Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Fall Meeting
Washington D.C.
September 9th – 12th

Meeting Summary

The 86th meeting of the National Advisory Committee on Rural Health and Human Services was held September 9th -11th, 2019, at Residence Inn by Marriott Washington, DC/Capital.

The committee members present at the meeting: Steve Barnett, DHA, CRNA, FACHE; Robert Blancato, MBA; Kari M. Bruffett; Wayne George Deschambeau, MBA; Molly Dodge; Carolyn Emanuel-McClain, MPH; Meggan Grant-Nierman, DO, MBA; Constance Greer, MPH; George Mark Holmes, PhD; Joe Lupica, JD; Brian Myers; Maria Sallie Poepsel, MSN, PhD, CRNA, APRN; Patricia Schou; Mary Sheridan, RN, MBA; Benjamin Taylor, Ph.D., DFAAPA, PA-C; Robert L. Wergin, MD, FAAFP; James Werth, Jr. PhD, ABPP; Loretta Wilson.

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

Truman Fellows present from the Office of Rural Health Policy: Ann Hall and Lamar Greene.

Ex-Officio Members: Lacey Boven, Aging Services Program Specialist, Administration for Community Living; Cara James, PhD, Office of Minority Health, Centers for Medicare and Medicaid Services; Nancy Geyelin Margie, PhD, Senior Social Science Research Analyst, Division of Family Strengthening, Administration for Children and Families; Benjamin Smith, MBA, MA, Indian Health Service.

MONDAY, SEPTEMBER 9th, 2019

WELCOME AND INTRODUCTIONS AND MEETING OVERVIEW

Paul Moore, DPH
Executive Secretary, NACRHHS
Federal Office of Rural Health Policy
Health Resources and Services Administration

Paul Moore welcomed the Committee and stated that he is the executive secretary of The National Advisory Committee for Rural Health and Human Services and will be chairing the

Committee since the acting chair's term expired and they are in the process of naming a new chair.

The Committee membership provides a diverse richness of rural health and human services expertise from across the country. To begin the meeting each of the members will introduce themselves. The ex officio members attending the meeting will be able to answer questions for the Committee and participate in discussions. Having a meeting in Washington DC gives an opportunity for federal staff to attend the meeting.

The National Advisory Committee on Rural Health and Human Services meeting is open to the public and there will be a call for public comment each day. The meeting is different from the meetings located in rural communities across the country. The site meetings give an opportunity to hear from rural health and human service stake holders in those rural areas of the country. This meeting gives an opportunity to hear from Rural Health and Human Service leadership and learn what rural policies are a focus of the department. The leadership also gets the opportunity to hear about topics that are important to the Committee.

The purpose of this meeting is to identify future topics, locations, and dates for upcoming meetings. Typically, the site location meetings focus on one or two rural health and human service topics and the Committee produces a brief to be presented to the Secretary of Health and Human Services. This meeting is for strategic planning and the Committee can send Secretary Azar, the Secretary of Health and Human Services, a letter to share what is planned for future meetings. There will not be a policy brief with recommendations.

Topics being considered need to be under Health and Human Services jurisdiction, have actionable steps, and are unique to rural or have rural specific obstacles.

REVIEW OF PAST COMMITTEE TOPICS & RECOMMENDATIONS

Steve Hirsch, MST, MSLS
Program Analyst
Federal Office of Rural Health Policy
Health Resources and Service Administration

Steve Hirsch shared that he has been with the Committee for nine years. It is such a privilege to work with the Committee that there have only been four chairs in the past thirty years. The National Advisory Committee on Rural Health and Human Services was established in 1987. Advisory Committees date back to Pres. George Washington and the point of these committees is to get expertise from outside government to inform the government on a broad range of issues affecting federal policies and programs. There are around 1,000 advisory committees with more than 60,000 members that advise the President and the Executive Branch**.** Under the Federal Advisory Committee Act, advisory committees can be created only when they are essential to the performance of a duty or responsibility conveyed upon the executive branch by law or Presidential Directive. Before committees can established, high-level officials within the sponsoring agency must review and approve the request. There are usually two or three meetings

a year and the committees' produce policy briefs/white papers, annual reports**,** letters to the Secretary**,** and/or comments on regulations.

The Committee charter includes an independent advisory body to the Department of Health and Human Services on issues related to how the Department and its programs serve rural communities. The Committee will be comprised of up to 21 members, including the chair, who represent the diversity of health and human service issues in rural America. These individuals shall represent an appropriate geographic representative mix from across the country

National Advisory Committee Rural Health and Human Services member professions include hospital CEOs, educators, experts on aging, physicians, certified registered nurse anesthetists, physician assistants, Health and Human Services Researchers, community health center directors and state office of rural health directors.

The Committee meets in person two to three times a year and selects topics upon which to focus during the year. Background documents are prepared for the Committee by both staff and contractors to help inform members on the issues. The Committee then produces reports/briefs with recommendations on those issues for the Secretary.

The purpose of the meetings in Washington, DC is to hear directly from policymakers and regulators. The purpose of the field meetings throughout the country are to hear directly from rural Human and Health Services providers.

Recent National Advisory Committee Rural Health and Human Service topics:

- Addressing the Burden of Chronic Obstructive Pulmonary Disease (COPD)
- Improving Oral Health Care Services in Rural America
- Exploring the Rural Context for Adverse Childhood Experiences
- Rural Health Insurance Market Challenges
- Modernizing Rural Health Clinic Provisions
- Understanding the Impact of Suicide in Rural America

In an assessment of Federal Advisory Committee Act Committees by the General Services Administration, the National Advisory Committee on Rural Health and Human Services was identified as one of the top examples of Federal Advisory Committees demonstrating superior stakeholder engagement. This survey, done by the Gallup Organization for the General Services Administration, noted that NACRHHS was one of the top examples of Federal advisory committees demonstrating high levels of consistent behaviors and practices.

Q&A | DISCUSSION SESSION

Bob Wergin shared that he appreciates the diversity of the Committee and stated that each rural location has their own culture and resource issues. He looks forward to working on topics that are broad enough to encompass all rural areas.

Connie Greer said that there are committee members who are from the social service spectrum among the larger group of health care members. The social service issues such as social determinants of health have always been part of the Committee discussions and that is a very positive aspect of being part of the Committee. Health and human services are intertwined, and it is important to discuss them together when working to improve rural communities.

Steve Barnett said that the staff creates very meaningful reports that are presented to the Secretary following the meetings. The COPD work that was done by the Committee has had actions taken by the national resource center through publications and there will be additional analysis coming up at the rural health meeting in Kansas.

EXAMINING ISSUES THAT IMPACT RURAL CHILDREN, YOUTH AND THEIR FAMILIES

Aleta Lynn Meyer, PhD
Team Leader – Community-Engaged & American Indian and Alaska Native Research
Senior Social Science Research Analyst
Division of Family Strengthening
Office of Planning, Research and Evaluation
Administration for Children and Families

Aleta Lynn Meyer shared with the Committee that she is from Iowa**.** She stated the department has a learning agenda for human services in a rural context so that will be part of the discussion. Nancy Geyelin Margie, the Home Visiting Research Team Leader, will provide a brief overview of the Administration for Children and Families and the role of the Office of Planning, Research and Evaluation within the Administration for Children and Families. Examples from the Learning Agenda for Home Visiting include: MIHOPE - a National Impact Study, MUSE – a Multi-Site Implementation Study of Tribal Home Visiting, and a new project named The Human Services Programs in Rural Contexts.

Aleta Meyer stated that she would share about OPRE's Home Visiting Program research. Home Visiting is a service delivery mechanism and not just one entity. The Home Visiting Program aims to improve a wide range of family outcomes, depending on family needs and provides individually tailored services to expectant parents and families with young children. Home visitors generally conduct three types of activities that include assessing family needs, educating and supporting parents, and providing referrals to community services. Evidence-based models differ on priority placed on various family outcomes, characteristics of families served, home visitor qualifications, professional development supports, frequency, duration, and length of home visits, and amount of flexibility provided to local home visiting programs.

Maternal, Infant, and Early Childhood Home Visiting Program was created in 2010 with funding through 2022 provided by the Bipartisan Budget Act of 2018. This program greatly expanded Federal funding of evidence-based home visiting programs. There was a collaborative implementation of the program by Administration for Children and Families and Health Research and Services Administration. There are grants awarded to states and territories for implementation of evidence-based home visiting that is administered by HRSA. There is three percent set-aside for grants to Tribal entities which equaled $12 million in FY19.

The Maternal, Infant, and Early Childhood Home Visiting Program efforts are guided by a learning agenda that has been created over the past few years. A learning agenda is a portfolio of

evidence to better learn what works for whom and under what circumstances. It is important in order to improve services and outcomes. The MIECHV learning agenda has engaged in a broad portfolio of research, evaluation, CQI, TA and performance measurement since its inception. Each piece provides important information about how the program is doing and how to improve the program and all the pieces to tell the most complete story.

MIHOPE is the legislatively mandated evaluation of the Maternal, Infant, and Early Childhood Home Visiting Program. The MIHOPE evaluation includes a state needs assessments analysis, multi-level implementation analysis, random assignment impact analysis, and cost analysis. There were more than 4,200 families randomly assigned for the evaluation. Women enrolled while pregnant or with a baby under six months old. The evaluation included 600 home visitors; 142 supervisors located at 88 sites in 12 different states. Sites are implementing one of four models chosen by ten or more states in their initial state plans. The four models are: Early Head Start – Home-Based Option, Healthy Families America, Nurse-Family Partnership and Parents as Teachers.

Seventy-eight percent of The Maternal, Infant, and Early Childhood Home Visiting programs are in metropolitan counties, fourteen percent are in non-metro areas, and eight percent in both metro and non-metro. Eighty percent of local program managers reported that there was a provider available in their community for all of the following 9 services: prenatal care, family planning and reproductive health care, substance use and mental health treatment, shelter for intimate partner violence, intimate partner violence counseling/anger management, pediatric primary care, early intervention services, adult education and employment services, and child care. However, less than 2/3 of programs perceived those providers as accessible and effective. Eighty-eight percent of MIHOPE participants reported receiving public assistance. Eighty-two percent of women participating in MIHOPE had health insurance at study entry. The metro/non-metro nature of the sample is important to keep in mind when examining the findings. Would these numbers be different for a more rural or solely rural sample?

