

Public Health and Rural America:

Ready AND Not!

Compelling Stories from the Front Lines of Public Health Preparedness in Rural America and Lessons for Policymakers

ARE WE READY?

Five years after the largest influx of new federal funds into the public health system ever, how prepared are we to respond to emergencies affecting population health? This question is being asked in Washington, D.C., as Congress considers reauthorization of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002. It is also being asked in state capitals, as governors and legislators review their states' emergency plans in the wake of Hurricanes Katrina and Rita, and by residents in communities across the U.S., as people acknowledge the 5th anniversary of 9/11 and the threat, and the fear, of pandemic influenza grows.

Understandably, public attention has focused on the preparedness of America's larger cities, which are centers for national and international travel and commerce, and where concentrated populations are vulnerable to terrorism, communicable disease, and natural disaster. However, rural communities are not immune to such emergencies and are, in some unique ways, more vulnerable than larger cities. Rural communities, with their fragile infrastructure often serving vast expanses of territory, are at risk for profound devastation during an emergency, and slow and inadequate recovery in its aftermath. Although fairly isolated from resources located outside their regions, such isolation offers little protection, particularly against infectious disease. When asking "Are we ready?" we must remember two fundamental truths about public health preparedness: We are only as ready as we are today; and we are only as ready as the least prepared of our communities.

To learn more about the preparedness of some of America's rural areas and the obstacles they face, journalists traveled to Mississippi, Nebraska, and Northern Maine in early 2006 to hear from people on the front lines of public health planning. Although reauthorization of emergency preparedness monies is vital to this effort, rural communities have unique needs that must be integrated into planning at the local, state, and national levels and that should inform public health policy and appropriations going forward. Some of these challenges are summarized below.

THE CHALLENGES TO PREPAREDNESS IN RURAL AMERICA

Communication challenges:

Although the need to communicate with diverse populations is not unique to rural areas, the problem in securing appropriate resources puts rural communities at a distinct disadvantage. Language and trust issues and the shortage of bilingual/bicultural professionals pose problems for public health personnel in Northern Maine, who must engage American Indian tribes in planning; in Mississippi, for health care staff assisting migrant workers who are rebuilding housing destroyed by Katrina; and in Nebraska for health care workers vaccinating non-English speaking populations against Rubella.

Public health threats, such as infectious diseases, do not respect state and international boundaries. The ease with which such threats can travel necessitates the ability to share surveillance data with public health officials in neighboring states and in Canada. Today, incompatible databases prevent easy sharing of surveillance data across state lines and international borders, posing unique challenges to tracking the spread of disease among Midwestern states and between Maine and Canada.

Resource challenges:

All communities require health care staffing and clinical resources, interpreters, transportation/roads, power, water supplies, laboratory and other resources to ensure preparedness. However, rural communities are more likely to rely on outside support to weather an emergency. The resources of a neighboring state are often closer and more feasible to access than those of a community in their respective states. But those resources are only useful if they can reach a needy community in time. Increased resources to strengthen the infrastructure of rural communities and policy changes that make it easier to rely on mutual aid are necessary to address the potential impact of such resource deficiencies. The Mid-America Alliance, a collaboration of 10 states formed to strengthen preparedness in the Midwest, offers a model for multi-state mutual aid.

"You have to draw a border for political reasons, but contaminated food, water and infectious diseases don't recognize those lines."

Mary Jude,
Maine Tribal Epidemiologist

Maine Center for Public Health
MCPH.org

Policy challenges:

Perhaps urban and suburban areas would benefit from policy changes that remove impediments to cross-border planning and response. However, for rural areas like Nebraska and Northern Maine, which must maximize relationships across state and international borders, respectively, such change is a necessity. For example, federal resources should be made available to support multi-state collaborations. The authority to make agreements with other countries related to emergency preparedness for the purposes of mutual aid is also vital for border states. As experienced by Mississippi residents following Katrina, changes in Medicaid rules are needed to allow reimbursement in other states for evacuees. Finally, licensure and legal issues (privacy, licensure, workers compensation) that present obstacles to health department collaborations across state and international borders must be addressed. Support for compatible data systems is also needed to allow for sharing of surveillance data among public health entities.

Planning challenges:

The more isolated a community and the further the distance between communities, the more important it is to emphasize certain household and local community preparedness issues in rural emergency plans. Families must stockpile the medications, water, and food they need for a prolonged emergency. Evacuation plans are necessary to prevent panic and save lives. Shelters designed to care for residents with special needs (e.g., elderly, sick, disabled) should be part of local emergency planning and well publicized in advance of a crisis. Flood insurance and safer storage (e.g., further inland/out of state) of patient data and health care financial records are needed to support faster recovery of the health system after an emergency.

"It's something [the rubella outbreak] that lives in the back of everyone's minds. It really stretched our capacity... If the Mid-America Alliance had existed then, it could have tapped resources in other states to help."

Dr. Joann Schaefer,
Nebraska's Chief Medical Officer

WHERE DO WE GO FROM HERE?

The public health challenges of the 20th century were not solved in half a decade. The daunting task of retooling public health to assure preparedness for all types of natural and human-made threats will also take time. Reauthorization of the Public Health Security and Bioterrorism Preparedness and Response Act is a critical next step. Rural communities will indeed require increased support to help them find creative, cooperative solutions to the unique challenges they face. Strengthening the preparedness of rural communities will help shift the balance of readiness to more ready than not. However, a solid foundation on which to build public health preparedness will also shift the balance and benefit all communities. Clear national policy based on the principles articulated below will establish such a foundation.

Sustainability:

Funding available to state and local public health agencies should be restored to \$1.3 billion, the level funded in FY2005. The funding should be provided in multi-year awards that have meaningful-yet-flexible state and local funding match.

Accountability:

Public health agencies must be held accountable to a set of reliable and valid national public health preparedness performance standards. These standards, while specific to all hazards preparedness, response and recovery, should be a part of overarching public health performance standards on the national, state and local levels. Financial accountability, including meaningful assurance by agencies of not supplanting existing state and local public health funding, must be addressed as well.

Flexibility:

Innovative practices by state and local public health agencies that address the unique risks, resources, vulnerable populations, health care industry/system characteristics, metropolitan or rural regional circumstances, Native American tribes, and international borders must be encouraged. While meeting the national performance standards, state and local agencies must have the flexibility to use funds to build the unique public health enterprise in their jurisdiction, assuring it has a real role in the all-hazards public health emergency prevention, preparedness, response and recovery process.

Connectivity:

Official state and local public health agencies must demonstrate operational coordination and collaboration with all the community components of the broader public health enterprise, particularly with emergency management, public safety and health care system partners.

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