The National Advisory Committee on Rural Health and Human Services (NACRHHHS)

Ronnie Musgrove, Chair

Webinar

January 28, 2016
What is the NACRHHS?

• An independent advisory board to the Department of Health and Human Services (DHHS) on issues related to how the Department and its programs serve rural communities
Committee Background

• **1987** Established by the Secretary of HHS
• **2002** Secretary Thompson expanded the focus to include human services
• **2010** Ronnie Musgrove, former governor of Mississippi appointed as Chair
What Does the NACRHHS Do?

• Serves as an independent, external voice to DHHS Secretary

• Prepares an Annual Report and/or Policy Briefs to the Secretary on key rural issues
  – In the past five years the Committee has sent twenty Policy Briefs to the Secretary
Meetings

• Meets in the spring and fall, usually in the field
  – Members hear presentations from national and regional experts on the selected white paper topics
  – The field visits include site visits to rural locations and panel discussions around the selected white paper topics
Field Meetings

• Mahnomen, MN
  – September 9-11, 2015,

• Slade, KY
  – May 27-29, 2015,

• Sioux Falls, SD
  – September 24-26, 2014
2016 Committee Meeting

• Beaufort, SC
  – April 18-20, 2016

• TBD
  – September 14-16, 2016
Uses for the Committee Reports

- Inform the policy decisions of the Secretary for HHS
- Resource for rural providers who can then share findings and recommendations with others in the field
- Resources for policy makers
Today’s Speakers

• Wayne Myers, MD
• Curt Mueller, PhD
• Alana Knudson, PhD
• Jocelyn Richgels
Wayne Myers, M.D.

• Wayne Myers is a retired pediatrician and rural medical educator. He directed the Federal Office of Rural Health Policy from 1998 through 2000, and was President of the National Rural Health Association in 2003. He and his wife, JoAnn, farm in rural Maine.
“While women in most of the nation were living longer lives, in 622 rural counties, longevity shortened between 1999 and 2009. In 24 percent of rural and exurban counties, women lived shorter lives in 2009 than in 1999.”

Even As Mortality Fell In Most US Counties, Female Mortality Nonetheless Rose In 42.8 Percent Of Counties From 1992 To 2006

ABSTRACT Researchers increasingly track variations in health outcomes across counties in the United States, but current ranking methods do not reflect changes in health outcomes over time. We examined trends in male and female mortality rates from 1992–96 to 2002–06 in 3,140 US counties. We found that female mortality rates increased in 42.8 percent of counties, while male mortality rates increased in only 3.4 percent. Several factors, including higher education levels, not being in the South or West, and lower smoking rates, were associated with lower mortality rates. Medical care variables, such as proportions of primary care providers, were not associated with lower rates. These findings suggest that improving health outcomes across the United States will require increased public and private investment in the social and environmental determinants of health—beyond an exclusive focus on access to care or individual health behavior.

FINDING WHO LIVES LONGER
By Roberto Gallardo | October 26, 2011 | Print article

Life expectancy in the U.S. is falling behind most other industrialized counties. And in a large number of rural counties, women are living shorter lives than did rural women of earlier generations. What is driving our longevity to decline?

A recent report published by the Institute of Health Metrics and Evaluation found that nearly one in four rural residents live in a county where female life expectancy is declining.

The report found that, overall, life expectancy in the United States is falling behind most other industrialized countries. People in the U.S. are not living as long as those in many other countries — and in a great number of rural counties, the average age at death is declining.
“Most of the U.S. counties with the worst declines in life expectancy in recent years are rural, according a study in the Journal of the American Medical Association.”
Age Adjusted Death Rates, Metro vs. Non-Metro
The Limits of Medical Care

by Wayne Myers

Look What’s Coming
by Wayne Myers, M.D.

