TASK FORCE ON RURAL HEALTH
Wednesday, March 20, 2013
Guilford County Department of Public Health
1203 Maple Street, Greensboro, NC 27405
10:00am – 3:00pm
Meeting Summary

Attendees

Members: Paul Cunningham (co-chair), Robin Cummings (co-chair), Donna Tipton-Rogers (co-chair), Ronnie Bell, Danielle Breslin, Silvia Cendejas, Olivia Collier, Anita Davie, Joy Grady, Jim Graham, Phillip Hardin, Jeff Heck, Ammie Jenkins, Polly Johnson, John Kauffman Jr., Mike Lancaster, Nena Lekwauwa, Armando Limon, Andy Lucas, Addie Luther, Will Mahone, Thomas Maynor, Jennifer Nixon, Becky Olson, Juvencio Peralta, Mary Perez, John Price, Andrea Radford, Nancy Reigel, Ray Rogers, Maggie Sauer, Jeff Spade, Willona Stallings, Jean Steverson, Dennis Streets, Henrietta Zalkind

Steering Committee and NCIOM Staff: Krutika Amin, Renee Batts, Libby Betts, Chris Collins, Linda Kinney, J. Nelson-Weaver, Joy Reed, Mikki Sager, Pam Silberman, Anne Williams, Berkeley Yorkery, Adam Zolotor

Other Interested people: Tom Irons, Dan Keller, Suzanne Lea, Doris Lucas, Bob Strack

WELCOME AND INTRODUCTIONS

Robin G. Cummings, MD, FACC, FACS
Director
Office of Rural Health and Community Care
North Carolina Department of Health and Human Services

Paul Cunningham, MD
Dean, Senior Associate Vice Chancellor for Medical Affairs
Brody School of Medicine
East Carolina University

Donna Tipton-Rogers, EdD
President
Tri-County Community College

Dr. Cummings, Dr. Cummingham, and Dr. Tipton-Rogers welcomed everyone to the Task Force's first meeting and asked all attendees to introduce themselves.

OVERVIEW OF THE NCIOM TASK FORCE PROCESS

Pam Silberman, JD, DrPH
President and CEO
North Carolina Institute of Medicine

Dr. Silberman welcomed the Task Force members and gave an overview of the NCIOM, the task force process, the background leading up to the task force, and the charge to the task force. The Task Force on Rural Health is a collaborative effort between the North Carolina Institute of Medicine (NCIOM), the Office of Rural Health and Community Care (ORRHCC), and Kate B. Reynolds Charitable Trust. The Task Force is charged with developing a comprehensive, coordinated North Carolina Rural Health Action Plan to provide policy makers, funders, and stakeholder organizations with a common vision and action steps to improve rural health. The task force will:

(1) Examine the health of rural North Carolinians.
(2) Identify potential strategies that are critical to improve rural health outcomes and actionable over the next three to five years.
(3) Gather input from eight rural communities across North Carolina.
(4) Consider the feedback from the local community forums and make adjustments to priority strategies as necessary.

The Task Force will meet three more times over the summer, break for the community meetings in September, and resume their work in October.

Dr. Silberman's presentation is available here: Overview of Task Force Process.

RURAL HEALTH PLAN OVERVIEW

Chris Collins
Deputy Director
North Carolina Office of Rural Health and Community Care

Ms. Collins gave an overview of the previous work done on a Rural Health Plan that the Office of Rural Health and Community Care (ORRHCC) was asked to develop by the federal government. ORRHCC hired a consultant who did a nice job identifying priorities, but the plan did not include the community input or identify actionable strategies the office hoped for. ORRHC is already doing a lot of work on the issues raised, but there is an exciting opportunity for this Task Force to move the discussion beyond the health care system and gather input from other rural systems such as the schools and employers. From this broader perspective more concrete strategies can be identified to have healthy rural residents.

DEMOGRAPHICS AND HEALTH STATUS OF RURAL NORTH CAROLINA
Adam Zolotor, MD, DrPH
Vice President
North Carolina Institute of Medicine

Dr. Zolotor presented to the Task Force an overview the current data describing the demographics and health status of rural North Carolina. Rural is defined several different ways, but the Task Force will use the Office of Management and Budget (OMB) definition, which identifies 60 NC counties as rural and accounts for about 25% of the NC population. (The late February updates to the OMB classifications are not represented in Dr. Zolotor's presentation, but the new map will be shared with the Task Force at the next meeting.)

Differences in prevalence of illness between rural and urban America is largely explained by differences in age, race/ethnicity, and socioeconomic status—rural Americans are more often older, of minority race/ethnicity, and poorer. Of the 60 rural counties in NC, 33 are Tier 1 counties and 22 are Tier 2 counties. In rural NC, the rate of job growth was ½ that of urban NC from 1990-2010, the median household income is significantly lower in rural NC, and there is a higher percentage of children in poverty. Housing is an important issue in rural NC with a high number of mobile homes and a higher percentage of substandard housing than in urban NC.

A higher percentage of rural NC residents report being uninsured, having an unmet need, and having no dental visit in the last year. Dr. Zolotor summarized the Healthy North Carolina 2020 (HNC 2020) goals and the process by which they were developed, and explained the reasoning behind using the HNC 2020 goals as a starting point for conversation. Dr. Zolotor shared some of the data showing the differences between rural and urban counties regarding the HNC 2020 focus areas including tobacco use/exposure, physical activity and nutrition, maternal and infant health, oral heath, injury and violence, and mental health.

