September 9-11, 2009, Sacramento, California

Health Resources and Services Administration
Office of Rural Health Policy

Sacramento, California
September 9-11, 2009

Meeting Summary

The 63rd meeting of the National Advisory Committee on Rural Health and Human Services was held September 9-11, 2009, in Sacramento, California.

Wednesday, September 9, 2009

The meeting was convened by Larry Otis, Vice 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; Deborah Bowman; B. Darlene Byrd, MNSc, APN; Larry Gamm, PhD; Sharon A. Hansen, Ph.D.; David Hartley, Ph.D., MHA; Donna K. Harvey; Thomas E. Hoyer, Jr., MBA; Todd Linden, MA; A. Clinton MacKinney, MD, MS; Karen R. Perdue; Robert Pugh, MPH; John Rockwood, Jr., MBA, CPA; Maggie Tinsman, MSW. Mr. Dennis Dudley attended representing the U.S. Administration on Aging.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Jennifer Chang, MPH; Michelle Pray-Gibson; Sherilyn Pruitt, Laura Merritt, and Kai Smith.

Setting the Context for Rural California

Mario Gutierrez, MPH, Chair, Rural Health Services Panel, Rural Policy Research Institute.

Mario Gutierrez opened his presentation by comparing peoples' perception of California to the reality in California. From an outsiders view there are large cities like Los Angeles and San Francisco and everyone appears to be wealthy. The reality is that California is the third largest rural state in the United States. Mr. Gutierrez gave a comparison point that the distance from Yreka to Chula Vista, California is 765 miles. This is further than the distance between

Washington, DC to Montgomery, Alabama which is 745 miles. Sacramento is one of the largest agricultural areas in the country. It is surrounded by diverse agriculture such as wheat, grapes, tomatoes and rice. Marijuana has become one of the largest cash crops valued at 1.8 billion a year. Logging and timber has become a thing of the past. When an industry dies, such as lumber and timber, so does the town. There are over one million farm workers in the area. Many farm workers are living in poverty and their families have very bad living conditions. Farm workers and their families are living under trees in tents. There are 107 recognized tribes and promoting their culture is a critical part of the community. The Hmong population is 65,000, which is the highest in the United States. A climate challenge in the area is that it may rain from November to May and then there is no more rain for the rest of the year. This causes tinder boxes in the state. Mr. Gutierrez stated that this is one of the biggest challenges in the area. There is a constitution that requires not only a balanced budget but two thirds of the legislature to approve it. In any government that is a challenge. The biggest challenge is how to deal with the constitutional revisions and dealing with the issues of the budget. There are more than 15 definitions in the federal government for defining rural. The two most common classifications, Census Bureau and Office of Management and Budget, result in very different definitions. San Bernardino County, Riverside County and Shasta County are all classified as urban counties. This is a problem because of funding issues and because it is important to describe accurately what rural is and to describe when there are levels of poverty that are finer grained in the county. There needs to be a more accurate picture of the conditions that exist. There are over one million farm workers in the area. Next, Mr. Gutierrez talked about the California advances in rural health care. FQHC Community Health Centers are the most extensive networks of federally qualified health centers throughout the state. It is one of the largest and best run comprehensive health care centers. Mr. Gutierrez has been working with Mr. Nesbitt for the past 15 years developing telehealth and telemedicine throughout the state. Telehealth is a way of helping to keep people in their communities. It is a way for a primary care doctor to have access to specialists. There is a new California Center for Connective Health which is a way to bring together all of the resources being used to do things in an efficient and effective way. That is created through the Governments Office with the California Emergency Technology fund to be able to provide resources for expanding broadband throughout the state. There is a model regional network that includes 435,900 residences, 30,000 square miles and 80% of the residents are living in frontier areas. It brings together a network of 42 health providers including primary care doctors, rural clinics, social services, prevention and wellness programs and they are all under one network. Mr. Gutierrez closed by saying that as when looking at models for the future that focus should be on ways that the most effective services for regional communities can be provided.

John Rockwood asked how the Model Regional Network is governed and how the services work together. Mr. Guiterrez responded that it is a challenge when they are spread out over 30,000 square miles. They are nonprofit and have a nonprofit board. They pull together all of their resources and also seek grant funding from state, federal and private sources. Mr. Rockwood asked if they set it up independently. Mr. Guiterrez stated that they definitely set it up independently but the California endowment provided their seed money to help stabilize, develop and give them the space to take the risk and time to create the network.

