

Health Resources and Services Administration

Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

NACRHHS Fall Meeting -- Held Virtually

July 30th, 2020

Meeting Minutes

The 88th meeting of the National Advisory Committee on Rural Health and Human Services was held July 30th, virtually due to the Covid -19 pandemic.

The committee members in attendance: Jeff Colyer, Committee Chair; Steve Barnett, DHA, CRNA, FACHE; Robert Blancato, MBA; Kari Bruffett;; Wayne Deschambeau, MBA; Molly Dodge; Meggan Grant-Nierman, DO, MBA; George Mark Holmes, PhD; Joe Lupica, JD; Brian Myers; Patricia Schou; Robert L. Wergin, MD, FAAFP; James Werth, Jr., PhD, ABPP; Loretta Wilson.

Ex-Officio members in attendance: Lacey Boven; Diane Hall, PhD, MEd; Darcy Graves, MPP, MA; Scott Miller; Ben Smith, MA, MBA; Aleta Meyer, PhD; Thomas Klobucar, PhD; Betty-Ann Bryce.

Present from the Federal Office of Rural Health Policy: Tom Morris, Associate Administrator; Paul Moore, Executive Secretary; Steve Hirsch, Administrative Coordinator; Sahira Rafiullah, Senior Advisor. Truman Fellows: Lamar Greene and Anne Hall.

Thursday, July 30th, 2020

The meeting was convened by Dr. Jeff Colyer, Chairman of the National Advisory Committee on Rural Health and Human Services.

WELCOME AND INTRODUCTIONS

Paul Moore

Executive Secretary

Paul Moore welcomed the members of the National Advisory Committee on Rural Health and Human Services and the attending audience. It will be a different experience holding a virtual meeting, the advantage is it reaches people who may not be able to join onsite meetings. Rural Health is important across The U.S. Department of Health and Human Services. It is an honor to introduce the new committee chair.

On February 27th, 2020, Secretary Azar announced the appointment of former Kansas Governor Jeff Colyer to serve as the Chair of the National Advisory Committee on Rural Health and

Human Services. Governor Colyer is a surgeon by training and the 5th chair in the 32-year history of the committee and the 2nd chair from Kansas after Nancy Kassebaum Baker, who served during the Bush Administration. Governor Colyer finished his gubernatorial term in 2019. Before serving as Governor of Kansas, he served in the House of Representatives and the Senate and was the longest serving lieutenant governor in Kansas history.

Governor Colyer is a 5th generation Kansan from Hays, Kansas. He practices cranial facial and reconstructive surgery. In addition to his medical practice, he has volunteered with International Medical Corps in war and conflict zones around the world including Rwanda, Afghanistan, Iraq, South Sudan, and Libya. He has an economics degree and studied pre-med at Georgetown University, as well as a master's degree in international relations from Cambridge University, and a medical degree from Kansas University School of Medicine.

As a Kansas doctor and former governor, he knows the importance of health care and human services in rural communities.

Jeff Colyer, MD

Committee Chair

National Advisory Committee on Rural Health and Human Services

Governor Colyer thanked the national advisory committee members, the Office of Rural Health Policy and everyone attending the meeting. This is the 88th meeting of the National Advisory Committee on Rural Health and Human Services. This is the 1st virtual meeting. This a citizen's panel and after talking the deputy secretary and Secretary of Health and Human Services, rural healthcare is a high priority over the next few years.

There are ex-officio members among several agencies within The Department of Health and Human Services in attendance today as well. Tim Keck is in attendance and has vast experience in health and human services and was the Secretary of Aging and Disabilities in Kansas and helped reform hospitals. Committee members will not make introductions.

Governor Colyer stated that the first national advisory committee meeting he attended involved the perspective of rural health care over the next few years. Following that meeting, a work group was developed to create a vision, mission, and values regarding rural healthcare. The focus of this meeting is to get the input from the national advisory committee and how to move forward as a committee. Keith Mueller and Clint MacKinney from The Rural Policy Research Institute have worked with the visionary taskforce and will be facilitating the meeting. They have great information and perspective and can help the group to shape policy in the next few years. There will be opportunities at the end of the meeting to share public comments with the meeting. In the last eight weeks there has been more happening in rural healthcare than in the last eight years. Rural providers have portrayed integrity and resiliency while providing innovative ways to assist people during the Covid-19 pandemic.