Goals of the Tribal Home Visiting Program are to support the development of healthy, happy, and successful American Indian and Alaskan Native children and families. This is accomplished by implementing high-quality, culturally relevant, evidence-based home visiting programs in AIAN communities, expanding the evidence base around home visiting interventions for Native populations, and supporting and strengthening linkages among early childhood programs and coordinated early childhood systems.

There are currently twenty-three grantees in twelve states, including tribal nations, consortium of tribes, tribal organizations, and urban Indian organizations. Grantees are implementing evidence-based home visiting models with adaptations, supplements, and enhancements to fit their communities and support local and tribal customs and culture.

The Multi-Site Implementation Evaluation of Tribal Home Visiting Program is an unprecedented look at how home visiting is being implemented across tribal communities. MUSE is the first multi-site, multi-model study of home visiting in tribal communities. The goal is to help programs build on what is going well across programs to improve services to families locally.

The Office of Planning, Research and Evaluation’s new Cross-Cutting Project

examines human services programs in rural contexts. Given the unique characteristics, strengths and challenges of rural America, it is important to understand how human services best meet needs in the rural context. The goals of this project are to provide a rich description of human services programs in rural contexts and determine the unmet need for human services in rural communities. The Cross-Cutting Project also identifies opportunities for strengthening the capacity of human services programs to promote the economic and social well-being of individuals, families, and communities in rural contexts.

The working plan for stakeholder engagement delineates project activities where stakeholders will be engaged and is refined throughout the project. Consultation with the Human Services Practice Field and all human services programs within the US Department of Health and Human Services is included. The priority programs include Healthy Marriage and Responsible Fatherhood, Temporary Assistance for Needy Families, Health Professional Opportunity Grants, and the Maternal, Infant, and Early Childhood Home Visiting Program.

Laying the groundwork includes reviewing and synthesizing relevant research on rural economic and social well-being, assessing federal and state reports on human services in rural communities, including policy briefs and publications of the National Advisory Committee on Rural Health and Human Services, and identifying gaps in the existing knowledge base produced by the above reviews and syntheses. Identifying the unmet need for human services in rural contexts includes determining the distribution of human services funds and creating a framework of needs, human services that would meet the needs, and indicators to show whether the needs are being met. Reviewing existing national survey and administrative data sources to identify data elements addressing key indicators is also necessary.

Key evaluation activities include designing and implementing a mixed methods approach, case studies and interviews of human services staff, participants, and non-participants and conducting secondary data analysis. The Mixed Methods Research Design and Execution Plan will include articulation of a priori theory, and assumptions guiding the hypotheses and analytic approaches. Data elements will be gathered to answer research questions and there will be a proposed plan for integrative and emergent use of mixed methods, secondary data analysis, and logistics for data collection and analysis. A proposed schedule for production of reports, briefs and other materials that can be disseminated throughout the period of the project.

The contract will be awarded before the end of September and the project will begin in October. The next step will be to engage the Secretary's Advisory Committee on Rural Health and Human Services.

Nancy Geyelin Margie, PhD
Team Lead- Home Visiting Research Team Leader
Senior Social Science Research Analyst
Division of Family Strengthening
Office of Planning, Research and Evaluation
Administration for Children and Families

Nancy Geyelin Margie stated it is a pleasure to be part of the group. The Administration for Children and Families is a division of the Department of Health & Human Services. We promote the economic and social well-being of children, families, individuals and communities with leadership and resources for compassionate, effective delivery of human services. ACF administers more than 60 programs with an FY19 budget of more than $58 billion. Programs include: Child Care, Head Start, Temporary Assistance for Needy Families, Child Welfare, Child Support Enforcement, Adolescent Pregnancy Prevention, Refugee Resettlement, support for Native American Communities, programs for Runaway and Homeless Youth, Family Violence Prevention and Services, community economic development, Rural Community Development, and more.

The Administration for Children and Families evaluation policy was established in 2012. ACF seeks to promote rigor, relevance, transparency, independence, and ethics in the conduct of evaluations. ACF's Evaluation Policy addresses these five key principles to govern ACF's planning, conduct, and use of evaluation.

The Office of Planning, Research and Evaluation builds, and disseminates knowledge about effective approaches to helping low-income children and families through rigorous research and evaluation projects including evaluations of existing programs and innovative approaches to help low-income children and families, research syntheses, and descriptive and exploratory studies. OPRE conducts research and other activities in the areas where Congress has given us authority and funds.

The Office of Planning, Research and Evaluation's mission is to advise ACF programs and leadership on issues related to quality effectiveness and efficiency. This is accomplished through policy oversite and performance management functions. The primary role is to conduct research and evaluation studies across the range programs and topics under ACF's umbrella. This includes partnerships with other federal agencies and with the broader research community to study human services programs and the populations they serve. An example is The Maternal, Infant, and Early Childhood Home Visiting Program is a partnership with the Health Resources and Services Administration.

The Division of Family Strengthening conducts research related to healthy marriage, responsible fatherhood, family violence prevention, runaway and homeless youth, home visiting, teen pregnancy prevention and sexual risk avoidance, and supporting positive youth development and transition to adulthood. OPRE's Division of Child and Family Development conducts research related to Child Care, Head Start and Early Head Start, and Child abuse and neglect. OPRE's Division of Economic Independence conducts research related to the labor market, education and Temporary Assistance for Needy Families, employment training, and cross-cutting safety net research.

The Office of Planning, Research and Evaluation's Division of Data and Improvement works to improve the quality, usefulness, interoperability, availability, and analysis of data, by leading ACF interoperability activities and promoting data sharing efforts within ACF and across state and local partners, conducting statistical analyses of ACF and related administrative data,

supporting innovative data linking & integration efforts across human services, and providing technical assistance to ACF programs to support continuous quality improvement.

Q&A | DISCUSSION SESSION

Pat Schou said that she thinks the Tribal Home Visiting Program is wonderful and appreciates the idea of home visits. Is the long-term goal of these studies to advocate for public policy change like with public aid money and health insurance programs that new families receive some type of home visiting program?

Nancy Margie stated that they want to create research and knowledge that can inform decision makers.

Steve Barnett asked if any of the research is giving results regarding the need for traditional walls to be removed in the way services are provided.

Nancy Margie stated that there will be lessons learned on how rural communities are removing traditional walls and there are ways that health and human services are structured that are contributing to the problem.

Aleta Meyer stated that within the home visiting field these silos are a huge conversation. The goal of home visiting is to help build early childhood comprehensive services more generally. It is hard when there is specific funding that is designated for something specific and the language is around a specific program. At the local level there are discussions about blending these and making things work so there are not these silos. The study is to find out what is happening now on the ground while there is so much funding going into home visiting. With all the implementation data there is a way to find out what can be done more efficiently.

Sallie Poepsel said that in the process of conducting the study and identifying the 17 communities what is the common limitation emerging from the study?

Nancy Margie stated that the 17 communities are the communities that received the tribal home visiting grants. They are going to be stellar examples. The results are not available yet and it will take about a year to know the outcomes. As a federal program, there is guidance provided but the guidance is informed by implementation science, so it will be interesting to find out what is most helpful and there may be guidelines that need to be removed so there is more flexibility. Relationships at the local level is important for home visiting programs so it is important to support improving relationships on the ground level.

Molly Dodge asked how they will identify challenges related to workforce in the new study?

Aleta Meyer responded that The Home Visiting Career Trajectory Study and those findings are coming out within the next few months and it was a national look at home visiting and there was an intentional rural focus so it will be more representative of The Maternal, Infant, and Early Childhood Home Visiting Program. It is specifically looking at the professional development supports.

WELCOME FROM HEALTH RESOUCES AND SERVICES ADMINISATRATION ADMINISTRATOR

Thomas J. Engels
Acting Administrator
Health Resources and Services Administration

Thomas Engels shared that he was working as a custodian at the State Capital in Madison, Wisconsin. In 1986, Tommy Thompson was the Assembly Minority Leader and the governor elect and called him into his office. He told him that had five seconds to answer the question of whether he wanted to continue working as a custodian at the State Capital or work for him at the Governor's Office as the Deputy Press Secretary. He began working for Governor Tommy Thompson as his Deputy Press Secretary and Governor Thompson went on to become President George W. Bush's Secretary of Health and Human Services.

Thomas Engels is the new Acting Administrator of the Health Resources and Services Administration and was the Deputy Secretary of Health for the Wisconsin Department of Health Services. The office in Madison had about 2,000 people and an annual budget of 12 billion dollars, which is about the same budget of HRSA. As Deputy Secretary he was able to see firsthand how the programs offered by HRSA interact and are implemented in the state.

The committee members have a broad range of talent and it will be a pleasure working together. Secretary Azar has identified rural as a priority within the department. The work that the Committee is doing will provide HRSA with great opportunities as Secretary Azar moves his initiatives forward. In 2018, the Secretary created the Rural Health Task Force. It includes leaders and stakeholders across Health and Human Services. The task force forms a better understanding of how policy changes can bring about transformational changes in rural communities. The goals of the task force include realizing affordable, accessible, and high-quality healthcare. In order to do this, the task force is focused on strategies and efforts around sustainability, innovation, and flexibility. Rural issues are a priority for this Secretary.

The Committee will hear from HRSA staff, entities from across the entire department, and stakeholders from rural communities. Work over the coming years to formulate plans. Admiral Giroir will be speaking to the committee and announce some grants being presented and bring ideas that will affect the Secretary's key priority issues. As you work to choose topics it makes sense to start with some of the key priorities that the Secretary has identified. The Secretary's priorities are the opioid epidemic, health insurance reform, drug pricing reform, and making the transition to value-based care. There are new focus areas that include bringing more attention to rural and addressing the challenges of maternal health. Across the department there is a focus on the President's plan to end the HIV epidemic. To do that there is a need to utilize the resources in seven mostly rural states that are uniquely challenged by this epidemic.

Think big for the future and ensure that the Committee's priorities are relevant to the rural communities being served. The Committee's input is welcome and when considering recommendations, be specific as possible. He shared that he grew up in Shullsburg. Wisconsin

which is a city by state's statute and has a population of 1,200 people. It is the second largest city in Lafayette County. The largest city is Darlington with a population of about 2,000 people and has a hospital where his mother used to be the administrator. There is not one stop light in Lafayette County, and he thought that was considered rural, but compared to other areas in the country it is considered urban. The hospital and access to healthcare keeps the community thriving. Access to dental care, nurses and pharmacists is healthcare that must be available in rural areas. HRSA is committed to providing those services and have workforce efforts to get more residencies into the rural areas. The staff at HRSA must reach across bureaus to discuss programs and have cross-cutting initiatives that serve people in rural areas. It is great to grow up in a rural area and it is important. Some people like to live in the big city and others like to live in the rural areas and that is the great thing about the United States – there is a great mixture of both.

