Housekeeping

Call Norms:

• All lines will be muted during the call.

• We will begin Q & A after the training portion of today’s call.

• Please submit questions via the WebEx chat box or press 14 and the monitor will call on you.

• We are recording this call, and will post slides, recording, and transcript on www.healthcarecommunities.org.

• Evaluation: Please fill out our evaluation at the end of today’s call.
World Diabetes Day: November 14, 2013

Help DNCC Celebrate By:

- Forming a Human Blue Circle
- Promoting the IDF diabetes logo
- Wearing Blue

SEND US YOUR STORIES
richardsonav@dfmc.org

Visit the
International Diabetes Federation
Website: http://www.idf.org/
## Agenda

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<td>Defining Rural Health</td>
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Webinar Goals

1. Discuss the differing definitions of “rural”.
2. Highlight prominent rural health disparities.
3. Provide an overview of organizations that support rural health.
4. Explain the unique challenges for Rural Minorities: the “Double Burden”.
5. Introduce innovative projects in rural health.
6. Understand QIO perspectives in meeting rural health challenges.
Today’s Speakers

Wayne Myers, M.D.  Janice Probst, Ph.D.  Juliana Anastasoff, M.S.
QIO Speakers

www.metastar.com

Jay A. Gold, MD, JD, MPH
Senior Vice President and
Chief Medical Officer

www.qiwwv.org

Natalie Tappe RN, MSN
Lead Project Coordinator EDC
Rural-Urban Health Disparities

Wayne Myers, M.D.
Former President of the National Rural Health Association, 2003
Director of the Office of Rural Health Policy, 1998-2000
Definitions of “Rural”

- “By exclusion”. Define “urban”: “rural” is what’s left.
- Fifteen federal definitions of “rural”, but only three are in general use in health research & statistics:
  - Metropolitan/ micropolitan/ nonmetro
  - Urbanized/ non urbanized
  - Rural/Urban Commuting Areas (“RUCAS”)
Metropolitan/Nonmetropolitan

- County based, OMB managed.
- Core urban area of > 50,000 people.
- Surrounding counties with > 25% of workforce commuting to core area.
- Multicounty complex = “Metropolitan Statistical Area” (MSA) named for city.
- Until 2000 census “NonMSA” = “Rural.”
Micropolitan

- Also county based, described by OMB.
- Conceptually similar to the MSA, BUT focuses on a county with an “urbanized core” (town) of 10,000-50,000.
- Used since the 2000 census.
- Therefore, “rural” may = nonMetro or nonMicro.
Urbanized/Nonurbanized

- Definition used by the Census Bureau
- >2,500 people
- Looks like a town, with blocks, lots etc.
- “Rural” = Non urbanized.
  - Non-urbanized population has approximated its non-metro population.
- Now at ~ 16% of the population
R.U.C.A.’s

- Rural – Urban Commuting Areas
- Recently developed by the Office of Rural Health Policy
- A ten point continuum
- Based on census tracts
- Considers urbanization, commuting patterns & population density
Frontier

- Several definitions,
- 6 people/square mile or less is most commonly used.
Rural-Urban Mortality Rates

No disparity until the 1990’s
Life Expectancy for Rural Women

The average age at death for women in four out of five rural counties falls below the national average of 81.3 years.

White areas are urban counties

Life expectancy for women in rural/exurban counties

- Above national average (81.3 years): 529 counties
- From 80 to 81.3 years: 580 counties
- From 77 to 79.9 years: 951 counties
- Under 77 years of age: 488 counties

Census and Daily Yonder: Average age of death for women in rural and exurban counties in 2009.
Changes in Rural Female Longevity: 1999-2009

Women in one out of four rural and exurban counties are living shorter lives now than a decade ago.

White areas are urban counties.

From 1999 to 2009 female life expectancy increased 1.7 years nationally, a rate matched or exceeded in only 168 rural or exurban counties.

