Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Spring Meeting
Held Virtually
April 11-13, 2022

Meeting Summary

The 90th meeting of the National Advisory Committee on Rural Health and Human Services was held April 11-13, 2022. It was a virtual meeting due to the Covid -19 pandemic. The meeting topics were Access to EMS in Rural America & Rural Human Services Programs and Issues.

The committee members in attendance: Jeff Colyer, Committee Chair; April Anzaldua; Steve Barnett, DHA, CRNA, FACHE; Robert Blancato, MBA; Kari Bruffett; Wayne Deschambeau, MBA; Molly Dodge; Isabel Garcia-Vargas; Craig Glover, MBA, MA, FACHE; Meggan Grant-Nierman, DO, MBA; George Mark Holmes, PhD; Cara V. James, PhD; Joe Lupica, JD; Michelle A. Mills; Brian Myers; Kellie M. Phillips, MSN, RN; Patricia Schou; Robert L. Wergin, MD, FAAFP; James Werth, Jr., PhD, ABPP; Loretta Wilson.

Present from the Department of Health and Human Services: Tom Morris, Executive Secretary; Office of Rural Health Policy; Steve Hirsch, Administrative Coordinator, Office of Rural Health Policy; Sahira Rafiullah, Senior Advisor, Office of Rural Health Policy; Tahleah Chappel, Public Health Analyst, Office of Rural Health Policy; Jocelyn Richgels, Director National Policy Programs, Rural Policy Research Institute; Michael Fallahkhair, Principal Advisor, Health Resources and Services Administration. Truman Fellows: Patrick Grady and Samia Ismail.

Ex-Officio Members: Lacey Boven, Administration for Community Living; Humberto Carvalho, Executive Director, Substance Abuse and Mental Health Services Administration; Ing Jye Cheng, Centers for Medicare & Medicaid Services; Darci Graves, MPP, MA, Office of Minority Health, Centers for Medicare & Medicaid Services; Diane Hall, PhD, MSED, Office of the Associate Director for Policy, Centers for Disease Control and Prevention; Thomas Klobucar, Executive Director, United States Department of Veteran Affairs; Scott Miller, MPA, Office of the Associate Director for Policy, Centers for Disease Control and Prevention; ; Aleta Myer, Office of Research and Evaluation, Administration for Children and Families; Benjamin Smith, MBA, MA, Deputy Director for Intergovernmental Affairs, and Indian Health Service.

Monday, April 11, 2022

Governor Jeff Colyer, Chair of the Committee, convened the meeting.

WELCOME AND INTRODUCTIONS

Jeff Colyer, MD
Committee Chair

Jeff Colyer welcomed everyone to the 90th meeting of the National Advisory Committee on Rural Health and Human Services. He stated that the primary focus of the meeting is to examine access to emergency medical services in the rural United States. Following the meeting, the ORHP staff will draft a policy brief and recommendations to submit to the Secretary of Health and Human Services. A segment of the meeting will be devoted to providing a concise overview of the federal programs that support rural human services. Historically, the committee has weighed heavily on the health side so this will assist the committee to think more broadly about future topics. There are ex-officio members joining the meeting from agencies within Health and Human Services including: Substance Abuse and Mental Health Services, Centers for Medicare & Medicaid Services, Office of Minority Health, Centers for Disease Control and Prevention, Department of Veteran Affairs, Administration for Children and Families, and Indian Health Service.

Dr. Colyer thanked the Office of Rural Health Policy staff for their work and dedication. He welcomed April Anzaldua, Isabel Garcia-Vargas, Craig Glover, and Cara James to the committee.

EMS TOPIC INTRODUCTION

Gary Wingrove
President, The Paramedic Foundation

Gary Wingrove stated that he would give a general perspective on the current state of rural Emergency Medical Services. The three key issues with rural EMS are the same issues from the 1980's and 1990's. These issues are difficulty with recruitment and retention of personnel, the need for restructuring, and revised methods of reimbursement.

It has become increasingly difficult for ambulance services to respond to emergencies. This became more apparent during the COVID-19 pandemic. There are difficulties retaining and recruiting personnel and filling positions of employees who retire. Rural EMS is primarily a volunteer workforce and that is not viable long-term, so transforming emergency medical services into a more sustainable system is necessary. In Southern Minnesota, there is an ambulance service in each town with similar services such as training, billing, hiring, policy manuals, and medical guidelines. It would be beneficial to replicate the services throughout the organizations for continuity throughout the region.

Concepts that may benefit reimbursement challenges are a Medicaid cost and payment method for ambulance services, an ambulance specific definition for medically underserved and health professional shortage areas, and an ambulance specific definition of rural. The paramedic professional could benefit from supports that are provided to other professions including the National Health Service Corps, Medicare payment for community paramedics, and a Hospital

Care at Home waiver extension. Practitioners pay for their own education and make a low salary when employed in rural communities, so it is difficult to recruit personnel.

Kaiser Health News authored an article about the pandemic exacerbating the EMT and paramedic shortage in rural areas. The article examined the number of paramedics per 10,000 residents and reported that in Montana, there are large areas that do not have a single licensed paramedic working in emergency services. In 2019, The Center for Medicaid and Medicare Services mapped the concentration of paramedics in each county. The map shows ambulance services that are participating in the Emergency Triage, Treat, and Transport (ET3) Model. Duluth County, in Minnesota, reaches from the tip of Lake Superior to the border of Canada. The only ET3 services in that county are in Duluth. It appears on the map that there is a large rural population being served, but it is only urban Duluth where the ET3 services are available. The definition of rural should be updated in a way that is not only based on counties.

To alleviate EMS shortages, communities are implementing the Informed Community Self-Determination Process. Community leaders create EMS system options so the members of the community can choose the option they think will work best. In 2008, a study was conducted in Nebraska, where the EMS volunteers could not cover 25% of the calls. Volunteers from other parts of the county were responding to the county seat. The city decided to upgrade from basic life support paramedics to hiring advanced life support paramedics. In 2013, the fulltime ambulance services were covering a substantial portion of the volunteer agency calls so paramedics began assisting the volunteer agencies when needed.

In 2018, a county in Wisconsin closed their volunteer ambulance service. The neighboring county agreed to temporarily cover the service area. In 2020, a critical access hospital created a new agency, opened an advanced life support service, and hired fulltime staff.

In North Dakota there are three tiers of rural, and each tier reflects the number of ambulances on duty. An analysis of the cost per year for services reflected that in Tier 1 the cost is $962 thousand, Tier 2 is $1.5 million, and the Tier 3 cost is $2 million. It is expensive to provide an ambulance service with a small population so cost-plus ambulance reimbursement would be beneficial.

