

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

National Advisory Committee on Rural Health and Human Services

**Washington DC
April 10th-12th**

Meeting Summary

The 81st meeting of the National Advisory Committee on Rural Health and Human Services was held April 10th-12th, in Washington DC.

The committee members present at the meeting: Kathleen Belanger, Ph.D.; William Benson; Ty Borders, Ph.D.; Kathleen Dalton, Ph.D.; Carolyn Emanuel-McClain, MPH; Barbara Fabre; Constance Greer; Octavio Martinez, Jr., MD; Maria Sallie Poepsel, MSN, Ph.D., CRNA; Chester Robinson, DPA; Mary Kate Rolf, MBA, FACHE; Mary Sheridan, RN. MBA; Benjamin Taylor, Ph.D., DFAAPA, PA-C; Peggy Wheeler, MPH.

Present from the Federal Office of Rural Health Policy: Tom Morris, Director; Steve Hirsch, Executive Secretary; Paul Moore, Senior Health Policy Advisor, and Adam Cohen, Truman Fellow.

Present from Rural Policy Research Institute: Jocelyn Richgels, Director for National Policy Programs.

**MEETING DAY 1 - HYATT PLACE - WASHINGTON, D.C
Monday, April 10th, 2017**

The meeting was convened by Paul Moore, Senior Health Policy Advisor. Governor Musgrove was unable to attend the opening day of the meeting.

WELCOME AND INTRODUCTIONS

Paul Moore welcomed the committee members and shared that he would be serving as the acting chair in the governor's absence. The National Advisory Committee on Rural Health and Human Services is made up of a wide range of health and human service experts. The committee members and federal office staff introduced themselves to begin the meeting.

MEETING OVERVIEW AND NACRHHS KEY PRINCIPLES

Paul Moore noted that the 81st meeting is a change from the past few years because it is in Washington D.C. instead of a site visit in a rural location. The meeting is being held in Washington D.C. as an opportunity to hear from Health and Human Services leadership and discuss rural policy priorities. The committee will identify future topics as a focus for upcoming site visits and recommendations. Today you will hear from some of the key national associations that focus on rural health and human service issues and engage in dialogue. Tomorrow the

committee will be at the Hubert Humphrey building at Health and Human Services and have the opportunity to hear from every part of the department that has an impact on health and human services in rural America. The Secretary of Health and Human Services will be visiting the meeting to introduce himself and acknowledge the work of the committee. This meeting will have a strategic planning approach for future meetings. When considering possible topics deliberate: are the topics under Health and Human Services jurisdiction, can Health and Human Services make a specific action regarding the topics, and are the topics unique to rural communities.

REVIEW OF PAST COMMITTEE TOPICS AND RECOMMENDATIONS

The committee has given recommendations on a wide range of topics. Some of the recent topics include alternative models of health care delivery and issues related to rural disparities and life expectancy in rural America. The committee prompted further research with their work on rural disparities and life expectancy and contributed to the Centers for Disease Control and Prevention recent reports on morbidity and mortality in rural America.

Tom Morris stated that Secretary Price met with the Office of Rural House Policy (ORHP), Health Resources and Services Administration (HRSA), The Agency for Healthcare and Research Quality (AHRQ), Indian Health Services (IHS) and with Substance Abuse and Mental Health Services Administration (SAMSHA). Secretary Price's four immediate priorities regarding rural health and human services are opioid abuse, childhood obesity, behavioral healthcare and the need to reduce regulatory burden.

HUMAN SERVICES PANEL

Denise Harlow
Chief Executive Officer
Community Action Partnership (CAP)

Denise Harlow stated that the Community Action Network is a national network of more than one thousand local community action agencies, forty-four state associations, fifty-six state and territory Community Services Block Grant offices and tribal organizations. The Community Action Partnership is the provider and funnel of the Community Services Block Grant.

Community Action Partnership serves 99% of America's counties and many are rural. The local community action agencies are in every corner of the country. Ms. Harlow stated that she was going to Jackson, Mississippi to spend time with the training and technical assistance staff to discuss how to assist Community Action Partnership Agencies in Georgia, Mississippi, Alabama and Florida. There has to be a strong national infrastructure in order to serve families and to keep agencies healthy and thriving. Social determinants of health that are critical in rural areas are poverty and access to opportunity. Community Action Networks are governed by local tripartite boards. One-third of the board members are elected officials, one-third representatives of low-income communities, and one-third are in from the private sector.

Community Action Agencies have a local needs assessment every three years and there is a range of services provided. No two Community Action Partnerships are alike; they all have different needs, resources, and partners. The agency takes a whole family/multi-generational approach with a strength based perspective to build on. Many of the agencies are Federally Qualified Health Centers providing dental clinics, women's health clinics, and mobile health clinics. Some other services provided by Community Action Agencies include housing, early childhood, Head Start, job training, senior services, and case management. The agencies provide economic development assistance and administrate Community Development Financial Institutions to assist people in starting small businesses through grants and with farming or agriculture assistance.

There are many barriers to self-sufficiency in rural America. There is a lack of affordable housing, transportation issues and a lack of jobs available that pay a living wage and offer benefits. There is a lack of mental, physical and dental health care. Opioid addiction is a huge concern in rural America. There is also a lack of child care and that makes it difficult for employment and educational opportunities for parents. Many rural communities lack internet access which is another major barrier. The benefit cliff effect is when a person earns just enough that they lose assistance benefits. They are still not making a living wage and this causes people to lose family supports.

The Community Action Partnership has breadth and depth and wants to partner to fight poverty which is the key social determinant of health. We can work together to help families strengthen and progress.

Sandy Markwood
Chief Executive Officer
National Association of Area Agencies on Aging

Sandy Markwood stated that she discuss how The National Association of Area Agencies on Aging works with the committee. The aging of rural America is a major issue for the country. The National Association of Area Agencies on Aging is an organization that has created in 1973. AAoA was established from the Older American's Act. There are 622 across the country that serves every community in the country. There are seven states that operate as the AAoA because of the sparsity of population. Area Agencies on Aging can be housed in county government, counsels of government and nonprofits.

The vastly increasing aging population is a particular issue in rural because the largest percentage of older adults live in rural communities. There are county governments in the country where the aging population can be 20% to 30% and one in four adults act as caregivers for another older individual. There are also grandparents raising grandchildren with is a national issue. The fastest growing segment of the aging population is those over 85 years old and these people need assistance to be able to stay at home in the community.

The AAoA runs The Elder Care Locator which is a locator telephone number that people can call to seek assistance. Some of the issues they are calling about are transportation, home and community-based services, housing, medical services and supplies and health insurance. Social

needs are just as important to address in patients as medical conditions and there is a need for integrated community-based supports. In a survey of 1,000 physicians, 85% stated that unmet social needs directly lead to deteriorating health. Most physicians are not confident in their ability to address social needs. One in five people over the age of 50 are affected by social isolation. Social isolation can lead to a greater risk of functional decline and risk of death. Prolonged isolation can be as detrimental to health as smoking fifteen cigarettes a day.

One in ten people over 65 and one in three over 85 suffer from Alzheimer's disease or related dementia. There was an organization formed and announced at The White House Council Conference on Aging in 2015 called Dementia Friendly America. In January, Dementia Friends Organization was launched. Dementia Friends is a national collaboration of more than 40 organizations ranging from Alzheimer's groups, locale elected officials, chiefs of police and faith groups. These groups are collaborating to find ways to make the community dementia friendly and assist healthcare professionals with responding to people with dementia.

Ways to respond to the needs of rural seniors include social services, home, and community-based supports. Volunteer driving programs, housing repair, and social engagement are important to supporting seniors and creating healthier communities.

