

**Health Resources and Services Administration
Office of Rural Health Policy**

National Advisory Committee on Rural Health and Human Services

**Washington DC
February 15-17, 2012**

Meeting Summary

The 70th meeting of the National Advisory Committee on Rural Health and Human Services was held on February 15-17, 2012 in Washington DC.

Wednesday, February 15th

The meeting was convened by Governor Musgrove, Chairman of the Committee.

The Committee members present at the meeting were: Governor Ronnie Musgrove (Chair); Eugenia D. Cowan, PhD; John Stewart Cullen, MD; Pamela deRosier; Barbara Fabre; Phyllis A. Fritsch; Larry Gamm, PhD; Roland J. Gardner, MS; David Hartley, PhD, MHA; Thomas E. Hoyer, Jr., MBA; Michele J. Juffer; Karen Madden; Barbara Morrison, MS; Wayne Myers, MD; Shane H. Roberts; John Rockwood, Jr., MBA, CPA; Gary Walton, DO; Roger Wells, PA-C; Christy Green Whitney, RN, MS.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Steve Hirsch, Executive Secretary; Paul Moore, Aaron Fischbach, Michelle Goodman, Deborah DeMasse-Snell and Nicole Comeaux. Truman Fellows present were: Aaron Wingad and Nicholas Lillios.

Richard J. Gilfillan, M.D.

Acting Director of the Center for Medicare and Medicaid Innovation

Richard Gilfillan thanked the committee for the opportunity to speak to them about the Center for Medicare and Medicaid Innovation. He shared that he had practiced as a physician in a small town of about 7,000 people in north central Massachusetts. He also spent time in a rural health system in north central Pennsylvania. He noted that he does not have the big policy perspective of many of the committee members.

Dr. Gilfillan shared a story with the Committee about a patient from rural Pennsylvania. The patient, Marie, had many health problems including COPD, congestive heart failure and diabetes. She was part of a medical home program providing support and managing her care with a dedicated nurse case manager. Marie shared her feelings about the program saying, "The idea of the program is to keep me healthy, keep me out of the hospital and to keep costs down. I don't think I would still be here without this program. It has been my lifeline." This is what the Center for Medicare and Medicaid Services is trying to accomplish as the health care system changes to a patient centered health care

system.

Dr. Gilfillan stated that the Centers for Medicare and Medicaid Services mission is to be a constructive force and a trustworthy partner for the continual improvement of health and health care for all Americans. A program that functions with a health plan and provider working together is important. Centers for Medicare and Medicaid Services have to be effective stewards of the resources when focusing on a patient centered health care system. CMS measures of success are better health, better health care and better costs for patient health care.

The health care system today is not focused on better health, better care and reduced costs. The payment system today is volume and revenue centered. There has to be a people-centered care model that is sustainable and affordable and delivers better health, better care and better costs. Dr. Gilfillan stated that The Centers for Medicare and Medicaid Services knows that providers need to change the way care is delivered and that the CMS and payers need to change how they operate from paying for à la carte care to paying for and supporting and providing information for coordinated integrated care. If everyone involved with patient care would view success as being defined as better health, better care and better cost there would be a dramatic change. The first visible change would be fewer cranes at hospitals building new towers. Hospitals do not need more beds but instead more integrated services.

The charge of the Innovation Center is to identify new care models and new payment models that support better care at reduced costs. The Health & Human Service Secretary has the authority to expand successful models to the national level. The challenge of the Innovation Center is making the change towards transformation of the system.

Dr. Gilfillan stated that there are many different types of providers so the Innovation Center presents different model options. For example, one model option allows states to participate in a program where Medicare will pay primary care doctors if they provide different services to the patients such as having a care manager in their office and analyzing their population and comparing data to others. There is the Independence at Home Model where physicians go into patient's homes to provide care. The Pioneer Accountable Care Organization Model is launched and has 32 organizations that are experienced in providing advanced care coordination services. Two of the organizations are in rural areas.

Dr. Gilfillan spoke about models with four bundled payment approaches which include providers taking responsibility for a patient's episode of care for up to 90 days after surgery instead of only while the patient is in the hospital. These models include retrospective acute care, retrospective acute care episode and post-acute, retrospective post-acute care and prospective acute care.

Dr. Gilfillan stated that it takes about 17 years for Best Practices to be adopted throughout the Country. The Center for Medicare and Medicaid Innovation has five key ways they

are working to spread innovation through Partnership for Patients, Community Based Care Transition Program, Million Hearts Campaign, Innovation Advisors Program and the Health Care innovation Challenge.

The Partnership for Patients is to improve transitions of care so people are not readmitted to the hospital. Agencies can sign up to be the agent of collaboration where there is a pipeline that connects institutions, spreads Best Practices and shares data.

The Health Care Innovation Challenge requested ideas from communities on how to promote better health, better care and reduce costs. Dr. Gilfillan stated that the emphasis is on sustainable models that will train and deploy the health care workforce of the future and can be deployed within 6 months of award. There were around 3,000 applications submitted. He noted that they were specifically looking for proposals from rural areas and would appreciate input from the Committee.

The Innovation Advisors Program has 73 areas around the country with innovation advisors in their home institutions who are linked to the Innovation Center. The innovation advisors meet to share Best Practices.

Dr. Gilfillan shared with the Committee how the Innovation Center is specifically working to include rural communities through The Pioneer ACO Model, The Advanced Payment Model, Rural Community Hospital Demonstration and The Frontier Extended Stay Demonstration.

The Pioneer ACO Model has two rural recipients: Tri-health in Iowa and Beacon Maine. The Advanced Payment Model provides an influx of capital for rural and physician-owned ACOs and is for Medicare shared savings participants. The Rural Community Hospital Demonstration has 23 participating hospitals and the Frontier Extended Stay Demonstration allows remote clinics to treat patients for more extended periods.

Q&A

Governor Musgrove asked if there had been an equal amount of participation from the rural health care providers in the initiatives, ideas and demonstrations.

Richard Gilfillan said there had not been as much participation from rural communities as they would have liked. They are seeing applications from rural areas but there have been structural obstacles to measuring results. Some of the obstacles have limited some of the participation. The Multi-Payer Advanced Primary Care Practice, which is driven at the state level, has much more going on in rural areas.

John Cullen stated that he is a physician from Valdez, Alaska. He asked if the new models of care are more or less provider intensive. Dr. Cullen said that he asked because they are suffering from a shortage of providers in rural communities and wonders if they will be able to implement these types of programs.

Richard Gilfillan stated that the entire Country can learn from rural areas. Innovation Center wants rural areas to figure out what works for them. The Innovation Center is interested in new models of workforce and using other types of health care workers in the office and throughout the communities.

John Rockwood said that rural practices are busy and stretched already. He asked how they would get the practices to agree to bring on additional people. Rural practices have to add people for the pilot program. They will not be able to guarantee that the additional people will have a job a few years down the line.

Richard Gilfillan stated that the Innovation Center will be paying for the additional people to be hired and if it is successful there should be funds available to sustain the extra employees.

Roger Wells stated that none of the proposals puts the burden on the patient and asked why the burden is on the physician and not the patient. The patient also needs some responsibility and to be accountable for their health.

Richard Gilfillan said that they have focused on the provider's side but feel that they will see some of that in the Innovation Challenge and will be focusing on that issue as well. Giving positive incentives for people to live healthy lifestyles and providing some free medications are considerations.

David Hartley stated that Federally Qualified Health Centers and Rural Health Centers are systematically left out of models due to requirements and criteria. Is there a way to bring in rural applications?

Richard Gilfillan said that they are mindful of this issue and the Pioneer ACO has a lower number established so that rural areas could qualify. He said they adjusted some of their programs to try and get more rural participation and would like suggestions from the Committee.

Howard K. Koh M.D., M.P.H.
Assistant Secretary for Health
U.S. Department of Health and Human Services

Howard Koh asked the committee members to introduce themselves and to share information on their professions and specialties in their rural communities. Dr. Koh

thanked the members for being on the Committee. He stated that he is a physician and was born to parents who were immigrants. Dr. Koh studied at Yale University and during medical school he worked at an inner city hospital in Boston. Dr. Koh noted that early on in his training he saw forces that impacted health care which physicians had no control over including patient's lack of insurance, discrimination and poverty.

Dr. Koh worked as a state health commissioner of Massachusetts and traveled throughout the State to meet with health professionals. The western part of the state is rural with a decentralized health system. He said that meeting with health professionals who are very aware and care about the health of all people sensitized him. He is very aware of disparities and spoke about the importance of prevention and the impact of geographic isolation on rural communities. Dr. Koh said that he is also aware of issues from beginning of life to the end of life and he oversees a program called Healthy People 2020 to maximize everyone's potential for health.

Dr. Koh stated that health reform is an opportunity to give better, more coordinated care to people. He said that two Pioneer ACO's are in rural areas and that health reform also focuses on creating medical homes as people get older and have multiple health conditions. HRSA has a focus on quality care of the patient and it is vital to providers and also has an emphasis on the primary care workforce. Improving rural health technology is an emphasis of the Department as well as helping the uninsured by setting up health insurance exchanges.

Dr. Koh closed by stating that prevention can not be overlooked. Patients are suffering from preventable illnesses and it is vital to build a better system of prevention in order to keep people healthy and out of the hospital.

Q&A

Governor Musgrave said that he wished that the rural delivery of health care problem in the country was homogeneous but it is not. He said that in some of the southern states like South Carolina, Alabama and Mississippi there is a disproportionate number of populations that may have a high rate of diabetes, lower education levels and additional issues. In the frontier west there is a completely different delivery with the Native American population. Governor Musgrove said that rural communities need to participate in planning the type of delivery system that best suits their geographic area.