HEALTH RESOUCES AND SERVICES ADMINISATRATION/FEDERAL OFFICE OF RURAL HEALTH POLICY AND RURAL ISSUES

Tom Morris
Associate Administrator, Rural Health Policy
Health Resources and Services Administration

Tom Morris stated that key themes that cut across HRSA programs and populations they serve are access, vulnerable populations, a focus on the safety net, and including rural and underserved. HRSA supports more than ninety programs that provide health care to people who are geographically isolated as well as economically or medically challenged. Much of the support is through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities. Every year, HRSA programs serve tens of millions of people, including people living with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care.

The Bureau of Primary Health Care administers the Community Health Center Program. Community Health Centers are access points that see all patients regardless of their ability to pay. There are approximately 1,400 service sites throughout the country. One in five rural residents are served by a health center. Forty percent of the sites are in a rural community. When discussing the rural health safety net, community health centers are at the core. They have made great advances in managing patients with chronic disease, care for people who do not have insurance and they have made great strides with electronic health record adoption.

The Health Workforce Program supports training for primary care, mental health, and oral health, through teaching health centers and other residency support programs. There are more than 1,400 service sites nationally. Some of the key achievements of the program are in chronic disease management and electronic health record adoption.

Maternal and Child Health Block grant focuses on infant mortality and child health. Between 2000 and 2017, the national infant mortality rate has been reduced by sixteen percent. HV Grants focus on at-risk pregnant women and parents with young children up to kindergarten entry.

Healthy Start and Emergency Medical Services for Children are potential focuses for the Committee related to maternal and child health and could include safety bundles, reducing maternal mortality, access to obstetrical care in rural communities, and workforce challenges.

There are focused efforts in 48 counties, Washington, DC, and San Juan, PR, where more than 50% of HIV diagnoses occurred in 2016 and 2017, and seven states with substantial rural HIV burdens. HRSA will be working in partnership with states and some of the initial steps include stakeholder engagement so this may be a topic that could be considered by the Committee.

Another topic that the Committee may want to address is the unique challenges of opioid and substance abuse disorder in rural communities related to workforce challenges, limited infrastructure, and the changing face of the epidemic.

COMMITTEE DISCUSSION

Possible Topics for Future Site Visits

Secretary Azar's has a focus on HIV rapid diagnosis and a regiment of care. The Committee has not focused on HIV and there is an increase of HIV in rural Southeastern United States. More of an urban issue but there are not as many services in rural. Seven states with higher numbers of HIV in rural.

Maternal Health is a consideration as a focus of the Committee because there is a national effort around safety bundles. A rural focus on the applicability of safety bundles to smaller hospitals could be a future topic.

The opioid epidemic is also a focus of Secretary Azar, so the Committee could examine the challenges of stigma and the changing face of epidemic. A sustained focus needs to be considered in order to address other types of substance abuse in the future.

INDIAN HEALTH SERVICES AND RURAL ISSUES

RADM Michael D. Weahkee
Principal Deputy Director
Indian Health Service

Michael Weahkee started by thanking the Committee for adding Indian Health Service to the meeting. He shared that he is from Zuni, New Mexico, which is south of Gallup. He is a member of the Zuni Tribe and said that he has rural health in his blood and background.

The Committee's focus on strategic planning is important as the Committee contemplates topics to address and develop recommendations for Secretary Azar. Indian Health Service has benefited from the work of the Committee related to telehealth, understanding the impacts of suicide in rural communities, oral healthcare, and examining rural cancer prevention and treatment. The Committee's collaboration on rural health is reflected through the wide representation from different organizations represented and geographies. The strategic plan within Indian Health

Service is to strategically build, strengthen, and sustain collaborative relationships that advance the Indian Health Service Mission. The mission statement is to raise the physical, mental, social and spiritual health of American Indians and Alaskan Natives to the highest level.

The Indian Health Service is the principal federal agency responsible for providing healthcare to 2.6 million American Indians and Alaskan Natives from across the country. IHS provides a comprehensive health care delivery system and disease prevention services through a network of 605 hospitals, ambulatory health centers, and small health stations that are mainly located on or near reservations. The budget for FY2019 was 5.9 billion and an there is an additional 1.2 billion from third party revenues. Indian Health Service healthcare facilities range across 12 regional offices. Rural and urban Native American populations are covered in 37 of the 50 States. Some healthcare facilities are in large native populated areas, but others are in some of the most isolated and remote locations like Barrow, Alaska, north of the Arctic Circle and the Supai Village in Arizona. About 60% of the programs are operated directly by the tribes Indian Self Determination and Education Assistance Act. IHS provides funding for 41 urban Indian Health Programs where the past policy of Indian relocation uprooted Native Americans from reservations and had them move to urban locations. There are large Native American populations in San Francisco, Boston, Oakland, Chicago and Denver. There is also The Purchased and Referred Care Program where care is purchased from other providers outside of the IHS health system.

In FY2018, there were more than 40,000 hospital admissions and almost 13.8 million outpatient medical care visits throughout the system of care. The IHS team is comprised of 15,400 professionals including healthcare providers, food service workers, security guards, IT professionals, attorneys, etc. About 70% of the employees are of American Indian or Alaskan Native descent. The Provision of Health Care Services to members of federally recognized tribes grew out of government to government relationships that exists between the federal government and 573 sovereign tribes throughout the nation. The United States government's commitment to providing access to healthcare as established through treaties and laws is the responsibility of the entire US government, not just Indian Health Service.

Native Americans have lower health status compared with other Americans and lower life expectancy. Disproportionate disease burden exists because of inadequate education opportunities, disproportionate poverty levels, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions. The IHS mission statement is broad because the different aspects of health are linked as are the social determinants of health. Availability of adequate housing, educational opportunities, healthy food, and jobs are all issues that IHS works hard to address. Health status starts in our families, homes, and jobs and is affected by the air that we breathe and the water that we drink.

Michael Weahkee stated that he has personally challenged all IHS members to explore how to relieve the stress and burden of the overtaxed healthcare system by partnering with external agencies across government, within states and cities, as well as academia and community non-profits. Indian Health Services works with the Department of Interior which houses the Bureau of Indian Affairs, Bureau of Indian Education, National Congress of American Indians, and the Robert Wood Johnson foundation. There are many different academic affiliation agreements

across the country and agreements with medical schools, providers and healthcare systems. Partnerships have been established to compliment health programs and examine how improvements in education, law enforcement, business practices and employment can have positive effects on the health status of American Indians and Alaskan Natives. Collaborations with partners is vital to provide quality and competent care.

Indian Health Services has recently released a new strategic plan that covers years 2019-2023. IHS has significant struggles mainly in the great plains in addressing the system of care. The agency has not had a strategic plan for the past decade, so this is a new milestone document. There was work with tribes and partners spanning over an 18-month consultation to gain their guidance and expertise to develop the plan. The goals are to expand access to care, improve the quality of care provided and improve management and operations of the agency. The plan was released in February and the budgeting for the coming year and performance plans for senior executives are being aligned to implement the plan.

One of Secretary Azar's top priorities in transforming the healthcare system is a focus on value-based systems leading to better healthcare by focusing on outcomes and health instead of procedures and sickness. IHS is building a culture of continuous quality improvement and embracing the latest technologies like high quality HIT that puts information in the hands of patients and providers. DOD and the Veteran's Administration are transitioning their HIT and IHS has historically relied upon the VA for their programming language. IHS no longer has VA's infrastructure for reliance so there are decisions being made about moving forward with IHS electronic health records.

The HHS Office of the Assistant Secretary for Planning and Evaluation is also working on a project to implement a value-based model of care across IHS. In collaboration with CMS and IHS, ASPE will host four focus groups this month to address value-based care and quality measures of reporting within IHS. With the new framework in place there must be response to change to remain effective. In the past two decades there has been a broad shift to outpatient care delivery. Overall, people are living longer with more chronic conditions that are managed through outpatient care. Across rural America, hospitals are closing, and new delivery designs are emerging such as telehealth and visiting nursing programs. There are examples of transitions in care in the form of rural frontier hospitals where the emphasis's is on primary care, short stay units for observations and on emergency care. These remote hospitals maintain close relationships with impatient facilities for those who need to be stabilized and transferred.

As the Committee meets and discusses strategies on the work ahead, include components of the Indian Healthcare System into the work and visits. Whether it is a federal or tribal operated facility, all the team members are open and ready to share best practices and challenges. There are some well-known healthcare champions in the IHS system. The South-Central Foundation's Nuka System of Care is an innovative system in Alaska where small village clinics refer to regional hospitals who in turn refer to the Alaska Native Medical Center.

Q&A | DISCUSSION SESSION

Steve Barnett stated that many of the facilities that are precious to rural communities are working to collaborate and bring agencies together. Sometimes there are barriers that restrict collaboration by financing and rules. The facilities are failing structurally and were not built to survive how healthcare is currently being delivered or financed. Is there hope in the future of rebuilding that infrastructure?

Thomas Engels has stressed from day one at HRSA to talk to one another and other bureaus within HRSA and agencies within HHS. It is important that Secretary Azar have the best information possible.

Tom Morris said that the hospital closings and viability of rural hospitals moving forward does not have a solution. The rural taskforce will be bringing more attention to the issue and stakeholders have met with the Secretary so there is an awareness and there are programs on the Medicare side to help hospitals at risk. There is a great collaboration with colleagues at CDC and they are interested in the issue.

Robert Wergin thanked Thomas Engels for speaking and said he is thankful that Secretary Azar is emphasizing issues that affect urban and rural issues. Are you addressing workforce, graduate medical education, and more primary care physicians that can be recruited to the rural areas? There has been a waning of emphasis regarding primary care physicians and a way to increase quality and reduce cost is by having full scope primary care physicians. How can we entice the millennials to work in rural areas? Is the department addressing how medical education is paid?

