Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Kansas City, Missouri
June 18-20, 2012

Meeting Summary

The 71st meeting of the National Advisory Committee on Rural Health and Human Services was held on June 18-20, 2012 in Kansas City, Missouri.

Monday, June 18th, 2012

The meeting was convened by Governor Musgrove, Chairman of the Committee. He shared that the Committee focus would be on the impact of rural health infrastructure changes on hospitals in rural communities as well as collaboration between rural Head Start and the Child Care and Development Fund and the impact of current program guidelines and regulations on rural areas.

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; Karen Madden; Barbara Morrison, MS; Wayne Myers, MD; Shane H. Roberts; John Rockwood, Jr., MBA, CPA; Roger Wells, PA-C; Christy Green Whitney, RN, MS. Mr. Dennis Dudley attended representing the U.S. Administration on Aging.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Steve Hirsch, Executive Secretary; Michelle Goodman, and Linda Bahrami. Truman Fellows present were: Aaron Wingad, Nicholas Lillios, Nathan Nash and Emily Schlichting.

Charles W. Fluharty, Ph.D
Research Professor, Truman School of Public Affairs, University of Missouri
Director, RUPRI Rural Policy Research Initiative

Charles Fluharty began by thanking the committee for their work and said that the importance of integration between health and human services will be vital in the next decade. He said that the Office of Rural Health Policy has been critical in this sector and is an important member of the Federal community.

Dr. Fluharty stated that he was going to give a heartland perspective that would help inform the Committee on issues related to the Medicare Payment Advisory Commission (MedPac) Report and the Supreme Court's decision on the Affordable Care Act. He said that he would give a broad view of structural trends that he thinks will have a huge

impact over the next decade. He noted that there are three daunting challenges in the next decade including: bifurcation in rural communities, the tax dynamic for federal, state and local government and rural capacity is significantly declining.

Bifurcation in rural communities is going to be the largest challenge. He said that structurally, from a geographic standpoint, this needs to be considered very soon. The regions in rural America that will deal with massive restructuring will spring forward in dynamic ways but the ones that do not will fall further behind and be more deeply challenged.

The tax dynamic for federal, state and local government and how American federalism is recalibrated is going to be an issue. It will be smaller, less impactful and be a greater challenge to local jurisdictions. There will be hard decisions to be made with difficult budgets.

Rural capacity is significantly declining and there is a continuing disadvantage in federal funding for community and economic development. This year there is a six hundred dollar per capita difference in community and economic development resources from the Federal Government to non-metropolitan counties compared to metropolitan counties. That amounts to 28 billion dollars in federal funds that are not going to rural regions if they were equitably received funding per capita. It is critical when thinking of cross sectorial alignments for rural futures.

There is a need for the American philanthropic community to take a more serious look at supporting rural areas. In 2010 foundations paid out 46 billion dollars and rural communities received somewhere between 1 to 3 percent. The foundations receive a tax advantage because they contribute to the good of the nation. If tax dollars are pulled out of a region to support the foundation and the region is not receiving a reciprocal response there is a further disadvantage.

There are rural communities doing amazing things including cross sectorial collaboration, greater work on getting assets in place and articulating them and aligning programs as a basis of development around those assets. Investment and leveraging is happening in many sectors and there is a focus on sustainability and resilience. Entrepreneurship is moving forward and regional platforms are being built. There is a focus on a regional continuum of work.

A strong health system is the key to bringing businesses and workers to an area. The nation is an urban centric nation and the nation’s urban foundations are making major investments. For the first time, the United States farm bill has no mandatory federal money for rural development.

Dr. Fluharty said that last November he keynoted a conference in a 20 county area of Southeast Kansas. After attending the conference, four senators in Kansas started Project 17 to move the region forward. A year later they received a grant from the Kansas Leadership Center to spend one million dollars over the next four years to build

collaborations because they acknowledge that health and human services are key in moving the workforce of the region into place. The goals of building collaboration are: economic growth, health outcomes, regional leadership and a cross sector collaborative platform to sustain it across all of the sectors.

Dr. Fluharty shared that last November in Northwest Missouri he participated in a new initiative for the community foundation. Six hundred people attended the meeting. By the end of the day, the foundation completely changed their focus from building their endowment to building their region. They have seventeen working groups centered on heartland health. The community foundation has taken a regional innovation focus for a health system based health foundation. In that region there are about seven micropolitan regions that have never worked together and they are now recognizing that the future of the region is tied to collaboration.

Dr. Fluharty said that the Rural Policy Research Institute (RUPRI) looked at indicators of need in rural and urban America and the document is on the RUPRI website. They built a need index of geographic, demographic and economic indicators for all counties. They took the bottom ten percent of all counties and gave them a scoring. They built an additive index across the indicators of need. A number of counties had 1-2 indicators of need but there were 149 metropolitan counties and 346 rural counties that had 2 indicators of need. There were 91 metropolitan counties and 459 rural counties who had 3-5 indicators of need. There were 8 metropolitan areas and 84 rural counties had 6-9 indicators of need. This is why there is a need for integrated service delivery.

Dr. Fluharty said that health and human services have to unite. He noted that without The Office of Rural Health Policy they would not be here today. The Office of Rural Health Policy is the shining model of how the rural differential in a sector builds an evidence based research track in alignment with state and federal policy that is needed in every sector of rural America. It is most needed in the human services sector. He said that there needs to be aligned research in health and human service because in the future those two sectors will be fully integrated.

Q&A

David Hartley said when discussing the challenges of attracting businesses and workers to rural communities he thought about a study out of Minnesota called the Brain Game and he asked what Dr. Fluharty's thoughts were about that study.

Charles Fluharty said there is a challenge with that data. The data is geographically unique. He said that the key is attracting the cohort of people from the age of 30-45 who return to the rural regions to raise their family. He said that it is beneficial for young people to leave rural areas and return with renewed skillsets and experiences.

John Rockwood stated that RUPRI had a set of goals of how to judge the effectiveness of rural health delivery in a rural community. As it has been stated all rural communities are somewhat different. He asked why they do not focus more on the access issue to

measurement as opposed to outcomes, education levels and other macro-measurements. The problems will not be solved and it needs to be assured that all rural communities have access to great services. It seems that the wrong issue is trying to be solved.

Charles Fluharty said that he would like for the Committee to read the BARCA report. It was written by the finance minister of Italy in the last government. He was asked to assess regional innovation in Europe. He released a phenomenal report that will alter regional investment strategies in Europe. He basically stated that until the right indicators are measured all that will be measured are efficiencies in economic development. There need to be equity indicators in regional innovation to deal with diversity disadvantage and scale of poverty. That was a macro document by the European Union to look at differential disadvantage with looking at innovation and regional scale.

He stated that the committee members who have senior leadership positions in health and human services are at an important moment because we are on the cusp of exciting change in health care but at the same time on the cusp of debilitating human services disadvantage as a result of the taxing dynamics. There is the risk of a number of challenges in the new environment what do we truly seek to do with rural geography. It is a national question and should not be solved by the health sector or human services sector. The deeper issue is if we going to have a peopled landscape.

Jay Angoff, J.D.
Acting Regional Director, Region VII, Department of Health and Human Services
Kansas City, MO

Jay Angoff thanked the advisory committee for inviting him to speak. He stated that the President is confident that the Supreme Court is going to uphold the law in regard to the Affordable Care Act. He said that he will discuss several of the grant programs for rural areas that are in the pipeline under the Affordable Care Act. He said that if the court strikes down the law in midst of all that has been done with grants related to the Affordable Care Act, it would be a huge problem.

Mr. Angoff stated that Region VII is a fitting site for the meeting because they are one of the more rural regions in the country. They have lots of rural and frontier areas and are very aware of the difference between them. There are small towns in Missouri but they are all within two hours of a city. In western Kansas or western Nebraska the people are far away from a city. There are different issues in those frontier areas.

Region VII is home to the largest number of Critical Access Hospitals in the nation and they play are crucial role in rural safety. Without them many people would not have anywhere within a reasonable distance to find healthcare. There are programs to strengthen rural safety net providers and ways that the Affordable Care Act is making dramatic improvements in rural healthcare.

The health reform law has helped millions of rural Americans gain access to insurance. Nearly 400 thousand young adults in rural areas have health insurance because the

Affordable Care Act allows them to stay on their parent's policies until they are 26. In Missouri and Kansas more than 61 thousand young adults gained insurance through this law. 5 ½ million rural Americans will gain insurance coverage by 2016 through the expansion of Medicaid and the creation of health insurance exchanges.

The Department of Health and Human Services recognizes that rural areas face unique challenges for the operation of exchanges and he thanked the committee for the hard work they have done in developing recommendations about how exchanges should operate to work for rural residents. Rural residents have fewer choices of insurance plans and are faced with plans that carry high deductibles and limited benefits. Farmers and small businesses lack the clout to negotiate with insurance companies. Exchanges give people clout if they are implemented correctly. They will give individuals in rural areas that have had no bargaining power, equal bargaining power to large businesses. People will be able to band together and insurance companies will have to give everyone buying through the exchange the same rate.

In order for people to have bargaining power through the exchanges they have to be able to make pricing comparisons and compare price for the same value of product and benefit level for each insurance company sharing through the exchange. Companies will be forced to compete on price and will have a tremendous incentive to sell through the exchange because there will be 16 million new people buying through the system. Many of the people purchasing through the exchange will be healthy and subsidized through the Government. There is a tremendous potential for the exchanges to drive down costs, especially in rural areas.

The National Advisory Committee's white paper last year on policy implications for rural health insurance exchanges helped inform many of the regulations and guidance on exchange operations. The recommendations regarding cultural aspects of rural communities, the infrastructure needs in rural areas and the realities surrounding the establishment of an adequate network of providers in rural regions were particularly important.

Small businesses that have struggled to provide health insurance to their employees will now be able to qualify for tax credits to help them pay for insurance. Small businesses with 25 or fewer workers that pay at least half the premium for the employees and the average wage for the employees is no more than 50,000 per year, they will be eligible for a tax credit.