Candy Hill
Senior Director, Policy & Government Affairs
American Public Human Services Association (APHSA)

Candy Hill shared that she has been with American Public Human Services Association since December 2016. Most of her career was at Health and Human Services in the State of Michigan. She contacted members of rural communities to get information for the committee meeting and will be sharing what she learns with them.

American Public Human Services Associations knows the importance of integrating health and human services. There need to be new ways to fund the programs that have the best outcomes and be efficient at the same time. The system has to be person-centered and based on prevention and integration of health and human services. Social determinants of health have to be addressed.

APSHA has created three collaborative centers: National Collaborative for Integration of Health and Human Services, Centers for Employment and Economic Wellbeing and Centers for Child and Family Wellbeing. Some of the functions of the centers are to develop and advance campaigns for policy change, elevate innovations and solutions and to develop tools and guidance for the field. Some key policy and practice accelerators are supporting the evolving delivery of health and human services from across sector enterprise. Interoperability and integration service delivery across health and human services includes building partnerships across service delivery providers.

American Public Human Services Association program titled Charting a New Pathway to Prosperity and Well-being is based on local organizations and local human services leaders. The local organizations are designing programs that foster partnership between consumers, employers, community partners and related sectors.

It is necessary to have a holistic approach to serving the family. There is generational poverty due to lack of education, employment, transportation, early childbirth, and family instability. There are generational mental health and substance abuse issues and high trauma levels in rural areas.

Some opportunities for health and human service agencies in rural communities are to create “care networks” that provide resources and infrastructures, integrated services across programs with a person-centered whole family approach.

Q&A

Barb Fabre asked if the Community Action Partnership is seeing more elders/grandparents raising their grandchildren due to opioid addiction. White Earth Tribe is able to use the state early learning scholarship which is vital because the childcare block grant has a work requirement. This is very important for elders who are 80 years old and raising their grandchildren.

Denise Harlow stated that grandparents raising their grandchildren is a significant issue and will be growing in intensity. A growing number of grandparents are bringing their grandchildren to head start services. Assisting them to navigate the educational spectrum is going to be an issue. We need more quantitative information and Generation’s United and Brookdale Foundation are two resources that have a focus on this issue. An increase in elder abuse is also a significant issue.

Chester Robinson referred to the aging network system that has a call center for people to get information about available resources. Usually, people wait until their situation is desperate before they call for assistance. Many times people make contact when there are exemplary needs. How can the individual, family, and agency decide the best way to address the person’s total care?

Denise Harlow responded that there has to be a person-centered strategy that evaluates the individual’s wants and needs. Some people may have the goal of walking their dog while others have more extended goals. Doing caregiver assessments and person-centered assessments and filling in the gaps with services is what is necessary. If there is a crisis situation it is necessary for the agency to take immediate action but it otherwise is up to the individual to decide what they need.

Sandy Markwood stated that generations are living far apart so there is a lack of inherent support systems. Children have moved away and there is not a family infrastructure to support aging parents.

Candy Hill said that the senior’s care plan can include other supports in the community to find assistance. The resources that are available are not nearly meeting the needs in rural communities.

Kate Rolf said that home and community-based services for the aging are her focus. In upstate New York, there is the frustration of burdensome regulations that are huge barriers. The regulations are in place to avoid fraud or because it can impact the greatest number of people. That makes it more difficult for rural areas. Most of the funding flows through the hospital or physicians and home and community-based services only receive a very small amount. What ideas do you have to embrace the community-based providers and encourage alignment of the resources to the most high-quality care where it is needed the most?

Sandy Markwood stated it is more expensive to serve rural communities and there has to be an investment in all parts of society to make sure change needs are met. There needs to be a line between realistic accountability and making sure communities are having their needs met in strategic and affordable ways.

Candy Hill said there has to be flexibility because there are systems of care relationships and partners that are non-governmental and are doing great work. Data to demonstrate that allowing other entities to run programs is important in meeting the needs of individuals in rural communities.

HEALTH SERVICES PANEL

Maggie Elehwany, JD
Government Affairs and Policy Vice President
National Rural Health Association (NRHA)

Maggie Elehwany stated that she represents the National Rural Health Association, a membership, nonprofit, healthcare association that represents patients and providers in rural America.

Rural Americans feel like they are the forgotten Americans. The great recession still exists in rural America. Ninety-five percent of the jobs that have returned have been in urban and suburban American. There is a rural divide in mortality rates and mortality is tied to income and geography. The five leading causes of death in rural America are heart disease, cancer, unintentional injuries, chronic respiratory disease, and stroke. These five diseases are higher among rural Americans. Minorities, especially Native Americans, die consistently prematurely nation-wide but more pronounced in rural. There is a startling increase in mortality of white, rural women. In rural America, people tend to be older, poorer and sicker. The highest areas of opioid abuse are concentrated in states with large rural populations.

There are a startling number of hospital closures in rural America. The hospital closings are happening in the poorest, neediest, populations in the country. A quote by John Henderson, Childress Regional CEO is, "Hospitals, schools, churches are the three-legged stool. If one of those falls down, you don't have a town." A hospital is usually the largest employer in a rural town and 20% of the local economy. When the hospital closes almost always the doctor, nurses and pharmacists leave the area. This causes medical deserts across the country. It is an economic

linchpin to have hospitals in rural areas and one in three is at the risk of closing. Some of the regulatory burdens have to be removed to keep rural hospitals from facing closures.

Medicare cuts are causing financial collapse for many rural hospitals. Urban hospital profit margins have increased while rural hospital profit margins are decreasing. The Affordable Care Act has helped to keep rural Americans insured but major insurance companies are not offering plans in rural markets. The prices and premiums are increasing the most for rural patients. The states that haven't expanded Medicaid are some of the poorest states in the country with the highest percentage of the rural population. There needs to be support of the expansion of Medicaid in these states and acknowledgment of the impact this is having on small hospitals.

John Supplitt
Senior Director
American Hospital Association (AHA)

John Supplitt stated that the American Hospital Association's advocacy and policy strategy has five objectives to help modernize the public policy environment and enhance providers' ability to improve the affordability of care. The five objectives are to reduce regulatory burden, enhance affordability and value, continue to promote quality and patient safety, ensure access to care and coverage, and continue to advance health system transformation and innovation. The American Hospital Association identified thirty-three duplicate and excessive rules and regulations that are administratively burdensome and redundant.

The Department of Health and Human Services and the Office of The Inspector General released a final rule that created new safe harbors for transportation services under the anti-kickback statute. The protection for cost-sharing waivers include pharmacy, emergency ambulance services, protection for certain payments between Medicare Advantage and Federally Qualified Health Centers, protection for discounts by manufacturers on drugs furnished to beneficiaries under the Medicare Coverage Gap Discount Program and protection for free or discounted local transportation services.

Expanding the definition for local has allowed transportation to be provided at greater distances. The rule allows hospitals and physicians to make financial arrangements with local transportation providers when shuttling patients to and from their home for up to fifty miles in rural areas. There are ways to reduce regulatory burden through administrative changes.

American Hospital Association priorities also include addressing threats to cyber security which affects rural providers disproportionately. Combating violence in rural communities and hospitals, increasing shared health information, telehealth and broadband and reducing health disparities are also a focus of the American Hospital Association.

Public policy change recommendations include the creation of new Medicare payment methods and transitional payments, new and expanded federal demonstration projects, modification of existing Medicare conditions of participation and laws regarding integration of healthcare providers. Other changes that need to be considered are modifications of Medicare payment rules

that impede coordination of care and the expansion of Medicare coverage and payment for telehealth.

Bill Finerfrock
Executive Director
National Association of Rural Health Clinics (NARHC)

Bill Finerfrock shared with the committee that the total number of Federally Certified Rural Health Clinics is 4,200. There are independent and provider-based Rural Health Clinics. Many small hospitals are buying rural health clinics which benefit the independent rural health clinics because they can get a higher reimbursement for the cost of a visit. Well over 50-60% of RHCs are hospital owned. This is due to higher reimbursement and the desire to create an integrated delivery network. The way that Rural Health Clinics are getting paid is cost-for-care instead of a fee-for-service system. Rural Health Clinics must be located in areas that are rural and underserved.

