March 3-5, 2002, Washington, D.C.

Health Resources and Services Administration
Office of Rural Health Policy

Washington, D.C.
March 3-5, 2002

Meeting Summary

The 40th meeting of the National Advisory Committee on Rural Health was held on March 3-5, 2002, at the Grand Hyatt in Washington, D.C.

Sunday, March 3

Washington, D.C.

Call to Order

Governor David Beasley of South Carolina, Chair

Governor Beasley convened the meeting by welcoming the National Advisory Committee on Rural Health (NAC) and thanking the Office of Rural Health Policy (ORHP) for the opportunity to serve as the new NAC chair. In addition to Governor Beasley, members in attendance included Stephanie Bailey, David Berk, Mary Wakefield, Alison Hughes, Monnie Singleton, John Martin, Keith Mueller, Tom Nesbitt, H.D. Cannington, Jim Ahrens, Steve Eckstat, Sally Richardson, and Dana Fitzsimmons. Present from ORHP were Marcia Brand, Tom Morris, Sahi Rafiullah, and Michele Pray. The members briefly introduced themselves to Governor Beasley.

Next, Dr. Brand provided an overview of the meeting's agenda. In addition to the following Committee business, she indicated that the NAC members would meet on Monday with congressional and administration representatives in tandem with the National Rural Health Association (NRHA) Policy Institute:

- Review and approve the safety net report.
- Identify a topic for 2002 (workforce versus quality).
- Set dates for upcoming NAC meetings, including the onsite meeting in Arizona.

Mr. Morris suggested that the NAC members review the safety net report section by section, and that he would place disputed text and other comments on the LCD projector to facilitate

consensus among the Committee. Furthermore, he explained that the introduction discusses global safety net issues, but the report clarifies that the Committee will deal with only a subset of these issues relevant to rural health.

Update on the Secretary's Initiative on Rural America

Marcia Brand, Director, ORHP

Dr. Brand presented an overview of the U.S. Department of Health and Human Services (HHS) Secretary's rural health initiative that was delineated in a memorandum on July 25, 2001. The initiative already has accomplished the following three action items:

- Established the HHS Rural Taskforce.
- Identified seven specific rural health issues to be addressed.
- Suggested next steps that would engage the Administration in similar efforts.

The Rural Taskforce's charge is as follows:

- Examine how HHS programs currently serve rural communities.
- Explore ways to strengthen these programs to better serve rural communities.
- Prepare a report and develop recommendations to inform HHS program development and policymaking.
- Develop a strategic plan on how to sustain the Department's commitment to rural America.

The seven specific rural health issues, with an emphasis on producing sustainable changes, are as follows:

- Develop a tool chest for small rural hospitals. This action item has been initiated with the $6.8 million Mississippi Delta Rural Development project to improve health care in a region comprising 235 counties (200 rural) across 8 States. The project's contractor will develop affordable and appropriate technical assistance for hospitals with less than 50 beds.
- Increase rural hospitals' access to capital for infrastructure and technology. ORHP is working with the U.S. Department of Housing and Urban Development and others to promote this action item.
- Improve primary care coordination. This activity is under way within HRSA to ensure that the President's initiative on expanding community health centers includes some rural communities
- Help rural providers prepare for the Health Insurance Portability and Accountability Act (HIPAA). ORHP was allocated an additional $15 million for activities to help hospitals with payment issues, quality, and safety, and to prepare for HIPAA.
- Strengthen the NAC.
- Strengthen rural emergency medical services (EMS). These efforts also will focus on terrorism response, including response to biological, chemical, and nuclear threats.
- Enhance rural workforce recruitment and retention.

Dr. Brand reviewed the next steps that the Secretary's Initiative on Rural America will consider and the progress that has been made already, including soliciting more than 450 comments from rural constituencies through a Federal Register notice. (ORHP abstracted the comments and sent them to the agencies of jurisdiction.) Transportation emerged as the predominant health-care issue facing rural communities. Oral and mental health care issues also were raised continually by this public forum.

The HHS Rural Taskforce briefed the Deputy Secretary, Chief of Staff, and other senior HHS staff members on its Report to the Secretary on an HHS-wide review of investments, barriers, and resources related to rural health. The Taskforce will brief the Secretary about this report in approximately 6 weeks.

ORHP staff members, including Mr. Morris, Ms. Rafiullah, Ms. Pray, Jennifer Riggle, and Tina Cheatham, helped coordinate rural workgroups to develop strategies to explore ways to strengthen HHS programs to better serve rural communities.

Discussion

Issues raised about the Secretary's Rural Health Initiative included the following:

- The Taskforce incorporated the seven specific rural health issues into its Strategic Plan, which is presently only an internal document but is scheduled for publication in about 6 weeks.
- It is commendable that HHS intends to collaborate with other agencies on rural health issues. For instance, the Substance Abuse and Mental Health Services Administration (SAMHSA) would be a logical partner given the disparity in mental health care within rural communities. SAMHSA's current grant program is extremely complicated and research-oriented; therefore, these programs likely are inaccessible to many potential rural applicants. Because States receive much of SAMHSA's funding, legislative or statutory changes may be needed to help rural communities-these changes are not easy to make. The events of September 11, 2001, have increased the need for adequate, accessible mental health care. (It may be useful to determine what percentage of SAMHSA funding is for block grants versus direct grants. The latter could be a viable resource for rural communities.)
- Even though the Federal Register notice on oral and mental health care in rural communities received a preponderance of responses, the rural safety net report does not fully address these issues. The reason for this is possibly because safety net programs for oral or mental health care on which to elaborate simply do not exist.
- The Center for Medicare & Medicaid Services (CMS) does not appear to understand the magnitude of the transportation problems in rural areas.
- It is not known at this time whether the Secretary will propose legislation to integrate HHS programs to use resources for rural health care collectively; however, some demonstrations will be conducted to allow some flexibility. Governor Beasely's experience working with Secretary Thompson demonstrates that the Secretary would be amendable to new ideas to improve rural health services. Oftentimes, the programs

servicing rural residents, albeit numerous, are disjointed and do not focus on the whole person.

