February 6-9, 2000, Washington, D.C.

Health Resources and Services Administration
Office of Rural Health Policy

Washington, D.C.
February 6-9, 2000

Meeting Summary

The 34th meeting of the National Advisory Committee on Rural Health (NACRH) was held February 6-9, 2000, at the Washington Court Hotel in Washington, D.C. A reception was held for NACRH members on the evening of Sunday, February 6.

Monday, February 7, 2000

Call to Order

Former Senator Nancy Kassebaum Baker, new chair of NACRH, convened the meeting and commended the former chair, Governor Robert D. Ray, for his work in the health field and acknowledged the expertise of the present Committee members. The following members attended the February meeting: James F. Aherns, J. Graham Atkinson, H.D. Cannington, Dr. William H. Coleman, Shelly L. Crow, Dr. Steve Eckstat, Dr. Barbara Jean Doty, Faye Gary, Rachel A. Gonzales-Hanson, Alison Hughes, John L. Martin, Dr. Tom Nesbitt, Dr. Monnieque Singleton, and Mary Wakefield. The complete meeting participant list is provided in Appendix A.

U.S. Department of Veterans Affairs and Rural Health

Dr. Tom Garthwaite, Acting Undersecretary for Health Affairs, U.S. Department of Veterans Affairs (VA), provided NACRH members with an overview of the VA-community challenges experienced in rural health. Non-VA, both private sector and Government agencies, may consider combining resources to help meet these challenges.

- The staffing issue is a major problem because the ability to deliver care is affected when a health care center is unable to recruit high-quality staff. Understaffing is exasperated by staff absences due to illness and vacation time. The VA has found that sending specialists to operate rural clinics works best if the clinics are not too remote and are within commuting distance from metropolitan areas. Another option is to recruit providers part-time and have the remainder of time covered by community providers. The only

other option is to send patients to specialists in urban areas, which leads to the next consideration.

- Transportation is another major obstacle for rural communities, including emergency transportation (e.g., ambulances, helicopters, and airplanes), as well as scheduled transit such as vans and buses from rural areas to tertiary care medical centers. It may be reasonable to use these scheduled transportation services for non-VA patients because it is likely that these vehicles are not always full. In collaboration with Ford Motor Company, the Disabled American Veterans has donated vans and volunteered to drive to meet these transportation needs. Because health care is provided more on an outpatient basis, not because fewer patients are seen, the VA has eliminated more than half of its acute beds. Many of these wards have been converted into "hoptels," which is a hotel-hospital hybrid. Hoptels provide overnight accommodations for families and patients who have been admitted for surgery. Fundamentally, transportation is a coordination issue in which doing the minimum amount necessary is preferable.
- Community-sharing issues include maintaining acute bed facilities that have too few beds to warrant keeping hospitals open. One solution is to contract for hospital beds and services in the community and place some VA providers on staff. About half of the VA community outpatient clinics located in rural areas contract for primary and mental health care and for some specialty care depending on the size of the population being served. In the last 5 years, the VA has moved toward contracting and away from building VA facilities with VA staff. Due to the inpatient care facility decrease, the VA has an increased capacity for laundry/food services and building space that could be contracted out. Enhanced-use leasing has allowed the VA to lease buildings and land to private developers. Nursing homes and homeless shelters have been established under these agreements. The VA has had some success with mobile clinics, but they are less efficient than stationary clinics. Often there are not enough veterans to serve at a particular stop to make this a cost-effective alternative. If the VA was to partner with another organization to serve other populations, mobile clinics could be more cost-efficient. The VA has saved millions of dollars through shared contracting for volume-committed pricing, which drives the prices down for medical supplies. Rural communities should consider banding together in purchasing cooperatives to save money. Long-term care is another area in which collaboration may be helpful.
- The VA has a fair amount of infrastructure that could be leased for joint clinics or rented for ventures in which the VA is or is not involved (bi-directional depending on the individual needs of the location).
- The solution to many of these issues is telehealth technology. This type of technology was used on Upper Peninsula Michigan when the local pathologist retired, and the community did not need a full-time replacement. Long-range interpretations could be garnered using remote-controlled microscopes. With use of the telehealth format, two medical facilities (one urban and one rural) began to operate as an integrated system. Studies of telehealth services indicate that many patients prefer the remote access format for psychological services. One pilot in-home program for spinal cord injury (SCI) patients is under way. These patients connect to SCI centers from home. It is a challenge for many communities to invest in telemedicine infrastructure, but it may be possible to provide better care once beyond the initial obstacles. In 1995, the VA transformed into a more community-based agency with community outpatient clinics. It has opened about 250 health care sites that did not exist 5 years ago. This growth was made financially possible by decreasing the inpatient workload and emphasizing preventive care.
- The VA information system is exceptional. Many medical residents who rotate through the VA and have worked in a variety of hospital environments agree that VA hospitals

have the best information system pertaining to clinical information and medical records. This is a public domain system that would be fairly inexpensive to replicate in a rural hospital setting.

Discussion

In the discussion that followed the VA presentation, several issues were raised:

- Community-sharing issue. Many vets do not want others to have access to VA facilities, especially if poor vets are not receiving the care they need. The VA has tried to overcome resistance to sharing VA facilities with non-VA populations by reinforcing the idea that the VA health care system would be healthier if it was more fully utilized. Higher utilization would support the infrastructure by decreasing the cost per case. The VA has also improved its method of cost accounting so that the costs of non-VA care can be quantified. At this time, there are only two programs in which non-VA patients receive care in the same facility as vets, not just in space rented by the VA. Two additional options include VA clinics that provide care for relatives of military personnel and combined clinics in which the VA has partnered with private clinics or medical schools.
- Duplicate services with the VA and the Indian Health Service. It was suggested that these two agencies, which are within each other's jurisdiction in Oklahoma and possibly in other States, could share providers and other resources. The challenge, as with the vets, would be overcoming the resistance of Native Americans in allowing other groups access to their health care services.
- Transportation issue for the frontier populations. In Alaska, transportation is a major issue. In the sparsely populated frontier areas, there are vets with VA eligibility that cannot access health care because of the long distance to VA facilities. It appears that efforts have been to centralize the VA system rather than to distribute it through communities. Partnerships between these remote communities and the central system are not well established. An improvement in communication, at least from the case management standpoint, may help overcome some of the more daunting transportation issues. Alaska has a good partnership with the military through the Department of Defense. Contracting care in sparsely populated areas can be expensive because there is no competition. Even with a nearly $20-billion budget, the VA cannot cover all regions of the United States where eligible vets, especially less eligible vets, reside.
- Contracting for local care in local hospitals is a solution to transportation problems. In Montana, there is a 12-hour drive to receive needed care in some cases. This State has about 100,000 vets, which is a high proportion of the State's total population (about 800,000). It is not economical to transport less eligible vets around a large, sparse State. Largely through contracting, the VA has opened community-based clinics to overcome transportation barriers. These efforts have helped to reduce the number of referrals made to central VA facilities. Some level of care, such as open-heart surgery, may be worth traveling long distances. Routine case management, such as blood pressure checks and immunization, may not be.
- Homelessness and substance abuse in rural communities. These problems are not just in urban areas but in rural areas too. The VA is the leading provider of hands-on care to the homeless in the United States and possibly for substance abuse care as well. There are initiatives in rural areas in conjunction with States, such as the Homeless Grant Per Diem Program. Under this program, the VA helps build facilities and provides per diem for vets who use these facilities. For substance abuse care, the VA strives to deliver

mental health services through primary care services, which are available through the community-based outpatient clinics.

- Attitudes of veterans' groups about potential closings of VA facilities. One VA group has stated that not one of these facilities is unneeded. Vets feel a sense of belonging through the VA facilities. These vets may be more accepting of sharing their community clinics if the older centers, which are often beautiful historical structures, were used as meaningful projects they could support (e.g., veterans museum or park). Ten out of 172 acute-care hospitals have been closed with no major outcry; others are slated for closure. The VA has not abandoned these buildings; many now house clinics, nursing homes, or residential facilities. These buildings symbolize the commitment made to veterans by representing tangible aid. An issue with maintaining these facilities is that many are not placed in areas where a present-day planner would build a hospital.
- Living facilities for veterans. Housing facilities with therapy for mental illness, substance abuse, and homelessness may help vets stay connected and remove the sense of isolation and alienation that drives substance abuse. Overall, VA models are excellent. But they could be improved by extending community-based programs that do not release severely psychotic vets who have improved during hospitalization. The VA does have a significant number of residential intensive treatment programs. For example, there is a 200- to 300-bed facility in Milwaukee that treats vets referred from the psychiatry program for longer-term rehabilitation. Many of these vets do require a longer experience because mental illness is a chronic disease.
- Partnering with other national telehealth efforts. The question was raised whether the VA had considered partnering with the growing network of Federally funded telemedicine programs nationwide (Office of the Advancement of Telehealth and Rural Utilities Service sites funded under USDA) to establish access points for specialty care. Dr. Garthwaite did not have a definitive answer to this question, but he was willing to pinpoint an answer for the Committee members.
- Quality improvement for smaller volume programs. At this time, the National Surgical Quality Improvement Program has not specifically analyzed data for rural communities, but this could be done. For higher volume programs, a database of 700,000 surgical procedures confirms that newer equipment does result in better patient outcomes. In terms of patient safety, a pilot project in Florida has trained experts in quality assurance/quality improvement patient safety to conduct a root-case analysis to recognize system issues that are behind an adverse event. This project will roll out nationwide by summer 2000.
- Migration from the Northeast to Florida affecting VA funding. The VA tries to account for cost of living and other variables so that the seasonal population depletion in the Northeast does not negatively affect this region's VA funding allocation. The VA is required by law to account for these dual residents who reside in Florida for winter and in the Northeast for summer by prorating on the basis of where their care is received. Even now, Maine and New England receive a rate per workload that is roughly 8 to 10 percent higher than the rest of the country.
- Tobacco lawsuit settlement. As a part of the Federal Government, the VA is entitled to funding from the tobacco lawsuit settlement. According to Ms. Crow, the veteran population within tribal communities is addicted to tobacco and often suffers from emphysema. This group has an average life expectancy of 52 years. It would be problematic if the VA did not receive funding from this settlement to help care for this population.
- Coordination of services between DHHS and the VA. The question was raised whether there are administrative mechanisms in place to ensure interagency dialogue, particularly with the Health Resources and Services Administration (HRSA) and HCFA.