Rural health clinic designations cannot be more than four years old. If a rural health clinic loses its health professional shortage area or rural designation, they are grandfathered into the rural health clinic status. If the rural health clinic has to physically move their location, Medicare treats them like a new rural health clinic and subjects them to the certification standards of being in a currently designated shortage area. Rural Health Clinics need the ability to move within the same shortage area and retain the grandfather clause.

Rural health clinic issues for 2017 include ensuring adequate Medicaid payments, increase staffing flexibility for Rural Health Clinics, removing and reducing regulatory burdens, and raising the rural health clinic consumer assistance programs.

Q&A

Chester Robinson asked what the issues are around a nurse practitioner being contracted or an employee.

Bill Finerfrock stated that Centers for Medicare & Medicaid Services require rural health clinics to employ a physician assistant or nurse practitioner as condition as a certification of a rural health clinic. There should not be a restriction to only an employer/employee relationship.

Tom Morris stated that Governor Musgrove wanted the committee to discuss shortage designation.

Bill Finerfrock stated that workforce issues are a policy priority. The shortage designation gives the ability for rural areas that are medically underserved to work with the National Health Service Corp and the National Health Nursing Corp to recruit clinical professionals in their areas. It isn't possible if they don't live or work in a health professional shortage area.

Mary Sheridan commented that with a lack of behavioral health specialists and also workforce shortages in rural that it would be a great benefit if rural health clinics could be the hub for telehealth services.

Peggy Wheeler said that the cuts feel like they are targeting the small, rural hospitals. The rural hospitals in California are being required to demonstrate transformation and innovation. The small, rural hospitals are working to just stay open but they want to be part of the transformation. What can these hospitals do to not be at risk for closure? What should they focus on?

Maggie Elehwany responded that this summarizes so many rural hospitals across the country. There needs to be an understanding of the challenges in rural America. Regulatory relief, reinvigorating the economy and getting more access to capital to rural communities is vital.

John Supplitt said that hospitals are dealing with problems on multiple dimensions. Telehealth and virtual care would be the most cost effective way to get services to those in rural America that are not available locally.

STATE AND COUNTY PERSPECTIVES ON RURAL HEALTH AND HUMAN SERVICES ISSUES

Lauren Block
Program Director, Health Division
National Governors Association (NGA)

Lauren Block said The National Governors Associations Office of Government Relations serves as the collective voice of the nation's governors in Washington, DC. There is the Office of Government Relations and there is the Center for Best Practices that works directly with governors on specific policy projects. The National Governors Association Center for Best Practices five divisions is the Economic Opportunity Division, Education Division, Environment, Energy & Transportation Division, Health Division and Homeland Security & Public Safety Division.

There are many opportunities for divisions to work together on projects. The Center for Best Practices has previously worked on healthcare workforce issues with The Economic Opportunity Division and with The Homeland Security & Public Safety Division on opioid issues. There is coordination across divisions. The Health Division has six core focus areas: health systems transformation, behavioral health and social determinants of health, Medicaid and health insurance, workforce, public health and data and analytics. These were established three years ago but are still relevant today and all connected. Many of the issues that exist around the country are even more prominent in rural America. Healthcare workforce, public health and access to coverage are ongoing concerns.

Healthcare workforce challenges in rural America are due to lower healthcare reimbursement rates in rural than urban and suburban areas. There is a lack of opportunity for continued learning for healthcare providers in rural areas. There is a lack of workforce data and resources to accurately assess needs, inform policy, and evaluate existing programs. Rural communities have

shortages in emergency medical services, behavioral health specialists, primary care providers and maternal and child health care providers

Opioid and substance abuse are public health challenges in rural America. There is a lack of capacity and effective care for pain management including alternatives to opioids. A shortage of addiction specialists and lack of access to harm reduction services and medication-assisted treatment programs in rural areas impedes opportunities for recovery. Long distances to services and a lack of public transportation make it difficult for individuals in rural areas to receive treatment. Emergency Medical Services are insufficient and underfunded in most rural communities.

Challenges accessing coverage in rural America is due to a limited number of private insurers and providers and a lack of negotiation power. Healthcare delivery system barriers are due to a poor payer mix with heavy dependence on public payers along with low volumes. Patients are choosing to go to more urban providers.

States are participating in roundtable meetings and learning labs to find solutions to the problems facing rural communities. Three states participated in a learning lab with University of New Mexico's project Expanded Capacity for Healthcare Outcomes. Two of the three states are starting an Extension for Community Healthcare Outcomes project based on that initiative. Telehealth is a focus to address the lack of access to health and human services in rural America.

Jack Peterson

**Associate Legislative Director – Human Services and Education; Veterans and Military Services Committee Liaison
National Association for Counties (NACo)**

Jack Peterson stated that he would focus on policy information with the committee. The National Association for Counties is the only organization that represents all 3,069 county governments. One-half of the US population lives in 100 large counties and the other half lives in 2,900 smaller and rural counties.

Counties invest over eighty billion dollars annually in community health. One out of every five dollars in county budgets goes to community health. The National Association for Counties supports: One thousand hospitals with two-thirds being rural, nine hundred long-term care facilities with one-half being rural, and run two-thirds of the nation's 2,800 local health departments.

The county role in human services is different in each state. Whether it is the opioid epidemic or aging services, it varies depending on the county. Temporary Assistance for Needy Families and Supplemental Nutrition Assistance Program are administered in ten states. Fifty-one percent of Temporary Assistance for Needy Families funds is in county-administered states and thirty-three percent of Supplemental Nutrition Assistance Program funds are in county-administered states. Thirty-three percent of Administration on Aging funds is county based.

Medicaid policy is going to be a focus of NACo and it greatly benefits rural economies. Rural health clinics receive enhancement Medicaid reimbursements and thirty-three percent of rural physicians receive at least twenty-five percent of patient revenues through Medicaid reimbursements. Counties play a key role in funding the Medicaid Program. In the last data year, local governments contributed thirty billion dollars to the Medicaid program.

Behavioral health, mental health, and telehealth are a focus of NACo. An opioid task force report including twelve county officials and twelve city officials from across the country created recommendations of what their peers can do in their local communities regarding the epidemic. The task force suggested federal recommendations including expanding access to medication-assisted treatment and partnering with local and state officials to reduce the supply of Fentanyl and Carfentanil, which are synthetic forms of opioid. The Medicaid Inmate Exclusion Policy allows individuals in custody, prior to sentencing, to continue to receive Medicaid benefits and suspend Medicaid instead of terminate it while individuals are in jail. Almost two-thirds of inmates have addiction related issues so access to care while in the justice system is very important.

The Social Service Block Grant is a flexible source of funding that is county administered in ten states and covers thirty or more services, blending many different services together. It allows counties to serve the programs that are most in need of disability services and child protective services. The Community Services Block Grant is active in 99% of the counties in the country and many of those are rural communities. The money goes to community action agencies and is flexible so it can be used for a variety projects needed in the communities.

Michelle Price
Health Program Manager
National Association for Counties (NACo)

Michelle Price stated that she would be talking about three initiatives: The Rural Impact County Challenge, Stepping Up and The Early Childhood Program.

The White House Rural Council and National Association for Counties joined to focus on a national initiative to reduce the number of rural children and families living in poverty. Counties developed an action plan to achieve results and they were encouraged to pass a county level resolution plan to work on the initiative. The topic was discussed at conferences and there was an informal poll taken by the members. Some of the factors that the members said contributed to poverty in their counties were unsafe or unaffordable housing, unavailable transportation, lack of jobs, lack of family and social supports and a need for economic development opportunities. County Health Rankings and Roadmaps partnered with NACo on a community coaching program with eleven counties across the country to work on a strategy focused on reducing childhood poverty. The eleven counties were used as examples for other rural counties.