NAC VISION, MISSION. AND VALUES WORKGROUP
BACKGROUND INFORMATION PRIOR TO THE MEETING

Governor Colyer and FORHP staff and a working group of Committee members previously developed a foundation for a new NAC Vision and Mission during three 90-minute calls facilitated by Keith Mueller and Clint MacKinney. In contrast to traditional Visioning exercises, the Workgroup selected the following definitions

- The Vision is what we wish rural health (including, but not limited to, health and human services) to be.
- The Mission is what we wish the NAC to do to forward the Vision.
- The Values are the core principles that guide and direct the NAC's work, and provide guardrails for the Mission.

Vision

To develop a draft Vision Statement, the Workgroup first differentiated a vision for rural America versus a vision for the NAC. The NAC Vision is the former, referring not to the NAC, but instead to the rural condition generally. The workgroup identified many desirable rural characteristics including:

- Integration of health services, including (but not limited to) medical care, public health, behavioral health, and social services; and integration of economic sectors, including (but not limited to) health care, education, and transportation
- Innovation in health care and human services design, delivery, and payment
- Self-determination that implies local input and policy flexibility
- Resiliency encompassing concepts of adaptability, growth, and vibrancy
- Diversity that welcomes all people of all ages
- Healthy communities where people choose to live

The Workgroup was presented with various Vision Statement alternatives. With near unanimity, the Workgroup chose “We envision rural as diverse people, places, and providers supported by policies that foster rural vibrancy, innovation, and resiliency – where rural living is a choice.” Through subsequent discussion, the Vision Statement was modified to:

We envision rural America as healthy people, places, and providers supported by policies that foster rural community vibrancy, innovation, and resiliency – where diverse people choose to live, work, play, and grow.

Values

The Workgroup chose to design NAC Values next. Values will serve as core principles to guide the NAC's work and provide guardrails for the Mission. Thus, it was appropriate to design values prior to designing the Mission. Many values were discussed and are listed below. The parenthetical statement after each potential value provides either support for value selection or a rationale why it might not be selected.

- Resiliency (incorporates sustainability)
- Diversity (incorporates inclusiveness)
- Self-determination (incorporates independence)
- Integration (includes behavioral health, public health, social services, but may also include integration of other economic sectors such as housing and transportation)
- Innovation (incorporates flexibility and adaptability)
- Cross-sector (includes non-health sectors such as education, transportation, and housing)
- Dissemination (more about the work of NAC rather than a value)
- Adaptability (included in innovation)
- Assets (more of a characteristic than a value)
- Science (more about the evaluative process)
- Truth-to-power (more about the work of NAC rather than a value)
- Long-view (more about a vision)
- Underlying causes (more about the work of NAC rather than a value)
 - *Aspirations (more about a vision)*
- Credibility (more about the work of NAC rather than a value)
- Prevention (both too specific [prevent disease] or too general (prevent rural demise))
- Ageing-in-place (more about a vision)
- Workforce (too specific)
- Leverage (more about work of NAC rather than a value)

After discussion, the Workgroup selected the following Value Statement:

Our work will be guided by our values that include:

- *Integration*
- *Self-determination*
- *Diversity*
- *Innovation*
- *Resiliency*

The NAC can use these values to select exemplars, programs, or projects for study. The NAC Values can also serve as the guardrails of the NAC's Mission, and thus the guardrails of the NAC's work.

Mission

The NAC Mission is what the NAC is to do, guided by its Values. The Mission can serve as a screen for selecting NAC projects and a prism by which the NAC can assess its work. Importantly, the NAC Mission is not a list of projects, themes, or subjects for study. This would inappropriately limit current NAC and future NAC decisions and evaluations. The Workgroup also recalled that its objectives and scope of activities are established under provisions of 42 U.S.C 217a; Section 222 of the Public Health Service Act. The NAC will serve as an “independent advisory body to the Department of Health and Human Services (HHS) on issues

related to how the Department and its programs serve rural communities.” The audience for NAC reports is the Secretary of Health and Human Services. NAC reports are published and publicly accessible following the Secretary’s review.

The Workgroup discussed the option of a succinct Mission statement, but instead chose a bulleted list to include a broader scope of activity. The Workgroup considered its Mission as serving two primary functions: screening potential programs (et al) for study and accomplishing its work. Screening considerations are reflected in the Values; that is, programs for study should exemplify one or more of the NAC Values.

