Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Grand Junction, Colorado
April 3rd – April 5th, 2013

Meeting Summary

The 73rd meeting of the National Advisory Committee on Rural Health and Human Services was held on April 3rd – April 5th, 2013 in Grand Junction, Colorado.

Wednesday, April 3, 2013

The meeting was convened by Governor Musgrove, Chairman of the Committee. He thanked Christy Whitney for hosting the meeting. Governor Musgrove stated that the primary focus of the meeting is the examination of two issues: Rural Poverty and Human Services Programs and Rural Hospice and End-of-Life Care.

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

Present from the Office of Rural Health Policy: Tom Morris, Director; Steve Hirsch, Executive Secretary and Michelle Goodman, Policy Coordinator. Truman Fellows present: Nathan Nash and Emily Schlichting.

COLORADO ORIENTATION

Tom Massey
Deputy Director
Colorado Department of Health Care Policy and Financing
Denver, CO

Tom Massey welcomed the Committee to the State of Colorado. He lives in a rural community in central Colorado with a population of 500 and is keenly aware of rural issues. He thanked the Committee for the work they do for their communities and constituencies and noted that it is needed and greatly appreciated.

Mr. Massey said that the mission of the Colorado Department of Health Care Policy and Financing is improving health care access and outcomes for the people served while demonstrating sound stewardship of financial resources. They are one of 25 states that are going to expand Medicaid coverage to about 160,000 new clients. It is an exciting time

and they will be collaborating with the governor's office. This will be beneficial for the rural community. The department serves 693,865 Medicaid clients. 60% of Medicaid clients are children 20 years or under. 30% of births in Colorado are paid by Medicaid.

Mr. Massey shared information about the department operations. The total funding is $5.6 billion. There are 313 fulltime employees and approximately 771,000 clients. The average per capita spending per client is $4,700. Administrative costs are approximately 3%.

There are more than 750,000 people living in rural Colorado. 15% of the population lives in rural areas and 82% of the land area in Colorado is rural. The large cities are the population bases in Colorado. The definition of rural is a city with 50,000 of less. There are 52 rural counties in Colorado. Rural Coloradans are more likely to be uninsured than urban Coloradans. It is more difficult to find access to services in rural Colorado than in urban areas. Many rural citizens have to travel great distances to receive health care services. Dental care is also a problem in rural counties because of a lack of providers.

Colorado services are state administered but county run. The Department partners with the Department of Human Services, and Department of Public Health and Environment in administering the programs. The Department of Public Health and Environment handles the immunizations and other public initiatives.

Medicaid's Accountable Care Collaborative is the foundation of health care reform for the State of Colorado. The goal is to improve clients' health and contain health care costs. The model was created two years before the Affordable Care Act was implemented. The state has been divided into 7 regions. There are Regional Care Collaborative Organizations in areas based on geography, population, health status in the populations and current health systems in place. The ACC is a system that holds providers accountable for health outcomes and manages integrative care.

The first year results of the Accountable Care Collaborative include reducing Medicaid health costs by $20 million and as a result $3 million was returned to state and federal tax payers. There were 3 key performance indicators identified and they are hospital readmissions, emergency room utilization and high-cost imaging.

Long-term service delivery is a huge cost to the State of Colorado. It is $1.8 billion for approximately 110,000 clients. It represents 58% of physical health and 16% of the caseload. There are efforts to improve the long-term supports and delivery including: program operations and management, data analysis, benefit management and partnership with clients, providers and stakeholders.

The Colorado Department of Health Care Policy and Financing has been working to improve value of Medicaid and cut costs. This is being achieved by enhancing value-based services, increasing effectiveness of care delivery, reforming payment systems to reward value instead of volume, leveraging health information technology and redesigning administrative infrastructure and reducing fraud, waste and abuse.

Q&A

Roger Wells asked what the state is doing about the loss providers. How do they overcome the administrative costs that were shifted to providers?

Tom Massey said there is a benefits collaborative and the state is working through the legislative process to fund Medicaid for all providers with a 1 ½% increase. The dental providers will get 4 ½ % on top of the 1 ½ % to assist. The model is changing from a hospital-based delivery system. There are more physician's assistants and nurse practitioners in rural areas. The model is changing and it is going to provide a better value delivery system. The state is going to work towards a prevention and wellness benefit for people who take responsibility for their own health outcomes. There will be incentives to reward healthy lifestyles.

John Cullen asked if the Accountable Care Organization is giving information to the providers. ACO's are to provide the providers with additional money based on the efficiency of care. Is that occurring within the ACO?

Tom Massey said they are working towards incentives based on value outcome. They are collecting data on a regular basis and looking at outcomes. The state is moving towards pay-for-performance instead of fee-for-service.

INTRODUCTION TO RURAL HOSPICE AND PALLIATIVE CARE

Carol Blackford, M.P.P.
Deputy Director
Chronic Care Policy Group, Center for Medicare Management
Centers for Medicare and Medicaid Services, U.S.D.H.H.S.
Baltimore, MD

Carol Blackford thanked the Committee and stated that rural issues are extremely important to the Centers for Medicare and Medicaid Services (CMS) and she appreciates the opportunity to speak about end-of-life care. Access to quality end-of-life care is a vital part of the Medicare program. This is an opportune time for a discussion specifically considering the Affordable Care Act requirements, for CMS to look at how Medicare pays for hospice care and to explore whether or not it is necessary for revisions to the payment methodology.

Ms. Blackford spoke to the Committee about the hospice program update. She stated that the mission of the hospice benefit is to approach care for terminally ill individuals that stresses palliative care with an emphasis on keeping the hospice patient at home with family and friends as long as possible. Inpatient care is available for respite or acute pain control or symptom management. Care is provided by a doctor, nurse, social worker and

pastoral or other counselor. This includes a broad range of Medicare covered services that are necessary for the palliation and management of the terminal illness. Eligibility requires entitlement to Part A, a certification of terminal illness, and an election to receive hospice. Medicare will no longer pay for curative care at this point.

