September 24-26, 2008, Brainerd, Minnesota

Health Resources and Services Administration
Office of Rural Health Policy

September 24-26, 2008
Brainerd, Minnesota

Meeting Summary

The 60th meeting of the National Advisory Committee on Rural Health and Human Services was held September 24-26, 2008, in Brainerd, Minnesota.

Wednesday, September 24, 2008

The meeting was convened by Governor David Beasley, Chairman of the Committee.

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

Present from the Office of Rural Health Policy were: Tom Morris, Director; Jennifer Chang, MPH; Michelle Goodman; Erica Molliver; Meghana Desale; and Jenna Kennedy.

Governor Beasley reviewed reporting procedures for the Committee and thanked the Committee members who were responsible for hosting the meeting.

Mr. Mark Schoenbaum, Director, Minnesota State Office of Rural Health welcomed the Committee to Minnesota and briefly described the principal economic areas of the State. There are 79 rural Critical Access Hospitals in the State that tend to score highly on quality indicators

under Medicare. He discussed the role of his Office in addressing rural health policy issues in the State.

Setting the Context for Rural Minnesota

Jim Krile, Former Director, Blandin Community Leadership Program.

Mr. Krile challenged the Committee Members to share their perceptions of Minnesota Then, he described how the demographics of the State are changing. Just a few counties in the State have over one-half the total population, and those counties are still growing. There has been a large influx of Hispanics and an influx of new religious traditions to the State. Traditionally, the indirectness of citizens in their relationships has been a dominant cultural trait in Minnesota. New waves of immigrants from various countries, most recently from Somalia, have introduced cultures that are more direct in their relationships among people. Mr. Krile indicated that Minnesota culture has recently entered a period of flux and fragmentation. He went on to say that Northern tier counties in the State are in economic and population decline. While the Minnesota economy is in good shape overall, eight rural counties have especially low incomes. There are 11 sovereign nations in Minnesota, which are among the poorest areas of the State. Minnesota prides itself on the quality of its labor force and its work ethic. The speaker concluded with a discussion of his work in developing leadership in rural communities. He spoke about the complexity of developing leadership in a population that is becoming more diverse. There is tension between developing creative new solutions to problems and overcoming resistance to change and between existing and emerging leaders in rural communities. His approach to leadership development recognizes these tensions by focusing on the results.

Workforce and Community Development Panel

Jay Fonkert, Senior Workforce Analyst, Minnesota Office of Rural Health and Primary Care.
Valerie Defor, Director, Health Education Industry Partnership.
Susan Speetzen, Health Care Specialist, Minnesota Department of Employment and Economic Development, Workforce Development.

Mr. Fonkert introduced his presentation by stressing the enormity of workforce challenges facing the health care sector, which affect both economic vitality as well as outcomes in the delivery of health care. Rural areas need a health care workforce that can assure timely and convenient access to health care and elevate the quality of care. The health care industry provides good jobs that allow young people to raise their families and retire in rural communities. One of every eight Minnesota private sector jobs is in health care and health care, which also represents ten percent of wages and salaries. Mr. Fonkert presented data on the total health care workforce in

Minnesota, including professional and technical occupations that are often overlooked. He showed that health care support occupations are growing more rapidly than all occupations in the State and also more rapidly than the more studied health care occupations. For example, the rates of growth for dental hygienists and home health aids far exceed the rates for dentists and Licensed Practical Nurses. Mr. Fonkert's Office conducts annual surveys of licensed health professionals in the State and he presented workforce data for the various market areas of Minnesota. He noted that most rural doctors are primary care specialists and spoke about how the geographic distribution of physicians and other providers affects the delivery of health care. There is a serious concern about the aging and retirement of dentists in Minnesota, because the State currently does not have nearly enough trained dentists to replace them. Mr. Fonkert concluded with a discussion of the policy levers for addressing rural health workforce needs. These include strategies for recruitment of students, incentives for workers to locate in high need areas, reimbursement issues, and a change in the licensing and scope of practice requirements.

Ms. Defor spoke about the Healthcare Education and Industry Partnership (HEIP) funded by the State in 1998. It is a partnership of health care providers, State agencies, seven State Universities, twenty-five Community Colleges, and other groups. Its initiatives encompass nursing expansion, allied health, policy development, student outreach, and community outreach programs. The Community Health Worker Project of the Partnership has developed a standardized curriculum for Community Health Care Workers that is offered at multiple campuses throughout the State. The Minnesota State Legislature has passed legislation that allows reimbursement of these workers. There is also a program designed to expand the role of Paramedics in health care delivery. Paramedics are an untapped resource for filling gaps in rural health care delivery and the project has developed a curriculum to support an expanded role for these workers. HEIP has also developed a partnership between the University of Minnesota and a Community College to support a dental clinic at the Community College where clinical training is provided for dentists and dental hygienists. This shared facility lowers the costs for training while providing more clinical practice opportunities for the students.

