Transcript for RHIhub webinar: NACRHHS Policy Brief on Social Determinants of Health

Kristine S.: Hello everyone, and welcome to today's webinar. Today we are going to be discussing the National Advisory Committee on Rural Health and Human Services Policy Brief on Social Determinants of Health, which is a very hot topic right now and I'm really excited to hear what our speakers have to say. I'm Kristine Sande, and I'm the program director of the Rural Health Information Hub, and I'm going to quickly run through a couple of housekeeping items before we begin the webinar. We hope to have some time for your questions at the end of today's webinar. If you do have questions for our presenters, I ask that you submit them at the end of the webinar using the Q&A section, and that's going to appear in the lower right-hand corner of the screen following the presentations.

We have provided a PDF copy of the presentation on the RHIhub website, and that's accessible through the URL that's on your screen right now or by going to our RHIhub webinar page, which is www.ruralhealthinfo.org/webinars and then clicking into today's presentation. If you do decide to go download those slides during the webinar, I do ask that you don't close the webinar window, or you'd have to log back into the event. If you experience any technical difficulties during today's webinar, please call WebEx support, and the number for that is 866-229-3239.

Our first speaker today will be Ronnie Musgrove, who has served as the chair of the National Advisory Committee since 2010. He previously served as the Governor of Mississippi from 2000 to 2004, serving as the Lieutenant Governor prior to that. For more than two decades, he's taken a leading role in the state of Mississippi to improve education and expand economic development. Governor Musgrove will give us an introduction to the work of the National Advisory Committee, and then introduce the other committee members who will be speaking today. Governor Musgrove?

Ronnie Musgrove: The Advisory Committee Board, it's a board that advises the sector of Health and Human Services on issues related to how the department and its programs serve rural communities. We have no animosity whatsoever against metropolitan areas, we just feel it's important when you talk about major issues to consider the rural areas in our state. Our presenters today, which some as a result of the work that we just did on our last meeting on determinants, I think will be very interesting with these three great presenters.

First will be Christina Campos, who is the administrator of the Guadalupe County Hospital in Santa Rosa, New Mexico. Following her will be Kathleen Belanger, who's Professor Emeritus at the School of Social Work, the Stephen F. Austin State University in Nacogdoches, Texas, and then Ona Porter who's President and CEO of Prosperity Works in Albuquerque will make their presentations, so I know that you will gain a lot of insight. With that Christina, I'll turn it over to you.

Christina C.: Thank you, Governor Musgrove. At our most recent meeting in September, the committee met in my hometown of Albuquerque, New Mexico and looked at

the issue of social determinants of health. We decided to focus on the social determinants of health because during our previous meetings, while studying issues such as the opioid crisis, child poverty and mortality, and life expectancy in rural areas, we noticed a distinct pattern. There were obvious disparities in outcomes, whereby the outcomes of rural communities were often much worse or at least significantly worse than their urban counterparts. In order to make recommendations for policy improvement, we needed to get a better understanding of the determinants or factors influencing well-being and leading to poor health outcomes in rural communities.

As a baseline, the committee chose to adopt the Robert Wood Johnson Foundation's philosophy, that health starts where we live, learn, work, and play. In other words, the elements contributing to health and well-being go way beyond healthcare and include genetics, individual behavior, and social environmental factors. Even though researchers, policy makers, and practitioners are increasingly coming to recognize the broad range of social determinants that affect health outcomes, our budgets and investments don't yet reflect this.

Whereas on average nations that are members of the Organization for Economic Co-operation and Development spend about $1.70 on social services for every dollar spent on health services, the US spends only 56 cents, or one third. Furthermore, the United States spends considerably more of our GDP on medical services than other developed nations, but our health outcomes are no better and in many cases are much worse. If we as a nation accept that the premise that health begins where we live, learn, work and play, the question then becomes how can we realign our health and human service systems to reflect this understanding and target some of the upstream determinants of health that you see listed on the previous page?

At the National Advisory Committee on Rural Health and Human Services, we focused on the question of what is the rural dimension of the social determinants of health? In other words, are the social determinants that are particularly challenging to rural communities, and how do they contribute to the poor health outcomes that we explored in our past policy briefs? Are there certain social determinants that we can target directly, or are there larger systemic changes that need to be made to improve how health and human services tackle these issues at large?