Community paramedicine takes existing EMTs and paramedics and trains them in primary care skills and public health skills so they can be integrated with their health care partners. College community paramedicine programs allow participants to go from a certificate level of education to a doctorate in paramedicine.

The Hospital at Home Program is largely urban based but also treats patients in rural areas. The Hospital at Home Waiver is going to possibly be extended for two years. This would allow community access hospitals to join the program and allow paramedics to provide care to patients in their home. Paramedics generally transport patients home from the hospital and provide oxygen and other services. The patients have access to nurses and physicians at the hospital virtually. The nurses are providing internet check-ins and paramedics are visiting the home twice a day.

Yvonne Jonk
Deputy Director, Maine Rural Health Research Center

Yvonne Jonk said she would discuss a project conducted by the Maine Rural Health Research center titled, "Ambulance Deserts: Addressing Geographic Disparities in the Provision of Ambulance Services." She said that due to a decreasing number of employees in rural hospitals and ambulance services, remaining ambulance services are covering expanded service areas. The delivery of ambulance services has not been systematically integrated, particularly in rural areas. The lack of systems planning has led to gaps in the provision of ambulance services which is referred to as ambulance deserts. An ambulance desert is a populated census block with its geographic center outside of a 25-minute ambulance service area. Policy makers are creating strategic plans to address the gaps by using a GIS framework to identify ambulance deserts. The two-year study objective is to identify geographic disparities in accessing ambulance services by identifying and creating maps of ambulance deserts within each state.

The research focus includes:

- Locating the areas of the states with ambulance deserts and the prevalence of ambulance deserts
- Establishing the percentage of each state's population that lives in an ambulance desert
- Examining the demographic and socioeconomic characteristics of people living in ambulance deserts

The methods of data collection include:

- Creating state maps in ArcGIS Desktop ArcMap version 10.8.1
- Geocoding ambulance station addresses using Esri World Geocoding Service
- Estimating the number of 25-minute ambulance service areas using ArcGIS Ready-To-Use Services (Generate Service Areas tool)
- Identifying populated census blocks with geographic centers outside of a 25- minute ambulance service area (ambulance deserts)
- Mapping ambulance deserts in relation to ambulance stations and healthcare facilities (hospitals, Federally Qualified Health Centers, Rural Health Clinics)
- Analyzing county-level differences in ambulance access by rural-urban location using Rural-Urban Continuum Codes (RUCCs)

Next steps were to compare demographic and socioeconomic characteristics of counties comparing the availability of ambulance access. The goal was to collect ambulance locations for all fifty states. Data requests were submitted to all fifty state EMS offices. In March of 2022, thirty-six of the states had provided data. Twenty-six of the states that provided data filled the request and 10 sent data with limitations. There are 7 states pending and 2 have been unresponsive. Five states responded that the data is either not available or the request was denied.

Data Sources include:

- Ambulance location data: State EMS offices
- Requested physical address of transporting ambulance stations
- In cases where physical addresses or individual station locations were not available, it was necessary to contact agency headquarter locations and/or mailing addresses. Data limitations will be noted on the maps.
- Addresses were geocoded in ArcGIS using Esri's World Geocoding Service
- Cartographic boundary files: US Census Bureau
  - States, counties, census tracts
- 2020 Census block-level population data: Esri, US Census Bureau
- Road network data: Esri, ArcGIS Online Ready-To-Use Services
- Rural-urban continuum codes (RUCCs): USDA, Economic Research Service
- Healthcare facility locations: Health Resources & Services Administration

The Preliminary Findings from the ambulance data research includes:

- In Alabama, the estimated number of people living in ambulance deserts is 314,841. The rural county ambulance desert population is 144,260.
- In Maine, the estimated number of people living in ambulance deserts is 82,346. The rural county ambulance desert population is 54,278.
- In Montana, the estimated number of people living in ambulance deserts is 140,365. The rural county ambulance desert population is 112,824.
- In New Mexico, the estimated number of people living in ambulance deserts is 119,854. The rural county ambulance desert population is 81,399.
- In South Carolina, the estimated number of people living in ambulance deserts is 83,587. The rural county ambulance desert population is 24,569.

Q&A

Bob Wergin shared that he is a medical director for two small communities in rural Nebraska. The EMS are volunteers in these communities. He asked what number of ambulance stations in the findings are volunteer ambulance sites and do they have a billable business model.

Yvonne Jonk stated that they did not distinguish between whether the staffing of the ambulance services was volunteer or paid or distinguish between the staffing levels. There was a 2-year limit on the project and doing that in-depth research would have taken longer than the allowed duration.

Gary Wingrove said that volunteerism is not the same today as it used to be. The younger generations want to do things on their timeline, but volunteers are giving up holidays with their family to serve their communities. There are other healthcare professions that are no longer using volunteers and some communities have decided to pay ambulance staff and create fulltime positions.

Joe Lupica said that a way for ambulance services to grow is by acquiring smaller companies and integrating ambulance services to alleviate duplication of services. A barrier to this concept is that community ambulance services are a point of pride in rural areas. It is necessary to have a regional resource to bring the different companies together.

Yvonne Jonk stated that integration of ambulance services was researched in North Dakota. It is possible to do with fewer ambulance services but with the current locations there were gaps so there would need to be an optimal location. Regionalization is a way to solve obstacles and meet the needs of communities.

Gary Wingrove responded that if North Dakota's critical access hospitals operated ambulance services that almost the entire state would be covered. This is applying the 25-minute drive definition.

FEDERAL EMS PROGRAMS

Kristi Martinsen
Flex Program, HRSA

Kristi Martinsen said she was eager to have the opportunity to speak to the committee about the EMS efforts in the Medicare Rural Hospital Flexibility Program. The Flex Program provides support to forty-five states to improve performance for critical access hospitals and rural Emergency Medical Service Agencies. State coordinated technical assistance is provided based on the needs of the hospital.

Ms. Martinsen stated she would share examples of work that is built into the Flex Program. South Dakota has a project to provide trauma performance improvement webinars to help EMS agencies enhance reporting. The Michigan Flex Program supports an EMS leadership academy to train participants in EMS leadership and management skills.

FY18 EMS Supplements awarded funding to thirty-seven states. Thirty-five of the states focused on sustainable models of rural EMS and two of the states focused on rural relevant EMS quality measures. The EMS project focuses were pediatrics, leadership training, community paramedicine, overall assessments, and additional trainings and tools.

