

November 27, 2019

The Honorable Richard E. Neal
Chairman
Rural and Underserved Communities
Health Task Force
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member
Rural and Underserved Communities
Health Task Force
Committee on Ways and Means
United States Senate
Washington, D.C. 20510

Dear Chairman Neal, and Ranking Member Brady:

For more than 70 years the Society for Public Health Education (SOPHE) has been working to ensure that opportunities to live full and healthy lives are available to all individuals regardless of race, ethnicity, or socioeconomic status, as such, SOPHE appreciates this opportunity to provide comments on the future directions of the Rural and Underserved Communities Health Task Force as you work to identify strategies to address the challenges that contribute to health inequities.

The Society for Public Health Education (SOPHE) is a 501 (c)(3) professional organization founded in 1950 to provide global leadership to the profession of health education and health promotion. SOPHE contributes to the health of all people and the elimination of health disparities through advances in health education theory and research; excellence in professional preparation and practice; and advocacy for public policies conducive to health. SOPHE is the only independent professional organization devoted exclusively to health education and health promotion. Members include 4,000 behavioral scientists, faculty, practitioners, and students engaged in disease prevention and health promotion working in both the public and private sectors. Collectively, SOPHE's national members and 21 state/regional chapters work in universities, medical/health care settings, businesses, voluntary health agencies, international organizations, and all branches of federal/state/local government.

Racial and ethnic minority communities are disproportionately affected by chronic disease in America. Preventable diseases like diabetes, heart disease, high blood pressure, renal disease, and stroke in ethnic minority populations cost the healthcare system more than \$23.9 billion annually. These costs are expected to double by 2050. Investing directly in community coalitions with a history of tackling these issues allows the time and resources necessary to address the many root causes of racial and ethnic disparities and reverse the upward trend of chronic disease.

Health disparities, like the examples listed below, continue to rise and widen in communities due to poverty as well as other social, economic, and environmental factors. According to CDC and other health experts:

- Hispanics (47%) and non-Hispanic blacks (46.8%) had the highest age-adjusted prevalence of obesity, followed by non-Hispanic whites (37.9%) and Asian Americans (12.7%).
- American Indians/Alaska Natives had the highest prevalence of diagnosed diabetes for both men (14.9%) and women (15.3%). Overall, prevalence was higher among American Indians/Alaska Natives (15.1%), non-Hispanic blacks (12.7%), and people of Hispanic ethnicity (12.1%) than among non-Hispanic whites (7.4%) and Asians (8%).

- The rate of new cases of cervical cancer was highest among Hispanic women (9.4 per 100,00) and second highest among Black women (8.6 per 100,000).
- Chronic kidney disease is estimated to be more common in non-Hispanic blacks than in non-Hispanic whites (18% vs 13%).
- Asian Americans are 25% more likely, and Native Hawaiians and Pacific Islanders are three times more likely, to be diagnosed with diabetes than non-Hispanic whites.

In addition to the underserved populations above, rural communities also experience significant health disparities and have less access to care, which results in poorer health outcomes compared to their urban counterparts. Rural populations have higher rates of low to moderate income, are less likely to have employer-sponsored health insurance coverage and are more likely to be a beneficiary of Medicaid or another form of public health insurance. Based on a report from The Kaiser Family Foundation, nearly 1 in 5 who live in rural areas are uninsured, with some states experiencing over 70% of uninsured rates in rural areas.¹ Medicaid plays a key role for people living in rural areas, as families experience incomes less than 200% of the poverty level. The Center for Children and Families (CCF) reported that rural areas that have expanded Medicaid had previously experienced some of the highest uninsured rates. The uninsured rate for low-income adults living in rural areas dropped from 35% in 2008/2009 to 16% in 2015/2016 in states that expanded Medicaid.²

While large proportions of rural America are reliant on Medicaid for health insurance, rural areas face high rates of hospital closures, health care worker shortages, and geographic challenges to receiving necessary medical care. Adequate transportation can be the difference between accessing medical care and not. Proximity to a medical facility has a significant impact on whether a person will travel and seek the medical care they need to be healthy.³ Based on the 2014 National Center for Health Workforce Analysis report, less than 8% of all physicians and surgeons choose to practice in rural settings. With nearly 20 percent of Americans living in rural areas, it is crucial for steps to be taken to improve the health and wellbeing of people living in rural areas.⁴

The Centers for Disease Control and Prevention reported that rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts. The CDC recommends that healthcare providers in rural areas screen patients for high blood pressure, increase cancer prevention and early detection, encourage physical activity and healthy eating to reduce obesity and chronic disease, promote smoking cessation, promote motor vehicle safety, engage in safer prescribing for opioids for pain, and identify additional support for families who have children with mental, behavioral, or development disorders.⁵

The Centers for Disease Control and Prevention (CDC) Division of Nutrition, Physical Activity and Obesity (DNPAO) funds three programs that have proven to be an effective, evidence-based model for tackling health disparities experienced by rural and underserved populations. The Racial and Ethnic Approaches to Community Health (REACH), State Physical Activity and Nutrition (SPAN), and the High Obesity (HOP) programs lead communities to improved health outcomes through culturally-tailored, evidenced-based strategies are the most effective to address the health disparities in rural and underserved areas. Strategies to address the disproportional rate of health disparities in rural

populations should be culturally tailored to effectively address the higher rates of chronic disease in these areas.

