

Twentieth Anniversary Report

The 2008 Report
to the Secretary:
Rural Health and
Human Services Issues

NACRHHS

The National Advisory Committee on
Rural Health and Human Services

April 2008

Acknowledgments

The 2008 Report to the Secretary culminates a year of collective work by the National Advisory Committee on Rural Health and Human Services. I would like to thank all of the Committee members for their dedication, particularly the subcommittee chairs: Tom Hoyer, Health; Larry Otis, Human Services; and Tom Ricketts, Building Rural Communities. I would also like to draw special attention to the hard work of Andrea Halverson, Thomas Pack, Judy Herbstman, and Nina Meigs, Truman Fellows, who assisted the Committee in drafting key chapters and prepared the report for publication. Jeff Human, Jennifer Roberts, and Jake Culp, consultants with McKing Consulting Corporation and the Nakamoto Group, managed the logistics for each of the Committee meetings.

In preparing this year's 20 year retrospective on rural health and human services, the Committee relied heavily on materials provided by the Rural Health Research Centers. I would like to acknowledge and thank the authors of the two retrospective chapters in the 2008 report: David Hartley, Andrew Coburn, John Gale, and Erika Ziller from the Maine Rural Health Research Center; Julie Schoenman and Michael Meit from the NORC Walsh Center for Rural Health Analysis; Daniel Patterson, Andrea Radford, Randy Randolph, Indira Richardson, and Rebecca Slifkin from the North Carolina Rural Health Research and Policy Analysis Center; Keith Mueller, Jocelyn Richgels, and Susan Nardie from the RUPRI Center for Rural Health Policy Analysis; and, finally, Michelle Casey from the Upper Midwest Rural Health Research Center. Daniel Patterson, Nels Sanddal, Chris Tilden, Denny Berens, Drew Dawson, Tami Lichtenberg, Gary Wingrove, and Terry Hill also assisted with the section on rural emergency medical services. Staff from the Rural Assistance Center helped with background research. The Committee is deeply indebted to these individuals for researching, analyzing, and preparing such valuable data.

The report benefited from the assistance of Federal staff, including Marcia Brand, Tom Morris, Carrie Cochran, Erica Molliver, Michele Pray-Gibson, and April Ward of HRSA's ORHP; and Dennis Dudley of the HHS Administration on Aging. Crucial expertise was provided by Robert Gibbs and John Cromartie from the Economic Research Service, as well as Brian Dabson and Bruce Weber from the RUPRI Center. Finally, I would particularly like to thank Jennifer Chang for her work as NACRHHS' Executive Secretary.

The Committee also benefited from the hospitality and rich information provided by various individuals connected with the Committee's two 2007 site visits. In June, the Committee visited Fort Collins, Colorado and heard testimony from several health and human services providers in the surrounding communities. In September, the Committee visited Madison and Sauk City, Wisconsin. I applaud the hard work of Sue Birch and Tim Size, who served as hosts and organizers for the two site visits. Also contributing to the visits' success were Lou Ann Wilroy, Executive Director of the Colorado SORH; Denise Denton, former Executive Director of the Colorado SORH; and John Eich, Director of the Wisconsin SORH. The number of people involved is far too many to list here, but I want to acknowledge the help of everyone involved with the Committee visits. The opportunity to get into the field and learn about rural health and human services delivery from those who are actually providing these services was critical in informing this report and the recommendations that are included.

Sincerely,
The Honorable David M. Beasley, Chair

About the Committee

The National Advisory Committee on Rural Health and Human Services (NACRHHS) is a citizens' panel of nationally recognized rural health and human services experts. The Committee, chaired by former South Carolina Governor David Beasley, was chartered in 1987 to advise the Secretary of the U.S. Department of Health and Human Services on ways to address health problems in rural America. In 2002, a 21-member limit was set and the Committee's mandate was expanded to include rural human services issues.

The Committee's private and public-sector members reflect wide-ranging, firsthand experience with rural issues – including medicine, nursing, administration, finance, law, research, business, public health, aging, welfare, and human services. Members include rural health professionals as well as representatives of State government, provider associations, and other rural interest groups.

Each year, the Committee highlights key health and human services issues affecting rural communities. Background documents are prepared for the Committee by both staff and contractors to help inform members on the issues. The Committee then produces a report with recommendations on those issues for the Secretary by the end of the year. The Committee also sends letters to the Secretary after each meeting. The letters serve as a vehicle for the Committee to raise other issues with the Secretary separate and apart from the report process.

The Committee meets three times a year. The first meeting is held in early winter in Washington, D.C. The Committee then meets twice in the field, in June and September. The Washington meeting usually coincides with the opening of a Congressional session and serves as a starting point for setting the Committee's agenda for the coming year. The field visits include rural site visits and presentations by the host community, with some time devoted to ongoing work on the yearly topics.

The Committee is staffed by the Office of Rural Health Policy, located within the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Additional staff support is provided by the Administration on Aging, the Administration on Children and Families, and the Secretary's Office of Intergovernmental Affairs.

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For Committee members' biographies, please visit the National Advisory Committee on Rural Health and Human Services' web site at: <http://ruralcommittee.hrsa.gov/>

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Introduction

The National Advisory Committee on Rural Health and Human Services (NACRHHS) was created in 1987. In 1988, it held its first meeting in Washington, D.C. and began a long-term effort to advise the Secretary of the U.S. Department of Health and Human Services (HHS) on how to address issues facing rural communities. This report commemorates the 20th anniversary of the Committee by looking back at key health and human services issues over the past two decades, looking ahead at key challenges that will face rural America in the future, and discussing how HHS and other Federal Departments can help address those challenges.

At its February 2007 meeting, the Committee received a comprehensive briefing on key rural health and human services developments over the past two decades from a variety of experts, including speakers from several Rural Health Research Centers, as well as experts from the U.S. Department of Agriculture's Economic Research Service (ERS). The briefings made it clear that substantial changes in rural demographics and economies over the past 20 years have resulted in a number of improvements. For example, the overall level of Federal assistance has increased in some areas. HHS has administered a number of rural health grant programs and Medicare and Medicaid payment changes that have helped to address some of the emerging needs of rural communities. However, other challenges have arisen that have not been addressed, which add pressure to the already stressed rural health and human services sectors.

The first chapter of this report begins with a retrospective analysis of what the Committee believes have been the key health and human services issues over the past 20 years, noting the changes that have occurred in the rural health and human services sectors between 1987, when NACRHHS was established, and the present. While 1987 is not in itself a particularly significant year, it serves as the 20 year comparison for this report. The sec-

ond chapter considers the essential issues and mechanisms that produced these changes, highlighting some of the key legislation and regulations that have shaped rural health and human services delivery. Chapters 1 and 2 were largely compiled by the Federally-funded Rural Health Research Centers. Again, the scope of this analysis is not meant to be comprehensive. Rather, the report focuses on those key indicators and conditions that the Committee saw as providing a broad picture of the rural health and human services delivery systems. Comparing two distinct periods of time poses some data challenges. When possible, this analysis includes specific data from 1987 and 2007. Where data on those years were not available, the report notes the lack of data or uses the nearest possible data points.

The third chapter draws on the retrospective analysis to broadly examine emerging issues for rural health and human services. These issues, ranging from workforce development to emergency preparedness to data needs, were identified by the Committee as significant challenges and opportunities facing rural health and human services delivery. The Committee discusses community development as an important link for future sustainable health and human services delivery. The report concludes with a series of recommendations and considerations for use by the Secretary and other policy makers in order to better equip rural America to confront the challenges of the next 20 years.

Rural America: 1987 and 2007

General Rural Demographics

This chapter begins by describing the context for considering rural health and human services issues. After defining rural for the purposes of comparisons over time, characteristics of rural places are described: population demographics, immigration, and key economic factors such as employment and poverty.

Defining Rural

There are many definitions of ‘rural’ that are used within the context of health care and human services programs and policies.¹ They are based on population density, town size, proximity to cities, and other factors. However it is defined, the hallmark of rural America is the geographic dispersion of its population, which has many implications for the delivery of health and human services. Many rural areas face unique geographic challenges in reaching their population, such as mountainous terrain or other natural barriers. Thus, any assessment of rural health and human services should begin by defining what is meant by ‘rural.’ The two most common definitions are the Office of Management and Budget’s (OMB) county-based definition and the Census Bureau’s census tract-based definition. See the box on the right for further details. For the purposes of this report, the Committee uses the geographic categorization of counties as non-metropolitan or metropolitan developed by the OMB.

In 1987, there were 2,390 non-metropolitan counties in the United States. By 2005, this number had dropped to 2,051 counties, reflecting the continuing suburbanization of the country; 366 non-metropolitan counties had become metropolitan during this time period while only 27

Definitions of Rural

The most commonly used definition of ‘rural’ is based on the Office of Management and Budget’s (OMB) categorization of counties as non-metropolitan or metropolitan, with the former being considered rural. The OMB system was modified in 2000 to further distinguish between non-metropolitan counties: Micropolitan was added as a new category, defined as non-metropolitan counties with urban clusters of 10,000 to 49,999 people. Both metropolitan and micropolitan areas are considered core-based statistical areas (CBSAs). Non-metropolitan counties that do not meet the 10,000 person urban cluster threshold are categorized as non-core-based statistical areas (non-CBSAs). Together, micropolitan and non-CBSA counties are generally considered rural.

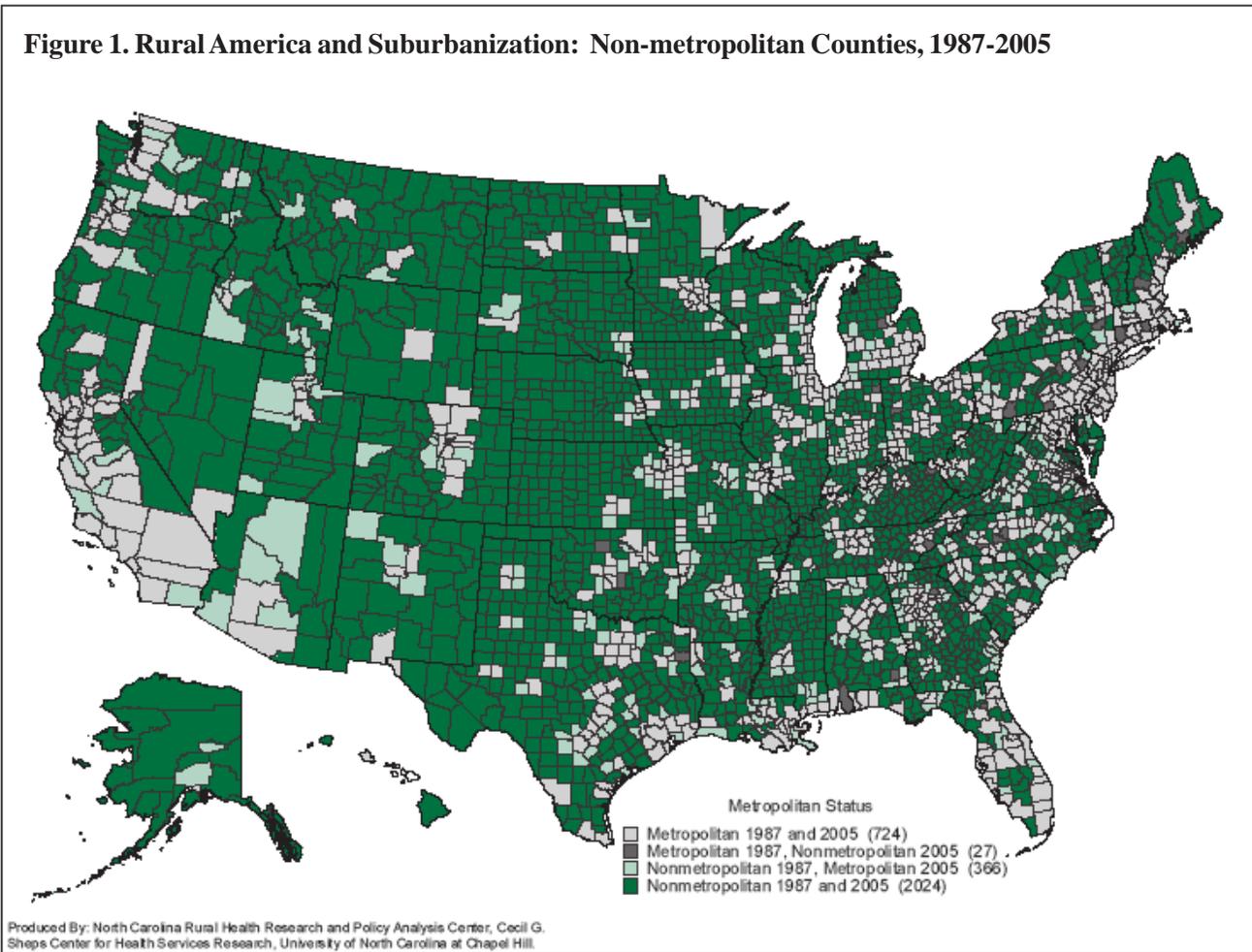
The Census Bureau’s definition of ‘rural’ explicitly identifies aggregations of Census blocks as rural or urban, based on population density and numeric thresholds. The Census Bureau’s definition identifies a substantially different group of people as rural when compared to OMB’s non-metropolitan versus metropolitan categorization: 30 million Census Bureau-defined rural residents live in OMB-defined metropolitan areas, and 20 million Census Bureau-defined urban residents live in OMB-defined non-metropolitan counties. The OMB definition counts fewer people as rural compared to the Census Bureau definition.

Sources: Office of Management and Budget. (December 27, 2000). “Standards for Defining Metropolitan and Micropolitan Statistical Areas.” *Federal Register*. Vol. 65, no. 249. 82228-82238. <http://www.census.gov/population/www/estimates/00-32997.pdf>; Bureau of the Census. (1994). “The Urban and Rural Classifications.” *Geographic Areas Reference Manual*. Washington, D.C.: U.S. Department of Commerce. <http://www.census.gov/geo/www/GARM/Ch12GARM.pdf>

transitioned from metropolitan to non-metropolitan (Table 1 and Figure 1, p. 4). The rural population comprises 17 percent of the total U.S. population.² The population within non-metropolitan counties has also diminished, both in total and as a proportion of the total U.S. population.

	1987			2005		
	Number of counties	Population	Percent of U.S. population	Number of counties	Population	Percent of U.S. population
Non-metropolitan	2,390	54,566,948	22.54	2,051	49,928,566	16.85
<i>Metropolitan</i>				693	30,407,234	10.26
<i>Non-CBSA</i>				1,358	19,521,332	6.59
Metropolitan	751	187,574,173	77.46	1,090	246,481,838	83.16

Source: See References.



Source: See References.

Population Demographics

Over the last 20 years, aging and migration patterns have changed the composition of the rural population. Both elderly and immigrant populations are on the rise, dramatically affecting the de-

mands for health care and human services in rural areas.

The Elderly

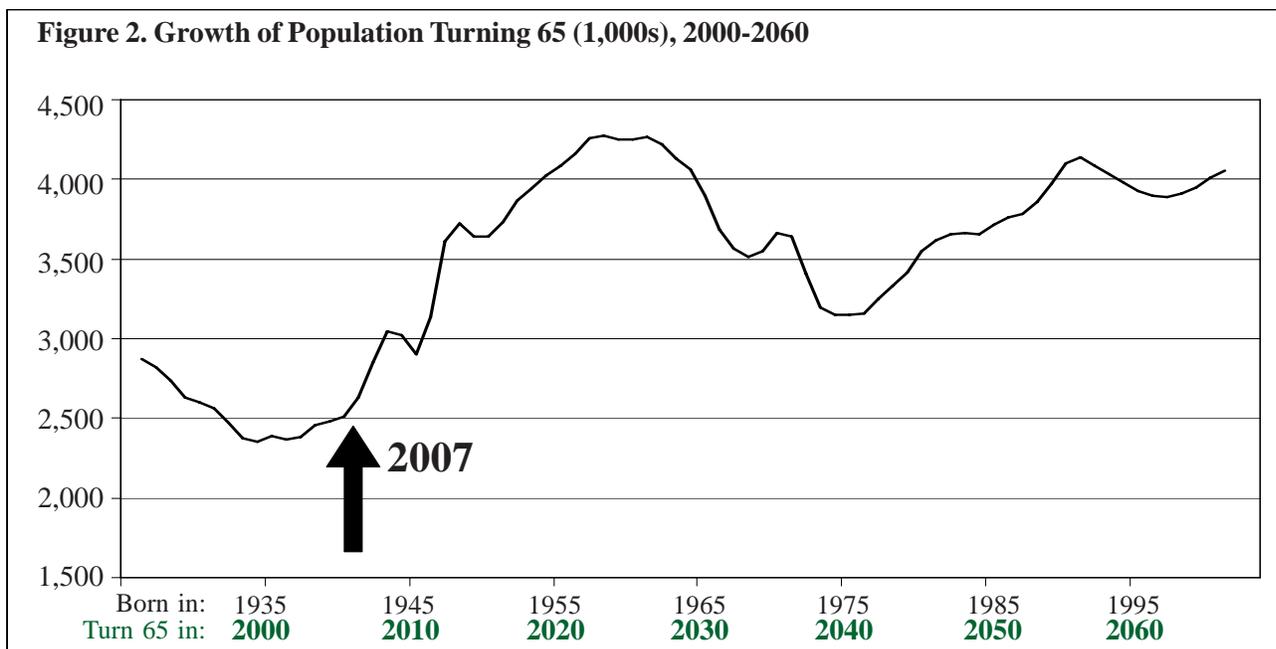
Approximately 7.5 million of the 50 million people who lived in rural America in 2005 were over age

65.³ Although the difference in percentage of elderly between rural and urban areas is not dramatic (15 percent versus 12 percent), the share of the elderly rural population is growing. In one quarter of all non-metropolitan counties, the percentage of rural elderly already reaches 18 percent.⁴

Two population trends in the United States have contributed to the growth in the percent of elderly Americans living in rural areas. First, the out-migration of young adults from farm-dependent counties has led to an older average age for the remaining residents. In rural counties that experienced population loss in both the 1980s and the 1990s, the percentage of elderly residents averages 17 percent.⁵ Second, rural America is becoming a more popular retirement destination, especially for the baby boomer generation. This influx of retirees, many of whom seek to invest in homes and have private health insurance, brings an immediate boost to local economies and health care providers. However, these individuals represent future expanded demand for health and human services in rural areas that often lack adequate infrastructure such as a workforce with specialized geriatric training. It remains to be seen whether additional resources brought by retirees will result in infrastructure improvements.

In addition to these two migration trends, the population of elderly living in rural America stands to increase substantially as the first crest of the baby boomer generation hits age 65. Figure 2 below shows the U.S. birth rate and the correlating year when those people would turn 65 years old, indicating that the U.S. is on the cusp of a significant increase in the number of elderly people. From this demographic change alone, elderly growth rates in non-metropolitan areas are set to triple from 6 percent in 2000-2010 to 18 percent in 2010-2020.⁶ These trends have direct impacts on health and human services delivery.

While urban areas will also experience significant elderly growth rates, the rural elderly face greater economic and health-related challenges than their urban counterparts. These concerns are particularly directed towards those who are “aging in place” rather than retiring from urban areas. Rural elderly are more likely to have lower educational attainment, worse health outcomes, and incomes below the poverty level than their urban counterparts.⁷ In the year 2000, 13 percent of non-metropolitan elderly residents were poor, compared to 9 percent of the metropolitan elderly. For those aged 85 years and older living in rural areas, the gap was even wider (20 percent versus 12 percent).⁸ Higher



Note: The first row of dates indicates the number of births (1,000s) each year. The second row of dates indicates when those people would turn 65 years old.
 Source: See References.

poverty rates translate into higher dependence on Social Security and Medicaid. This situation is a problem for the entire nation, but many rural areas with fragile service systems may find it particularly challenging to meet the needs of their growing elderly population.

Immigration

Immigration patterns in rural America have also changed in the past 20 years. Since 1980, the Hispanic population in non-metropolitan areas of the U.S. has doubled.⁹ In fact, Hispanics are the most rapidly growing segment of the rural population. With a growth rate of 67 percent in the 1990s, the Hispanic population boom in rural areas contributed to an overall rural population growth of 10 percent. Over 100 non-metropolitan counties that would have experienced population loss in those years instead remained stable or grew, because loss in original population was balanced by growth in the Hispanic population.¹⁰

Immigration creates other challenges in rural areas. These demographic changes have exacerbated what researchers at the ERS term “residential separation,” a measure of the racial separateness of sub-county places, including neighborhoods and towns. Hispanic immigrants are disproportionately young males, markedly so in the Midwest and Southeast.¹¹ Many of these immigrants lack a high school education, proficient English skills, and naturalized immigration status. These factors contribute to a persistent income gap between Hispanics and non-Hispanic whites, despite higher employment rates for Hispanic residents.¹² The migration of Hispanics may offer an opportunity to revitalize many rural communities as the presence of a younger workforce is a resource that could attract and keep employers in the community. The influx of this population could also bring about increased demands for social services, including prenatal care, child care, and bilingual education programs.¹³ The success with which rural communities prevail over residential separateness through improvements in education and social services may affect their long-term social and economic well-being.

Population Decline and Rural Prosperity

Population decline is not necessarily a negative indicator for rural areas. Andrew Isserman, Edward Feser, and Drake Warren at the University of Illinois argue that “a growing community can have high unemployment rates, high poverty rates, crowded and expensive housing, and difficulty getting and keeping children enrolled in schools. Growth does not guarantee the prosperity of a community’s residents or their community.” Instead, the researchers propose that *prosperity*, not growth, be used as an indicator for the well-being of rural counties. They define prosperity, for the sake of research, as better than average performance on each of four outcome measures: (1) poverty rate, (2) unemployment rate, (3) high school dropout rate, and (4) housing problem rate. This conception “does not build into the definition of prosperity a bias in favor of growth or against it. What matters is the outcome.” The map in Appendix A indicates a county’s performance on the prosperity measures, displaying how prosperity plays out nationally.

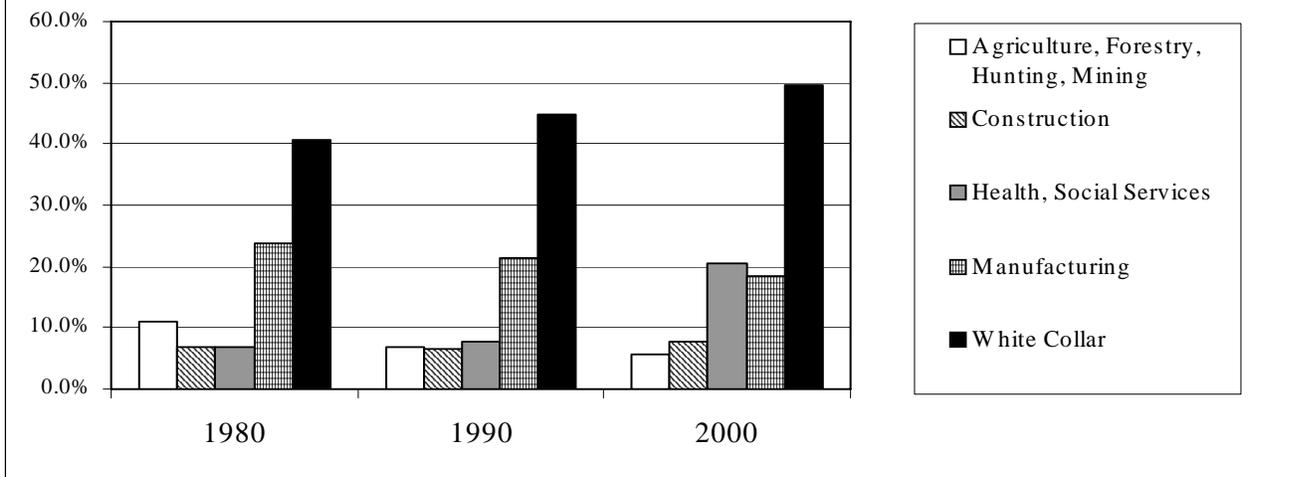
Source: Isserman, A.M., Feser, E., & Warren, D. (May 2007). *Why Some Rural Communities Prosper While Others Do Not*. (Prepared for USDA Rural Development, cooperative agreement no. AG RBCS RBS-02-12). Urbana, IL: University of Illinois at Urbana-Champaign.

