

# The RURAL MONITOR

*A Publication of the Rural Assistance Center*

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*Rural children in the United States are getting poorer.*

*According to a recent Carsey Institute report, 22.5 percent of children living in non-metropolitan areas in 2005 were poor—an increase of more than 3 percent since 2000. Five states had rural child poverty rates above 30 percent.*

*In this issue of the Rural Monitor, we look at activities and research related to poor rural children including: Head Start, early child development, transportation and public health insurance programs.*

## A Head Start for Rural Kids

by Candi Helseth

In a doublewide trailer down a narrow dirt road, Cindie Thomas and her family live in rural West Virginia's Wetzell County, "back in the woods 25 miles from any town." For Thomas and her daughter, Kiera Morgan, Head Start has given them a destination, a way out of their isolation and poverty.

Since Kiera enrolled in Head Start last year, the whole family has gotten involved. "Head Start isn't just for what teachers do at the school," Thomas said. "It has to be a home effort too. I've learned how to teach my child with play instead of workbooks. My daughter loves going to Head Start, and it's helped her socially and with learning."

Thomas is learning, too. Although she had already earned her high school diploma, with the encouragement of their local Head Start, she is studying with a local GED study group to refresh her skills so that she can get ready to go to college. And she is developing computer skills through Head Start programming for adults. She's also gaining new leadership skills as a parent involved in the program. She is Head Start's policy council president for the five-county Council for the Northern Panhandle and a liaison to the board of directors. In December she and three other parents from her district attended the National Parent Training Conference in New York.

Disadvantaged children from low-income families succeed better in school



*Children at a Head Start center in Virginia enjoy spending time with each other and learning new skills. (Photo courtesy of the National Head Start Association).*

when they have access to preschool programming that addresses educational, social and physical needs, according to Head Start research. In fiscal year 2005, Head Start served 906,993 children ages three to five. The Early Head Start (EHS) component for children under three supported 62,000 children in more than 650 child development and family support programs. In rural areas, especially with the higher percentage of children in poverty, Head Start may be the only preschool experience available for many children.

"Head Start is the longest-running national school readiness program in the United States, having served more than 22 million children in all 50 states," National Head Start Association CEO



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Sarah M. Greene said. “Substantial research done on a regular basis has proven that Head Start programming is very effective.”

Head Start Family and Child Experiences Surveys (FACES) indicate that Head Start students, by the spring of their kindergarten year, have reading assessment scores equal to national norms and general knowledge assessment scores close to national norms. Another recent study funded by the U.S. Department of Health and Human Services concluded Head Start children performed better on cognitive, language and health measures than comparison group counterparts. The EHS Impact Study found that these children had a higher cognitive development score and larger vocabularies at age three than children in a control group. (Head Start research doesn’t differentiate between rural and urban children, according to Greene.)

Statistics can’t capture the heart of Head Start, says West Virginia Head Start Executive Director Becky Gooch-Erbacher. All 23 Head Start programs in this Appalachian region include rural areas experiencing declining populations, limited resources and high rates of poverty. Head Start offers many families a lifeline.

“Poverty, domestic violence and substance abuse go hand in hand,” Gooch-Erbacher said. “Many of these families are very isolated, and Head Start gets the whole family involved in positive social experiences.”

Darlene Martin, West Virginia Mercer County Head Start director, said her staff sees Head Start’s success individually in the lives of children and families they work with every day. She recounted the recent story of a four-year-old child large for his size and angry at the world. In the classroom, he broke furniture and bullied others with his temper. Working with behavior modification

professionals from the local board of education and the child’s family, Head Start staff developed an individualized plan that rewarded the child for positive behaviors. From the family they learned the child loved video games, so they used age-appropriate video games as positive reinforcement.

“It’s amazing to see how much he’s improved,” Martin said. “He’s maybe not there yet, but he’s come a long ways.”

Head Start assesses every child’s needs and develops an individualized educational plan for each one, Greene said, “to help the child achieve the fullest potential and ability to move forward in the educational process.”

In addition to center-based programs, Head Start instructors and social workers do at least two home visits per year. Home visits are particularly important in rural areas, Greene said, because lack of transportation and distances between services can be barriers for families.

“Head Start is a very comprehensive program that works with the family as a whole,” she noted. “Our standards require certain things, such as all children having physical exams, dental exams, and vision screenings because we know that good health plays a large role in terms of children’s ability to learn. Local committees can also design their programs to meet specific needs. For instance, a certain area in Florida has a high lead poisoning rate so their Head Start includes lead screenings.”

Obesity among pre-kindergarten children is a major concern in West Virginia, Gooch-Erbacher said. The Region III Office of the Administration for Children and Families (ACF) helped develop the “I am Moving, I am Learning” project, a physical and nutritional educational program for children, families and staff members. The program received the ACF Assistant Secretary’s 2006 Partnering for HHS Excellence

Award. Gooch-Erbacher said the best rewards, though, are the changes they’ve seen in the families and center staff.

“Our children are moving more and requesting milk, water or juice when they want a drink,” she said. “Soda or pop isn’t in their vocabulary. We’ve had entire families and staff that have participated as a team effort and really improved their health. Over the last year, we implemented this program statewide and now it’s being provided to other states.”

Family involvement is an integral component of Head Start, Greene said. During the 2004-2005 fiscal year, 890,000 parents volunteered with their local Head Start.