Howard Koh said there is a plan in place that focuses on rural disparities. He understands that America is a diverse Ccountry and he is very sensitive to those types of issues. He stated that he would appreciate input from the Committee.

Roland Gardner said that social determinates of health are an issue in South Carolina. He asked for Dr. Koh to address issues of social determinates of health and said that they are seeing more in the South. Education, jobs, sanitation and environmental health issues are some of the problems they face in South Carolina.

Howard Koh replied that in order to keep people healthy there has to be outreach to as many nontraditional resources as possible. Healthy People 2020 embraces the social determinates approach. Housing, transportation, education and the justice department are working together to build partnerships and there has to be this type of outreach in rural communities.

Tom Hoyer stated that health care reform is an opportunity for the Government to look at the whole costs for physicians in rural areas and find ways for collaboration and savings.

Howard Koh stated that it is important not just to focus on a patient when they are hospitalized but there has to be post hospitalization care and follow-up so that patients are not re-hospitalized.

Larry Gamm said that he worked on Healthy People 2010. One of the things they did other than look at the focus areas was to look at 8 or so practices. One challenge is that there had to be an evidence base to support the argument that it is something worth replicating elsewhere. Are there additional steps being taken to insure that some of the states can evaluate how well the innovations models are working?

Howard Koh responded that they need leaders in the community to make a commitment. They are going to heavily evaluate outcomes by talking to patients and getting information on their experience. He said that they are going to get new best practices based on what works and sustain it and make the country healthier.

Pamela deRosier said that Howard Koh talked about being mindful of professional time and about collaboration between health and human services. She asked if there are incentives for collaborations.

Howard Koh said that there has been a divide between health and human services which they would like to close. They are interested in the health from the beginning of life to the end of life and collaboration is very important. He said that Mr. Sheldon could give more details about incentives available.

John Cullen from Valdez, Alaska asked what Dr. Koh thinks will happen to Critical Access Hospitals in the future.

Howard Koh replied that they value and will support Critical Access Hospitals but they have to be efficiently run and located in the right place. He stated that the goal is to reduce health disparities.

George Sheldon
Acting Assistant Secretary
Administration for Children and Families

George Sheldon began by telling the Committee that the Administration for Children and

Families speaks to the needs of the most vulnerable. He stated that two things that make children and families stronger are access to health care and education. Head Start is still one of the most successful programs for early childhood education.

Children are facing poverty on an ongoing basis and 1 in 5 children are living in poverty. Historically, rural poverty has a big role in changing policy. Mr. Sheldon said that President Kennedy spoke about the needs of the rural poor which led to many of the programs that are in place today. He added that the attention on the rural poor has lost its zeal and it is time to refocus and the Whitehouse Rural Council is doing that. This is an excellent time of opportunity to rethink how to deliver services. It is a time to think outside the box when looking at programs and leveraging dollars. For example, a single mother does not only need child support but also child care, employment and educational services.

Mr. Sheldon said that there are many programs like Head Start that are doing a great job of getting children ready for school but this is a time of constantly justifying expansion of dollars into programs. He noted that the Administration for Children and Families has had to rethink their strategic plan and how they are delivering support in order to be the most cost efficient.

Mark Greenberg
Deputy Assistant Secretary for Policy
Administration for Children and Families

Mark Greenberg said that the Administration for Children and Families has responsibility at the federal level for a wide range of programs which include early childhood education, child welfare and adoption. There is also funding for runaway youth services and domestic violence services.

Mr. Greenburg shared that he worked at Jacksonville Area Legal Aid in Florida and the Western Center on Law and Poverty in Los Angeles, California.

The Administration for Children and Families fiscal year 2012 budget is \$50 billion. Half of the budget goes to Temporary Assistance for Needy Families and Head Start. There are 10 regional offices around the Country and a research office, public affairs office, planning, research and evaluation office.

Mr. Greenberg stated that the Administration for Children and Families work with rural areas to identify their most promising practices. Some of the challenges in rural communities are access to educational institutions, transportation issues and access to health institutions.

Shannon Rudisill
Director
Administration for Children and Families
Office of Child Care

Shannon Rudisill said that when thinking about early childhood services the first thing that comes to mind is access. Head Start is a direct Federal to local program with grantees in every county of the nation with significant reach into rural communities. There are 1,600 grantees including 156 American Indian, Alaska Native Grantees and 26 Head Start grantees that focus on migrant populations which tend to be more in rural areas. The Child Care and Development Fund Program is a 5 billion dollar block grant serving 1 in 6 children that are eligible which is 1.7 million children every month with funding provided to help them access child care. The Child Care Program is for children 0-13 years old. A recent study shows that the Administration for Children and Families serve rural children proportional to the total number that are eligible for services. There are 260 tribal grantees in the Child Care Program.

Some of the challenges across Head Start and Child Care are the supply of facilities and services. Head Start has to have facilities that will meet the criteria for health and safety standards for early childhood education. For Head Start there is a shortage of dentists and dental providers which are services that they are mandated to provide. There is also a shortage of childhood mental health specialists. The child care program allows families to use vouchers so they can use a family child care home or center. Families use the vouchers to purchase services where in rural communities family child care homes are the most practical. Some of the challenges in family child care homes are maintaining a stable base of providers. There is turnover in family child care homes so the Office of Child Care is working to invest in the family child care providers so they can be on a career path to move up. Child care facilities link with family child care providers to give support.

Ms. Rudisill stated that professional development is a challenge. There is an increasing awareness of the level of specialized skills that are needed for young children so they are prepared for school. Rural practitioners need early childhood education training to prepare the children for school. Head Start has grants for colleges and institutions to create more capacity for awarding credentials and degrees to rural practitioners. Head Start has done an infant and toddler course with the University of Cincinnati and the Office of Head Start and the Office of Child Care joined forces to fund a professional development technical assistance center nationally.

Ms. Rudisill said that there are a number of initiatives that are involved in rural communities. Last year The Office of Head Start and The Office of Child Care teamed up on a project called Early Head Start for Family and Child Care and looked at home-based providers. Early Head Start offers mental health services and screening that most family child care providers do not have the capacity to do. There was a demo project with 22 communities that funded consultants in early head start to reach out to family child care facilities and assist with screening. Out of the 22 communities, 10 of them were in rural. They are looking at ways to disseminate funds and how to work with partners to help with funding.

Ms. Rudisill said that the Administration for Children and Families worked with the

Department of Education on the Race to Top Early Learning Challenge. It was a competitive \$500 million grant for states to build early childhood systems across their state. Nine states won the grant and some of the applications had a focus on a place-based strategy. North Carolina has been a leader in childhood education and they identified a rural area of the state where their efforts had not taken hold in the past ten years as a focus.

Ms. Rudisill stated that communities have unique needs and it is vital to look beyond the statewide level and consider a community-by-community basis.

Q&A

Barbara Fabre stated that she has been in the child care realm for 20 years. She said that in most communities Head Start serves about 1/3 of the community and another 1/3 is in the child care sector. Child care professionals have to reach out to partners like Head Start and educational institutions to get the services needed for children. Ms. Fabre said she would like a discussion about being more inclusive on child care.

George Sheldon said that the issue of collaboration is essential to move forward due to a shrinking budget. Mental health and poverty are huge issues in terms of child abuse. There is no incentive for states to provide prevention. Mental health services and substance abuse services need to be brought into the home for mothers. There is a huge need for collaboration in order to provide the services need for families.

Shannon Rudisill shared that Race to the Top Early Learning Grant lays out a forward looking vision. It is not just a program-by-program vision. It includes developmental screening and it is flexible enough that it could reach all the kids in need statewide. It looks at education, developmental screening, and access to health care and family and parent engagement needs. It provides a common vision that communities, states and the Federal Government and Health and Human Services can move forward on together.

Pamela deRosier said that there are regions in her state that will not apply for the Race to the Top Grant. She asked if there was a way to promote it.

Shannon Rudisill responded that they are not just looking at the states that are applying for the Race to the Top Grant, especially in child care. There are quality initiatives that will receive money. The quality initiatives mirror what is in the Race to the Top Grant like building out professional development, better referral systems, technical assistance for providers and they are encouraging states to participate. In the President's 2013 budget there is an additional \$300 million for a child care quality initiative, part of it will be formula and part will be competitive. It will focus on providing a system of quality indicators that parents can use in child care and it is written in a way that the money will be awarded to the states that make the largest stride. States that are looking to improve can show a plan and a commitment to move forward and receive funding. These strategies can complement Race to Top Strategies.

HEALTH WORKFORCE SHORTAGE DESIGNATION

**Diana Espinosa, Deputy Associate Administrator, Bureau of Health Professions
Health Resources and Services Administration
U.S. Department of Health and Human Services**

Diana Espinosa began by giving context on the Health Professional Shortage Area Designation Process and the Medically Underserved Population Designation Process that is currently in place. Ms. Espinosa told the Committee that designations are used to identify areas that are experiencing underservice in medical resources, facilities, people, and to determine funding eligibility for programs. The Health Professional Shortage Areas were originated for The National Health Service Corps. The Medical Underserved Populations were originally created for the Community Health Service Program. The rural health clinic certification started using both of the shortage designations.

Centers for Medicaid and Medicare Services added a Medicare incentive program and pays a 10% bonus for services provided in HPSA's. Currently there are about 25 Federal programs using the designations in a variety of different ways. There are 3 different types of Health Professional Service Areas but the Negotiating Rulemaking is focused on the Primary Care.

The Health Professional Shortage Areas rely on a rational service area and the ratio of patients to primary care physicians. There are automatic designations through statute. The current methodologies have been in place since the 1980's. There was interaction between the states and localities to submit data and request designation.