A recent analysis found that Perry County had the shortest life expectancy for women, and the third shortest for men, of all the counties in the United States. Hazard, the county seat, has an abundance of doctors and a large, sophisticated hospital. It had a nurse practitioner training program in the 1990s until the regional need seemed satisfied, and has a patient navigator program. A new osteopathic medical school that is oriented toward rural primary care opened less than 50 miles away, about 15 years ago. Hazard has a family practice residency. On balance, Hazard has an abundance of medical resources. While all these resources were developing, the life expectancy of people in Perry County was getting shorter.

Details about the local medical care and patterns of mortality don’t add much to this discussion. Suffice it to say the community is long on referral specialists and arguably short on primary care. Diseases related to inactivity, smoking, excess weight and prescription drug abuse start among the young and affect many.
Location: Perry County

Key Indicators

Health Outcomes

<table>
<thead>
<tr>
<th>Health Outcomes</th>
<th>Perry</th>
<th>Kentucky</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature Death (years lost per 100,000 population)</td>
<td>17,050</td>
<td>9,436</td>
<td>7,562</td>
</tr>
</tbody>
</table>

About the Indicator: Years of Potential Life Lost prior to age 75 is a measure of premature mortality that is calculated over the age range from birth to 75 years of age.

Data Source: Kentucky State Data Center - Vital Statistics

<table>
<thead>
<tr>
<th>Health Outcomes</th>
<th>Perry</th>
<th>Kentucky</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Mortality (per 100,000 population)</td>
<td>1,357</td>
<td>892</td>
</tr>
</tbody>
</table>

About the Indicator: Age-adjusted rate of death (from all causes) per year.

Data Source: Kentucky State Data Center - Vital Statistics

<table>
<thead>
<tr>
<th>Health Outcomes</th>
<th>Perry</th>
<th>Kentucky</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor Vehicle Deaths (per 100,000 population)</td>
<td>49.5</td>
<td>17.0</td>
</tr>
</tbody>
</table>

Data Source: FARS, Kentucky State Data Center
Curt Mueller, Ph.D.

- Director of Research and Evaluation
- Federal Office of Rural Health Policy
- U.S. Department of Health and Human Services
Purpose and Plan

• Purpose – review research on life expectancy and some policy implications

• Findings for:
  ➢ U.S., urban v. rural
  ➢ Kentucky, Appalachia v. non-Appalachia

• What accounts for observed disparities?
# OMB County Designations

<table>
<thead>
<tr>
<th>Year</th>
<th>Metro</th>
<th>Micro</th>
<th>Neither</th>
<th>Non-Metro (Total Neither and Micro)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>870 (27.7%)</td>
<td></td>
<td></td>
<td>2270 (72.3%)</td>
</tr>
<tr>
<td>2009</td>
<td>1100 (35.1%)</td>
<td>688 (21.8%)</td>
<td>1353 (43.1%)</td>
<td>2041 (66.9%)</td>
</tr>
<tr>
<td>2013</td>
<td>1167 (37.1%)</td>
<td>641 (20.4%)</td>
<td>1335 (42.4%)</td>
<td>1976 (62.8%)</td>
</tr>
</tbody>
</table>
## OMB Counties, 2010 Census

<table>
<thead>
<tr>
<th>Type</th>
<th>Population (%) (2013 OMB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro</td>
<td>262,452,132 (85)</td>
</tr>
<tr>
<td>Micro</td>
<td>27,154,213 (8.8)</td>
</tr>
<tr>
<td>Neither</td>
<td>19,139,193 (6.2)</td>
</tr>
<tr>
<td>Total Non-metro</td>
<td>46,293,406 (15)</td>
</tr>
</tbody>
</table>
Trends in Life Expectancy at Birth (Years) in Metropolitan and Non-Metropolitan Areas of the United States, 1969-2011

The Metro Versus Non-Metro Difference in Life Expectancy (Years), United States, 1969-2011