Thomas Engels stated that he and Dr. Luis Padilla briefed the Assistant Secretary of Health, Admiral Giroir, on the HRSA health workforce initiative. There is the Bureau of Health Workforce and it is a major priority. Once people work in rural communities and learn to appreciate them, they tend to stay. When he was Deputy Secretary of Health in Wisconsin, he met with UW Hospital and had to explain that the residences who go to rural areas and are from the city, don't understand the plight of a farmer and agriculture so they couldn't relate to them. The hospital had to revamp their educational opportunities so that the residents understood their patients and could better serve them. It is one of the cross-cutting areas for HRSA.

Patricia Schou said she had a summit with hospital CEO's in Illinois. The focus used to be about staffing hospitals, but economic development was their top priority in the discussion at the summit. How can HRSA or the Committee bridge the gap with other agencies to help the hospitals CEO's be integrated in their community and assist with economic development? Another area of concern is the transition from the Medicaid state programs to commercial Managed Care Organizations for rural communities because instead of working with one state organization they must work with five managed care companies or five different contracts it becomes very difficult. Is there anything HRSA or the Committee can address on these issues?

Thomas Engels encouraged Patricia Schou to talk to CMS about the issues with MCO's. Recruiting practitioners to rural areas is the key to attracting economic opportunities because there must be a healthcare workforce to attract businesses to an area.

Mary Sheridan stated that there was discussion about value-based health care and in Idaho some Critical Access Hospitals have embraced population health and are successfully keeping patients out of the hospital. In doing so they are destabilizing health care within their communities. Do you have a vision of how reimbursement may catch up – especially for those who are on the leading edge?

Tom Morris replied that there is still the transition from fee-for-service towards population health and this is an important discussion. Cara James, with Centers for Medicare and Medicaid Services, would be discussing this topic later in the day.

Loretta Wilson stated that training more students to take part in healthcare in rural areas is vital. In rural Alabama, there is the issue of the aging population of physicians that are covering the emergency room. There is a gap of rural providers who are not coming into the area. With rural scholars and loan repays, residents used to be assigned to areas. Is that something that can be revisited?

Tom Morris responded that the National Service Corp and Nurse Corp programs are over prescribed, so a high threshold must be met regarding a health professional shortage area. People are having to relocate year after year because they are not in a high enough Health Professional Shortage Area. If the Committee wants to work on this topic, there can be experts from across the department to work with the Committee.

CENTERS FOR DISEASE CONTROL AND PREVENTION AND RURAL ISSUES

Diane Hall, PhD, MSEd
Senior Scientist for Policy and Strategy
Office of the Associate Director for Policy and Strategy
Centers for Disease Control and Prevention

Diane Hall said she would discuss Centers for Disease Control and Prevention, public health and work in rural health. CDC is the nation's public health agency and protects the health and safety of America. CDC has always done work in rural health, but the work is spread across the agency. In 2016, the CDC organized a working group to evaluate CDC's portfolio of work throughout the different offices and programs. A rural health morbidity/mortality weekly report series started in 2017.

Centers for Disease Control was established in 1946 in Atlanta as the Communicable Disease Center to prevent the spread of malaria. The work has been greatly expanded throughout the years in issues related to health and safety of the population. There are ten United States facility locations other than Atlanta and work is being conducted in more than 50 countries. There are 14,000 people who work at CDC representing more than 170 occupations.

Annual funding is around 11 billion dollars. The funding is geared toward a specific purpose or block grant funding which is more flexible. The Committee discussed COPD a year ago and it is one of the five leading causes of death, but CDC does not get funding for that specific topic.

There are people in CDC who are passionate about the topic of COPD, so they run data analysis and write reports when possible. There is no CDC funding for suicide prevention, so the Center for Injury Prevention thought it was critical to put funding towards suicide prevention. SAMSA gets a bulk of the funding for suicide prevention and examines it from the mental illness perspective while CDC is examining it from a public health perspective. CDC does not have an office of rural health but started a Rural Health Learning Community Initiative and held the first meeting August 1st with 200 people participating.

Usually the conversation about health is based on healthcare so the focus is on being sick or injured. The public health system is a connection of many organizations focused on keeping populations healthy which has a focus on prevention. The public health model is defining the problem, identifying risks and protective factors, developing prevention strategies, and assuring widespread adoption of the strategies.

The CDC website has a rural health page and all the Morbidity and Mortality Weekly Reports that are part of the Rural Health Series are posted on the page. The MMWR reports receive a great deal of attention, especially from people who were not familiar with rural issues. Since 2017, three or four rural focused MMWRs are done per year. Now people across the agency consider "what about rural" when discussing research projects and other projects throughout CDC. Inadvertently there may be issues for rural communities to be eligible for CDC funding opportunities. A rural fact sheet was created so that program offices can create strategies and language that will assure rural will have equal opportunity to receive funding. CDC works with the Federal Office of Rural Health Policy and collaborate on webinars on rural issues. There are also six policy briefs on the website that highlight policy options that rural communities may consider.

Center for Disease Control has access to electronic health records and are using those as a source of data to research rural communities. Data collection is an issue in rural communities so that is being considered across CDC. There are rural focused data briefs by the National Center for Health Statistics.

Collogues across CDC are getting creative in doing projects that are rural focused and have rural grantees, such as a MMWR on disparity in adolescent HPV vaccinations in rural and non-rural communities. CDC will be awarding a contract soon to determine what is driving the disparity. In Southeastern Kentucky, there are counties where the opioid overdose rate is reducing. CDC is carrying out a mix methods study to research why there is a reduction in overdoses and if there is a program or policy reason then it will be shared with other communities.

The eleven Agriculture Safety Centers are located at universities and all doing projects on mental health in rural communities and the projects are listed on their websites. Influenza and Zoonoses Education among Youth in Agriculture program ("Youth in Ag") is working with 4H and Future Farmers of America on educational programs to set up hand washing stations, creating signs to display. They are educating youth about illnesses that travel between people and animals.

Teens Link to Care is a CDC foundation funded program. There are three rural schools working on a curriculum focused on STD prevention and substance misuse prevention. The findings will lead to a larger project in the future.

The High Obesity Program is for counties where 40% or more of the people are obese. CDC is working through land grant institutions to get information out with a focus on increasing access to healthy food and increasing physical activity.

CDC email address ruralhealth@cdc.gov. is a way to contact the CDC with questions or comments related to rural issues.

Q&A | DISCUSSION SESSION

Molly Dodge asked if the impact of trauma is being considered regarding the research on emotional wellbeing.

Diane Hall stated that the behavioral scientists working on Adverse Childhood Experiences research at CDC are part of the steering committee. There are experts on suicide prevention, ACEs work, and the Division of Population Health.

Bob Wergin asked how the CDC defines rural.

Diane Hall stated that there are over 70 definitions of rural used by the Federal Government. For the Morbidity and Mortality Weekly Report Series, the majority used the National Center for Health Statistics classification of rural/urban.

REVISITING CHALLENGES AND OPPORTUNITIES THAT AFFECT OLDER RURAL AMERICANS

Lacey Boven
Aging Services Program Specialist
Regions V & VII – Chicago and Kansas City
Administration for Community Living

Lacey Boven stated that she would speak about challenges and opportunities related to older rural Americans. She was raised by her cattle ranching grandmother in Cassoday, Kansas which is known as the Prairie Chicken Capitol of the World. The population of Cassoday is 120 so she grew up in a rural area.

The Administration for Community Living believes that all Americans should be able to live at home and receive the supports needed and participate in communities that value their contributions. The FY 2019 budget was $2 billion with more than 3,000 grants and contracts allocated to help people of all ages living independently in their communities. The strategic direction of the Administration for Community Living is connecting people to resources,

protecting rights and preventing abuse, supporting families and caregivers, strengthening aging and disability networks, and expanding employment opportunities.

By 2020, an estimated seventy-seven million people will be over the age of sixty. Two thirds will need assistance with dressing, showering, or similar tasks at some point. There will be fifty-seven million people living with disabilities in a non-institutional setting with twenty percent needing assistance with daily living tasks.

The Aging Network was established by The Older Americans Act that was signed into law in 1965. The Administration on Aging is responsible for the Administration of the Older American's Act and believes in the power of prevention and intervention with the aim of getting older adults the supports they need to thrive in their communities. This is accomplished through The Aging Network that provides services and supports to one in five seniors. The services and supports include meals, transportation, personal care, caregiver assistance, respite care, and ombudsman consultations.

Nutrition programs under the Older Americans Act help approximately 2.4 million older adults receive meals in order to stay healthy and decrease their risk of disability. The program's goal is to decrease hunger and food insecurity, decrease isolation, and offer health promotion activities. Sixty-three percent of the congregate meal recipients reported that receiving meals allowed them to continue living in their own homes. Ninety-three percent of home delivered meal recipients reported that meals allowed them to continue living in their own homes. This could be the only meal or social interaction in a person's day.

When Lacey Boven was in middle school, her grandmother told her that she was buying the restaurant in town. If she did not purchase it no one else would and there needed to be community support for the cattle ranchers. The restaurant served as a community hub and tourist attraction. Over fifteen years ago her grandmother was approached about hosting a meal site as an innovative approach to serving more adults in the rural community. She created a healthy menu in a café setting for participants to enjoy their meal with friends.

The Older Americans Act is intended to be comprehensive for community living with supportive services identified specifically for seniors. Some services identified in rural areas include minor home modifications, nutritional supplements after hospitalization or assisting with chopping wood in the winter.

Administration for Community Living created an interconnected framework for carrying out the OAA's Vulnerable Elder Rights Protection activities under OAA, Title VII. The Administration for Community Living leads The Elder Justice Coordinating Council on behalf of Secretary Azar. The Council is seeking Public Input on EJCC Priorities through 12/31/19.

It is a necessity to have informal caregivers and they require support. A 2015 study by the Rand Corporation estimated the economic cost of replacing unpaid caregiving to be about $522 billion annually. Two caregiver advisory councils were recently enacted, and they are providing opportunities to support informal caregivers and grandparents raising their grandchildren due to the opioid epidemic.

Aging and Disability Resource Centers across the country seek to address the frustrations many older adults, people with disabilities, and family members experience when trying to learn about and access long term services and supports. A collaboration between the Administration for Community Living, the Centers for Medicare & Medicaid Services, and the Veterans Health Administration, the No Wrong Door Initiative supports states working to streamline access to long-term services and supports for older adults, people with disabilities, and their families.