Committee on Role in the Department

Andy Knapp, Counselor to the Secretary

Mr. Knapp cancelled his presentation due to illness.

Committee Administrative Business

Sahi Rafiullah, Acting Deputy Director

New Membership Selection

The onsite Arizona meeting in June will be the last NAC meeting for the following members: H.D. Cannington, Shelly Crow, Alison Hughes, John Martin, and Tom Nesbitt. ORHP is in the process of filling these approaching vacancies. Once identified, ORHP will submit the potential candidates for approval to the Secretary. ORHP seeks to balance the geographic location, gender, ethnicity, and expertise among the candidates. ORHP anticipates representatives from mental health, dental health, and mid-level practitioners will fill the vacancies. The first meeting with these new members will be in September in Montana.

Upcoming Onsite Meetings

The Committee discussed potential scheduling conflicts for the upcoming onsite meetings in June and in September. ORHP will most likely continue to hold the annual NAC meeting in Washington, D.C., in early March rather than in February to coincide with NRHA's annual Rural Health Policy Institute.

The NAC members decided to visit Arizona on June 9-11, 2002, and to table the decision on the September meeting to allow absent and new members an opportunity to select the dates. The Committee did decide, however, not to schedule the Montana visit on September 15-17 due to Yom Kippur.

The Committee discussed ideas for the Montana site visit. As host, Mr. Ahrens indicated that there are many significant places to visit in Montana, but that transportation logistics will be an issue when planning the site visits. Governor Beasley suggested that the Committee members prioritize what they would like to do and decide whether to visit the more populated eastern part of the State or the more remote western part. Dr. Mueller suggested that it might be useful to visit the original Medical Assistance Facilities located in eastern Montana to compare these

facilities with critical access hospitals (CAHs). Furthermore, rural hospitals would be an ideal topic because it is one of Mr. Ahrens's areas of expertise.

Dr. Singleton proposed that the Committee observe the local EMS system, which is probably much different than systems in other rural regions. Ms. Richardson inquired about collaboration between State and Indian Reservations in Montana. Montana comprises seven tribes with a combined population of 80,000 people. State-tribe coordination is lacking, and tribal populations have a high prevalence of diabetes, alcoholism, and unemployment. It may be worthwhile to look into the Turning Point projects that focus on tribal community health issues in Montana. (The Kellogg and Robert Wood Johnson Foundations funded these projects.)

NAC members should e-mail any other suggestions for the Montana meeting to ORHP, which then will forward them to Mr. Ahrens so that he can begin to synthesize a tentative agenda.

The June 2003 onsite meeting will be held in Texas.

Committee Charter

Tom Morris, Policy Analyst, ORHP

Mr. Morris listed the following changes made to the Committee Charter:

- The NAC can formally consult with additional groups including the Medicare Payment Advisory Committee, the Council on Graduate Medical Education, the Secretary Advisory groups on migrant health issues, and the National Health Service Corps (NHSC).
- The NAC can add an ex officio member from the Department as needed to augment the Committee's expertise in a certain area.
- In response to a question from Dr. Singleton, the Committee could cover issues of trust territories, if the interest exists, because they receive HHS grant monies.

Call for Public Comment

Governor Beasley called for public comment but none were made. The meeting was then adjourned for the day.

Monday, March 4

Washington, D.C.

Washington Update: Policy, Regulations and Legislation

Tom Morris, Policy Analyst, ORHP

The President's 2002 Budget

Democrats and Republicans are debating over the specifics of the proposed low-income prescription drug program as part of Medicare Reform. Both sides are concerned that the $77 billion allocated to States for this program is not enough.

CMS pledged to correct the methodology quirk in the physician fee schedule related to the sustainable growth rate that resulted in no money being available for the 5.4 percent physician reimbursement cut. To make this correction, however, CMS will need to make cuts elsewhere.

ORHP actively campaigned for set-aside funding for rural areas as part of the $125 million for bioterrorism planning and hospital preparedness. Ultimately, HHS decided to use a population-based formula, but indicated that the State Offices of Rural Health (SORH) will be listed as participating entities. ORHP is hopeful that there will be rural representation on the review panels for the State plan applications, which are due by April 15, 2002.

Regulatory Agenda for 2002

The following rulings from the Balanced Budget Act (BBA) have been finalized or will be soon:

- The Ambulance Fee Schedule was published on February 27, 2002. The final rule, similar to the proposed rule, includes a redistribution of money from hospital-based ambulance services to sole providers and from urban to rural. The affects of this ruling will vary greatly from State to State.
- The Rural Health Clinic rule is expected to be published this summer.
  ORHP has ongoing concerns regarding the outpatient prospective payment system (PPS). Last year, Congress allowed payments for medical devices and technology at cost, resulting in a budgetary loss. This loss will require a reweighting of the Ambulatory Payment Classifications. It appears that the first-year PPS data is now useless. These cost report data are important to many rural hospitals that are debating whether to seek CAH status. ORHP will continue to monitor this situation and report any changes to the Committee.

HHS Activities

Recent HHS activities include the following:

- The Secretary's Rural Initiative as outlined by Dr. Brand.
- The Secretary's Regulatory Reform Initiative, which includes the Secretary's Advisory Committee on Regulatory Reform. This Committee is conducting regional meetings that address rural issues and will develop recommendations to alleviate regulatory burden for health care providers. The Committee's final report is due in October 2002.