The Stepping Up Initiative encourages county leaders to pass a resolution and convene teams of decision makers to reduce the number of people with mental illnesses in jails. Many county jails are the largest mental health institutions in the country so counties have a large responsibility for dealing with the increasing issue of people with mental illnesses being warehoused in jails. There

are two hundred and fifty counties who have signed up for the Stepping Up Initiative. Half of the counties have fewer than 100,000 people. Key challenges that were expressed by counties included the need to develop workforce capacity and training, lack of transportation, lack of data capacity, sparse housing, limited internet and cell phone access and poverty. A key opportunity discussed is strong stakeholder relationships in rural communities that foster collaboration. Telemedicine was conversed as a way to assist people with mental health issues to get counseling.

The Early Childhood Program and two generational strategies are an important focus of NACo. Rural counties have a sense of community and family that can be leveraged and developed in a positive way to get better results.

Teryl Eisinger
Executive Director
National Organization of State Offices of Rural Health (NOSORH)

Teryl Eisinger said that The National Organization of State Offices of Rural Health is the member association that is focused strictly on the needs of the state offices of rural health. The state offices of rural health receive a variety of state and federal funds. The three core activities of State Offices of Rural Health information discrimination, coordination, and technical assistance. Twenty-two thousand three hundred and forty-nine clients have received technical assistance from state offices. The States Office of Rural Health really is an avenue for connecting state-wide and national partners.

Population health, workforce, transforming care delivery, and working on community health needs assessments is also a function of the State Offices of Rural Health. They are an interface for bringing together public health institutions and primary care institutions. State Offices of Rural Health are based on many different types of organizations: ten in universities, three in nonprofits, and the rest are in state government offices, mainly state health departments. The States Office of Rural Health really is an avenue for connecting state-wide and national partners.

The state perspective on rural health and human services is important because it provides licensing, makes Medicaid expansion decisions, and provides funding for rural graduate medical education. Focusing on the rural landscape and social determinants of health is important when beginning work around strategic planning. Strategic planning is building on the foundation that is already there and on successes.

Center for Medicare and Medicaid Innovation State Innovation Model Initiative project is effective. There are additional projects that are going to have the great potential around rural. Rural Accountable Care Organization's Success in Michigan Investment Model Accountable Care Organizations has achieved three percent shared savings in their first year and a reduction in cost in twenty-four out of thirty hospitals that are participated.

The Federal Office of Rural Health Policy Programs serves as models for other programs. The Medicare Rural Hospital Program is having an impact on quality improvement and innovations. Network grants are bringing together experts in the community who know their populations. The

Rural Opioid Overdose Reduction Program shows that there is the capacity to make a difference with overdose reversal. These types of programs can be a foundation for more Health and Human Service programs. The Office of Rural Health Policy workforce grants is allowing people to train in their community, giving rural health care facilities the opportunity to partner with local and state educational institutions to become a clinical training site for students or medical residents. Allowing people to train in the community is essential.

A challenge is the lack of a Health and Human Services rural focal point and an understanding of rural distances. Programs are being designed that will not work in rural communities. Health and Human Services would benefit from a rural impact assessment or cross-agency council with a focus on rural to assist in implementing and integrating rural into programs.

Q&A

Kathleen Dalton asked Lauren to share options for market reform in rural and share information about what Arkansas did.

Lauren Block said that Arkansas used a Medicare waiver to put their Medicaid population in the private market. One challenge is that it is more expensive to cover people so there is a cost concern. It may work in some states and may not work in other states.

Octavio Martinez asked what seven states are involved in the learning collaborative to identify and implement strategies to improve access to high-quality, cost-effective health care in America.

Lauren Block responded that the states involved are Kentucky, Michigan, North Carolina, New York, Nevada, North Dakota and Pennsylvania.

Ty Borders said that there is a lot of conversation about opioid abuse. It is a problem in many rural areas but not all. Methamphetamine and cocaine are prevalent in rural areas also. Why is opioid abuse the focus instead of the other drugs that are being abused?

Michelle Price responded that it may be because it comes from prescription drugs so it makes it a unique problem.

COMMITTEE DISCUSSION AND OVERVIEW OF DAY 1

There were five issues that were a theme throughout the discussions and presentations from health and human service representatives: housing, transportation, lack of jobs, lack of family and social supports and lack of economic development opportunities.

The committee discussed the burdens of disproportionate data gathering requirements in rural communities. There may be data but there's no funding for anyone to analyze it and this is especially the case for human services. This may result in bad data or gaps in data and a lack of funding and effective policy.

The committee also discussed: the need for health insurance markets to be strengthened and stabilized in rural communities, accessibility to virtual care and telehealth in rural areas to address health and human services, opioid abuse, and regulatory issues impeding progress in rural communities.

CALL VOR PUBLIC COMMENT

No Public Comment.

MEETING ADJOURNED

MEETING DAY 2 - HUBERT HUMPHREY BUILDING - WASHINGTON, D.C
Tuesday, April 11th, 2017

INTRODUCTIONS AND OVERVIEWS

The meeting was convened by Paul Moore. The committee had the chance to hear from a wide range of organizations that advocate on behalf of health and human services on the first day and now they will have the opportunity to hear from representatives from most of the Health and Human Services agencies.

FEDERAL PANEL #1

Jennifer Burnszynski

**Acting Deputy Assistant Secretary and Associate Deputy Assistant Secretary
Office of the Assistant Secretary for Planning and Evaluation (ASPE)
U.S. Department of Health and Human Services**

Jennifer Burnszynski said that she is with the human services office. The discussion will be about how human services may be different in rural areas than in urban areas and also about recent work that The Office of the Assistant Secretary for Planning and Evaluation is doing.

The highest poverty levels are in the rural, southern United States where 21.7% of the people are living in poverty. For all ages, poverty is higher in nonmetro areas. Single female-headed households with children who live in nonmetro areas have a higher rate of poverty than those in metro areas. Among all races, poverty is higher in nonmetro areas but nonmetro black individuals have the highest poverty rate. American Indians and Alaskan natives have the second highest poverty rate.

ASPE's recent work includes the Rural Integration Models for Parents and Children to Thrive, Early Childhood and Peer Learning and Action Network, and Building Nebraska Families.

Rural Integration Models for Parents and Children to Thrive is a multi-agency demonstration to address rural poverty and two-generational supports in a coordinated way. It was created in 2015 with a whole family approach to end poverty. The ten rural impact sites were in Kentucky, Utah, Arkansas, Ohio, Oklahoma, Maine, Minnesota, Maryland, Mississippi, and Iowa. The key findings were that there is a variation in tactics, program approaches and funding among the different locations. Collaboration is vital between agencies in order to achieve success and technical assistance is critical. All of the sites made substantial progress even though they achieved success through different avenues. Some of the lessons learned from Rural IMPACT is tailoring the technical assistance to a site is necessary, there has to be a range of partners involved, systems change is necessary and there has to be strong leadership.

The Early Childhood Peer Learning and Action Network was a year-long, community-driven, federally-organized technical assistance program. Early Childhood Plan Participants included the Kentucky Highlands, South Carolina low country, Choctaw Nations, and Pine Ridge. There were webinars and the building of a peer community group. There was work done with the sites in advance so the program could be tailored to meet their needs. One site had an interesting

stakeholder to lead the early childhood work and it was the children's museum. They were able to bring together partners and it was very effective.

Building Nebraska Families Initiative had very strong outcomes. The objective was to provide remote, rural families with self-sufficiency case management via home visits. Masters level educators assist with life skills, family management practices and gave informal counseling and support to access services. This program has had a positive impact on short-term and long-term employment and benefits receipt. The most disadvantaged subpopulations saw positive impacts that continued to progress for thirty months.