Larry Gamm asked to what extent has the telehealth network been successful in terms of meeting the need of primary care challenges. He asked if they were running out of resources. Mr. Guiterrez said it is a challenge as far as recruitment of primary care physicians. The training centers through the CTEC Program at UC Davis and the University of California have been effective at bringing in the primary care practitioners and staff to learn how to use the equipment so that they are not intimidated by the new technology.

Robert Pugh asked if funding in California is being cut because of receiving stimulus money. Mr. Guiterrez said that it is a crisis because if there is a cut in urban areas there are ways of finding some funds but if there is a cut in rural areas you are left with nothing. In part it has been with stimulus but more important it is because the area is in dire straits. The state budget also cut funds that would have leveraged federal matching funds.

David Hewett asked how they are working with the undocumented workers and their families in provided health care services. He asked if it is done through hospitals or are there designated programs that look to their health care needs. Mr. Guiterrez stated that this is also a huge challenge because most of the farm workers are undocumented. Some children are eligible but their moms and dads aren't. There is a fear of using federal programs. There was a study through the University Of California School Of Public Health and it showed that the lowest users of emergency rooms were undocumented workers from Mexico. It used to be that people would go back to Mexico to get care. The community health centers have outreach programs to be able to bridge the cultural gaps and provide prevention and education. There are fundamental problems for the Mexican workers and their families such as isolation from the community and mental health issues due to their situation and work conditions. There was a program that was launched at the endowment called the community building effort to help farm workers and their families. Over 90% of the births in some areas are to Mexican families. In the past seven years there has been a closer relationship to the Mexican government. Now all of the counsels have created a Window of Help to give people access to information and to find medical services.

Dave Hartley asked if the state has come up with a strategy to deal with the mental health problems of the undocumented workers. Mr. Guiterrez noted that the outreach workers from the

community, the connections that are being made with Mexico and working through a transnational program for health to bring resources from Mexico is helping.

Larry Ortis asked how they got broadband in such a rural, spread out area. Thomas Nesbitt stated that through the FCC dollars and rural health care pilot program they are working on this issue. Applying for money is difficult because it is considered that the area is penetrated with broadband because the area is so large but many rural areas are underserved. The California Emerging Technology fund has given money.

Maggie Blackburn asked if the kids in the rural areas are getting school based healthcare. Mr. Guiterrez noted that often the school is the community center. It is a place for families to come together and is critical in creating the coalition for the community. The fact is that the kids are being drawn to work in the fields and child labor laws are exempt in farm work. That is taking them away from the schools.

Dave Hewett asked about the elderly population and services available such as assisted living and Meals on Wheels. Mr. Guiterrez stated that organizations like the Northern Sierra Network are coordinating specialty care for the elderly. He noted that telehealth will provide opportunities to monitor the elderly at home.

David Hewett asked what problems with the economy have impacted the endowment. Mr. Guiterrez said that it had been impacted greatly. They were creating large projects and after 10 years the board said they weren't being strategic enough and the funding was being reduced by 30-40%.

Larry Gamm asked if while focusing on community development if other ideas and medical options were emerging. Mr. Guiterrez noted that community building is part of a healthy community. In the communities there needs for people who have the knowledge, the connections, language and the ability to bridge between the traditional medical provider and traditional providers. Larry Gamm asked about getting oral hygienist for oral health and counselors and therapists. Mr. Guiterrez said there are pressures to do this but there is big money with the dental association.

Graham asked about taxing marijuana and if the dollars would be used for the states debt or for the rural communities to support infrastructure. Mr. Guiterrez said that marijuana is virtually legal in the state. Part of the discussion is that medical marijuana be taxed. The society is moving a lot faster than the government and it is time to talk openly about it.

Overview of California State Rural Health Association

Desiree Rose, Executive Director, California State Rural Health Association.

Desiree Rose started by saying that she became the executive director of California State Rural Health Association in March of 2008. She emphasized how vast California is and the challenges that come along with the geographic and demographic diversity of the state. California is the most populated state in the nation. It is also a distinctly rural state. Between 85-92% of the landmass is designated as rural. Rural California is home to more than 5 million people. Ms. Rose said that there are 935 residents per doctor in rural California and 45% of rural Californians live in health professional shortage areas. There are high rates of chronic disease, diabetes and heart disease. A greater percent of the rural residents don't have health insurance than in the urban community. The California State Rural Health Association is a non-profit, state wide association that represents over 300 members. The mission of the agency is to link rural organizations and individuals together to facilitate information exchange, collaboration, and advocacy to promote healthy rural communities. The vision is to empower rural people and create healthy and sustainable rural communities. Some of the ways this is accomplished is by promoting adequate reimbursement for health care providers and preserving funding for rural healthcare programs and facilities. The organization works to educate rural communities about the effects of policy, legislation and regulation on the health of rural residents. The agency coordinates the annual rural health care conference. They also send a delegation of members to participate in the National Rural Health Association Policy Institute. This helps engage in more federal level issues with the membership. The budget is $450,000 a year so the focus is on infrastructure development. Ms Rose also stated that they develop and disseminate weekly electronic "Advocacy Alerts" on priority health policy issues impacting rural communities. They want to be recognized as the "Google" for all things rural in California.