This brings us to the site visit in New Mexico, the Land of Enchantment. We first heard from a variety of expert speakers that had been doing excellent work and research related to the social determinants of health in rural areas. Later we split into three groups to visit three distinct rural communities in New Mexico. While there, we learned some frontline community leaders, who while facing challenges are coming up with innovative solutions on a daily basis. You can read more about some of the amazing work we saw at each of these visits in the appendix to our brief, but I'll give you a brief outline of where we went and with whom we spoke.

One group went to Cuba, New Mexico, where they met with healthcare and economic development leaders at the Cuba Health Center, and learned about ... Excuse me, I'm just boarding here. There we go. That group went up to Cuba, New Mexico in Northern Mexico where they met with healthcare and economic development workers at the Cuba Health Center, and learned about the health center's role in developing a series of walking trails throughout the community.

The second group came to Santa Rosa, New Mexico and visited my hospital. Here, I and the group met with healthcare, education, economic development leaders in the community who spoke about how our hospital has been able to partner with the schools and other organizations to make community investments that target issues related to the social determinants of health. They heard how my hospital's non-profit governing board had invested over a million dollars in the Santa Rosa community over the past 10 years, helping to fund community initiatives such as youth employment, higher education scholarships, senior walking programs, and exercise equipment in local parks.

Finally, the third group visited the Laguna Pueblo, where they met with the Native community finance organizations and learned about efforts to consolidate funding streams in order to create more holistic solutions to improve health and well-being. The Partners for Success program consolidates and leverages funds from five different federal and tribal programs, thus increasing the effectiveness and efficiency of these programs, providing education and job training services to the community.

In a bit, you'll hear from my colleague Kathleen Belanger, who will tell you about some of the lessons the committee learned during our New Mexico visit. However, I want to leave you with two really important takeaways learned from our partners in New Mexico. These are lessons that can be used going forward when seeking about addressing health disparities for historically marginalized communities.

First, historical trauma and land loss matter when examining the root causes of health. In Laguna Pueblo, stakeholders shared stories of disruption and displacement, and also spoke about the legacies of enslavement and forced assimilation that produced social trauma, with which these communities are still grappling today, so when we think about social determinants of health, outcomes, and potential solutions, we absolutely must take into account culture and history.

Second, families or clans can be strong sources of knowledge, influence, and expertise in efforts to improve health and well-being. In all three communities, we learned about multiple generations living under the same roof or nearby, and we learned how these multi-generational families and networks of families work together to overcome legacies of historical trauma, survive adverse economic conditions, and improve overall well-being, also empowering individual community members. As such, we must remember to engage families

and networks of families as essential partners in our quest for viable and sustainable solutions to the social determinants of health.

Now I'll turn it over to Kathleen.

Kathleen B.: Thanks, Christina. Let's go back to our first guiding questions. Which social determinants of health seem to pose significant challenges to rural communities? The short answer is all of them, but we wanted to look in more depth at them, so we visited those three communities, and the challenges we heard about in those communities were similar, and yet they were unique, but there were some common themes we heard from our speakers and on our site visits that policy makers should consider when we think about how social determinants of health manifest in rural communities.

First is to think about geography. As we talked about in many of our previous briefs, outcomes related to chronic disease, mortality rates, and live expectancy all tend to be worse in rural geographies than in urban ones. As you can see on the slide, life expectancy is shorter in rural areas. As a rural woman, it seems that every time I read a new report, my life expectancy shortens. We've also talked a bit about how geographic isolation in rural communities has made it incredibly difficult to sustain and support even basic health and human services, but we need to point out that in talking about social determinants of health in rural communities, place matters. The communities in which we live determine the quality of available housing, the opportunities to accrue wealth, and the extent to which the built environment may offer opportunities to make healthy choices. HHS programs and policies should keep in mind that the policies and programs intended to address the social determinants of health in rural areas can't take a one size fits all approach.