Terminal illness and related conditions require an individual to be certified by a physician as having a prognosis of six months or less to live if the illness runs its normal course. The hospice assumes full responsibility for the professional management of the patient's care related to the terminal illness and related conditions. An individualized plan of care is developed and is directed at helping the patient live as comfortably as possible. Covered services must be available as needed and provided by hospice.

Hospices are paid per diem, based on four levels of care, regardless of the amount of services provided on a given day. The four levels of care include: routine home care, continuous home care, general inpatient care and inpatient respite care. The daily rate includes everything needed for the palliation and management of the illness and related condition. It is a managed care payment.

Ms. Blackford said that hospice reform is necessary due to payments not being aligned with resource use, a change of population and utilization and site of service changes. Hospice payment reform is needed due to the requirement of Section 3132 (a) of the Affordable Care Act stating that data be collected and be used to revise the methodology for determining the payment rates for routine home care and other services including hospice care. The payment system has not been revised since 1983 and at that point hospice was based on a cancer diagnosis which is no longer true today. In 2011, 68% of all hospice patients had a non-cancer diagnosis. More patients are receiving hospice in a nursing facility or skilled nursing facility.

Ms. Blackford spoke about urban and rural differences regarding hospice utilization. The diagnosis of urban and rural patients is predominately non-cancer patients. Numbers are similar for urban and rural but rural hospices tend to treat more lung and chest cancer, respiratory disease, Alzheimer's and colo-rectal cancer patients.

Ms. Blackford shared the impact of face-to-face visits regarding urban verses rural agencies. The Affordable Care Act requires a beneficiary must have a face-to-face visit with a hospice physician or nurse practitioner prior to the 180th day recertification. The visit has to occur no more than 30 calendar days prior to the certification. The requirement went into effect January 1, 2011. A very low percentage of beneficiaries left hospice because they were not able to be recertified in rural and urban areas.

More rural patients receive care at home than in urban areas. Both rural and urban beneficiaries are receiving hospice care in a nursing facility. There are fewer inpatient hospice stays in rural areas.

Ms. Blackford closed by stating that activities at CMS include strengthening the hospice benefit and analyzing available data and collaborating to identify and address program

vulnerabilities. The Medicare hospice benefit is unique and can provide individual's opportunities to receive high quality, patient focused care at the end-of-life.

Q&A

Barbara Fabre asked why there is a lower rate of ethnic and racial minorities using hospice.

Carol Blackford said there may be many factors including lack of insurance or cultural factors. She said that she could find information about outreach that has been done within the agency.

John Cullen asked if the lower number of inpatient days is because Critical Access Hospitals have a difficult time setting up hospice units because of the impact on the cost report.

Carol Blackford said that they have tried to deal with cost reporting issues and some of the barriers are statutory and some are difficulty addressing the issue without double paying for the service. The hospice inpatient payment is supposed to pay for the care and the expectation is that the hospice would contract with the inpatient facility for care. Whether or not the inpatient rate is adequate to pay the facilities cost could be a factor. It would be difficult for Medicare to pay through cost based reimbursement when they are also paying hospice.

THE STATE OF END-OF-LIFE CARE IN RURAL

Alana Knudson, Ph.D.
Principal Research Scientist and Co-Director
NORC Walsh Center for Rural Health Analysis
Bethesda, MD

Alana Knudson thanked the Committee for the opportunity to speak. She noted she will be speaking about national hospice issues and will give specific information regarding where hospice services are currently provided on a national level and specific to Colorado. She said that she hopes that questions from the Committee will give her additional direction of issues to pursue considering rural and frontier hospice.

National hospice issues include: access, reimbursement, cost of care in hospice, workforce, quality and recent regulatory changes. There are a number of issues pertaining to access. There are limited inpatient hospice options in many rural communities. Being interconnected really impacts what is being done in end-of-life care in rural communities. There are similar issues with home health agencies because there may be an expanded geographic area being served by a hospice provider. Reimbursement is a capitated amount but which may not cover the actual cost for instance with mileage coverage or driving time. There is also no specific reimbursement provided for bereavement which is

a very important component of hospice as well as no funding provided for the expenses that volunteers incur. Volunteers are important to the delivery of hospice services, but if they travel and are on a limited income it may be prohibitive for them to be able to participate as a volunteer if there is no reimbursement for their cost of travel. The length of stay and cost of care in hospices is a concern of the rural task force.

Dr. Knudson stated that when looking at the capitated payment, hospice has to negotiate with vendors. In rural areas, pharmacy services may only include small pharmacies that lack the ability negotiate lower rates because their margins are so small.

Another issue is the workforce providing care to rural and frontier America. There are a limited number of nurses and licensed clinical social workers which presents a problem for hospice providers. Many primary care providers are not certified in hospice and palliative care but they provide care anyway. Adding additional time and expense for them to get the certification may not be an option even though they have the advanced training to provide the care. Another workforce challenge is that physician assistants are not allowed to serve as primary care providers. There is discussion about that requirement and there are physician assistants providing care in rural health clinics who have been providers there for a long time. It is a challenge that they are not able to serve as a primary care provider for that person when they enter hospice.

Dr. Knudson said another issue is regarding quality and though rural and frontier hospice providers have voluntarily provided hospice quality indicators to the National Association of Hospice, this is the first year they are required to provide quality indicators to Centers of Medicare and Medicaid Services which will provide additional information to make better comparisons and help to understand how different services are delivered.

Dr. Knudson stated there have been discussions on regulatory changes and proposed regulatory changes and the physician assistant issue is at the top of the regulatory discussion list as is allowing rural health clinic providers to serve in hospice during their working hours. Many rural primary care providers are stretched thin and asking them to serve as hospice primary care providers after the hours when they are already working in rural health clinics can make it very difficult. Being able to have a bit more flexibility as to when they can serve in that role will help the availability of the providers being able to support hospice.