The Rural Economy

A growing part of the rural economy lies in the service sector. The service sector has consistently grown as a share of rural employment and now accounts for nearly two thirds of all jobs in non-metropolitan counties.¹⁴ However, it is worth noting that even within this overall trend, there is tremendous regional variation. In the Upper Midwest and Great Plains, agriculture remains a dominant part of the economy, whereas the South relies more heavily on manufacturing. Coastal and Mountain areas in the South and West are experiencing more service sector expansion to meet the demands of retirees.¹⁵

While regional variations exist, for the most part from 1980 to 2000, rural communities saw a shift in their employment base away from occupations such as agriculture and mining to jobs in the service sectors. White collar jobs grew while manu-

Figure 3. Change in Employment Sectors in Non-metropolitan Counties, 1980-2000



Note: Data are calculated applying the current non-metropolitan status of counties to all three time periods. White collar workers include: management, professional, and related occupations; and technical, sales, and administrative support occupations.

Source: See References.

Table 2. Change in Per Capita Income, Poverty, and Unemployment

	Non-metropolitan	Metropolitan
Per Capita Income		
1987	\$12,322.75	\$17,123.23
2004	\$25,103.98	\$34,658.74
Percent Unemployed		
1987	8.32%	5.93%
2005	5.71%	5.03%
Percent in Poverty		
1989	16.19%	12.03%
2004	14.45%	12.44%

Source: See References.

facturing employment slowly declined (Figure 3). Non-metropolitan unemployment decreased from 8.32 percent in 1987 to 5.71 percent in 2005 (Table 2). The gap in unemployment between rural and urban areas also decreased, with the rate in non-metropolitan counties only slightly exceeding the metropolitan unemployment rate in 2005. Non-metropolitan per capita income, unadjusted for inflation, increased from \$12,323 in 1987 to \$25,104

in 2004. If adjusted for inflation, the data show that a smaller increase in real per capita income occurred; from \$20,491 in 1987 (expressed in 2004 dollars) to \$25,104 in 2004. Non-metropolitan per capita income as a percent of metropolitan per capita income remained constant at 72 percent.

Poverty

The percent of the rural population in poverty declined from 16.9 percent in 1987 to 14.2 percent in 2003.¹⁶ However, rural poverty rates continue to outpace those in urban areas; 12.5 percent of the urban population was in poverty in 1987 and 12.1 percent in 2003.¹⁷

The Economic Research Service defines “persistent poverty counties” as those with at least 20 percent of the population living in poverty for the previous 30 years. Of the 386 counties in America that meet this definition, 340 are non-metropolitan.¹⁸ The minority populations are greater (51.5 percent as compared to 30.8 percent of all counties) and the unemployment rates are higher (9.3 percent compared to 5.8 percent).¹⁹

A pressing issue facing rural America is child poverty. Approximately 2.6 million children, or 20 percent of children living in non-metropolitan areas, are poor, accounting for 35 percent of the non-metropolitan population in poverty and 20 percent of the nation’s child poverty.²⁰ Since 1985, the child poverty rate in non-metropolitan areas has never fallen below 18 percent.²¹ The ERS found that families with related children in a female-led household

were worse off in non-metropolitan areas, where 43 percent of such families are poor, compared to 35 percent of similar families in metropolitan counties.²²

The non-metropolitan poverty rate varies significantly by region. In the Midwest, the non-metropolitan poverty rate was lower than the metropolitan poverty rate in 2004.²³ However, in every other region the non-metropolitan poverty rate was higher than the metropolitan poverty rate, most markedly in the South and West. Out of the 340 non-metropolitan persistent poverty counties, 280 were in the South.²⁴

Transfer Payments

A related rural economic trend is the rising level of transfer payments to rural residents compared to the level of transfer payments to urban residents. These transfer payments are “income payments to persons for which no current services are performed” and include payments from government programs such as Temporary Assistance for Needy Families (TANF), Food Stamps, Supplemental Security Income (SSI), Earned Income Tax Credit (EITC), and Medicare and Medicaid, among oth-

Why Poverty Persists in Rural America

Why do some rural communities thrive while others suffer? That’s a question that is at the heart of the book *Worlds Apart: Why Poverty Persists in Rural America* by sociologist Cynthia Mil Duncan.

Dr. Duncan, the founding director of the Carsey Institute, spent five years examining the social fabric of three rural communities: one in Northern New England, another in Appalachia, and the third in the Mississippi Delta. All three communities faced the typical socioeconomic challenges that all rural communities contend with, but the book reveals that there were also stark differences present. The community in northern New England had incorporated a longstanding, rich civic culture that served as a bridge for residents out of the cycle of poverty. This characteristic seemed to be missing in the other communities. The book argues that, in some communities, social history can create a self-perpetuating cycle that segregates the haves from the have-nots, with a negative impact on upward mobility.

Worlds Apart also provided a road map for communities seeking to bridge the gap between the haves and have-nots. The community in Northern New England relied on a rich tradition of collaboration in which industry leaders invested in public education and culture in the 19th century; this helped to establish civic norms of philanthropy and volunteerism. Widespread community activism is apparent in vibrant social organizations run by and for the workers. Steady work in a stable industry, combined with community-wide commitment, laid the foundation for a broad, independent, blue-collar middle class.

Source: Duncan, C.M. (1999). *Worlds Apart: Why Poverty Persists in Rural America*. New Haven, CT: Yale University Press.

ers.²⁵ Between 1980 and 2004, the percentage of non-metropolitan total income accounted for by transfer payments grew from 16 to 22 percent.²⁶ The continued growth of transfer payments has had a positive impact on the ability of some rural communities to offer and sustain needed health and human service programs. In particular, Medicare has had a strong impact on rural poverty in the years since its implementation, which may be associated with adjustments made in the Medicare payment systems to take account of rural economic factors.

These trends – in aging, immigration, the economy, employment, poverty, and transfer payments – have transformed rural America over the past 20 years. The overall picture has improved, but disparities between rural and urban America endure. These trends comprise the context within which the health and human services sectors function and present diverse opportunities and challenges for service provision in rural America today.

Rural Health Care

The demographics of rural America have a direct impact on many factors of health care delivery and outcomes, including rural residents' health status, health insurance status, access to health care providers, and their communities' economic viability. What follows is a retrospective analysis of some of the key health issues facing rural communities.

Health Status

Analysis of comprehensive data from the National Health Interview Survey (NHIS) and the Medical Expenditure Panel Survey (MEPS) shows that health status is generally worse among rural residents compared to urban residents and that this situation has persisted for the past two decades. For example, even after adjustments were made for the older age distribution of rural populations, NHIS respondents living in non-metropolitan counties were more likely than metropolitan residents to rate their own health as fair or poor. Similar patterns in

self-reported health status were found using the MEPS data. Likewise, most chronic diseases have been, and continue to be, more prevalent in rural areas. Data from the NHIS confirm these patterns for chronic conditions, such as various types of joint pain, lower back and neck pain, and vision and hearing problems. Information from the Centers for Disease Control and Prevention (CDC), which produced a report on rural versus urban health differences using data from the mid-to-late 1990s, also demonstrates the poorer health status of rural residents, particularly for people in the most rural areas.²⁷ The CDC data show higher rates of obesity, cigarette smoking, and total tooth loss in non-metropolitan counties. Poorer health status among rural residents translates into higher rates of health-related activity limitations.

Whether poorer rural health status also translates into higher mortality rates is a more nuanced question. Crude, or unadjusted, mortality rates are higher in rural areas and tend to increase as the geography becomes more rural (not adjacent to a metropolitan area and without a city of 2,500 or more people).²⁸ Adjusting for underlying differences in the age and gender composition of the population, however, largely eliminates the observed rural versus urban differences in crude mortality rates.²⁹ One striking exception is that death rates for unintentional injuries and motor vehicle accidents are significantly higher in rural areas, even after adjusting for age differences.³⁰ The aggregate national statistics mask important regional differences, however. In particular, numerous analyses have demonstrated persistently higher mortality rates in the Southeast, along the lower Mississippi River, in central Appalachia, and in a few small areas scattered throughout the West and Upper Midwest.³¹ While not all of this territory is rural, much of it is.

Research into whether living in a rural location exacerbates health problems associated with particular races is limited. Findings are mixed but do suggest that rural minorities fare worse on some measures. Analysis of 2004 MEPS data indicates that rural blacks were more likely to rate their health as poor or fair and more likely to report limitations in work and physical activity, relative to both ur-

ban blacks and rural whites. A study comparing data from 1991 through 1995 also found similar relative disadvantages for rural minorities regarding the prevalence of diabetes and death rates from diabetes and cardiovascular disease.³²

Insurance Coverage

Between 1987 and 2005, the number of uninsured non-elderly Americans rose by about 2 percent for both rural and urban residents, a change that preserved higher rates of uninsurance in rural areas (about 20.5 percent versus 19.3 percent in urban, Figure 4). Nearly four million rural families (30 percent) had at least one uninsured member in 2001 or 2002.³³ Additionally, there is growing evidence that even rural residents with private health insurance may face large out-of-pocket costs for care as a result of being ‘underinsured.’³⁴

Since 1987, rates of private health insurance have declined for all Americans, but particularly in rural areas, where private coverage fell from 72.4 percent to 60.2 percent (Figure 4). This decline in private coverage is the result of rising premium costs and changes in the rural economy. Since the late 1990s, rural areas have seen a marked decline in manufacturing jobs, which tend to offer higher rates of employer-sponsored health insurance (86 percent), accompanied by a rise in service sector employment, in which access to employer-

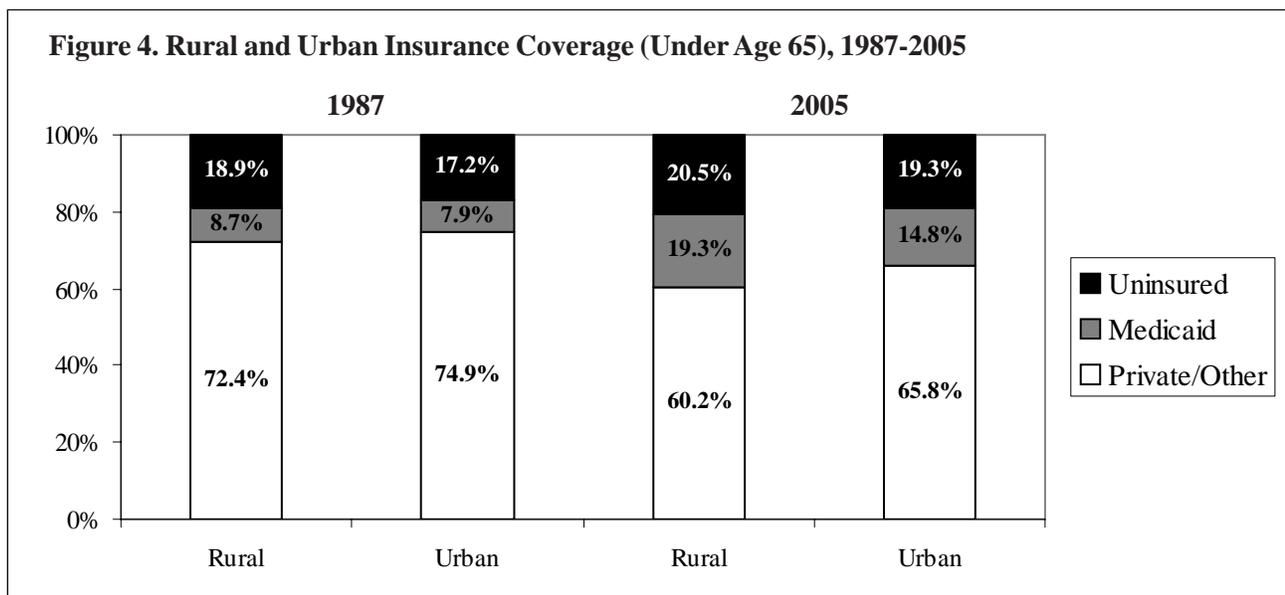
sponsored health insurance has been much lower (63 percent).³⁵ The lack of employer-sponsored health insurance has been particularly apparent for low-skilled jobs.³⁶

Expansions of Federal- and State-sponsored insurance programs in the past 20 years have been important in filling the gaps in coverage in rural America. Public insurance, primarily Medicaid and the State Children’s Health Insurance Program (SCHIP), has grown from covering 8.7 percent of rural non-elderly residents in 1987 to covering 19.3 percent in 2005 (compared to 14.8 percent of urban individuals in 2005). Nearly 40 percent of families in which one family member is uninsured also have a member with public coverage.³⁷

Health Care Workforce

Over the past 20 years, workforce shortages have posed a fundamental systemic challenge to the rural health care delivery system. These shortages are a long-standing problem for rural communities and appear likely to continue. Rural areas are vulnerable to workforce shortages, in part because small population size and scale often means that the loss of just one physician can have profound effects on a community’s ability to ensure reasonable access to care.

The primary method through which workforce shortages are tracked is through the



Source: See References.

designation of communities as shortage areas, either as Health Professional Shortage Areas (HPSAs) or as Medically Underserved Areas (MUAs). Both of these designations predate the creation of this Committee and they continue to be the primary standards by which the Federal government assesses the ability of a community to meet its health care provider needs.

Underserved areas are defined and designated by the Shortage Designation Branch in the Health Resources and Services Administration's (HRSA) Bureau of Health Professions. Both geographic areas and population groups can be classified as either shortage areas or underserved. More than 34 Federal programs use shortage designations as a funding preference or to determine eligibility. In addition, there are provisions in Medicare that offer enhanced reimbursement based on these shortage designations, explained in more detail later in the report, on p. 31.

HPSA designations are determined by strict

population to provider ratios and are used to designate shortages of primary medical care, dental, or mental health providers. Through HPSA designation, communities can become eligible for enhanced Medicare physician payments and National Health Service Corps placements, in addition to eligibility for some Federal grant programs and funding preferences. MUAs are defined geographic areas whose residents have a shortage of personal health services.³⁸ MUAs are primarily associated with the Community Health Center program. Applicants for this designation must qualify based on service area, population to primary medical care physician ratio, infant mortality rate, percent of population living below the Federal poverty level, and percent of population over age 65.

The percentage of both non-metropolitan and metropolitan counties with either a whole or partial county primary care HPSA designation increased from 1987 to 2004 (Table 3). Non-metropolitan counties experienced an increase in coun-

	Non-metropolitan		Metropolitan	
	Number	Percent	Number	Percent
Primary Care HPSAs Whole or Partial County				
1987	1,066	51.97%	606	55.60%
2004	1,555	75.82%	783	71.83%
Dental HPSAs Whole or Partial County				
1985	460	22.43%	247	22.66%
2005	1,162	56.66%	618	56.70%
Mental Health HPSAs Whole or Partial County				
1995	1,120	54.61%	321	29.45%
2004	1,616	78.79%	597	54.77%
MUAs				
1981	1,650	80.45%	839	76.97%
2005	1,680	81.91%	863	79.17%

Source: See References.

Federal Health Workforce Programs

Several Federal programs have played key roles in rural workforce development and retention over the past 20 years. The programs detailed below support training in both rural and urban areas. Because data quantifying rural versus urban impact are often not collected, comparisons cannot be made between 1987 and 2007.

The National Health Service Corps (NHSC) was created to address the disproportionate distribution of physicians, nurse practitioners, physician assistants, and psychologists across the Nation. Through scholarships and loan repayment programs, the NHSC has placed over 27,000 primary care providers in HPSAs since its creation in 1970. In 2005, over 4,600 NHSC clinicians were serving rural and urban communities nationwide.¹

The NHSC is complemented by the Area Health Education Centers (AHEC) program, which focuses on the recruitment, training, and retention of health professionals who care for underserved populations.² AHECs have provided resources to rural communities since 1971. At present, AHEC programs operate in 45 States and provide training to 37,000 students and continuing education for 315,000 practicing providers annually.³

The Federal government also supports training for a range of health professionals through Title VII (including primary care and dentistry training grants) and Title VIII (nurse training and practice) of the Public Health Service Act. All together, these programs continue to provide much needed training and support for the health professionals who practice in rural communities.

Notes:

¹ Bureau of Health Professions. (n.d.). "About NHSC: 35 Years of Excellence." Rockville, MD: U.S. Department of Health and Human Services. <http://nhsc.bhpr.hrsa.gov/about/history.asp>

² National Area Health Education Centers Organization. (n.d.). "About Us." <http://www.nationalahec.org/about/aboutus.asp>

³ Bureau of Health Professions. (n.d.). "Area Health Education Centers." Rockville, MD: U.S. Department of Health and Human Services. <http://bhpr.hrsa.gov/ahec/>

ties designated as primary care shortage areas, from 52 percent in 1987 to 76 percent in 2004. A similar increase in the percentage of dental shortage areas occurred in both non-metropolitan and metropolitan counties. From 1981 to 2005, the percentage of non-metropolitan counties designated as either whole or partial county dental shortage areas increased from 22 percent to 57 percent.

Counties with mental health HPSA designations have a shortage of psychiatrists and/or other core mental health professionals, such as clinical psychologists and clinical social workers.³⁹ In 1995, the first year for which historical data on mental health HPSAs were available, 54 percent of non-metropolitan areas were classified as whole or partial county mental health HPSAs, compared with 29 percent of metropolitan counties. As of 2004, 79 percent of non-metropolitan counties and 55 percent of metropolitan counties were identified as being either whole or partial county mental health HPSAs.⁴⁰

While the percentage of counties with HPSA designations has increased substantially over the last 20 years, there has been little growth in the

percentage of counties designated as MUAs (Table 3, p. 11). From 1981 to 2005, the percentage of non-metropolitan counties with an MUA designation increased by approximately 1.5 percentage points. Metropolitan counties saw a similar small increase in the percentage of MUA designations, 2.2 percentage points.

Physicians

Attracting and retaining practicing physicians in rural areas was a problem in 1987 and continues to be a concern today. Even so, physicians of all specialties practice in rural America, including in some of the nation's leading diagnostic and treatment centers such as the Mayo Clinic in Minnesota, the Marshfield Clinic in Wisconsin, and the Geisinger Clinic in Pennsylvania. However, the most ubiquitous model of physician care in rural areas is the primary care clinic, which often includes a small number of physicians (e.g., one to six) and other primary care providers (e.g., nurse practitioners or physician assistants).

In 1988, the distribution of all non-Federal physicians in the U.S., regardless of specialty, was

Table 4. Non-Federal Physicians in Non-metropolitan and Metropolitan Areas, 1988-2004

	1988			2004		
	No. of Non-Federal Active MDs	Percent	Rate per 100,000	No. of Non-Federal Active MDs	Percent	Rate per 100,000
Non-metropolitan	41,742	8.25%	92.5	59,289	7.79%	119.3
Metropolitan	464,044	91.75%	231.8	701,452	92.21%	287.5
Total	505,786	100.00%	206.2	760,741	100.00%	259.1

Note: Non-Federal Physicians are physicians not employed by the Federal government. They represent 98 percent of all U.S. physicians and include both allopathic physicians (MDs) and osteopathic physicians (DOs).
Source: See References.

heavily weighted to metropolitan areas, where 92 percent of all physicians were located (Table 4). For primary care physicians (family practice, general internal medicine, general pediatrics, obstetrics/gynecology), the distribution was closer to the distribution of the population, 24 percent in non-metropolitan areas and 76 percent in metropolitan areas.

There has been modest improvement in access to care, as judged by the physician to population ratio. For all physicians, the rate per 100,000

people in non-metropolitan areas has increased from 92.5 per 100,000 in 1988 to 119.3 per 100,000 in 2004. Unfortunately, the increase in non-metropolitan primary care physicians has been less substantial, growing from 28.2 per 100,000 in 1985 to 28.5 per 100,000 in 2004. The actual percentage of general practitioners in non-metropolitan versus metropolitan areas has decreased from 24.0 percent in non-metropolitan areas in 1985 to 19.8 percent in 2004.⁴¹

J-1 Visa Waivers

The J-1 Visa allows foreign citizens to enter the United States for graduate medical education and/or residency training programs. Upon expiration of the visa, participants must return to their home countries for a minimum of two years before becoming eligible to apply for another visa or Legal Permanent Resident Status. The J-1 Visa Waiver allows this home residency requirement to be waived for foreign physicians who commit to practicing in a HPSA or MUA within the U.S. for a three year period.

In an effort to ensure that the J-1 Visa Waiver’s service requirements are met, physicians must have a waiver request submitted on their behalf by a Congressionally-authorized Federal or State Interested Government Agency. Currently, there are several bodies that can request these waivers. They include the U.S. Department of Health and Human Services (HHS), the Veteran’s Administration, and two Federal-State partnership organizations, the Appalachian Regional Commission (ARC) and the Delta Regional Authority (DRA). In addition, the Conrad 30 Program authorizes each State to request up to 30 J-1 Visa Waivers annually. The U.S. Department of Agriculture used to request waivers but ended its program in 2002.

J-1 Visa Waiver physicians have long been a key part of the rural physician workforce. In fact, at the end of fiscal year 2005, the estimated number of physicians practicing in underserved areas through this program was roughly one and a half times the number practicing there through NHSC programs.

Sources: U.S. Department of Agriculture. (2002). “Fact Sheet: J-1 Visa Waiver Program.” (Release no. fsj-1visa.02). U.S. Department of Agriculture. <http://www.usda.gov/news/releases/fsj1visa.htm>; Aronovitz, L. (May 2006). *Foreign Physicians: Preliminary Findings on the Use of J-1 Visa Waivers to Practice in Underserved Areas*. Testimony before the House of Representatives, Subcommittee on Immigration, Border Security, and Claims. (Pub. no. GAO-06-773T). Washington, D.C.: U.S. Government Accountability Office. <http://www.gao.gov/new.items/d06773t.pdf>

	1988			2004		
	No. of Registered Nurses	Percent	Rate per 100,000	No. of Registered Nurses	Percent	Rate per 100,000
Non-metropolitan	366,944	18.06%	813.3	528,741	19.69%	1063.9
Metropolitan	1,664,331	81.94%	831.5	2,155,967	80.31%	883.7
Total	2,031,275	100.00%	828.1	2,684,708	100.00%	914.2

Source: See References.

Registered Nurses

Both the number of registered nurses and the percentage of total registered nurses in non-metropolitan counties have increased during the past 20 years (Table 5). In 1988, there were approximately 370,000 registered nurses in non-metropolitan areas, representing 18 percent of all registered nurses; by 2004 those numbers increased to nearly 530,000 and 20 percent.

Mental Health Professionals

In 1990, a Federal report on rural health care, *Health Care in Rural America*, noted that more than half of all U.S. counties had no mental health provider (psychiatrist, PhD psychologist, social worker, master's degree psychologist). That publication also reported that 61 percent of all rural residents—over 34 million people—lived in mental health HPSAs and noted that primary care practitioners provided a significant amount of mental health care in rural areas.⁴² A decade later, *Rural Health in the United States* reported that 76 percent of the 518 mental health HPSAs were rural, accounting for 30 million rural residents.⁴³

Assessing the adequacy of the rural mental health workforce has been hampered throughout these two decades by a lack of reliable data for the five key mental health professions: psychiatry, social work, psychology, marriage and family counseling, and psychiatric nursing. Complete lists of licensed providers with practice locations are not available at the national level, with the exception of psychiatry.

Promising developments in workforce in-

clude growth in psychiatric nursing and in marriage and family counseling.⁴⁴ Since psychiatric nurses are allowed to prescribe medications in most States, their addition to the rural workforce is particularly valuable. In 2002, New Mexico passed a law authorizing PhD psychologists to prescribe psychotropic medications. Louisiana followed in 2004.

Dentists

Though the national supply of dentists has grown over the last two decades (Table 6, p. 15), a smaller percentage of dentists practice in rural areas today than 20 years ago. While there are 3.82 general practice dentists per 10,000 urban residents, there are only 2.30 per 10,000 rural residents.⁴⁵ Rural areas have long struggled with access to oral health care, an issue that seems likely to continue.

Public Health Workforce

Though public health is a key part of rural health care, the public health workforce is difficult to quantify because there is no consistent national provider structure. In addition, the first national analysis of public health workforce by geographic location did not take place until recently, so there is no valid comparison point for 1987.

In 2001, the National Association of County and City Health Officials (NACCHO) analyzed public health workforce differences between non-metropolitan and metropolitan Local Health Departments (LHDs), finding that non-metropolitan LHDs report an average of 31 full-time employees, and metropolitan LHDs report an average of 108 full-time employees. These estimates are lim-

	1987			2004		
	Number	Percent	Rate per 100,000	Number	Percent	Rate per 100,000
All Active Dentists						
Non-metropolitan	20,004	15.25%	36.6	17,367	10.36%	34.9
Metropolitan	111,194	84.75%	59.3	150,254	89.64%	61.7
General Practice Dentists						
Non-metropolitan	14,543	16.85%	26.6	11,514	10.90%	23.2
Metropolitan	71,743	83.15%	38.2	94,083	89.10%	38.6

Source: See References.

ited, in that they were not compared to population served and did not include non-governmental public health providers. Nonetheless, a 2000 HHS study did note that public health nurses provide the majority of care in many rural areas, and importantly, that the public health workforce is aging and retiring, especially within public health nursing.⁴⁶

Primary Care Infrastructure and Providers

Rural residents rely on a variety of providers to meet their primary health care needs, ranging from private physician practices to other Federally-designated ambulatory care sites such as Federally Qualified Health Centers (FQHCs) and Medicare-certified Rural Health Clinics (RHCs).

