# The 2005 Report to the Secretary: Rural Health and Human Service Issues

---

## The NACRHHS

The National Advisory
Committee on Rural Health and
Human Services

April 2005

# Acknowledgements

This report is the culmination of a year's work by the Committee. I wish to thank all of the Committee members for their hard work but particularly the chairs of the subcommittees: Keith Mueller, Collaborations to Enhance Community and Population Well-Being; Glenn Steele, Access to Obstetrical Care in Rural Communities; Ron Nelson, Obesity in Rural Communities; and Bessie Freeman-Watson, Welfare Reform in Rural Communities. I also wish to acknowledge the work of McKing Consulting's Jake Culp and Sahira Raifullah, who drafted much of the report, and Jeff Human, Jenny Yingling, Debra Papanek and Felicia Pratt, who handled the logistics for the Committee's meetings. Craig Williamson and Deanna Durrett, two Truman Fellows with the National Rural Development Partnership, also provided invaluable assistance in gathering information for the report and in drafting key sections. I want to thank Beth Blevins for her assistance with the editing and lay-out of the report.

The Committee is deeply indebted to the work and analysis on obstetrical issues provided by Rebecca Slifkin, Katie Gaul and Jennifer Groves at the Rural Health Research Center at the University of North Carolina's Cecil G. Sheps Center for Health Services Research and Curt Mueller and Lan Zhao at the Walsh Center for Rural Health Analysis with the University of Chicago's National Opinion Research Center. Craig Kennedy of the National Association of Community Health Centers and Gary Hart and his colleagues at the University of Washington also provided background information that was instrumental on this issue. I would also like to acknowledge and thank the RUPRI Center for Rural Health Policy Analysis at the University of Nebraska Medical Center. The Center's director, Keith Mueller, and staff, especially Michael Shambaugh-Miller and Brandi Shay, provided extensive assistance in researching and drafting the Collaborations chapter for this report.

This report also benefited greatly from the contributions of Federal staff. This includes Marcia Brand, Jennifer Riggle, Tom Morris, Michele Pray-Gibson, Steve Hirsch, Heather Dimeris and Carrie Cochran of the Office of Rural Health Policy. Dennis Dudley of the Administration on Aging, Ann Barbagallo of the Administration for Children and Families and Robert Gibbs of the U.S. Department of Agriculture provided outstanding technical support and guidance. Caroline Ayoyama and Matt Newland of the Health Resources and Services Administration and Detrice Sherman of the Centers for Disease Control also provided assistance in the preparation of this report.

I also need to acknowledge all of the individuals connected with the Committee's two site visits in the past year. In June of 2004, the Committee visited Nebraska City, Nebraska and heard from a range of health and human service providers. In September, the Committee visited Tupelo, Mississippi and a number of its surrounding communities. In particular, the Committee acknowledges the hard work of Keith Mueller and Larry Otis for serving as hosts and organizers of those two site visits. In both cases, the number of people involved is far too many to list here but I want to acknowledge the help of everyone connected with the site visits. The opportunity to get into the field and learn about rural health and human service delivery from those who are actually providing these services is critical in helping to inform this report and the recommendations that are included.

Sincerely,

The Honorable David M. Beasley, Chair
The National Advisory Committee on Rural Health and Human Services

# The National Advisory Committee on Rural Health and Human Services

## Chairperson

The Honorable David Beasley
Former Governor
South Carolina
Darlington, South Carolina
**03/01/02 – 03/31/06**

## Members

James R. Agras, CEO
Triangle Tech Group
Pittsburgh, PA
Term: 03/31/03 - 03/31/07

Susan Birch, RN, MBA
Northwest Colorado Visiting Nurse Association, Inc.
Steamboat Springs, CO
Term: 07/01/03 – 06/30/07

Evan S. Dillard, FACHE
Administrator
Walker Baptist Medical Center
Jasper, AL
Term: 07/01/02 – 06/30/06

Joellen Edwards, PhD, NP
Dean and Professor
East Tennessee State University College of Nursing
Johnson City, TN
Term: 07/01/02 – 06/30/06

Michael Enright, PhD
Chief of Psychology
St. John's Medical Center
Jackson Hole, WY
Term: 07/01/02 – 06/30/06

Bessie Freeman-Watson*
Youth Services Director
Isle of Wright County Office on Youth
Suffolk, VA
Term: 04/01/03 – 03/31/07

Joseph D. Gallegos
Vice President for Planning and Development
Presbyterian Medical Services
Albuquerque, NM
Term: 07/01/03 – 06/30/07

Julia Hayes, MS, RD
Assistant Director of Minority Health
Alabama Department of Public Health
Montgomery, AL
Term: 07/01/04 – 06/30/08

Leonard W. Kaye, DSW
Director, Center on Aging
Professor, School of Social Work
College of Business, Public Policy and Health
University of Maine
Orono, ME
Term: 04/01/03 – 03/31/07

Michael Meit, MA, MPH
Executive Director
University of Pittsburgh Center for Rural Health Practice
Bradford, PA
Term: 07/01/04 – 06/30/08

Arlene Jaine Jackson Montgomery, PhD
Professor of Nursing
Hampton University
Newport News, VA
Term: 07/01/03 – 06/30/07

Ron L. Nelson, PA*
President & CEO
Health Services Associates
Fremont, Michigan
Term: 07/01/03 – 06/30/07

Sister Janice Otis
SE Idaho Community Action Agency

Pocatello, ID
Term: 04/01/03 – 03/31/07

The Honorable Larry Otis
Mayor of Tupelo, MS
Tupelo, MS
Term: 04/01/03 – 03/31/07

Patti J. Patterson, MD, MPH
Vice President for Rural & Community Health
Texas Tech University Health Sciences Center
Lubbock, TX
Term: 07/01/04 – 06/30/08

Senator Raymond Rawson, DDS
Majority Leader
State Senate
Las Vegas, Nevada
Term: 07/01/02 – 06/30/06

Heather Reed, MA
Rural Health Administrator
Ohio Department of Health
Primary Care and Rural Health Program
Columbus, OH
Term: 07/01/03 – 06/30/07

Thomas C. Ricketts III, PhD
Deputy Director
Cecil G. Sheps Center for Health Sciences Research
University of North Carolina School of Public Health
Chapel Hill, NC
Term: 07/01/04 – 06/30/08

Tim Size, MBA
Executive Director
Rural Wisconsin Health Cooperative
Sauk City, WI
Term: 07/01/03 – 06/30/07

Glenn D. Steele, MD, PhD*
President & CEO
Geisinger Health System
Danville, PA
Term: 07/01/02 – 06/30/06

## Members Whose Terms Expired in 2004

Stephanie Bailey, BC, MD, MSHSA
Director of Health
Metro Davidson County Health Dept.
Nashville, TN

Dave Berk
Consultant
Rural Health Financial Services
Anacortes, WA

Keith Mueller, PhD*
Professor and Head
Dept. of Preventive and Societal Medicine
University of Nebraska Medical Center
Omaha City, NE

Sally Richardson
Executive Director
Center for Healthcare Policy and Research
Robert C. Byrd Health Sciences Center
West Virginia University, Charleston Division
Charleston, WV

*Subcommittee Chairs

## 2004-2005 Subcommittees

### Collaborations

Keith Mueller, Chair
Tim Size
Joe Gallegos
Len Kaye
Larry Otis

### TANF

Bessie Freeman Watson, Chair
Jim Agras
Sue Birch
Stephanie Bailey
Sally Richardson

### Obesity

Ron Nelson, Chair
Ray Rawson
Sister Janice Otis
Patti Patterson
Michael Meit
Arlene Montgomery
Joellen Edwards

### Obstetrics

Glenn Steele, Chair
Evan Dillard
Michael Enright
Heather Reed
Dave Berk
Julia Hayes
Tom Ricketts

# About the Committee

The National Advisory Committee on Rural Health and Human Services (NACRHHS) is a 21-member citizens' panel of nationally recognized rural health and human service experts that provides recommendations on rural issues to the Secretary of the Department of Health and Human Services. The Committee was chartered in 1987 to advise the Secretary on ways to address health and human service problems in rural America.

The Committee is chaired by former South Carolina Governor David Beasley. The Committee's private and public-sector members reflect wide-ranging, first-hand experience with rural issues—in medicine, nursing, administration, finance, law, research, business, public health, aging, welfare and human service issues.

Each year, the Committee selects several issues on which to focus. Background documents are prepared for the Committee by both staff and contractors to help inform its members. The Committee then produces a report with recommendations on those issues for the Secretary by the end of the year. In addition to the report, the Committee also may produce white papers on select policy issues. The Committee also sends letters to the Secretary after each meeting. These 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, D.C. 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 ongoing work on the yearly topics with some time devoted to site visits and presentations by the host community.

# Table of Contents

# Executive Summary

This is the 2005 Report to the Secretary of the U.S. Department of Health and Human Services (HHS) by the National Advisory Committee on Rural Health and Human Services (NACRHHS). This year's report features a chapter that focuses on collaborations in rural communities, as well as issue-specific chapters on access to obstetrical services in rural communities, obesity in rural communities and welfare reform in rural communities. All four chapters represent particular areas of interest for the Committee that were identified at its March 2004 meeting.

## Collaborations to Enhance Community and Population Well-Being

The purpose of this chapter is to suggest a policy and program agenda for HHS that would foster collaborations among community organizations and local rural leaders to improve the well-being of the community and its residents. The NACRHHS has established the following principles to guide the development of collaborative relationships that advance community health and well-being:

- Genuinely engage people in the community in all programs and in collaboration/coordination across programs.
- Measure expected outcomes of program interventions and demand accountability for those outcomes.
- Target resources effectively by following an integrated strategy focused on community-wide goals and objectives.
- Support local leaders who believe in an action model that integrates the activities of multiple programs.
- Discourage redundancy across programs as they are implemented in rural communities.

The NACRHHS collected information and observed successful examples of local collaborations in Southeast Nebraska and Tupelo, Mississippi. In addition, through reviewing current literature and the experiences of its members, NACRHHS learned of other examples in which local organizations overcame obstacles to collaboration and were able to merge resources for independent sources of support on behalf of common goals. An important indicator of local success in collaboration is strong, creative and consistent leadership. The NACRHHS examined models of local leadership, including strategies for recruitment and programs for training. Those models, summarized in this chapter, generated suggestions for rethinking the administration of Federal programs.

Actions the Secretary should undertake would include the following:

- Create common reporting requirements for programs that are linked at the local level.
- Encourage programs in other Federal agencies to participate in multi-sector collaborations.
- Facilitate interagency cooperation that allows for single lines of accountability for funds.

The Committee makes the following recommendations:

- The Secretary should support the creation of a Web resource page for "models that work," showing successful collaborations in rural places.
- The Secretary should support research that will further specify opportunities and barriers.
- The Secretary should support leadership development for rural community organizations and residents.
- The Secretary should require grant recipients engaged in direct delivery of services to demonstrate an effect on community development.

# Access to Obstetrical Services in Rural Communities

Access to obstetrical (OB) services is an increasing problem in many rural communities. Current data show a disparity in access to OB care between urban and rural areas of the country. The ratio of physicians trained in obstetrics to women of childbearing age is higher in urban areas than in rural communities, and this ratio will only worsen as fewer physicians choose obstetrics and even fewer elect to practice in rural settings.

Several factors influence the rural physician supply, such as excessive professional demands on physicians who practice obstetrics in rural areas, physician payment issues and the increasing cost of malpractice insurance. If these issues are left unchecked, rural communities will see an even greater erosion of OB services. Limited accessibility to OB care will affect decisions that families must make on where to live and raise their children and will subsequently have a negative influence on rural economic growth.

This chapter reports some of the difficult problems that rural hospitals face in maintaining OB services. During the Committee's site visits this past year, rural hospital administrators and medical staffs stressed the importance of OB services to the mission of a rural community hospital. The Committee visited several hospitals that were managing to maintain OB services in the face of significant financial loss. Some of the most important challenges rural hospitals face involve physician shortages, shortages of non-physician providers, low Medicaid payments and declining birth rates in their communities.

The Committee describes programs and authorities of HHS that are helping to strengthen OB care in rural communities. It believes that the Department can place a greater emphasis on rural concerns in its administration of some of these programs.

The Committee makes several recommendations, including:

- The Secretary should increase support through Title VII for medical schools that have distinct programs and a proven track record for training physicians to practice obstetrics in rural areas.
- The Secretary should make the recruitment and placement of physicians trained in obstetrics a major goal of the National Health Service Corps.
- The Secretary should support programs to create hospital and physician networks that will sustain and improve access to OB care in rural areas.
- The Secretary should, under Section 301 of the Public Health Service Act, promote the development of demonstration projects that use a team approach to providing OB services in rural communities, involving physicians, clinical nurse midwives and other non-physician providers.
- The Secretary should work with States to increase Medicaid reimbursement for OB services in high-need rural areas.
- The Secretary should address the malpractice insurance issue by supporting legislation that would extend the Federal Tort Claims Act to rural OB providers in federally designated shortage areas.

# Obesity in Rural Communities

Obesity kills approximately 400,000 Americans each year. In March 2004 the Centers for Disease Control and Prevention (CDC) released a study predicting that the overweight epidemic soon will become the leading preventable cause of death of Americans, outranking tobacco use. Being overweight or obese increases the risk of individuals developing diabetes, heart disease and other health problems.

Obesity trends tracked by the CDC show that more and more Americans are becoming obese, with rural Americans leading the way. Health status and provision of health services are worse in rural America for almost any disease or health issue, and obesity is no exception. The reasons are due to the unique characteristics of rural health care: more dependence on Medicare, which does not cover the full range of preventative health care services; lack of coordination of local providers; socio-economic disadvantage; geographic isolation; provider shortages; lack of transportation; and lifestyle changes.

When national obesity data are examined to compare rural and metropolitan areas, rural Americans have a

higher incidence of obesity than their metro counterparts. While it is true that rural areas have had lower rates of overweight and obesity in the past due to the physical nature of rural occupations, this is no longer the case because those occupations are continuing to decrease. Obesity is now more common in low-income and rural populations due to a number of factors, including the high cost or limited availability of nutritious foods and recreational activities.

Programs to increase physical activity, improve diet and increase the success of smoking cessation are more important than ever. Especially in the often-forgotten rural areas of the Nation, basic public health must be promoted across the lifespan, and prevention of obesity must be acknowledged as a public health concern.

To begin addressing the growing challenge of obesity in rural communities, the Committee makes several recommendations to the Secretary, including:

- The Secretary should encourage the States to revise Medicaid policy. Medicaid should follow Medicare and remove all references to obesity not being an illness.
- The Secretary should make refinements to the HealthierUS community grant program so that rural concerns can be more thoroughly represented.
- The Secretary should ensure that the next publication of the CDC Chartbook includes more rural-specific data and that other, future publications include references to rural.
- The Secretary should ensure that rural residents are seen as a separate and unique segment of the population in funding, research and data collection.

# Welfare Reform in Rural Communities

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), dramatically changing the Nation's welfare system from a program designed to provide income maintenance to one focused on moving families into the workforce. The Act replaced the entitlement program, Aid to Families with Dependent Children (AFDC), and several other associated programs with Temporary Assistance for Needy Families (TANF), a $16.5 billion Federal block grant. The new program gave significant authority and flexibility to the States, yet it established Federal work requirements for welfare recipients (30 hours/week) and mandated a five-year lifetime limit on the receipt of cash assistance.

In the years following the implementation of TANF, welfare caseloads significantly declined in both urban and rural areas as the rate of employment for low-income families, especially single mothers, drastically increased. However, some TANF recipients still struggle to find and keep a job and to lift their families out of poverty. These families often deal with a number of obstacles, including lack of education or job experience, drug and alcohol abuse, domestic violence, disabilities and health problems. Yet rural TANF recipients face additional barriers in moving from welfare to work, such as a lack of public transportation systems, few child care services, and limited employment and training opportunities.

***Transportation*:** Transportation is often cited by welfare recipients as the number one obstacle to leaving public assistance, and public transportation in rural communities is rare. Forty percent of rural communities have no public transit system at all, and another 28 percent have very limited services available. Private vehicle ownership is often the primary mode of transportation, but more than half of the rural poor do not own their own cars.

***Child Care*:** Like transportation, reliable child care has been proven essential to moving welfare recipients into work; however, rural communities commonly have a shortage of child care providers. Rural areas have fewer trained child care professionals and fewer available slots at child care centers than urban areas.

***Labor Markets*:** Rural communities typically have higher rates of unemployment and underemployment than urban areas, and the majority of available positions are in low-wage industries. Many rural jobs tend to be temporary, part-time or seasonal, and do not present the opportunity or security of long-term career development.

Studies have shown that the more barriers a welfare client faces the more difficult it is for the client to suc-

cessfully find employment and leave welfare. Rural TANF recipients often face many barriers. Therefore, the Committee believes it is vital for HHS, in collaboration with other agencies and organizations, to continue to address the obstacles of transportation, child care and job and training opportunities in rural communities.

To aid rural low-income families, the Committee makes several recommendations, including:

- The Secretary should work with the Administration for Children and Families (ACF) to provide targeted technical assistance that would encourage States to address the transportation, child care, and employment and training needs of rural TANF recipients.
- The Secretary should emphasize collaboration and encourage States to utilize best practices, such as those identified by ACF.
- The Secretary should strengthen leadership among Federal partnerships and collaborations, such as with the Coordinating Council on Access and Mobility, which addresses the transportation needs of rural Americans; with Head Start, Early Head Start, child care and TANF; and with the Internal Revenue Service on the Earned Income Tax Credit, which provides tax breaks to low-income families.

# Introduction

The 2005 Report to the Secretary from the National Advisory Committee on Rural Health and Human Services is the product of several meetings and much work over the past year. The 21-member Committee, made up of rural health and human service experts from across the country, met in Washington, D.C. in February of 2004 to begin work on the 2005 Report. At this meeting, members identified possible issues to bring to the attention of the Secretary. In addition, the Committee heard testimony from a range of health and human service experts on key issues affecting rural communities. From within the Department of Health and Human Services (HHS), the Committee heard presentations by Wade Horn, Assistant Secretary for Children and Families, and Elizabeth Duke, Administrator of the Health Resources and Services Administration (HRSA). Other presenters included Marcia Brand of HRSA's Federal Office of Rural Health Policy, Jennifer Bell, a member of the Senate Finance Committee majority staff, and Chuck Fluharty, Director of the Rural Policy Research Institute. The Committee also heard from a panel of rural association experts that included Alan Morgan, Vice President of Governmental Affairs for the National Rural Health Association, Sandy Markwood, Executive Director of the National Association of Area Agencies on Aging, and Gary Cyphers of the American Public Human Services Association.

After hearing testimony from these experts, the Committee decided to modify the format of its annual report. Typically, the Committee's report focuses on several individual topics that affect the delivery of health and human services in rural communities. This year, the report includes three chapters that each focus on a specific rural issue. However, the 2005 Report begins with a chapter that is broader and more crosscutting. This particular chapter examines the issue of collaboration in rural communities and the need to develop public policies that foster the ability to work across programs and disciplines to better serve the unique needs of rural communities.

This idea of collaboration is not necessarily new. For years, rural advocates have talked about the need for more of a cross-sector approach to assist rural communities. The interest in this issue has only increased over the years with the advent of block granting in the 1980s and the continued growth of Federal programs that serve rural communities. The idea of collaboration to better serve rural communities received additional support after the release of the report "One Department Serving Rural America" in 2002 from HHS. That report to the Secretary from the Department's Rural Task Force identified approximately 220 programs within HHS that serve rural communities. All members of the Committee noted the challenges rural communities face in trying to navigate across that daunting number of programs. Therefore, in an effort to build on the attention that the HHS report garnered, the Committee decided to take a more in-depth look at the idea of collaboration.

As in previous years, the report also looks more intensely at some specific issues affecting rural communities. Through the work of subcommittees, the Committee examined the barriers to obstetrical care in rural communities, the impact of growing rates of obesity on rural communities, and how welfare reform, specifically the Temporary Assistance for Needy Families (TANF) program, can better meet the needs of rural communities as they seek to help residents make the transition from welfare to work.

After selecting these topics at the first meeting, the Committee continued to investigate these issues by conducting two site visits to rural communities. The Committee visited Nebraska City, located in the southeastern corner of Nebraska, in June and Tupelo, located in the northeast corner of Mississippi, in September. Both meetings afforded the Committee uniquely different perspectives on challenges rural communities face in providing health and human services.

The Nebraska City field meeting emphasized the geographic isolation of the upper Midwest region of the United States as an area populated by very small towns

with agriculture-based economies. Nebraska's total population is 1.6 million, with the majority of the people living in the eastern part of the State. Ironically, by Nebraska standards, that section of the State, which is predominately rural, is considered relatively populous compared to the western half, which is mostly a frontier area. Nebraska City, a town of approximately 7,000 people, lies in the east on the Nebraska-Iowa border and is tightly linked to both Omaha and Lincoln, Nebraska's two metropolitan areas.

The Tupelo site visit provided a very different picture of rural America than that of Nebraska City. Tupelo has one of the larger populations of any rural area in the country. Under new standards developed by the Office of Management and Budget (OMB), Tupelo is a perfect example of those areas now identified as "micropolitan."

Prior to the 2000 census, the primary way to delineate geographic areas was to identify those areas that are metropolitan, cities of more than 50,000 people and their outlying suburbs, and then to categorize all other areas as non-metropolitan.[1] The standardized definitions of metropolitan areas were first issued in the 1950s as a means to create uniformity among different Federal entities by providing one nationally accepted definition. While these determinations offered a workable national standard, it also left rural areas relatively undefined. For the 2000 census, the OMB added the "micropolitan" category, creating a new and more precise way to define those areas with less than 50,000 in population.[2]

Tupelo, population 34,211, sits in the middle of a 16-county area in Northeast Mississippi and is home to more of the area's residents than any other town. Tupelo is the primary center of commerce for the area, with a diversified economy that serves as an anchor for the region and a 650-licensed-bed hospital.

These kinds of communities have always existed, but the creation of a demographic term that clearly identifies them can help to provide insight into the important roles these communities can play in supporting the rural areas that surround them. These communities can help provide the resources and infrastructure necessary to build meaningful networks of health and human service providers that support rural communities on a regional level.

