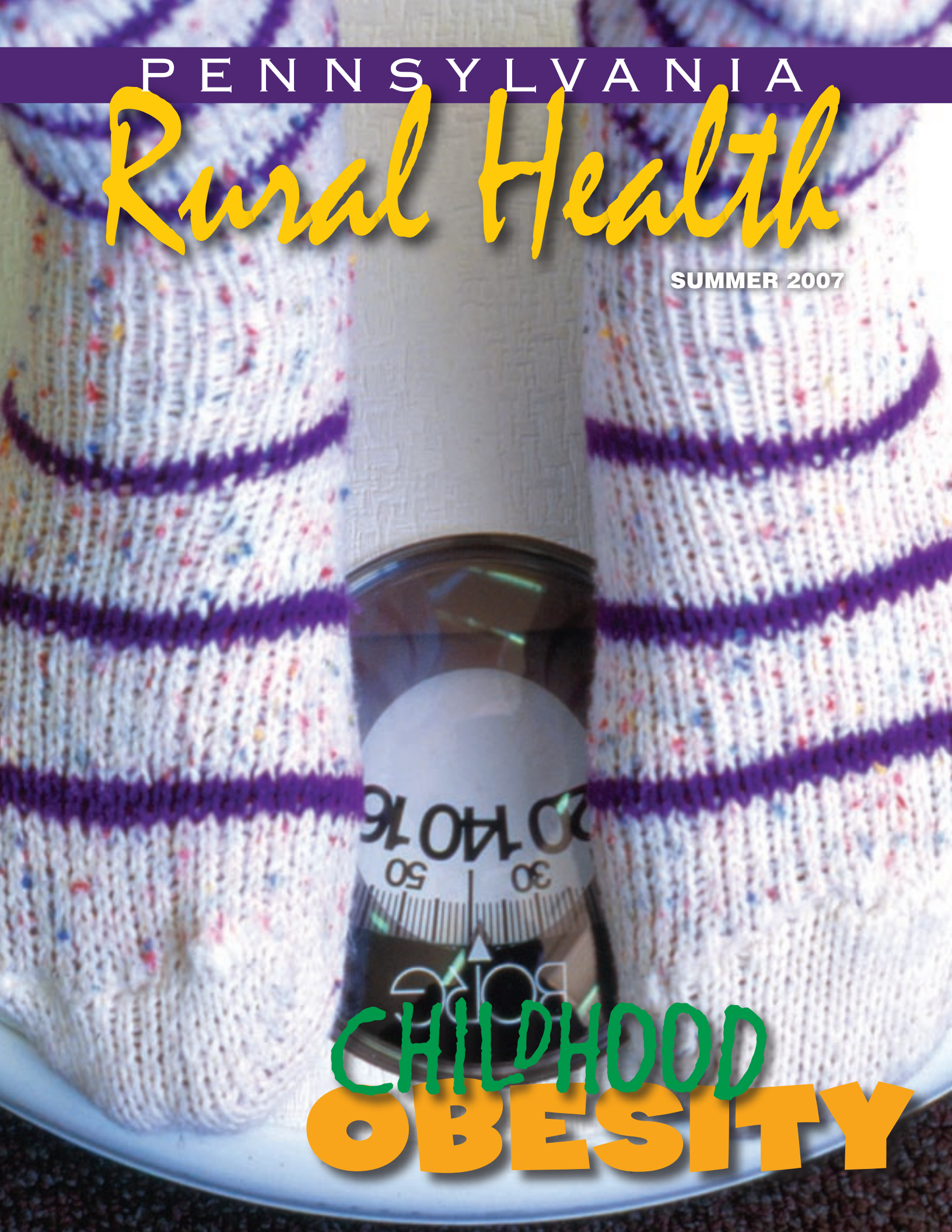

PENNSYLVANIA

Rural Health

SUMMER 2007

CHILDHOOD OBESITY

CONTENTS

3 **Prescription for Pennsylvania: Gov. Rendell Proposes Changes in Pennsylvania Health Care**
By Alan Finnecy

5 **Childhood Obesity**
By Alan Finnecy

8 **Pennsylvania Rural Health Association: The Voice of Advocates for Health Care in Rural Pennsylvania**

9 **Department of Health BRFSS Local Sampling Program Provides Rich Source of Data**

11 **Peterson Named "Rural Health Legislator of the Year"**

Vorberger Receives National Rural Health Association Award

12 **Penn State Cooperative Extension Prevention Program Sees Results**

13 **Research on the Run**

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FROM THE DIRECTOR | LISA DAVIS

WELCOME to the second issue of *Pennsylvania Rural Health*. The inaugural issue received very favorable comments, reinforcing PORH's commitment to offer through this publication expanded opportunities to showcase the significant efforts of rural health advocates and providers in the state.

Since the last issue, much has happened in the state and nationally that will have a substantial effect on the delivery of healthcare services. On January 17, Pennsylvania Governor Ed Rendell announced the Prescription for Pennsylvania, joining the Commonwealth with a number of other states that have addressed the complex issue of providing health care access to all residents. The Governor's plan, which focuses on health insurance, affordability, access and quality, is summarized in this issue. Over the coming months, the response to the plan and the work that needs to be accomplished in order to implement the needed legislation and regulation, will prove to be interesting.

On the national level, President George Bush announced in February his plan to address the health care needs of the nation. His plan replaces most current tax exclusions and deductions for health insurance premiums and out-of-pocket costs with a new $7,500 or $15,000 standard deduction in the federal income tax, as well as an exemption from payroll taxes-for all taxpayers who obtain qualifying health insurance. The plan also eliminates the current emphasis that focuses on health insurance obtained through employers, provides tax incentives for the purchase of health insurance in the private market and reduces current tax incentives to overspend on health care services.

