February 20-22, 2008, Washington, D.C.

Health Resources and Services Administration
Office of Rural Health Policy

Washington D.C.
February 20-22, 2008

Meeting Summary

The 58th meeting of the National Advisory Committee on Rural Health and Human Services was held February 20-22, 2008, in Washington D.C.

Wednesday, February 20, 2008

The meeting was convened by Governor David Beasley, Chairman of the Committee. Governor Beasley welcomed new members of the Committee and asked them to introduce themselves.

The Committee members present at the meeting were: Graham Adams, Ph.D.; April M. Bender, Ph.D.; Maggie Blackburn, MD; Deborah Bowman; B. Darlene Byrd, MNSc, APN; Sharon A. Hansen, MEd; Donna K. Harvey; Thomas E. Hoyer, Jr., MBA; Tom Linden, MA; A. Clinton MacKinney, MD, MS; Michael Meit, MA, MPH; Larry K. Otis; Patti J. Patterson, MD, MPH; Karen Perdue; Robert Pugh, MPH; Thomas C. Ricketts, Ph.D., MPH; Julia Sosa, MS, RD; and Maggie Tinsman, MSW. Mr. Dennis Dudley attended representing the U.S. Administration on Aging.

Present from the Office of Rural Health Policy were: Acting Director Tom Morris, Michele Pray-Gibson, Kristi Martinsen, Michele Goodman, Judy Herbstman, Jennifer Chang, and Carrie Cochran.

Governor Beasley reviewed the Committee reporting process and asked for a motion to approve the Committees' report to the Secretary on its work during 2007. The motion was approved.

HRSA's View of Medical Home

Dr. Elizabeth Duke, Administrator, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS)

Dr. Duke greeted the Committee and expressed her thanks to Tom Morris for his service as Acting Director, Office of Rural Health Policy. She provided a brief overview of HRSA programs and the HRSA budget request for FY 2009. She said that the Medical Home concept emerged over 20 years ago with a focus on coordinated and culturally competent care for children with special needs. She commented on the diversity of American families and the need for health care that is centered on the entire family. She emphasized the importance of oral health and noted that the 2009 budget request contains a first-time budget increase for HRSA in this area. Currently, HRSA is making creative use of its grant programs to support the Medical Home concept. Some specific approaches involve the use of electronic medical records, a Family Health Information Center, and an emphasis on assisting community colleges to address workforce shortages in health care and human services. HRSA has asked for additional grants to community colleges to support education for health professionals. The agency is also supporting efforts to promote distance learning for health care workers. She stated that distance learning opportunities for adults can address workforce shortages in health and human services occupations. She concluded by noting the importance of community development to improving the infrastructure for health care delivery.

Dr. Patterson commented on the shortage of oral health practitioners and asked about support for mid-level dentistry providers. Dr. Duke responded that this continues to be a top priority for HRSA and noted that Dr. Marcia Brand, former director of the Office of Rural Health Policy, will be representing HRSA on a study of oral health by the Institute of Medicine. She also described some HRSA grant supported programs in oral health.

Larry Otis stated that community college efforts to educate dental care workers are hampered by the lack of clinical training space. Dr. Duke replied that HRSA is trying to encourage federally supported Community Health Centers to become sites for clinical rotations. The Centers are also encouraged to work with community colleges on placement of dental care providers. She also spoke about the shortage of faculty in health professions education and HRSA activities to address this issue.

ACF and Serving At-Risk Children

Joan Ohl, Commissioner, The Administration on Children, Youth and Families in the Administration for Children and Families

