March 20-22, 2005, Washington, D.C.

Health Resources and Services Administration
Office of Rural Health Policy

Washington, D.C.
March 20-22, 2005

Meeting Summary

The 49th meeting of the National Advisory Committee on Rural Health and Human Services was held March 20-22, 2005, at the Grand Hyatt Hotel in Washington, D.C.

Sunday, March 20

Governor David Beasley, Chairman of the Committee, convened the meeting on Sunday afternoon. He announced that Dr. Glenn Steele and Mr. James Agras had resigned from the Committee and that applications for new members were in process.

The members present were: Ms. Susan Birch, RN, MBA; Mr. Evan S. Dillard, FACHE; Joellen Edwards, Ph.D.; Michael Enright, Ph.D.; Ms. Bessie Freeman-Watson; Ms. Julia Hayes; Mr. Joseph Gallegos; Leonard Kaye, D.S.W.; Michael Meit, M.P.H.; Arlene Jackson Montgomery, Ph.D.; Ron L. Nelson, P.A.; Sister Janice Otis; The Honorable Larry Keith Otis; Patti J. Patterson, M.D.; Ms. Heather Reed; Thomas C. Ricketts, Ph.D.; Mr. Tim Size; Senator Raymond Rawson, D.D.S. Present from the Office of Rural Health Policy were: Marcia Brand, Ph.D. (Director of the Office of Rural Health Policy); Tom Morris, MPA; Michele Pray Gibson, MHS; Jennifer Riggle, J.D.; Karen Stewart, M.P.H.; and Ms. Deanna Durett. Mr. Dennis Dudley attended representing the Administration on Aging, U.S. Department of Health and Human Services (DHHS), and Ms. Anne Barbagallo represented the Administration on Children and Families.

Governor Beasley asked for a motion to approve the 2005 Report to the Secretary. A motion was offered and approved. The minutes of the last meeting were also approved.

Governor Beasley thanked Ms. Anne Barbagello for her work with the Committee. This was her last meeting.

Health Information Technology and Rural Communities: An Introduction

Mr. Neal Nueberger, President, Health Tech Strategies, VA.

Mr. Nueberger began his presentation by saying that health information technology (HIT) has its origins in telehealth applications that focused on clinical care, training, population-based health issues, etc. It was university-based and generally funded by federal grants. There are at least 200 telemedicine programs throughout the country. The new focus on electronic health applications is due to the urgent need to improve health quality and safety. To bolster this point, he presented data on preventable deaths and adverse events, as well as the costs associated with these problems. The Office of the National Coordinator For HIT in DHHS has developed a strategic framework for HIT to inform clinical practice, provide incentives for the development and use of electronic health records, interconnect physicians, and improve population health surveillance. Mr. Neuberger explained the core components of an electronic health records system and provided information on major HIT funding efforts through the public and private sectors. He described some active programs in HIT and reviewed several examples in rural areas that are available in the handout materials. He introduced major planning considerations for designing and implementing HIT programs and then spoke about the new technologies that are available. He also discussed some of the common problems associated with the use of electronic technologies. These involve equipment issues, software compatibility, and human factors. He stated that HIT is not widely used at the present time. Major policy considerations are reimbursement, the need for uniform standards, infrastructure issues, human dimension issues related to provider acceptance, licensure, accreditation, and liability laws. He noted that the DHHS budget for HIT is $125 million in 2006. He closed the presentation by emphasizing the collaborative role of the various players in HIT (state, Federal Government, private sector) and the great opportunities that exist for HIT applications.

Mr. Size noted a new emphasis on workforce training that is emerging in his state as a result of new health information technologies. Mr. Neuberger said that rural interest groups need to become more engaged with the various players working on HIT.

Dr. Enright said that more information is needed on mental health information technologies. Mr. Neuberger said that he would get more information on the subject and provide it to ORHP.

