**Health Resources and Services Administration**
**Office of Rural Health Policy**

**National Advisory Committee on Rural Health and Human Services**

# Slade, Kentucky
**May 27 – 29, 2015**

**Meeting Summary**

The 77th meeting of the National Advisory Committee on Rural Health and Human Services was held May 27th – 29th, 2015, in Slade, Kentucky.

**Wednesday, May 27th, 2015**

The meeting was convened by Tom Morris, Associate Administrator for Rural Health Policy. Governor Ronnie Musgrove, Chairman of the Committee, arrived soon after the meeting began. Tom Morris stated that the primary focus of the meeting is disparities in life expectancy in rural areas compared to urban.

The committee members present at the meeting: Ty Borders, PhD; Christina Campos, MBA, FACHE; Barbara Fabre; Roland J. Gardner, MS; Michele J. Juffer; Karen Madden, MA; Octavio Martinez, Jr., MD; Carolyn Montoya, PhD, CPNP; Barbara Morrison, MS; Wayne Myers, MD; John Sheehan, MBA, CPA; Peggy Wheeler, MPH.

Present from the Office of Rural Health Policy: Tom Morris, Director and Steve Hirsch, Executive Secretary. Truman Fellows present: Catherine Fontenot and Charity Porotesano.

## KENTUCKY ORIENTATION

**Dr. William D. Hacker, MD**
**Former Commissioner for Public Health**
**Lexington, KY**

**William Hacker** welcomed the committee to Kentucky. He worked as a pediatrician in Knox, Laurel and Whitley Counties for 18 years. In 1975, he became the first pediatrician between Lexington and Knoxville.

Kentucky has a population of around 4 million people. He stated that Kentucky has three distinctly different regions: the eastern mountainous part of the state, central region and flat western part of the state. Each area has its own culture and different histories. People migrated to Kentucky in the late 1700's mainly from North Carolina, Virginia and Pennsylvania.

The eastern part of Kentucky was difficult to develop because of the mountainous terrain. During the 1800's the area was deforested and lumber was sent via the rivers to be processed. Much of the lumber was sent to North Carolina to make furniture. Coal became the major economic driver

for Appalachia when railroads were developed. Coal mining became a significant employer and paid well but is dangerous work. Today the coal economy is depressed because it is competing against cheaper natural gas. Many mine owners in Appalachia were from New York. The value they reimbursed the farmers who owned the land did not correlate to the value of the coal being extracted. The Kentucky landowners did not benefit from the extraction of the coal.

President Lincoln and President Davis were born in Kentucky. Kentucky's seal is United We Stand and Divided We Fall. This is ironic because during the civil war there were brothers fighting each other. People fighting for the confederacy and for the union came home and continued to fight. Appalachia was primarily pro union because there were not large farms.

Since 1960, many areas of Kentucky have seen a decrease in poverty except for Appalachia. Appalachia has significant challenges related to poverty. Kentucky premature deaths per 1,000 are the highest rate in Appalachia. Wolfe County, in Appalachia, the average life expectancy is 68, compared to 76 in Lexington. Eleven of twenty five of the poorest counties in the United States are in eastern Kentucky. Kentucky was rated 47$^{th}$ in the 2014 America's Health Ranking Report. The New York Times stated that Clay County, Kentucky is the hardest place to live in the United States.

Long standing issues in eastern Kentucky include low tax base, underfunded schools systems, limited employment opportunities, poor health status and depression which results in self-medication and substance abuse. Strengths in eastern Kentucky include strong family bonds and sense of place. Over the last 30 – 40 years there has been a growing base of community leaders who are interested in the civic responsibility to improve eastern Kentucky. There is a growing recognition for the need of regional cooperation.

Dr. Hacker attended the University of Kentucky and became a primary care physician in southeastern Kentucky. After eighteen years, he transitioned from being a primary care physician into administration. Six years later he became the commissioner of public health for the State of Kentucky. He shared that his story is not unique in Kentucky because people take on many roles because they feel a commitment to improving the state. Appalachia is an anchor holding back Kentucky because of health issues and lack of economic progress.

The Center of Rural Health and University of Kentucky College of Public Health are laying the academic foundations to move eastern Kentucky forward.

**Dr. Fran Feltner, DNP, MSN, RN Director**
**University of Kentucky Center of Excellence in Rural Health**
**Hazard, KY**

**Fran Feltner** welcomed the committee to Kentucky. She stated that the Center of Excellence in Rural Health was located in Hazard County with the intent that students would stay in eastern Kentucky after finishing residency. She moved to Florida for one year and returned to eastern Kentucky because she loves her home state. She is now working to improve the lives of the

people in eastern Kentucky. The UK Center of Excellence improves the health of rural Kentuckians through education, research, services and community engagement.

There have been over eight hundred and sixty nine graduates in the academic programs. The UK Center of Excellence works with the UK Department of Family and Community Medicine, the College of Health Science and the College of Social Work. There is a variety of research being done to examine issues including health disparities, health outcomes and workforce needs.

Kentucky Homeplace is a program created to provide access to medical, social, and environmental services for the citizens of the commonwealth. Community health workers are used in the counties where they live to educate residents, identify risk factors and use preventative measures to become healthier. Kentucky Homeplace serves the twenty seven counties with the highest levels of disease disparities. Research shows that community health workers can improve patient experience, population health and reduce the costs of the health care system.

There is a federally qualified healthcare center located in the UK Center of Excellence. It includes family practice services, a women's health center, psychology department, dental services, a pharmacy and laboratory. Ms. Feltner stated that almost everyone in eastern Kentucky has some form of depression so it is very important to have therapy available. Dental health is also very important so there is a mobile dental unit that goes to schools to meet the children's needs. The UK Center of Excellence continues to work to improve the lives of the citizens in eastern Kentucky.

**Ernie Scott, Director**
**Kentucky Office of Rural Health**
**Hazard, KY**

**Ernie Scott** shared that while there was a federal focus for the rural health program, the Kentucky Office of Rural Health was developed. He thanked committee member, Dr. Wayne Myers, for his contributions while working as a physician in eastern Kentucky.