State Health Insurance Assistance Programs empower, educate, and assist Medicare-eligible individuals, their families, and caregivers through objective outreach, counseling, and training, to make informed health insurance decisions that optimize access to care and benefits. SHIPs recruit and train both volunteer and in-kind counselors to provide program services. SHIP counselors are highly trained and certified to help Medicare beneficiaries.

There is limited knowledge as to the prevalence, incidence, and specific community needs of rural communities impacted by Alzheimer's and related dementia, given that these communities are often underserved. The Administration on Aging provides funds via its Alzheimer's Disease Supportive Services Program and the Alzheimer's Disease Initiative-Specialized Supportive Services program to support dementia capable programming throughout the United States. Through the Dementia Friendly America Program, communities and individuals have an opportunity to learn about being a Dementia Friend in their rural area.

Community Partnerships challenges in rural communities are workforce shortages, lack of broadband/internet access, technology issues and resource shortages. Community partnership opportunities in rural communities include the Geriatric Workforce Enhancement Program utilization, community health partnerships, park partnerships, and use of volunteers. Administration for Community Living has supported successful evidence-based programming in the areas of chronic disease self-management, diabetes management, behavioral health, and falls prevention.

The World Health Organization's The Decade of Healthy Ageing Initiative, is an opportunity to bring together governments, civil society, international agencies, professionals, academia, the media, and the private sector for ten years of concerted, catalytic and collaborative action to improve the lives of older people, their families, and the communities in which they live. Healthy Ageing is the process of developing and maintaining the functional ability that enables wellbeing in older age.

Q&A | DISSCUSSION SESSION

Steve Barnett said that older Americans aging in place is what is preferred. Broadband, transportation, and social isolation are all issues with aging in place. Every county seat in America needs a community health center and it is not the same as the hospital. It is a place where people can go to interact and work on physical fitness as well. The cost of a CHC is far lower than paying for managing chronic health conditions. Is this something that your group would be involved in bringing together?

Lacey Boven stated that yes, that is a huge part of the role of The Administration for Community Living. Promoting the idea with the Area Agencies on Aging and partnering with community health partners is a way to create this in rural communities.

Kari Bruffett stated there is a need for managed services networks and building the capacity of the community-based organizations to meet needs of the ageing population and people with disabilities. Identifying needs is not as much of an issue as a lack of providers and a way to pay the providers. In some communities Older Americans Act funding is being combined with other funding but there tends to be more success in communities that have more value-based reimbursement.

Lacey Boven stated there are some best practices in rural areas for payment models and she can share that information with the Committee.

RURAL IMPLICATIONS REGARDING MEDICARE & MEDICAID SERVICES

Cara V. James, PhD
Director | Office of Minority Health
Co-Chair | Rural Council
Centers for Medicare and Medicaid Services

Cara James shared that the Rethinking Rural Health Initiative began with the Centers for Medicare and Medicaid Services Rural Health Strategy in May of 2018. The rural health strategy objectives are to apply a rural lens to CMS programs and policies, improve access to care through provider engagement and support, advance telehealth and telemedicine, empower patients in rural communities to make decisions about their health care, and leverage partnerships to achieve the goals of the CMS Rural Health Strategy. CMS has collaborated with The Office of Rural Health Policy and the Administration for Children and Families, and other stakeholders, in order to meet these objectives. Listening sessions in rural communities in ten regions and national conferences were conducted to gather information and create the five objectives. Applying a rural lens to programs and policies is essential.

Centers for Medicare and Medicaid Services does not have grant programs and work is done through rule making. Some of the key CMS rules include: Inpatient Prospective Payment System, Outpatient Prospective Payment System, Medicare Physician Fee Schedule, Ambulatory Surgical Center Payment System, Hospice Payment Rate Update, Home Health Prospective Payment System, Skilled Nursing Facility, Inpatient Rehabilitation Facility Prospective Payment System, Long Term Care Hospital Prospective Payment System, End Stage Renal Disease Prospective Payment System, Durable Medical Equipment Prosthetics, Orthotics and Supplies, and Inpatient Psychiatric Facilities Prospective Payment System.

The Quality Payment Program has been implemented and technical assistance is required for small, underserved and rural providers. Over 94% of eligible clinicians participated in the program and most rural practices reported data for 90-days or longer. Ninety three percent of rural providers received a positive payment adjustment, and 65% of them received an additional adjustment for exceptional performance. The median score for rural providers was 63 points, compared to 74 for non-rural large practices. This reflects the commitment of rural providers.

CMS submitted a report on telehealth utilization regarding the shift between 2014 and 2016. In 2016, almost 90,000 Medicare Fee-For-Service beneficiaries utilized 275,199 telehealth services. There was significant growth in utilization among the oldest population, including beneficiaries 85 years and older. Psychotherapy is among the services most commonly furnished through telehealth. States with the highest utilization are Texas, Iowa, California, Missouri, Michigan, Minnesota, Wisconsin, Georgia, Virginia, and Kentucky.

Advancements in virtual care included modernizing Medicare physician payment by recognizing communication technology-based services. The 2019 Physician Fee Schedule Rule finalized several policies to expand access to virtual services such as virtual check-ins with five to ten minutes of medical discussion and remote evaluation of pre-recorded patient information and added prolonged preventive services to an approved telehealth list.

As one of the largest healthcare payers, CMS has a key role in addressing the opioid epidemic with a focus on prevention, treatment, and data. Stronger Medicare prescription opioid policies started January 1, 2019 with seven-day acute limits, care coordination, and a pharmacy/provider lock-in program. State Flexibility for states pursuing 1115 waivers focused specifically on ground-level solutions. CMS is promoting payment system innovation through new demonstrations and models.

The Centers for Medicaid and Medicare Integration include: The Vermont All-Payer ACO Model, Pennsylvania Rural Health Model Rural Community Hospital Project, Accountable Health Care Model, and Frontier Community Health Integration Project (Ended July 2019). New models that have come forward in the past year include The Maternal Opioid Misuse Model, Integrated Care for Kids, Emergency Triage, Treat and Transport, and The Primary Care Initiative.

CMS also reviews the intersection between population groups in rural America and has been working with the CDCs office of Minority Health and Health Inequity regarding racial and ethnic disparities in rural communities. Ninety four percent of rural African Americans live in the southern United States. Fifty nine percent of rural Hispanic adults also live in the south. The impact of where a person lives matters regarding access to care, state policies, and scope of practice. More than half of American Indians, Alaska Natives, and African Americans have incomes less than 25,000 a year. Social determinants of health impact rural minorities regarding supportive housing, transportation, and ability to age in place.

In order to identify and address social determinants of health, CMS finalized adding certain social determinants of health data elements on patient assessment forms completed by institutional rehabilitation facilities, skilled nursing facilities, and long-term care hospitals. CMS is also accepting comments on whether additional social determinants of health data elements should be proposed.

Looking ahead, CMS will be assessing improving access to maternal healthcare in rural communities, understanding the impact of rural hospital closures and nursing home closures. These may be future topics of interest for the Committee. Tom Morris has discussed challenges with maternal health care. There is a focus on maternal mortality specific to rural communities which is not just a mortality issue but an access issue. Rural health services need to be available for women and children before, during and after pregnancy.

Q&A | DISCUSSION SESSION

Mary Sheridan said that she did not hear mention of Hospice or palliative care.

Cara James replied that Hospice is an important piece for people being able to age in place. Nursing homes is more of a focus now, but Hospice is very important as well.

Steve Barnett when talking about OB services, is CMS discussing new, innovative ideas as an alternative to only traditional delivery methods?

Cara James stated that there is work through the Center for Medicare and Medicaid Innovation. There was just an issue brief summarizing what CMS thinks are some issues, such as scope of practice when considering certified nurse midwives and use of birthing centers. Strong Start Innovation Model Birthing Centers and the impact they can have on positive outcomes. There are several pieces being discussed and maternal health outcomes is a priority for the department and CMS is assuring that there is also a rural lens because of rural issues being unique.

CALL FOR PUBLIC COMMENT

Hannah Martin, MPH, RDN
Director, Legislative and Government Affairs
Academy of Nutrition and Dietetics

Hannah Martin stated that nutrition is often at the intersection of human services and health, especially related to chronic diseases like diabetes, kidney disease, and obesity. Nutrition is often where the social determinants of health are first manifested. The discussion of nutrition was not discussed much during the meeting. The loan program through HRSA that pays for physicians, dentists and social workers does not include dieticians. Dieticians do not have GMA paid for or qualify for many of the other programs even though there are over 100,000 dieticians.

TUESDAY, SEPTEMBER 10th, 2019

WELCOME

Paul Moore, DPh
Executive Secretary, NACRHHS
Federal Office of Rural Health Policy
Health Resources and Services Administration

Paul Moore welcomed the attendees to the second day of the 86th meeting of the Rural Health and Human Service National Advisory Committee and introduced Admiral Brett Giroir.

WELCOME AND REMARKS BY THE ASSISTANT SECRETARY FOR HEALTH
ADM Brett Giroir, MD
Assistant Secretary for Health
Office of the Secretary
U.S. Department of Health and Human Services

Brett Giroir welcomed the Committee to Washington and stated that he was pleased to speak to the Committee and to let them know that the work they do matters. The reports and recommendations are accessed and used as much as possible as part of the decision-making process. The committee members are highly qualitied in their field and very busy people, and it is appreciated that they volunteer their time to improve the lives of those in rural communities. Federal Advisory Committee participation is not only intellectually and physically exhausting, but also emotionally exhausting due to the issues involved. The work of the Committee is vital for the people being served and is appreciated.

Admiral Giroir was a pediatric ICU doctor at a referral center in Dallas, Texas. He started in the ICU in 1990 and practiced through 2014. He spent much of his time in rural Texas working with rural practitioners, nurse practitioners, pharmacists on approaches to interact better and identify sick children. He has probably executed about 1,000 transports including a couple of hundred air transports. Frequently the air transports landed on the high school baseball diamond because it was the only place to land in many rural areas. Admiral Giroir shared that he also ran the Texas A&M Health Science Center working with rural populations to eliminate health disparities.