Current medically underserved areas have criteria and weighted values that include percentage of population at 100% poverty, infant mortality rate, and primary care physicians per 1,000 population.

Section 5602 of the Affordable Care Act required the establishment of a Negotiated Rulemaking Committee to reexamine the methodology for designation areas and populations that are experiencing medical underservice or health professional shortages. The Negotiating Rulemaking Committee was an appointed 28 member committee of stakeholders. The NRMC met 14 times over the course of 14 months. The focus of the NRMC was on medically underserved area designation methodologies and primary care HPSAs. The final report was submitted to the Health and Human Services Secretary in October with the recommendations for revised shortage designation methodologies. The report was endorsed by a vote of 21-2.

Ms. Espinosa stated that major points from the final report were to maintain separate designations for Health Professional Shortage Areas and Medically Underserved Populations, revise some of the concepts used in the designations and revise all 5 primary care shortage designations.

The rational service area concept was streamlined and it could be relevant to rural areas. The change in the provider count added additional primary care providers so that nurse

practitioners, physician's assistants and certified nurse midwives were added at .75 FTE relative weighting.

The Negotiated Rulemaking Committee revised the geographic Health Professional Shortage Areas methodology by lowering the designation threshold to 3000:1, expanding the areas that would be eligible for designation and making all Frontier Rational Service Areas with population to provider ratios about 1500:1 eligible for designation without consideration of health status or ability-to-pay.

The Negotiated Rulemaking Committee revised the population Health Professional Shortage Areas methodology by lowering the designation threshold, expanding eligibility and creating a flexible local data option.

Revisions to the Facility Health Professional Shortage Area Methodology included three new pathways for designation: safety-net providers, essential community providers and magnet facilities. An example of a magnet facility is an HIV/AIDS facility that may draw people from a broader geographic area because of the specialized care they can receive at the magnet facility.

There were also revisions to the Medically Underserved Population Methodology that include more indicators for demonstrating underservice and an emphasis on ability-to-pay above all other components because of correlations to health status. Other revisions are a greater emphasis on barriers to care, flexible options for barrier and health status indicators and flexible local data options.

Ms. Espinosa stated that the next steps are for the Health and Human Services Secretary to consider the recommendations of the Negotiating Rulemaking Committee and the Department will draft an interim final rule considering the NRMC's report and publish the interim final report for public comment.

Ms. Espinosa closed by telling the Committee that the decision to include the different type of providers had a disproportionate effect on rural communities because there is a higher ratio of primary care providers who are nurse practitioners and physician assistants in rural areas. Some of the flexibilities were added to attempt to address some of the rural needs. Also, the exclusion of providers from the count has been an issue in the past for rural areas because of the different models of health care. There was an impact analysis done, but it would be helpful to have an understanding from the Committee of what the impact of the proposals will be on rural areas.

Q&A

John Rockwood asked why Health Professional Service Areas and Medically Underserved Populations were kept separate since access to care is the problem.

Diana Espinosa replied that the rural health representatives on the Committee were the

strongest proponents to keeping them separate. The decision is based on the fact that they do two different things in the way they are used for their initial functions. The National Service Corps only brings in providers and focuses on ratio and availability. The Medically Underserved Population Designation is primarily used for the Community Health Center Program in terms of allocating dollars for systems of care where there may not be a provider problem at all. There may be health status problems that need a different type of intervention.

David Hartley said he has read the Minority Report from McBride and Scanlon and an issue they raise is that in the process of compromise there was eligibility expanded to too many areas. This kind of inclusivity was required to get the consensus. Explain what people were disagreeing about that required the compromise because the compromise also has problems.

Diana Espinosa said that it is a classic public policy challenge of re-distributing resources and coming up with a national system that works across the board. There were many different concerns and the issue of 33% underserved is a philosophical issue, a data call. Some of the issues are challenging because there is analysis that can inform but in the end some things are public policy decisions.

Aaron Fischbach said that at the time of making the decision about the threshold, there was an article in the Washington Post on new poverty data that stated that 1 in 3 people in the country were at least at 200% so there was a rational basis that one third of the country could be underserved.

Roland Gardner asked if it was true that National Service Corps will not allow physician assistants or nurse practitioners to work in a hospital and get credit for that time.

Diana Espinosa said that 10 of the 40 hours of the week are supposed to be in the outpatient setting. They are allowed to do the rounding and other things for nonclinical care within that.

Tom Hoyer asked if the Department has done anything to price a rule based on the report.

Diana Espinosa replied no and said that there are still details that the report does not define and there needs to be a position on them before a rule cost can be estimated.

John Cullen said that related to back outs of providers, the loan repayment recipients are usually a 3 year program and there seems to be a lot of transition in rural communities within 3 years even with non-loan repayment providers. He asked if there is data on that subject.

Diana Espinosa said that the National Service Corps does have data for short term and there is a high retention rate. The longer term data is being updated and can be given to

the Committee.

John Cullen said that if they are looking at the yoyo affect, at what point will that be an issue? He said that he thought that 3 years would be a little long to consider it as an issue due to physicians and providers changing over more rapidly.

Tom Morris responded that the data Ms. Espinosa referred to looks at whether they stayed in an underserved area even if it was not the original community. There was a research study done to look more broadly at not only the National Service Corps but also in state loan repayments. That information can be presented to the Committee to inform decision making.

David Hartley said that physicians tend to move to larger cities and somehow there needs to be a way to get physicians to smaller communities. He asked what the Committee can do to help move the process along.

Diana Espinosa said some clarity on the impact to rural communities would be something that the Committee could do. Also, if there are specific analytical questions that can help answer some concerns that would be helpful.

Tom Morris stated that the addition of nurse practitioners and physician assistants makes it difficult for rural areas not to take a hit given their reliance on them but what is the right thing from a public policy perspective.

Roger Wells said that 13 states have their own rural health designation areas and asked if there was any relationship?

Diana Espinosa said that there is no relationship between this process and the Governors certified shortage areas for rural health clinics. There is not relationship between those and the HPSA and MUAs.

Larry Gamm asked if there was any research looking at forecasting the use of telemedicine or patient navigators or alternative providers that could potentially reduce the degree in which a patient needs to have a face to face contact with a provider.

Diana Espinosa said that the Committee addressed some of the concepts and acknowledged it was an issue but there was no analysis done but it will be taken into account when addressing what kind of services that people are getting.

Wayne Myers said that an issue is community health centers with points of service remote from their home base and without an ownership in the community. The fate of the small community is being determined by people who are not in the small community.

Committee Discussion on Rural Hospitals and Long-Term Medicare Policy Options

Tom Morris opened the Committee discussion on the future of the rural health care

infrastructure. He noted that there have been recent policy proposals to change the reimbursement structure for Critical Access Hospitals and other rural hospitals to reduce the long-term budget deficit. The National Rural Health Association asked the Chair of the Committee to bring this issue to the Committee's attention.

The Committee noted that Critical Access Hospitals can be the largest employer in a rural community. If a Critical Access Hospital can not survive due to a 1% cut, the whole community will be affected. Hospitals and other services are already pulling from Critical Access Hospital funds. It is a complicated issue that needs attention.

The Critical Access Hospital may not be the only model that holds services together. Critical Access Hospitals are not a homogeneous group and there may be a subset of them that need to look at a different model. Critical Access Hospitals in many communities are the nucleus of emergency response so it is important to maintain them. Instead of cutting Critical Access Hospitals maybe it should be considered to make them better.

The Innovation Center is looking at a new program based on Accountable Care Organizations. The rural facilities need the infrastructure to make this work. It is hasty to cut rural hospitals while trying to promote plans that emphasize primary care and advanced primary care programs. More robust primary care will keep providers in rural communities and there will ultimately be a lower cost to the Medicare and Medicaid system. They should not move forward just to cut cost when there has not been exploration on Accountable Care Organizations and Partnerships for Patients that will help Medicare lower costs.

Critical Access Hospitals should have a period of time when the cost per discharge is measured against other hospitals. This approach was suggested in the past. In Michigan there is a group that compares information on Critical Access Hospitals. By sharing information they have been able to make a difference. There needs to be criteria but cuts in the absence of understanding where the CAHs stand is premature.

Regionally Critical Access Hospitals are very different. Some Critical Access Hospitals are emergency rooms that can hold patients, a nucleus for ambulatory care, and a place to hold specialty clinics. CAHs in many communities are the nucleus for care. To have a Critical Access Hospital a community has to meet the full conditions of participation. The emergency capability and outpatient capability can be more important than the inpatient services. There may be a need for a model that lets different communities choose what works best in their community.

Tom Morris closed by asking the Committee to consider issues discussed and there will be a future dialogue on how the Committee would like to move forward.

HRSA UPDATE

**Dr. Marcia K. Brand, Deputy Administrator
Health Resources and Services Administration**

Marcia Brand began by sharing the Health Resources and Services Administration agency priority. The key policy issues include the top line messages in the President's FY 2012 budget which include: building a healthy workforce for the 21st Century, improving access to health care for the underserved areas, protecting at-risk populations and supporting healthy families.

Dr. Brand said that HRSA has a concern about the adequacy of the workforce and numbers of providers leaning into 2014. HRSA has a strong direct role for workforce development so they would like to do what they can to address those shortcomings. HRSA received resources from the Prevention and Public Health Fund in 2010 and invested in physician, nurse practitioner and physician assistant education. HRSA is retooling existing programs to focus on primary care. Thinking about reframing programs holistically gives more levers to drive people into the primary care practice. There is a program through the National Service Corps that provides support to medical students in their last year if they commit to going into primary care as their area of practice. There were 80 awards this year. This is an example of using existing resources to encourage students to go into primary care. The National Service Corps repayment program is growing and they are trying to drive people into the highest need areas by looking at Health Professional Shortage Areas. The number of Nursing Loan Repayment Program awards to nurse practitioners and nurse midwives will be increased to 50% which will be beneficial in rural communities.