Life Expectancy at Birth (Years) by Levels of Rurality, United States, 2007-2011

## Life Expectancy (years) at Birth, 2007-2011

<table>
<thead>
<tr>
<th>Area</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.: Non-Metro</td>
<td>77.0</td>
</tr>
<tr>
<td>Metro</td>
<td>79.0</td>
</tr>
<tr>
<td>Kentucky: Appalachian</td>
<td>73.9</td>
</tr>
<tr>
<td>Non-Appalachian</td>
<td>76.9</td>
</tr>
</tbody>
</table>

**Source:** Based on updated data reported by Singh GK, Siahpush M. *American Journal of Preventive Medicine*. 2014;46(2):e19-e29, and separate estimates for Kentucky counties.
Life Expectancy at Birth In Appalachian and Non-Appalachian Counties, KY

<table>
<thead>
<tr>
<th></th>
<th>Appalachian</th>
<th>Non-Appalachian</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Both Sexes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990-1992</td>
<td>73.9</td>
<td>75.0</td>
<td>-1.1</td>
</tr>
<tr>
<td>1999-2001</td>
<td>74.1</td>
<td>75.7</td>
<td>-1.6</td>
</tr>
<tr>
<td>2007-2011</td>
<td>73.9</td>
<td>76.9</td>
<td>-3.0</td>
</tr>
<tr>
<td><strong>Male</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990-1992</td>
<td>69.9</td>
<td>71.4</td>
<td>-1.5</td>
</tr>
<tr>
<td>1999-2001</td>
<td>70.9</td>
<td>72.8</td>
<td>-1.9</td>
</tr>
<tr>
<td>2007-2011</td>
<td>71.1</td>
<td>74.3</td>
<td>-3.2</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990-1992</td>
<td>77.9</td>
<td>78.5</td>
<td>0.6</td>
</tr>
<tr>
<td>1999-2001</td>
<td>77.3</td>
<td>78.4</td>
<td>-1.1</td>
</tr>
<tr>
<td>2007-2011</td>
<td>76.8</td>
<td>79.4</td>
<td>-2.6</td>
</tr>
</tbody>
</table>
Life Expectancy at Birth In Perry County, KY

<table>
<thead>
<tr>
<th></th>
<th>1996-1998</th>
<th>2008-2012</th>
<th>Net Decline in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Sexes</td>
<td>73.83</td>
<td>69.81</td>
<td>4.02</td>
</tr>
<tr>
<td>Male</td>
<td>70.48</td>
<td>66.96</td>
<td>3.52</td>
</tr>
<tr>
<td>Female</td>
<td>77.13</td>
<td>72.89</td>
<td>4.24</td>
</tr>
</tbody>
</table>
Selected Demographic Characteristics of the Appalachian and Non-Appalachian Regions of Kentucky, 2008-2012

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Appalachia</th>
<th>Non-Appalachia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of counties</td>
<td>51</td>
<td>69</td>
</tr>
<tr>
<td>Percentage of State population, 2008-2012</td>
<td>26.8</td>
<td>73.2</td>
</tr>
<tr>
<td>% Minority population, 2008-2012</td>
<td>3.7</td>
<td>15.4</td>
</tr>
<tr>
<td>% Black population, 2008-2012</td>
<td>1.9</td>
<td>10.0</td>
</tr>
<tr>
<td>% Rural population, 2010</td>
<td>71.1</td>
<td>30.8</td>
</tr>
<tr>
<td>Population density per square mile, 2010</td>
<td>92.4</td>
<td>711.6</td>
</tr>
</tbody>
</table>

Source: Based on data from the 2008-2012 American Community Survey and 2009-2011 BRFSS. Minority population includes Blacks, American Indians, Hispanics, and Asians and Pacific Islanders.
Selected Education and Income Indicators of the Appalachian and Non-Appalachian Regions of Kentucky, 2008-2012

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Appalachia</th>
<th>Non-Appalachia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median family income, current $, 2008-2012</td>
<td>41,918</td>
<td>59,970</td>
</tr>
<tr>
<td>% Population below poverty level, 2008-2012</td>
<td>25.3</td>
<td>16.1</td>
</tr>
<tr>
<td>% High school graduates or higher, 2008-2012</td>
<td>73.7</td>
<td>85.7</td>
</tr>
<tr>
<td>% College graduates, 2008-2012</td>
<td>13.0</td>
<td>24.1</td>
</tr>
</tbody>
</table>

Source: Based on data from the 2008-2012 American Community Survey and 2009-2011 BRFSS.