*(continued on Page 12)*

## FACTS ABOUT RURAL CHILDREN

- Approximately 2.6 million rural children are poor.<sup>1</sup>
- Poverty rates are nearly 33 percent higher for rural children than for urban children.<sup>2</sup>
- 48 of the 50 counties with the highest child poverty rates in the United States are rural.<sup>2</sup>
- Rural parents have the lowest education levels of any demographic group, a disparity that affects their children.<sup>2</sup>
- Children who live in non-metropolitan areas have higher mortality rates and are more likely to use tobacco.<sup>3</sup>

### Sources:

1. Economic Research Service, *Rural Poverty at a Glance* (<http://www.ers.usda.gov/publications/rdr100/rdr100.pdf>);
2. Save the Children (<http://www.savethechildren.org>);
3. U.S. Department of Health and Human Services, *The National Survey of Children’s Health 2003* (<http://mchb.hrsa.gov/ruralhealth/intro.htm>).

# Rural Kindergartners Found to Be Disadvantaged

by Candi Helseth

There is a substantial lack of reliable data on the status of young, rural children, according to Cathy Grace, director of the National Center for Rural Early Childhood Learning Initiatives. To fill that need, the Center has conducted several research projects analyzing data about rural young children, and in 2006 published some of those findings in *Rural Disparities in Baseline Data of the Early Childhood Longitudinal Study: A Chartbook*.

The Chartbook draws upon data presented in Early Childhood Longitudinal Study (ECLS), an ongoing study by the U.S. Department of Education (ED), which follows nationally representative groups of children, from birth through elementary school.

“Two of the most striking disparities evident in the ECLS data are that rural children are significantly more likely to enter kindergarten behind in certain early literacy skills, and significantly more likely to be placed in special education at kindergarten entry,” Grace said. “This suggests that early literacy experiences for rural young children need to be enhanced, and raises the

question of whether early intervention services for children with developmental needs are available equally to rural and non-rural children.”

Through their analysis of the ECLS baseline data, Grace and her colleagues found that rural children are less likely than non-rural children to be in center-based care, other than Head Start, during the pre-kindergarten year. “This is important to know because it affects methods of professional development for early childhood teachers and caregivers,” Grace said. “In other words, to really help improve early literacy experiences for rural young children, we have to be careful to support the child care providers who care for a few children in their homes.”

In addition to Head Start, Grace said, two well-recognized federal government programs supporting early childhood care are the Child Care and Development Fund (CCDF) and Special Supplemental Nutrition Program for Women, Infants and Children (WIC). CCDF, a block grant program, subsidizes childcare expenses and funds training and technical assistance to improve

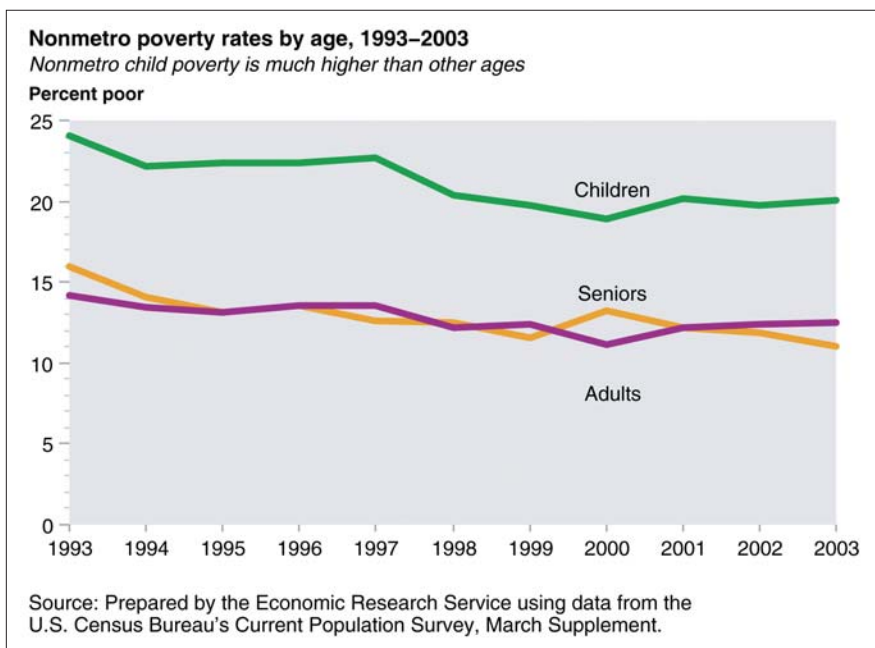


*Cathy Grace, director of the National Center for Rural Early Childhood Learning Initiatives says that rural children are often behind in skills when they enter school.*

early education. WIC, a nutritional program for women, infants and children, provides nutrition, education and social services for women who qualify and children up to age five. Recipients in both programs must fall within certain income levels to qualify.

Systems that ensure better quality and accountability also improve services for young children, Grace added. Accrediting programs promoting quality improvements, quality rating systems offering federal incentives for childcare providers, and childcare registries tracking qualifications of early childhood educators are among these positive developments. Because early care and education is “such a fragmented sector of our educational system,” Grace said, “these registries are going to be important for understanding professional development needs.”

Research done by the National Center for Rural Early Childhood Learning Initiatives helps providers determine where efforts should be targeted. Established in 2004 with a ED grant to the Mississippi State University Early Childhood Institute, the Center researches quality, accessibility and replication of early educational intervention services for at-risk young children and families in rural America. To learn more, go to <http://www.ruralec.msstate.edu>.



# Getting Children Where They Need to Go

by Candi Helseth

Without public transportation, many rural children would not get to Head Start, doctors' appointments, day care or other services.