Overview of California Department of Healthcare Services

Samantha Wilburn, MPH, FNP-Director, California State Office of Rural Health, California Department of Health and Human Services.

Samantha Wilburn stated that there are a greater number of rural residents than urban that fall below the poverty level. In rural areas there are a smaller proportion of residents 25-34 than in urban areas. There are a greater number of retired people in rural areas. Rural counties have more people with health concerns such as diabetes and mental health issues. Ms. Wilburn noted that because of the state deficit budget there was a 31 billion dollar budget cut. Medi-Cal and Medicaid is vital for local providers. There were reductions in Medi-Cal. There were 10 optional benefits eliminated. It almost caused some local providers to close their doors. The Adult Day Healthcare has been decreased from fives days a week to three days a week. There was a reduction in nursing home rates and cuts to rural hospitals. The cuts to the community

clinic program were from 6.9 million dollars to zero. In 2009 there have been 5 rural hospitals close. One of the clinics that closed had been in operation for 30 years. Ms. Wilburn stated that they do not do face to face visits anymore and have changed to teleconferencing. The area is known for wildfires, earthquakes and other natural disasters. The agency works with the local tribes because they are not part of local health department jurisdictions so systems have been developed between the tribes and the health departments. There aren't enough people to go out and vaccinate children so things like H1N1 are worrisome. She noted that this is the last week of California legislative session. There have been some limitations and cuts to the Federal Child Insurance Program. It insures almost 1 million children in the state. A way that the program is trying to be restored is to have a tax levied on the managed care corporations and the money will go to the healthy families program. There is also a bill that will levy a provider fee on hospitals and help the reimbursement rates on Medi-Cal and also go to the healthy families program. There are laws in the State of California that prohibits hospitals from hiring their own physicians and that is a huge problem. Ms. Wilburn closed by saying that they need well over a thousand primary care physicians today to meet the minimum number according to the HRSA analysis.

Between Crisis and Opportunity

Cathryn Nation, MD- Associate Vice President for Health Sciences, University of California, Office of the President.

Cathryn Nation began by stating that there are immense opportunities and that there is the ability to be optimistic even during difficult times. She quoted Winston Churchill, by stating that a "pessimist sees the difficulty in ever opportunity; an optimist sees opportunity in every difficulty." Ms. Nation noted that by 2025 the population will increase a total of approximately 48 million and one in five people will be over the age of 65. Latinos will be the largest ethnic group in the state and will be the majority by 2050. There are widening gaps in access to primary care, especially in rural areas. There are 6.6 million people without health insurance. There is a huge shortage of nurses, pharmacists and allied health professionals. The Inland Empire and Central Valley are expecting worsening shortages. There are approximately 935 residents per physician in rural areas compared to 460 in urban areas. UC has developed a plan to encourage enrollment growth in five health professions across 8 campuses by 2020. The plan also has efforts to increase diversity of UC professions faculty and staff. Programs in Medical Education were started by all the UC medical schools to focus on supporting the underserved groups and communities. PRIME's core elements are program identity, recruitment, admissions, curricular enrichment, clinical training, dedicated faculty and mentorship. PRIME has more student diversity than is usually seen and has given a new focus on health disparities. The challenges to PRIME are that there is a projected $24 billion dollar budget deficit and there will be no new

resources for enrollment growth of any kind at UC. The UC medical school is still moving forward with the admissions to next year's PRIME classes. There was $100 million awarded in funding support from the Gordon and Betty Moore Foundation which was greatly needed. In closing, Catherine Nation talked about the importance of telemedicine and that the advancement in telemedicine will give opportunities in accessing people in rural communities.

Family Healthcare Network Overview

Harry Foster, MSCM, President & CEO, Family HealthCare Network.