Ms. Birch asked about the potential problems of regional vs. national databases on health. The speaker responded that regional organizations should be questioned on the need for regional models and he raised concerns about the need for national patient identifiers. He said that disease registries are another issue that needs to be reconciled between national and regional approaches.

Mr. Morris asked the speaker to comment on potential target issues for the Committee to address. Mr. Nueberger said there are unique rural challenges: (l) lack of HIT support and resources in rural hospitals (2) need for physician leaders and change agents; (3) need for community leadership in HIT; (4) need to make a business case for HIT, as well as for clinical applications; (5) potential to aggregate buying power; and (6) resolution of reimbursement issues and limitations.

Mr. Nelson stressed that rural primary care providers need support in HIT. A major impediment is that profit-makers are unable to receive grant support in this area.

Update from the Office of Rural Health Policy

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

Dr. Brand began by describing the new environment in the Department and stated that key issues for the Administration are implementing the Medicare Modernization Act (MMA) and reforming Medicaid. She reported that the Office now has 34 staff and introduced Ms. Karen Stewart who she said, would be working with the Committee. The Office has a new role in Border Health and staff in the border regions. A website on border health is under development and there is a new border leadership program. Dr. Brand reviewed issues that the Office continues to monitor and described new areas of focus, including access to pharmacy services, HIT, MMA implementation, and Medicaid reform. Quality and networking will also be focus areas. She reviewed the current work of the Office in areas that will be addressed by the Committee this year. She spoke about several initiatives in quality of care and reviewed the budget for the Office.

Mr. Size voiced his concern about a recent Medicare report that defines some rural hospitals as something other than a "real" hospital and makes them seem lesser than what they are. The report also places rural hospitals in a separate category that makes it impossible to compare them with other hospitals on quality measures. Dr. Brand said that the Office would be looking at this issue.

Washington Update

Mr. Alan Morgan, Vice President of Government Affairs, and Acting Executive Director, National Rural Health Association (NRHA).

Mr. Morgan thanked the Committee for its efforts on behalf of rural heath. He identified three major issues for this Congress: (1) full funding for rural health programs; (2) promotion of quality health care in rural America; and (3) Congressional oversight of MMA implementation. He

expects that funding for programs will be restored, citing a Senate amendment to this effect. Some newly emerging issues are eye care and hospice care in rural areas. He emphasized that rural America can provide leadership on the quality issue.

Mr. Size pointed out that a report on Critical Access Hospitals by MedPAC will be extremely important and needs to be followed closely. Mr. Morgan responded that the NRHA would be working on this issue.

Dr. Mueller commented on the subject of community collaboration addressed in the Committee's current report and asked for comments from the NRHA. Mr. Morgan replied that NRHA is committed to collaborative models and is promoting them as part of its agenda.

Public Comment

Governor Beasley called for public comments. There were no comments and the meeting was adjourned until Monday morning.

Monday, March 21

Governor Beasley convened the meeting and described the agenda for the day. He introduced the first panel of speakers on Health Information Technology.

Health Information Technology and Rural Communities: Panel Discussion

Helen Burstin, M.D.; Agency for Health Care Research and Quality (AHRQ), DHHS. Ms. Kelly Cronin, Office of the National Coordinator for Health Information Technology, DHHS.

Dr. Burstin: Health IT and Rural Communities.

Dr. Burstin presented an overview of her Agency and its research focus on patient-centered care. The mission of the Agency includes production and dissemination of evidenced-based information for use in the daily practice of medicine. Dr. Burstin provided examples of knowledge diffusion in some common clinical procedures to illustrate how far we have come and how much is left to do. She spoke about the role of HIT in reducing medical errors and how the United States lags behind many other countries in the adoption of electronic patient health records. Data was presented to show how a systems approach to HIT could improve quality of care. She reviewed the AHRQ grant portfolio on HIT projects and its sponsorship of major national meetings to evaluate emerging technologies and develop a business case for HIT.