Current projects include a National Poverty Research Center that is federally funded and will be housed at the Institute for Research on Poverty at The University of Wisconsin. It is dedicated to understanding the causes and consequences of poverty in the United States, analyze policy and programs which can improve well-being and increase the self-sufficiency of the poor.

There will be a meeting convening to look at Deep Poverty hosted by The Institute for Research on Poverty, The Urban Institute of Practitioners, and researchers and policy makers. Rural models will be highlighted at the meeting including Aid to Distressed Families of Appalachian Counties, Oak Ridge, Tennessee and Moore Community House in Biloxi, Mississippi.

Human Service Policy considerations for the national advisory committee include the need for collaboration between agencies, the opioid crisis, economic challenges, physical isolation, and a limited number of service providers, small social networks, and lack of anonymity.

RADM Sarah Linde, MD
Acting Director, Office of Clinical and Preventative Services
Indian Health Services (IHS)
U.S. Department of Health and Human Services

Sarah Linde began by sharing that the mission of Indian Health Services is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The foundation of Indian Health Services is to uphold the federal government's obligation to promote health in these communities and to honor and protect the inherent, sovereign rights of tribes. Indian Health Services is a comprehensive health service delivery system that serves 2.2 million American Indians and Alaska Natives.

Dr. Linde shared that she has worked in the Federal Department of Health and Human Services for her entire career and is a family physician. She has field experience in rural communities and it has been interesting transitioning to Indian Health Services which is another healthcare system. There are five hundred and sixty-seven federally recognized tribes with a government to government relationship. This adds complexity to the mission but it is a great opportunity. Current Indian Health Services priorities are recruiting and developing a dedicated workforce and building and strengthening relationships that advance mental, social and spiritual health. The significant legislation that underpins Indian Health Services is The Snyder Act, Indian Healthcare Improvement Act, and the Self-Determination Act.

There are many challenges facing tribal communities including population growth and an increased demand for services, disparities in chronic diseases, behavioral health, oral health, lack of resources and difficulty recruiting healthcare professionals. Tribal communities have historical trauma, a culmination of emotional, physical and spiritual wounds that are carried across generations. It is a persistent cycle of experiences that overwhelm the ability to respond. Historical trauma isn't just about what has happened in the past but what is still happening.

Indian Health Service has six major focus areas around the opioid crisis including policy, training, proper pain management, increasing access to naloxone, expanding medication-assisted treatment programs and reducing utilization of methadone.

Indian Health Services partners with Centers for Medicare and Medicaid Services and are included in the nationwide hospital improvement and innovation networks to focus on reducing adverse events and hospital readmissions. IHS is also participating in the Quality Innovation Network and Quality Improvement Organization efforts to support best healthcare practices. The Centers for Disease Control also works with IHS on the National Immunization Program, sexually transmitted disease prevention, and cancer prevention projects.

Investing in people is one of the key factors for an agency to succeed. There is a new global recruitment initiative to make it easier for health professionals to find and apply for jobs. There is an ambassador program which is a mentorship initiative. College faculty, residency, and rural health program directors can partner with Indian Health Services to entice clinicians to consider a career in Indian Health Service. People can join through civil service, be hired directly by the tribes, transition from the military or join the Commission Corp of the United States Public Health Service. There are programs to entice health professionals to join Indian Health Services. There are scholarship programs and partnerships with different health professional programs and colleges for residencies and rotations and special programs for psychology, nursing, and medicine.

Q&A

Kathleen Belanger said that the human services are integral to health. There are human service deserts in rural areas where there are no human service workers and it is very hard to find data on rural human services. Children in rural areas are twice as likely to go into foster care as children in the metro areas. There is no data to know why this is happening and if it is due to the lack of a human service structure in rural America. An office of human services would be a benefit to assist with these issues.

Jennifer Burnszynski replied that most human services offices are The Administration for Children and Families and the regional office. There are a number of programs that are small and the challenge with human services is that it is more fragmented and siloed.

Octavio Martinez said that IMPACT is a great program and process evaluation. Is there going to be an evaluation based on outcome metrics or deliverables? Did it actually decrease poverty?

Jennifer Burnszynski said that HHS doesn't have plans at the moment but it is a great idea.

Ty Borders asked about research related to rural Native Americans and health issues. There isn't much research being done in this area. Maybe a reason is there isn't enough data related to Indian Health Services. Is there data through the tribal epidemiological centers or is there administrative data that could assist to inform the committee?

Sarah Linde responded that through tribal epidemiological centers and the national data warehouse within Indian Health Services there is data available but some of it is difficult to access so it needs to be more accessible.

Peggy Wheeler shared that she is with the California Hospital Association representing the rural hospitals. She said that workforce issues are chronic and persistent. Retention is an issue because there is such burn out because of the lack of medical providers in rural areas. "Growing your own" is important in rural communities. Enticing students from rural areas, who are going into the medical and human service fields, to practice in rural regions is important. Is Indian Health Services working to increase the pipeline of students in the medical and health services field to practice in rural communities?

Sarah Linde said that not only for physicians and nurses but they are having an expanding community health aid program. There are many partnerships with different colleges for students to rotate in Indian Health Services facilities.

Tom Price
Secretary of Health and Human Services
U.S. Department of Health and Human Services

Secretary Tom Price thanked the committee for their work. It is an honor to lead the Federal Department of Health and Human Services. He is a third generation physician and spent twenty years practicing medicine and the spent twenty years in the public arena as an elected official and having the opportunity to serve as The Secretary of Health and Human Services feels like the culmination of a life's work and is an incredible honor. In the 9th week as Secretary of Health and Human Services, the work has been so impressive from everyone who contributes. Secretary Price congratulated the Rural Health and Human Services National Advisory Committee on the 30th anniversary. He noted that the three clinical areas of focus are childhood obesity, mental illness, and the opioid crisis. There was a wealth of information in the Rural Health and Human Services National Advisory Committee's 2016 report related to the opioid crisis in rural areas. Rural America has remarkable challenges, especially in the arena of healthcare regarding resources, transportation and access to services. The physicians in rural America who are trying to provide care often feel like there isn't anyone thinking about them so it is important to have this committee and to emphasize that they are a priority. The challenges that face rural America are the same challenges that are faced everywhere else but are unique because of the expansive landscape and getting services to those places.

FEDERAL PANEL #2

Andre Chappel
Director, Division of Public Health Services
Office of the Assistant Secretary for Planning and Evaluation (ASPE)
U.S. Department of Health and Human Services

Andre Chappel said that there is research by The Office of the Assistant Secretary for Planning and Evaluation regarding the performance of rural hospitals. There have been a number of rural hospitals that have closed and three are at risk of closure. There is research concerning wage adjustment for rural hospitals by CMS and if there is adequate reimbursement for hospitals in terms of labor costs to provide services. Some of the hospital challenges are driven by low occupancy rates that increase the fixed cost that hospitals face per discharge. Wage index reclassified hospitals were close to an urban area. These hospitals tend to perform better than other rural hospitals and that is due to higher occupancy rates, teaching, and disproportionately shared payments.

There was an issue brief published on rural hospital delivery system reform. A number of rural hospitals can't participate in value-based purchasing programs. Approximately 60% of rural hospitals are critical access hospitals and are paid on a cost-based reimbursement system which makes it challenging to integrate them into some of the value-based purchasing programs. The rural hospitals that do participate in the program perform better than urban hospitals regarding the hospital value-based purchasing and the hospital acquired condition reduction programs. Rural hospitals have advantages in some ways because they can be located next to other types of service providers, which enhance the ability for coordinated care. Rural hospitals also do well concerning the patient experience metrics. There are challenges integrating into delivery system reform because rural hospitals are small in size which makes it difficult to measure quality. They have less infrastructure in terms of financial resources and staffing.