- Gains at or above national average, 168 counties
- Below average gains in longevity, 1,790 counties
- Longevity declined in 622 rural/exurban counties
Rural Health: Place Matters

- Income
- Occupation
- Culture
- Environment
Factors in Rural/Urban Health

- Access to Health Services: Primary care, referral care, mental health services.
- Emergency medical services: Time to services ("golden hour"), sophistication of services, dangerous occupations, auto crash impact velocity, the *one doc phenomenon*.
- Lack of emergency transfer & other regional responsibility agreements.
Factors in Rural Health Disparities

- Rural income generally lower than urban
- Insurance:
  - Public...issues in getting enrolled
  - Private...fewer large employers offering coverage.
- Provider/patient culture gap: most doctors are urban raised & trained.
- Exposure to environmental chemical hazards?
Rural Health Agencies

DHHS

HRSA

ORHP

CMS

Funds 7 Rural Health Research Centers

Rural Assistance Center

5600 Fishers Lane
Rockville, MD 20857
http://www.hrsa.gov/rural health/
Office of Rural Health Policy (ORHP)

- Within the Health Resources & Services Admin, DHHS
- Funds Offices of Rural Health in every state that has non-metro counties.
- Advises CMS on rural impact of Medicare policy
- Funds Rural Research Centers, Rural Assistance Center.
- Other rural grants & programs
Rural Assistance Center

- At the University of North Dakota
- The place to start looking for rural information.
- Access to the research centers, resource papers, research librarians, federal announcements, newsletters
- Website: www.raconline.org
  - Phone: 1-800-270-1898
  - Email: info@raconline.org
Janice Probst, M.S., Ph.D., Director, South Carolina Rural Health Research Center
Professor, Department of Health Services Policy and Management
Arnold School of Public Health
University of South Carolina
Rural Minority Health
Challenges and Opportunities

Janice C. Probst, PhD
Director, South Carolina Rural Health Research Center
Professor, Department of Health Services Policy and Management
Arnold School of Public Health

South Carolina
Rural Health Research Center
At the Heart of Health Policy
Sneak Preview: Conclusions

- A lifetime of reduced financial and geographic to health care leads to a rural Medicare population sicker than its urban counterpart
- This trend is pronounced among rural minority populations
Definitions

- **Inequity**, per WHO:
  - “differences in health status or in the distribution of health determinants between different population groups”

- Rural:
  - A context in which people live, including services, opportunities and culture

- Race:
  - Used as a social construct
Minority presence in rural America: African Americans in rural counties
Minority presence in rural America: Hispanics in rural counties
Minority presence in rural America: American Indian/Alaska Natives
Rural areas often lack providers.
Afr. American population and HPSA status
Hispanic population and HPSA status

[Map of the United States showing the Hispanic population and HPSA status with different colors representing different categories.]
American Indian population, HPSA status
Rural ≠ Mayberry: Rural/urban HIV prevalence, 16 states, 2010
(Data from AidsVu.org)

Source: AIDSVu. Restricted to 16 states with complete county data
Percent of adults age 18 – 65 without health insurance, 2009 – 2011

- Urban Large Central County
- Urban Large Fringe County
- Urban Medium & Small Counties
- Rural Micropolitan Counties
- Rural, other counties

Source: Health US 2012, Table 74
Rural residents at risk for *early* death

Hazard ratio for death before age 65 among persons age 45-64 when interviewed, 1986-2000 NHIS LMF, adjusted for sex and age. Referent group = urban white.

Source: Probst et al, Health Affairs, 2011
Dual eligible beneficiaries

A higher proportion of the Medicare population is dual-eligible in rural counties

<table>
<thead>
<tr>
<th>Urban</th>
<th>All Rural</th>
<th>Micropolitan Rural</th>
<th>Small Adjacent Rural</th>
<th>Remote Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.4</td>
<td>16.4</td>
<td>15.8</td>
<td>17.4</td>
<td>17.3</td>
</tr>
</tbody>
</table>

