March 2-4, 2003, Washington, D.C.

Health Resources and Services Administration
Office of Rural Health Policy

Washington, D.C.
March 2-4, 2003

Meeting Summary

The 43rd meeting of the National Advisory Committee on Rural Health (NACRH) was held on March 2-4, 2003 at the Grand Hyatt Hotel in Washington, D.C.

Sunday, March 2

Call to Order

The Honorable David Beasley, Chair

Governor David Beasley convened the meeting by welcoming members and guests. He spoke briefly about the new challenges and dynamics the Committee will face as its mission and membership expand to encompass human services issues. He also explained that during the course of the meeting the Committee would have several joint sessions with the National Rural Health Association's Policy Institute

Members present at the meeting were: Mr. James Ahrens; Stephanie Bailey, MD, MSHSA; Mr. David Berk; Mr. Evan Dillard; Joellen Edwards, Ph.D.; Michael Enright, Ph.D.; Dana Fitzsimmons, R.Ph.; Ms.Rachel Gonzales-Hanson; Keith Mueller, Ph.D.; Ms. Sally Richardson; Glenn Steele, M.D., Ph.D.; and Mary Wakefield, Ph.D. Those not in attendance were: Steve Eckstat, D.O.; Raymond Rawson, D.D.S.; and Monnieque Singleton, M.D. Present from the Office of Rural Health Policy (ORHP) were Marcia Brand, Ph.D.; Mr. Tom Morris, MPA; Ms.Michele Pray-Gibson.

Governor Beasley asked for comments on the minutes from the September meeting of the Committee in Montana. There were no comments and the minutes were approved.

Draft Report on Quality of Care

Governor Beasley and Tom Morris

Governor Beasley and Mr. Morris reviewed the status of the Committee's draft report on quality of care issues in rural areas and asked the Committee to comment on recommendations in the report. The Members agreed on several changes to the recommendations.

There was considerable discussion of the second recommendation, which asks the Secretary to solicit input from rural providers and interest groups on quality measures for hospitals, nursing homes, and other rural providers. Mr. Dillard questioned how the Secretary would gather information from the providers. Mr. Morris suggested that the Secretary could publish a notice in the Federal Register. The Committee agreed to this approach and the recommendation will be changed accordingly. Dr.Mueller and others suggested adding "benchmarking" to the language on outcome measures. Benchmarking would allow for comparisons among similar facilities on quality performance measures. The recommendation was changed to reflect these comments.

Ms. Richardson suggested that the recommendation to amend the Seventh Scope of Work for Quality Improvement Organizations be combined with the recommendation to increase funding for these organizations. The Committee concurred and asked staff to make the necessary changes. Staff was also instructed to combine other recommendations where they feel it is appropriate.

Mr. Morris provided more background on Committee concerns about the recommendation to develop a new evaluation methodology for reviewing the work of Quality Improvement Organizations. Dr. Mueller recommended language changes that were adopted by the Committee.

Dr. Wakefield asked staff to change the wording of the recommendation to increase the rural focus of the Agency on Health Research and Quality. She wanted to include more emphasis on the dissemination of research findings to rural providers. The Committee concurred.

The last recommendation that asks the Secretary to work with the Centers for Medicare and Medicaid Services (CMS) in promoting rural quality demonstrations generated several comments from the Committee. Dr. Wakefield and Mr. Ahrens suggested adding a request for payment incentives on quality. Dr. Steele emphasized that rural populations offer unique advantages for quality demonstrations. The recommendation will be changed to reflect these ideas.

The Committee agreed to add one or more new recommendations based on suggestions from three members. Dr. Mueller suggested adding a recommendation to strengthen the role of the

National Institutes of Health in rural quality research. It would be combined with the earlier recommendation calling for increased funding for quality research. Ms. Richardson proposed a new recommendation for increased funding to promote the quality improvement efforts by State Licensing and Certification Agencies. Dr. Edwards raised the issue of training in rural areas for quality improvement initiatives and technologies. The staff will develop a new recommendation or modify existing ones to address these issues.

Governor Beasley called for a Committee vote on the recommendations. The Committee approved, authorizing staff to make the changes that were discussed. The revisions will be E-mailed to the Committee for a final review.

Workforce White Paper

Governor Beasley and Tom Morris

Governor Beasley, Mr. Morris, and Michele Pray-Gibson led a page-by-page review of the draft white paper on allied health workforce issues affecting rural communities. During a lengthy discussion of the paper, the Committee recommended several changes. Some of the important changes are as follows.