Tupelo may be one of the more well-known examples of regional community development. Public policy experts have lauded the accomplishments of this community, which over the past 100 years has transformed itself from one of the poorest counties in America to a model for rural economic development. "The Tupelo Model" is often cited as an example of what one community can do to revitalize a region.[3]

The designation of Tupelo as a micropolitan area reflects the latest move by the Federal government towards the spatial analysis of community. Smaller than metropolitan areas, these regions are based on the premise that one centralized location or place acts as the focus for a multi-county area—politically, culturally and economically. It is obvious that this is the situation in Tupelo. It is not so obvious that this situation exists in Southeastern Nebraska. This reality supports the Committee's belief that "rural" is not just a small scale of "urban" and, therefore, solutions to rural problems need to be tailored to the local context.

## *References*


[1] "Guide to the 2002 Economic Census." *U.S. Census Bureau*. Available at: http://www.census.gov/econ/census02/guide/g02geo2.htm.

[2] "Main Street America Gets a New Moniker." *The Wall Street Journal*; Aug. 23, 2004. Available at: http://www.realestatejournal.com/relocation/relocation/20040823-mccarthy.html.

[3] Putnam RD, Feldstein LM, Cohen D. *Better Together: Restoring the American Community*. New York: Simon & Schuster; 2003.

# Collaborations to Enhance Community and Population Well-Being

## Purpose

The purpose of this chapter is to suggest a policy and program agenda that would foster collaborations among community organizations and local rural leaders to improve the well-being of their community and its residents. The National Advisory Committee on Rural Health and Human Services (NACRHHS) believes that sustaining rural communities requires effective local collaborations in which federally funded programs and payment systems are a significant but not exclusive part. Any strategy to improve and sustain the quality of life in rural communities must include coordination among service providers and local leaders in multiple sectors (e.g., health and human services, transportation, education, economic development) so that programs are additive not duplicative, complementary not contradictory, and focused on individual and community outcomes not processes.

## Why The Committee Chose This Topic

The Committee's support for local collaborations is directly related to "One Department Serving Rural America," the July 2002 Report to the Secretary of the U.S. Department of Health and Human Services (HHS) from the Department's Rural Health Task Force. That report put forth five goals that focus on communities, populations and policy efforts that combine the work of otherwise disparate programs:

1. Improving rural communities' access to quality health and human services
2. Strengthening rural families
3. Strengthening rural communities and supporting economic development
4. Partnering with State, local and Tribal governments to support rural communities
5. Supporting rural policy and decision making and ensuring a rural voice in the consultative process

The HHS Rural Task Force Report to the Secretary acknowledged the importance of coordinating programs in rural communities and the need for broad consideration of relevant programs.

The strong relationship between adequate income, sufficient food, strong social networks and good health necessitates coordination among various health care and

### Terminology

**Collaboration:** Two or more local organizations taking action based on decisions they reach together.

**Community:** An aggregation of individuals in a geographic space that includes at least one public entity for general governance. In rural America, a community is typically a local government jurisdiction and surrounding area.

**Integration:** Two or more organizations arrange to have at least one service from each contribute to the same program. Integration can be as minimal or extensive as the organizations desire. A memorandum of understanding or similar document may be used to combine services; a separate organization may be formed to operate a new program that combines services from multiple organizations, or organizations may merge into a new formal governance structure. In any of these arrangements, the connection of related services is seamless to the end user.

**Services:** Those activities that deliver value directly to clients of a local organization.

social service agencies. This coordination is especially important in rural communities, where services and providers are limited in numbers. In many rural communities, service providers often make alliances with one another and exhibit extraordinary resourcefulness and resilience.[1]

More than 225 HHS programs are available to rural communities. The Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis prepared an inventory of these programs for the NACRHHS, which is available through the Rural Assistance Center at http://www.raconline.org/pdf/rural-hhs-programs.pdf. The NACRHHS concurs with the HHS Rural Task Force recommendations that there should be a formal structure within HHS to coordinate rural policy initiatives and a process to include a specific focus or crosscutting discussion about serving rural America as new policies/programs are developed. The NACRHHS has learned, through site visits and literature reviews, that even in the short time since the Task Force completed its work, innovative efforts have succeeded at the State and local levels that have achieved coordination across programs. What remains is to make coordination a reality at all levels in the Federal system.

Just as HHS has taken the initiative within the Federal government to push for community-based, comprehensive policy, the NACRHHS believes that local health and human service leaders will take the initiative to push for broad-based community collaborations. With health and human services as a starting point, community collaborations can quickly incorporate economic development, housing, education, transportation and other sectors representing essential services.

Achieving the Rural Task Force's goals requires a comprehensive perspective on who should be engaged in collaborations to benefit the community. Commu-

## Figure 1. Application of IOM's Six Aims to Community Collaboration

| Aim | Population Health Definition | Example of Community Program |
|---|---|---|
| Safe | Avoid accidents and injuries from hazards that may be in the community | Community planning to enhance traffic safety |
| Effective | Pursue community-wide interventions to enhance health based on scientific knowledge | Community planning to encourage exercise and policies to encourage nutritious food in schools |
| Patient- and Community-Centered | Ensure that stakeholders (education, business transportation, health care) are respectful of community needs, preferences, and values | Establishment of population health programs for minority populations responsive to ethnic cultural and language issues |
| Timely | Ensure early intervention to prevent or delay onset and progression of disease | Education programs on importance of nutrition and exercise |
| Efficient | Seek efficient allocation of community resources to maximize health impact for the community | Development of public policy that encourages a balance between personal health care and community health improvement programs |
| Equitable | Provide all community residents with an environment that promotes health | Creation of partnerships across sectors to raise awareness of environmental forces that impact health |

nity well-being is not the exclusive purview of any particular sector or revenue stream. Successful collaborations achieve objectives that improve service delivery and, subsequently, community health. Throughout this discussion, the NACRHHS intends "collaboration" to mean two or more local organizations taking action based on decisions they reach together. (At the same time, "collaborations" are multiple actions initiated by and among various groups.)

The NACRHHS believes collaboration is a means to a broad-based goal: healthy rural communities. The goal can be realized, at least in part, by achieving the six aims the Institute of Medicine (IOM) developed to guide policies and actions that close the chasm between the current health care delivery system's level of quality and a system of optimum quality. The IOM's Committee on the Future of Rural Health Care applied those aims to the broader goal of community well-being. In doing so, they recognized the importance of an inclusive approach that reaches beyond traditional health care delivery:

> The Committee believes rural communities must build a population health focus into decision making 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.[2]

Figure 1 on the preceding page shows the Committee's application of the six aims of the IOM's *Crossing the Quality Chasm* report to community collaboration.

# Chapter Organization

The NACRHHS collected information during site visits to Nebraska and Mississippi detailing experiences local agencies had in creating community-wide initiatives that integrate the resources of multiple programs. The Committee also reviewed the literature and, in this chapter, presents other examples of successful local collaborations. The NACRHHS recognizes that local leadership is important to successful collaboration. From the site visits and the literature, the Committee learned more about how to develop and sustain the capacity for local leadership. The Committee's purpose was to draw lessons from these local experiences that would inform the Secretary about initiatives Federal agencies could undertake to further enhance cross-program integration.

# Making Collaborations Work Locally: Examples, Barriers, and Incentives

## Examples of Collaborations

The NACRHHS learned that successful local collaborations advance community interests across a number of policy sectors, demonstrating the role of health and human services as a catalyst for other activities, or vice versa. Any number of configurations constitute collaborations, as illustrated in the text box (see next page) on the Eastern Maine Transportation Collective (EMTC), which describes how almost 30 different entities from several sectors collaborated to ensure public transportation services for the elderly and others. This collaboration includes a university program and is facilitated by the local United Way.

### Blue Valley Community Action Partnership

Collaborations can take the form of "one-stop" service delivery, offering clients access to a variety of programs in one location. Such collaboration exists in Southeast Nebraska, through the Blue Valley Community Action Partnership (BVCA). BVCA is a community-based, private, not-for-profit corporation serving 15 counties in Nebraska and Kansas. BVCA partners with various community and religious groups, public entities, schools and local businesses to offer more than 30 programs in the following areas: health services, family services and development, child development, children and youth services, outreach services (including case management), nutrition services, emergency services, crisis intervention, housing services and development, transportation services and rural development.

## The Eastern Maine Transportation Collaborative

In August 2003, almost 30 social service, health care, transportation, State and academic organizations united to form the Eastern Maine Transportation Collaborative (EMTC). EMTC's purpose is twofold: (1) to better understand problems that older adults in rural areas experience when they need transportation to access health care, and (2) to advocate for improvements in local and regional transportation policies and programs. EMTC is an ongoing multi-county organizational collaboration. Additional organizations have continued to join the collaborative effort over time. Its member agencies span three large rural counties and include Community Action Programs, Area Agencies on Aging, community health advisory committees, health care systems and hospitals, community health centers, State and local departments of transportation, Senior Corps programs, both Medicaid-reimbursed and volunteer transportation services, and the University of Maine Center on Aging. The United Way of Eastern Maine facilitates the work of the EMTC.

During the summer of 2004, EMTC applied for and received a $36,000 planning grant award from the Maine Health Access Foundation to carry out a comprehensive community analysis of the transportation needs of older adults in Washington, Hancock and Penobscot counties who regularly require chronic care medical services. A deciding factor in the EMTC's receipt of the award was the extent of collaboration evidenced in their work. The University of Maine Center on Aging will perform the needs assessment, with local health and social service agencies assisting in identifying key stakeholders in eight communities where intensive case studies will be carried out to better understand the special challenges to accessing chronic care services. The project will identify roadblocks to health care access including the availability of affordable health transportation options in the designated geographic region. Assessment will focus on older patients seeking chronic care services in the areas of physical and occupational rehabilitation, renal dialysis, diabetes and cancer care. The project team will work toward designing a coordinated and systematic strategy of scheduling patient transportation across multiple services and building a comprehensive database of transportation programs both large and small that is Internet accessible.

BVCA was the first multi-agency family resource center in Nebraska, as well as the first multi-county public health system (a partnership between public and private entities). Current collaborations include the following:

- **Health Services Program**. The BVCA collaborates with several county health departments to offer a wide range of health services, health screenings and financial assistance. Collaborations also occur with local clinics, churches and hospitals to offer minority health services, immunizations and lead screening. Case management is a vital component of the Health Services Program, integrating multiple services into one visit.

- **Gage County Safe Schools/Healthy Students**. This program is funded collaboratively by the departments of Education, Justice and Health and Human Services. Locally, mental health providers, hospitals, police and the school districts in Gage County are collaborating to address six issues: a safe school environment; alcohol, tobacco, drug and violence prevention; mental illness prevention and treatment; early childhood services; reading levels among students; and safe school policies.

- **Housing Development**. BVCA is collaborating with private investors, local lenders, government and quasi-government partners to develop affordable housing for families.

### Community Hospitals and Community Health Centers Collaborations

Collaborations can occur within a more narrowly defined scope of services, such as those delivered by two or more health care providers. A study of five collabo-

rations between community hospitals and Community Health Centers (CHCs) illustrates both this type of collaboration and a variety of organizational arrangements:

- A CHC assumes responsibility for outpatient care operations of the hospital, on the same campus, under the Medical Director of the CHC who is also Medical Chief of Staff of the hospital; a joint foundation supports both entities.
- Two entities supply joint care coordination in home health, disease prevention programs, outpatient services, hospice and mental health, electronic medical records shared between the CHC and the emergency room of the hospital.
- Two CHCs and a regional hospital form a separate 501(c)(3) network, sharing management information systems to create an integrated delivery system with a focus on disease management, quality improvement, increasing access and supporting hospital and community pharmacies.
- A regional CHC collaborates with three hospitals for physician recruitment, wellness promotion programs and regional dialysis/cancer treatment.
- A CHC, regional hospital and Critical Access Hospital (CAH) are affiliated to handle tertiary referrals at the regional hospital and geriatric services at the CAH, and to share inpatient/discharge case management; they also jointly participate in disease management collaboratives for diabetes and cardiovascular conditions.[3]

Even in these examples, collaborations reached beyond the narrow boundaries of a single sector to incorporate other sectors. One of the collaborations in the study works with congregate housing for the elderly, a logical connection for health care providers focused on geriatric services. The collaborations used funding from multiple HHS programs: the Federal Office of Rural Health Policy (ORHP), the Rural Hospital Flexibility Grant Program that assists CAHs, and the Bureau of Primary Health Care's special funds for disease collaboratives. Secure funding from patient care resulting from CHC status and CAH certification helped these collaborations create a stable fiscal environment for providers, which allowed management to spend energies on tasks other than meeting monthly payroll.

## CREATE

Local collaborations connecting services across a broad array of sectors might be supported by local sources of funding, aggregated in a local community foundation. The NACRHHS found an example of this in Mississippi, with the Christian Research Education Action Technical Enterprises (CREATE) Foundation that was started by a local newspaper owner, George McLean, in 1972 and now serves as an administrative entity with eight county affiliates.

The community spirit represented by CREATE has roots back to the 1940s when community leaders came together to create a dairy industry that, by the 1950s, was generating millions of dollars of revenue for Tupelo. Now Lee County is home to facilities from 202 firms, including 17 Fortune 500 companies. The North Mississippi Medical Center, which is headquartered in Tupelo, is the largest non-urban medical center in the country.[4] The Community Development Foundation has been active since the 1940s and, among its activities, conducts an annual leadership institute. CREATE is now an umbrella foundation capable of managing funds for other organizations such as the Boy Scouts, United Way, the Good Samaritan Health Services free clinic and the Sanctuary Hospice House.

In 2003, the CREATE Foundation completed a strategic planning exercise. Using its Commission on the Future of Northeast Mississippi (created in 1995), the foundation will invest more than $1 million over a five-year period in a regional workforce development effort. The project's focus areas are an indication of the breadth of activities, consistent with what the NACRHHS has learned, that contribute to healthy communities built and maintained through collaborative efforts: workforce development, economic development and social environment.

The Commission will measure its success through *State of the Region* reports that include indicators of the state of the economy, education, public safety, social environment, health, housing and infrastructure. Examples include the following:

**Economy**: Employment composition (from the Claritas data base)

**Education**: Graduation rate (MS Department of Education)

**Public Safety**: Traffic fatalities (MS Department of Public Safety Planning)

**Social Environment**: Births to single teens (MS Department of Health)

**Health**: Percentage receiving prenatal care (MS Department of Health)

**Housing**: Percentage of owner-occupied housing (Claritas)

**Infrastructure**: Airport departures (from two regional airports)

The Commission works well as a multi-county entity that brings public and private organizations together to make programs happen. The Commission itself provides no direct services, nor does it develop its own programs. Each of the 16 counties in the region is represented on the board of directors of the Commission. A consistent theme of the Commission, and of CREATE, is that all activities are regional, on behalf of all 16 counties. CREATE makes that commitment obvious to all counties by providing a fund of $100,000 for each county.

The NACRHHS identified several elements of CREATE's success that can be incorporated by other collaborations:

- Having a clear, consistent message that "community development precedes economic development" (the importance of this message was highlighted in a recent description of "The Tupelo Model": "that treating town and region as an interdependent community would be more productive than focusing on narrower interests, that community development is the sturdiest foundation for economic development."[5]
- Having a forum such as the Commission for building trust among key stakeholders.
- Anchoring activities and measuring progress, by having a set of valid indicators of community well-being.
- Having support of local media (for Northeast Mississippi, the Tupelo newspaper)
- Creating influence through the power of convening without interfering with program operations.
- Taking advantage of dynamic, committed local leadership.
- Having a vision for the future that is broader than any single activity, such as creating jobs solely for the purpose of creating jobs (e.g., focusing on the quality of life in the community, including the quality of the jobs created).

The role for health and human services in building and sustaining this successful collaboration was obvious and manifold. First, the regional medical center is a powerful economic and social force as well as being a large health care provider. The center encourages regional collaboration through such efforts as sharing workforce projects with local colleges so that career paths are available to students, working with local clinics and hospitals in the 16-county region and financing a residency program. A social environmental task force works on issues that cut across all sectors, with a major focus on racial reconciliation in the region.

## Panhandle Partnership

Collaboration is not meaningful unless it yields outcomes that meet community-wide objectives. A two-step process is involved. The first step is to create the possibility for successful collaboration by bringing organizations together and providing resources to enable them to work toward common objectives. The CREATE Foundation is an example of a permanent infrastructure designed for this purpose. Another example is the Panhandle Partnership for Health and Human Services (Panhandle Partnership) in Nebraska. This small, non-profit organization applies for grant funds to support the activities of regional agencies that work toward common objectives. For example, the Panhandle Partnership recently received a grant award from the Agency for Healthcare Research and Quality to establish an electronic medical record that will link the information systems of eight hospitals in a nine-county region. The grant was made possible because the partnership pro-

vided a forum for those hospitals to develop the plan. In human services, the same framework has facilitated a children's outreach program and a Native American health project.[6]

The Panhandle Partnership is a 501(c)3 organization made up of more than 60 agencies and organizations. It does not provide services, nor does it compete with existing agencies. Instead, its primary function is to bring agencies together to maximize the use of their resources. Examples of the Panhandle Partnership's projects include the following:

- Service Point Information System - A central client database that is available at every service point. To date, 16 agencies participate, with over 9,000 unduplicated clients.
- Children's Outreach Program - A home-visit program for newborns.
- Comprehensive Community Planning Process - A process that includes all of the Panhandle communities.

## Barriers to Collaboration

Collaboration takes significant time investment by involved parties and sizeable resource investments from local and Federal levels. Collaboration does not occur overnight. Trust must be built, common ground must be established and a vested interest must be made by participating parties in order for collaboration to occur. In Mississippi, the Committee learned that nearly 10 years of building trust preceded the development of the CREATE Foundation's strategic plan in 2003. Once the initial foundation for collaboration is built, other system-wide and program-wide barriers challenge service delivery collaboration.

Challenges to collaboration in rural areas include a lack of resources at the community level, lack of established communication between parties, long travel distances and a low population base (and therefore a small client base). In addition to these barriers, sometimes communities simply do not want to collaborate. The communities may have a history of mistrust or competition, and thus any efforts to collaborate are futile.

Federal grants tend to be categorical and lack the flexibility needed for collaborative service delivery. The result is territorial service delivery instead of client-focused service delivery. Furthermore, if services are being delivered in an integrated manner, challenges may arise with the varied requirements for time reporting, evaluation, data reporting or technology. For example:

- Payment for services is often denied when a case manager conducts a home visit that covers multiple programs. Thus, the need exists for accountable, yet flexible, time reporting that recognizes the cost savings of delivering a variety of program services through one case management visit.
- If BVCA conducts a home visit for multiple programs, the caseworker has to complete separate paperwork for each program and enter the data into separate reporting systems. A need exists for blended technology instead of the current system of multiple, duplicative data entry.

## Incentives for Collaboration

One of the primary incentives for service delivery collaboration is to better serve the client. For example, families often struggle with multiple issues simultaneously. By offering integrated case management services, as the BVCA does, a case manager can visit a family and cover a variety of issues from several programs. Further, that case manager can continue to work with the family, which means continuity of services in a single point of contact with less family disruption.

A second incentive for service delivery integration is the efficient use of financial and personnel resources. At the funding level, collaboration can mean significant cost savings for federally funded programs. Cross-training personnel across a variety of programs can mean significant cost savings to the funders, as well as to the program administrators at the local level (a more efficient use of personnel means more money to use elsewhere for additional services). In the instance of a cross-trained case manager in rural Southeast Nebraska, money is saved because only one case manager is used to cover a variety of programs, and only one case manager is incurring travel expenses. Cross-training is also effective because rural areas may not have enough clients in a program to justify a case manager dedicated to that program. However, in consideration of the variety of needs clients may have, and thus the variety of programs

they may need access to, a cross-trained case manager could deliver those needed services across a variety of programs.

A third incentive, obvious in Northeast Mississippi, is to link collaboration with broad goals of community well-being that include community development and economic development. When George McLean started getting local businesses and others to contribute to collaborative efforts, he did so based on the best interests of the community. That theme has continued with the commission's current workforce objectives, which also emphasize activities in each of the 16 counties in the region.

A fourth incentive is to encourage and facilitate the efforts of strong local leaders. In the two communities the Committee visited, the influence of a small group of leaders, and at times a single individual, was obvious.

## Sustaining Local Collaboration: Leadership Development

Well-known preconditions for successful collaboration reported in the research literature and reaffirmed by the Committee's site visits can be encouraged by federally supported public investments. Foremost among them is the development of local leadership and leadership training for those who are in positions to influence collaboration but who lack the skills.

The Heartland Center for Leadership Development (Heartland Center) in Nebraska is an independent, nonprofit organization that focuses on leadership training, citizen participation, community planning, facilitation, evaluation and curriculum development.

The Heartland Center developed the Home Town Competitiveness (HTC) approach for rural communities to build and revitalize their communities.[7] HTC focuses on assets that exist in the community and builds on those assets in four strategic areas:

- Mobilize local leaders. HTC encourages rural communities to think beyond the "usual suspects" and include women, minorities and youth in decision-making and leadership roles.

- Capture wealth transfer. Wealth often disappears from the place it was created when inherited by a beneficiary who no longer resides in the community. HTC sets a target of converting at least five percent of the local wealth transfer into charitable assets that can then be used to fund community and economic development efforts.

- Energize entrepreneurship. HTC encourages rural communities to foster local growth by (1) planning business ownership succession, (2) assisting entrepreneurial companies that have the potential to break through to a larger market, and (3) using local charitable assets to support entrepreneurship development.

- Attract young people. HTC teaches communities how to engage youth before they leave, and how to attract youth through career opportunities, business transfer and entrepreneurial support.