According to Dr. Garthwaite, some strides have been made in this effort but clearly not enough. He has met with Dr. Claude Earl Fox, Administrator, HRSA, and Robert Berenson of HCFA on a regular basis to discuss such topics as Federal benefits. An example of uncoordinated care shows that in 1 year, HCFA paid $300 million of presumably complete coverage under a Medicare HMO, whereas the VA paid $150 million to the same vets. There is a large-scale project under way with HCFA to merge the two agencies' databases. It is hoped that this results in better coordination of benefits without taking away any benefits.

Dr. Garthwaite urged the Committee members and Chairwoman Kassebaum Baker to determine ways in which to establish communication mechanisms to resolve problems as they occur, such as having a point of contact within each of the VA's 22 clinical networks nationwide.

Kaiser Commission on Medicaid and the Uninsured

Dr. Diane Rowland, Executive Director, Kaiser Commission on Medicaid and the Uninsured, provided the NACRH members with an update on the Commission's activities. The Commission was established in 1991 to analyze the issues that affect the low-income population and health care coverage. At that time, little attention was being focused on the poor. In 1996, the Commission was reconstituted as the Commission on Medicaid and the Uninsured. Jim Tallon now chairs the Commission.

An overview of national health care expenditures shows a mix of public and private entities. In 1998, the total spent on health care in the United States was $1.15 trillion, with the Government paying for nearly 50 percent of it through a combination of Medicare, Medicaid, and other Government programs. Even though the majority of health care coverage is employer-based (56 percent) and privately acquired (5 percent), the majority of dollars spent on health care come from Medicare/Medicaid and other Government programs.

It is important to remember that health care coverage is more than what medical insurance pays for under a standard managed care plan. It should include long-term care services, which are largely financed out-of-pocket or through Medicaid. Health care costs also include a range of other services, such as prescription drugs, which are currently not covered by Medicare. Often these extended services are not available in rural areas. The differences between what is available in rural areas compared with metropolitan areas must be addressed when analyzing health care system expenditures and financing.

The major problem dominating health policy and the national agenda is the growing uninsured population. Approximately 18 percent of the population under age 65 are without health insurance coverage¾approximately 44 million Americans. Elderly Americans are excluded from this calculation because most of them have Medicare; thus, they are receiving some form of

health care assistance. Nonetheless, many older citizens have financial problems but are technically not among the uninsured.

During the 1990s, Medicaid played a major role in health care for children and pregnant women. It is speculated that this responsibility has tapered off in the last 2 to 3 years for several reasons. First, welfare reform implementation has allowed potential recipients to slip through the cracks. Second, changes in immigration policy have discouraged certain population groups from enrolling. Third, the strong economy has allowed many individuals to work in positions that offer employer-sponsored coverage. However, many workers are still not receiving health care benefits and are ineligible for Medicaid due to increased income levels. This situation results in a continued increase in the number of uninsured individuals throughout the country.

The problem is not uniform throughout the United States. In southern States, especially in the Southwest, more than 17 percent of these States' populations are uninsured. These States are typically more rural and small-business oriented. The characteristics of the uninsured reveal that 27 percent are children. This finding has resulted in HCFA's recent extension policy efforts. Moreover, buying into Medicare may be a possibility for the 55 to 64 age group that comprises 8 percent of the Nation's uninsured. Still, the bulk of the uninsured is working adults¾55 percent are families with children and one full-time worker and another 19 percent are families with two or more full-time workers. Being uninsured is a problem that predominates at the lower end of the income spectrum (one-third of all families that are considered poor are uninsured versus only 9 percent of correlating families in the high-income category). Overall, these working families are ineligible for Medicaid and excluded from employer-sponsored health insurance.

Low-wage jobs, which are common to rural areas, are less likely to offer workers health insurance than are high-wage jobs. Of low-wage workers earning less than $20,000 per year, which is slightly above minimum wage, 46 percent of them do not have health coverage through the workplace. Another 12 percent of these individuals decline coverage most likely because the premiums are too expensive. Affordability becomes a key issue in how to deal with the uninsured population. The risk of being uninsured also correlates with the type of industry in which one works. Agriculture has the highest rate of uninsured at 38 percent versus government at only 6 percent. The primary factor that contributes to the manufacturing and mining industries' relatively low percentage of uninsured (14 percent) is their high rates of unionization. Small agricultural firms are less likely to have unions that can help negotiate health benefits as part of the fringe benefit rate.

The Kaiser Commission uses a study conducted by Project HOPE (Scher and coworkers) to show the discrepancy between rural and urban communities in health care coverage. Unfortunately, the current source of data is the population survey, other than SMSA and non-

SMSA, which does not provide the breakdown necessary to analyze rural areas. If we are to fully understand the differences between rural America and the rest of the country regarding health insurance coverage, we need to secure better information than what is available from the standard insurance data source. Scher and colleagues used the 1996 National Medical Expenditure Panel Survey to create more descriptive categories of rural settings, thus breaking out data beyond metropolitan versus nonmetropolitan. According to these data, the most remote rural areas present a serious problem, with 29 percent of the nonelderly population uninsured.

Some progress has been made over the last few years in providing extensive coverage to low-income children. Medicaid is covering roughly half of poor children and a quarter of near-poor children, but we are still leaving more than a quarter of children uninsured in both categories. Today, 11 million children in the United States are without health coverage. These children are the focus of the Child Health Insurance Program (CHIP) legislation.

States are implementing CHIP by using Medicaid expansions, establishing separate CHIP programs to complement or build above Medicaid, or developing combination programs that extend coverage to low-income adolescents and working families. Under the CHIP legislation, basing eligibility solely on parents' income levels has helped eliminate family barriers. Most States have eliminated the asset test for both Medicaid and their new CHIP programs. An estimated 24 percent of uninsured children are eligible for CHIP. These data may be significant for rural communities.

According to a survey of parents under 200 percent of poverty, 60 percent reported that they would be more likely to enroll their children in health care if they could do so by mail or phone. It is hoped that simplification of the CHIP and Medicaid enrollment processes will help reach more children in outlying areas. CHIP is trying to be as user friendly as possible. It is important to understand the barriers that families in rural areas face with enrollment, the families' knowledge of the programs, and their access to these programs.

The importance of health care insurance is indisputable. Uninsured individuals are less likely to receive needed care, more likely to postpone care, and less likely to have a regular doctor or to have visited a doctor within the last 12 months. The lack of health care insurance is also a problem because this population does not receive preventive care, which increases the burden of some diseases that could be effectively eliminated by better access and better insurance.

In the last decade, there has been a major shift in health care delivery from a fee-for-service model to an increasingly managed care orientation. This change has implications for rural America because HMO models depend on having a population base and a central source of care that may not be feasible. Other models, such as PPO and POS, may be more effective for

rural areas. Nonetheless, the managed care trend has helped focus on the importance of health care delivery.

Medicare must be supported because many people who are poor and near poor (both 16 percent) depend on Medicare as their only form of health insurance. When discussing Medicare, the extent of coverage and the income range for rural populations should be considered. Another important consideration is that one-third of Medicare beneficiaries have no prescription drug coverage. Finally, a substantial growth in the share of Medicare beneficiaries who participate in Medicare options is expected by 2009 (approximately 31 percent). Unfortunately, this positive growth may not affect the elderly populations in rural areas because these options are not well developed in these parts of the United States.

Discussion

In the discussion that followed the Kaiser presentation, several issues were raised:

- Chairwoman Kassebaum Baker inquired about the survey results that showed that 60 percent of parents would prefer enrolling their children in CHIP by phone or mail. Five States have implemented a phone and/or mail-in enrollment process with post-verification. The forms have been simplified to 4 to 6 pages from forms as long as 24 pages. The initial phone or mail application process may be simple, but the follow-up verification still requires parents to go in person with required paperwork. This is often difficult for dual-income families when neither parent can afford to take off work. Possibly, enrollment centers could stay open later after business hours, or they could participate in weekend health fairs so that parents could bring their children and sign up at the same time.
- Two observations about the variability of State programs were noted. First, the Commission reported that 67 percent of low-income, uninsured children tried unsuccessfully to enroll in CHIP and Medicaid. Second, farm-worker children are not receiving services because State-based programs are not mobile. Furthermore, these children may be carrying disease from area to area. State programs vary because they are given options, not mandates, in how to operate and deliver these services. With Medicaid, progress has been made in providing better coverage to children by instituting mandates for States to follow. One way to help keep families on Medicaid is simplified, uniform coverage across States that does not fluctuate with variables such as income level and children's ages.
- The Commission's parent survey indicates that a major reason parents chose not to enroll their children in CHIP was that they had been rudely treated or humiliated by the welfare office. Parents also reported receiving misinformation such as their two-parent family status would make them ineligible for the program. The survey results recommended providing sensitivity training for welfare workers and hiring individuals who have been in the welfare system and who therefore may be more responsive to these needy families. Furthermore, many of these families prefer nurses and social workers, especially during home visits, rather than dealing with State workers at the welfare office.
- In Oklahoma, large employers like Wal-Mart keep employees below 40 hours per week so that they are not required to provide benefits such as health insurance. Otherwise,

employers, even hospitals, provide substandard insurance with little or no employee consent. Oftentimes, coverage does not include long-term care such as rehabilitation for severe or chronic conditions. These occurrences also illustrate the problem that underinsured individuals are experiencing throughout the United States. The Kaiser Commission has also actively examined how Medicaid and other programs interact with the Indian Health Service and how well the Native American population accesses these services (e.g., State policies that are roadblocks to these programs).

