Re-Inventing A Healthier Rural America

Policies, Politics, Practicalities

Phillip L. Polakoff MD MEnvSc MPH
David S. Angelson MMedSci PhD
Foreword by Dennis Berens MA

A Healthier *WE*

Table of Contents

Authors & Acknowledgements

Phillip L. Polakoff MD MEnvSc MPH
Founder/CEO - A Healthier WE
Consulting Professor - Stanford University School of Medicine
Affiliated Scholar - Stanford University Bill Lane Center for the American West
Member - New England Journal of Medicine Catalyst Council

David S. Angelson MMedSci PhD
Research Director – A Healthier WE
Director of Rural and Global Projects – Prospekt Mira
Research Fellow – Dunedin School of Medicine

Dennis Berens MA
Strategic Advisor – A Healthier WE
A farm boy by birth, a teacher by training, a newspaper publisher by accident, a public servant by choice and a rural health advocate and strategic advisor by request.

A Healthier WE owes a debt of gratitude to the rural health experts who have so graciously shared their time and wise counsel. In particular, Dennis Berens, Bill Bryan, and John Langefeld have served as core thought leaders for the drafting of this compendium. Rural health leadership from the Robert Wood Johnson Foundation, National Rural Health Association, Bipartisan Policy Center, National Organization of State Officers of Rural Health, American Hospital Association, American Heart Association, and many others, has been invaluable.

Participants in the 2019 Healthier Rural West Summit provided vital inspiration and texture for A Healthier WE's efforts. We look forward to working with you again at the Healthier Rural America Summit in 2020.

Foreword, by Dennis Berens

Health/healthcare change at the community level: How to bring about the reality of the ideal

American health and healthcare has its own terminology, its own paradigms and frames. What it is missing is a vision and mission that build on the knowledge, entrepreneurship, and practical ideas that will continue to allow everyone living in our nation an opportunity to stay healthy and be provided the best care, at the best time, by the best practitioners.

Could this nation be a nation where all communities matter and where we understand that words matter as we look to build a sustainable future for the many generations that follow us? What are the stories we should know about? How can those stories best be told? And what are the proper frames that ensure that rural communities and their citizens can help build a more healthy nation?

Many authors have tried to help us get at some of the root causes of our health/healthcare dilemmas. Many have been from the urban part of our nation and from research centers. The rural voice is often missed or not sought out. One author seems to have captured not only the rural issues but global issues under the same heading.

In 2005, Professor John Ikerd, then at Cornell University, wrote 'Sustainable Capitalism: A Matter of Common Sense.' He focused on a new type of capitalist economy modeled on living systems capable of regeneration and renewal and that are ecologically sound, socially just and economically sustainable. This economic system should recognize the importance of relationships and ethics. He believes that our country needs to build a sustainable capitalist society whose goal is 'triple bottom-line management — where the bottom line isn't economic but ecological and the management is driven by ecological integrity, social responsibility, and economic viability'.

What would this model mean for rural areas and their health systems? WORDS MATTER.

Responsible news organizations must spend time and resources to better understand the many rural communities and economies that exist in our nation. They must help tell the story of life in rural areas, tell people's stories and cut through the myths so that policy makers understand rural health and healthcare issues. WORDS MATTER – AS DOES THE STORY THEY TELL.

From 1990 on, this nation has struggled to find health and healthcare models that will work. In each effort, met with resistance. The result has been continued suffering due to lack of services, financial stress, and loss of care, especially in our rural communities. News media often failed to do the research that would help rural citizens understand the major drivers in health and healthcare. As a result, people did not understand that healthcare is not a purely market-driven system. If it were, insuring more people might mean that providers, pharmacies and insurance companies might reduce charges for care. MODELS MATTER.

We are seeing renewed support for sustainable healthcare reform. Citizens are more and more aware that everything in the healthcare system is actually connected to everything else and cannot function well when each part tries to function separately. The potential new model will break down the silos between providers, pharmaceuticals, and insurers.

New digital communication tools will bring about some dramatic changes provided a rural community has access to adequate broadband to connect to high tech centers.

In addition, people must understand that maintaining good health goes beyond simple access to medical care. It must include prevention as well as understanding and following best practices for self care.

Future reforms of care and costs require input from involved citizens – especially rural citizens – something that has been lacking in past discussions.

Also, how will an employer-based health insurance model remain viable in a globalized world? How can any existing plan cover totally integrated care?

And how do we assure that the voices of citizens in our most remote rural areas are respected as much as those of citizens in urban areas?

How can we enhance our care and care delivery models to ensure a sustainable future for generations to come? CITIZEN INPUT MATTERS.

What if all individuals and institutions with a connection to health and healthcare would agree to find a new reality of the ideal? What impact would/could that have on the nation?

Political scientist Harold Lasswell said politics is the process of deciding who gets what resources. Policies are the frameworks that we use to deploy our resources. Practicalities are the way local citizens use the resources. In an era of broken relationships, trust trashing, and power politics, the citizen is not only confused but lacks an understanding of how to influence politics and policies. We must do better. We must find a sustainable vision and pathway to help all our residents. What will that take?

Who are the knowledge makers and who are the vision keepers at all levels?

Is it national and state government? Is it the local communities? Is it the rural health practitioners? Is it the residents of our nation, young and old? Is it the media?