Since NAC project selection for its study and reports is guided by the NAC Values, the NAC’s Mission is left to guide the NAC’s work. The Mission should advance the Vision. Thus, the proposed NAC Mission describes how the NAC will do its work and support its Vision for rural America.

We will advance our Vision for rural America by:

- *Examining rural health care and human services innovations*
- *Highlighting opportunities that integrate health care services and non-health sectors*
- *Recommending public policies that advance rural community diversity, vibrancy, and resiliency*
- *Engaging science and evidence during deliberations*

Clint MacKinney
Deputy Director
Rural Policy Research Institute
University of Iowa

Clint MacKinney stated that the meeting will be a discussion about the work that has been achieved so far by the visioning workgroup. The strategic planning workgroup created a vision statement, mission statement and values that will be shared with the committee to get input. This is the time to review the role of the national advisory committee and how to move forward.

The workgroup has a vision of what they want rural health to be and it is integrative and encompassing. The mission is what the National Advisory Committee on Rural Health and Human Services can do to realize the vision for rural health. The values are the core principles that guide and direct the work of the national advisory committee and provide guard rails around the work and mission that is chosen. The result is the mission statement, vision statement, and core values to be shared with the national advisory committee for feedback.

There are many themes that are important in rural America. Integration of services is key to assist with poverty, housing, transportation, food access, healthcare and other essential needs that are lacking for rural Americans. Rural communities can be incubators and innovators for new ways of delivering health and human services. Innovation is not only an opportunity but a strength in rural America. Self-determination, local input, and policy flexibility are essential in

rural communities. There is always a balance between flexibility and policy, but the idea of self-determination is central with local input in rural communities. Resiliency is important and encompasses thoughts of adaptability, growth, and vibrancy in rural communities. It is a choice to live in rural America, these are healthy and vibrant communities, and these characteristics should be captured in the vision statement.

The workgroup created the following vision statement, “We envision rural America as healthy people, places, and providers supported by policies that foster rural community vibrancy, innovation, and resiliency – where diverse people choose to live, work, play, and grow.”

The values will guide the mission statement so the workgroup discussed the core values that should guide the work forward. After much discussion, the decision was made to focus on five core values, and they are integration, self-determination, diversity, innovation, and resiliency. Self-determination adds a requirement for flexibility and consideration of local circumstance in rural communities. A focus on diversity is important so programs and policies include everyone and provide equal opportunities for growth. Innovation incorporates the adaptability to be flexible when thinking about programs. Resiliency is vital to preserve any of the other core values. There must be resiliency in people, programs, and policies.

The mission is a way to select and screen the committee’s topics. We will advance our vision for rural America by, examining rural health care and human services innovations, highlighting opportunities that integrate health care services and non-health sectors, recommending public policies that advance rural community diversity, vibrancy, and resiliency, and engaging science and evidence during deliberations.

There were three questions to express how to use the framework created by the workgroup.

- Vision, Mission and Values framework.
- Vision is aspirational for rural health “to be”
- Mission is what the NAC “can do”
- Values guide the work.

FEDERAL OFFICE OF RURAL HEALTH POLICY INPUT

Tom Morris said that today’s focus is a conceptual framework but ultimately it is under the charter to provide recommendations to the Secretary that are under the purview to make changes that are actionable by the secretary. The Office of Rural Health Policy tracks the recommendations broadly, and in some cases, thematically. For example, the Committee recommended a reform of the RHC payment methodology and this past year an RHC reform was put forth in the president's budget.

I would also note that to the degree a recommendation is more specific the more likely it can be linked to an actual policy proposal or change. Conversely, if the recommendations are overly broad or not specific to HHS authorities it is difficult to track it back to a policy change. So, there is a place for both big picture considerations that can speak to the broader considerations of today's discussion but also a need for the more specific action-oriented recommendations.

Paul Moore shared that the Charter (see appendix) asserts that the primary audience is the Secretary of Health and Human Services and Health and Human Services at large. The primary audience is not the only audience because it is published for public viewing and consideration. The Charter is focused on dealing with issues that HHS has purview over, however there are times that go broader with considerations. This is a framework that is being discussed today. The committee has dealt with specific topics. This discussion is how to look at the topics with a lens of the priorities of the committee.