During our site visits, we heard a lot about the ways poverty in rural communities adversely affect people's ability to lead healthy lives, so this map highlights persistent poverty counties, and those are counties in which 20% or more of the population was living in poverty over the last 30 years. As you can see on the map, almost two thirds of rural counties are persistent poverty counties, compared to just 14% of urban counties. Persistent poverty can negatively impact people's perceptions of mobility, and that can ultimately lead to toxic stress and a variety of other poor health and human behavior health outcomes. At the end of this presentation, you'll hear from one of our expert speakers who will tell you about how asset building strategy can help to reverse the trends in rural areas.

Looking at this slide, you can see that even though educational levels have increased since the year 2000 overall, over a third of the rural counties have more than 20% of their population without even a high school diploma, and that's compared to under a fifth of the urban counties. There are often few job training and employment options for high school graduates wanting to stay in their rural communities, and the committee heard about the need to foster apprenticeship programs, entrepreneurial and technical education, and co-

operative development options. We believe that HHS's workforce and health professional training programs may have a role to play in this.

Transportation: in rural areas, only 32% of the counties have full access to public transportation services, with another 28% having just partial access. A lack of reliable transportation makes it extremely difficult to travel to work, doctor's offices, and grocery stores, unless you have a private vehicle or access to one. While the committee understands that HHS's ability to support transportation activities is limited, there are several programs including Head Start, the Community Health Center Program, and Medicaid's Program of All-Inclusive Care for the Elderly that include transportation components. Going forward, HHS programs attempting to address social determinants of health should consider transportation barriers in rural areas and think about ways more transportation options can be included or ways that services can be co-located in order to reduce these transportation barriers.

Given some of those challenges that we heard about during our meeting, I want to return to our second question, which is how can HHS programs and policies be created, altered, or enhanced to improve outcomes related to the social determinants of health in rural communities? That's always the tricky question: what can we do about it? We want to reiterate that across our three site visits, we saw three incredibly resilient, creative, and hardworking communities that were working to overcome very difficult issues contributing to poor outcomes in their areas. Given the innovative work we saw occurring on the ground, the committee had two main concerns regarding federal barriers that were either hindering the extent to which rural communities are able to focus on the upstream causes of poor health, or hindering the extent to which their work to address these upstream causes was actually leading to improved outcome.

The first concern we have is that even though there have been several new financing and community integrated care models that aim to improve population health by targeting the social determinants, for example accountable care organizations and care coordination, we believe that federal funding mechanisms for social and community services have limited the extent to which rural communities can participate in these efforts, so in order to do this work well health systems rely heavily on human service agencies as essential partners to address the upstream determinants on health. However, based on what the committee saw and heard, there seems to be a real lack of human services in rural areas. We might even call them human service deserts. We think there are a few factors related to funding mechanisms that might be causing this, and those factors include reduction in block grant funding, an uneven playing field in applying for competitive grants, and possibly less advantageous indirect rates to administer the grants.

First, rural areas rely heavily on block grants to fund human services, and as you can see on this slide, block grant funding has declined significantly, roughly 26% since it began in 2000. With small populations, which may already mean less block grant funding and more reliance on that funding, it's possible that rural

areas are feeling the decrease in funding the hardest. Second, urban communities may have greater capacity to hire professional grant writers and collect larger amounts of community level data than smaller, rural governments and community-based organizations. Rural communities may be competing on an uneven playing field when it comes to competitive federal grant program.

Finally, let's think about indirect rates. That's the administrative overhead and application that includes funds for part- or full-time staff to administer the grant program. A lack of knowledge about indirect rates may reduce the impact of the federal grants that rural communities do receive. While large, urban organizations may be applying for and receiving more federal grants and negotiating adequate indirect rates, rural organizations may have less experience or ability to negotiate indirect rates that they actually need to administer their programs.

The committee's second concern, as you see on this slide, is that many federal programs that seek to improve health outcomes may actually impose solutions on rural communities without having a full understanding of the true problems facing that community. They may not fully appreciate how service delivery operates in those communities. The committee believes that rural community leaders and service providers are the experts when it comes to understanding the factors affecting health outcomes in their area and that they need to be brought to the table to work alongside funders when devising solutions to those issues.

Christina, back to you.

Christina C.: Good, thank you, I got locked out there for a second. Let me just get my notes back on page. Hold on a second. Could you advance the screen for me? There we go. All right, sorry about that. Now I'm going to walk us through the committee's recommendations.