- The CMS Rural Listening Groups, initiated by Tom Scully, have generated a great deal of participation. These open-door meetings are held twice a month: one nationally based call-in meeting for field-based professionals and one Washington-based meeting for lobbyists with rural constituencies. The meetings are intended to identify issues, legislative or otherwise, that could potentially become problematic. CMS will need to determine how to manage participants' expectations given that not all the suggested changes can be made quickly, if at all.

Capitol Hill Activities

A congressional committee voted to reauthorize the Safety Net Bill that will include the Community Health Center program, NHSC programs, and ORHP's Outreach, Network, and Telemedicine Grant programs. Although the House discussed the bill, no hearings or votes are scheduled to reauthorize it. The House bill number may or may not change.
ORHP will update the NAC members if any action occurs regarding this bill.

Collectively, the Caucus and Coalition Omnibus Bills address rural issues annually and include recommendations from last year's Medicare Payment Advisory Commission (MedPAC) report. At this time, it is unclear whether these bills will include a Medicare vehicle.

The Medicare Rural Hospital Flexibility (Flex) Grant program is authorized under the Social Security Act, not under the Public Health Service Act as are many HHS programs. Therefore, the congressional committees of jurisdiction that handle this program are the Senate Finance Committee and the House Ways and Means Committee. Despite this atypical congressional route, ORHP is hopeful that Congress will reauthorize the Flex program as part of a larger Medicare bill.

In addition, the SORH program, which is under the purview of the Bureau of Health Professions, is up for reauthorization.

Discussion

The following issue was raised regarding Mr. Morris's presentation:

- The Safety Net Bill reauthorized telemedicine grants; however, ORHP does not have its own grantmaking mechanism. Therefore, the Health Resources and Services Administration (HRSA) chose to integrate telehealth initiatives across agencies rather than maintain them as part of a small independent program. At this time, the Office for the Advancement of Telehealth is under the HIV/AIDS Bureau because the Bureau is a large agency with a well-developed grantmaking enterprise.

Office of Rural Health Policy Update

Marcia Brand, Director, ORHP

Dr. Brand provided an overview of ORHP's activities during 2001 and upcoming activities for 2002. With a supportive administration and the Secretary's Rural Initiative generating new relationships across HHS, rural health care is at least on the radar screen.

ORHP has grown to 22 staff members, with the most recent additions having EMS expertise, and has initiated several new programs, such as the Automatic External Defibrillator (AED) program, and a new research center in South Carolina that focuses on minority populations.

To foster relationships with SORH, ORHP initiated a regional liaison that increases the number of points of contact from two to five people. Furthermore, with the addition of the Regional Liaisons, a total of nine people now focus on State-based issues.

To help fund its many programmatic objectives in 2002, such as working across HHS as part of the Secretary's Rural Initiative, enhancing the Flex program, and strengthening the Outreach and Network Grant programs, ORHP received a budget increase from $100 to $140 million.

In FY 2002, ORHP will fund 36 new outreach grant projects and 92 ongoing outreach projects. Furthermore, ORHP will support a promising outreach project known as Seeds of Hope-a mental health program now in seven States. Because this grant program is not categorical, it allows rural communities the flexibility to address unmet needs over the 3-year grant period at approximately $200,000 per year.

The Mississippi Delta project's upcoming activities for 2002 include the following:

- A small-hospital performance initiative will pilot test technical assistance tools used by 25 sites. Once finalized, these tools will be available at no cost online to other small hospitals.
- The Delta Health Ventures will conduct a small pilot project in 10 counties.
- ORHP awarded Network Development grants to the eight States with counties in the Delta region.

In 2002, ORHP plans to broaden the Network Development Grant program by focusing on horizontal and vertical network integration. For instance, instead of a clinic having to partner with a hospital, the program will encourage small rural clinics to pool resources and form a network. ORHP will fund 15 new Network Development grantees and continue to fund 22 existing grantees in FY 2002.

In 2002, ORHP will award 47 States with Flex program funding and will support the new Flex Technical Assistance Services Center. In addition to the CAH program, the Flex grants support

statewide planning, networking, and quality and EMS activities. To date, more than 550 CAH hospitals exist.

Through grants and technical assistance, ORHP will help rural hospitals' performance by helping the facilities to implement PPSs, to prepare for HIPAA requirements, to reduce medical errors, and to improve quality. (This is the aforementioned $15 million program that ORHP informally refers to as Rural Hospital Performance Improvement.)

The SORH Grant program's budget doubled for FY 2002 from $4 million to $8 million. This grant program requires States to provide a 1 to 3 match with Federal funds. With this additional funding, ORHP plans to develop a new technical assistance center to support States in administering the Flex Grant program and addressing other issues, such as workforce recruitment and retention.

ORHP would like to expand its ongoing policy development activities in 2002. The newly initiated $12.5 million AED program will provide grants to rural community partnerships to purchase AED equipment and conduct AED training. Furthermore, an EMS technical assistance center will engage States in placing AEDs with EMS and first-responder units and at other locations.

The events of September 11, 2001, pushed the EMS-related activities to the forefront. ORHP will use Title XII set-aside funding to support the EMS technical assistance center, to develop a rural EMS agenda and implementation guide, and to promote rural EMS recruitment and retention.

Dr. Brand ended her presentation noting several potential HHS-wide activities that will support the Secretary's Rural Initiative. Two proposed ORHP activities that will support this initiative are: (1) State-based health and human services planning meetings piloted by 40 States through an NRHA cooperative agreement, and (2) collaborations between tribal and local providers in rural communities.