The Federal of Rural Health Policy tracks the work of the committee. The work is tracked over years because it could take years to have impact. Legislative and regulatory changes can sometimes be tied to a topic that the committee presented prior to the changes. Other changes may take longer to present themselves but are related to topics that have been submitted to the Secretary of Health and Human Services by the National Advisory Committee on Rural Health and Human Services. This information will be shared with the committee in the future.

COMMITTEE VISION, VALUES AND MISSION STATEMENT NATIONAL ADVISORY COMMITTEE DISCUSSION AND RECOMMENDATIONS

The National Advisory Committee on Health and Human Services discussed adding the importance of equity and access to the vision, values and mission statement.

VISION STATEMENT DISCUSSION

“We envision rural America as healthy people, places, and providers supported by policies that foster rural community vibrancy, innovation, and resiliency – where diverse people choose to live, work, play, and grow.”

Meggan Grant-Nierman appreciated including physician wellness in the vision statement. That is a critical piece and the wording is appreciated.

Bob Wergin said that it characterizes many of the National Advisory Committee discussions and is nicely done.

The term “providers” is not limited to physicians but includes health systems and public health systems. It needs to encompass the entire health and human service workforce.

Robert Blancato asked if the word equity be included in the vision statement.

Clint MacKinney said that the workgroup sought to capture the topic of equity within diversity, but it is a valid point to be deliberated.

Jim Werth asked if the vision is around rural America at large or based on health and human services. There has been focus on providers during meetings and the health of the whole organization is important.

There are more people beyond providers that need to be considered.

Clint MacKinney stated that the workgroup views health in an extremely broad way as community health, so healthcare and human services was too limited for the vision.

The word providers are not representative of those working to assist people in rural America. If the committee can assist with a term that recognizes the individuals and organizations that make a rural community healthy, it would be appreciated.

Bob Wergin shared that even spiritual and ministerial assistance is part of the team of providers. Health systems and public health systems are providers.

Steve Barnett asked if rural is removed from the vision statement would it look different than if it were done for urban? It needs to be distinguishing and specific to rural.

Kari Bruffett how can we assure that rural communities are a place someone would choose instead of a place they feel stuck.

Paul Moore pointed out some of the suggestions in the chat box about the word “provider” being too limited. Some examples of terms to encapsulate the entire community:

Care Communities

Healthcare ecosystem

Healthcare team members

Healthcare communities

Meggan Grant-Nierman stated that the words around innovation helps point out the idea of rural communities being innovative and have demonstrable best practice because rural communities are small and nimble. Rural should be a place of choice and not a sacrifice to live and a place where people get to stay if that is their choice. So many patients in rural communities must leave where they love because they need more services. They live their golden years in urban areas where they are uncomfortable socially because they need more nursing care or closer specialists. Part of the vision is rural communities where people could stay and receive the services they need.

Joe Lupica stated that health equity is an important modifier. Equity can mean lots of things.

Chairman Colyer stated that everyone realizes that rural healthcare is pivotal and central to everything in rural communities.

CORE VALUES – TO GUIDE COMMITTEE’S WORK – DISCUSSION
Integration, Self-determination, Diversity, Innovation, Resiliency

James Werth stated that equity and inequities need to be highlighted for policy and regulatory consideration. Health equity or equity could be considered as a core value.

Joe Lupica said that promoting positive ideals will be more effective and looking at health wellness – thriving, vitality, and health equity.

Pat Schou stated that access was not included, and it is sometimes the initial starting point and always seems to be a basic parameter.

Aleta Meyer said that access is something physical to consider and particularly important.

Kari Bruffett stated that adding definitions to the values would be helpful.

Loretta Wilson said that access is a prominent issue in rural America, so she appreciates it being discussed. Access is not as available to certain populations; can you discuss the self-determination value related to access? What was the workforce focus when discussing self-determination?

Clint MacKinney responded that when the workgroup discussed self-determination, they were speaking more general. Local control and flexibility were discussed. Rural Americans living in rural communities should be able to determine their own future and needs. It should not be dictated by people outside the community. Flexibility to respond to individual rural needs is important instead of one size fits all policy.

Governor Colyer stated that every rural community there are many independent people and that is one of their strengths. Solutions in one community may not fit another and they are not one size fits all. That was the thoughts of the workgroup when considering self-determination as a core value.