Dr. Knudson shared that in Colorado there are more hospices located in metro areas. However, when looking at counties, there are a fair percentage of hospices serving rural counties. In Colorado there are a higher percentage of people using hospice than nationally. The message is that rural Medicare beneficiaries are less likely to use hospice than urban or metro counterparts. Many of the rural areas have different arrangements of where hospice is located. The majority of hospice is provided in home, however in metropolitan areas there is a high proportion in nursing facilities. This is probably because there is less penetration of assisted living facilities in rural communities.

Donna Roberts, B.S.N.

Hospice Administrator
Hospice of the Plains
Sterling, CO

Donna Roberts shared with the committee that she was from a community in Colorado with a population of about 100. She began by sharing that physician's assistants are underappreciated in Colorado. They are frustrated that they are not utilized as primary care providers. They follow their patients from birth to graduation.

Ms. Roberts asked the committee to consider allowing rural health clinics to be reimbursed for hospice services. Rural health clinic practitioners can bill for hospice services when they are not working at a rural health clinic but cannot bill for hospice services as a rural health clinic practitioner because rural health clinics are not authorized to be attending physicians for hospice.

Ms. Roberts stated that they serve 70,000 people in a 10,000 square mile area with Critical Access Hospitals. Those areas are majority farming and ranching and there are many accidents that occur. She also added that suicide rates are high in that area. She talked about a physician that would travel 12 miles to visit a patient. The patient was 80 years old and the physician cared for her so much that when she passed, he was a pallbearer at her funeral. That is what it is like to be rural.

Ms. Roberts said some issues that make it difficult for rural hospice services include: a large service are, long distances to drive to see patients, a lack of 24 hours pharmacies and durable medical equipment delivery services, rulemaking lacks rural and frontier perspective, an aging workforce, accessibility of caregivers, limited educational opportunities and traveling physicians being unfamiliar with patients and hospice.

Ms. Roberts closed by saying that they provide quality care for the most vulnerable of the population and do it at a deficit from what funding they receive. The cost report in the last 3 years averaged $18 less per patient/per day for Medicare recipients from what it cost to provide services.

Q&A

Christy Whitney said that they have a doctor that covers 3 counties for palliative care consults. The area is very large and the patients are spread out. Having physicians travel to see patients in rural and frontier areas is very expensive.

Barbara Fabre asked why the reimbursement is lower for rural than urban when the windshield time is expensive.

Donna Roberts said that it is based on the wage factor of the county.

John Cullen asked if the physicians that work with hospice in Colorado are employed or private.

Donna Roberts said there are a few private physicians. Most physicians are paid by a hospital or clinic group. Some work as contractors and their bill is through Medicare Part B.

GEOGRAPHIC AND DEMOGRAPHIC TRENDS OF POVERTY

Tracey Farrigan, Ph.D.
Geographer
Economic Research Service, U.S.D.A.
Washington D.C.

Tracey Farrigan thanked the Committee for inviting her to speak. She gave an overview of the demographic and geographic trends of poverty. Poverty in rural America is a pervasive problem. One out of six rural Americans is poor. One out of every four rural county has a poverty rate of 20% or greater. Rural poverty is persistent and one out of every seven rural county has had high poverty for at least four consecutive decades.

Dr. Farrigan shared that since 1959, poverty rates have been higher in non-metro areas every year. In the Southern United States poverty is more prevalent in non-metro areas at 21%. Poverty in the southern United States is at its highest rate than in the past 20 years in rural areas. In metro areas in the southern United States, poverty has declined somewhat. The northeast United States has the lowest poverty rate.

Dr. Farrigan spoke about poverty by race. Blacks have the highest rate of poverty in non-metro areas at 35.9%. Native Americans in non-metro areas have a poverty rate of 30.3%. These two groups have the highest rate of poverty in non-metro areas of the United States. The low income of racial and ethnic minorities is reflected in these statistics.

Dr. Farrigan said that the definition of persistent poverty is a place that has a high level of poverty over many decades. There are 313 non-metro persistently poor counties in the United States from 2007 to 2011. There has been a decline in the number of persistent poverty counties. It is not that there has been significant change in poverty rates in those counties but they are counties that were on the margin and slightly dipped below.

Dr. Farrigan shared that there is a decline in elderly poverty in non-metro areas but child poverty reached a 20 year high in 2011. 25.6% of children in non-metro areas are living in poverty. Children living in absolute poverty lack food, water, shelter, medical care, education and security. Those living in relative poverty may have the minimum basic needs met but they are excluded from activities and advantages that are considered normal by their peers. In the United States, those most likely to be poor are children in rural areas, racial and ethnic minorities, single parent families, unemployed and underemployed and children with parents who have little education.

In closing, Dr. Farrigan shared that poverty continues to be prevalent in rural America.

Non-metro high poverty has become more widespread and growth in high poverty is connected to national economic trends. Historic regional and racial concentrations of poverty persist and poverty is most prevalent for Southern and black populations. Non-metro residents face the double burden of person-based and place-based poverty. Rural children are particularly vulnerable and one in four children lives in absolute poverty.

AoA/ACL PROGRAMS ADDRESSING RURAL POVERTY

Dennis Dudley, M.P.A.
Aging Services Program Specialist, Region IX
Administration for Community Living, U.S.D.H.H.S.
San Francisco, CA

Dennis Dudley spoke to the Committee from San Francisco, CA. He noted that in April 2012 there was the advent of the Administration for Community Living. The new United States Department of Health and Human Service operated division brings together the Administration on Aging, the Office of Disability and the Administration on Intellectual and Developmental Disabilities. The mission is to maximize the independence and wellbeing of older adults, people with disabilities and their families and caregivers across the life span.