An upcoming program is the State Flex Program Grant EMS Supplement. The purpose of the program is to improve access to quality emergency medical care in rural communities. The 3-year flex program will develop an evidence-base for EMS activities. The two focus areas are: Implementing demonstration projects on sustainable models of rural EMS care and Implementing demonstration projects on data collection and reporting for a set of rural-relevant EMS quality measures.

Arizona focused on using telemedicine to support EMS agencies in reducing unnecessary transports to reduce costs. Ohio and South Carolina implemented community care medicine projects to reduce readmissions by developing a statewide model of Community Paramedicine

and improving the ability of EMS agencies to treat patients in counties without hospitals. The model worked well, even during the COVID-19 pandemic.

Washington used the *Attributes of a Successful Rural Ambulance Service assessment tool* to work with EMS agencies on improving models of care. The enrolled agencies learned from each other and realized they have similar challenges and can work together on ways to improve rural EMS care. The takeaway from the grantees is the importance of bringing the right people together and recognizing that some agencies might not have the capacity to participate.

The four states that focused on rural relevant quality measures were Florida, Kentucky, North Dakota, and New Mexico. Florida and North Dakota examined quality measures from a broader standpoint. Kentucky focused on improving out-of-hospital cardiac arrest survival rates and used carryover to provide "mini grants" for additional training and training equipment. New Mexico focused on improving accuracy of data entry and use of reports to improve patient care. State level data helped with the ease of project implementation.

The next project is the FY22 Rural Emergency Medical Services Supplement. The purpose is to focus on increasing accurate EMS reporting and using data to drive quality improvement efforts at the agency level. The project requires EMS measures that include health disparities, health equity measures, and education and training on the use of data and quality improvement efforts. This will be a two-year project with funding awarded to 6 participants.

Max Sevareid
Director, Office of EMS, NHTSA

Max Sevareid thanked the committee for the opportunity to speak and shared with the committee that he is an EMS specialist with the National Highway Traffic Safety Administration within the US Department of Transportation. The NHTSA's Office of EMS serves as the intersection of healthcare, public safety, public health, and emergency management. There are over one million EMS clinicians in the US including cross trained law enforcement officers, volunteers, and firefighters. There are twenty-three thousand EMS agencies and systems that respond to over forty-two million patient encounters per year.

The National Highway Safety Administration supports the improvement of patient care in the out-of-hospital setting on a national level, including rural areas where access care is limited. This includes care for motor vehicle crash victims in rural areas. Once treated by EMS on scene, crash victims have a limited higher level of care in a majority of rural areas. The NHTSA supports the improvement of patient care through bringing together available data and industry experts to identify the most critical issues facing the EMS profession as well as collaborating with federal agencies and national associations. NHTSA also provides awareness and education about best practices and evidence-based guidelines.

The national 911 program's goal is to help states make progress towards optimal 911 services and encourages the transition into the Next Generation 911 initiative that is an internet or IP based digital system to better serve communities. This system will have the ability to share text videos and photos to an EMS 911 Center. Most states are overseeing 911services through laws

and governance at the state and local level. The national 911 program focuses on convening federal agencies and 911 state and local representatives to developing and share resources. A grant that partners with The National Telecommunications and Information Administration within the US Department of Commerce will assist with the Next Generation 911 program.

In 2021, there were approximately 1.3 million motor vehicle fatalities worldwide, according to the National EMS Information System. Annually, there are approximately 10,000 motor vehicle accidents where victims with severe injuries have less than or equal to 36% probability of survival so there is a national initiative to improve the response system.

In January of 2022, The US Department of Transportation Secretary, Pete Buttigieg, released the National Roadway Safety Strategy. It is the first comprehensive federal proposal to reduce road deaths. At the core of the strategy is the department-wide adoption of the Safe System Approach or SSA. The Safe System Approach focuses on five key objectives: safer people, safer roads, safer vehicles, safer speeds, and post-crash care. This approach emphasizes preventing fatalities and serious injuries over preventing crashes and is focused on caring for people injured in a crash to decrease fatalities.

EMS is one of the major elements of post-crash care within the Safe System Approach. An estimated two-out-of-five people who died from car accidents were alive when first responders arrived on the scene. Twenty percent of trauma deaths are preventable with optimal emergency and trauma care, so it is vital for people who are alive after a crash to get the right care at the right time. The National Highway Traffic Safety Administration implemented a Fatality Analysis Reporting System that found in 2019, there were 16,000 rural traffic fatalities and rural areas accounted for 45% of all traffic fatalities.

The Federal Interagency Committee on EMS was established in 2005 by Congress and works with state EMS offices. The committee supports state, regional, tribal, local, and territorial 911 and EMS systems in the development and implementation of evidence-based guidelines, promoting standardization and quality improvement of prehospital data, and EMS system all-hazard preparedness.

The National EMS advisory council provides input and guidance to the US Department of Transportation and has around twenty-five members who represent all aspects of the EMS and health care. The council presented recommendations focused on rural EMS issues titled Rural and Volunteer EMS Recruitment and Retention. The project was coordinated with state and national offices of EMS and 911, as well as highway safety partners.

Mr. Sevareid stated that the Bipartisan Infrastructure Law increases the NHTSA's budget more than 50%. These resources will support post-crash care and EMS systems. Data collection is one of the key elements of the Bipartisan Infrastructure Law with state funding for rural systems.

A way to support rural and tribal EMS agencies is by sharing EMS.gov and other resources with communities. NHTSA would like to collaborate with the Federal Office of Rural Health Policy to provide resources to rural EMS agencies. Rural EMS agencies are struggling to acquire

sufficient resources. There is useful information available on EMS.gov, 911.gov, and NEMSIS on the EMS.gov website.

Maria Durham
Director, Division of Data Analysis and Market Based Pricing

Maria Durham stated that it was a privilege to be among people who have dedicated their lives to improving health systems. Ms. Durham said she would share information about the ambulance fee schedule with the committee and give a quick overview of ambulance benefits through Medicare. Also, she stated she would share about equity and COVID-19 flexibilities and the Medicare Ground Ambulance Data Collection System.

The CMS vision is to serve the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes.