Bob Wergin stated that the workgroup was considering that public policy can be developed in urban without an understanding what works in rural. Self-determination is referring to rural communities making decisions for themselves.

Aleta Meyer said there is a value in liberty and freedoms and that is what she considered self-determination was about. It is also about self-referral rather imposed regulations.

Paul Moore stated that one comment was that there is historic context in some words, and one is “self- determination”.

Clint MacKinney said that is an important point that self-determination can have a negative connotation and needs to be reconsidered. He welcomes suggestions from the national advisory committee members for more appropriate terms and sharing terms with the workgroup that do have negative connotations for future consideration.

Shobha Srinivasan stated that self-determination has a specific meaning for American Indian, Alaska Native and Native Hawaiian communities. It has been a legal battle for recognition and maintaining that self-determination as Nations. To use it in the context of rural communities may be an overreach and ignoring the historical and current implications.

Joe Lupica said that someone stated in the Q&A – asked if the committee was aware that people are stuck in rural America. There has been discussion about this issue. Doctors who are in rural communities do choose to be there and are proud to work in rural communities.

Clint MacKinney said he realizes that some people do feel stuck in rural America and that the vision is about how people want it to be in the future. Rural living should not be a sacrifice but a choice. The discussion is aspirational for rural America.

Kari Bruffett said that community self-determination and being part of a solution and not have a solution forced on a community. If there is a way to communicate that better, it would be beneficial.

Meggan Grant-Nierman shared ideas of definitions that could be added to the core values. She submitted these suggestions:

- **Integration:** We value integration of provision of health care across the care continuum to include health, human services, and community stakeholders.
- **Self-determination:** We value and seek to uphold self-determination of individuals and communities to develop individual processes for community health and wellness.
- **Diversity:** We value diversity including but not limited to generational, economic, social, cultural, and geographic.
- **Innovation:** We value the unique ability of rural communities to innovate and create best practices in health and wellness.
- **Resiliency:** We value the rural culture of resiliency.

NATIONAL ADVISORY COMMITTEE MISSION STATEMENT DISCUSSION

We will advance our Vision for rural America by:

- *Examining rural health care and human services innovations*
- *Highlighting opportunities that integrate health care services and non-health sectors*
- *Recommending public policies that advance rural community diversity, vibrancy, and resiliency*
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Bob Wergin said to identify and remove barriers to healthy communities and define and expand resources. Innovative ways to find resources that may specifically support rural areas. Rural health clinic payment models have been a great benefit as an example. If there is no margin, there is no mission

Clint MacKinney asked if there is value in having the wording to be positive as opposed to identifying barriers? Might the idea of identifying resources be included in “*Examining rural health care and human services innovations*”?

Bob Wergin said he thinks that clinical access could be included in “*Examining rural health care and human services innovations*”.

Clint MacKinney asked the committee to submit further thoughts, comments, and recommendations related to the mission statement.

Governor Colyer thanked the committee for their comments and stated they have been extremely beneficial.

NATIONAL ADVISORY COMMITTEE MEMBER DISCUSSION HOW TO USE THE FRAMEWORK – VISION, MISSION, VALUES

Clint MacKinney asked the committee how the of vision, mission, and values framework should be used. How should the committee incorporate the vision into its future documents and meetings? Should it appear as a preamble, used as an informal barometer, or as a measuring stick of the impact of the committee’s work?

Meggan Grant-Nierman stated that she likes the idea of it being an opening piece of any document that is generated by the committee because it helps the reader know the committee’s intentions. It helps hold the committee accountable to the vision, mission, and values as well.

Kari Bruffett said it would be beneficial to provide the vision, mission, and value statements to stakeholders attending site visits and speakers who are presenting at future meetings. It could be highlighted in future reports as well.

Paul Moore said that the Office of Rural Health Policy provides an orientation for those speakers and provides information to the stakeholders so this will be an excellent addition to what they are doing. They are the content experts, and this will provide them an emphasis and additional guidance.

Steve Barnett stated that Kari and Meggan captured his opinion so that the reader or presenter can have a better understanding of the focus.

Clint MacKinney asked the committee if when developing its approach for topics or recommendations, how should the committee be sure that the themes identified in the mission statement guide the development of reports? It would be worthwhile as you have an outline of the report and a first draft, to compare to the vision, mission, and values. Using them to check an outline would be useful.