The Administration on Aging originated in the Older Americans Act. It was created in 1965 during the Johnson era. The Older Americans Act is the major federal vehicle in the delivery of social and nutritional services for older persons. It provides policy direction to states and on a local level grants funds to states for home and community based long-term services and supports.

The impact of poverty is addressed in the Older American Act programs and there is a mandate to the states to provide services with particular attention to low-income individuals.

Currently the environment for long-term care services and supports is a fragmented system with institutional bias. Throughout the efforts with state partners, the bias is moving in the direction of prevention and offering consumer direct services. The Older Americans Act is consumer focused and provides a social model of care and there is a demonstrated system of leadership working on systems change and reforms on a state and local level driven by a nationwide network.

The Administration on Aging network includes: 56 state units on aging, 629 Area Agencies on Aging, 254 tribal organizations and 2 native Hawaiian organizations, 20,000 providers, 11,400 senior citizens, federal partners and 500,000 volunteers.

The Administration on Aging provides care management, case management, prevention, care giver services and elder rights services. In the past year, the Agencies on Aging provided services to over 11 million people and 36% of the services were offered in rural

areas and 29% were offered to people below the poverty level. The Agencies on Aging served over 218 million meals, provided 28 million people with personal care services, and 400,000 people participated in the chronic disease self-management programs. 194 caregivers were served, 7% of the caregivers were grandparents or relatives raising their grandchildren.

The Administration on Aging is striving to empower older individuals to make informed choices and better maintain their health. The empowerment programs include exercise, chronic disease self-management programs and fall prevention programs. Within the chronic disease self-management program they have involved 48 states and held over 11,000 workshops at various locations. 129,000 people participated in the program and 61% of the participants had multiple chronic conditions.

The Aging Disability Resource Centers are the new front door to aging disability services. This program is supporting states to develop single points of entry to help older adults, the disabled and other populations such as caregivers and veterans to learn about access to programs. It provides consumer choice and independence and consolidates access to public, private health and long-term care services. It is designed to integrate information. It provides consumer choice and independence.

The Veterans Directed Home and Community Based Care Services Program is a relatively new program. The medical center authorizes a spending budget based on the veteran's assessed needs. It is responsible for meeting the needs of the veteran so they can live independently in the community.

In conclusion, Administration for Community Living has a diverse network of people whose intent is to reach out to those in need. The desire of consumers to direct their own services and have services that can be developed to their individual needs is the foundation of the program.

Dave Norman
Director
Northwest Colorado Area Agency on Aging
Grand Junction, CO

Dave Norman shared that they are sponsored by the associated governments of Northwest Colorado and they contract with the Mesa County of Human Services for the administration of services. This covers 16,000 square miles. There are a variety of resources, problems and area of concerns. The Northwest Colorado Area on Aging has faced challenges with the people living in the area trying to secure services for themselves and their elderly parents. Healthcare has been difficult to achieve in the area. There are many resources available. There are about 37,000 seniors over the age of 60 in the area and they are serving about 1 in 10 of those seniors. To the east is the non-urbanized area of Clifton and there are more people living in Clifton than in Montrose. In 1974, there was one senior center in the west slope but now there is a senior center in

every community in the region and they are all community-based and supported. There is also senior housing, senior centers and nutrition programs in every community.

Mr. Norman shared that the Colorado Area Agency on Aging has various partnerships they have developed throughout the years and they have developed unique services within the Mesa County Area. There are veteran services and a workforce center within the department so it is a one-stop location. The case managers in the single entry point program noticed that there were some people who did not qualify but needed services. Under the Older Americans Act there was a structure to provide material aid and the agency began using a voucher system that is now called cash and counseling. Through the voucher system they can provide things like water heaters, air conditioners and dental services.

Mr. Norman shared that The Home Connections program was created for people who were not eligible for long-term support services to stay in their home. Local agencies and the Area Agency on Aging donated money and case managers donated their time. Students who were getting their masters in social work used this as their project, doing all the research in lower tier prevention improving quality of life and saving the state money. The program is still implemented and assisted in implementing the Adult Research for Care and Health that served about 158 people last year. 80 were home connections people who are clients who are referred by case managers and have long term support services that cannot be filled. People under the age of sixty who are disabled can also take part in the Adult Research for Care and Health Program which serves over 352 people and assisting people in staying in their home.

Integration of long-term services in Colorado is moving forward. Everyone agrees that there needs to be an Adult Research Care and Health Program as a point of entry, and then a client can be handed off to a service and case manager. The process diagram is very complicated and there are 56 different agencies doing Medicaid eligibility in the state. There is plenty of access but the process needs to be simplified. There are recommendations to the state for resources to implement four to six Adult Research Care and Health Programs around the state in order to coordinate activities.

The Colorado Health Foundation has announced an initiative of $6 million dollars for long term support services and the Mesa County area is going to ask for some of that funding to expand the Adult Resources for the Care and Help program throughout other counties. In Mesa County they would like to take the ARCH program a step farther and merge the 211 program, Adult Resources Care and Help program and eligibility for single entry point for services.

Mr. Norman said that the Area Agency will keep their core services, home delivered meals, support of legal services but everything else has been changed into a new way of delivering services. Families are in the discussion and they can use their own resources and choose their own providers. Many services are employers that are willing to contribute at a reduced rate. At the end of the year there will be recognition and the providers will be able to meet the people they served where they can share their stories.

This builds a sense of community living that they are trying to achieve.

Q&A

Barbara Morrison asked Mr. Norman if federal and state funding for elderly services comes through the Agency on Aging and if they have formulas to help protect rural areas.

Dave Norman said that they do have a formula that has a base funding per region per area agency. They also deal with factors of rural poverty, minority and low income.

ADMINISTRATION FOR CHILDREN AND FAMILIES PROGRAMS ADDRESSING RURAL POVERTY

Mark Greenberg, J.D.
Deputy Assistant Secretary for Policy
Administration for Children and Families, U.S.D.H.H.S.
Washington, D.C.

