

[ Captioner is ready and standing by ]

Please stand by. We ask for your patience and ask that you please remain on the line.

Good afternoon and welcome to the disparate rights -- disparities national coordinating call. We'll go over a few housekeeping issues. First, all lines will be muted during the call. We will begin Q&A after the training portion. If you missed anything, don't worry. We will be posting the recording transcript to slides. Please remember to fill out our evaluation at the end of today's call. Lastly, the disparities coordinating national center would like you to celebrate world diabetes day. Please enter the website to learn more about the campaign and what you can do to raise awareness. Without further delay, I will pass it on to Dr. Barbara Leavens.

Hi, well could. I've really enjoyed our growth of topics around rural health and disparity. I, myself, recently retired from rural Tennessee as a physician. Today we're going to look at the topics and expand from March and look deeply at the issues of world health, look at definitions and problems of rural minorities and what can be done. Specifically Juliana will give us ideas coming from New Mexico and Dr. Jay Gold and Natalie will share the perspective. The goals are very clear, simply to look at greater definitions of rural health. To look at some of the organizations that can help you and to move us on to the idea of actualizing change. With that, I'm going to once again ask you if you have questions to write them in and I'll introduce Dr. Wayne Myers as speaker. Each speaker will go in order. Their bios have been sent to you previously and we're happy to answer any questions you might have. Dr. Myers?

Dr. Myers, are you there?

He may be on mute -- Dr. Myers.

Perhaps while we're adjusting it, there's not a particular order this needs to go. Jan, are you there?

Quickly turning my phone off mute, yes, I am and I can go if you're waiting for Dr. Myers.

Yes. We'll just flip the order here.

Okay. Can you move the ball?

Dr. Myers if you can move the ball to Jan, we'll get your audio taken care of.

There we go. It's going really fast so this is me. I am the director of the South Carolina rural health research center, which is one of approximately seven, as Dr. Myers also tell you. That it's funded by the office of rural health policy within the department of health and human services. What I would like to talk to you about the specialty of our center is not just rural health but rural minority health. I've labeled

it challenges and opportunities since I'm one of those disgustingly optimistic. I'll start by giving you a sneak preview -- you a sneak preview. The concept that basically a life lived in reduce -- with reduced financial and geographic access to healthcare leads to a Medicare population that is sicker than its urban counter parts. And this trend is pronounced among rural minority populations. I'm going to talk about and interchangeably use the terms inequity and disparity. With inequity I will use the world health organization or the distribution of health determinants. I will focus on differences that are inequitable. I was privileged to run a track event with my daughter. She finished significantly faster than I did it's a difference but not an inequity because hey, she's young enough to be my daughter. I want to talk about the differences in disparities that matter. Rural, and Dr. Myers has this wonderful definition of what rural is and he Mr. talk in more detail but I'm talking about the context in which people live, the services, and the rural culture of when one seeks help and when one does not. I wish to clarify that in this sense I am using race, a term that I will use, race or ethnicity as a social construct. We do not study the biological differences which there may be some based on races but more interested in what race means for someone who grows up in the United States. I'll also point out, stealing a little bit of Dr. Myers thunder when I'm talking about rural, I'm talking about rural at the county level there. Are there some problems with that because some counties are big. Those are typically the smallest unit of local government. Now, the first thing I want to do is tell you that minorities live in rural America. I started to sound snarky. It has taken us a long time to discover that minorities live in rural America. There is a heavy African-American presence in the historic -- presence in the historic south. This is the planning that I country to be blunt and roots that go back hundreds of years in some cases. The darkest color is 50 to 75%. There is a significant number of counties in the rural south that's majority African-Americans and the dark orange would be 10% to 25% throughout much of this region. Similarly. There is a strong minority presence in terms of the hispanic population and these are generally where we would expect them. Notice, this goes all the way up into the northwest a little bit so there is a significant rural hispanic population, which we already knew about and they're not just picking crops in the midwest. There is a -- an American Indian population in riewmplet it, too, is geographically bound. The dark red is 5%, the dark brown is 75%. There are counties in the U.S. highly restricted that are principally inhabited by American Indians or Alaskan populations. Why is all this important? A to establish that all black people don't live in cities or all hispanics don't live in Texas or southern California but they're present across the whole U.S. What do you get when you have a minority of -- concentration of minority populations. Minorities often living in poor areas. Rural areas as a whole, as Dr. Meijer Myers will point -- Dr. Myers will point out are often underserved. The white spaces are urban. The rural counties that are marked in this dark color, the Maryland dark color is partial county HPSA. So big take away if you just squint at the map most are either hole or partial HPSA. The distribution of where they're present is not entirely random if you consider also the minority population. Remember that map of where the African-American rural population is? Let's look at where those beneficiaries or