The Kentucky Office of Rural Health is based in Hazard County. The program serves all one hundred and twenty counties of the state and has a staff of five people. The Kentucky Office of Rural Health coordinates rural health resources and provides technical assistance to different entities. The Kentucky Office of Rural Health has twenty eight critical access hospitals and provides services to approximately thirty small, rural hospitals. They provide assistance to one hundred eighty seven rural health clinics and around twenty community health centers. There are workshops and training available and four federal grants are administered through the office: the hospital flexibility program, small rural hospital program, state loan repayment program and the state office of rural health program.

Community Leadership of Kentucky is a new program that assists community leaders in the rural Appalachian counties to reduce health disparities, leverage funding and learn how to use data to improve services and programs.

The Bridge Magazine is a collaborative effort between the University of Kentucky Center of Excellence in Rural Health and the Kentucky Office of Rural Health. It is a publication that focuses on rural health issues. The publication highlights individuals and programs that are excelling and shares their innovative rural health initiatives with others.

**Q&A**

**Michele Juffer** asked regarding high death rates are there many long-term care facilities.

**Fran Feltner** said there are quite a few long- term care facilities but not enough. Patients are transitioned from the hospitals to other sources of care and there need to be more long-term care facilities. Sometimes there is a waiting list, especially in eastern Kentucky.

**William Hacker** stated that many people have to leave the community for long-term care and that can be an issue with the migration and families involvement.

**Barbara Morrison** asked how many Area Agencies on Aging are in Kentucky.

**Fran Feltner** said that there is Sanders-Brown Center on Aging at the University of Kentucky. Each county has a senior center and they are very active and keep the seniors updated on medical and access issues.

**William Hacker** said there is a senior citizen state program that is comparable to the social service structure. The challenges with the senior populations are health problems related to tobacco use, chronic obstructive pulmonary disease and obesity. Obesity is a critical problem in eastern Kentucky and this impacts their mobility.

**Roland Gardner** asked how many community health centers there are and how many counties they serve.

**Ernie Scott** responded that there are twenty one community health centers and one hundred thirty four sites. Collectively they cover the entire state.

**Barb Fabre** asked if they have maternal and child home visiting in the most rural counties.

**William Hacker** said that they have several programs through the public health system. There is a program targeting young parents who are at risk. The programs are successful in decreasing preterm delivery as well as other good outcomes. Many health departments have home health as a function. Homeplace is a home visiting program.

**Fran Feltner** said that Homeplace provides a range of services for the newborn to the end of life. Homeplace makes home visits to understand the living environment and identify health disparity issues. They are also working with care coordination and work collaboratively with a healthcare team.

**Octavio Martinez** asked about the healthcare workforce and specialists in the areas that are struggling.

**William Hacker** said that the numbers of healthcare providers are limited in eastern Kentucky but the numbers are growing. There is a medical school in Pikeville, Kentucky graduating primary care physicians that are settling back in the area. They are homegrown and coming back to work in rural Kentucky. There is a need for more primary care physicians and psychiatrists. In terms of subspecialty services, they still have to go to the city because there is not enough volume to justify the service. Some specialists are doing clinics in rural areas of the state.

**Wayne Myers** asked what the group would recommend to the Secretary that would assist the most.

**Fran Feltner** said that there have to be places for children to go to exercise in rural areas. There needs to be sidewalks and safe places for children to ride their bikes in rural communities. Children are not eating healthy and children in the fourth and fifth grades are having obesity issues. There needs to be an alliance formed with schools, parents and students and an advisory group to find ways to improve the health of children.

## HEALTH DISPARITY

**Dr. Curt Mueller**
**Health Resources and Services Administration**
**US Department of Health and Human Services**
**Rockville, MD**

**Curt Mueller** welcomed the committee and shared that he has been with the federal office for two and a half years. He stated that the work done by the committee is important to the office, research and policy. The federal office is concerned with the roles of quality, measurements, accountability and outcomes in the healthcare system. Most of the work focuses on process measures of quality. Life expectancy is a good outcome measure. The Institute of Medicine's recent report includes life expectancy as one of its core measures. It is an important measure when looking at population health. It is a much more general measure and encompasses many more factors than process measures that physicians report.

Appalachia is an example of a persistent poverty area. From 1970 – 2011 there have been improvements in life expectancy in rural and urban areas. The rural rate is increasing at a much slower rate than in metro areas. The rural life expectancy is seventy seven years old and seventy nine in metro areas. In the 1970's the difference in life expectancy was less than a year. Something has happened in the last few decades that caused a decline in rural areas. From 1990 – 1992 the rural mortality rate exceeded the metro rate by 5%. The rate increased 13% by 2005. For people ages forty five to sixty four, the mortality rate in rural areas is 18% higher than in metro areas. The rural mortality rate associated with cancer was slightly less than metro in 1992 but 8% higher by 2005. Life expectancy is directly related to the level of rurality. The more rural a community, the shorter the life expectancy is for the residents.

If you live in the Appalachia region of Kentucky, your life expectancy is three years less than residents living in non-Appalachia regions of Kentucky. 59% of people age twenty five to sixty four accounts for the gap. Unintentional injuries account for 32% of the Appalachia verses non-Appalachia gap in life expectancy. Cardiovascular diseases account for 30% of the gap. Many of the problems related to the causes of death in rural Kentucky are not easily solved in the short-term. Diabetes, cancer and heart disease are associated with the lack of a healthy lifestyle. It takes time to see results from these types of cultural changes.

Factors that account for the differences comparing Appalachia to non-Appalachia include: population density, health and behavioral characteristics, prevalence of diseases and smoking prevalence. Income and education also affect life expectancy in Appalachia verses non-Appalachia. The poverty level is more than one quarter of the population. There are fewer high school and college graduates in Appalachia as well as lower income levels. Socioeconomic status and life expectancy link is different in rural and metro areas. People living in poverty in metro areas have a higher life expectancy than people living in poverty in a rural area.

Short term gains in income are associated with adverse health consequences. A sustainable, long term gain in income has a positive effect on health. Education affects the cognitive ability to impact health throughout the lifecycle. Something has changed in the past few decades in rural areas that have led to an increasing gap in mortality and life expectancy.