With 46 million Americans living in rural America, Secretary Azar identified rural health as a key priority within HHS. He brought together key leadership to form a Rural Health Taskforce and identify how to work together. There are many great things happening in HHS, but the key is to coordinate efforts and work together in synergy. Those living in rural America have higher rates of smoking, hypertension, obesity and physical inactivity. Rural Americans are less likely to access health care and have a higher overall mortality rate as well as a higher mortality rate in the five leading causes of death in Americans. HRSA has leadership and staff that want to make a difference.

America's overdose and addiction crisis is the most daunting public health challenge of our time. In 2018 there were over 28,000 Americans who died from overdose. The Committee gave significant recommendations in 2016 and there have been many positive changes since that time. Not one agency has all the authority to reach the solutions needed, for example ending inappropriate opioid prescribing. There are, however, people who need appropriate opioid prescribing and pain-relieving medications. There must be better prevention and treatment services, medication assisted treatment for opioids, and psycho behavioral support, and wrap-around services. Support for individuals transitioning in and out of the criminal justice system is vital. The highest risk of death due to overdose is when someone exits the criminal justice system without appropriate therapy or MAT. What once had given them a minor high before incarceration can be a deadly dose after leaving incarceration.

Social determinants of health related to opioid abuse, substance use, hypertension, obesity and maternal health are also a focus. Housing insecurity, food insecurity, existing mental illness and access to care are all important when dealing with the health of a community. There are unique issues facing veterans, minority populations, and those in Indian Country. There is an opioids cabinet chaired by Kelly Anne Conway every week that includes all government departments.

There has been over 9 billion dollars in grants provided since 2016 to communities for programs like Naloxone distribution, peer support, and working with faith-based communities to get

people into treatment and for prevention services. Last week Admiral Giroir joined President Trump and Secretary Azar in announcing another 1.8 billion dollars in grants going to all 50 states and territories. “Stopping the Bleeding” with band aid measures is very important and equally important is looking at long term and sustainable solutions. CMS is working on new proposed payment rules that are very important for rural America and include bundled payments for opioid abuse disorders. Starting MAT in emergency rooms could also affect rural communities. The fourth wave of the overdose crisis in America is methamphetamine. Out of thirty-four states that report monthly overdose deaths, twelve states now have more deaths from methamphetamine than fentanyl and all other synthetic opioids. Guam and Hawaii have more deaths from methamphetamine than opioids combined. The methamphetamine now is nearly 100 percent pure and very highly addictive and there is no MAT or Naloxone for methamphetamine. The Committee’s input on this issue would be greatly appreciated.

Ending the HIV Epidemic in America Initiative was announced during the State of the Union and has been championed by the President. Admiral Giroir and Tom Engels, are included in the group of five individuals leading the Ending the HIV Epidemic in America Initiative. The places where most HIV occurs will be targeted which are 48 jurisdictions including Houston, Baltimore, San Juan and Washington DC. Seven states with the highest rural HIV are included because the problems are different from urban HIV. The programs are being implemented now and there will be 300 million dollars next year to support the HIV initiative. There are 40,000 new cases of HIV a year and with treatment, the disease is incapable of transmitting HIV to partners, so this initiative is very important.

Ending HPV associated cancers is another focus of HHS. Immunizing against HPV can eliminate 90%-95% of HPV related cancers and rates of immunization are about 15% lower in rural America. If there is a liaison to work with The National Vaccine Advisory Committee to have joint efforts on how to improve the HPV immunization rates in rural America, that would be greatly appreciated.

Health and Human Services also has a focus on improving maternal health and this is particularly a challenge in rural America. Today there will be three new grants awarded as part of HRSA’s Rural Maternity and Obstetrics Management Strategies Program. Maternal mortality in the United States ranks among the lowest in all the developed countries. There are tens of thousands of women who suffer severe maternal morbidity in the United States but do not die so there has to be a focus on a wide spectrum of prevention care before entering the hospital to the post obstetric care after mother’s deliver their babies. Secretary Azar convened a steering committee in May on maternal mortality and morbidity so each staff and operating division can work together.

HRSA’s Rural Maternity and Obstetrics Management Strategies Program Award Recipients are The Bexar County Hospital District - Texas RMOMs Comprehensive Maternal Care Network, The Saint Francis Medical Center – Boot Hill Perinatal Network Project, and Taos Health Systems, Inc. - New Mexico Rural OB Access and Maternal Services.

The Texas project will link the Bexar County Hospital District with rural hospital clinics in Uvalde and Val Verde Counties in the southern part of the state with a focus on social

determinants of health and how they feed into poorer health outcomes. The Missouri project concentrates on the rural underserved southeastern region of the state and brings together hospitals, home visiting, and Healthy Start programs with a focus on reducing infant mortality and improving birth outcomes. The New Mexico project connects providers in three rural counties in the Northeastern part of the state will a focus on improving health literacy and addressing challenges such as low birth rates, substance abuse and pregnancy, and expanded use of nurse midwives.

The takeaway for the Committee is giving HHS support on the opioid epidemic, methamphetamines, HPV vaccination and maternal health.

Q&A| DISCUSSION SESSION

Bob Wergin stated that he is a practicing family physician in rural Nebraska. More people have died of opioid overdose than in the Vietnam War, so it is a huge issue. He is concerned about the appropriate use of opioids and the pendulum swinging the other direction and some of the elderly, rural individuals will be denied opioids when they truly are necessary.

Admiral Brett Giroir responded that the pendulum has swung the other way. Guidelines are not meant to be rules or legislation. Each patient is unique, and the provider-patient relationship is special, and medications should be tailored for individuals. It is amazing how far you can go to assist with pain with non-opioid medications and complimentary therapies. CMS will now pay for acupuncture for lower back pain. HHS is working with the DEA on this issue. There has been overprescribing but there are many patients who still need relatively high doses of opioids as they are moved to other alternatives.

Mark Holmes said he was glad to hear Admiral Giroir talk about substance abuse disorder instead of just a focus on opioids. Can you give advice on discussing with colleagues about focusing on broader substance abuse issues instead of just opioids?

Admiral Brett Giroir replied that opioids have been the focus for good reason, but the substance abuse crisis has gone from one focus to the next throughout the years. There is an exponential curve upward. Community strength and resiliency needs to be built and strong family and personal relationships. There is also the issue of mental illness that must be discussed along with substance abuse. Methamphetamine and cocaine are now on the rise. Many of the people on methamphetamine have an opioid abuse disorder and are transitioning. Cartels are now putting methamphetamine in the heroine to create multiple dependencies at the same time. Marijuana use is also an issue. Years ago, there used to be a 2% THC content in Marijuana but now there is a 14% THC or higher and highly psychoactive and other major side effects. Marijuana has been made highly available with the risks being minimized. Adolescent brains are being affected by today's Marijuana and data shows that IQ points are dropping 6-8 points and that impacts a person's potential and economic security.

Steve Barnett stated that he is a CEO at a Critical Access Hospital. Social determinants of health are not being measured well and are not required fields within electronic health records. It would be useful to contribute to a Hierarchical Condition Category score. Can you comment on this?

Admiral Brett Giroir responded that there are health systems that do record certain pieces of social determinants. Healthy People 2030 has a small number of social determinants that will be measured moving forward and think there is evidence that they are very important related to health. Some of these can and should be incorporated into health records. How much of a person's income is paid towards rent/mortgage or if a child has witnessed a violent act are two issues that have a correlation to health. Health and Human Services does expect a national initiative with CMS in early 2020 that focuses on social determinants of health, funding and tracking. The HHS Physical Activity Guidelines for Americans include 150 minutes of moderate activity a week. The impact of physical activity, a reasonable diet and not drinking excessively or smoking reduces the risk of Alzheimer's and dementia.

DAY ONE RECAP AND COMMITTEE REFLECTIONS

NATIONAL STAKEHOLDERS PERSPECTIVES – HUMAN SERVICES PANEL

Denise Harlow, CCAP, NCRT
Chief Executive Officer
Community Action Partnership

The Community Action Network is a national network of 1,000 or more local community action agencies, tribal organizations, 46 State Associations, and 56 State Community service block grant offices. Community Action Agencies served more than 15.3 million individuals and more than six million families across 99% of America's counties. Community Action Agencies are often the largest human services provider and a trusted partner in rural communities to help families access the human services they need. Addressing the social determinants of health is also a focus of these agencies.

Community Action Agencies conduct local needs assessments every three years. A localized response to needs and a range of services are provided. This includes a whole-family approach to support. Emergency assistance and health care is provided through FQHC's, dental clinics, women's health clinics, and mobile health clinics. Community Action Agencies also include community and economic development, housing, Head Start, job training, senior services, and case management. Barriers to self-sufficiency and challenges in rural America include lack of affordable and safe housing, transportation, jobs, health care, benefit cliff effect, opioid addiction, childcare, generational poverty, job training, educational opportunities, and internet access.

Rural Development Hubs are primary players advancing a fresh approach to community and economic development. They consider their job as identifying and connecting community assets to market demand to building lasting livelihoods, always including marginalized people, places and firms in both the action and the benefits. Hubs focus on all the critical ingredients in a

region's system that either advance or impede prosperity — the integrated range of social, economic, health and environmental conditions needed for people and places to thrive.

In Minnesota, a Community Action Partnership runs the largest rural transportation system in America. For access to health care there must be transportation and Community Action Agencies are filling that space. Every CAP provides services and strategies that are unique to their community. Community Action Agencies are finding ways to blend funding to make sure people have access to services. There is a disparity regarding the private money going to rural communities. There is an equity of access that is important and community action agencies provide that equity and connection. Community Access Agencies make wonderful rural development hubs and are a great source for getting people to complete the census which is extremely important in rural communities.

Q&A| DISCUSSION SESSION

Molly Dodge asked for topics that the Committee could focus on regarding Community Access Partnerships.

Denise Harlow responded that data integration is important because it is difficult to tell the story about rural and show outcomes without reliable data. Transportation, housing, and jobs are issues in rural communities.

Carolyn Emanuel-McClain shared that she was a Head Start mother many years ago and believes in Head Start and Community Action Programs. She said that she operates a Community Health Center and partners with the CAP agency and serves on the board. In the past few years there has been a push for Community Based Organizations that were receiving federal funds to partner with CAP agencies.

Denise Harlow stated that CAPs have used the past 5 years to modernize their data systems and measurement systems. CAPs are collecting data and holding organizations accountable through standards so it would be a good idea for community-based organizations to partner with CAPs in their area.