Assistant Secretary for Planning and Evaluation has done work regarding retention rates and the National Health Service Corp. Retention rates within the same health professional shortage area are approximately 40% over a five-year period. Providers are also moving to a different health professional shortage area so it maintains a workforce in a HPSA.

The Office of the Assistant Secretary for Planning and Evaluation measures the health insurance marketplaces enrollment, the operations of the market and general information that is provided to the public. Through the research that has been conducted, the uptake of health insurance in rural was slightly more than urban areas. Rural areas struggle to recruit, incentivize and gain interest among insurers. Many rural areas of the country have one or two insurers in the marketplace and employer-sponsored insurance. There is a higher consolidation of providers in rural areas and higher input costs, however, smaller base of people in the plans.

Some future research ASPE will be conducting includes approaches to maintaining access to services in rural areas, rural providers, value-based payment, fostering health insurance competition in rural areas and successful arrangement to coordinate specialty care.

Cara James

**Director, Office of Minority Health
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services**

Cara James stated that The Whitehouse Rural Health Council was established a year ago to focus on embedding a rural lens into the agencies work when developing, evaluating and implementing programs and policies. There is an emphasis on ensuring access to high-quality healthcare, addressing the unique economics of providing health care in rural America, and bringing a rural healthcare focus to the delivery and payment reform initiatives.

Engaging the stakeholders by hearing for rural residents about their challenges is important to the work being done by CMS. There was a rural health solutions summit at CMS headquarters in Baltimore that featured about six hundred people who participated in person and virtually in sessions held by regional offices. There have been listening sessions in each region that include going to communities to talk to stakeholders, providers, and consumers to about their vision of a healthcare system in rural America in the next ten years.

The emerging themes from the listening sessions include a lack of reimbursement for certain services ad comprising human services and social services. Reimbursement is too low for some services and quality measures and reporting are a challenge for rural providers. Lack of access to specialty care and unavailability of transportation is a major issue. There are technology and infrastructure challenges and difficulty navigating the health care system. People in rural areas have problems affording health care coverage and paying high co-payments.

The critical assess hospitals have concerns about closures and that issue needs to be addressed. It would be helpful for the committee to give feedback on how Centers for Medicare and Medicaid Services can support the critical access hospitals. Centers for Medicare and Medicaid Services would also like to have input on how to support the rural healthcare workforce and comprehensive workforce strategy to make sure there is access to critical services.

The Office of Rural Health Policy and Office of Minority Health are working together on chronic care management services to raise awareness of providers and consumers about the new chronic care management codes that are helping to support care coordination, particularly for rural and minority beneficiaries.

There is a Medicare disparities tool that allows research on the county level that includes eighteen different conditions to assist in comparing factors. Some of the social determinants of health are being added for comparison as well. A way that the committee can assist is by sharing topics of research that is necessary to inform policy.

**Carol Blackford
Director, Hospital and Ambulatory Policy Group
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services**

Carol Blackford shared that she would like to discuss with the committee about managing the pace of change in the Medicare program. The challenge is that everything that Medicare does affects rural providers. Medicare is a huge program that covers 55.3 million people with a total expenditure of over sixty billion dollars and the trustees predict that Medicare spending will continue to grow. Medicare is in the process of delivery system reform and paying for value instead of volume. The quality payment program is for clinicians to participate in an advanced, alternative payment model on the merit incentive payment system to present opportunities for performance-based payment adjustment. The fee-for-service payment systems have incentives to move from volume to value.

Primary care and care management services are valued in the physician fee schedule. There are new codes and payments for comprehensive assessments, care planning for payments for patients with cognitive impairments, chronic care management, and new codes and separate payments for primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions.

Site neutral payment will be implemented in the acute and post-acute setting. The provision is to address the increasing trend of hospitals acquiring physician practices and integrating the practices to optimize Medicare reimbursement under the current payment system. The site neutral payment is to reduce those incentives.

There are changes being implemented in how Medicare pays for clinical lab fee services. There will be a more market-based pricing system. A weighted median will be calculated that will become the Medicare payment for diagnostic lab testing. Small, independent labs are concerned that the legislation was written so that the private payer data from the larger labs will be driving the Medicare pricing and they will have difficulty competing.

Providers have to be aware of sub-regulatory and regulatory billing changes and how it is going to impact their business. Medicare policy encompasses a national lens and pricing is based on an average cost of providing care which is not always reflective of the unique circumstance in rural communities. The rural health council work is critical to making sure that the concept of rural is being included when making policies.

The workforce is changing and having the clinical staffing needed is vital in rural areas but there is also the need for information technology staff, project managers, and data analytics. These issues are very difficult and feedback from the committee on how to support rural providers so that they can keep up with the pace of change is greatly appreciated.

Q&A

Chester Robinson stated that rural areas do not have the financial resources and staff for reporting data but know that data gathering is important. Do you know how to support the rural areas regarding collecting data?

Cara James responded that the Transforming Clinical Practice Initiative Model will support providers in the practice transformation so they can engage in reporting. The Quality Payment

Program has a technical contract to help rural providers meet requirements for Merit-Based Incentive Payment System.

Mary Sheridan said rural health clinics are the hub in many communities in delivering primary health services. They have additional burdens, in particular, to nurse practitioners and physician assistants being required to be employed by the health clinic in order to provide services. Rural Health Clinics and Federally Qualified Health Centers could serve as a hub for telehealth in supporting workforce, behavioral health, and opioid issues but there are limitations around telehealth. Rural Health Centers need flexibility and opportunities.

Carol Blackford responded that the Medicare statutory construct around benefits is descriptive in the definition of Rural Health Centers and who can provide services and how they are billed. Recently, there were published regulations to allow chronic care management services to be billed outside of the Rural Health Center. This matter continues to be reviewed to make sure there is flexibility and to take advantage of Rural Health Center's ability to be a hub for services. It is essential to get feedback on regulations that are burdensome and the limitations that are making it challenging to provider services.

Peggy Wheeler said that rural hospitals have so few resources to keep up with the pace of change but it is difficult to find the specific action to recommend to the Secretary of Health and Human Services.

Cara James responded that there are challenges in the way the system is structured that make it difficult for rural providers. This is a great opportunity to break down silos and have a collaborative approach to connecting human services and health care. Examining social determinants of health and a holistic approach is not how the healthcare system is setup. The Accountable Health Communities Model is linking social determinants and health and as a way to map the services.

COMMITTEE DISCUSSION

FEDERAL PANEL #3

James Macrae
Acting Administrator
Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human Services

James Macrae stated that sometimes policy is developed as one-size-fits-all and when developing performance measures and policy the unique rural perspective has to be considered.

Health Resources and Services Administration supports about ninety programs throughout the country with a focus on underserved populations. HRSA has over 3,000 grantees including hospitals, universities, states and communities. HRSA works in partnerships and in collaboration with grantees so the program touches tens of millions of people which include community health

centers, Ryan White program, home visiting programs, rural health programs, and the National Service Corp. There is an annual survey to get feedback from grantees.

The vast majority of HRSA's budget goes to community health centers. The Ryan White HIV and AIDS program and maternal and child health and health workforce programs receive a significant investment from HRSA. Rural health does not receive a large amount of funding but it is used in innovative ways that make a significant difference.

The Health Center Program is a leading program supporting about 1,400 health centers across the country with over 10,000 sites. It is a source of affordable and accessible care and primarily focuses on people living in poverty. About 42% of the funding goes to rural communities. Access to proper medical care is a focus of this program but there are also oral and mental health services. High-quality and cost-effective services are a priority. The top two health conditions of people visiting health centers are heart disease and diabetes. Health centers are expanding their capacity around mental health and are screening patients for depression. If there is a larger investment in primary care, it translates into less use of specialty care and readmissions so this is a priority.