**Dr. Alana Knudson**
**Principal Research Scientist**
**NORC Rural Health Reform Policy Research Center**
**Bethesda, MD**

**Alana Knudson** said she would share information from two studies that are funded by the Federal Office of Rural Health Policy and data gathered for the updated CDC 2001urban and rural health chart book. The chart book provides information on differences in health and healthcare seeking behavior in urban and rural communities. The chart book study is an opportunity to set a baseline, since healthcare reform has been implemented, to see if increased access to healthcare services in communities is impacting the health status of rural residents.

The same data and geographic designations were replicated from the 2001 CDC chart book so the updated data could be compared. Metropolitan counties in the chart book are categorized as large central, large fringe, and small metro. Nonmetropolitan counties are categorized as micropolitan with approximately ten thousand to fifty thousand people and noncore with less than ten thousand people. The data was also divided into four different census regions of the United States: West, Midwest, Northeast and South.

The chart book data shows that over the last ten years there is an increase in the number of people living in poverty and the highest percentage of people living in poverty live in rural areas. Comparing race and ethnicity, there is a decrease in diversity in sparsely populated communities. Large fringe and suburban areas are different in their health outcomes and behaviors than micropolitan and noncore areas. Large fringe and suburban areas have lower mortality rates and

risk factors than micropolitan and noncore areas. The highest percentage of poverty in large and small rural is concentrated in the southern region of the country.

Chart book data also reflects that there has been an overall decrease in infant mortality, but the highest infant mortality rates are in rural areas. The mortality rate for working age adults in large and small areas has not been reduced in the past decade. People with chronic obstruction pulmonary disease have increased dramatically, especially for females. Rural adolescents are smoking at twice the prevalence compared to urban adolescents. The number of adults smoking is increasing in rural areas while decreasing in urban areas. Regarding obesity statistics, rural areas are increasing dramatically compared to urban areas. Inpatient substance abuse treatment over the past decade in rural areas has increased at a high rate for opiates; also, people in rural areas are seeking more treatment for alcohol abuse compared to urban communities.

The Regional Mortality Study examined the impact of rurality on mortality and explored the regional differences in the primary and underlying causes of death. Place matters regarding health and causes of death. The highest rate of infant mortality is in the southern United States and part of the northeast. The highest rate of male and female suicide, ages fifteen to twenty four, is in the western part of the country. The higher rate in the western United States may be related to isolation or seasonal effective disorders. The female overall suicide rate is about one third less than the male suicide rate. The highest mortality rates for unintentional injuries are in the southeast and the western United States, while the highest mortality rates for diabetes and heart disease are in the southeastern United States.

In Appalachia, the number one cause of death of males ages twenty five to sixty four is chronic respiratory diseases. Unintentional injures is also a foremost cause of death for males ages twenty five to sixty four in Appalachia.

There are programs that have been developed to address issues from a local perspective in rural communities. The Federal Office of Rural Health Policy has invested in evidence based tool kits and created an innovation hub called the Rural Assistance Center Community Health Gateway. The Rural Community Health Gateway is a system to research programs that have worked well in rural communities. There are program descriptions and contact information available for program specialists so they can share their insights and perspectives.

**Q&A**

**Wayne Myers** asked if there is the belief that inequality in societies has direct impact on health inequality in a social system.

**Alana Knudson** responded that she spoke to a woman who lives in a rural area with bad health outcomes. She said that the people in the community did not realize they lived in an area that was considered to have poor health until she heard the comparison to the more affluent areas of the state. They did not realize they were not eating well or getting enough physical activity. The great divide between the have and have not is lack of information. Public health can try to

address some of these issues. In other countries healthcare and public health are intertwined. Here there are huge differences in the way public health is funded.

**Curt Mueller** said that is a good question when considering how to move forward. Good education is important not only because it gets a person a better paying job but it also affects the way you view healthy habits.

**Christina Campos** said that she lives in a high poverty area but still have good outcomes. Maybe it is the programs in the community that helps people manage their care. Maybe it is the social connections and more community activities.

## SOCIAL DETERMINANTS OF HEALTH PART I: POVERTY

**Jocelyn Richgels**
**Rural Policy Research Institute (RUPRI)**
**Washington, DC**

**Jocelyn Richgels** said that the Rural Policy Research Institute has a long history of doing work in rural poverty. Rural poverty analysis and practice models provide insight related to social determinants of health. There is no greater indicator of social determinants of health than poverty status.

The human services safety net is important in rural because rural America is poorer than urban America. One in four rural children currently lives in poverty. This is the highest rate since 1986. The gap between rural and urban child poverty rates continue to rise. The Whitehouse Rural Council has a new rural child initiative called Rural Impact. The Whitehouse Rural Council understands that rural poverty is a burden to the economy and national wellbeing.

Rural America is older and sicker than urban America. This population experiences limitation of activity caused my chronic health conditions. There needs to be a focus on coordinated care programs in rural areas to examine how social services and human services can address some of the factors that lead to chronic health conditions.

The life expectancy in rural areas is lower than in urban areas and the gap is consistently widening. Female life expectancy in rural areas has decreased by at least eighteen months from 1996 -2010. The higher percentage of rural verses urban population lives in a primary care, mental health or dental health professional shortage area. More than one out of every three non-metro counties has poverty rate of 20% or greater. One out of every seven non-metro counties has had high poverty for at least four consecutive decades.

The importance of human services to population health is reflected in an Adverse Childhood Experiences Study by the Centers for Disease Control that shows adverse childhood experiences have a direct impact on health outcomes later in life. Addressing these childhood experiences early in life and being proactive about prevention can have a long-term impact on peoples' health later in life. International research indicates that funding for a human service infrastructure has a

more positive effect on health outcomes than funding for health infrastructure. Amongst developed countries in the world, the United States spending is inverted in comparison to other countries regarding human services and health. Most other countries spend more on human services than health and this may be the path to population health improvements in rural America.

Federal research and data collection can support population health in rural America by having a human services research center funding line in order to compare it to healthcare data. Less is known about human and social service conditions in rural areas, the social services rural residents need and use, and the effectiveness of those services, according to a 2006 report on Rural Research Needs and Data Sources for Selected Human Services Topics by the Assistant Secretary of Planning and Evaluation, Department of Health and Human Services.

Rural Policy Research Institute believes that family resource centers and the concept of school at the center are models that are applicable to rural communities. Wrap around services and being able to link a wide array of community resources may be a good model for rural human service delivery.