The section on Training will be modified to make the language more positive. Issues about training costs and the lack of financial incentives for training allied health providers in rural areas will be discussed. The importance of vocational education will also be mentioned in this section. The Committee agreed that a "bullet" format would be more effective for parts of this section and directed the staff to make these changes.

The section on Licensing and Certification will be changed to avoid any implication that these functions are not essential in rural areas. The emphasis will be on whether the requirements and their costs are realistic and appropriate for rural environments.

The Committee agreed that the section on Challenges should recognize the importance of health care to the overall economy of the states.

Some minor changes will be made in the paper's final paragraph and it will be expanded into a separate section for Conclusions.

Governor Beasley reiterated the underlying rationale for a white paper on allied health providers and Dr. Brand spoke about the timeliness of this issue in the Department of Health and Human Services. Governor Beasley then asked for a motion to approve the white paper subject to Committee changes that will be made by staff. The motion was approved.

September Meeting

There was a brief discussion of plans for the meeting of the Committee in September. Ms. Richardson's offer to host the meeting in West Virginia was accepted. The exact location will be determined at a later date. The meeting is scheduled for September 7-10 2003.

Mr. Dillard asked that Alabama be considered for a later meeting of the Committee.

Public Comment

Governor Beasley opened the meeting for public comment and then recognized Dr. Pat Taylor, former Director of the Research Center Grant Program managed by ORHP. Dr Taylor spoke about the problems of funding health care for the uninsured in rural areas of the country. She mentioned that the uneven distribution of Community Health Centers (CHCs) and other safety-net providers is a big problem for rural areas that places enormous burdens on private practitioners. She suggested that the Committee investigate alternatives such as utilizing financial support from appropriations for CHCs and Community Migrant Health Centers (CMHCs) to subsidize sliding fee schedules for Rural Health Clinics (RHC) and Critical Access Hospitals.

Ms. Gonzales-Hanson responded to Dr. Taylor by reporting that fifty percent of CHCs are located in rural areas. She also stressed the importance of CHCs as a model for community involvement in local health care delivery, and the legal and policy problems of diverting CHC funds for providers that are not community directed.

Governor Beasley adjourned the meeting until the next day.

Monday, March 3

Governor Beasley convened the meeting and introduced the first speaker.

Remarks from the Health Resources and Services Administration (HRSA)

Dennis Williams, Deputy Administrator, HRSA

Mr. Williams congratulated the Committee for its work on rural health care issues and talked about its importance to the Secretary and the Department. He provided a brief overview of the President's health care initiatives, including expansion of CHCs and CMHCs and increased funding for the National Health Service Corps. He talked about Secretary Thompson's strong

commitment to rural health and his goal to put 9,000 more CHCs in communities across the country. He also mentioned the Secretary's regulatory initiative that will allow more foreign-trained physicians to remain in the country. He highlighted the importance of telehealth and telemedicine to rural areas and described some ongoing projects in these areas. He mentioned that HRSA is developing geo-mapping technologies to better identify areas of under-service in the country.

Mr. Ahrens encouraged him to think about funding opportunities for places where there are no CHCs. Mr. Williams responded that HRSA is attempting to place more CHCs in both rural and frontier areas.

Ms. Gonzales-Hanson reiterated the importance of the community-based philosophy of CHCs and urged that it remain fundamental to the program. Mr. Williams affirmed that community-based boards are indeed fundamental to the program and that more attention will be given to their training needs.

Dr. Mary Wakefield affirmed the importance of CHCs, but cautioned that one size does not fit all in rural communities. She urged flexibility on HRSA's part and the consideration of other options for rural areas. Mr. Williams responded that HRSA can be flexible, but only within the constraints imposed by law. He said that HRSA is working on a new frontier clinic model in Alaska and with Medicare on new payment options for rural clinics.

Joint Session with the National Rural Health Association Policy Institute

The Committee attended a joint session with the Policy Institute of the National Rural Health Association. The group heard from Mr. Tom Scully, Administrator, Centers for Medicare and Medicaid (CMS). He spoke about recent Medicare and Medicaid legislation developed by the Administration as well as CMS initiatives to address the concerns of rural health care providers.