In the majority of cases where children need public transportation, parents lack the means to get their children to the desired place, said Judy Owens, director of the Sweetwater Transit Authority Resources (STAR). "Their vehicle is broken down, they're a one-vehicle family and Dad takes the car to work all day, they don't have a vehicle at all, there are other young children at home and the parent can't leave—there are a variety of reasons."

STAR is a nationally recognized service in rural Wyoming that provides transportation for riders of all ages. In fiscal year June 2005 through July 2006, STAR provided 47,312 rides in Sweetwater County, which covers an expanse of 10,000 miles.

Owens said parents appreciate STAR because children can be transported to child-care centers, medical appointments and after-school activities, but also to the library, entertainment events and group trips. Approximately one-third of all STAR trips are to and from the county's Child Development Center, which offers services for young children with disabilities.

"If they're children 10 and over, they can use STAR independently, but if they are under 10 they need to have an adult with them unless they are traveling as part of our contract with the Child Development Center," Owens explained. "In those cases, the Child Development Center provides an aide to ride with the children."

While the area is experiencing growth due to oil and gas expansion, circumstances weren't nearly so positive back in the early 1980s when local leaders first began discussing a collaborated transportation service. At the time, services

were divided among several government agencies, resulting in duplicative systems in some areas of the large, rural county and no public transportation in other areas.

In 1989, county commissioners selected STAR to be the single transportation system. Other agencies that owned vehicles were required to place vehicle ownership under STAR. Initial resistance vanished once they realized they could successfully provide transportation to a greater number of people while spending less, Owens said.

In addition to the Child Development Center, human service agencies, senior centers and nursing homes also partner with STAR. These organizations pay STAR directly and provide riders with passes.

Sweetwater County and its municipalities save more than \$1.6 million per year, or \$3.50 in benefits for every \$1.00 spent on



*Center employee Peggy Roberts helps Mark Sanchez get from the STAR bus to the Child Development Center.*

STAR. The Federal Transportation Association and the State of Wyoming provide grant assistance. State agencies, employers and community providers are among more than 10 different organizations that contribute to funding STAR, which operates with an annual budget of approximately \$500,000.

## GETTING HEAD START CHILDREN TO SCHOOL

One of the biggest challenges for Head Start programs in rural areas is getting the children to school.

While poor families often lack a reliable family car, there is limited or no public transportation in many rural communities, and providing bus service specifically for Head Start children can be costly due to the greater distances between homes.

"Transportation for children has been a big need that we've seen in rural areas over the years," said Sarah M. Greene, National Head Start Association CEO. "Due to increasing expenses and the regulations associated with transporting children, many Head Start programs have completely cut out their transportation services, or at least cut back on

them. Buses are expensive, it's tough to keep qualified drivers, and fuel costs have increased. Yet, many poor families don't have their own transportation."

Greene said many Head Start programs use school districts to transport their students. But school buses don't have safety restraints or aides riding on the buses. Both are required under Head Start regulations. To better accommodate rural needs, Head Start's stringent safety regulations for preschool children were relaxed somewhat in the 2006 Head Start Appropriations Bill. Head Start grantees in rural areas are allowed now to apply for waivers if they can demonstrate the requirements will prevent them from being able to transport the children.

## Rural Updates in Real Time: RAC's RSS Feeds


by Maren Niemeier

Visitors to the Rural Assistance Center web site find a wealth of news, funding opportunities and rural resources, with new information added daily by RAC information specialists. Short of visiting the site each day, how can you keep up with our latest discoveries?

To address the need for timely and ongoing updates, the Rural Assistance Center (RAC) offers a wide range of RSS feeds. RSS, or Really Simple Syndication, is method for distributing news headlines on the Web. You may subscribe to the feeds that interest you and view the updates as often as you choose—weekly, daily or even hourly. RAC's feeds are also available as an easy source of current content that may be included on your organization's web site.

A full list of RAC feeds, with subscription information, is available at <http://www.raconline.org/rss/>. Available rural feeds include:

- News headlines
- Upcoming events
- *Federal Register* notices of interest to rural audiences
- Funding opportunities, including RSS feeds for specific funding topics and a feed listing all new funding opportunities
- Information guide feeds, with separate feeds for each of RAC's 76 guides
- State resource feeds for each state
- Publications from a variety of sources on rural topics
- Rural web sites and other tools

You can view RSS feeds using a news reader. There are two types of news readers: web-based services that can be viewed from any computer with Internet access; and dedicated programs, which are installed on your computer. Newer web browsers, including the latest versions of Firefox and Internet Explorer, integrate RSS feed subscriptions into the browser software. (For more information about news readers, please see RAC's RSS page, <http://www.raconline.org/rss/>.) Once you have chosen a news reader and signed up or installed it, you can add feeds manually by pasting each feed's web address into your news reader. Please read the instructions for your news reader to learn how. Web pages on the RAC site that have associated feeds are identified with the orange feed icon. 