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) include several types of entities. Grant-Supported Federally Qualified Health Centers (Section 330 health centers) are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act), and receive funds under the Health Center Program (Section 330 of the Public Health Service (PHS) Act). Section 330 health centers include:

- Community Health Centers, which serve a variety of underserved populations and areas.
- Migrant Health Centers, which serve migrant and seasonal agricultural workers.
- Healthcare for the Homeless Programs, which reach out to homeless individuals and families and provide primary care and substance abuse services.
- Public Housing Primary Care Programs, which serve residents of public housing and are located in or adjacent to the communities they serve.

Federally Qualified Health Center Look-Alikes are health centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services (CMS) as meeting the definition of “health center” under Section 330 of the PHS Act, although they do not receive grant funding under Section 330. Finally, there are outpatient health programs and facilities operated by Tribal organizations (under the Indian Self-Determination Act, P.L. 96-638) or urban Indian organizations (under the Indian Health Care Improvement Act, P.L. 94-437).

Section 330 health centers are private, non-profit, and public consumer-directed entities that provide primary and preventive health care, as well as services such as transportation and translation for the underserved and the uninsured, regardless of their ability to pay. HRSA grants provide approximately 20 percent of Section 330 health cen-

ters' revenue, with most of the remaining revenue coming from Medicaid, Medicare, other public and private insurance payers, and State and local grants and contracts.⁴⁷

In 1984, the Bureau of Health Care Delivery and Assistance (now HRSA's Bureau of Primary Health Care) listed a total of 608 rural and urban FQHCs funded under the Health Center Program.⁴⁸ The number of rural FQHCs has increased substantially in the past 20 years, making the centers a significant component of America's health care safety net. HRSA currently funds 1,071 health center grantees under Section 330 of the PHS Act, of which approximately half have a majority of their patients coming from rural areas.⁴⁹ The President's Health Center Initiative provided grant support for over 1,200 new and expanded health center sites from 2002 through 2007, significantly expanding access in rural areas. Between 2002 and 2007, the number of HRSA-supported health centers serving rural areas increased by 35 percent to 526 and the number of patients served by these centers increased by 38 percent to 6.7 million.⁵⁰

The number of Health Center Program grantees, though large, fails to reflect the total number of service delivery sites. Many Section 330 health centers operate multiple service delivery sites, and some service delivery sites serve both rural and urban areas. A definitive count of the number of rural service delivery sites will be available in mid-2008. In addition, there are 236 FQHC look-alike service sites, 40 of which are located in non-metropolitan counties.⁵¹

Rural Health Clinics

The Rural Health Clinic (RHC) is another provider type that has become increasingly important to rural areas during the past 20 years. Established in 1977, the goal of the RHC designation was to expand rural access to primary care services by providing Medicare and Medicaid cost-based reimbursement to RHCs and extending that reimbursement to mid-level health professionals. An RHC must be located in a rural HPSA, deliver outpatient primary care, employ at least one mid-level health professional active during half of its operating hours, and operate under the medical direction

of a licensed physician.⁵²

RHCs have seen significant growth since the designation was first established. In 1980, there were only 285 designated clinics nationwide, as compared to the 2,801 clinics designated in rural areas in 2006.⁵³ Many rural hospitals use provider-based RHCs to employ physicians and improve recruitment and retention in their communities.

Inpatient Care

Across the U.S., the number of hospitals and hospital beds has decreased over the last 20 years, reflecting a national trend toward shorter lengths of stay and movement of services to outpatient facilities. In 1987, there were 2,343 rural acute care hospitals, compared to 3,401 urban facilities. In 2007, there were 2,032 rural hospitals, compared to 2,723 urban hospitals.

Rural hospitals have struggled over time to remain financially viable. The median operating margin in 1987 was -3.63 percent, reflecting a financial loss from the provision of patient care. Losses improved to -2.04 percent in 2004, but remained inadequate to ensure financial stability. It is also important to note that in 1987, all hospitals, both rural and urban, were paid under the Medicare Inpatient Prospective Payment System (IPPS), whereas many rural hospitals are now paid under a variety of alternative reimbursement methodologies that emerged to address rural hospital viability under prospective payment methodology. These payment designations include Sole Community Hospitals (SCHs), Medicare-Dependent Hospitals (MDHs), Rural Referral Centers (RRCs), and Critical Access Hospitals (CAHs). The designation of CAHs proved to be the biggest change for rural hospitals over the past 2 decades, as it created a cost-based reimbursement system for hospitals located in a rural area with 25 beds or fewer. The CAH model has proven to be successful in ensuring access to inpatient, outpatient, and emergency medical services in rural communities. The primary benefit of conversion to CAH status has been that these facilities no longer lose money on Medicare because they are paid for 101 percent of costs. However, the designation does not address any financial shortfalls that occur when Medicaid or pri-

vate pay reimbursement falls below hospital costs. For more information, see Key Changes, p. 31.

Post-Acute Care

Post-acute care services can be defined as skilled services rendered to patients after an episode of acute illness, as part of the rehabilitation or recuperative phase of a patient's recovery.⁵⁴ Post-acute care includes but is not limited to care provided by home health agencies (HHAs), skilled nursing facilities (SNFs), and nursing facilities (NFs).

Data on the prevalence of rural HHAs or SNFs in 1987 were not available. HHAs provide a variety of services within patients' homes, such as skilled nursing care, physical therapy, occupational therapy, and speech therapy.⁵⁵ In 2006 there were 2,116 HHAs located in non-metropolitan counties, although it is quite likely that many rural areas were also served by agencies with a home office in a metropolitan county.

In addition to HHAs, Medicare records show that in 2006, rural areas contained 130 stand-alone SNFs, 3,708 facilities that were dually certified for SNF and NF care, and 766 SNF or NF facilities that were units of rural hospitals.

In rural hospitals and CAHs, skilled nursing care is increasingly provided with swing beds, arrangements which allow a facility to use its beds to provide either acute or skilled nursing care as needed. The proportion of small, under 100-bed hospitals that used swing beds increased from 50 percent in 1996 to 68 percent by 2003. Data on swing bed utilization prior to 1996 do not exist. The largest increase in swing bed use occurred in hospitals that had converted or were converting to CAH status, with 95 percent of CAHs using swing beds by 2003.⁵⁶

Emergency Medical Services

Access to emergency medical services (EMS) is an important issue for rural communities given the realities of geographic isolation and travel time to care. Half of the nation's ambulance services provide care to the 75 percent of Medicare beneficiaries living in urban areas while the other half of services provide care to the 25 percent living in rural areas.⁵⁷ Unfortunately, there is little data avail-

able to analyze the current rural EMS system or how it has evolved in the past two decades. A 1989 study of rural EMS by the U.S. Congress Office of Technology Assessment (OTA) noted that the ability of rural communities to provide EMS services was made more difficult by struggling rural economies, a lack of an adequate workforce, and a reliance on volunteers to provide needed services. The role of EMS as a front-line health care service is more significant in rural areas where access to preventive, primary, and specialty health care services is limited and EMS is often the only source of health care for miles.⁵⁸

In 2007, the Institute of Medicine (IOM) published *The Future of Emergency Care in the United States Health System*. The report notes that while there have been some advances, such as broadened 911 coverage, there was an abrupt decline in Federal funding and leadership in the early 1980s. Since then, "the push to develop more organized systems of EMS delivery has diminished, and EMS systems have been left to develop haphazardly across the United States."⁵⁹ In addition to the OTA's listed challenges, the IOM report cited low patient volume, vast distances to travel, limited infrastructure, and inadequate support funding as complications to progress in rural EMS. Meanwhile, the challenges recognized by the OTA in 1989 remain challenges today.⁶⁰

Including first responders, there are an estimated 1 million EMS personnel nationally serving over 18,000 EMS agencies.⁶¹ Roughly 10 percent of all Emergency Department care is initially provided by EMS providers and millions more EMS encounters occur annually for non-emergent needs.⁶² EMS utilization has increased 16 percent from 2001 to 2004 and is expected to increase more dramatically as the population ages.⁶³

Costs of providing services are higher for rural-based EMS agencies.⁶⁴ These cost disparities derive from low call volume and thus less opportunity to bill for services, and high staff turnover. The GAO recently reported that rural ambulance Medicare payments were 17 percent less than the actual cost to provide them.⁶⁵

Public Health Infrastructure

As noted earlier, rural public health comparisons over the past two decades cannot be quantified due to a lack of data. The primary source for understanding rural public health infrastructure comes from the 2001 NACCHO study, *Local Public Health Agency Infrastructure: A Chartbook*, which included the first non-metropolitan versus metropolitan comparison of Local Health Departments (LHDs).⁶⁶ The NACCHO report notes that the scale of resources available to LHDs varies greatly; mean annual expenditures in 2001 were \$1.2 million for non-metropolitan agencies compared to \$8.9 million for metropolitan agencies (median expenditures were \$0.5 million and \$1.2 million, respectively).

Contrasts in the source of funding were also found, with non-metropolitan LHDs deriving a smaller proportion of their overall resources from the local government and a larger proportion from State reimbursement for services.⁶⁷ Given that local resources are traditionally accompanied by fewer restrictions than State categorical funding, the disproportionate reliance on Federal and State sources may limit the ability of rural LHDs to address serious local health threats that fall outside of categorical grant guidelines.

Despite the dependence of rural LHDs on service reimbursement, far fewer LHDs are directly providing clinical services today than 20 years ago.⁶⁸ Indeed, while the 1992 NACCHO study reported that 30 percent of all LHDs provided primary care services, that percentage had dropped to 14 percent by 2005. This trend is particularly salient in non-metropolitan areas, as only 11 percent of the LHDs within the smallest jurisdictions (less than 25,000 people) reported providing primary care services in 2001, compared to 43 percent of the LHDs within the largest jurisdictions (over 500,000 people).⁶⁹

Rural Human Services

Human services are provided by a patchwork of Federal programs that support specific populations from young children to families to the

elderly. Unlike most health services, which address the entire population including the healthy, human services cater to only those people with specific needs, such as housing, employment, or child care. Human services emerge in order to address these needs, which may differ by community in both the type of need and the best way to address it. Thus, the resulting Federal human services infrastructure is a composite of Federal and State solutions to a variety of local needs. There is no rural focal point for human services at either the State or Federal level. While HHS has an Office of Rural Health Policy, there is no similar entity that focuses on rural human services issues. The array of programs targeted to human services needs is vast and their administration is fragmented and incompletely documented and reported from a rural perspective. Therefore, for this retrospective, we have only been able to consider the larger programs that significantly affect rural residents.

Publicly available data and published analyses on rural human services programs are limited. Therefore, the following comparison between 1987 and 2007 lacks some rural-specific data. Because human services often target individuals and families with low incomes, one proxy for human services need is degree of poverty. While there may not be specific rural data from Federal human services programs, extensive data document the scope of rural poverty. As discussed in the first part of this chapter, overall poverty is higher in rural areas, child poverty is especially pronounced, and fully 88 percent of persistent poverty counties are in rural areas. Given this extensive poverty, it is clear that human services are essential to the well-being of millions of rural Americans.

Human Services Provider Infrastructure

Many Federal human services funds are distributed by formula or block grants to States. Block grants were specifically designed to allow for State flexibility in spending Federal funds and thus, many human services block grant programs may structure their services differently. Thus, a medley of State departments, non-profit organizations, faith-

based organizations, and other entities provide human services nationwide; there is no consistent delivery system as with hospitals, rural health clinics, community health centers, and the other providers discussed in the health care section. While health services are coordinated in terms of the provider, human services delivery is designed around the individual client. Thus, as a corollary to the health care section's explanation of provider structures, this section considers a variety of Federal programs themselves.

What follows is a brief analysis of some of the key human services programs that benefit rural residents. Some of these programs are administered by HHS while others are targeted anti-poverty/income support programs situated in other Cabinet-level Departments. At their core, however, these programs provide important services to rural low-income families, individuals, children, and seniors.

Economic Assistance

In 1987, the most significant form of cash assistance to low-income families was Aid to Families with Dependent Children (AFDC), an entitlement program. There were over 11 million recipients, 7.4 million of whom were children, who received nearly \$10 billion (\$18.5 billion in 2007 dollars) in benefits.⁷⁰ After welfare reform in 1996, this cash assistance was replaced by Temporary Assistance for Needy Families (TANF), a block grant for States to distribute, with a five-year life-time participation limit and stringent work requirements. In 2007, TANF was appropriated \$16.5 billion and aided an average monthly total of four million people nationwide, just one third of the 1987 caseload.⁷¹

In 2003, an average of 293,000 rural families received payments from TANF each month, which represented 14.5 percent of all TANF recipient families.⁷² These numbers are disproportionately low considering the proportion of rural people who live in poverty compared to the broader population.⁷³ TANF has low utilization rates in rural areas in part because of job scarcity, lack of public transportation, low wages, and few services such as job readiness programs or child care. These factors combine to make the TANF welfare-to-work

model particularly trying for rural residents.⁷⁴ The Administration for Children and Families (ACF) in HHS supported a seven-year demonstration project that evaluated strategies to address these rural challenges. While this demonstration yielded mixed success, it did find that effective local staffing is vital to program success, collaboration with other programs is crucial, and data for evaluation are difficult to gather.⁷⁵ A discussion of the transformation from AFDC to TANF is provided in the next chapter on p. 37.

Energy Assistance

The Low Income Home Energy Assistance Program (LIHEAP), also administered through ACF and initiated in 1981, provides block grants to States for financial assistance to help low-income households cover heating and cooling costs. LIHEAP provided \$1.88 billion in energy assistance in 1987 and \$1.98 billion in 2007.⁷⁶ Adjusted for inflation, 1987 LIHEAP funding was \$3.48 billion in 2007 dollars, reflecting a 34 percent relative decrease to 2007. Although there is no documentation of the expenditure of LIHEAP funds in rural areas, LIHEAP is an important program for low-income households and anecdotal evidence suggests that LIHEAP is a significant source of financial assistance for rural low-income households.

Head Start

Head Start, administered through ACF, provides grants to local institutions to provide comprehensive child development services to economically disadvantaged children and families. These local institutions provide education, nutrition, health services, parent training, and other services. Head Start, which serves children from age 3 until they start school, began in 1965, and Early Head Start, for children ages 0 to 3, was created in 1994.

The Committee examined Head Start in its 2007 report, discussing the limitations of rural data while noting that Head Start and Early Head Start serve millions of rural children and families.⁷⁷ In both Head Start and Early Head Start, rural programs are more likely than urban programs to utilize a home-based approach rather than a center-based one.⁷⁸ Rural communities have struggled to

meet the enrollment requirements for sustaining a Head Start center.⁷⁹ In its 2007 report, the Committee found that minor population shifts or modest changes in family income could change enrollment numbers and jeopardize the continuation of a Head Start program.

Eligibility for participation in Head Start is determined by family income; to enroll, the family income must either be below the Federal poverty level or at a level eligible for public assistance.⁸⁰ Given that poverty rates are higher in rural areas, it can be inferred that Head Start remains critically important to rural children, especially considering the lack of high quality preschool centers or licensed child care as well as the distances families must travel to access such services. The Committee could not find rural enrollment data for 1987 but in 2000, 30 percent of children enrolled in Head Start lived in rural areas.⁸¹ Nationally, in 1987 Head Start spent \$1.13 billion (\$2.01 billion in 2006 dollars) for 446,523 children and in 2006 Head Start spent \$6.78 billion on 909,201 enrolled children.

Child Care

Affordable child care remains a concern in rural areas. Rural areas may not be able to support localized child care providers because of smaller

population bases. Parents may have difficulty finding alternative care options due to long distances, limited hours of operation, and fewer qualified care-takers.⁸² Nationally, child care support for parents on welfare began with enactment of the Family Support Act of 1988 and was expanded in 1990 into the Child Care and Development Block Grant and the At-Risk Child Care Program.⁸³ In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) synthesized previous Social Security Act child care opportunities and the Child Care and Development Block Grant into the Child Care and Development Fund (CCDF). Families receive cash assistance for child care from State dispensers of CCDF.⁸⁴ CCDF is the nation’s largest child care resource for low-income parents engaged in work or job readiness activities.

The earliest publicly available data on child care from CCDF are from 1998, when 1.5 million children received child care through CCDF on average each month. In fiscal year 2005, CCDF spent almost \$9.4 billion to provide child care for approximately 1.75 million children each month, reflecting modest growth over the past 10 years. While the percentages of children in rural and urban areas supported by CCDF were roughly the same (Table 7), the site of care differed. Com-

Table 7. Number and National Percentage of Children in CCDF by County Type*, 2004

	Children in CCDF**		All Children Ages 0 to 9	
	Number	Percent of U.S. Total	Number	Percent of U.S. Total
U.S. Total	1,737,000	100%	39,675,000	100%
Rural	133,000	8%	3,646,000	9%
Mixed-Rural	542,000	31%	12,131,000	31%
Mixed-Urban	239,000	14%	5,903,000	15%
Urban	823,000	47%	18,177,000	46%

Note: Numbers rounded to the nearest thousand.

*Based on the Census Bureau's definition of rural and urban, "Counties that almost entirely consist of either urban or rural areas are designated simply as urban or rural. Counties that are not easily defined as primarily urban or rural are designated as mixed-urban or mixed-rural, depending on their population density." See table reference, p. 2.

**CCDF funding is available for children through age 13, or through age 19 if the child is incapable of self-care or under court supervision.

Source: See References.

pared to urban areas, rural areas were less likely to use center-based care and more likely to use family-based care.⁸⁵

Elderly Services

As discussed earlier in this report, a disproportionate number of elderly individuals live in rural areas and this number continues to rise. Statistics show that rural elderly are less healthy, less educated, more isolated, have lower incomes, and have fewer transportation options than their urban counterparts. In non-metropolitan areas, 15.3 percent of seniors have at least one limitation in Activities of Daily Living (ADL) compared to 12.7 percent in metropolitan areas. ADL difficulty provides a good proxy for human services need, suggesting that rural elderly need some human services even more than urban elderly.⁸⁶

President Lyndon B. Johnson signed the Older Americans Act (OAA) into law on July 14, 1965. The OAA created the Administration on Aging (AoA) and authorized grants to States for community-based nutrition programs, as well as research, demonstration, and training projects in the field of aging. With authority from the OAA, the AoA funds services for the elderly including personal care, homemaker assistance, chores, home

delivered meals, adult day care, case management, assisted transportation, congregate meals, nutrition counseling, legal assistance, and other services. Data could not be located from 1987 on rural participation but in fiscal year 2005, 979,954 rural clients were registered, comprising 33.4 percent of OAA program recipients.⁸⁷

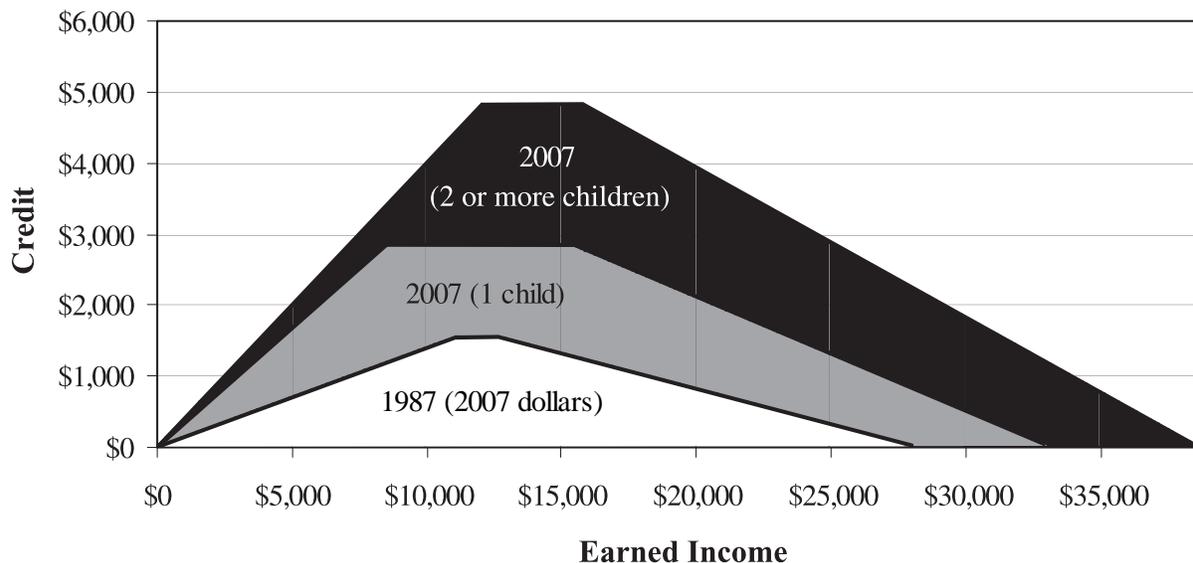
Key Non-HHS Human Services Programs

In addition to the HHS programs discussed above, other Federal Departments provide much needed human services support, in large part through anti-poverty programs.

Earned Income Tax Credit (EITC)

The Internal Revenue Service (IRS) in the U.S. Department of the Treasury administers the Earned Income Tax Credit (EITC), a Federal refundable tax credit available to taxpayers with low earnings. The EITC functions as a wage supplement and work incentive for low-income workers. Taxpayers receive a percentage of their earnings; the more one makes, the more one receives in cash credit, until the income level at which the EITC phases out (Figure 5). EITC payments do not count when determining income eligibility for most other benefits.

Figure 5. Earned Income Tax Credit, 1987-2007



Source: See References.

The EITC has become one of the largest Federal programs providing cash supports to low-income families and has grown in both absolute value and relative importance in the past 20 years (Figure 6).

The EITC was originally enacted in 1975.⁸⁸ Rural Americans rely particularly heavily on the EITC and there are higher rural rates of EITC receipt.⁸⁹ Although the Committee could not find rural data from 1987, in 2004, while only 16 percent of U.S. tax filers lived in rural areas, 20 percent of the \$39.8 billion EITC went to rural Americans. In 42 of 48 States with rural populations, a higher percentage of rural taxpayers received the EITC compared to urban.⁹⁰ Rural families receiving the EITC were credited with \$1,850, on average.⁹¹

Section 8 Certificates and Vouchers

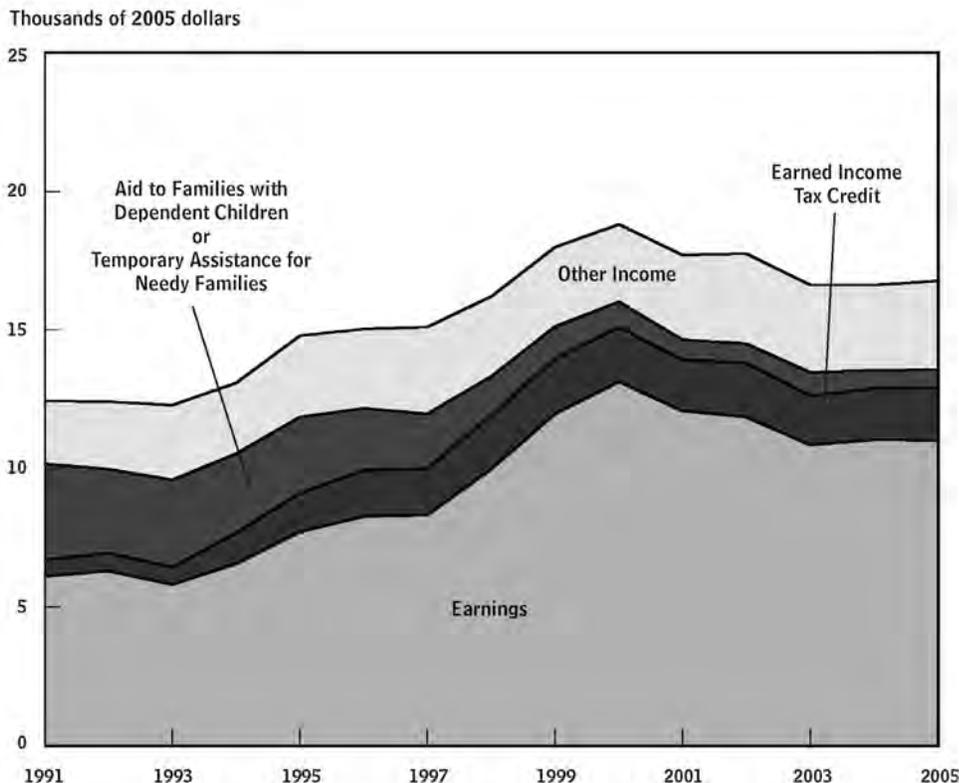
Low-income families, the elderly, and the disabled are eligible to receive Section 8 certificates and vouchers administered through the U.S. Department of Housing and Urban Development (HUD) to help them lease or purchase decent, safe, sani-

tary, and affordable housing.⁹² These certificates and vouchers were created through the Housing and Community Development Act of 1974 and require that individuals spend 30 percent of their income on rent with the remainder of the cost made up by the Federal government. Although 1987 data were not publicly available, the Committee found that in 2000, 630,300 individuals in non-metropolitan areas lived in housing through Section 8 certificates and vouchers, representing 15.8 percent of national Section 8 certificate and voucher recipients.⁹³ The program remains an important component in the rural human services safety net.