A provision already in effect is the medical loss ratio rule that requires insurers to spend no more than .20 of the premium dollar on administrative cost and .80 of the premium dollar on health care costs and or quality improving activities. That is in the individual small business market. This standard has caused insurers to reduce their rates or file for lesser rate increases. It has also resulted in insurers offering increased benefits and if the insurers cannot meet the 80% test and at the end of the year have only spent .75 of the premium dollar on health care costs and .25 on administered of overhead, the .05 goes back to policy holders in rebates. It is estimated that in 2011 alone that insurers

nationwide will rebate between 1.2 billion and 1.3 billion to their customers. In Missouri figures show that insurers will rebate more than 64 million dollars to consumers and Missouri will get about 5% of all rebates nationally even though Missouri has only 2% of the nation's population. That is good news because Missouri will be getting much more rebates than the share of the population would indicate. The bad news is that the rates are so much higher in Missouri because there is no insurance rate regulation. Insurance companies do not even file their rates in Missouri and the medical loss ratio rule will have a substantial impact in Missouri and several other states where companies do not file their rates or the regulation is lenient. The Affordable Care Act requires all companies proposing a rate increase of more than 10% to file that increase and the data to justify the increase with the state department of with the Department of Health and Human Services. The rate will be reviewed as to whether it is excessive or not. HHS or the state will not have the authority to roll back rates but it makes the rate increases public and the disclosure of information will help keep rates down.

The Affordable Care Act provides an improvement to public health in neighborhoods and rural areas in ways that help people to be more active, eat better and stay healthier. The Centers for Disease Control and Prevention announced that it is taking applications for new community transformation grants designed for rural areas. There will be 70 million dollars going to small communities to help them improve health using goals outlined in the health reform law. Communities devising innovative ways to help people do things like reducing tobacco use and controlling their weight will receive the grants. There has been progress in reducing tobacco use but in the past 30 years obesity rates have risen. The First Lady is very concerned about the problem of obesity and created the Let's Move Initiative.

Other major changes in the Affordable Care Act include an unprecedented investment in rural health care. There is a shortage of primary care doctors and nurses in rural health care. One fourth of America's population lives in rural areas but only 10% of physicians practice there so the law sets aside 11 billion dollars to expand Community Health Centers and 1 ½ billion to place doctors, nurses and other healthcare providers in underserved areas. In Missouri and Kansas, Community Health Centers have received 70 million dollars to expand their services and build and renovate new clinics. Community health centers in Nebraska and Iowa have received grants. The Community Health Centers are an example of what is working well in the system. They provide high quality healthcare to people regardless of their ability to pay. In some areas Community Health Centers have large numbers of people who have private insurance and some people can pay part of the cost. Some people have Medicaid and some have no insurance or Medicaid and cannot pay anything. The Affordable Care Act has funded them expansively.

The expanded National Health Service Corps has 350 new primary care providers in underserved parts of Missouri and Kansas. The Department of Health and Human Services also expanded primary care residency training and 15 of the new 22 teaching health centers serve rural communities. Fifty percent of the clinicians participating in the National Health Service Corps practice in rural areas. New resources have gone into

training nurse practitioners and physicians assistants to meet the growing need for primary care. The scopes of practice laws are at the state level and there is a big difference among the states. Missouri is very restrictive as to what nurses, nurse midwives and nurse practitioners can do. Iowa is very liberal. It would be great to see people in rural areas getting the best access to the most health care possible.

The Whitehouse Rural Council has expanded the National Health Service Corps to include work at Critical Access Hospitals and has given the states the authority to allow pharmacists to participate in the state loan repayment program.

Residents in rural areas suffer higher rates of chronic conditions. The health insurance reform law requires insurance companies to provide preventative care without any copay or deductible. This saves money for everyone by keeping people healthier and catching illnesses early to reduce cost.

Last week 81 new health care innovation awards were announced. 107 awards have been announced in the past two months. The grants are worth 1.9 billion dollars for projects in all 50 states to test ways to improve health care in big cities and small towns, in rural areas and frontier regions. Health care innovation awards will finance projects designed to improve the delivery of medical care, enhance the health care workforce and save money. The rural focus of many of the awards reflects the Committee's influence. The Department of Health and Human Services is well aware of the Committee's recommendation for the Centers for Medicare and Medicaid Services Center for Innovation to focus on rural areas.

The conference will provide the opportunity for the Committee to discuss two important issues in Region VII. The first is Medicare's current special hospital designations for rural hospitals and second the Head Start and Early Childhood Service Block Grant programs in rural communities. In Region VII they are very aware of the sensitivity of the hospital designations because many communities are served by a Critical Access Hospital or Medicare Dependent Hospital. Region VII is interested in the Committee's views on the interplay of Head Start and services offered through the Early Childhood Development Block Grant. The programs play a key role in providing early intervention that is critical in getting children on the right path. Providing these services can be challenging in small rural communities with limited infrastructure.

Mr. Angoff thanked the Committee for meeting in Kansas City. He noted that the Committee will get an up close view of the progress and challenges surrounding health care providers and early childhood programs in the heartland of America.

Q&A

Ronnie Musgrove asked how many states have little to no regulation authority on the cost of pricing of health insurance.

Jay Angoff replied that some states do not require companies to file their rates at all.

Several other states require them to file but do not really look at them.

Phyllis Fritsch asked if in their work with the Missouri commission with healthcare reform, are there things that they learned that would be beneficial nationwide.

Jay Angoff said that what they did in Missouri really worked. The state set up a classic exchange for state workers in Missouri. The benefit package was standardized and they asked the insurers to give a price that they will take any employee that wants to purchase from them. Each worker was allowed to get the low bidding plan for free. The employee had to pay the difference between the low bidding plan and other carriers bid. The insurers said that they would not do competitive bidding but they did and they bid low. Bidding low gave the carrier who bid the lowest a tremendous advantage. The Affordable Care Art does not allow an exchange to be that pure a competition model but states have discretion so the closer to the managed competition model the more likely the insurers will compete vigorously on price.

SETTING THE CONTEXT FOR KANSAS AND MISSOURI

Margaret Donnelly, J.D., M.S.W.
Director, Missouri Department of Health and Senior Services

Margaret Donnelly opened by thanking the Committee for their interest in the perspective of Missouri and Kansas. Improving rural health is a challenging task and she stated she is glad to have the opportunity to speak to the committee about how they are approaching the task. The rural communities are constantly evolving so the rural health infrastructure has to change to meet the needs of the rural clients.

Understanding who the clients are is the first step in meeting needs. 101 of 114 counties in Missouri are considered rural. Out of 6 million residents, 37 percent live in rural areas. 82 percent of Missourians are white and non-Hispanic and 11 percent are African American. Only 3 ½ percent of residents are Hispanic but they are the fastest growing population in the state. Of 101 rural counties, 93 experienced an increase in minority populations between 2000 and 2010. In 17 rural counties minority populations nearly doubled in that time period. Some of the challenges that face the rural communities in addition to normal barriers in health care are the language and cultural differences.

The other demographic growing in Missouri is the elderly population. The median age in Missouri increased from 36.1 in 2000 to 37.6 in 2009. The population age 75 and older increased by 8 percent during that time period. The state rate of poverty is 14.4 and lower than the national rate in 36 of rural Missouri counties but more than 20 percent of the residents over the age of 25 lack a high school education. Health status and life expectancy are positively correlated with increased levels of education so it is a critical factor in developing intervention strategies. Tied closely to education are the personal income and poverty rates.

The 2010 United States Census showed that the average poverty rate for Missouri's rural counties was approximately 17.2 percent as compared to 13.1 percent for urban counties. Under the age of 18, Missouri's rural counties have a poverty rate of 25.3 percent compared to 18.2 percent in urban counties.

Within the Missouri Department of Health and Senior Services is the Office of Primary Care and Rural Health whose responsibility is to address health care structural needs in rural Missouri. The Division of Community and Public Health houses many traditional public health programs and works closely with the rural providers on programs such as immunization, Women, Infants and Children (WIC) and chronic disease management.

Missouri faces similar issues to rural areas in the rest of the country. The limited availability of providers is a problem. 37 percent of Missouri's population lives in rural areas and only 18 percent of primary care physicians live in rural areas. There are 118 general medicine surgical hospitals in Missouri and 68 of them are located in rural counties. 41 rural counties in Missouri have no hospitals. Of the 68 rural hospitals, 36 are Critical Access Hospitals. Over the past 40 years the network of Community Health Centers has expanded. There are 21 health centers providing care at 180 community based delivery sites. There are 377 certified rural health clinics in 98 of the counties. There are staffing shortages so hospitals may not always be able to provide services fulltime. There are 101 primary care Health Professional Shortage Areas (HPSAs) in Missouri. Of 101 HPSAs, 76 are low-income primary care HPSAs and 25 are geographic primary care HPSAs.

Ms. Donnelly stated that the health professional shortages are only going to grow so they are working with the state and federal partnership programs to address those issues. In addition to available programs they have developed collaboration with the Community Health Centers through the Missouri Primary Care Association that represents the network of Community Health Centers. This is an additional effort to help the community recruit and retain health care providers who are interested in practicing in rural and underserved areas. The services provided through the program are very personalized. It is not only focusing on the need of the community but also on the experiences and interests of the health care providers.

Through National Health Service Corps there are 393 participants at 313 sites and their slot of the J1 Visa waivers is thirty each year. Lack of insurance and lack of providers is a dangerous combination and exists disproportionally in rural Missouri. About 15.3 percent of Missourian adults do not have health care coverage. Access to oral health services is difficult and in recent years they have tried to develop programs to meet those needs. Those programs are successful and they continue to work to increase oral health education efforts and it is a primary focus in their rural health care workforce. Rural health care providers' implementation of electronic health records is a huge endeavor. In Missouri the Regional Extension Center is housed at the University of Missouri. To date there are 2,200 providers in 56 hospitals which have received incentives totaling 72 million dollars for electronic health records.

Ms. Donnelly said that the Missouri Department of Health and Senior Services have the responsibility for licensing and regulating child care providers in Missouri. The child care block grant funding is administered in the Department of Social Services but they work very closely with them on the efforts. They share the goal of making sure that quality and accessible child care is available.