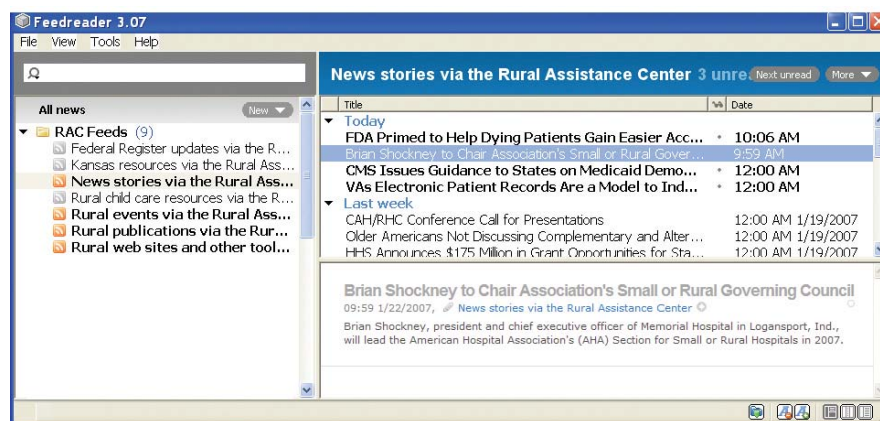
Feeds are listed in the left-hand column, and each feed with unread items is bold. The upper-right box

lists the headlines for the selected feed, again with unread items in bold, and the lower right box shows an individual headline and description. The headline is a link to the full news story.

RAC's feeds may also be used to add dynamic content to your organization's web site. Content from any of RAC's RSS feeds may be incorporated into your non-commercial web site free of charge. Adding RSS feeds will keep your site fresh and keep users coming back, all without using your valuable resources to update the site. Details about using RAC content on your site, including the terms and conditions of use, are available at <http://www.raconline.org/rss/>.

For more information about RAC's RSS feeds, please contact Maren Niemeier, Lead Information Specialist, Rural Assistance Center, at [maren@raconline.org](mailto:maren@raconline.org) or 800-270-1898.

### RSS feed viewed in the FeedReader news reader





## Rethinking Human Services

by Tom Corbett, Ph.D.

### What Is Poverty in America?

In the United States, overall poverty is higher than it was a generation ago—13.3 percent in 2005 as opposed to 11.1 percent in 1973. That rate is much higher than those found in virtually all Western countries with advanced economies. Moreover, income poverty remains discouragingly persistent among specific racial groups and in many rural communities. As one example of extreme rural poverty, some 44.5 percent of people living in Apache County, New Mexico were classified as officially poor in 2005.

Are we really doing this badly? Was the so-called War-On-Poverty (WOP) declared by President Lyndon Johnson some 43 years ago such a failure? As in so many areas of public policy, the issue is complex and answers not easily obtained.

In some respects, we have reason to believe that things are better in this decade than in 1973, the year overall poverty fell to the lowest level ever recorded. By some measures, much has improved since then. Per-capita income is up by well more than 60 percent, the proportion of youth dropping out of high school has fallen from two out of five to one out of six. Over the same period, public anti-poverty spending doubled.

It would appear that we have one of those very intriguing policy conundrums. Why does it seem that a country that is richer, more educated, and investing more on a public challenge falling further behind?

Let us look at how we measure poverty. The “official” measure of poverty used by the Census Bureau was developed in the early 1960s by Mollie Orshansky, an analyst with the Social Security Administration, and adopted as the “official” measure of the federal government as the WOP gathered steam. Essentially, Orshansky took a 1950s estimate of

what it cost to purchase a minimal diet and multiplied that by a factor of three since low-income families spent about one-third of their income on food. Separate poverty lines were established for different size families (equivalency thresholds) and were updated annually by changes in prices.

Other than a little tinkering, that was it. What Ms. Orshansky thought would be a temporary measure became a permanent aspect of our policy landscape upon which the health of our nation is assessed and upon which many federal dollars are distributed to states and communities. Until her death a few years ago, she continued to be bemused and even shocked that her back-of-the-envelope measure had so long endured.

So, what is the problem? Well, low-income families now have very different consumption patterns, no longer spending a third of their resources on food. Wages have gone up faster than prices, so the poverty thresholds have fallen relative to median earnings over time. Nor do we adjust the thresholds based on where a family resides, no matter how much more it costs to live in San Francisco than it does in Fargo, ND.

That is just for starters. What if a low-income family has very high work-related expenses, as do a good many rural families who must travel great distances to work? Or what if that family has high out-of-pocket medical expenses, which happens to a number of rural, self-employed families? Or what if affordable housing evaporates as high-cost urban areas expand? Sorry, those difficult-to-avoid expenses are not included in the poverty calculus.

On the other hand, we have witnessed substantial increases in non-cash or cash-like help for the poor over the past generation. Food Stamp use continues to rise as cash welfare caseloads fall. The Earned Income Tax Credit has become the

largest income support program for low-income working families. Child-care subsidies have exploded. Medicaid coverage now includes most poor children and many more low-income families. Yet, none of these forms of public help are counted as income in the calculation of poverty.

The failings of our national poverty measure are not a secret. The National Research Council, part of the National Academy of Sciences, called for retooling this measure more than a decade ago. Some of my colleagues and I tried mightily to get this issue on the public agenda in the late 1990s.\* In response, the U.S. Census Bureau does publish alternative estimates that account for some of the shortcomings mentioned above. But the official measure essentially remains unchanged while the more accurate alternative measures typically are ignored. The politics around poverty resist appeals to reason.

Of course, we might conceptualize poverty in other ways. We might focus on *consumption* as opposed to income, since the capacity of poor families to purchase goods and services appears to have increased as their measured income has stagnated in real terms.

We might focus on what some call *earnings capacity*, the ability to provide for one’s self, which might get around sticky issues of motivation.

Or we might focus more on a broader set of behavioral and social *indicators* on the assumption that income alone cannot really tap the health of any community.

These are possibilities we ought to think about.

