chapters, conferences, survivor support & training
- **2003** – Idaho Suicide Prevention Plan (ISPP) was developed

### SPAN Idaho – 9 Regional Chapters

- |                    |                  |
|--------------------|------------------|
| (1) Coeur d'Alene  | (6) Pocatello    |
| (2) Lewiston       | (6) Fort Hall    |
| (3) Caldwell/Nampa | (7) Idaho Falls  |
| (4) Boise          | (7) Teton Valley |
| (5) Twin Falls     |                  |



For more information about SPAN Idaho, visit their website at <https://www.spanidaho.org>.

## Idaho Suicide Prevention Efforts, Pt. II

- **2001** – First Suicide Prevention Conference was initiated
  - 2001 – National Strategy for Suicide Prevention was released
- **2002** – Suicide Prevention Action Network (SPAN) of Idaho was created to develop and implement prevention activities statewide
  - 2002-2017 – SPAN Idaho regional chapters, conferences, survivor support & training
- **2003** – Idaho Suicide Prevention Plan was developed
- **2006** – Idaho Council on Suicide Prevention was commissioned
- **2012** – Idaho Suicide Prevention Hotline was established
- **2014** – Idaho Suicide Prevention Coalition was formed
- **2016** – Idaho Suicide Prevention Program – Division of Public Health at the Idaho Department of Health and Welfare (IDHW)
  1. Provide funding for upstream youth education
  2. Provide funding for the Idaho Suicide Prevention Hotline
  3. Conduct a public awareness campaign

## “Rock Your Role” Campaign



To view additional PSAs and for more information about suicide prevention activities from IDHW, please visit: <https://healthandwelfare.idaho.gov/Families/SuicidePrevention/tabid/486/Default.aspx>.

## Site Visit – Emmett, Idaho



Community Stakeholder Panelists – local behavioral health providers and practitioners; first responders; school-based counselors; and faith-based leaders

Personal image of Emmett; Emmett map image provided by Wikipedia. Retrieved from [https://en.wikipedia.org/wiki/Emmett,\\_Idaho](https://en.wikipedia.org/wiki/Emmett,_Idaho).

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# Policy Recommendations

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## Recommendation 1

The Committee recommends the Secretary require HHS to conduct a national comprehensive evaluation that assesses existing state and Tribal efforts to reduce rural suicide rates and that identifies successful evidence-based, rural-specific strategies that can be implemented within states and Tribal communities.

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## Recommendation 2

The Committee recommends the Secretary require AHRQ and NIMH to conduct research on the use of Community Health Workers to determine if these efforts can reduce suicide risk and increase referrals for at-risk individuals. The study should also look at cost- and clinical effectiveness of these efforts and broadly disseminate findings.

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## Recommendation 3

The Committee recommends HRSA to expand and increase the promotion of the Rural Health Care Services Outreach, Network, and Quality Improvement grant programs through HHS partners to inform rural communities on the opportunity to incorporate suicide prevention activities and increase access to mental health services using grant funds.

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## Recommendation 4

The Committee recommends HHS Agencies and Offices to promote the broader use of the PHQ-9, a clinically validated depression screening and monitoring instrument, in rural health facilities and to educate providers on how to bill for services.

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## Recommendation 5

The Committee recommends SAMHSA to integrate rural-specific research and considerations for prevention into the National Strategy for Suicide Prevention if it is revised and updated so as to reflect existing rural suicide trends and disparities.

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## Resources

- [National Strategy for Suicide Prevention](#)
- [National Suicide Prevention Lifeline:](#)  
1-800-273-8255
- [Preventing Suicide: A Technical Package of Policy, Programs, and Practices \[CDC\]](#)
- [Suicide Prevention Resource Center](#)
- [Suicide Prevention Resource Center – Rural Areas](#)
- [Zero Suicide](#)

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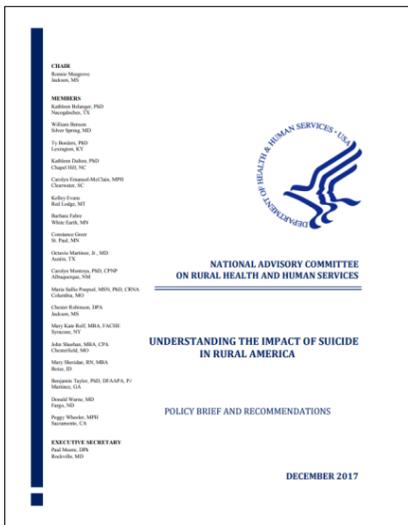
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## For More Information

To find out more about the Committee, please visit our website at <http://www.hrsa.gov/advisorycommittees/rural/> or contact:

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Health Resources and Services Administration  
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Rockville, Maryland 20857  
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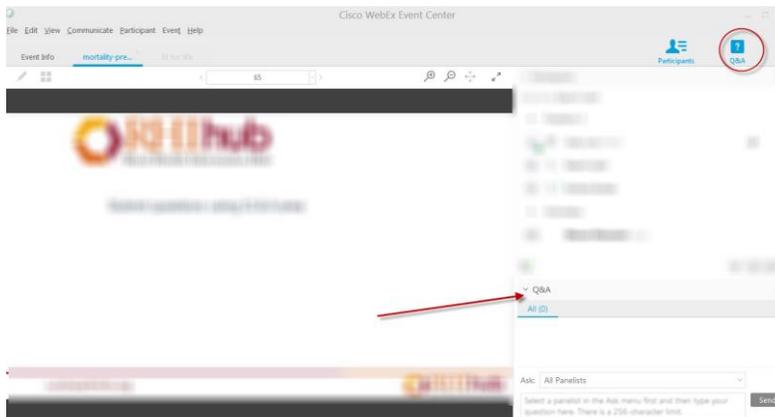
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## Publications Page



# Questions?



# Thank you!

- Contact us at [ruralhealthinfo.org](http://ruralhealthinfo.org) with any questions
- Please complete webinar survey
- Recording and transcript will be available on RHIhub website

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