And the president released his proposed budget for 2007–08 which, while it includes level funding for some rural health safety net programs, including Community Health Centers, also zeros out support for other programs such as rural emergency services, Area Health Education and Health Education Training Centers as well as geriatric programs. As in previous years, rural health advocates look to members of Congress to assure funding for the programs that help to serve the health care needs of rural Americans.

Discussion on the 2007 Farm Bill, announced last fall, continues with the proposed support for rural development, capital expenditures for Critical Access Hospitals, rural infrastructure and food and nutrition programs. The 2007 Farm Bill and the sixty-five proposals that comprise this five-year plan, offers support for rural communities and may well be a selling point to those communities during the 2008 Presidential campaign.

So, there is much to consider. The national and state legislative landscape will be the focus of the **2007 Pennsylvania Rural Health Conference**, set for June 12–13 in State College. The conference will kick off with a keynote presentation from the president and CEO of the National Rural Health Association and include panel presentations with key leaders from the National Conference of State Legislatures and the Pennsylvania Office of Health Care Reform. I hope that you will join us!

AS ALWAYS, thank you for your support of your state office of rural health. Please continue to stay in touch.

Prescription for Pennsylvania

BY ALAN FINNECY

FOLLOWING on his *Cover All Kids* and PACE/PACENET initiatives, Governor Rendell in January proposed sweeping changes addressing health care in the state in his proposed "Prescription for Pennsylvania." The Governor's plan outlines three major target areas: providing affordable basic health coverage to small businesses and the uninsured, increasing access to health care, and improving quality. The plan also calls for measures to improve the affordability of health care through greater efficiency and effectiveness. The Governor's office has estimated that forty-seven pieces of legislation will need to be addressed to implement the plan.

The Governor's plan outlines three major target areas: providing affordable basic health coverage to small businesses and the uninsured, increasing access to health care, and improving quality.

HEALTH INSURANCE

The Governor has proposed a new program—Cover All Pennsylvanians (CAP)—to replace the existing adultBasic program administered by the Pennsylvania Insurance Department. The program would provide health insurance through the private market for businesses with fifty or fewer employees and uninsured individuals. Employers who choose to join the program would pay approximately $130 per employee per month with employees paying from $10 to $70 per month, depending on their income. Every uninsured adult who earns more than 300 percent of the federal poverty level would be able to participate by paying the full premium of approximately $280 per month. The state would subsidize those with incomes below 300 percent of the poverty level. For example, a family of four earning $60,000 or less per year would be eligible for assistance. Coverage under CAP would add pharmaceuticals and behavioral health coverage to those services already covered by adultBasic such as physicians, tests, emergency, hospitalization, maternity, rehabilitation and skilled care. The program will be voluntary, in its initial stages. The Governor's plan also calls for requiring all full-time students at four-year colleges and universities in Pennsylvania to have health coverage for admission and continued study.

To fund the plan, the Governor proposes dedicated taxes on smokeless tobacco and cigars and an increased tax on cigarettes. Businesses not providing health insurance could be assessed three percent of their payroll to help fund the plan. Other possibilities include restructuring the tobacco settlement and continued use of Blue Cross community reinvestment funds, among others.

ACCESS

To promote greater access to primary care providers across the state, the Governor's plan outlines several approaches aimed at decreasing unnecessary and costly emergency room visits. One strategy would provide financial incentives for primary care providers to offer evening and weekend hours. The Governor also wants to ensure that nurses, advanced nurse practitioners, midwives, physician assistants, pharmacists and dental hygienists can practice "to the fullest extent of their education and training" and are appropriately recognized and compensated by insurers. To further decrease expensive emergency room visits for routine medi-

For more information on the plan, visit the Governor's Office of Health Care Reform at www.ohcr.state.pa.us/ or call 717-772-9022.

cal concerns, the Governor also proposes all general acute care hospitals with emergency rooms to establish a service providing non-emergent care.

The Governor's plan also recognizes the need for continued health care workforce development in the state, including attracting and retaining health care providers in underserved areas. John George, president of the Pennsylvania Rural Health Association (PRHA) suggests adding more residency opportunities in rural areas. "Most doctors locate within fifty miles of where they trained as residents," George explains. "By the time they are finished with their residency they are invested in the community and more likely to stay." Lisa Davis, director of the Pennsylvania Office of Rural Health (PORH) says the Pennsylvania Department of Health's Primary Care Loan Repayment Program is another successful incentive for attracting primary care providers to underserved communities. "That program currently provides loan repayment for primary care practitioners to serve in medically underserved areas." Davis says. She says the Governor is now proposing 100 percent loan repayment for primary care providers in qualifying underserved areas.

The Governor's plan also addresses the state's changing population. One goal is to increase the diversity of the health care labor force. A more specific measure would require hospitals to provide their patients with access to real-time language translation services.

QUALITY

The Governor's plan proposes wide-ranging changes aimed at improving the quality of hospital care, better management of chronic disease, addressing long-term care needs and greater efforts in palliative care.

Improving hospital quality, the Governor says, would not only benefit patients but create potential savings for insurers and government programs as well. One initiative would require hospitals to adopt and implement system-wide quality management and error reduction systems. As further incentive, the Governor is proposing that Medicaid and other government programs, over time, would cease paying for care associated with medical errors and hospital-acquired infections. To increase efficiency and quality, the plan also would require hospitals to develop a plan by 2008 to implement interoperable electronic medical records.

To combat the high percentage of health care costs associated with chronic diseases, the Governor's plan proposes incentives to encourage effective prevention and treatment of diseases such as asthma, heart disease and diabetes. Wellness initiatives such as creating smoke free environments in all restaurants, bars and workplaces and expanding school children's access to school breakfasts and nutritious foods throughout the day also could help reduce the incidence of chronic diseases associated with smoking and obesity.