Food Stamps

The first Food Stamp Program started in 1939, ended in 1943, and became permanent with the Food Stamp Act of 1964. It is administered by the U.S. Department of Agriculture’s (USDA) Food and Nutrition Service. In 1987, 19.1 million people received an average of \$45.78 per person in food stamp benefits each month (\$81.24 in 2006 dollars).⁹⁴ That number rose to nearly 26.7 million

Figure 6. Sources of Income for Low-Income Households with Children, 1991-2005



Note: Annual cash income was adjusted for inflation using the research series for the consumer price index for all consumers. Other income consists of Social Security, Supplemental Security Income, child support, unemployment compensation, workers’ compensation, disability benefits, pension or retirement income, educational assistance, financial assistance from outside of the household, and other cash income.

Source: See References.

people receiving an average of \$94.31 per month in 2006.⁹⁵ In that same year, approximately 22.4 percent of food stamp beneficiaries lived in non-metropolitan areas.⁹⁶ Participation rates in the food stamp program are higher in non-metropolitan areas, where 78 percent of those eligible receive food stamps, compared to 62 percent of those eligible in metropolitan areas.⁹⁷

Women, Infants, and Children (WIC)

Women, Infants, and Children (WIC) is also administered by the USDA Food and Nutrition Service and provides grants to States for “supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.”⁹⁸ Started in 1974, WIC had 3.4 million participants in 1987 and nearly 8.1 million in 2006.⁹⁹ National participation increased 3.3 percent between September 2006 and September 2007, continuing the upward trend.¹⁰⁰ The average monthly food cost per person allotment has increased in the past 20 years, from \$32.68 in 1987 to \$37.08 in 2006.¹⁰¹ However, in real terms the per person allotment has decreased, since the 1987 allotment represents \$58.00 in 2006 dollars. WIC is not an entitlement program and each year Congressional appropriations determine funding levels. While data were not publicly available for a comparison of rural and urban areas, the previously discussed socio-economic factors facing rural areas indicate that WIC may play an important role for low-income rural women, infants, and children.

Workforce

The Committee is not aware of any significant and targeted Federal programs that focus on human services workforce development and training. There is no basis for a comparison between 1987 and 2007 because there are no standards by which to measure the human services workforce and no programs to promote it. Anecdotal reports indicate that the rural human services workforce suffers from professional isolation, low wages, and increasing stress and caseloads.

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Key Changes

There have been a number of key legislative and regulatory changes affecting health and human services delivery in rural America since 1987. The past 20 years have been a time of significant change in national health policy, with rural health issues playing a key role in midcourse corrections to major initiatives, and more recently by influencing significant policy changes. While cost containment has often dominated policy debates and decision-making, there have been significant strides in policies affecting access to and quality of health care services. In addition, there have been several major initiatives affecting human services since 1987, the most significant being the transformation of the Federal welfare benefits from providing standard benefits to a system that focuses on helping unemployed individuals make the transition to work. What follows is a basic analysis of these key changes as identified by the Committee.

Health Care

Rural Hospitals

Major policy changes in rural health care over the past 20 years have focused heavily on hospitals. Medicare coverage of the elderly and its steady stream of cost-based payments to hospitals has been a major force in mitigating elderly poverty in rural America and improving access to care.¹ As Medicare's overall costs grew in the late 1970s and 1980s, pressure to develop a cost containment strategy emerged. Cost containment policies, while at least modestly successful, created new challenges. Congress' first major attempt to control costs in the Medicare program came in 1983 when titles of the Tax Equity and Fiscal Responsibility Act (TEFRA) provided the authority to create an Inpatient Prospective Payment System (IPPS) and set a general direction for changing physician payment as well.

Prior to the IPPS, inpatient hospital payments had been made on a cost-based system, which reimbursed hospitals for the allowable full cost of services provided. The new payment system, known as the Prospective Payment System (PPS), a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount, was developed and implemented rapidly at a national level without much study of the potential rural impact. As small, low-volume rural hospitals cannot achieve the same economies of scale as high-volume urban hospitals, the fixed reimbursements determined by national averages were often not sufficient to cover rural hospitals' operating costs. The move to PPS added a host of financial problems for these hospitals in the mid-1980s resulting in the closure of 304 rural hospitals between 1983 and 1991.² This crisis surprised policy makers who saw the need to pay closer attention to the impact of Federal programs on rural areas. Congress responded, in 1987, by establishing the Office of Rural Health Policy (ORHP) and the NACRHHS to act as internal and external voices for rural health, respectively.

Many Medicare policies since 1983 can be characterized as 'fixes' to problems originating in prospective payment. The 1983 legislation helped plant the seeds for a strong rural voice in Federal policy by creating a highly visible problem affecting a large segment of rural health care delivery systems.

In 1983, Congress created the Sole Community Hospital (SCH) designation. The intent of the SCH designation was to maintain access to care by providing financial assistance to hospitals that are geographically isolated. These facilities are rural hospitals with fewer than 50 acute care beds and are located at least 35 miles from the nearest hospital. As of 2007, there were 407 SCHs.³

The Medicare-Dependent Hospital (MDH) designation was created by Congress in 1987 to support small rural hospitals for which Medicare

payments make up at least 60 percent of payment for inpatient services. The MDH designation was designed to reduce the financial risk for rural hospitals with a greater dependence on Medicare due to prospective payment.

In 1983, Congress created the Rural Referral Centers (RRC) program for rural tertiary hospitals that receive referrals from surrounding small primary care hospitals. The RRC designation was intended to support the costs these facilities may have due to a higher intensity of services provided than other rural providers. The RRC status makes it easier for these facilities to reclassify their wage index to an urban rate. The wage index is an adjustment in the Medicare payment formula designed to take into account the relative wages a particular hospital has to pay its workforce. In 1989, Congress also changed the Medicare regulations to allow other rural hospitals to apply for a higher wage adjustment to their wages. This provision allowed qualifying rural hospitals to increase their Medicare reimbursement by qualifying for a higher wage index.

In addition to allowing for different types of hospitals and associated payment systems, in 1980, Medicare policy authorized payment for swing beds in rural hospitals with fewer than 100 acute care beds in order to enhance access to long-term care in rural communities. The swing bed provision allows rural hospitals to provide long-term care services to Medicare and Medicaid patients without establishing a separate unit. As of 2005, there were 1,152 rural hospitals using swing beds.

During the late 1980s and early 1990s, Medicare began examining different models of acute care delivery for small rural communities. This began with the Medical Assistance Facility (MAF) demonstration in Montana in 1987 and continued with the seven-State Essential Access Community Hospital/Rural Primary Care Hospital (EACH-RPCH) demonstration, authorized in 1989. The goal of both demonstrations was to see what kind of reimbursement system and changes in conditions of participation would work best for isolated low-volume facilities that played a key role in providing access to health care services for rural Medicare beneficiaries.

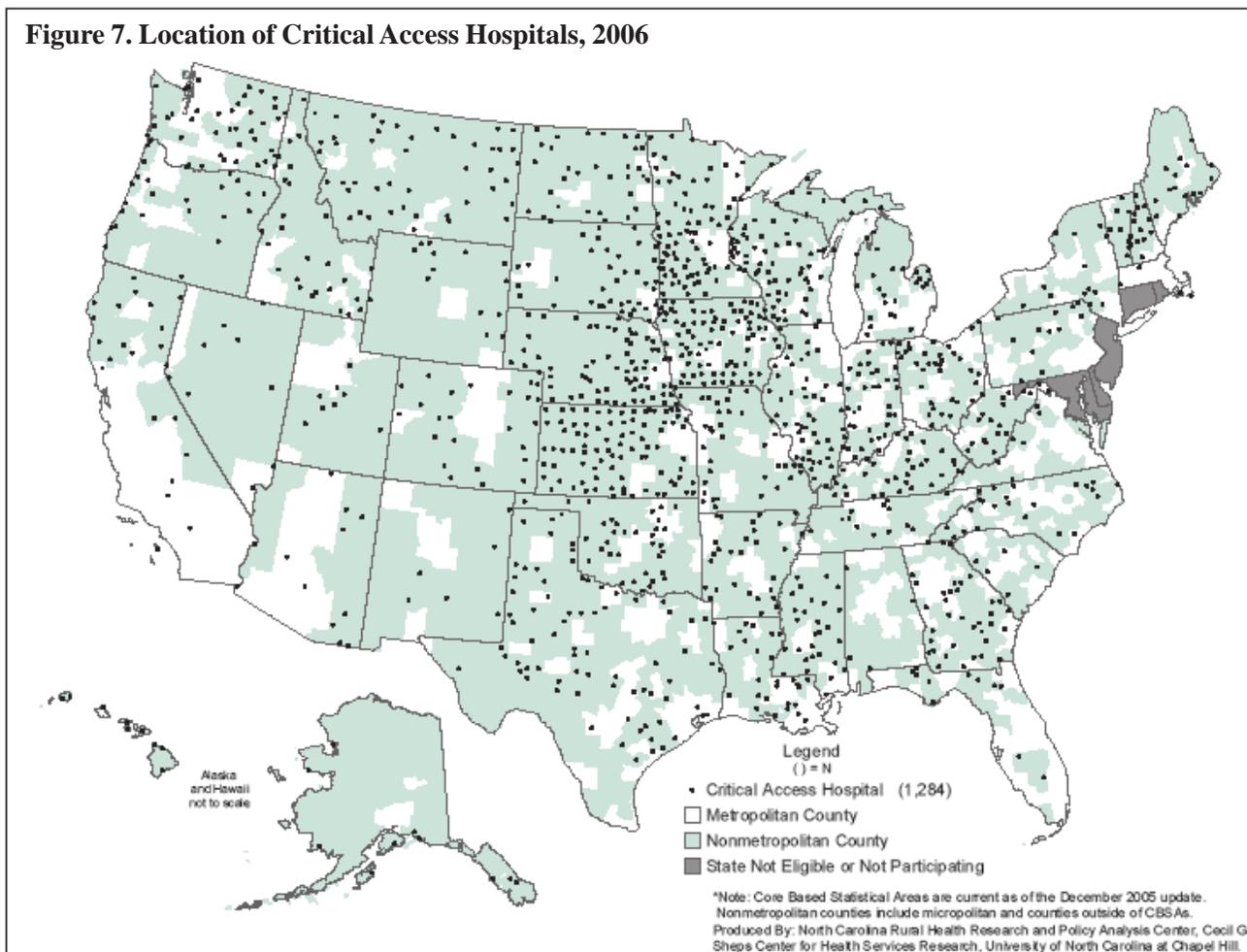
The findings from both of those demonstrations helped pave the way for a new class of rural hospitals. The Balanced Budget Act (BBA) of 1997 created a new type of Medicare provider called the Critical Access Hospital (CAH) and also created the Rural Hospital Flexibility (Flex) program to provide additional support to these facilities by making grants available to State Offices of Rural Health and State Hospital Associations. CAHs were originally restricted to 15 acute care inpatient beds plus 10 swing beds and had to be located at least 35 miles from the nearest hospital of any type unless a State plan used other criteria to declare them a necessary. The criteria were modified by the Balanced Budget Refinement Act of 1999; the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000; and the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Now CAHs can staff up to 25 beds of any type and States can no longer designate hospitals as CAHs that do not meet the original Federal legislative restrictions regarding distance from other hospitals. CAHs were originally reimbursed for both inpatient and outpatient services based on allowable costs, which has since been changed to be 101 percent of costs. As of December 2007, there were 1,292 CAHs (Figure 7, p. 33).⁴

Ambulatory and Post-Acute Care

The 1997 BBA made a number of other key changes to the Medicare program by extending the methodology of PPS to other payment policies, such as hospital outpatient services, home health, and skilled nursing care. These changes were the final move from payment systems based on cost to prospective payment. This transition created some initial challenges for rural communities as they adjusted to the new payment systems, but the process was relatively smooth compared to IPPS implementation in the 1980s.

Outpatient Care

Rural hospitals have long been dependent on outpatient reimbursement.⁵ When Medicare began

Figure 7. Location of Critical Access Hospitals, 2006

Source: See References.

developing regulations for a new Outpatient Prospective Payment system (OPPS) to be implemented by 1999 there was initial concern about its impact on rural hospitals, including concerns over low volume and case mix.⁶ Although the initial regulations did not include any special protections for rural hospitals, Congress mandated that CMS implement a “hold harmless” protection for rural hospitals with 100 beds or fewer. Under this provision, rural hospitals were guaranteed to get the higher of either OPPS payment or an approximation of what they would have received based on a 1996 base year. This protection was extended in the MMA in 2003 and again in the Deficit Reduction Act of 2005, although the latter legislation called for a gradual phase-out of the payments by the end of 2008. After the first few years of the OPPS, CMS analyzed payment data to assess whether the methodology had a negative impact on rural hospitals. As a result of that analysis, CMS

created a payment adjustment for SCHs that provided a 7.1 percent increase for all OPPS services and procedures in 2006. Thus far, the hold harmless provision has played a key role in mitigating any dramatic negative impacts of the OPPS. When the hold harmless protection ceases in 2009, the resulting change in revenue may pose a challenge for rural hospitals.

Home Health

After several years of decline, the number of Medicare-certified home health agencies (HHAs) has once again begun to increase. Between 2002 and 2006, the number of home health agencies grew at a rate of 6.1 percent. Currently, home health care services are offered by 8,880 agencies located throughout the U.S.⁷ Data from 2003 indicate that approximately one third of these agencies are located in rural communities.⁸ The initial implemen-

tation of the home health PPS, done through an interim payment system, precipitated some initial loss of agencies. However, subsequent analyses by the Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office (GAO) have not identified any broad access problems in rural areas, although there are anecdotal reports of some access concerns in rural areas. From 2004 through 2006, HHAs received a 5 percent add-on for serving patients located in rural areas, a reduction from earlier years when agencies received a 10 percent add-on for treating rural beneficiaries. The HHA add-on payment expired January 1, 2007.⁹

Skilled Nursing Facilities

Payment for skilled nursing care in freestanding Skilled Nursing Facilities (SNFs) and hospital-based SNF units transitioned from cost-based reimbursement to a per-diem-based prospective payment system (SNF PPS) with a three year phase-in, beginning in 1998. In 2002, Medicare payment for skilled nursing care provided in PPS hospital swing beds also came under SNF PPS. Although there has been a decrease in the number of hospital-based SNF units since the implementation of SNF PPS, the 34 percent decline in urban areas between 1997 and 2004 was greater than the 20 percent decrease in rural.¹⁰ The number of freestanding SNFs actually increased during the same time period, with a greater percentage increase in rural areas. Between 1997 and 2004, the number of freestanding SNFs increased by 11 percent in non-metropolitan counties and by 4 percent in metropolitan counties, including growth in the use of swing beds to deliver skilled nursing care.

Federally Supported Primary Care Facilities

As noted earlier, there has been substantial growth in the number of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) providing services in rural areas. The growth in FQHCs can be attributed to the President's Health Centers

Initiative, which began in 2002 and ended in 2006. In 2007, HRSA funded a specific expansion for health centers in high-poverty counties, many of which are in rural areas. FQHCs continue to be attractive models for communities because the associated Federal funds help defray the cost of providing care to the rising number of uninsured. In addition, FQHCs are eligible for the 340B drug discount program which gives them access to reduced prices on outpatient prescription drugs, and health centers funded under Section 330 of the Public Health Service Act have the ability to obtain malpractice insurance for their providers under the Federal Tort Claims Act (FTCA).

The RHC designation has been available since 1977, but by 1987 only slightly more than 400 clinics had been certified as RHCs. From 1990 through 1995, however, the number of RHCs grew by 650 percent to 2,350 clinics. This significant growth was fueled by program and reimbursement enhancements, efforts by Federal officials to promote the designation, streamlining of State scope of practice regulations for midlevel health professionals, and a changing reimbursement environment that increased interest in RHC certification.¹¹

Following this period of growth in the number of facilities designated as RHCs and resulting increases in Medicare and Medicaid payments to RHCs, State and Federal policy makers commissioned a number of studies to evaluate the extent to which the RHC program was meeting its original goals.¹² In response to these studies and to budgetary concerns, the BBA of 1997 created reimbursement and regulatory changes to curb the growth in RHC spending while also tightening program eligibility criteria to ensure that RHCs continued to serve rural areas facing shortages of primary care providers. The BBA changes, however, were never implemented and are still pending the regulatory process. RHCs continue to be an important source of primary care in rural communities with 3,673 clinics providing services in 46 States as of 2006.¹³

State Children's Health Insurance Program

The BBA of 1997 created the State Children's Health Insurance Program (SCHIP), a national program designed for families with incomes too high to qualify for Medicaid, yet who cannot afford to buy private insurance. SCHIP represented a significant expansion of eligibility for publicly funded health insurance for children. The program has been particularly important for rural communities given their higher rates of child poverty. SCHIP and Medicaid continue to be important programs that help to provide basic health insurance coverage to low-income rural children; 32 percent of rural children are enrolled in these programs, compared to 26 percent of urban children.¹⁴

The MMA: Medicare Advantage (Part C) and Prescription Drug Benefit (Part D)

The MMA has been the largest expansion in Medicare benefits since the program's inception, in part due to the addition of a prescription drug benefit. This program has had particularly positive effects on rural elderly. Studies prior to the creation of the Medicare Part D prescription drug benefit found that 46 percent of the rural elderly did not have private prescription drug coverage, compared to 31 percent of urban seniors. In addition, rural Medicare beneficiaries were paying more than \$500 in out-of-pocket prescription drug costs compared to \$125 in urban areas.¹⁵ A 2006 study found that more than half (53.2 percent) of all rural Medicare beneficiaries were enrolled in a Medicare Part D prescription drug plan, compared to 51.2 percent of urban beneficiaries.¹⁶

While the Part D benefit has had a positive impact on costs for rural beneficiaries, it has also precipitated some challenges for rural pharmacists. As a result of Part D, rural pharmacists have struggled with decreased cash flow and other administrative burdens associated with contracting with Part D plans. In addition, some rural pharmacists have noted that they have had to hire extra

staff to help counsel Medicare beneficiaries about how to choose a plan or to collect payment from the Part D plans.¹⁷ The emerging challenges to rural pharmacists are discussed in more depth on p. 47.

The MMA also made significant changes to the managed care benefits offered to Medicare beneficiaries. The Medicare program took several small steps toward offering managed care options through the 1990s, including offering cost-based managed care plans and creating the Medicare+Choice program. The creation of Medicare Advantage (MA) from Medicare+Choice in the MMA increased the number of plan options that were offered through third-party insurance companies. The goal of the new MA options was to create more choices for beneficiaries. Enrollment in the plans has been higher for rural beneficiaries than enrollment in the Medicare+Choice program. More than 845,000 rural Medicare beneficiaries were enrolled in an MA plan as of September 2007, which is an increase of 50 percent since November 2006.¹⁸ Still, even with that increase, MA plans remain more popular in urban areas where 21.7 percent of seniors are enrolled, compared to 8.6 percent of rural seniors.¹⁹ The impact of the MA program on rural provider reimbursement is still emerging though some rural experts have expressed concern about how the plans will affect a fragile rural health care delivery system.

Health Care Quality Improvement

In recent years, a national focus on the quality of care provided in health care facilities has been spurred by landmark reports published by the Institute of Medicine (IOM) – *To Err is Human* (1999) and *Crossing the Quality Chasm* (2001). These reports, and subsequent efforts by the IOM, have spurred national interest in quality improvement strategies.²⁰ In response, national and State organizations, Federal agencies, business coalitions, and health care providers have begun implementing multiple initiatives to improve health care quality and reduce medical errors. The emphasis on quality improvement is positive for all health care

providers and patients including those in rural areas.

Over time, the quality discussion has led to the establishment of public reporting of quality data in order to provide information to consumers and allow health care providers to implement quality improvement activities. Currently, rural PPS hospitals and over half of the CAHs are participating in public reporting of quality measure data on the CMS Hospital Compare web site. However, as the NACRHHS noted in its 2003 report, the majority of the quality discussion up until that time had failed to acknowledge the contextual differences between rural and urban health care environments.²¹ The report contained a vision for the future in which rural settings could function as a location to test quality-focused innovations.

Rural health leaders were also interested in this emerging national movement and pushed for the IOM to include rural health care in its ongoing work on quality. The IOM, with funding from HRSA's ORHP, the Agency for Healthcare Research and Quality (AHRQ), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Kellogg Foundation, produced

a third report as part of the quality series, *Quality Through Collaboration: The Future of Rural Health*, in 2005. This report provided a detailed analysis of health quality issues as seen through the rural lens and provided an impetus to rural health care providers to focus on quality improvement.

Efforts to incorporate the unique aspects of rural health care provision into national quality improvement initiatives are ongoing. These are discussed further in the next chapter, p. 45.

Health Information Technology

The use of health information technology (HIT) has gained momentum in the past few years. Proponents believe that this technology can decrease administrative costs and improve the quality of care by ensuring that providers have access to up-to-date patient information and decision support technology that aids clinical decision-making while also helping to avoid medical errors.²² Electronic health records (EHRs) can make complete medical information about patients available to clinicians at the point of care and help improve coordination of care,

Promoting Quality Through Public Reporting

In an effort to encourage quality and transparency, the Wisconsin Hospital Association (WHA) has developed an extensive public reporting system for quality, safety, and service measures. Nearly every hospital in the State voluntarily releases data to the online system, known as CheckPoint. The WHA specifically included only measures that are comparable and evidence-based. The system is voluntary and non-punitive; hospitals decide which measures apply to them based on the services that they provide. The information is also trustworthy, since hospitals' data are first submitted to CMS and audited for accuracy, then accessed by MetaStar, the Wisconsin quality improvement organization (QIO). MetaStar sends the files to the WHA for publication on CheckPoint.

The WHA has taken special care to accommodate rural hospitals, which often have lower volumes of patients. Since the measures for quality of care are reported as averages, a lower volume of patient cases can lead to reported measures that misrepresent a hospital's quality. In an effort to encourage rural and other low volume hospitals to participate in public reporting, CheckPoint releases only a measure trend report for hospitals with fewer than 25 cases, instead of a measure average.

The readily accessible measures help consumers to identify high quality providers, assist employers and insurance companies in assessing the quality of care available to their charges, and minimize conflicting or misleading information on quality within the State. Perhaps most importantly, hospitals can use the data to improve care through benchmarking and sharing of best practices. Because hospitals need only submit data to one source, the CheckPoint system controls the growth of hospital administrative resources. By taking into account many perspectives, including the specific needs of rural providers, Wisconsin's public reporting system can be seen as a model for improving health care quality.

Source: Richardson, D. (September 13, 2007). "CheckPoint: Wisconsin Hospitals Accountable for Quality." Remarks to the NACRHHS September Meeting.

especially for patients with multiple chronic conditions. Clinical decision support systems can help improve treatment decisions by providing clinicians with the most current information about medical conditions and treatment options, and computerized pharmacy systems can help prevent medication errors. Telepharmacy and telehealth applications can improve access to specialty care for patients living in isolated rural areas.

Use rates for many types of HIT tend to be lower in rural areas than in urban areas. Some studies on the cost-effectiveness of HIT found that it is difficult to generalize findings from the many studies of HIT implementation in large academic and institutional environments to small physician practices and small hospitals.²³ Over 95 percent of CAHs use HIT for administrative applications such as claims submission and billing, but fewer than one third use HIT for most clinical applications except teleradiology.²⁴ In its 2006 Report to the Secretary, the NACRHHS concluded that rural communities face many challenges in adopting HIT, including limited access to capital and infrastructure, lack of workforce expertise, and difficulty in obtaining community buy-in. However, rural communities also have strengths that may facilitate HIT adoption, including the smaller size and less complex nature of rural health care systems.²⁵

Human Services

Over the past 20 years, rural human services programs have changed in significant ways. In some cases, this change has happened incrementally with much iteration, and in others, with major paradigmatic shifts. This section focuses on three major changes: welfare reform, changes to the Older Americans Act (OAA), and the creation of Early Head Start.