Discussion

Issues raised regarding ORHP's current and upcoming activities included the following:

- ORHP will use the Title XII set-aside funding ($350,000 of the $3.5 million Title XII FY 2002 budget) to address EMS issues, such as EMS transportation for nonemergencies, and to establish the technical assistance center. ORHP deemed a center to be a better use of this relatively small amount of funding than a grant program. Nursing home transfers and older patient office visits increase the need for nonemergency transportation in rural areas.

- The Plain States and the Southwest States would both benefit from a project similar to the Mississippi Delta initiative. Any region can propose a valid rural initiative.
- Pre-hospital care is especially critical in rural areas because of the delay experienced by many rurally and remotely located patients in reaching the hospital. EMS units need technology, such as wireless phones, to support their efforts. Possibly, rural communities could serve as demonstration sites for bioterrorism-response initiatives to advance bioterrorism technology while introducing much-needed technology to these rural areas. Because of September 11, 2001, many EMS units are now working on bioterrorism response; however, it is not known yet whether $170 million in funding will support demonstrations on this issue. Evan Mayfield took over EMS issues for Ms. Riggle at ORHP.

Governor Beasley recognized the following four guests: Forrest Calico, Jake Culp, George Greenberg, and Wayne Myers.

Review of the Safety Net Report

Tom Morris, Policy Analyst, ORHP

Introduction

Page 1: Okay as written.

Page 2: Add a paragraph that broadens the formal rural safety net definition by including other services and facilities, such as nursing homes, home health care, and adult day care centers, and that mentions small rural community hospitals.

Include two or three paragraphs that provide clear information on rural populations.

Page 3: Include the politically necessary, albeit somewhat apologetic, text box that explains the Committee's reasoning for focusing on the rural safety net.

Page 4: Okay as written.

Section One: Programs That Support the Rural Safety Net

Page 5: Clarify in the text box on graduate medical education (GME) that GME is actually a subsidy program for urban areas so that the report does not imply that only rural areas need subsidies.

Page 6: Possibly indicate that though programs are available, many rural communities cannot make the required loan payments to participate in them.

Indicate that a benefit of telemedicine (last bullet on the page) is that patients seek care within their communities rather than traveling to metropolitan areas, which bolsters local economies and health care systems.

Page 7: Given that Medicare has four categories, it may be better to keep the section on Medicare more generic than is currently written.

Add one or two sentences on the State Planning Grant Program's goals regarding strengthening the rural safety net because this program is not only rurally focused. (The bullet on the State Planning Grant Program is generic because each State administers the program differently.)

Page 8: The Committee should consider creating a section to address mental health, oral health, or GME recommendations.

Mention provider training to some degree regarding oral health and mental health.

Although gaps have been identified in mental and oral health, few Federal authorities are available to link to these services.

Change public health to "local public health departments."

Incorporate a condensed version of Ms. Hughes' language on Tribal organizations into the report.

Section Two: Key Rural Safety Net Programs: A Deeper Analysis

Page 9: Either mention the Flex program in the bullet on CAH certification (the last bullet on the page) or incorporate additional information on the Flex program in the subsection on CAH on page 12.

Include a text box on wage index issues. The bullet on maintaining an adequate workforce targets community-based issues, not safety net issues.

Page 10: Okay as written.

Page 11: If allowable under disproportionate share hospital (DSH) legislation, change the language on the DSH requirements from "two obstetricians" to either "two maternity care providers" or "two obstetric providers," and then modify the language regarding obstetrical services in the related Committee Recommendation (the last bullet on the page).

Page 12: In the top bullet on the page, include the wording, "assist rural hospitals," and delete the reference to urban DSH hospitals.

Possibly delete the third paragraph under the CAH section because the CAH program does not function uniformly from State to State as a safety net.

Possibly include the other two hospital categories (Medicare Dependent and Sole Community Hospitals) in addition to CAHs. However, possibly include these categories only parenthetically because these payment methods serve the same purpose as CAHs.

Page 13: Okay as written.

Page 14: Update FY 2002 to FY 2003 in the final line under Federally Qualified Health Centers (FQHCs) and the Uninsured and Underinsured.

Page 15: Include a text box on Health Professional Shortage Areas (HPSAs).

Page 16: Expand the third bullet under Committee Recommendations to include the replacement of computer hardware and software. (The report already addresses loan repayment and access to capital.)

Possibly indicate in the fourth bullet that administrative barriers exist to becoming an FQHC for some rural areas.

Page 17: Okay as written.

Page 18: Indicate what is being phased out.

Page 19: Delete the last paragraph because of inaccuracies related to providers' misunderstandings on violating the anti-kickback statute.

Page 20: Integrate the prescription drug text box into the main narrative and recommend the continuation of 340B and other Medicare prescription drug programs.

Replace the word "limited" with "important" in the prescription drug header.

Clarify the term "adequate workforce" throughout the document, or replace the term if it cannot be adequately clarified.

Page 21: Okay as written.

Page 22: The following statement in the second paragraph is not accurate: "outstrips the limited supply available under the program."

The second bullet under Committee Recommendations should state that it would be easier to make the J-1 Visa Waiver program locally based. Furthermore, include this amended recommendation in the report cover letter to make it more visible to the Secretary.

Page 23: Include supportive information to preface the third bullet under Committee Recommendations to make it similar to the other three recommendations.

Section Three: Conclusions, Mending the Net, Expanding the Net

Page 24: Emphasize strengthening and improving the safety net, not just mending and modifying it.

Add a bullet under Committee Recommendations on how lifestyle and behavior influence one's health status. For example, provide payment mechanisms to compensate for counseling and other assistance for behavioral and lifestyle changes.

Add a bullet under Committee Recommendations on transportation issues.

Add a bullet under Committee Recommendations on access to rehabilitation services.