The role of the media in disseminating knowledge seems obvious at first, but their effectiveness has been diluted by lack of hard reporting and too much focus on commentary. Good storytelling, accurate storytelling can still provide knowledge and help to connect rural and urban people. Good journalism should be the community talking to itself and then acting on that discussion. The storytellers should not be the story.

How can media report on the complicated issue called health? Like citizens they need to identify legitimate and multiple sources. Accurate research creates accurate reporting and then accurate action. Few stories are told from rural locations for broader audiences. Fewer reporters have a rural background or rural resource identification. More journalists need to be trained to report on rural issues in order to serve both rural and urban Americans.

The role of the government has evolved, and many of our residents are confused by the many levels of government in their lives. They are uncertain how they can have influence at each level.

Over the decades, the role of the federal government has greatly increased in our lives. More programing and policies are being directed from Washington, D.C. It often feels as if

we have less and less influence on what policies are being created. The focus seems to be on politics and parties, not on sustainable models and programs.

Citizens, especially young people, are reconsidering their assumptions about government and discussing new models. It appears we need to find new ways to influence policies developed by the federal government. The rural influence needs a clear channel of access, and the entrepreneurs from rural areas need to be able to show what is being developed and used. More ear and less mouth seem to be needed.

The role of the community has often been overlooked by policy makers. The focus seems to have shifted to the local government officials and not the civic leaders found in the local communities.

The community is the glue that holds people and families together. It provides a set of mores that makes local interaction more possible. It provides the framework for discussions and growth. It is a prime source of information transfer, including information about healthcare.

Communities who work hard to connect with other communities often see and have opportunities that others miss. We must consider strengthening these valuable resources.

Healthcare looks too much like a historical cottage industry. Too much effort was focused on protecting practice and funding and not on the citizens who needed help with prevention and care.

Local rural health practitioners are largely respected in rural communities. They have the calling and opportunity to provide some collaborative leadership at the local, regional and state level to help their communities. Silo thinking must be removed, and all health practitioners must adopt a new, networked model.

Practitioners have large health data sets that can be used by themselves and the community to identify common health and healthcare issues. They have relationships with specialists who can provide the next level of care when needed. They also now have the opportunity to use digital technology to help citizens receive some care in their homes. Collectively, they know the common health and healthcare needs. They know the telecommunication needs of their communities and practices. They also have health stories that need to be told to help the community talk to itself about health and healthcare. STORIES MATTER.

You and I have a role in this fast-paced health and healthcare world. We must accept that we are responsible for our health and also must work collectively to ensure that healthcare system resources are available for all of us when needed. We are the way wellness is created.

Digital connectivity is a wonderful addition to our rural tool kit, but resources are not adequate in many areas. It is often fragmented, costly and siloed.

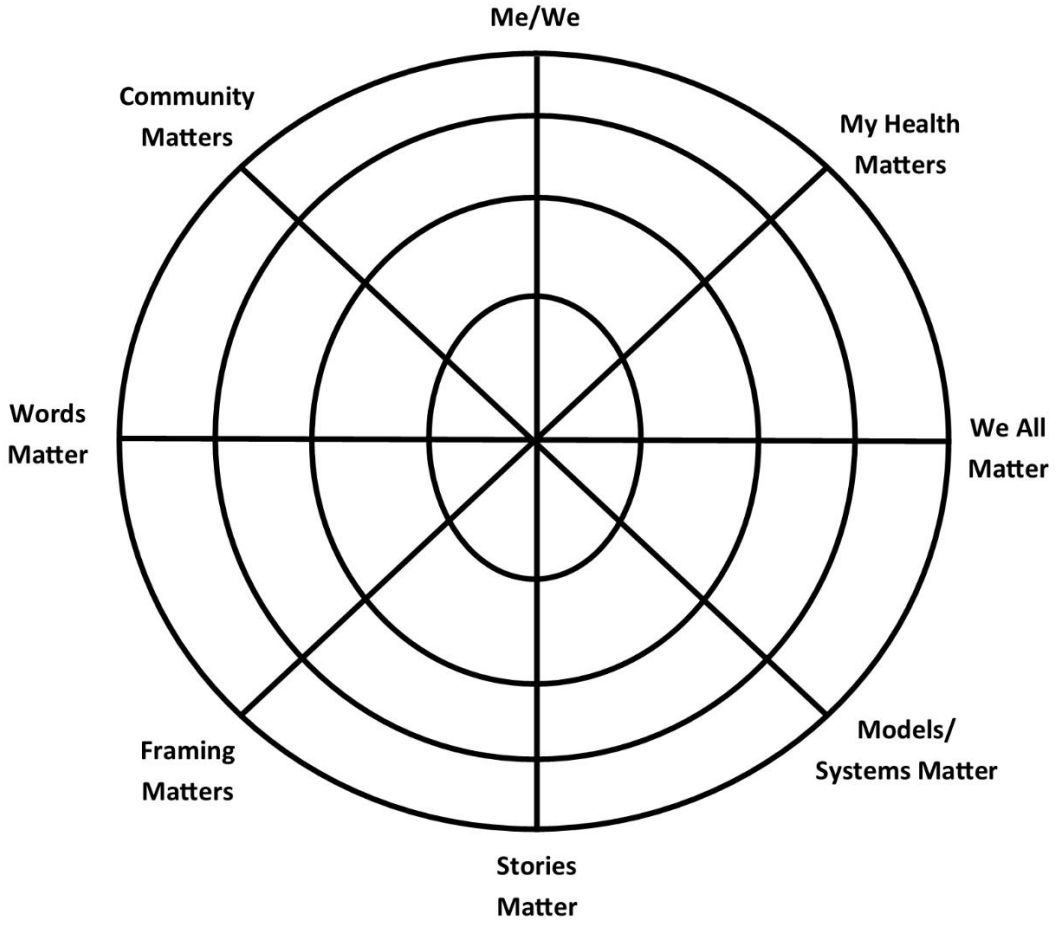
In the early years of the agricultural revolution, rural citizens created cooperatives to share their resources to address common needs. That kind of partnership still seems to be appropriate in today’s world.