population for everybody are living. The dark brown is a whole county health profession area. The everything is a whole county health profession area and the sort of dark bluey green are partial county HPsa's. They're also lighting up as health professional shortage areas and you'll see the same thing and you can compare the maps at your Lee sure. We have the same situation when we look at populations at close to or above the national mean for the percentage of the population that is hispanic. We're looking at health professional shortage areas, American Indian populations and I have maps of the asian Pacific population if one is interested. However, as you would probably guess, those are limited to Hawaii and places like that but we can support you if you're interested. So what have I really rapidly just said? That there are minority populations giving in rural counties and they are significant, not just a little bit here and there and these populations like most live in areas that are typically labeled health profession areas but you can say why does that matter? After all everybody living in the country surely is living a healthy life-style and we know that rural America is not Bessette by all the problem the of urban America. Actually, we know no such thing which is why entitle this slide rural does not equal Mayberry. I have a number of slides going from problems among kids in schools to problems of adults, behaviors, like tobacco smoke, obesity, are more prevalent in rural than urban areas but here is one that's sort of a classic urban problem. HIV,

human immunosuppresant virus, the virus that causes aids. We have county level data for all states. It's in 2010. Notice in two states, Florida and South Carolina, the HIV positivity rates are higher in rural than in urban counties. You want me it say that again? Higher HIV prevalence in rural than in urban areas. I have a whole rant about why that is happening and why that has increasingly become the case in the south and other areas but I'll safe that. You'll notice in a lot of states, the rural urban rates are not that different. Maryland -- that must be Baltimore. A lot of areas rural has caught up with or exceed areas in terms of problems. I'm sure we all know things as meth as a rural disease, okay. Moving on. Okay. No providers, same healthcare problems what do you get. Plus, we look at a few more social determinants. Gray and plaque are the urban counties. These are two levels. Notice as you become more rural, the proportion of people who have health insurance decloins among working aged adults. They will become the Medicaid, Medicare population. Not surprisingly as morale increases, the number reporting fair or poor health also increases. Okay. You've got no health insurance. You aren't as healthy. This means you're more likely to die before 65. This is from a study that we did a couple years ago that looked at people who were interviewed over basically a 15-year period and followed them up. People in the transition age, 45 to 64. Notice how much more likely black rural adults are to die than anybody else. Our baseline condition, the -- we have rural residents with fewer resource, poorer health, earlier death but, hey, some will live long enough to become medicaid Ben fesh ris and -- beneficiaries. Here's something you need to think about among rural. Is that and I chose this as one thing to analyze for this study. Notice this is draft data. Please do not sir you can late this outside of the audience here but we looked at 2 million Medicare beneficiaries and found the proportion who are often eligible for Medicaid is higher in rural, micropolyton rural. These counties are adjacent to these