<table>
<thead>
<tr>
<th>Cause</th>
<th>Gap (years)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes</td>
<td>3.00</td>
<td>100.0</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>0.90</td>
<td>30.0</td>
</tr>
<tr>
<td>Heart disease</td>
<td>0.81</td>
<td>27.0</td>
</tr>
<tr>
<td>Stroke</td>
<td>0.08</td>
<td>2.7</td>
</tr>
<tr>
<td>All cancers combined</td>
<td>0.52</td>
<td>17.3</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>0.27</td>
<td>9.0</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>0.04</td>
<td>1.3</td>
</tr>
<tr>
<td>COPD</td>
<td>0.26</td>
<td>8.7</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.04</td>
<td>1.3</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>0.96</td>
<td>32.0</td>
</tr>
<tr>
<td>Pneumonia &amp; influenza</td>
<td>0.09</td>
<td>3.0</td>
</tr>
<tr>
<td>Nephritis/kidney diseases</td>
<td>0.04</td>
<td>1.3</td>
</tr>
<tr>
<td>Chronic liver disease &amp; cirrhosis</td>
<td>0.03</td>
<td>1.0</td>
</tr>
<tr>
<td>All other causes</td>
<td>0.16</td>
<td>5.3</td>
</tr>
</tbody>
</table>

**Source:** Based on updated data reported by Singh GK, Siahpush M. *American Journal of Preventive Medicine*. 2014;46(2):e19-e29, and separate estimates for Kentucky counties.
Life Expectancy (years) by Poverty Level, U.S., 2005-2009

Alana Knudson, Ph.D.

Principal Research Scientist
NORC Rural Health Reform Policy Research Center
Rural Mortality and Health Disparities in the U.S. and Appalachia
Examination of Trends in Rural and Urban Health: Establishing a Baseline for Health Reform

- CDC published *Health United States, 2001 With Urban and Rural Health Chartbook*
  - No urban/rural data update since 2001

- Purpose of this study:
  - Update of rural health status ten years later to understand trends
  - Provide baseline of rural/urban differences in health status and access to care prior to ACA implementation
Methods

• Replicated analyses conducted in 2001 using most recent data available (2006-2011)

• Used same data source, when possible:
  • National Vital Statistics System
  • Area Resource File (HRSA)
  • U.S. Census Bureau
  • National Health Interview Survey (NCHS)
  • National Hospital Discharge Survey (NCHS)
  • National Survey on Drug Use and Health (SAMHSA)
  • Treatment Episode Data Set (SAMHSA)

• Applied same geographic definitions, although classifications may have changed since 2001:
  • **Metropolitan Counties:** Large central, Large fringe, Small metro
  • **Nonmetropolitan Counties:** Micropolitan, Non-core
Mortality: Chronic Obstructive Pulmonary Diseases

Death rates for chronic obstructive pulmonary diseases among persons 20 years of age and over by sex and rurality
Risk Factors: Adolescent Smoking

Cigarette smoking in the past month among adolescents 12-17 years of age by rurality
Risk Factors: Adult Smoking

Cigarette smoking among persons 18 years of age and older by rurality

- Large central: 15.8 (1997-1998), 22.6 (2010-2011)
- Small metro: 20.0 (1997-1998), 20.0 (2010-2011)

Graph shows increase in smoking rates by rurality from 1997-1998 to 2010-2011.
Regional Mortality Study

• **Purpose:** To examine the impact of rurality on mortality and to explore the regional differences in the primary and underlying causes of death.