- The inadequacy of data-gathering systems and the need for more rural versus urban data in health care analysis were discussed. The Commission has not given recommendations to HCFA about definitions related to rural health issues, but it has on issues such as Medicaid and children. The Commission is in the process of assessing how to breakdown the uninsured data by rural and urban differentials, but other than the Medical Expenditure Panel (MEP) survey, adequate census data are not currently available.
- Approximately 20 percent of Medicare and 12 percent of Medicaid dollars are spent on outpatient care, an amount that equals relatively small proportions. What is alarming is that the majority of preventive care occurs during routine outpatient services.
- Many rural areas do not have adequate access to technology such as the Internet. However, in Alaska, due to the remoteness of many areas, an investment in computers with Internet access has helped overcome isolation issues. Therefore, one possible solution to health care access to is to have online enrollment for Medicaid, CHIP, and other programs.
- The issue of incentive programs to enroll children was addressed. For example, a PTA in a rural community in Alaska provided financial incentives to enroll children. These incentives were then folded back into educational programs for the school. Medicaid and CHIP need to move away from the welfare approach and the stigma that is associated with it. Furthermore, alternative approaches should be developed (e.g., require employers who do not offer health care to supply information on Medicaid/CHIP to employees and use employers as outreach (Missouri is planning to do such a campaign). Before implementing these types of alternatives, it should first be determined whether these approaches would discourage employers from offering health insurance. To date, Rhode Island is the only State using an incentive system that hires former welfare recipients to enroll new beneficiaries.
- The phenomenon known as "crowd out" relates to those families that are higher-end income eligible for subsidized coverage but are already paying for private insurance. The question is should they be excluded from receiving subsidized care. This is unrealistic because the private insurance for which these families are paying may have expensive premiums and may provide inadequate coverage.
- Children recognize that CHIP is associated with being poor. Furthermore, parents do not know how to access health care that is respectful of their needs because they are accustomed to clinics. These parents must be educated about the value of health care coverage. One possible way to decrease the stigma associated with these programs is to make beneficiary insurance cards resemble private coverage cards.
- It was asked whether Medicaid and CHIP have minimum standard levels for mental health services for children. Medicaid covers some mental health services, but it is still not adequate. Private insurance is not much better. Mental health is often treated secondarily and thus is not adequately covered. An added concern is that even though Medicaid does provide some mental health coverage, the implementation of managed care plans may further reduce these services. Much of the specialized mental health care that was available is now no longer reimbursable by Medicaid, making this a crucial issue for this population.

- A pilot project was conducted in South Carolina that allowed small businesses with less than or equal to 50 employees to buy into Medicaid. At the end of the 3-year project, $1.8 million had not been used. These attempts at improving health care insurance offerings in small firms, especially those under 20 employees and with a lower wage base, have not been successful. Therefore, it is not necessarily the size of the firm but the nature of the business¾small law firms do well, but small grocery stores, even large Wal-Marts, do not. A survey of small business owners found that they were not uninsured but had coverage under a spouse's employer-sponsored plan. Furthermore, most owners reported that their work force turnover rate was too high, and therefore, it was too troublesome to insure employees. Many strategies, such as South Carolina for example, demonstrate how difficult this issue is. At this point, it appears more effective to modify employee behavior rather than the employer behavior that is related to the importance of health care insurance.
- Dr. Rowland suggested that local rural health advisory boards examine the experience of Medicaid and CHIP and their implementation in nonurban areas. In addition, rural health leaders should focus on Native Americans, children, and the elderly. Comprehensive data on urban versus rural areas are needed to gain public support on these issues.

Update on Public Health and Hospital Capital

Dr. Fox presented an update on public health and hospital capital as they specifically pertain to rural health. His comments on recommendations published in the NACRH public health report titled Stabilizing the Rural Public Health Infrastructure: National Advisory Committee on Rural Health are as follows:

- Improved coordination of Federal public health activities. The program needs to be seamless at the community level so that beneficiaries are not aware of which Federal program is funding their care. Dr. Fox believes this goal can be achieved and considers it one of the major seminal objectives that he is trying to accomplish during his tenure as HRSA Director. The problem is not statute or regulation but policy. HRSA has reorganized its field offices into State teams primarily to better integrate its programs and, ultimately, to better coordinate its efforts. Improving coordination at the Executive Branch will be logistically challenging, but it should be done with as little process as possible. The following Federal agencies should participate: CDC, EPA, HRSA, HUD, SAMSHA, and USDA.
- Creation of a dedicated funding stream for public health activities. At present, there is no dedicated funding for public health in rural areas. Previously, rural health often funded public health services, such as immunization and infectious disease case management, through direct services. This funding is no longer available through public health departments, raising the concern about how to support public health infrastructure at the community level. The lack of dedicated funding makes it prohibitory for health departments to conduct key prevention activities as well. In order to sell flexible funding, it must be presented to Congress categorically so that policymakers can observe the benefit these public health objectives would have on their constituencies.

The report also raised the issue of data collection. HRSA, through the Office of Rural Health Policy (ORHP), currently has a cooperative agreement with the National Association of County

and City Health Officers (NACCHO) to look at providing data along urban and rural lines. Moreover, HRSA is stepping up its data activities and now has an epidemiologist in each field office and is adding five epidemiologists to the Maternal and Child Health Bureau. Data that are not down to the State or community level are not meaningful. The challenge is to provide data at the microlevel so that policymakers can better understand the populations that they represent at the State or Federal level. One missed opportunity involves State Medicaid data. These data are readily available, but States do not analyze them. Organizations such as the National Governors Association and the National Conference of State Legislatures should be approached to help encourage State agencies to coordinate data analysis efforts to better understand what is happening within local communities. Unfortunately, the fact remains that developing data systems is expensive but warranted and is an issue that should be pursued by NACRH.

An important concern is the issue of capital needs for rural hospitals. Dr. Fox testified, among others, during a hearing held by Senator Cochran about the problems associated with rural hospitals and what has happened since Hill-Burton. In a 1997 study by Mathematica, 67 percent of rural hospitals were unable to upgrade their buildings and equipment because of insufficient capital. Furthermore, during the 1990s, many rural hospitals, especially those with less than 100 beds, had negative operating margins. These hospitals need alternatives because they do not have access to the capital market.

At present, HRSA is the only agency in HHS with an engineering staff that looks specifically at the capital needs issue. Over the last 3 years, Congress has earmarked funding for a series of projects ($30, $60, and $122 million, respectively). HRSA is using this funding for pilot projects in the Mississippi Delta area and possibly at one or two other sites to access the capital needs within defined areas. HRSA would develop a methodology for assessing rural hospitals and primary care, including health departments, community health centers, and mental health facilities, that could be carried out through a contract with an engineering firm within a given State. The capital needs assessment would act as an incentive to encourage collaboration among the different rural health programs. The next step would be garnering State policymakers' support to fund the assessment outcomes, which may appear daunting but not impossible. In Alabama, a public health bill, which passed for $45 million, received cosponsorship from the majority of senators and house members.

Dr. Fox also commented on the Rural Hospital Flexibility Program. The concept of this program mesh well with the idea of coordinating rural health services so that there is a core capacity that can survive rather than smaller units that must struggle. Also, for the first time, HRSA will present Medicaid and CHIP options to State legislators and governors. Most State policymakers do not fully understand how they can use these programs to suit their States' policy needs. In

this effort, HRSA is developing a series of marketing or issue papers that will be distributed to State policymakers.

Discussion

In the discussion that followed Dr. Fox's presentation, several issues were raised:

- Mr. Nesbitt stated that at least two earmarked telemedicine projects have sought his advice on how best to spend their funding. A statewide capital needs assessment would help determine funding needs. Dr. Fox commented that getting communities to assess what will work best for them is crucial in meeting the capital needs while leveraging collaboration in the process.
- Dr. Doty inquired about VA and HRSA collaboration efforts. First, HRSA may use the VA's information systems software. Second, the two agencies are exploring possible quid pro quo. For instance, in Philadelphia, only 5 percent of eligible vets are using the VA. There may be an opportunity for community health centers to serve some of the remaining 95 percent in exchange for low-cost laboratory services or mail-order pharmacy services.
- Dr. Singleton broached the issue of developing training programs for medical professionals in rural communities. HRSA is working with Area Health Education Centers (AHECs) to promote public health training that is traditionally not offered through AHECs. HRSA has revamped the grants for the AIDS education training centers so that these sessions take place in the communities, not in large hotel conferences. There has been little support for medical and nursing programs within the Bureau of Health Professions. Moreover, proposals for public health training and preventive medicine programs have not gone beyond OMB. These training programs must be supported because they increase training in underserved areas, as well as increase diversity within the health provider work force.
- It is difficult to gain support, much less funding, from State policymakers for health care. Possibly money from tobacco settlements could be used in these efforts to conduct capital needs assessments and, ultimately, change Medicaid policy to improve rural health. Many State legislators still view Medicaid as a welfare program. It needs to be marketed as an economic program that can be tapped to improve rural health care. Mr. Cannington added that rural hospital closings have a widespread economic impact on communities. Therefore, State policymakers need to recognize that expanding Medicaid helps improve the overall rural economy. According to Dr. Fox, the two main funding engines in rural communities are schools and hospitals.
- The marketing/issue papers that Dr. Fox discussed during his presentation are still being developed. They will summarize, in brochure format, how State legislators can improve rural health and what it would mean to their communities. This information will be posted online and linked to the Medicaid manual. These papers should be available within 1 or 2 months. Time is a concern because State legislatures are currently in session and may allocate the tobacco money before even reviewing these issue papers.
- In response to Dr. Fox's discussion about streamlining services and maximizing dollars, Dr. Wakefield mentioned an example of one remote community that has a van that transports seniors to a tertiary health care facility 95 miles away. It seems it would be more practical to also use this van for Medicaid and CHIP beneficiaries in addition to transporting the elderly patients in this rural area

- In general, the public, policymakers, and the media only respond to gory data. Data are important to make informed decisions and gain support for investing infrastructure. The Centers for Health Work Force Planning and Analysis are helpful in tracking workforce trends at the State and regional levels. At this time, HRSA has reallocated some of its funding for further workforce analyses (additional funding was not approved). The goal is to provide each State with a workforce profile by profession at least every other year. For physicians, AMA and State licensure records are used, but other provider categories are less clear due to licensure differences. (ORHP will determine whether these centers are analyzing data urban vs. rural). Another data collection activity is gathering information on workforce that is related to designations looking at J1 visa waivers in medically underserved areas. This activity is performed through cooperative agreements with State health departments called Primary Care Offices.
- Ms. Crow brought up the issue of raising nursing education standards in rural areas. Currently, there is a shortage of nurses with RNs, BSNs, and master's degrees. Dr. Fox stated that the Nursing Bureau in HRSA is emphasizing baccalaureate training. There is a supply issue in both nursing and dentistry. The aging nursing workforce and low enrollment will be an issue in the next decade. For dental care, the demands are only increasing with aging baby boomers and increasing numbers of children through CHIP.
- Many rural communities are undergoing a paradigm shift about emergency services by maximizing downtime and expanding roles (i.e., conducting prevention activities). There is no Federal funding for rural EMS. HRSA plans to work with State EMS directors to collect assessments about each State's EMS system, especially for rural areas, that can be presented to Congress to show the extent of unmet needs.
- Ms. Gary suggested training community health workers who could teach their peers about the importance of health care. This training may help increase CHIP service utilization. HRSA does train some community health workers but does not have the funding to meet the demand. One way to generate income for these health workers while increasing Medicaid or CHIP enrollment would be to pay a per head fee as an incentive. Another possibility is for States to use TANF funding, which has been reallocated and is back on the table ($500 million). Ms. Crow inquired whether TANF funding is available to tribes.
- In response to a question about disproportionate share payments, Dr. Fox stated that this issue would be included in the marketing/issue papers being developed for State policymakers.
  Indian Health Service: Contracting, Compacting, and Rural Health

Overview of IHS

Dr. Phil Smith, Maternal and Child Health Consultant, Indian Health Service (IHS), provided an overview of contracting and compacting IHS services in rural communities. During his presentation he also shared a video with the Advisory Committee members that highlighted the Alaska Native Medical Center (ANMC) in Anchorage. ANMC serves as the area's referral center and gatekeeper for specialty care.