Ways to achieve the Centers Medicare & Medicaid Services vision include:

- Advance health equity by addressing the health disparities that underline our health system
- Build on the Affordable Care Act and expand access to quality, affordable health coverage and care
- Engage CMS partners and the communities served throughout the policymaking and implementation process
- Drive innovation to tackle health system challenges and promote person-centered care
- Protect programs' sustainability for future generations by serving as a responsible steward of public funds
- Foster a positive and inclusive workplace and workforce and promote excellence in all aspects of CMS's operation

CMS is working to improve health care delivery through the development of a comprehensive cross-centered strategy. Due to health disparities in rural areas, often ambulance services are the only form of transportation for people who require health services. Under the Administration for Children and Families, Medicare Part B covers ground and air ambulance transport services to a Medicare beneficiary.

The Medicare beneficiary must meet the following requirements:

- There is medically necessary transportation of the beneficiary to the nearest appropriate facility that can treat the patient's condition and any other methods of transportation are contraindicated, meaning that traveling to the destination by any other means would endanger the health of the beneficiary
- The beneficiary's condition must require both the ambulance transportation itself and the level of service provided for the billed service to be considered medically necessary

Ambulance transports use the lower of the actual billed amount or the fee schedule payment methodology. Medicare will pay for 80% of the approved amount with a 20% deductible. The

Medicare fee-for-service program spending for ambulance services in 2019 was $4.5 billion, or about 1% of total Medicare fee-for-service spending, and approximately 11% of all Medicare fee-for-service beneficiaries used ambulance services.

Ambulance fee schedule rates were established in the 2002 ambulance fee schedule final rule. Payment for all the ambulance transports includes 3 components. The 3 payment components are the base payment, a separate payment for mileage, and the geographic adjustment factor. There are also add-on payments for ground ambulance services in rural and super rural areas.

The add-on payments are as follows:

- 3% increase to the base and mileage rate for ground ambulance transports that originate in rural areas
- 2% increase to the base and mileage rate for ground ambulance transports that originate in urban areas
- 22.6% increase in the base rate for ground ambulance transports that originate in "super rural" areas

Equity is a priority for the administration and how to address the disproportionate and severe impact of COVID-19 on communities of color and other underserved populations. The COVID-19 Public Health Emergency Flexibility was particularly important in rural communities because they were disproportionately affected by COVID-19.

Congress enacted legislation that requires CMS to collect cost revenue utilization and other information from ground ambulance organizations. The data is provided to the Medicare Payment Advisory Commission who submits a report to Congress on the adequacy of payments for ground ambulance services and geographic variations in the cost of furnishing such services.

CMS developed the Medicare Ground Ambulance Data Collection System with the following policies:

- Effective January 1, 2020, and continuing through 2024, ground ambulance providers and suppliers that have been selected to participate in the Medicare Ground Ambulance Data Collection System must collect information on cost, utilization, revenue, and information in accordance with the Medicare Ground Ambulance Data Collection Instrument for a continuous 12-month period.

- The collected information will be provided to MedPAC, which is required to submit a Report to Congress on the adequacy of Medicare payment rates for ground ambulance services and geographic variations in the cost of furnishing such services.

- Failure to sufficiently submit the required information will result in a 10% reduction to payments under the AFS for one year unless a hardship exemption has been granted or a successful informal review.

Q&A

Joe Lupica said that he worked in the ambulance services business and paramedics were under pressure to transport a patient so that the ambulance service would get paid. He asked if there a way to pay for EMS when the patient receives care in the field instead of only paying for their care when they are transported by an ambulance to a medical facility.

Max Sevareid responded that the only exception for receiving care in the field instead of for transport is when a patient has cardiac arrest. CMMI spent forty-six million dollars proving that paramedicine works but it has not been put into policy thus far.

Steve Barnett said that Max Severeid highlighted that 25% of patients end up in a level 1 or 2 trauma facility. There is rarely a Level 1 or Level 2 within the 30-minute transport area in rural communities.

Max Severeid responded that there was research done in 2006 about the obstacles transporting patients to Level 1 or 2 trauma centers. For trauma patients on a severe level, there was a 20% improvement in odds of survival if transported to Level 1 or Level 2 trauma center, but this only occurs for one third of patients. In rural areas it may because it is too difficult and too much of a distance. There is a need for resources and procedures to address this issue.

STATE PERSPECTIVE ON EMS ACCESS

Dia Gainor
Executive Director, NASEMSO

Dia Gainor said she would share state rural EMS information with the committee. There is an EMS office in every state including the District of Columbia and five territories. The state EMS offices license paramedics, EMTs, ground EMS, and air ambulance agencies. The state EMS offices also manage patient care records, engineer systems of care, and implement innovative programs to improve safety and outcomes.

The State EMS Offices license EMT and paramedic functions including conventional ground ambulance services and non-transporting EMS services in rural areas. The non-transporting services respond and care for patients until an ambulance from a more distant location arrives. Helicopter EMS agencies can make a critical difference in patient outcomes when a patient is severely injured. EMS offices are also primarily responsible for the collection of the patient care reporting that leads to the national EMS information system. In calendar year 2021 alone, state EMS offices submitted Forty-nine million patient care response records to the national repository at the University of Utah. The patient care response records give a more precise insight of rural and frontier issues than in the past.

The state EMS responsibilities include detection and dispatch so modern technology and the implementation of the New Generation 911 system will help with making choices regarding distance and designation determination. This also allows for utilizing information through photographs and video that a caller can share. Once the New Generation 911 system is in place

across the country, information at the scene of a motor vehicle accident could be shared pre-dispatch to include the potential need for an extraction, the number of occupants in the vehicle, and the need for an air medical vehicle to be dispatched.

The state license renewal process can include a survey that collects information from the state. It can also include how long it takes EMS to respond to a call at the furthest point for which they are responsible and the distance to a hospital. The survey can establish where there are ambulance deserts and other vital information. Triage guidelines are published in the American College of Surgeons to determine when patients need to be transported to a Trauma 1 or Trauma 2 hospital.

In 1994, a national EMS database was created. Most states had migrated to an electronic patient care reporting system, but every state was using different fields and definitions. If systems were standardized across all the states, it would be an effective way to compare and aggregate data. In the early stage, there was not a national data collection effort. In 2001, the first national data dictionary and software compliance testing was in place and EMS data collection was transmitted to a national depository.

The EMS database has evolved, and real time submission and validation of data arrives at the state and is retransmitted to the National Emergency Medical Services Information System. January of 2022, over 75% of all expected records were in the national repository and that made it possible to look at trends in specific topics of interest and compare rates based on prior years.

Guy Dansie
Director, Utah Emergency Medical Services Bureau

Guy Dansie said about 90% of the population of Utah resides within a short distance of Salt Lake City. The national parks and tourism in Utah attract tourists to rural areas where there is a lack of a telecommunications infrastructure and EMS services. There are mountain ranges and desert plains that make transmission particularly challenging due to an absence of internet services.