There is a commitment of agencies within the department to collaborate and address workforce challenges. The Office of the Assistant Secretary for Planning and Evaluation, Centers for Medicare & Medicaid Services, Agency for Health Care Research and Quality and Health Resources and Services Administration have been exploring opportunities to leverage their programs and work together to address workforce shortages. Secretary Sebelius has a personal interest in rural issues and workforce. The Administration realizes that you can not provide access if you do not have a well distributed workforce.

There is an investment in data and analysis that has not been available in the past and will be beneficial in dealing with workforce challenges. In 2008, the Office of Management and Budget wanted analysis on how many physicians are needed and where nurse practitioners are located and other similar questions that HRSA could not answer. There needs to be a systematic way to answer workforce questions. The National Center for Health Workforce Analysis is underfunded so the President has asked for 10 million dollars in the 2013 budget so there will be a way to know how to invest a finite set of resources into workforce.

The President's budget for FY 2012 includes improving access to underserved areas and at-risk populations with a focus on direct services. HRSA makes ongoing investments into health centers. Health centers saw more than 19 million patients last year. There were more than 3 million dental visits last year. There is a 2.7 billion dollar investment in FY 2012. There are significant investments in the Maternal and Child Health Program, Home

Visiting Program and the Ryan White/HIV/AIDS Program. The Home Visiting Program is a new program that provides resources to at-risk families to have better outcomes for the mothers and the children.

Health Resources and Services Administration is working to find better avenues of outreach for grantee technical assistance. If grantees receive grants focusing on how small, community based programs are as successful as possible since they have the least developed infrastructure. Streamlining programs and improving efficiencies such as on-line applications and site certification for the National Health Service Corps is another HRSA priority.

Dr. Brand asked for input from the Advisory Committee in terms of identifying new and innovative models. Rural communities are great laboratories since they are a closed system and most people will participate. It is important that the Committee provide input on the rural impact of proposed regulations as the Affordable Care Act is implemented.

Dr. Brand gave some general information about advisory committees since one half of the members of the Office of Rural Health Policy National Advisory Committee are new members. There are more than 1,000 advisory committees that range from very broad to targeted responsibilities. Anything pertaining to rural, health and human services are germane to the responsibility of this Committee. The composition of membership for advisory committees varies from specific to general. The Office of Rural Health Policy National Advisory Committee has a broad focus and people with a variety of expertise. Deciding what to focus on can be a challenge. Members reflect their own constituency and are representing their constituency so it is important to compromise to be able to address the broad array of stakeholders.

Dr. Brand said that an effective advisory committee stays within the purview of the Secretary. Statutory or regulatory changes are difficult to make happen so staying within the existing authorities is recommended. Making recommendations for huge investments in the current environment is not recommended so it is better to focus on what to do to retool a program. Dr. Brand commended the Committee for having a broad range of expertise. There are members with research experience that can give council on what the data suggests. The Office of the Rural Health Policy staff to the Committee provide the best material to inform decision making and need the Committee's input on what is needed to be successful and how to make the best use of the site visits.

The White House Rural Council is a huge opportunity for the Committee to have the Government consider how to better serve rural communities and it is led by the President. Secretary Sebelius is adamant that the Affordable Care Act is implemented in a way that best advantages rural communities.

Dr. Brand closed by saying that this is a great climate to rethink the way that health care is provided. The Affordable Care Act means that access, workforce and distribution are in the paper every day. Also, there is a willingness to look at innovation in ways that there have not been in the past.

Q&A

David Hartley asked why there are so few health centers in the center of the country.

Marcia Brand said that the way that the guidance was structured before was to serve as many people as possible. There are efforts now to make sure that underservice is considered as well as the number of people who can be served.

Rowland Gardner said that the Bureau of Primary Health Care is making an emphasis to stress services in rural communities but that he is not hearing anything about the Substance Abuse and Mental Health Services Administration putting forth efforts in rural communities. Is there a concerted effort by SAMSA to get services in rural communities?

Marcia Brand stated that she could not speak for the Substance Abuse and Mental Health Services Administration but she would get the information and share it with the Committee.

Tom Morris stated that his office had a workgroup with SAMSA about integrating behavioral health and primary care. One of the purposes for having Dr. Brand speak was to foster future topics for the Committee. It has been 8 or 9 years since the Committee looked at the issue of mental health, behavioral health and primary care integration. With new members, this is the time to think about what issue we want to consider.

David Hartley asked if with workforce at the top of the list is there coordination with SAMSA on mental health.

Marcia Brand replied that there is the Behavioral Health Coordinating Committee in the department that Dr. Koh chairs. There are sub work groups and one is looking at the adequacy of the behavioral health workforce. That group has representation from HRSA, SAMSA and ARC. They are looking at existing resources and part of the challenge is that there has not been a lot of money available for mental health training so they considering opportunities to collaborate using existing resources.

Roland Gardner asked about the Students to Service Loan Repayment Program in the National Service Corps.

Marcia Brand stated that it is a new program with the National Service Corps and that she can send the press release to the Committee.

Tom Morris said that it is an innovative approach to a scholarship loan program so they will see if it generates interest during its first year.

Barbara Fabre asked if there will be a priority in regard to mental health services for infants and toddlers. People do not connect infants and toddlers with mental health issues and there are screenings that need to be done but in rural areas there is a lack of

professionals that specialize in infant and toddlers.

Marcia Brand stated that there is a great concern about at-risk kids and that is one of the reasons that the Home Visitation Program was created. She said that she did not know if the Behavioral Health Committee had targeted specific populations but she could get more information about that.

Announcement of Subcommittees

Steve Hirsch, Executive Secretary, announced subcommittee information in preparation for workgroup meetings.

Center for Medicare and Medicaid Innovation Subcommittee:

Chair of Subcommittee: Larry Gamm

Members of Subcommittee: Phyllis A. Fritsch, Thomas Hoyer, Michele Juffer, Wayne Myers, Shane H. Roberts, John Rockwood, Jr. and Christy Green Whitney

Staff: Aaron Wingad, Nicole Comeaux and Paul Moore

Health Workforce Shortage Designation Subcommittee:

Chair of Subcommittee: Karen Madden

Members of Subcommittee: John Stewart Cullen, Roland Gardner, David Hartley, Gary Walton and Roger D. Wells

Staff: Aaron Fischbach and Nick Lillios

Administration for Children and Families Subcommittee:

Members of Subcommittee: Eugenia Cowan, Pamela deRosier, Barbara Fabre and Barbara Morrison

Staff: Tom Morris, Steve Hirsch, and Shannon Wolfe

PUBLIC COMMENTS

There were no public comments and the meeting was adjourned.

Thursday, February 16th

RURAL HUMAN SERVICE TOPICS: STAKEHOLDER COMMENTS

Mario Gutierrez, Rural Policy Research Institute Human Services Panel

Mario Gutierrez opened by sharing information about himself with the Committee. Mr. Gutierrez said that he has worked in rural communities his entire career in public health. He said that right after graduate school he worked with the California Rural Indian Health board to develop and plan tribally operated health programs. That program became the spearhead for some of the Indian Self-Determination Act efforts to have tribes operate their own programs.

Prior to his current position, he worked for 12 years with the California Endowment and was the Northern California representative for all rural programs and health care programs for all of the Northern State and became the Director of Rural Health Programs with special initiatives in access to telemedicine, community health development programs and special programs for farmer workers and new immigrants.

Currently, he is the Director of the Center for Connected Health Policy which is funded and established by the California Health Care Foundation to examine issues related to access to broadband in relationship to health and human services and other issues related to isolated, rural communities. In an area where there is a shortage of funding and access to specialist and other types of providers, with help of the Federal Government and the FCC on high speed broadband they can bridge the gap and bring the best specialists in the country to the most isolated areas in the State.

Mr. Gutierrez said that he has been the Chair of the Rural Policy Research Institute Human Services Panel from the beginning. RUPRI has been around for almost 40 years. The health panel that preceded RUPRI was established under the Clinton Administration. RUPRI recognized that much of what happens in rural communities goes beyond health care. The issues in families are related to poverty, housing, child care employment issues and behavioral health problems. They are all interrelated. Health and Human Services are interchangeable and closely connected to dealing with the issues for families. The panel was created to look at human services and issues unique to rural where Federal policy may not be working in relationship to rural specific issues.

The RUPRI process looks at policy related to practice and research. Their recommendations have to be grounded in well-established research and are also looking at practice models to advance their work moving forward. The panel consists of rural researchers and public policy representatives.

A public policy brief that RUPRI produced that changed the course of the way the panel thinks is called *The Case for the Service Integration*. Services tend to be silod according to categorical funding and this has been an issue for many years with Federal and State funding. The goal is to find a seamless approach to services and that maximum efficiency is gained utilizing the limited dollars available. A follow-up paper that will be released is *A Promising Model for Rural Human Services Integration and Transformation*. It is a study of a community that has been practicing integration of services for the past 15 years.

RUPRI is working on a paper with the health panel. There was a meeting of the two panels to discuss integrated services and look at issues that affect both human services and health. The Affordable Care Act will give many opportunities for integrated services. A component of the Affordable Care Act and the creation of the health exchanges are to have a mechanism to sign up people for services and utilizing outreach workers and navigators. Having a navigator to sign up people for health care is an opportunity to

screen families for any form of services that may be available including publically funded and community based services.