Harry Foster began by explaining his connections to the people who had presented before him. Mr. Foster said that he wanted to present a microcosm of the state and nation through the eyes of a small community and a large federally qualified health center. Mr. Foster shared some of the obstacles that they face and also recommendations. The Family Healthcare Group was established in 1976 as a private non-profit and became a rural health clinic in 1986. They became a Federally Qualified Health Center in 1989. They have 11 health center sites and provided 426,189 outpatient visits and 20,149 inpatient visits. The agency has 707 total staff. Recruiting tools have included residency program visits and outreach and advertising for positions in journals and on the web. They have two full time provider recruiters. He noted that the agency believes that it is important to have an initiative to encourage people to come back and practice in their own community. Recruitment resources include a loan payment program through the Health Professions Education Foundation. The difficulties with the loan payment program are that the program funding is limited and foreign medical graduates or non US Citizens are not eligible. There are foreign medical graduates who are not eligible to apply for the National Health Services Program. Over 50% of Primary Care Providers in the country are International Medical Graduates. The State of California doesn't give enough support to IMGs and it is a problem to rural communities. He said that 3 providers who applied for the Federal Loan Repayment Program are still waiting for a response. Mr. Foster closed with recommendations. They included expediting CA licensure processing, considering patient visa ratios with J-1 visa waiver issuance and coordinating with the visa application process to overcome licensing issuance obstacles.

Prime Program Student Input

Christopher White, University of California, Davis, Rural PRIME Program Medical Student.

Christopher White started by stating that he is a second year student at UC Davis in the rural PRIME Program. He is co-Director at Willow Clinic which is a free clinic that serves the

homeless population in Sacramento through the Salvation Army. He noted that he is from a small town in North Eastern Washington which made him want to pursue a career in rural medicine. Rural areas are often less healthy and have lower incomes so many physicians think it is risky to go into rural communities. There need to be more rural health scholarships to help attract people to the area. Mr. White noted that telemedicine would help make medicine more economical in rural areas. People who do dual residence in primary care serve a special place in rural areas. There should also be more scholarships offered to people who are doing dual residency.

Estaban Verduzco, University of California, Davis, Rural PRIME Program Medical Student.

Estaban Verduzco began by telling the committee that he is the co-director of one of the seven students-run free clinics at UC Davis. It serves the working poor and primarily the Hispanic population. Mr. Verduzco grew up in Delano, California with a population of 10,000. He noted that he became aware of the problems in rural medicine when he went back home after undergraduate school. He became aware of the shortage in primary care and specialty physicians. He couldn't find a job that offered healthcare benefits and became uninsured. He noted that just because you have health insurance it didn't mean that you would have access to care in his home county. The largest hospital in the county only employed two fulltime psychiatrists and the regional population is nearly 400,000 people. Mr. Verduzco said that through rural PRIME he has been able to testify on the behalf of legislation to improve healthcare in rural areas, to speak to rural physicians and researchers and been exposed to telemedicine. Financing the application process was the largest barrier. He was not able to apply to medical school sooner and spent about $5,000 on the application process which was paid for on credit cards. He recommended assistance on the application process for students that are going to return to rural areas to work.

Q&A

Todd Linden asked if they are having difficulty with retaining H1Bs or J1s medical graduates. Once we help get their green cards they are gone. That may be because they have a less diverse population and they want to go to a more diverse area. Have you all had that experience? If there are several people wanting to work together and working with groups would make more sense so that we retain people. Harry Foster noted that he thinks it makes sense to work with a group. Two of the four pediatricians in his area are Filipino and the medical director is Filipino and it is a really tight community. He stated it does make sense to do that.

Graham Adams stated that Christopher and Estabon are exactly what rural America needs. They are passionate and going in the right direction. He then asked Mr. Foster how much of his budget was from the 330 grant and had he looked at the DHSS waiver option.

Harry Foster responded that they get $5.9 million a year from the 330 grant.

Maggie Blackburn asked about having rural sites for the students to train. She also asked about how diverse the faculty is and is there an effort to have a diverse faculty. Ms. Nation responded that the Davis program is in its third year and in a period of evolution and students are just moving into the clinical settings and is expected to expand. In every step in the educational pipeline there is a decline in diversity and this makes it difficult. We are lacking in diversity in faculty. On the students side there are profound challenges as respect to costs. Ms. Nation said that she is seeing that the UC schools are 5 of the 8 highest ranking schools in the increase of student debt. There are graduating with more debt than Stanford students. UC hasn't had the endowments.

Darlene Byrd asked if there are plans for team based training of health professionals on part of the universities. Ms. Nation said yes there at UCSF there is a presence of residents, medical students, pharmacist and nursing. San Diego has a medical school also that they are connected with.