Since long-term care, like chronic disease, accounts for large percentages of the state's funds spent on health care, the Governor's plan seeks to increase the availability of home- and community-based living services as an alternative to more costly skilled-care facilities. He also wants to increase Pennsylvanians' planning for, and purchase of, long-term care insurance. The plan also addresses improving palliative care options for end-of-life patients.

AFFORDABILITY

Underlying the Governor's many proposals is improving the affordability of health care—from reducing unnecessary emergency room visits to reducing the cost of caring for the uninsured by providing affordable health insurance. The Governor's plan calls for specific measures such as requiring that hospitals comply with standard billing and collection practices and assist uninsured individuals in enrolling in coverage programs. He also wants greater transparency on costs by collecting and reporting on average hospital payments for procedures and monthly reporting on prices for the most commonly prescribed drugs.

GOVERNOR RENDELL sees his "Prescription for Pennsylvania" as the first dose of necessary medicine—not the final cure—to what he's identified as the state's health care ills. "The Governor was right when he said 'almost everyone will be unhappy with some part of this but we have to do it,'" says Davis. "Unfortunately, there is no perfect solution."

The Pennsylvania Rural Health Association has developed a white paper that reviews the effect of the proposed "Prescription for Pennsylvania" on the delivery of health care services in rural areas of the state and provides recommendations for action. The white paper can be accessed on the association's Web site at **www.paruralhealth.org**.

Alan Finnecy *works as an attorney and freelance writer. He is a graduate of Penn State's College of Health and Human Development and the University of Pittsburgh School of Law. He lives in rural Central Pennsylvania.*

Dr. John George, Lisa Davis, U.S. Rep. Peterson, and Alison Hughes

Peterson Named Rural Health Legislator of the Year

UNITED STATES Rep. John E. Peterson (PA-05), co-chair of the Congressional Rural Caucus, has been selected as the 2006 Legislator of the Year by the National Organization of State Offices of Rural Health (NOSORH), one of the nations leading rural health advocacy groups.

The annual award recognizes a legislator who is helpful in advancing a legislative agenda that supports programs and initiatives that increase the health and well-being of rural communities. The award was presented to Peterson by NOSORH President Alison Hughes, Dr. John George, president, Pennsylvania Rural Health Association, and Lisa Davis, director, Pennsylvania Office of Rural Health during a ceremony in Rep. Peterson's Washington office on February 27, 2007.

"Congressman Peterson has a strong reputation within Pennsylvania and throughout the nation as a champion of programs and funding that support the delivery of health care services in rural areas. We look forward to his continued leadership as we seek effective ways to provide high quality, affordable, and accessible healthcare for rural residents," said Davis who also serves as the co-chair of the NOSORH policy committee.

"I am honored by this recognition and would like to thank NOSORH and their leadership for being strong advocates for rural health care here in Washington" said Peterson, a member of the Appropriations subcommittee with jurisdiction over rural health care funding. "When communities in rural America are cut off from quality health care services, nobody wins, not our residents, not the taxpayers, not the urban and suburban health care facilities—no one benefits when folks in rural America are deprived access to preventive care, emergency care, or prescription drugs. As we begin the 110th congress, I look forward to working with the NOSORH and my fellow members of congress to further advance comprehensive affordable healthcare in rural America."

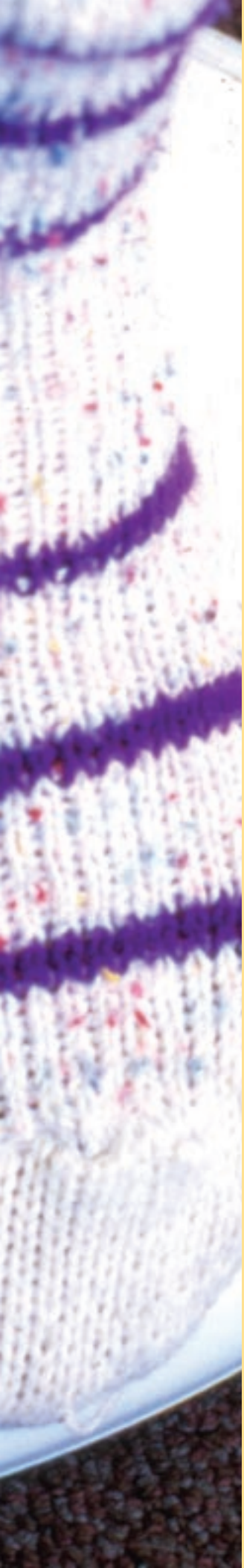
NOSORH was created in 1995 by the State Offices of Rural Health to promote a healthy rural America through state and community leadership. Its membership is comprised of the fifty state offices of rural health. Find out more at www.nosorh.org.

Vorberger Receives NRHA Legislative Award

Jeff Vorberger, legislative director for U.S. Representative John Peterson (R-PA) received the National Rural Health Association's 2007 Legislative Award. Jeff has been instrumental in continually making a strong case for the rural health safety net to the House Appropriations Committee Republican staff. Both Jeff and his boss were key forces behind the scenes this year in ensuring that rural health programs were not singled out for funding cuts in the fiscal year 2007 appropriations process. Furthermore, his insights into the appropriations process have helped NRHA to devise our appropriations strategy. Jeff also was proactive in ensuring that his boss's support for the extension of rural health provisions from the Medicare Modernization Act was known to key House Members negotiating the Tax Relief and Health Care Act of 2006.

ALARMING TREND SEEN IN RURAL PA CHILDREN

CHILDHOOD OBESITY



However you slice the pie, Americans should be eating less of it.