Ms. Speetzen presented workforce innovations undertaken by the Minnesota Department of Employment and Economic Development. Her Agency is working within the various economic regions of the State to address skills development and capture the experience and talents of the workforce. The programs take many approaches to workforce development, such as transitioning adult workers into new occupations or engaging the youth in science and technology. The Agency supports "First Grants" to help regions develop workforce plans to fit their own needs. The grants act as a catalyst between businesses and educational institutions in developing cooperative training projects for new jobs and retraining existing employees.

Some of the grants are directed specifically toward health and human service occupations. Ms. Speetzen provided examples of specific programs in these areas and noted that Minnesota will be the first State to have a web-based State-wide assessment tool for all member hospitals of its State Hospital Association. This tool will provide data on the current hospital workforce and will be used for projections of future workforce needs. Ms. Speetzen described another innovative partnership between community hospitals and educational institutions to develop career ladders for health care workers and to help them obtain college credits in order to have an expanded role in health care delivery. One such program offers on-site training for LPNs that emphasizes geriatric care. Similar opportunities are available to Associate Nurses who wish to enhance their skills and education.

Donna Harvey asked about incentives for nurses to work in nursing homes. Ms. Speetzen responded that there is an image problem in long-term care, but the growth of more attractive care options in community settings may help to overcome the negative image.

Dr. Blackburn inquired about the income levels of Community Health Workers. Ms. Defor replied that they are paid about $12.00 per hour and the State is thinking about adding specialty training to improve pay and retention.

Maggie Tinsman asked about the expanded role of Paramedics that was discussed in the presentation. Ms. Speetzen said that an expanded role could involve something as simple as developing an inventory of medications that are available in the community. She said that this would be discussed in more detail during the Medical Home panel.

Serving at Risk Children Panel

Penny Hatcher, MSN, Dr.PH, PHN, Child and Adolescent Health Unit, Supervisor, MN Department of Health, Community and Family Health Division, Maternal and Child Health Section.
Ralph McQuarter, Prevention and Research and Grants Support Manager, MN Department of Human Services, Child Safety and Permanency Division.
Linda Kaufmann, Senior Program Manager for Children, Youth and Families, Initiative Foundation.

Dr. Hatcher spoke about activities under the Minnesota Childhood Comprehensive Systems (MECCS) initiative. The programs are funded by HRSA grants and philanthropic donations. The Federal grant supports activities related to mental health, parent education, early education and child care, family support, and the concept of a medical home. The grant is part of a larger framework of State initiatives to coordinate assistance programs for children and their families. The key players who developed MECCS came from a wide range of public and private

organizations in Minnesota. The program is developing a centralized data resource that will include demographic information on children and evidence-based strategies for early education and child health programs. Dr. Hatcher described how the many different components of the system are coordinated and how difficult this has been given the large number of agencies in the State that work with childhood education and child health issues. She spoke about a unique partnership between State agencies and physician organizations to support continuous quality improvement in clinical practices where children are served. She discussed some of the challenges in using health screening instruments for evaluating the needs of children and the work that is being done to improve these instruments. At the close of her presentation, Dr. Hatcher mentioned some new Federal grant opportunities that are becoming available, and she indicated that the national and State agencies need to work together in the effort for better program coordination. She described the need for more funding from Federal sources, greater Federal participation in collaborative activities, and additional investments health screening for children.

Mr. McQuarter began with an overview of child health services in the State, emphasizing that Minnesota is in the top tier of States on some measures of child welfare. Most children are doing well, and there has been a decline of child abuse and neglect. Most counties are meeting Federal performance standards for programs that deal with child abuse and neglect. Under a block grant from the State, Minnesota counties must also meet standards of performance in these areas. Half of the funding of social services programs for children is provided by the counties. Having noted that minorities are over-represented in the data on child neglect and abuse, the State has undertaken several initiatives to work with minority populations. Mapping tools have been developed on the availability of services for children. There is a parent-awareness system that provides lists of licensed child care providers. Mr. McQuarter made three recommendations to the Committee: 1) Put children issues back on the national agenda; 2) Support early child care and education; and 3) Support early prevention activities and services.