- HOP-CDC funds 15 land grant universities to work with community services to increase access to healthier foods and safe and accessible places for physical activity in countries that have more than 40% of adults with obesity. The estimated annual medical cost of obesity in the United States was \$147 billion in 2008.
- CDC funds 16 SPAN recipients to implement evidence-based strategies at state and local levels to improve nutrition and physical activity
- CDC currently funds 31 recipients to reduce health disparities among racial and ethnic minority populations with the highest burden of chronic disease (i.e., hypertension, heart disease, Type 2 diabetes, and obesity) through culturally tailored interventions to address preventable risk behaviors (i.e., tobacco use, poor nutrition, and physical inactivity). The REACH Program continues to show measurable change in the health and wellbeing of racial and ethnic minority communities with the greatest burden of disease.

Despite the prevailing gains of the REACH program, Congress has not increased core REACH funding for many years, and since FY2017, REACH has been reduced in order to fund the valuable Good Health and Wellness in Indian Country (GHWIC) program, which supports effective community-chosen and culturally adapted strategies to reduce the leading causes of chronic conditions, increase health literacy, and strengthen community-clinical links with American Indian/Native American populations. SOPHE encourages the committee to continue and increase funding for these valuable programs that have a proven track record of improving health outcomes in the exact populations at which the task force is aimed.

Thank you for consideration of our comments. As a nonprofit organization at the forefront of health education and health promotion we welcome every opportunity to engage and collaborate with the committee as the social determinants of health that negatively impact rural and underserved Americans are considered. SOPHE looks forward to working with the taskforce on policy guidance that improves our nation's population health and strengthens health systems for rural and underserved Americans. Please contact Dr. Cicily Hampton at (champton@sophe.org) or 202-408-9804 with any additional questions.

Sincerely,

A handwritten signature in black ink that reads "Elaine Auld". The signature is fluid and cursive, with the first name "Elaine" and last name "Auld" clearly distinguishable.

Elaine Auld, MPH, MCHES
Chief Executive Officer

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

There are several factors that are negatively affecting underserved urban and rural populations. Transportation access is a huge driving factor that we see in both rural and urban underserved populations.⁶ In many cases providers, particularly specialty and subspecialty providers, are not located in areas where underserved populations can easily access them. In rural America, the closest in-network provider or hospital could be several hours drive away. This is also a factor in urban America where it may take several different modes of public transportation and several hours to go just a few miles.

Ironically rural Americans may also struggle with gaining access to healthy, nutritious foods, even in areas where farming is a critical aspect of the economy. In food deserts, both urban and rural Americans may be reliant on less nutritious “convenience” foods rather than travel long distances to stores that stock fresh produce. Over time food insecurity has been shown to be correlated with increased rates of chronic disease and poorer health outcomes.⁷

All of these factors are exacerbated by poverty as both urban and rural Americans may need to calculate whether they can afford to take off of work to get the care they need or if they can afford healthy foods.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Telemedicine expands access to health services to areas and populations that may not have access to certain care. Telemedicine has the potential to address health care disparities due to geographic location and racial and ethnic differences. Telehealth is on the rise in the US-among rural Medicare beneficiaries, the number of telehealth visits increased from 7,015 in 2004 to 107,955 in 2013.⁸ Telehealth visits provide patients with the ability to get care from specialists that may not be present in the area. Increasing the type of providers such as health educators eligible for reimbursement in federal health programs, such as Medicare and Medicaid which many rural and underserved populations are reliant on, would enable additional initiatives to address the social determinants of health as well as preventing and managing multiple chronic conditions.

These programs use expertise from certified health educators to ensure community-based health education programs use effective, culturally relevant strategies effective for the community population.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

Recruitment and retention programs create a more sustainable health workforce in rural areas. Supporting the Interstate Medical Licensure Compact creates fluidity in the States physicians practice

in. Restrictions on state licensing to practice medicine are a barrier to telemedicine as they restrict telehealth services, only 17 states have legislation that supports the Interstate Medical Licensure Compact.⁹ More programs like this need to be developed to address workforce shortages and challenges in rural areas.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Health education incorporates a variety of physical, social, emotional and nutritional components focused on reducing health-risk behaviors and promoting healthy decision-making. Health education curricula emphasizes a skills-based approach to help students practice and advocate for the health needs of themselves, their families and their communities. Given that children and adolescents spend the majority of their day at school, health education provides a unique opportunity to disseminate evidence-based health information and skills building to adolescents. Health education may include aspects of both sex education and physical education, but the main focus is on improving health literacy and awareness. These skills help children and adolescents find and evaluate health information to make better health decisions for themselves and others. Ultimately, health education aims to increase students' awareness of healthy behaviors as well as how to advocate for their own wellbeing. Exposure of students to health education curricula reduces obesity, improves health promoting behaviors such as increased physical activity and improved dietary behaviors.¹⁰ Health education curricula focuses on reducing risky behaviors before they become habits.