Community & Home Based Care Options for Seniors

Jim Davis- Chair, California Commission on Aging

Jim Davis started by stating that access to community and home based care is a major barrier to the quality of life of rural elderly and seniors with disabilities. There is a diverse population in the area that he serves including veterans and Native Americans. He said that he grew up with his father and older brother who were doctors in a rural agricultural area in upstate New York. His brother retired a few years ago and after 90 years the family practice came to an end. The practice closed due to trouble recruiting and retaining doctors. In 1976, Mr. Davis moved to Willows which is a town of 5,500. There was a community and county hospital that was staffed by visiting doctors from San Francisco. The hospital is now an emergency care and staffed by volunteers and traveling physicians. The nearest medical services are 40 miles away. In 1983 Mr. Davis moved to Yreka and there were 3 hospitals within a two mile radius. In the past three years all three hospitals have had financial problems and reduced staff. Mr. Davis said that no matter where he has lived and worked there has always been a lack of services for rural seniors. There is a lack of medical and respite support for caregivers and seniors have to be relocated away from their community to larger cities for long term care. The California

Commission on Aging is an Advisory body and advises the Governor and the legislature on policies and programs that affect older adults. They hold hearings in rural counties throughout the state. The findings and recommendations are from the hearings. The findings include that there are too few trained caregivers, home health programs and respite options. Funding for respite care is limited and there aren't many health care visits from trained personnel. Once an elderly person is discharged from a hospital families are realizing that they can't find proper care for them in their homes. Service providers have a difficult time reaching clients in rural communities. It is too costly and difficult to deliver and people can't get out of the towns because of lack of public transportation. Adult day healthcare programs are needed. Assisted living is also desperately needed and it makes home care essential. Family members and in home care are often the only option for seniors in their home. There needs to be support to family caregivers and noted that there is a high percentage of abuse of seniors by family caregivers. Mr. Davis noted that it would be helpful if nurse practitioners could be able to serve a broader range. California rural areas are considered underserved and the state budget crisis is making matters worse. In summary he reiterated there is insufficient home and community based options, caregiver respite and support programs, and education on the services that are available locally and too many primary care physicians. There is limited or no specialist care and a limit of doctors that will accept Medi-Cal or Medicare patients. There is a shortage of long term care facilities and lack of transportation services. Mr. Davis recommended promoting the vocation of caregivers through financial support, health insurance coverage and tax credits. He advised to sustain and expand caregiver respite programs and provide mobile services and expand telemedicine in rural communities. Rural hospitals should be able to employ their own physicians. The federal poverty limit should be abandoned as a benchmark for elderly eligibility and replaced by the use of the Elder Economic Security Index. Mr. Davis closed by saying that the passage of the Elder Justice Act would expand protections for vulnerable older adults.

Overview of California Department of Aging

Lynn Daucher, Director, California Department of Aging

Lynn Daucher began by telling the committee that Jim Davis had painted an accurate picture of rural health home and community based issues and she was going to focus on the discussion of what can be done about the issues. Frontier also because it is even more sparse than rural. Two areas that will be talked about are big policy and others that are more specific. In big policy she touched on an article that she read about millions of dollars of stimulus money that were going to build an airport in Alaska. There were less than 100 people living in that area in Alaska. She questioned whether everyone should expect the same baseline of services. Ms. Daucher challenged the commissioner to consider what the moral obligations and baseline is because it is an issue. She noted that if you live in certain parts of Northern California you have to pay for a

helicopter or have helicopter insurance in order to get to a hospital. Next she spoke about people wanting to age in place and in their own homes. It is difficult for people to live in their own homes when they grow older. If people are told that they can age in place will they truly be able to stay in their homes? Should we be telling people that this is the best option? If people are poor and on Medicaid the government covers them going to a nursing home but not to stay in their own home. This is institutional bias. If there is no one in the area to help an elderly person then they will end up in a nursing home. People will live at home in terrible conditions and stay in their home. If the government was to change intuitional bias and tell people that they can stay in their homes the fear is that people will "come out of the woodwork" for community based services. There is a study on institutional bias that shows that for five years the cost will go up and then level off. The people who come out of the woodwork will be absorbed as it levels off. The Older Americans Act funds home and community based services and each state is supposed to design their own formula. She stated that the criteria is that low income, rural, minorities have to be targeted. There are 33 Area Agencies on Aging in California and funding is distributed. Each AAA gets $50,000 for administration to assure everyone that they had enough to run an agency. Ms. Daucher said that Imperial County gets an additional $45,000 to run their AAA and it is the poorest county near the Mexico border. The director can afford to go to meetings and she does all that is possible to meet the demands in her community. Sustaining rural communities is a big issue. If population growth is at a slower rate then the agency loses money. Generally the rural areas are losing money to the more populated areas. There is no vast internet or cell phones in some areas. Ms. Daucher said that what she would like to encourage is the PACE program. It is a Medicaid approved program, not a waiver, so you get it automatically. It has Adult Day Health Care and all of the community based services is through the ADHC. It isn't reasonable to have an adult day health care that you can travel to so rural communities are left out. Rural communities need a virtual PACE. SCAN foundation is funding a study on doing a virtual PACE. She suggested building a PACE program be designed that doesn't have a building. Ms. Daucher said that she has identified three "wildly important goals" in her state. The three "wildly important goals" are improving transportation, volunteerism and advocacy issues. She explained that the federal government has directed that transportation people need to work with the human services people. The department is applying for a Freedom grant so that they can have a mobility management coordinator at every Area on Aging Agency. They will connect transportation efforts between, churches, school buses and other organizations that are offering transportation. Ms. Daucher stated that volunteers are required for many of the services and in some communities they are training retired teachers and social workers to be hospital transition coaches and this is very important. Advocacy for seniors is lacking and needs to be improved. Ms. Daucher closed by saying that she is not counting on money but they need to be smarter, more strategic and not give up.