The key pieces of legislation that allow IHS to operate as an agency are the Indian Self Determination and Education Assistance Act enacted in 1975 and the Indian Health Care Improvement Act enacted in 1976. The self-determination legislation gives tribes the option of

staffing and managing IHS programs in their communities and provides funding to improve tribal capability to contract under the Act. As a result, increasing numbers of American Indian and Alaska Native governments are exercising operational control of hospitals, outpatient facilities, and other health care programs.

IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 Federally recognized tribes in 34 States. This health care delivery system conducts a wide range of activities that includes 49 hospitals in 14 States, which are essentially in rural hospital settings. The majority of the IHS clinics are also stationed in rural settings as varied as the California desert to the Florida Everglades.

The IHS has several missions. Foremost, this system has a community-based orientation with a strong family practice/primary care focus, which refers through the contract health program for tertiary care. Next, it provides environmental services (e.g., sanitation, water quality, and access for people who have disabilities) to enhance the health and quality of life for all American Indians/Alaskan Natives. Many of the agency's efforts to overcome such barriers for tribal communities have also produced tremendous strides within rural health communities.

Data from the Healthy People 2010 report show the disparities that exist between different ethnic groups. The Native American population has grisly statistics in certain settings. One must be mindful that aggregate data will downplay these problems by averaging data from both good and bad areas. For instance, taken alone, the infant mortality rate in the Northern Plain States is three times the national average. Furthermore, the national averages for homicide, suicide, and diabetes are still between 2 to 3 times higher for Native Americans than with the general population. Infant and maternal mortality rates have improved, but issues related to morbidity have not.

One unique part of the IHS is that it can incorporate a spiritual component by integrating traditional healing practices into the clinical setting, which has shown to be efficacious through anecdotal data. It is difficult to collect efficacy data because the practitioners do not typically participate in scientific research (i.e., double blind studies).

Contracting and Compacting

IHS purchases Contract Health Services (CHS) from the private sector, such as in a physician's office or in a private hospital. In general, the CHS program may pay for physician and other health professional services, inpatient and outpatient hospital services, patient and escort travel, and other health care support services. However, IHS funds may not be available to pay for all CHS referrals.

On the other hand, compacting allows tribes to assume responsibility for Federal programs within IHS. The agency's operating budget is $2.5 million, approximately 87 percent is from appropriated Federal funding and 13 percent is from third-party collections. Roughly 40 percent of this total budget is compacted so that tribes can assume control of these programs. Compacting is a smart solution that works within budget constraints and creates a team-oriented plan. This option offers more flexibility than do programs that have strict, unilateral Federal mandates. In addition, compacting promotes long-term commitment by tribes, which leads to lower provider attrition rates. Compacting also allows tribes to assume control over database planning. One drawback is that through compacting, tribes only receive about 58 percent of what they need; thus, they must seek supplemental funding. However, this can lead to better collaboration between tribes, State, and local systems, as demonstrated in the video of the Alaska site.

Discussion

In the discussion that followed the IHS presentation, several issues were raised:

- The first question related to data collection in small communities once services have been integrated through compacting. In areas with 95 percent Native Alaskans, the health status of the other 5 percent is still needed. Certain data have always and will continue to be collected at both the State and Federal levels but capturing the different populations is a concern. IHS does invest in some data collection, and tribes have seen the benefits of these efforts. Sister agencies, such as CDC and NIH, that are interested in data sets from a research standpoint may help. Many efficacy trials, such as vaccine studies, have used Native American populations as subjects. Through support from these other agencies, IHS would like to establish data epicenters throughout different geographic regions.
- According to Ms. Hughes, the Navajo Nation, under PL 93-638, is planning to assume health care services in a relatively brief period of time. This issue has national implications because telemedicine programs are developing all over the United States, and tribes will increasingly exercise their self-determination rights. Therefore, planning for tribal-owned telecommunication systems could be integrated with the existing networks. Dr. Smith stated that this would raise legal issues such as tort claims between collaborators.
- As understood, the compacting scheme not only allows tribes to combine different funding streams and resources, but it also allows them to provide care for local people regardless of beneficiary status. When there is good collaboration among the tribes, State programs, and the community, those without entitlement do use these resources by paying for the services they receive. However, tribes are concerned that they will be overwhelmed, which has been the case many times because they have produced such a good product in terms of health care. What the tribes have realized is that, because of the high demand, they can expand their services through the revenue that is generated. For example, approximately 29 percent of the Alaska Native Medical Center's operating budget is from third-party resources. This integration is also a result of intermarrying between tribes, tribal members marrying non-Native Americans, and individuals who do not meet the blood quantum for their tribe. Clearly, tribes will stay committed to their

members, but they are beginning to understand their responsibility to serve the entire community.

Tuesday, February 8, 2000

Call to Order

After Chairwoman Kassebaum Baker called the meeting of the NACRH to order, she noted how much she has enjoyed becoming acquainted with Dr. Wayne W. Myers. She also asserted her respect for what he has accomplished in his 18 months as Director of ORHP and in his long-term dedication to rural health issues. She then turned the floor over to Dr. Myers for his ORHP update.

Update on the Office of Rural Health Policy

Dr. Myers provided NACRH members with an update of the Office's activities. First, he introduced four new staff members: Joan Van Nostrand, Blanca Fuertes, Kathy Hayes, and Dr. Forest Calico. He also welcomed back staff member Sahi Rafiullah, who had recently returned from maternity leave.

Dr. Myers briefly discussed committee issues. The NACRH public health report, Stabilizing the Rural Public Health Infrastructure: National Advisory Committee on Rural Health, has received attention from organizations, such as the National Association of City and County Health Officers (NACCHO), that may not have understood the relevancy of NACRH before the report. Now ORHP is establishing a relationship with NACCHO, which has public health data that have not been sorted by rural and urban perimeters. To date, NACCHO has only sorted these data by the size of health departments' jurisdictions. Therefore, for example, there would be no difference between a wealthy St. Louis suburb and Perry County in Appalachia because both counties have approximately the same size populations. ORHP is contracting with this association to reanalyze these data, and NACCHO will likely devote more resources to rural health issues.

Dr. Myers explained that NACRH is technically one meeting behind from the previous year. At this time last year, the Committee members decided to focus on rural public health and, subsequently, entered into a contract with the University of North Carolina. However, during 1999, the focus was not as well defined. Therefore, ORHP would like to hear what issues the Committee members would like to emphasize so that a decision can be reached during this meeting. Furthermore, they need to inform ORHP what studies would provide the necessary background to maximize the effectiveness of their time and contribution.

Dr. Myers reported that collaboration efforts are going well with HCFA. ORHP staff meets with Tom Hoyer, a senior staff member in HCFA, about every other month. Mr. Hoyer is able to call upon highly specialized people to make presentations to ORHP on particular issues. HCFA is making an effort to include ORHP in its regulation drafting process.

Next, Dr. Meyer discussed broader policy issues, particularly the steady increase over the last 50 years of the percentage of the Nation's total economy that is spent on health care, from 3 to 17 percent. In 1974, an increase to 7 percent resulted in switching from more robust efforts (i.e., building hospitals, creating Hill-Burton) to initiatives such as health planning and case reviews, which did nothing to change the upward direction of this trend. By 1984, this upward trend caused the implementation of prospective payment and closed 10 percent of rural hospitals, again to no avail. The health care reform of 1992 resulted in an emphasis on corporate managed care, which has had no impact on this continuing trend. Ironically, fiscal year 1999 was the first year that Medicare spent less money than the previous year. Although this seems like a positive outcome, it causes increases in other areas of health care, particularly insurance premiums. There has been a reduction in payments to providers, but this money has been used for management costs. Today, the Nation's health management costs are likely approaching those of our total national investment in defense. Moreover, this is just the cost on paper; it does not account for care.

The cost of biomedical research is also responsible for the climbing trend in dollars spent on health care, because it is driven by the desire to control disease through better detection, treatment, and prevention. The most consistent recipient of new Federal funding is NIH. Its budget, which is expected to double in the next 5 years, already totals $18 billion. This amount is 18 times what is spent on community health centers. If we are going to be able to afford the improved technology and methods that emanate from this research, then we must improve methods of health care delivery so that units of service are affordable within our health and social systems infrastructures. Ultimately, we want to know how to pay less for a unit of health care so we can afford more units. This will be especially necessary once the affect of the aging baby boomer population is felt.

It appears that confidence in managed health care is waning, but it is unclear what the next approach will be and how it will affect rural issues. Presently, as the urban market has tightened, the rural health workforce issue has improved, causing first-rate nurse practitioners, family practitioners, and referral specialists to seek work in rural areas throughout the country. On the negative side, it is acceptable to question why money is going to rural health when care expenditure is not seen as an efficient use of funding. This view is misguided because we continue to spend only $0.80 for a rural Medicare beneficiary versus $1.05 for an urban beneficiary. The highest cost areas are urban, but areas with low population density are

deemed inefficient. Many of these issues occur because transportation is not factored into the cost, and comparisons only begin at the point patients enter health care facilities. Savings from inexpensive rural health care systems have not been considered as a resource to solve logistical problems that are encountered in these communities. Dr. Myers predicts that there are going to be continuing problems with the current pattern of reimbursement, which is a distorted pattern based on high urban costs.