A client centered medical home that can look at a full array of needs is important. This could include access to food and housing and all needs related to health care could be screened and part of the effort to meet the needs of people. Broadband is a critical aspect of achieving increased access, quality improvement and cost efficiencies. Having a virtual connection allows access to multiple services. In Wisconsin and Florida applications for food stamp services are all being done electronically and people can apply from home instead of going to an office to apply.

Mr. Gutierrez spoke to the Committee about the Administration for Children and Families and how it can have an impact in rural communities. Administration for Children and Families is not always adaptable and responsive to the cultural uniqueness of rural service delivery systems. The array of child welfare services is an example. If the array of services is not available in a rural area, it is a concern that children are being unnecessarily removed from their homes. A recommendation is for ACF to think through all of their programs related to human services and look at them from a rural perspective and how they may have shortcomings in Federal policy that limit their opportunities to access in rural communities.

Improving coordination of federal early care and education programs through alignment of program goals and priorities is one of the principles of ACF Child Care and Development Fund reauthorization. Mr. Gutierrez said that these goals need to be aligned goals across Federal Government programs and not just within the ACF. This also needs consideration just related to rural.

Mr. Gutierrez said that they had done research on the child care services supply which is a market based model and in rural communities there are fewer kids and limited numbers of families that can afford to pay the market price and a subsidy is connected to employment. In rural communities unemployment can be higher or seasonal which can disrupt access to health care. Another concern regarding the ACF Child Care and Development fund is that the Child Care Subsidy for Working Families is more of an urban-based model.

The ACF Family and Youth Services Bureau Rural Homeless Youth Demonstration is a collaboration of state and local governments working together with transitional living programs. The success of this program means it could be a model for other services being provided. The demonstration focuses on improving coordination of services and creating supports for rural youth to improve their circumstances. The ACF Flexible Integrated Block Grants are social and community grants with great potential as well.

Mr. Gutierrez spoke about the Integrated Service Delivery in Humboldt County, California. He said that Humboldt County is as large as the State of Connecticut and is isolated by the sea on one side and mountains on the other. There are 8 tribes in one county and unemployment is high due to the lumber industry deteriorating and fishing

not being as robust as in the past. Around 15 years ago the community came together with the support of the Humboldt Area Foundation to find a better way to serve the rural population. They came up with a model called Integrated Transformation 3 x 5. Rather than thinking about programs in a categorical contest where money flows from federal, state and local efforts, they divided services into three major categories. The categories are primary prevention, secondary intervention and tertiary intervention. If resources are invested in primary prevention and secondary intervention, the high cost of tertiary intervention can be prevented. The services are organized according to the 5 categories of the age span including children and families, transition age youth, adults, older adults and community. This model also had help from the State that permitted blending of resources so that they could integrate funds so it is about the service and not the particular funding source.

Key elements for integrated service delivery are a shared vision, goals, and principles of practice, responsibility and accountability for success. There needs to be a culture of service with a focus on the whole person and fully integrated funding streams and shared resources. Integrated service delivery requires reorganization of centralized and decentralized functions, family resource centers, community driven transformation and quality and appropriate leadership at each stage of development.

Mr. Gutierrez closed by asking the Committee to visit California again in the future to enjoy the State and understand some of the issues in the rural west.

Q&A

Christy Green Whitney asked about the model in Humboldt County and when the services are integrated if the department provides the services directly or do they provide the coordination of services.

Mario Gutierrez said that there is authority maintained by the county of funding for the programs but they do decentralize to the extent that they can be administered by local agencies. It is a way of reducing the number of county staff needed to provide the programs. Mr. Gutierrez said that one of the panel members went into the Humboldt County community and talked to people in family resource centers and to providers in the front lines and she was pleased with how well the program was working. She interviewed the county administrator of how the progress is being evaluated he said that they have benchmarks according to the 3 x 5 model and that he puts together a report of how they are doing in each category and send out the report. One of the outreach workers in an isolated area of the county stated that they know if they are being successful because of the newsletter that they receive from the county administrator.

Barbara Fabre said there is not much funding for child care facilities and USDA does allow for some of the funding but it is \$50,000. She said that the Humboldt County model is similar to the Harlem Children's Zone concept with the holistic approach to family and that is commendable. Ms. Fabre said that she agrees with Mr. Gutierrez recommendations as well.

Tom Hoyer said that Mr. Gutierrez referred to developing coordination between block grants and state driven programs. He said that the nature of the block grant is that the state can do what it wants and there should not be a need for coordination for the state. The Committee gets both requests for the Federal Government to be more involved and less involved. Mr. Hoyer asked Mr. Gutierrez's opinion if the difficulty is inherent in the way states administer block grants or does it require Federal action.

Mario Gutierrez said that his point is to identify where there are opportunities and sometimes the states are not being proactive and funds are not used in the most appropriate manner. Their goal is to identify where there are resources and where there is flexibility and find ways at the Federal, state and county level for funds to be used appropriately.

Tom Hoyer said there are two things that are needed, one is money and one is effective leadership, and much of what has been discussed is the need for effective leadership at the place where the programs are operated.

Mario Gutierrez responded that there are other counties in California that had the same opportunity as Humboldt County but they did not have the support of leadership for collaboration of services from the administrator, the county board of supervisors and the local community leaders. They have to work together and hold each other accountable by keeping a balance of respect and appropriateness and focusing on the goal they want to achieve.

David Hartley asked about the 3 x 5 program in Humboldt County and if they had dealt with the issue of out of home placement of children when there are not enough resources available in rural areas to keep them in the home. Also, are there other models around the Country that have found ways of doing a better job with out of home placement of children.

Mario Gutierrez said that he is not aware of other models but RUPRI is going to be focusing on the issue. Humboldt County has been successful and the out of home placements are doing much better and the statistics reflect that success.

WHITEHOUSE RURAL COUNCIL UPDATE

Doug McKalip, Domestic Policy Council

Doug McKalip said that he has spent two decades in Federal service and has spoken on many occasions but is a little nervous about speaking to the Office of Rural Health Policy National Advisory Committee because he will begin by talking about himself and his own background. Mr. McKalip shared that he was born in 1971 in a rural county in Northwest Pennsylvania to teenage parents. He said that his parents were two of the hardest working people you could ever meet. His grandparents gave his parents a few acres of pasture land and they put a trailer on the land and that is where he lived until

high school. His father had diabetes since the age of seven. The early 1970s were similar to the situation in 2007 and 2008 with many of the manufacturing jobs being lost at a high rate in Pennsylvania, high unemployment and uncertain gas prices. There were many foreclosures in that area of Pennsylvania.

Mr. McKalip shared that his father was very fortunate to get a job at the railroad. His father was an incredibly honest person but when it was time for him to get his physical for the job and insurance policy, he told the doctor that he did not want to take a urine test because he did not want to reveal that he had diabetes for fear that he would not be able to work for the railroad. Mr. McKalip said that his father was hired and was one of the best crane operators that the railroad ever had. His father's diabetes caused him to lose his eyesight by 1976 and in 1977 he had kidney failure. Mr. McKalip said there was no dialysis system in his hometown so his mother quit her job as a secretary and they took his father to Erie, Pennsylvania three times a week for dialysis.

Mr. McKalip said his hometown physician, Dr. John Nesbitt, whose office was in his house, read medical journals every evening and read about a pioneering physician at the University of Minnesota who was just beginning to do transplants for diabetics. Mr. McKalip said that his community had bake sales and his uncles raffled off hunting rifles to raise money for his father's kidney transplant. Once they raised enough money, they drove an RV to Minneapolis and parked it in the Minnesota Gopher's football stadium parking lot and lived there the summer of 1977 and his father had his kidney transplant with a kidney donated by his grandmother in the fall.

Mr. McKalip told the Committee that he shares his story with the Committee not as a sad story and said that these were some of the most inspirational days in his life to see resourcefulness and community and family working together to make great things happen. He said that two decades later he comes to work every day and works for a President that feels it is unacceptable for a 20 year old father with a baby at home to have to be scared of taking a urine test because of a pre-existing condition that will effect whether or not he can provide for his family. This is a President who feels it is unacceptable for physicians in small, rural clinics not to have broadband so they can have access to the latest information.

Lack of access to community facilities still exists today in Native American communities and many rural minority communities. Through the Recovery Act, the President's initiative has resulted in 6,000 new community facilities and over 500 new rural facilities and change is resulting from those investments. The President feels there is much more to accomplish in health care, education and many other areas. There are physician shortages and lack of access to facilities. On June 9th, the President created the White House Rural Council and it has already expanded the National Health Service Corps so that Critical Access Hospitals with 25 beds or fewer can attract physicians. There have been policy changes so USDA's Community Facilities Program in Rural Development would support local health care facilities. There are initiatives to help train more local information technology workers in their communities for those jobs so people are not being imported from cities to take jobs in rural areas.

The White House Rural Council includes the Veteran's Administration. Forty four percent of America's service men and women come from rural America. The veterans deserve to have a rural Veterans Administration system and rural health care facility that is prepared to support veterans and they deserve quality jobs.

For the first time since the 1990s, manufacturing jobs are growing which is encouraging. The farm economy has been doing relatively well. There were 173 billion dollars in exports last year and almost a 40 billion dollar trade surplus. Most farm families have to have someone go out into the workforce to get health insurance. It takes about 80 hours a week to run a farm but most people have to have some other form of income in addition to farming to support their health care and income.

Mr. McKalip stated that the Office of Rural Health Policy National Advisory Committee is vital to what they are trying to do as an Administration. He noted that Tom Morris and HRSA are invaluable. Mr. McKalip stated that he is excited about the new ideas that the Committee will recommend after the site visit and committee meeting in June. What the Committee does is vital and he stated that he is sure that many of the committee members have had similar situations or know people who have been through similar situations to his story of growing up. Anything that the Committee can do to advise of ways to improve rural health care and human services is valued and appreciated.