Mark Greenberg thanked the Committee and said that he appreciated the opportunity to also meet with the Committee a year ago in Washington, DC. The Administration for Children and Families has been invited to participate on a regular basis with the Committee. Mr. Greenberg said they would like to explore areas to discuss with more detail relating to human services.

Mr. Greenberg said that ACF could assist with exploring issues around demographics and trends. Some of the discussions about Temporary Assistance for Needy Families and other ACF programs can be discussed at future meetings. Place-based strategies and the importance of coordinated and integrated approaches in place-based strategies in relation to rural areas is also a topic to be discussed.

Nikki Hatch
Deputy Executive Director of Operations
Colorado Department of Human Services
Denver, CO

Nikki Hatch said she would share information on how her agency is approaching challenges they are facing. Strategies and initiatives shared are reflective of the agencies orientation and values. She shared that she would appreciate guidance and direction from the Committee on how they can better serve rural populations.

The State Department of Human Services in Colorado is a $2 billion dollar organization with 5,700 employees. The full array of human services provided include: senior veteran homes, regional centers for people with developmental disabilities, youth correction facilities and two mental health hospitals. The vast majority of work is through different

entities- particularly counties.

Colorado is a state supervised and strong county administered system. The state is committed to working with counties. Struggles in the economy have caused an increased demand in services.

There are 3 major strategic initiatives that will be discussed: consolidation of the state early childhood services into a new office, child welfare and behavioral healthcare reform.

The right services at the right time and in the right location are important. Services should be provided as early as possible and preventative care is important. Services should be provided in the right location and very often that is in the home or community with natural supports that exist.

The Child Welfare 2.0 plan was announced February of 2012. The plan consists of five key strategies: common practice approach, performance management, workforce development, funding alignment and increase transparency and public engagement. The first year of accomplishments included implementation of C-Stat. IV-E Waiver, expansion of differential response, training academy redesign and investigation of near fatalities and egregious incidents.

The Child Welfare 2.0 plan increases prevention services and will have a statewide child abuse reporting hotline. IV-E waiver allows the federal funds that would be used for children who have been placed in foster care to be used towards preventative solutions to keep children in their homes. The plan broadens workforce development and will increase transparency and public engagement.

Last year there was an Office of Early Childhood created. This brought together a variety of early childhood programs. Colorado received second round funding for the Race to the Top early learning challenge grant. The state is developing a statewide quality rating system for licensed early learning facilities. The grant will also assist in instituting a statewide kindergarten entry assessment.

The Governor's Behavioral Health Plan is an important state initiative to strengthen Colorado's mental health and substance abuse system. The behavioral health plan will establish crisis response and enhance crisis services. There will be a 24 hour crisis hotline statewide. There will be walk-in crisis stabilization units providing immediate clinical intervention. This will assist in meeting the needs of a person in a mental health crisis without them going to jail or the emergency room. The plan will also enhance community care, expand inpatient capacity and build trauma informed approaches.

C-Stat is a performance management strategy that is being used in Colorado. The C-Stat program provides real time data, an environment of accountability and face-to-face meetings to discuss the data and the public sharing of data. The performance measures are monitored on a monthly basis. C-Stat prevents the state from losing site of the

statewide representation. C-Stat is an important tool used to keep track of counties and communities.

Carol Hafford, Ph.D.
Principal Research Scientist
NORC Economics, Labor, and Population Studies
Bethesda, MD

Carol Hafford told the Committee that it is a pleasure to share what she has learned over many years of conducting research and evaluations of human service programs. Dr. Hafford said she will speak about the intersection of rural poverty, family self-sufficiency, risk and protective factors in tribal communities. In tribal communities it is important to understand that different paths are taken and it requires an understanding of program and policy making from a different perspective.

Ms. Hafford spoke about three programs administered by Administration for Children and Families. They are Tribal HPOG, Tribal TANF and Tribal PSSF. Tribal programs operate in a complex policy environment because they interact with federal law, state and county jurisdictions and also interact internally in terms of different value systems and cultural informed models. All studies represent approaches to alleviate poverty and strengthening the safety net. Two programs focus on strengthening families and child and youth wellbeing. The HPOG program focuses on innovations and post-secondary education and training, success in the labor market and helping families involved with Temporary Assistance for Needy Families.

The Tribal Health Professions Opportunity Grants are a subset of a larger group of grants that are awarded to create pathways to health related training initiatives. Target populations include Temporary Assistance for Needy Family eligible individuals, individuals that have dropped out of high school and single mothers with children. All 32 of the Health Professions Opportunity Grant programs involve training and education programs in health related fields. Blackfeet Community College was awarded the grant in 2010. There is a preference for local tribal members who understand the values of the community. Blackfeet Community College has developed partnerships with other universities to allow students to transfer to a 4 year college. The challenge is creating a highly integrated infrastructure and recreating it at a statewide level.

Tribal Temporary Assistance for Needy Families involves families that are at risk of child abuse and/or neglect and other at risk families. The human service delivery structure includes a family resource center that serves as a focal point for all family programming. It is integrated with access to a wide variety resources and tools. The resource center also has activities available to the community that make it a community based center.

Tribal Promoting Safe and Stable Families targets families on the verge of eviction who are referred by the housing authority. The program addresses families' immediate concerns such as transportation, concrete supports, and child care for very young children

and referrals for other services. This program resulted in a 100% success rate with the Omaha Tribe of Nebraska and Iowa.

These programs are operating in very high poverty counties in Northern Montana and Northeastern Nebraska and Wisconsin. The average Native American resides in a county with a poverty rate higher than 22%. The three communities highlighted in the study have high percentages of families that live within subfamilies with very young children and very elderly who rely on a worker for support. The tribes have a high percentage of people without vehicles. High percentages are receiving food stamps and general assistance.