Integrating Behavioral Health and Primary Care

Michael J. English, J.D., Director, Division of Service and System Improvement, Substance Abuse and Mental Health Services Administration (SAMHSA)

Dr. English first provided an overview of the mission and programs of SAMHSA and described SAMHSA activities related to mental health services in rural and primary care settings. He identified four key policy issues related to integrating behavioral health and primary care in rural areas: (1) Workforce shortages in mental health and the resulting competition for staff; (2) Historically "stove-piped" physical and mental health service systems treating the same individuals without consultation; (3) Declining public financial support for mental health and

substance abuse services; and (4) The social stigma that prevents some individuals from seeking services. Dr. English talked about SAMHSA approaches to addressing these issues, including a study to compare integrative strategies (such as co-location, either concurrent and collaborative) and referral models for linking mental health/substance abuse services with primary care. He then identified and discussed areas of opportunity for integrating mental health and substance abuse treatment with primary care in rural areas. He focused on workforce incentives, cross training of mental health and primary care professionals, use of alternative providers, the importance of cultural competence in the workforce, and the use of telehealth technologies, team treatment, and managed care. Dr. English offered to work with the Committee as it continues to study these issues.

Dr. Steele asked if there were any preliminary conclusions from the study comparing collaborative and referral models of integrated care. Dr. English replied that more data is needed before conclusions can be reached.

Dr. Steele also asked Dr. English if he could identify the top two or three issues or themes for rural areas. In response, Dr. English mentioned service integration, greater use of family caregivers, use of telehealth technologies, and the use of algorithms for monitoring medications.

Dr. Fitzsimmons asked if there are any urban/rural differences in the prevalence rates of major mental health disorders. Dr. English replied that there are no data to suggest any significant differences.

Governor Beasley asked Dr. English for his thoughts on where limited dollars for mental health and substance abuse could best be spent. Dr. English would target young people and adolescents because so many disorders such as bi-polar disease and depression have early onset in adolescence.

Governor Beasley and Dr. Bailey spoke about the problem of pediatricians who are untrained to recognize the mental health problems of children and how reluctant some providers have been to deal with children suffering from attention deficit disorders. Dr. Edwards supported the need for more training of primary care givers. Dr. English asserted that more focus should be on rural schools because they are places with the best chance of early recognition and intervention. He stated that schools offer opportunities for bringing prevention and treatment together in one place.

Mr. Ahrens described the stress placed on rural families by children who need care and their uncertainties about what to do. Dr. English stressed the need to build community based systems that will keep patients out of hospitals and with their families. He emphasized the

importance of family in treatment and prevention and the urgent need for training to support family care givers.

Mr. Morris asked how SAMHSA could best influence policies on care for mental health and substance abuse patients in rural areas. Dr. English responded that while it is a small agency, SAMHSA can have a big impact by working with other agencies in the Department such as HRSA, and by coordinating activities with other federal departments such as Labor and Education. He referred the Committee to reports that may inform its deliberations on rural issues. He also mentioned that SAMHSA generally does not work closely with CMS on payment issues because SAMHSA is focused on populations that do not receive services.

Behavioral Health and Primary Care

Mr. Bill Finerfrock, Executive Director, National Association of Rural Health Clinics

Mr. Finerfrock's presentation focused on problems of access to mental health and substance abuse services in rural areas and the role of RHCs in providing these services. He informed the Committee that mental health services are part of the RHC benefit package, but that Medicare requires a fifty percent co-payment. RHCs can only claim 62.5 percent of their allowable costs for these services. These issues are a disincentive to the provision of mental health services by RHCs and a deterrent for Medicare beneficiaries who need them. He stated that in rural areas social stigma is a powerful deterrent to those who need care. Mr. Finerfrock spoke about opportunities for better utilization of mental health counselors and family counselors who are more likely to be available in rural areas than more highly trained mental health professionals. He described some telehealth programs that have been successful in bringing mental health services to small rural towns and correctional facilities. He urged the Committee to think about possibilities for expanding the use of qualified alternative providers in rural areas and placing these providers in primary care settings.

Dr. Enright warned that we should not short-change rural areas by using unqualified providers, that rural communities should not receive a lesser level of care. Mr. Finerfrock strongly agreed, but he reaffirmed that there are opportunities to take advantage of new providers without compromising quality. He mentioned that some states have licensed alternative providers and there are opportunities to use them appropriately.

Dr. Enright asked about RHC expenditures for mental health. Mr. Finerfrock replied that about .07 percent of RHCs provide mental health services because financial incentives are lacking. He

further stated that one way to deal with this issue would be to raise the overall payment cap on RHC services.

Ms. Richardson asked about the percentage of RHC services funded by Medicare and Medicaid. Mr. Finerfrock replied that the Medicaid population served by RHCs is larger than the Medicare population they serve.