• **Methods:** Mortality data from National Vital Statistics System (NVSS) from 2011-2013

• Data are grouped by:
  – 2013 NCHS Urban-Rural Classification Scheme for Counties (Large Central, Large Fringe, Small/Medium Metro, Micropolitan, Non-core)
  – 10 HHS Regions
  – Age and Gender
  – Cause of Death
    • Top 10 nation-wide causes of death for each age group
Mortality Rates by HHS Region: 25-64, Males – Lower Respiratory

SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death.
Mortality Rates by HHS Region: 25-64, Females – Lower Respiratory

SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death.
Please select:

Age      25 to 64 Years
Sex      Males
Region   Appalachia Region

Index for Mortality Rates for Cause Related to the National Mortality Rate among Persons (Males) Age 25 to 64 Years, in Appalachia Region, by Rural-Urban Status: United States, 2011-2013

Objects above the horizontal line where index=100 indicates mortality rates higher than the national average, below the line are values below the average.

SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death.
Please select:

Age 25 to 64 Years
Sex Females
Region Appalachia Region

Index for Mortality Rates for Cause Related to the National Mortality Rate among Persons (Females) Age 25 to 64 Years, in Appalachia Region, by Rural-Urban Status: United States, 2011-2013

Objects above the horizontal line where index=100 indicates mortality rates higher than the national average, below the line are values below the average.

Sources: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death.
Suggested Citation: Rural Health Reform Policy Research Center. Exploring Rural and Urban Mortality Differences, August 2015 Bethesda, MD. 2015.
Please select:

Age 65 Years and Older
Sex Males
Region Appalachia Region

Index for Mortality Rates for Cause Related to the National Mortality Rate among Persons (Males) Age 65 Years and Older, in Appalachia Region, by Rural-Urban Status: United States, 2011-2013

Objects above the horizontal line where index=100 indicates mortality rates higher than the national average, below the line are values below the average.

Sources: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death.
Suggested Citation: Rural Health Reform Policy Research Center. Exploring Rural and Urban Mortality Differences, August 2015 Bethesda, MD. 2015.
Please select:

Age  
65 Years and Older

Sex  
Females

Region  
Appalachia Region

Index for Mortality Rates for Cause Related to the National Mortality Rate among Persons (Females) Age 65 Years and Older, in Appalachia Region, by Rural-Urban Status: United States, 2011-2013

Objects above the horizontal line where index=100 indicates mortality rates higher than the national average, below the line are values below the average.

SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death.
Rural Community Health Gateway

Build What Works

The Rural Community Health Gateway can help you build effective community health programs and improve services you offer. Resources and examples in this Gateway are chosen for effectiveness and adaptability and drawn from programs with a strong history of service and community success. By starting from approaches that are known to be effective, you can make the best use of limited funding and resources.

Evidence-Based Toolkits

- Care Coordination Toolkit
  Resources and best practices to help you identify and implement a care coordination program.

- Community Health Workers Toolkit
  Resources to help you develop a community health worker (CHW) program to reach underserved populations, using evidence-based approaches from other rural communities.

- Health Promotion and Disease Prevention Toolkit
  Resources and best practices to help you identify and implement a health promotion program in your community.

- Mental Health and Substance Abuse Toolkit
  Resources to develop and implement programs to improve community mental health using proven approaches and strategies.

- Obesity Prevention Toolkit
  Resources to help you develop an obesity prevention program, building on best practices of successful obesity prevention programs.

- Oral Health Toolkit
  Resources and best practices to help you develop and implement a program to address oral health disparities in your community.