Cooperatives might be a way to address inadequate digital resources. By banding together, people may be able to underwrite digital connectivity that would serve multiple individuals and communities.

If healthcare is about relationships, values and appropriate care model development, we need to rethink cooperatives or other partnerships that meet the needs of rural residents, communities, and governments. We then need to help our media to explain the forces and opportunities that may change and improve rural people's lives.

WE MATTER. WE ALL MATTER. MY HEALTH MATTERS.

Put graphically, this interconnectedness could be visualized as a spider web, with interlinked strands for community and narrative/framing, health systems and healthcare delivery models, and public and individual health.



Further expository questions to help contextualize this call to action:

1. What is the present rural reality versus the present healthcare model? What do rural people have to contribute to healthcare in this era of rapid change and focus on efficiency?

Rural communities should never have been treated as if they are just smaller urban communities. But in a nation where more than 70 percent of our citizens live in urban areas, rural-specific healthcare models are seldom researched or shared with the rest of the world. What message regarding sustainability can a rural community of 400 or 800 have that our nation as a whole should know about and use?

2. What past, present, and future partners are available and connectable to create a new and sustainable health and healthcare model? Everything and everyone is an asset in our connected world. What can rural churches offer? What can rural agricultural cooperatives offer? How about trucking companies and rural delivery systems? What about 4-H and FFA?

Every institution has resources that could be deployed to help all citizens with their health and healthcare needs. Why isn't the full scope of practices of all health providers being

utilized? Is payment or 'silo thinking' preventing it? What vision and bridges do we need to allow this to happen?

3. Place and geography continue to influence everyone, including those in rural and remote areas. Available land allowed settlers from around the world to find and build new livelihoods and new homes in the U.S. Those settlers often settled with others who came from the same old countries and tried to maintain old-world work models. Over time, cultures adapted but often tried to maintain the core values. They also brought with them health issues because of genetics as well as care models that had a hard time surviving in our industrial and now digital worlds. Do we consider the impact of history and geography as much as we should when we try to provide essential healthcare?

4. How can we make health-related research work for all places and citizens? Paradigms and framing often make it hard for ordinary people to understand or relate to the research. Who is going to interpret with pragmatic terminology accessible to laypeople?

Introduction

Perhaps the most salient characteristic of rural America is the high degree of connectedness and interdependence among residents. It is a commonplace that 'Everybody Knows Everybody Else's Business' in rural communities[1]. Less frequently acknowledged is the centrality of rural wellbeing for urban and broader national wellbeing and holism.

The fates of Rural and Urban America are inextricably intertwined. Improving the opportunities, accessibility and viability of rural areas is critical - both to the people who live there and to a much larger urban population that depends on rural America's contributions to their material, environmental, and social wellbeing. A vibrant rural America broadens the nation's economic, intellectual, and cultural diversity[2].

Transitioning from narratives of separation, isolation, and deficit to an acknowledgment of the interconnectedness, symbiosis, and mutually reinforcing strengths of the rural-urban relationship will be key to the re-invention of a healthier rural America. In this compendium, drafted in the lead-up to the **2020 Healthier Rural America Summit** in Omaha, Nebraska, A Healthier WE outlines a new, evolving, dynamic model of rural health that emphasizes integration, mutualism, and the common good.

Rural America: Historical Perspective

The history of rural public health can largely be encapsulated in the years spanning 1908 - when Kentucky's Jefferson County Health Department was incorporated, representing the earliest known instance of county appropriations for full-time public health personnel[3] - to 1945, with the passage of the Hospital Survey and Construction Act, commonly known as the Hill-Burton Act, which provided federal grants and guaranteed loans to improve healthcare infrastructure. Prior to 1908, the focus of public health was almost exclusively urban, and since 1945, the focus of rural health has been largely on the important issue of access to healthcare services[4]. Healthcare provision will always be an important component of rural wellbeing, but a sole focus on access to services – in the absence of a consideration of the full spectrum of economic and social conditions that influence health status – will not suffice to meaningfully change the trajectory of rural health and rural America.

Rural America has long been home to passionate communities of practice devoted to the preservation, protection, and advancement of a uniquely American way of life. From John Deere and the cast steel plow, to Daniel Halladay and the self-governing windmill, to Orville and Wilbur Wright and the airplane, to Philo T. Farnsworth and the television, to Anna Baldwin and the milking machine, to George Washington Carver and crop rotation methods, innovators on the American frontier have sparked revolutions in national life. Unpacking the motivations behind these inventions underscores the inherent difficulties faced by residents of rural areas: vast distances, rocky or friable soils, and a fragile, physical/social environment.