Specific rural themes at these meetings were the need to promulgate best practices, the need for technical assistance to rural providers, and the need to build collaborative models for HIT. She reviewed the HIT initiatives for the Agency in 2004 and provided information of the AHRQ National Resource Center for Health Information Technology. The Center provides technical support to HIT grantees. There are over 100 grants to communities, hospitals, and health care systems for development and use of HIT. State and regional demonstration programs also receive support. Dr. Burstin briefly reviewed the Institute of Medicine report on health systems reform and presented the rural recommendations in the report. The report calls for comprehensive system reforms in rural areas, expanded workforce training programs in HIT, and assistance with HIT financial resources. She concluded by discussing future program emphasis in HIT.

Governor Beasley asked about recent reports on negative aspects of HIT. Dr. Burstin responded that these reports had provided valuable information on issues that need to be addressed.

Mr. Nelson said that providers need technical assistance at their sites because human errors and the lack of uniform standards for HIT are a big problem. Dr. Burstin replied that technical assistance is absolutely critical for rural areas.

Dr. Ricketts mentioned a study of human behavior in the use of IT and asked if anyone is working on behavioral issues. Dr. Burstin said that her Agency is working on these issues.

Dr. Montgomery asked what should be done now to train users of HIT. Dr. Burstin responded that HIT should be taught in all health professions schools and that more training may occur as young professionals come on board.

Dr. Kaye commented that some pressure for use of HIT should be coming from consumers. Dr. Burstin replied that there are studies on consumer applications for HIT.

Ms. Cronin: Overview of Strategic Actions to Drive HIT Adoption.

Ms. Cronin talked about the rising costs of health care and the benefits of HIT in preventing medical errors. She provided information on the diffusion of HIT, including ambulatory and inpatient electronic records. The vision for HIT is for medical information to follow the consumer with physicians having a complete patient history. Consumers will be able to choose providers based on clinical performance and public health surveillance must be integrated into care. She spoke about the Executive Order creating her Office and reviewed its mission. She talked about barriers and challenges to the use of HIT including lack of a strong business case, market

failures, and limited capacity for interoperability. Her office has developed a strategic framework for electronic health record adoption that includes formation of a national group for the advancement of HIT, as well as efforts to reduce the risks of HIT investments. A private sector Certification Commission on HIT has been formed and will be linked with Federal financing of electronic health records. The strategy also calls for national and regional health organizations to oversee and support state and regional information exchange. A national health information network would allow for secure and seamless information exchange at the national level. Ms. Cronin spoke about the health care industry responses to the strategic framework and the leadership that is emerging from the industry. Policy discussions are planned with the Business Round Table and other groups. Widespread adoption of HIT should be a priority for the health care system and the Federal government should use its leverage as a health care payer to drive HIT adoption.

Governor Beasley asked how the Committee could help these efforts. Ms. Cronin responded that help is needed to create incentives for HIT adoption since there is such a negative business case for HIT. She would like to hear from the Committee on what kind of incentives will work best in rural areas to increase implementation rates.

Dr. Ricketts described a Governor's commission in North Carolina that identified excessive competition in HIT applications. He discussed a public utility approach to HIT that could overcome the negative business case for collaboration among providers. He said there should be more debate about a public utility model. Ms. Cronin said it is a complex public policy issue, but some groups responding to the strategic framework of the Office had suggested this approach.

Mr. Size agreed that a public utility approach is one solution and asked about other alternatives. Ms. Cronin replied that regional groups could be established to certify vendors of HIT and maintain uniformity.

Ms. Reed asked about consumer acceptance of HIT. Ms. Cronin said that the timing of consumer education campaigns is under study and that public awareness must be addressed after more systems are in place.

Dr. Kaye asked about HIT applications in the human services sector such as automated access points for services. Ms. Cronin replied that school applications are under study as are other non-health care applications.

Dr. Muller said that the challenge of HIT implementation is linked to regular payments for HIT. Returns on investment have not supported a business case in Nebraska. Quality of care may

have to replace the business argument and payers should help underwrite the costs since they may reap the benefits.