Discussion

In the discussion that followed the ORHP update, several issues were raised:

- The impact of special initiatives funded by ORHP was recommended as a topic for a future meeting. Ms. Hughes indicated that it would be interesting to learn more about these "invitational" initiatives (not those established through RFPs), including how are they chosen, how are they measured, and in the case of demonstrations, if they are replicated elsewhere. This would be a great learning experience.
- About 55,000 sites related to health care exist on the Internet. This indicates that Americans are, indeed, searching for solutions to health care problems. Unfortunately, rural communities are most likely not connected to this important information stream. Consequently, these communities are missing out on valuable prevention and wellness information. Dr. Myers stated that it would be worthwhile to study urban versus rural access to the Internet. He theorizes that low connectivity in rural areas is more an economical issue rather than a geographic one based on the fact that there is a higher proportion of poorer families in rural communities. In frontier areas, Internet connectivity, if available, is often a solution that reduces isolation and prevents long trips to health centers.
- In Maine, there are no private, propriety hospitals; it is a nonprofit hospital system. Mr. Martin inquired whether Maine was the only State that provided money to hospitals to match the Medicare losses experienced last year. According to Dr. Atkinson, Maine has a relatively unique system. Other States are concerned about the impact of these cuts; for example, Connecticut, which once paid for Medicare shortfalls through an uncompensated care pool, is conducting an evaluation.
- In regard to telehealth, some rural citizens are not accessing this technology, especially minority and migrant populations. ORHP may want to support a study on how to best disseminate information to rural minority populations. For instance, different media (video e-mail) may be a more cost-effective method of reaching the African American population as opposed to printed text. Dr. Nesbitt stated that ORHP should consider working with the Office for the Advancement of Telehealth on issues related to rural versus urban (i.e., access points in rural communities and culturally appropriate media). The problem with video streaming is that it requires technology not readily available to rural areas (i.e., high bandwidth). Dr. Coleman cautioned against conducting a study on rural Internet connectivity that breaks down the data by different races. The outcome is already known¾rural areas have low rates of connectivity due to high rates of poverty. The biggest factor is low income, which may vary between different rural communities (i.e., African American, Hispanic, or Scotch-Irish Mountain people of Northern Alabama).
- Dr. Singleton suggested that ORHP invite representatives from the Departments of Agriculture, Education, and Transportation to provide presentations at upcoming NACRH

meetings (similar to the presentations given by the VA and IHS) on the exploration of ways to strengthen the safety net in rural communities.

- In response to the other Committee members' comments, Ms. Crow stated that tribal governments do provide such a safety net. Tribes in Oklahoma have been acquiring existing hospitals that are going under. It appears for the last 40 years that Oklahoma has received less IHS funding than States like Alaska ($300/person vs. $2,400/person). Tribes are able to subsidize Medicare losses through gaming and other economically viable sources. These tribes need to collaborate with other rural health entities to learn how to recoup funds; for instance, undercoding and underestimating the cost for patients have resulted in losses. Tribes do not know how to cost out a patient because IHS has never done so. In the private sector, determining the cost of a patient is required. However, the private health care system has never had to account for costs related to the environment, transportation, prevention, or education.
- Mr. Cannington also responded to Mr. Martin's question about hospitals and Medicare cuts, adding that both Georgia and Florida are dealing with the cuts by beefing up Medicaid payments. Legislation in these two States has given responsibility for indigent care to the counties. From his perspective, in the hospital industry, urban hospitals receive large amounts of funding by effectively communicating their needs to county officials while rural hospitals continue to absorb losses unnecessarily.
- Dr. Coleman stated that there appears to be two issues that are time sensitive¾the President's budget and prescription drug benefits. According to Mr. Morris, what takes place in Congress has more of an impact on rural health programs than the Administration's budget; therefore, he recommended that NACRH focuses its efforts in this direction.

Medicare Payment in Rural Areas: The Ground-Level Perspective

David Berk, Rural Health Financial Services, Inc., provided a summary of how his consulting company helps restructure small, rural health care facilities. This firsthand experience has provided Mr. Berk with extensive knowledge about Medicare payment in rural hospitals. At this time, his company is working on two major projects¾the Community Health Services Development Project in collaboration with the University of Washington (UW) School of Family Medicine in Seattle and the Networks for Rural Health through the Georgia Health Policy Center in Atlanta. The UW project has encompassed five States. Mr. Berk provided a handout of the financial review process that his company has developed to conduct administrative/financial evaluations of the fiscal operations of health care facilities.

From June through September 1999, Mr. Berk was involved with evaluating the financial effects of the Balanced Budget Act of 1997 on rural health systems at the UW WWAMI Research Center. The first myth that he encountered was that all the Research Centers were conducting six site visits at rural hospitals. In fact, this was the total number of site visits conducted for this evaluation, which did not seem adequate.

It was found was that, because of all the other issues confronted by rural hospitals, many were not cognizant of BBA effects until their business offices began noticing decreased cash flow. In

reality, nothing was wrong with their business management; they simply were not being reimbursed at the same level. To isolate the BBA as a variable, the sites that were visited were stable, had reasonable community support, had minimal infighting, and were typically financially sound. The outcome of the project was that the BBA had a negative effect on each hospital studied, not just a bottom-line effect but also a drain on cash reserves within the first year of this legislation.

One unique aspect of rural communities is that they take care of their own regardless of whether money is being lost or gained. However, some of these hospitals started to move away from this philosophy by focusing on the bottom line rather than on allowing service to undermine the whole system. This was most apparent with home health in which some hospitals dropped from 35,000 to 1,500 visits per year to overcome the losses they were experiencing in these programs. To accomplish this reduction, the hospitals stopped serving areas known to be nonpaying. Such strong business decisions are not typical of rural communities.

It is a matter of perspective. In rural hospitals, the number of patients per day (often as low as 0.1 ADC) does not measure quality of service; instead it is an attitude of how patients are cared for in a setting close to home. Studies have shown that better care is received in rural communities than in urban areas. Furthermore, these small rural hospitals are not only critical to the to the health care system but to the overall economy of a given community. These facilities are the most vulnerable to Medicare changes. Nevertheless, they can be profitable with just 0.5 ADC if they have community support.

CAH presents barriers to rural hospitals, including State Medicaid participation, other State insurance programs, and managed care programs. It is wrongly assumed that States are already paying costs so adjustments are unnecessary for CAH. Rural hospitals are often blocked: State workers and teachers in small, rural communities cannot get health care insurance, and some States only allow JCAHO-accredited hospitals to participate in providing services to beneficiaries of managed care plans.

Infrastructure issues exist, such as the aging Hill-Burton hospitals that are 40 to 50 years old. These hospitals are not in a design mode to provide care and services up to today's standards. Clearly, these structures must be remodeled to meet service needs to be cost efficient for the future. Replacing these hospitals would be extremely expensive. Furthermore, some rural communities are actually growing, resulting in a need for a health care system beyond just clinics. However, finding capital to build new hospitals is not easy.

CAH is a payment-system change. Many moderate-size hospitals ($10,000-15,000 annual revenue) are converting to this program for financial gains, not for survival like rural

communities. Small hospitals that have converted are still closing. Therefore, this initiative is not saving rural hospitals.

In conclusion, rural hospitals are beginning to recognize the need and value of developing affiliations and/or networks with larger tertiary hospitals so as to survive. At this time, affiliations between urban and rural hospitals often result in takeovers that do not benefit rural communities. Fundamentally, urban hospitals do not know how to operate rural hospitals.

Discussion

Following Mr. Berk's presentation on Medicare payment and other financial issues pertaining to rural hospitals, the following issues were raised:

- Ms. Crow inquired about accreditation to receive Medicare funding. According to Mr. Berk, State Medicare programs provide an initial license for hospitals, which then can become certified by Medicare. Each State has an insurance commissioner's office that decides who participates in managed care programs. Unfortunately for rural hospitals, these decisions are often based on monetary issues.
- In response to the affiliation issue, Dr. Nesbitt discussed the Coalition of Independent Northern California Hospitals. This group of small hospitals did not want a larger health care system to dominate them. Within the network, these small hospitals are helping one another and facilitating independence. The coalition is promoting the idea that local rural health care is the portal to a larger, integrated system. They have also affiliated with universities. Furthermore, the coalition offers mock JCAHO evaluations to help them determine how they can become accredited. Mr. Berk added that compatibility between urban and rural hospitals is possible once you get beyond typical mistrust and control issues.
- Mr. Ahrens suggested creative models other than the conventional hospital model (i.e., providing long-term care and storefront settings). The traditional model and Medicare participation hinder rural hospitals. Mr. Berk agreed that small hospitals are not equipped to make required Medicare changes. For example, Alaska hospitals were advised that CAH would not be worthwhile. They did not do the calculations themselves (many rural hospitals do not know how), even though they would benefit under the program financially. There are consultants preying on small hospitals that do not know better, which was the case in Alaska.
- Many small hospital boards are burdened with making business decisions on whether or not to provide care for the indigent and the uninsured. This is against the rural philosophy of taking care of one's own. The system needs to be designed to handle these problems with access. In the past, rural providers volunteered many services to take care of their own. However, in Florida, the migration of wealthy retirees has changed the dynamics of the community health care system throughout the State. On paper, the system appears to be growing and integrating, but in actuality, it only supports the new, high-income residents. People in rural areas are still not receiving better care. In response, Mr. Berk stated that rural communities need to determine what their health needs are today, not 10 years ago, and how to meet them so as to be successful (i.e., services for which rural residents will stay in town instead of commuting to urban centers).

- NACRH needs to focus on and push forward supportive research and policy. Dr. Doty stated that the Research Centers should conduct studies that provide data to support small, rural health care systems (i.e., the multiplier benefit factor of hospitals on rural communities). Supportive policies and procedures, such as core curriculum guidelines for quality assurance, could be posted online. There could also be an information exchange through the small hospital chapter of the American Hospital Association. Furthermore, the current JCAHO accrediting system is onerous and unaffordable, but a credible accreditation system that is designed for rural health is possible. Alaska is examining the possibility of an accrediting system that is applicable to CAH hospitals.

Research and Regulatory Update

Joan Van Nostrand provided an update on ORHP research and regulatory activities, both past and future. The cooperative agreements with the five current Research Centers ends in August. She provided the Committee members with an announcement for cooperative agreements for six Research Centers. This adds an additional Research Center for the fiscal year. The applications for these 4-year grants are due May 1 and will be awarded in September. Many of the focus areas are in existence from previous years, such as reimbursement and workforce issues. One new focus area will be health disparity issues related to minority populations.