Dr. Bailey asked if the RHC Association staff were in constant contact with the Clinics on the issues of mental health services and what the first steps might be to improve access in these Clinics. Mr. Finerfrock responded that contacts are frequent and that RHCs are very much aware of the needs for mental health services in their communities. There is no lack of desire to provide these services, but financial constraints are in place.

Dr. Steele raised the issue of providing mental telehealth services across state lines. Dr. Enright spoke about the liability issues involved. Mr. Finerfrock stated that in some areas these issues have been overcome. He mentioned examples of teleradiology services that cross state lines. Mr. Morris added that some states have developed reciprocity agreements to deal with licensure and liability issues.

Oral Health in Rural America

Marcia Brand, Ph.D., Director, Office of Rural Health Policy

Dr. Brand addressed the Committee on oral health issues in Rural America. She began by emphasizing that poor oral health is often a risk factor for many other disease conditions such as heart disease, diabetes, and low birth weight babies. She characterized oral health as a silent epidemic, citing tooth decay as the most common chronic childhood disease and noting that one-third of all adults have untreated cavities. She noted that disparities in oral disease and lack of access to care particularly affect low income, minority and disabled populations. She stated that about 108 million Americans lack dental insurance coverage. Other factors that limit access to care are the low number of dentists participating in Medicaid, uneven distribution of practitioners, and the generally limited scope of practice of dental mid-level professionals. She also mentioned the limited coordination between general physical and dental services. Rural communities face additional barriers, including geographic isolation, lack of fluoridated water, chronic shortages of providers, and higher rates of uninsurance. As a result, oral health indicators such as untreated dental decay are higher than in urban areas. One hundred million Americans still do not have fluoridated water, including a disproportionate share of rural residents. Dr Brand reported that dentistry is the only health profession that is expected to decline over the next decade and that few new dentists intend to work for underserved

populations. She described how grant programs funded by the ORHP are helping some rural communities address their needs in oral health. She concluded her presentation by reviewing some of the strategies under consideration for improving access to oral health services in rural areas. These include new dental practice equipment purchasing strategies, expanded use of mid-level providers, expanding the dental safety net (CHCs, RHCs, etc.), and efforts to advance consumer and provider education.

At the beginning of the question period, Ms. Richardson described innovative programs in West Virginia that involved public health dentists educating State Medicaid officials on the importance of oral health. She mentioned a second program that gives primary care practitioners the tools they need to assess the oral health risks of infants and refer them to dentists. She indicated that lack of knowledge of oral health on the part of primary care physicians and pediatricians is an enormous problem.

Ms. Gonzales-Hanson stated that CHCs are trying to offer more dental services, but the competition for providers is fierce.

Dr. Steele asked what would be the two or three highest priorities for rural areas. Dr. Brand responded that oral health needs to become more of a focus for Department grant programs; that more money could be allocated for training; and that scope of practice and licensure laws need to be examined to encourage a greater role for mid-level dental professionals.

Dr. Edwards asked if there was funding for oral health in the Bureau of Primary Health Care. Dr. Brand responded that some funding was available and mentioned ongoing partnerships with the Department of Education.

Committee Business

Governor Beasley

Governor Beasley discussed the June 2003 meeting of the Committee in San Antonio and Uvalde, Texas. The meeting is schedule for June 8-10, with members arriving in San Antonio on June 7. The preliminary agenda calls for presentations on day care, oral health and mental health.

Governor Beasley then discussed a sub-committee structure for the Committee. He said that sub-committees would be meeting on specific issues and writing reports for consideration by the Committee. The Committee will be fully informed of sub-committee activities and there will be opportunities for all members to participate. Reports from the sub-committees will be subject to

a straight up or down vote by the Committee. Initially, there will be two sub-committees working respectively on mental health and oral health issues. Mr. Morris said that reports from the two sub-committees would be used as chapters in the new annual report format.

The Governor asked members to express their preferences for a sub-committee based on interest and expertise. The sub-committee membership was determined as follows.

Mental Health: Dr. Enright (Chair); Dr. Steele; Dr. Bailey; Mr. Dillard; Dr. Edwards; Mr. Berk; and Dr. Fitzsimmons.

Oral Health: Ms. Richardson (Chair); Dr. Bailey; Ms. Gonzales-Hanson; Dr. Mueller; and Dr. Rawson.