Mr. Size observed that consumers might be ahead of providers in acceptance of HIT. Ms. Cronin then suggested that the federal Office of Personnel Management could give consumers information on providers that have adopted HIT and physician payments for Medicare could foster HIT development.

Medicare and Access to Pharmaceutical Services

Ms. Emily Costich, Office of Rural Health Policy

Ms. Costich explained the new Medicare Part D coverage options and benefits for prescription drugs, including low-income assistance programs. She also spoke about prescription drug coverage under the Medicaid program. She identified four Part D issues for rural communities: (1) network adequacy; (2) local access to pharmaceutical services; (3) plan outreach to providers and beneficiaries; and (4) educational needs and opportunities.

Mr. Size asked about the "any willing pharmacist" provision. Ms. Costich said that it is unclear whether the provision will work as intended. Plans may exclude some pharmacists such as those who cannot communicate electronically.

Dr. Patterson questioned requirements for telepharmacy. Ms. Costich replied that telepharmacy may come into play during negotiations between plans and pharmacies, but there are no federal requirements.

Ms. Birch asked about the so-called "clawback" provision. Ms. Costich answered that Medicare will now cover dual eligibles and will require money from some States since they will no longer cover this population. States with generous formularies may benefit from the provision. Other States will pay Medicare the difference in costs between Medicare and their Medicaid drug programs.

Elderly Caregiver Support: Panel Discussion

Ms. Kathleen Kelley, Family Caregiver Alliance
Mr. Rick Green, Administration on Aging
Ms. Donna Butts, Generations United

Ms. Kelley: Findings from the State of the States in Family Caregiver Support: A 50-State Study.

Ms. Kelley presented findings from a 50-state study of caregiver support conducted by her organization. The study found that most caregiver support programs are administered at the state level by the State Unit on Aging. Area Agencies on Aging are the most common agency to have responsibility for local programs. Only fifteen states have a single entry point for consumer access to caregiver support. The organization that most frequently acts as the single entry point is the Area Agency on Aging. Ms. Kelley provided data on types of caregiver support provided, ranging from respite care to legal and financial support. Respite care is the service most commonly provided. She reported that caregivers in the states can access programs through toll-free numbers, Area Agencies on Aging, the Internet, and through state agencies. The study showed that the supporting available services varied widely from state to state. Most states pay families to provide care in at least one state program. The top five unmet needs of caregivers are lack of resources, limited respite care, lack of public awareness about issues and programs, shortages of providers, and limited access to services in rural areas. The study concluded that while publicly funded caregiver support programs are increasing, there is great unevenness across the country and within the states. The National Family Caregiver Support Program is fueling innovation in the states, but the program is not adequately funded. Issues for the future include raising funding levels and improving data collection on service availability. In rural areas workforce shortages require more creative use of technology and consumer materials need to account for diverse population groups.

Mr. Green: Rural Caregivers

Mr. Green said that very little is known about rural caregivers, but we do know that they are older and more likely to report health problems associated with their caregiving responsibilities. At the same time, rural elderly caregivers are more hesitant to seek help, resist formal services, may live in very remote areas, and often believe that service use implies accepting welfare. Mr. Green said that rural nursing homes are often a surrogate for home care and in many rural counties there is no agency to provide caregiver support. Barriers include lack of coordinated services, costs, overburdened providers, lack of physician referral to caregiver services, and other issues. The National Family Caregiver Support Program passed by Congress in 2000 is funded at $162 million in 2005. Its focus is on organizing and supporting service delivery systems for caregivers. Most funds are allocated to states based on proportionate share of the elderly population. Mr. Green discussed the services supported through the program and the characteristics of the population served. He spoke about a program of the Robert Wood Johnson Foundation, and provided examples of other private and public caregiver support programs in the states.