The link between health and academic performance is closely connected and related. Healthier students are better learners; whereas, educationally relevant health disparities may impede students' achievement abilities.¹¹ Complications with vision, asthma, occurrences of teen pregnancy, aggression and violence, lack of physical activity and cognitive and emotional ability all contribute to academic success. For example, childhood obesity has adverse effects on academic performance. Students with better physical fitness have better academic achievement success.¹² Health education is essential for the short-term and long-term health of our nation. Quality health education can decrease health illiteracy, which has been estimated to cost the nation 1.6-3.6 trillion dollars annually.¹³

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

While current payment and delivery systems in federal health programs prioritize treatment of chronic health conditions, more resources should be devoted to preventing these conditions and managing them after onset but before an acute episode. To that end, SOPHE recommends that the role of health education and health educators as providers be considered by the task force to advance the prevention of chronic disease in rural and underserved populations as well as address the social determinants of health. As supported by the multitude of examples of evidence-based research that proves prevention is the solution to reduce risk for disease and adverse health outcomes, we hope the

integration of public health occupations in the agenda of the task force will lead future efforts to eliminate factors that contribute to adverse health outcomes.

Health educators work to encourage healthy lifestyles and wellness through educating individuals and communities about behaviors that can prevent diseases, injuries, and other health problems. Although many professionals may possess the requisite skills to conduct education campaigns, health educators are equipped to provide the necessary education to more vulnerable populations disproportionately affected by poor health outcomes. A core competency of health educators is communicating with and understanding the needs of the underserved, vulnerable and/or limited English-speaking populations, including those who are disabled and suffer from one or more chronic diseases, inclusive of mental health disorders. Health educators also supervise community health workers, trusted members of the community served, who can facilitate access to priority populations, and improve the cultural competence of the education or service delivery. Given the wide range of populations with which they work and the diverse settings in which they are employed, health educators have significant capacity to conduct education about chronic disease prevention, substance use disorders, and navigating social determinants of health, without the stigma. Health educators skills in health communications, cultural competency, community engagement, community needs assessment, health coaching, and interdisciplinary collaboration make them natural leaders to work with toward an integrated health care system that better serves rural and underserved populations to better access and utilize the services that are available to them as well as prevent the onset of disease that would necessitate this utilization.

¹ The Kaiser Family Foundation. (2003, April). The Uninsured in Rural America. Retrieved November 26, 2019, from <https://www.kff.org/wp-content/uploads/2013/01/the-uninsured-in-rural-america-update-pdf.pdf>.

² Hoadley, J., Alker, J., Holmes, M., Searing, A., & Burak, E. W. (2018, September 25). Health Insurance Coverage in Small Towns and Rural America: The Role of Medicaid Expansion. Retrieved November 26, 2019, from <https://ccf.georgetown.edu/2018/09/25/health-insurance-coverage-in-small-towns-and-rural-america-the-role-of-medicaid-expansion/>.

³ Rural Health Information Hub. (2019, April 22). Rural Health Disparities. Retrieved on November 26, 2019, from <https://www.ruralhealthinfo.org/topics/rural-health-disparities>.

⁴ Nasser, H.E. (2019, May 23). What is Rural America? Retrieved November 26, 2019, from <https://www.census.gov/library/stories/2017/08/rural-america.html>.

⁵ Centers for Disease Control and Prevention. (2017, August 2). About Rural Health. Retrieved November 26, 2019, from <https://www.cdc.gov/ruralhealth/about.html>.

⁶ Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling towards disease: transportation barriers to health care access. *Journal of community health*, 38(5), 976–993. doi:10.1007/s10900-013-9681-1

⁷ Christian A. Gregory, Alisha Coleman-Jensen. Food Insecurity, Chronic Disease, and Health Among Working-Age Adults, ERR-235, U.S. Department of Agriculture, Economic Research Service, July 2017.

⁸ American Hospital Association. (2019). Rural Report. Retrieved November 26, 2019 from <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>.

⁹ American Hospital Association. (2019). Rural Report. Retrieved November 26, 2019 from <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>.

¹⁰ Melnyk, B.M., Jacobson, D., Kelly, S., Belyea, M., Shaibi, G., Small, L., O'Haver, J., Marsiglia, F.F. (2013) Promoting Healthy Lifestyles in Adolescents: A Randomized Control Trial. *American Journal of Preventive Medicine* 45(4): 407-415.

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- ¹¹ Basch, E. (2011). Healthier Students are Better Learners: High-Quality, Strategically Planned, and Effectively Coordinated School Health Programs Must be a Fundamental Mission of Schools to Help Close the Achievement Gap. *Journal of School Health* 81(10):650-662.
- ¹² London, R.A., and Castrechini, S. (2011). A Longitudinal Examination of the Link Between Youth Physical Fitness and Academic Achievement. *Journal of School Health* 81(7): 400-8. doi: 10.1111/j.1746-1561.2011.00608.x.
- ¹³ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2016). National Action Plan to Improve Health Literacy. Washington, DC: Author, p.10.