Ms. Donnelly stated that she is proud of what they are doing in Missouri to enhance the health and wellbeing of their citizens. She said that she was grateful to the Committee for helping address the needs in rural communities. It is a time of promise for improving health care delivery and human services delivery systems and she thanked the Committee for their efforts to make that potential a reality.

Robert Moser, M.D.
Secretary, Kansas Department of Health and Environment

Robert Moser thanked the Committee for their role in improving rural health care and human service delivery. He thanked the Committee for visiting the heartland of the United States. He began by sharing that most of the residents in Kansas are located in the eastern part of the state. Many of the counties in the western part of the state meet the federal designation of frontier with less than two people per square mile. 89 percent of rural or frontier counties in Kansas are in the western half of the state. Dr. Moser practiced in Greeley and Wallace Counties, which are frontier counties, for over 20 years doing full service family medicine.

Dr. Moser spoke to the committee about Greeley County Health Services. It is located on the Kansas-Colorado border and is over 90 miles from the nearest tertiary care center. There is only one stop light in the two county basic service area. Greeley County Health Services has clinics in Tribune and Sharon Springs, Kansas.

The population of Kansas is 2.8 million with a population density of 34.9 persons per square mile. The median age of the population was 36 in 2010. There has been a decrease in ages 25-44 in the last 20 years and an increase of 16 percent in those over the age of 75. The average per-capita income for Kansas in 2010 was $38,977 with rural per-capita income at $35,412. The 2010 estimate poverty rate in rural Kansas was 14.9%.

Rural and frontier counties have been declining in population since the 1960’s. Governor Brownback implemented the Kansas Rural Opportunity Zone program to address the declining population issue and grow the economy. There are 101 primary care Health Professional Shortage Areas in Kansas.

Last year Kansas passed the Rural Opportunity Zones bill. It is an addition to the student loan repayment and National Health Service Corps to encourage youth and professionals to move back to underserved and rural Kansas locations. The bill has been in place for a year and there has been an increase in youth moving back to those areas.

The average rate of uninsured in Kansas according to the Kansas Health Institute is 19 percent for adults age 19-64 and is highest in the age groups of 19-44 and higher in ethnicities other than white, non-Hispanics.

There are 179 Rural Health Clinics in Kansas and 19 Federally Qualified Health Centers providing services at 47 sites in the state. Federally Qualified Health Centers are the dominate health care provider in some communities which unfortunately are eliminating private physicians due to competition.

The State-Funded Primary Care Clinic provides funds in the development and operation of clinics that focus on improving access to health care with an emphasis on community-based services and reducing health disparities for underserved populations.

Dr. Moser stated that there are 127 community hospitals in Kansas. 96 are small hospitals with less than 50 beds and are located in rural areas. There are 83 hospitals identified as Critical Access Hospitals. He said that there are some Critical Access Hospitals that have supporting hospitals across state lines. This has caused issues with health information exchange because each state has a different fee and they are connecting across state lines. Kansas Health Information Exchange, Inc. is developing policy but is not involved in technical support. KHIE has become a regulatory entity and there is a discussion whether that responsibility should be moved back to a state agency to lower cost and not create an additional cost barrier.

Dr. Moser spoke about public health concerns in Kansas. From 2001 to 2010 the prevalence of obesity in adults increased by 39 percent. 28.7 percent of Kansas adults had high blood pressure in 2009. The leading cause of death in Kansas is heart disease with cancer being the second leading cause of death. Chronic lower respiratory disease is the third leading cause of death.

In 2009 Kansas formed a Blue Ribbon Panel on infant mortality. They have held awareness campaigns addressing the infant mortality issues. The panel consists of 22 representatives from state, local and private organizations.

Q&A

John Cullen asked if telemedicine and telehealth will have an impact in their frontier and rural areas.

Robert Moser said in the western part of the state are Hays and Garden City that are level 3 trauma centers. Tertiary transports in the western part of the state are to Denver or Wichita. The cost is about 10,000-15,000 dollars to transport by fixed wing aircraft in areas where rotary aircraft is not an option. Most of the time when consultants are called for transport, the consultants know it is a true need and were willing to take the patient. The rotary aircraft capability has been expanded across western Kansas but sometimes they go to the rural facility pick up the patient and take them to Garden City and put them in fixed wing aircraft to transport them on to a higher level of care if needed. That may

add to the cost.

Margaret Donnelly said they are trying to expand telehealth in Missouri to assist people who have to travel long distances for care.

John Rockwood asked Dr. Moser to expand on the state designated rural health network and on the obligations of the supporting hospitals verses the referring hospitals. He asked if it is a legal relationship, something the state designates.

Robert Moser said that there are 93 Critical Access Hospitals in Kansas. It is an agreement that the hub hospital will take referrals and transfers in from those hospitals. The smallest county in Kansas was the last county hospital to become a Critical Access Hospital. They could keep a patient if they were not likely to be in acute care for more than three days. Now patients can be admitted into a swing bed program so the patient can stay in the same room when they are on stable medical care and orders. It is a beneficial program for the Critical Access Hospitals.

Barbara Fabre asked Margaret Donnelly if she included human service providers when she spoke about the rural health care providers related to health information technology. If not, has she thought about including human service providers?

Margaret Donnelly responded that they have thought about including human service providers but the eligible populations for the incentives for meaningful use are physicians and hospitals primarily.

Larry Gamm said that 15-20 years ago there have been discussions on bypassing local hospitals. Is there a generalization or trend that you see? There are increased efforts in urban settings to build relationships with Critical Access Hospitals. Do you see this happening in Kansas or Missouri?

Robert Moser said that some hub hospitals are interested in having conversations with the Critical Access Hospitals. No one wants to have an outpatient procedure and drive home 80 miles so good quality health care needs to be provided where the patient lives or to have access nearby to eliminate barriers. There are good partnership arrangements with CAHs and the hub. They provide outreach specialty services. Some places are developing telehealth and the patients are comfortable with it but some would rather have face to face visits.

HOSPITAL PANEL

Victoria A. Freeman, Research Fellow
George H. Pink, Senior Research Fellow
NC Rural Health Research & Policy Analysis Center, University of North Carolina at Chapel Hill

George Pink stated that the North Carolina Rural Health Research & Policy Analysis Center objective is to provide information about rural hospitals and rural reimbursement programs to the National Advisory Committee on Rural Health and Human Services using data derived from multiple data sets. He focused on specific questions that were of interest to the Office of Rural Health Policy and Committee members. The first topic that Dr. Pink spoke about was the percent of hospitals with positive operating margins verses percent of hospitals with positive total margins. Urban Prospective Payment System (PPS) Hospitals, Rural Referral Centers and Sole Community Hospitals (SCH) are doing well and most have positive operating margins. Only half of Rural Prospective Payment System (PPS) Hospitals and Medicare dependent hospitals have positive margins on their basic patient care business, particularly Critical Access Hospitals (CAH).

Dr. Pink discussed the effect of eligibility change on sole community hospitals. There are proposals to change the distance requirements for Critical Access Hospitals. The number of Critical Access Hospitals and sole community hospitals affected depends on the mileage criterion used. If CAHS have to convert to PPS hospitals if they are within 5 miles from another hospital, not many will be affected. If the criteria is 35 miles almost all of the Critical Access Hospitals and sole community hospitals will be affected.

Dr. Pink discussed how distance affects Critical Access Hospitals. Distance is only one eligibility criterion and is frequently mentioned in policy debate. Most Critical Access Hospitals are between 10-35 miles from another hospital and there is a large number that are greater than 35 miles from another hospital. The more remote the Critical Access Hospital, the older the population is served by that hospital. This basic demographic is driving the financial performance of many hospitals.

The more remote the Critical Access Hospital, the smaller the Critical Access Hospital average daily census. The more remote hospital have smaller patient volumes and revenue, lower operating margins and less debt due to their inability to bear the fixed charges.

Dr. Pink spoke about why Critical Access Hospital differ by state. Compared to the United States, Kansas Critical Access Hospitals are smaller in terms of net patient revenue than the United States. A high percentage of Critical Access Hospitals are government managed and provide long-term care. A large portion of the Critical Access Hospitals in Kansas have rural health clinics. All of these factors affect financial performance and there are substantial variations among states. Other potential reasons Kansas Critical Access Hospitals are less profitable than the average United States Critical Access Hospital include: lower proportion of outpatient revenue, higher Medicare payer mix, lower Blue Cross payment rates, higher outpatient cost to charge, older age of plant and higher Average Daily Census (ADC) acute beds.

North Carolina Rural Health Research & Policy Analysis Center developed a model to predict financial distress for Critical Access Hospitals. There is variation throughout the country. Critical Access Hospitals in New England or the Northeast part of the country are doing well. One quarter of Critical Access Hospitals in the Pacific and Southwest

Central part of the country are at high risk of financial distress. Dr. Pink shared that Kansas has about 23 percent of Critical Access Hospitals at high risk of financial distress, while Nebraska only has 2 percent at high risk of financial distress. Nebraska and Kansas are geographically adjacent and are plain states but are totally different when it comes to the financial health of their Critical Access Hospitals. Dr. Pink said that in Nebraska Blue Cross pays a higher percent of charges than in Kansas and that may be the reason for the variation.

In order to answer the question of whether low volume hospitals are sustainable, they evaluated all Critical Access Hospitals in Kansas against twelve benchmarks and divided them into quartiles, Quartile 4 were high performers and Quartile 1 were low performers. The conclusion of the data was that Quartile 1 lower performers are smaller, serve more Medicare patients, are located in less populated areas and have rural health clinics.

Dr. Pink stated that distance is a factor to take into consideration when making the decision to close a hospital but cost, quality and access are also important. There has to be a level of affordability but there need to be safety net providers. Some of the hospitals are the only health care facility within a large area. It is better to travel and get high quality care than not travel and get low quality care. Another consideration is that when a hospital closes it also affects other providers in small, rural communities.

Q&A

David Hartley asked about the association between rural health clinics, long-term care and poor performance. The way it was presented there is an implication that having a rural health clinic or long-term care causes a Critical Access Hospital to perform poorly. Another explanation is that a poor performer may be exploring options to make a hospital more profitable so they open a clinic and try long-term care as diversification. The hospital could have been a poor performer before adding a clinic or long-term care.