Incorporate into the text the concept of encouraging cooperation and coordination of safety net services.

Page 25: Okay as written.

Mr. Morris will incorporate these modifications and suggestions into the safety net report and will redistribute the updated version to NAC members for a 5-day review period. At this time, Mr. Morris will accept only technical changes, not substantive changes, to the document.

A motion was made to adopt the safety net report in its entirety by the Committee. This motion was passed unanimously.

Topic One: Workforce

Wayne Myers, M.D.

Dr. Myers provided a brief history of the health care workforce and how certain trends and policies shaped the current workforce in rural areas.

Physicians

For approximately 30 years, there have been half as many physicians per capita in nonmetro areas as in metro areas. This rural-urban physician disparity is not unique to the United States, but it is an ongoing issue worldwide.

The rural workforce shifted from general practitioners who completed 1-year internships to more family practitioners with specialty training.

Primary care is the backbone of rural health. Since the 1960s, roughly 30 percent of physicians have practiced primary care, with only the following marked swings in this stable trend:

- In the mid-1980s, many physicians chose specialties to avoid treating AIDS cases.
- In anticipation of President Clinton's health plan in 1996, many chose primary care to avoid potential nonpayment issues.

Another trend that negatively affects rural communities is the steady decline in the number of osteopathic doctors who provide primary care. Osteopaths are disproportionately located in rural areas.

Medical Education

Before World War II, medical schools financed their own research when they could afford to do so. During wartime, however, the Federal Government began funding medical schools to conduct research on combat. The NIH budget soon skyrocketed to advance similar medical and drug breakthroughs. After World War II, NIH became the dominant influence on medical schools.

In 1965, the Federal Government introduced Medicare and Medicaid. Because medical schools did not adequately support medical students after graduation, many residents seized upon Medicare to pay for their GME at teaching hospitals. This system continues today.
Medical education is a byproduct of many medical schools. The majority of schools receive no incentives to help rural areas with workforce distribution. These institutions receive incentives, however, to conduct research, provide referral patient care, or both. Rural communities would benefit from the Federal Government (which has useful data) collaborating with the States (which own about half of all medical schools nationwide) on workforce issues.

International medical graduates have helped serve the unmet health care needs of some distressed rural areas, such as central Appalachia. NHSC places approximately 1,300 clinicians and 2,000 J1 doctors each year.

Medical schools are static in enrollment and the number of new schools, whereas osteopathic schools are expanding in both areas. Oftentimes, osteopathic schools have less money available to focus on research and referral care; therefore, they remain focused on education, whether by choice or not.

Physician Assistants and Nurse Practitioners

Physician assistants (PAs) and nurse practitioners (NPs) were formally recognized during the 1960s: NPs developed from a civilian tradition that empowered nurses who had extensive clinical experience, whereas PAs developed from a military tradition during the Vietnam War. Despite their inherent differences, both professions are extremely important to rural communities.

States with adequate rural health care access more readily recognize NPs and PAs. To the contrary, States with major rural access problems often have more restrictive practice environments for NPs, PAs, and powerful, organized medical organizations.

Mentor-based clinical training associated with NP and PA education lends itself to the rural experience. Furthermore, local training of place-committed students (i.e., recruiting within rural areas) is very powerful. Overall, these two professions are well suited for this dynamic.

Nursing

Nursing education had to forfeit its Medicare funding when it shifted from hospital based to university based. This shift marked a move from a vocational-based to an intellectual-based profession.

Nursing is the most well-distributed health care workforce, due in part to community colleges offering nursing programs, including midcareer advanced training. Case in point: In Hazzard, Kentucky, 36 out of 37 nursing students trained at the local community college stayed in the area to work after receiving certification.

It is likely that working conditions outweigh training issues as the major problems faced by the nursing workforce.

Other Key Personnel

It is well documented that mental health care is a major problem in rural America. To solve this problem, a hierarchy of professions should be made available to provide mental health care in rural areas, that is, regulate mental health care as a system, not as discrete professions. Many rural communities would accept Master's-level (or lower) and social work personnel willingly in lieu of doctorate-level professionals. The dominant mental health workforce climate, however, actively promotes the latter.

Similar to the nursing profession, working conditions for mental health care providers are likely more problematic than training issues. In rural communities, these workplace issues must be addressed first before addressing the educational issues.

The emergency profession is an example of a troubled system that works. EMS demonstrates a distressed system that works without overly relying on outside entitlement funding.

Crosscutting Issues

The original vision for Area Health Education Centers (AHECs) was a community-controlled program that met local needs. By 1974, however, only medical schools received AHEC program funding (nursing schools were eligible for this funding by the late 1970s).

From high school to graduate school, rural students leave the education continuum at a higher rate than their more urban counterparts. This problem results in a low representation of rural students throughout the educational system, including in health care professional education.

Although telehealth was introduced in the mid-1970s, the technology did not become affordable until the 1990s. The clinical applications of telehealth to help overcome rural workforce shortages may be overestimated because even with high-tech equipment, a provider is still needed to facilitate the consultations. Possibly, educational applications of telehealth (e.g., train-the-trainer) are more appropriate for rural settings.

Why No Clear Federal Workforce Policy?

As demonstrated in other countries, a Federal health care workforce policy does not work effectively. At this time, the provider market dictates where providers will go, not a Federal policy. Furthermore, legislators from training center districts more actively advocate shaping workforce policies than those from underserved areas. One such legislative district is New York City with 13 percent of all resident physicians located there.