counties. When you get away from the rural counties, you have yet more of eligible beneficiaries. The dual eligibles are more likely to be our high risk, multiply ill populations. More likely to be sicker, more than one chronic condition and it increases as the county level becomes more rural. Similarly, looking at race ethnicity, while there are white disparities with the white population becoming increasingly more dual eligible as areas become more rural look at what's going on in the minority population. If you are a minority rural resident, it's about a 30% or better shot that you are going to be dually eligible. It's interesting. These are the people we have to figure out how to get costs under control. And with all that, this is really, really, really complicated. This overview of diabetes among Medicare beneficiaries. These are all, in the just rural shows how complex it is and you had hard it is to interpret. Overall diabetes is more prevalent in more rural counties. 17% in rural. There are some good ones and bad ones. Less likely to have a follow-up visit. That's bad but rural black beneficiaries are less likely to have a first hospitalization. That's good but if they are admitted they are more likely to be readmitted in 30 days. Untangling this is something we have trouble doing at the 33,000 not level with national data and something I will turn over to you in a slide or two because my sum up is rural and minority populations have health access inequities. So with that did that mean for quality improvement? The first thing from that really complicated slide is that all solutions will be local, but I will say one of the things that we have seen and I apologize for the typo down there, it will take coordination among rural hospitals and rural physician, rather than all players. That was fast but I could talk about this forever because it is of such concern to me but they have limited my time. Here is my contact information and I have provided my contributions to the list of helpful websites at the end of this.

Dr. Probst, could you pass the ball to Dr. Myers, please.

Okay. Dr. Myers, you should have the ball.

Okay. Let's try. Can you area me now?

Yes. We can hear you.

Okay. Nice to be with you and we're going to talk about the most boring things in the world which are definitions. You define urban or metropolitan and rural is what's left. The first definition system is one by the office of management and budget, and that consists of -- oh dear. There we go. Can I ask you to do the slide change.

Put the ball to avap and everything will be fine from there.

Okay.

Ashley, can you advance the slide or pass the ball to me.

The counties that have the workforce commuting into that. Up until the 2000 census everything that was -- census, everything that was not on in the statistical area was referred to as rural. Move on to the

next. Beginning with the 2000 census, OMB recognized an in between place called a micropolitan statistical area. Those are the areas within the 50,000 residents, otherwise the same. You may encounter rural referred to as nonmetro or nonmetro nonmicro. Let's go on to the next. The second system is run by the census bureau. The census refers to anything that looks like a town, anything over 500 people. Blocks and blocks and street markers and so forth is an urbanized area. That leaves about 16%, 17% of the population as nonurbanized or rural. Just by sheer coincidence, the nonmetro office of management and budget population is about the same as the nonurbanized census rural population. The third system is managed by the office of rural health policy and it is referred to as the system of RUCA's, rural urban commuting areas. It's a more discriminate system with a 10-point continuum. It considers urbanization, commuting patterns and population density. The reasons for needing that was, otherwise, you wind up with rural areas in Connecticut and Montana and the Alou Shon train being considered

rural. You need definition from frontier. One specifying six people per square mile or fewer. Go ahead. No. This just shows you what you get if you lump all those counties as metropolitan and micropolitan. Look at southern California. We seem to not have the systematic rural urban disparity until around 1990. You can see the death rates of rural and the urban areas declining together until about 1990. At that point the metropolitan death rate continues to decline but the rural death rate levels off and stays higher than the rural -- than the urban death rate. Go ahead. Here's the life expectancy for rural women. With 86%, 87% of the population living in rural areas, that's what drives the national average rate. The dark green areas are the only rural counties with above average deaths, life expectancy -- expectancy is. The pale areas are slightly below. The pink areas are significantly below and the bright red areas are frighteningly below national area. Those frighteningly low life expectancy are found in east Kentucky and southern west Virginia, called central Appalachia. They're in the low lands along the lower Mississippi that; the flood plain of the state of Mississippi and Alabama and in the lowlands of Georgia, south and North Carolina. The next slide is even more frightening. These are in counties that actually lost life expectancy. That is they suffered an increase in mortality of -- mortality of shortening of a life spans and those areas are in central Appalachia. In southeast Georgia, this Tim in northern Alabama, practically all of Oklahoma, north Texas. I never really thousands dollars I would see a shortening of life expectancy in parts of America but I have. Let's talk about why. Life expectancy is determined by access to care, by income, culture, the environment. Primary care, referral care, in emergency medical services it takes more time to get to emergency services in rural areas, more time for the ambulance to get there. More time to get back. The sophistication of services in the emergency room when you get there will likely be modest. Rural occupations tend to be dangerous, logging, mining. The velocity of vehicles that crash are higher. There's the one Doc phenomenon. Other factors include rural incomes are generally lower than urban and poverty is an equal opportunity liability. Rates of insurance are lower for both public insurance. There are issues about getting people covered by Medicaid between rural and urban populations, and there are fewer large