Five sites across Nebraska are using the HTC approach. The Heartland Center conducted its first HTC academy in February 2004. The Center is currently responding to requests from around the country to engage communities in leadership development. The Heartland Center has published a booklet focused on building local leadership.[8] They also suggest 10 ideas for recruiting new community leaders:

1. Ask the question, "Who's not here?"
2. Look for skills, not names
3. Try involvement by degrees
4. Appeal to self-interests
5. Use a wide-angle lens
6. Define the task
7. Use current leaders to recruit new leaders
8. Create a history of efficient use of people's time
9. Offer membership premiums
10. Market your wares[9]

## Other Leadership Building Activities

The University of Massachusetts offers a special program, the Master Teacher in Family Life Program, to teach "natural leaders within poor communities the information and skills they need" to create a community system with fellow residents about important issues that include health and education, and to create and sustain a network for people to use their knowledge to make changes in their lives.[10] The W. K. Kellogg Foundation has a special set of instructional modules on its Web

site for developing community capacity and sustaining community-based initiatives. The first chapter of the "Developing Community Capacity" module is "Leadership: Building Capacity to Lead a Community-Based Process." The chapter describes the skills that are needed and provides case studies. The learning objectives for the chapter include the following:

- Comprehend the essentials of the new kind of leadership required for collaborative community efforts and the difference between traditional forms of leadership and this new model.
- Understand the primary role of the new leader.
- Recognize the skills and attributes needed by an effective collaborative leader.
- Become aware of traps to avoid in exercising collaborative leadership. [11]

## The Role of Foundations in Fostering Leadership Development

Rural areas often face challenges in fostering leadership in their communities, as we heard from Milan Wall, Co-Director of the Heartland Center. Rural areas are attempting to find new, non-traditional leaders; keep and attract young people to their communities; capture wealth; and promote entrepreneurship, all in an effort to develop leaders within rural communities. This requires significant resources. Thus, community foundations can play a vital role in promoting leadership development. One such example is the Nebraska Community Foundation. (See text box).

### The Nebraska Community Foundation

The Nebraska Community Foundation helps mobilize charitable giving to 147 Nebraska communities through over 160 component funds. With current assets exceeding $18.6 million, the Foundation has reinvested over $40 million during its ten-year history. Thus far, most of the funds have been used for specific small projects, such as small grants to fire departments and youth activities. The Foundation participated in a few larger projects, most notably the Home Town Competitiveness program, which is now in five Nebraska sites. The program is a "come-back/give-back" approach that encourages young people and entrepreneurs to return to rural communities, and it solicits contributions from people who have left the community.[1] This program focuses on building the leaders that communities need to continue with comprehensive economic development. The Nebraska Community Foundation is an exemplary effort to claim some of the generational wealth that will transfer either to the next generation or to charitable causes during the next 50 years. A five percent capture of that wealth in rural Nebraska would yield approximately $5 billion.

[1] Hendee D. "For rural residents, charity begins at hometowns." *Omaha World-Herald;* November 15, 2004.

## The Results: Creative Local Leadership from a Variety of Sources

A case example of creative leadership in New Mexico was summarized for the NACRRHS. In the four corners region of the State, specifically the community of Farmington, a 30 to 40 year history of conflict is coming to a close thanks to the efforts of two leaders with a shared vision of improving the regional economy through collaborative programming. The region includes both civic and Tribal jurisdictions whose history includes discrimination so obvious that in the 1970s the U.S. Department of Justice conducted an investigation. In 2000, the mayor of Farmington and the vice chairman of the Navajo Tribe developed a friendship that enabled them to jointly examine problems in the community. They convened nine organizations and signed an agreement creating a new health authority. In the spring of 2001, they received funding through the Community Action Program that helped them maintain momentum for the activities of the new authority. Thanks to the experiences of the Community Action Program grant, the Navajo Nation has brought together other mayors to address regional problems in economic development, housing and roads. They have solidified a

commitment to collaborative work that achieves common goals.

Another example is Chuck McCauley, a physician at the Marshfield Clinic in Marshfield, Wisconsin, who became a local leader after recognizing that obesity was a community problem that needed community solutions. Dr. McCauley was instrumental in launching a community program, "Healthy Lifestyles." Key to the success of the program was the fact that it originated with a physician and the clinic in which he worked. In September 2001, the clinic launched Healthy Lifestyles, with a $100,000 budget. The school system was an early partner in the community collaboration, believing that the best starting point in the community was with children. Private businesses in the community were among the next organizations to participate, with one firm mapping out a one-mile walking path on its grounds for use by a walking club.[12] Also, leadership from the medical community was essential. The program's success can be attributed to the effort of one leader with credibility and standing in the community to address the issue.

## Sustaining a Community Vision: The Role of Health and Human Services in Integrating Programs Across Sectors

Meeting the needs of rural residents for health care and social services should be seen as an element of a broader mission to build sustainable rural communities that create the best possible quality of life for everyone. The NACRHHS recognizes a shift occurring in public policy responding to rural needs, from a focus on land-based agricultural policy to human capital-based comprehensive development policies. The 2001 Annual Report of the Center for Rural America described an emerging consensus that policies for a "new rural America" would have three focal points: places, collaboration and regional competitiveness.[13] The NACRHHS believes the focus of that report, on business and economic development policy, should be applied to health and human service policy, and that advocates of a new rural policy should incorporate health and human service policy into their models.

The NACRHHS agrees with Charles Fluharty, Director of the Rural Policy Research Institute, that the health (and human service) sector is well positioned to provide leadership in communities across the country to establish new linkages across local community organizations that will advance rural policies and programs. Mr. Fluharty sees the health sector as critical to achieving new directions in rural policy because the sector is ahead of many others in having what is needed: vision for healthy communities, community-based orientation, local and national leadership, linkages across the Federal system (National, State, and local) and multi-sector, multi-jurisdictional understandings.[14]

The importance of thinking of health and human service programs and policies as integral to overall community development is obvious when considering, for example, welfare reform. The human service policy of helping people find opportunities to work and end participation in public welfare has to be integrated with health care programs aimed at increasing opportunities to purchase health insurance and/or opportunities to receive health care services at little or no cost. Another chapter in this report addresses issues and programs specific to the reauthorization of the Temporary Assistance for Needy Families program, which is part of a fabric of approaches to local community development.

Ideally, health and human service programs would establish collaborative relationships with programs in transportation, justice, economic development, housing and education. The Safe Schools Healthy Students program in Gage County, Nebraska, combines support from the Department of Health and Human Services with support from the Department of Education and Department of Justice to create a single, integrated program. The Panhandle Partnership in Nebraska includes over 60 separate agencies and organizations that coordinate programs under this nonprofit umbrella to ensure optimum use of resources. The NACRHHS believes that the Secretary can continue to provide leadership in rural policy development by demonstrating successful collaborations in health and human service programs that will be models for extending collaborations across sectors. The objective is better rural policy focused on community and individual well-being. As the Rural Task Force said in its report, health care and social services are "essential for the health and well-being" of rural communities and the well-being of rural residents.[15] These services are central to the success of rural econo-

mies, both directly through jobs and revenue, and indirectly through additional economic activity generated by those services.

Sustained community collaborations can achieve a great deal to continuously advance community health. Collaborations produce traits that, if successfully nurtured, contribute to sustaining community improvement efforts: individual empowerment (active involvement of people in solving the problems that affect their lives), building social ties (building trust and a sense of community across social dividing lines) and synergy (combining knowledge, skills and resources of a diverse group of people).[16] Collaborations that produce these traits also will be assuring their continued success because local citizens will continue to identify next steps to enhance the quality of their lives through community action. Lasker and Weiss argue that collaborations of community groups and individuals can do the following:

- Obtain more accurate information about concerns, priorities and trade-offs people in the community are willing to make.
- Look at issues in relation to each other and the community's goals, and know how services and programs relate to each other.
- Challenge accepted wisdom to understand root causes of problems and discover innovative solutions.
- Understand the local context, including community values, politics, assets and history.[17]

Local collaborations can develop strategies to build on local community assets and connect multiple services, programs, policies and sectors. Leadership is a key variable that explains the success of community collaborations:

> Community collaborations appear to benefit from having leaders and staffs who believe deeply in the capacity of diverse people and organizations to work together to identify, understand, and solve community problems. These kinds of individuals understand and appreciate different perspectives, are able to bridge diverse cultures, and are comfortable sharing ideas, resources, and power.[18]

The NACRHHS believes HHS programs should devote a portion of their resources (budgets) to leadership development and continuing management programs for community leaders.

Well-led successful community collaborations become part of what scholars identify as the community environment that contributes to community health. Such collaborations can influence all 12 dimensions of what M.H. Hillemeier and colleagues identify as the contextual characteristics for community health[19]:

- Psychosocial
- Behavioral
- Transport
- Economic
- Employment
- Education
- Political
- Environmental
- Housing
- Medical
- Governmental
- Public health

Those authors offer indicators and sources of data for each characteristic that could be used to assess the progress of community collaborations. For example, measures of environmental hazards could be used to establish targets for programs implemented by local collaborations led by health and human service sector leaders.

As discussed earlier, the CREATE Foundation in Mississippi provides support to the Commission on the Future of Northeast Mississippi. The Commission assesses conditions in the region, determines key issues facing the region and recommends strategies to address those issues. Consistent with the recommendations of Hillemeier and colleagues, the Commission tracks indicators in seven topics affecting community health: economy, education, public safety, social environment, health, housing and infrastructure.

# Actions and Specific Recommendations to Facilitate Collaborations

HHS could do much to foster collaborations among locally based organizations. Because health and human services are essential for community health and well-being, organizations and individuals in this sector have the opportunity to spearhead collaborations that integrate activities across sectors. While the Federal government cannot force community organizations into lasting collaborations (which require trust and working relationships that cannot be mandated), it can help establish a policy environment in which collaborations flourish. Existing HHS programs can be used for this purpose, and new programs could be established within existing authority.

## Actions

As recognized by the report *One Department Serving Rural America* and the creation of the Secretary's Rural Task Force within HHS, achieving the objectives of effective collaborations will require a new way of administering many of the programs in the Department and other Federal agencies. The details of specific programs need not necessarily change, but the intersection of programs needs to be explicitly recognized and new policies and procedures adopted that bring those programs together at the local level in new and creative ways. The following actions by the Secretary would encourage a new relationship among Federal programs, to the benefit of local action through successful collaboration:

- *Create common reporting requirements for programs that are linked at the local level.*

When two or more programs under the Secretary's jurisdiction are implemented at the local level by the same community collaboration, those programs should be instructed to develop a consolidated reporting format. Local agencies should be allowed flexibility to co-mingle funding from multiple programs to develop creative local programs that advance and sustain community development. The value of this flexibility was evident at BVCA, where multiple programs and services were delivered through one agency via one case manager visit, which in turn meant a better use of staff and money in a format that was client-centered. Additional ideas include combining funds provided through information technology grants (such as the new programs funded by the Agency for Healthcare Research and Quality) with grant funds for telemedicine projects (through the Office for the Advancement of Telehealth), special grants to Community Health Centers and grants to small rural hospitals to develop information networks that improve quality of care for rural residents as they receive services from multiple providers.

- *Encourage programs in other Federal agencies to participate in multi-sector collaborations.*

The Secretary should consult directly with other Cabinet Secretaries to issue directives to programs implemented through local action stating that they must all assess the effects they have on local collaborations and act based on those assessments to encourage collaborations. For example, housing programs, transportation funding, rural development projects and programs in early child development all contribute to the type of community-based collaboration for local development the NACRHHS learned of in Tupelo, Mississippi. Federal programs should explicitly recognize the contribution to local collaboration as well as the traditional measures of program outputs and outcomes.

- *Facilitate interagency cooperation that allows for single lines of accountability for funds.*

The Secretary should work with other Cabinet Secretaries to develop a memorandum of understanding that Federal agencies can use to follow a consolidated reporting system to meet requirements that local collaboratives be accountable for use of Federal funds. Those systems should include reporting achievements using measures of success for collaborations and broad-based measures of impact on the community. For example, the program the NACRHHS learned of in Southeast Nebraska combined funds from three Federal departments, but still had to report back to each department using that department's reporting format.

# Specific Recommendations

The following are specific recommendations the Secretary should undertake to further local collaborations that will enhance the impact of the Department's programs.

- *The Secretary should support the creation of a Web resource page for "models that work," showing successful collaborations in rural places.*

The Federal Office of Rural Health Policy (ORHP) should build this recommendation into its cooperative agreement with the Rural Assistance Center (RAC). A special page should be built that is devoted to describing successful rural-based collaborations and that can be accessed in one step from the home page of the RAC Web site. The funding to RAC should support a reporting function to collect and present information regarding those collaborations.

- *The Secretary should support research that will further specify opportunities and barriers.*

ORHP should dedicate a portion of its research budget to further specify opportunities for and barriers to collaboration, funding activity either through its research centers or its solicitation of independent research proposals. Researchers should develop models that explain reasons collaborations are successful, with success being defined, in part, as long-term sustainability. Research findings should identify barriers to successful collaborations as well as community, Tribal, State and Federal actions that facilitate successful collaborations.

- *The Secretary should support leadership development for rural community organizations and residents.*

The Secretary should instruct all agencies with programs supporting local service delivery to include funds for leadership development in their grant-making portfolios. The ORHP program for rural leaders should be continued. The Secretary should consider supporting regional leadership academies by combining current programs from separate entities in HHS. The Secretary should encourage private foundations to expand their efforts to train future leaders. The Nebraska Community Foundation is one example of the important and crucial role a foundation can play in fostering leadership development in rural areas.

- *The Secretary should require grant recipients engaged in direct delivery of services to demonstrate an effect on community development.*

The Secretary should require that all grant applications in programs supporting service delivery in rural areas include an analysis of how the program will relate to broad-based efforts in community development. CREATE, in Mississippi, is measuring its success based on community indicators, such as the economy, education, public safety, social environment, health, housing and infrastructure.

# Next Steps

The NACRHHS intends to continue to support local collaborations that work to achieve a broad-based program of activities that contribute to community development in rural America. The NACRHHS intends to monitor several initiatives that contribute to a growing national consensus about the value of integrating otherwise disparate activities into cohesive programs at the local level:

- Follow-up activities resulting from the IOM report, *Quality Through Collaboration: The Future of Rural Health Care*, including those initiated by other organizations such as the National Rural Health Association and State offices of rural health.
- Demonstrations of the applicability of the Program of All-Inclusive Care for the Elderly model in rural areas.
- Collaborations between CAHs and CHCs.
- Rural entrepreneurship programs.
- Activities of organizations that share the goal of integrated activities and collaborations across sectors, including the Rural Policy Research Institute, the National Rural Health Association, the National Organization of State Offices of Rural Health and organizations representing local and State government officials.

The NACRHHS intends to monitor related initiatives

that are not directly engaged in promoting collaborations but that do influence community development. These include the following:

- Pay-for-performance initiatives affecting health and human services.
- Advances in leadership training.
- Measures of quality in health and human services that are influenced by variables other than direct service delivery (e.g., outcomes measured at both the individual and community levels).

The realization that programs across sectors are targeting the same goal—sustained healthy communities—is not new. However, pressures to be cost-effective and accountable for measurable outcomes are greater now than ever before. This creates an opportunity to base accountability on the effects of programs on communities, which in turn creates pressure to combine programs that target the same population for the same purpose. The NACRHHS believes the health and human service sector can lead a reinvigorated attention to community (population and infrastructure) outcomes that focuses on successful collaborations.

## *References*


[1] HHS Rural Task Force. "One Department Serving Rural America." *Report to the Secretary;* July 2002. Available at: http://ruralhealth.hrsa.gov/PublicReport.htm.

[2] Committee on the Future of Rural Health Care. *Quality through Collaboration: The Future of Rural Health.* Washington, DC: National Academies Press; 2004.

[3] Wilhide SD. "Rural CHC/Hospital Collaboration: An Opportunity to Improve Community Health Status." Presentation at 2004 Critical Access Hospital Conference; October 6-8, 2004; Kansas City, MO. Available at: http://www.dhh.state.la.us/offices/publications/pubs-88/Steve%20Wilhide%20PP%20Show.pdf.

[4] Putnam RD, Feldstein LM. "The Tupelo Model: Building Community First." In: *Better Together: Restoring the American Community*. New York: Simon & Schuster; 2003.

[5] *ibid.*

[6] Palm D. "Building an Integrated Rural Health Delivery System: The Nebraska Panhandle Experience." Presentation to the National Rural Health Association Board; August 11, 2004.

[7] "Home Town Competitiveness: A Blueprint for Community Builders" handout. Received from Milan Wall, Co-Director of The Heartland Center for Leadership Development. See also: http://www.heartlandcenter.info.

[8] Wall M, Luther V. "Building Local Leadership: How to Start a Program for Your Town or County." Lincoln, NE: Heartland Center for Leadership Development; 2001.

[9] Wall M, Luther V. "Ten Ideas for Recruiting New Leaders." Lincoln, NE: Heartland Center for Leadership Development; 2001.

[10] Slinsky, MD. "Building Communities of Support for Families in Poverty." Cooperative Extension, University of Massachusetts; May 25, 1994. Available at: http://crs.uvm.edu/nnco/communsupp.

[11] Trasolini S, Chrislip D, Larson CE. "Leadership: Building Capacity to Lead a Community-based Process." In: Bandeh J, Kaye G, Wolff T, Trasolini S, Cassidy A. *Developing Community Capacity.* Battle Creek, MI: W. K. Kellogg Foundation; 2004.

[12] Johnson M, Fauber J. "Marshfield Mobilizes to Fight Fat: Citywide Effort Offers Blueprint for How to Battle Obesity Epidemic, Experts Say." *Milwaukee Journal Sentinel*; July 9, 2003.

[13] Center for the Study of Rural America. "A New Focus on Rural America: New Paths for Rural Policy." *Annual Report 2001*. Kansas City, MO: Federal Reserve Bank; 2001. Available at: http://www.kc.frb.org/RuralCenter/annreport/CenterAR-2001.pdf.

[14] Fluharty CW. "Toward a Community-Based Rural Policy for Our Nation." Presentation to the Nebraska Rural Association Annual Conference, September 3, 2003; Kearney, NE. Available at: http://www.rupri.org/presentations.

[15] HHS Rural Task Force. "One Department Serving Rural America."

[16] Lasker RD, Weiss ES. "Broadening Participation in Community Problem Solving: A Multidisciplinary Model to Support Collaborative Practice and Research." *J Urban Health*. March 2003; (80,1).

[17] i*bid*.

[18] *ibid*.

[19] Hillemeier MH, Lynch J, Harper S, Casper M. "Measuring Contextual Characteristics for Community Health." *Health Services Research.* December 2003; 38(6, Part II).

# Access to Obstetrical Services in Rural Communities

## Why The Committee Chose This Topic

The Committee chose this topic out of a growing concern for the viability of obstetrical (OB) services in rural communities throughout the country, a concern that was heightened by the Committee's recent visits to rural hospitals and conversations with physicians working hard to maintain these services.

The challenges of sustaining OB care in rural areas are in many ways similar to those of other specialty services, such as anesthesiology, general surgery and behavioral health. A recent paper on the general surgery workforce in rural America found wide disparities in the distribution of general surgeons between urban and rural areas and highlighted issues related to malpractice costs, the gender shift in general surgery, lifestyle demands and other concerns that will be discussed in this chapter on OB care.[1] Hence, some of the Committee's observations and recommendations on OB care are relevant to other specialty services in rural areas. It must be said, however, that OB care has a singular importance to the social and economic life of rural communities. In addition, the Committee believes any discussion of OB care includes both prenatal and neonatal care, which are critically important to rural communities. The Committee's appreciation for these relationships was also an important factor in its selection of rural OB care as a topic for this report.

### Geisinger Health System

The Geisinger Health System is the sole provider of OB services for a town in Pennsylvania where there is a national manufacturing company with 2,300 employees. There are 240 annual deliveries. OB admissions are 10 percent of the business for the local community hospital. Without OB services in town, the hospital would not be viable and the manufacturing plant would be gone.

In their testimony before the Committee, rural hospital officials and independent physicians practicing in rural areas repeatedly emphasized the importance of OB care to the health of their communities. They emphasized that rural families want assurance that prenatal care and OB services will be readily accessible where they live. Local access to these services is among the most important factors that young married couples may consider when deciding where to live and raise their children.

In order to maintain their status in the community, small rural community hospitals are struggling to provide OB care when financial loss from providing those services is severe. Many rural hospital administrators believe that OB care is a service that helps to define the mission of a community hospital and strengthens local support for the entire range of other hospital services.

The economic impact of limited or non-existent OB care in rural communities is difficult to measure; however, it is apparent that this particular service is especially vital to rural communities that are trying to create and sustain a favorable climate for business and economic growth. Local access to OB care can be a significant consideration for businesses that wish to locate in communities where they can recruit and retain a stable workforce and provide a favorable climate for working families.

Many rural physicians are also struggling to maintain OB care in their practices. They are confronted with significant issues related to declining birth rates, low reimbursement, excessive professional demands and the rising costs of malpractice insurance. Most physicians the Committee encountered were reluctant to abandon the struggle because of their strong commitment to the community, their emphasis on treating the entire family and their desire to maintain continuity of care for their patients.

Physicians were concerned about the potential risks when expectant mothers need to travel long distances to deliver their babies. The risks are magnified when there are complications with pregnancy that cannot always be anticipated. In extreme situations, delayed access to OB care can become a life or death issue for both mother and child.

Apart from the possible health risks, geographic isolation from OB care is also an economic consideration for expectant parents. When long-distance travel for care is necessary—it is not uncommon for some families to travel more than 100 miles in rural and frontier areas—there are costs associated with travel and lost hours of work, child-care and other issues.

The Committee believes that the access issues identified in this chapter are likely to become more pronounced in the coming years, as fewer physicians choose to train for obstetrics and some decide to drop obstetrics from their practices. Also, many new physicians trained in obstetrics will be seeking a more stable lifestyle environment than can be offered in small rural communities.