Q&A

Roland Gardner said that Mr. McKalip mentioned the Council's role in getting more physicians in the rural areas using the National Service Corps and about more money being available through USDA and asked for more information about those two subjects.

Doug McKalip said that previously physicians could be attracted to rural areas using National Health Service Corps but Critical Access Hospitals with 25 beds or less did not qualify for loan repayment assistance so the change in policy in August will allow that and there is robust interest from Critical Access Hospitals. This was a recommendation that was made by the Office of Rural Health Policy Committee that resulted in the policy change.

The farm bill is a resource and support for rural communities. The rural development title of the farm bill has billions of dollars of assistance for municipal water and waste to build community facilities. The department is able to build fire stations, libraries, small health care facilities. USDA can be a partner in local areas to assist a health care facility that needs computers and software to run their Health Information Technology systems.

David Hartley asked if there has been progress in Health Resource Centers getting meaningful use incentive payments. He said that the language had left some people out and it probably was not intentional.

Doug McKalip stated that the first wave of policy ideas had the critical access change that was recommended by the Committee and put into place and the next focus is on training local Health IT workers. He said that if there is a common sense change that needs to be put in place they will go to Congress and ask for assistance.

Larry Gamm said that Health and Human Services could be a resource among various programs and services and also write grants for the county. Service integration efforts take leadership and he proposed creating a county health extension worker position. Mr. Gamm said that he is in the school of rural health at Texas A&M and there are students from rural areas that want to go back to rural areas and have the skills to hold that position.

Doug McKalip said that is not only true in health care but across the board. He said that rural school districts do not have professional grant writers and when it comes time to apply to the Department of Education, they are competing with the New York City Department of Education who has a PhD and does nothing but grant writing their whole career. A rural health clinic does a grant application and it takes a person off the job for a week to write it and if they do not get it, it is their only chance. Local technical assistance extension model is a good idea and if the Federal Government could use flexibility of a two tiered process where the proposal model is used more, it would be beneficial. The first tier could be a one page application that tells how the grant will benefit the local community and if it is feasible they can move to the second step.

John Cullen said that he is a physician in rural Alaska. There are people returning from Afghanistan and Iraq and their benefits are with the Veterans Administration so they have to go to Anchorage, Alaska to get primary care. They can only get local care at the emergency room and it is a 6 hour drive to Anchorage usually in bad weather. There needs to be a way for them to receive care in their local communities.

Doug McKalip said this is a very important issue that needs to be discussed by the Council.

RURAL HEALTH TOPICS: STAKEHOLDER COMMENTS

Alan Morgan, National Rural Health Association

Alan Morgan began by welcoming the new members of the National Advisory Committee. He said that The National Rural Health Association is known for their advocacy efforts but they are not just an advocacy organization. NRHA publishes the Journal of Rural Health which is the world journal of rural research.

Mr. Morgan said that he served on the Negotiating Rulemaking Committee for the Health Professional Shortage Area and Medically Underserved Area re-designation process. He asked the Committee to urge the Secretary to implement the report that was submitted. The result of the Rulemaking Committee is fair, reasonable and backed-up by data and is also fair to rural America.

Mr. Morgan said that the National Rural Health Association would like the Committee to urge the Office of Innovation to utilize rural relevant quality measures as they move forward.

Mr. Morgan said he provided a letter to the Committee and asked them to look at the successful payment methodologies that are being utilized for rural hospitals. NRHA membership includes all types of providers but he said that he will be focusing on rural hospitals in this discussion. He focus is on data regarding the type of care and quality of care being delivered in rural America. The Institute of Medicine's 2005 report was about what makes rural special. The Medicare Payment Advisory Commission is in the process of creating a rural report for Congress. The discussion among commissioners is that there are things that rural is doing better than urban and those need to be highlighted as options that all health care can incorporate. There are ample research articles on rural relevant measures that rural can do better than urban.

Mr. Morgan shared an article about a Critical Access Hospital in Southeastern Virginia that had the highest HCAP scores in the State of Virginia last year. It outperformed patient satisfaction of every other hospital in Virginia including Northern Virginia and Richmond.

Mr. Morgan stated according to MedPAC 2007, that payments to all hospitals made under the acute inpatient prospective payment system totaled \$107 billion and accounted for about 25 percent of Medicare spending. He also shared that according to the Agency for Health Care Research and Quality in 2007, on average, costs per stay in rural hospitals were less than those in urban hospitals and Medicare patients accounted for almost half of all the stays at rural hospitals. He said that Medicare payments to 50 bed or fewer hospitals represent less than two percent of overall Medicare budget. Within the rural hospitals, Medicare patients represent a disproportionate amount. Mr. Morgan said that roughly half of the hospitals in the United States are rural hospitals but the payments to them are disproportionally efficient and people are not hearing this information.

Mr. Morgan said it would be helpful internally for the Administration to highlight a successful payment methodology that is currently being employed for rural hospitals.

JoAnne Hiatt Kim, American Hospital Association

JoAnna Hiatt Kim said that she would discuss the Center for Medicare and Medicaid Innovation, the HPSA Negotiated Rulemaking and the Physician Supervision Issue.

The Director of the Patient Care Models group with CMMI spoke with some of the rural hospital groups. The Center for Medicare and Medicaid Innovation are interested in involving rural partners but often times the rural hospital CEOs have a tepid response. Ms. Kim said that she thinks that rural hospital CEOs wear many different hats and do not have the resources to think about innovation and health care reform or to apply for

complicated demonstrations. There is not much rural participation in the Center for Medicare and Medicaid Innovation demonstrations.

In the Pioneer Accountable Care Organization demonstration most of the participants serve solely metropolitan areas. There are a few that serve rural communities but most of the participation is from urban hospitals and providers. In the Innovation Advisors Program that are 65 advisors from large metropolitan hospitals, 5 from small metropolitan hospitals and 3 from rural hospitals.

The Center for Medicare and Medicaid Innovation Bundled Payment Initiative has 4 Models. An applicant can choose which model to apply for and the Models are very different. The CMMI Bundled Payment Initiative provided flexibility on applications. An example is in Model 4 where they can define how long they want readmissions to be included in their bundle. It has to be at least 30 days but it can be longer. In order to help the applicant choose, Centers for Medicare and Medicaid Services is providing them with data and they need to analyze the data. That is a difficult task for a small, rural hospital.

Ms. Kim stated that despite the Center for Medicare and Medicaid Innovations best intentions they have created a program that works best for urban and they are trying to fit rural into the program but it is not working. The program is designed for urban, sophisticated hospitals and a better approach is to design a program tailored for rural areas.

Ms. Kim said that Center for Medicare and Medicaid Innovation does not have to make their programs budget neutral. Currently under some of the bundling models, if a hospital does not meet their target they have to repay CMS so that is a huge deterrent for rural hospitals. Alleviating some of the risks that rural hospitals encounter in some of the demonstrations will help make them more likely to participate.

Ms. Kim said that the scope of some of the demonstrations is another issue. In Model 4 talks about the hospital stay. Many times in a rural hospital a patient comes into the rural hospital and gets some services and then is transferred to a larger hospital for more services. Instead of having the rural hospital responsible for the transfer, the urban hospitals services and the readmissions they can currently only be responsible until the time of the transfer. Technical assistance is another issue. Instead of CMS helping rural hospitals analyze data it may be better for CMS to analyze the data for the rural hospital.

Ms. Kim said that the American Hospital Association agreed with many of the conclusions in Health Professional Shortage Areas Negotiating Rulemaking report. Ms. Kim said that they would like to see more data and empirical evidence for recommended Population to Provider ratio, weight of Nurse Practitioners, Physicians Assistants and Nurse Midwives and would like to see more state level modeling.

Ms. Kim spoke about supervision of outpatient therapeutic services. This is a problem for rural hospitals because there are not enough physicians available for this type of supervision. There was an APC panel established as an independent review body to

review assignment of supervision levels. There will be 2-4 Critical Access Hospital representatives added to the panel. The panel will decide whether the supervision level for services will go up or be downgraded from direct to general supervision which will be much more appropriate for rural hospitals. The panel will make recommendations to Centers for Medicare and Medicaid Services and they will choose to implement the recommendation or not. The final decisions on the supervision levels will not be handled through the regulatory process instead they will make the decision and post it on the website and CMS does not have to consider responses to the decision and this is something that the American Hospital Association thinks should be changed. CMS is not enforcing the policy on Critical Access Hospitals or rural hospitals until the end of the calendar year. The extension through calendar year 2012 is intended to allow hospitals to come into compliance but the time is not an issue for rural hospitals. They would have to have money if they need to hire new physicians in order to directly supervise infusion drugs so it would be impossible for many of these rural hospitals to comply with this policy.

Q&A

John Rockwood said that in Michigan they have a closed hospital system with 6 hospitals, one large hospital and 5 smaller hospitals. Even within the large hospital they had a bundle for cardiac surgery and unless everyone is employed it is impossible. The administrator has to decide how to split the dollars. It is a complicated issue. Now bundling gets expanded to other hospitals and one of the unintended consequences may be that hospitals and physicians will want to have control of the patient and may not be willing to allow the patients to be treated at outlying hospitals even if they are part of their system.

Joanna Hiatt Kim said that is a very good question and is exacerbated by the fact that Centers for Medicare and Medicaid Services will not limit patient choice. Even with a closed system, if the patient wants to get post-acute care from somewhere not related to your system, they can do that. If the initial hospital agreed to a bundle for post-acute care then the hospital is responsible for that. This is one reason to think about rural hospitals in the bundling demonstration to define a smaller scope of services.