BY ALAN FINNECY

The increase in overweight and obese adults and the resulting health consequences—diabetes and heart disease are the most common—is well documented. To fight obesity, medical professionals and researchers are intervening before adulthood, where rates are also increasing. The Centers of Disease Control and Prevention (CDC) reports that the number of overweight school-aged children has tripled in the past thirty years. Nationwide, one in three children is overweight (Body Mass Index of 25-30) and one in seven is obese (BMI greater than 30). In Pennsylvania, an estimated 20 percent of all middle school-age students are overweight. When the Center for Rural Pennsylvania compared body-mass index data on 25,000 seventh graders from rural and urban communities several years ago, they found that 20 percent of rural students were overweight or obese compared to about 16 percent of urban students. Even more alarming was the fact that the number of overweight and obese students in rural Pennsylvania rose at twice the rate of their urban counterparts during the period studied.

Nationally, the steady rise in overweight and obese children has been blamed on everything from fast food and high-calorie juices and soft drinks to the number of hours the "Nintendo Generation" spends in front of computer screens. But what accounts for the fact that obesity rates in rural children are climbing faster than for urban or suburban kids? As researchers try to answer that question, everyone from schools to nutrition advocacy groups in the state, is already working to reverse the trend and improve the health of Pennsylvania's children.

LIMITED OPTIONS

Few people realize that lush, green Pennsylvania also contains significant deserts: "food deserts," that is. Penn State education professor and director of the Center on Rural Education and Communities (CREC) Kai Schafft recently mapped the state's food deserts. Schafft used various data—including GIS mapping software—to determine areas within the state where people live more than ten miles from a large grocery or retail food store. Because BMI data are available for all school children, Schafft used Pennsylvania's 501 school districts rather than counties as his unit of analysis. He found that school districts in rural food desert areas are more likely to be socio-economically disadvantaged and exhibit higher levels of poverty and food insecurity. Schafft also found that, independent of that economic disadvantage, children schooled within food deserts are at greater risk of obesity. One explanation, he says, is that within these food deserts, residents often rely more on convenience stores which stock mostly high-calorie processed foods and few, if any, fresh fruits and vegetables. "The food choices that people make are limited to what is available to them," Schafft says. "In areas where there are limited options for purchasing food from full-scale grocery outlets, research shows that there is a higher risk of overweight and obesity. And that's what we're seeing among rural children in Pennsylvania."

Food insecurity—not always having enough to eat, which affects nearly 10 percent of Pennsylvania households each year—at first seems unlikely to contribute to obesity. Not so, says Berry Friesen, executive director of Pennsylvania Hunger Action Center (PHAC), a non-profit group dedicated to ensuring food security for all Pennsylvanians. "People who are food insecure can't afford to eat a balanced diet so they load up on carbohydrates, which are cheaper and more widely available," he explains. "In the short term, high carbohydrate foods give you

more energy for your dollar but because these foods often also have high fat and salt content, you get the associated health risks." Friesen says another deterrent to healthy eating is the difference between the USDA's recommendations for daily servings of fruit and vegetables and what a family receiving food stamps realistically can buy. "It turns out that food stamps for a family of four only would buy enough fresh vegetables and fruit for, maybe, one person," he says. Groups like PHAC are hoping the farm bill Congress is considering this year will address this disparity by increasing food stamp allowances.

Friesen says schools that don't offer breakfast to their students also could be contributing to rising obesity rates in children. "A student who hasn't had breakfast, in addition to not performing as well in school, is more likely to snack and snacks are more likely to be high in carbohydrates and fat," he says.

START WITH SCHOOLS

As research continues into the causes behind the rising rates of overweight and obese children, groups across the state are working on various strategies to reverse the trend. Because children spend the majority of their time at school, much of the focus on improving nutrition and increasing activity is directed there. Since 2004, school nurses have been calculating body mass index as part of annual student health screenings to determine students' risk for being underweight, overweight or obese. Parents receive a letter with their child's BMI rating and the state gets an annual "snapshot" of what percentage of children are overweight and obese. The data also prompt many schools to act: improving the nutritional values in school food choices, increasing opportunities for physical activity and educating everyone involved on the importance of making these changes.

One group working to improve the health of the state's children is Pennsylvania Advocates for Nutrition and Activity, or PANA, established by the Pennsylvania Department of Health with funding from the CDC. One of their successful programs is the Keystone Healthy Zone Schools Campaign that offers training, technical assistance and $2,000 mini-grants to schools wanting to improve nutrition and physical activity. "It doesn't take millions of dollars to get schools launched on this path," says Allison Topper, PANA's executive director. "It just takes seed money, some resources and support." In three years, the number of schools participating rose from 912 to nearly 1,700. Topper says the schools that have been most successful in making changes have involved the entire school community—parents, physical education teachers, school nurses, food service directors, consumer science teachers and other staff members. Mini-grant recipients have used the money for efforts as simple as hiring a crossing guard so more kids can walk to school to providing Pennsylvania-grown apples for snacks.

PANA offers schools a Web site overflowing with helpful hints—"offer more raw vegetables to students and bake fries and chicken instead of deep frying"—and examples of what other schools have tried. In one central Pennsylvania rural district, the school nurse used the BMI data she collected (showing that 42 percent of the district's high school students were overweight) to convince school officials that changes were necessary in the snacks and lunches offered at school. The school now limits the sale of high-calorie, low-nutrition foods like chips and donuts and health teachers include more nutrition education to teach students to make healthy choices. Titusville School District in Western Pennsylvania changed the focus of its physical education classes from traditional competitive individual and team sports to personal fitness. Now, success isn't measured by wins and losses but if students, using heart monitors, keep their heart rate in their target zone while using cardiovascular and strength training equipment or playing games like "heart rate Frisbee." Other schools have restored recess and added minutes back to their physical education periods, both cut to provide more academic time to meet performance standards and No Child Left Behind mandates.

In the cafeteria, PANA cites the 2,345-student Southern Tioga School District as a good example of how many small changes add up to healthier eating. There, the food service director has worked for years on reducing the fat content in student lunches by using more turkey products and low-fat dressings and mayonnaise, among other measures. The district does not sell chips, substituting pretzels and a low-fat snack mix instead. Southern Tioga also strives to serve more fresh fruits and vegetables, recognizing that school is often the only place where many students will have the opportunity to eat fresh produce.