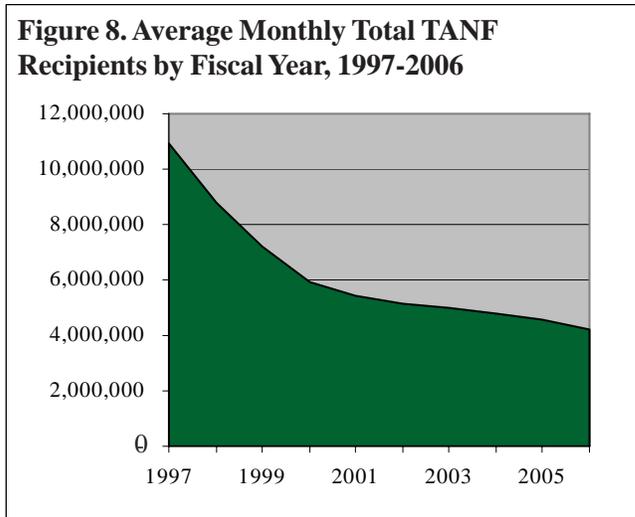
Welfare Reform

From 1935 to 1996, the primary vehicle to support low-income families was the Aid to Families with Dependent Children (AFDC) program. This program was administered by HHS' Office of Family

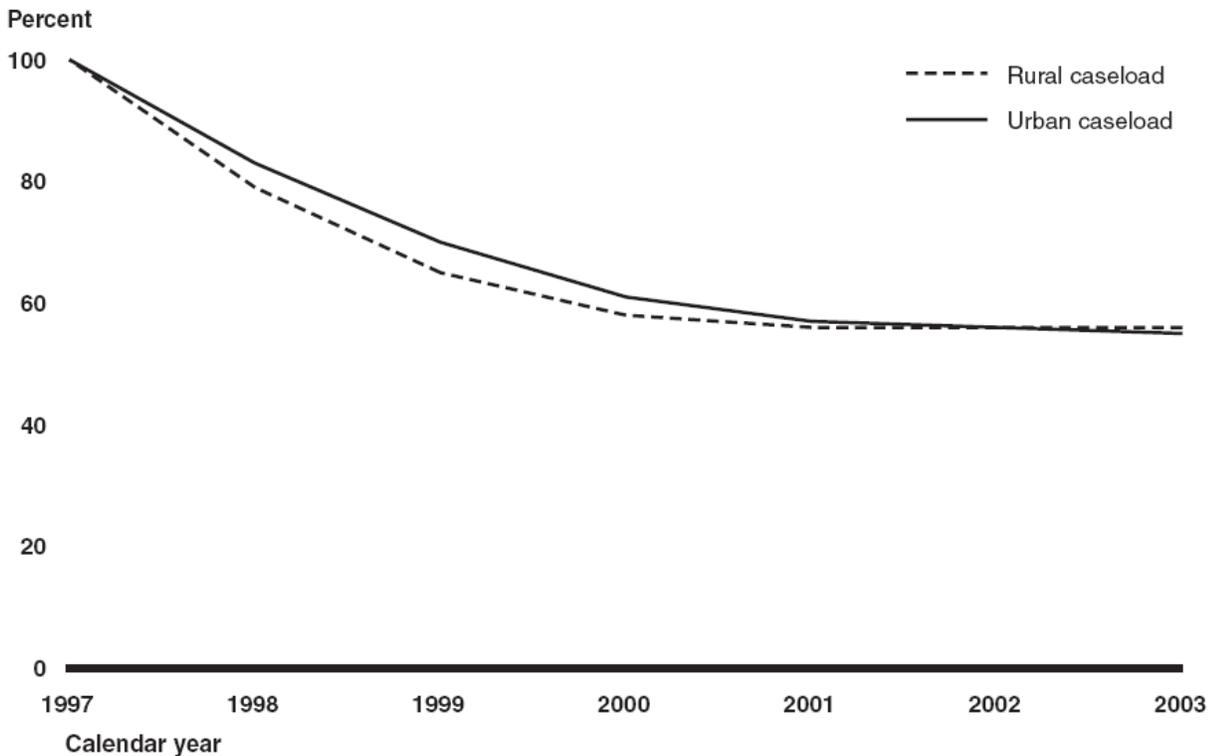
Assistance (OFA) and functioned as the primary Federal social welfare program in the U.S. AFDC was designed as an entitlement program. Therefore, every person who met eligibility requirements received money according to a formula determined by the State and reimbursed by the Federal government.

In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) transformed AFDC to Temporary Assistance for Needy Families (TANF). TANF sought to “end the dependence of needy parents on government benefits.”²⁶ Instead of welfare providing assistance to help low-income individuals maintain sufficient resources, TANF was designed to transition these low-income people to higher incomes with more economic security. TANF is administered through the OFA in the Administration for Children and Families (ACF) as a block grant to States rather than as an entitlement. There is a five year lifetime limit on receiving cash through TANF and one must be either employed or actively seeking work within the first two years to remain eligible for benefits. These changes transformed the program. This paradigm shift from welfare to work also resulted in significant reductions in the caseload (Figure 8). This decrease has occurred symmetrically in both rural and urban areas (Figure 9, p. 38).

The transition to TANF has been challenging for some rural communities. In the 2005 report, the NACRHHS found that the lack of available jobs in rural areas complicated the work re-



Source: See References.

Figure 9. Rural and Urban TANF Caseload Changes, 1997-2003

Source: See References.

quirement. Long distances to jobs, insufficient reliable transportation, inaccessibility of key social and educational services, and few child care options impede the move from welfare to work in many rural areas.²⁷ In addition, the poorest and most remote rural counties show fewer positive outcomes compared to urban and adjacent rural counties. The life-time limit of five years on TANF means that many people choose to save that allotment for a more difficult time in their lives. Thus, people cannot find jobs because of these specific rural factors, nor can they continuously stay on welfare because of the five-year life-time cap with the welfare-to-work model.

Despite these challenges, an Urban Institute study of 12 counties in 4 States concluded that various cultural and structural factors in some rural communities influenced the positive reception and implementation of TANF.²⁸ TANF policies offered some benefits for rural areas. TANF strengthened the general support for work that exists in some rural communities and it permitted flexibility in the use of funds, which enabled those communities to tailor their services to their unique circum-

stances. TANF also stimulated employer and community support for welfare recipients. Many rural communities noted that the proximity of family and friends provided not only emotional support, but also in-kind support, such as child care, meals, and housing.

Changes to the Older Americans Act

As discussed earlier, the OAA created the AoA and a variety of programs to serve the elderly. Between 1987 and 2007, Congress reauthorized the act three times, each with implications for rural America. The 1992 reauthorization required that State funding formulas take into account the geographical distribution of older individuals in the State. This change reflected the first concerted effort to target rural seniors. The rural focus became more explicit in the 2000 reauthorization of the OAA which added elderly rural Americans as a target population of the act, including rural with low-income and minority elderly. As mentioned earlier, 33.2 percent of AoA registered clients came from rural areas in

the 2005 fiscal year.

President George W. Bush signed the 2006 reauthorization of the OAA into law on October 17, 2006, extending the OAA for five more years. The legislation streamlines, consolidates, and grants more flexibility to State Units on Aging (SUAs) and Area Agencies on Aging (AAAs) in developing comprehensive and coordinated service systems. The primary change in the legislation was that principles of the “Choices for Independence” initiative were embedded within the 2006 authorization to promote consumer-directed and community-based long-term care options. This concept has the potential to help rural areas by providing the kind of flexibility needed to meet the many different challenges of elderly service delivery in rural areas. The continued rural focus, will continue to play out in the coming years.

Early Head Start

Head Start has been an important program in child development in rural locations. Committee members have seen the lack of available high quality preschool on site visits and in their professional experience. In 1996, Head Start was expanded to create Early Head Start, a program similar to Head Start that serves children from birth until they are 3 years old. In fiscal year 2006, 62,000 children in all 50 States participated in Early Head Start.²⁹ A 2006 ACF report based on a survey of Early Head Start programs found that there are equal numbers of programs in rural and urban areas.³⁰ Rural programs were found to be staffed by individuals with fewer credentials and by fewer specialists compared to urban programs.³¹

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Emerging Issues and Trends

The changes that occurred between 1987 and today have influenced the strengths and weaknesses of current rural health and human services delivery systems. Several challenges are products of emerging trends in demographics, industry, or government policy. Many of these are ongoing, undermining service delivery without much foreseeable respite. This section seeks to highlight the principal issues that the Committee believes will be central to rural health and human services discussions in the years to come.

The Future of Rural Health Services

In recent years, there has been some improvement in rural health care delivery systems, thanks in part to a body of rural-specific initiatives developed by health care providers, advocates, and national policy makers. Unfortunately, the status of these delivery systems is still tenuous. The Committee believes that the following issue areas will determine the future ability of rural communities to meet the health care needs of their populations.

Ongoing Workforce Challenges

Rural workforce shortages continue to weaken health care delivery and the quality of health care services. According to *The Chronicle of Higher Education*, the nation will need at least 20,000 more physicians over the next decade to care for elderly patients, though fewer than 8,000 geriatricians are in practice today.¹ High caseloads, long hours on call, isolation from colleagues, lack of easily accessible continuing education and professional enrichment opportunities, limited professional opportunities for spouses, and heavy school debt loads are some concerns that can deter medical students and residents from practicing in rural areas. The first half of this report described the principal Fed-

eral programs that have been created to reduce rural physician shortages; however, the Committee is concerned that several recent trends may undermine the ability of these programs to attract the next generation of physicians to rural areas. Concerning trends include the continued cuts in the HHS Title VII primary care training grants and the declining match rates for family practice residencies. These trends indicate that fewer medical students will be prepared to practice in family medicine, a disturbing prospect given that primary care

Wisconsin Academy for Rural Medicine

Although Wisconsin boasts 2 medical schools, the State's 52 rural counties are home to only 11 percent of all Wisconsin physicians. As with other rural areas, this physician shortage is projected to increase as current providers retire and the needs of an aging rural population increase. In response to these significant workforce shortages, the University of Wisconsin School of Medicine and Public Health created an innovative new program, the Wisconsin Academy for Rural Medicine (WARM). Admission criteria to WARM contain a preference for applicants who are more likely to practice in rural areas, e.g., those who are from a rural community. Having welcomed its first class of medical students in fall 2007, WARM structures the medical education to deepen students' awareness of and commitment to health in rural Wisconsin. For example, the traditional medical curriculum is enhanced by incorporating population health concepts and rural health electives. During the third and fourth years of medical school, WARM students relocate to regional rural learning sites, in order to gain practical clinical experience in rural areas. Teaching methods such as these help ensure that a robust workforce pipeline exists between health training programs and rural communities; hopefully the innovative rural focus of programs such as WARM will be considered a model by training facilities across the country.

Source: Golden, R. (September 12, 2007). "Wisconsin Academy for Rural Medicine: Meeting the Healthcare Needs of Rural Wisconsin." Remarks to the NACRHHS September Meeting.

physicians constitute the cornerstone of rural health care provision. While international medical graduates have helped to reduce rural physician shortages in the past, the apparent decline in applicants for the J-1 Visa Waiver program has the potential to exacerbate current and future gaps in health care access. This rural dependence on international medical graduates persists because these clinicians have filled a need in some rural communities where U.S. trained physicians have been reluctant to practice.

J-1 Visa Waiver Trends

Rural communities are reliant on J-1 Visa Waiver physicians. Some rural advocates are concerned because waiver requests have decreased over the past 10 years by 26 percent (1,374 in 1995 to 1,012 in 2005).¹ It is difficult to pinpoint what is causing this decline, because limited data and analysis are available to quantify exactly what is happening. Some have suggested that more foreign-born physicians are choosing to enter the country through the H1-B visa, which does not have a requirement to practice in underserved areas as the J-1 Visa Waiver does. Others point to tightened immigration policies after September 11, 2001. Regardless, if the trend of fewer physicians remaining in the U.S. through the J-1 Visa Waiver process continues, there could be negative consequences for underserved rural areas in need of physicians.

Note:

¹ U.S. Government Accountability Office. (November 2006). *Foreign Physicians: Data on Use of J-1 Visa Waivers Needed to Better Address Physician Shortages*. (Pub. No. GAO-07-52). Washington, D.C. 13. See also Aronson, R. (October 2007). *Recent Developments with Conrad J-1 Waivers*. Special Physician Newsletter. Minneapolis, MN: Aronson and Association, P.A.

During its site visits, the Committee heard testimony on the inadequate supply of a range of health care professionals, from nurses and physical therapists to radiation technologists and dentists. These professionals not only face many of the same rural challenges experienced by physicians, but they also receive less Federal assistance for training. Rural facilities are disproportionately staffed by nurses who have graduated with two-year associ-

ate degrees from local community colleges, yet HHS provides support mostly for four-year baccalaureate degree tracks.² Stronger support for local community colleges is key to strengthening the overall rural health system. Unfortunately, HHS' orientation on this matter is unlikely to change until the rural workforce gap becomes better quantified; at present, few national studies of vacancy rates report their data by rural or urban location.

The shortages of rural dentists have been repeatedly emphasized during past Committee site visits. Tooth decay is the most prevalent health problem after the common cold and contributes to many serious health conditions, including heart disease, diabetes, and respiratory diseases.³ Yet even CHCs and rural Head Start facilities that have received funding for dental care struggle to recruit dentists.⁴

There are a number of reasons that rural areas struggle to attract dentists. Some cite concerns with reimbursement, while others worry about the ability to start and maintain an economically viable practice in isolated rural areas. While dental access is also inadequate in many urban areas, this report has already noted that dental shortages remain substantially worse in rural areas. The Committee is encouraged that Wisconsin and North Carolina are considering opening new dental schools to focus more directly on public health dentistry and on the needs of underserved areas. Nonetheless, the trend of vastly unmet dental needs in rural areas remains a primary concern for the future.

Mental health is another specialty area in which the rural health care delivery system is particularly fragile. Clinically defined mental health problems are as prevalent in rural as in urban areas, yet the data presented previously show that most rural residents do not have access to mental health care providers.⁵ Due to this shortage, primary care doctors who may not have adequate training in mental health care shoulder the responsibility of providing the majority of mental health services in rural areas. Additionally, residents are reluctant to seek care even when a provider is present, due to the common misconception that mental and behavioral health problems are unre-

lated to physical health.⁶ Whereas seeking treatment for physical health conditions is considered socially acceptable, there is often stigma associated with receiving mental health treatment.⁷ The fear of being stigmatized is compounded by the concern that confidentiality and anonymity cannot always be assured in close-knit rural communities.

The results of all of these workforce challenges across the various professions weigh heavily on a rural community's ability to provide services. Health workforce shortages remain one of the principal challenges for the future of rural health care. *The Chronicle of Higher Education* argues that solutions will require long range planning.⁸ It is important that HHS play a role in addressing the looming workforce challenges. In addition, other Cabinet-level Departments have key roles, including the Department of Education and its links to community colleges, and the Department of Labor (DOL) through its administration of the Workforce Investment Act programs. The Committee believes that there is a clear need to begin a discussion among these three Cabinet-level Departments to promote coordination and joint efforts geared towards rural workforce needs.

Current and Future Rural Health Care Reforms

Whereas rural workforce shortages have remained a national concern for over 20 years, several innovative health-related reforms currently being discussed and implemented also have the potential to substantially transform the rural health delivery system. Indeed, health care reform is emerging as a leading national issue, with many State and national policy makers seeking to restructure the health care system to better coordinate care, improve quality of care provided, and reduce costs. The Committee strongly believes that the Executive and Legislative branches must both continue to recognize the special needs of rural areas as they examine health care reform issues in the future to prevent unintended consequences of undifferentiated policy decisions, such as those that caused the widespread rural hospital closures following the 1983 IPPS reform. Given these and other well-documented

policy implementation difficulties, the Committee hopes that the Secretary will closely monitor the initiatives discussed below.

Quality

As noted previously, one of the key changes in the past 20 years has been the emerging focus on quality improvement and medical error reduction. To date, CMS has highlighted the importance of health care quality by establishing public reporting and taking initial steps towards a pay-for-performance mechanism. However, rural advocates have voiced concerns that these new systems do not take into account the distinctive features of rural health care, namely the lower volume of patients, fewer acute cases, and high rates of transfers to larger tertiary hospitals. There is growing recognition of the need to assess the rural relevance of national quality measures and patient safety interventions, and to develop new measures and interventions for processes that are especially pertinent to rural settings, such as triage, stabilization, and transfer of emergency patients.⁹ It is important to note that while rural hospitals have a different case mix than urban hospitals, they do provide important acute care services as well as emergency and transfer services.

In its 2007 working paper regarding the development of a Value-Based Purchasing (VBP) plan for Medicare inpatient payment, CMS acknowledged many of these ongoing challenges, including low volume and case mix, but did not identify specific ways to address these issues.¹⁰ As CMS and Congress consider how and when to implement a VBP plan that is relevant for rural providers, they must remember to accommodate the distinctive features of rural health care providers and to incorporate CAHs, who are not paid within the IPPS and therefore not currently included in the VBP plan.

In addition to the adaptation of quality policies to the rural setting, future challenges in rural quality improvement include addressing and reducing the large standard deviation in rural hospitals' quality scores. Some rural hospitals seem to perform notably better and improve faster than others. While waiting for researchers to determine the causes underlying these disparities, multiple

initiatives are underway to equip rural providers with quality improvement resources and technical assistance. For the first time, CMS included a specific rural-focused task in the 8th Scope of Work for the Quality Improvement Organizations (QIOs), a nationwide network of contractors dedicated to improving the quality of care for Medicare beneficiaries. The new task encouraged QIOs to support CAHs in data reporting and quality improvement efforts and to help all rural hospitals improve their patient safety culture. The Committee believes that it is important that the 9th Scope of Work maintains an explicit role for working with rural providers, particularly CAHs. In many States, Flex grant funds are being used to promote quality improvement activities in CAHs, such as quality benchmarking programs, peer review systems, and staff training in quality improvement techniques.

Health Information Technology

The national quality movement has led to a larger discussion of how to use HIT to improve quality of care and increase efficiency. HIT is envisioned as a technology application that will enable the seamless transfer of patient data across the continuum of care. Though HIT does not necessarily allow for communication or interoperability, it encourages better coordination of patient care. These facilitated exchanges could be of particular use in rural areas, where patients often receive care in more than one setting. However, as noted previously, rural health care providers have lagged behind their urban peers with regard to the automated systems needed for HIT implementation.

President Bush has called for all Americans to have an electronic health record by 2014.¹¹ The Medicare Payment Advisory Commission

Toyota's Employee Health Care Model

“Our health care costs per U.S. plant worker had doubled over five years,” explained Dr. Ford Brewer, Medical Director for Toyota Motor Engineering and Manufacturing, North America. In an effort to contain rising health care costs, Toyota will implement a novel, integrated health care system at its new manufacturing plant in Tupelo, Mississippi. Instead of contracting with an insurance company to provide health insurance plans to the employees, or “team members,” Toyota will directly contract with hospitals and health care providers, thereby incurring an immediate cost savings of 25 percent.

As part of the quality health and wellness initiative at Toyota, designers of the health care system placed a strong focus on disease management. A primary care clinic, pharmacy, and occupational health care will be available on-site. Easy access to quality preventative and primary care services can help reduce the absentee rate of employees, which has been shown to increase productivity and retention rates. In addition, readily available preventative care can reduce long-term expenses on costly specialty care and hospitalizations.

In the Toyota model, specialty care is accessed through the physician network, established by direct contracting between Toyota and local providers with high quality rankings. An integrated data system will be able to track patient records, facilitating and simplifying patient flow through the health care system. Team members will have the option to use providers outside the network, but with higher associated co-payments and deductibles.

Toyota has extended the health care system to family members of employees and suppliers. In designing its own health care plan, the company was also able to consider the unique needs of its team members; for example, the on-site pharmacy will open at 4 a.m., two hours before one standard work shift begins. The on-site injury programs are open 22 hours per day. Should any team member be injured on the job, the incident will be examined through the occupation health model processes, in order to prevent future accidents and eliminate possible systematic risks.

While it is recognized that this model of patient-centered care is not easily transferable to other employers, it can perhaps provide inspiration for other rural employers to develop innovative solutions for employee health care coverage. It illustrates an integrated health care model with components that can yield better community health *and* cost savings to both the employer and employee. Toyota has taken a couple years to plan this design properly; however, the new health care system is expected to pay for itself within two years and yield significant long-term cost savings for the company.

Source: Brewer, F. (September 12, 2007). “Toyota Family Health Center/Innovative Health Network Update.” Remarks to the NACRHHS September Meeting.

(MedPAC), the Institute of Medicine, and other national organizations have proposed several strategies to attain this goal, including technical assistance and financial incentives for health care providers to adopt HIT.¹² In an effort to facilitate the use of electronic health records, the Federal Communications Commission announced in November 2007 that it would provide \$417 million over three years to help build high-speed Internet networks for rural and underserved health care clinics nationwide. Within HHS, the Agency for Healthcare Research and Quality (AHRQ) awarded more than \$15.3 million in grants in fiscal year 2005 to small and rural communities to plan, implement, and demonstrate the value of HIT to improve patient safety.¹³ AHRQ has also established an online National Resource Center for Health Information Technology with tools and resources for implementing HIT in small and rural communities.¹⁴ In fiscal year 2007, ORHP granted \$25 million to implement HIT systems in rural health care networks across 16 States.

The Committee recognizes that rural residents would greatly benefit from universal HIT adoption and commends the numerous HIT programs with a rural focus, yet notes that several barriers remain. The American Hospital Association found that the single most significant barrier to rural HIT adoption is the high and increasing cost of installing and maintaining HIT systems.¹⁵ These costs include not only the necessary equipment but also the recruitment and training of staff to operate the technology. Indeed, during its site visit to Wisconsin, the Committee heard testimony that rural areas can be overwhelmed by the system maintenance requirements for HIT.

The Medicare Modernization Act (MMA): Medicare Advantage (Part C) and Prescription Drug Benefit (Part D)

Another looming challenge in rural areas is access to pharmaceutical services, given that the economic viability of community pharmacies is becoming increasingly threatened. While the Medicare prescription drug benefit, known as Part D, has benefited low-income rural seniors, it has created cash flow problems for rural pharmacists by changing their customer mix from one that was largely cash-based

to one that is now dominated by third-party private sector payers. In addition, the Deficit Reduction Act of 2005 decreased the payment quantities that community pharmacists receive from Medicaid. Instead of relying on an Average Wholesale Price (AWP), the Medicaid reimbursement for prescription drugs is now based on Average Manufacturers Price (AMP), which is generally lower, although there are current legal challenges to the rule's implementation. In a report dated December 2006, the GAO found that an AMP-based Federal Upper Limit reimbursement will fall an average of 36 percent below pharmacy acquisition costs for multiple-source outpatient prescription drugs.¹⁶

These recent changes to the Medicaid payment methodology, coupled with the Part D pressures, have the potential to destabilize sole community independent pharmacies, which are the only providers of pharmacy services in many parts of rural America.¹⁷ The Committee is concerned about the impact on rural patients, for whom such pharmacies may be the only local sources of pharmacy services. In addition, rural pharmacists often provide clinical services to rural hospitals and nursing homes part-time, representing important community health cornerstones. Rural pharmacy closure may make it difficult for residents to obtain emergency medicines or medication counseling, which has the potential to increase the number of adverse drug events among seniors taking multiple prescription drugs.

Another challenge for rural health care pertains to the Medicare Advantage (MA) program, also known as Part C. New options through MA create more choices for beneficiaries, but if MA is implemented in a manner that is not sensitive to the rural context, it could adversely affect health care delivery in rural communities. The Committee focused heavily on this issue in its 2007 report and recommended that the Secretary facilitate the dissemination of information more widely to rural beneficiaries and providers so that they can make well-informed decisions about Medicare options. CMS has taken steps to work with MA plans to curtail deceptive and fraudulent marketing and enrollment practices.

The Medical Home Model

In recent years, physicians and patient advocates have pushed a new concept, the “medical home” model. Medical homes consist of providers who guide patients in accessing preventative, primary, and specialty care, a concept that has been proven to decrease medical errors and may provide cost savings.¹⁸ While this concept shares the original goals of managed care models, medical homes are not necessarily financial models focused on managing risk. The Committee is encouraged that CMS will include rural sites in its upcoming Medicare Medical Home Demonstration.¹⁹ Urban areas have already implemented a long-term care model of a medical home through the Program of All-Inclu-

sive Care for the Elderly (PACE). The Committee has high hopes that the PACE model will soon take root in rural communities, with the help of CMS’ new rural PACE development grants that were awarded in 2006. This patient-centered model could greatly improve the quality of life for the rural elderly by coordinating their care effectively and allowing them to remain in their home communities.