Ms. Butts: Elderly Caregiver Support

Ms. Butts introduced "Generations United," a non-profit organization dedicated to improving the lives of children, youth, and older people through intergenerational collaboration, public policies, and programs. The main focus of her presentation was on grandparents raising their grandchildren. In the U.S. there are 2.4 million grandparents raising children. About 75 percent of them are over age 50. Many of them raise a grandchild for more than five years. Over six million children are under care, half under age six. The children have a higher incidence of physical and mental health problems and learning disabilities. One in three lack health insurance and two percent live in poverty. The reasons grandparents assume responsibility include parental substance abuse, incarceration, poverty, HIV/AIDS, mental health, child abuse, military deployment, and others. Generations United provides a range of support to caregivers, including access to services and information, respite care, legal assistance, and financial aid. Ms. Butts described various support groups available in the United States and some of their success stories. She spoke about consent laws that vary from state to state. Subsidized guardianship programs are available in half the states. Ms. Butts also talked about federal legislation on caregiver support and the action agenda for Generations United.

Governor Beasley raised the issue of elderly persons using many different medications. Mr. Green responded for the panel, saying that the Elder Americans Act has some funding for health education for the elderly that might address this issue.

Sister Otis mentioned a program of her organization that provides medication management and reviews for elderly clients.

Ms. Birch asked about local councils on aging in rural areas because many rural caregivers in her state of Colorado have no support. Mr. Green said that some states do not have local councils, but do have regional organizations that can help.

Mr. Morris asked about potential tensions between families and caregivers on financial and other issues. Ms. Butts responded that grandparents are very commonly called upon as caregivers and the financial implications for them are now huge. Ms. Kelley added that Medicare and Medicaid are pushing folks into community-based care, placing more burdens on families. Further, informal family caregivers are rarely seen as partners in a health care team.

Dr. Kaye mentioned a forthcoming report on children who are caregivers for elderly parents and grandparents. This is yet another dimension of the caregiver support issue.

Pharmacy Issues for Rural Communities

Mr. Jimmy Mitchell, Director, Office of Pharmacy Affairs (OPA), Health Resources and Services Administration.
Rebecca Slifkin, Ph.D., Rural Health Research Center, University of North Carolina at Chapel Hill.

Mr. Mitchell reported that the OPA is responsible for promoting access to comprehensive pharmacy services and for maximizing the value of participation in the 340B drug-purchasing program for selected health care providers. The Office also develops innovative pharmacy services programs and is a federal resource for pharmacy practice. He described the 340B program created in 1992 that provides discounts to covered entities for outpatient drugs and administers pricing agreements with drug manufacturers. Covered entities include Federally Qualified Health Centers, Ryan White Programs, certain Family Planning Clinics, Disproportionate Share Hospitals, and other providers. The number of covered sites is projected to increase rapidly over the next several years. Mr. Mitchell also spoke about the provisions in Medicare Part D that will allow more disproportionate share hospitals to qualify for 340B. He presented findings from HRSA's Clinical Pharmacy Demonstration Projects which showed that access to needed pharmaceutical services makes a substantial and affordable contribution to improving the health status of the mostly low-income patients served by Community Health Centers. The recommendations coming from this evaluation were: (1) payment policy should recognize clinical pharmacy services as a legitimate approach to care; (2) HRSA should consider the value of pharmacy services in its funding decisions; (3) HRSA should encourage supportive physicians to speak about their experience with pharmacy services; and (4) collaboration between schools of pharmacy and grantees would benefit both and should be strengthened. He described HRSA's Pharmacy Services Support Center and its role in providing assistance to 340B entities. He also spoke about the role of the Prime Vendor in securing drug discount under the 340B program. The program provides opportunities for rural providers to negotiate and receive reduced prices for outpatient drugs and the option to negotiate reduced prices for inpatient medications. They may also receive free technical assistance through the Support Center.