Dr. Van Nostrand prepared a handout for Committee members on 1999 and upcoming publications from the Rural Health Research Centers by subject area. In 1999, the Balanced Budget Act was a major area of emphasis. Last October, the Research Center directors participated in a Rural Health Roundtable with more than 80 attendees. This meeting was viewed as an indication that Federal staffers are interested in rural issues. Dr. Wakefield and her staff were instrumental in focusing the directors on policy-oriented aspects of these reports and away from the typical topic of survey methodology.

The directors also participated in a Medicare Payment Advisory Commission (MedPAC) meeting chaired by Dr. Gail Wilensky from Project HOPE. Dr. Wilensky places an emphasis on sound research before entering into policy decisions. During this meeting, Dr. Wakefield was again helpful at getting rural issues on the agenda, wherein a special session allowed four Research Center directors to make presentations.

Next, Dr. Wakefield highlighted some upcoming reports. One report is a University of North Carolina (UNC) study titled "Race and Place Series." This study looks at urban and rural differentials in health for racial and ethnic groups as well as addresses the paucity of data on these issues. Under long-term care, the Maine Rural Health Research Center will study the "ping pong" phenomenon that occurs when nursing home residents undergo multiple hospitalizations, a problem found more often in rural areas. Project HOPE will be investigating home health users' vulnerability to recent reforms. Another upcoming report is on the ever-

important issue of CAH, specifically on the effects of the new prospective payment system and some of the implications of the BBA. A report on rural public health and market effects is also forthcoming.

Dr. Van Nostrand also provided a handout on the policy research projects that the Rural Health Research Centers will undertake in fiscal year 2000, including the following:

- The Financial Impact of Outpatient Reform on Rural Hospitals (Project HOPE)
- Describing the Health Care Infrastructure in Rural Towns (UNC)
- Rural Ethnic Communities and Access to Hospitals and Physician Services (UNC)
- Best Strategies for Promoting Rural Practice among Women Physicians (UW-WWAMI).
- The Individual Insurance Market: Patterns of Coverage among Rural Individuals and Families (University of Southern Maine)

Dr. Van Nostrand also announced that the Research Centers have formed a consortium on CAH. Under this coalition, the Centers are conducting an evaluation on the CAH Program and are in the process of developing research protocols and a management information system. Through Keith Mueller's Center, the consortium is providing technical assistance to States on best practices for designing and developing CAHs. In addition, Terry Hill's Center is providing States technical assistance on CAH development and implementation processes. A new project on the table with Project HOPE will help identify approaches that can be used by low-volume hospitals and will, ultimately, describe the key issues on CAH hospitals to policymakers.

For all of these reports, executive summaries called policy briefs are available. In general, each of the Research Centers distributes its own materials to State health departments, the National Governors Association, and other relevant groups. On occasion ORHP conducts a special mailing on Capitol Hill. Furthermore, these reports are available online through the Centers' individual Web sites. A list of these Web sites is available from Dr. Van Nostrand. Committee members may contact Dr. Van Nostrand for hard copies of the reports.

Rural Mental Health Issues

Dr. Bernard Arons, Director of the Center for Mental Health Services (CMHS), presented an overview of mental health issues related to rural communities. He first introduced two colleagues that accompanied him to the meeting: Dr. Harriet McCombs and Jerry Katzoff. Although CMHS does not have a program devoted to rural mental health, Dr. McCombs is with the Center's Special Programs Development Branch, which focuses on this issue. Mr. Katzoff, HRSA, has been on an executive potential development assignment within CMHS.

Established in 1992, CMHS is one of three centers of the Substance Abuse and Mental Health Services Administration (SAMHSA). The Center's primary mission is to find better ways to deliver mental health services by

- Conducting research on promising techniques that can be replicated throughout the United States.
- Increasing access to mental health services for all citizens.
- Gathering and disseminating information on mental health. Dr. Arons referred to an article on rural mental health issues in the biannual CMHS report.

In 1994, CMHS convened a work group on mental health providers in rural areas. The group published a report that is used by the Center as a guideline. This report is available online at the Center's Web site (www.mentalhealth.org). From this first work group, CMHS has developed ongoing working relationships with the National Association for Rural Mental Health and the Frontier Mental Health Services Resources Network.

Approximately 1 in 5 Americans suffer from a mental illness. This number is neither higher nor lower in rural communities. However, in rural areas, individuals who require mental health care are far less likely to receive mental health services. Historically, mental health care in rural America has been a low priority within the Government. Author Joel Dyer stated that rural people feel powerless and disenfranchised because they are powerless and disenfranchised. Under these circumstances, it is uncertain how to overcome the problems of mental health in rural communities.

Dr. Arons outlined four basic issues in rural mental health to help the Committee members understand the problems. These problems are not new: they were included in a 1969 report on rural mental health published by the U.S. Department of Health, Education, and Welfare. They were reiterated 10 years ago in the President's Commission on Mental Health report. Although a number of reports have been written, little attention has been paid to these issues. What follows are four pressing issues in rural mental health delivery:

1. Inadequate resources. These sparsely populated areas cannot support mental health clinics or mental health professionals with Ph.D. degrees. Dr. Arons listed the following current trends that negatively affect available resources for rural mental health services:
    - Less subsidization for social services with public funding. Rural mental health care depends on such funding.
    - More specialized training and credentialing within the mental health field results in fewer generalists. Again, rural areas cannot support highly specialized professionals.
2. An increase in managed care systems that have paperwork and referral requirements that overburden already strained rural health care systems.
3. New model programs have been developed to help rural mental health providers overcome some of these trends (i.e., integrate mental health and primary care, require

public funds for interdisciplinary training, and allow flexibility with service delivery among mental health care workers).

4. Domination of urban models. Typically, mental health delivery systems are developed in metropolitan areas and imposed on rural areas. They are based on assumptions that are reasonable for the urban experience but often cause serious problems when implemented in rural communities. These assumptions may occur in regulation and policy, financing, licensing and credentialing, training materials, ethical standards, managed care and Medicaid decisions, and grant applications. A list of urban assumptions and correlating rural realities is provided on. pages 86-87 of the 1998 CMHS report. This urban bias contributes to people not receiving mental health care in rural areas. The new report, Mental Health: A Report of the Surgeon General, regards urban bias as a major issue. CMHS could provide a copy of the executive summary to the Committee members.
5. It is now widely understood that insensitivity to other cultures can create barriers that impede access to care and to effective treatment delivery. The concept of cultural competence has been applied to African Americans, Asian Americans, Pacific Islanders, Latinos, and Native Americans but not rural populations. Rural America may be helped by such a concept because policymakers would have to listen to those who live there.
6. Stigmatization of mental health care. In rural areas, receiving treatment for alcohol, drug abuse, or mental illness is stigmatized, a common problem throughout the country. However, this stigma is particularly difficult to overcome because anonymity and privacy are more vulnerable in small communities where everyone knows one another. The issue of stigma must be addressed nationwide to help make progress in small towns. National efforts include a White House conference on mental health stigma and a public awareness campaign. Australia and New Zealand have provided good examples of effective public awareness campaigns against stigmatization.
7. Consumer advocacy. The influence of the consumer movement has been one of the most profound changes under way in the mental health system in recent decades. Links among consumers, patients, and families form a strong voice in Congress that helps push for budget increases. Consumer groups have effectively influenced State legislatures, a move that is reflected in the number of States that requires parity for mental health in employee benefit plans. By pushing for representation, consumer groups have gotten laws passed that allow consumers to serve on State mental health planning councils. Furthermore, consumer groups are operating drop-in centers and self-help groups (in person and online) to support people who are recovering from mental disorders. Unfortunately, forming these organizations in sparsely populated areas is not feasible, which is a major loss considering what these groups have been able to accomplish in other areas.

Dr. Arons highlighted the following activities undertaken by CMHS and are related to rural mental health delivery:

- A strategic plan for rural areas and models for integrating mental health with primary health.
- Comprehensive Community Mental Health Services for Children's Program grants in 40 States, with 15 grants in rural Ohio, Kansas, Maine, North Carolina, North Dakota, Nebraska, New Mexico, Vermont, and Wisconsin. CMHS has established a new interagency component for Native American children called "Circles of Care."

- The School Violence Prevention Program in 94 communities, including the first Federal funding for mental health counselors in public schools. About 25 percent of these programs are in rural area schools.
- Community Action grants that help States and local groups adopt better mental health practices. Nine of these grants are in rural Louisiana, Montana, Oregon, Pennsylvania, South Carolina, and Wyoming.
- Consumer and Family Network grants, with five grants in rural Arkansas, Idaho, Minnesota, and Oklahoma. Two of these grants are with chapters of the National Alliance for the Mentally Ill and three are with State social service agencies to help foster consumer networks in rural areas.

As with other Federal agencies, CMHS research projects result in reports. A publication on contracting managed care systems for mental health in rural areas by Dr. McCombs will be available online this spring.

The other Centers under SAMSHA¾Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT)-also work on issues related to rural health. A recent study released by the National Center on Addiction and Substance Abuse at Columbia University has found that drinking and drug use among young adolescents are higher in rural areas than in urban centers. According to this report, rural eighth graders are 104 percent more likely to use amphetamines and 50 percent more likely to use cocaine. Dr. Arons cited the incident of 29 young people who died due to heroin overdoses last year in Plano, Texas. In response to these alarming numbers, CSAT is developing a heroin treatment model that can be delivered by primary care providers in rural areas. Conventional methadone maintenance is an example of an urban model that does not translate well in rural areas. In another initiative, CSAT is collaborating with FDA and the National Institute on Drug Abuse to develop a new medication for opium addiction that can be administered by primary care providers sublingually and that cannot be liquefied into an injection by the user.

Dr. Arons stated that telecommunications might help overcome the four issues discussed earlier. CMHS has been exploring the potential of telecommunications since 1997 and will be releasing a publication on this topic in April, which will be posted online. It is hoped that as costs for technology decrease, mental health and substance abuse counselors will become virtual members of local service delivery teams. Consumers are overcoming travel barriers not only to get professional help but also to form organizations and to support each other. CMHS provides computer access to its Web site for consumers through a toll-free number.

Fiscal year 1999 provided reasons for optimism. The following occurrences demonstrated a growing national commitment to improving mental health services:

- First annual White House Conference on Mental Health.
- Surgeon General's call to action to reduce the Nation's suicide rate.