NATIONAL STAKEHOLDERS PERSPECTIVES- HEALTH SERVICES PANEL

Alan Morgan, MPA
Chief Executive Officer
National Rural Health Association

Alan Morgan welcomed the Committee to Washington DC. The National Rural Health Association is the voice of rural health. More than 90% of the nation's rural health clinics, hospitals, and rural community health centers are members of NRHA and forty-nine state offices of rural health are members. Forty-two state rural health associations, rural health practitioners, and state employees, convene together within the organization to determine best practices and identity policy obstacles to replicating the best practices.

Trying to tell an accurate story about rural America is a challenge. Rural communities really are hubs of innovation. Patient navigators, community health workers, dental health aids and the concept of a team-based approach all began in rural. Rural policy directly impacts national politics. People running for President all recognize the relevance and importance of rural communities. Workforce shortages and health disparities are more prevalent in rural areas. People are dying younger in rural. Population shifts are changing the dynamic of rural and the changing face of rural is becoming more inclusive.

Congress is back in session and there is a focus on rural policy in the House and Senate. The past decade of recommendations of the Committee are making a direct impact on discussions on The Ways and Means Task Force and The Senate Finance Task Force. Much of the national focus is rural hospital closures and there have been 113 since 2010. NPR is going to run a story in the next few weeks on the economic impact of rural hospitals. The last research focused on the economic impact of rural hospitals and was conducted in 2006. Research has not been a priority because there has been a focus on immediate needs for rural people such as dying younger in rural America.

Maternal health is a key topic on the federal level and there is attention to what is going to happen on the finance committee and looking at their proposal package. The National Rural Health Association knows there is more to rural health than rural hospitals, but rural hospitals serve as anchor institutions that include EMS, long-term care, home health, and skilled nursing. NRHA is building on prior work of the Committee and looking at new design models, particularly hospitals without inpatient beds and new payment models. CMS is specifically working on new demonstration authority, payment options and models for rural hospitals. NRHA believes in global budgeting as a promising way to change from sick care to well care – keeping people out of the hospital in the first place. This is how to build a sustainable healthcare model moving forward.

There are some key points for the Committee to keep in mind when deciding on topics. Rural hospital closures and rural health clinic closures are under reported. No one knows how many rural nursing homes have closed in the last decade because there has not been any data collected. Every community is talking about their nursing homes closing but there has not been comprehensive reporting on the issue. How about assisted living and the impact? What is the impact of changes of telehealth regulations moving forward? It is not about the providers but about the community and rural health life expectancy is decreasing.

When Congress was debating the creation of the Ryan White HIV legislation, NRHA was one of the leading organizations advocating for it to happen. It was not until 2004 that it dropped off the legislative and regulatory agenda because all the funding was going to urban areas.

Census data shows that rural populations have been stable for the last 5 years. Rural is not going away and it is not just elderly people returning home, but also younger people. There must be OB services and hospitals in these communities, or this trend will stop.

Lastly, advice for the Committee is to choose topics that are as specific as possible.

Bill Finerfrock
Executive Director
National Association of Rural Health Clinics

Bill Finerfrock shared that rural health clinics are primary care clinics in rural underserved areas. The program has been in existence since 1977 and there are about forty-four hundred federally certified rural health clinics in the United States.

"At its best the American health care system is unsurpassed. But its uneven distribution leaves millions of our people without access to adequate care. This problem effects both urban and rural areas but is more widespread in the latter. Two thirds of the people in areas without adequate health care live in rural America." This statement was made by President Jimmy Carter upon signing the Rural Health Clinics Services Act into law, December 13, 1977. This is a problem that we are still struggling with today.

Since the Rural Health Clinics Services Act was signed into law in 1977, there have been many changes with the RHC program. The numbers show that RHC program is growing but seven hundred rural health clinics have either closed or transitioned to another type of RHC. Three hundred and eighty-eight Rural Health Clinics have ceased operations, 64% were independent and 36% were provider-based. Three hundred and twelve independent RHC's have converted to provider based RHC. Independent RHCs make up 39 % of active RHCs. In the past seven years, 13.2 % of independent RHCs have closed, almost three times the rate of provider based RHC closures.

Physician owned rural health clinics are capped at $84.70 per visit and the average cost of a visit is $130.86. The uncapped RHCs get their costs reimbursed which are on average $216 per visit. A physician in a rural community who is struggling and gets an offer from a critical access hospital to be purchased and converted will likely take the opportunity. In addition, sixty percent of closed independent RHCs were within five miles of an active provider based RHC. This suggests that the ability of provider based RHCs to offer higher salaries and better wages creates a distinct advantage for RHCs to be small hospital owned clinics.

In 2016, 63% of rural health clinic visits were in hospital owned RHCs and 37% in independent physician, PA, and NP owned rural health clinics and that affects the costs. Eighty percent of Medicare spending was going to hospital owned RHCs. Unless the cap issue is addressed there will be few if any independent RHCs in a few years.

The National Association of Rural Health Clinics is promoting the Rural Health Clinic Modernization Act of 2018 to raise the cap on Rural Health Clinic Payments and increase the upper limit (or cap) on RHC reimbursement incrementally over 3 years. The Modernization Act modernizes physician supervision requirements in RHCs by aligning scope of practice laws with state law. This allows PAs and NPs to practice up to the top of their license without unnecessary federal supervision requirements that apply only because the PA or NP is practicing in a RHC. Rural Health Clinics would still be required to have a physician who serves as the Medical Director of the RHC. Allowing Rural Health Clinics, the Flexibility to contract with PAs and NPs Removes a redundant requirement that RHCs employ a PA or NP and allows RHCs to

satisfy the PA, NP, or CNM utilization requirements through a contractual agreement if they choose to do so.

NARHC supports removing outdated laboratory requirements, removes a requirement that RHCs must demonstrate the ability to directly provide certain lab services on site, and allow RHCs to satisfy this certification requirement if they have prompt access to lab services. Also, allowing the professional personnel responsible for the RHCs policies and procedures, instead of the Secretary of Health and Humans Services, to determine the drugs and biologicals necessary for emergency cases in each specific RHC.

Currently, RHCs are limited to hosting the "originating" site for Medicare covered telehealth services. Allowing RHCs to offer telehealth services as the distant site (where the provider is located) and bill for such telehealth services as RHC visits will be valuable. Creating a state option for rural designation grants new authority to the states to define additional areas as rural for the purposes of establishing an RHC.

Under the Medicaid program some states are allowing RHCs to be the distance site. In Louisiana, rural health centers work with the school and if there is a child who has a medical issue, they are seen through tele-medicine by the RHC. The child does not have to leave the school to go to the clinic.

Rather than cover diabetes prevention programs, chronic care management, remote patient monitoring, and virtual communication services, under the RHC per visit rate, CMS has created unique payment rates for these services when provided by RHCs. CMS is recognizing new services, but the method by which CMS is accomplishing this objective destabilizes the concept of an all-inclusive rate and creates operational challenges for the RHC community.

Erika Rogan, PhD, MSc
Senior Associate Director, Policy| American Hospital Association
Adjunct Associate Professor | Georgetown University

Erika Rogan thanked the Committee for inviting her to speak and stated that she would give a rural hospital update. Rural hospitals are the cornerstones of their communities and have national reach because nearly twenty percent of people live in rural areas. Hospitals are key access points for care and economic anchors for employment opportunities, transactions and an attraction for business investment. Rural hospitals contribute to local taxes and public services. Hospitals are typically the largest employer in rural communities.

One hundred and ten rural hospitals have closed since 2010. There have been sixteen closures in 2019 which outpaces previous years. There are still a few months to go in 2019 and the number will likely increase. The closures are happening in many parts of the country but are concentrated in the south and southeast. Closures occur more frequently for the smaller PPS hospitals but are seeing critical access hospitals close as well. When there are closures there is lower access and availability to care. In some cases, there are other providers to fill the gap but that is not true for the emergency departments or certain specialty care.

When rural hospitals close there are job losses and it is more difficult to bring in new business. Modern Healthcare did a long form series looking at rural closures and what they found is that the community was not only about the access to health care but the ripple effect beyond the hospital. Disparities grow when hospitals close and people of color and those of lower income are disproportionately affected. Vulnerable groups like pregnant women, older adults and people with disabilities may not be able to travel longer distances for care once rural hospitals close.

The American Hospital Association Report states that challenges that face rural hospitals include emergent, recent, and persistent barriers. The challenges do not happen one at a time but at the same time. The problems compound each other and require hospitals to have dexterity and excess resources to shift and that is not possible with rural hospitals. A persistent challenge is the payer mix. More than half the revenue comes from Medicaid and Medicare so many have negative operating margins. It makes these hospitals vulnerable to policy changes. Workforce is another persistent challenge. Less than 10% of US physicians are in rural areas. Most of the shortage areas are in rural communities and less than 1% of physician residents and fellows report preference for rural areas. Recent burdens include regulatory burden, hospitals spend $39 billion each year on non-clinical regulatory requirements There is a disproportionate impact on smaller & rural hospitals due to higher per-case cost. The context for stark and Anti-kickback statutes are different in rural areas given there are fewer physicians. Trying to recruit physicians is concerning to whether they are addressing the fair market component of the statutes. Opioid deaths in rural communities are surpassing those in urban areas and many Americans say that opioids and drug abuse are the biggest concern in their communities.

The AHA report findings also demonstrate that any solutions to the problems need to allow for flexibility in rural areas. Rural varies substantially so what is good for a frontier area in Montana may not work for a rural area in Georgia. There needs to be flexibility built into models and policies. The report recommends updates to existing policies and calls for federal investments in rural areas. There are six priority areas that include insuring fair and adequate reimbursement for rural hospitals, supporting new models of care, bolstering the workforce, removing red tape, supporting telehealth and health information technology, reining in prescription drug prices, and supporting 340B.

Recent activity for fair and adequate reimbursement related to legislation and regulatory has been action around the wage index, and this can support some of the lower wage hospitals. There are cuts on site-neutral payments and those are affecting rural areas and other parts of the country. There is new coverage in Part B for Opioid Use Disorder Services and some bundled payments for opioid disorder treatments.

The American Hospital Association opposes site-neutral policies and cuts and continue to urge an end to sequestration. AHA is also looking for more funding for behavioral health services.

Q&A | DISCUSSION SESSION

Mary Sheridan said that the committee has discussed access to OB services in rural areas and the closure of OB departments in rural hospitals. Can you discuss this issue of maternal health and access to OB services?