First, HHS should develop a federal health communities designation that recognizes place-based, community-driven plans to address the social determinants of health. This designation could be modeled after rural or other rural place-based efforts, such as the rural impact in Promise Zones, which will allow rural communities to have the local autonomy to develop their own plans to improve outcomes related to the social determinants of health.

Second, HHS should facilitate coordination and collaboration among hospitals, health systems, and human service providers on community needs assessments and community benefit agreements in order to support the development of local strategies to address the social determinants of health.

Third, HHS should structure grant review panels to allow rural applicants to be reviewed as a separate cohort, in order to compete against similarly resourced communities. This will help to solve the issue discussed earlier, where rural

communities are often competing against larger organizations with many more resources.

Fourth, HHS should encourage the use of priority points for rural applications that face unique structural challenges related to the social determinants of health, such as but not limited to geographic isolation, low population density, higher poverty, and lower life expectancy.

Finally, HHS should offer technical assistance and funding opportunity announcements, which highlight the ways rural organizations can factor in administrative costs of effectively managing grants into their budgets and plans.

Now I'm going to turn it over to Ona Porter. Ona is the President and CEO of the organization called Prosperity Works, which has taken a really, really innovative approach to improve outcomes related to the social determinants of health for families across New Mexico.

Ona Porter: Thank you for this opportunity to speak with you. Prosperity Works is a state-wide organization in New Mexico that works to alleviate poverty. We work really to develop assets among low-income people with the understanding that income gets you by, but assets get you ahead. One of the things that I think is really important to understand is the concept of wealth versus income, and the disparities in wealth are much greater than those in income. Wealth actually reflects our ability to invest in the future and the future of our children. Assets deliver families financial stability, providing secure economic foundations from which families can address day to day challenges and major economic shocks. This is the work of Prosperity Works. Sorry, we're not advancing. There we go.

What we do is actually enable people to plan for their future by helping them build assets. We have a couple of strategies that I'm going to tell you about. Unlike income, which can be very unpredictable, assets can be drawn on in times of need, and provide security and support upward mobility. With assets, households move from making ends meet to achieving their aspirations. This is hope in concrete form.

One of the products that we have is called Individual Development Accounts. And Individual Development Accounts are matched savings accounts. People complete 10 weeks of financial capability training, and then they're eligible to save. When they reach their goal, we match them four to one for the purchase of a first home, to capitalize a small business, or for post-secondary education. The impact in New Mexico in the past 10 years has been dramatic with these. First of all, we've assisted 319 families in securing safe and affordable housing. Now, it's apparent from this that this is a household strategy, but it's also a community economic development strategy. You can see there that $57 million in new mortgage money holdings are in New Mexico.

We also helped 512 residents achieve some level of college or post-secondary education, we took almost $2 million of tuition money into New Mexico institutions of higher education, but in addition to that, the 512 people that we're talking about actually now have now have an aggregate increased income in our state of almost $4 million annually. That money is spent in their communities, another community economic development driver. The other thing that has happened is that we opened and grew 660 locally owned businesses and created 1,155 jobs, again a local community economic development driver.

We started this work 10 years ago in rural and deeply rural New Mexico. We started there, because we know that rural communities have high needs, are always underserved, and are also difficult to serve. Our idea was that if we could address the needs of rural people, not only could we stabilize and help grow those communities, but we also learned about how to serve the larger community all over our state.

A new product that we have is called Prosperity Kids. It actually is a true collective impact strategy. Now, I know for many of you on the call collective impact has become a buzzword, but this actually incorporates all of the organizations on the left, each of those bringing their own missions and resources to the work of serving a particular population. Prosperity Works is the backbone organization in this, and our grants have actually been distributed to the other organizations who were involved also. With Prosperity Kids, what we're actually doing is a child savings account, but it's unlike any other child savings program in the nation. It's different because we start first with parents. Parents receive 10 weeks of child development and community leadership training, and additional personal economic training. Then, their children from birth to 11 are eligible for a savings account, which we open at a local credit union with $100. Then we match family money up to $200 a year for 10 years.