- Surgeon General's first report on mental health.
- A new law that protects individuals recovering from mental illness from losing medical benefits once they return to work.
- Increased media coverage on mental health issues.
- Increased number of consumers accessing the CMHS Web site.
- Increase in CMHS block grant funding for fiscal year 2000 by $67 million. This 23-percent increase is the first major advance in funding in a decade. Although States will determine how to spend these block grants, rural communities should pursue this funding opportunity. Consumers are involved in this process so States with rural populations should be represented on planning councils. An additional $60 million is being sought for these block grants for next year.

Discussion

In the discussion that followed Dr. Aron's presentation, the following questions and issues were raised:

- In many States there has been a proliferation of juvenile justice systems that place children as young as 8 years old in confinement facilities. Many of these children suffer from mental illnesses. A scholarship program that provides funding support is available to children regardless of their parents' income. The following CMHS programs are working on this issue:
    - The Comprehensive Community Mental Health Services for Children and their Families Program encourages the development of intensive community-based services with a multiagency, multidisciplinary approach that involves both the public and private sectors. This approach helps develop comprehensive coordinated systems of care that link mental health with child welfare, schools, and juvenile justice.
    - The Criminal Justice Diversion Program, in collaboration with CSAT, identifies innovative jail diversion programs for young people with co-occurring mental health and substance use problems. The nine study sites evaluate existing pre- and post-booking police diversion and criminal justice intervention models.
- Ms. Hughes referred to the section "The Promise and Pitfalls of Technology" of the 1998 CMHS report (p. 91) by stating that more studies should be conducted to determine the effectiveness of programs such as telemedicine. More support and resources should be allocated to increase accessibility in rural communities.
- Dr. Singleton asked how quickly SAMHSA responds to data with programs and policies (i.e., rural youth using drugs more than urban children do). State block grants are the Center's primary funding mechanism, which oftentimes are set aside for certain providers and, therefore, are not responsive to new problems. CMHS has developed an approach called "Targeted Capacity Expansion" that provides funding to cities, counties, and tribal entities for specific local issues. These are 3-year grants that enable the local governmental entity to respond to the problem and to build support for the future. Furthermore, CMHS is proposing having reserve funds for emergency services for disaster and crises situations, which could quickly mobilize State crisis teams. This proposal has been modeled after presidential disaster declarations.
- Is grant money available to fulfil recommendation nine in Mental Health Providers in Rural and Isolated Areas? CMHS Community Action grants may help accomplish this goal. CMHS is developing a partnership with HRSA that oversees community health clinics, migrant health, and other relevant programs. HRSA is becoming increasingly

interested in mental health. Admittedly, not enough is being done, and there is no comprehensive program to fund mental health in primary care settings. In conjunction with the VA, CMHS is studying whether integrating mental health services in primary care settings is better for elderly patients than delivering these services in separate clinics that may be located far away. Primary care providers are providing mental health services out of necessity, but they may not be the best qualified. Dr. Arons suggested that NACRH present these concerns to the Department and seek awareness about this issue in Congress. Dr. McCombs added that there is an assumption that additional funding will bring change. A small study conducted by CMHS has outlined a process for integrating services. The first phase is a philosophical integration. It cannot be assumed that all communities want to integrate mental health and primary care.

- At this time, States and Medicaid are not willing to pay for mental health in schools. Furthermore, school counselors and other school personnel are providing services without adequate training. Typically, rural areas cannot attract qualified clinical psychologists. CMHS hopes that the school violence initiative will provide enhanced mental health services in school settings. Funding is also needed for after-school programs that would provide organized activities and supervision for children and adolescents.
- Dr. Martin described a successful incentive program that has been implemented in his rural county in Maine.. The program helps retain mental health providers by providing full tuition remission, full residency, and lodging in exchange for providing care in the community after completing college.
- The question was raised whether CMHS has programs that deal with violence in families and communities. When children are suspended or expelled from school, they often become more vulnerable to the streets. One solution is to have in-school suspension so that there is adequate supervision. Some of the Center's best documented, best proven, and most effective interventions emphasize family-strengthening approaches. School and Community Action grants provide funding to organizations and schools that have a proven approach.
- Reimbursement has caused the mental health system to completely restructure the way in which individuals receive mental health services. Often a psychiatrist writes prescriptions and conducts drug checks while another provider manages therapy. This situation forces patients from rural areas to make two trip and causes a split rather than facilitating comprehensive, holistic services. CMHS should be able to justify and mobilize funding for training for interdisciplinary teams in mental health service delivery. The upcoming study by Dr. McCombs that was mentioned earlier addresses some of these issues that are related to reimbursement. Behavioral health managed care companies must understand the type of services required in rural areas. Instead of imposing urban models in these areas, these companies should negotiate for different types of services, patterns of credentialing, and staffing that are more appropriate for rural communities.

Committee Discussion on Meeting Process Issues

The afternoon agenda was revised and distributed to the Committee members when the meeting was reconvened after lunch.

After a brief discussion, the Committee members made the following decisions about the format of future meetings:

- The February meetings will remain in Washington, D.C.
- NACRH will conduct two site visits per year. Chairwoman Kassebaum Baker clarified that IHS would be a primary focus for the Oklahoma site visit agenda, possibly with some preliminary papers on the main topic selected during this meeting. Committee members should provide Mr. Morris with feedback on specific topics they wish to focus on as secondary issues during the June meeting.

Potential Topics Discussion

The next order of business was to select a topic as a focus for the next year. Chairwoman Kassebaum Baker proposed the following potential topics for the Committee's consideration.

- Mental health
- Uninsured and underinsured
- Public health
- Medicare reform

The Committee members then discussed these topics so as to arrive at a consensus.

Ms. Gary stated that mental health care does not receive the attention it deserves. Substance abuse is a major problem that involves all organ systems, and mental illness is usually chronic, requiring long-term treatment. Too often, people with mental illness are disenfranchised, and programs designed to serve them are underfunded. Even if mental health were selected as the primary topic for next year, the other three topics would also be discussed because they all are interrelated.

Chairwoman Kassebaum Baker suggested public health as the primary topic because she believes it is critical to rural communities. On the basis of the NACRH public health report, perhaps the Committee members could follow up on what has happened with these recommendations and explain their importance to the Secretary and Surgeon General Satcher so as to have one or two of the items implemented. Whether or not public health is selected, Mr. Morris stated that when the rural versus urban data are released, ORHP plans to re-issue the report to the new Secretary.

Medicare reform is a sweeping, all-encompassing topic that affects the other three topics. It was suggested that Medicare reform be a first-tier topic, with mental health and uninsured/underinsured as a second-tier topic. One Committee member recommended Medicare reform as a primary topic, with the other three issues as subtopics and possibly payment issues as a fourth subtopic. Moreover, the issue of drug benefits is a major component of Medicare reform and should be considered. In light of the urban assumptions versus rural realities, the Committee should remain focused specifically on rural health Medicare reform if they want to deal with issues of disparity and payment inequity. Chairwoman Kassebaum Baker

discussed her involvement with the Robert Wood Johnson (RWJ) and Kaiser Foundations. RWJ plans to research Medicare reform, and Kaiser has been studying this topic for sometime. Both organizations do a fair amount of funding in rural areas.

Dr. Singleton asked whether the Secretary might identify her priorities in terms of these four topics. According to Mr. Morris and Dr. Myers, DHHS is working on all four topics to some degree. The following initiatives demonstrate this:

- CHIP's expansion of coverage to the uninsured.
- A bioterrorism initiative that is technically a public health issue.
- Long-term management of Medicare as a major agenda item.
- The first-ever Surgeon General's report on mental health.

Ms. Hughes raised the issue that in an election year, it is important to think pragmatically about what NACRH can reasonably submit to the current Secretary because of possible changes in the Administration and in Congress. Chairwoman Kassebaum Baker responded that the Committee might consider presenting any recommendations to the new Secretary in light of this transitional year. Furthermore, Ms. Hughes questioned as to what degree do these four topics have constituencies that advocate on behalf of rural America in determining where NACRH efforts would be most needed.

Dr. Atkinson recommended that the Committee focus on an ambulance fee schedule as a short-term issue. He believes that this issue is on the horizon because the required prospective payment system enacted under the BBA may be devastating for low-volume, rural EMS providers. He also recommended that the Medicare payment system be considered as a long-term topic. Dr. Culp added that the issue of an ambulance fee schedule is imminent, possibly within the next few months. In the past, ORHP staff has announced time-sensitive issues so that NACRH could respond in a timely manner between meetings. At this time, ORHP is conducting a survey for Dr. Fox of EMS directors in every State to determine what problems exist in rural areas. These data should be available by May or June 2000. Dr. Culp asked Mr. Martin to review the data in light of his experience as president of a nonprofit organization, Ambulance Service Inc., which owns and operates five ambulances, with additional volunteer first responders on staff.

Picking Topic Priorities

The Committee members decided that Medicare reform, with an emphasis on rural health, would be the main issue through February 2001. Mr. Morris will send pertinent information to Committee members on their topic(s) of choice so that they may become subexperts on these topics by June. The Committee members and their selected topics are as follows:

- Jim Ahrens-veterans affairs (Mr. Morris will follow up with Dr. Garthwaite on this issue and report back to the Committee.)
- J. Graham Atkinson - Medicare reform and public health
- H.D. Cannington - uninsured/underinsured and veterans affairs
- Bill Colemen - uninsured/underinsured and mental health
- Shelly Crow - Medicare reform
- Barb Doty - veterans affairs and mental health
- Steve Eckstat - mental health
- Alison Hughes - public health and mental health
- Monnieque Singleton - uninsured/underinsured and mental health
- Mary Wakefield - Medicare reform and uninsured/underinsured

It was suggested that NACRH draft a letter in support of Dr. Fox's proposal to use capital investment to foster community-based collaboration. Dr. Myers stated that this would be consistent with what the Committee has done in the past. Dr. Coleman requested a point of information to clarify whether this letter was to the Secretary supporting Dr. Fox's initiative or just a personal letter of support to Dr. Fox. Ms. Gonzales-Hanson cautioned against NACRH's giving a blanket endorsement without knowing all the details. It was decided that ORHP would research the proposal, and if recommended, the Committee could draft a letter during the June meeting for either Dr. Fox or the Secretary, whoever was deemed most appropriate at that time.