employers that provide insurance for their employees in rural areas. There are issues about a culture gap between patient and physician. Most clinicians are urban raised and trained. The more distress the population be it rural or urban, the more likely they are to be served by international medical graduates and with the consequent gap between clinician and patient. Let's go ahead. The organization you need to know about is the office of rural health policy that's smack in the middle of that slide. It funds seven rural health resource centers at the moment. It funds a rural assistance center that you really need to know about. That's the place you go to find real information. Go ahead. I'm sorry. Go ahead to the next one. Its main job is to advise CMS on the changes. If nothing else, know about the rural assistance center. It's within the university of North Dakota. It's a terribly valuable resource. It will tell you all about the definitions I've been talk bsmght it will give you access to the research center and start you on your way in most any rural project you care to enter. So with that, I'll turn it on to the next person, who is not Jan. Thank you very much.

Thank you very much. Juliana is our next speaker.

She has the ball eye have the ball. Okay. Great, thank you so much. Are my slides up? You need mow to go back, go forward.

Go forward.

Okay.

Again, my name is Juliana Anastasoff. I want to thank all of our presenters for painting a very compelling picture of the challenges around rural health. I'm going to share a little bit about our initiative, health extension initiative. To con sep yalize what we've learned, this is a look at new Mexico. We're a minority majority and with 123 federally recognized Indian -- 23 federally recognized Indian tribes, not enough care to improve health. Adding to that is the education and mortality rates. This graphic shows how improving our educational outcome would improve the life expectancy. Food insecurity prevents illness and to manage chronic conditions in Mexico. If you look at the maps. In the centers of the small circle, communities that are within those small circles are within 10 miles of that store. Communities within the large are outer circles about 20 miles. Outside the circles huge areas of the state more than 20 miles' way. In the unincorporated community I live, we're about 35 miles away from a full service dress pri store which takes about 50 minutes of travel time in daylight on a good day and maybe up to one hour and 15 minutes if the weather or roads are bad. These childhood indicators that have to do with income, education, health, social factors are very, very powerful determinants of lifelong health and adult disease. You can see where we are now ranked 50th in the nation. These indicators are worse in our try bam communities. So what are we as the public health academic center doing?

A critical step has been to link our strategic vision, performance measures as an academic health center to improving the well-being have

you new Mexicans, to step health extension and we developed strategic partnerships, extend university resource and ensure that the goals are better aligned with the needs, opportunities and priorities of our public stakeholders in new Mexico.