In addition to that, families get an emergency savings account. The emergency savings account is opened with only $10, but we do put incentive deposits in those accounts for things that the families do to support healthy outcomes for their children for up to five years. In addition to that, the families also get a secured credit card attached to that so that they can build credit. One of the major barriers, not only to having fair credit and opportunities to purchase things at a fair price, is that without a credit history it's difficult for people to get a job. Credit information is being used as a primary screening in employment, so here we've combined the children and their families into a system that really is future oriented and also has a college identity for children.

Now, one of the things that you may or may not know is that child savings account has been demonstrated by Dr. Willie Elliott at the University of Kansas to be a powerful change agent for not only the children, but also their families. Children who have an account in their own name are four to six times more likely to go to post-secondary education and three and a half times more likely to complete. This is critical, for the future of our jobs in America are with post-

secondary education. We expect that by 2025 that up to 80% of jobs in America will require post-secondary education. You probably realize that a small amount of money is not paying for college, but we are creating a future orientation and also a college identity.

The other thing important to know when we're talking about health: moms whose children have a savings account have 50% less depressive symptoms than moms whose children don't have a savings account. This is hope in concrete form, and hope changes not only a future orientation, but also chemicals in our brain. The other thing that happens is that by preschool, children are ahead of their peers in emotional and social development, which is critical to learning. By third grade, they're ahead of their peers in language and math, so we think that this is a product that holds great hope in our state.

One of the things also that's important to note, and I'd like to direct you to the Asset Funders Network recent paper called Wealth and Health that was just released. What they found was that people with more wealth have lower death rates, lower rates of chronic disease, improved mental health, better ability to function in daily life, lower rates of smoking, obesity, and excessive alcohol use. Their children also do better. They have lower obesity rates, fewer markers for asthma, and their social emotional development is better.

The reason that I talk about that is that wealth gaps between rural and urban residents cannot be overcome by changing individual behaviors in areas such as education, family structure, full- or part-time employment, or personal consumption habits. Similar achievements do not lead to similar rewards in terms of wealth for rural and urban workers. Though attending college, getting married, working full-time are all associated with more wealth for each group, the asset value of the household's level does not compare favorably. Barriers to wealth equality in the United States can't be combated by individual or household level activity. Instead, public policy is needed to eliminate these wealth disparities. Thus, I appreciate the recommendations of the committee that lead in this direction.

Finally, we believe at Prosperity Works that changing systems instead of programs is really the potential of our future. Rather than imposing solutions or fixes on people, we are proving that investing in the initiative and ingenuity of low-income families and communities by making asset building opportunities available to them is the most effective way forward. Early in this webinar, I was referred to as an expert. What I believe is that community people are the experts in their own well-being and in their future. For six years, I worked with Native communities, and while we were there our philosophy was that we don't do anything to or for people, that people know what is good for them and it was our job to facilitate the resources that communities needed to achieve their goals. I think that the work that the committee has done is certainly pointing in that direction, and I appreciate the opportunity to participate. Thank you very much.

Kristine S.: Great, thanks so much for that great information. Now we'll open it up for Q&A. You'll see that the Q&A box did just appear on the bottom right-hand side of your screen, and if you're not seeing that you might need to click on the Q&A icon up on the top right. As you enter your questions, we ask that you do please select the option to send the question to all panelists rather than to a particular panelist, just so we don't miss your question. While we're waiting for people to submit their question, I do have a question for Christina. I'm just wondering about your efforts in Santa Rosa and how that got started? How did you get started working on social determinant issues?

Christina C.: Santa Rosa is very similar to the other communities. We have a very high Hispanic population and a lot of poverty, and we had some needs for human resources as well in the community. Our non-profit board gets a stipend of sorts to manage the hospital on behalf of the county, and rather than use it on salaries or anything like that they chose to establish scholarships, so it started with nursing scholarships to try to develop our own workforce. It was incredibly successful. We haven't used any agency nurses, lab techs, X-ray techs or anything in about 12 years through the development of that program, and as we started building momentum and getting some savings going the board decided to reach out into the community to help partner with other service agencies, so we worked with senior citizens centers to develop walking programs to get them up and moving in a safe environment. We hired coaches, then that developed into a Zumba class for seniors, and then expanded into Zumba for all ages.