Commissioner Ohl reviewed the organizational structure of the Administration on Children, Youth and Families and briefly described the major programs administered by the agency. The Children's Bureau supports programs in foster care, adoption assistance, independent living, child abuse prevention, and child welfare services. Rural initiatives include grants for regional partnerships that provide services to children affected by a parent or caretaker's substance abuse. Other rural initiatives include home visitation programs, community-based child abuse prevention, child welfare training in rural communities, and rural distance learning education programs for child welfare workers. A large project is underway involving comprehensive federal reviews of state child and family service programs. The goal is to improve the capacity of states to create positive outcomes for children and families. In the first round of reviews no state was found to be in substantial conformity with all of the outcome measures used during the reviews. Ms. Ohl highlighted some of the major weaknesses found in the states and discussed how the reviews are helping states to address deficiencies. The Family and Youth Services Bureau has rural programs focusing on Native American youth, mentoring of rural children who have family members in prison, and domestic violence prevention. The Administration on Developmental Disabilities provides grants to rural agencies to support families and youth. The Administration for Native Americans has a mission to promote economic and social self-sufficiency for Native Americans. The Office of Child Support Enforcement supports a wide range of services to rural families that are serving as custodians of children and families receiving assistance under the Temporary Assistance for Needy Families (TANF) program. The Office of Community Services has created a priority grant program for organizations that provide social services in rural areas. The Child Care Bureau supports low income rural working families through child care financial assistance and other programs. Commissioner Ohl described several important rural initiatives under TANF and how some of these programs are being coordinated with the Head Start program. Her concluding remarks described the Office of Refugee Resettlement and its programs to help families achieve self-sufficiency through cash and medical assistance, skills and language training, etc.

Governor Beasley asked about sharing the best practices of states in supporting children and families. Commissioner Ohl responded that her agency has been disseminating best practices through web sites and resource centers.

Dr. Patterson commented that prevention services must be emphasized before children become victims of abuse. She mentioned a web site of the Center for Communicable Diseases that highlights the long-term effects of child abuse. The speaker agreed on the need for primary prevention, but that the funding does not flow that way. Funding tends to come after a child has been forced to leave an abusive home. She also talked about the importance of the Head Start program in prevention.

Mr. Linden asked the speaker what she would recommend to the president or the Secretary. She responded that the focus should be on strengthening the entire family and that more funding should be directed toward prevention. Mr. Linden then asked about the factors that are holding us back. The speaker said that we must show results in order to make changes in programs and funding streams. Further, there is a need for good data on program results that states do not yet have.

Governor Beasley commented that the National Governors Association can be a catalyst for change.

AT-Risk Children in Rural Areas and Mental Health Services

Dr. Larke Huang, Senior Advisor on Children, Office of the Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA)

Dr. Huang opened her presentation by noting the the poverty rate is higher for children in rural areas, especially for African Americans and Hispanics. The incidence and prevalence rates of mental illness and substance abuse are comparable with urban areas, but access to services is more limited. More than 90% of all psychologists and psychiatrists and 80% of MSWs work exclusively in metropolitan areas. The mental health crisis responder for most rural Americans is a law enforcement officer. Family poverty is a risk factor for behavioral health and rural teens have a much higher rate of suicide than their urban peers. Due to chronic shortages of mental health care providers, recent college graduates are making many of the vital decisions on the future of children who come from abusive home environments. SAMHSA manages a variety of programs to provide community mental health services for children, adolescents, and their families. There are no grant programs specifically targeted at rural areas. The speaker described these program activities and some of the tools and resources available to rural communities. A National Plan for Rural Behavioral Health has been developed with specific action steps to address mental/behavioral health and service needs in rural communities. The plan adopts a public health approach to meeting the mental health needs of children and families. The National Center on Substance Abuse and Child Welfare in SAMHSA is assisting communities throughout the country, and gathering and disseminating information to improve mental health services nationwide. A Community Guide has been developed that enables communities to identify all of the grant supported mental/behavioral health resources locally available. A partnership of ten federal agencies provides information on federal grants and assists communities in strategic planning for services. Addiction Technology Transfer Centers across the country are designed to enhance the quality of addiction treatment and recovery services through technology translation and transfer activities. They are funded to upgrade the skills of existing practitioners and responds to emerging needs and issues in the treatment field. SAMHSA also supports on-line resources for locating drug and alcohol treatment programs. There is a toll-free number for suicide prevention services and a Suicide Prevention Resource Center that provides services in prevention, dissemination of best practices, informational exchange, and other areas.

Dr. Adams commented on the narrow funding silos for mental health services in the states and asked whether SAMHSA was working on this. Dr. Huang said that her agency was trying to break down the silos both within the agency and in the states. She said that some SAMHSA grants to states require state agencies to collaborate at the state level.