## Rural duals: sicker, non-white persons

### Proportion of dual eligible beneficiaries:

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>All Rural</th>
<th>Micropolitan Rural</th>
<th>Small Adjacent Rural</th>
<th>Remote Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 1 Chronic Condition</td>
<td>18</td>
<td>21</td>
<td>19</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>11</td>
<td>14</td>
<td>14</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Afr.Amer.</td>
<td>14</td>
<td>23</td>
<td>15</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15</td>
<td>27</td>
<td>16</td>
<td>30</td>
<td>41</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>31</td>
<td>30</td>
<td>41</td>
<td>42</td>
</tr>
</tbody>
</table>

**Draft:** SCRHRC analysis of 2009 Medicare Claims data. **Not for circulation.**
Complexity: diabetes as an example

- Rural beneficiaries slightly more likely to be hospitalized, 13% versus 12% for urban.
- Rural beneficiaries slightly less likely to receive follow-up visit within 30 days, 86% versus 88% for urban.
- Rural black beneficiaries less likely to be hospitalized, 12% vs 13% white rural beneficiaries.
- Rural black beneficiaries more likely to be readmitted in 30 days, 16% versus 12% for white rural beneficiaries.
Summing up

- Rural minority populations experience **significant health access inequities**
- In consequence, they experience **significant health inequities**
Implications for quality improvement

- All solutions will be local, but…

- Coordination is essential
  - Rural hospitals ↔ local providers
  - Tertiary hospitals ↔ local hospitals and providers
  - All players ↔ social, educational and economic development
Questions / Comments

Thanks!

Jan Probst
Phone: (803) 251-6317
Email: jprobst@sc.edu
Website: http://rhr.sph.sc.edu/index.php
Rural Health Innovation

Juliana Anastasoff, M.S. Health Extension Officer, Northern Region, Health Extension Rural Office (HERO) University of New Mexico-Health Sciences (UNM-HSC)
Health Extension Rural Offices (HERO)
Partnering with New Mexico Communities to Improve Health & Health Equity

Juliana Anastasoff, MS
Health Extension Officer, Northern Region
Lecturer, Family & Community Medicine
University of New Mexico-Health Sciences Center
Context for Understanding Health Disparities in NM

- 5th largest state
- 2 million people
- Minority-majority population
- 23 federally-recognized sovereign Tribal Nations
- Ranked 50th in U.S. in poverty
- One-fifth of population is uninsured
- 32 of 33 counties are federally-designated HPSAs/MHPSAs
Quality Care is Not Enough
Example: Diabetes in Native Americans

- Recommended Preventive Services:
  - Native Americans have best rates

- Deaths from Diabetes:
  - Native Americans have highest rates

Source: NM Dept of Health Racial and Ethnic Disparities Report Card
Education & Health

- 56% of New Mexicans had some college education (we rank 36th in nation)
- If 24% more (80%) had some college, we would avert 677 deaths/year

Source: Robert Wood Johnson Foundation
Commission to Build a Healthier America
“Food Deserts” in New Mexico

Areas with Limited Access to Affordable and Nutritious Food
These NM disparities are worse in rural and frontier communities