BUY LOCAL

Getting more fresh foods into school cafeterias—through Farm-to-School, or FTS, programs—could prove to be another effective tool in reducing obesity rates among children. FTS programs not only improve the nutritional quality of school meals but enhance markets for local farmers and offer potential savings for tight food service budgets. As

SEE **OBESITY** ON PAGE 15 ➲

MORE INFORMATION

For more detailed information on programs and groups working on issues mentioned in this article, visit:

Pennsylvania Hunger Action Center (PHAC)
www.pahunger.org

Pennsylvania Advocates for Nutrition and Activity (PANA)
www.panaonline.org

The Food Trust
www.thefoodtrust.org

Center for Rural Education and Community (CREC)
www.ed.psu.edu/crec

The Center for Rural Pennsylvania
www.ruralpa.org

Pennsylvania Rural Health Association

THE PENNSYLVANIA Rural Health Association, PRHA, is dedicated to enhancing the health and well-being of Pennsylvania's rural citizens and communities. Through the combined efforts of individuals, organizations, professionals and community leaders, the Association is a collective voice for rural health issues and a conduit for information and resources.

There are unique challenges that affect the delivery of quality health services to the rural population of the Commonwealth. These challenges include geographic barriers, sparse population and a shortage of health care providers. One of the goals of the Association is to make a difference in the health care in rural areas of Pennsylvania through policy, regulation, legislation, activism and involvement.

The burden of providing quality health care services is directly affected by the growing elderly population, the lack of public transportation and limited access to primary care providers. Elderly patients have increased health risks, poorer physical condition and limited income. There is a greater reliance on the government programs of Medicare and Medicaid which increases the vulnerability of hospitals and health care providers. In rural communities poverty is more prevalent, public transportation is lacking and there are a limited number of health care providers. Secondary to these limitations, the elderly have a greater reliance on others and a higher percentage of undiagnosed, untreated medical conditions, which, in turn, lead to disease progression and more costly emergency care. These findings lead to a compromised ability of the elderly to maintain their independence and remain in their own homes. Rural communities often lack adult day care, personal care homes, and low-income housing which put the elderly further at risk.

The future of all communities depends on the health and well-being of all citizens, especially children. Hospitals and primary care providers are the key to the delivery of quality health care in the community. Hospitals are especially critical because of the in-patient and acute care services they provide and the economic value to the communities where they reside. Access to this health care system is hampered by the limited numbers of primary care physicians in rural areas. In the Commonwealth, only 12 percent of all primary care physicians practice in rural areas which severely limits the availability and timeliness of patient appointments.

PRHA is composed of individuals and organizational members interested in providing leadership on rural health issues. Members include health care professionals and administrators from private and public settings, state and local government leaders, researchers, educators, consumer groups, consultants, and others who are concerned about rural health. It is a nonprofit organization governed by an all-volunteer, elected Board of Directors.

The Pennsylvania Rural Health Association invites new members to strengthen the rural health voice. The benefits of membership include advocacy for rural health within the state and nationally, state and federal legislative action and updates, data and information on rural health status in Pennsylvania, linkages to the Pennsylvania rural health network, opportunities for leadership development, professional and community networking, technical assistance, and reduced registration fees to state rural health conferences and training programs.

Participate in the association's initiatives and be a strong voice for rural Pennsylvanians. To learn more about the Pennsylvania Rural Health Association, visit **www.paruralhealth.org** or call 717-561-5248.

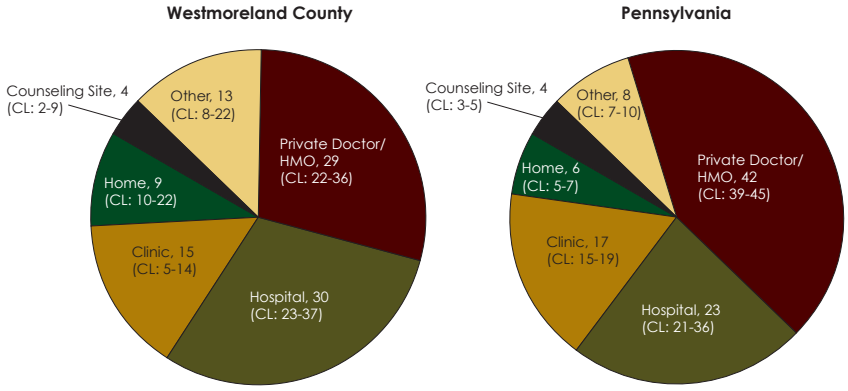
PRHA GOALS

1. Serve as an advocate for rural health development at the local, state and federal levels.
2. Maintain a coordinated rural health emphasis in federal, state, and local health policy development and implementation.
3. Promote improved rural health services.
4. Provide continuing education opportunities for rural health professionals.
5. Improve awareness and public education of rural health issues.
6. Foster cooperative partnerships to improve rural health.
7. Provide opportunities for leadership development through active membership involvement.
8. Promote regulatory flexibility and effectiveness for rural health providers.
9. Promote maintenance and enhancement of Pennsylvania's rural health infrastructures.

DEPARTMENT OF HEALTH BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

Local Sampling Program Provides Rich Source of Data

NEARLY HALF of all deaths occurring annually in the U.S. are the result of modifiable behavioral risk factors. To track the incidence of health issues affecting Americans, the Behavioral Risk Factor Surveillance System (BRFSS) was implemented in 1984 by the Centers for Disease Control and Prevention (CDC). The BRFSS is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States. Conducted by the fifty state health departments as well as those in the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands with support from the CDC, the BRFSS provides state-specific information about issues such as asthma, diabetes, health care access, alcohol use, hypertension, obesity, cancer screening, nutrition and physical activity, tobacco use and more. Federal, state and local health officials and researchers use this information to track health risks, identify emerging problems, prevent disease and improve treatment.