George Pink said that most hospitals know that long-term care, revenue per day is insufficient to pay the cost per day. Hospitals are getting out of long-term care in many states because of the pure business case scenario.

Phyllis Fritsch said there is less reimbursement for clinics and it is costing hospitals money.

Wayne Myers reminded the Committee that 70 percent of the revenue coming into the Critical Access Hospitals came from outpatient operations. In the next year or so it would be helpful to get information on what percentage of the expenses for Critical Access Hospitals come from the inpatient side.

Keith Mueller, Ph.D, Gerhard Hartman Professor and Head
Department of Health Management and Policy
College of Public Health, University of Iowa

Keith Mueller spoke to the Committee about rural health systems of the future. He said that he is drawing from the work of the Rural Policy Research Institute (RUPRI) health panel to discuss the future of health care delivery. He recognizes that the current context is that there are categories of hospitals under challenge because of fiscal constraints and considerations in federal spending. There are service delivery issues locally because of workforce and what is going on in the market place. He stated that he would like to focus on what should be the future of rural health systems and how to get there.

Dr. Mueller said the changes in organization and delivery is underway and they need to be discussed. The context of change include: increasingly intensive focus on cost, new models rolling out, system expansion and mergers, acquisitions and affiliations.

Dr. Mueller shared that foundations for rural health systems of the future include better care and making health care more patient-centered and improving the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher quality of care. Another foundation for rural health systems should be reducing the cost of quality care for individuals, families, employers and government.

Rural Policy Research Institute (RUPRI) Panel stated that the characteristics of a high performance rural health care system is that cost is equitably shared, primary care readily accessible, quality improvement a central focus and a partnership between the patient and health team. Another high performance characteristic is priority on wellness, personal responsibility and public health.

The central points of what the change should be are: to preserve rural health system design flexibility and expand and transform primary care. Local access to public health, emergency medical, and primary care services need to be best suited for the individual community. The Patient-Centered Medical Home (PCMH) can be used as a framework. Use all of the primary care professionals in the most efficient manner possible. There should be the use of health information to manage and coordinate care including records and registries. To deliver value in a measurable way that can be basis for payment and collaboration to integrate services and to strive for healthy communities is necessary.

Using innovation to accelerate the pace of change is important. Thinking about how to use community paramedics and health workers is necessary for innovation. Sometimes this may require remaking the delivery of health care and payment models. Centers for Medicare and Medicaid Services (CMS) will be awarding innovation grants over the next cycle. Providing clinical services through local providers linked by telehealth and emergency care centers, e-pharmacy and e-consultation can expand the scope of what is available locally without having to hire local professionals.

The health care organizations of the future will have to be able to accept insurance risks. There has to be a focus on population health while also trimming organization costs. Data needs to be captured via electronic health records. Considerations have to include using

population data and an evolving service system including telehealth. There needs to be consideration of how to best use local assets including the physical infrastructure of the hospital.

The upcoming change includes moving away from fee-for-service toward value-based purchasing. There is a move from face-to-face encounters towards more telehealth. Independent entities are moving towards systems. Transitions are going to have to be managed and relationship will be needed between urban and rural providers.

Q&A

John Rockwood said it is difficult to do what is right for a region because small hospitals want their autonomy and typically are the largest employers in town and do not want to transfer functions to a central agency or institution. There needs to be state control over that. Providing states with Medicare funds so that they have some leverage to make the hospitals collaborate is necessary because there is no reason for a small hospital to have a purchasing department or finance department. There needs to be consideration about what services are available locally and discussions on Emergency Medical Systems and what services a community needs. There should be a score card that can be created by someone in the community for what services are available and what services are not available.

Keith Mueller said the perceived threat is if a small hospital affiliates with a larger system then it will take the business from the local hospital and there will be a loss of service availability. The value proposition is if locally a high quality service can be delivered at a modest cost that results in a high level of satisfaction then it should be something of value locally and with affiliated systems. The Critical Access Hospital may be able to do a better job than a remote tertiary center in rehabilitation once a surgical procedure is done. If it can be done in the local hospital and is cost effective with patient satisfaction, allowing the patient to remain close to their support network, it needs to be done locally. If outpatient surgery is being done in a facility but a tertiary center forty miles away can do it more cost effectively, it needs to be considered. It is difficult when there are payment systems to consider and local pressures of keeping a hospital a full service hospital. It is not an easy conversation but it is encouraging to hear people discussing the issue.

John Cullen said he was curious about the difference between retail verses wholesale business models. He said that it is difficult to talk about business models in medicine because the standards are much higher than a professional standard. He asked what the difference is between the wholesale and retail business model.

Keith Mueller said that the move toward retail means that as payment models move towards value based purchasing or some notion of shared risk or moving the risk from the insurer to the provider, what becomes important to the system providers is having people sign up for care in the system and stay with that provider. Attracting and retaining patients and small businesses will be important and not just focusing on big contracts and

insurers.

David Hartley commented about affiliated verses network verses independent hospitals. He has a doctorate student that just finished her dissertation. The Critical Access Hospitals that are part of health systems performed better financially. She also looked at which hospitals were picked up by the relationships and they were ones closer to metropolitan areas. Everything is driving things in the direction of leaving the remote areas out of the equation. It seems there needs to be a whole new way of thinking of a subset of about 300-400 Critical Access Hospitals.

Keith Mueller replied that often when he is speaking to rural hospital administrators he says you can form an accountable care organization, join an accountable care organization or sit this one out. The most remote hospitals may be able to sit this one out because they are not in an attractive market. Someone is going to have to provide a level of benefit to the most remote places. Patient revenue alone will not sustain it. At a state level there will be need for public resources and at a federal level there will need to be a payment system to drive payment to low volume remote hospitals but there are targeting issues.

Karen Perdue said the unaffiliated hospitals have dangers in remote areas affiliating with a system. If it is a for-profit organization they are at the end of the food chain. Local communities are providing tax revenue and local support to the hospitals. What tools are local communities being given to make a broader range of choices so that the inevitable is not affiliating with a large system? There are good operations that have taken on rural hospitals but there could also be some negative results. Health Resources and Services Administration (HRSA) had authority in the federally qualified health center area and that is a healthcare dollar stream that is not available locally to look at integration.

Keith Mueller said that some of the very remote places need a different model and it will not be one that has enough health care dollars to aggregate locally so there will need to be other approaches.

HOSPITAL PANEL

Brock Slabach, M.P.H, F.A.C.H.E
National Rural Health Association

Brock Slabach thanked the Committee and welcomed them to Kansas City. He stated that the National Rural Health Association is non-profit and non-partisan. They are a membership organization representing 62 million people in rural America.

Mr. Slabach said that the end of this year will be momentous on how policy affects rural providers. The moratorium on the input application of the sustainable growth rate is going to expire and that could result in a 30 percent decrease in fee-for-service payments to physicians. At the end of the year the sequester will take affect that was a result of the

Budget Control Act of 2011 and it will affect all Medicare revenues to providers in rural communities by a 2 percent reduction. Congress will have to deal with the Bush era tax cuts that will end December 31st and the payroll tax cuts. Congress will have multiple priorities and the debt ceiling has to be raised by the end of the year as well. There will be funding issues of all rural health programs to deal with in the midst of these changes.

Mr. Slabach said they are entering into a period where the Congressional Budget Office indicated several options for deficit reduction. The Republican proposal for rural cuts totaled about 14 billion dollars and the House Ways & Means Committee copied the Congressional Budget Office's recommendations. The President stated in his budget narrative that we need to better align Medicare payments to rural providers with the cost of care and eliminate higher than necessary reimbursements. The perception seems to be that the care for rural Americans is expensive and costs too much and something needs to be done about it.

The President's budget also included issues like the mileage restrictions and reductions in payments and zeroing out certain targeted grant programs. The President did include in his 2013 budget to reduce cost-based reimbursement from 101% to 100% and to eliminate Critical Access Hospital status if it is located within 10 miles of another hospital.

Medicare Payment Advisory Committee (MedPac) released its rural report on June 15, 2012. The report concluded that access in rural America is not a problem and it noted that Medicare reimbursement for rural hospitals is adequate.

Mr. Slabach said that Hold Harmless Provision for outpatient services is set to expire and it is an important program for prospective payment system hospitals. Without this program there will be significant stresses on hospital margins. There is a list of Medicare extenders that the National Rural Health Association is working to restore that are set to expire. The Medicare Dependent Hospital Program needs to be reauthorized and the low-volume hospital adjustment needs to be restored. The Medicare Dependent Hospital and low-volume hospital adjustments are important programs and if they expire it would jeopardize small to medium size rural prospective payment system (PPS) hospitals.

Mr. Slabach stated that it is a time of concern for rural hospitals. From 1980 to 1991 there were at least 360 rural hospitals that closed. The prospective payment system (PPS) led to the decline in the numbers of rural hospitals.

Rural hospital quality measures show that rural hospital performance on CMS Process of Care Measures is on par with urban hospitals. Rural hospital performance on CMS Outcomes measures is better than urban hospitals. Rural hospital performance on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) inpatient patient experience survey measures is better than urban hospitals and rural hospital performance on price and cost efficiency measures is better than urban hospitals.

Don Sipes, M.A., F.A.C.H.E.
Vice President, Regional Services, Saint Luke's Health System

Don Sipes started by sharing that he has been with Saint Luke's health system for 17 years. They are comprised of 11 hospitals that include: Saint Luke's Hospital on the plaza, 5 suburban prospective payment system hospitals, 1 cancer hospital, a child adolescent behavioral health hospital and 3 Critical Access Hospitals.

Saint Luke's does not own the facilities but lease them. They have a couple of flagship programs that are nationally renowned. One is a center for stroke reversal and a renowned brain tumor center. They host physician and nurse training and are internationally renowned for research programs. They circle the metro area with the community hospitals and 90 miles out are the regional hospitals.

Each of the designations had a special purpose and was tied to the number of hospitals that closed in the late 80's and mid 90's. Rural hospitals are vital in their communities and are a source of emergency care. There are examples of people who would be debilitated with strokes or would not have survived a heart attack if they had not been treated in one of the small, rural hospital emergency departments. They are also a source of primary care and primary care providers. It is difficult to recruit professionals in rural communities without having an anchor. The rural hospitals are an economic engine in rural communities. The populations are older in rural areas and it is difficult for them to travel to metro areas for health care services.