Governor Beasley announced that five members would be leaving the Committee in June. They are: Dr. Wakefield; Dr. Singleton; Mr. Ahrens; Dr. Fitzsimmons, and Ms. Gonazles-Hanson.

It is expected that the new members of the Committee will be appointed in time for the June meeting and the sub-committee structure may be changed at that time.

Update on the Office of Rural Health Policy

Dr. Marcia Brand, Director, Office of Rural Health Policy

Dr. Brand described the Secretary's Task Force on Rural Health and its implementation strategies. She highlighted creation of the new Rural Assistance Center and a soon to be announced mapping project that will help identify areas for potential grant support. She highlighted recent accomplishments of the Office working with The CMS and the Bureau of Primary Health Care in HRSA. She provided information on ORHP grant programs, regulatory activities, and research programs. She reported substantial budget increases for the Office in FY 2003.

Public Comment

There were no public comments and the meeting was adjourned until Tuesday morning.

Tuesday, March 4

Joint Session with the National Rural Health Association Policy Institute

The joint session featured presentations by Senator Craig Thomas (R-Wyoming) and Congressman Earl Pomeroy (D-North Dakota) Senator Craig is Co-Chairman of the Senate Rural Health Caucus and sits on the Senate Finance Committee. Congressman Pomeroy is Co-Chairman of the House Rural Health Coalition and sits on the House Ways and Means Committee. Both speakers praised the work of the Association and commented on rural health legislative initiatives in the Congress.

Aging Issues

Melanie Starns, MAG, Program and Policy Analyst, Center for Planning and Policy Development, Administration on Aging (AOA).

Ms. Starns informed the Committee about the mission and history of the AOA and its network of agencies throughout the country. She presented a profile of the rural elderly population and described current initiatives of the AOA. The AOA is a small agency with a broad mission to help older people maintain their independence and remain in their homes and communities as long as possible. Legislative authority for the AOA derives from the Older Americans Act that provides for a variety of grant-supported programs. Ms. Starns called attention to the demographics of the aging population, noting that over 10 million (25 %) live in rural areas. By 2025, 70 million Americans will be over age 65. The AOA has developed and supported an extensive network of Agencies on Aging in all states and territories. These agencies support senior centers, adult day care, legal assistance, and delivery of meals, homemaker services and many other programs. Ms. Starns briefly described programs and activities in each major organizational component of the AOA. She provided information on where the rural elderly are most concentrated geographically. She reported that while rural elders are more likely to have stronger social support networks than urban elders, they are also more likely to be poor and have higher rates of chronic disease. Some of the key issues in providing services to this population are insufficient transportation, lack of a qualified workforce, low tax bases for local services, and the urban bias in many healthcare reimbursement systems. She listed AOA priorities for addressing these issues, which include development of integrated systems for health and social support, support for families in caring for their loved ones at home, and ensuring the rights of older people. About 33 % of all AOA supported services are rural. Rural issues will continue to be a priority for the AOA and it plans to work closely with the Department of Health and Human Services on crosscutting issues.

Dr. Wakefield asked whether states are required to provide matching funds for the ombudsman program and whether ombudsmen for the elderly work with state survey and certification programs. Ms. Starns said there is a 25 % match for the program and that they do work closely

with state certification authorities. However, their first priority is to work directly with facilities that care for the aging.

Dr. Steele mentioned the importance of electronic health records to help children away from home better understand what is being done for their elderly parents. Ms. Starns said that AOA is examining this concept and thinking about the possibility of promoting it through discretionary grants or demonstration.

Mr. Morris asked if AOA pays for direct patient care. Ms. Starns replied that support is provided under contracts with Area AOAs.

Dr. Wakefield mentioned that the new Center for Rural Health is receiving strong support from the AOA on programs for Native Americans.

Dr. Starns offered to work closely with the Committee, as it gets more involved with aging and other human services issues.

Committee Business

Mr. Morris said that the staff will draft a letter to the Secretary on what happened at the meeting. The letter will be sent out to the Members for their approval. Mr. Morris also raised the possibility of conference calls with the Committee prior to the next meeting in June 2003.

Mr. Berk asked if there are any finance issues that the Committee should address at next meeting or thereafter. He specifically mentioned recent legislation on Rural Essential Access Hospitals as one possibility. Mr. Morris responded that the staff would share information on hospital issues using E-mail. He also mentioned that the Committee's new report format would allow for finance issues to be discussed in a chapter dealing with the overall status of rural health.

Public Comment

There were no public comments.

The meeting was adjourned.