The typical EMT in Utah makes around fourteen dollars per hour and paramedics make around eighteen dollars per hour. It is advantageous that paramedics quickly advance into other types of employment or leadership roles, but it exacerbates the problem of recruitment and retention of EMTs. In the past, flex funding has supported training residents in EMS leadership roles and services which has been effective. Best practices shared between agencies has been a beneficial training tool as well. A barrier is that young people from rural communities leave the area to attend college and pursue careers for higher pay. After graduating from college, they often move to the city to earn a higher salary.

Utah collects data for the fiscal year and the information is used to set a maximum and base rate for services as well as mileage rates that can be used as add-ons. The state can increase the drawdown from the federal funding by doing an assessment of the ambulance services and derive funds to match federal dollars. This is especially beneficial in areas with a sizeable Medicaid and Medicare population.

The state has a Critical Incident Stress Management Program for medical providers and is in the process of creating a peer support program. A CMS grant funds a statewide assessment, and the state is working with the University of Utah to develop training. The crisis support technician will receive sixty to eighty hours of basic training that includes joining the mobile crisis team to assist EMS or law enforcement agencies with behavioral health calls.

Sam Hurley
Director, Maine Office of Emergency Medical Services

Sam Hurley told the committee he was the former Director of the Office of EMS in Washington, D.C. He also performed EMS training in North Carolina, Georgia, and other parts of the East Coast.

The Greater Portland metropolitan area is the most densely populated area in the state comprising 40% of Maine's total population. The interior of the state has large rural areas. Baxter State Park is in Piscataquis County in north-central Maine. The national park is an optimal place to view the aurora borealis. There are about twenty-three million tourists that visit Baxter State Park, Acadia State Park, and Portland every year.

Emergency Medical Services are in small towns throughout the United States, and generations of families have passed down the desire to volunteer and serve their community. It is time to reevaluate the volunteer model of service delivery. In Maine, volunteerism is the predominant model of EMS service delivery and volunteers are working 72-hour shifts and multiple jobs to support their families. EMTs have a high rate of divorce, suicide, and cardiac arrest. EMS is an essential service and should be designated as an essential service on the federal level which would allow for more funding opportunities.

The State of Maine is increasing licensure and authorization to offer more opportunities for EMS clinicians. There is now an advanced EMT certification program, but a community paramedic program is necessary to allow people further opportunities and to build a sustainable system of coverage. EMTs and paramedics should be offered the same opportunities of training and advancement as nursing and other fields in the medical profession.

Kevin McGinnis, Program Manager at the National Association of State EMS Officials, helped develop the EMS Informed Community Self-Determination Model. This model gives the community the power to determine what EMS services should be in their community. Maine is deploying the model and just invested $200,000 to assist communities to initiate using the model.

The 4 Steps of the EMS Informed Community Self-Determination Model are:

Step 1: Assessment

Discover the reality and adequacy of current EMS system:

- Response characteristics
- Clinical level and performance
- Operational characteristics
- Financial characteristics

Step 2: Alternative Models and Cost Impact

Explore and discuss alternative models, including:

- Various levels of service
- Different response levels
- Outside of the box alternatives
- Cost of each alternative

Step 3: Decision-makers forum

- Ideally, public forum including officials/representatives
- Present report from previous steps
- Straw poll

Step 4: Operating Model Chosen/Funded

- Commit to a model and its funding through a binding decision process
- Designate follow-up reporting process

The State of Maine is going through the grant process to outfit every ambulance with high-speed internet. EMTs and paramedics can facetime in Skype and connect with doctors in these tertiary care centers to receive guidance and perform specialized consults in collaboration with home health. Starting next year, EMS clinicians in Maine will be able to initiate suboxone and medication-assisted-treatment for persons suffering from substance use disorder.

Q&A

Steve Barnett said an issue with the system in Michigan is that Medicaid managed care organizations can decide whether to pay for an EMS service when they are on the scene or downgrade the payment by using the Medicaid payer manual as a guide.

Dia Gainor responded that Medicaid provisions vary widely by states. There are instances where the EMS community had to demand rulemaking or other inner policy interventions with the state Medicaid program to change policy. CMS could assist with declarations about the policies that are inappropriate and support those who have changed their Medicaid rules to reimburse ambulance services for treatment-in-place and treat and release.

Kari Bruffett said there has been discussion about barriers to reimbursed for treatment without transport but what about reimbursement barriers regarding transportation to alternate destinations other than a hospital or emergency room. In Kansas and other states there are behavioral health

crisis stabilization centers where assessment and triage are performed but it does not qualify for ambulance transport reimbursement. This may be an opportunity to become knowledgeable and potentially have a recommendation for the secretary of health and human services.

Dia Gainor responded that guidance about alternative destinations would be welcomed by the state EMS offices. Due to the rapidly evolving behavioral health and substance use disorder expectations, until mobile crisis teams exist, ambulance services are the mobile clinical resource in rural and frontier communities. If the best option is for a person to be transported to an alternative destination, then resolving the distance incentive limitations should be a consideration.

COMMITTEE DISCUSION

Topics discussed include:

- Ambulance service transport issues in rural due to distance
- Business mode verses medical mode
- Low volume
- EMS deserts have a significant impact on healthcare outcomes
- Subsets of rural residents are underserved
- Need innovative payment models that can manage low volume services that are critical in rural and frontier areas
- Medicare payments are less that it costs to treat patients
- Community paramedic program to treat people in the field when possible
- Issues with reciprocity of EMTs and paramedics from one medical region to another
- Work on solutions about non-emergency transport
- In various elements of healthcare there is a shift from volume to value but there are still silos and a need for more collaboration. Community paramedicine could assist with this issue
- Supporting rural EMS will be paramount for communities that choose the rural emergency hospital designation
- EMS training support and workforce
- Funding is going to the fire department but not going to EMS – need support of tax dollars for EMS
- Volunteer workforce is not viable and there is a decline in volunteerism
- Grant opportunities for EMS training in high schools and promoted EMS as a career path

CALL FOR PUBLICT COMMENT

No Public Comment

Tuesday, April 12, 2022

VIRTUAL SITE VISITS

Provider Panel - Reimbursement and Provider Panel - Workforce

Subcommittee members attend break off sessions to discuss EMS reimbursement and workforce topics.