The need to integrate the different care providers in communities is important and Saint Luke's is an active partner in those activities in the communities. Critical Access Hospital (CAH) status is vitally important and no hospital is making money on Medicare or Medicaid. Saint Luke's Health System is in the process of working to take millions of dollars of costs out of their system and is trying to adapt to lower reimbursement. The hospitals have high fixed cost with lower volumes of patients to sustain the costs. Very few physicians coming out of training want to work in private practice in rural areas and they want professional situations where they can rely on their colleagues.

Saint Luke's Health System is on target for meaningful use in all of their facilities including the rural facilities but it is an expensive process. There is reimbursement if you complete steps in the time frame but penalties if you do not. There are occupational therapist, physical therapist and pharmacists on staff and they are in high demand and costly but necessary. It is important the facilities adapt as the care models change in rural communities.

Mr. Sipes talked about replacement of aged facilities. Anderson County hospital in Garnett, Kansas has a physical structure that is 60 years old. It has been well maintained but it has mechanical systems that could fail at any time. There is Wright Memorial Hospital in Trenton, Missouri and it is 56 years old and was just replaced last year with a new Critical Access Hospital facility. Hedrick Medical Center in Chillicothe, Missouri has a section that is 80 years old. The Trenton facility was built and opened last year. At

Hedrick Medical Center they are ready to announce ground breaking for a new facility and in Anderson County they are working with the county commissioner on the details of the replacement hospital. Critical Access Hospital status is vital and without it there is no way to partner with the owners of facilities to have them replaced.

Mr. Sipes said that the majority of their doctors are employed which allows affective partnerships with the owners because they are related parties through Medicare payment regulations. They are in true partnership with the entities that are the closest to the grassroots organizations in the community. It supports their systems investments and information and clinical technologies and that is important because it supports integration. Saint Luke's Health System has developed telemedicine services and is a leader in the community and region in regards to telemedicine and e-health.

Mr. Sipes shared concerns about the future. He said that pay-for-performance is going to get intensified and realignment of care delivery has to happen at an accelerated pace. Technology advances will be critical and there is a higher need for care and unavailability of professional staff. Universally there is a shortage of providers and there are reductions in reimbursement. Hospitals have to stay modern and the community expects it. Patients are better served if they can remain closer to home. There is higher patient satisfaction and lower costs for treating people in facilities in their communities.

Mr. Sipes recommendation to the Committee that the existing special payment designations should be preserved for rural providers but those who receive the payments have to operate consistent within the defined purposes of the payments. He recommended financially supporting providers to develop local and regional evidence-based integrative models that improve effectiveness and efficiency of care delivery.

Q&A

Wayne Myers said that the hospitals that would close if some of the Critical Access Hospitals lose support are the ones that are most needed. The Critical Access Hospitals in the prosperous suburbs are doing fine. He stated that there needs to be perspective thinking before facilities are closing that are needed the most.

Tom Hoyer said that a more thoughtful process may be required to decide which Critical Access Hospitals close. A categorical decision may cause the wrong facilities to be closed.

John Rockwood said that the types of reimbursement designations that are in place were enacted for specific reasons that may be difficult to understand now. Instead of finding how to cut designations, it would be beneficial to look at a model like Saint Luke's and create an incentive to create more similar systems around the country. This type of model provides collaboration and financial options. A visionary approach about ideal systems of the future is needed and recommend future reimbursement approaches around the ideal system that could include two or three models that would work around the country.

Brock Slabach said that he was a hospital administrator in 1997 when Critical Access Hospitals were created. In 2003 the hospital was converted to a Critical Access Hospital. There is a provision in the Critical Access Hospital regulation that requires network relationships so that regulation could be made more stringent than what exists today.

John Rockwood replied that the individual payments from hospitals could be centralized in a place like Saint Luke's Health System. There has to be individual corporations and individual cost reports filed. There could be a single payment to the system that would provide savings to the entire system.

FRONTIER DEMONSTRATION PROJECTS

Michelle Goodman, M.A.A.
Policy Coordinator, Office of Rural Health Policy, U.S. D.H.H.S.

Michelle Goodman stated that her presentation is to inform the Committee on two current frontier demonstrations by the Office and Rural Policy and Centers and Medicare and Medicaid Services. Ms. Goodman asked the Committee to consider the lessons learned from these demonstrations to apply to the Committee discussion on the future of the rural health care delivery system.

Ms. Goodman said policy development in rural health care in the past 25 years has mainly focused on Medicare reimbursement. An attempt to address challenges faced by low-volume providers has focused on specific Medicare designations such as sole community hospitals, rural referral centers, Medicare-Dependent Hospitals and critical access system.

Ms. Goodman said that Medicare's move to Inpatient Prospective Payment System (IPPS) in the mid 1980's added financial problems for small rural hospitals and many closed. In the late 80's and mid 90's Medicare began considering different models of acute care delivery for rural communities. In 1987, the Centers for Medicare and Medicaid Services funded the Medical Assistance Facility (MAF) in Montana. In 1989, the seven-State Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) demonstration was authorized. That demonstration led to the development of the Critical Access Hospital.

The Frontier Extended Stay Clinic (FESC) was authorized by the Medicare Modernization Act (MMA) and the demonstration is for clinics in very remote frontier communities. It was designed to address the needs of critically ill or injured patients who are unable to be transferred to an acute care referral center. It is also for patients that need monitoring and observation.

The demonstration is testing the feasibility of the Frontier Extended Stay Clinic as a new provider type in remote areas. Ms. Goodman asked the Committee to think of the model as a rural health clinic or a federally qualified health clinic or a health clinic plus

emergency services. It is a clinic that has a place for an ambulance system to transport a patient to the facility to be monitored.

The demonstration was authorized in 2003 and Health Resources and Services Administration (HRSA) began providing funding for selected clinics based on demonstration eligibility criteria. The money from the Office of Rural Health Policy was used to support facility life safety improvements, equipment and enhanced staffing to prepare the clinics to become participants in the demonstration. The Office of Rural Health Policy and Centers for Medicare and Medicaid Services are evaluating the project for cost, appropriateness, quality of care, sustainability and community impact.

There are five Frontier Extended Stay Clinics in the demonstration. Four are in Alaska and one in Washington. The demonstration has shown that very few clinics in the lower 48 states would meet the current location requirements specified in the statute and it would take significant upfront costs that the clinics would have to incur before being able to meet the conditions of participation.

The Frontier Extended Stay Clinic payments may not be adequate to cover the costs as the 4-hour bundled service payment does not take in consideration the other ancillary costs required to care for the patient.

The demonstration does save money, even with the lower number of services provided and the small Alaska Medicare population. One estimate shows that the project save about 14 million over 5 years through avoided medevac's.

Ms. Goodman spoke about the Frontier Community Health Integration Demonstration (FCHIP). It is a demonstration that was authorized by the Medicare Improvements for Patients and Providers Act of 2008. The Office of Rural Health Policy and The Centers of Medicare and Medicaid Services are collaborating on the demonstration.

The purpose of the demonstration is to develop and test new models of health care delivery in frontier areas. Another purpose is to increase access to, and improve adequacy of payments for, essential health care services. The demonstration will also evaluate regulatory challenges facing frontier providers and communities. Different from the Frontier Extended Stay Clinic Demonstration (FESC), the language for the Frontier Community Health Integration Demonstration (FCHIP) does not provide for the actual structure of what model should be tested.

The Office of Rural Health Policy funded an 18-month cooperative agreement to Montana Health Research and Education Foundation. In 2011 the Office of Rural Health Policy awarded a Frontier Community Coordination Grant to Montana to support a network that focuses on clinical service coordination by a care coordinator working with community health workers to improve quality, reduce avoidable hospitalizations, and facilitate independent living for Medicare beneficiaries.

The model proposed by the Montana grantee is a local, integrated care organization

serving as a medical home. The purpose is to improve quality and care transitions with a shared savings component with networks of 10 or fewer local systems. It takes the network approach to care transitions using community health workers.

Ms. Goodman shared that even though the demonstration has not started, a lesson that the Office of Rural Health Policy has learned is the need for long-term care services in the demonstration communities. Another lesson learned is that some care could be provided in patient's homes by expanding the rural health center visiting nurse services.

Although the two demonstrations focus on frontier communities, they do touch on a broad range of concerns that have been voiced by providers across the country. They give a perspective on how to look at the future of the rural health care.

Kim Moore, J.D.
President, United Methodist Health Ministry Fund

Kim Moore said that he appreciated having the opportunity to attend the meeting and learn more about rural health systems through a broader perspective. His foundation is a hospital conversion foundation that was formed about 25 years ago. He noted that the board has been interested in the rural health system particularly in frontier Kansas. Rural health care in Kansas is primarily a rural health center or Critical Access Hospital delivery system.

United Methodist Health Ministry became interested in the rural health system because the system is fragile. A focus of his organization is to develop the safety net in Kansas, to help start federally qualified health centers and expand dental care access. They have just now succeeded in getting those programs in rural Kansas. The application process for federally qualified health centers have population and demographic requirements for receiving funds that makes it difficult for frontier or rural communities unless two or three counties apply together.

How does the rural health system enter the age of integrated, coordinated, patient-centered health care is an important discussion. United Methodist Health Ministry formed a group of about 25 people including hospital administrators, state government representatives and academic representatives and created a vision statement as a way to prepare for future changes. The hospital administrator said that the way the Medicare reimbursement system works penalizes health care entities for doing wellness or prevention or being the base operations for activities. One administrator said that they could not be involved in building a wellness center in their community because it would have cost too much on the Medicare reimbursement. Mr. Moore said he would like to see hospitals held harmless for doing the right thing.

Mr. Moore spoke about how to get federally qualified health centers into rural communities. A problem in Kansas is when you try to regionalize there are competitive issues in local communities. The issue is that the competition comes from being side by

side so what about having a non-contiguous federally qualified health center.