Erika Rogan stated that AHA is addressing this especially for the maternal mortality legislation. OB service closures are a huge issue and there is a group of colleagues working on this issue. It is part of the overall AHA agenda.

Alan Morgan said that they need to identify a sustainable model moving forward regarding OB services in rural.

Bill Finerfrock stated that rural health clinics being part of hospitals works as an advantage to clinics and patients because they are part of an integrative model. It is a challenge for independent rural health centers.

Steve Barnett asked if rural is behind in terms of being able to adjust payment methods in rural America? Is rural able to catch up and is there anything that can be done from a policy perspective?

Alan Morgan responded that once a hospital closes there is less than a 10% chance of getting it back. Committee recommendations about stabilization of the current system as there is a transition to the new system would be very beneficial. There must be stabilization during the shift. There are many communities losing access so there must be a role back on Medicaid cuts and Medicaid needs to be expanded as a path is built for the future.

Bill Finerfrock shared that The Equality in Medicare and Medicaid Treatment Act has identified a problem with the new payment models due to the focus of The Centers for Medicare and Medicare Innovations of pursuing demonstrations that can lower costs and that do not negatively impact quality. There is no focus on whether it will reduce access, what it does to health disparities, and if it will exclude certain populations. This can cause a behavioral change by providers that causes them not to see a certain patient population because they are at risk of rehospitalization or hospital acquired infection. CMMI needs to broaden the focus of the demonstrations and understand what the changes will do to access in rural areas.

Loretta Wilson stated that some of the patient population in rural areas think that urban is better so when you look at the creation of a sustainable model for rural areas it is concerning. Rural residents need to understand that they can get the same quality of treatment in rural hospitals. Will the rural emergency hospital model benefit the areas with hospital closures or any area that qualifies for the 24-hour emergency model? Some hospitals make money from inpatient services so what would be the payment model?

Erika Rogan responded that it would be an option for critical access hospitals, hospitals with less than fifty beds, or ones that have recently closed and fit one of the criteria. It would allow the facilities to continue to get hospital Medicare rates. It would be focused on emergency and outpatient and the hospitals will be required to have transportation to acute care facilities for those needing inpatient services.

THE BIPARTISON POLICY COMMITTEE: FOCUS ON RURAL HEALTH

Anand Parekh, M.D.
Chief Medical Advisor
Bipartisan Policy Center

Anand Parekh said The Bipartisan Policy Center is a nonprofit organization that was created twelve years ago and gathers data from both political parties to promote health security and opportunity. Specific to rural health, the first focus was a couple of years ago on the Appalachia Region, with a health component focus on the opioid epidemic and chronic disease prevention. A couple of years ago the organization felt the issue of rural health policy needed to be elevated so that policy makers knew it was a top tier issue that every state in the country experiences and needs to address. There was exploratory work done with a focus on the Upper Midwest since these are rural and frontier regions. Some of the states had expanded Medicaid and some had not. There was a case study of seven states and there were roundtable discussions with thought leaders in rural health care about the most important challenges and opportunities.

The Upper Midwest Case Study identified several issues important to rural health care access, including rightsizing health care services to fit community needs, creating rural funding mechanisms, building and supporting the primary care physician workforce, and expanding telemedicine Services. The ability for a community to transform from where they are to where they want to be is not easy. There must be options and opportunities from Congress to help communities transform. Many rural health care providers were excluded from alternative payment models and others did not have enough patient size to be eligible to participate in a model. Value-based healthcare transformation must include rural and when health care entities were involved in models, they were doing better than their counterparts. Developing a pipeline of a healthcare workforce at a young age is very important. Exposing young people to not only primary care medicine but a variety of healthcare fields makes it more likely they will enter these fields in the future.

Marilyn Serafini
Director, Health Project
Bipartisan Policy Center

Marilyn Serafini said that three or four months ago The Rural Health Task Force was launched. The Rural Health Task Force including co-chairs: Governor Tommy Thompson, Governor Ronnie Musgrove, Senator Olympia Snowe, and Senator Tom Daschle. Taskforce members include Georges Benjamin, M.D., David Blair, Rep. Henry Bonilla, Sen. Kent Conrad, Karen DeSalvo, M.D., Senator Bill Frist M.D., Chris Jennings, Jennifer M. McKay, M.D., Keith Mueller, Karen Murphy, Rep. Tom Tauke, and Gail Wilensky.

The Rural Health Task Force joined with the American Heart Association and hired Morning Consult (a polling company) to conduct a poll. The poll showed four priority areas for rural health transformation. Rural residents talked about barriers to accessing care in their community. The areas that stood out were medical specialists. People discussed difficulties accessing primary

care providers, but there was a larger differential between how rural and nonrural people responded regarding medical specialists. Other barriers noted in rural were access to behavioral health care services, distance to receive care, and access to obstetricians. During a meeting with The Iowa hospital Association and a provider from Iowa it was stated that since 2004, 42% of hospitals in Iowa that offered OB services no longer offer them. In both rural and non-rural areas are the cost of healthcare and the cost of prescription drugs. Making it easier to access health care was also stated as an issue in both rural and nonrural areas.

The Bipartisan Policy Center will focus on building on the work of the report and strengthening the rural healthcare system. Redesign and transformation assistance need to be available for critical access hospitals, rural health clinics, and rural hospitals that are ready to make the transition. Other focuses include removing barriers to provider participation in value-based delivery models, supporting the development and maintenance of an adequate rural health workforce, and incentivizing virtual health care as a means of increasing access to care.

Short term relief involves developing and promoting policies that will stabilize access to critical access hospital, small rural hospital and rural health clinic services in rural communities. This entails increasing financial stability in the short-term and mid-term, promoting new flexibilities in care delivery, supporting new opportunities to expand CAH and rural hospital service lines and partnerships, and ensure continued access to vital rural health clinic services.

Critical Access Hospitals and other small rural hospitals may continue with the current model or choose from multiple pathways to transition to new delivery models. Options for infrastructure transformation are to make it financially possible for critical access hospitals to transform to an emergency room with outpatient services, transform to a federally qualified health center and receive the benefits of this designation, or to integrate with rural health centers or federally qualified health centers.

Dena McDonough
Associate Director of Health Policy
Bipartisan Policy Center

Dena McDonough stated there has been a move towards value-based payment models and moving from volume to value but there has been a limited uptake in rural areas. Low volume and tighter margins are impediments in rural but there are ways to reduce the risk profile that impedes participation in the programs. The administrative burden and upfront investment with alternative payment models are also barriers in rural.

Value-based delivery model proposals should address barriers to successful participation in current value-based payment models such as the Quality Payment Program, Alternative Payment Models, and Centers for Medicare and Medicaid Innovation Demonstrations. Proposals should also support efforts to improve outcomes through care coordination and population health. This includes expansion of virtual care and telehealth services and addressing site of service and supervision restrictions that impede patient-centered care.

Development and support proposals are essential to increase overall training and workforce in rural areas through strengthening and expanding the current graduate medical education, and public health programs. Increasing workforce stability by leveraging technology to support providers and aid in staff retention and supervision and licensure flexibilities is also necessary.

Some of the public health programs like the National Health Service Corp and Teaching Health Center, have a requirement that the providers are in a federally qualified health center. There also needs to be a workforce that can be involved in the independent practices. There is a need to rely more on virtual care and technology that is being used for patients can also be helpful for the workforce. Project ECHO is a lifeline for primary care providers that can receive some training on services that would likely be covered by a specialist and allows them to do more in their rural communities. Rural residents are more likely to practice in a rural area, so hospitals and medical schools are reaching out to rural high schools and medical schools to create a pathway to medical fields.

COMMITTEE DISCUSSION

Some of the Topics Discussed by the Committee Included:

- Recommend the creation of an Office of Rural Human Services Policy
- Propose the Committee follow the recommendations of Admiral Brett Giroir.
- Creating a link between Healthy People Objectives within the context of Indian Health
- Administration of Native Americans had a youth engagement summit from Guam to Maine. The Native American youth asked how they could communicate in the policy discussions.
- Use Community Action Program to build networks in rural areas and weave systems together.
- Healthy People-Healthy Places – EPA program
- Home Visiting Network to build connections across all the organizations
- Workplace violence is an issue and occurs frequently in medical facilities
- Disaster relief planning in small, rural communities
- Substance abuse focus rather than only focusing on opioid abuse
- Committee building on Community Development Grant findings
- Innovative ways to use community resources to unite people with health and human services.
- The rural health innovation hub is creating a Community Health Gateway for people to submit program best practices
- Alternatives means of support for mental health and drug abuse issues in rural communities
- The need for prescription monitoring programs in every state
- Incentives for coordination of care in the community
- Meaningful Health Information Exchange necessary for value-based care in rural Vaccinations is a significant issue.
- Rural is behind regarding value-based transformation

CALL FOR PUBLIC COMMENT

No Public Comment.

WEDNESDAY, SEPTEMBER 11th, 2019

PRIORTIZING OF FUTURE TOPICS

- Maternal and Early Childhood Issues
- Substance Use Disorder
- Aging and Coordination of Services
- Rural Number Issues
- Vaccine Issues
- Rural Hospital and System Redesign
- Community Capacity Building
- Focusing on Kidney Disease
- Human Services Programs in Rural Contexts
- Value in Rural Health Care Context
- HIV: Rural and Ending the Epidemic
- Replicating an HHS Agency Rural Focus and a Federal Office of Human Service Policy
- Rural Development Hubs
- Healthy Behaviors in Rural Communities and the Limited Infrastructure and Risk Factors and Workplace Safety
- Rural Disaster Planning
- Rural Bright Spots – Promote Rural Models that Work
- Youth Engagement and Leadership
- Refining and Enhancing Definitions of Rural
- Rural Minority Health Considerations and the Changing Demographics of Rural
- Rural Workforce

FUTURE TOPICS AND MEETING LOCATIONS

2020 NACRHHS SPRING MEETING
The spring meeting will most likely be held in Atlanta, Georgia. The topic consideration is Maternal/Early Childhood Health with a brief related to vaccines.

2020 NACRHHS FALL MEETING
The fall topic consideration is substance abuse disorder/infectious diseases. Rural Hospital and System Redesign is also a topic consideration. The location being considered is Arizona.

CALL FOR PUBLIC COMMENT

No Public Comment.