NAC Policy Options

Dr. Myers listed the following potential policy changes for the Committee's consideration:

- Allocate Medicare billing numbers according to local need.
- Waive the requirement that JI Visa students must leave the country for 2 years before returning to practice medicine. Many rural areas in the United States would be attractive to foreign medical residents.
- Increase the amount of U.S. medical residents' indebtedness for loan repayments as an incentive to work in rural areas.
- For nursing, analyze whether education or workplace issues have a rural peculiarity.
- In the mental health field, address system capabilities rather than professional credentials. Currently, the major obstacles to contend with include State licensure issues and Washington-based politics. Nonetheless, Federal funding for community mental health centers may be a potential leveraging tool.
- Develop an EMS Federal training and skill maintenance initiative. EMS professionals, from first responders to emergency medical technicians to paramedics, are very well trained.

Discussion

Issues raised regarding the workforce presentation included the following:

- The dentist shortage in rural areas is a national problem, and the professional response is discouraging. Many dentists will not accept Medicaid or provide care for the uninsured. It may be beneficial to rural areas to push for dental hygienists and other providers (e.g., family practitioners) to be permitted to perform basic dentistry.
- Given that the average debt a medical resident faces after medical school is around $200,000, indebtedness could be used as a powerful leveraging tool to help workforce distribution. In addition, State initiatives that provide incentives, such as loan repayment, for residents to stay in state may be advantageous for rural communities. However, these statewide initiatives do not always focus on placing residents in areas with the greatest need.
- Although most rural residents do not know the difference between allopathic and osteopathic medicine, a strained relationship still exists between these two professions, which may affect the capacity to help rural communities. Increasing parity exists between these two camps, and it is arguable that D.O.s are more knowledgeable about treating patients than are M.D.s.
- An increase in disease-specific health care professionals, such as health educators focusing on diabetes or respiratory therapists focusing on asthma, would potentially help alleviate rural health care workforce issues.
- Because many people in rural areas want to stay and work locally, it would be beneficial to determine how to link university courses to rural sites.
- If the NAC takes on the workforce issue, the Committee members would need to determine the level of specificity beforehand. (Cover all the disciplines broadly versus some of the disciplines intensely.)
- Although the Secretary expressed interest in nursing issues and kicked off a nursing recruitment program and the Bureau of Health Professions recently published press releases on the nursing shortage, no organized departmentwide initiative on this issue has been developed.
- To some degree, the Department of Labor is dealing with health care workforce issues.

- A possible barrier to investigating certain disciplines is that many health care professions are self-controlled.
- One concern regarding emergency personnel is that the enforcement of Federal or health insurance training requirements would put many of these volunteer organizations out of business, not just limit their availability.

Topic Two: Quality

Mary Wakefield, NAC Member
Forrest Calico, Health Systems Advisor, ORHP

Dr. Wakefield, a member of the Committee, and Dr. Calico presented background information and current trends on the increasingly more pivotal issue of quality among policymakers, purchasers, providers, the media, and the public at large.

The issues of access, cost, and quality act as catalysts for rural health policy at the State and Federal levels. Traditionally, much of the policy generated has related to cost and access, that is, to slow the growth rate of spending and to increase access to health care services. Quality is a relative newcomer as a public health policy issue. The following elements helped to catapult the quality issue to the forefront in recent years:

- The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. This Commission produced a report on quality and a consumer bill of rights. The report briefly mentions rural issues in a section about underserved populations.
- National Roundtable on Care Quality (the Institute of Medicine [IOM]).
- Medicare Payment Advisory Commission.
- Committee on Quality of Health Care in America (IOM). This Committee published two reports: one on medical errors and patient safety and the other on other broader quality issues.
- The June 2001 MedPAC report on Medicare and rural health includes a chapter on quality.

Different external forces (regulation and legislation versus economic and other incentives) affect different dimensions of quality, such as health care errors, patient safety, and overuse and underuse of health care services. There is a movement toward developing economic and other incentives to influence quality. For instance, the Leapfrog Group is a purchaser organization that compels hospitals to follow certain safety standards to gain the business of its Fortune 500 members.

In 2000, the IOM Committee on Quality of Health Care in America released To Err Is Human: Building a Safer Health System. To date, the majority of evidence-based research on errors focuses on acute care in urban hospital settings. It is questionable whether these findings can

be generalized for rural settings. Quality studies on nursing home care and ambulatory care would better reflect the rural dynamic.

Three major problems associated with quality are as follows:

- Overuse-providing health care services when the risk of harm exceeds the potential benefit
- Underuse-not providing scientifically based care that could provide benefit
- Errors

IOM made the following recommendations on patient safety:

- Create a Federal Center for Patient Safety under the auspices of the Agency for Healthcare Research and Quality (AHRQ). President Bush has $60 million for patient safety and medical error initiatives.
- Strengthen voluntary reporting systems and establish mandatory reporting systems to identify lessons learned. At present, error data cannot be aggregated because all States are different. However, any system changes should avoid overburdening rural hospitals and providers with additional data-collection requirements.
- Set safety standards through regulatory and legislative changes as well as market forces (e.g., the Leapfrog Group).
- Implement safety systems in health care organizations.

The IOM Committee on Quality of Health Care in America recently released its second report, Crossing the Quality Chasm, which focuses on the importance of consistent quality standards across all health care institutions. (Both reports are available online from the National Academy Press at www.nap.edu.)