Rural Policy Research Institute has examined poverty trends over fifty years. Many previously high poverty counties returned to high poverty status and a large number of counties are experiencing high poverty rates for the first time. There is a sharp rise in the micropolitan poverty rates. It is difficult to identify why there are micropolitan counties who are experiencing high poverty for the first time. More analysis is needed to examine what transpired to make these counties decline. It is questioned whether they were on the cusp of high poverty when the great recession occurred and if significant, but time-limited public investment could benefit these counties. There may be progressive changes in these counties now that the great recession is over.

Rural Policy Research Institute created a typology map to identify geographies with indicators of high human service needs. Economic indicators considered were: counties with poverty, households without vehicles, households that receive Supplemental Nutrition Assistance Program benefits and income from government transfer programs. Demographic indicators considered were: minority population, sixty five and older, veterans, adults without high school diplomas, subfamily households, work age dependency ratio, children population and foreign born. The highest rates of risk were in micropolitan and noncore counties. Seventeen percent of mircropolitan counties had three or more risk factors. Thirty one percent of noncore counties had three or more risk factors and only nine percent of metropolitan areas had three or more risk factors. Eight counties in the Promise Zone designation in Kentucky fall into the top ninety percentile of indicators in terms of economics.

Rural Policy Research Institute studied intergenerational mobility, specifically, if there are different factors regarding intergenerational economic mobility in rural verses urban. On average, absolute upward mobility is higher in rural areas. Family structure (the share of single mother families) in the county is the single most important indicator of upward mobility in both rural and urban. The quality of spatial job matching and income inequality are also factors related to upward mobility.

Measured characteristics of places explain more upward mobility in rural areas than in metro areas. A positive impact in rural areas can be achieved by enhancing the special match between rural workers and jobs. Finding ways to prevent single mother households would also have significant effects on upward mobility.

**Gerry Roll**
**Executive Director**
**Foundation for Appalachian Kentucky**
**Chavies, KY**

**Gerry Roll** shared that the Foundation for Appalachian Kentucky is a community foundation that serves forty three counties in the Shaping Our Appalachian Region. She lives in Busy, Kentucky on the north fork of the Kentucky River. She shared that she had been a single, unmarried mother and had been on WIC and food stamps. As a single mother, she went to college through the Job Training Partnership Act Program. Her first job was the director of a nonprofit organization in Hazard, Kentucky.

Ms. Roll spoke about a community's response to living in the unhealthiest place in the nation. Many of the poorest counties in the United States are around Perry County, Kentucky. The Kentucky Appalachian region has fifty six of eighty three distressed counties in the Appalachian range from Maine to the Delta. In 2014, Perry County was not a distressed county for the first time ever but is distressed again in 2015. Perry County lost many jobs due to the transition in the energy economy. Socioeconomic factors matter when looking at health issues in a region.

Perry County and most of Appalachia and southeastern Kentucky has learned to be helpless. Sometimes they are on the edge of hopelessness but will not get there because there is not a poverty of spirit. Some people think that becoming helpless originated from the war on poverty and public welfare and others because of the coal industry, timber industry and the patriarchal political system. The trend has to be turned around and everyone wants to do better.

In 2000, a local group of community leaders came together to discuss how eastern Kentucky was in such a desperate situation. They had used all of HUDs programs and in Perry County, Kentucky, there were three federally qualified health centers serving one county. There was the first stand-alone healthcare for the homeless program. They had been a rural health outreach grantee and community access grantee. There was a wonderful Housing and Urban Development program continuum of care and early childhood system in the area. They had a three hundred bed acute care hospital and felt they had done everything right. Perry County had a great foundation for success and could not understand why they could still have such negative health outcomes. The community came together to identify the problems in order to do something different and achieve success. The leadership group spent time talking to people in the community. They went to churches, fire departments, homes and high schools to hear from the local people. What was most important to the residents was preparing their children for success. The local people wanted arts, culture, recreation and ways to be a community. The local citizens wanted safe housing, ways to build family assets, a strong education system, ways to build community, ways to be healthy and a clean environment.

The community foundation was created as an anchor in Perry County after a best practice model based on rural development philanthropy. There is a huge amount of wealth in the region but no capacity for people to invest the wealth locally. Playgrounds, side-walks and smoke free high schools are needed in these counties and the discussion was how to move forward. It was imperative not to get hindered on what caused the problems but discussing how to move forward.

The Foundation for Appalachian Kentucky realizes there has to be the capacity to use funds effectively. There is a need for high performing entrepreneurs to loan money and a way to create these entrepreneurs in the region. Using the dollars effectively to build the capacity and addressing the issues of helplessness was the focus. When the community is involved in the solution, they are engaged and change happens. Overtime the gaps began to shrink in the poverty rate and unemployment rate in Perry County. Bringing people together to achieve a common goal is vital to success in rural America.

Ms. Roll ended with a quote from a local community play, “Maybe we need to come up with a different quality of life index for little country places like ours. How many points could we get for each hill? How much is a river worth. Can we add a category for walking on ground your ancestors walked or percentage of neighbors who would show up in five minutes if you needed them day or night. How could you measure that or how could you measure how much you would miss a place if you had to leave.”

**Q&A**

**Octavio Martinez** said that many organizations do not know how to communicate. What is your strategic approach to communication? How are you getting the message out to the community and build on the cultural structure to deal with the issues?

**Gerry Roll** responded that there needs to be a neutral facilitator to make things happen. The foundation demonstrated that working together will increase funding for everyone. They work together as a group to raise money for local nonprofits. There are seventeen local nonprofits that work for three months to raise money and the money flows through the foundation. The foundation matches the amount the nonprofit raises and puts it in an endowment fund. All of the nonprofits have permanent endowments.

**Carolyn Montoya** shared with Gerry Roll that they can do qualitative research as a success measurement. That is just as important as statistics.

**Governor Musgrove** asked Jocelyn Richgels if there is plan to find answers concerning the data.

**Jocelyn Richgels** said yes. There is currently research being gathered on upward mobility data and it is one of their main focuses. The next set of data will give additional information on the counties that are entering high poverty for the first time.