ABOUT THE RURAL COMMUNITY HEALTH GATEWAY

The Rural Community Health Gateway showcases program approaches that you can adapt to fit your community and the people you serve, allowing you to:

- Research approaches to featured community health programs
- Discover what works and why
- Learn about common obstacles
- Connect with program experts
- Evaluate your program to show impact

Gateway resources are made available through the NORC Walsh Center for Rural Health Analysis and the University of Minnesota Rural Health Research Center in collaboration with the Rural Assistance Center. Funding is provided by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration.

MORE USEFUL TOOLS

Economic Impact Analysis
Show how your program’s grant funding affects your community’s economic well-being and share this information with sponsors, funders and your community.
Gary Hart, PhD, Director
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University of North Dakota
School of Medicine & Health Sciences, Room 4909
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Alana Knudson, PhD, Deputy Director
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4350 East West Highway, Suite 700
Bethesda, Maryland 20814
301.634.9326 • walschcenter.norc.org • knudson-alana@norc.org
Mortality and Life Expectancy in Rural America: Connecting the Health and Human Service Safety Nets to Improve Health Outcomes over the Life Course

Key Findings

• The Committee is deeply concerned about the gaps between rural and urban life expectancy and mortality that has largely gone unnoticed in the larger discussion about health disparities that tend to focus solely on populations and ignore the geographic aspects of this issue.

• Life expectancy and mortality are key health indicators, but there are a variety of factors that contribute to both outcomes, health care is only one of them. Others include human services components, socioeconomic status, and the fragmentation between health services, human services, and mental health services.

• In the last several decades, rural and urban life expectancy and mortality have diverged, and rural communities are not keeping pace with urban communities on these indicators.
Key Findings - 2

- In rural areas, 18 percent of the population is living below the poverty threshold as compared to less than 16 percent of the urban population.
- Many chronic diseases affect rural residents at higher rates than their urban counterparts.
- Behavioral health and drug use concerns were priorities of stakeholders who spoke to the Committee.
- There is a need to develop the evidence base for communities that have low life expectancies, not only in Appalachian Kentucky but also in other geographic areas with similar outcomes, in order to accurately understand the health outcomes of these unique communities.
- Access to care alone is not enough to fully address complex health outcomes including mortality and life expectancy of populations.
Recommendations to the Secretary

1. The Committee recommends the Secretary support research projects that examine behavioral health and primary care integration in rural communities to expand the evidence base for these efforts.

2. The Committee recommends that the Secretary direct the National Institute on Drug Abuse to conduct research into the rural-urban implications of opioid use and overdose, including the use and/or potential use of heroin.

3. The Committee recommends that the Secretary increase funding for training for primary care providers and all levels of emergency medical providers on the use of opioid overdose treatment drugs including naloxone (see page 8).

4. The Committee recommends that the Secretary include key programs from the Health Resources and Services Administration, the Administration for Children and Families, the Substance Abuse and Mental Health Services Administration, and the Centers for Disease Control and Prevention in future Promise Zone competitions.

5. The Committee recommends that the Secretary enhance the departmental assessment, evaluation, and lessons learned from existing Community Health Worker projects in a manner that makes the findings easily accessible by the public.

6. The Committee recommends that the Secretary consider a budget request for funding under Title XII of the PHS Act to support trauma system training and designation for small rural hospitals in high mortality areas.
Jocelyn B. Richgels

Associate Director
National Policy Programs
Rural Policy Research Institute
Tackling Social Determinants of Health at a Young Age Through Place-Based Initiatives

Rural Policy Research Institute (RUPRI)

www.rupri.org
Rural Policy Research Institute

RUPRI’s Mission

• Provide unbiased analysis and information on the challenges, needs, and opportunities facing rural America.