This has three corp. aims. Those are around building workforce. Addressing determinants of health and local health capacity. We started about five years ago with three regional offices and we've now expanded to six regional offices and also have about a half dozen more local hero affiliate sites across the state. So in terms of what does this look like and how does it work? Here's a key attribute of heroes. There's the people part of the health extension officers who are community based field factors that clab rat over the fence -- collaborate over the finance and work with farmers and ranchers. Just like the ag agents, we are women known. We don't commute back and forth from the university. We're trusted professionals with a high degree of credibility as well as accountability sense we ourselves are rural stakeholders who have skin in the game. As one of my partners describes it, we know where she lives. So that often happens with universities. You can't really get away with it. The best way to describe my hero roll is a cross between a dating service and Swiss army knife. Sometimes they need opportunities with various resource back at the academic health center. Sometimes I grab the tool box and get busy. Again to use that as an example if I have some type of invasive plant in my pasture, I call the ag agent. He comes out and takes a look. He might look at it and go, wow, I have no idea what that stuff is. Let me take a picture. I'll send it down to the specialist at the university and see what she recommends. You get idea of how we work directly with communities to do a whole bunch of things. And that function is on your lefthand side of the screen. The second box from the bottom as well as the other boxes represent activities that we engage in aiming for engaged community outcomes in those three core areas, work forks determinant of health and structure. A common question people always ask is what do heroes know what to do. We are a diverse group of folks who share a common skill set that's central to a sill teating community health and processes and, also, we come from a wide range of back grounds and we put it all together it. Makes it possible to respond to the diverse opportunities across the statement of here's some examples related to workforce, everything from getting studentsd in health careers to shores up the roles and skills, even supporting the retention of season priors and rule practice, sort of their trusted link to the mothership as one rural physician described it. We engage across key determinants of health. We recognized priorities and readiness to work on a particular aspect. It may not align in terms of prevalence data. We honor the wisdom about what matters to the most knowing that when we work with patients, efficacy is a long-term investment in building transferable skills and for communities to take care of them. In terms of capacity, they're fragile. They're underresoarsd. Overburdened. It's critical that we support it, those who may not have access for improvement activities. So kind of winding up here, I want to let everybody know there are several states where health centers and partners are involved reaping from states where health extension is focused on primary care practice to the very broad approach we've

I've lost my connection. I would appreciate it if you just add Vance the slide.

If you want to give the ball to him, we'll go from there.

So I'm Jay gold. I'm senior vice-president at medi star, the Wisconsin PYO. Wisconsin has one and a half million residents who are considered rural, which is roughly one out of four. So we have done a fair amount of work in the hear of rural health with a number of partners, in particular, the one I want to talk about today, the office of rural health at the university of Wisconsin, center for health sciences. If you go to the slide, the eight states have started to work with their

QIO's on this topic in partnership with the state Medicare, rural hospital flexibility program offices, what we call the flex offices, flex being the program that originally established the critical access hospital designation in 1997 appointment the flex office am Wisconsin is the office of rural health. So we're partnering with 19 rural contract Cal access hospitals in Wisconsin for a national pilot project focusing on transfers from the emergency department. Now the emergency department is particularly critical where the dips tans makes the effective triage and transfer of patients e sefntle for example, when a patient arrives in an emergency department needing time sensitive care, rural hospital's ability quickly to assess, arrange and get patient out the door with the necessary and appropriate information can be a life or death importance. Now data indicating how well the rural hospital serves this stabilized and transfer care role, those data are not currently widely available and this project is designed to provide training and support in rural hospitals to be trained to collect information on emergency department transfer communication and it use the data to improve quality of care and outcome. If you go to the next slide with the cupcation quality measures set, you'll see a list of seven measured doe mains which I won't read to you but there are measures within those domains and the objective of this project is to improve on the mesh sures in all of those domains. So that's one major project we're working on. Another one, if you go to the transitions of care slide, it is a project in our Medicare core contracts set to decrease readmissions by improving transition of care and the office of rural health is an active participant in the statewide trap session of care steering committee, consistent with funding for the workshops. It's assisted with county coalitions, transitioned from one healthcare center to another and the state, so far, has seen a 4.6% statewide relative improve the for add messing and 5.8 for estate wide readd messings. I will pause there. Thank you for the opportunity top present and look forward to any questions.

Thank you very much Dr. gold. That's wonderful information and we're going to slide on to Natalie Tappe and hope to have team for questions. Natalie would you like the ball? Thank you.