**FEDERAL PROGRAMS**

**Earl Gohl**
**Federal Co-Chair**
**Appalachian Regional Commission (ARC)**
**Washington, DC**

**Earl Gohl** thanked the committee for visiting eastern Kentucky. The area has incredible potential with a strong sense of community and family but is also a region with huge challenges. The Appalachian Regional Commission was created in 1965 as part of the war on poverty. In 1980, funding was cut dramatically so Appalachian Regional Commission began to develop partnerships. The commission was important to the people in the region so they found ways to work together.

In 1964, there was a debate between the cabinet secretaries and the governors because both wanted funds to solve the problems in the communities. The compromise was that the thirteen governors met with a federal co-chair to assess and make a judgment about the proposals submitted each year for investment. This was an opportunity for collaborating and completing projects with less funding. They also work closely with seventy four local development districts throughout the region. Every year the governors are able to establish what is important in their state. The focus varies as example from dental care to small business. The governors' are encouraged to focus on a specific issue instead of trying to make everyone happy. They support regional research and work with community colleges and advisory groups on healthcare, tourism and energy.

The Appalachian Regional Commission covers four hundred and twenty counties from upstate New York to northeast Mississippi. Every year there is analysis of every state regarding employment, poverty rates and per capita income. Each gets ranked from one to three thousand seventy. The bottom 10% of the counties in the nation are considered distressed; the top 10% are defined as attainment. Counties in eastern Kentucky are in the bottom 10% and considered distressed counties. The Appalachia Regional Commission's mission is to work towards economic parity.

Appalachia Regional Commission had the mission to build a 3,090 mile highway system throughout the region. Ninety percent of the highway system is completed but the last ten percent is the most difficult, expensive, and environmentally challenged. Another challenge in the region is the lack of access to broadband.

For its 50$^{th}$ anniversary, Appalachia Regional Commission did research on where they have been and where they are going. They are developing a new strategic plan and created a study called Appalachia Then and Now. When ARC started in 1960's, there were two hundred seventy one counties that had poverty rates in 150% of the national rate. Today there are ninety counties in high poverty.

The mortality issue in Appalachia is a concern because life expectancy in eastern Kentucky is not comparable to the rest of the nation. The advisory committee can assist in helping solve this problem. It is an issue about lives, family and the economy and a problem that impacts the federal government.

**Eric Stockton**
**Program Operations Division**
**Appalachian Regional Commission (ARC)**
**Washington, DC**

**Eric Stockton** shared that he is the health program manager at the Appalachian Regional Commission. Health grants used to receive more funding focusing on infant mortality, black lung, hospitals and primary care. The recent health grants focus on healthcare access, health promotion and clinical services. All the clinics and hospitals that were funded in the 1970's are in forty year old buildings or going out of business. There is still a need for that type of grant making which is done with the U.S. Department of Agriculture.

Since 2000 there has been research on geographic health disparities. The research shows that Appalachian health disparities include: heart disease, stroke, oral disease, lung cancer, diabetes, prescription drug abuse, cost of primary care and access to treatment. When socioeconomic status is controlled, Appalachia is substandard in almost every one of the areas. There is something uniquely bad about Appalachian health. This creates a great opportunity to make great improvements in Appalachia. The Appalachian Regional Commission partners with Health and Human Service agencies and with the Whitehouse Rural Council. They are able to connect state and federal partners so that Kentucky is represented when issues are discussed in Washington D.C.

Residents in distressed counties are one third more likely to have Type 2 diabetes than non-distressed counties. For fifteen years, the Appalachian Regional Commission has been working with the Centers for Disease Control to build a diabetes coalition in distressed counties called the Appalachian Diabetes Control and Translation Project. There are seventy nine coalitions and they receive funding and training. The diabetes coalitions partner with local health departments, churches, schools and clinics.

There is a comprehensive cancer control plan in Appalachian communities to link state agencies with local coalitions. Mini grants are used to demonstrate models in an Appalachian context. There is also an Appalachian patient navigation project that offers coordinated, culturally-sensitive, standardized training for cancer patient navigators.

A major new initiative in rural Appalachia is called: Creating a Culture of Health in Appalachia: Disparities and Bright Spots. The Robert Wood Johnson Foundation was interested in studying poor counties in Kentucky that were having better than expected health outcomes. Over the next three years, they will research distressed counties with better outcomes than expected, document community based models and policy implications, and translate data and models to local action. The research initiative will overlay socioeconomic and health data.

Some challenges for Appalachian health are the need for more county level data and research, cultural factors that affect health behavior, hesitation from leaders related to health reform and a need for workforce development in all sectors. Opportunities include the coalition infrastructure

in high need areas, positive new health and nutrition policies, opportunities for new community health workers and the building of new partnerships and collaboration.

A coordinated federal approach to Appalachian health would be beneficial. It would be advantageous to enlist partners to translate evidence based practices to an Appalachian and rural context. There needs to be a connection between the economic development community, public health and healthcare delivery.

**Lynda Perez**
**Director of Discretionary Programs**
**Office of Community Services**
**Administration for Children and Families (ACF)**
**Washington, DC**

**Lynda Perez** said that she is humbled by the committee and the work that they have done. She is honored to speak to the group. The Office of Community Services is a part of the Administration for Children and Families. Programs that are relevant to the discussion in eastern Kentucky are the Community Economic Development Program and the Rural Community Development Program.

The Community Economic Development Program supports business development projects designed to create jobs that lead to economic self-sufficiency for low-income residents and their communities. The funding is flexible and can be used to start a business, expand a business, for capital investments, buy real property or for operating expenses. Community development corporations can either lend or invest the money into a business.

Two Community Economic Development Programs in rural communities are: the Southeast Kentucky Economic Development and Westmoreland Community Action Agency. The Southeast Kentucky Economic Development project provides capital for Somerset Recycling Services, Inc., a paper and plastic recycler in Somerset, Kentucky. The project will create twenty five fulltime jobs for low-income individuals. Westmoreland Community Action Agency expanded a Shop Demo Depot in southwestern Pennsylvania; a business that salvages building materials for reuse and recycling. The expansion will create twenty seven fulltime jobs.

The Community Economic Development Program partnered with the Department of Agriculture and the Department of Treasury to create the Healthy Food Financing Initiative. The objective of the initiative is to improve the access to healthy foods in food desert communities and to create jobs for low income individuals. The program is creating or expanding retail outlets that provide healthy food in food desert communities. It is enhancing distribution systems to increase the amount of healthy food going to the outlets. Another strategy is to promote and encourage the purchase of healthy foods in the food desert communities. One example of a Healthy Food Financing Initiative Project is the expansion of ASSETS Lancaster Company, in Lancaster Pennsylvania. It is a local business that produces and supplies organic foods throughout the eastern region of Pennsylvania. The expansion will create forty two fulltime jobs.