# What We Know

While a typical small rural community might have a hospital with less than 25 beds, staffed by one or two family physicians who provide OB services, existing systems for providing OB services in rural areas differ widely from place to place. The strengths and weak-

**Table 1. National Totals by Metro/NonMetro for OB/GYNs, Family Practice with OB/G Secondary Specialty, and CNM**

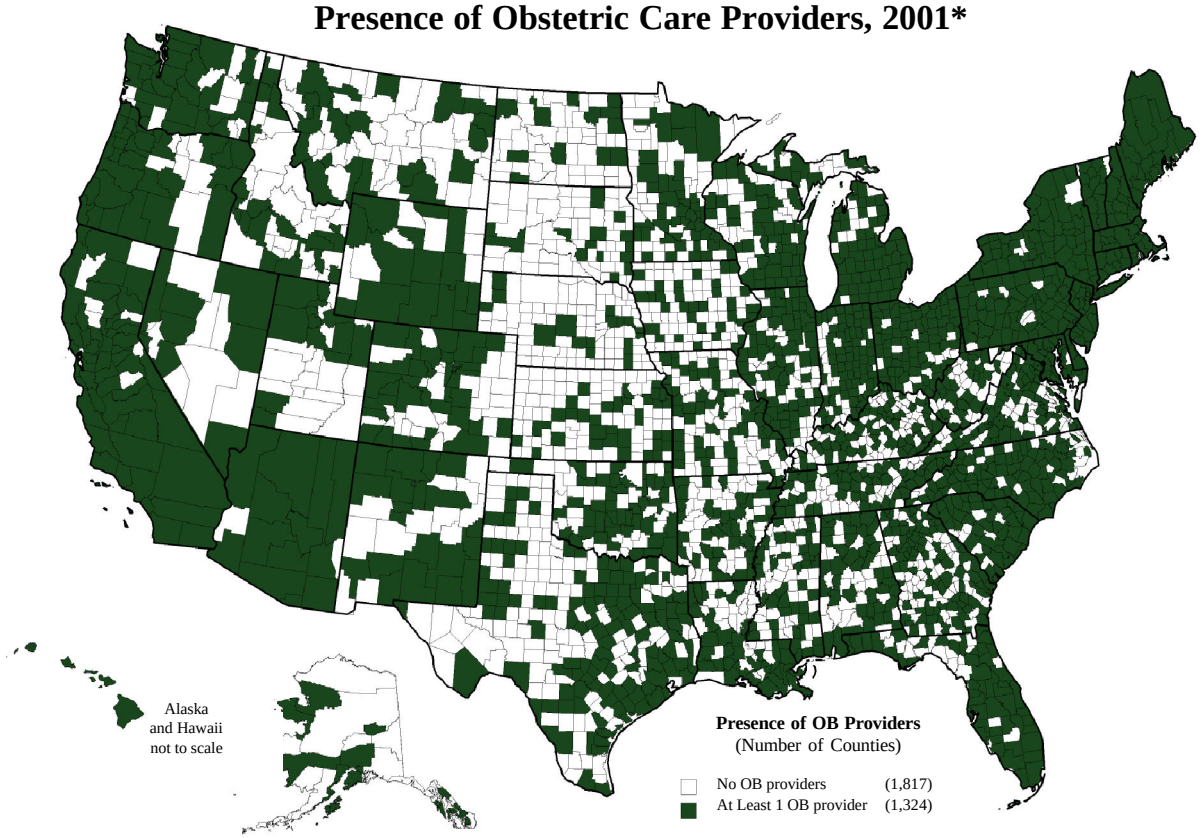
| | National Total | NonMetro | | Metro | |
|---|---|---|---|---|---|
| | | n | % of tot | n | % of tot |
| # Counties | 3,141 | 2,287 | 73% | 854 | 27% |
| Fem 15-44 Pop | 61,576,997 | 10,976,843 | 18% | 50,600,154 | 82% |
| OB/GYN FTEs | 36,973 | 3,624 | 10% | 33,348 | 90% |
| FP w/obg secondary spec FTEs | 1,112 | 399 | 36% | 713 | 64% |
| CNM FTEs | 2,399 | 376 | 16% | 2,023 | 84% |
| Tot Provider FTEs | 40,483 | 4,399 | 11% | 36,084 | 89% |
| OB/GYN per 10K Fem 15-44 | 6.00 | 3.30 | | 6.59 | |
| FP w/obg Per 10K Fem 15-44 | 0.18 | 0.36 | | 0.14 | |
| CNM Per 10K Fem 15-44 | 0.39 | 0.34 | | 0.40 | |
| Tot Prov Per 10K Fem 15-44 | 6.57 | 4.01 | | 7.13 | |

**Notes:**
Date Created: July 20, 2004
Created by: Southeast Regional Center for Health Workforce Studies, Cecil G. Sheps Center for Health Services Research, UNC-CH

CNM Data Source: American College of Certified Nurse Midwives (May 1999)

Physician Data Source: BPHC's Application Submission and Processing System (ASAPS) National Physician Listing, a compilation of December, 2001 data from AMA Master File, AOA Master File, NHSC Participant Listing. Physician data include clinically active, non-federal MDs and DOs.

**Presence of Obstetric Care Providers, 2001***




Sources: American College of Certified Nurse Midwives, 1999; Application Submission and Processing System (ASAPS) National Physician Listing, a compilation of December, 2001 data from AMA Master File, AOA Master File, NHSC Participant Listing.

* Note: "OBG Provider" includes active, nonfederal MDs and DOs with OB/GYN as primary specialty, family practice as primary specialty and OB/GYN as secondary specialty, or Certified Nurse Midwives (CNMs).

Produced by: Southeast Regional Center for Health Workforce Studies, Cecil G. Sheps Center for Health Services Research, UNC-Chapel Hill.

nesses of any given system will depend on many different variables, including the availability and training of local physicians, geographic location, referral arrangements among providers, relationships between hospitals and physicians, and other factors. The ideal system will have the full range of prenatal and OB services readily accessible in the local community, including specialty care. The reality in most rural communities is quite different.

Obstetricians are not found in most small rural and frontier communities. Further, the number of rural obstetricians has been decreasing since the early 1980s.[2] Low birth rates, professional isolation and lifestyle issues are some of the most significant factors limiting their availability in rural areas. In Nebraska, it is not uncommon for rural patients to travel 50 miles or more to see an obstetrician. If obstetricians are not present, emergency transportation from rural communities to larger hospital centers is required when there are complications of pregnancy that cannot be managed by local providers. While relevant data on birth outcomes are not available, there is a legitimate concern that inaccessibility to specialists in OB care services may hinder the quality of care.

When specialized OB care is unavailable in a rural community, this type of care is most likely performed by family physicians, often working with nurses, physician assistants and other non-physician health care providers. Some States also issue licenses to Certified Nurse Midwives (CNMs). The Committee has seen first-hand the dedication and skill of all of these providers in maintaining high quality OB care despite financial loss, severe restrictions on personal lifestyle, declining birth rates and significant increases in the cost of malpractice insurance.

# Workforce Issues

## Supply

Access to OB care in rural areas cannot be sustained or improved without an increase in the number of physicians trained in obstetrics. There are chronic shortages of obstetricians, as well as family physicians trained in high-risk obstetrics. Data on obstetricians compiled by the Sheps Center for Health Services Research at the University of North Carolina in July 2004 reveal striking contrasts between urban and rural areas in the availability and ratio of these providers to women of childbearing age. In metropolitan areas, the ratio of OB/GYNs per 10,000 women ages 15-44 is 6.59, while the same ratio in non-metropolitan areas is 3.30. When one combines OB/GYNs with family physicians who have a sub-specialty in OB, and with CNMs, the ratio for all of these providers per 10,000 women is 7.3 in metropolitan areas and 4.01 in rural areas. The total number of full-time equivalent providers (OB/GYNs, family practitioners with OB sub-specialty and CNMs) was 36,084 in metropolitan areas and 4,399 in non-metropolitan areas. The data also show that the ratio of providers to women of childbearing years in rural areas declines as a function of distance from metropolitan areas.[3]

There are no current or reliable data on the number of family physicians practicing obstetrics in rural areas or on the number who have chosen to drop this service. However, family physicians who practice obstetrics have testified to the Committee that they may not be able to replace themselves with younger physicians trained in obstetrics. In Mississippi, the Committee learned that the State does not have a program to train new family physicians in high-risk obstetrics. Moreover, established physicians in Mississippi and other States reported that they are seeing fewer family physicians who have a subspecialty in obstetrics. The reasons most often cited were the higher costs of malpractice insurance for OB care and the reluctance of new physicians to be constantly on-call.

In rural areas there are also well-documented shortages of CNMs, certified nurse practitioners and other non-physician providers. CNMs are licensed in only 17 States, despite evidence that they can provide quality care to OB patients. Further, they may experience difficulty in obtaining hospital privileges or finding physicians who will meet State requirements for their supervision.

## Lifestyle Issues

Rural physicians testifying before the Committee spoke about the harsh demands of rural obstetrics. They talked about the burden of being on-call 24 hours a day and on weekends, with no back-up support and only uncertain access to specialists. Most of these physicians were sacrificing time with their families to keep obstetrics in their practices. The demands were such that some physicians found it difficult to schedule training and educational opportunities required to maintain and upgrade their skills. The Committee visited a physician in Nebraska who had not traveled beyond the borders of his county for many years. While this example may be extreme, there is little question that the practice of obstetrics increases on-call time for physicians and often contributes to rural physician "burnout." Many rural physicians have dropped obstetrics to maintain a more reasonable lifestyle. The same lifestyle concerns apply to CNMs, nurse practitioners and other non-physician providers in OB care.

Practice styles can ameliorate some of the lifestyle burdens on physicians. In one rural community visited by the Committee a solo physician was working closely with a certified nurse practitioner in providing OB care. The nurse was heavily involved with prenatal care, assisted with deliveries and provided triage for the more complicated cases. When non-physician providers are present there is a sharing of the burdens associated with OB care, but physicians are still responsible for day-to-day supervision of these midlevel providers. Also, non-physician providers are not fully trained to manage some of the more difficult and unforeseen complications that can arise during pregnancy and deliveries. In general, the Committee believes that a team approach to obstetrics can help sustain this service in rural communities.

## Gender Shift

Overall, there is a downward trend in popularity of OB specialty training nationwide. At the same time, the gender composition of the OB/GYN workforce has changed rapidly over the past 20 years. The percentage of women in the OB workforce has increased from 12

percent in 1980 to 32 percent in 2000, and it is projected to increase to 50 percent by 2014.[4] The gender shift may make it harder for rural communities to recruit physicians trained in obstetrics. Rural practice sites, with their unrelenting demands on a physician's time and energy, (especially in smaller and more remote communities) may be less attractive to women who want time to raise their families while pursuing a rewarding career. The lack of day care services and other support systems are also major barriers to the recruitment of female physicians in rural areas.

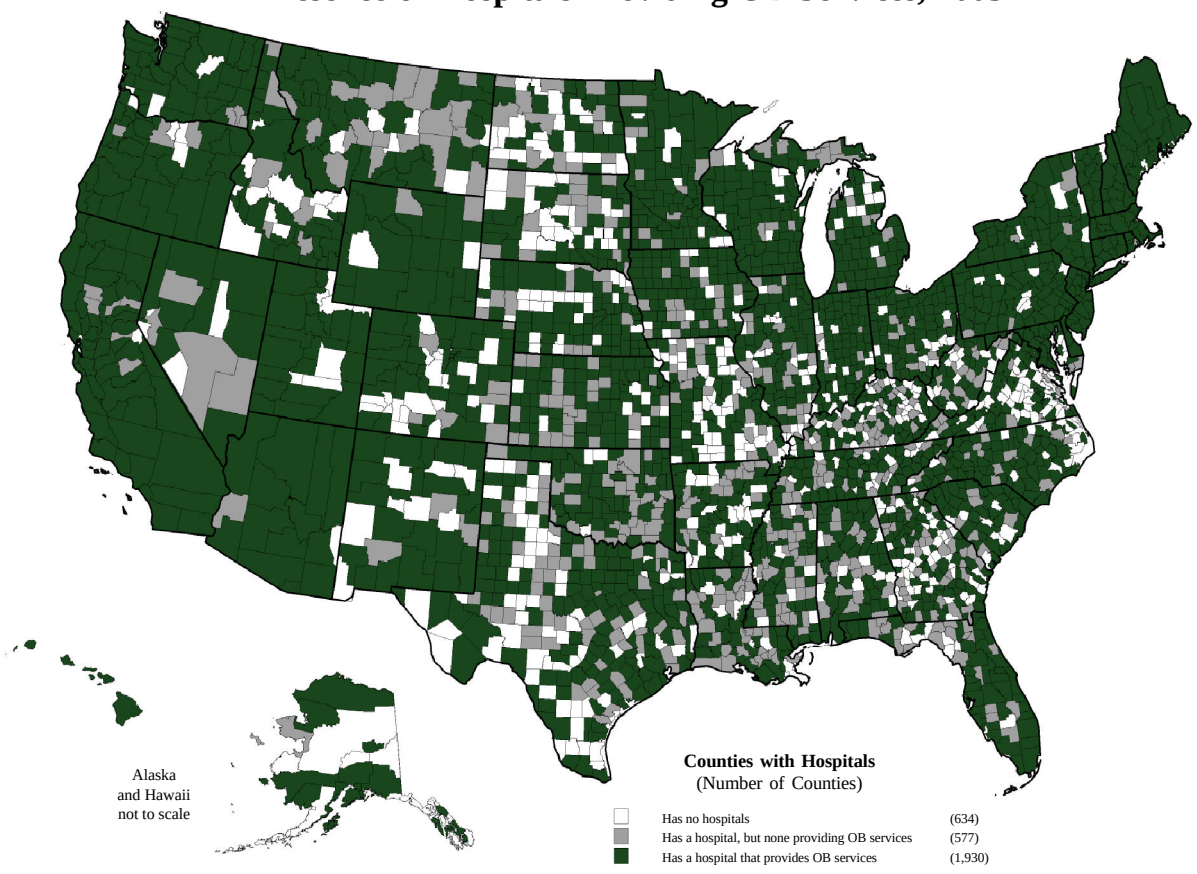
### Training

Some highly experienced rural physicians visited by the Committee during the past year expressed concern about the training of current residents in family practice. They observed that some new family physicians do not have sufficient experience in performing Cesarean sections to feel comfortable with the procedure, particularly in settings where specialty back-up support is not readily available. The training they receive in obstetrics is often based on an urban practice model that assumes ready access to specialty services in obstetrics. The main policy implication of these observations is that family medicine residencies need to make Cesarean section training available to residents who are planning to practice in rural areas.

## Obstetrics in Rural Hospitals

Many small rural hospitals continue to offer OB care despite low birth rates and lower payments than in urban facilities. In the majority of rural hospitals there are no obstetricians on staff and the responsibility falls upon family physicians. Maintaining OB services requires family physicians who are capable and comfortable with performing Cesarean sections, particularly on an emergency basis. Two of the most difficult aspects of obstetrics for both hospitals and physicians are the

**Presence of Hospitals Providing OB Services, 2003**




Source: OSCAR, 2004.

Produced by: Southeast Regional Center for Health Workforce Studies, Cecil G. Sheps Center for Health Services Research, UNC-Chapel Hill.

unpredictable timing of deliveries and the uncertainties of complications. No matter how well screened, some women will require emergency interventions. If physicians who can perform Cesarean sections are not always available, OB care usually cannot be sustained.

According to an ongoing study by the Walsh Center for Rural Health Analysis in Washington, D.C., of the 2,306 rural counties in the United States with adequate data, 117 counties lost local access to OB services in the six years between 1994 and 2000. A 1996 survey of rural hospitals in Washington State showed that hospitals no longer providing OB services listed three main reasons: 1) an inadequate number of deliveries; 2) an insufficient number of obstetrically active physicians; and 3) the excessive costs of providing OB services.[5] According to data from the Rural Hospital Flexibility Program tracking project, few federally certified rural Critical Access Hospitals reported discontinuing services over the past two years, with the exception of OB care, which was dropped by more than five percent of these hospitals. The effects on communities where hospitals have closed or abandoned OB services have not been adequately studied.

Rural hospitals must contend with low reimbursement rates for obstetrics under the Medicaid program. Hospital administrators testifying before the Committee stated that the rates are rarely high enough to cover costs and that Medicaid patients were an increasing percentage of their total cases. A second critical issue for hospitals is the decreasing willingness of local physicians to deliver babies and the difficulties of maintaining birthing services when physicians leave the community. The Committee visited a community in Nebraska where two physician practices were providing OB care at the hospital. If one of those physicians was to leave, the system could not be sustained.

Yet another challenge that rural hospitals and physicians face is that of predicting complications from pregnancy and the resulting need for higher level services at birth. Washington State has developed a regionalized hospital system for perinatal services to deal with this issue.[6] The system identifies patients at higher risk and refers them to an appropriate facility.

In Mississippi, the Committee visited the North Mississippi Medical Center, a hospital that has employed all of the obstetricians on staff and is paying the cost of their malpractice insurance. This was the only way the hospital could sustain its OB services. Most small rural hospitals do not have sufficient capital or revenue to adopt this approach on their own. The Committee believes that hospital networks for OB care, or even formally constituted regional systems of care with designated birthing centers, are viable alternatives for hospitals and physicians struggling to maintain obstetrics in their rural communities. Networks that would concentrate OB services in fewer locations appear to make sense when birth rates are low and travel distances are reasonable. Examples of such networks are already in place in some States and may be used as models for others.

### UHHS Brown Memorial Hospital

The UHHS Brown Memorial Hospital, a Critical Access Hospital in Ohio, recently closed its OB service due to the lack of professionals in obstetrics and the crisis in malpractice costs. At the beginning of 2004 they had four OB providers, but only one provider who would be available in the coming year. The lack of anesthesia providers was also an issue.

## Malpractice Insurance

Medical malpractice insurance and reform is currently a contentious topic nationwide but it is undoubtedly part of any discussion of OB care. Yet, a full discussion of the issue would exceed the scope of this report. Therefore, the Committee wishes to provide only brief comments.

In conducting a literature review, the Committee discovered a wealth of analysis and information on the topic of medical malpractice insurance; however, much of this information appeared only to reflect the strong divisions in the debate on the issue. While one cannot refute that there has been a rise in the cost of malpractice insurance and, subsequently, an increased burden on practitioners, the Committee found no definite national consensus that malpractice rates are driving out physicians, although the debate has been more contentious in some States. In addition, national research has not revealed any differences between urban and rural areas in either the extent or the impact of the situation.

## Low Volume OB Services

Some States are concerned about the low volume of births in rural areas and the impact on hospitals and other providers. In Minnesota last year, the State provided grants to 27 small hospitals to implement a low-volume training program in OB services. The program helps physicians and nurses maintain adequate skill and comfort levels, and will develop best practices for OB services in rural areas. Maryland has a highly regulated hospital system that establishes minimum thresholds for births that hospitals must meet in order to provide birthing services.

Because the increases in malpractice insurance vary across the country, many State studies have been conducted in recent years and have documented physician responses to the rate increases, including physicians practicing in rural areas. A new survey of family practice physicians and obstetricians in Washington State found that rate increases and fears of litigation were the reasons many physicians in the State were discontinuing provision of high-risk services, including OB care. Fifty-one percent of the physicians in the survey said they were less willing to perform procedures with potentially greater liability.[7]

Family physicians who met with the Committee have said that malpractice insurance costs may be the main factor in forcing them to abandon OB care. While the issue does not seem to flow evenly across urban and rural boundaries, the loss of even one physician practicing obstetrics in a small rural community can create a major access problem for rural families. The Committee believes that the potential impact of the issue on access to OB care in rural areas is great, and that steps must be taken to closely monitor the situation in rural areas over the coming months and years.

Some States have dealt with the challenge by placing limits on malpractice awards and/or creating State malpractice insurance pools. The Federal Tort Claims Act has been extended to cover malpractice costs for Federally Qualified Health Centers (FQHCs) and the Committee has a recommendation to expand this coverage to other settings. The Department of Health and Human Services (HHS) can play a role in advocating strategies for dealing with the issue, monitoring the effects of the insurance increases on access to care in rural areas and sharing best practices.

# Low Birth Rates and Outcomes

Declining birth rates are the reality in many rural communities. As stated previously, it is one of the major reasons that OB care is hard to sustain. It places financial strains on providers and makes it more difficult for providers to maintain their skills. The Committee is also aware that low birth rates could have a negative impact on the quality of care that women receive. The Committee was unable to find any data on the volume/outcome relationship in obstetrics to suggest problems at this time. In fact, some studies have shown little or no relationship between volume and outcomes when comparing rural and urban areas.[8] However, the Committee believes that data on this issue need to be collected and analyzed as part of ongoing efforts in performance measurement and quality assurance. Ultimately, the healthcare system must address both improved access to care and decreased costs. Further, it is important to define the appropriate scope of services at the local level that will strengthen outcomes in ways that are cost efficient.

# Federal Programs

The Committee believes that maintaining and improving access to OB care in rural communities should be a primary objective of Federal programs that support the rural healthcare delivery system. There are several programs in HHS that can be used effectively to address this objective. One of these is the Healthy Community Access Program authorized by Section 340 (J) of the Public Health Service Act and administered by the Bureau of Primary Health Care in the Health Resources and Services Administration (HRSA). Providers eligible for the program include FQHCs, hospitals with low-income utilization rates of greater than 25 percent, public health departments and private organizations that have traditionally served the medically uninsured or underinsured. The program can assist a consortia of providers to develop or strengthen integrated commu-

nity healthcare delivery systems that coordinate services for individuals who are uninsured or underinsured. The program seems especially suited for hospitals and other providers in rural communities that are seeking opportunities to better meet community needs for OB care, particularly for low-income populations that represent a large percentage of OB patients in many small rural hospitals.

The Rural Network Development Program administered by the HRSA Office of Rural Health Policy (ORHP) has similar goals and objectives. The program supports rural hospitals and other providers who come together in partnership arrangements to develop more efficient and effective healthcare delivery systems in their communities. ORHP also administers the Rural Hospital Flexibility Grant Program, which supports designated Critical Access Hospitals in rural areas that are required to establish relationships with larger hospitals in other communities. Both programs could be utilized to support new and innovative delivery systems for OB care that would address the problems of low patient volumes, physician shortages and long-distance travel to obtain specialty care.

The Maternal and Child Health (MCH) Services Block Grant Program (Title V), administered by the Maternal and Child Health Bureau (MCHB) in HRSA, provides funding to enable each State to promote the health of mothers and infants by providing prenatal, OB and postpartum care for women. However, States determine how MCH funds are administered at the State level and there are no requirements or set-aside funds for rural communities.

As part of the Title V Grant, the Special Projects of Regional and National Significance (SPRANS) and the Community Integrated Service Systems (CISS) are discretionary grants that further support perinatal services. SPRANS funding, authorized by Sections 501 and 502, is comprised of 15 percent of the Title V Grant funding for MCH special projects, including MCH professional training and OB services. CISS, authorized by Section 501(a)(3), designates a 12.75 percent of the Title V Grant amount appropriated above $600 million for six categories of grants, including projects that increase the participation of obstetricians and pediatricians under the Title V Program.