<table>
<thead>
<tr>
<th>Domain</th>
<th>2013 Kids Count Profile: New Mexico</th>
<th>Overall Rank</th>
<th>The Annie E. Casey Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Economic Well-Being</strong></td>
<td>49</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Children in poverty</td>
<td>$31%</td>
<td>157,000 children</td>
<td>2005 26%</td>
</tr>
<tr>
<td>Children whose parents lack secure employment</td>
<td>37%</td>
<td>192,000 children</td>
<td>2006 30%</td>
</tr>
<tr>
<td>Children living in households with a high housing cost burden</td>
<td>36%</td>
<td>188,000 children</td>
<td>2005 31%</td>
</tr>
<tr>
<td>Teens not in school and not working</td>
<td>11%</td>
<td>13,000 teens</td>
<td>2008 10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>2013 Kids Count Profile: New Mexico</th>
<th>Overall Rank</th>
<th>The Annie E. Casey Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td>49</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Children not attending preschool</td>
<td>62%</td>
<td>35,000 children</td>
<td>2006-07 63%</td>
</tr>
<tr>
<td>Fourth graders not proficient in reading</td>
<td>79%</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>Eighth graders not proficient in math</td>
<td>76%</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>High school students not graduating on time</td>
<td>33%</td>
<td>9,019 students</td>
<td>2006/08 33%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>2013 Kids Count Profile: New Mexico</th>
<th>Overall Rank</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
<td>49</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Low-birthweight babies</td>
<td>8.7%</td>
<td>2,427 babies</td>
<td>2005 8.5%</td>
</tr>
<tr>
<td>Children without health insurance</td>
<td>9%</td>
<td>47,000 children</td>
<td>2008 14%</td>
</tr>
<tr>
<td>Child and teen deaths per 100,000</td>
<td>36%</td>
<td>200 deaths</td>
<td>2005 47</td>
</tr>
<tr>
<td>Teens who abuse alcohol or drugs</td>
<td>9%</td>
<td>15,000 teens</td>
<td>2006-08 9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>2013 Kids Count Profile: New Mexico</th>
<th>Overall Rank</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Family and Community</strong></td>
<td>49</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Children in single-parent families</td>
<td>43%</td>
<td>208,000 children</td>
<td>2005 38%</td>
</tr>
<tr>
<td>Children in families where the household head lacks a high school diploma</td>
<td>22%</td>
<td>115,000 children</td>
<td>2005 21%</td>
</tr>
<tr>
<td>Children living in high-poverty areas</td>
<td>21%</td>
<td>108,000 children</td>
<td>2000 20%</td>
</tr>
<tr>
<td>Teen births per 1,000</td>
<td>53%</td>
<td>3,872 births</td>
<td>2006 62</td>
</tr>
</tbody>
</table>
UNM-HSC Vision 2020

‘The University of New Mexico - Health Sciences Center will work with community partners to help New Mexico make more progress in health and health equity than any other state by 2020.’
HEALTH EXTENSION RURAL OFFICES

- Translates the Cooperative Extension Service model from agricultural to health sector
- Decentralizes university resources and expertise throughout rural and Tribal communities via agents from/in the field
- Facilitates community-campus engagement and partnerships
- Educates and advocates so university priorities and activities are better aligned with community-identified priorities, needs, and opportunities
A ‘HERO’ IS:

• A UNM-HSC health extension office

• **People**: Health Extension Officers, coordinators, and champions who live in rural communities, possess community health improvement skills, and build bridges between communities and UNM-HSC

• A **model** for public university engagement in rural communities

• A **strategy** for community health improvement: addressing determinates of health, building health workforce, developing health capacity & infrastructure
HEROS ON THE GROUND:

LIVE in community
LINK local health needs w/UNM-HSC resources
IMPROVE local health services and systems
ENCOURAGE youth to finish school, enter health careers
RECRUIT and retain a local health workforce
BRING latest research, health care practices to community
STRENGTHEN community capacity to address local health issues
SHAPE their work in response to local needs
PARTICIPATE in local knowledge networks, systems of care, and communities of practice
HERO = Dating Service + Swiss Army Knife
HERO Generalist Skills
(change agent toolbox)

- Facilitation
- Coaching
- Training
- Convening
- Promoting conversations
- Motivating decision-making
- Project design & management
- Writing & research

- Advocacy
- Organizing
- Visioning & strategic planning
- Systems analysis
- Customer service
- Quality improvement
- Leveraging social capital
- Disseminating best practices
HERO Specialist Areas
(transdisciplinary team)

- Primary care and health systems
- Health outreach and education
- Community and population health improvement
- Border, Indian, Rural/Frontier Health
- Hispanic/Latino, African-American, Women’s Health
- Health professions training and education
- Health economics
- Health policy
- Community development
Examples: *Pipeline & Health Workforce*

- Strengthen the **distal pipeline inlet**: student recruitment, health career exploration and navigation, health career clubs
- Support **rural clinicians**: liaison to HSC for continuing education, training, professional development
- Serve as field faculty and support to HSC **students for rural rotations**, precepting, rural community health projects
- Provide training to frontline health workers, including rural **community health workers** or *promotores* (CHWs), Tribal Community Health Representatives (CHR); Mental Health First Aid training to rural first responders, primary care professionals, community groups
Examples: *Determinates of Health*