---

[1] Leung, J., Smith, A., Atherton, I. *et al.* "Everybody Knows Everybody Else's Business"—Privacy in Rural Communities. *J Canc Educ* **31,** 811–812 (2016). https://doi.org/10.1007/s13187-015-0862-8

[2] https://theconversation.com/where-is-rural-america-and-what-does-it-look-like-72045

[3] Hiscock I. V. (1937). History of County Health Organizations in the United States, 1908-33—Bulletin 222, U. S. Public Health Service. *American Journal of Public Health and the Nations Health*, *27*(1), 90.

[4] Meit, M., & Knudson, A. (2009). Why Is Rural Public Health Important? A Look to the Future. *Journal of Public Health Management and Practice*, 15(3), 185–190.

Many of the seemingly intractable problems in rural America stem from siloes that prevent otherwise effective communities of practice from joining together and leveraging innate strengths and common interests.

Unprecedented advances in medical intervention, innovative and disruptive technologies, and increased inter- connectivity amongst all stakeholders offer opportunities to radically improve health and well-being in rural America and beyond.

But poorly nuanced policy, underfunded public health, rising healthcare costs, and disparities in access to care are exacerbating poor health outcomes in our rural areas. These sub-optimal circumstances are driven by deteriorating social determinants - including increasing poverty, an aging population, antiquated educational approaches, inadequate housing, transportation, technology and a rapidly changing environment - and pose imminent challenges to health and well-being in rural America and beyond.

Perhaps the most critical and underreported health crisis in the United States today is community health and well-being in rural America. Rural healthcare is deficient everywhere in the United States. According to the National Conference of State Legislatures (NCSL), rural American households have the nation's highest rates of death, disability, and chronic disease, owing to poorly resourced and badly fragmented rural healthcare delivery systems and a chronic lack of qualified heath personnel across the entire health workforce. Because most rural residents live more than an hour from a Level I/II trauma center, 60 percent of all trauma deaths in the United States occur in rural areas. And more than three-quarters of the nation's 2,070 rural counties have a shortage of health professionals.

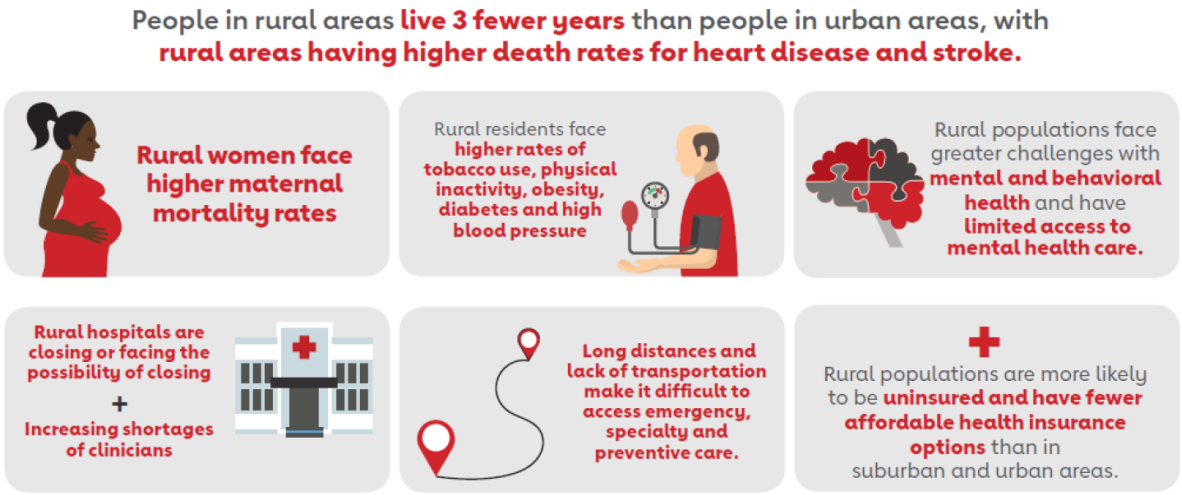


Figure source: American Heart Association[5]

The health crisis in rural America is multi-faceted and complex. It cannot be resolved by one individual, one industry, or one state; only dedicated collaboration and commitment among the communities' residents, health practitioners and systems, local, state and federal policymakers, business owners, educators, faith-based organizations, labor, environmentalists, innovators, media, and philanthropists throughout the region and beyond will bring about the critically needed changes.

[5] Sanchez, E. (2020). National Rural Health Association: 2020. Rural Health Policy Institute - NRHA: American Heart Association.

Our mission is to help scale best practices based on lessons learned, with the **Healthier Rural America Summit** serving as a continuance of our role in convening stakeholders and catalyzing action. AHW convenes, connects, and fosters collaboration to create communities focused on pressing health/environment/economic issues.

Rural America Demographics

There are *many* unique rural Americas, and highlighting narratives from a narrow swath of rural communities would correspondingly decrease the accuracy of any description. With the **2020 Healthier Rural America Summit**, we look forward to putting rural experience and the particularities of rural life at the center of the health dialogue. For the purposes of this compendium, general trends in rural demographics are discussed, but will need the full complement of **Summit** materials and speakers to be appropriately contextualized.