We're called the City of Lakes. There's lakes all around town and really pretty walking areas, so we put some park courses for exercise. Many of the best ideas came from the community itself. It wasn't the board sitting around thinking what they should offer or do, but people asking us if we could partner with them in these efforts to improve health at home, and it's kind of interesting because it's a hospital. In a sense we're funding keeping patients healthy and out of the hospital, but I think that's the real goal for communities just to create a quality of life that attracts more people to town, but it's quite gratifying to do more than just wait for people to come into a hospital sick, but to actually reach out and make their lives better overall.

Kristine S.: Great, thank you. It looks like we've got a few questions here. The first one is for Ona, and it is where does the funding come from for the Prosperity Works program?

Ona Porter: For individual development accounts, we have had three and a half million dollars of federal funds, and that's for the Assets for Independence initiatives. I always say there's good news and bad news about that. Today, I got a million dollar grant, that's the good news. The bad news is I need to match that money one for one, and it's money. It's not anything but money, one for one, and to operate a rural network of 21 organizations I actually need two dollars for every million dollars, so all of that money has to be raised locally. With the Prosperity Kids accounts, the pro forma budget for 500 children in the two poorest zip

codes in the South valley, which is a rural area of Albuquerque, my budget was $1.25 million, and that's for the kids, the training, the families, and following them for a long time plus the research that Dr. Elliott is doing on our project, $1.25 million. $25,000 of that has come from the city of Albuquerque. Everything else has been raised privately.

Kristine S.: Okay, great. Ona, there's also a question about could you give the reference to the Wealth and Health report?

Ona Porter: Yes, that is Health and Wealth, and it's the Asset Funders Network, so afn.org.

Kristine S.: Okay, great, thank you. For the committee members, in your rural visits did you learn of any successful transportation programs?

Christina C.: This is Christina. I don't recall any in particular, but I know that we're struggling with the same thing, and so we're partnering with the city here to provide a safety officer that would be a non-certified police officer that would provide transportation within town, and seeing if we could do something similar to like the Uber in the rural area. We're also working with the USDA on a set grant for economic development, and they looked at different industries, energy and housing, and transportation came up and it was really interesting. I actually wasn't at that one meeting, but the rest of the committee came up with a goal of non-emergency medical transportation as the priority goal, and kind of creating a network among the civil community here in Eastern New Mexico for a little transit system that would take patients to the different specialists in the different communities so that we could work together as partners in it, so we are struggling with it as well but it looks like we might be coming up with some solutions.

Kristine S.: Great. I would also put in a plug for the RHIhub Models and Innovations section. If you go to the topic of transportation, there are some nice models there of things that people have done in communities across the nation to address transportation issues. Let's see what else we have. Here's a question: from your experience or research, what indicators are particularly important or effective for assessing social determinants of health in general and in rural areas in particular? What indicators are particularly important or effective for assessing social determinants?

Christina C.: I think a lot of the data that we got from the Bureau of Economic Research from the University of New Mexico helped us here in our community, but poverty is really one of the most important determinants because poverty kind of touches on everything, on lower education, on substandard housing and everything, but that was something that was really important and I think that's why programs like Ona's that give people a hand up are so important in improving healthcare overall and the quality of life. The community has also helped bring that information forward.

Kathleen B.: This is Kathleen. I'd also like to say I don't know that we are ... I think that these indicators all overlap. As you can tell in Ona's program, which is it, economic stability? Is it community and social contexts? Are we looking at income, employment, is she looking at literacy, early childhood education? Their programs are looking at all of it, so teasing out individual indicators is a little more difficult than it may first appear, because they do all influence each other. That's my two cents on it, and just a little warning.

Ona Porter: This is Ona, and I couldn't agree with both of them more. Actually, 30 years ago I did the first comprehensive study of the status of New Mexico's children and families, which was published in a book called "Kids in Crisis: New Mexico's Other Bomb", and the real bomb is poverty. I can commiserate or try to lead with Governor Musgrove, because Mississippi and New Mexico are always the poorest states in the nation. We have got to reverse that trend, or we can't reverse any of the other things.

Kathleen B.: I just want to add, the Rural Policy Research Institute has done some recent research looking at individual social determinants that have been impacted by education systems, and really they do overlap. Education overlaps with community and social context and economic stability and healthcare. All of these and healthcare impacts education. It's very, very interesting, so I just wanted to add that I know RUPRI hasn't taken this question lightly. It's investigated it in some depth.