- Provide technical assistance to growers & producers to connect **food systems to community health**
- Coordinate outreach and education activities related to **Medicaid expansion** and the Marketplace in communities and across NM’s higher education system
- Provide training and support to instructors to integrate **health literacy** into adult education & ESL classrooms
- Educate stakeholders on the connection between **health and rural economies**
Examples: Health Capacity & Infrastructure

• Provide training, technical assistance, and coaching for rural practice transformation; development of community-centered health homes
• Provide facilitation, strategic planning support, and technical assistance to rural health networks, programs, health councils, local health leaders
• Recruit local clinicians into practice-based research networks
• Provide grant writing assistance for safety-net needs assessment, planning, and funding applications
• Facilitate affiliation agreements between UNM-HSC and regional health and higher education systems
Click on any of the toolkit chapters below to get started:

**GETTING STARTED:** Overview & How to Use the Toolkit
What is the purpose of this toolkit? How do I navigate it? What is “health extension”? How can we begin implementing this innovative model in our state?

**ENGAGEMENT:** Public Institutions for the Public Good
What is true community engagement? How does the concept of university “extension” relate to engagement? What is the role of different kinds of institutions in the community?

**HEALTH EXTENSION:** Core components
What are the components within health extension? What does a health extension agent do? What are the outcomes from implementing health extension?

**PRIMARY CARE:** Transforming Practices
How does health extension relate to primary care practices? How can health extension help small, independent practices in their path towards transformation into patient-centered medical homes?

**POPULATION HEALTH:** From Disparities to Equity
What really makes us sick? How can addressing the so-called “social” determinants of health improve community health outcomes? What is the role of community health workers in improving population health?

**SUSTAINABILITY:** Financing & Evaluation
How are movements created? What kind of financing exists for implementing health extension? How will we know we are being effective?
EMAIL AN EXPERT FOR TECHNICAL ASSISTANCE

Understanding the Health Extension Model

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Alan Adams, MD
Vice Chair for Academic Affairs & Research
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Email: AlanAdams@hmc.psu.edu

Addressing Health Needs of Specific Populations

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Email: FAviles@navajohealth.gov

Charlene Rice, LSW
Health Specialist, Navajo Health
Tribal Health Extension Manager

Health Extension Partner State: Oregon

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Oregon Health & Science University
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Oregon Health & Science University
Email: PMcGinnis@ohsu.edu

Roger Ridenour
Agricultural Extension for Outreach & Engagement
Oregon State University
Email: RogerRidenour@oregonstate.edu

Find out more about the states participating in health extension across the country:
- [State Name Touched Through Digitally] (State) (State) (State)
- Oregon Community Partners

UNM HEATH SCIENCES CENTER
THANK YOU !
MetaStar and the Wisconsin Office of Rural Health

Jay A. Gold, MD, JD, MPH
November 12, 2013
Critical Access Hospital Emergency Department Transfer Communication

- Partnership between MetaStar, the Medicare Quality Improvement Organization for Wisconsin, and the Wisconsin Office of Rural Health
- Importance of emergency care in rural hospitals
- Support and training
- Anticipated results
Emergency Department Transfer Communication Quality Measure Set

Measure Domains:

EDTC-1 Administrative communication
EDTC-2 Patient information
EDTC-3 Vital signs
EDTC-4 Medication information
EDTC-5 Physician or practitioner generated information
EDTC-6 Nurse generated information
EDTC-7 Procedures and tests
Transitions of Care (TOC)

- ORH is an active participant in the statewide TOC steering committee, chaired by MetaStar.
- ORH assisted with funding for the 4 regional TOC workshops to allow easier access for all providers in rural areas to participate.
- Rural county providers formed county coalitions to assist patients’ transition from one health care setting to another within their county.
- Wisconsin has seen a 4.6% statewide Relative Improvement (RI) for admissions and 5.8% RI for statewide readmissions.
Contact Information