The Rural Community Development Program is to ensure that people in rural communities with low incomes have access to safe and affordable drinking water. It protects the health of individuals in rural areas through environmentally sound disposal of waste water and sewage. It also strengthens the economic conditions and opportunities for low income individuals in rural communities by training and providing technical assistance in safe ways to dispose of wastewater. Grants are awarded to multi-state, regional, private and non-profit organizations. An example of a program is the Midwest Assistance Program that assisted the City of Coleman, South Dakota. There were discrepancies in water records, water main breaks and stagnant water. The water meters were obsolete and unserviceable. Funds supported purchasing additional meters and water main projects.

Additional Office of Community Services programs of interest in rural communities include: Assets for Independence, Health Profession Opportunities Grants, New Pathways for Fathers and Families and Healthy Marriage and Relationship Education Grants.

The Assets for Independence Program assists participants to save earned income in matching savings accounts called individual development accounts. Each dollar saved is matched from a range of one to eight dollars. Savings are used for first time home purchases, capitalizing a business and pursuing post-secondary education or training. Many of the community colleges are using scholarship funds for this program. Health Profession Opportunities Grants provides education and training to Temporary Assistance for Needy Families recipients. This program assists with education and training to low income individuals for occupations in the health care field. New Pathways for Fathers and Families purpose is to strengthen positive father-child engagement, improve employment and economic mobility opportunities, and improve healthy relationships. Healthy Marriage and Relationship Education Grants provide a broad array of services designed to support healthy marriage and relationships, enhance employment skills and help clients secure employment.

**Janet L. Collins, Ph.D.**
**Director, Division of Nutrition, Physical Activity and Obesity**
**National Center for Chronic Disease Prevention and Health Promotion**
**Centers for Disease Control and Prevention**
**Atlanta, GA**

**Janet Collins** said that it is a pleasure to join the committee and she has been considering how federal agencies can work more in collaboration regarding rural issues. There is a need for greater attention and organizational structure.

The Centers for Disease Control and Administration for Children and Families is working to change the context in rural communities and assist individuals make healthier decisions. The Centers for Disease Control focuses on healthy food choices at schools as well as work places and on creating smoke free communities. There are communities where it is hard to be healthy because of exposure to second hand smoke or lack of healthy options in vending machines. Employment, education and housing are critical to health but the Centers for Disease Control are not working on these types of issues yet.

There is a Chronic Disease Center at the Centers for Disease Control with a one billion dollar budget and one thousand employees. Quality of life, healthcare costs and premature mortality is largely driven by chronic disease issues. The Centers for Disease Control is the nation's prevention agency so the focus is on healthy eating, active living and being tobacco free. Centers for Disease Control are working to prevent the risk factors that cause obesity, diabetes and cancer which are all more prevalent in rural areas. Centers for Disease Control are an action organization and the mission is to make a difference in health by taking findings and putting them into action.

Centers for Disease Control funding focuses on: epidemiology, surveillance, monitoring, an environmental approach that promotes health and supports healthy behaviors. Health system interventions are imperative in order to improve the delivery and use of clinical and preventative services and community and clinical linkages to manage chronic diseases.

Centers for Disease Control identify interventions that are evidence based and proven to be effective. Quality physical education programs, walk to school programs, and community design that promotes physical activity have to be established and be sustainable. Centers for Disease Control funds state health departments to assist with healthy eating initiatives, physical activity and tobacco programs.

Congress created a five million dollar grant to fund an obesity program. The grants were administered to some universities with counties with obesity levels of 40% or higher. Roughly half the states in the country have high obesity rates. There were six states that were funded and the universities work with the county extension offices on local solutions. Each location is doing the same kind of work but it is looking different in each location. Whether it is a mobile produce market, a farmers market or school based program they all have to consider how to source the produce, distribute it and make it consistently available. The issue is not only access but encouraging purchasing by affordability or couponing. Creating community design with access for pedestrians and bicycles is important when considering obesity rates in rural areas. When resurfacing streets, making them more bicycle and pedestrian friendly is a way to promote physical activity in rural communities.

There are positive initiatives in Kentucky regarding tobacco. There is a hotline available for people who want to quit smoking, there are smoke free schools and there are tobacco coordinators providing education and cessation resources.

Centers for Disease Control not only offer funding but offers direct technical assistance. There are cooperative agreements and work collaboratively with grantees. When a community is funded, their success or failure is also Centers for Disease Control's success or failure.

**Q&A**

**Peggy Wheeler** asked Eric Stockton if human services factors and not just health factors are being considered as part of the Robert Wood Johnson research.

**Eric Stockton** said that there is quantitative analysis and documentation of health disparities but not a human service measure. Once the target communities are identified, it would make sense not to just look at health factors.

**Tom Morris** asked if the requirements or regulations for a minimum number of people to be impacted in order to do programs are a barrier when competing for grants. A problem may be the requirement to show impact or quality improvements which is more difficult in rural areas. There may be thresholds that inadvertently get in the way of rural communities being competitive in getting grants.

**Janet Collins** said the Partnership to Improve Community Health Program has a floor of fifty thousand people. Another complexity is that small rural areas are in competition with metro areas which have a lot more capacity. It works better with a set-aside that is specifically directed to rural communities. We want to reach large populations but also want to reach the people who need it the most. No bottom floors and some set-aside would be helpful.

## SOCIAL DETERMINANTS OF HEALTH PART II: ECONOMIC DEVELOPMENT

**Michael Hayes**
**Special Projects Coordinator**
**Kentucky Highlands Investment Cooperation**
**London, KY**

**Michael Hayes** shared that Kentucky Highlands Investment Cooperation is a community development corporation that works in southeast and southcentral Kentucky. He talked about the Red River Gorge which is a series of gorges cut through the limestone and one of the most rugged, wilderness areas east of the Mississippi. When he was younger he read a Sports Illustrated about a flood control dam that would be constructed at the Red River Gorge to avoid downstream flooding. It had been approved but was delayed and then ultimately cancelled because it would have destroyed the ecosystem. The Red River Gorge became the mecca for rock climbers and visitors from around the world.