Joe Lupica said that using it as a measuring stick is a great idea. The committee must take the responsibility to keep track of it and refer to the vision, mission, and values during meetings and discussions.

Jim Werth stated that he thinks having the mission available at meetings would be helpful. Using them as a guide may be limiting because the topics need to be specific. It can guide the reports, but it could be constraining if it is used too literally.

Clint MacKinney said that the values could be used as guardrails not to venture outside of the values, but the report does not have to touch on all values or mission statements. They need to be in there to some degree.

Pat Schou said there could be three or four questions that the committee asks themselves while making decisions to assure they are not venturing from the vision, mission, and values. It is also important that the policy addresses relevancy. It could fit into the vision, mission and values but not be relevant or be able to make an impact.

Governor Colyer is the goal of the mission statement is to have an indication of how the committee did make changes in rural communities and “moved the ball”.

Molly Dodge said that the urgency of issues is important to remember because some issues are more urgent than others, so urgency and relevancy need to be considered.

Steve Barnett said that he likes having the mission as a guidepost at meetings. When discussing issues at the meetings, it is easy to wonder away from the topic. The mission statement and vision should not stifle the committee from the massive conversation that always returns to topic at the end. The overall conversation is still especially important.

Clint MacKinney said the mission is the work of the committee that advances towards the vision for rural health and rural America. How will the committee assess its contribution to the vision?

Meggan Grant-Niermann stated that reviewing the mission statement at the beginning each year would also be beneficial with orientation of new members.

Wayne Deschambeau said that it is important to review the mission statement on a regular basis and make changes when needed.

Ben Smith stated that many of the themes discussed are part of the Indian Health Service Strategic Plan.

The Indian Health Service Strategic Plan link: <https://www.ihs.gov/strategicplan/>

For the Indian Health Service system (federal, tribal health programs, and urban Indian organizations, we have a statutory definition of health care provider (25 USC 1675(a)(1)): (1) Health care provider The term “health care provider” means any health care professional, including community health aides and practitioners certified under section 1616 l of this title, who is— (A) granted clinical practice privileges or employed to provide health care services at—

(i) an Indian health program; or (ii) a health program of an urban Indian organization; and (B) licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

Shobha Srinivasan said that social determinants of health need to be addressed to have healthy people. When talking about social determinants of health, the comparison is with urban and it feels like a wasted effort because rural is unique.

Scott Miller encouraged the committee to think about public health when developing mission and vision statements as well as the values. Thinking upstream and considering social determinants of health and the effects on health is important when developing a mission and vision.

Tom Klobucar said that when veterans return home from the military to a rural community it is important to provide care that is sensitive to their military culture and to the fact, they made the choice to live in rural communities. The Veteran's Administration has been serving the entire community during the Covid-19 pandemic. There have been hundreds of people in the VA hospitals that are not veterans. It is encouraging to hear the inclusive discussion from the committee. The VA rural health advisory committee meets next month and information from this meeting will be shared so it is appreciated.

SUMMARY

Clint MacKinney stated that there are themes that need further discussion and consideration.

- Further discussion about equity
- Defining "Providers"
- Equity and Access Relevancy
- Providing further information about the core values
- Using vision, mission, and values on documents, for presenters, and as a measurement for committee's work

CLOSING COMMENTS

Governor Colyer thanked the committee and participants for taking the time to attend the 88th National Advisory Committee on Rural Health and Human Services. The next step is further virtual meetings to continue discussions and being in contact with The Department of Health and Human Services.

PUBLIC COMMENT – QUESTION & ANSWER

Governor Colyer stated that many of the public comments are questions about Coronavirus response in rural communities and asked if members would like to share information at this time.

Ben Smith stated that on Thursdays, there is an Indian Country COVID-19 Call hosted by the White House Council on Native American Affairs. The dialogue portion of each call is intended for Tribal Leaders, but the calls are open for anyone to observe. The updates are helpful as many Tribes are in rural settings. Registration is required for each call. You can access information about today's call on the IHS Web site at: <https://www.ihs.gov/ihscaledar/calendar/indian-country-covid-19-update-call-and-update-from-the-white-house-council-on-native-american-affairs/>

Bob Wergin shared that COVID has highlighted the challenges our whole health care delivery system has and revealed some of the challenges that are unique to rural health care delivery in terms of infrastructure. It also highlights some of the urgency of topics. Adding access as a value statement bullet would be important and this is more than just providers but all access. Housing and reliable food sources are unique issues in rural areas related to social determinants of health. Health equity could cross several areas. A person's health care outcome should not be determined by zip code or ethnicity. Covid-19 changed delivery of care in rural communities and will hopefully not revert. A telehealth platform was developed but is not working consistently. Testing was a challenge and some rural residents went to urban location to get testing and the results were not shared with the rural providers. The Covid-19 pandemic has revealed communication and integration needs.