\* These colleagues included Barbara Wolfe, then director of the Institute for Research on Poverty, Gary Burtless of the Brookings Institution, and Wendell Primus, then of the Center for Budget and Policy Priorities.

(continued on Page 12)



## Look What's Coming

by Wayne Myers, M.D.

### Hospitals and Insurance: The Weak Protecting the Strong

Politicians are calling for health care reform. Unfortunately, that will involve some tough choices, given the range of American political philosophy. The duet between hospitals and insurance companies provides a good example.

In recent years hospital administrators have changed into CEOs. They like to depict hospitals as entrepreneurial, navigating the complexities typical of the world of free enterprise.

On the other hand, hospitals also like the role of essential public institutions with "certificate of need" laws to protect them from competition, disproportionate share payments to help with bad debt, cost-based reimbursement from Medicare and Medicaid if they can get it, tax-exempt status for the hospital and its donors, and "any willing provider" regulations to force all payers to do business with them.

We saw in an earlier column that the amount charged by the same hospital for the same service may vary enormously depending on who is paying. The payers with the deepest pockets, i.e., Medicare, the federal government, pay the least. Large insurers and Medicaid come in next, with Medicaid's rate depending on the state and the specific service. People paying for their own care get charged the most, often paying several times as much as their care actually cost the hospital.

Not many individuals actually pay those inflated "self-pay" rates. They aren't very important to the hospital, but they keep the health insurance industry in business. Insurance companies are moving away from their traditional mission of spreading risk, preferring the role of "third party administrator." They get bills for medical care, pay them and then pass them on to employers for

reimbursement. Their function resembles that of a credit card company with one important exception. They typically get a much higher premium for handling the money. Fifteen percent is typical. Would you give your credit card company 115 dollars to pay for the hundred-dollar tire you bought? You would if you'd have to pay 300 to 600 dollars for the tire if you paid for it yourself.

Long ago that sort of price fiddling was banned in the transportation industry. A "common carrier" has to charge every customer the same tariff for the same service. That sort of requirement applied to hospitals would have many advantages. Insurance companies would have to compete on the basis of the services they provide instead of contrived price discounts. They might work harder to bargain for lower prices if they were competing against direct payment. Debates about the value of free care provided by hospitals would be readily resolved. Personal bankruptcies would decline. Taxes and Medicare premiums would increase slightly as government payers began to pay their full share. Other payers' bills would decrease by a similar amount as cost shifting decreased. Most notably the overall cost of doing health business would decrease if the convoluted billing deals were simplified.

So why don't we require that every hospital establish a fee schedule and use it for every payer? Let each hospital use its best business judgment to set rates that will cover its costs and retain business. That's what every other business does. The problem is that the hospital has to get it right. If it goes too low it goes broke and pleads for help as a critical community service. The mayor, governor and Congressional representatives spring into action. Or the hospital sets rates too high and Medicare, Medicaid or the big

private payer leaves the deal. Again the hospital, threatened with bankruptcy, becomes a public responsibility. Conclusion: if we stay with "free enterprise rate setting" with a new requirement for fair and equal pricing we get the hospital as a public responsibility.

If we take the route of government rate setting, we risk the MedPAC model. It is difficult for people to agree on assumptions and lots of subjective values must be considered. For example, compare the value of care in the small local hospital in comparison with economies of scale in the large regional facility. State setting of hospital rates was common in the 1980s. One reason it lost popularity was a pattern of efforts to allow for various levels of discounting depending on the "desirability" of various payers. The payers were able to game the rate-setting processes more adroitly than the state commissions. No one tried single rates without discounting. (For a discussion of state setting of hospital rates, see "Tracking the Demise of State Hospital Rate Setting" by John E. McDonough (*Health Affairs*, Vol.16, no. 1, 1997; <http://content.healthaffairs.org/content/vol16/issue1/>).

Fixing our health care will force answers to many tough, value laden questions. But it really is time to start.

*Wayne Myers, a pediatrician, founded the University of Kentucky Center for Rural Health and served as its director. He also served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration. He is a past president of the National Rural Health Association and currently serves on its Board of Trustees.*

**Opinions expressed in this column are those of the author and do not necessarily reflect the views of the Rural Assistance Center.**

### Special Series: Technical Assistance Centers

*Editor's note: This is the sixth and last in a series of articles on rural health technical assistance resources around the country that are funded by the federal Office of Rural Health Policy (ORHP). The first article (see The Rural Monitor, Fall 2005) gave an overview of what is meant by technical assistance. For a complete list of technical assistance resources available through ORHP, see <http://ruralhealth.mrsa.gov/links/TACenters.asp>.*

by Candi Helseth

## Technical Assistance for Critical Access

Local health care facilities turn to community and state leaders for direction when they need assistance—and state leaders turn to the Technical Assistance and Services Center (TASC) when they want to support their local health care facilities. TASC offers customized, technical assistance in response to a state's request for help, according to Terry Hill, executive director.

Based in Duluth, MN., as a program of the nonprofit Rural Health Resource Center, TASC was one of the first technical assistance programs. The Balanced Budget Act of 1997 created the Medicare Rural Hospital Flexibility (Flex) Program, which established the Critical Access Hospital (CAH) as a new category eligible for cost-based Medicare reimbursement and created a \$25 million grant program for state governments to assist hospitals interested in converting to CAH status. ORHP, which administers the Flex grant program, funded the creation of TASC and funds its ongoing operation. TASC has helped interested hospitals in 47 states evaluate the feasibility of converting. More than 80 percent of these rural hospitals, or a total of

1,300 in 45 States, have now converted to CAH status.