Ms. Kaufmann described the Minnesota Early Childhood and Thrive Initiative. Her organization is one of six foundations created and funded by the McKnight Foundation during the economic downturn in the 1980s. Early childhood development is not an exclusive focus of the Foundation, but there is important work underway in this area. For the first time, all six foundations have come together to conduct a State-wide campaign on meeting the needs of children. They have created coalitions with health providers, educational institutions, parents, businesses, and faith-based organizations to look at the needs of children in their communities. Some of the common challenges in rural areas are the lack of mental health resources, the lack of training opportunities for providers, and the stigma associated with mental health. The Thrive

Initiative has created a unique community organization model to increase capacity, strengthen existing services, and foster systemic changes to improve the social and emotional well-being of children. Six early childhood mental health coalitions have been formed throughout the State. Ms Kaufmann described how the coalitions were formed and the processes they use for planning and implementing their programs. One major priority is to better integrate medical and mental health services. Ms Kaufmann closed with a brief discussion of several projects in early childhood mental health education that are designed to increase the knowledge of providers and embed an early childhood mental health curriculum across higher education disciplines.

Maggie Tinsman asked about funding for the Children, Youth and Families Initiative Foundation. Ms. Kaufmann said that all funds are private. It was started by the McKnight Foundation and later received funds from the Bush Foundation. The total cost of mental health initiatives is $2.5 million over three years.

Robert Pugh asked about the Minnesota Child Health Insurance Program. Mr. McQuarter replied that it is not a large program and mentioned a Federal initiative on foster care that is in the works.

Dr. Blackburn asked about substance abuse programs for kids, particularly those from Native American Nations. Mr. McQuarter indicated that the Native American Nations are working with the court system, and he offered to provide more information to the Committee.

Dr. Hanson asked about funding for prevention services. Mr. McQuarter replied that about $25 million is used for child welfare preventive services out of a total amount of $450 million.

Medical Home Panel

Scott Leitz, Assistant Commissioner, MN Department of Health.
Ray Christensen, Assistant Dean for Rural Health, University of Minnesota School of Medicine.
Michael Wilcox, Medical Director, Mdewakanton Sioux Communities' Fire Emergency Service and Hennepin VoTech's EMS Educational Services Division.

Mr. Leitz said that Minnesota is a good place to start the medical home concept, where there are high rates of insurance coverage, a strong workforce, a history of collaboration in medical care, active groups of purchasers, and a strong Child Health Insurance Program; nevertheless, total health spending is rising. Furthermore, only one in seven diabetics receives optimal care, obesity rates are increasing, and there is an erosion of group coverage. These and related issues influenced the creation of a Minnesota Health Reform Task Force in 2007 that recommended a series of key reforms. The reforms include an expansion of Minnesota Care to

250 percent of the poverty level, new insurance requirements for employers, and the promotion of primary care case management. The State has already developed standards to certify Health Care Homes and policies for the payment of care coordination services. Quality measures have been developed, and the State has defined “baskets of care” for some common medical conditions that are used for pricing services and payments to providers. Mr. Leitz discussed the State’s definition of a Health Care Home and outlined the goals of the program for 2008 and beyond.

Dr. Christensen began with a reminder to the Committee of the value of primary care services and a brief discussion of well-known workforce realities in rural areas. He provided an overview of the Health Care Reform Act passed in Minnesota that provides the legislative basis for Health Care Homes. The Act calls for the coordination of primary care for patients with chronic conditions and payments to providers for care coordination. The program is voluntary for the physicians, nurse practitioners and physician assistants who will have primary roles in the new system. Dr. Christensen said that Health Care Homes cannot restrict access to specialists and cannot be held accountable for other care that patients may need. He reviewed the criteria for Health Care Homes which include maintenance of care plans, on-going access to care, dedicated coordinators, and a focus on patients with chronic conditions. The Act calls for payment reforms including pay-for-performance and payments for bundled services called “baskets of care.” Dr. Christensen expressed concern that the legislation could be interpreted differently in different clinics. The legislation contains many new regulatory requirements, but is largely silent on what the State Medical Society will do to facilitate and enhance the rural health care home. He said that it would help if State employees were included under the new system. He is also concerned about consistency between commercial and government payers and whether the quality targets will be the same for all payers. Another concern is that a subset of programs in the legislation covers the worst paying population. He noted that a payment system based on complexity has yet to be developed and there is a concern about how the quality initiatives may work in rural communities. In addition, there are unanswered questions about how care coordinators will be paid and whether existing staff can be utilized. Dr. Christensen said that about $400-600 per hour is needed to maintain a rural family or primary care physician. He spoke about some of the financial realities in rural physician practices that must be addressed and the enormous pressures that rural physicians face in trying to maintain their practices. His concluding remarks centered on other key questions that must be resolved under the new program.

