

Disparities in the Health and Well-Being of Children and Youth in Rural Areas of the United States

May 31, 2016

Questions and Answers

Q: What are some of the policy interventions that have shown the most promise in addressing health disparities and outcomes among rural families and children?

A: (Jan Probst) This is too big a question for an email, so I'm going to refer the reader to the [HRSA-funded Rural Health Information Hub](#). This site compiles information on rural health and rural health disparities, and also serves as a repository for evidence-based intervention results.

(Alana Knudson) Local solutions are often the most effective to address health disparities among rural families and children because the strategies are identified at the local level are embraced by the community. An excellent example of a locally-driven program that has improved the health and well-being of a rural community is found in Conetoe, North Carolina, where a community garden transformed health behaviors. As such, a culture of health has taken root in this rural community – health status has improved, health care costs have decreased, and high school graduation rates have increased. Please see the video "[Nash Health Care Chaplain Sows Seeds of Healthy Living](#)" from [UNC Health Care](#).

(Steve Holve) I think the most interesting intervention are the natural experiments in which tribal members are lifted out of poverty by casino gaming money. I mentioned two articles from the *Journal of the American Medical Association* discussing a [reduction in substance abuse and mental illness](#) and a [reduction in obesity in tribal groups](#) that had sudden increase in income. I think there is general agreement that poverty is a major cause of poor health and stress in AI/AN communities and strategies to reduce poverty are probably the most effective health interventions needed in the 21st century for Native people.

Q: How broad is internet access across rural communities available for telemedicine and home health efforts including home visiting and CSHCN?

A: (Jan Probst) This is a question that I can't answer fully, as it encompasses a lot of territory (access, plus telemedicine & home visiting). There is actually a website called [Broadband.gov](#) that provides information about the accessibility of various services. It has a [mapping feature](#) that assumes that the user knows what type of service is required (DSL, cable, wireless, fiber). Since I think the individual is really looking for programmatic information, I would also direct him/her to the [Rural Health Information Hub](#), referenced in the previous question.

(Alana Knudson) There are different broadband capacity requirements for different types of telemedicine or telehealth technologies. For example, store and forward technologies requires

less broadband than real-time video interactions. There are also differences in the way in which people access the internet – such as dial-up, cable modem, fiber, wireless and satellites. In addition, there are some rural areas that lack cell coverage so if there is an expectation of entering data or consulting with another provider during a home visit in real-time, it is not possible. It is important for providers and other rural stakeholders to identify their broadband needs. The Federal Communications Committee (FCC) has grants and loans available to enhance rural broadband services. The FCC provided this information regarding broadband access on their website in the [2015 Broadband Progress Report](#).

(Steve Holve) Until recently internet access was poor in many rural areas but there is a new federal initiative specifically aimed at bringing internet to rural areas including reservations. Some clinics currently use telehealth: Alaska has a very robust telemedicine program given their geographic challenges. I think telemedicine is a real opportunity for federal and tribal groups in the near future.

Q: Is the gap in health insurance for Hispanic kids due in any part to fears related to not being documented?

A: (Jan Probst) Providing a nuanced answer to this question is difficult. “In any part,” the answer would be yes — but the part is very small. Most children had insurance in 2011-2012, with values ranging from 96% among white kids to 90% among Hispanic children. When parents were asked why they did not have health insurance for their child, the most common response across all racial/ethnic groups was “it costs too much.” (29% of all respondents; 42% among white parents, 18% among Hispanic parents). Other answers addressed a range of possibility, such as currently changing jobs/insurance, or moving. Among Hispanic parents whose children lacked insurance, the second most common reason was “cannot meet residency/citizenship requirements,” (14% of Hispanic uninsured children), and “ineligible due to other program requirement” (7%). Thus, documentation issues are present, but issues such as poverty are also driving lack of coverage.

Q: How do parents know if their kids are healthy or not?

A: (Jan Probst) Parents have to guess at kid's health, but they are generally the best observers. If a child is experiencing notable health problems (asthma, diabetes, cancer), the parent is highly likely to know and report this.