"As the majority of conversions have taken place, TASC has refocused to assist these stakeholders with other critical issues such as leadership, quality, performance improvement and health information technology," Hill said. "Our goal is to proactively meet states' needs so they have the best Flex programs possible. Often, that means identifying needs before being asked."

For instance, he said, four years ago TASC identified large turnovers in Flex program staff throughout the country. TASC created the Flex Program Orientation to "quickly get new state staff up to speed on the program so that they could be as effective as possible."

TASC's ongoing support provides states with consistent expertise. In 2004, Wyoming Flex Program administrators asked TASC to conduct a strategic planning session for program staff and others in the state. From that session a Critical Access Hospital network emerged. TASC also has helped state Flex programs and hospitals initiate statewide performance improvement and measurement programs.

"TASC has the ability to connect all these states and their hospitals and communities with information and resources that we've gleaned from our knowledge of the programs in all 45 states we work with now," said Tami Lichtenberg, TASC program manager. To really succeed, we need to work cooperatively with both health providers and community leaders. We match our resources to the needs in each state. The mantra right now is performance improvement, leadership and health information technology."

Last spring TASC conducted the first national survey of CAH health

*Terry Hill, director of the Technical Assistance and Services Center in Duluth, MN., says their goal is to help states have the best Flex programs possible.*



information technology (HIT). TASC also sponsors an annual Flex program conference for approximately 300 rural hospital and state program leaders as well as periodic national summit meetings on quality, leadership and health information technology.

TASC currently supports state Flex programs with a variety of services. In a typical year, staff members respond to about 800 requests for assistance and travel to 15 to 20 states providing on-site education and technical assistance. Lichtenberg noted that TASC also works directly with small, rural hospitals and communities, emergency medical services and networks, but always tries to keep states in the loop.

TASC offers education, resources and tools through its web site. Web site "hot topics" change continually, Lichtenberg said. "TASC tries to help states from having to reinvent the wheel by contacting each state for tools and resources, and then making them available on the Web for all to share. A lot of the most accessed tools and resources come from other states."

For more information on TASC, write the Technical Assistance and Services Center, 600 E Superior St. Suite 404, Duluth, MN 55802; phone 218-727-9390; email [tasc@ruralcenter.org](mailto:tasc@ruralcenter.org); or visit <http://www.ruralresource.org/>.

## Georgia Health Policy Center's Technical Assistance Program

More than 140 rural communities in 49 states are benefiting from research and support provided by the Georgia Health Policy Center, a technical assistance program established in 1995 and operated at Georgia State University. The Center works to improve, sustain and strengthen community health systems.

"More than a decade ago the Center's research team produced evidence that rural health care systems were more fragile than their urban counterparts," said Center Director Karen Minyard. "Since then, it has provided strategic support and tailored technical assistance to help some of the most rural, medically underserved regions of the country."

The Center helps communities connect public and private health providers, county governments, local foundations and social service agencies to explore ways to better serve the health needs of area residents. One of the Center's main programs, funded by a contract with the Office of Rural Health Policy (ORHP), is the Rural Health Network Development and Rural Health Care Outreach Services Technical Assistance Program (TAP). Working primarily with grantees that have received funding through ORHP's rural health network and outreach grants, the Center assigns each grantee an individual provider who coordinates technical assistance and educational programs specific to the grantee's needs.

One of the key components of TAP is its web site, which offers information on such topics as best practices, business planning,



*Director Karen Minyard (bottom row, center) and her staff at the Georgia Health Policy Center offer strategic support and tailored technical assistance to communities and providers in 49 states.*

collaboration and cultural competency. TAP also hosts periodic TAP Tele-Seminars on various subjects related to rural health grantee programs. Recent Tele-Seminar topics have included "Strategic Planning," "Program Evaluation," and "Experiences in Board Development." The next Tele-Seminar, scheduled for March 21, 2007, will discuss "The Relationship between Sustainability and Evaluation." The web site contains an archive of past Tele-Seminars, including PowerPoint presentations and information on how to access an audio replay of the most recent Tele-Seminar.

In addition, the Center has published reports and articles covering a variety of topics, such as strategic planning, legal issues, funding, technology and sustainability. Recently, responding to more requests on sustainability, Center staff has conducted three intensive sustainability projects for communities and given numerous presentations on this topic at national conferences, Minyard said.

For more information about TAP, write them c/o the Georgia Health Policy Center, 14 Marietta Street,

Suite 221, Atlanta, GA 30303; phone 404-651-3104; email Beverly Tyler, Research Associate, at [alhbat@langate.gsu.edu](mailto:alhbat@langate.gsu.edu); or visit <http://networkassist.ruralhealth.hrsa.gov/>.

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# Focus on Funding

A guide to rural funding opportunities and how to access them

## Funding for SCHIP Outreach

by Beth Blevins

The pending reauthorization of the State Children's Health Insurance Program (SCHIP) at the end of this fiscal year (September 30, 2007) is bringing about a renewed interest in health care for children. In rural areas, there have been several challenges in expanding SCHIP coverage, including finding providers for rural SCHIP enrollees within the 30-mile range designated for the program and finding the children to enroll, especially from isolated and frontier areas.

This guide offers a brief look at funding for outreach for public health insurance programs serving children.

### What is SCHIP?

SCHIP is a program that provides health insurance coverage to low-income children under age 19 whose family income is above that which would qualify them for Medicaid. It is run as a partnership between the federal government and state governments.