Tom Hoyer asked if the American Hospital Association would support the limitation of patient choice in the pursuit of quality.

Joanna Hiatt Kim said that they have not officially taken a position on that. They do think that at some point if a patient is going to a hospital for a heart surgery there should be an opportunity to tell the patient that they are doing bundling and the patient needs to buy into the process. The patient will get the care they need but they need to stay in network. Ms. Kim said they are exploring that but have not taken an official decision on at this time.

John Cullen said that on the negotiated rulemaking, he wondered why the physicians working in the Rural Health Centers and the loan repayment physicians were included in

the back outs. It seems like most of those physicians will be in the rural hospital for at least 3 years and should be considered providers in the area.

Alan Morgan said that the policy rationale is if the Federal Government is providing assistance to a federally funding facility because of a shortage of physicians, why the clinicians would be counted when trying to determine shortages. If they are not counted under the negotiating rule making component there will not be any Health Professional Shortage Areas. If you have rural health center status you are an underserved area by definition.

Phyllis Fritsch said that the data issue keeps coming up and she feels there needs to be more technical assistance in rural areas but it also needs to be current data because Critical Access Hospitals are constantly changing.

Phyllis Fritsch shared that the supervision issue is not only that a physician has to be there at infusion of specific drugs but also for cardiac rehab and a list of other procedures. She said that if there is input that the Committee could provide it would be helpful.

She also stated that related to post-acute care after tertiary that Medicare could save money if when a Critical Access Hospital or rural hospital does tests/procedures on a patient that they are not repeated after the transfer to another hospital.

RURAL HEALTH TOPICS: STAKEHOLDER COMMENTS, CONTINUED

Bill Finerfrock, National Association of Rural Health Clinics

Bill Finerfrock said that he appreciates the opportunity to talk to the Committee. He stated that “first do no harm” is the principle that many people are familiar with and whether it is innovative delivery models or the way that shortage areas are designated, that has to be a focus. In regards to shortage area designations there has been a good job addressing the issues to improve the way that Health Professional Shortage Areas and Medical Underserved Areas are designated. Innovation and the effect on rural providers need to be addressed. When considering the care innovations triple aim of better health, better care and lower cost, there needs to be a discussion on if these are of equal value. He questioned if a model can result in better care and better health but costs more, does that mean it does not get consideration. Cost should not out way quality and access. The Accountable Care Organization formulation, where providers receive an incentive payment or bonus if they achieve certain quality markers, states that unless it is demonstrated that costs can be lower than an organization can not do the demonstration.

Mr. Finerfrock asked what should happen if a proposal raises short-term costs but reduces long-term costs. He questioned how long it should be before there is a test to determine whether an initiative lowers costs. He also questioned how the value of preventative services can be determined. When considering lowering cost is it for the government, provider or patient. He said that under the current formulation he feels it is only the government’s costs that are being lowered.

Mr. Finerfrock questioned if an initiative can lower the unit cost of care to the patient but raise the initial cost of care to the system due to increased access, if it would be approved. He said that he worked for the physician assistant profession and they were securing Medicare coverage for physician assistants. The proposal was that Medicare would cover physician assistants and nurse practitioners at 85% of what Medicare was paying a physician to provide the same services. The budget analysts said that it would cost Medicare money but if a physician assistant sees a patient then Medicare would pay less than if the patient saw a physician. The budget analyst stated that more people would access the system so even though the unit cost is lower to the patient and Medicare the aggregate cost to Medicare goes up so it is not a legislative proposal that can be pursued. Mr. Finerfrock said that there are times when the way that costs are analyzed can be counter intuitive to what is appropriate health care and social policy in the United States. There always has to be a proper balance when talking about costs.

Mr. Finerfrock said access to care approach should be a Triple A approach including if the health care is accessible, affordable and if it is A plus quality. That is the approach that should be taken into consideration in rural communities.

Mr. Finerfrock spoke about how Accountable Care Organizations are going to save money. The analytics say they are going to reduce hospitalizations and emergency room utilization but a small rural hospital with 55% occupancy, hospitalization will be reduced to 45% level and reduce emergency room utilization. This will cause hospitals to be unable to stay in business and eliminate access due to a hospital having to close. There needs to be consideration of some of the policies and the interactions with other providers and what it will mean in communities.

Mr. Finerfrock said that the Rural Health Clinics Committee is seeing greater integration where independent rural health clinics are moving on to a provider based status. One reason is they are preparing for the integration concept. An Accountable Care Organization with an integrated delivery model with a vertical integrated, multi-specialty delivery system would be ideal. He questions if rural health clinics will be viewed more as extremities of the system that are disposable because they are higher cost per visit and per patient. This will bring patients into larger organizational systems where the economies of scale are more efficient and rural hospitals and rural health clinics will have to close.

Mr. Finerfrock said there are interesting trends that may have many advantages to rural health clinics integrating with hospitals but the rural health structure can not be harmed in the process. There are few rural models that are coming from the Innovation Center but the rural community has the responsibility to control their own destiny instead of waiting for someone else to step forward with innovative ideas.

The Shortage Area Designations have two different criteria that include Medically Underserved Population and Health Professional Shortage Areas. Each designation methodology looks at different criteria so it is important to maintain two designations.

The Negotiated Rulemaking Committee decided that there should be a distinction between rural and frontier and those frontier communities should have a different threshold test because of lower population. The National Association of Rural Health Clinics agrees with that decision.

Mr. Finerfrock stated that the Negotiated Rulemaking Committee discussed whether or not primary care givers other than just physicians should be counted in the Shortage Area Designation Methodology formula. The Committee decided that nurse practitioners and physician assistants should also get counted because the current formula does not recognize them. The National Association of Rural Health Clinics supports the .75 Full-Time Equivalent adjustments and the nurse practitioners and physician assistants should be calculated.

Mr. Finerfrock spoke about the yoyo effect. The yoyo effect is when programs and formulas are changed and communities no longer qualify as underserved and lose their eligibility to participate in a program, later the Government assigns them shortage area status and they put in a rural health clinic again. There is a yoyo effect of communities being in and out of the program which is not efficient. The Association of Rural Health Clinics advocate a back out process where the Government looks at the provider to patient ratio in a community and what the ratio would be if the providers who were there due to participating in a Federal program were backed out. The Negotiated Rulemaking Committee supports the idea of a back out of providers that are in communities for programs. Those providers are taken out of the ratio count to decide whether the area is a shortage area. Mr. Finerfrock suggested that the Committee ask the Secretary to consider rural health clinic providers being backed out of the process whether or not they should have a sliding fee scale.

Craig Kennedy, National Association of Community Health Centers

Craig Kennedy shared that he grew up in rural Oregon and works for the National Association of Community Health Centers. The National Association of Community Health Centers represents Community Health Centers, Federally Qualified Health Centers, Migrant Health Centers, public housing and Homeless Health Centers. They do not represent Rural Health Clinics. He stated that the Medically Underserved Population portion of the Negotiated Rulemaking is very important because it is one of the four requirements of law of a Community Health Center. The Health Professional Shortage Area is a count of providers and Medically Underserved Population is a level of service. Mr. Kennedy stated that they are pleased that the programs are separately designated. Health Centers are 60% urban and 40% rural by law. Growth must reflect that range and now it is about 55% urban and 45% rural. The patients of health centers nationwide are about 45% rural.

Mr. Kennedy said that in 1999 or 2000 there was a notice of proposed rulemaking concerning eliminating 10% of health centers. He felt there was more need for health

centers and they were being asked to lose 10%. That change would have a huge impact on rural communities but it did not go into effect. In 2008, there was another notice of proposed rulemaking that would have impacted rural health centers so the National Association of Community Health Centers asked for a negotiated rulemaking. The negotiated rulemaking process is something that the National Association of Community Health Center supports.

There were three focuses of the negotiated rulemaking and they are to “do no harm”, be evidence-based and data driven and to be simple. Every community is different so creating a national overlay of service is difficult. There are four components in the law that are not negotiable. Mr. Kennedy said that the negotiated rulemaking committee decided that the four factors could be in different percentages in Medically Underserved Populations and Health Professional Shortage Areas. He stated that the process needed to come to a consensus and the National Association of Community Health Centers considers that 21 votes of support and 2 non-supports on the final agreement is an overwhelming vote of support. Many of the various provisions were unanimous and there was no opposition and those should be accepted. The ones that were not unanimous should have the burden of proof on why not to follow through on those proposals.

Mr. Kennedy said it is difficult to see how rural fit into The Innovation Center and there is not a rural component to it yet. There are coop models that may end up being more rural. The National Association of Community Health Centers applied for a grant to improve quality and Community Health Centers and address some of the workforce needs. Eventually it will hit 45% of the health center population but not because it has a rural component of the innovation grants. He said that if rural is excluded in innovations then it has to be fixed up front or it will be too late.

Other topics that Mr. Kennedy stated need attention are how to continue to encourage recruitment and retention in rural communities and how exchanges and Medicaid expansions occur in rural America differently than urban America. The National Association of Community Health Centers recognizes unique challenges in migrant health and there needs to be a policy discussion on that subject.

Q&A

Tom Hoyer said that it seems that the statute lays out for the Innovation Center the things that have to be considered. If you make the argument that they need to focus on three other topics then it would be an argument to Congress for a different statute. Secretary Sebelius knows about rural issues and cares about them but she can not change the act. The only way that rural will get part of the innovation grants is if Congress changes the law or Dr. Gilfillan can work with the grants and make sure rural is included. The Committee can not do anything useful if it can not make a recommendation to the Secretary about what she can do with the current law.