Q: Are there any data on teen birth rate in rural vs. urban counties?

A: (Jan Probst) Two recommendations can be offered here. First, the National Campaign to Prevent Teen and Unplanned Pregnancy produced an [overall report on teen pregnancy last year](#). Their analysis is excellent from a national perspective on rural problems. If you wish detailed data about a specific community, the [RWJ County Rankings data sets](#) are available for download and provide teen pregnancy rates at the county level.

Q: What is included under unintentional deaths?

A: (Alana Knudson) The unintentional injury cause of death is the CDC definition and includes motor vehicle crashes, falls, firearms, drownings, suffocations, bites, stings, fires or burns, poisonings (includes unintentional drug overdoses).

Q: Does your children data include Native American?

A: (Alana Knudson) Yes.

Q: Dr. Knudson seemed to use terms of sex and gender interchangeably. Is this common convention? What effect might that have on data?

A: (Alana Knudson) No, it is no longer common to use sex and gender interchangeable as it once was – my mistake. I used to give many presentations to public health audiences 20 years ago and routinely used sex and gender interchangeably. At this time, most states do not capture gender identity on death certificates (e.g., California includes gender identity on death certificates). There may be effects on mortality for some causes of death; however, given the few states that report gender identity on the death certificates, it is difficult to determine.

Q: Are there any recent comparisons or studies between US rural youth health and rural youth in other countries?

A: (Alana Knudson) Dr. Gopal Singh and his colleagues published a study, [All-Cause and Cause-Specific Mortality among US Youth: Socioeconomic and Rural–Urban Disparities and International Patterns](#), in *Urban Health* (2013 Jun; 90(3): 388–405) that compared causes of death for youth in the U.S. and other industrialized countries. They found that the U.S. ranks poorly in all-cause mortality, youth homicide, and unintentional-injury mortality rates when compared with other industrialized countries.

Q: Has more research been done to determine why the suicide rate is higher in the Plains Region?

A: (Steve Holve) I don't know of any research looking at why suicide rates are higher on the Northern Plains as compared to the Southwest. Rates are as elevated in Alaska as they are in the Northern Plains so it is not an isolated finding and while rates in the southern plains and the southwest are lower than the northern Plains they are still 2-3 times higher than US whites. You might look at paper by [Wong et al. in the American Journal of Public Health \(2014\) on infant and pediatric mortality for AI/AN](#).

Q: What kind of health education efforts are ongoing for youth in rural/Native American areas?

A: (Steve Holve) Health education is available at clinic visits similar to other federally-qualified health centers (FQHCS) in the US.

Q: Have you found any ways to spread vaccine acceptance (specifically HPV) to rural areas?

A: (Steve Holve) Vaccine acceptance is generally high in AI/AN populations if only because many parents have personal memory of the recent past when morbidity and mortality for infectious illnesses was high. Overall HPV vaccine rates for AI/AN teens on reservations is far higher than that of the general US population though there is still room for improvement.

Q: In regards to the Native American population, have you noticed any trends with inherited conditions/diseases that are or could be associated with parents who had jobs in mining/mining affiliated work (like uranium) or from environmental impacts of these mines (ex: contaminated water sources). For instance higher rates of cancers than in the general population.

A: (Steve Holve) In the early 1960s and 1970s there were markedly elevated rates of lung cancer in Navajo uranium miners. All of these mines closed by the early 70s not for health reasons but because there was no longer a market for uranium.

There was an alleged link between Navajo Neurohepatopathy and uranium in the 1980s but since then a specific genetic mutation has been identified which is found in other populations which do not have uranium exposure.

About DataSpeak

The Maternal and Child Health Bureau's DataSpeak webinar series is dedicated to the goal of helping MCH practitioners on the Federal, State, and local levels to improve their capacity to gather, analyze, and use data for planning and policymaking.

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This question and answer sheet was created by moderator Sarah Lifsey, MPP.

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