Mr. Hewitt asserted that political will is critical to improving services in rural areas, noting that low provider payments and recruitment issues must be addressed. Dr. Huang replied that there are no easy answers and that it will take different models of service delivery, including the use of telehealth technologies.

Workforce Projections

Rose Woods, Economist and Betty Su, Economist, Division of Industry Employment Projections, Bureau of Labor Statistics, U.S. Department of Labor

Ms. Woods and Ms. Su presented changes in the national labor force and projections of labor force growth over the period 2006-2016. They also provided unofficial projections for the labor force in rural areas of the country. The projections show that the nations labor force will continue to grow, but at a slower rate than in the past. Work force participation rates for men and women have converged and workers over age 55 will have an increased share of the total labor force. Participation by minority groups will grow at an increased rate over the ten year period, but Whites remain the largest group of workers. The projected average rate of change in real growth of the GDP (Gross Domestic Product) is 2.8%. Personal consumption expenditures will account for most of GDP and the projections assume a 5% unemployment rate. Service-providing industries will have the largest share of total employment. Real output in the health and social assistance sector of the economy is projected to grow at an annual rate of 4% over the period, a faster rate of growth than for most other sectors of the economy. The percent change in wage and salary growth for health and social assistance (27%) is the highest of all economic sectors. Also, this sector is in second place for the projected number of new jobs that will be added over the period. With respect to rural areas, health and social assistance employment is projected to be the fastest growing segment of the rural economy over the next 10 years. Health care occupations with large shares of total employment in rural areas are emergency medical technicians and paramedics, ambulance drivers, respiratory technicians, nursing aids, licensed practical nurses (LPNs) and vocational nurses. The speakers observed that rural areas are more likely to have employment in nurse’s aids, LPNs, and home health aids, while urban areas are more likely to have RNs, medical assistants, and several types of health technicians. The highest categories projected for rural employment growth in health occupations over the 10 year period are registered nurses, home health aids, personal and home care aids, nursing aids, and licensed practical nurses. Other occupational groups such as pharmacists and dental assistants are expected to continue to grow, but at a slower pace.

Dr. Ricketts asked whether workforce training programs were considered in making the projection, using physician training as an example. Ms. Woods replied that the projections assumed that training would be available to meet the projected needs of the workforce. She also said that economists in the Labor Department will be working with groups that are developing models for estimating future health care workforce needs.

Dr. MacKinney asked whether the Department was testing the validity of the methodology used in the projections. Ms Su responded that when the period for which projections are made is over, the actual data is compared to the projections and the methodology is improved as needed.

The Workforce Investment Act: Implications for Rural Communities

Gay Gilbert, Administrator of the Office of Workforce Investment, U.S. Department of Labor

Ms. Gilbert began by saying that the demographics of rural areas are shifting due to an ageing population and immigration. Economies are being transformed and rural areas face an uncertain economic future. Rural workforce challenges include a mismatch of jobs and skills, low education levels, more limited accessibility to education, and more limited availability of transportation and child care. The Workforce Investment Act of 1998 authorizes programs to assist states and communities in workforce development. There is a nationwide network of local One-Stop Career Centers to coordinate and deliver services for job seekers and businesses. Over seventeen federally funded employment and training program resources are available. The speaker said that 90% of the fastest growing jobs require education and training beyond high school and that 63% of all new jobs in the next decade will require a college degree. Currently, only 30% of the population has a college degree. In response to these challenges, the President’s High Growth Job Training Initiative is working to develop education and training solutions to specific workforce need, including the key industry sector of health. Experience with the initiative shows that community colleges must improve their ability to develop talent through expanded and specialized faculty improved facilities and equipment and expanded clinical opportunities. In consultation with the National Rural Health Association, grants have been awarded with a special focus on long- term care direct service workers and for other investments in rural communities. There is an emphasis on technology-based learning and increased accessibility to remote learning opportunities. The Workforce Innovation in Regional Economic Development (WIRED) initiative aims to expand employment opportunities in selected regions of the country and to align public welfare funding with regional economic needs. Data collection and asset mapping are key features of the program. In addition, WIRED works to leverage public and private investments and transform regional economies through innovative talent development. In closing, the speaker noted that there is extensive ongoing work in the health care sector, but limited work in human services.