Quality initiatives in urban settings that may or may not be applicable to rural communities are as follows:

- Technology applications.
- Research.
- Payment policies (e.g., purchasing power by influential purchasing groups). It is questionable whether Medicare, a major payer in rural areas due to a high ratio of beneficiaries, can be enticed to focus on quality.
- Professional workforce (e.g., inadequate training and deployment)

Next, Dr. Calico provided an overview of current Federal activities related to quality issues, which involve the following components:

- AHRQ
- Quality Interagency Coordination (QuIC) Task Force's Ambulatory Workgroup
- The PRO/QIO Contract's Scope of Work
- ORHP
- Rural Quality Vision Conference (ORHP and AHRQ joint initiative)

The "big tent" concept applies a corporate-minded approach to health care quality. In other words, organized systems of care should focus on developing a quality product as would a corporate entity; however, this economic model should fit into a care model that places care first, not the profit margin. A care model could galvanize around developing organized systems of care with characteristics such as disease management, continuity of care, effective information systems, and responsiveness to IOM's six aims. These aims are that care be timely, effective, safe, patient-centered, efficient, and equitable. Equitable care is a major issue for rural communities.

The NAC should address the following issues if quality is selected as the topic for 2002:

- Recognize that quality is a systemwide issue.
- Address resource requirements.
- Develop strong leadership and positive organizational culture.
- Improve health care quality at the grassroots level in rural communities (i.e., the rural laboratory).

The NAC recommendations on quality could have implications for the following programs and agencies:

- Reimbursement (CMS)
- QuIC
- Flex Grant program
- Research and demonstrations (e.g., AHRQ and CMS)
- Grant programs that focus on community-based quality improvement (e.g., HRSA and HHS-wide)

Discussion

Issues raised regarding the quality issue included the following:

- A current project in Nebraska is examining how CAHs report errors. The project collected current reporting forms and estimates of medication error rates from four hospitals. It appears that the error issue is not necessarily a resource shortage but a knowledge shortage-rural hospitals need guidance. As medical and technological advances expand exponentially, rural disparity will increase. Many high-tech applications (e.g., electronic order entry databases) are not feasible in most rural hospitals.
- The lack of pharmacists in rural areas forces many nonpharmacists in emergency rooms to dispense prescriptions. This trend will continue in concert with the increase in the number of prescription drugs, thus making the need for trained pharmacists even that more critical. Possibly telehealth consultations between pharmacists (even rural to rural) could help alleviate this problem.
- How does telemedicine affect the quality of care? Rural hospitals and providers can potentially adapt telemedicine to help improve quality. Furthermore, telemedicine could help familiarize rural providers with conditions they do not often see, such as critically ill or injured children. However, research on telemedicine is in its infancy. (Dr. Nesbitt is

presenting a paper on telemedicine for psychiatry, dermatology, and endocrinology to the American Telemedicine Association in June.)

- Best practices should be developed to set standards for rural hospitals and providers. As a first step, the standard of care available in rural areas should be measured. Rural hospitals and providers could use telehealth as an educational tool to learn how to develop better practices and to provide better quality care.
- Do studies exist on the overuse of services by Medicaid patients who seek care because it is free and therefore monopolize providers' time? The issue of how intervention and treatment utilization follows funding and reimbursement streams is broader than just Medicaid.

Call for Public Comment

Governor Beasley's call for public comment resulted in the following comments:

Pat Taylor introduced a new method that uses census track data rather than counties to determine rurality. Zip code files were developed to access census track data.

Ms. Taylor also mentioned a recent study that used a Medicare database to determine what type of treatment was received by beneficiaries who had a heart attack over a 1-year period. The study findings indicate that the more rural the beneficiary's location, the worse the treatment received for the heart attack. Dr. Eckstat questioned how the study measured quality because many times the less treatment received the better the outcomes for heart attack patients.

A physician with the Indian Health Service (IHS), noted that as the largest rural health provider in the United States, IHS struggles with both quality and workforce issues and that these two topics are intertwined and therefore cannot be addressed without one another. IHS suffers from a perception of poor quality; nonetheless, quality is still difficult to define. IHS used credentials of the Joint Commission on Accreditation of Healthcare Organizations (JCAHOs) as measures of quality. However, JCAHO credentials are rudimentary measures of quality because they are indicative of only compliance to the credentials. Therefore, using these credentials as measures of quality implies that compliance assures quality. He stated for the record that IHS is not relinquishing its responsibility in caring for its constituents despite the increase in the number of tribes assuming control for their own health care. Regardless, IHS still addresses safety net issues for the majority of the Native American population.

Tuesday, March 5

HHS Regulatory Reform Initiative

Bela Agrawal, Office of the Assistant Secretary for Planning and Evaluation

Ms. Agrawal provided an overview of the Secretary's Regulatory Reform Initiative and the activities of the Secretary's Advisory Committee on Regulatory Reform. Overall, the Secretary would like to make practical regulatory changes that could have a large affect on rural health care providers and beneficiaries and that could be implemented in the short term during his tenure with HHS. Reducing regulatory burden and removing barriers to health care access to improve patient care are the initiative's key goals.

The Secretary's Advisory Committee on Regulatory Reform, an official FACA committee that was established in September 2001, held its first regional hearing in Miami, and plans to hold four more regional hearings in Denver, Phoenix, Pittsburgh, and Minneapolis. Following the last hearing in June 2002, the Committee will draft a report on its findings.

As an important information-gathering activity, the Committee published a Federal Register notice for public comment in January to garner additional input from rural constituents and other stakeholders on the regulatory reform issue.

The Committee will develop recommendations for potential regulatory changes in the following four broad areas: health care delivery, health systems operations, biomedical and health research, and pharmaceutical and other product development. The Committee's four subcommittees are as follows:

- Data and Information
- Flexibility (especially regarding scalability to population size, etc.)
- Communications and Oversight
- Coordination (primarily between Federal and State agencies)

Ms. Agrawal encouraged the NAC members to recommend any names of people who would be informative on regulatory reform, possible sites to visit, or potential regulations to review. She indicated that travel money is available for those who would like to attend the regional hearings. NAC members may send additional comments or suggestions to Ms. Agrawal at (202) 260-3321 or visit the HHS Regulatory Reform Initiative Web site at www.regreform.hhs.gov

Discussion

Issues raised about the HHS Regulatory Reform Initiative and the Secretary's corresponding committee included the following:

- The exact number of regulations that the Secretary's Advisory Committee on Regulatory Reform must cover is unknown at this time, but the number would include regulations from sources beyond those published in the Code of Federal Regulations. For instance, other sources that users receive with Federally mandated regulations include program memoranda, preamble, guidance, and carrier communications.