Overview of California Association of Area Agencies on Aging and Seniors Council of Santa Cruz and Benito Counties

Clay Kempf, President California Association of Area Agencies on Aging and Executive Director, Seniors Council of Santa Cruz and Benito Counties.

Clay Kempf said that it was especially nice to see a group that is looking at community based services. He directs a two county AAA that includes Santa Cruz and Benito Counties. Santa Cruz County is more of an urban county and San Benito County is more rural and has frontier areas with cattle ranches. Highlighting the variety of communities in California is important. It is a large state with large urban areas and lots of remote rural areas. One of the challenges of rural service is lack of resources. Some are arbitrary borders that create rural challenges. An example he gave is that the county that he lives in and the county that his agency serves do not have HMOs available through health insurance plans. The people getting services usually drive into the county that does have HMOs. It creates rural challenges when people are not even in a rural area. There was a senior that was disabled and wanted to buy a house. He had checked out the services available and everything was great. Six weeks later the bus decreased services and the bus stop out side of his condominium didn't exist any longer. He couldn't take paratransit because he was more than three quarters of a mile from a bus route. He became rurally isolated in an urban area because of a policy change. There are barriers on paper that are creating problems. Lack of resources causes rural isolation. There is a lack of formal caregivers and family caregivers and these needs should be addressed. Home health agencies are having a difficult time finding qualified caregivers. As the population ages there will be a huge increase in informal care that is needed. The workforce is unprepared for that. People need to be encouraged to learn new skills and they need to be rewarded for them. The area is working with the community college to begin caregiver training and certification courses. This is the first junior college in California who has this type of training. This will give people the opportunity to stay in their homes and stay independent. Reimbursement rates, especially around Medicare, are a challenge. The only way that the reimbursement can be increased in a rural county is to decrease an allocation in all of the other counties. This is a huge problem. Mr. Kempf said that their rural county lost its United Way because there wasn't enough staff to keep it operating. It was transferred to an urban area and the rural county lost a lot of funding to the urban area. Mr. Kempf stated that there are some current services that work well. Home delivered meals keep people in their home. Respite care allows a caregiver to continue to provide care to a loved one and not end up in a hospital themselves or send the person to an institution. Funding "tried and true" services that are core should get funding instead of putting money into new demonstration pilot programs. Something else that is important is that if a program is effective then just let it work. Mr. Kempf closed by saying that another issue is

reporting requirements have become so sophisticated that it takes away from the time to provide the service.

Q&A

John Rockwood responded to Mr. Kempf's presentation by telling about his own experience with living in a different state than his elderly parents. He said that his parents would call him when they had a problem and he couldn't get in contact wit the primary health physician most of the time. He noted that it would have been helpful to have an intermediary person that he could contact and get details on his parents' situation and what needed to be done. Mr. Rockwood said that he put both of his parents in a nursing home probably too early because he couldn't handle the tension. It would be great to have a group of health professionals that can provide their interim service so that a person could call to check on the elderly person and tell the loved one who is out of town what needs to be done. Donna Harvey noted a recommendation will be coming out of home and community based services. There are services but they don't talk to the medical community. There need to be silos of funding removed and to just look at the person and what they need. That is going to be some of the work of the committee. Larry Gamm said that this is a cost issue that is going to hit hospitals. There is a strong incentive for people to do better jobs at case management and discharge management. This is the perfect time for hospitals and the aging agencies to work together