There has to be place-based strategies in human service delivery. Service delivery, accessibility, stability and infrastructure in rural/frontier communities present particular challenges. There is a lack of opportunity in the rural labor markets and challenges related to seasonal work and transportation. In and out migration within counties can affect the sustainment of the service infrastructure that is created. When addressing these challenges, coordination of services and strong networks are essential.

It is important to take into consideration tribal sovereignty, self-determination and nation building while understanding that partnerships are needed with state and federal initiatives. All three of these programs leverage community resources and strong integrated service structures. There has to be a considerable amount of coordination and rural service barriers have to be addressed such as lack of child care options and transportation issues. All of the models focus on the social and economic wellbeing of the family. The models recognize the importance of services across the continuum and stability post intervention. Once someone graduates from a training program there need to be supports in place for them to maintain stability over time and become self-sufficient.

Q&A

Barbara Morrison asked Nikki Hatch how new funding was being distributed to counties or individuals. Is it on a formula basis or per client basis?

Nikki Hatch replied that they are using existing mechanisms for allocation of funds. In the child welfare program there is an allocation committee. That group will make the majority of those decisions. Some piloting initiatives in counties will receive resources to for pilot participants. Instead of creating different funding streams, they are staying with what is working.

Christy Whitney said she was fascinated with the collective impact approach that Carol Hafford spoke about. Are there modifications of that? Is it a model that you adopted when you started the work?

Carol Hafford said that the collective impact framework is one that is used by community stakeholders that are trying to address a large scale social problem. She did

not evaluate the model but it is a promising approach to get people to the table.

David Hartley asked Nikki Hatch about reforms to the state behavioral health services. The crisis response hotline is used for provider referral to local services but many places do not have local services. How do you deal with that?

Nikki Hatch said that the behavioral health agenda is in the development stage and there is a committee working to solve those types of problems. The group is working to identify mobile response so crisis hotline can work with mobile response. They do not know the details of how it will work or what geography it can cover but it is being discussed.

Ronnie Musgrove asked Carol Hafford if there were metrics in place to measure success of the programs

Carol Hafford stated that the Tribal Health Professions Opportunity Grant program is concerned with metrics and outcomes and there has been a performance system developed to gather baseline data on participants and track program services that they have received and to track their post training outcomes. The data will be linked to other data to observe long-term outcomes.

HHS UPDATE

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

Michelle Goodman spoke to the Committee about the rural policy landscape and Affordable Care Act Programs. Key regulations and revisions include health insurance marketplaces, insurance market reforms and Medicaid expansion. Some of the changes in the rural landscape are an increase in poverty rates, a higher number of uninsured and a larger number of small businesses.

Ms. Goodman said that health insurance market places will begin enrolling individuals on October 1, 2013 and begin providing coverage January 1st, 2014. They can be state run, federally run or through a state and federal partnership. At the same time the market places are being created, the insurance market is undergoing reforms to assure individuals and employers will have a minimum set of protections inside and outside the marketplace. How and if states chose to expand the Medicare programs will have an impact on a rural community's access to care.

Some issues that the Office of Rural Health Policy is monitoring are the ways that the market places will set up provider networks, how the issuers will work with essential community providers in their coverage areas and how the contracts between the essential

community providers and qualified health plans work. What they will look like in the states that are federally run and the states that have their own state marketplaces.

Rural communities have many small businesses and the Office of Rural Health Policy is looking at how the Small Business Health Insurance Option Programs will work in rural communities and how temporary and seasonal farmworkers fit into the picture.

It is important to remember that the laws and regulations are minimum standards rather than maximum standards for the states and a state may decide to go above and beyond the federal requirements.

Each state exchange will have a navigator program to facilitate the enrollment of individuals, employers and small businesses in the qualified health plan. Within the training for the navigators and assistant personnel, all individuals must be trained on a variety of issues including rural populations.

Tom Morris, M.P.A.
Associate Administrator
Office of Rural Health Policy, U.S.D.H.H.S.
Rockville, MD

Tom Morris spoke to the Committee about the White House Rural Council activities. The focus moving forward is continued management of the federal response to the drought, policy initiatives on health information technology and expansion of the National Service Corps to critical access hospitals and using telemedicine to reach out to rural veterans.

There is a lack of understanding about the Affordable Care Act, especially in rural communities. Outreach and education needs to take place and the White House Rural Council is going to make this a priority moving forward. The exchanges will open in October so the Committee may want to discuss this issue as well. Hospitals can play a role in outreach and enrollment with those who are eligible. There are things unique to rural communities that can be considered and the Committee may be a great place to originate some discussion.

PUBLIC COMMENT

Rebecca J. Davis, Ph.D.
Executive Director
National Cooperative of Health Networks Association, Inc.

Good Afternoon, I would like to add my welcome and thank you all for coming to the western slopes of Colorado! And thank you for providing time for public comment.

I am Rebecca J. Davis and serve as the Executive Director of NCHN (the National Cooperative of Health Networks Association). We are located in Montrose, which I understand some of you will have the opportunity to visit tomorrow. NCHN is a professional membership organization devoted to supporting and strengthening rural health networks. We do so through collaboration, networking, leadership development and education.

Our largest educational event of the year is our annual conference. In fact, two weeks from today at about this time, after a packed day of presentations, Award winner announcements, and network sharing, we will be boarding a Riverboat for a Jazz Dinner Cruise on the Mississippi River in New Orleans.

We are excited that our keynote speaker this year is Jessica Lipnack, CEO and co-founder of NetAge. For three decades, Jessica and her husband, Jeff Stamps, who unfortunately passed away in 2011 (1944-2011) have provided expertise and tools that allow their clients to collaborate more effectively in virtual teams, cross-boundary organizations, and networks. Jeff and Jessica literally wrote the book on Networking – which, on a personal side note, this book was given to me by Dr. Kenneth Studer, Virginia Department of Health, Office of Rural Health, back in 2000 when I first started working in the rural health field. Dr. Studer told me, read this book – networks will be the wave of the future and you need to know all about them! Little did he know at the time! ☺ (The Age of the Network – Organizing Principles for the 21st Century.)