Each state runs its own version of SCHIP, sometimes as an expansion of its Medicaid program, sometimes as a separate child health program and sometimes as a combination program. Each state also sets its own perimeters for coverage and costs. For example, California's Healthy Families program offers the same coverage for families with different income levels, but sets premium based on three income categories and requires co-pays on most services. It also offers various plans according to county of residence, some through private insurers and some through community provider plans.

The federal web site for SCHIP is <http://www.cms.hhs.gov/home/>

[schip.asp](http://www.insurekidsnow.gov/states.htm). A list of state health insurance programs is available from the U.S. Department of Health and Human Services, at: <http://www.insurekidsnow.gov/states.htm>.

### Outreach for SCHIP and Other Public Health Insurance Programs

According to a Kaiser Family Foundation report, *Outreach Strategies for Medicaid and SCHIP* (<http://www.kff.org/medicaid/upload/7495.pdf>), outreach can include targeting those who are potentially eligible for a program, and making them aware of their eligibility; assisting those identified as eligible in actually enrolling in the program, and in renewing their coverage in the program at a later time if relevant; and ensuring their access to care within the program.

Outreach is especially important in rural areas because the population is more dispersed and access to care is often more difficult.

A brief look at state and national SCHIP outreach efforts is presented in the Alliance for Health Reform report, *SCHIP and Medicaid Enrollment: What's Next?* ([http://www.allhealth.org/Publications/pub\\_6.pdf](http://www.allhealth.org/Publications/pub_6.pdf)).

### Federal Funding for Outreach

The SCHIP statute permits up to 10 percent of states' SCHIP spending to be for administrative expenditures and outreach. In addition, other federal programs offer funding towards outreach efforts.

• The **Office of Rural Health Policy's Outreach Grant Program** is designed to encourage the devel-

opment of new and innovative health care delivery systems in rural communities that lack essential health care services. The emphasis of this grant program is on service delivery through creative strategies requiring the grantee to form a network with at least two additional partners. Grantees receive \$150,000 for the first year, \$125,000 for the second year and \$100,000 for the third year.

**Example of use:** The **Tulare County Children's Health Initiative (CHI)** in California is focused on increasing dental and medical health access for children ages 0-18 through outreach and enrollment into publicly funded programs and by offering a new gap insurance product, Healthy Kids, for children ineligible for state Medicaid (known as Medi-Cal) or the State Children's Health Insurance Program. The program received an Outreach grant starting in 2006. (For more on CHI and other Outreach grantees, visit the RAC's **Success Stories** web site at <http://www.raconline.org/success/>).

**For more information:** Contact Nisha Patel, Outreach Program Co-Coordinator, ORHP, 5600 Fishers Lane, 9A-55 (Rockville, MD 20857; phone: 301-443-6894; email: [NPatel@hrsa.gov](mailto:NPatel@hrsa.gov); or visit the Outreach Grant Program web site, at <http://ruralhealth.hrsa.gov/funding/outreach.htm>.

• The **Healthy Tomorrows Partnership for Children Program (HTPCP)** is a cooperative agreement between the federal Maternal and Child Health Bureau (MCHB) and the American Academy of Pediatrics (AAP). Federal grants of \$50,000 per year for five years are awarded annually through the

program to support community-based child health projects that improve the health status of mothers, infants, children and adolescents by increasing their access to health services. Program requirements include direct health services, pediatrician involvement and \$100,000 non-federal matching funds in years two through five. Ten new grants are awarded annually.

**Example of use:** A 2006 grant was awarded to **Starting Points for Idaho Youth**, which aims to reach uninsured youth with information about state health coverage programs, with a goal of enrolling 1,500 eligible youth in rural Idaho counties in the state's health insurance coverage programs.

**For more information:** Healthy Tomorrow Partnership for Children Program, Division of Community-based Initiatives, (AAP, 141 NW Point Blvd., Elk Grove Village, IL 60007-1098; phone: 847-434-4000; email: nmiller@aap.org or kpalmer@aap.org; or visit <http://www.aap.org/commpecds/htpcp/>.

## Private Funding for Outreach

• **Covering Kids & Families**, a project of the Robert Wood Johnson Foundation, works to reduce the number of uninsured children and adults who are eligible for low-cost or free health care coverage programs but are not enrolled. The project promotes the Back-to-School Campaign, a nationwide effort encouraging parents to enroll their eligible, uninsured children in Medicaid or SCHIP. It has worked with coalitions in 50 states and the District of Columbia, with more than 5,500 member organizations. Since 1997, the program has invested more than \$150 million in this campaign. **Note: Additional grants are no longer available, but**

**the project offers other means of support (see below).**

**Past examples of use:** The nonprofit coalition, **New Mexico Covering Kids**, worked with the local Human Services department in Dona Ana County and with the El Paso Electric Company to design and distribute a billing statement insert promoting New Mexikids, the statewide children's health insurance program. The insert was distributed to 65,000 households.

**For more information:** The project's web site, <http://coveringkidsandfamilies.org/>, offers ideas on outreach activities, free promotional materials for distribution, and allows organizations to advertise their outreach events and efforts. For a list of projects in each state, and who to contact for each program, visit <http://coveringkidsandfamilies.org/projects/>. For more information on how to get involved in Covering Kids and Families, email Elaine Arkin at [earkin@rwjf.org](mailto:earkin@rwjf.org).