Maggie Tinsman referred to her father living alone and the telephone company had a program set up and they called him every morning just to talk. The telephone company actually initiated it and there was no cost involved. That person became his friend and after a couple of years there was a story about it in the newspaper. Simple things like that can happen in communities with organization. She asked about the community college caregiver training and wanted more information. Mr. Kempf said that the agency held a community solutions unit and pin pointed important goals. Family and professional caregivers were brought up. They brought in Government agencies, non-profit agencies, for profit agencies and interested families members to design something to address the need. The local community college participated. The group designed core classes that they thought were most important for caregivers to learn. They worked in partnership with the local nursing program. There is gateway to becoming a registered nurse. It is being approached on a local level and people who complete the core classes and an elective will be certified.

Deborah Bowman stated that they have the same discussions and same issues in South Dakota. She asked if they have a long term facility bed shortage. Someone answered yes in some areas. She said they have the opposite problem of a surplus of beds. Have you looked at any of the licensure issues and services provided that may "step on the toes" of some

professional licensure. Lynn Daucher said that she was in the legislature and that they vote on scope of practice issues. Ms. Daucher said that she thinks that policy wise it should be taken away from political areas.

Todd Linden asked if the corporate practice of medicine issue in California is unique to California or do other states have the same issues? Also, is the medical association the primary obstacle to getting that change? He notes that it has to be a huge issue to rural practice. Lynn Daucher stated that there is a bill going through the legislature now to allow hospitals to be the umbrella for doctors. The CMA is the biggest opponent. Jim Davis responded that there are some pilot efforts along that line too and there seems to be some acceptance of that corporate change. Todd Linden asks what the CMAs concern is with the issue. Lynn Daucher said that the article that she read was that the fear is that hospitals would start dictating just like the insurance companies dictate how to practice medicine. Jim Davis replied that the independent action of doctors is the issue. The more rural the area the more support there is because it is a way of financial help to get doctors in remote areas.

Tom Hoyer commented to his colleagues that he has written down a lot of the issues and many of the issues he has worked on like guild issues. He noted that every time he wanted to write a regulation that required a functioned as opposed to a credential it caused problems. A lot of the issues that have come up are political questions that would be difficult to address or report. It seems that there are general issues that need to be considered when we write this report. It is worth recommending something that no one thinks of doing right away because it is too hard but it should be “put on the table”.

Larry Ortis said that he has difficulty in shifting responsibility back to the federal government to make a regulation that should be dealt with locally.

Maggie Blackburn commented on trying to keep people in their homes and what is involved in that. She noted that where there is a struggle is keeping people out of the hospital. Home health is tied to discharge. Home health needs to be looked at to give them the services they need to keep them out of the hospital. In rural areas it sometimes can be easier because there is a close community and you can “tap into” the services and people in the area to bring together coalitions to service the population that could work. She said as a family doctor in a rural community that is the way she knew what was going on. People in the church and EMS were her patients and she relied on them to help her find out what was going on with others in people in the community.

Clay Kempf said that once someone is released from the hospital the work begins. The discharge planner or case manager has to be a resource and know the needs of the person

they are managing. They need to know the services that are available and in contact with the medical community and family. Then the case manager could be the person that family members who live out of town can call to check on their loved ones. This can be modeled for the community and it prevents people from being readmitted to the hospital and institutionalization.

Tom Hoyer asked about family caregivers and making recommendations on paying family caregivers. This is the first time at a meeting that I have heard about elder abuse by family caregivers. Jim Davis commented that family caregivers are effective if they are trained and have medical support. About 80% of elderly abuse is attributed to family members. Donna Harvery said that it was true in Iowa and across the nation and the biggest type is financial exploitation. Title 3B does allow you to do case management, so there is that and Medicaid case management that is available. Have you figured out a mechanism to connect the funding variables together? Lynn Daucher answered, no, that is not integrated.

Jim Davis referred to elder abuse by family members and stated that there have been hearings on it. At the next commission meeting in Los Angeles it is the subject of the public hearing. It is that big of an issue.

Larry Ortis thanked the panel and speakers on the information that they shared. He stated that visiting local areas and hearing “real life stories” is very helpful and that they will send information that was shared in the upcoming report.

Rural Health Provider Integration in California

Kevin Erich, MBA, FACHE, President & CEO, Frank R. Howard Memorial Hospital.