Emergency Preparedness

After the terrorist attacks of September 11, 2001, Congress increased the funding available for Local Health Departments (LHDs) to increase their capacity to prepare for and respond to emergencies.

State Oversight of Medicare Advantage Plans

Over the past two years, the Committee has heard complaints from health care providers and beneficiaries about aggressive and misleading marketing practices by insurance companies selling Medicare Advantage (MA) plans.

The Committee learned firsthand about this issue from Wisconsin Insurance Commissioner Sean Dilweg, who testified during the Committee’s September 2007 meeting in Madison. The Commissioner stated that since January 1, 2006, the Wisconsin Office of the Insurance Commissioner has received more than 400 complaints from consumers about the marketing and sales of MA plans. Dilweg noted that some consumers have found MA plans difficult to navigate due to the number of options available and the lack of clarity regarding the differences between MA plans and traditional Medicare. In the worst cases, deceptive marketing practices have included forged signatures on enrollment forms, mass enrollments, and door-to-door sales at nursing homes, leaving beneficiaries unsure about their benefit packages, out-of-pocket expenses, and access to their customary network of local providers. Wisconsin is not alone in this problem; according to the National Association of Insurance Commissioners (NAIC), most State insurance departments have received complaints regarding inappropriate marketing practices of MA plans, including cases which may even be considered fraud. These types of marketing practices are normally prohibited by State law or controlled by the State regulatory structure.

However, as Commissioner Dilweg testified, State regulators are limited in their ability to hold insurance companies accountable for inappropriate marketing, sales, or advertising of MA plans. State regulatory authority is confined to the licensure, solvency, and regulation of individual agent and broker conduct; State appointment laws are preempted by Federal law and the marketing guidelines for MA plans are determined by CMS. As a result, State regulators who receive MA complaints from beneficiaries cannot take any action other than referring the complaints to CMS.

CMS, however, has taken steps to address some of the marketing and sales concerns. In June of 2007, seven health plan sponsors signed an agreement with CMS to voluntarily suspend the marketing of their MA private fee-for-service (MA PFFS) health plans because of questionable and unscrupulous sales and marketing practices. The 2008 CMS Call letter for MA, effective October 1, 2007, requires increased oversight on PFFS plan marketing. These changes should ensure that the organizations and sales agents correctly represent their plan offerings through mechanisms such as outbound verification calls, disclaimer language, and documentation of agenda and broker training. These requirements will hopefully improve the operation and accountability of MA PFFS plans.

Sources: Dilweg, S. (September 13, 2007). “Medicare Advantage Private Fee-For-Service Plans.” Remarks to the NACRHHS September Meeting; Dilweg, S. (May 22, 2007). “Testimony of Sean Dilweg, Commissioner of Insurance, State of Wisconsin.” Testimony before the House of Representatives, Committee on Ways and Means, Subcommittee on Health. <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=5964>

Disaster response planning presents some unique challenges to rural LHDs, as urban residents fleeing an emergency will most likely travel to and through rural areas, straining fuel, food, water, and sanitation resources. As such, in addition to maintaining general all-hazards plans in case of local disasters, rural planners must also develop multi-county plans to prepare for urban disasters.²⁰ Unfortunately, the initial increase in emergency planning funds has not been sustained, even though the additional expectations and requirements remain in force. Without the necessary funding, rural LHDs may experience difficulties maintaining adequate disaster response capabilities.²¹

Conclusion

As new strategies and proposals for health care reform are implemented, the Committee believes that unintended consequences are more likely to play out first in rural communities. This scenario has happened repeatedly over time, whether it was due to a national shortage of physicians since the 1980s, or the closure of rural hospitals from Medicare's switch to IPPS in the mid 1980s. The impact of those situations was felt more acutely in rural areas. Though every potential crisis cannot be anticipated, some potential problems can be averted by establishing a level playing field in the policy development and implementation processes. A dramatic restructuring of the health care delivery system runs the risk of erasing 20 years of important incremental changes designed to assist rural communities. New health care proposals and program restructuring must take into account the economic and demographic realities of rural health care delivery. The Committee urges the Secretary to work with Congress to ensure that rural considerations are taken into account in any redesign of the health care system.

The Future of Rural Human Services

The rural human services system is comprised of rural families and individuals, local case-workers, community-based and faith-based organizations, and Federal programs. Unlike health care, in which delivery systems are defined by the provider type, human services delivery is concerned with the client in need of services. In addition, health care concerns both the healthy and sick, while human services assist a subset of the broader population, individuals with specific needs, such as people dealing with food insecurity or unemployment. In part because of these aspects, rural human services lag behind rural health care in the development of a delivery infrastructure and in securing rural protections to counter the per capita distribution trends that may put rural America at a disadvantage.

What we call human services include assistance in the form of money, subsidies, services, or advice to individuals in need of external support for their well-being. This assistance ranges from income support to food or food subsidies to assisting with transportation needs to providing education and training. The services that one person might need are not the same as another's. The human services delivery system must both make services available and ensure that individuals are able to access those services successfully. For example, one individual might simply require a place where he or she can pick up food stamps while another person might need intensive case management in order to qualify for and then to receive benefits successfully. A system tailored to individuals and designed for such varied uses is difficult to describe and understand.

Not only are human services provided through numerous mechanisms that vary by community, but little data differentiate rural from urban human services. Without this data, it is difficult to conduct even a basic needs assessment and to conceptualize an ideal rural human services model.

This section discusses the current need for rural human services and six important issues: (1)

lack of rural human services data; (2) utilization of available resources; (3) the strained human services workforce; (4) the role of the community in service delivery; (5) the one-stop shopping model in service delivery; and (6) the need for leadership and planning.

The Need for Human Services in Rural America

Rural Americans vary greatly in terms of their economic means. As discussed earlier in this report, rural America faces poverty that is consistently higher than in urban areas, and persists for longer. Poverty is a good proxy for human services need so rural poverty suggests greater rural demand. Another proxy for need is disability, where rural areas also lead urban areas. In 2006, 19.5 percent of the non-metropolitan population had one or more disabilities compared to 14.2 percent in metropolitan areas.²² Age is another indicator; a higher percentage of the rural population is elderly, a population that often requires support services. Finally, the presence of children is a fourth proxy. Children necessitate services, such as child care, and are also specifically entitled to certain benefits. Children are a slightly smaller percentage of the population in non-metropolitan compared to metropolitan areas (26.5 percent versus 27.7 percent, respectively), but, as noted earlier, child poverty is greater in rural areas and so their human services needs are likely to be greater.²³ During its 2007 Wisconsin site visit, the Committee heard that children who grow up in poverty have higher risks of poor health and poor developmental outcomes, struggle more in school, are more likely to become teen parents, and are more likely to be maltreated and involved in the criminal justice system.²⁴ Family income correlates with academic abilities of entering kindergarteners.²⁵ Thus, the demand for services such as child care and early childhood intervention (e.g., Head Start) may be greater in rural America. These four factors in human services need – poverty, disability, old age, and childhood – complicated by geography, together suggest that there should be a higher demand for human services in

non-metropolitan areas compared to their metropolitan counterparts. Available data corroborate the accuracy of these proxies (Appendix B).

In addition to higher demand, the rural setting affords unique challenges in service delivery. Some programs require a critical mass of people in order to function; for example, in order for a homeless shelter to be viable, it must have a constant minimum population of homeless people to serve throughout the year. Rural communities often do not have enough clients to sustain programs that require greater scales. Also, the greater geographic dispersion of rural areas creates greater transportation needs, such as requiring additional services to transport scattered clients to local centers for programs spanning job readiness to child care. Finally, individuals seeking help may be discouraged by a close-knit community because of associated stigmas and stereotypes. In order to make their service systems work, rural areas need better coordinated delivery systems, diverse options for services, and solutions to problems of access. For this improvement to happen, the government (Federal, State, or local) needs to look specifically at rural human services needs and establish separate standards for meeting them, much the way the Medicare program has done with rural provider designations in the past 20 years.

Federal funds for human services are often distributed by a block grant, leaving more detailed decisions about administration to the individual States. States generally use a distribution formula calculated per person. This per capita distribution scheme may put rural areas at a disadvantage because with farther distances to cover and fewer providers, it is costly to provide rural human services. For example, a Meals on Wheels program in Somerville, Massachusetts covers a service area 4 miles across, while an aging program in Fort Morgan, Colorado, feeds elderly individuals from an area 150 miles across. Regardless of the total number of meals provided, the Colorado program will have higher per person costs than the Somerville program due to these more exigent transportation and logistics needs. However, block grants in and of themselves are not necessarily the problem. The lack of detailed county-level data inhibits the abil-

ity of policy makers to target these resources to best meet local needs. Analysis of data can help to point out where differences lie, in order to design a better mechanism for program administration.

Health and human services are so closely intertwined as to be at times inextricable. Thus, in addition to the need to alleviate human services needs for their own sake, these conditions can have profound health impacts. A *New England Journal of Medicine* article explained that “differences in rates of premature death, illness, and disability are closely tied to socioeconomic status.”²⁶ Socioeconomic status – including financial situation, educational attainment, occupation, family history, housing, and social connectedness – plays an important role in health outcomes; researchers are increasingly turning to these social determinants of health in efforts to improve America’s health system.

One study considered health status based on poverty and found that:

Poor health status and poverty are closely linked. For every age group and every indicator, the health of the poor is worse than that of the near poor or non poor.... We find poverty to have a strong correlation with poorer health status and clear statistical evidence of the increasing association between income and health for nearly all age groups and all three measures of health [that we considered].²⁷

Thus, the successful delivery of effective human services may enhance America’s health status.

Federal Programs Providing Rural Human Services

Although data are limited, the Committee’s site visits have firmly reinforced what research suggests: Federal programs play a significant role in the well-being of rural Americans. HHS and other Cabinet-level Departments provide a variety of programs that serve rural human services, discussed in depth in the retrospective portion of this report. Heavy utilization rates confirm the importance of these programs. For example, approximately 78 percent of those eligible use food stamps in non-metropoli-

tan areas compared to 62 percent of eligible individuals in metropolitan areas, pointing to a rural reliance on Federal programs.²⁸

Rural residents’ dependence on current government transfer payments as a percentage of their total income is growing.²⁹ These income support programs, including TANF, Food Stamps, and Supplemental Security Income (SSI), provide many rural Americans with the helping hand that they need to subsist in fragile rural economies. A heavier reliance on these public assistance programs requires more caseworkers to register and enroll individuals and to help obtain benefits for rural residents.

Wisconsin Works

Wisconsin Works is a successful State program which began in 1997 on the heels of welfare reform. It connects low-income people to work and focuses on workforce development. There is an emphasis on providing training so that clients can obtain higher paying, quality jobs and also to connect them to resources for retention and support, such as mentorship opportunities. In 2006, Wisconsin Works placed 631 people in rural counties at new jobs, with nearly 50 percent of them earning \$7 to \$10 per hour. This program serves people in Wisconsin, demonstrating the importance of various Federal, State, and local programs in the network of resources available to people in need.

Source: Gassman, R. (September 12, 2007). Remarks to the NACRHHS September Meeting.

Challenges in Providing Rural Human Services

Programs are often designed with an urban setting in mind even though the urban models do not necessarily transfer well to rural settings. Thus, the intensity of the demand for human services is compounded by the difficulty of using an urban model to provide human services to rural communities. Geographic dispersion complicates access to jobs, transportation, and child care.³⁰ Combined with low population density and physical isolation, rural residents thus have worse access to services,

and communities and States face larger per capita costs for providing services in rural compared to urban areas.³¹ Further, research suggests that traditional socio-cultural factors in some rural communities, such as mistrust of government, reluctance to seek outside assistance, and a priority on privacy, in tension with the difficulty of preserving anonymity in small communities, may reduce the likelihood that rural residents will report problems or seek support.³²

There are some rural areas that have overcome these factors. For example, the Committee has found small communities that maintain a collaborative approach, seeking partnerships to achieve common goals. Regional networks have yielded economies of scale and better access to human services. The Committee heard from the North Colorado Health Alliance, which shared a volunteer base, population health data, and a vehicle among several service providers in order to leverage each others' resources and achieve a scale large enough to achieve county investment.³³

In addition to structural and cultural difficulties, the following issues present unique challenges in providing rural human services. Their resolution affords great potential for growth and development in rural America.

Lack of Rural Human Services Data

The Committee has found that human services delivery is not well understood, in part because the effort has not been made to collect enough data to perform analysis. While issues in health provision focus on known health disparities and workforce challenges, the defining issues for human services delivery vary more for each rural community and are not as transparent or easily identified. Hence, rural human services providers often do not know how rural services compare to urban or how best to provide these crucial services.

There are several contributing factors responsible. Most significant is that funding streams in human services are heavily reliant on block grants, or on State-wide resource allocation formulas that are based on population size as opposed to need. Thus, accountability mechanisms ask only for overall figures and do not require identification of rural

versus urban areas. There are few, if any, rural-specific programs or funding protections for rural communities within human services, and so there are no purely rural data samples either. Research methodology limits the reliability and generalizability of rural human services research, in part because of small sample sizes, which are difficult to avoid.³⁴ Often, agencies choose not to collect geographically-coded data or they consider rural analysis infrequently. Thus, minimal data exist to study rural versus urban differences. When data do exist, definitions of rural are not consistent, data are not analyzed, or data are only considered once, offering no baseline measure. These data issues prevent in-depth analysis of rural human services needs and solutions.

The Committee believes that it is time for consistent rural and urban distinctions in human services data to be made. The Committee's analysis suggests that human services policy experts and researchers have rarely looked at issues through a rural versus urban lens. The following five data issues provide examples of the sorts of gaps in human services data.

Data Without Geographic Specificity

While all Federal agencies collect data on their programs, much of this data is aggregated for the entire U.S. or by State. Thus, there is no way to determine rural investment or how rural programs fare. The Committee's 2007 report focused one chapter on Head Start and found that no publicly accessible national-level rural versus urban data exist for Head Start.³⁵

Data Can be Costly to Analyze

Sometimes even geographically-coded data do not yield relevant information about rural America. For example, TANF collects zip code information on its recipients. Zip codes can be converted to designation by rural or urban but the conversion is complicated and is rarely performed. In addition, because zip codes are designed for the U.S. Postal Service, they can change from year-to-year, making comparisons difficult and data conversion costly.³⁶

Data Analysis Does Not Yield Useful Results

Even when rural data exist, they are often not useful for policy analysis. The Administration on Aging (AoA) collects data through the National Aging Program Information System (NAPIS) which asks providers if they are rural, but only yields whether or not a State has services in rural and urban areas. Thus the AoA cannot track what specific services are available to rural residents and how they are provided. In spite of the AoA’s significant financial contribution to rural America, there are no data available to measure the result of funding provided specifically to rural seniors.

Data Collected Infrequently

Even when rural data exist, it is often the result of a one-time initiative that is not repeated. These sporadic revelations offer no longitudinal analysis, thereby limiting insight into rural change over time or how policies influence outcomes. For example, the GAO rural TANF report provides useful data for rural TANF participation in 2004, but there is no comparison of the situation in 2004 to any other point in time. Without that analysis it is difficult to extrapolate policy considerations into the future.

Lack of Uniform Data

As the previous sections suggest, programs may or may not collect rural data, and when they do, they may not analyze the data comparing rural to urban areas. Much of available rural data derives from independent studies conducted once. Thus, no data exist each year to understand Federal human services investment in any given community or even county. Further, because so much of the data comes from many different sources, the data often do not compare well to each other. The Committee believes that HHS and States need an overarching data strategy so as to recognize trends across geography. Data are isolated by program and it is impossible to determine the cross-influ-

ence of various programs. To be more useful, data need to be uniform so that they can be presented collaboratively.

Why These Data are Important

Without rural and urban data, policy makers cannot fully understand rural human services needs, which hinders the design of effective human services systems. Data are necessary to describe the basic prevalence of problems, services available, utilization of services, and effectiveness of the programs.³⁷ Without rural- and urban-specific data to help understand challenges, rural areas must make do with programs designed for potentially vastly different circumstances, i.e., urban locales. The Committee believes that the human services sector

“The Committee believes that the human services sector needs to examine the differences in need that exist between rural and urban areas and to fashion programmatic changes that will enable clients in both locations to be properly served.”

needs to examine the differences in need that exist between rural and urban areas and to fashion programmatic changes that will enable clients in both locations to be properly served. Funding cannot be allocated equitably without more information. While providing human services to rural areas is known to be more costly, it is not yet clear by how

much. Distribution formulas estimate cost per capita but higher per capita costs and greater need together indicate that rural areas would need to receive more funding per person than urban areas to achieve an equity in access to services, as demonstrated in the Meals on Wheels example discussed earlier (p. 50).

In addition to improving rural human services policy, data are essential to ensure that Federal dollars are spent wisely and achieve their intended goal. The Committee believes that HHS would benefit greatly from looking at ways to streamline this reporting for those programs that tend to serve the same target population. This efficiency has the potential for reducing the administrative burden on small rural communities and avoiding duplication of effort.

The first study on available rural human services data was conducted by Mathematica Policy Research, Inc. for the HHS Assistant Secretary for Planning and Evaluation (ASPE).³⁸ The ASPE report makes recommendations to human services researchers in order to collect more useful data: (1) include rural populations, areas, or systems in more studies; (2) incorporate rural sites into program evaluations; (3) oversample rural sites and populations; (4) report rural findings; (5) make better use of existing, detailed rural classification systems; (6) disclose rural definitions and classifications used in studies; and (7) add information to make small, region-specific rural studies more generalizable.³⁹ Implementing these recommendations would allow leaders to improve rural human services and better serve rural America. With improved data, policy makers can better identify rural-specific needs. For example, data could be used to develop human services information technology, such as electronic casework records, population management systems, and simpler eligibility determinations.

Utilization

The percent of eligible individuals utilizing a human services program varies greatly from program to program and community to community. Rural Americans rely more on some programs compared

to urban Americans, but not in all cases. However, during site visits the Committee has confirmed that utilization often falls well below the number of all eligible individuals, even when there is demonstrated need and available support. Approximately 20 percent of eligible low-income workers who would qualify do not receive the Earned Income Tax Credit.⁴⁰ Similarly, the percentage of single mothers eligible for welfare payments but not receiving them has steadily risen since 1990 and reached 19.6 percent in 2005.⁴¹ Even the greater rural uptake on the food stamp program compared to urban areas leaves 22 percent of eligible rural Americans without access to potentially essential food stamps. One of the most difficult challenges in human services delivery is connecting individuals to resources; people must be aware of programs, able to access them appropriately, and willing to seek necessary help. In rural America, geographic dispersion complicates outreach activities to promote awareness and transportation to ensure access. In addition, as discussed previously in this section, some socio-cultural norms may discourage people from seeking help. Thus, creating resources is only the first step in ensuring that people receive the support they need. Planners must also develop strategies to address the challenges so that they connect people to these services.

Mississippi's Use of Workforce Data

Recognizing that data can be a powerful tool, Mississippi initiated a collaboration to harness this potential. The Mississippi Integrated Workforce Performance System project is a product of the State Workforce Investment Board under the authority of the Office of the Governor. Under this system, 5 State agencies and 15 community colleges have become partners in developing and maintaining an integrated performance and accountability information system. This system tracks workforce training progress across State agencies and funding streams. The system is also used to identify best practices in the design, implementation, and delivery of workforce initiatives in Mississippi. Data from this system:

- Enable proper resource management for workforce development activities across State agencies and funding streams;
- Promote data sharing to reduce duplication of services, measure performance, calculate return on investment, and identify best practices;
- Help State agencies meet their Federal reporting requirements;
- Provide economic and financial forecasts to promote workforce initiatives;
- Market existing businesses and attract new businesses; and
- Secure additional Federal dollars.

The Mississippi program is an example of the capacity for improved data to yield significant positive policy changes.

Advertising, Marketing, and Outreach

Aging and Disability Resource Centers (ADRCs) are required to conduct marketing and outreach campaigns. Donna McDowell, the director of the Wisconsin Bureau of Aging and Disability Resources, Division of Long-Term Care, told the Committee that the ADRC program “doesn’t work unless people know about you.” The ADRCs in Wisconsin aggressively advertise and market themselves to potential consumers. There is a billboard for an ADRC on the highway near the Green Bay Packers stadium, so that everyone who goes to a Packers game sees the billboard. In addition, McDowell recommended continuous advertising that is available when people need it. As part of that strategy, the ADRCs distribute thousands of refrigerator magnets, pillboxes, tote bags, and other items with the ADRC toll-free telephone number. Further, they market themselves as inviting. One resident said, “I don’t feel like a case, and I feel like people are being welcoming.” The Wisconsin ADRCs seek this public image and cultivate the perception that they are welcoming, caring places.

Source: McDowell, D. (September 13, 2007). “Integrating Services for the Aged and Individuals with Disabilities.” Remarks to the NACRHHS September Meeting.

Rural Human Services Workforce and Caseloads

Rural areas continue to experience workforce shortages; many human services struggle to attract and retain human services professionals in rural areas. They often cannot achieve the economies of scale necessary to support specialty service providers. In addition, it is more difficult to retain staff because social workers and case managers often have fewer opportunities for professional advancement.⁴² During site visits, the Committee noted much frustration and concern with high staff turnover, increased caseloads per staff, and burnout among human services workers.⁴³ A 2001 study found that on average, counties experienced an increase in ad-

ministrative workload, with non-metropolitan counties reporting a 70 percent workload increase for child care, 56 percent for Federal and State transportation programs, 38 percent for food stamps, and 67 percent for workforce training and development.⁴⁴ In addition, human services staff members work with populations that more frequently have mental health or substance abuse issues, though few staff have the certification or receive the pay commensurate with such responsibilities. The Committee expects that the human services workforce will continue to be a pressing issue.

There are no formal training programs for human services workers within HHS. The Committee believes that training local people who are

Difficulty for Human Services Workers

The work environment in human services casework is growing increasingly difficult.

“We used to work with people. Today, my caseworkers spend at least 50 percent of their time behind the computer,” said Fred Crawford, director of the Logan County, Colorado Department of Social Services. “We have so much accountability and so much detail that it’s not possible to get the job done without massive amounts of computer work.”

While accountability is important, the human services work environment is growing less fulfilling, making it more difficult to fill necessary staff positions. In addition, Crawford lamented that allocations change, making it a “gamble” to spend for any one program. The rules are also becoming more complex and changing frequently.

In this environment, Crawford emphasized the problem of high staff turnover. He described difficulty in retaining case workers, citing that the average case worker in Logan County stays for only 18 months. This more challenging work environment and continual high turnover threaten the human services workforce and the capacity of the human services delivery system.

Source: Crawford, F. (June 11, 2007). Remarks to the NACRHHS June Meeting.

more likely to remain and work in the area can help remedy these personnel shortages. Much of this training can be done at the community college level. HHS could partner with the Department of Education and the DOL Workforce Investment Act programs to help support training of needed human services workers at the associate degree level.

Rural areas also need to capitalize on informal and personal collaborations to succeed.⁴⁵ Time and resources spent creating an appropriate infrastructure can yield longer term successful outcomes. One study reported that rural social workers experience higher levels of job satisfaction and have greater autonomy and decision-making power.⁴⁶ These factors could be leveraged to enhance the human services workforce.

Positive Directions

In spite of these troubling trends, the Committee recognizes three paradigms that would serve rural human services as they face upcoming challenges.

Community Flexibility and Funding Streams

In lieu of continuing to try to fit rural America to one-size-fits-all programs, the Committee proposes that communities be given flexibility in allocating funding and designing local programs in order to tailor them to local needs. Discretionary Federal grant programs have strict guidelines for spending and are targeted toward specific needs, to ensure efficient and appropriate resource allocation. Unfortunately, this specificity can be in tension with the ability to integrate across programs or geographical boundaries; thus it is sometimes called “silo” funding. This limitation makes adapting funding to specific community needs difficult. On the other hand, block grants give the States great flexibility. However, these grants rely on a population-based funding mechanism which may have unintended consequences for small and isolated rural areas with dispersed populations. One of the questions is whether or not block grant funding flows to the intended recipients equally regardless of geography. Unfortunately, there are little data available to answer this question. It may be that by

allowing communities some flexibility with their funding but maintaining a framework and guidelines, communities can develop support services that more appropriately fit their needs. However, the Committee also recognizes the need for accountability and oversight. The funds should be used for specific human services needs and administrators should be required to adhere to a basic framework with reporting performance measures connected to the funding goals. For a further discussion of funding silos, see *Building Rural Communities*, p. 58.