• The American Academy of Pediatrics also offers the **Community Access to Child Health (CATCH)** program. The CATCH program works to improve access to health care by supporting pediatricians and communities that are involved in community-based efforts for children. CATCH Implementation Funds, Resident Funds and Planning Funds can be used to support SCHIP outreach. Grants of up to \$10,000 are awarded each year on a competitive basis.

**Example of use:** A 2006 grant, **Increasing Access to the Medical Home**, aims to identify uninsured, low-income families utilizing an inner-city emergency department and assist them with the Medicaid/SCHIP enrollment process.

**For more information:** CATCH Program, Division of Community-based Initiatives, AAP (see address

above); phone: 847-434-7085; email: [catch@aap.org](mailto:catch@aap.org); or visit: <http://www.aap.org/catch/>.

## Additional Resources

For more on the topic of SCHIP reauthorization, see the SCHIP Reauthorization Resource Center, <http://ccf.georgetown.edu/schip.html>.

For information on health insurance coverage for rural children, including SCHIP, see the RAC's **Health Insurance** information guide at: [http://www.raconline.org/info\\_guides/insurance/](http://www.raconline.org/info_guides/insurance/).

## GENERAL FUNDING INFORMATION

For general information on all kinds of funding sources, see RAC's Funding Guide: <http://www.raconline.org/funding>.

You may also call the information specialists at the RAC, who can assist you in your search for information on SCHIP Outreach or other kinds of funding. Contact them at (800) 270-1898 or by email at [info@raconline.org](mailto:info@raconline.org). Please include the following information in your request: your name and organization; the type of project you are interested in funding; and the location for your project: city, county and state.

“The parental involvement, from the decision-making process to volunteering in the classrooms, is one of the most successful areas of Head Start,” Greene asserted. “Every program has national program performance standards, but within those standards are opportunities for local needs to be developed.”

A governing board, with 51 percent of its membership comprised of parents and community leaders, determines program direction. Federal funding, allocated by the Administration for Children and Families, is distributed to local grantee boards. About one-third are school boards, one-third community based organizations, and the remainder various local entities. Head Start services are based on family income. In 2006, for instance, a family of four with an income below \$20,000 would qualify for services.

Providing services in rural areas presents additional challenges, Greene said. Lack of transportation and unavailability of professional health care providers top the list. “Every one of our 55 counties must provide transportation for the children,” Gooch-Erbacher said. “We wouldn’t be able to service them without having transportation.” (See “Getting Children Where They Need to Go,” pg. 4).

Gooch-Erbacher added that West Virginia has “a horrific time getting oral health needs met in every one of our counties.” That holds true across the nation. “Limited access to oral health care is the most pressing health need for Head Start and Early Head Start children,” reported Head Start health specialist Robin Brocato in a 2006 address to the American Dental Education Association.

Dentists aren’t the only shortages. Other areas of medicine are in limited supply in rural areas, including pediatricians and family practice physicians. And many rural centers experience difficulties recruiting licensed teachers and social workers.

## GET CONNECTED

For more information on rural children, please see the following:

- RAC information guides on:
  - Child Care, [http://www.raconline.org/info\\_guides/child\\_care/](http://www.raconline.org/info_guides/child_care/)
  - Child Support, [http://www.raconline.org/info\\_guides/child\\_support/](http://www.raconline.org/info_guides/child_support/)
  - Child Welfare, [http://www.raconline.org/info\\_guides/child\\_welfare/](http://www.raconline.org/info_guides/child_welfare/)
  - Rural Schools, [http://www.raconline.org/info\\_guides/schools/](http://www.raconline.org/info_guides/schools/)
- RAC “Funding by Topic” pages on Children, Child Welfare, Child Care and Schools, accessible from [http://www.raconline.org/funding/funding\\_topic.php](http://www.raconline.org/funding/funding_topic.php).
- Success Stories on Children, [http://www.raconline.org/success/success\\_topic\\_details.php?topic=Children](http://www.raconline.org/success/success_topic_details.php?topic=Children).
- Maps on Child Care and Youth, accessible from the RAC’s Maps page, <http://www.raconline.org/maps/>.

At least half of all Head Start teachers in center-based programs must have an associate, baccalaureate, or advanced degree in Early Childhood Education or a degree in a related field, with preschool teaching experience. To help teachers get their degrees, the NHSA created the Heads Up! distance-learning initiative, through which more than 2,000 Head Start sites can access a satellite television network that offers continuing education training and courses for college credit.

Even with the added challenges in rural areas, research from the Head Start Impact Study and elsewhere indicates that Head Start children are in better overall health, more likely to have had their immunizations, and show reduced frequency and severity of problem behavior than counterparts not enrolled in

pre-school readiness programs. A study of five-to-nine-year old children enrolled in Head Start as preschoolers concluded these children demonstrated increased confidence, better coping skills and decreased feelings of anxiety. And FACES research shows that Head Start students in recent years have made significant gains in vocabulary, early math and early writing.

Still, for many parents, the value of Head Start is in the effect it has had on them and their children.

“It’s nice to be able to come here and know we’re not forgotten, that we can brush up on our skills and our kids can get the advantage of Head Start learning,” Thomas said. “When you get better self esteem, you pass that on to your kids too.

“Head Start is just an awesome program.”

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## Continued from *Rethinking Human Services*, page 4

*Tom Corbett has emeritus status at the University of Wisconsin-Madison and is an active affiliate with the Institute for Research on Poverty where he served as Associate Director. He has worked on welfare reform issues at all levels of government and continues to work with*

*a number of states on issues of program and systems integration.*

**Opinions expressed in this column are those of the author and do not necessarily reflect the views of the Rural Assistance Center.**