It was discussed whether ORHP would provide the Committee members with hardcopies of reports from Research Centers and with materials from other entities, such as SAMSHA, that are of interest. In this way, NACRH would generate interpretative recommendations on these data using these materials as supportive appendices. By a show of hands, Mr. Morris confirmed those who were not receiving reports so as to update the mailing list. It was decided that the reports were not too long and could be sent in their entirety.

The final discussion of the day was on the joint meeting with the three HRSA Advisory Committees-the National Health Service Corporation (NHSC), Migrant Health, and Rural Health. This joint subcommittee meeting will have two representatives from each of these three groups: Mr. Martin and Mr. Ahrens will represent NACRH this time (this responsibility would rotate). The three committees share common ground so a joint recommendation to the Secretary is one possible outcome. The results of this meeting will be part of the NACRH June meeting agenda.

Dr. Singleton will also be attending on behalf of NHSC. He said that the reauthorization of NHSC is one of the major purposes of the joint meeting. Rural placements should be a priority, but with the current system, it depends on whether a community has paid for a scholarship. Another major issue is tax relief for scholars who are taxed on the funding they receive. The Committee members agreed to wait until after Thursday's subcommittee meeting before formulating a NACRH position on the NHSC reauthorization to present to the Secretary.

Chairwoman Kassebaum Baker gave her appreciation to the Committee members for their participation and dedication, remarking that working with such an impressive group of individuals has been a learning experience for her. She also commended them on the important work they have accomplished and would accomplish in the future with the NACRH.

Wednesday, February 9, 2000

Call to Order

Due to her early flight, the order of the final day's agenda was switched so that Ms. Crow could provide the NACRH members with some information about the Oklahoma site visit before leaving. Therefore, the wrap-up segment of the meeting followed the Oklahoma planning segment.

Oklahoma Planning

The meeting will be held June 4-7 at the Fountainhead Resort (about $49 per night), near Eufaula, Oklahoma. Participants should fly into Tulsa, which is a 1 hour 45 minute drive from the resort. The meeting will take place in the five civilized Tribe territory (Choctaw, Cherokee, Muscogee, Creek, Seminoles, and Chickasaw). The tribal leaders have been notified of the meeting.

Chief Chad Smith was recently elected by the Cherokees, ushering in a new era for this tribe, one of the largest in the United States (roughly 250,000 nationwide). The Cherokees' jurisdiction boundaries cover 14 counties with a $49 million health care budget. Chief Jerry Haney represents the Seminoles, with an approximate population of 10,000. The Muscogee Creek Nation governs between 8 to 11 counties, with an overlapping citizenship of about 50,000. This jurisdiction provides health care services to around 60,000 Native Americans.

The Choctaw Nation is one of the most progressive in terms of health care. Chief Gregory Pyles has offered to co-host the NACRH meeting and has approached Dr. Nesbitt about serving Choctaw citizens in California. Moreover, this tribe has received a $15 million in USDA grant money for telemedicine and has established an agreement with the Oklahoma State University School of Osteopathic Medicine to administer this program.

The meeting will take place in the Muscogee Creek Nation area, hometown of Congressman J.C. Watts. This area is farm country, with a constituency of co-op farmers who are confronted with many health care accessibility issues and, therefore, are looking forward to the Committee's visit.

The following elected officials may attend the meeting: Congressmen Coburn and Watkins and Senators Enhoff and Nichols. Mr. Val Schott, President of the National Organization of SORH, will be attending as well. The Choctaw Nation will represent the 39 tribes in Oklahoma by giving a presentation on the health disparities within the jurisdictions and statewide. This presentation will cover different health care systems, including tribal self-governed, State-operated, and IHS. These tribes are leaders in health care, with some exploring joint ventures with the VA and State agencies (e.g., the Cherokee Nation operates EMS for its 14-county area). A representative from Governor Keating's office will likely participate at the meeting. Ms. Crow serves on his Sexual Transmitted Diseases and Prevention of Adolescent Pregnancy working group. The Committee members will be visiting the Tahlahinia hospital as well.

Before departing early, Ms. Crow thanked NACRH for coming to Oklahoma, which means "land of the red man" in Choctaw, and for allowing this region of the country to be heard on issues related to health care. She invited everyone to come on either Friday or Saturday to participate in the Green Corn Festival, a traditional Native American celebration to honor the first harvest.

Chairwoman Kassebaum Baker requested that one day be reserved exclusively for NACRH business. Dr. Doty reported that a speaker from the Department of Agriculture at the University of Oklahoma would present. His presentation is in response to the Committee's request for follow up on ways in which small, rural hospitals can network and demonstrate validity to communities. Dr. Doty volunteered to help Ms. Crow prepare a presentation on workforce issues related to IHS. Furthermore, with Ms. Crow's support, Dr. Doty has offered to present a follow up on graduate medical education for rural areas, emphasizing special population training.

Wrap-up of Meeting/Final Business

Dr. Eckstat provided a summary of what he believed had occurred during the meeting. He was concerned that future collaboration with the VA and IHS would not be generated from this meeting and that the speakers only presented what these agencies were doing independently. He believed the door had been closed on the possibility of working together and sharing resources on rural health initiatives. Ultimately, he felt that some large gaps must be filled before the Committee could begin to discuss some of the initiatives.

Furthermore, Dr. Eckstat believed that NACRH did not adequately address the issue of mental health. He cited a statistic that family practitioners, nurse practitioners, and physician assistants treat more than 80 percent of cases of depression. Therefore, mental health training for primary care providers in rural areas is critical. Finally, he stated that the duty of NACRH is to advise the Secretary about the allocation of resources for projects and research that might benefit rural

health delivery. He believed that the Committee should remain pragmatic and focus on working together to help those in the trenches on issues such as CAH hospitals, transportation barriers, and the Corps. One encouraging point is the document mentioned by Dr. Martin that records the Committee's recommendations that have come to fruition over the years. Chairwoman Kassebaum Baker added that oftentimes adequate follow through does not occur. Therefore, the Committee should track its suggestions and possibly reinvigorate issues, such as reworking the public health report. She also stated that NACRH has the ability to track recommendations on narrow topics. She hoped that this would be accomplished during the meetings this year.

Mr. Ahrens responded to Dr. Eckstat's comments on mental health by suggesting that the Committee explore the issue of training school teachers in the delivery of mental health services because school is where children spend most of their time and they often act out in this setting. Dr. Coleman suggested shifting medically oriented mental health disorders, such as Alzheimer's disease, depression, and anxiety, which have medical treatments, to primary care. This move would help mental health providers focus on children and patients with mental illness. Alzheimer's disease in the elderly is one of the health issues that Dr. Coleman believes will eventually overwhelm mental health services.

Dr. Singleton viewed the VA presentation as a significant attempt by the VA to break down walls between agencies because Dr. Garthwaite was willing to discuss internal problems. Chairwoman Kassebaum Baker agreed that the VA has made significant progress in the last 10 years. Mr. Martin discussed the collaborative efforts of the VA at the Togas facility in Maine and rural clinics that serve veteran and nonveteran populations. It would be helpful for those persons focusing on VA issues to determine for DHHS what models, such as the Maine program, could be replicated elsewhere.

Ms. Gary felt that the meeting's agenda was impressive and that it followed through with the objectives and intentions of the previous meeting. The presentations provided insight into these agencies' thinking processes that will allow NACRH to be better positioned to interact with these agencies to advance the Committee's agenda.

Mr. Cannington raised his concern that two site visits per year may not allow enough time for ongoing Committee business. Chairwoman Kassebaum Baker determined that 1½ days of meeting time would be set aside for Committee discussions. It was agreed that the site visits were valuable because they represent different rural settings but that the Committee should be careful of how time is spent during these meetings.

Mr. Morris helped to elucidate the role of NACRH. He stated that, while the primary audience of NACRH is the Secretary and DHHS, there are tangential benefits. For instance, both the

Association of State and Territorial Health Officials and NACCHO are presenting the NACRH's public health recommendations to their board members. Furthermore, he and Dr. Atkinson discussed the possibility of Dr. Atkinson drafting a letter on the issue of an ambulance fee schedule before the next meeting that could be circulated to the Committee members for approval and then forwarded to the Secretary. The Committee members agreed to this proposition.

As senior Committee member, Dr. Coleman stated that he felt that the Committee is going through temporary transitions with a new chair and a relatively new ORHP director. Patience is necessary with these processes because the Government does not work as fast as some would like. One effective solution has been to retool and recirculate previous papers or projects back into the system. He offered the suggestion that the NACRH meetings move out of Washington, DC, and restructure site visits. He also suggested that because the political clout of veterans would be impossible to change, the Committee should focus on veterans in rural areas as a special population with specific health issues that can be addressed.

Dr. Singleton stated that the Committee members should be mindful that they are only one of many committees dealing with the same topics, allowing each committee to concentrate on specific aspects of each topic. Together all the committees make up the big picture. It was agreed that there be updates on the four suggested topics at each meeting so that NACRH is moving forward on these issues. The Committee will continue to focus on broader topics while focusing on more specific, time-sensitive issues, as needed. Ms. Gary suggested that the members write internal papers on these four domains in addition to the minutes that are produced from these meetings.

Dr. Wakefield suggested that it would be helpful to capitalize on the expertise of the Committee members and ORHP by framing specific questions to focus on during presentations that would ultimately help develop policy recommendations. Furthermore, NACRH should be hawk-like in its advocacy efforts on timely issues (e.g., ambulance fees. To do this, Committee members should remain more in touch and work together between meetings.

It was suggested that a representative from the Bureau of Indian Affairs be invited to the Oklahoma meeting, which would likely provide a different perspective than what they will see on site. It was clarified that site-visit agendas are shaped by ORHP, with recommendations from the hosting Committee member as well as from others. Dr. Doty added that the Alaska sites have valued the summaries that Committee members wrote about their visits. Possibly the Committee could summarize the Oklahoma site visits by using the four topics as foci.

Chairwoman Kassebaum Baker suggested that the Committee members arrive for the Oklahoma meeting on Saturday, June 3, to take advantage of lower airfare and participate in the Green Corn Festival. This Saturday-to-Wednesday schedule has been established on other site visits.

Presenters

Tom Garthwaite
U.S. Department of Veterans Affairs

Diane Rowland
Kaiser Commission on Medicaid and the Uninsured

Claude Earl Fox
Health Resources and Services Administration

Phil Smith
Indian Health Service

Dave Berk
Rural Health Financial Services, Inc.

Joan Van Nostand
Office of Rural Health Policy

Bernard Arons
Center for Mental Health Services