Mr. Morris commented that the programs discussed by the speaker have as much or greater relevance to the needs of rural communities as the workforce programs in DHHS.

Mr. Hewett asked whether the Labor Department has done studies on what rural areas will have to pay to remain competitive in attracting health care workers. Ms. Gilbert was not aware of any specific studies, but did say that a wealth of wage data is available.

Ms. Perdue said that Alaska is looking to expand in the area of telemedicine and asked if there was information available in this area. Ms. Gilbert said that she would provide some relevant information to ORHP staff.

Dr. Blackburn asked if the Department has looked at the rural infrastructure for high speed transmission. Ms. Gilbert replied that the Department was working on this issue with the broadcast industry in Colorado to expand state education programs.

Dr. Ricketts commented on the need for entrepreneurial skills in rural areas and asked if this was emphasized by the Department. Mr. Gilbert said that the WIRED initiative has a focus in this area.

Mr. Otis asked about support for training the prison population. Ms. Gilbert said there is some funding for this, but a very small amount. There are some models that are being developed.

Public Comment

There was no response to the call for public comments and the meeting was adjourned.

Thursday, February 21, 2008

Governor Beasley convened the meeting and announced the Sub-Committee assignments for the coming year. They are as follows:

At Risk Children: Sharon Hansen (Chair); Deborah Bowman; Patti Patterson; Maggie Tinsman; and Julia Sosa.

Workforce and Community Development: Larry Otis (Chair); Todd Linden; Karen Perdue; April Bender; Michael Meit; and Donna Harvey.

Medical Homes: David Hewett (Chair); Tom Hoyer; Robert Pugh; Clint MacKinney; Darlene Byrd; Graham Adams; Maggie Blackburn; and Thomas Ricketts.

The Medical Home Model: Implications for Rural Areas

Dr. Bob Berenson, Senior Fellow, The Urban Institute

Dr. Berenson said that the challenges facing Medicare make a strong case for a new model of care, the Medical Home. There will be 78 million beneficiaries by 2030 compared to 43 million now. About 29% of beneficiaries are in fair/poor health and 23 % have cognitive impairments. Chronic conditions are associated with large numbers of prescription medications, high utilization of physician services, high percentages of adverse medical incidences such as harmful drug reactions, and a large percentage of total Medicare expenditures. Currently, 5% of Medicare beneficiaries account for 43% of total spending. Over 20% of beneficiaries have 5 or more chronic conditions and account for 66% of Medicare spending. The potential for medical mishaps with this population is huge, and the lack of effective coordination of services is a big problem. It is exacerbated by the fact that fewer physicians are training for primary care. He said that the basic problem is how Medicare and others pay physicians. The Resource Based Relative Value Scale (RBRVS) used by Medicare has inherent limitations even if it is improved. The payments are at best an approximation of actual resources used and the process for determining payments is inherently subjective. Dr. Berenson discussed the problems related to budget neutrality and the limitations of the system in paying for the coordination of care. The system does not pay for critical functions in the coordination of care for beneficiaries with chronic conditions. Some examples of services that are not reimbursed are: coordination of care with other physicians; the harnessing of community resources; E-mail communications between physicians and patients; use of patient registries; and the higher costs of submitting bills for non face-to-face encounters. He said that we need to think about alternative forms of payment and described the reasons why we should not expect pay-for-performance to solve the problem. The bottom line is that the payment system should promote integrated care, including multi-specialty groups, but not single specialty consolidation like we are seeing now. There is a continuum of approaches for paying for Medical Home services including: aggressive and politically difficult RBRVS changes; new payment codes for medical home activities; new monthly payments per patient for care management activities; and bundled payments for medical services and Medical Home activities. Dr. Berenson reviewed some of the problems associated with payment changes, noting that in rural areas the coordinated care of chronic patients could take too much time away from healthier patients when physicians are in short supply. Small practices would have to restructure for a small number of patients who account for a high share of health spending relative to a small share of their time and attention.