The MCHB also oversees three additional grant programs that support OB services, administered by the Division of Research, Training and Education (DRTE) and the Division of Healthy Start and Perinatal Systems (DHSPS). The MCH Research Program, administered by DRTE, supports research to improve health services for mothers and children. The findings are published in leading medical journals such as the Journal of the American Medical Association (JAMA), Obstetrics and Gynecology, and Pediatrics. The MCH Training Program, also administered by DRTE, provides funding to institutions of higher learning to support the training of public health professionals in MCH. Continuation of research and professional training in rural communities is the foundation of providing quality OB services to this population. DHSPS administers the Healthy Start Initiative to address disparities in perinatal health by supporting local, community coalitions of women, their families, health care providers, businesses and various public and private organizations. All of these programs might offer some resources to rural communities to focus on increasing access to OB care. However, because all communities are eligible for these grants, there is a great deal of competition for these funds. MCH does not track the percentage of grants that flow to rural communities either through its discretionary programs or through the block grant.

## Virginia Working Group on OB Services

In 2004 the Governor of Virginia convened a working group on OB services in rural areas. The group reported that OB care had reached a crisis level and called for immediate steps to improve access to medical care for pregnant Medicaid patients. The Group found that, of the women who gave birth in rural Virginia, 65 percent chose or were forced to obtain OB care in metropolitan areas. The working group is seeking a 45 percent increase for Medicaid reimbursements to offset years of stagnant rates that have added to the financial crises of some doctors who provide OB services. For more information on the working group, see their web site at: http://www.dmas.virginia.gov/prexecutive_directive_rural_obstetrical_care.htm.

Federal programs supporting telecommunication projects in rural areas also can address issues of OB care. There are several applications of this technology that have become available, including fetal monitoring systems that allow physicians in remote areas to receive specialty consultations from large birthing centers in urban areas. HHS should place greater emphasis on OB care in its management of these programs.

The rapid expansion of FQHCs over the past few years has resulted in an increasing number of centers located in rural areas, and with that expansion has come improved access to prenatal care and OB services for thousands of low-income patients. In 1995, the Federal Tort Claims Act created a medical malpractice insurance program that offers full coverage for the centers at no cost to grantees that participate. Health centers can apply to be deemed as Federal employees for the purpose of medical malpractice and thereby become immune from lawsuits. After meeting specific criteria, the need for "deemed" centers to purchase private medical malpractice insurance is eliminated, thus freeing more funds for services to those who need them. The program recently has been expanded to cover free clinics that meet certain Federal requirements. The Committee believes that the Department should give serious consideration to working with the Congress to develop legislation that would expand this program to other rural providers. For example, small rural hospitals that meet very specific criteria related to a low volume of OB patients, high rates of medical malpractice insurance premiums, proven provider shortages, geographic isolation from alternative care sites and specialty care, etc., could be made eligible for the program. Likewise, federally certified Rural Health Clinics could be made eligible if they provide OB care and meet the specific criteria. The expansion could be designed to address the needs of rural communities that have either lost OB services or are on the brink of loss. The Committee would be interested in working with the Department to explore this possibility.

On the supply side, the National Health Service Corps (NHSC) in HRSA continues to achieve great success in placing primary care physicians in rural medically underserved areas of the country. While the number of physician placements has been increasing in recent years, many rural areas remain underserved and limited access to OB care is a leading indicator in the designation

## Rural OB/GYN Recruitment and Retention

Dr. Barb Patridge and her colleagues at Georgetown Family Health Center in Georgetown, Ohio, a clinical site of Southern Ohio Health Services Network (SOHSN), have developed a successful approach to recruitment and retention of OB/GYNs in their rural community.

Georgetown Health Center, a Federally Qualified Health Center, has overcome the same barriers many rural providers face, including the absence of a nearby training program and the reluctance of physicians to commit to a community where professional responsibilities exceed those of urban physicians. In addition, reimbursements are lower and social isolation is always an issue.

Dr. Patridge was a National Health Service Corps (NHSC) scholar 16 years ago and stayed when her service obligation ended. Since then she has become an integral part of the community and is the core of an OB/GYN staff that still draws from the NHSC as well as from a variety of State residency programs and recruiting companies, and by word of mouth. The recruitment process begins when medical students from the University of Cincinnati rotate with clinicians in one of SOHSN's 13 sites. This enhances the familiarity with rural settings and gives SOHSN a broad applicant pool when vacancies occur. The Network also then offers assistance with medical liability and provides practice administration services to reduce the paperwork burden on physicians. As a result, SOHSN has built a staff of five female OB/GYNs of varying levels of experience and longevity with SOHSN, giving each woman a variety of interaction with peers in her own community. SOHSN had more than 175,000 patient visits in 2000, serving five counties in rural southern Ohio.

of underserved areas. The Committee believes that the NHSC program must be aggressive in identifying rural communities that lack OB services and placing physicians in these locations. Further, the program should focus its recruitment efforts on family practitioners who have sub-specialty training in obstetrics.

In its previous reports, the Committee has made several recommendations on the Department's long-standing support for primary care training programs in medical schools. Some medical schools have a proven track record for training physicians to practice in rural settings and have a significant percentage of graduates electing rural practice. These programs should receive strong support from the Department. Moreover, the Committee believes that improving access to OB care in rural areas should be a clearly stated objective for these programs, and that program managers should look for ways to utilize these programs more effectively to further this objective.

The Committee understands that recent increases in malpractice insurance premiums have created a growing concern in many States, both rural and urban. The Federal interest in this situation is evidenced by legislation currently under consideration by the Congress that would place caps on malpractice insurance awards. The Committee believes that this is an important issue for many rural communities. The Department should continue to work closely with the States, health profession associations and other groups to address this issue.

# Recommendations

- *The Secretary should increase support for medical schools that have distinct programs and a proven track record for training physicians to practice obstetrics in rural areas.*

An increased supply of rural physicians trained in obstetrics is essential to sustaining these services in hundreds of small rural communities. The Secretary should increase or reallocate funds under Title VII of the Public Health Service act to target medical schools that train obstetricians and family physicians for rural practice, especially those that provide residents in family medicine with training in high-risk obstetrics. Family physicians are more likely to practice in rural areas than obstetricians, and programs that prepare them for high-risk obstetrics must be supported. Support for the training of CNMs and nurse practitioners who are interested in obstetrics also should be increased.

- *The Secretary should make the recruitment and placement of physicians trained in obstetrics a major goal for the National Health Service Corps.*

The Committee believes that the National Health Service Corps must focus more attention on rural areas that lack adequate OB services. Recruitment efforts should focus on physicians who are trained in obstetrics and who are willing to deliver babies in the communities they serve. Additional incentives for new physicians are also needed and should be explored. One approach would be to pay the malpractice insurance costs of new Corps physicians who are fulfilling their obligation in areas with measurable and pronounced shortages of OB care providers.

- *The Secretary should support programs to create hospital and physician networks that will sustain and improve access to OB services in rural areas.*

There are several existing grant programs in the Department (Healthy Community Access, Rural Network Development, Rural Hospital Flexibility Grants) that should be used to promote the development of hospital and physician networks in OB care. The Committee believes that OB services in many small rural hospitals and physician practices will be unsustainable over time, given the issues discussed in this report. Providers need encouragement and incentives to find more sustainable and efficient strategies for maintaining access to OB care. Existing grant programs should be more aggressive in encouraging and funding grant applications that address the problem.

- *The Secretary should use existing authorities under Section 301 of the Public Health Service Act to promote the development of team approaches to OB care involving physicians, nurse practitioners, Certified Nurse Midwives and other non-physician providers.*

The Secretary should use this demonstration authority to develop a model program that supports regional approaches to improving access to OB care in rural communities through networking and an emphasis on using

interdisciplinary teams in several rural areas as a pilot project.

- *The Secretary should work toward increasing Medicaid payments for OB services.*

The Committee understands that Medicaid payments for services are determined by the States; however, the Secretary does have authority over State Medicaid waivers that affect the scope of services that Medicaid provides and the populations served. The Secretary should explore ways in which the waiver approval process could be used to provide incentives for the States to increase payments and improve access to OB services in rural areas.

- *The Secretary should address the malpractice insurance issue by supporting legislation that will extend the Federal Tort Claims Act to rural OB providers in federally designated shortage areas.*

The malpractice insurance program for FQHCs and Free Clinics should be extended to cover rural hospitals and physicians providing OB services in underserved rural areas. The Committee believes that the current system for designating Health Professional Shortage Areas (HPSAs) may not be able to identify the rural areas most underserved by OB services. Data are available to identify rural areas that have the lowest ratios of OB providers to women of childbearing age, which may be a more effective access measure. Another approach would be to give greater weight to OB services as a variable used in the HPSA designation process. The method used must be limited to those rural areas where access to OB care is most severely limited by provider shortages.

## *References*


[1] Thompson MJ, Lynge DC, Larson EH, Tachawachira P, Hart LG. "Characterizing the General Surgery Workforce in Rural America." Rural Health Research Center, University of Washington School of Medicine. May 2004.

[2] Peck J, Alexander K. "Maternal, Infant, and Child Health in Rural Areas: A Literature Review." *Rural Healthy People 2010*. U.S. Department of Health and Human Services. Washington, D.C: U.S. Government Printing Office; November 2000.

[3] Unpublished data provided by the Sheps Center for Health Research, University of North Carolina at Chapel Hill, Chapel Hill, N.C.

[4] Benedetti TJ, Baldwin LM, Andrilla CH, Hart LG. The Productivity of Washington State's Obstetrician-Gynecologist Workforce: Does Gender Make a Difference? Obstet Gynecol. March 2004;103(3).

[5] Norris TE, Reese JW, Pirani MJ, Rosenblatt RA, WAMI Rural Health Research Center. Are Rural Family Physicians Comfortable Performing Cesarean Sections? J Fam Pract. November 1996; 43(5).

[6] Nesbitt TH, Larson EH, Rosenblatt, Roger A, Hart GL. "Local Access to Obstetric Care In Rural Areas: Effect on Prenatal Care, Birth Outcomes, and Costs." WAMI Rural Health Research Center. Seattle, Washington; August 1993.

[7] Washington State Medical Education and Research Foundation. "Overview of Survey of Physicians on Medical Liability." 2004. Available at: http://www.yesoni330.org/documents/I330_ResearchOverview.pdf.

[8] Larson EH, Hart GL, Rosenblatt RA. "Is Rural Residence a Risk Factor for Poor Birth Outcome?" WAMI Rural Health Research Center. Seattle, Washington; December 1995.

# Obesity in Rural Communities

## Why The Committee Chose This Topic

The alarming increase in the prevalence of obesity makes it one of the most important health and social issues of our time. In his 2001 "Call to Action to Prevent and Decrease Overweight and Obesity," the Surgeon General reports that an astonishing 64 percent of Americans (approximately 129.6 million) are overweight or obese. Nine million of those are children.[1] This epidemic has staggering implications for individuals, families, businesses, the health care system and our society overall. A report from the Centers for Disease Control and Prevention (CDC) predicts that if current trends continue, our children will be the first generation in history with a shorter life expectancy than their parents. The figure on the next page, "Obesity Trends among U.S. Adults," reveals how, over time, the U.S. population has become more and more overweight. Much of the increase has occurred in rural areas.[2]

Obesity is defined by the CDC as an excessively high amount of body fat in relation to lean body mass.[3] The term "overweight" refers to an increase in body weight in relation to height, measured by Body Mass Index (BMI). Adults with BMIs of 25 or more are considered overweight and adults with BMIs of 30 or more are considered obese. In 2002, researchers at RAND compared the effects of obesity, smoking, heavy drinking and poverty on chronic health conditions and health expenditures. Their finding: "Obesity is the most serious problem. It is linked to a big increase in chronic health conditions and significantly higher health expenditures. And it affects more people than smoking, heavy drinking, or poverty."[4]

The RAND research on obesity reveals that obese individuals spend 36 percent more dollars than the general population on health services, such as in-patient care, doctor's visits and medications, and 77 percent more dollars on medications than daily smokers and heavy drinkers. Only aging has a greater effect—and only on expenditures for medications.[5]

Being overweight or obese increases an individual's risk of developing diabetes and heart disease. Excess body weight is also associated with an increased risk of developing an ever-growing list of diseases and poor health conditions. In a research review conducted by the American Obesity Association, obesity also is listed as an independent risk factor or an aggravating agent for 32 co-morbidities or health conditions including: birth defects, breast cancer, cardiovascular disease, colon cancer, diabetes mellitus, end stage renal disease, gallbladder disease, impaired immune response, liver disease, renal cancer, rheumatoid arthritis, stroke and surgical complications.[6]

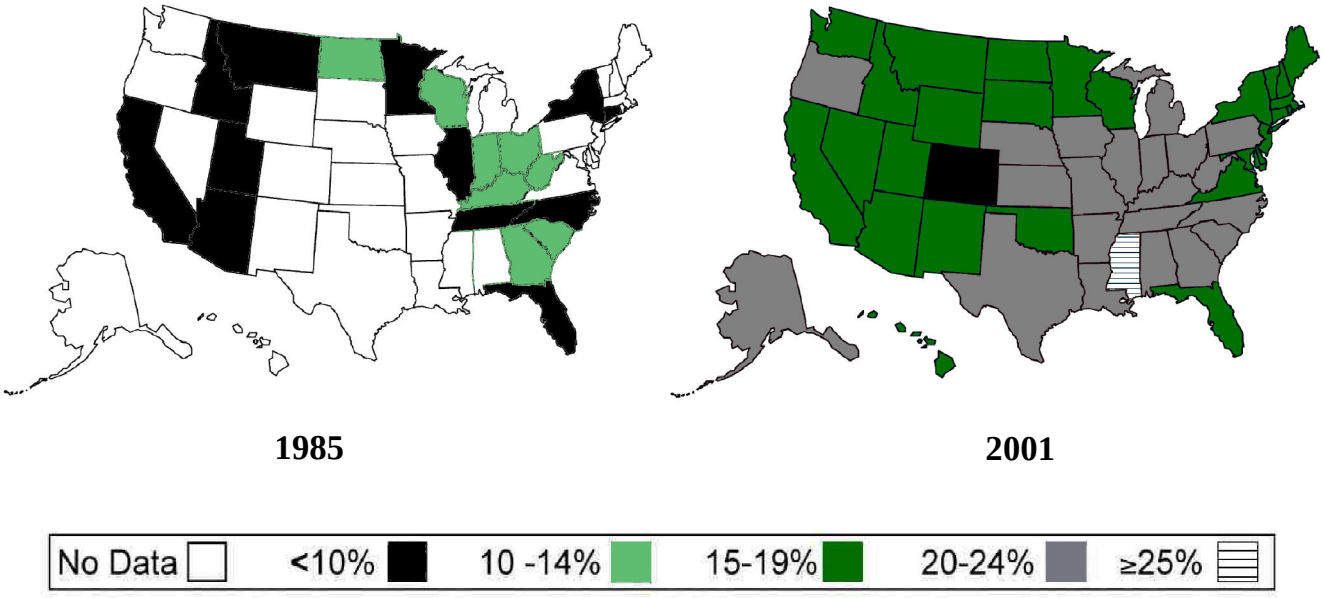
In December 2004 the CDC announced that obesity is the second leading cause of preventable death of Americans, ranking after tobacco use. The agency reports the number of obesity deaths at 400,000, compared with 435,000 from tobacco.[7] The report cites deaths due to poor diet and physical inactivity rose by 33 percent over the past decade.[8] In 2000 alone, 17 percent of all deaths were related to poor diet and physical inactivity.[9]

As the obesity epidemic continues, it will further diminish quality of life and place greater stress on both providers and payers of health care and medical treatment. Total direct and indirect costs, including medical costs and lost productivity due to America's overweight and obesity epidemic, are estimated to be $117 billion nationally for 2000.[10] In a study released earlier this year, researchers at RTI International and the CDC reported that obesity-attributable medical expenditures in the U.S. were an estimated $75 billion in 2003. Approximately half of these costs are paid through Medicare and Medicaid,[11] thus increasing the urgency of addressing obesity nationwide.

The economic impact of obesity at the State level was reported by the CDC in a January 21, 2004 press release entitled, "Obesity Costs States Billions in Medi-

## Obesity Trends Among U.S. Adults

**(Obesity=BMI~ 30 lbs. overweight for 5'4" woman)**




Source: The Centers for Disease Control, http://www.cdc.gov/

cal Expenses." The estimates of the percentage of annual medical expenditures attributable to obesity ranged from four percent in Arizona to 6.7 percent in Alaska. For Medicare expenditures, the percentage ranges from 3.9 percent for Arizona to 9.8 percent for Delaware. For Medicaid recipients, the percentages range from 7.7 percent in Rhode Island to 15.7 percent in Indiana. [12]

## Why is Obesity Important to Rural America?

Trends tracked by the CDC show that Americans are increasingly becoming obese, with rural America leading the way.[13] Health status and the availability of health services are worse in rural America for almost any disease or health issue one can name, and obesity is no exception. While the obesity epidemic is probably rooted in the interplay of very complex cultural and societal factors, the unique characteristics of rural public health and health care services also are likely contributors. Examples of these contributors are the lack of local public health capacities, changing lifestyles, dependence on Medicare, lack of knowledge or information, lack of coordination of local providers, socio-economic disadvantage, geographic isolation, provider shortages and lack of transportation.

Small rural hospitals are heavily dependent on the Medicare payment structure. Until recently, Medicare explicitly stated in its Medicare Coverage Issues Manual that "obesity cannot be considered an illness." Thus, obesity-related services were not reimbursable under Medicare. With the removal of this language, policies can be changed to allow Medicare coverage of obesity-related treatments.

Because of isolation and multiple responsibilities, administrators of small rural hospitals may have difficulty maintaining current knowledge of services covered by Medicare that are related to obesity prevention or treatment. Some services, such as nutrition counseling, are covered but may not be incorporated into Medicare billing by rural hospitals or clinics. During a recent site visit to Nebraska, Committee members spoke with the director of a fitness program for Medicare recipients who suffer from diseases associated with obesity; the director was unaware that Medicare would re-

**TABLE 1**
**Percentage of Adults with Obesity in the U.S. by State**

| U.S. States | 1991 (%) | 1998 (%) | 2000 (%) | 2001 (%) |
|---|---|---|---|---|
| Alabama | 13.2 | 20.7 | 23.5 | 23.4 |
| Alaska | 13.1 | 20.7 | 20.5 | 21.0 |
| Arizona | 11.0 | 12.7 | 18.8 | 17.9 |
| Arkansas | 12.7 | 19.2 | 22.6 | 21.7 |
| California | 10.0 | 16.8 | 19.2 | 20.9 |
| Colorado | 8.4 | 14.0 | 13.8 | 14.4 |
| Connecticut | 10.9 | 14.7 | 16.9 | 17.3 |
| Delaware | 14.9 | 16.6 | 16.2 | 20.0 |
| District of Columbia | 15.2 | 19.9 | 21.2 | 19.9 |
| Florida | 10.1 | 17.4 | 18.1 | 18.4 |
| Georgia | 9.2 | 18.7 | 20.9 | 22.1 |
| Hawaii | 10.4 | 15.3 | 15.1 | 17.6 |
| Idaho | 11.7 | 16.0 | 18.4 | 20.0 |
| Illinois | 12.7 | 17.9 | 20.9 | 20.5 |
| Indiana | 14.8 | 19.5 | 21.3 | 24.0 |
| Iowa | 14.4 | 19.3 | 20.8 | 21.8 |
| Kansas | No data | 17.3 | 20.1 | 21.0 |
| Kentucky | 12.7 | 19.9 | 22.3 | 24.2 |
| Louisiana | 15.7 | 21.3 | 22.8 | 23.3 |
| Maine | 12.1 | 17.0 | 19.7 | 19.0 |
| Maryland | 11.2 | 19.8 | 19.5 | 19.8 |
| Massachusetts | 8.8 | 13.8 | 16.4 | 16.1 |
| Michigan | 15.2 | 20.7 | 21.8 | 24.4 |
| Minnesota | 10.6 | 15.7 | 16.8 | 19.2 |
| Mississippi | 15.7 | 22.0 | 24.3 | 25.9 |
| Missouri | 12.0 | 19.8 | 21.6 | 22.5 |
| Montana | 9.5 | 14.7 | 15.2 | 18.2 |
| Nebraska | 12.5 | 17.5 | 20.6 | 20.1 |
| Nevada | No data | 13.4 | 17.2 | 19.1 |
| New Hampshire | 10.4 | 14.7 | 17.1 | 19.0 |
| New Jersey | 9.7 | 15.2 | 17.6 | 19.0 |
| New Mexico | 7.8 | 14.7 | 18.8 | 18.8 |
| New York | 12.8 | 15.9 | 17.2 | 19.7 |
| North Carolina | 13.0 | 19.0 | 21.3 | 22.4 |
| North Dakota | 12.9 | 18.7 | 19.8 | 19.9 |
| Ohio | 14.9 | 19.5 | 21.0 | 21.8 |
| Oklahoma | 11.9 | 18.7 | 19.0 | 22.1 |
| Oregon | 11.2 | 17.8 | 21.0 | 20.7 |
| Pennsylvania | 14.4 | 19.0 | 20.7 | 21.4 |
| Rhode Island | 9.1 | 16.2 | 16.8 | 17.3 |
| South Carolina | 13.8 | 20.2 | 21.5 | 21.7 |
| South Dakota | 12.8 | 15.4 | 19.2 | 20.6 |
| Tennessee | 12.1 | 18.5 | 22.7 | 22.6 |
| Texas | 12.7 | 19.9 | 22.7 | 23.8 |
| Utah | 9.7 | 15.3 | 18.5 | 18.4 |
| Vermont | 10.0 | 14.4 | 17.7 | 17.1 |
| Virginia | 10.1 | 18.2 | 17.5 | 20.0 |
| Washington | 9.9 | 17.6 | 18.5 | 18.9 |
| West Virginia | 15.2 | 22.9 | 22.8 | 24.6 |
| Wisconsin | 12.7 | 17.9 | 19.4 | 21.9 |
| Wyoming | No data | 14.5 | 17.6 | 19.2 |

*Source: CDC, Behavioral Risk Factor Surveillance System, 1991-2001.*

imburse for the services of a nutritionist. In addition, expertise in obesity prevention and treatment may be limited in rural communities and access to such services may require long or arduous travel in areas where public transportation is not available. The Committee applauds Medicare's new obesity coverage but urges the Department of Health and Human Services (HHS) to make sure providers are aware of the change.