A sample of the data available from the Pennsylvania Department of Health.

In an effort to provide local BRFSS data addressing many of these risk factors, the Pennsylvania Department of Health instituted in 2002 the Pennsylvania BRFSS Local Sampling Program. Participation in the program is open to Pennsylvania's State Health Improvement Plan (SHIP)-affiliated partnerships located statewide. Participants select a Pennsylvania county or county group to specifically survey during their participation year. The survey is conducted by sampling monthly throughout the entire length of the calendar year. As of 2007, thirty-four counties have been included for surveying by the requests of participating SHIP-affiliated partnership in the Pennsylvania BRFSS Local Sampling Program. In 2004, six SHIP partnerships that covered the Northcentral region of the state chose to participate in one of the samples and collected data for the entire region.

In addition to the survey questions asked by everyone using the BRFSS survey or the core survey questions, local sampling program participants can ask an additional forty-five to fifty questions depending on the survey space availability in their particular participation year. These surveys cover a wide range of topics including health risk behaviors such as smoking, drinking, lack of exercise and obesity; access to and cost of health care; diagnoses and management of chronic disease; and social, community and environmental concerns affecting health.

The Pennsylvania Department of Health covers approximately two-thirds of the survey costs in addition to providing standard statistical reports of the data results, additional data output upon request and technical support with data interpretation. The standard statistical reports consist of a series of three reports. These include a summary report, a

detailed core survey questions report and detailed locally added survey questions report.

The **summary report** includes a brief review of local statistical results from core questions measured to be statistically different from Pennsylvania estimates. It also includes tables displaying statistics for select core, module and locally-added question for the locally sampled areas and Pennsylvania. Healthy People 2010 is addressed for the specific objectives covered by the data collected from the local BRFSS survey.

The BRFSS has been well documented as a rich and reliable system for the collection of a variety of essential public health data since the system's inception in 1984.

The detailed **core question tables report** provides a section detailing statistical differences between local and corresponding Pennsylvania demographic groups. A demographic differences section compares statistics within demographic groups surveyed in the local area. The detailed core questionnaire tables section displays core questionnaire responses by demographic characteristics for the local area and Pennsylvania and are compared by corresponding demographic characteristic.

The detailed **local question tables report** consists of similar information as the detailed core question table report but it reports statistics on locally added question results. Pennsylvania statistics are included, in addition to other local area statistics, when comparable data are available.

The following is a sampling of the statistics and comparisons currently available through the Pennsylvania Behavioral Risk Factor Surveillance System (BRFSS) Local Sampling Program.

> "A significantly higher percent (29) of adults in Mifflin and Juniata counties were considered to be obese compared to Pennsylvania adults (24 percent) in 2004. Only 33 percent (CI: 23-42) of Armstrong County adults age 50+ had a sigmoidoscopy or colonoscopy—significantly lower than for all Pennsylvania adults age 50+ (48 percent) in 2002. Elk County adults had a significantly higher percentage (24 percent, CI: 21-27) compared to all Pennsylvania adults (18 percent) for binge drinking in 2003."

The statistics presented here represent only a small fraction of the possibilities for analyses available using the data collected by the Pennsylvania BRFSS Local Sampling Program. The consistency of the core questions, allowing for comparability across geographies and the flexibility of the locally added questions, provide an opportunity to address issues not approachable with previously existing data sources. It also provides participating SHIP-affiliated partnerships and their collaborators the opportunity to perform community assessments not achievable in the past.

The fact that this program is built on the framework of the BRFSS administered nationwide by the Centers for Disease Control and Prevention speaks to its validity as a viable source of public health data. The BRFSS has been well documented as a rich and reliable system for the collection of a variety of essential public health data since the system's inception in 1984. The BRFSS has been using methods for data collection that have been repeatedly tested and substantiated. These same methods are being instituted in the collection of the data for the Pennsylvania BRFSS Local Sampling Program. This, coupled with two-thirds of the cost of sampling and the cost of analysis, report development and technical support being absorbed by the Pennsylvania Department of Health, makes participation in this program not only important to a county's or region's ability to assess many of the public health aspects affecting their community but a bargain compared to the cost they would potentially experience if they attempted to set up a system to collect comparable data themselves.

To review all of the comprehensive data reports developed for the participating partnerships, go to the Department's Bureau of Health Statistics and Research Web site at **www.health.state.pa.us/stats/** (select BRFSS and then Behavioral Health Risks of Local Adults).

For questions, please contact the Pennsylvania Department of Health's Bureau of Health Statistics and Research at 717-783-2548 or via an e-mail link from the Health Statistics Web page at **www.health.state.pa.us/stats**.

PENN STATE COOPERATIVE EXTENSION

Smoking Prevention Program Sees Results

BY SHIRLEY BIXBY

STATE GOVERNMENT, local communities, families and individuals all have a vested interest in decreasing tobacco use among Pennsylvania citizens. Smoking tobacco is the number one cause of preventable disease and death in Pennsylvania, with tobacco smoke pollution being the third cause of death and illness. Tobacco use increases the risk of respiratory, cardiac and other smoke-related disease and reduces life span. Children in households where one or both parents smoke have twice the amount of ear infections, bronchitis and pneumonia, and infants born of mothers who smoke are at greater risk of low birth weight and premature delivery. Eliminating tobacco use and protecting non-smokers from tobacco use has health, economic and social consequences for all Pennsylvania citizens. Programs developed by Penn State Cooperative Extension focus on community and school tobacco use reduction, cessation programs and tobacco smoke pollution.