Borrowing from Jessica's presentation description, "In the long history of organizations—beginning when we first formed small tribes to survive—the network is the newest, the most powerful, and, at the same time, the oldest form of organization. Networks motivate people and organizations to take risks and do what they cannot do alone. Networks become powerful magnets to attract others and spur participation. Members of networks compete and cooperate at the same time." Jessica will be discussing these concepts, along with talking about how can everyone, every organization, in the network become a leader in their community. And she will continue on the discussion started on Tuesday afternoon during a special workshop, "Got Outcomes? What's Your Evidence?" by asking and discussing and discussing with the audience, how can we think differently about evaluating and measuring networks? And, we will have a first – Jessica's presentation will be broadcast live, so that network leaders that were unable to attend the conference can hear her presentation. If you also would like to listen in on Wednesday, April 17th at 9:15 AM CT, please let me know and I can provide you with the link.

Also, at the conference, attendees will carry on discussions about "challenges and opportunities" that keep network leaders up at night. Just yesterday I posed this question to conference attendees (over 70) and already I have received numerous responses.

There's a lot keeping us up at night! Specifically, I asked, ""In regards to managing your network organization, what keeps you awake at night?" They said:

- Our challenge is how should we respond as a 26-member network to ACO type initiatives, WV
- What keeps me awake at night is the new healthcare landscape seems to be driving mergers and acquisitions. How will networks stay relevant in the future? MT
- Sustainability – after government funding, how will the network sustain? MD
- Having enough cash flow to make payroll twice a month. TX
- Network growth & value (not in terms of growth in membership – but increasing the value to members through growth of services/programs) – especially in the current environment of affiliations. KS
- Sustainability for a vertical network, how do we diversify our funding sources and find funding sources that support operational expenses? AZ
- How might rural networks hold meaning for large systems/teaching institutions? WA
- Right now my network of 25 hospitals is being very quiet. I have roundtables (CEO, CFO, CNO, MU, Pharm, MM and HR) so quarterly we do gather; however, outside of these meetings my folks are in the weeds. So many demands are being put on them around various implementations, requirements, etc. that it's challenging for me to keep my pulse on those that may really need something OR worse yet that may not realize they need something. 2012 – 2014 have been and will continue to be very stressful for small rural hospitals and as the network director I've got to attempt to help them in as many different aspects as I can. Meaningful Use, ICD-10, quality measures, tools to drill down for cost containment, ACA, ACO's and what's happening around the state, etc., etc., etc. I guess a better question might be what's not keeping me up! IN

So, as you can hear, from these responses received in less than 24 hours, --- so far the recurring themes seem to be – Finances/Sustainability and providing value in face of mergers, affiliations, acquisitions, and ACOs.

Conference participants will learn not only from the great speakers, but from beginning and experienced network leaders through their network leader-to-network leader discussions. This event provides network leaders a place and time to come together with their peers, the folks that understand what they do on a daily basis! There is so much sharing and learning taking place between these amazing folks, I am almost always overwhelmed! A full agenda is available for review on the NCHN website, which can be accessed at nchn.org and, if interested in attending and learning more about networks, come on down to New Orleans! We would love to have you!

And, if I had time and knew you wanted to stay here and listen to me continue on about networks and the work they do, I could share with you some great best practice models and success stories, but you can learn more about networks and what they have been doing by viewing, NCHN's Networking Section on the Rural Assistance Center website.

But, I will just mention one network at this time, since we are here in Grand Junction and one of your members on, his Committee is also a member of the network, Christy G. Whitney, Hospice and Palliative Care of Western Colorado. The network, Western Healthcare Alliance (WHA), is a founding member of NCHN. WHA, was founded in 1989. WHA has grown to become a profitable, multi-million dollar network with four separate limited liability companies and a staff of over 75 employees. The alliance is comprised of 26 full members and 39 affiliate members. Just yesterday, Carolyn Bruce, WHA's CEO, was our feature in the NCHN eNews, which you can access on the NCHN website.

At this time, I would like to publicly and personally thank Tom Morris and the staff at ORHP, not only for their support and partnership with NCHN, but for their leadership and foresight in providing funding and support for the development of rural health networks through their Rural Health Network Development Programs since 1997. They have provided actual sound pre-work for the extraordinary collaboration required as the Affordable Care Act rolls out --- We have networks with up to 30+ years of experience, yes, even before funding was available to networks, folks in rural areas were forming such organizations. Across the country there are network organizations and network leaders with experience in sharing patients, supplies, sitting as competitors, yet collaborating where it makes sense to save dollars and then plowing those dollars back into healthcare and their communities.

And, NCHN is the learning community that brings these organizations and leaders together – as a membership organization, our programming and services are developed and designed by network leaders, who bring both a varied background and experiences to the table. After working with these leaders, experienced and new over the past seven years, repeatedly I hear about the need for leadership training, particularly for new network leaders and for network board members. If I were to attempt to make one suggestion to this committee today, to add to you long list of issues you are exploring and researching – it would be supporting rural health networks, both those that are fortunate enough to be receiving federal funding and those that are functioning without federal funding, in the area of leadership development. Research supports that one of the critical success factors for a network is its leadership, both network leader and board members (O'Sullivan, 2009; NCHN 2011).

Thank you for your time today. We look forward to working with ORHP and this Advisory Committee, as everyone moves forward with the implementation of the

Affordable Care Act; and the shared overarching goal of ensuring that rural citizens have access to quality healthcare."

Thursday, April 4th, 2013

Thursday morning the subcommittees' departed for site visits as follows:

HUMAN SERVICES SUBCOMMITTEE
Montrose County Department of Health and Human Services
Montrose, Colorado
Subcommittee members: Eugenia Cowan, Barbara Fabre, David Hartley, Barbara Morrison and Carol Hafford (NORC).
Staff Members: Tom Morris and Nathan Nash.