Poverty is a determinant of nutritional quality and poor health. In a Harvard University study of U.S. counties, life expectancy was decreased by as much as 15 years in the poorest communities.[14] The American College of Physicians reports that 46 percent of Mexican-American women living below the poverty line are overweight compared with 40 percent of those living above the poverty line; comparable figures for non-Hispanic women are 39 percent and 25 percent for women below and above the poverty line, respectively.[15]

When compared to urban or suburban areas, rural America generally experiences higher unemployment, lower education levels and more poverty. Forty-eight of the 50 counties (96 percent) with the highest child-poverty rates are in rural America. Low incomes limit the ability to purchase and prepare adequate meals, which can translate into poor nutrition and overweight. Rural areas often lack transportation systems that might otherwise facilitate use of food stamps or access to a food bank or a supermarket with low-cost, nutritious food.[16] Unfortunately, in poorer rural households, low-cost, high-fat foods are often standard fare.

Obesity in rural America can also be attributed to changes in the rural

## Food Scarcity

The vast majority of households in America are food secure. According to the U.S. Department of Agriculture Foreign Agricultural Service, food security means that all people at all times have access to enough food for an active, healthy life. At a minimum, food security includes the ready availability of nutritionally adequate and safe foods and the assured ability to acquire acceptable foods in socially acceptable ways (for example, without resorting to use of emergency food supplies, scavenging, stealing and other coping strategies).

However obstacles to obtaining food are faced by those individuals living in rural and remote locations, those with high unemployment and high poverty rates. U.S. migrant and seasonal farm workers also may have difficulty getting access to food. Low incomes and difficult working conditions limit their ability to purchase and prepare adequate meals. Because migrant labor camps are in rural areas, workers often lack transportation that would enable them to purchase varied and reasonably priced foods.[1]

Food insecurity may coexist with obesity. Research by David Holben, a professor at Ohio University who researches food security, suggests that people without a steady diet are more likely to be overweight. In fact, his studies have shown that obesity was greater among food-scarce households compared with households that had enough food, and, surprisingly, obesity increased as levels of food security worsened. Reasons for this counterintuitive relationship have yet to be fully studied. However, Holben offers a few possible explanations: people overeat when they have food because meals often are few and far between; the lack of education regarding which foods are nutritious; and the belief that healthy food is not affordable.[2]

[1] Foreign Agriculture Service, U.S. Department of Agriculture Foreign Agricultural Service. "Discussion Paper on Domestic Food Security" February 13, 1998. Available at: http://www.fas.usda.gov/icd/summit/1998/discussi.html.

[2] For more information on Holben's research, see: http://www.hhs.ohiou.edu/hcs/staffdetail.asp?section=HCS&id=HolbenDavid.

way of life. Over time, work in many traditional rural-based industries has become much less physically demanding than even a few decades ago. In many areas, the family farm, where a few human beings perform most of the labor, has been replaced with corporate "mega" farms, where machinery and automation perform the vast majority of the tasks. This is true of the fishing, logging and livestock industries, as well. At the same time, telemarketing, mail order, and various "live" support and telephone survey organizations have set up operation in rural areas because it is less expensive than in urban or suburban areas. Thus, rural residents have, over time, gone from a lifestyle with vigorous physical demands to a much more sedentary one.

In addition to the diminished quality of life for overweight or obese individuals and the staggering systemic costs associated with treating the sequelae, there are serious economic reasons for rural America to address its obesity problem. For example, manufacturing and food processing companies have often sought rural locations because of favorable economic factors but these companies have found that obesity is costly. To address these issues, employers in rural McKean County, Pennsylvania, have come together as a group to implement and evaluate employer-sponsored health promotion efforts and their impact on the health of the community at large. HealthWorks for the Bradford Region, as the group has come to be known, has focused its initial efforts on the issues of nutrition and physical inactivity based on rising health insurance premiums and associated healthcare and productivity costs borne by area employers.

# What Is Known About Rural Obesity

When national obesity data are examined, rural Americans have a higher incidence of obesity than their metropolitan counterparts.[17] While it is true that rural areas have had lower rates of overweight and obese people in the past due to the physical nature of rural occupations, this is no longer the case.[18] Obesity is now more common in low-income and rural populations—where access to low-cost nutritious foods and recreational activities may be limited.

Contrary to the image of bucolic, healthful living,

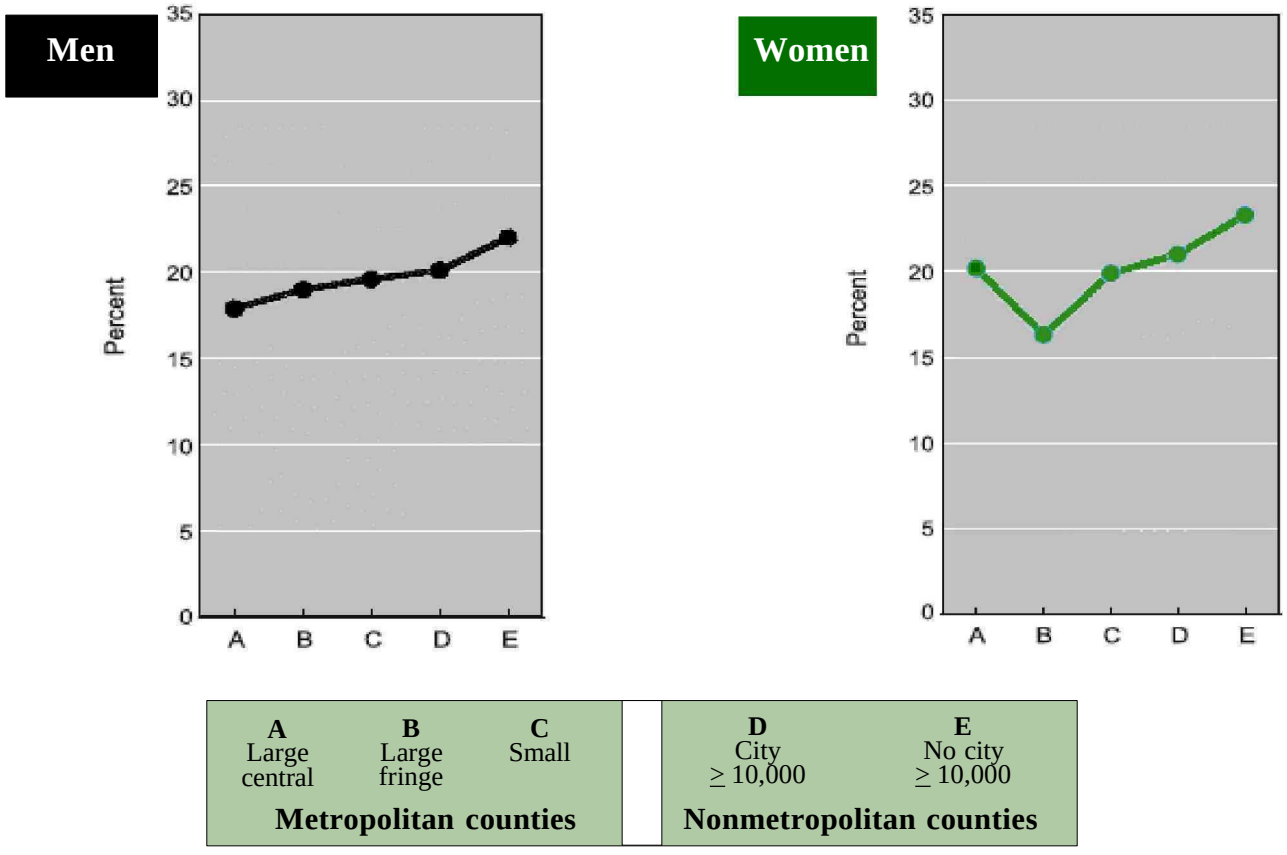
most rural communities lack coordinated recreational activities and organized activities. In addition, individuals often cannot walk to complete errands because distances are so great. Even if there were destinations close by, most rural areas lack sidewalks and streetlights, making walking dangerous. The economic decline of rural downtown shopping districts has further inhibited activity in rural areas by reducing access to nearby shopping and recreation.

Culture influences the perception of what is healthy, attractive and desirable. In some cultures, a fat baby is a healthy baby and therefore, formula and bottle feedings are encouraged long past the infant's true nutritional need. In other cultures, if a man has a large belly, it is a sign that he is successful. These cultural influences stifle the message that being overweight is unhealthy and not a condition to be admired. In some rural areas where the majority of the adult population is overweight, being plump or even fat is not seen as being unusual or even undesirable.

Cultural influences also affect the reasons individuals do not seek or achieve care—belief systems, stigma, lack of culturally competent care and limited accessibility, availability and affordability of public health and health care services all contribute to reasons why an individual will or will not attempt to access the healthcare system. To be effective, information on how to utilize community public health and healthcare services and support programs must be available and culturally appropriate. Often, weight loss programs are not well integrated into primary care services, much less incorporated into the context of a culturally competent plan.[19]

The culture created by advertisers includes messages that urge consumption of large quantities of foods with little nutritional value. At the same time, our culture reveres celebrities who are overly thin, achieved by

**Obesity Disparities, *Health, United States, 2001 Rural and Urban Chart Book*, CDC**




NOTES: Obesity is defined as BMI ≥ 30 based on self-reported height and weight. Percents are age adjusted. See related Health, United States, 2001, Table 69.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Interview Survey.

**Increase in Overweight and Obesity Prevalence Among U.S. Adults* By Racial/Ethnic Group**

| | Overweight (BMI > 25) Prevalence (%) | | Obesity (BMI > 30) Prevalence (%) | |
|---|---|---|---|---|
| **Racial / Ethnic Group** | **1988 to 1994** | **1999 to 2000** | **1988 to 1994** | **1999 to 2000** |
| Black (non-Hispanic) | 62.5 | 69.6 | 30.2 | 39.9 |
| Mexican American | 67.4 | 73.4 | 28.4 | 34.4 |
| White (non-Hispanic) | 52.6 | 62.3 | 21.2 | 28.7 |

Source: CDC, National Center for Health Statistics, National Health and Nutrition Examination Survey. Flegal et. al. JAMA. 2002; 288:1723-7 and IJO. 1998;22:39-47. *Ages 20 and older for 1999 to 2000 and ages 20 to 74 for 1988 to 1994.

means that are, probably, equally unhealthy. Our culture also promotes inactivity in the form of television, videogames and spectator sports. No longer does leisure time include physical activity as a matter of course. Indeed, it is the exception for people to get out and move around.

Ethnicity does carry with it certain risk factors for obesity. The prevalence of adult obesity between 1991 and 2001 increased from 12 percent to 20.9 percent. This increase was just slightly higher among men and most pronounced among minorities.[20] Obesity in the U.S. continues to escalate, particularly in minority populations (African Americans, Hispanics and Native Americans) and individuals with low incomes.[21]

Mexican American and black (non-Hispanic) adults in the U.S. are considerably more overweight and obese than white (non-Hispanic) adults.[22] Researchers have found that among rural Native Americans in Oklahoma, for example, the prevalence of obesity, high blood pressure, diabetes and heart disease was higher than in the general population.[23] The highest rates were reported for American Indians in Arizona, at 80 percent for women and 67 percent for men in 1995, according to researchers of the Strong Heart Study. (Rather than using the standard definition for overweight, this study defined overweight as a BMI $\geq$ 27.8 for men and $\geq$ 27.3 for women, possibly *understating* the problem.)[24] Cultural factors that influence dietary and exercise behaviors are reported to play a major role in the development of excess weight in minority groups.[25]

In many cases, the lack of resources and the geographic isolation of rural communities make it difficult for them to attract services and providers of any kind, let alone those specializing in diet, nutrition, weight loss and exercise. Aside from rural areas popular among wealthier retirees, providers of any specialized services, such as those related to weight control, are often overwhelmed with clients. In addition, local providers in rural areas have little time available in heavy patient workloads to share current information about preventing or combating obesity. Finally, rural public health generally lacks the capacity to track health issues, such as obesity, and then develop resources to address them. Federal grant funds to address obesity issues rarely make it to rural communities and there are fewer local resources available compared to metropolitan areas.

## What Is the Community's Role?

Despite the barriers and difficulties in addressing obesity in rural areas, some community-based initiatives are underway. There are rural school-based programs that focus on preventing diabetes, making lunches nutritious and increasing physical activity. One such program is being implemented on behalf of Native American school children by the University of Nebraska Medical Center in Omaha, Nebraska and the Whirling Thunder Wellness and Diabetes Program in Winnebago, Ne-

braska. This program implements a physical activity intervention to prevent or reduce obesity in the school children of the community.[26]

Twenty-eight States have legislation pending that would limit the vending and sale of non-nutritious foods and beverages in schools. While none of these measures has been enacted,[27] individual school districts in many areas have already implemented a policy that would eliminate the sale of non-nutritious foods and beverages in school vending machines. For example, the Texas Commissioner of Agriculture has mandated the removal of soft drink vending machines from elementary schools.

Lawmakers in 27 States are considering legislation that would increase requirements for physical activity in schools. The bills address physical education in a variety of ways. Some initiatives require physical education as part of the school curriculum; others expand the duration of physical education classes or require year-round or daily physical education courses. Other bills propose to tax school vending machine sales, and to use the revenue to augment physical education budgets.[28]

Arkansas has legislative measures aimed at childhood obesity already in place through "health report cards." By law, schools there are now required to measure and report on the BMI of students. The Virginia Legislature is considering a similar "fitness report card" program that would be developed by the board of education. The New Mexico Legislature has called for a feasibility study of such a program for that State.[29] Also, the West Texas Area Health Education Center (AHEC) has implemented a comprehensive health and fitness program in 30 rural schools where BMIs are being tracked for third graders.

In Connecticut, current law requires each child to undergo a health assessment prior to public school enrollment. A piece of legislation under consideration there would require health care practitioners to include measurement of BMI-for-age in the physical examination. The new law also would require local or regional boards of education to report annually to the local health department and the Department of Public Health the total number of pupils per school and per school district who have been diagnosed with obesity based on the BMI-for-age recorded. Iowa, Indiana and Washington also have introduced legislation that would require measurement and reporting of the BMI of students. [30]

## Childhood Obesity

The CDC reports that four percent of children (age 6 to 11) in 1963 through 1974 were overweight. In 2000 the prevalence was 15 percent.[1] One known factor contributing to overweight children is poverty, which is of particular concern for rural communities since one in five children in rural America lives below the poverty line.[2]

In response to the increased prevalence of obesity, the Institute of Medicine's Committee on Prevention of Obesity in Children and Youth has developed a comprehensive national strategy that recommends specific actions for families, schools, industry, communities and government.

For the first time, blood pressure is now a medical concern for young children. The National High Blood Pressure Education Program Working Group on High Blood Pressure in Children and Adolescents now recommends that blood pressure screening for hypertension and prehypertension begin as early as age three. This recommendation was fueled by the strong association of hypertension with obesity and the marked increase in the prevalence of childhood obesity.[3]

In any discussion of obesity, the idea of preventing the problem early in the life of a child is critically important. Attempting to "fix" the national epidemic by only treating obese adults will be nearly impossible. Prevention is recognized as the key to reducing obesity rates in many rural states. Indiana, for example, is targeting the risk factors and causes of obesity among children: parental obesity and behaviors, sedentary behaviors, caloric intake, low socioeconomic status, low birth weight, formula feeding, genetics and the environment. These areas are being tackled through Indiana's Childhood Obesity Strategic Plan. The areas of focus of the plan all stress the importance of prevention.

[1] CDC Behavioral Risk Factor Surveillance System (BRFSS) and National Health and Nutrition Examination Survey (NHANES) 1999-2000.

[2] "Poverty Tightens Grip on Mississippi Delta." *Washington Post*; July 17, 2004.

[3] "The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents." *Pediatrics;* August 2004; 114 (2).

## Site Visit to West Point, MS

The Committee visited a weight loss program in West Point, Mississippi in September. This unique program sprang from the Governor's Commission, which put together a physical fitness report card for Mississippi and found that the State was the worst State in the Nation in terms of obesity. It was started by the local hospital and the county extension service. For the "Weigh To Go" program, teams of 10 participants committed to lose a total of 100 pounds in 12 weeks. Ninety-eight teams initially signed up for the weight loss challenge. Each team selected a team leader to be their champion and encourager. The team members had to attend weekly seminars on weight loss and nutrition. Seventy-eight teams completed the program requirements (attending all the sessions) and attended the final weigh-in. Twenty teams lost at least 100 pounds and completed the program requirements. A total of 780 people in the city of West Point lost 5,612.75 pounds. Local businesses donated money for the graduation prizes, which consisted of a $20 VISA card for the members of the 20 teams who lost 100 pounds and $10 VISA cards for all participants who individually lost at least 15 pounds or attended all the seminars. The effects of the program are still evident. For instance, many local restaurants began offering more nutritious items on the menu such as whole wheat bread and low fat milk. Some of the local neighborhood residents have also begun walking together daily. Seven miles of an unused railroad were turned into a walking trail. Currently there are plans to take the program statewide.

# What Are the Current HHS and Governmental Roles?

HHS supports the Healthy Lifestyles and Disease Prevention Program (http://www.smallstep.gov), a national education campaign with the Ad Council to inform Americans that small, achievable steps can be made to improve their health and reverse the obesity epidemic. The Secretary advocates "tackling Americans' weight issues as aggressively as we are addressing smoking and tobacco."[31] Partners in this effort include Lifetime Television, Sesame Workshop and the United Fresh Fruit and Vegetable Association.

Healthy People 2010, a set of health objectives for the Nation to achieve over the first decade of the new century, is also sponsored by HHS. Healthy People 2010 was developed through a consultation process and built on the best scientific knowledge. It is designed to measure programs over time and to be used by individuals, States, communities and professional organizations to develop programs to improve health. Under the Healthy People 2010 initiative, HHS produced *Healthy People in Healthy Communities: A Community Planning Guide Using Healthy People 2010.* This document is a guide to developing an action plan through building community coalitions, creating a vision, measuring results and creating partnerships.

The Steps to a HealthierUS community grant program is administered by the CDC. In 2003, a total of $13.7 million was awarded through 12 grants to States to fund local efforts to help reduce diabetes, obesity and asthma by addressing three related risk factors—physical inactivity, poor nutrition and tobacco use. Four States included rural communities in their efforts: Washington, New York, Arizona and Colorado. In September of 2004, 10 new grants were awarded a total of $35.7 million.[32] While the intent of this program is laudable, there are problems with it when examined from the rural perspective. Of the total $49.4 million (FY 2003 and FY 2004), $25.8 million was designated to fund large cities; slightly more than $2 million was designated to fund three Tribal applications; and $21.4 million was designated to fund programs in small cities and rural communities in seven States. The grant requires each State to choose communities of total residence size not to exceed 800,000 persons. In addition, each community must be "geographically contiguous and include a minimum population of 10,000."[33] These stipulations exclude the smallest rural communities and those remote communities in geographically large States.

The CDC administers the Overweight and Obesity State Programs. Twenty States were awarded funding

in 2004 for programs designed to help States maximize the effectiveness of their efforts to prevent obesity by improving nutrition and physical activity. Two of the States, New York and Texas, incorporate rural communities in their efforts.

The CDC also administers *Prevention Research Centers: Preventing Disease through Community Partnerships*. This program funds three extramural research centers—the University of Colorado, the University of Iowa and the University of North Carolina at Chapel Hill—to support programs that add to the current understanding of preventing and controlling chronic disease.

The National Institutes of Health (NIH) administers the Strategic Plan for NIH Obesity Research. NIH Director, Dr. Elias A. Zerhouni, announced this strategic plan in the spring of 2004. The plan was created through the work of the NIH Task Force on Obesity Research and coordinates the work of 25 institutes, centers and offices at NIH that will focus on: behavioral and environmental approaches to modifying lifestyle; pharmacological, surgical and other medical approaches to combating obesity; and breaking the link between obesity and diseases such as Type 2 diabetes, heart disease and some forms of cancer. Current NIH funding for obesity research is $400.1 million. The budget request for FY 2005 is $440.3 million, a 10 percent increase. In addition, the National Heart, Lung, and Blood Institute, one of the NIH Institutes, launched the Obesity Education Initiative in January 1991 to help reduce the prevalence of obesity along with the prevalence of physical inactivity in order to reduce the risk of coronary heart disease (CHD) and overall morbidity and mortality from CHD.

The Food and Drug Administration issued the final report of its Obesity Working Group in March 2004. The report includes an action plan that covers six areas:

- Food labeling, especially with respect to giving more prominence to calories, serving sizes and carbohydrates
- Enforcement activities against weight loss products having false or misleading claims
- Educational efforts aimed especially at youth
- A campaign to urge restaurants to voluntarily provide point-of-sale nutrition information
- A meeting to address therapeutics for treatment of obesity; and
- Research support for obesity studies

# What Are the Shortcomings of the Current Response?

Until July of 2004, neither Medicare nor Medicaid recipients could benefit from certain health care services, such as nutrition counseling and exercise. Prior to that date, providers for these services could not be reimbursed because obesity was not recognized as a disease or illness. Local programs spend enormous resources combating heart disease, diabetes and other obesity-related illnesses. For example, during the site visit to Syracuse, Nebraska the Committee was impressed to see a small hospital working to address obesity by getting Medicare patients to exercise. Medicare or Medicaid reimbursement for patients with obesity will aid these local programs in providing interdisciplinary care to treat or prevent their patients' chronic diseases. However, the Committee also recognizes that focusing on just one aspect (exercise) within one population subgroup (Medicare patients) is not enough.

Overall, there is a need for greater emphasis on prevention. While the treatment of illnesses, in general, is much better supported than prevention efforts, the Committee feels strongly that more focus should be placed on prevention of obesity, especially in the childhood years.

In addition, there is not enough support for rural issues in relation to obesity. In much of what is proposed, NIH, HHS, the Steps to a HealthierUS program and other efforts fail to factor in the unique characteristics of rural America. Examples are program guidances that consider a "small" community one which has a population of fewer than 800,000 people; agency strategic plans that do not break down goals to include rural populations; and a general lack of recognition that many rural areas do not have the public health infrastructure, resources or capacity for program implementation.