Research and censuses conducted within rural communities show lower incomes, lower educational attainment, lower health status, and higher age indicators for rural residents, compared to their urban counterparts. In rural areas nationally, 24 percent travel 13 to 50 miles to see a doctor while only 7 percent travel this distance in urban areas[6]. Nearly half of rural Americans cannot afford to pay off an unexpected $1,000 expense right away. In addition, four in ten rural Americans say their families have experienced problems affording medical bills, housing, or food in the past few years. When it comes to healthcare, even though most rural Americans have health insurance, about one-quarter say they lack adequate healthcare access, as they have not been able to get healthcare they needed at some point in the past few years. Hospital closures are also problematic for some rural Americans, as almost one in ten say hospitals in their local community have closed down in the past few years[7].

But for every dour demographic detail, a positive corollary should also be noted. Lower incomes can sometimes reflect lower costs of living (including lower housing costs); for a health system where provider salaries are a key driver of healthcare spending, lower provider salary costs in rural areas may increase access to care. Difficulties in accessing healthcare may be partially offset by the family and community connectedness and prosocial attitudes characteristic of rural areas. A transition from the hospital-based model of care delivery and coordination to one where telemedicine and flexible EMS provisioning can open up space for innovation and subtend rural connectedness. Perhaps most importantly, the scale of rural America lends itself well to grassroots effort: a majority of rural adults (62%) say people like them can make an impact in their community, including more than one-quarter (27%) who believe they can make a *big* impact. More than half (61%) belong to a health, social, or community service group[8].

---

[6] Edelman, Mark A., and Brian L. Menz. Selected comparisons and implications of a national rural and urban survey on healthcare access, demographics, and policy issues. *The Journal of Rural Health* 12.3 (1996): 197-205.

[7] Harvard T. H. Chan School of Public Health. (2019). Life in Rural America: Part II: Experiences and views from rural America on economic and health issues and life in rural communities. In NPR, RWJF & Harvard School of Public Health (Eds.), *Public Opinion Poll Series*: NPR/Robert Wood Johnson Foundation/Harvard School of Public Health.

[8] Ibidem.

Rural Health Definition, Transition, and Current Issues

Rural populations are different than urban areas in population density, cultural norms, and remoteness. Rural communities also differ from urban areas in healthcare needs, resources, and access to healthcare, which can lead to increased vulnerability for developing poorer health outcomes[9].

A literature review of rural definitions of health found that rural populations commonly characterize good health as a function of the ability to work, reciprocate in social relationships, and maintain independence[10]. These conceptions of rural health originate from a backdrop of rural transition and change that is arguably accelerating. Declining farm incomes (and increasing debt), land sales, unemployment in primary sectors, and economic diversification can all give rise to painful shifts in rural economies and demographics. But correspondingly, an increasing ability to work remotely, value-added secondary agricultural products, and high rural amenity values open opportunities for tourism development and other non-traditional rural enterprises[11].

Put generally, current issues in rural health are largely a byproduct of broader trends. Surveys of rural adults have found them to be satisfied with their quality of life and safe in their communities, although many struggle to stay ahead of mounting medical and housing expenses. Nearly half of rural adults have experienced problems affording medical bills, housing, or food in the past few years and more than a quarter lack access to adequate healthcare. Despite these challenges, rural optimism and spirit are undimmed: the majority of rural adults feel they can make an impact in their local community[12].

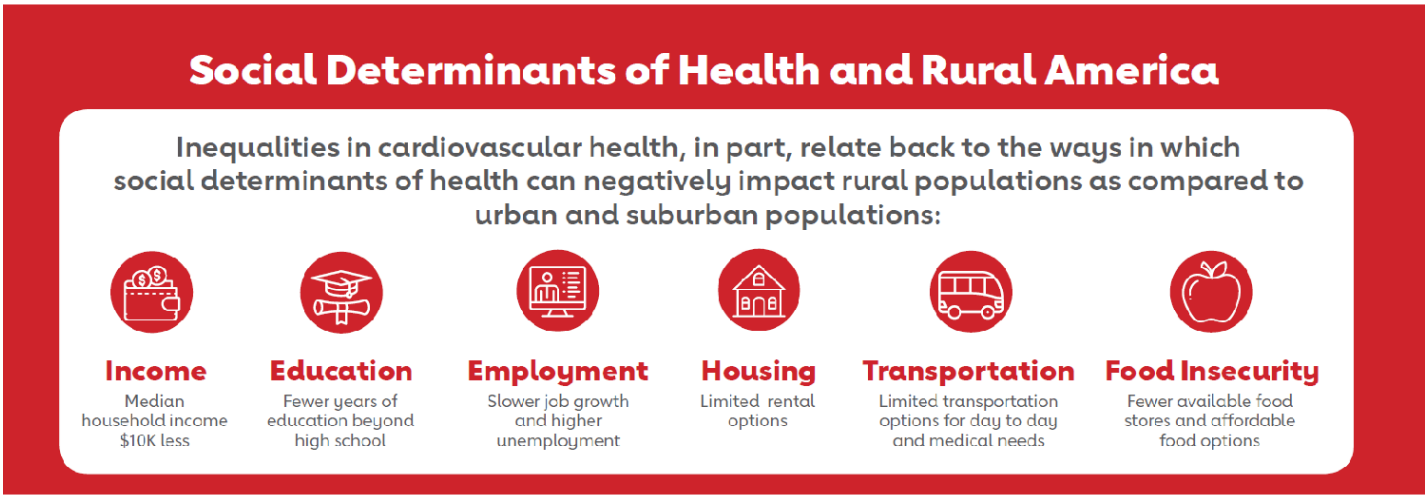


Figure source: American Heart Association [13]

---

[9] Galloway, A. P., & Henry, M. (2014). Relationships between social connectedness and spirituality and depression and perceived health status of rural residents. *Online Journal of Rural Nursing and Healthcare*, *14*(2), 43-79.