HRSA is serving about one-half of the people in the country with HIV through the Ryan White Program. It is important to make sure individuals with HIV and AIDS are getting care and for reduction and viral suppression rates. The Ryan White Program is identifying Rural America because more needs to be done concerning the epidemic.

The Maternal Child Health Block Grant provides services to about one-half of the pregnant women in the country. It is imperative to provide home visiting for at-risk pregnant women and support services for mothers after their baby is born. Early intervention makes a difference in a child's overall health and their ability to do well in school as they get older.

About 25% of The National Service Corp. providers are in rural communities and are caring for about a half million people. One-third of the providers are delivering behavioral health services. HRSA supports the Children's Hospital Graduate Medical Education Programs and The Teaching Health Center Program.

Rural health policy looks at all of the policies in HRSA to make sure rural is taken into account. Some of the Office of Rural Health Policy Programs includes rural health networks, black lung clinics, and telehealth. The Office of Rural Health Policy assists rural hospitals and providers to move from volume to value-based healthcare.

CDR Karen Hearod, LCSW
Regional VI Administrator
Substance Abuse and Mental Health Services Administration (SAMHSA)

Karen Hearod shared that she grew up in McAlester, Oklahoma in the heart of the Choctaw Nation. Her mother was a community mental health case manager so she had exposure to mental health and substance abuse issues at a young age. Mrs. Hearod is a licensed clinical social

worker and worked in a small hospital and experienced the challenges in rural America concerning mental illness and substance abuse. There is difficulty with crisis bed shortages and with the interaction between law enforcement and those with mental health and/or substance abuse issues. The community hospital's rural clinic had an integrated care system because health and human services were all in one building. This is one benefit in rural communities that house all of the services in one location due to necessity. It allows for inherent collaboration between agencies.

There are so many more challenges in rural related to workforce development, primary care innovation, and the opioid crisis and it is necessary for funding to converge to meet these challenges. A discussion about how SAMHSA'S state block grants and primary care behavioral health funds can augment one another for more successful outcomes would be valuable.

SAMHSA has 500 million dollars of funding going to states in 2017 and 2018 to fight the opioid abuse. Medication-assisted treatment will receive funding and it is a very important means of saving lives. There are stigmas attached to substance abuse disorder and medication-assisted treatment that need to be addressed. Recovery-oriented systems of care and a public health approach for substance abuse disorder needs are vital for the success of individuals with opioid addiction. There needs to be opioid crisis intervention treatment and education for law enforcement so they will have the necessary tools to assist people in dire situations.

A challenge with tele-behavioral health in rural areas is license reciprocity. There are four states that have success regarding reciprocity and can be an educational model. The Extension for Community Healthcare Outcomes model is a huge opportunity to spread knowledge and expertise into the rural areas. The Extension for Community Healthcare Outcomes increases access to specialty treatment in rural and underserved areas by providing clinicians with the knowledge and support they need to manage patients with complex conditions. The use of technology connects specialty teams with primary care clinicians. This is especially important in rural communities due to the shortage of a specialty care workforce.

Karen Hearod shared the following recommendations for The Rural Health and Human Services National Advisory Committee to consider:

- Recommend broadening focus of treatment for substance use disorders to a recovery approach and highlighting Recovery-Oriented Systems of Care. (ROSC)
Encourage support and expansion of Project ECHO sites to increase workforce capacity and provide best practice care.
- Ensure access for prevention and treatment services for all pregnant women and their families affected by substance use disorder. Services should be affordable and interventions should be evidence based and delivered with special attention to confidentiality, legal and human rights.
- Recommend creation of a pilot project with Western Interstate Commission for Higher Education to work towards the establishment of an Interstate Licensure Compact Agreement for interstate behavioral health licensure reciprocity.

Q&A

Barb Fabre asked if behavioral health is offered at all of the Indian Health Service sites.

Karen Hearod responded that some sites have full-service sites with access to psychiatry, psychology and clinical social work. Others may have a peer support group with oversight from a licensed provider. Indian Health Services has been looking at broadening its base of community health workers and training behavioral health aides and this would be a very effective model in rural areas.

Octavio Martinez asked how many primary clinics have the collaborative care model to insure that behavioral health is being addressed and what type of coordination there is between their two agencies to change the delivery model.

James Macrae responded that people are showing up at primary care clinics with undiagnosed behavioral health issues. More psychiatrists and psychologists were hired at the primary care clinics and as a result they are training primary care providers in behavioral health and how to do the initial screening. This has assisted with true integration and the “no wrong door” concept.

Octavio Martinez asked what the committee can recommend to the Secretary of Health and Human Services.

James Macrae said the importance of true integration. Many times problems are multifaceted and need to be viewed in a larger perspective. People don’t enter clinics with just one condition so there are many issues that need to be addressed.

Karen Hearod responded that historically healthcare and human service dollars are segregated so a recommendation about how money is allocated to allow for expansive treatment of the “whole person” is very important.

Carolyn Emanuel-McClain said that her hospital is an integrated model of primary care and behavioral health and also have telepsychiatry. An option being considered is hiring a psychiatrist and contracting out with four community health centers in the rural area. Social workers and licensed behavioral health counselors have to be licensed independent in order for CMS reimbursement through Medicare. If the restrictions could be altered it would be beneficial.

FEDERAL PANEL #4

Mishaela Duran
Director, Office of Regional Operations
The Administration for Children and Families (ACF)
U.S. Department of Health and Human Services

Mishaela Duran shared that she is from a family of farmers and ranchers in rural Arizona so she is sensitive to the efforts in rural America. The Administration for Children and Families

administers more than fifty-three billion dollars a year and operate through over sixteen program offices and ten regional offices.

Most ACF funding goes through the states and counties. There is also funding for the community action agencies that serve rural counties and sometimes are the primary service provider in rural communities. The AFC represents the assistant secretary and the Administration for Children and Families, in the field. Stakeholders are focused on the social determinants of health so it is also the focus of the state human services commissioners and county commissioners. Some of the county service agencies operate both health and human services in collaboration. Building partnerships with places of higher education to strengthen workforce is a priority. In rural communities, it is difficult to attract social workers and early childhood developers so it is important to produce talent inside the communities.

Cost-cutting strategic initiatives are also a focus of AFC. There are strategic initiatives that span across sixty-two programs and ACF works comprehensively with states on systems integration and to better serve the customer. On a regional level, there is a focus on forging public-private partnerships and this is especially important in rural communities. The states budgets are becoming more constrained so it is important to support states in serving populations with existing resources and concentrating on results.

ACF provides regional leadership by working with HHS and SAMSA and other federal agencies. The core functions are strategic initiatives and serving the state and local human service agencies. There are interfaces with the governors' offices on human services and linking with the state legislators on funding regarding the innovations emerging in county and state governments. Emergency preparedness and response and internal and external communications and affairs are also part of ACF.

The Administration for Children and Families promising models to reduce intergenerational poverty and increase school readiness includes Friends of the Children of Mississippi, Garrett County Community Action/Allegheny County Resources Development Commission, White Earth Reservation Tribal Council and Family Futures Downeast. It is helpful for communities to learn from the best practices of rural models in order to solve problems.

White Earth Reservation has been doing amazing work around a universal intake data system. The focus is on early head start and workforce development. The WE CARE, new case management system, serves the whole child. The system is based on no wrong door. The family goes to one program for all of their needs instead of many different programs. Breaking down silos was very successful in better serving the needs of families. There are strong partnerships with education systems which are very important.

Garrett County and Allegheny County human services have gone through a major change management initiative to focus on the whole family. They have implemented a universal investment to track the outcomes of the families. The families are coached and the families assess their needs around each of the health and human service domains. There is a data system that tracks the progress of the families based on the increase of the family earnings, the child's

school readiness, and how much they are paying towards housing. There is an entire integrated system with no silos so all agencies are working together to support the family.