# Conclusions

The Committee agrees with CDC Director, Dr. Julie Gerberding, in her assertion that, "investments in programs to increase physical activity, improve diet and increase smoking cessation are more important than ever before and must continue to be high priorities." Basic public health must be promoted across the lifespan, especially in the often-forgotten rural areas of the Nation. Prevention of obesity must be acknowledged as a public health concern. Current efforts to curb obesity focus on treatment of obesity-related diseases, such as heart disease, diabetes, etc. Instead, efforts should be aimed at health promotion and disease prevention, which must include issues of nutrition[34], and should focus first on the areas of the country where the problems are the worst.

Unlike tobacco, no windfall from lawsuits aimed at the fast food industry is anticipated. The U.S. House of Representatives recently voted to ban such obesity lawsuits.[35] Rather than using legal methods to address the obesity epidemic, support should be given to a massive public relations campaign that graphically depicts the perils of obesity.

# Recommendations

- *The Secretary should encourage the States to revise Medicaid policy. Medicaid should follow Medicare and remove all references to obesity not being an illness.*

The Department should take the lead in working with the States to classify obesity as an illness and cover procedures related to treatment of obesity. This change is even more critical in Medicaid than it is in Medicare since it will allow health care providers to aggressively treat those with obesity and it will potentially help patients avoid more serious obesity-related health complications in the future.

- *The Secretary should make refinements to the HealthierUS community grant program so that rural concerns can be more thoroughly represented.*

The Committee commends the Secretary for launching the Steps to a HealthierUS community grant program, especially since it includes rural participation. However, the Committee is also hopeful that refinements will be made to assure that the concerns identified with respect to rural representation are addressed. Additional opportunities for direct granting to rural communities would be helpful, as many States did not include rural communities within their grants.

- *The Secretary should ensure that the next publication of the CDC Chartbook includes more rural-specific data and that other, future publications include references to rural.*

The Committee commends the efforts the CDC has made to conduct studies that include rural areas. These studies have consistently shown that rural areas have higher rates of obesity and are, in general, less healthy than urban or suburban areas. The Committee would encourage the publication of a new CDC Chartbook to provide current, more rural-specific items compared to the previous 2001 publication, and to continue the inclusion of rural areas in its other studies. In addition, the Committee encourages NIH and the CDC to include studies of rural-specific prevention and intervention.

- *The Secretary should ensure that rural residents are seen as a separate and unique segment of the population in funding, research and data collection.*

The Committee commends the efforts CDC has made to conduct studies that include rural areas. These studies have consistently shown that rural areas have higher rates of obesity and are, in general, less healthy than urban or suburban areas. The Committee would encourage the publication of a new Rural-Urban Chartbook by no later than 2006 to provide current, more rural-specific items compared to the previous 2001 publication, and to continue the inclusion of rural areas in its other studies. In addition, the Committee encourages NIH and the CDC to include studies of rural-specific prevention and intervention.

## *References*


[1] *Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*. U.S. Department of Health and Human Services; 2001.

[2] "Obesity Trends." CDC Behavioral Risk Factor Surveillance System (BRFSS) and National Health and Nutrition Examination Survey (NHANES).

[3] *Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*. U.S. Department of Health and Human Services; 2001.

[4] Sturm R, Wells KB. "Does Obesity Contribute As Much to Morbidity as Poverty or Smoking?" *Public Health*; May 2001; 115(3).

[5] Sturm R. "The Effects of Obesity, Smoking, and Problem Drinking on Chronic Medical Problems and Health Care Costs." *Health Affairs;* 2002; 21(2).

[6] Data from the American Obesity Association website, http://www.obesity.org/.

[7] "CDC Admits Errors in Obesity Risk Study." *New York Times;* November 24, 2004.

[8] Mokdad AH, Marks JS, Donna SF, Gerberding JL. "Actual Causes of Death in the United States." *JAMA*; March 10, 2004.

[9] *ibid.*

[10] *Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*. U.S. Department of Health and Human Services; 2001.

[11] Finkelstein EA, Fiebelkorn IC, Wang G. "State-Level Estimates of Annual Medical Expenditures Attributable to Obesity." *Obes Res*. January 2004;12(1).

[12] "Obesity Costs States Billions in Medical Expenses." *CDC Press Release*; January 21, 2004.

[3] "Obesity Trends." CDC Behavioral Risk Factor Surveillance System (BRFSS) and National Health and Nutrition Examination Survey (NHANES); 1999-2000.

[14] Murray CJL, Michaud CM, McKenna M, Marks J. "U.S. Patterns of Mortality by County and Race: 1965-1994." Harvard Center for Population and Development Studies; 1998. Available at: http://www.hsph.harvard.edu/organizations/bdu/images/usbodi/.

[15] Kumanyika SK. "Special Issues Regarding Obesity in Minority Populations." *Ann Intern Med*. 1993 Oct 1;119(7 Pt 2).

[16] Food Research Action Center. "A Guide to Food Stamp Program Outreach". Available at: http://www.frac.org/html/federal_food_programs/programs/fsoutreachprg.html

[17] Centers for Disease Control and Prevention. Health, United States, 2001.

[18] Gamm LD, Hutchison LL, Dabney BJ, Dorsey AM. *Rural Healthy People 2010: A Companion Document to Healthy People 2010*. College Station, TX: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center; 2003. Available at: http://www.srph.tamhsc.edu/centers/rhp2010/.

[19] National Rural Health Association, 8th Annual Rural Minority Health Conference, "Race, Culture, Technology: Impact on Rural Minority Health." Conference Program; December 5-6, 2002, San Diego, California.

[20] CDC Behavioral Risk Factor Surveillance System (BRFSS) and National Health and Nutrition Examination Survey (NHANES) 1999-2000.

[21] Yancey AK, Kumanyika SK, Ponce NA, McCarthy WJ, Fielding JE, Leslie JP, Akbar J. "Population-Based Interventions Engaging Communities of Color in Healthy Eating and Active Living: A Review." *Prev Chronic Dis*; January, 2004. Available at: http://www.cdc.gov/pcd/issues/2004/jan/03_0012.htm.

[22] "Obesity in Minority Populations." AOA Fact Sheet. American Obesity Association. Available at: http://www.obesity.org/subs/fastfacts/Obesity_Minority_Pop.shtml.

[23] Paper delivered at 2002 Rural Women's Health Conference 2002. "Behavioral Risk Factors among Rural Native American Women in Oklahoma." *Oklahoma REACH 2010* by Janice E. Campbell, Ph.D.

[24] In the early 1980s, a review of existing data by the Subcommittee on Cardiovascular and Cerebrovascular Disease of the Secretary of Health and Human Service's Task Force on Black and Minority Health concluded that information on cardiovascular disease (CVD) in American Indians was inadequate and strongly recommended epidemiologic studies of this problem. The Strong Heart Study (SHS) was designed to respond to this recommendation.

[25] "Obesity in Minority Populations." AOA Fact Sheet. American Obesity Association. Available at: http://www.obesity.org/subs/fastfacts/Obesity_Minority_Pop.shtml.

[26] National Rural Health Association, 8th Annual Rural Minority Health Conference, "Race, Culture, Technology: Impact on Rural Minority Health." Conference Program; December 5-6, 2002, San Diego, California.

[27] "Nutrition, Obesity & Physical Education." National Conference of State Legislatures; April 2004. Available at: http://www.ncsl.org/programs/health/hpts/nutrition_obesity.htm.

[28] *ibid.*

[29] i*bid.*

[30] *ibid.*

[31] U.S. Department of Health and Human Services. "Citing 'Dangerous Increase' in Deaths, HHS Launches New Strategies Against Overweight Epidemic." *News Release*; March 9, 2004. Available at: http://www.hhs.gov/news/press/2004pres/20040309.html.

[32] U.S. Department of Health and Human Services. "HHS Awards $35.7 Million to Support Community Programs That Promote Better Health and Prevent Disease." News Release; September 28, 2004. Available at: http://www.hhs.gov/news/press/2004pres/20040928.html.

[33] Tracey Teuber, MPH, CHES, Policy and Communication Specialist, Steps to a HealthierUS, Office of the Director, NCCDPHP, CDC, Atlanta, GA. Email; December 7, 2004.

[34] Ham RJ. "Best Practices in Service Delivery to the Rural Elderly." West Virginia University, Center on Aging; March 2003.

[35] "House Votes to Ban Obesity Suits." *Trenton Times*; March 11, 2004.

# Welfare Reform in Rural Communities

## Introduction

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), dramatically changing the Nation's welfare system from a program designed to provide income maintenance to one focused on moving families into the workforce. PRWORA replaced a package of entitlement programs—Aid to Families with Dependent Children (AFDC), the Job Opportunities and Basic Skills Training program and the Emergency Assistance program—with a new, $16.5 billion Federal block grant program titled Temporary Assistance for Needy Families (TANF).

The new program devolved significant programming authority to the States, giving the States tremendous flexibility in the design and operation of their welfare programs. However, the legislation set forth requirements for both States and welfare participants. PRWORA imposed work participation rates on the States, required them to maintain at least the level of their pre-TANF State funding and held them subject to financial penalties if they did not comply with certain requirements. For recipients, PRWORA established strong work requirements and ended the entitlement to welfare benefits. PRWORA mandated a five-year lifetime limit on the receipt of cash assistance (though up to 20 percent of the caseload could be exempted from the time limit due to hardship), but allowed States to shorten the time limit if they chose. All of these requirements were to reinforce the goal of reducing extended welfare dependency and promoting self-sufficiency.

In the eight years since the legislation was enacted, a wealth of literature has surfaced examining the effects of the sweeping reforms on America's low-income families. From the literature, one conclusion resounds: since the creation of TANF, welfare participation has drastically decreased in both urban *and* rural areas. Between August 1996 and September 2003, the number of TANF recipients declined by 60 percent nationally.[1] The rate of employment of TANF recipients has increased significantly, up from less than one in five adult recipients in 1991 to one in every three adults in 2002.[2] In addition, between 1996 and 2001, the national child poverty rate fell by 20 percent (from 20.5 percent to 16.3 percent).[3] Based on these national numbers, many pronounced welfare reform a success.

## Why the Committee Chose This Topic

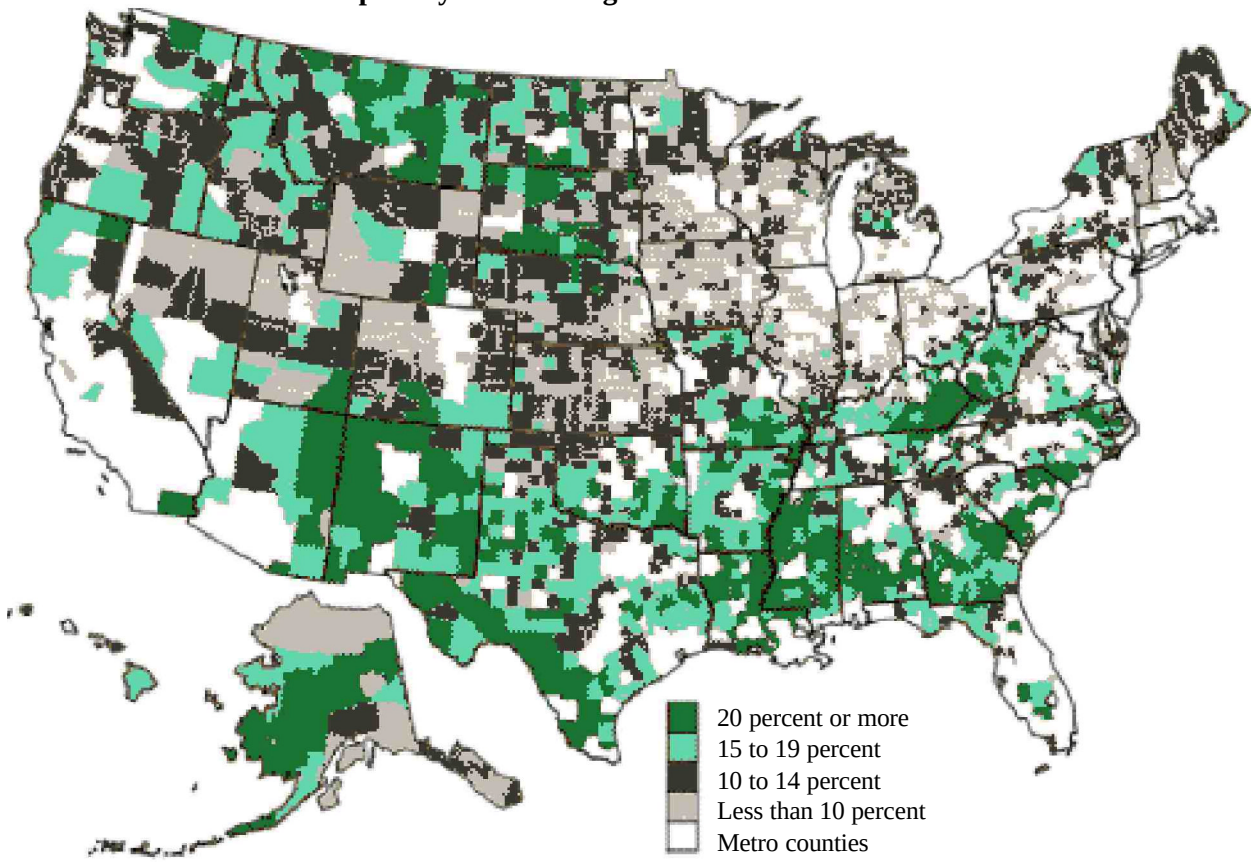
While many agree that welfare reform, backed by the robust economic growth of the 1990s, successfully moved many recipients into the workforce, the effects of welfare reform vary across the country. Tremendous variation between States' programs often complicates attempts to get an accurate picture of its effects on rural America. In addition, in national studies, the stories of individual localities are often overshadowed, especially the unique struggles faced by some rural communities.

### Welfare Reform Report

In September 2004, the U.S. Government Accountability Office (GAO) issued a report titled "Welfare Reform: Rural TANF Programs Have Developed Many Strategies to Address Rural Challenges." This report examines the status of welfare reform in rural communities and discusses the significant barriers faced by rural TANF recipients, such as limited transportation, lack of child care services, job shortages and low wages. The report also highlights the strengths of rural TANF programs in collaboration and personal attention to TANF recipients, and provides examples of innovated strategies for overcoming barriers and moving recipients toward self-sufficiency. The report can be found at http://www.gao.gov/new.items/d04921.pdf.

**Nonmetro Poverty Rates, 1999**

**Nonmetro poverty rates are highest in the South and Southwest**




Source: Calculated by ERS using data from the 2000 Census of Population.

Approximately 14 percent of the Nation's welfare recipients live in rural communities, although in some States, rural TANF recipients make up a much larger percentage of the State's total number of recipients.[4] Rural TANF families are primarily concentrated in areas of high unemployment, causing these recipients to have a difficult time transitioning into the workforce. In some States, analyses have found lower caseload declines in rural communities, particularly those in areas of persistent poverty.[5]

When taken as a whole, rural areas have greater rates of poverty than urban areas. Only poverty rates in central cities surpass those of rural areas. Areas of persistent poverty, such as parts of the Appalachian and Delta regions, tend to have a disproportionately higher number of "economically at-risk" people, such as single mothers, high school dropouts and ethnic/racial minorities.[6] Rural communities often have higher rates of unemployment and underemployment due to more limited economic opportunities and a higher percentage of low-wage, part-time jobs. All of these factors make it difficult for rural residents to find jobs that will remove them from the welfare rolls and lift them and their families out of poverty.[7]

In addition, a true picture of welfare reform is far more complex than decreasing caseloads. To more accurately judge TANF's success, one should examine the experiences of those who have left the welfare system. Although research finds that most "leavers" enter the workforce, about 25 percent of leavers are not currently working and have no partner working.[8] For those who do find work, the work is often temporary and does not pay enough to meet all financial needs. It has been found that approximately 21 percent of TANF recipients who leave welfare due to employment or higher earnings return to the welfare system.[9]

The Committee has chosen to focus on TANF in this report because of TANF's important implications for rural communities. The Committee recognizes that low-income families often face multiple obstacles to both

## Building Nebraska Families

During its site visit to Southeast Nebraska, the Committee met Sondra Germer, of the University of Nebraska Cooperative Extension and learned about Sondra's efforts to construct a stronger community, one family at a time.

As the extension educator of the *Building Nebraska Families* program for Gage, Saline and Jefferson counties, Sondra works one-on-one with TANF recipients, teaching them skills they need to better manage their family resources. Going into their homes, Sondra conducts individualized workshops for her clients on a variety of topics ranging from parenting to problem solving to money management. Sondra has found that TANF clients are more successful at transitioning from welfare to work and maintaining employment if these adults are skilled at managing their personal relationships and lives.

*Building Nebraska Families* works specifically with hard-to-employ TANF recipients; yet, in spite of the multiple obstacles faced by their clients, the program has assisted 122 (22 percent) of 581 participants to achieve self-sufficiency since 1999. While research has shown that rural welfare recipients, on average, face a greater number of challenges than their urban counterparts, it has also shown that rural clients often receive and benefit from more personalized attention and a stronger local support system. Sondra Germer and *Building Nebraska Families* are successfully providing that assistance and support.

Building Nebraska Families is one of three rural welfare-to-work programs from across the country selected for an evaluative study conducted by the Mathematica Policy Research, Inc. with funding from HHS. The study, which began in 2000 and will continue through 2007, hopes to assess the impact innovative service programs have on rural low-income people. The report, to date, can be found at:

http://www.mathematica-mpr.com/welfare/ruralwtw.asp.

finding *and* keeping a job, such as lack of education or job experience, drug and alcohol abuse, domestic violence, or disabilities and health problems. Yet rural residents face additional barriers in moving from welfare to work. Rural areas generally lack public transportation systems, ample child care services and diverse employment opportunities, compounding the number of obstacles already faced by low-income residents and possibly frustrating the success of welfare reform in rural communities.

The Committee also acknowledges that the TANF program interacts with an array of other Department of Health and Human Services (HHS) programs, such as Medicaid, State Children's Health Insurance Program (SCHIP) and the Child Care Block Grant, and has important connections to the overall health and well-being of rural residents. Such interactions provide HHS with a unique opportunity to foster collaboration and coordination across several programs, which could increase outcomes for low-income residents in rural America.

Finally, this topic is especially timely because the reauthorization of TANF is currently pending in Congress. In February of 2003, the House of Representatives passed a reauthorization bill that closely mirrored the President's reauthorization proposal, which includes an increase in the work requirements for TANF adult recipients; however, no reauthorization bill passed in the Senate. In the meantime, the TANF program has been operating under a series of continuing resolutions and has been extended through March 31, 2005. Reauthorization will be addressed again in the 109th Congress. The Committee believes that any increase in work requirements is invariably coupled with an increased need for jobs and for work support services, and it is therefore vital for any reauthorizing legislation to account for the unique make-up of rural communities and the employment needs and obstacles of rural TANF recipients.

# What We Know

Studies have shown that the more barriers a welfare re-

cipient faces the more difficult it is for the recipient to successfully find employment and leave welfare. Unfortunately, low population density, characteristic of rural areas, usually leads to three primary barriers: fewer modes of transportation, especially public transportation, fewer child care services, and fewer job openings and job training opportunities. Therefore, rural TANF participants often face these three barriers to employment in addition to any personal challenges, increasing the difficulty of entering the workforce and becoming permanently self-sufficient. Yet, regardless of these barriers, TANF's legislation limits cash assistance to a lifetime maximum of five years, making it of utmost importance that rural low-income families receive timely help in overcoming these challenges.

# Rural Obstacles to Success

## Transportation

Transportation is often cited by welfare recipients as the number one obstacle to leaving public assistance. Great stretches of open land and small, dispersed populations often make rural public transportation unsupportable. In fact, 80 percent of rural areas have no public bus system, compared to only two percent of urban areas.[10] While 40 percent of rural communities have no public transit system at all, another 28 percent have very limited services available.[11,12]

Clearly, the number one means of transportation in rural areas is personal vehicles; however, almost 57 percent of the rural poor do not own a car, and a staggering 96 percent of all public assistance recipients do not have their own vehicles.[13,14] In addition, cars owned by low-income families are often unreliable and in need of repair, further exacerbating the problem.

Prior to PRWORA, Federal law limited the value of a vehicle owned by a family receiving AFDC benefits to not more than $1,500 equity value. Under TANF, States can alter or dismiss this limitation, as well as use Federal and State funds to subsidize car ownership, repairs and auto insurance. In response, all States have taken advantage of this new liberty, and many are seeing positive results, especially in their rural communities.[15] For example, Jump Start, a non-profit organization in Wisconsin, helps TANF-eligible families purchase safe and reliable cars for employment or employment training. To date, Jump Start has helped more than 160 families obtain and maintain a vehicle and these families report dramatic improvements in work attendance and wages. Conclusively, access to employment increases when recipients have access to reliable transportation, and in rural America, this frequently equates with an increase in personal vehicle ownership.

Overall, low-income rural residents have less access to transportation than do their urban counterparts, yet rural residents must travel much greater distances to obtain needed services. This makes it difficult for them to take occasional trips to acquire food or health care, much less to travel to and from an employment site each day.

## Child Care

PRWORA provided States with an increase in Federal funding for child care in the form of the Child Care and Development Fund (CCDF). CCDF assists low-income families, including those receiving welfare benefits or transitioning from TANF, in obtaining child care so that they can work or, as an option in some States, attend training or educational courses. PRWORA also allows each State the option of transferring up to 30 percent of its TANF block grant to CCDF. In addition to the funds that each State must provide in order to receive the Federal child care funding, many States spend additional State funds on child care services. Finally, States may use TANF funds to provide child care services directly, without transferring the money to CCDF.

States, recognizing the importance of caring for low-income children as their parents enter the workforce, have taken advantage of the law's flexibility. In fact, the greatest redirection of TANF funds from 1996 to 2001 has been to child care. For Fiscal Year (FY) 2001, $4.6 billion in CCDF was made available through block grants to all 50 States, the District of Columbia, five Territories and approximately 500 Indian Tribes. With State and Federal funds in aggregate, more than $11 billion in CCDF- and TANF-related funds was available for child care in FY 2001.[16] Yet questions of the availability, reliability and cost of child care in rural areas still remain, for low-income families continue to identify child care as a significant barrier to employment.