Bill Finerfrock replied that on statutory issues the Secretary does not have authority but how cost savings are defined is not specified in the statute so there are opportunities on

how one chooses to define cost savings. There was an issue in the rural health program and questions raised about the program growing and costing money. There was a study done and it found that expenditures for rural health clinics were growing but when looking at hospital utilization amongst the Medicaid patients in the communities there was a significant decline and that offset the cost. There has to be consideration of how it all interacts and what initially is viewed as a cost could be viewed as a cost savings.

Tom Hoyer said that he just wanted to make the point that this Committee has to work within the statute.

David Hartley said that if the argument is made that access should be equally important to cost then there should not be much time spent talking about cost. He asked why some parts of the country have more Rural Health Centers and fewer Community Health Centers and other parts of the country it is the other way around. If the Medically Underserved Areas and Health Professional Shortage Area designations explain the distribution it is not clear. The criterion that has been set up so people can apply for grants has something to do with the distribution.

Craig Kennedy said that he thought it was more the historical structure of the market places. As health centers have grown there has been a strong volume of applications from the middle of the Country. There is a historical infrastructure issue so there are health centers in the South and the familiarity with health centers grew in those areas. He said that he does not know if the designation process has hindered certain areas from getting health centers.

Bill Finerfrock said that he thinks there are factors that may help to explain and one is the historical way in which health care is delivered in different regions of the nation. To be a Federally Qualified Health Center it is required to be a non-profit organization that is governed by a board of directors. For profit practice is excluded from being a Federally Qualified Health Center. A state like Iowa where there are a lot of doctors and there is not a large proliferation of nonprofits, may not want to become a nonprofit, have a board of directors and become an employee of the organization and sell the practice. Instead a physician can become a Rural Health Clinic and continue to own their practice and get the benefits of the program. That is a component of the mindset of the providers in communities as the programs were evolving. The difference in the Medical Underserved Areas and Health Professional Shortage Areas also helps to explain part of the differentiation. Health Professional Shortage Areas focus on the provider to patient ratio and Medically Underserved Areas focuses on socio-economic and demographic characteristics that are indicative of a problem of accessing care. Rural communities are generally healthy. The poverty levels in many Midwestern states are not particularly low as a consequence their score is not very good when it comes to Medically Underserved Area but they do not have health professionals so they can get a Health Professional Shortage Area designation but can not get a Medically Underserved Area designation.

Roland Gardner asked Bill Finerfrock about the .75 Full Time Equivalent calculations and why it is not .5. He also asked about veteran services.

Bill Finerfrock said that .75 was a political decision that was made and .5 seemed too low and 1.0 seemed too high so .75 was the decision.

Craig Kennedy said there is a health center specific hiring initiative that National Association of Community Health Centers is engaged in and in the past two years they have been identifying veteran patient populations on the Uniform Data System forms to understand veteran service levels around the Country. They are working with the Veterans Administration to identify veteran service levels in rural areas of Maryland, Virginia and West Virginia. National Association of Community Health Centers is aligning their efforts better with veterans service needs.

BREAKOUT SESSIONS OF SUBCOMMITTEES

Tom Morris announced subcommittee information in preparation for workgroup meetings.

Center for Medicare and Medicaid Innovation Subcommittee:

Chair of Subcommittee: Larry Gamm

Members of Subcommittee: Phyllis A. Fritsch, Thomas Hoyer, Michele Juffer, Wayne Myers, Shane H. Roberts, John Rockwood, Jr. and Christy Green Whitney

Staff: Aaron Wingad, Nicole Comeaux and Paul Moore

Health Workforce Shortage Designation Subcommittee:

Chair of Subcommittee: Karen Madden

Members of Subcommittee: John Stewart Cullen, Roland Gardner, David Hartley, Gary Walton and Roger D. Wells

Staff: Aaron Fischbach and Nick Lillios

Administration for Children and Families Subcommittee:

Members of Subcommittee: Eugenia Cowan, Pamela deRosier, Barbara Fabre and Barbara Morrison

Staff: Tom Morris, Steve Hirsch, and Shannon Wolfe

PUBLIC COMMENT

There were no public comments and the meeting was adjourned.

Friday, February 17th

SUBCOMMITTEE KEY POINTS & POSSIBLE RECOMMENDATIONS

Center for Medicare and Medicaid Innovation Subcommittee:

Chair of Subcommittee: Larry Gamm

Members of Subcommittee: Phyllis A. Fritsch, Thomas Hoyer, Michele Juffer, Wayne Myers, Shane H. Roberts, John Rockwood, Jr. and Christy Green Whitney
Staff: Aaron Wingad, Nicole Comeaux and Paul Moore

Larry Gamm presented for the Center for Medicare and Medicaid Subcommittee. He stated that under specified conditions, Centers for Medicaid and Medicare Innovation has the authority to implement new demonstrations and the Secretary has the authority to expand models through formal rule-making processes without seeking direct authority from Congress. This is beneficial because it may allow the Centers for Medicare and Medicaid Services to expand demonstrations that directly address health challenges in rural communities.

Topics that will guide the Subcommittee's recommendations are:

- Budget neutrality based upon a regional population health perspective of care, cost, and outcomes rather than institution specific cost and quality.
- Long-term investment in population health improvement strategies combined with technical assistance for more "rapid cycle" adoption of evidence-based practices. This principle is based on the recognition that some essential infrastructure will take time to develop or integrate in rural areas, but there are some evidence-based practices that can be more rapidly implemented with benefits to population health more quickly demonstrated.
- Recognition of key rural resource needs can better ensure effective participation of rural health providers with the triple aims of improving the experience of care, improving health outcomes of populations and reducing the per capita cost. The resource needs include support of information technology, support for addressing isolation challenges and technical support for functioning in a complex reimbursement and regulatory system.

Health Workforce Shortage Designation Subcommittee:

Chair of Subcommittee: Karen Madden

Members of Subcommittee: John Stewart Cullen, Roland Gardner, David Hartley, Gary Walton and Roger D. Wells

Staff: Aaron Fischbach and Nick Lillios

Karen Madden presented for the Health Workforce Shortage Designation Subcommittee. She said the Subcommittee respects the process of the Center for Medicare and Medicaid Innovation Negotiated Rule Making Committee report and the subcommittee recommends the report is accepted with a few caveats.

The Subcommittee would like to find out if flexibility can be built into the regulations so that if problems arise there can be improvements made based on data that can be reviewed. Some of the research questions that the Subcommittee would like answered by means of data:

- What percentage of the National Health Service Corps loan repayment providers remain at the same location once their commitment is over.
- What data is available regarding nurse practitioner and physician assistant productivity?
- What is the impact of the backing out of various providers?
- Would like to see data based on the inclusion of non-physicians when they are backed out.

As the Negotiated Rule Making Committee recommendations are being implemented, the Subcommittee would like to look at improving the analysis and securing data in time for the next department review that is supposed to happen in 3-5 years. The Subcommittee would like to evaluate the impact of the designations in the intervening 5 years and their resulting programmatic impacts. If there are unintended consequences, will there be a chance to make changes before the 5 year period is a concern of the Subcommittee. The system needs to be updated as frequently as possible, especially if there is adverse impact on rural areas.

Administration for Children and Families Subcommittee:

Members of Subcommittee: Eugenia Cowan, Pamela deRosier, Barbara Fabre and Barbara Morrison

Staff: Tom Morris, Steve Hirsch, and Shannon Wolfe

Steve Hirsch presented for the Administration for Children and Families Subcommittee. He said that integration and coordination of services were focuses of the discussion.

Topics discussed by the Subcommittee included:

- Integration of services – Not separating health care and human services. Considering the overall wellbeing of the family. Collaboration between health and human services.
- More of a focus on prevention is vital. People will continue to get repeatedly sick until the social conditions are corrected that facilitated their illness. There needs to be a commitment at the policy level for collaboration and integration to work. People have to be equipped with what they need to make this work.
- Care transition is important regarding readmissions to the hospital. Social issues play a huge role in the health of children and families. People being discharged from hospitals may not have transportation to follow-up visits, food at home or remember details about their medications.

- The close relationship between county operated services, non-profit sector and the volunteer sector are the fabric of human services working. This is a safety net of support for communities. Recognizing this and incorporating it into a model is important.
- Coordination of human services and wrap-around services is important in rural communities.
- Technology is a priority and an issue when assisting rural communities due to lack of access. Making home visits and having the technology to input information to assist families in applying for eligible services.
- Administration of Children and Families should encourage programs to think outside the box. Funding should not single out programs but reach out to different programs.

Governor Musgrove added that the delivery of human services is difficult to narrow down to specifics that integrate into the entire delivery of services. He said that he felt that the Administration for Children and Families Subcommittee discussion was positive and they could have some conference calls to narrow down to a more specific focus. The Subcommittee members in this group were all new members and he commended them on their first meeting.

Tom Morris said that the Office of Rural Health Policy will staff the conference calls.

UPCOMING MEETINGS

Governor Musgrove stated that the Committee will meet in Boise, Idaho in June 2012 and in September 2012 the meeting will be held in Austin, Texas. He asked the Committee members to consider hosting future meetings.

Tom Morris added that they could consider Central Nebraska in June 2013 and Grand Junction, Colorado in September 2013.

KEY POINTS AND POSSIBLE RECOMMENDATIONS FOR UPCOMING MEETING

Tom Morris said that potential topics for Boise, Idaho include: the Medicaid tax credit exchange issues, the broadband issue, a human service topic and the hospital infrastructure debt limit and deficit reduction discussion.

PUBLIC COMMENT

There were no public comments and the meeting was adjourned.