[10] Gessert, C., Waring, S., Bailey-Davis, L. *et al.* Rural definition of health: a systematic literature review. *BMC Public Health* 15**,** 378 (2015). https://doi.org/10.1186/s12889-015-1658-9

[11] Mackay, M., Perkins, H. C., & Espiner, S. (2009). The Study of Rural Change from a Social Scientific Perspective: A Literature Review and Annotated Bibliography. Lincoln: Lincoln University Department of Social Science, Parks, Recreation, Tourism and Sport / Faculty of Environment, Society and Design.

[12] Harvard T. H. Chan School of Public Health. (2019). op. cit.

[13] Sanchez, E. (2020). op. cit.

Rural Health Stakeholders

Coordinated efforts in rural health rely on the dedication of numerous stakeholders. Increasing the breadth of stakeholders at the table is vital to all four Essential Culture of Health Action Areas, created by the Robert Wood Johnson Foundation[14]. The Rural Health Information Hub highlights a variety of key stakeholders for a rural health initiative, including: public and private health service providers; local and state health departments and departments of health and human services; tribal agencies; agencies focused on aging, employment, education, and housing; local businesses and national businesses with chapters located in the community; community-based and nonprofit organizations; and rural and national philanthropic organizations and foundations[15]. Expanding this list and stressing the interconnectedness of diverse domains is a core part of A Healthier WE's mission and vision.

Policies

Rural health policy in the United States to date has largely been an unintentional byproduct of national health policy. As a result, it suffers from the assumption that a market-driven medical/industrial complex will solve rural health problems. The goals of current national health policies are primarily cost containment and economic efficiencies, rather than population health goals or a health promotion agenda emphasizing reduced health disparities and increased longevity and quality of life. Current policies reinforce the biomedical model of health/healthcare goods and services, and have led to an increasingly fragmented healthcare system that is biased in favor of consumers who can afford to purchase health commodities directly or via comprehensive insurance.

Rural regions require special attention in health policy. Healthy People 2010 lists six broad categories where health disparities exist in the US: race and ethnicity, socioeconomic status, gender, age, disability, and geographic location. Disparities in age, socioeconomic status, and race and ethnicity are critical factors in explaining geographic differences in population health. Health policies that primarily focus on medical infrastructure may reward cost efficiencies and encourage continuing innovation in medical science, but will not reduce health disparities until rural populations have an equivalent ability to access these products and services.

A framework of five interlinked concepts underpins successful rural health policy. First, nationwide and rural policies must be evaluated on their ability to achieve improved population health rather than individual health gains. Second, generalized risk factors such as social and economic infrastructures affect population health. Rural regions differ among themselves and in comparison to urban regions on a number of characteristics: geography, population density, racial and ethnic mix, age, occupations, and social and economic conditions. These differences influence inequities in health status and the adequacy of rural medical infrastructure. Third, connections among rural and urban insurance risk pools and medical infrastructure are necessary to share costs and mitigate risk. Rural primary care services must be networked into a larger system that incorporates interventions for primary, secondary, and tertiary care. Fourth, health decisions are inherently political. Local

[14] Robert Wood Johnson Foundation Health Action Framework.
[15] https://www.ruralhealthinfo.org/toolkits/transportation/4/stakeholders

civic structures, including human and social capital, affect capacities for local problem solving, including the integration of rural health, social, and economic goals. Fifth, rural population characteristics prevent competitive market solutions from solving basic rural health problems. Location- and institution-specific interventions will be necessary if health and wellbeing are to be shared across all populations in the U.S.[16] Coordinated efforts in rural health rely on the dedication of numerous stakeholders. Increasing the breadth of stakeholders at the table is vital to all four Essential Culture of Health Action Areas, created by the Robert Wood Johnson Foundation, detailed in the *Practicalities* section, below.

Politics

A combination of factors can promote or inhibit rural health/healthcare legislation. In John Kingdon's 'policy streams' approach[17], three streams are identified: the political, problem, and policy streams, all of which play prominent roles in rural healthcare policy. The national political environment, legislative branch composition, and executive branch prioritization comprise the political stream; urban-centrism, the agribusiness lobby, and focusing events affect the problem stream; and policy coherence characterizes the policy stream. A favorable national political environment, prominent and informed representatives, and a strong executive branch contribute to rural healthcare policy enactment; ungenerous public opinion, an absence of rural legislators, and an unsympathetic executive branch can engender legislative failure. Urban-centrism and the agribusiness lobby consistently influence rural healthcare legislation, but research indicates that these factors may be superseded by an assertive executive branch. This suggests that the political stream, within the rural healthcare policy arena, is the most influential factor impacting legislative initiatives. Coherent policies encourage legislative success; incoherent and competing policies engender inertia[18].