• Spur public dialogue and help policymakers understand the impacts of public policies and programs on rural people and places.
RUPRI’s Health and Human Service Work

Over 20 Years of Health and Human Services Research and Policy Analysis

• RUPRI Center for Rural Health Policy Analysis
• RUPRI Rural Health Panel
• RUPRI Rural Human Services Panel
Importance of Place-Based Policy Design

Developing Effective Place-Based Policies for FY 2011 Budget

White House OMB Memo (No. M-09-28) August 11, 2009

“It is important to note the urgency of this effort. The prosperity, equity, sustainability, and livability of neighborhoods, cities and towns, and larger regions depend on the ability of the Federal government to enable locally-driven, integrated, and place-conscious solutions guided by meaningful measures, not disparate or redundant programs which neglect their impact on regional development….Furthermore, various Federal programs can function more effectively if they include well-focused, place-based strategies. Evaluations of Federal programs commonly underscore the importance of encouraging local networks of referral, support, and coordination.”
Federal Place-Based Initiatives

• Promise Zone Initiative
  – designate a number of high-poverty urban, rural and tribal communities as Promise Zones, where the federal government will partner with and invest in communities to accomplish the following goals: Create jobs, leverage private investment, increase economic activity, expand educational opportunities, and reduce violent crime.

• Race to The Top- District Program, United States Department of Education
  – “support bold, locally directed improvements in learning and teaching that will directly improve student achievement. Program grantees serve as innovation laboratories, advancing new ways to educate our students through a personalized approach
NACRHHS Place-Based Focus

• Looked at influence of place in health and human service policy implementation and outcomes since its origins in late 1980s.
• Recent Social Determinants of Health Focus
  – Rural Homelessness
  – Rural Intimate Partner Violence
  – Rural Life Expectancy
  – Rural Childhood Poverty
Federal Initiatives in Action in Rural America

Appalachia, Kentucky and White Earth Reservation, Minnesota

- Two most recent NACRHHS Site Visits
  - Rural Life Expectancy
  - Rural Childhood Poverty

- Promise Zone Initiative and Race to The Top – District Program grantees
Appalachia, Kentucky

Both Promise Zone Initiative and Race to the Top – District Grant

Promise Zone: Wide range of partners to coordinate and collaborate on the whole system

NACRHHS Site Visit Location Partners:

• University of Kentucky Center for Excellence in Rural Health (Kentucky Office of Rural Health)
• Kentucky Homeplace
Appalachia, Kentucky

Race to the Top – District Grant

Appalachian Renaissance Initiative (ARI)

• Kentucky Valley Educational Cooperative (KVEC) grantee for 17 participating rural school districts
  – School Wellness and Readiness Component
    • Collaboration with multiple partners to provide health care access to students and community members in the schools
    • Nurse Practitioners, Physician’s Assistants, Telemedicine
    • Partners with existing Family & Youth Resource Centers to address “needs beyond cognitive ability that affect ability to learn”
Appalachian Renaissance Initiative

“During our visit, Melinda and I never spotted a teacher just standing in front of the class lecturing while the students just sat and listened. Instead, students were the ones doing the most work. They were actively engaged, sharing their ideas, solving problems, and, as a result, learning. Weeks after my visit, I still remember all the lessons vividly.”

Bill Gates, Gates Foundation visit to Betsy Layne High School, Eastern Kentucky
White Earth Reservation

Race to the Top: MN’s Race to the Top Early Learning Challenge Grant

White Earth Early Learning (WEEL) Scholarship Program

• Scholarships cover the cost of early childhood education/child care
• Reaching most at-risk children, giving children opportunities to be kindergarten ready
• Empowering families to take an active leadership role in education of their children
• Creates more work and education flexibility for parents and families
• Increased training for educators and childcare providers
Children and Families Served

“As a parent, it has been much easier raising them knowing that they go to a quality daycare; learn, play with friends and eat great meals. This gives me more time to love and snuggle them.” Barb, Jolynn & Joseph

64% of children were new to early childhood programming
54% were from single parent families with or without support
56 of the children were in foster care and/or being raised by relatives
30% of parent’s highest education is a HS diploma
31% of families unemployed
For More Information…

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

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