Dr. Slifkin showed how the retail market for pharmaceuticals has been changing. Market share for supermarkets has increased most rapidly and the total number of drugs dispensed has increased from 7.6 per person to 10.6. Independent pharmacies have a greater dependence on prescription drug revenues than their competitors and are more common in rural areas. The use of mail order prescriptions is much more common in urban areas. Medicaid and cash purchases for drugs are also more common in rural communities. Rural pharmacies are more likely to be independent, have lower volumes, more likely to receive cash payments, and have less competition from mail order programs. Dr. Slifkin said that the environment is changing due to Medicaid budget constraints, the new MMA benefits, and mandatory mail order for chronic

disease. Medicaid costs for pharmacy are rising rapidly and many states are looking to cut expenditures by reducing payments to pharmacies. She explained how Medicaid drug benefits work and the formulas used for payments. Medicaid cuts are a rural concern because a higher proportion of business is Medicaid and payments based on average costs will adversely effect pharmacies with lower volumes and higher than average acquisition costs. The Administration's proposal for Medicaid would cut $15 billion over 10 years through reduced payments to pharmacies. The effect of MMA benefits and changes on rural pharmacies is largely unknown and should be monitored closely. More insurance coverage should lead to more prescriptions filled, but the use of mail order will increase. It is unknown how many rural pharmacies will be included in the new MMA pharmacy benefit networks. Dr. Slifkin described post-MMA payment changes, pointing out that small rural pharmacies may have little or no negotiating power regarding contract terms with benefit plans. Other rural issues involve preferred networks under Medicare; employees moving to mandatory mail order for chronic disease; and large inter-state variations in utilization, payers, proportion of independent pharmacies, and Medicaid payments. The role of pharmacists in rural areas, particularly in disease management, also needs to be addressed. Workforce issues include the supply of pharmacists, their age structure, and the scope of practice for pharmacy technicians.

Mr. Nelson asked if there were any restrictions on telepharmacy under 340B and whether anyone was looking at the value of free drug samples. Mr. Mitchell replied that there were no special restrictions pertaining to telepharmacy and that free drug samples could involve some quality issues. Mr. Nelson agreed on the need to address safety issues associated with free samples, including their impact on prescribing patterns.

Dr. Ricketts asked why pricing is so complicated for drugs. Mr. Mitchell said that one key issue is that it is a felony to share pricing information on drugs, even for the federal government.

Tuesday, March 22

Governor Beasley announced the Sub-Committee assignments for 2005. They are as follows:

Health Information Technology: Mr. Meit (Chair); Mr. Tim Size; Dr. Enright; Ms. Hayes; Dr. Patterson; The Honorable Larry Otis; Ms. Reed. (Staff: Ms. Durett)

Pharmacy Services: Dr. Ricketts (Chair); Mr. Nelson; Dr. Edwards; Dr. Rawson; Mr. Dillard; Mr. Gallegos. (Staff: Ms. Riggle and Mr. Midberry)

Family Caregiver Support: Ms. Birch (Chair); Sister Janice Otis; Dr. Kaye; Ms. Freeman-Watson; Dr. Montgomery. (Staff: Ms. Stewart and Ms. Pray).

Mr. Morris talked about the report preparation process this year. There will be conference calls between meetings and the staff will be working with subcommittees on presentations at the meetings. The same standardized format will be used again this year.

Mr. Size suggested that the subcommittee on caregivers should drop the word "elderly" from its title to put the focus on families. A motion to approve this change was approved.

Dr. Enright and Dr. Edwards talked about the meetings they will be hosting in Johnson City, Tennessee and Wilson, Wyoming. Visitations are planned for both meetings.

Mr. Morris asked for comments on the letter to the Secretary that will be prepared following the meeting. Mr. Size raised his concern about the CMS website called "Hospital Compare" where data on quality measures has been segregated between urban and rural hospitals. He stressed that this segregation of data has negative symbolism and implies that Critical Access Hospitals are not acute care hospitals. The Committee asked staff to draft language on this concern for the letter to the Secretary.

Public Comment

Governor Beasley called for public comments. There were no comments and the meeting was adjourned.