Practicalities

A Healthier WE's efforts to improve rural health build on the efforts of multiple stakeholders, and are inspired in part by the Robert Wood Johnson Foundation's Culture of Health Action Framework.

Proven rural solutions across all four RWJF Culture of Health Action Framework areas are worthy of showcasing.

Action Area 1, on *Creating Healthier, More Equitable Communities*, is a challenge taken up in rural Pennsylvania on a project to facilitate physical activity and mobility where sidewalks are scarce, fitness facilities are limited, and access to public transportation can be difficult. The WalkWorks network, representing a partnership between the Center for Rural Health Practice at the University of Pittsburgh at Bradford, NGOs, CBOs, government agencies, and local healthcare providers, established walking routes and social support via a network of

---

[16] Morton, L. W. (2004). Rural Health Policy. In D. L. Brown (Ed.), *Challenges for Rural America in the Twenty-First Century* (pp. 290-302). State College, PA: Penn State University Press.

[17] Kingdon, J. W., & Stano, E. (1984). *Agendas, alternatives, and public policies* (Vol. 45, pp. 165-169). Boston: Little, Brown.

[18] Yamashita, C. (2011). *The Politics of Rural Healthcare Reform.* Pacific University, Forest Grove, OR.

walking groups. Outcomes include democratized access to green spaces, increased mobility for rural residents, and greater opportunities for physical activity[19].

Action Area 2, on *Making Health a Shared Value*, may be exemplified by the state of Vermont – the state with the second highest proportion of its population living in rural areas (after Maine). In May 2011, Vermont was the first U.S. state to enact a law for a universal, publicly financed health care system[20]. The state's ambitious efforts towards universal healthcare (though not yet operationalized) led the nation in promoting efforts to improve healthcare access and inculcate health as a shared value[21].

Action Area 3, on *Fostering Cross-Sector Collaboration to Improve Well-Being*, is a hallmark of rural life. Given cultures of household entrepreneurship and resourcefulness in rural America, cross-sector collaboration comes naturally to rural residents (if not as readily to organizations and institutions). Cross-sector collaboration takes three main forms: cross-sector exploration (wherein organizations work across sectoral boundaries and implement programmatic activities outside of their traditional scope of practice); cross-sector interaction (where a primary/lead organization spearheads activities with limited or infrequent input from other participants); and cross-sector partnership – those collaborations in which the full panoply of participants are fully and equally engaged. True partnerships, though rarer than simple exploration or interaction, are more durable and sustainable. Contextual and practical factors are key influences on the success of cross-sector collaboration; structuring strategies and policy interventions appropriately can enhance cross-sector collaborations in rural communities and bolster residents' health[22].

One such cross-sector partnership is centered in Chadron, Nebraska, where the local community hospital has partnered with local government, NGOs, regional healthcare networks, and community health services to provide comprehensive healthcare (including behavioral health), family services, nutrition and employment support, and education, under the rubric of 'Western Community Health Resources'. Fittingly, their motto is 'health and wellness - together we do more'[23].

Action Area 4, on *Strengthening Integration of Health Services and Systems*, is perhaps best embodied by the *Promotora de Salud* model, employed throughout the Southwest U.S.[24] In this model, community health workers - or *promotoras* – are themselves members of the target population, and serve as liaisons between the broader health system and their own peers/community. *Promotoras* may serve as patient advocates, educators, mentors, outreach workers, and/or translators (among others), and remove impediments to health

---

[19] National Recreation and Park Association. (2013). *Parks Build Healthy Communities: Success Stories*. Ashburn, VA: NRPA.

[20] Rudiger, Anja, Reviving Progressive Activism: How a Human Rights Movement Won the Country's First Universal Health Care Law. New Politics (Web-Only Article), November 6, 2011. Available at SSRN: https://ssrn.com/abstract=1984318

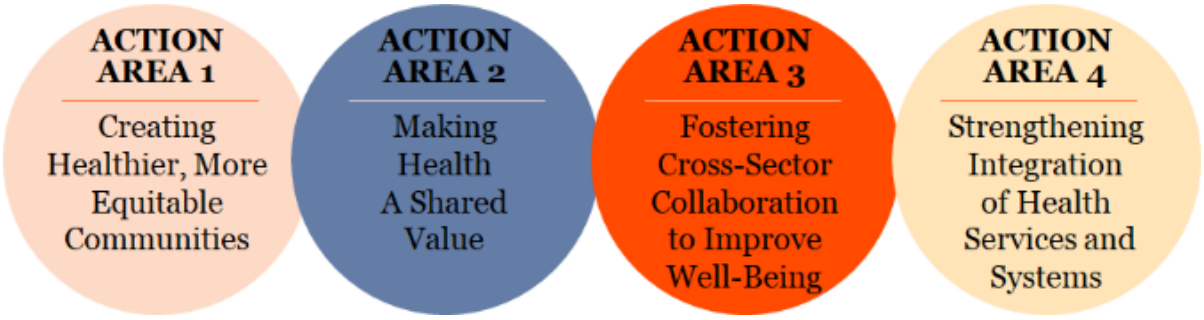
[21] Robert Wood Johnson Foundation. (2019). RWJF Culture of Health Community Portrait: Vermont *Sentinel Communities Surveillance*. Princeton, NJ: RWJF.