A published Administration for Children and Families resource to help address the opioid crisis is *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*, a guide promoting collaborative efforts between providers and agencies serving pregnant and post-partum women with opioid dependence and their infants.

Kathleen Votava

Ageing Services Program Specialist, Office of Regional Operations

Administration for Community Living (ACL)

U.S. Department of Health and Human Services

Kathleen Votava shared that the Administration for Community Living was formed in 2012 and joined the Administration on Aging and the Administration on Disabilities under the Administration for Community Living oversight. The mission of the Administration for Community Living is to maximize the independence, well-being and health of older adults, people with disabilities across the lifespan, and their families and caregivers.

The Administration on Aging includes the aging network that derived from the Older American's Act. At the federal level funding is provided to state units on aging and the money goes to local Area Agencies on Aging and then to local providers in the community. There are two hundred and seventy tribal organization grantees and the funds go directly to the organizations. The core services include nutrition services, home delivered meals, caregiver support services, disease prevention, and health promotion. The Older American Act program is not an entitlement program. The eligibility age is age sixty and older and is directed toward those with the greatest economic and social needs and also for those living in rural areas.

The Administration on Intellectual and Developmental Disabilities provides funding for state councils on developmental disabilities that include conducting outreach and providing training. There is also protection and advocacy organizations that work on the state level to empower adults with intellectual and developmental disabilities to advocate on their own behalf.

There are sixty-eight University Centers for Excellence in Developmental Disabilities Education Research and Services that is affiliated with universities so that allows them to service as liaisons between academia and community. The Independent Living Administration was formed with The Department of Education. The Centers for Independent Living are also funded non-profit agencies that provide information, referral and peer counselling. They facilitate transition from nursing homes and other institutions to the community and provide assistance to those at risk of entering institutions.

The National Institute on Disability, Independent Living and Rehabilitation Research provide grants to generate disability and rehabilitation knowledge and promote its use in adoption. The focus is to put policy into practice. The Rehabilitation Research and Training Centers is a program in rural communities that conducts research on disability as part of The Rural Institute for Inclusive Communities at The University of Montana.

National Adult Maltreatment Reporting System is the first comprehensive service for adult protective services. This is a step closer to getting data collected on adult maltreatment. The goal is to provide consistent, accurate, national data on exploitation and abuse on older adults and adults with disabilities. Fifty-eight states are expected to participate in 2017.

The cover to cover (C2C) initiative is The Administration for Community Living that connects veterans to community or veteran eligible resources, especially in rural America. Older veterans and veterans with disabilities, who live in rural areas, have difficulty accessing resources within their communities. Community agency staff may have limited knowledge of Veteran's Administration benefits and have challenges connecting veterans to Veteran's Administration benefits. The Veteran's Administration partnership with Aging and Disability Resource Centers collaborate work together to provide resources that are available.

An emerging issue is the number of people aging with disabilities in rural America. People with disabilities develop chronic diseases and cognitive issues at earlier ages. Twenty five percent of adults with Down Syndrome will be affected with dementia after age forty; and fifty to seventy percent will be affected by age sixty. Caregivers will be aging and not have the capacity to care for their family member with disabilities and people with disabilities will be outliving their family caregivers.

Q&A

Connie Greer stated that she worked in Minnesota for a rural community action agency and then for the state of Minnesota and as a senior citizen she is on the board of directors for a community action agency. It is difficult to make recommendations for the future without knowing what changes will occur with the budget.

Kathleen Votava replied that a challenge in Minnesota is how to identify how to measure results. They have talked to counties in Minnesota about ways to measure the results and community action agencies have a performance based framework. Continue to use the framework and focus on the customer and proving results and it will give an emphasis on state appropriations and will also make progress on a national level. Data systems that measure results, focus on improving outcomes, and are connected with shared information, will allow for integrated services on all levels.

Kathleen Belanger asked how ACF is measuring outcomes for rural children and families. Is there a rural lens?

Mishaela Duran replied that there are sixteen program offices and they all measure their programs differently. Some programs are emerging and some things are statutory, especially in child welfare. States and local counties are focusing on how many people are being served and how well they are being served. ACF is working to integrate state and local performance measurements into the federal system. The performance management system depends on the program.

Barb Fabre said that she administers the Child Care Development Block Grant at White Earth Reservation. The Secretary's priorities are childhood obesity and behavioral health. In rural childcare, those issues are prevalent and do not receive support. The White Earth reservation serves three hundred children and has two child care centers. The rest of the child care is in home locations. The department is working with the behavioral health departments to get them into the childcare sites to establish a relationship and be able to make referrals when needed. There is no data system in place and that is detrimental to progress because there is not information to share with legislatures.

Mishaela Duran replied that the new Office of State Data Capacity has made gains and states and counties are being identified that have robust systems that can be procured.

DISCUSSION OF HEALTH AND HUMAN SERVICE PRIORITIES

- A need for accurate human Services data. Data needs to be separated in a rural/urban cut in order to get accurate information and shared between federal agencies and the rural research center.
- A rural agenda across Health and Human Services. Encourage rural agenda for the Secretary's focus areas.
- A rural human services structure to integrate with health services, integrating behavioral health services within primary care.
- Improve communications regarding regulatory burdens in rural areas. Create a list of human service regulatory burdens.
- Health and Human Service plans, programs, and policies that focus on children 0-3 years.
- Opioids are related to a huge realm of human service issues. Address the issues as connected and related.
- Focus on integration of services without consolidation.

CALL FOR PUBLIC COMMENT

No Public Comment.

MEETING ADJOURNED

MEETING DAY 3 - HYATT PLACE - WASHINGTON, D.C
Wednesday, April 12th, 2017

The meeting was convened by Paul Moore, Senior Health Policy Advisor. Governor Musgrove was unable to attend the opening day of the meeting.

HEALTH AND HUMAN SERVICE RURAL UPDATE

Tom Morris
Associate Administrator for Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services

Tom Morris stated that the Health and Human Services Secretarial priorities are opioids, childhood obesity, and behavioral health.

The Center for Disease Control and Prevention Morbidity and Mortality Weekly Report will be doing a 2017 year-long series of planned articles that will highlight disparities between rural and urban populations and includes mortality, chronic diseases, healthy behaviors, reproductive health, injuries and exposures, and agriculture safety and health. Three studies have been released and additional studies will be released in April and through the summer.

The Centers for Disease Control and Prevention has created a new National Center for Health Statistics rural-urban data visualization tool. The tool allows comparisons between rural-urban by age group, at the state level for five different causes, and different time spans. This gives a great opportunity to better understand the data. <https://www.cdc.gov/nchs/data-visualization/>

The viability of rural hospitals and challenge of ensuring access to basic services in many rural communities is a concern. There have been eighty closures since 2010. Rural hospitals are at a high risk of financial distress but there is policy discussion about this issue.

Some issues to follow include implementation of the Quality Payment Program, supporting the Chronic Care Management Campaign, tracking the implementation of the 21st Century Cures Opioids funding, and year five of the Marketplaces.

STRATEGIC PLANNING FOR FUTURE MEETINGS

Some topics that the committee has not previously covered or could revisit:

- Modernizing/Updating the Rural Health Clinic designation
- Oral Health in Rural America
- Opiate Abuse for the Rural Elderly
- Access to Obstetrical Care in Rural America
- Reducing Burden for Rural Providers in the Quality Payment Program
- Enhancing Chronic Disease Treatment in Rural America
- Improving Rural Insurance Markets

National Advisory Committee discussion of topics to consider for future meetings:

- Suicide (including workforce issues, human services issues)
- Opioids
- Rural health insurance markets
- Childhood Obesity
- Rural Children

CALL FOR PUBLIC COMMENT

No Public Comment.

MEETING ADJOURNED