- The Secretary's Advisory Committee on Regulatory Reform may want to examine the following issues:
    - Health care delivery as it relates to Medicare beneficiaries, especially so older residents in rural areas can receive screening and preventive services for catastrophic diseases. (Ms. Agrawal indicated that the Committee likely will not address alleviating payment burden for beneficiaries, but will deal with regulations that affect how rural residents access health care services. For example, the Committee could look at the advanced beneficiary notice that is often confusing for providers and patients. Payment and policy issues are not within the Committee's purview.)
    - Data and information regulations (e.g., pharmaceutical studies that must store paper records for 7 years), and how these records can be stored in more compact ways by using new technology. The Data and Information Subcommittee has already raised these issues.
    - The regulations that govern the NHSC placements in Medically Underserved Areas or in HPSAs. Providers with J1 Visa Waivers have leeway to work in other rural areas. In addition, the elimination of the J1 Visa Waiver program by the U.S. Department of Agriculture may have a negative affect on rural communities.
- Small rural hospitals often retain outside consultants to meet their cost reporting requirements; this process is usually more burdensome for these hospitals compared with their urban counterparts.
- The Rural Policy Research Institute's Center for Rural Health Policy Analysis recently completed a policy brief on regulatory and contractor reform legislation, which is available online at www.rupri.org/healthpolicy/index.html.

Selection of an NAC Topic for 2002

Tom Morris, Policy Analyst, ORHP

The Committee debated whether to work on the quality or workforce issue during 2002. Because the topics are so commingled, it was suggested that the NAC members consider working on both topics simultaneously.

One advantage to focusing on quality is that the Committee would represent a unique perspective on this issue, whereas many agencies, such as the U.S. Department of Labor and the Bureau of Health Care Professions, are focused on workforce (albeit not necessarily from a rural viewpoint). On a cautionary note, quality issues often evoke an emotional response, and many rural providers become defensive about being perceived as providers of poor quality health care and as secondary providers to their urban counterparts.

At the rural community level, workforce is a larger concern than quality. Furthermore, due to its subjectivity, quality is difficult to define and measure. For example, is it measured by outcomes or patient satisfaction? Accordingly, the Committee should consider developing recommendations on how to get providers into rural areas first before focusing on quality.

Moreover, an approach that goes beyond HHS on workforce issues will strengthen the Committee's recommendations.

These two topics are very interrelated and crosscutting. Case in point: Quality problems in rural areas, such as in nursing homes, are related to personnel shortages. A possible compromise to cover both topics would be to determine what type of workforce is required to have quality health care in rural areas. This approach, however, would limit how thorough the Committee could evaluate the quality issue. For instance, this approach would not include systems issues related to quality.

Due to the relevance of quality and workforce to rural America and the interrelationship of the two topics with one another, a majority of the Committee (14 of the 15 members present, excluding the Chair) voted to cover both topics and produce two separate reports during 2002.

ORHP will develop outlines for each topic and will present them to the Committee at the June meeting. At that time, the Committee may choose to reverse its decision to cover both topics if ORHP's outlines indicate a possible poor reception for one of the topics or if one topic is more legislatively timely than the other.

To help facilitate this two-topic process, the following subcommittees were established:

Quality Subcommittee:

Chair: Mary Wakefield
Members: Stephanie Bailey, Shelly Crow (pending), Dana Fitzsimmons, John Martin, Keith Mueller, and Tom Nesbitt

Workforce Subcommittee:

Chair: Dave Berk
Members: Jim Ahrens, Steve Eckstat, Rachel Gonzales-Hanson, Alison Hughes, Sally Richardson, and Monnie Singleton

The quality subcommittee's initial activity will be to review what work has already been done on this issue (including Dr. Wakefield's two reports). The workforce subcommittee's first task will be to determine the appropriate depth in which to approach this topic and from what angle (e.g., by discipline, health care problems, demographics, hospital needs, or type of care).

June Meeting

Michele Pray, Program Analyst

The June onsite meeting is in Arizona from Sunday, June 9, to Tuesday, June 11, 2002. Ms. Pray strongly encouraged the NAC members to travel on Saturday, June 8, 2002, because traveling on Saturdays is significantly less expensive than on Sundays, which is important in light of current budgetary constraints.

Dr. Singleton inquired whether the Arizona visit would be conducive to bringing a child to sightsee in the area. Ms. Hughes, the host for this site visit, indicated that it would be conducive, as there are many interesting places to visit with children. In addition, the Copper Queen Hotel in Bisbee, Arizona, should be very accommodating for children.

Although it would maximize the Sunday Committee session if the meeting were to begin between 10 a.m. and 11 a.m., Governor Beasley does not want the Sunday agenda to infringe on any NAC member's religious observations on Sunday morning.

A tentative schedule for the June meeting is as follows:

- Arrive on Saturday (Ms. Hughes offered to host a dinner reception at her home in Tucson).
- Conduct the Committee meeting Sunday and Monday in Tucson.
- Travel to Bisbee late Monday afternoon.
- Conduct site visits in Bisbee on Tuesday.
- Leave on Tuesday or Wednesday.

Call for Public Comment

Governor Beasley called for public comment but none were made. The meeting was then adjourned.