A final recommendation is to have one community health organization that would organize and affiliate all providers in the area to provide coordinated care. It could reach out and do regional work with other groups. There are four sites in Kansas that are interested in this type of approach.

Mr. Moore shared that his experience is that community readiness for change is highly variable. A policy decision may be imposed on a community but communities have to be ready for change. Community readiness is not always there. The level of provider capacity is usually a key factor whether an area is ready for change. Mr. Moore said that he is not clear whether the new system should be centered on the hospital. The positive is that the hospitals are already available in communities and have the capabilities that other operations do not have available. Having a local hospital is also about the local economy and economic development and jobs, not just health care. A system has to be virtually neutral in terms of what it means for the employment in the community and that is restrictive in determining models.

Mr. Moore said that the voice of rural interest needs to be raised inside of philanthropic organizations. Members of the rural communities need to talk to these organizations so they can hear about rural issues and understand them.

Q&A

David Hartley asked what needs to be done to have multiple communities come together and collaborate.

Kim Moore said that the federally qualified health center model had incentives built in to become part of it. The assurance that there will be equal community governance involved also helps. It is a plus for communities and they will not lose anything or have a competitor that takes volume from their system.

Barbara Morrison said that the area agency on aging has been coordinating home and community based services that keep people in their own homes. There needs to be collaboration with the Critical Access Hospitals and integrating that and moving forward.

Karen Perdue said that she was involved with the Frontier Extended Stay Clinics (FESC) project and it takes a long time to do a demonstration. One recommendation could be to speed up the process. Could there be an Office of Rural Health Policy (ORHP) application to the Center for Medicare and Medicaid Innovation (CMMI) to expand some of the demonstration programs and move them to more sites.

John Rockwood said that if they are commenting on how to find dollars in the rural payment models that exist and if the Committee responds to that, he feels they are making a mistake. This is an opportunity to think of different types of models. There needs to be a more creative solution and focusing on existing payment mechanisms and

critiquing them is not a good idea.

Tom Morris said that they want to do what the Committee members would like to do. The way the meeting was structured was to give the Committee a chance to weigh in on the short-term policy issue that is related to all the designations but to also have a broader discussion. This is the chance to have the broader discussion and there is an opportunity to offer different factors to be considered and give a more creative approach on the larger discussion on the way rural health care will be delivered in the future.

Larry Gamm said that he would like to think about a strategy to have basis for appeal in any change of the programs. One would be that any hospital within 10-15 miles would have to use claims data to show that it would cause hardship if they were to lose Critical Access Hospital status. There are remote facilities that have an important role but it is difficult to come up with a solution backed up with data. For those, it may be better to give the state responsibility. There needs to be a different model for those settings maybe involving the state, county and private employers and similar types of contributors.

Tom Hoyer said that if the Committee comes up with something innovative that it will make many people unhappy. Small communities want a hospital with beds and where local people are employed.

CHILD CARE PANEL

Amanda B. Bryans
Education and Comprehensive Services Division Director, Office of Head Start
Washington, D.C.

Amanda Bryans said she is grateful to have to opportunity to talk to the Committee about national issues related to serving young children in rural areas of America. Head Start serves hundreds of thousands of low income children and families in rural areas. Head Start is a program for pregnant women and children from birth to age 5 who meet the federal poverty guidelines. Almost every county in the United States has at least one Head Start grantee and there are over 1,600 nationwide. Approximately 1 million children are enrolled in the country. 26 grantees provide services to children of migrant and seasonal farmer workers. 156 grantees provide programs for American Indian and Alaska Native children.

Head Start programs provide comprehensive services with the primary role to provide school readiness. In order for children to learn, they need to be healthy enough and have their needs for food and shelter met. The program provides education, health, mental health, parent involvement, social service and nutrition services. There is a large emphasis on forming partnerships with parents since they are the most influential teacher of their children.

Head Start grantees also provide services for children with disabilities and many

programs also provide transportation services. There are large programs in urban areas but they are well acquainted with the complexity of meeting the needs in rural areas. It is difficult and sometimes impossible to locate pediatric dentists and mental health providers or even pediatricians, especially ones that will accept Medicaid or other forms of insurance for children and families. Grantees go to extraordinary lengths to find sponsors who will outfit mobile vans as clinics to help meet the needs of children. The programs in rural areas often transport children long distances which is expensive. They not only transport them to Head Start centers but also to get services. They may transport the child and parents several hours to get to a dentist or provider.

Head Start programs that are center based must provide a care and education licensed site and they can be difficult to find in rural areas. It is difficult to hire qualified staff in rural areas. Due to high unemployment and low availability of services the effects of extreme poverty can be severe in rural areas and children in rural areas are more likely to be poor and in deep poverty than their urban peers. Many programs have found innovative ways to meet challenges but there is a continued struggle to do that.

The Office of Head Start and the Office of Child Care are working hard to find ways for local agencies to partner to increase the access and quality of services for children. Head Start's requirements and funding allow the delivery of comprehensive services and support for people to provide those services. Head Start families are assigned to a family worker who helps them access social and other services. Programs also have a health manager and health assistants who help conduct screenings, track children's' health care needs and the provisions of services to meet those needs.

There are many children eligible for Head Start who do not get it. Many children in Head Start who need care are not getting it solely from Head Start. Children in Head Start may only get care half of the day and use other services as well. Head Start programs in many areas have formed partnerships with local childcare agencies. This allows them to offer better access and more responsive services for full day and full year services.

Ms. Bryans said that there are many things that are working well in Head Start but there are many challenges. Some challenges are regulatory or have to do with facilities and others are cultural or things that are perceived as too complicated. Many states have employment requirements around eligibility for Child Care Development Fund (CCDF) vouchers. If Head Start and Child Care partner to offer full year and full day services and a family loses the child care because they lose a job, it is a problem. Children should not be dropped from child care because a family involuntarily loses a job.

Head Start has regulations and it can be a problem if they partner with an organization that is not aware of the regulations or does not have all of the resources it needs to be in full compliance. That can be managed but it creates tension.

Some of the perceived problems are the issue of funding and how to allocate funds. The belief is that when Head Start and Child Care partner that it should be seamless but how to allocate costs appropriately has to be considered.

Q&A

Barbara Fabre said that there are challenges between Head Start and Child Care. One of the issues is Head Start serves about 1/3rd of the children, 1/3rd are served by informal or formal child care and another 1/3rd are not served at all. 2/3rd of the children are not receiving services such as intervention services or health screening. There needs to be a happy medium between the Head Start Program and the Child Care Program.

Amanda Bryans said when she was a Head Start director she formed partnerships with two child care agencies and for the first year the staff argued but after 12 months everyone worked together and felt like the same family and the separation disappeared. There had to be creative things done but it was clear that every child regardless of their primary source of funding had to get Head Start services and it was challenging. The Head Start grant could not pay for 200 children from child care to get hearing screenings but it was possible to have the Head Start health provider trained to do hearing screenings and they can administer them to the kids in child care. Getting community providers to provide services to children in child care is another option. All the children belong to the community so all of the children need to be considered and their needs met in the most efficient and effective way.

Roland Gardner said that in Beaufort, South Carolina they have affiliated the Head Start Program with three of the Title 1 schools and it has worked well. He asked if they have seen more readiness with the children who are in the Head Start Programs that are in the schools verses the kids not affiliated with the public schools. He also shared that in Beaufort, South Carolina they have a contract with the Head Start Program and migrant health program for Head Start in the county. It has worked out well for the migrant seasonal farm workers. Mr. Gardner asked if there has been a push to affiliate the Head Start Program with some of the Title I schools in certain places.

Amanda Bryans said there is a push to align Head Start with the local education agencies which means their K-3rd grades. All Head Start Programs have to meet school readiness goals and they do that in conjunction with their local education agencies.

Betty Lammle
Region VII Child Care Program Manager
Administration for Children and Families
Kansas City, Missouri

Betty Lammle shared with the Committee that she is the Child Care Program Manager for Region VII. The regional offices carry out the priorities, programs and policies. Their functions throughout all of the regions are the same, however, the way the functions are carried out region to region are based on staffing in the region and the needs of the programs within the regions. Ms. Lammle said that the information she would share would be about Region VII.

Ms. Lammle stated she would share information about the early childhood population in Missouri and Kansas and the families with young children that they serve. In Missouri, 39 percent of the children under the age 6 are considered low income and 59 percent face multiple risk factors. In Kansas, 46 percent are considered low income and 58 percent face multiple risk factors. There are 86,364 children receiving child care subsidy in Missouri and there are 36,277 receiving subsidy in Kansas.

The regional program unit for the Office of Child Care provides program and technical administration of the child care funding to the states, tribes and territories in collaboration with the child care central office. The grantees are lead agencies in the state or tribe who use the block grant to develop child care subsidy systems, quality improvement systems and support regulatory systems for the comprehensive child care industry in their jurisdiction. The lead agencies have flexibility to design their systems to support all types of providers and they use a variety of early childhood stakeholders such as state, county, city, tribal governments and public and private organizations to carry out their program delivery. Region VII Child Care Program provides technical assistance to entities to resolve identified problems and to insure required rules, regulations and policies are adopted within the Child Care Development Fund (CCDF) requirements. Ms. Lammle stated that they inform these entities of promising practices to develop and implement outcome based goals that support the mission of the Office of Child Care which is to increase affordable, accessible, high quality programs for low income families.

The Office of Head Start's regional program unit provides program and technical administration for the discretionary programs that are related to the Office of Head Start. The regional staff guides the day to day management of Head Start Programs in the region providing technical assistance and information to the programs. The staff insures that appropriate procedures are adopted and monitor the programs to insure they are efficient and conforming to federal laws, regulations, policies and procedures governing them.

There are many functions that appear to be the same between Head Start and Child Care. The differences that come into play between the staffs are the differences between Child Care Development Fund (CCDF) and Head Start. Child Care Development Fund (CCDF) supports and funds statewide systems development and Head Start supports and funds local service delivery to families through their grantees. The recipients of the activities they do are very different but there is a recognized value of working together to better serve the families. The different functions are done cooperatively and collaboratively.