TRIBAL PERSPECTIVES ON EMS ACCESS

Loretta Christensen
Chief Medical Officer, IHS

Loretta Christensen thanked the committee for the opportunity to speak about IHS and tribal EMS challenges. She shared that she is a critical care surgeon and was the director of a trauma center. Ms. Christensen said she met with Navaho EMS and would like to convey the struggles and challenges of providing high quality Emergency Medical Services in tribal communities.

Indian Health Services is within the Department of Health and Human Service and responsible for providing federal health services to American Indians and Alaska Natives. The IHS mission is to raise the mental, physical, social, and spiritual health of American Indians and Alaska Natives to the highest level. Delivery of services can be achieved through federal, tribal, or urban Indian health programs. There are twelve geographic regions throughout the United States where IHS provides care. Approximately one hundred and six EMS programs are funded by IHS, and the services are provided through independent programs and health-based programs. EMS are rescue and transport services with mainly paid employees and a small number of volunteers.

In Navaho Nation, IHS covers 27,000 square miles and there are similar distances in the Great Plains which becomes a challenge with providing optimal and timely EMS services. Reimbursement for EMS services is problematic, especially in areas without third party coverage. EMS does not get reimbursed for the cost of going out on calls in those areas. Purchase Referred Care Agreements provides funding for services outside the confines of facilities in IHS and tribal programs.

Codifying EMS and 911 essential services is challenging because many tribal communities do not have 911 services, and this increases delays. A lack of integration with local level organizations is a broad problem across tribal EMS, and there are state barriers that result in a disconnect and delay with county and state level organizations. There are inadequate EMS training and education programs, and this deters people who start at the EMT level to make career improvements. EMS personnel were trained as vaccinators and staffed care and isolation sites during the COVID-19 pandemic but were not prioritized for supplies.

In tribal communities, ambulances respond to call areas that do not have coverage due to staff shortages. The distance and terrain in rural areas takes a toll on ambulances and upkeep is costly. There are limited air ambulance services, and it is difficult reaching patients because there are

not enough landing zones available. Ambulances are used to transfer patients to different facilities and there are a limited number of ground ambulance services and vast areas of coverage. An EMS comprehensive approach is necessary in rural areas because the services are a vital part of the healthcare system.

Q&A

Governor Colyer asked if the addition of the professional fulltime staff provided supplementary services.

Loretta Christensen responded that having the upper-level paramedics allows a higher scope of care delivery in the field. At the EMT level, which is most of the staff, the level of care delivery is extremely limited. EMTs can monitor patients, perform vitals, and provide oxygen, but cannot provide the level of care of the paramedics.

Jim Werth asked what type of EMS innovative ideas are being considered.

Loretta Christensen responded that the Office of Clinical and Preventive Services is exploring how basic on-site services can be addressed by paramedics in the field without transferring the patient to a hospital.

Bob Wergin asked what role telehealth could have in the region.

Loretta Christensen said that telehealth can have a huge role in assisting patients. There are areas without broadband so that is a barrier concerning telehealth. During the pandemic telehealth was utilized and telephone visits with patients was especially beneficial in areas without broadband.

DEBRIEF ON SITE VISITS AND NATIONAL, STATE, AND TRIBAL PERSPECTIVES

Provider Panel – Workforce

Bob Wergin shared that the subcommittee focus was on EMS workforce in rural areas. The main topics were:

- EMS being designated as an essential service on a federal level and in all fifty states
- Reimbursement is tied to treatment and not transport
- Blending volunteer and paid staffing positions
- Staffing Incentives – benefit packages, tax breaks
- EMS Education including cost control of initial courses and retaining and maintaining EMS certification
- Recruitment and Retention

Kari Bruffett shared that the subcommittee focus was on EMS reimbursement in rural areas. The main topics were:

Rural Ambulance Agency Challenges:

- Long distances and challenging terrain that prolong emergency response and transportation times
- Insufficient payment by insurers to cover standby and fixed costs
- A changing workforce that has historically relied on volunteers but increasingly must include paid personnel
- A lack of regional EMS plans to coordinate services
- Insufficient state and federal policy coordination across oversight agencies

Types of assistance needed by EMS include:

- The five-year extension of the Medicare add-on is necessary in rural communities
- Reclassifying of misclassified zip codes by CMS as urban instead of rural
- End Sequestration and PAYGO cuts
- Direct funding for ambulance services
- Additional Medicare adjusters for EMS
- End the productivity adjustment for EMS

DISCUSSION OF EMS POLICY RECOMMENDATIONS

Potential themes for possible recommendations:

- Re-emphasize EMS/ambulance as a provider of health care services and not just a supplier.
- EMS/Ambulance policy incentive obstacles
  - It is a vital health service, but limited programs and resources are spread across HHS programs. FICEMS is a valuable resource but may need broader support.
  - EMS services are only compensated if patient is transported
  - Is EMS a health care service or an adjunct to the fire department/first responder community
  - Rural EMS/ambulance is dependent on an ever-dwindling supply of volunteers but lacks the volume and scale to be viable in areas under current billing realities.
  - Maintaining training for rural EMS is a challenge and the reality of rural service provision is the need for training at a higher level than urban EMS
- Jurisdictional challenges (Federal to State to County to sovereign tribal entities)
- Ground and air ambulance are critical parts of the rural health infrastructure. Ground ambulance services are available 24/7.
- Reimbursement: The FFS structure is incompatible for rural low-volume communities.
- Workforce: The bulk of HHS training dollars do not focus on EMS other than the SAMHSA program. EMS training not part of broader HHS health professional education training.

National Association of State EMS Officials:

- There is a lack of national understanding about regional EMS capacity. Better data coordination and a dedicated organization to house this data could address this.
- There is not a sufficient understanding of what factors make an ambulance service vulnerable for closure. The development of an index like the financial distress index that is used for rural hospital closures could solve this problem.

American Ambulance Association:

- Create a reimbursement model that includes factors like Health Professional Shortage Areas, Medically Underserved Areas, and the Medicaid disproportionate-share payments
- Create an ET3-like pilot program that eliminates the minimum number of transports and the requirement for a 24/7 care destination to allow for rural services to participate.
- Make the Medicare Add on Payments permanent and pause/eliminate Sequestration and Productivity Adjustment.
- Medicare should provide an appeal process for reconsidering a change in a ZIP Code's status as rural or super-rural. In addition, a new exception should be established under Medicare that maintains rural ZIP Codes in large urban counties as rural or super-rural, if there are 1,000 or fewer people per square mile in the ZIP Code.
- Ensure inclusion of EMS in federal grant programs, including but not limited to, workforce development programs, tax incentive programs, healthcare innovation projects and mental/behavioral health programs.
- Payment policies need to include funding for accessing behavioral and mental health experts through a variety of modalities including online zoom sessions, referrals, and group therapy, none of which are reimbursable under the current system.