Mr. Linden commented that the Medical Home model is being implemented in some places despite payment limitations and was skeptical that Medicare would pay for what is already happening. Dr. Berenson replied that the most basic level of medical home care would require physicians to be available 24/7, provide basic service coordination services, etc. These are the things physicians should be doing, but we are not paying appropriately.

Dr. MacKinney spoke about the RBRVS updating and reevaluation process that is highly political and dominated by physician specialty groups. He asked how we can focus more on primary care prevention and life-style issues. Dr. Berenson said that the current focus of demonstration projects is on financial returns and that we are avoiding holding practices accountable for medical home activities. We need to pay extra for these services, and a graduated approach to payment changes may be appropriate.

Dr. Berenson made some further comments on the RBRVS updating process, emphasizing that it is a public process and that those who disagree with it should become involved. Medicare needs to hear from those who want change.

Ms. Harvey spoke about the need to involve consumers in these issues. Dr. Berenson responded that some elements in the standards for Medical Homes speak to the role of patients and their responsibilities.

Workforce and Rural Community College Panel

Marcie McLaughlin, Rural Policy Research Institute
Jane E. Batson, Division Chair, Eastern New Mexico University
Roxanne Fulcher, Director, Health Professions Policy, American Association of Community Colleges

Ms. McLaughlin began with a discussion of the American Association of Community Colleges, an organization originally funded by the Ford Foundation. It is an alliance of rural community colleges working to improve educational and economic prospects for their communities. She also reviewed health professions programs offered at Howard College in Big Spring, Texas.

Ms. Fulcher said that 1,200 community colleges across the country are serving more than 11 million students and that 63% of the nation’s allied health workers are educated by community colleges. Associate degree programs educate about 69% of new Registered Nurses. She said that a key issue impacting rural health care (in addition to provider and faculty shortages) is that new health professions students often require remedial education to prepare them for college level curriculum in the health professions. Community Colleges are constrained by their budgets and the inability to pay competitive salaries for faculty. They are also constrained by a lack of facilities and capital budgets. There is great need for clinical facilities to meet increasing enrollments in rural areas. Large urban hospitals providing clinical experiences are recruiting graduates from rural areas, thus creating a retention problem for these areas. She spoke about nursing workforce shortages in rural areas and community college nursing faculty shortages. She also reviewed data on shortages of pharmacists and dentists in rural communities. Community colleges are responsible for a significant percentage of allied health professional education in rural America, including nurses, dental hygienists, respiratory therapists, and pharmacy technicians. These colleges can develop capacity to increase the number of allied health providers in rural America, but they need federal and state support.

Ms. Batson said that her institution is working with public schools to improve student success and help them stay in school. They are challenging middle school students to get involved in health care professions and some communities are giving scholarship incentives for kids to stay in school. Other creative programs utilize distance learning technology in education, increased use of web-based delivery, class offerings at non-traditional times, and partnerships with local health care entities (i.e. Hospitals) to increase enrollment and provide student financial support. She said that a local hospital is providing one nursing faculty member and the State is supporting new programs in dental hygiene. Her recommendations to the Committee were: 1) Direct a more proportionate share of federal support to nursing and allied health programs at the community college level; 2) Make community colleges eligible for participation in both existing and new federally funded programs; 3) Explore RN to MSN faculty scholarship programs to alleviate nursing faculty shortages; 4) Encourage inclusion of community college representatives on federal and state task forces, committees, etc; 5) Support data collection of the impact of community colleges in health professions education.

Following the individual presentations, panel members briefly discussed training for human services providers in rural areas. They also discussed the role of community colleges in adult continuing education

Dr. Patterson commented that the Area Health Education Center Program brings community colleges together with other health educational institutions.

Dr. Blackburn asked about salary issues for health workers. Panel members replied that this is a huge problem for lower level workers in rural areas.

Mr. Meit suggested the need for maps to study the coverage of community colleges in rural areas.