MORE INFORMATION

For more information on tobacco cessation programs offered through Penn State Cooperative Extension, contact:

Marilyn A. Corbin, Ph.D.
Penn State Cooperative Extension
401 Agricultural Administration Building
University Park, PA 16802
814-863-6109
mcorbin@psu.edu

SCHOOL AND COMMUNITY PROGRAMS

Given the fact that adult tobacco users indicate they started using before the age of 18, it is critical to educate middle and high school students about the health risks of tobacco through Tobacco Prevention Education. Across the state, 4,524 youth and adults participated in Penn State Cooperative Extension prevention programs. For example, *Tobacco is a Drug, Too*—an in-school program—reached 691 students in Westmoreland County middle and high schools. *Chalk Talk—Tackling a Tough Opponent!*—an anti-spit program—reached sixty-five athletes and coaches. Pre- and post-survey results indicated that eighty-eight percent of the participants declared an unfavorable attitude toward tobacco use. Another 1,291 middle school students gained resistance skills through their involvement with the *Project Alert Curriculum*, an evidenced-based recurring prevention curriculum identified by the Centers for Disease Control and Prevention. Pre- and post-tests document an average 32 percent increase in knowledge of the harms generated by tobacco use and recognition of the pressures that initiate use of tobacco products.

Teens advocating against tobacco use belong to *Teens Against Tobacco Use* (TATU) Clubs. The 298 youth members of the seventeen active TATU clubs in Westmoreland County reached 4,968 students and families through their anti-tobacco campaigns. An additional 268 students from nine schools participated in the *World No Tobacco Day Essay Contest* while another thirteen youth focused on preventing tobacco use in the Westmoreland Fair Public Speaking and Demonstration Contest.

As participants in regional and state events, eighty Westmoreland youth from eight tobacco free coalitions participated in the *Smoke Free Air Affair*, reaching 1,000 families while fifty-two youth attended *BUSTED Youth Quest Mission Elimination Rally* in Harrisburg. At the rally, youth visited eleven legislators from Southwestern Pennsylva-

SEE **TOBACCO** ON PAGE 15 ➲

COMMUNITY FACTORS characteristic of some rural areas may make children in those locales more susceptible to obesity, suggest results from research conducted by Penn State's Center on Rural Education and Communities (CREC) and the Department of Agricultural Economics and Rural Sociology in the College of Agricultural Sciences.

The team has recently conducted two related studies that examine health and nutrition among school children in rural areas. One study looks at the effect of a relatively narrower choice of foods for consumers at grocery outlets. The other examines the opportunities and constraints faced by school districts attempting to purchase fresh foods from local agricultural producers in a practice known as farm-to-school (FTS) programming.

"Food Deserts" in Rural Pennsylvania

Most people envision a desert as an isolated region that lacks the most necessary ingredient for sustaining life: water. But one particular type of desert, known as a "food desert," often is lacking in other nutritional components—those found in healthful foods.

Food deserts are defined as areas that have limited access to full-service grocery stores. Within these areas, residents often tend to rely more on small-scale convenience stores that stock an abundance of high-caloric processed foods, while offering fewer choices of fresh fruits and vegetables.

Kai Schafft, CREC director, sees a strong relationship between food deserts and obesity. "The food choices that people make are limited to what is available to them," he said. "In areas where there are limited options for purchasing food from full-scale grocery outlets, research shows that there is a higher risk of overweight and obesity. And that's what we're seeing among rural children in Pennsylvania."

Working with **Clare Hinrichs**, Associate Professor of Rural Sociology, and **Eric Jensen**, Rural Sociology Ph.D. student, Schafft used U.S. Census data and GIS mapping technology to identify food desert areas in rural Pennsylvania. The research yielded two interesting findings: (1) school districts in those rural food desert areas are more likely to be socio-economically disadvantaged and exhibit higher levels of poverty and insecurity, and (2) independent of that economic disadvantage, children schooled within food deserts are at greater risk of obesity.

FOOD DESERTS are defined as areas that have limited access to full-service grocery stores.

"Gaining a better understanding of how community contexts such as food deserts affect public health outcomes is an important step in developing more comprehensive school and community-based interventions to increase the health of rural children," noted Schafft.

FARM-TO-SCHOOL PURCHASING refers to school food purchasing programs that emphasize bringing fresh, regionally-sourced foods onto school menus.

Farm-to-School Purchasing

FTS programs are one possible intervention now attracting public interest. FTS refers to school food purchasing programs that emphasize bringing fresh, regionally sourced foods onto school menus. The programs could enhance markets for local farmers and improve the nutritional quality of school meals. They sometimes also incorporate educational programming to increase student understanding of their food sources and the importance of their nutritional choices.

Both the nutritional and the educational components of FTS are seen as strategies to combat obesity in the schools. This is especially important since schools receiving federal lunch program assistance are now mandated to develop local wellness policies promoting nutrition, physical activity, and overweight prevention in compliance with the federal Child Nutrition and WIC Reauthorization Act of 2004.

Schafft sees farm-to-school programs as one potential school-based approach to help combat obesity and Hinrichs sees promise for Pennsylvania farmers in new regional institutional markets emphasizing healthy diets. This has led the team to examine more closely the opportunities and barriers for schools in implementing FTS programs.

To determine the effect of location on farm-to-school efforts, this past year the researchers conducted a comparison study, interviewing thirty stakeholders connected to two Pennsylvania FTS programs—one rural and one urban. The urban group saw school children and their parents as the primary beneficiaries of the program, by virtue of more healthful food options along with the reinforcing nutrition education. Rural stakeholders were more likely to view FTS programming as a community-based effort. The rural group cited extended community-level benefits, including preservation of the agricultural landscape and improved local economies.

At both the urban and rural sites, consistency in the quantity and quality of local food, seasonal availability, cost, and time concerns emerged as possible barriers to FTS implementation.