Dr. Zolotor's presentation is available here: Demographics and Health Status of Rural North Carolina.

Selected Questions and Comments:

- Q: Could the difference in median household income be explained by cost of living?
  A: The difference seen--$38,433 in Rural counties, and $47,622—is greater than could be explained by cost of living. In addition, cost of living considerations may represent significant differences in living conditions.
- C: The unintended pregnancy rate should be assumed to be much higher than shown by PRAMS data because PRAMS only surveys women after they've given birth.
- C: Without looking at this data broken down by race, this may not represent the reality for immigrants in rural NC.

- There was also some discussion among the Task Force about why rural residents are more likely to report that they have a personal doctor. Much of the discussion pointed to community differences in rural NC that might lead a resident to be more likely to know the name of his/her doctor, seek medical advice in less formal settings, or seek care through their pharmacist or veterinarian. The rural-urban age have an impact if individuals decide they need a doctor as they get older.

SOCIAL DETERMINANTS OF HEALTH
Robert W. Strack, PhD, MBA
Associate Department Chair/Associate Professor
Department of Public Health Education
University of North Carolina Greensboro

Dr. Strack gave a presentation framing the social determinants of health. He summarized the obesity and diabetes trends among US adults and argued that there are multiple contributing factors for any one disease. He outlined two arguments in response to the question: what determines your health? Individual choice and collective realities. Dr. Strack illustrated his argument with a metaphor comparing an individual's ability to be healthy and Sisyphus rolling a boulder up a hill—socio-economic factors such as family structure, educational opportunities, socio-economics, media, and the built environment influence how steep the hill is for the individual.

The conversation about health is greatly impacted by the framing of an individual as either making bad choices, or as the victim of circumstance. Dr. Strack argued that strategies to influence the health of our community must alter the environment to make the desired behavior easier, more affordable, and/or more accessible. Using a handful of examples such as recycling, lead poisoning, and adolescent sexual behavior, he illustrated how strategies can address the community environment and the need for interventions to reach across all levels of the socio-ecological model.

Dr. Strack concluded with an overview of some of the lessons from research on social determinants of health, both how community organizations overlap and collaborate and ways to frame the discussion that are less threatening and usually better received.

Dr. Strack's presentation is available here: Social Determinants of Health.

RURAL HEALTH SYSTEMS IN NORTH CAROLINA
Suzanne Lea, PhD, MPH
Professor of Public Health
Brody School of Medicine
East Carolina University

Tom Irons, MD
Professor of Pediatrics Associate Vice Chancellor, Regional Health Services
Medical Director, NC Agromedicine Institute
Director, Generalist Physician Program
Brody School of Medicine
East Carolina University

Dr. Lea introduced the Task Force to the typical cancer patients experience interacting with the health care system in rural eastern North Carolina using example case scenarios. The "Agnes" case scenario followed Agnes' breast cancer case through the process of a clinic visit and her referral to the Breast and Cervical Cancer Control Program (BCCDP), her treatment, and finally her search for a survivorship support, and the barriers and transition difficulties she faced. The "Pedro" case scenario followed Pedro through his colon cancer diagnosis and treatment. According to Dr. Lea the same case scenarios played out in different counties can look very different.

Dr. Irons shared some examples of pediatric patients and the barriers faced from his own experiences of working in rural health care. From workforce issues to EMS transportation, Dr. Irons described some of the issues that come up in pediatric medicine in rural NC.

Dr. Lea's presentation is available here: Rural Health Systems in North Carolina.

NEXT STEPS AND FEEDBACK
Berkeley Yorkery, MPP
Project Director and Research Associate
North Carolina Institute of Medicine

Ms. Yorkery outlined the goals and next steps of the Task Force before opening up the remaining meeting time for discussion. The Task Force will prioritize 4-6 strategies for the Rural Health Action Plan that state level organizations can undertake to help local communities improve the health of their communities. The Task Force will also work with local communities to identify 4-6 strategies that can be implemented at the local level to improve rural health. At the next three meetings, the Task Force will discuss determinants of health in the health behaviors, health services, and community and environment categories. A draft of the Rural Health Action Plan will be shared with local communities at community meetings for feedback. These communities are: Beaufort, Bladen, Halifax, Jackson, McDowell, Rockingham, Montgomery, and Wilkes counties.

Recommendations for members of these communities who should be invited to these meetings are welcomed by the NCIOM staff and steering committee members.

Ms. Yorkery's presenatation is available here: Task Force on Rural Health Next Steps.

Selected Questions and Comments:
The Task Force discussed the plans for the upcoming task force and community meetings, asked questions, and expressed concerns.

- Q: How were the counties chosen for the eight community meetings?
  A: The counties were chosen to get diverse locations across NC, with consideration for Tier designations, and existing collaborations.
- Q: How will people be invited to the community meetings?
  A: These details are still being worked out by the steering committee.
- C: We will need an interpreter for the community meetings.
- C: We can learn from failures in addition to hearing about creative community solutions. What are the barriers faced by the communities that "almost got it."