[22] Zhu, X., Weigel, P., Baloh, J., Nataliansyah, M., Gunn, N., & Mueller, K. (2019). Mobilising cross-sector collaborations to improve population health in US rural communities: a qualitative study. *BMJ open*, *9*(11), e030983. doi:10.1136/bmjopen-2019-030983

[23] Supplitt, J. T. 2019. "The Rural Report." Chicago, IL: American Hospital Association.

[24] Martin, L. T., Plough, A., Carman, K. G., Leviton, L., Bogdan, O., & Miller, C. E. (2016). Strengthening integration of health services and systems. *Health Affairs, 35*(11), 1976-1981.

due to physical access, cultural, linguistic, economic, or social access barriers. The *promotora* model has been singled out for its promise for health promotion and wellbeing, especially in vulnerable and hard-to-reach populations.



Notwithstanding formal definitions that counterpoise urban and rural, or metropolitan and nonmetropolitan, the realities of settlement, commuting, and migration patterns reflect a complex interface wherein a great deal of mixing occurs among and between urban and rural populations, and rural areas themselves exhibit a great deal of diversity. International research, especially in the developing world, has recognized the complicated human, market, environmental, and functional interactions that link urban to rural areas, especially at the peri-urban interface where urban and rural meet. Strategies to achieve greater rural prosperity emphasize the value of strengthening productive ties between rural and urban places, with an attendant need for efforts to preserve rural natural resources; improve labor market connections (including through technological infrastructure); upgrade education in rural areas; and ensure that America's rural economy keeps pace with changing metropolitan demand at home and abroad. America's rural and urban areas share many degrees of interdependence: rural areas provide critical consumption goods for metropolitan consumers (such as food, energy, lower-cost land and labor, and unique lifestyle and amenity values); metro areas constitute the end market for much of rural production; provide specialized services; offer diverse job opportunities; and generate resources for public and private investment in rural America[25]. Both rural and urban Americans are better off when we recognize how symbiotic the rural-urban relationship is. Sustainability will be the watchword for both the ecosystem services provided by rural America as well as the health systems and structures in place.

Call to Action

Rural America matters; rural people matter; rural health matters.

Rural people and issues generally receive only passing attention from the urban-centric media and policy elites. Yet, Rural America makes unique contributions to this nation's character and culture as well as providing most of its food, fuel, fiber, natural resources, not to mention healthy drinking water and clean air.

[25] Dabson, B. (2007). Rural-Urban Interdependence: Why Metropolitan and Rural America Need Each Other *The Blueprint for American Prosperity Metropolitan Policy Program*. Washington, DC: The Brookings Institution.

Rurality and the frontier ethos is a foundational part of this country's heritage, and rural core values are much like ours today; they must be valued and nurtured as we define our future.

Understanding how we are connected to the land, air, and water must continue to define who rural America is going forward.

Join us as we strengthen the web that undergirds rural health.

Resources

Besser, R., & Plough, A. (2018). Moving Forward Together: An Update on Building and Measuring a Culture of Health. Princeton, NJ: Robert Wood Johnson Foundation.

Compton-Phillips, A., & Mohta, N. S. (2018). Care Redesign Survey: Lessons Learned From and For Rural Health *Insights Report: Advisor Analysis*. Waltham, MA: NEJM Catalyst / Massachusetts Medical Society.

Dabson, B. (2007). Rural-Urban Interdependence: Why Metropolitan and Rural America Need Each Other *The Blueprint for American Prosperity Metropolitan Policy Program*. Washington, DC: The Brookings Institution.

Harvard T. H. Chan School of Public Health. (2019). Life in Rural America: Part II: Experiences and views from rural America on economic and health issues and life in rural communities. In NPR, RWJF & Harvard School of Public Health (Eds.), *Public Opinion Poll Series*: NPR/Robert Wood Johnson Foundation/Harvard School of Public Health.

Kingdon, J. W., & Stano, E. (1984). *Agendas, alternatives, and public policies* (Vol. 45, pp. 165-169). Boston: Little, Brown.

Mackay, M., Perkins, H. C., & Espiner, S. (2009). The Study of Rural Change from a Social Scientific Perspective: A Literature Review and Annotated Bibliography. Lincoln: Lincoln University Department of Social Science, Parks, Recreation, Tourism and Sport / Faculty of Environment, Society and Design.

Martin, L. T., Plough, A., Carman, K. G., Leviton, L., Bogdan, O., & Miller, C. E. (2016). Strengthening integration of health services and systems. *Health Affairs, 35*(11), 1976-1981.

Morton, L. W. (2004). Rural Health Policy. In D. L. Brown (Ed.), *Challenges for Rural America in the Twenty-First Century* (pp. 290-302). State College, PA: Penn State University Press.

National Recreation and Park Association. (2013). *Parks Build Healthy Communities: Success Stories*. Ashburn, VA: NRPA.

Sanchez, E. (2020). National Rural Health Association: 2020. Rural Health Policy Institute - NRHA: American Heart Association.

Yamashita, C. (2011). *The Politics of Rural Healthcare Reform.* Pacific University, Forest Grove, OR.

Contact Information

Phillip L. Polakoff, MD, MEnv.Sc..MPH
Founder/CEO A Healthier WE
plp@sbcglobal.net
510-508-9216
http://healthierruralamericasummit.org