One-Stop Shopping

The problems confronted when delivering human services in rural communities are numerous. Many programs lack necessary resources, have poor mechanisms for service delivery, and must confront long distances and transportation difficulties. As a result, many programs can only be offered in a fragmented manner that may impair the ability of rural citizens to gain useful access to them. When service agencies fail to work together, gaps in services and duplicative actions can emerge. Without a centralized organization for human services distribution, rural residents may find themselves in need but with no way to identify and access resources.

One-Stop Shopping in Humboldt County

The Del Norte County ADRC in rural California has combined several Area Agency on Aging (AAA) services along with non-age specific disability services in a central one-stop location. When seniors or people with disabilities go to the Del Norte Community Wellness Center, they can find senior information and assistance, health insurance counseling, a volunteer center, and a community clinic and health care provider. Co-location has provided cost savings in rent to the ADRC. It has the possible additional benefit of integrating social services from the ADRC with the health clinic. This partnership ultimately benefits county residents who do not have to travel great distances to multiple locations in order to find information, case management, and services. This move into the Del Norte Community Wellness Center not only provides an ongoing cost savings to agencies and programs, but also represents easier access to health care and human services, and the potential for coordinated care.

A ‘one-stop shopping’ model for human services distribution may be a constructive method for providing access to necessary supports for people in need. Traditionally, one-stop shopping has been seen as an ideal model that has been successfully implemented in various metropolitan areas. However, this model may not have penetrated non-metropolitan communities to its full potential. In part, this lack of proliferation may be due to the difficulties for a dispersed population when several resources are localized in one center. Effective one-stop shopping in rural areas would require innovations to allow transportability, whether it is centralized administration and local outreach, a mobile unit instead of or in addition to an office building, mobile case workers, or a hotline. Indiana and Utah have pioneered an on-line one-stop shop for human services. The ONE Application is a web site with convenient eligibility and application functions for all State human services programs.⁴⁷ This model holds potential for populations that have familiarity with and access to the Internet, which may be a limiting factor in many rural areas. In addition, the Committee has recognized the need for and reliance on a strong volunteer base. On its June 2007 site visit, the Committee was informed that the Area Agency on Aging (AAA) in Fort Morgan, Colorado, received 27,000 hours of volunteer support in the past year and that volunteers logged more than 16,000 miles, which helped enable programs to reach dispersed individuals.⁴⁸ Further, a collaborative model where multiple programs work together, e.g., traveling to small population centers together or sharing audiovisual equipment for presentations, can further augment available resources. The Committee recommends examining sites that are moving toward effective rural one-stop shopping and transportability of services, and supporting projects that foster these goals.

Leadership and Planning

Rural human services face several challenges: high demand despite limited resources and access, growing need from increasing demographic pressures, and a workforce that needs to develop in both numbers and qualifications. The Committee recognizes that local leadership and planning are essential in

confronting these issues and working with State and local government to achieve effective solutions. Because the people who need human services are not necessarily best positioned to promote them, rural America requires strong leaders to carry the charge. Thoughtful planning can help resolve inefficiencies and ensure that services provided match rural residents’ needs. Effective leadership can better align community resources to improve performance and catalyze regional improvements. In addition, these community leaders can more productively partner with Federal and State agencies to create synergies in total available resources. Leadership and planning are discussed in the following section on community development, p. 58.

The Ingram Leadership Institute

What do the Mayor of Saltillo, MS, the President of Lee County NAACP, and the Director of the Northeast Mississippi Regional American Red Cross have in common? They all graduated from the Jim Ingram Community Leadership Institute and are applying skills they learned in the program to better lead their community. Administered by the Tupelo Chamber of Commerce, a division of the Community Development Foundation, the Ingram Leadership Institute is a three year program that strives to cultivate local leadership and to enhance personal and professional development. The program entails one year of training and nearly two years of community re-investment, to ensure that graduates employ their new skills toward the benefit of the community. The Chamber of Commerce in Tupelo, Mississippi, understood the need for effective local leadership and its investments through the Ingram Leadership Institute are paying off; so far it has provided training to 110 successful graduates, and counting!

Conclusion

This section on human services examines human services as one aspect of population well-being. However, the human services system is intricately connected to the health care, education, and other systems in contributing to both individual and community well-being. Moving forward, policy makers must recognize that human services function within this broader system and focus on it as one

important component of a community's development.

Building Rural Communities

Health and human services play a pivotal role in developing and sustaining vibrant rural communities because these services allow communities to maintain the well-being of their residents. The relationship between a community and health and human services is a self-reinforcing cycle: while these services stabilize and support the community, the community itself must be well-equipped in order to deliver effective and comprehensive health and human services. There is currently no overarching strategy to support rural communities in their efforts to put together comprehensive health and human services. Rural communities can easily be hindered while trying to navigate the rules and procedures related to the patchwork of Federal programs that support health and human services. Typically, urban local governments are often able to devote considerable legal and administrative expertise to such matters. The Committee believes that more must be done to give rural communities the tools to work with the programs and available resources. Community development is further challenged by current budgetary realities that limit the resources available to expand or develop new programs.

Given the fragmentation of service delivery and the budget limitations, the Committee believes that rural community development can best be supported by: (1) fostering cooperation, collaboration, and integration of programs at the local, State, and Federal level and (2) cultivating and training community leaders to facilitate collaboration and to guide and develop the community.

Barriers to Collaboration and Coordination

Communities stand to benefit from cooperation across health care and human services programs.

Close partnerships can encourage communities to collaborate across various programs that target the same population, resulting in more comprehensive, coordinated service delivery. Better coordination of programs can improve the quality of care provided to clients and create cost savings for providers and Federal programs. For example, networks of providers can create economies of scale by pooling resources to fill a common need. Collaboration can also shift an administrator's focus from program specifics to overall community welfare. On the whole, better collaboration and coordination between programs could permit rural communities to maximize the impact of scarce resources.

And yet Federal programs are administered through a number of different channels, frequently referred to as functioning in 'silos,' and therefore have varied requirements for eligibility, information systems, data reporting, and evaluation. The incongruity among funding requirements arises out

Successful Community Collaboration: North Colorado Health Alliance

Rural North Colorado is facing a perfect storm in terms of population growth, high percentages of the population under 200 percent of the Federal poverty level, and large numbers of uninsured. In response, between seeing patients and serving with the Weld County Department of Public Health and Environment, Dr. Mark Wallace organized the North Colorado Health Alliance (NCHA). Comprised of public and private health and human services providers in Weld and Larimer Counties, NCHA strives to ensure that all underserved residents have access to care through an integrated service delivery system. For example, NCHA sends a mobile unit throughout the counties to bring checkups, pap smears, screenings, and primary care to people living in isolated areas. NCHA reaches out to community stakeholders in order to develop collaborative systems of care, workforce development strategies, and programs for improved quality of care. As Wallace noted on creative rural leaders, "innovation doesn't come from a different set of tools, but from someone who tries to use the tools differently."

Source: Wallace, M. (June 10, 2007). "Health Care Access, System Integration, and Community Partnerships." Remarks to the NACRHHS June Meeting.

of the incremental nature of policy development: the legislation that established today's health and human services programs was enacted in a piecemeal fashion. The resulting lack of alignment in requirements renders the coordination of numerous programs at the local level difficult and daunting, particularly in small rural communities with limited physical or human capital. Even though several programs may be designed for similar populations, the inclination to coordinate and streamline service delivery can be defeated when a staff is faced with the bewildering array of differing requirements for eligibility, application processes, and reporting, each in separate systems. These funding silos run the risk of disregarding the needs of specific communities and mandating inefficient implementation practices.

In 2001, HHS created a Department-wide HHS Rural Task Force, an internal coordinating body of HHS officials. It was charged with assessing how HHS programs and initiatives serve rural America. The Rural Task Force's 2002 report to the Secretary, *One Department Serving Rural America*, found that HHS funded more than 225 programs serving rural communities but that com-

munities struggled to use these resources efficiently because individual programs had unique eligibility criteria, applications processes, implementation constraints, and evaluation requirements.⁴⁹ When the Rural Assistance Center analyzed all of the HHS funding announcements in 2006, it found that only nine grant programs either required or strongly encouraged collaboration or coordination of services as eligibility criteria for the grant funds.⁵⁰ Some of the program segregation inadvertently created by Federal legislation is mirrored at the State level, since States must adhere to Federal requirements to receive funding.

Finally, barriers can emerge at the community level. Rural areas, by their very nature, face a high degree of geographic isolation. Lengthy travel times and transportation costs can consume valuable resources. As a result, it is difficult to reach out to rural residents so as to increase awareness and facilitate access. Models of service delivery common in urban areas can be inefficient in rural areas, because the smaller population base frequently acts as a barrier to economies of scale.

These problems are not all caused by the structure and administration of the programs. The

In (Partial) Praise of Silos

Funding for Federal programs is often described as being provided in 'silos,' too restrictive and inflexible to be tailored to local needs.

Many have conjectured that service delivery would be improved if Federal funding had fewer strings attached. For example, if the funds were administered through a single, unrestricted pot, State and local governments could use local wisdom to direct funds to the right places. A myriad of interest groups petition the Federal government for a share of its limited resources. One way to think about silos is as Christmas club accounts or IRAs, mechanisms that accumulate resources and earmark them for a specific use. Individual health and human services programs are usually the product of strong and continuous advocacy, and are maintained because their citizen advocates and the Congressional advocates fight hard to make sure that the programs remain separate and that each year they receive the resources required to provide the benefits.

Though we can think of situations in which eliminating silos could yield substantial benefits, we should be careful in what we wish for. Local leaders with the flexibility to move funds from one program to another might, in a world of flexibility, deem it in the public interest to divert the health and human services funds to build a new bridge or to repave a critical road.

Silos can hinder program coordination and efforts to tailor services to local needs; however, a more flexible approach could hamper program oversight and accountability. As such, for all their disadvantages, silos can serve a useful purpose. They can protect the integrity of rural health and human services, by containing and guarding the resources earmarked for specific Federal programs. While silos may not be an ideal model, any alternative mechanisms must ensure that accountability is not sacrificed for flexibility.

Source: Hoyer, T. (October 2007). "In (Partial) Praise of Silos." *Eye on Health*. Sauk City, WI: Rural Wisconsin Health Cooperative. 4-6.

Committee has learned that some rural communities may be reluctant to work with neighboring communities, due to competition and local rivalries. At the Committee's June 2007 site visit, Dr. Jack Westfall presented an example of neighboring rural communities that had a history of mistrust and competition, which curtailed attempts at service coordination. Part of this hostility may be driven by a perceived 'zero-sum' nature of resource allocation. If one rural community can attract an employer or recruit a physician, it may be at the expense of its neighbor. It is difficult to ascertain how often local rivalries prevent collaboration for health and human services delivery, but it is important to understand that such factors exist.

Better Coordination: Looking at HHS and Beyond

Five years after its inception, the HHS Rural Task Force still exists and remains complementary to the

NACRHHS, but the sense of urgency and purpose that accompanied its creation and first few years have not been sustained. The Rural Task Force continues to enjoy strong commitment from HRSA and the HHS Office of Intergovernmental Affairs, but the Committee believes that for the Rural Task Force's work to continue, the Secretary must recognize the importance of the recommended initiatives and give the Rural Task Force a renewed mandate to accomplish them.

While the NACRHHS is charged with advising the Secretary of HHS on rural issues, it has also become apparent that many programs critical to rural communities are situated in other Cabinet-level Departments. HHS must better coordinate with programs in other Departments in order to provide essential support to rural communities. The following Departments administer significant programs for rural communities:

- The U.S. Department of Agriculture (USDA): The USDA has long been an important rural partner. Rural Development is one of the seven USDA core mission areas, administering \$86 billion in loans and nearly \$16 billion in programs through loans, loan guarantees, and grants. These financial programs, outlined in Appendix C, support rural economic development, essential public facilities and services, technical assistance and information for business cooperatives, and community empowerment programs. State Offices of Rural Development assist USDA in administering these crucial programs. "In a typical year, Rural Development programs create or preserve more than 150,000 rural jobs, enable 40,000 to 50,000 rural Americans to buy homes and help 450,000 low-income rural people rent apartments or other housing."⁵¹ While the Rural Development programs specifically target rural America, rural residents also benefit from other USDA programs, such as food stamps and agricultural support.

- The U.S. Department of the Treasury (Treasury): The Treasury administers the EITC, one of the most significant sources of support for low-income rural residents, discussed earlier. Since 2000, the Treasury has also administered the New Markets Tax Credit (NMTC), which permits taxpayers to

Service Coordination in the Ho-Chunk Nation

Jean-Ann Day, the Social Services Director for the Ho-Chunk Nation, believes that rural community development extends beyond township limits and jurisdictions. The Ho-Chunk Nation consists of 6,750 tribal members, half of whom live in rural Wisconsin while the other half are scattered across the United States. The Ho-Chunk Nation, a rural "community" far more expansive than most, nonetheless experiences significant needs for health and human services. By carefully coordinating services and mobilizing resources from Tribal gaming facilities, Day has been able to provide her remote community with youth programs, programs for the aged, a child care voucher program, emergency financial assistance programs, and activities to address domestic violence. While this success is notable, Day maintains that a creative, mutually supportive relationship between States, Tribes, and the Federal government is necessary. "By working together, we can become great Nations with great families."

Source: Day, J.A. (September 13, 2007). "Health & Human Services for Minority Peoples in Rural Wisconsin." Remarks to the NACRHHS September Meeting.

receive a Federal income tax credit for investing in designated Community Development Entities (CDEs), financial institutions that serve primarily low-income communities. In turn, CDEs make seven-year investments, ranging from affordable housing units to small business financing. As of February 2007, NMTC recipients had raised \$7.1 billion to invest in low-income communities, many in rural areas.⁵²

- **The U.S. Department of Labor (DOL):** Rural communities have substantially benefited from the DOL's Workforce Investment Act (WIA), a comprehensive initiative that helps States and localities design and implement innovative employment programs for current workers, potential employees, and local employers. The WIA seeks to increase employment, retention, earnings, productivity, and competitiveness, characteristics that are often substandard in rural economies. Low-income rural residents also benefit from the WIA's efforts to reduce welfare dependence; these efforts include teaching them skills so that they can move more effectively into the workforce. As part of its efforts to cultivate economically competitive skills within the rural workforce, the DOL also supports distance-learning and scholarships for rural students through Rural Education grants.

- **The U.S. Department of Housing and Urban Development (HUD):** One of HUD's longest-running programs, the Community Development Block Grant (CDBG), funds anti-poverty programs, infrastructure development, and affordable housing, primarily to urban communities. CDBG funds, \$3.7 billion in fiscal year 2007, support activities that benefit low- and moderate-income people, maintain public services and spaces, or address urgent threats to health or safety. These are activities that are particularly needed in distressed rural areas.

- **The U.S. Department of Transportation (DOT):** Without efficient transportation systems, it is more challenging for rural communities to provide health and human services and achieve economic viability, due to geographic isolation and dispersion. Limited mobility directly affects the delivery of health

Rural Eligibility for CDBG Funds

The Community Development Block Grant (CDBG) primarily seeks to develop viable urban communities, as authorized under Title 1 of the Housing and Community Development Act of 1974, Public Law 93-383. The CDBG eligibility criteria allocate funds annually to "entitlement communities," which are central cities of Metropolitan Statistical Areas, metropolitan cities with at least 50,000 residents, and qualified urban counties with more than 200,000 inhabitants.

In 1981, Congress amended the authorization to enable States to administer a portion of the funds, "with the view that States are in the best position to know and to respond to the needs of local governments."¹ The States can now administer CDBG funds to non-entitlement areas, which are all communities that do not qualify for HUD's "entitlement" category. Rural areas fall within the "non-entitlement" designation and therefore compete with smaller metropolitan areas to receive non-entitlement CDBG funds; there is no specific set-aside for rural areas. In fiscal year 2007, the CDBG granted approximately \$2.6 billion directly to entitlement communities directly and \$1.1 billion to non-entitled communities through State competitions.² While there is less funding available to non-entitled communities, the CDBG represents an important step towards providing rural areas with critical community development assistance.

Notes:

¹ Office of Community Planning and Development. (n.d.). "CDBG Entitlement Community Grant." U.S. Department of Housing and Urban Development. <http://www.hud.gov/offices/cpd/communitydevelopment/programs/entitlement/>

² Office of Community Planning and Development. (n.d.). "Community Planning and Development Appropriations Budget." U.S. Department of Housing and Urban Development. <http://www.hud.gov/offices/cpd/about/budget/>

care and human services, communities' access to outside products, and the ability of low-income residents to connect to jobs. In addition, there is no Federally-designated body to plan transportation in small communities and rural areas, whereas metropolitan areas benefit from specially designated organizations that do so. The DOT seeks to bridge this gap through the Rural Transportation Initiative, an array of grant programs and technical assistance that enables communities to plan, develop,

and improve transportation infrastructure.⁵³

- The Department of Commerce (Commerce): Within Commerce, the Economic Development Administration (EDA) and the Minority Business Development Administration (MBDA) seek to promote employment and business growth through targeted programs and grants. While most of these programs do not specifically target rural areas, the EDA has funded several studies examining rural economic development strategies. The MBDA and the USDA entered into a Memorandum of Understanding in 2000, in order to “increase rural business financing for minority-owned rural firms and cooperatives in an effort to further expand and create new markets to provide jobs for rural Americans.”⁵⁴ The Committee hopes that this cross-Departmental relationship can be expanded, so that Commerce can play a more deliberate role in rural economic development.

As the Committee has conducted site visits in rural communities over the years, it has become more apparent that there is a need for a coordinated rural strategy by each of the Cabinet-level Departments, in order to share information, coordinate efforts, and provide more effective rural programs.

Rural Leadership Development

The Committee recognizes that local leadership is an important catalyst for rural community development. Motivated people who are well-connected and understand local needs are often able to use resources effectively. The IOM argues that the success of any rural health care initiative depends on the involvement of such community leaders:

Every rural community needs its own health care leadership to participate in strategic planning, oversee the management of services delivered locally, and ensure accountability to local needs. Committed leadership of senior clinicians and administrators is key to the institutional and environmental changes necessary to achieve improved quality of care and patient safety.⁵⁵

While the IOM report focused solely on health care,

the core message can be applied to all sectors of the rural community. The prevalence of impoverished areas, population loss, and gaps in service infrastructure in rural America accentuates the need for community activists who can maximize the impact of available resources.

Within the public health sector, there is an emerging conviction that overall population welfare can be addressed and maintained best by collaborations within the local community, especially between health care providers and human services programs. This “third revolution in public health” is substantiated by the IOM’s assessment that governmental public health agencies, currently the backbone of the public health system, could achieve more widespread population health improvements if they build and maintain partnerships with community-based organizations.⁵⁶

Rural communities must build a population health focus into decision-making within the health care sector, as well as in other key areas (e.g., religious institutions, agricultural extensions, rural cooperatives, education, community and environmental planning) that influence population health. Most important, rural communities must reorient their quality improvement strategies from an exclusively patient- and provider-centric approach to one that also addresses the problems and needs of rural communities and populations.⁵⁷

This movement towards increased community collaboration stands to greatly benefit rural areas, stretching scarce resources and distinct skill sets to cover local health needs holistically.

Indeed, as noted earlier, traditional service models are not always effective in rural areas due to unique demographics and long distances. Local initiative is needed to streamline service delivery and combine programs so as to offer comprehensive and coordinated care and support. The Committee believes that HHS, along with other Federal Departments with key rural programs, can and should play a role in developing these future leaders, perhaps by refining the focus of existing leadership training models.

An Example of Local Leadership in Rural Colorado

During its June 2007 site visit to Colorado, the Committee learned that one local leader, Kindra Mulch, was behind the many successes of the Health and Human Services Department in Kit Carson County, Colorado. Mulch has spearheaded every public health challenge that the community has brought to her attention, from family planning to immunizations to emergency preparedness. Her willingness to coordinate such disparate programs as child welfare, chronic disease management, and animal odor control in her community resulted in the merging of the County Board of Health, the County Board of Human Services, and several State and Federal programs under one roof. By emphasizing flexibility and striving for a generalist model of service integration, Mulch and her staff are able to pursue innovative initiatives to meet emerging local needs. In order to overcome the challenges of rural service delivery, she told the Committee, a successful rural leader must be energetic enough to tackle problems proactively and practical enough to realize when local context requires that programs be creatively adapted.

While the Committee recognizes that Mulch's extraordinary facility for personally coordinating programs is not a feasible model for all counties, the successes achieved by her efforts are demonstrated proof that, with effort and communication, it is possible to coordinate rural health and human services programs effectively.

Source: Mulch, K. (June 10, 2007). "A Historical Perspective and a Future Hope for Health and Human Services." Remarks to the NACRHHS June Meeting.

Several different programs have emerged to help train community leaders. The Rural Leadership North Dakota (RLND) program is one of the few that focuses specifically on the needs of small rural communities. Indeed, RLND seeks to help its community leaders understand the resource spectrum, foster connections across long distances, and manage an independent project in their home communities. Operated by the North Dakota State University Extension Service, RLND encompasses all forms of rural community growth and prosperity instead of focusing specifically on health and human services.

In addition to executing innovative projects

independently, rural leaders are also needed to foster committed, sustainable partnerships with community stakeholders. Employers, schools, and local government can play important roles in service delivery; dedicated local leaders are needed to engage and coordinate all partners. In order to promote such inclusive partnerships, the Healthy Wisconsin Leadership Institute has structured its leadership training around cross-sector community teams. Members of these teams are leaders in either the same geographic service area (e.g., within a county) or the same field (e.g., adolescent health). Over the course of the program, each team applies new skills to a health improvement project in its home community or field. This innovative leadership training format helps to create permanent local coalitions, catalyzing community development in Wisconsin for years to come.

HHS has implemented a similar program on a national scale, though it is not rural-specific. The Public Health Leadership Institute (PHLI), funded through the CDC, uses a training format that is also centered on multi-organizational teams. PHLI has trained 800 leaders since 1991, all of whom were senior leaders overseeing large regional service areas. Unlike the Healthy Wisconsin Leadership Institute, PHLI team members are grouped by State and subsequently develop a project. The objective is to create widespread alumni networks instead of founding specific localized coalitions. PHLI has identified and trained public health leaders across the nation. The Committee hopes that a similar program could pay special attention to rural issues and train leaders to foster partnerships, tie together disparate funding streams, and identify opportunities to bring together health and human services delivery in ways that build strong communities.

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Recommendations

This report considers the challenges facing rural communities in terms of health care and human services. Significant steps can be taken to help build strong rural communities and improve their ability to provide needed health and human services. The following recommendations focus on two essential needs identified by the Committee: the need to coordinate programs and the need to measure rural impacts of HHS programs.

Goal 1: Coordinate Programs

Create an Inter-Departmental Rural Working Group for Cross-Program Collaboration

The Committee recommends that the Secretary of HHS create an Inter-Departmental Rural Working Group to determine how to improve collaboration among programs that serve rural communities. The Rural Working Group should include all pertinent agencies or operating divisions with programs that serve significant rural populations, such as: HHS, USDA, the U.S. Department of Veterans Affairs, the Treasury, Commerce, DOL, and DOT. The Rural Working Group should consult closely with States to identify elements in regulation implementation that may complicate coordination (e.g., opposing definitions, different reporting time frames). The Rural Working Group should produce an annual report to the Administration with recommendations to promote efficiency, coordinated service delivery, and integration and collaboration across programs that serve rural communities, emphasizing the reduction of administrative barriers, common reporting elements, and combined funding streams. This report should serve as a basis for regulatory changes that improve coordination.

Use Demonstration Projects to Integrate Funding Streams

The Committee recommends that the Secretary use existing demonstration authority to support two rural-focused demonstrations.

Demonstration 1: Coordinated Services for Children and Families

This demonstration should foster the integration of health and human services for children and families through coordinated care, case management, and increased access to services. This program should draw on the funding and programmatic intent of the following existing HHS programs: the Health Center Program, ORHP's Rural Health Care Services Outreach (Outreach) and Rural Health Network Development (Network) Grant Programs, the SAMHSA Mental Health Block Grant, Head Start, Early Head Start, and TANF. Each of these programs plays a key role in supporting rural families but each addresses only one issue, which has resulted in a fragmented delivery system. By funding programs that address all of these issues instead of just one, this demonstration should promote coordinated services and allow for advertising and outreach activities.

Demonstration 2: Coordinated Services for Elderly

This demonstration should foster the integration of health and human services for the elderly. This demonstration should draw on the funding and programmatic intent of the following existing programs: the Outreach and Network Grant Programs, Meals on Wheels, Elderly Family Caregiver Support, and the United We Ride initiative. Integrating programs can help to simplify and coordinate navigation of services. By creating a single funding stream, the demonstration would promote ease of access, care management, better coordinated ser-

vices for the elderly, and allow for advertising and outreach activities.