CALL FOR PUBLIC COMMENT
No Public Comment

Wednesday, April 13, 2022

RURAL HUMAN SERVICES: CONTEXT SETTING AND EMERGING ISSUES

Jocelyn Richgels – Moderator
Director, National Policy Programs, RUPRI

Jocelyn Richgels shared that there have been changes in human services throughout the COVID-19 pandemic including improved interconnectedness and new opportunities. Health providers recognized the importance of human services for the wellbeing of rural people, places, and communities. COVID-19 pandemic challenges included people experiencing social isolation, loss of jobs, and mental health issues.

Workforce is not only an issue in the healthcare system but also in human services. The ability to recruit and retain staff with the necessary skills is an increasing issue. Service delivery is different today than what it was twenty years ago when the focus was on recovery and rescue. Today human service delivery includes collaboration with community members, integrated services, the whole family approach, and addressing upcoming issues.

The American Public Human Services Association represents state human service offices and has created Core Principles for Temporary Assistance for Needy Families including:

- Achieving economic mobility and social and emotional wellbeing for individuals and their families
- Tailored solutions to assist families succeed long-term
- Foster conditions that advance a person's sense of agency over their life and belonging within their community
- Centered in evidence and promising practices that reflect the lived experiences of families
- Deliver a coordinated continuum of services that support all jobseekers' strengths, goals, and needs
- Provide access to adequate assistance and services that allow them to meet their basic needs while working to achieve their long-term goals

The Two Generational Model is a new, holistic approach to designing programs around human services and community action agencies. This model transitions from focusing on the individual child or parent to holistic service delivery for the entire family. Obstacles to achieving objectives is the lack of access to human service providers in rural counties and drives most human service policy considerations.

Lacey Boven
Regional Administrator, ACL

Lacey Boven shared that her division is one of eleven operating divisions in the Department of Health and Human Services. ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers. The vision is that all people, regardless of age or disability, live with dignity, make their own choices, and participate fully in society. There is a person-centered approach to support the services that are provided through networks to stakeholders.

The ACL recognizes that the preferences of an individual are not the only factor in determining how to support them in their community. The availability of services and supports may not exist in rural areas and hinders support. Sometimes it is the resources that are available through family caregivers or other factors that need to be considered for someone to remain independent in their community.

There have been innovations and changes to the systems approach through partnerships and flexibility. The innovations are supported with flexibility in policies and ongoing applications of

evaluation, which the committee has recommended in the past for ways to address human services in rural areas.

ACL provides funding for national resource centers with specific objectives. The Americans with Disabilities Resource Network provides supports including ramps for access to buildings. The ACL budget is small but works across agencies on various initiatives. ACL has established the National Aging and Disability Network which are key in finding community champions in rural areas and expand supports and services. The social determinants of health are an emphasis and enhancing relationships with partners to ensure that individuals can remain healthy and in their homes. An example of partnerships in rural communities happened in Kansas with EMS being a key partner in mapping overdose cases so data was easily accessible. The data allowed using the information for community-based programs to address deaths from overdose cases.

The older adult population is increasing, and most older adults are still living at home. The Older Americans Act is an operating division that provides services to 1 in 5 adults in the United States. The services include home delivered meals, transportation, personal care, and care giver support. The Older American's Act works in partnership with states, and Tribal Area Agencies on Aging, including nearly 20,000 service providers and 500,000 volunteers. Older adults staying engaged in enjoyable activities is associated with better physical and mental health. The World Health Organization has declared this the Decade of Healthy Aging, so it is an opportunity to coordinate global initiatives.

Emerging issues include:

- The effects of COVID-19 including social isolation and mental health issues
- Technology and telehealth availability
- Addressing poverty and elder abuse
- Caregiver support

Aging Network Service Considerations include:

- Meeting immediate needs
- Intentionally responding to current situations in ways that may position the aging network to meet future needs
- Demonstrating use of the funds to meet needs

Falls are the leading cause in fatal and non-fatal injuries of people 65 years and older. The ACL Falls Prevention Program sustains evidence-based fall prevention programs that have been proven to reduce falls, the fear of falling, and fall related injuries in older adults. Chronic Disease Self-Management Education programs provide older adults and adults with disabilities, education, and tools to help them better manage chronic conditions such as diabetes, heart disease, arthritis, chronic pain, and depression.

Access to broadband services to support high-speed internet access is needed to support community living for individuals. Broadband access provides resources to maintain healthy communities and can be critical in survival during and after a disaster. Leveraging telehealth was

supported during the pandemic and presents an opportunity to communicate with a doctor without having an office visit. Fewer than 1% of primary care visits in Medicare occurred virtually in January of 2020, but nearly half of telehealth visits occurred virtually by April of 2020, according to data compiled by the Medicare Payment Advisory Commission. Area Agencies on Aging groups in rural areas are administering their health insurance assistance program to Medicare recipients.

Jeannie Chaffin
Former Director, The Office of Community Services, ACF

Jeannie Chaffin said that human services and health services both have their own systems, and it is important for health and human services to have one comprehensive system to support the wellbeing of the whole person. A person's wellbeing is dependent on having housing, food, employment opportunities, education, and childcare. Each one of these needs have their own funding streams. Housing is a challenge in rural communities and elements of housing are supported under HHS.

Health and human service interventions are initiated through Head Start, Maternal, Infant, and Early Childhood Home Visiting programs, Infant and Maternal Mortality programs, and home delivered meal programs. Head Start is an early childhood program but has a robust dental and medical component that combines health and human services. North Carolina is launching an innovative program for human service needs to be met with healthcare subsidies. Often there are interventions that health providers can perform to assist with human service issues, but the interventions are not to scale. People in rural communities need support with utilities and other services but only about 18% of the population is eligible for utility assistance. It is necessary for services to be available to a higher percentage of people in rural areas. The location of services can make it difficult for people who do not have transportation or cannot travel long distances to receive care.

Temporary Assistance for Needy Families, Head Start, and child welfare programs are federal programs and are not coordinated among states. In some states, funding is accessed through the Department of Social Services and is allocated out to different counties. In 99% of counties in the country, TANF funds are managed through community action agencies. The National Community Action Partnership website lists community action agencies across the United States. An opportunity for the committee is to explore the structural factors that exist in communities. The inequities, disparities, discrimination, and racism are all part of health and wellbeing. Allies in rural areas can work together to address these structural factors.