HEALTH SUBCOMMITTEES
Family Health West
Fruita, Colorado
Subcommittee members: John Cullen, Phyllis Fritsch, Wayne Myers, Tom Hoyer, Michele Juffer and Carol Blackford (CMS).
Staff Member: Steve Hirsch

Plateau Valley Health Clinic
Collbran, Colorado
Subcommittee members: Karen Madden, Shane Roberts, Roger Wells and Christy Whitney.
Staff Member: Emily Schlichting

The subcommittees' returned to Grand Junction and attended break-out sessions for discussions.

PUBLIC COMMENT

There was no public comment.

Friday, April 5th , 2013

The meeting was convened by Tom Morris.

REVIEW OF SUBCOMMITTEE VISITS

HUMAN SERVICES SUBCOMMITTEE
Montrose County Department of Health and Human Services
Montrose, Colorado
Subcommittee members: Eugenia Cowan, Barbara Fabre, David Hartley, Barbara Morrison and Carol Hafford (NORC).

Staff Members: Tom Morris and Nathan Nash.

Site Visit Key Points:

- Montrose County Department of Health and Human Services Department hosted a broad cross section of human service organizations including many of the traditional entities (Home Visiting Services, WIC, SNAP, Immunizations, TANF, Area Agency on Aging, Community Health Center, Fatherhood Initiative as well non-traditional such as juvenile justice and corrections). This promotes collaboration and coordination of services because they are mainly dealing with the same clients.

- The participants noted that the relative small size of the community was a key factor in collaborating across the programs. There is no formal ongoing mechanism for coordination other than it is part of the culture of the community and because programs are co-located.

- The 1451 program (named after the State Bill) provides funds to support a case manager to coordinate early intervention with families to reduce truancy, short-term and long-term out of community youth placements and also allows funds to be used to meet needs that fall outside existing programs. The program is coupled with continuing reductions in the cap of state-supported placement beds. It is a place-oriented approach that works across a variety of programs and allows a detailed family-focused plan for keeping families together and avoiding risk factors and legal interventions. The Community representatives also noted that leadership was a big key in getting the 1451 project off the ground.

- The Community is planning on applying to be part of the State's ACF 4E waiver to look at alternative ways to serve families and clients in the juvenile justice system. This would focus on early family engagement.

- The community was heavily involved in early childhood services and had some Head Start Services but no Early Head Start.

- The Community Area Agency on Aging collaborated with the Medicaid Office on home and community based waivers and also provided those services to some non-Medicaid populations that met AoA/ACL requirements.

The subcommittee's next steps are learning more about the 4E waiver and writing up a text box on how the 1451 program may be a metaphor for the Administration to consider replicating at the Federal level along the lines of the "Race to the Top" philosophy.

The Committee will look at key need indicators like poverty and service areas that work best for rural communities as well as what sort of Federal programs could be considered as "anchor" grants to show the administrative capacity to meet program goals.

HEALTH SUBCOMMITTEES
Family Health West
Fruita, Colorado
Subcommittee members: John Cullen, Phyllis Fritsch, Wayne Myers, Tom Hoyer, Michele Juffer and Carol Blackford (CMS).
Staff Member: Steve Hirsch

Site Visit Key Points:

- Family Health West includes a hospital, various clinics, a Nursing Facility and Alzheimer's unit, and assisted living and was well represented at the meeting. Also represented was "Visiting Angels" a for-profit non-medical home assistance company and the Hospice of Western Colorado.

- There were no Medicare complaints about servicing remote area. There was a discussion of physical and logistical problems in serving remote patients.

- There is a need for much more unskilled home care than is available through Visiting Angels for Medicare patients.

- Discharge planner, social workers, home care workers – all cooperate to make patients aware of hospice options and end-of-life needs, though sometimes it is a hard sell.

- The main Medicare complaint had to do with the hospital, which has declined to provide hospice general inpatient care because the Hospice rate is lower than the hospitals reimbursable cost. Hospice patients must revoke and then re-enroll to make use of the hospital.

- Hospice staff suggested that one improvement would be changes to allow nurses and doctors to use telehealth on remote patients and count them against mandatory visit requirements.

- There was discussion about the use of non-physician practitioners to certify and re-certify and perform face-to-face visits with patients.

Plateau Valley Health Clinic
Collbran, Colorado

Subcommittee members: Karen Madden, Shane Roberts, Roger Wells and Christy Whitney.
Staff Member: Emily Schlichting

Site Visit Key Points:

- Rural hospice has a specific ideology. Everyone knows everyone—there is a strong sense of community and the community bands together to support one another. As patient symptoms progressed and death approached, patients were moved from their homes to the nursing homes and hospital in Grand Junction. As the nursing home closed, the patients had to leave their community for end of life care.

- Hospice and Palliative Care of Western Colorado allows the small town to provide the best care and other services that they could never afford without the larger organization.

- Plateau Valley adopted electronic medical records years ago to avoid paying a typist for dictations of charts. This helps manage more efficiently, but there is a need to examine whether technology is saving time and creating better care or unnecessary in some circumstances and time consuming.

- In frontier areas there could be a significant cost savings by having a hospice to prevent the use of Medivacs and other high-cost care.

COMMITTEE BUSINESS

Letter to the Secretary

Some topics discussed by the Committee for the letter to the Secretary included: Regulatory rate burden reduction, the role of providers and community organizations assisting in affordable care act health insurance enrollment in rural communities, the cooperation and unique collaboration of services and agencies as a positive aspect moving forward, and an opportunity for private sector businesses to be part of the solution in health and human services in rural communities.

Bozeman, Montana Meeting Topic Considerations:

Two topics being considered for the meeting in Bozeman, Montana are affordable care act outreach and enrollment in rural communities and how to utilize navigators or consumer assistance programs.

PUBLIC COMMENT

There was no public comment.