MetaStar, Inc.
2909 Landmark Place
Madison, WI  53713

Phone: (608) 274-1940
Email: jgold@metastar.com
Website: www.metastar.com

This material was prepared by MetaStar, the Medicare Quality Improvement Organization for Wisconsin, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-WI-MISC-13-18.
Q&A

Please type your question into the chat box or press 14 on your telephone.
Everyone with Diabetes Counts

Natalie Tappe, RN, MSN
WVMI

- WVMI is one of three Medicare QIOs with EDC initiatives. The other two being Texas and New York, serving both the Hispanic and African American populations.
- WV’s EDC is the first to focus on a solely rural population, not targeting racial/ethnic health disparities.
Why West Virginia?

- Approximately 229,379 people in West Virginia have diabetes. Over 62,162 are undiagnosed \(^{(1)}\)

- Year after year, WV is ranked among the top states with the highest prevalence of diabetes as well as obesity, MI and stroke

- Rates in Southern WV are approaching 16 percent of the population

- Less than half of West Virginians with diabetes have had any education about the disease

- Access to any type of diabetes education or self-management class is limited or non-existent in most *rural* counties
Where?
Barriers/Challenges

- Reaching Medicare beneficiaries, changing attitudes and beliefs
  - Many West Virginian’s have a fatalistic attitude regarding health care.
  - Very distrustful of physicians and the government
- Class retention - Motivating beneficiaries to complete all eight modules
  - Reluctance to change
- Weather in the winter months plays a major role in transportation
- The mountainous terrain in WV can make travel difficult and long.
  - Most Coordinators travel 1 ½ -2 hours to teach class
  - Roads most often 2 lane and winding
  - Very limited cell service and GPS capabilities in the most rural counties
Barriers/Challenges

- Availability or access to health care
  - Some counties do not have a hospital
  - Limited availability of primary care physician
  - No public transportation available i.e. buses or cabs

- Inability to provide food, refreshments for classes under CMS government contract regulations
Sustainability

- Continuing partnerships within the communities
  - Agencies on Aging, FQHCs, state associations, existing health based coalitions, providers, faith based organizations, etc.

- Training Community Health Workers

- Training people who are already part of the communities where we work

- Training CDEs, lay persons, pharmacists, students, RNs, LPNs, etc.

- Establishing and promoting diabetes coalitions

- Promotion of EDC classes using a local “celebrity”
This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Everyone with Diabetes Counts Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy.

Publication No. 10SOW-WV-EDC-MV-110813 App. 11/13
Useful web sites:

South Carolina Rural Health Research Center- Investigates rural health disparities: 
http://rhr.sph.sc.edu/index.php

Health Resource Services Administration:  http://www.hrsa.gov/ruralhealth/

Census Definitions: https://www.census.gov/geo/reference/urban-rural.html

Rural Voices: Rural Health Journal 

National Survey of Children’s Health- Data Resource Center for Children and Adolescents- Assesses aspects of children's lives (rurality) that impact health:  
http://childhealthdata.org/learn/NSCH

USDA Rural Classifications- Conducts research to further classify rural areas- 
http://www.ers.usda.gov/briefing/rurality/

USDA Food Environment Atlas- Uses geospatial data to display and report access to healthy foods on the county level:  http://www.ers.usda.gov/foodatlas/

Rural Policy Research Institute- Studies the dynamics of rural America 
http://www.rupri.org/

Rural Assistance Center: Serves as an “information portal” for rural health.  
http://www.raconline.org/
New DNCC Resources

Look for these new learning toolboxes during the month of December:

- Rural Health v 2.0
- Behavioral Health
Affinity Groups

• DNCC Affinity Groups will launch in January 2014

• Topics:
  ▪ Disparities Data
  ▪ Rural Health
  ▪ Behavioral Health
  ▪ Community Engagement

Contact Dr. Shanta Whitaker for more information

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LEARN HOW TO SHARE YOUR SUCCESS ON THE CMS PULSE WEBSITE!

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Thank you for participating in today’s webinar.

At the close of the presentation, you will automatically be directed to an evaluation screen.