Identify Statutory and Regulatory Provisions that Hinder Local Coordination

The Committee recommends that the Secretary work with the Administration to commission an independent study that would examine the statutory and regulatory provisions of the various Federally-funded health and human services programs now administered in rural areas. This study should identify provisions that act as barriers to coordination and integration at the local level. This analysis should be shared with the Rural Working Group, which should consider inconsistencies identified in the independent report and work with the Administration to develop recommendations to address the inconsistencies.

Goal 2: Better Information on HHS' Rural Impacts

Require that all HHS Programs Collect Rural-Specific Data

The Committee recommends that the Secretary require that all HHS programs collect data that delineate the rural versus urban geographic location of each recipient of Federal funds through direct grants, transfer payments, and block grants.

Require that Human Services Programs within HHS Implement a Standardized Rural Performance Measurement System

The Committee recommends that the Secretary require the following human services programs

within HHS to evaluate their impacts in rural areas each year: Head Start, TANF, Family Caregiver Support, and the Alzheimer's Disease Demonstration Grants to States. Performance measures that focus on how fully and effectively HHS programs serve rural communities could provide the tools necessary for Federal program administrators and policy makers to identify and account for the specific needs of rural communities. In addition, data and performance evaluation will help policy makers measure the success of improvements.

Produce an Annual Report on HHS Rural Investment

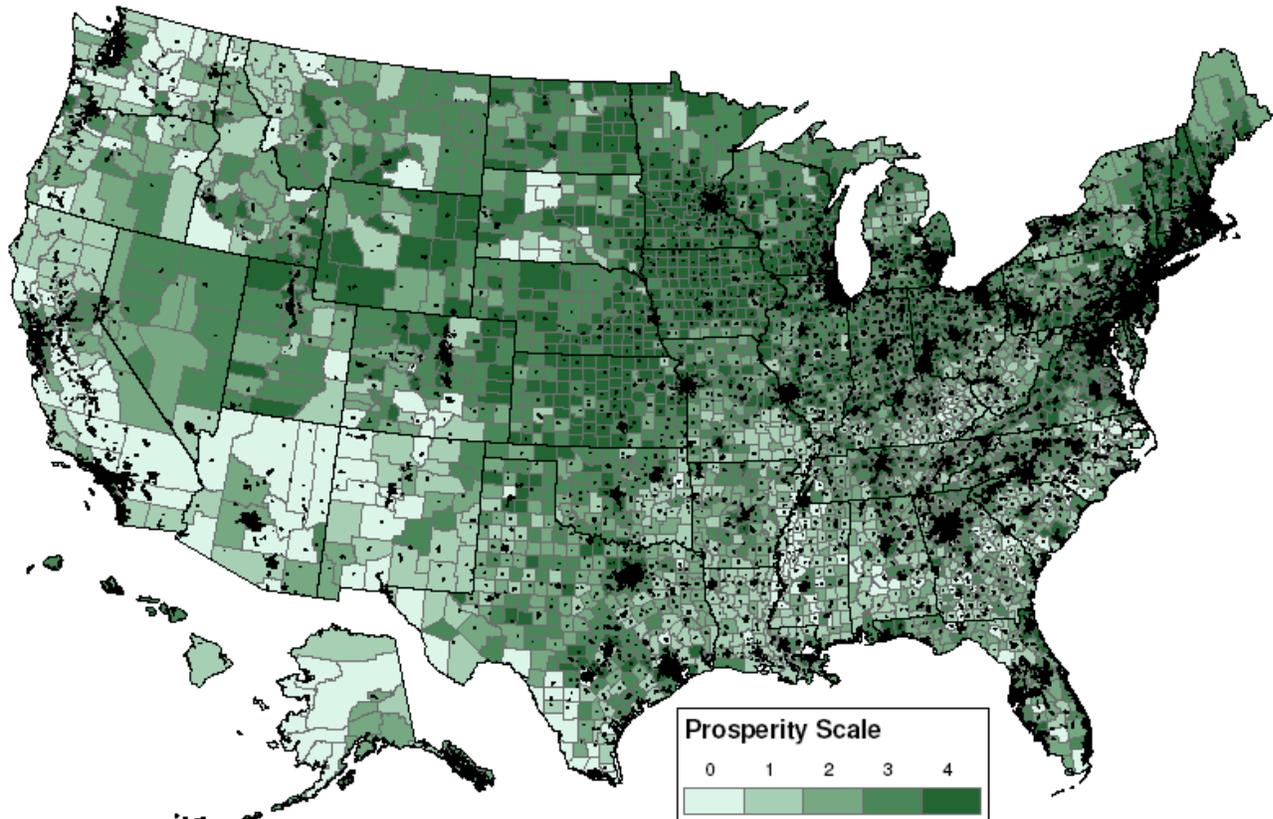
The Committee recommends that HHS use this rural-specific data to produce an annual report that quantifies the annual investment of HHS programs in rural communities. This initiative is most important for the Department's human services programs, which historically have not supplied this information or evaluated their rural investment.

Require Rural Impact Statements on All Major HHS Regulatory Policies

The Committee recommends that the Secretary work with Congress to extend the intent of Section 1102B of the Social Security Act, so that HHS would prepare a rural impact statement on all major regulatory policy decisions that may have a significant economic impact on rural communities. Currently, Section 1102B requires HHS to prepare an impact statement for public comment on any regulation under Title XVIII (Medicare) or Title IX (Medicaid) that may have a significant effect on the operations of a substantial number of small rural hospitals. The Committee believes that similar provisions in the authorization laws for all HHS programs would help ensure that program changes and new program designs take into account the needs of rural communities.

Appendix A

Number of Prosperity Measures At or Better than the National Level, 2000



The four prosperity measures are: (1) poverty rate, (2) unemployment rate, (3) high school dropout rate, and (4) housing problem rate. Their definitions are all based on official categories from the long form of the decennial census of 2000.

The map shows whether counties do better than the national average on all four, three, two, one, or none of the prosperity criteria. The prosperous ones are shown as “4” on the map. The black areas are considered ‘urban’ according to the Census Bureau’s definition of urban and are not included.

Source: Isserman, A.M., Feser, E., & Warren, D. (May 2007). *Why Some Rural Communities Prosper While Others Do Not*. (Prepared for USDA Rural Development, cooperative agreement no. AG RBCS RBS-02-12). Urbana, IL: University of Illinois at Urbana-Champaign.

Appendix B

Human Services Data

Human Services Need	Data Needed	Non-metro	Metro or Overall	Source
Disability	Percent of the population with one or more disabilities	19.5% of the non-metro population had one or more disabilities in 2006	14.2% of the metro population had one or more disabilities in 2006	U.S. Bureau of the Census. (2007). American Community Survey, 2006: Disability Characteristics. (S1801). Washington D.C.: U.S. Bureau of the Census.
Domestic violence	Violent crimes committed by an intimate partner	Data not available	0.5% of women and 0.09% of men had violent crimes committed against them by partners in 2001	Rennison, C.M. (February 2003). "Intimate Partner Violence, 1993-2001." Bureau of Justice Statistics Crime Data Brief. U.S. Department of Justice, Office of Justice Programs. http://www.ojp.usdoj.gov/bjs/pub/pdf/ipv01.pdf
	Rate of intimate partner murder	.25% of people were murdered by intimate partners from 1995-1999 in non-metro non-adjacent areas .9% of people were murdered by intimate partners from 1995-1999 in "completely rural" areas with populations under 2,500	Average rate of intimate partner murder from 1995-1999 was 0.15% in metro areas	Gallup-Black, A. (June 30, 2004). Rural and Urban Trends in Family and Intimate Partner Homicide: 1980-1999. (Prepared for the U.S. Department of Justice under grant no. 2003-IJ-CX-1003). Washington, DC: U.S. Department of Justice, National Criminal Justice Reference Service.
Education	High school completion	76.8% of people age 25 and older in non-metro counties had a high school diploma or GED equivalent in 2000	81.3% of people age 25 and older in metro counties had a high school diploma or GED equivalent in 2000	Economic Research Service. (November 2003). Pamphlet: Rural Education at a Glance. (Rural Development Research Report no. 98). Washington, D.C.: U.S. Department of Agriculture.
	College completion	15.5% of people age 25 and older in non-metro counties had completed bachelor's degrees in 2000	26.2% of people age 25 and older in metro counties had completed bachelor's degrees in 2000	

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Human Services Need	Data Needed	Non-metro	Metro or Overall	Source
Employment	Unemployment rates	5.71% of people in non-metro counties were unemployed in 2005	5.03% of people in metro counties were unemployed in 2005	See reference for Table 2, p. 28.
	Per capita income	\$25,103.98 was per capita income in non-metro counties in 2004	\$34,658.74 was per capita income in metro counties in 2004	
Food security	Households with food insecurity	12.0% of households in non-metro areas were food insecure at some point in 2006	10.7% of households in metro areas were food insecure at some point in 2006	Nord, M, Andrews, M & Carlson, S. (November 2007). Household Food Security in the United States, 2006. (Economic Research Report no. 49). Washington, D.C.: U.S. Department of Agriculture, Economic Research Service.
Health Insurance	Uninsurance rates	20.5% of people under age 65 in non-metro counties were uninsured in 2005	19.3% of people under age 65 in metro counties were uninsured in 2005	Agency for Healthcare Research and Quality. Datafile: "Medical Expenditure Panel Survey." U.S. Department of Health and Human Services. http://www.meps.ahrq.gov/mepsweb/
	Underinsurance rates	10% of people in non-metro counties adjacent to metro counties were underinsured in 2001/2002 12% of people in non-metro nonadjacent counties were underinsured in 2001/2002	6% of people in metro counties were underinsured in 2001/2002	Ziller, E.C., Coburn, A.F. & Yousefian, A.E. (2006). "Out-of-Pocket Health Spending and the Rural Underinsured." Health Affairs. Vol. 25, no. 6. 1688-1699.
	Payor Mix	60.2% of people under age 65 in non-metro counties had private insurance in 2005 19.3% of people under age 65 in non-metro counties had Medicaid in 2005	65.8% of people under age 65 in metro counties had private insurance in 2005 14.8% of people under age 65 in metro counties had Medicaid in 2005	Agency for Healthcare Research and Quality. Datafile: "Medical Expenditure Panel Survey." U.S. Department of Health and Human Services. http://www.meps.ahrq.gov/mepsweb/
	Child uninsurance rates	22% of children in non-metro areas were uninsured in 2001	12% of children overall and 11% of children in metro counties were uninsured in 2001	Economic Research Service. (March 2005). Pamphlet: Rural Children at a Glance. Economic Information Bulletin No. (EIB-1). U.S. Department of Agriculture.

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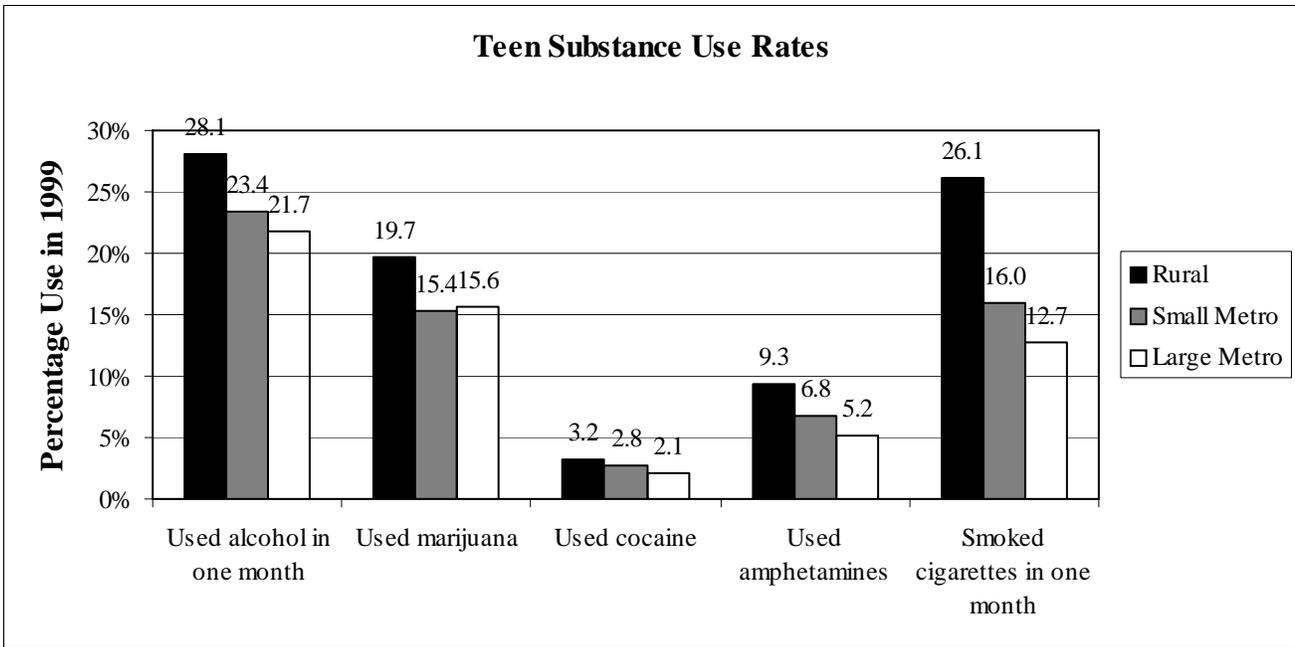
Human Services Need	Data Needed	Non-metro	Metro or Overall	Source
Homelessness	Number of people who experience homelessness	Data not available	3.5 million people nationally are likely to experience homelessness in a given year	National Coalition for the Homeless. (August 2007). "How Many People Experience Homelessness?" NCH Fact Sheet #2. http://www.nationalhomeless.org/publications/facts/How_Many.pdf
	Amount of targeted funding	5% of targeted homelessness assistance funds go to non-metro counties	95% of targeted homeless assistance funds go to metro counties	Strong, D.A., Del Grosso, P., Burwick, A., Jethwani, V. & Ponza, M. (May 2005). Rural Research Needs and Data Sources for Selected Human Services Topics. Vol. 1: Research Needs. (Prepared for the U.S. Department of Agriculture under contract no. 233-02-0086 (07)). Washington, D.C.: Mathematica Policy Research, Inc. 32.
	Crowded housing units	3.3% of housing units were crowded in non-metro counties and counties without an urbanized population in 2000	6.4% of housing units were crowded in metro counties with some urbanized population in 2000	Housing Assistance Council. (2007). "Rural Housing Data Portal." http://www.ruralhome.org/dataportal/
Mental health	Rates of mental health disorders	Approximately 20% of the non-metro population has mental health disorders	Approximately 20% of the metro population has mental health disorders	Strong, D.A., Del Grosso, P., Burwick, A., Jethwani, V. & Ponza, M. (May 2005). Rural Research Needs and Data Sources for Selected Human Services Topics. Vol. 1: Research Needs. (Prepared for the U.S. Department of Agriculture under contract no. 233-02-0086 (07)). Washington, D.C.: Mathematica Policy Research, Inc. 29-30.
	Suicide rates	17 per 100,000 people in non-metro counties completed suicides in 2001	12-15 per 100,000 people in metro counties completed suicides in 2001	
Obesity	Percent of people who are overweight or obese	Data not available	66.3% of people over age 20 overall were overweight or obese in 2003-2004	Ogden, C.L., Carroll, M.D., Curtin, L.R., McDowell, M.A., Tabak, C.J., Flegal, K.M. (April 5, 2006). "Prevalence of Overweight and Obesity in the United States, 1999-2004." Journal of the American Medical Association. Vol. 295, no. 13. 1553.

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Human Services Need	Data Needed	Non-metro	Metro or Overall	Source
Obesity, continued	Percent of children who are overweight or obese	31.5% of children age 10-17 in rural areas were overweight or obese in 2005 (rural indicates urban influence codes 3-12)	30.4% of children age 10-17 in urban areas were overweight or obese in 2005 (urban indicates urban influence codes 1-2)	Liu, J., Bennett, K.J., Harun, N., Zheng, X., Probst, J.C. & Pate, R.R. (2007). Overweight and Physical Inactivity among Rural Children Aged 10-17: A National and State Portrait. (Prepared for the U.S. Department of Health and Human Services under grant no. 6 UIC RH 03711-01-00). Columbia, SC: South Carolina Rural Health Research Center.
Poverty	Percent of individuals in poverty	14.2% of people in non-metro counties were below the Federal poverty level in 2002	11.6% of people in metro counties were below the Federal poverty level in 2002	Economic Research Service. (July 2004). Pamphlet: Rural Poverty at a Glance. (Rural Development Research Report no. 100). Washington, D.C.: U.S. Department of Agriculture.
	Percent of children in poverty	22.2% of children in non-metro counties were below the Federal poverty level in 2006	18.3% of children overall and 17.6% of children in metro counties were below the Federal poverty level in 2006	U.S. Bureau of the Census. (2007). American Community Survey, 2006: Poverty Status in the Past 12 Months. (S1701). Washington D.C.: U.S. Bureau of the Census.
Substance abuse	Alcohol abuse rates	7.14% of people age 12 and older in non-metro counties abused alcohol in 2003	7.66% of people age 12 and older in metro counties abused alcohol in 2003	Van Gundy, K. (2006). Substance Abuse in Rural and Small Town America. (Reports on Rural America Vol.1, no.2). Durham, NH: University of New Hampshire, Carsey Institute.
	Illicit drug abuse rates	2.61% of people age 12 and older in non-metro counties abused any illicit drug in 2003	2.92% of people age 12 and older in metro counties abused any illicit drug in 2003	
	Nonmedical use of any prescription-type pain relievers, tranquilizers, stimulants, or sedatives rates	7,276,000 people age 12 and over in metro areas used prescription drugs non-medically by 2006 (15% of users)	42,566,000 people age 12 and over in metro areas used prescription drugs non-medically by 2006 (85% of users)	Office of Applied Studies. (October 2007). Table 1.78A - Nonmedical Use of Prescription-Type Psychotherapeutics in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older, by Geographic Characteristics: Numbers in Thousands, 2005 and 2006." 2006 National Survey on Drug Use & Health. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

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Human Services Need	Data Needed	Non-metro	Metro or Overall	Source
Substance abuse, continued	Teen substance use rates	See table below.		
Transportation	Car ownership rates	92.7% of households in non-metro counties had access to a car in 2000	88.9% of households in metro counties had access to a car in 2000	Economic Research Service. (January 2005). Pamphlet: Rural Transportation at a Glance. Agriculture Information Bulletin No. 795. U.S. Department of Agriculture.
	Public transportation availability	60% of non-metro counties had access to public transportation in 2005	Data not available	
	Population served by long-distance bus service	89% of people in non-metro counties had access to long-distance bus service in 2005	Data not available	



‘Large metro’ are areas with over one million in population. ‘Small metro’ are areas with populations between 50,000 and one million. ‘Rural’ are counties with no city of over 50,000.

Source: The National Center on Addiction and Substance Abuse. (January 2000). No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America. (Commissioned by the U.S. Conference of Mayors). New York, NY: Columbia University.

Appendix C

USDA Rural Development

USDA Rural Development is divided into three program fields. The Business and Cooperative Programs create jobs and diversify the rural economy by financing new businesses and business expansions. The Housing and Community Facilities Programs assist low-income people in achieving homeownership and help finance critical community facilities, such as schools and hospitals. The Utilities Programs facilitate equal access to utilities for rural areas. Private utility companies suffer from low returns on investments in rural areas, due to low population density. USDA offers low-interest loans, loan guarantees, and direct technical assistance to applicants who can demonstrate sound financial practices.

Business and Cooperative Programs

- 1) Loan Guarantees
 - Community Investment
 - Armament Manufacturing
 - Energy Efficiency
- 2) Grants
 - Rural Business
 - Rural Cooperative Development
 - Small Minority Producer
- 3) Technical Assistance
 - Cooperative Development
 - Research and Public Information
 - Community Development
- 4) Other
 - Biomass Research
 - Technology Transfers
 - Business Information System Network

Housing and Community Facilities Programs

- 1) Housing
 - Single/Multi-Family Housing
 - Home Repair
 - Housing Preservation
 - Farm Labor Housing
 - Self-Help
- 2) Community Facilities

Utilities Programs

- 1) Electric
 - Renewable Energy
 - Technologies
 - High Energy Cost
- 2) Telecommunications
 - Telecommunications Infrastructure
 - Broadband Access
 - Distance Learning and Telemedicine
- 3) Water and Environment
 - Infrastructure Building
 - Improving Operator Skills

Source: Rural Development. (October 11, 2001). "Introduction to Rural Development." Webinar for RD Professionals' Training. Washington, D.C.: U.S. Department of Agriculture.

Acronyms Used

AAA	Area Agency on Aging	DOL	U.S. Department of Labor
ACF	Administration for Children and Families, HHS	DOT	U.S. Department of Transportation
ADL	Activities of Daily Living	DRA	Delta Regional Authority
ADRC	Aging and Disability Resource Center	EDA	Economic Development Administration, Commerce
AFDC	Aid to Families with Dependent Children	EHR	Electronic Health Record
AHEC	Area Health Education Center	EITC	Earned Income Tax Credit
AHRQ	Agency for Healthcare Research and Quality, HHS	EMS	Emergency Medical Services
AMP	Average Manufacturers Price	ERS	Economic Research Service, USDA
AoA	Administration on Aging, HHS	Flex	Rural Hospital Flexibility
ARC	Appalachian Regional Commission	FQHC	Federally Qualified Health Center
ASPE	Assistant Secretary for Planning and Evaluation, HHS	FTCA	Federal Tort Claims Act
AWP	Average Wholesale Price	GAO	Government Accountability Office
BBA	Balanced Budget Act	HHA	Home Health Agency
CAH	Critical Access Hospital	HHS	U.S. Department of Health and Human Services
CBSA	Core-Based Statistical Area	HIT	Health Information Technology
CCDF	Child Care and Development Fund	HPSA	Health Professional Shortage Area
CDBG	Community Development Block Grant	HRSA	Health Resources and Services Administration, HHS
CDC	Centers for Disease Control and Prevention, HHS	HUD	U.S. Department of Housing and Urban Development
CDE	Community Development Entity	IOM	Institute of Medicine
CHC	Community Health Center	IPPS	Inpatient Prospective Payment System
CMS	Centers for Medicare and Medicaid Services, HHS	IRS	Internal Revenue Service, Treasury
Commerce	U.S. Department of Commerce	LHD	Local Health Department

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LIHEAP	Low Income Home Energy Assistance Program	OMB	Office of Management and Budget
MA	Medicare Advantage	OPPS	Outpatient Prospective Payment System
MAF	Medical Assistance Facility		
MBDA	Minority Business Development Administration	ORHP	Office of Rural Health Policy, HRSA, HHS
MDH	Medicare-Dependent Hospital	OTA	U.S. Congress Office of Technological Assessment
MedPAC	Medicare Payment Advisory Commission	Outreach	Rural Health Care Services Outreach
MEPS	Medical Expenditure Panel Survey	PACE	Program of All-Inclusive Care for the Elderly
MMA	Medicare Prescription Drug, Improvement, and Modernization Act	PFFS	Private Fee-For-Service
MUA	Medically Underserved Area	PHLI	Public Health Leadership Institute
NACCHO	National Association of County and City Health Officials	PHS	Public Health Service
		PPS	Prospective Payment System
NACRHHS	National Advisory Committee on Rural Health and Human Services	PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
NAIC	National Association of Insurance Commissioners	QIO	Quality Improvement Organization
NAPIS	National Aging Program Information System	RHC	Rural Health Clinic
NCHA	North Colorado Health Alliance	RLND	Rural Leadership North Dakota
NCSL	National Conference of State Legislatures	RRC	Rural Referral Center
Network	Rural Health Network Development	RUPRI	Rural Policy Research Institute
		SAMHSA	Substance Abuse and Mental Health Services Administration, HHS
NF	Nursing Facility	SCH	Sole Community Hospital
NHIS	National Health Interview Survey	SCHIP	State Children's Health Insurance Program
NHSC	National Health Service Corps		
NMTC	New Markets Tax Credit	SNF	Skilled Nursing Facility
OAA	Older Americans Act	SORH	State Office of Rural Health
OFA	Office of Family Assistance, ACF, HHS	SSI	Supplemental Security Income
		SUA	State Unit on Aging
		TANF	Temporary Assistance for Needy

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Families

TEFRA	Tax Equity and Fiscal Responsibility Act
Treasury	U.S. Department of the Treasury
USDA	U.S. Department of Agriculture
VBP	Value-Based Purchasing
WIA	Workforce Investment Act
WIC	Women, Infants, and Children
WWAMI	University of Washington School of Medicine Partnership between Washington, Wyoming, Alaska, Montana, and Idaho