The committee has explored the topic of Adverse Childhood Experiences and that is a key factor in a person's wellbeing. The Center for Disease Control has collaborated with the Association for State Tribal Health Officials and are funding a pilot program in 6 locations across the country to increase vaccine uptake and reduce racial disparity. Rural communities experience barriers when competing for grants, for example, grants that are based on population. The federal government should initiate policies that allow rural communities to compete for more discretionary funding.

HUMAN SERVICES PROGRAMS IN RURAL CONTEXTS: PRELIMINARY FINDINGS

Aira Jae Etheridge
Public Health Analyst, HRSA

Aira Jae Etheridge said she would be providing an overview of the Human Services Programs in Rural Contexts study. The overview will describe how "rural" was defined and the approach taken to estimate the remaining need for human services in rural counties. The discussion will also include preliminary findings about remaining needs for Temporary Assistance for Needy Families in rural counties.

The purpose of the study was to examine the unique opportunities and challenges for administering human services programs in rural communities. While rural communities have assets, they can struggle with access to economic opportunities, transportation, broadband internet, and health and human services. These disparities in rural populations' access to services and benefits can lead to people's basic needs going unmet. The ACF and HRSA seek to better understand human service programs in rural contexts. Human services are a broad, interdisciplinary field comprised of diverse programs serving a variety of populations.

In this study, the focus was on a set of ACF and HRSA programs, including:

- Healthy Marriage and Responsible Fatherhood
- Health Profession Opportunity Grants
- Maternal, Infant, and Early Childhood Home Visiting
- Temporary Assistance for Needy Families

Temporary Assistance for Needy Families fosters economic security and stability for low-income families by providing states with block grants to design and operate programs to support families to achieve self-sufficiency.

TANF offers a range of supportive services, including:

- Assistance for children who receive care in their own homes or with relatives.
- Promoting job preparation and incentivizing work and marriage
- Preventing and reducing out-of-wedlock pregnancies
- Encouraging the formation of two-parent families

When defining "rural" for the study, the definition had to be used to inform planned, quantitative analysis on measuring the level of remaining need within rural counties and represent the diversity of rural settings. A challenge in rural areas is that most data is suppressed for geographies smaller than a county. The definition selected was the US Department of Agriculture's Rural-Urban Continuum Codes. RUCCS subdivide nonmetropolitan counties in terms of population size, population density, and adjacency to metro areas.

The definition of remaining need was controlled for non-federal human services in the county and for the baseline of need present in the county. The larger the non-federal activity, the smaller the remaining need, the larger the baseline of need, the larger the remaining need. The larger the difference between eligible populations and populations served, the larger the remaining need.

Lisa Zingman
Research Analyst, ACF

Lisa Zingman shared that the three categories to identify remaining need were family self-sufficiency, individual self-sufficiency, and programmatic support services. There was an estimate calculated for each category and then scores were averaged to create an overall estimate of remaining need. The data sources included the Census Bureau and the Bureau of Labor Statistics. Each county had a number that provided an estimate of the remaining need of TANF basic assistance, and the counties were compared and divided into quintiles with approximately the same number in each quintile. The quintiles are from low remaining need to high remaining need in rural counties.

The funding for TANF basic assistance was mapped in each rural county. In 2018, overall funding for TANF assistance was 6.5 billion dollars. Out of that funding, the amount of assistance to rural counties was 725 million. There are extremely elevated levels of remaining need for TANF basic assistance in most parts of the United States, with some southern states, northeastern counties, and native lands having the highest numbers. There are also pockets of high and extremely high remaining need throughout the Midwest and west. There are several reasons that these areas could have extremely high and high remaining need.

Rural counties with different population sizes all have similar levels of extremely high or high remaining need. The rural counties with the highest population sizes or population centers have higher need than the rural counties with smaller numbers of people in population centers. Rural counties adjacent to metropolitan areas were more likely to have extremely high and high remaining need compared to rural counties that are a further distance to a metropolitan area.

Q&A

Jim We rth stated that it is interesting that the counties near urban areas are more in need than rural communities that are further from urban areas. Is it because the money goes to the urban areas instead of the rural areas in proximity?

Lisa Zingman stated that the cause is unknown but there was less remaining need in extremely rural areas.

Governor Colyer stated that services in surrounding counties to metropolitan areas are much more robust. The findings of analysis are counterintuitive to the reality in Southeast Kansas and Western Kansas.

Lisa Zingman responded that this is just one program of focus, so it could vary across programs.

Governor Colyer said that every state gets a different amount of money per person for TANF and how they use the funding varies.

Lisa Zingman said the study focused on basic assistance; it does not address how states use TANF funding.

Bob Wergin said that a large proportion of the areas in need were in tribal populations. There could be collaboration with Indian Health Services regarding these findings.

PLANNING FUTURE RURAL HUMAN SERVICES TOPICS

- The American Rescue Plan is funding Head Start and Childcare Development Block Grant so the committee could create a short brief highlighting rural considerations
- Integrating health and human services in rural communities
- How to sustain EMS in rural communities including better payment models to reimburse for services, transferring patients long distances for higher levels of care, and difficulties with transport
- Low-income subsidies assist with people finding housing but does not assist with maintaining the home. There is a need for broader human services to support independence at home
- Absence of data integration between health and human services
- Rural health and human service agencies cannot compete for grants due to lack of grant writers. Urban agencies can apply for grant funding if they show a presence in rural areas.
- Eligibility across programs is not consistent
- Models to consider regarding abuse, neglect, and exploitation
- Head Start eligibility for undocumented individuals and eligibility for program or housing
- Training for EMS and CDA through federal resources offered through community colleges

NEXT STEPS

Governor Colyer stated that a subcommittee will meet to create a short brief highlighting rural considerations regarding the American Rescue Plan is funding Head Start and Childcare Development Block Grant.

Plans are being developed for the next NACRHHS meeting, which will be held in September.

In closing, Governor Colyer thanked the outgoing committee members for their contributions which included Joe Lupica, Bob Wergin, and Steve Barnett.

Truman Fellows, Sami Ismail, and Patrick Grady were recognized for the important work they have done over the years for the committee as they complete their term with the Office of Rural Health Policy.

Governor Colyer also shared that Steve Hirsch, from the Office of Rural Health Policy, will be retiring and his work on the committee has been invaluable.

Tom Morris added that Mr. Hirsch updated the standards for how rural is defined in the country, in addition to his other responsibilities that includes the work he has done for the committee.

CALL FOR PUBLIC COMMENT
No public comment