A Head Start representative may be working with a local grantee in a rural area about transportation issues or to help families find medical homes. The Child Care Development Fund (CCDF) administrator may be providing information, promising practices and research about online education opportunities for rural providers. They may also support subsidy administration policies that would align eligibility for the subsidy program along with the Head Start eligibility. The processes are similar but different because one is systems and one is service delivery on the local level.

Stakeholder meetings include Head Start grantees and Child Care providers who discuss one another's programs and common needs and issues to provide an atmosphere of collaboration. There is an early childhood collaborative team that includes leadership from the Office of Child Care, Office of Head Start, Office of Regional Administration for Administration for Children and Families (ACF), child welfare, the home visiting program and the maternal child health staff. The meeting is held monthly to consider ways to collaborate and reduce duplications of efforts. Ms. Lammle stated that they continue to look at ways to develop systems that are accessible for all programs.

Barbara Fabre asked why the tribal Head Start programs do not have representation in the regional office.

Betty Lammle said it was a decision by the Office of Head Start to make Region XI staffed out of the central office. Ms. Lammle said it should be reconsidered because it is necessary to work closely together and it is not easy with the tribal programs. There are approximately 250 tribal grantees and many have Head Start programs and it is hard to coordinate when the regions are not working closely together, but it is still possible.

Barbara Fabre said it would help with collaboration if the state and tribal programs were working regionally together and it would make more sense. Everyone needs to support one another.

Leadell Ediger
Executive Director
ChildCare Aware Kansas

Leadell Ediger shared that in Kansas there are 6 counties that are urban, 10 counties that are semi-urban, 21 counties that are densely settled rural, 32 counties that are rural and 36 counties that are frontier.

Kansas is 82,000 square miles with 105 counties but the concentration of population is in 16 counties. The 16 counties are located in the eastern half of the state. Two thirds of the population is located in one third of the state. 85 percent of people live in rural areas in Kansas.

57 percent of children live in urban areas, 16 percent of children live in semi-urban areas, 17 percent of children live in densely-settled rural, rural is 7 percent and frontier is 3 percent.

The number of child care facilities in the six urban counties is 548 facilities per county. In the semi- urban there are 109 facilities per county, in the densely-settled rural is 58 facilities per county, in the rural counties there are 23 per county and in frontier there are 9 facilities per county. In 27 counties in Kansas there are fewer than 10 child care providers. In 1 county in Kansas there is one provider.

There is a stark difference between rural and urban counties in economic indicators. Child poverty is the highest in the rural communities and is growing fastest in those counties. Free and reduced lunch is higher in densely-settled rural, rural and frontier areas of Kansas than any other areas. The number of children under 18 years of age living below 100 percent of the poverty is highest in the densely-settled rural, rural and frontier areas of Kansas.

Ms. Ediger said that child care resource and referral is available in every state but is not fully developed in each state. The child care development block grant is the funding source and it is written into the regulations that child care resource and referral can be funded. Activities that can be included in the state plan are: recruitment and technical assistance for infants, toddlers and child care providers, Kansas Early Head Start, resource and referral consumer information and education, Kansas Enrichment Network and licensing and regulations.

Child care resource and referral assists families in finding child care. Fifty percent of the calls they receive are families that need subsidies. They work every day to increase the quality of child care providers and there is a quality rating and improvements system in Kansas. Scholarships are awarded to assist child care providers in getting associate's degrees or bachelor's degrees. They do a tremendous amount of work to increase the quality of care. There is a large amount of the infant, toddler set aside from the Child Care Development Fund (CCDF) that they use for recruitment.

The challenges that the child care resource and referral agency recognize as child care provider issues in rural communities include: affordability, accessibility, availability and quality. In rural areas formal daycare is often too expensive for families and childcare is not a profitable business in rural communities. There are fewer clients and the cost of travel to get supplies is expensive for child care providers. Parents lack choices around child care in rural areas due to the lack of child care centers in some rural areas and very few child care providers. A family may work in another county than where they can find child care and that can be difficult. Recruiting and retaining providers that will accept subsidies is a challenge. Parents with several children have difficulty finding child care in the same setting. There is a need for part-time, weekend, evening and overnight care in rural areas. There is little quality, legal school age care in rural areas. Services for special needs are very difficult to arrange.

There is a lack of awareness by parents and communities about what quality care should look like and with a limited number of childcare providers available a parent has to over-look quality for convenience. Providers in rural communities lack capital resources and education to start and maintain quality early childhood businesses. Most providers in rural areas cannot afford the process of getting accredited.

Access to professional development for child care providers is minimal in rural areas. Some providers cannot afford to purchase professional development. Many child care providers do not have access to computers or internet access so it is difficult for child

care providers to take part in online course work. There are only a few community colleges in Kansas that offer early childhood programs. In Kansas, they have gone through a significant licensing change for child care. Before caring for a child, the provider has to go through training. A continuity of care is always an issue in child care.

Transportation is a huge issue in rural areas. It is not unusual to have to drive 10-15 miles to a job or child care. There are no volume stores within an hour of many communities and that is an issue. The building stock in rural areas is often dated back to the 1930's so the licensing cannot be accommodated in those buildings without significant investments in the facilities.

Mike Abel, M.A., Institute for Human Development
University of Missouri, Kansas City

Mike Abel shared with the Committee that he works with Missouri's Early Childhood Comprehensive Assistance Project at the University of Missouri. He coordinates and facilitates local infrastructure development by forming local stakeholder teams across the comprehensive perspective about early childhood systems.

Mr. Abel said that the delivery of comprehensive services is essential for local communities and requires a high level of interagency relationships of cooperation, coordination and collaboration. He works to help agencies move along that continuum. Local teams, family leadership engagement, and collaborative training and cross training and local and regional communication are working in the communities. Interviews were conducted with thirteen teams in the state and eight of the teams were in rural communities. The Head Start grantee regions were chosen as regions for interviews. There are twenty two grantees but some overlap so they came up with 18 regions.

Mr. Abel stated that one of the most remarkable things that he learned from interviews from team leaders was with the interview from Joplin. He asked how it had changed in the community in the past 3 years. He expected a negative answer due to tornado destruction but she said that it was remarkable how resilient the early childhood community was in the wake of the tragedy. The tornado devastated the town but the next morning they were getting cribs to babies and people were making sure that the children were cared for in wake of the devastation. In rural America, there is a pulling together of spirit that is not always visible in more densely populated communities.

Mr. Abel spoke about the model of Head Start and how they engage families from day one. Recently there was an early childhood summit and there were 22 family leaders who shared their stories with state leadership. It was a successful way to change the tone and discussion about policy in the State of Missouri. Hearing directly from families is a way to insure that state and local leaders are listening to what they have to say in regards to the early childhood system. There has been a framework of core competences for family leadership development and a network for local agencies and groups to match up with family leaders that have been identified and trained in local communities.

Moving from the continuum of coordination to collaboration is important. Early childhood training for providers needs to be extended across the system and the divides broken between community-based child care and Head Start training. One example is the infusion of the special quest materials that are available for children with special needs. Training has to be available for providers so they can include children with special needs into their program.

Communication between programs is important in Missouri and the systems work is helping benefit the communication level. Stakeholders throughout the communities have to believe that their voices are being heard. The work that they have done to establish communications includes creating a social networking site but there are barriers for people conducting their work online and that is an issue.

The rural community is very interested in work that is being done on creating data systems in Missouri. There is an information system that is being developed that is working towards following people from the age of birth to twenty years old. This is exciting for agency representatives because it provides a continuum of understanding of children over time.

There are a challenges include indigenous differences. He was part of a team in the boot hill of Missouri. Nearby the boot hill is Cape Girardeau, Missouri and many of the services in the boot hill are housed in that area. When discussing the boundaries of the boot hill area or what they consider their community, he asked if they considered Cape Girardeau, part of the community and they said no. When he asked where the boot hill begins they said it was the 2nd hill on I55 when driving from Cape Girardeau. It has nothing to do with county lines or a place on the map. These types of challenges in rural settings are real and there has to be respect for these indigenous boundaries.

Q&A

Ronnie Musgrove asked Leadell Ediger about the information she shared about free or reduced lunch. He noted that in Kansas the free and reduced lunch in the densely rural areas was 56 percent and in frontier was 48 percent. The statistic showed similar numbers for poverty. Are those figures unique for Kansas or can they be mirrored across the nation.

Leadell Ediger said she was surprised that densely populated rural had higher poverty rates than rural or frontier areas. She stated that the information was from Kids Count and the Committee could compare those numbers to other parts of the nation.

Barbara Fabre said that with child care resource and referral agencies she recommends that they do not only refer to child care providers but Head Start. It is sad to see the numbers for child care because in rural America the infrastructure is delicate and if child care is lost, where will kids go and how will the parents go to work.

Announcement of Subcommittees

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

Tuesday morning the Subcommittees' depart for site visits as follows:

- Hiawatha Community Hospital (Hospital Subcommittee—Group) Hiawatha, Kansas
- Carroll County memorial Hospital (Hospital Subcommittee—Group 2) Carrollton, Missouri
- ECKAN Head Start (Human Services Subcommittee—Group 3) Ottawa, Kansas

PUBLIC COMMENT

Dr. LeeAnn Barrett, Executive Director, Missouri Optometric Association, addressed the Committee with the following statement:

"Good afternoon. My name is Dr. LeeAnn Barrett and I'm the executive director for the Missouri Optometric Association. On behalf of Missouri doctors of optometry, our Kansas Optometric Association colleagues here with us today, and the more than 36,000 members of the American Optometric Association, thank you for affording me the opportunity to address this committee today on such a critically important topic.

In short, optometrists are rural health care. From the school-aged child learning to read, to the American manufacturing worker, to the senior seeking continued independence at home, healthy eyes and clear vision are central to the overall health and wellness of Americans at every life stage. And, doctors of optometry – America's family eye doctors – are there to provide this essential care at each step along the way.

Fully recognized as Medicare physicians, optometrists provide more than two-thirds of all primary eye and vision care as well as the vast majority of comprehensive eye examinations in the United States. Optometrists have historically been and continue to be providers of first-contact care for basic health services that are needed by most or all of the population.

In fact, optometrists are among the only primary care health care professionals many patients see and, as a result, optometrists continue to play a critical role in the delivery of primary and systemic preventive care and serve as a critical entry point into America's health care system - a fact noted by the Institute of Medicine's well known 1996 report "Primary Care, America's Health in a New Era."