Dr. Wilcox discussed plans for a program that will train Paramedics in a Sioux community to provide a higher level of care under close medical direction from physicians. Paramedics are often an underutilized workforce resource in their communities. They could be used to help in

such areas as management of chronic conditions, immunizations, health screening, etc. He is developing a program called “Community Paramedics” to train these workers to become physician extenders. The curriculum will take about 100 hours to complete and will include a clinical component. There is a mobile clinic in place that could be used for training in local communities. Outcomes from the model will be available in a year or two. Dr. Wilcox believes that the program is a model that could be widely used.

Donna Harvey expressed her concern about duplication of efforts in Home Care Health settings. Dr. Christensen answered that much thought has been given to this issue and that efforts must be made of make sure that confusion is avoided. For example, Public Health Nurses may be needed in Health Care Homes to coordinate some services.

Dr. Blackburn asked about financial support for training Paramedics. Mr. Wilcox said that it will be difficult for volunteers to find the resources needed to upgrade their skills if they are not paid as providers.

Robert Pugh asked about liability issues related to emergency services providers. Mr. Wilcox responded that licensing boards are participating in planning for the program and they seem to be open to changes. There have been few liability cases as yet, but there is an ongoing discussion about the need for additional insurance protections. Coverage has already increased for medical direction.

Maggie Tinsman asked about the impact of the Health Home on quality and costs. Mr. Leitz said that cost savings will be measured in the aggregate after three to five years. There will be peer groupings on quality measures that may stimulate competition.

At the conclusion of the panel presentations, Jennifer Chang reviewed the site visit plans for Thursday. Tom Morris asked the Members to think about formal recommendations to be included in the Committee report.

Public Comment

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

Thursday, September 25, 2008

The meeting was convened Thursday morning and the Subcommittees departed for site visits as follows:

At-Risk Children Subcommittee: Early Childhood Family Program, Hillside School, Sauk Rapids, MN.

Workforce and Community Development Subcommittee: Cuyuna Regional Medical Center, Crosby, MN.

Medical Home Subcommittee: Lakewood Health Systems, Staples, MN

The Subcommittees returned to the hotel on Thursday afternoon. Subcommittee meetings were convened to continue work on the annual report to the Secretary. Following the Subcommittee sessions, the Full Committee was convened to hear reports from each of the Subcommittees.

Subcommittee Reports

Medical Home: Dr. MacKinney reported for the Subcommittee. He said that the site visit earlier in the day provided insight on the Medical Home concept at the State level and that Minnesota was moving quickly to implement the new model. The Subcommittee learned that having physician support for the concept is critical. The group is considering recommendations in the following areas: 1) The development of physician payment codes for care coordination; 2) The need for Medical Home models that represent rural areas and needs; 3) The use of Medicaid waiver authorities to promote rural Medical Homes; 4) Incentives for rural Critical Access Hospitals to support the Medical Home concept; and 5) The use of Rural Health Outreach Grants to support Medical Homes.

At-Risk Children: Dr. Hansen reported for the Subcommittee. At the site visit, the Subcommittee saw an excellent example of collaboration between child education and child health programs. The visit showcased a one-stop shopping model for health and human service programs, which has shown effective coordination of funding streams. This program highlighted the need for greater collaboration at the Federal level, particularly in terms of incorporating the educational component. Dr. Hansen also reported that the program in Sauk Rapids is working to establish an innovative and unique certification process for "family educators". Transportation issues for children and their families were cited as a continuing problem and there is need for greater flexibility at the Federal level in this area. The program is also training pediatricians to administer social and emotional developmental screening tools for young children..

Workforce and Community Development: Ms. Perdue reported for the Subcommittee. She reviewed the site visit to Cuyuna Hospital, a beautiful Critical Access Hospital that has developed collaborative arrangements with physician groups and other hospitals through the use of limited partnership corporations. The hospital invests heavily in staff training and

development to promote recruitment and workforce retention. It has a keen understanding of the hospital's role in local economic and community development. The Subcommittee is considering recommendations related to: 1) The need for national data on the workforce in allied health professions; 2) Changes to Federal health care workforce programs to support community colleges where local health care workers are trained; 3) Demonstration projects on regional training programs for health workers that focus on Critical Access Hospitals and Community Health Centers; 4) Distance learning for healthcare workers; and 5) Leadership development in rural communities.

Letter to the Secretary

Mr. Morris asked for comments on the Letter to the Secretary that is prepared following each meeting of the Committee. Mr. Meit suggested that the letter should emphasize the theme of leadership development. This was approved by the Committee.

Committee Business

There was a brief discussion of plans for the next meeting that will be held on February 18-20 in Washington, D.C. The June meeting will be held on June 9-11 in the Rapid City South Dakota area.

Mr. Morris announced that some members could meet informally on Friday morning if their transportation plans would allow for it.

Public Comment

There were no public comments and the meeting was adjourned.