The Medicare Medical Home Demonstration

James Coan, Social Science Research Analyst, Office of Research Development and Information, Centers for Medicare and Medicaid Services (CMS)

Mr. Coan set the context for his presentation with a discussion of CMS demonstration authorities and the limitations imposed by congressional language authorizing demonstrations. He stressed that the primary goal of CMS demonstrations is cost reduction. The legislative mandate for the Medical Home demonstration is the Tax Relief and Health Care act of 2006. This demonstration will evaluate a Medicare Medical Home model for individuals with multiple chronic illnesses who require regular medical monitoring, advising, or treatment. He said that 83% of Medicare beneficiaries have at least one chronic condition, while 23% have five or more such conditions. The demonstration will cover a three year period in up to eight states, and will involve physician practices with fewer than three full-time-equivalent physicians. The concept of Medical Home involves a physician practice, availability of safe and secure technology, patient access to personal health information, and providing patients with enhanced and convenient access to care. Participation in the demonstration will be voluntary and all practices that agree to become Medical Homes will meet prescribed standards. Patients will be informed of expectations for the practice and themselves. Medicare will pay a monthly fee for a "personal physician" who will ensure patient access to care and health information. Pilot studies are underway to provide information on the costs of the demonstration. The expectations are that the demonstration will improve care coordination, improve outcomes, and result in cost savings to Medicare. A contract has been awarded to design the demonstration and CMS is working with the Relative Value Scale Update Committee to establish fees. Target recruitment of qualified practices is set for October, 2008, but Mr. Coan reported that this date is probably too ambitious.

Dr. Ricketts said that a similar project in North Carolina has provided valuable lessons and asked about the degree of flexibility under the demonstration. Mr. Coan replied that the legislation offers no flexibility to choose other areas of focus. The current focus is on areas of greatest savings. CMS staff has studied the North Carolina project.

Mr. Hewitt asked if physician quality measures would be used in the project. Mr. Coan said that quality measures will not be used in selecting the sites, but that all sites will meet minimum acceptable standards for a Medical Home.

Mr. Hoyer asked if CMS will be looking at the implications/applicability of Medical Home to the Medicaid program. Mr. Coan said that CMS will not report on implications for Medicaid, but this does not mean that the lessons learned will not be applicable.

Ms. Byrd asked if an independent advanced practice nurse would be eligible for the demonstration. Mr. Coan responded that there was room only for physician practices to serve as Medical Homes.

Dr. Ricketts said that it would be better not to promote this only on the basis of cost. Quality must also be a selling point. Mr. Coan reiterated that quality is not the driving process – the real question is whether the additional fees can save money.

Public Comments

Mr. Allan Morgan of the National Rural Health Association thanked the Committee for addressing on the Medical Home issue.

Dr. Paul Craig who is no longer a member of the Committee took the opportunity to say farewell.

Friday, February 22, 2008

Mr. Otis convened the meeting and asked for reports from the Subcommittees.

Medical Home: Mr. Hewett outlined the elements of Medical Home that will be addressed by the Subcommittee. They include definitions, unique rural challenges, the need for flexibility, and freedom of choice. They will also explore links to Medicare best practices and will examine reimbursement models. Consideration will be given to workforce issues, the role of Community Health Centers and Rural Health Clinics, as well as the role of telehealth technology.

At Risk Kids: Ms. Hansen reported that the topic is quite broad and will have to be narrowed down. Her group will examine problems unique to rural areas and will look for model programs to review. The reported strengths and weakness of states will be studied and may lead to some specific recommendations. North Carolina has a model program that will be studied at the June meeting. Medical, social, and educational aspects of the problem will be examined.

Workforce and Community Development: This group will focus on policy issues related to community improvement and the training of rural health care workers. One focus will be the potential for greater coordination among federal agencies. The need for more data on the rural workforce will be addressed. Recruitment and retention of students a faculty is an issue, as well as the rural infrastructure for health professions training. Gaps between workforce demands and need will be explored. The Subcommittee expects that its report will establish a dialogue on the issues and set the stage for more specific and detailed reports in future years.

Jennifer Chang of the ORHP reviewed the next steps in preparation of the Committee report. Outlines will be developed and conference calls will be scheduled for April, 2008. She briefly described tentative plans for site visits during the June meeting in North Carolina.

Letter to the Secretary

There were no comments on the letter to the Secretary

Public Comment

There were no public comments and the meeting was adjourned.