Kristine S.: Okay. Let's see, it looks like there's a question about Appalachia. It says Appalachia was not mentioned as a separate area in this presentation. Does the committee think that these themes and recommendations are also applicable in Appalachia?

Christina C.: We actually had one of our visits in Kentucky. My geography is not as it should be, but it would be on the Western slopes of Appalachia in that area, and my group went up to Hazard, Kentucky. These things definitely would apply to those areas. When we go out to the rural communities with the committee, the scenery may look a little bit different and the accents of course are very different, but the issues are the same. They had this incredible health center there that provided so much care, from primary care all the way to cancer treatment and behavioral health, dental health, pharmaceuticals, everything. That healthcare, that provision of highly, highly organized excellent healthcare was not solving other issues. Their issues had a lot of social determinants, like transportation issues, lack of sidewalks lining up in the mountains, no jobs, a lot of drugs and other substance abuse, grandparents raising their grandchildren.

One thing that we really saw and I think Ona hit on it several times was kind of a hopelessness, inter multi-generational hopelessness, and that's the nut that needs to be cracked, but the characteristics, you can go to some areas up in Northern New Mexico or Western New Mexico in the Navajo Nation and see a lot of the same social issues affected as we saw up in Hazard, Kentucky.

Kristine S.: Okay. Another question for Ona: how does the community access the Prosperity Works program and/or initiate the classes for individuals and families?

Ona Porter: This is another part of the strategy that we employ. We are looking for the high trust organizations in local communities, and they become our partners, and so they are the face of the work. There are very few individuals across our state that would know the name Prosperity Works. They would know instead Habitat for Humanity, they would know Central New Mexico Community College, they would know Cuatro Puertas, which is an Indigenous farmers organization, they would know those things, so one of our strategies is to build the capacity of community organizations to serve their communities, and so they are all part of our New Mexico Asset Consortium. We provide technical assistance and training to those organizations.

What we know is many of those are as fragile as the families that they serve, and so helping them develop capacity, whether it has to do with having the new resource to deliver to their community or having the new skills and understanding that frame the work in their community, that that's a critical piece of developing what needs to be done in local communities. We also have a belief in a process of coaching, and so we coach our partners that are in the communities that they in turn coach the participants in the programs, and a coaching model is one that says these are whole and complete people who have lacked opportunity. They know what's good for themselves. They may need some assistance in really naming that, but they know, and once they know that and articulate that then our job is a road map and a pep rally to help them achieve that.

Kristine S.: Great, thank you. It looks like there are a couple of questions asking about how the committee will proceed or how the administration and Secretary Price will be engaged on these issues? I don't know if somebody wants to just weigh in on what are the next steps with the policy brief in terms of sending it on to the administration?

Paul Moore: Thank you Kristine. This is Paul Moore. I'm the executive secretary for the committee, and I thought that was an excellent question. The committee is non-political, non-partisan, and we work with any of the administrations. We will continue to support the secretary and the administration in the same way that we have. At the end of each meeting that we have, we generate a policy brief, wherein the committee makes the recommendations just as you heard Christina share with you today. Also from time to time, as the committee becomes aware of issues that affect rural providers in rural communities, Governor Musgrove will also write a letter to the secretary, so the secretary has received a letter and this most recent brief on social determinants from the committee. You can also access the brief itself on our website, National Advisory Committee for Rural Health and Human Services. Thank you for the question.

Kristine S.: Great, thank you Paul. I don't see any other questions at this point, so I think we will move to wrap things up. On behalf of the Rural Health Information Hub, I'd

like to really thank our speakers for the great information and insight that you've shared today. Also, thanks to our participants for joining us. A survey will be mailed to you following the webinar. We would encourage you to complete that survey. That helps us to know what you're looking for in future webinars and how we can improve. Please do note that the survey that will appear on your screen at the end of this webinar is a WebEx survey, and it's not the survey from RHIhub, which will be emailed to you.

The slides used in today's webinar are currently available on our website at www.ruralhealthinfo.org/webinars. In addition, a recording and transcript of today's webinar will be made available on our website and sent to you by email in the very near future, so you can listen again and share the presentation with your colleagues. Thank you again, and have a great day.