Kentucky Highlands was formed in 1968 and was one of the original one hundred community development corporations. In 1990, Kentucky Highlands Investment Cooperation had fifteen million dollars in assets and today has seventy four million in assets. Currently, Kentucky Highlands Investment Cooperation has a staff of twenty three people.

Kentucky Highlands Investment Cooperation has provided financing for over seven hundred businesses. This support has created over eleven thousand jobs that are still in place and paid 1.6 billion in salary and wages. Entrepreneurial education and training is imperative, especially in rural communities. Getting a job is the key to a person’s security. They are a flexible; nonregulated lender that can structure a project without repayment for eighteen months because the company is not getting revenue. As long as the business is still working at building its commerce and is paying employees, Kentucky Highlands Investment Cooperation will support them. It is not just about making money but supporting the local businesses.

Promise Zones are a new initiative by the Administration for designated areas with two hundred thousand people or less with a focus on changing the community structure. Promise Zone focus areas are creating jobs, increasing economic activity, improving career education opportunities, reducing drug-related problems, improving broadband access and improving healthy food access. There are five promise zones and the one in Kentucky is the southeast corner. The Kentucky Highlands Promise Zone Project Area includes: Bell County, Clay County, Harlan County, Knox County, Leslie County, Letcher County, Perry County and Whitley County. This is a multiagency initiative in the southeast corner of Kentucky and was chosen because the unemployment rate is extremely high and incomes are low. The median family income is thirteen dollars an hour so even when people are working they are not making a livable salary. Deaths by drug overdose in the region are extremely high.

Around twenty years ago, the Administration started an Empowerment Zone Initiative in economically depressed areas of Kentucky and provided extra assistance from the federal government. Lessons learned from the Kentucky Highlands Empowerment Zone Program were that it has to be community driven, public effort that is supported locally, statewide and nationally. Resources must be devoted to what is sustainable. The essentials must be established and there has to be a focus on local entrepreneurs and policy drivers. The initial plan has to be evaluated each year to identify progress and areas of concern. It is significant to create and value partnerships.

Other programs in place are the American Health Management Program, Grow Appalachian/Kentucky Highlands, Shaping Our Appalachian Region Food Project and the Strong Economies Together Program. These programs address workforce issues, health care needs, healthy foods availability and adult daycare services.

Kentucky Highlands Investment cannot make big changes but can make important changes in peoples' lives and that is its mission.

**Charles W. Fluharty**
**President and CEO**
**Rural Policy Research Institute (RUPRI)**
**Columbia, MO**

**Charles W. Fluharty** told Governor Musgrove that it is great to be back with the Committee and is very pleased that the meeting is in Appalachia. Mr. Fluharty thanked committee member, Wayne Myers, for his years of service that made lasting changes in Appalachia. He stated that his presentation is about citizen engagement and citizen trust. Without trust there is no real hope, and without voice there is no real trust. Culture does more to shape institutions than institutions change culture. There are unique Kentucky challenges including too many county lines, family name significance from generation to generation and football rivalries being connected to relationships. It is also difficult to let go of the history of coal and move forward.

Congressman Hal Rogers and Governor Steve Beshear met in 2013 to talk about the issues in eastern Kentucky. The region was losing jobs in the coal sector at a rapid pace and the sense of

empowerment and hope in the region had disappeared. A challenge in the region was to reframe the future in the voice and vision of the residents. December 9th, 2013, a meeting was held to hear from the local citizens and seventeen hundred local people attended. It was a humbling experience; there was no dissonance and no conversation about coal. The residents stayed for the entire day even though there was bad weather and snow. The youth spoke first and then the entrepreneurs about what the future should look like in Appalachia. At the end of the day they collected two thousand innovation or idea cards from the local people. The summit was called Shaping Our Appalachian Region. The goal was to renew hope, build a regional identity and surface ideas and innovations. Shaping Our Appalachian Region Development goals are to build an organization, create a leadership commitment, have a common vision, seek resources and frame a program of work. The Shaping Our Appalachian Region Program 2015 work plan is to discuss and align priorities, have a summit and create action teams.

Quality of place is important as well as a knowledge network and workforce. Schools need to consider a full range of services. There has to be a new narrative of how a community works together and collaboration of leadership. Integrative programs can work through prioritizing regional innovation ideas. Complementing instead of competing is needed on a regional level. Spreading impact of successful, evidence-based policy and practice strengthens regional collaboration and identity. It is important to seek and advance new approaches on a regional scale.

School systems can be a haven where there is a food system, behavioral health is addressed, and two generations of change can occur. Schools could be a huge benefit to rural communities with family resource centers available in the summer. There can be classes on entrepreneurship for parents while the child is getting a healthy meal and immunizations. Keeping schools open for these types of services needs to be considered in rural communities as a model for the future. The Whitehouse Rural Council will deliberate place based policy and there is opportunity to highlight departments that have the most innovative programs to use as models. A recommendation is to request that silos work together so there can be further collaboration.

**Q&A**

**Octavio Martinez** asked if there has been an evaluation of in-home services for the elderly and if these types of services can save money. This could be an opportunity for partnership with an academic center and for students working on their masters and could be quite cost effective.

**Michael Hayes** responded that the State of Kentucky has researched in-home care related to keeping people from going to nursing homes. At this point it is industry driven. Home health services were reimbursed twelve dollars an hour so they could not afford to do it. The adult day program raised it to twenty dollars an hour.

**Michele Juffer** said that she is the administrator of a nursing home and they prefer that no one end up in a nursing home but sometimes people are uninformed regarding reimbursement. In South Dakota, she receives one hundred and twenty three dollars a day to care for an individual and it costs one hundred and sixty dollars a day. One hundred and sixty dollars a day pays for everything which includes medicines and transportation when needed. They are losing money on most patients who are moved to nursing homes.

**Barbara Morrison** said that there is a network to care for elderly and silos need to be broken down so there can be collaboration between agencies. The Older American's Act is fifty years old and every county is covered by an Area Agency on Aging. People want to stay in their homes and there is funding provided. Working together will help spread the funding and get positive results. There has to be collaboration from the federal level to the local level.