But, while doctors of optometry stand ready to serve in more than 6,500 communities across the nation, the situation facing working men and women, children and seniors in underserved areas has grown more urgent. According to the most recent government data,

vulnerable individuals do not have access to needed eye and vision care and, as a result, America is facing a real public health emergency.

While many adults continue to lack access to needed eye and vision care, as many as 7.4 million children in our nation's health center system are now going without comprehensive primary care vision services. For instance, in the 21 federally-qualified health centers in Missouri, there are only 3 optometrists compared with 89 dentists. While we fully value the importance of children's oral health, too many children are going without the eye and vision care they need to succeed in school and later in life.

Doctors of optometry are working to fix this problem by urging Congress to approve legislation that would allow optometrists to compete for loan repayment and scholarship support through the National Health Service Corps. While we continue working with the HRSA on this important fix, we urge this committee to recognize the lack of access to primary eye and vision care services at Community Health Centers and the need for optometrists to participate in the National Health Service Corps.

As this committee's knows, individuals living in rural America have unique health needs. Patients living in rural areas are particularly vulnerable to eye diseases and eye injuries, especially those working in high-risk farming and timbering positions.

Though, when patients do not have access to a local optometrist, they seek care in other settings, often at far-greater cost. Recent research indicates that treatment by optometrists can substantially reduce costs that are currently associated with care provided in emergency departments and other health care settings. A study in one state found that nearly $120 million was spent for treatment of conditions in emergency departments that could have been treated by optometrists at less than 1/10 of the cost. These savings are not insignificant. Access to primary eye care in rural areas should be encouraged by this committee and we urge you to work with the American Optometric Association to address this important issue.

In addition to having the capacity to address the unique needs of those in rural America, optometrists can also play an important role in managing conditions that are impacting an increasing number of individuals, such as diabetes and hypertension.

According to the Centers for Disease Control, 26 million children and adults in the United States have diabetes and an estimated 68 million American adults have hypertension. Both diabetes and hypertension are detectable through a comprehensive eye exam when the patient's eyes are dilated allowing the optometrist to examine the blood vessels in the eye directly.

While these two diseases are having a significant impact on the American public, early detection of diabetes and hypertension can ultimately reduce the enormous financial burden that these diseases place on our health care system by reducing morbidity, disability and mortality.

To help bring down the costs associated with managing these conditions, optometrists and other health care providers who can help to offset higher-cost health care interventions through early detection and condition management must be fully engaged in the health care system and be accessible to patients across the country.

And finally, as a way to address access issues in rural America, many individuals are suggesting the use of increased telehealth services. For certain conditions, telehealth services can be especially helpful to patients and health care providers alike. However, telehealth services must be used appropriately.

These services are often too rudimentary to be of value and they are not linked back to individual and community health efforts that form the basis of a coordinated team approach to care and prevention.

For certain conditions, such as diagnosing and managing diabetic retinopathy, telehealth services are simply inadequate. The use of chart reviews to diagnose and manage patients is far more effective and less costly than attempting to manage this disease through telehealth services that are available. We caution the committee to carefully consider how telehealth services can help those in rural areas and for which particular conditions and services.

Once again, thank you for the opportunity to address the committee today. The American Optometric Association and the Kansas and Missouri Optometric Associations thank you for your time and would welcome the opportunity to further discuss potential areas of collaboration that would help move us toward solutions to better meet the needs of patients in rural areas."

Tuesday, June 19th, 2012

Tuesday morning the subcommittees' depart for site visits as follows:

Rural Health Infrastructure Changes
Hiawatha Community Hospital (Hospital Subcommittee—Group1) Hiawatha, Kansas
Carroll County Memorial Hospital (Hospital Subcommittee—Group 2) Carrollton, Missouri

Collaborations between Head Start and Child Care and Development Fund
ECKAN Head Start (Human Services Subcommittee—Group 3) Ottawa, Kansas

The subcommittees' returned to Kansas City and attended break-out sessions for discussions.

PUBLIC COMMENT

Dan McKinney, Administrator, Hermann Area District Hospital, shared the following concern with the Committee:

"I wanted to share a concern that we feel if put into place would save some money for the system. When tertiary facilities discharge patients back into a local skilled environment they go to medicare.gov/NHCompare to find a skilled facility. Unfortunately, this site only lists facilities that are on RUG reimbursement. If this site was expanded to include Swing Bed facilities, it would save the system money since you would swap a RUG reimbursed stay for a stay that was covered under cost reimbursement. We would greatly appreciate your assistance in making this modification to the web site. Most patients would rather stay in a hospital verses a nursing home while recovering as well as reducing the overall Medicare cost."

Wednesday, June 20th, 2012

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

REVIEW OF SUBCOMMITTEE FINDINGS

Rural Health Infrastructure Changes

Hiawatha Community Hospital (Hospital Subcommittee-Group1) Hiawatha, Kansas.
Subcommittee Members: Christy Green Whitney, Shane Roberts, Tom Hoyer, Karen Madden, Karen Perdue and John Rockwood.
Staff Members: Tom Morris and Michelle Goodman.

Carroll County Memorial Hospital (Hospital Subcommittee-Group 2) Carrollton, Missouri.
Subcommittee members: John Cullen, Larry Gamm, David Hartley, Phyllis Fritsch, Wayne Myers and Roger Wells.
Staff Members: Aaron Wingad and Nathan Nash.

The subcommittees' visits to community access hospitals in rural Kansas and Missouri were informative and assisted the Committee in upcoming decisions of recommendations.

Regarding rural health infrastructure changes, the hospital subcommittees' recognize the budget crisis and analysis of cost reduction options that will affect rural hospitals. There are concerns that while some closures could be beneficial there may be unintended consequences with mileage being the determining factor of what hospitals will be affected. The committee will be discussing short and long-term issues of the rural health infrastructure changes in order to move forward with recommendations.

Collaborations between Head Start and Child Care and Development Fund

ECKAN Head Start (Human Services Subcommittee—Group 3) Ottawa, Kansas.
Subcommittee members: Geni Cowan, Pamela deRosier, Barbara Fabre, Barbara Morrison and Roland Gardner.
Staff Members: Nicholas Lillios, Emily Schlichting, Steve Hirsch and Linda Bahrami.

Pamela deRosier spoke for the subcommittee. She shared challenges and ideas of recommendations to be considered in the future related to Head Start and the Child Care and Development Fund.

Challenges determined included in rural and frontier communities include:

- A shortage of licensed child care facilities
- Lack of pediatric dental health providers and mental health providers
- Transportation issues due to great distances to care and training
- Lack access to broadband
- Smaller numbers can place rural areas at a disadvantage for meeting Head Start requirements
- Minimal resources to meet the increased mandates that are presented

Ideas of recommendations include:

- A waiver system -exemptions for busing and health services
- Education criteria that justifies Child Care and Development Fund and Head Start collaboration to reach more children
- Update funding formula for older grantees
- Create a single, weighted set of performance standards that closely align Child Care and Development Fund and Head Start
- Same training for Head Start integrated forms and data systems
- Head Start classrooms for Child Care
- Shared benefits for children who are dually enrolled
- Encourage Head Start and Child Care and Development Fund to collaborate with Federal Qualified Health Centers
- Transportation and internet access issues need to be evaluated

UPCOMING MEETINGS

Governor Musgrove stated that the Committee will meet in Austin, Texas in September 2012. He asked the Committee members to consider hosting future meetings. Grand Junction, Colorado was discussed as an area to look at rural residency programs in primary care and Independent Practice Association Model in primary care that has made positive changes in health care as a consideration. Nebraska was mentioned as a place to look at the primary care training programs and for integration models, Northern California was discussed as a possible site visit. There is also a reservation community that could be part of that visit.

Governor Musgrove announced that there will be two meetings a year instead of three in the future due to budget changes and the Committee discussed how they should structure future meetings to best meet the needs of the Committee. Webinars, teleconferences and Skype were options discussed. The Committee decided to have site visits but also feel it is important to include a Washington meeting in the schedule, even if it is not every year.

KEY POINTS AND POSSIBLE RECOMMENDATIONS FOR UPCOMING MEETING

In Austin, there will be a continued discussion on the future of rural hospitals and long term issues regarded the rural health infrastructure changes. Another topic that the Committee wanted to discuss is training in primary care in rural areas and the importance of building the primary care workforce.

The human services Committee members would like to discuss the integration of health and human services. Human service members will have a follow-up conference call to decide on topics to focus on at the Austin meeting.

PUBLIC COMMENT

W. Bryant McNally, J.D., MPH, VP of Rural Services & Regulation, Missouri Hospital Association shared the following:

"Thank you for allowing the Missouri Hospital Association and several of its members to participate in the Health Care Infrastructure's panel discussions during the recent National Advisory Committee on Rural Health and Human Services meeting in Kansas City. I appreciate the time and insights of the committee members.
As discussed, we recognize that the health care delivery system is changing, and Missouri hospitals are eager to adapt. However, dramatic changes to the programs designed to ensure access in rural America would make it very difficult for small rural providers to meet the demands of their communities. The current standards, although potentially arbitrary, are fully known.

The goal for many of the rural provisions and designations is to provide and continue access to medical care for Medicare beneficiaries. The challenges that created the programs are still present and require the committee to adhere to several principles as they evaluate and modify the various rural supports, such as the following.

- Transparency — Changes to the programs must be open and transparent. This transparency allows governing bodies to be fully aware of the changes ahead without having to address unknown or undisclosed variables.
- Stability — As designed, the programs must be stable to provide an opportunity for governing bodies to accurately plan for the future needs of their communities.

- Predictable — The programs must be predictable and provide hospitals with the opportunity to model the changes so they can effectively adapt to the new environment.

Flexible — The programs must realize a “one-size-fits-all approach” will not work because states have varying degrees of ability to respond to changes due to differing state scope of practice laws.

Finally, hospitals are more than a care delivery site in rural America. Because hospitals also serve as economic engines for rural communities and provide jobs, they help to eliminate and reduce rural poverty and reliance on other assistance programs.”