Like transportation, reliable child care has been proven essential in moving welfare recipients into work,

## Grandparents As Caregivers

According to the Department of Health and Human Services, in 2000, 2.2 million children in the United States were living with a grandparent, aunt, sibling or some other relative because their parents were no longer able to care for them. The majority of these children (69 percent) were cared for by a grandparent.[1]

Because many grandparents do not anticipate becoming primary care-givers for their grandchildren, these families often face financial hardships and are more likely to be poor and in need of public assistance than parent-maintained families.[2]

In 1996, a primary focus of welfare reform was moving low-income adults with children into the workforce and off of public assistance. Over the subsequent years, as these adults have found work and left welfare, a growing share of the TANF caseload has become child-only cases, cared for by grandparents. In fact, nine percent of TANF children are grandchildren of the head of their household.[3]

To ensure the well-being of these families, HHS should further examine their unique needs and identify any policy barriers to providing both the children and their grandparents with needed services. In addition, with TANF reauthorization on the horizon, Congress has an important opportunity to institute new policies that will serve these families as they continue to become more and more prevalent.

[1] Geen R, Holcomb P, Jantz A, Koralek R, Leos-Urbel J, Malm K. "On Their Own Terms: Supporting Kinship Care Outside of TANF and Foster Care." *The Urban Institute*; Sept. 2001. Available at: http://aspe.hhs.gov/hsp/kincare01/index.htm.

[2] Bryson K, Casper LM. "Coresident Grandparents and Grandchildren." Current Population Reports. U.S. Census Bureau; May 1999. Available at: http://www.census.gov/prod/99pubs/p23-198.pdf.

[3] Administration for Children and Families. "TANF Sixth Annual Report to Congress." U.S. Department of Health and Human Services; November, 2004. Available at: http://www.acf.hhs.gov/programs/ofa/annualreport6/ar6index.htm.

especially single parents. Most studies on the topic report an insufficient amount of child care services. Compared to urban areas, rural areas have fewer trained child care professionals and fewer available slots at child care centers, often requiring rural parents to rely on friends and relatives to care for their children. Unfortunately, child care provided by friends and relatives tends to be less reliable.[17] Furthermore, many TANF parents find work in low-paying service or manufacturing positions, and their problems with finding child care are often exacerbated by irregular work schedules, such as weeknight or weekend hours. One study finds that more than a quarter of former TANF recipients who are employed work night hours.[18]

It has also been reported that children in low-income families have a higher rate of disability, with 18.1 percent having difficulties performing everyday activities, compared to 10.9 percent of children in families above the poverty line.[19] Finding child care is particularly challenging for these families, especially in rural areas that are less likely to have specialty child care services.

For many low-income families, the cost of child care is another barrier to face. According to a study by The Urban Institute, families with incomes below the Federal poverty line spend, on average, 23 percent of their monthly earnings on child care.[20] This becomes problematic when the cost of child care is too high, because the financial incentive to work diminishes, and parents, especially single parents, may not find it beneficial to work. A 1994 GAO study calls the cost of child care a decisive factor in moving low-income single mothers into the workforce. The study concludes that reducing the costs of child care through subsidies increases the likelihood that low-income mothers will work;[21] however, only one in seven eligible children in the country are currently receiving Federal support for child care.[22] Clearly, additional child care support is needed for TANF families, especially those in rural areas.

## Labor Markets

Even if a rural welfare recipient can access reliable transportation and child care, the challenge of finding a job that can lift his or her family out of poverty is great. This difficulty exists because, even after a period of economic expansion in the 1990s, rural labor markets still have slower job growth, higher unemployment rates

and smaller earnings than the national averages. With a good share of the available positions in low-wage industries, it is slightly harder to get a job, especially a good paying job, in rural areas.[23] Additionally, many rural jobs tend to be temporary, part-time or seasonal, and do not present the opportunity or security of long-term career development.

In a study of job availability in Mississippi, it was found that only one job was available for every two TANF clients.[24] In addition, a study by Mathematica compared the earnings of current and former TANF recipients in rural and urban areas of Nebraska and found that those working in urban areas had higher earnings than those with jobs in rural areas.[25] Overall, studies conclude that it is harder to get a job, especially a high-wage job, in rural communities than it is in urban areas.

Although the success of welfare to work depends on the viability of local labor markets, economic studies report that rural areas may be the hardest hit during times of recession.[26] Rural areas are often supported by a few employers, and the loss of one major employer may cause increased competition for existing jobs and cripple attempts to successfully transition rural residents from welfare to work.[27]

Another challenge for rural welfare clients lies in the low number of educational and vocational training opportunities. A study of Iowa's communities indicates that, in addition to being an individual hardship, "low wages also depress the tax revenue of communities, affecting local public services, such as education, libraries, and infrastructure."[28] Problematically, rural adults have lower levels of educational attainment than urban adults, hindering their chances of finding work, yet their communities are home to fewer educational centers and institutions as well as fewer social support centers that offer vocational training.[29,30]

While rural recipients typically have shorter spells on welfare than their urban counterparts, possibly due to the heightened stigma of public assistance in close-knit communities, some studies show that rural residents are more likely to cycle off of welfare, only to shortly return to the rolls. Some of this cycling has been attributed to the greater instances of seasonal employment in rural communities.[31] For example, in California, one seventh of all TANF recipients reside in rural or agricultural communities. In these areas, TANF use fluctuates greatly from the summer to the winter season, and

## Head Start and Welfare Reform

Head Start, a Federal program created in 1965, provides low-income preschool children with comprehensive child development and educational services and their families with parental support. Since at least 90 percent of Head Start participants must be at or below the Federal poverty line, many participants are also TANF recipients. In 2003, 21 percent of Head Start families were in the TANF program.[1]

Because of the connection between the two programs, welfare reform has affected Head Start in several ways. First, Head Start requires parental participation; however, with TANF's new work requirements, many low-income parents are finding it difficult to meet both the demands of a full-time job and the Head Start requirement. Some States have allowed the Head Start requirement to count toward the TANF requirement as well. Second, in their move off of welfare and into the workforce, many parents now have a need for full-time child care services, yet most Head Start programs provide part-day, part-year services. To address this need, HHS has begun fostering cooperation between Head Start and child care services by giving priority of funding to full-day, full-year collaborative programs.[2] Such programmatic flexibility and collaboration is vital to meeting the needs of TANF families in their move off of welfare.

[1] Hart K, Schumacher R. "Moving Forward: Head Start Children, Families, and Programs in 2003." *Head Start Policy Brief*, No. 5. Center for Law and Social Policy; June 2004. Available at: http://www.clasp.org/publications/hs_brf_5.pdf.

[2] United States General Accounting Office. "Education and Care: Early Childhood Programs and Services for Low-Income Families." GAO/HEHS-00-11. Washington. DC: General Accounting Office; Nov. 1999.

low-income seasonal employees often find it difficult to lift their families out of poverty year-round.[32]

# Current HHS and Federal Governmental Role

The effects of these unique and challenging barriers are well documented, as some studies show that rural recipients have a harder time transitioning into the workforce.[33] However, studies also have shown that removing even one of these barriers for rural communities can drastically improve welfare's success there. For example, the Good News Garage program is tackling the transportation barrier in Vermont, supplying TANF recipients with personal vehicles. This non-profit organization reports that 75 percent of the TANF recipients who received a car to date have subsequently left welfare.[34]

To address rural TANF recipients' unique barriers, HHS has taken several measures at the Federal level.

## HHS' Rural Initiative

In July of 2001, Secretary Thompson launched the HHS-wide Rural Initiative by appointing a cross-department Rural Task Force to explore options and opportunities for strengthening the Department's commitment to rural America. The Task Force has led to the creation of a rural information clearinghouse, the Rural Assistance Center (RAC) (http://www.raconline.org), and to unprecedented and targeted technical assistance to rural areas. The Task Force also has served as a catalyst for a strong rural focus in the Department, which has provided a backdrop of support for the following activities aimed at assisting rural TANF recipients.

## Administration for Children and Families

Within HHS, the Administration for Children and Families (ACF) is responsible for administering the TANF block grant program. Although all of the design and implementation power for the program largely resides in the individual States, various components in ACF have actively worked to address common issues among the States, including the barriers faced by rural communities.

### Technical Assistance

ACF's Office of Family Assistance (OFA) provides technical assistance via the Welfare Peer Technical Assistance Network (http://peerta.acf.hhs.gov), which promotes best practices and encourages conversation and collaboration between various organizations, programs and providers. OFA also provides targeted technical assistance, upon request, to State or local TANF programs. From January to June of 2004, three of the nine technical assistance events held by OFA were rural-specific.[35]

### Earned Income Tax Credit Initiative

The Earned Income Tax Credit (EITC), a refundable tax credit available to low-income employees, began in 1975 and was expanded in 1990 and 1993. The EITC can help low-income families meet their financial needs, even after their welfare benefits have ended. In 1996, the EITC provided rural areas with an estimated $6 billion; however, the effectiveness of the EITC, on an individual level, requires TANF and former TANF recipients to have heard of the EITC and to take advantage of it.

In 2003, ACF collaborated with the National Organization of Black County Officials and the Internal Revenue Service (IRS) on the Delta Initiative Earned Income Tax Credit Project to increase awareness of the EITC in seven southern States in the Mississippi Delta region (Louisiana, Alabama, Tennessee, Mississippi, Arkansas, Missouri and Illinois). Through outreach efforts, the initiative met its goal of doubling enrollment in the EITC in two selected counties of these seven Delta States. The initiative hopes to have all eligible TANF and former TANF clients in the Delta region take advantage of the EITC once they are employed. To meet this larger goal, ACF has met with community leaders and local and State officials for each Delta State and developed strategies to raise awareness of the EITC.

## Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation has contracted with Mathematica Policy Research to establish a foundation for rural human services research, to facilitate research on human service

## Monroe County Families Resource Center

During a meeting in Tupelo, Mississippi in September, the Committee visited the Monroe County Families Resource Center, operated by *LIFT, Inc*., and saw first-hand the importance of strong leadership in rural TANF programs.

TANF recipients in Monroe County face an uphill battle against the county's 14.3 percent unemployment rate and the State's limited financial resources, but Linda Blackwell, Executive Director of *LIFT*, and Ann Tackett, Resource Center Director, are committed to serving the community's low-income families, and their commitment has led to success.

Blackwell and Tackett's leadership has resulted in collaborations among programs and has limited duplication of efforts in their community. The new Families First Resource Center is located in a facility that houses multiple programs and services under one roof, including Head Start and Early Head Start, tutoring for school children, GED classes, parenting classes, family counseling, adult literacy programs and "Kids in the Kitchen," a nutrition course for children. The Center serves as a one-stop resource for low-income families in need of assistance.

As natives of the community, Blackwell and Tackett have strong ties to their fellow residents. They have recruited dozens of volunteers for the Center, who gave over 950 volunteer hours last year. And most importantly, Blackwell and Tackett know each of their clients by name, providing personal attention and helping the families to receive the assistance they need. While Blackwell and Tackett often struggle to find funding for the Center's programs from year to year, they continue to foster collaborations and forge public and private partnerships that have provided great opportunities for their clients. The Committee believes the efforts of those like Blackwell and Tackett should be recognized and rewarded.

conditions in rural areas, and to inform local and Federal policymakers and researchers about the human services needs of rural communities. The project is scheduled to be completed by March 2005. A description can be found at http://aspe.hhs.gov/hsp/ongoing.htm#id-cond-rural-areas.

### Inter-agency Collaboration

In 1986, HHS joined with the Department of Transportation to coordinate transportation programs at the Federal level. The two departments created the Coordinating Council on Access and Mobility. In January of 2004, the Department of Education and the Department of Labor were invited to join the Council and in February, President George W. Bush issued an Executive Order calling for expanded membership of the Council to include representatives from other departments as well. The Council has since launched *United We Ride*, a five-part initiative to break down any barriers to coordination among the 62 Federal programs that fund transportation services; encourage collaboration among local programs; and better serve elderly, disabled and low-income Americans.

# Conclusion

The Committee believes that rural TANF recipients face unique challenges as they move off of public assistance and into full-time employment. The very characteristics that distinguish rural areas from urban centers, such as low population density and open landscapes, can create additional obstacles such as lack of transportation, child care and jobs for TANF families. However, the Committee recognizes that rural communities possess inherent advantages as well.

Rural communities are often close-knit communities, with active religious or social organizations, providing TANF recipients a strong support system. With fewer people, social service caseworkers tend to have fewer TANF clients, affording the caseworker and client an opportunity to build a relationship that will benefit the client. In addition, rural areas have fewer and limited resources; yet this limitation frequently results in collaboration. For example, personal contacts and established relationships between TANF caseworkers and community employers can yield job placements for TANF clients.

The Committee would also like to acknowledge that other issues in relation to welfare reform and rural communities—such as health care for TANF recipients—were not addressed at length in this report, but are of utmost importance. The Commonwealth Fund reports that higher-wage workers are more likely than lower-paid workers to have health insurance and health-related benefits. Furthermore, workers without access to the health care system are at greater risk of financial ruin in the event of a serious illness.[36] Inadequate health care coverage can cause former TANF recipients to return to the welfare rolls if their health worsens. The Committee believes it is tantamount for both health care and social service providers to explore the relationship between good health and social well-being for low-income families.

In March of 2004, the Committee heard testimony from Dr. Wade Horn, Assistant Secretary for Children and Families. Dr. Horn explained that in 1996, when Congress passed welfare reform, $16.5 billion was given as a block grant to the States while only $1 million was allocated to the Federal government for conducting technical assistance to the States. Dr. Horn expressed his desire for more funds for technical assistance so that ACF may assist States in addressing rural communities' unique challenges and training rural caseworkers so they may better serve TANF recipients. It is the Committee's hope and recommendation that Congress, when reauthorizing the legislation, provides ACF with more money to help improve rural service delivery and support TANF's success in rural areas.

While the Committee recognizes that most progress is contingent upon TANF's reauthorization and the allocation of additional funds for technical assistance, it also believes HHS can continue to monitor TANF's effects on rural low-income families. The Committee supports HHS' work, to date, to address the obstacles to welfare's success in rural communities and recommends the following additional actions to further assist rural TANF recipients.

# Recommendations

- *The Secretary should work with the Administration for Children and Families (ACF) to provide targeted technical assistance that would encourage States to address the transportation, child care, and employment and training needs of rural TANF recipients.*

- *The Secretary should emphasize collaboration and encourage States to utilize best practices, including those identified by ACF, particularly in efforts to serve rural clients.*

- *The Secretary should strengthen the Department's leadership among Federal partnerships and collaborations.*

As a leader of the Coordinating Council on Access and Mobility, which addresses the transportation needs of elderly, disabled and low-income Americans, the Secretary should emphasize the realities of rural transportation and encourage innovative programs that reach rural residents through the United We Ride program. To address rural TANF recipients' child care needs, the Secretary should encourage coordination and collaboration among Head Start, Early Head Start, child care and TANF in serving families in rural areas. Finally, the Secretary should work with the IRS to strengthen outreach efforts on the Earned Income Tax Credit in rural communities.

## *References*


[1] U.S. Department of Health and Human Services. "Welfare Rolls Drop Again." *News Release*; March 30, 2004. Available at: http://www.acf.hhs.gov/news/press/2004/TanfCaseloads.htm.

[2] Administration for Children and Families. "TANF Sixth Annual Report to Congress." U.S. Department of Health and Human Services; November, 2004. Available at: http://www.acf.hhs.gov/programs/ofa/annualreport6/ar6index.htm.

[3] *ibid.*

[4] United States Government Accountability Office. "Welfare Reform: Rural TANF Programs Have Developed Many Strategies to Address Rural Challenges." GAO-04-921. Washington. DC: Government Accountability Office; Sept. 2004.

[5] Whitener L, Gibbs R, Kusmin L. "Rural Welfare Reform Lessons Learned." Economic Research Service; June 2003.

[6] Weber B, Duncan G, Whitener L, "Reforming Welfare: Implications for Rural America." *Rural America*. 16:3, Fall 2001.

[7] Findeis JL, Henry M, Hirschl TA, Lewis W. "Welfare Reform in Rural America: A Review of Current Research." Rural Policy Research Institute. P2001-5. Feb. 2, 2001.

[8] Loprest P. "Families Who Left Welfare: Who are They and How are They Doing?" *The Urban Institute;* 1999.

[9] Loprest P. "Who Returns to Welfare?" *The Urban Institute*. Series B, No. B-49; Sept. 2002.

[10] Federal Highway Administration. *1995 Nationwide Personal Transportation Survey*. United States Department of Transportation.

[11] Rucker G. "Status Report on Public Transportation in Rural America." Rural Transit Assistance Program, Federal Transit Administration; 1994.

[12] CTAA. "Mobility: Key to Welfare Reform." *Community Transportation*. Community Transportation Association of America; Winter 1995.

[13]Federal Transit Administration "Moving Rural Residents to Work: Lessons Learned from Implementation of Eight Job Access and Reverse Commute Projects." Available at: http://www.fta.dot.gov/14550_ENG_HTML.htm.

[14] Miller J. "Welfare Reform in Rural Areas: A Special Community Transportation Report." Community Transportation Association of America; Sept. 1997.

[15] Waller M, Blumenberg E. "The Long Journey to Work: A Federal Transportation Policy for Working Families." *The Brookings Institute*; July 2003.

[16] Administration for Children and Families. "Child Care and Development Fund, Report to Congress–FY 2001." United States Department of Health and Human Services. Available at: http://www.acf.hhs.gov/programs/ccb/policy1/congressreport/index.htm.

[17] GAO. "Welfare Reform." GAO-04-921.

[18] Loprest P. "Families Who Left Welfare: Who are They and How are They Doing?" *The Urban Institute;* 1999.

[19] Federal Interagency Forum on Child and Family Statistics. "America's Children: Key National Indicators of Well-Being." 1999. Available at: http://www.childstats.gov/ac1999/ac99.asp.

[20] Giannarelli L, Barsimantov J. "Child Care Expenses of America's Families." *The Urban Institute*; April 2001.

[21] United States General Accounting Office. "Child Care: Child Care Subsidies Increase the Likelihood that Low-Income Mothers Will Work." HEHS-95-20. Washington, DC: General Accounting Office; 1994.

[22] United Way of America Public Policy Factsheet. May 2004. Available at: http://national.unitedway.org/publicpolicy/docs/TANF_Fact_Sheet.pdf.

[23] Gibbs R. "Rural Labor Markets in an Era of Welfare Reform." Economic Research Service, U.S. Department of Agriculture. In: *Rural Dimensions of Welfare Reform*, ed. Weber BA, Duncan G, and Whitener LA. Kalamazoo, Mich.: W. E. Upjohn Institute for Employment Research, 2002.

[24] Howell, FM. "Will Attainable Jobs Be Available for TANF Recipients in Local Labor Markets?" In: *Rural Dimensions of Welfare Reform*, ed. Weber et al., 2002.

[25] Ponza M, Meckstroth A, Faerber J. "Employment Experiences and Challenges among Urban and Rural Welfare Clients in Nebraska." Mathematica, Aug. 2002.

[26] Hamrick, Karen. "Rural Labor Markets Often Lead Urban Markets in Recessions and Expansions." *Rural Development Perspectives* 12(3); 1997.

[27] Marks E, Dewees S, Ouellete T, Koralek R. "Rural Welfare to Work Strategies–Research Synthesis." June 10, 1999.

[28] RUPRI. "Rural American and Welfare Reform: An Overview Assessment." Feb. 10, 1999.

[29] Economic Research Service, U.S. Department of Agriculture. "Rural Labor and Education: Rural Education." Briefing room. Available at: http://www.ers.usda.gov/Briefing/LaborAndEducation/ruraleducation/.

[30] Pindus N. "Implementing Welfare Reform in Rural Communities." *The Urban Institute*; Feb. 2001.

[31] Henry M, Reinschmiedt L, Lewis W, Hudson D. "Reducing Food Stamp and Welfare Caseloads in the South." In: *Rural Dimensions of Welfare Reform*, ed. Weber et al., 2002.

[32] Brady H, Sprague M, Gey F, Wiseman M. "Seasonal Employment Dynamics and Welfare Use in Agricultural and Rural California Counties." In: *Rural Dimensions of Welfare Reform*, ed. Weber et al., 2002.

[33] Whitener L, Gibbs R, Kusmin L. "Rural Welfare Reform Lessons Learned." Economic Research Service, U.S. Department of Agriculture; June 2003.

[34] GAO. "Welfare Reform." GAO-04-921.

[35] i*bid*.

[36] Collins SR, Davis K, Doty MM, Ho A. "Wages, Health Benefits, and Workers' Health." *Issue Brief*. The Commonwealth Fund; Oct. 2004. Available at: http://www.cmwf.org/publications/publications_show.htm?doc_id=241931.

# Acronyms Used

ACF - Administration for Children and Families

AFDC – Aid to Families with Dependent Children

AHEC - Area Health Education Center

AoA - Administration on Aging

BMI – body mass index

BVCA – Blue Valley Community Action

CAH - Critical Access Hospital

CCDF – Child Care and Development Fund

CDC - Centers for Disease Control and Prevention

CHC – Community Health Center

CHD – coronary heart disease

CNM – Certified Nurse Midwife

DHSPS – Division of Healthy Start and Perinatal Systems

DRTE - Division of Research, Training and Education

EITC - Earned Income Tax Credit

EMTC - Eastern Maine Transportation Collaborative

GAO - Government Accountability Office (formerly General Accounting Office)

HHS - Department of Health and Human Services

HPSA - Health Professional Shortage Area

HRSA - Health Resources and Services Administration

HTC - Home Town Competitiveness

IOM – Institute of Medicine

JAMA – Journal of the American Medical Association

MCH – Maternal and Child Health

MCHB - Maternal and Child Health Bureau

NACRHHS - National Advisory Committee on Rural Health and Human Services (also known as NAC)

NIH - National Institutes of Health

NHSC – National Health Service Corps

OB – obstetric, obstetrical, obstetrician

OB/GYN – obstetrician/gynecologist

OFA – Office of Family Assistance

OMB - Office of Management and Budget

ORHP - Office of Rural Health Policy

PRWORA – Personal Responsibility and Work Opportunity Reconciliation Act of 1996

RAC - Rural Assistance Center

RUPRI – Rural Policy Research Institute

SOHSN – Southern Ohio Services Network

TANF - Temporary Assistance for Needy Families