**Roland Gardner** said that approaching the school as a family resource center and working in collaboration with other entities is a great concept. In Beaufort County, South Carolina, there is a high school that had the highest drop-out rate of any high school in the county. The churches and technical college began working with the school. The technical college allows the students to work on an Associate's Degree while in high school. Now that high school has the lowest drop-out rate.

**Charles Fluharty** said there need to be some pilot programs. We have to start with younger children in the schools. The educational sector needs to create pilot programs.

**PUBLIC COMMENT**

Rebecca Davis thanked the Committee for the opportunity to speak. She is the Executive Director of the National Cooperative of Health Networks. They are the only professional membership organization devoted to supporting and strengthening rural health networks through education and leadership development.

Ms. Davis also spoke to the Committee in April of 2013, in Grand Junction, Colorado and now lives in Kentucky. She shared that Breckinridge County is the sixth largest county in the state. The population of Breckinridge County is around twenty thousand people. It is one and a half hours west of Louisville. There are not many resources and the county is very poor. The town of Hardinsburg, where she lives, is the county seat of Breckinridge and has twenty five hundred people. There is a critical access hospital in Hardinsburg but no community access hospital in Breckinridge County. There are primary care providers that are mostly employed by the hospital. She shared that her primary care provider is leaving the county and it will be a challenge for many of the residents to find a new primary care provider. A physician from another town may come on Saturdays to see patients. Health care funds may go out of the county due to patients going to physicians in other cities. This is an issue in many rural communities.

In 1997, the Office of Rural Health Policy provided funding for the development the Rural Health Networks. Now more than ever there is a need for collaboration, coordination of resources and protection of access to quality healthcare services in rural communities. Rural Health Networks are an important link in overall rural healthcare delivery system. National Cooperative of Health Networks was founded in 1995 and rural health network leaders are still addressing some of the same issues as in 1995. Working with competitors to provide quality health care, close to home, remains a priority. The mission is to support and strengthen health networks through collaboration, leadership development, and education. National Cooperative of Health Networks will hold a Rural Health Summit September 1st and 2nd in Portland, Oregon, in partnership with Shaping Our Appalachian Region, the National Organization of State Offices of Rural Health and the Rural Recruitment and Retention Network. The intent of the meeting is

to bring together recruitment and retention specialists and state offices of rural health staff to explore opportunity for collaboration and sharing resources.

Ms. Davis thanked the Committee for allowing her to speak and welcomed them to the great state of Kentucky.

**Thursday, May 28th, 2015**

Thursday morning the subcommittees' depart for site visits as follows:

**CENTER OF EXCELLENCE IN RURAL HEALTH**
**Hazard, KY**
Subcommittee members: Christina Campos, Michele Juffer, Octavio Martinez, Jr., Barbara Morrison, and Peggy Wheeler.
Staff Members: Steve Hirsch and Catherine Fontenot.

**MARCUM AND WALLACE MEMORIAL HOSPITAL**
**Irvine, KY**
Subcommittee members: Ty Borders, Barb Fabre, Roland Gardner, Karen Madden, Carolyn Montoya, Wayne Myers and John Sheehan.
Staff Members: Tom Morris and Charity Porotesano.

The subcommittees' returned to Natural Bridge State Park in Slade, Kentucky, to discuss site visits and for the Federal Update.

**DEBRIEF Of CENTERS FOR MEDICARE AND MEDICAID SERVICES**

**Governor Musgrove** stated that it is the responsibility of the Committee to make recommendations to the Secretary of Health and Human Services that will apprise what is happening in rural America relating to health. These recommendations can make a difference. When the Committee recognizes unintended consequences of regulations, it is important to bring it to attention. Sometimes one regulation alone will not have an impact but collectively they can have negative impacts on rural healthcare delivery. The collective impact has to be considered. The Committee contacted Center for Medicare and Medicaid Services and had a meeting in December. Committee members Christina Campos and Roger Wells attended the meeting and shared how some of the regulations are impacting their communities. This meeting will be scheduled each year so that the Committee can continue to provide information on regulation concerns that are affecting rural communities.

**FEDERAL UPDATE**

**Tom Morris**
**Associate Administrator**
**Federal Office of Rural Health Policy, HRSA, HHS**
**Rockville, Maryland**

**Tom Morris** said the Secretary's announcement focused on delivery system reform. Delivery System reform links the cost of services to the quality of the services. Medicare providers must implement a value focused payment system as soon as possible. Moving forward it is important to make sure that there are rural considerations.

The White House Rural Council has a new initiative to focus on rural child poverty. In 2013, there were 1.5 million children living in poverty in rural America. Some of the considerations measured for improvement are bundled services for children in rural areas. Taking a two generational approach to solving these problems is essential because statistically high rates of poverty persist for generations. Leveraging technology and research to fight rural child poverty and addressing food insecurity are also part of the initiative.

Topics to be considered for the September meeting may include delivery system reform and rural child poverty. Medicare Access and Child Health Insurance Program Reauthorization Act could also be considered as a topic.

**PUBLIC COMMENT**
There was no public Comment.

**Friday, May 29th, 2015**

The Meeting was convened by Governor Ronnie Musgrove, Chairman of the Committee. Governor Musgrove stated that he would like the committee to discuss the site visits and potential recommendations. Life expectancy and mortality is a broad topic so the Committee will need to discuss the themes and possible recommendations.

**RURAL MORTALITY AND LIFE EXPECTANCY: CONNECTING THE HEALTH AND SOCIAL SERVICE SAFETY NETS TO IMPROVE OUTCOMES OVER THE LIFE COURSE.**

Possible recommendations discussed by the Committee include:

- Research in behavioral health and primary care integration.
- Uniformity in community health worker programs.
- Need for more substance abuse research/data.
- Reimbursement associated with recognition of different health providers.
- Concerns with quality and outcomes reporting requirements.
- A study comparing rural areas with the same characteristics but different health outcomes.
- Possible collaboration of participants when applying for grants (with consideration for accounting/auditing and shared resource issues).

**COMMITTEE BUSINESS**

Topics for the September meeting include: Child Poverty and Delivery System Reform.

Locations considered for the September meeting include: upstate New York; Beaufort, South Carolina; White Earth, Minnesota and Santa Rosa, New Mexico.

**PUBLIC COMMENT**
There was no public comment.