Goof good morning. My name is tat -- Natalie Tappe. I was asked to speak about this project because it's on going to in west Virginia and to speak a little bit about the challenges we have in enrolling in this

project. The next slide. West Virginia medical ebbs suit is within of three participating, the other two serving the hispanic and African-American populations. West va, everyone with diabetes counts is the first to focus on the rural population. Why west Virginia. Approximately 220,000 people in west Virginia have diabetes. Year after year we range among the top states with the highest prevalence of dpeeb as well as obesity, MI and stroke. Less than half of the patients in west Virginia with diabetes have had any education or any access, limited access to diabetes self-management education. Next slide, please. So as you can see, this is the slide of our estate. Actually, the dark blue counties are the actual 13 original counties that we started with, looking for Medicare beneficiaries to enroll in our classes. We were tasked by Medicare to enroll 6,000 Medicare beneficiaries by July 231 -- 2014. The project was awarded in 2012. So we started enrolling, basically, in January of 2013. Some of our barriers and challenges in reaching the Medicare lags are -- in west Virginia in particular they have a fatal less tick attitude -- fatal list tick attitude regarding healthcare. Mom and dad have sugar. So I will have sugar. That's the way it S they're distrustful of the government. Now you want to tell me how to eat. In teaching the Medicare beneficiaries, we have eight modules, so they're very reluctant to change. Unfortunately, part of our problem, when we schedule our classes, as you know, it's during the winter months. In west Virginia it's particularly mountain nas. In each of the counties that we have, we have -- we had the 13 original. Now we've expanded to 2 -- 22. The coordinatetors can travel up to two hours to teach one class. When they get off the interstate, it's often too many roads and it's winding. When we get there's elemented gps. We have trouble getting people out to the counties. The next slide. Again, to reiterate what mess people have said, a lot of these counties that we are trying to teach and don't have access to a hospital, they have limited availability and virtually no public transportation whatsoever. Another barrier is the time frairnlings the 18-month time frame. Because it was very difficult to get the 6,000 Medicare beneficiaries. The number of beneficiaries related to the size of our state. It's very difficult to try -- some people live if a sit it that's five miles or they don't come down from the hollow to come to any of hour classes, so it as been a challenge to get our numbers of people that we need, and a lot of times we do find difficulty in getting people to come because we have nothing other than class to offer them. We can't provide it. One thing that we hope top accomplish is the sustainability by continuing our partnerships within the comoopt by training community health workers to teach to the Medicare beneficiaries once the project is over. We train lay people, students, nurses, anyone who wants it it learn. We establish and premoat diabetes coalition and promote using a local celebrity within our state. And we hope by 2014 to moat our doles. That's all I have for everyone with diabetes counts.

I want to thank our speakers once again and our participants. We have a few announcements. If you want to look up any of this information during our presentation, feel free check out the websites we have here. In December of 2013DNCC will release their rural health tool cet versus 2.0 as well as a behavioral tool kit and we will be launching four affinity groups, one an behavioral health and infinity data.

Please contact Dr. Shanta Whitaker to learn more. If you wish to share your story, please contact me with that information.

want to thank you once again for joining the call today.

I just want to say we have, because of time constraints, questions, I know, are -- all of our speakers are willing to answer questions, so I would really ask you if you could possibly put them on the chat or send them in to Ava directly, we will get them answered and will have time on our office hours next week to deal with this, but I want to thank you all for your time. We would also like to thank you for thinking about that group of people in most of our states, our rural populations. I think we're just right on. If any of the speakers have any last parting words, any thoughts? Thank you very much for participating in today's webinars. I wish to say it's been a wonderful set of speakers to bring together to focus on the different aspects of rural health. Please be certain to fill out the evaluation. Actually, you can't close your computer without it popping up. We look forward to talking to you next week. Bye-bye.

Ladies and gentlemen, that does conclude the conference for today. We ask that you please disconnect your line. Have a great day. [ Event concluded ]