James Werth stated that from a broad perspective, rural has received much consideration during the crisis but there is a potential for some of the services to dissipate in time. Federally qualified health centers are not eligible for Medicare reimbursement for a provider using telehealth and that was waived during the Covid-19 pandemic. Is that something that can remain? Also, reimbursement for phone telehealth visits as well.

Loretta Wilson stated that related to the mission and vision – Covid-19 must be considered because it has reshaped rural. If some of the funding provided for Covid-19 patients does not continue, it could be very detrimental. As an administrator of a rural hospital, it will be detrimental if the funding does not continue that has been provided for Covid-19.

Pat Schou asked if the committee has the capability to provide an impact evaluation from Covid-19 and what has and has not worked to plan and be innovative in the future. Could general recommendations of the RHHS NAC could be provided?

Tom Morris said it could be valuable and it could be a letter to the Secretary. The value has been recognized regarding telehealth waivers and relaxation of HIPPA rules. It would be beneficial to express what has been learned related to Covid-19 in rural areas.

Governor Colyer stated that the Covid-19 pandemic is going to strategically change rural healthcare in the future and the lessons learned will assist in modifications to systems moving forward. It would be great to have the committee meet again for further discussion.

Bob Blancato asked what are the options with communicating with Congress on some of these issues?

Paul Moore reiterated that we advise the Secretary and it is beyond our purview as a Committee to communicate directly with Congress.

Meggan Grant-Nierman shared that there are unique concerns protecting and isolating groups of people in rural areas. A provider in a rural community may have to see a person in the clinic, and then a woman in labor, followed by visiting an elderly person with a fever. This crosses many vulnerable settings and causes issues with isolation.

The Covid-19 pandemic has given people access to specialized care via telehealth that had not been available. It produced immediate and innovative responses to barriers in small communities. Public health and community resources have kept the country afloat in rural during the Covid-19 pandemic. These services need continued and there should be enhanced funding.

Steve Barnett the supply chain has been directly from manufacturers instead of being under one umbrella and that has been a problem. Most supplies are going to hotspots and it makes other areas vulnerable and unable to get the needed supplies.

Joe Lupica stated that the Coronavirus has exposed glaring gaps in the health system that need to be addressed.

Paul Moore reminded the Committee that he sent an email link to a Covid-19 Response team in the Federal Office of Rural Health Policy and again solicited Covid-19 input from the Committee members.

Appendix – NACRHHS Charter

CHARTER NATIONAL ADVISORY COMMITTEE ON RURAL HEALTH AND HUMAN SERVICES

1. Committee's Official Designation: The Committee shall be known as the National Advisory Committee on Rural Health and Human Services (NACRHHS or the Committee).
2. Authority: The National Advisory Committee on Rural Health and Human Services is authorized by 42 U.S.C. 217a; Section 222 of the Public Health Service (PHS) Act, as amended. The Committee is governed by provisions of the Federal Advisory Committee Act (FACA) of 1972 (5 U.S.C. Appendix 2), as amended, which sets forth standards for the formation and use of advisory committees.
3. Objectives and Scope of Activities: NACRHHS provides advice and recommendations on issues related to how the Department of Health and Human Services (HHS or the Department) and its programs serve rural communities. The Committee represents a public/private partnership that will focus attention and existing resources on rural health and human service problems, including the provision and financing of health care and human services in rural areas.
4. Description of Duties: In accordance with the FACA of 1972 (5 U.S.C. Appendix 2), NACRHHS shall have the option of producing reports on key rural issues along with recommendations for possible solutions and may solicit input from the Department and the field regarding issues on which to focus. The committee also has the option of conferring with and coordinating its activities with other advisory groups in the fields of rural health and human services.
5. Agency or Official to Whom the Committee Reports: The NACRHHS provides advice and recommendations to the Secretary of HHS (Secretary).
6. Support: Management and support services are provided by the Federal Office of Rural Health Policy (FORHP) of the Health Resources and Services Administration (HRSA).
7. Estimated Annual Operating Costs and Staff Years: The estimated annual cost for operating NACRHHS, including compensation and travel expenses for members but excluding staff support is \$188,969. Estimated staff support required is 1.3 FTE years at an estimated annual cost of \$136,520.
8. Designated Federal Officer (DFO): HRSA will select a full-time or permanent part-time federal employee, appointed in accordance with agency procedure, serves as the DFO and ensures that all procedures are within applicable statutory, regulatory, and HHS General Administration Manual directives. The DFO (or designee) approves and prepares all meeting agendas, calls all committee or subcommittee meetings, attends all committee and subcommittee meetings, adjourns any meeting when the DFO (or designee) determines adjournment to be in the public interest, and chairs meetings when directed to do so by the Secretary.