Hinrichs and Schafft have just received a grant from The Center for Rural Pennsylvania to continue and extend their study of farm-to-school programming through a statewide survey of school district food service managers and further case studies at Pennsylvania schools. This work will be taking place in 2007 and should result in a guide that includes “best practices” in farm-to-school programming and policy recommendations for Pennsylvania. This information will support Pennsylvania schools, communities and farmers interested in planning and implementing farm-to-school programs.

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TOBACCO FROM PAGE 12

nia and provided tobacco-related talking points to education policy makers.

The general public has been educated too, on tobacco issues, tobacco smoke pollution, and clean indoor air through the use of brochures and newsletters, community events, presentations to adults at organizational meetings, and through materials handed out at children's puppet shows and carnivals. The *Tobacco Free Coalition of Monroe County* wanted to expand this outreach to the townships and their public places, namely ball fields where people attend games. *Be a Winner...Tobacco and Sports Don't Mix* signs were created and offered to townships for parks and recreational areas. Seventeen out of twenty municipalities accepted seventy-three signs for their public areas at a press conference covered by Blue Ridge Cable TV–13 which also included information on cigarette butt litter, the dangers of tobacco smoke pollution and display resources for placement in municipal buildings.

INDOOR AIR QUALITY

It is postulated that food service workers are fifty percent more likely than the general public to develop lung cancer because of their constant exposure to tobacco smoke at work. As a result, increasing the number of smoke free restaurants will result in healthier employees and patrons. Restaurant owners were targeted with media packets on health risks associated with second hand smoke and encouraged to declare their facilities smoke-free. Through a media campaign, youth and adults who eat out were asked to thank owners who are smoke-free and to request a change at those who allow smoking. Restaurants who established smoke-free environments received certificates of appreciation, newspaper publicity, and a listing in the *Guide to Smoke-Free Restaurants* in either Westmoreland or Monroe Counties.

SMOKING CESSATION PROGRAMS

Surveys show that less than fifty percent of health professionals talk to patients about quitting tobacco use or the effect that their tobacco use has on the present illness. In an ongoing effort to increase rural health professional's knowledge of tobacco issues, six programs on clinical practice guidelines and best practices were provided for 104 health professionals this year in partnership with the Pennsylvania Area Health Education Center (AHEC) Program, Westmoreland County Community College's nurse and dental programs and individual medical and dental offices. In a follow-up survey, sixty-two dental professionals responded with documentation that ninety-one percent were using one or more of the recommended clinical practice guidelines in brief tobacco cessation counseling.

Most smokers try to quit five to seven times before being successful. Tobacco cessation classes and individual cessation sessions by telephone or in person were conducted to reach rural residents without easy access to cessation programs. Of the fifty-four individuals enrolled in six seven-session programs, thirty-two completed the program with eighteen maintaining abstinence after the program and another ten making one attempt to quit.

Through partnerships with groups serving these populations, eighteen one-hour on-site presentations given by extension educators reached 254 individuals directly and another 1,075 through forty-weight partnership activities which focused on health risks to children and adults inhaling tobacco smoke. In surveys after the direct presentations, individuals were more likely to identify tobacco as a health risk and also ask smokers to smoke outside their homes.

Shirley Bixby *is the (retired) extension coordinator for Special Projects.*

OBESITY FROM PAGE 8

other states with effective FTS programs have found, they also can incorporate educational programming to increase students' understanding of food sources, the importance of proper nutrition and the environmental and economic cost of transporting food over long distances. Penn State rural sociologist Clare Hinrichs and her CREC colleague Schafft are studying FTS programs in Pennsylvania. They're examining what products schools are buying from local farmers and what obstacles they face—such as existing contracts with suppliers—in implementing or expanding their FTS efforts. "I'm very interested in what happens after the initial enthusiasm and financial support wears off," Hinrichs says. "I want to see if the programs are sustainable over the long haul." Schafft and Hinrich received a grant from The Center for Rural Pennsylvania to continue and extend their study of FTS programming through a statewide survey of school district food managers and further case studies. One goal of their work is to produce a state-based guide for teachers, food service directors, and parents on how best to include farm-to-school programming in their schools.

Hinrichs thinks the educational and nutritional components of FTS programs are especially important for schools to consider since, starting this year, any school receiving federal lunch program assistance is required to develop wellness policies and programs promoting nutrition, physical activity and overweight prevention to comply with the Child Nutrition and WIC Reauthorization Act. That requirement may inspire more schools to seek mini-grants and develop programs like those pioneered in Pennsylvania and highlighted on PANA's Web site. At the state level, Governor Ed Rendell is pushing for every school with 20 percent or more children living in low income households to offer breakfast and for all schools to improve the nutritional health of food available to students, says Friesen of PHAC. Schafft and Hinrichs summarized the challenges in turning the tide on overweight and obesity rates for children, "So often the debate over obesity blames the kids' inactivity or the parents for not feeding their children healthy food. While those factors must be considered, the discussion should also take place at the broader community level.

SAVE THE DATE

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CALENDAR OF UPCOMING EVENTS

July 25–26
Third Annual NRHA Quality Conference
National Rural Health Association
Hyatt Regency, Kansas City, MO
For more information: **www.nrharural.org/quality/QConf.html**

June 7–9
2007 Amish Conference
The Amish in America: New Identities and Diversities
Elizabethtown, PA
For more information:
www.etown.edu/YoungCenter.aspx?topic=Amish+Conference+2007

August 13–15
Charting New Frontiers in Rural Women's Health
Washington, D.C.
For more information: **www.esi-bethesda.com/ruralfrontier2007**
Barbara James, 301-443-4422, barbara.james@hhs.gov

August 23–26
2007 Minority Women's Health Summit
Washington, D.C.
For more information and to register: **www.womenshealth.gov/mwhs**

November 3–7
2007 AHPA Annual Meeting
Washington, D.C.
For more information: **www.apha.org/meetings**
or **apha.confex.com/apha/135am/oasys.epl**

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