9. Estimated Number and Frequency of Meetings: NACRHHS may meet up to three times a year. Each meeting must be called or approved by the DFO (or designee). Meetings may be in person or via webcast. NACRHHS may hold meetings in the field to gather input from rural citizens. Meetings shall be open to the public except as determined otherwise by the Secretary or designee in accordance with the Government in the Sunshine Act (5 U.S.C. 552b(c)) and the FACA of 1972 (5 U.S.C. Appendix 2). Notice of all meetings shall be given to the public. Meetings shall be conducted, and records of the proceedings kept, as required by applicable laws and departmental regulations.

10. Duration: Continuing.

11. Termination: Unless renewed by appropriate action prior to its expiration, NACRHHS will terminate 2 years from the filing date of the charter.

12. Membership and Designation: NACRHHS consists of up to 21 members appointed by the Secretary to each serve a term of 4 years, with a minimum of 15 members. Members represent the diversity of health and human service issues in rural America. Approximately two thirds of the members should be rural health experts and approximately one third should be rural human services experts. These individuals shall represent an appropriate geographic representative mix from across the country, including the Chair, selected by the Secretary, from authorities knowledgeable in the fields of delivery, financing, research, development, and administration of health care and human services in rural areas. Such authorities shall include representatives from state and local governments, foundations, provider associations, and other rural interest groups. Committee members should reflect a broad array of expertise, including Title XVIII, IX, and XXI of the Social Security Act, and be knowledgeable with the range of rural-focused health programs under the purview of the Secretary, as well as knowledgeable in the fields of rural human and social services, including issues related to transportation, children and family services, social work, services for the elderly, and rural economic development. The Committee's health members should include representatives from the following key rural health care sectors: rural hospitals, physicians with experience practicing in rural areas, nurses with experience practicing in rural areas, rural health clinic clinicians, community health center administrators or clinicians, rural health researchers, mental health clinicians with experience practicing in rural areas, and State Office of Rural Health executives. The Committee's human service members should include representatives from the following key rural human service sectors: State health and human service department executives, 3 Area Agencies on Aging, Head Start centers, rural human service research experts, and community action agency executives. The Committee has the option of appointing ex-officio members from the Department who bring an area of expertise needed to support and enhance committee activities. These positions will be filled by senior policy experts from any of the departmental operating divisions on issues related to human services in rural areas. Non-federal members will serve as Special Government Employees (SGEs). SGEs shall be invited to each serve a 4-year term; terms of more than 2 years are contingent upon the renewal of the Committee by appropriate action before its termination. Ex-officio shall serve under no-fixed term.

13. Subcommittees: Standing and ad hoc subcommittees, composed of members of the parent committee, may be established with the approval of the Secretary or designee to perform specific functions within the NACRHHS jurisdiction. Subcommittees must report back to the parent

Advisory Committee, and do not provide advice or work products directly to the Department or HRSA. The Department's Committee Management Officer will be notified upon the establishment of each subcommittee and will be provided information on the subcommittee's name, membership, function, and estimated frequency of meetings.

14. Recordkeeping: Records of the Advisory Committee, formally and informally established subcommittees, or other subgroups of the Advisory Committee, shall be handled in accordance with General Records Schedule 6.2, or other approved agency records disposition schedule. These records shall be available for public inspection and copying, subject to the Freedom of Information Act, 5 U.S.C. 552. 15.

Filing Date: OCT 29, 2019

Approved: OCT 29, 2019

Thomas J. Engels Acting Administrator, Health Resources and Services Administration.