Kevin Erich began by saying that it has been fascinating to hear the discussions and that he was glad to be a part of it. Mr. Erich began by noting that he is the President and CEO of Frank R. Howard Memorial Hospital in Mendocino County. The hospital was built in 1928. He told about Frank R. Howard was the son of Charles Howard and was driving and pinned under his vehicle. A physician tried to help him but couldn’t save him. He was only 15. The physician told Charles Howard that if there had been a hospital in the town that they probably could have saved his son. Mr. Howard donated around $40,000 in 1927 and the funds built the hospital. They are now in the process of building a new hospital because several departments of the hospital are in the 1928 building. They are a critical care hospital with 25 beds and serve a population base of 20,000 to 25,000 people. There are 29 critical access hospitals in California. CMS policy issues inhibit the access of hospital and health care in rural areas. Part of it has to do with the county level metropolitan designation. It has an impact on some of these hospitals.

Shasta County has the town of Redding and there is a critical access hospital quite a distance away. It can't get some of the benefits because it is considered being in a metropolitan county even though it is designated as one of the most rural areas in the state of California. When there are problems with designation it impacts funding for electronic medical records, malpractice coverage and other services. The USDA's rural urban community area is a method that we can use to find new ways to constitute rural areas. Next Mr. Erich talked about robotic technology and telemedicine that is available in the hospital and has been successful. Telemedicine and robotics provides needed care and levels the field between rural and urban. It gives rural communities access to specialists that would not be available otherwise. The specialist can look at the patient and consult with the physician and make a determination to whether or not a patient needs to be transferred. There are significant cost savings to the system and it allows patients families to have access to their loved ones while they are getting care. The robot helps the physician resolve issues without physically being there with the person. He noted that Tom Nesbitt was helpful in getting telemedicine into the emergency room. It has helped provide better care in the community and is the way of the future. Mr. Erich ended with recommendations including payment bundling policies that don't jeopardize hospital-physician relationships and also recommended that CMS pay costs for physicians and some non-physician practitioners and ancillary allied health staff. The final recommendation was to allow reimbursable transfers to nursing homes after a one-day hospital stay or referral from a physician.

Creating a Technology Integrated Rural Health Care System

Tom Nesbitt, MD, MPH, Associate Vice Chancellor, Strategic Technologies and Alliances, UC Davis Health System; Director, Center for Health and Technology and Chief Scientist, CITRIS

Tom Nesbitt started by thanking the committee for the opportunity to talk. He noted that he had been on the committee and appreciates the committee members. Mr. Nesbitt stated that there is a growing expectation that technology is going to transform the healthcare system. There are funds and effort going into it but the healthcare system is not a static situation. All of the talk and debate about healthcare is going on while there is an explosion of knowledge and new science and different ways of treating patients that is actually creating greater disparities. As new science is created some people have access and others don't to the new technology. There needs to be awareness that if we discover a cure for a disease and only half of the people have access to the treatment then we have only discovered half the cure for the disease. If medical science is not applied to all patients then it is worthless. He stated, "We need to spend as much money trying to get what we already have to the people who need it as trying to discover the next cure for a disease or the next drug to treat somebody's hypertension." Advances in

telecommunication and information technology can help redistribute expertise to places that it is needed at the time of need. The technology has the ability to create new models of care across the geographic spectrum. The problem is that technology has been layered onto a broken healthcare system. There have to be new models of care and ones that provide care in a way that hasn't been done before. Reimbursement policies never considered the technology environment that is going on today. Hospitalized patients are much sicker than in the past. The people there really need expertise 24 hours a day. To access expertise is a challenge in smaller hospitals. Telemedicine can bring the expertise to the smaller hospitals. Pediatric critical care doctors can talk to a doctor in another part of the state about a critically ill child. Robotics can be used in the emergency department. Then Mr. Nesbitt gave an example of a boy who fell off the couch and was staring at his mother and couldn't say anything. She had to drive a long distance to the Willits Hospital. He was comatose and hyperventilating and the doctor was afraid he was going to die. The doctor was also dealing with another critical emergency case in another bed. The doctor realized that the boy was in a diabetic coma. The child's family doctor happened to be in the hospital and was trying to help but they needed expert advice from someone 107 miles away at the University of California Davis Medical Center. They dialed up the portable terminal and connected to the pediatrics critical care clinic in Sacramento. The specialist talked the local doctor through a difficult procedure that had to be done to save the child's life. Mr. Nesbitt then talked about the need for broadband in the area in order to maintain telemedical services. He explained that Universal Services Fund is a subsidy program for broadband. There was a change to allow big entities to apply for the fund. There were 69 programs funded and many locations to receive subsidy. The governor decided there would be one application and a coalition of people was put together. The University of California became the lead entity. The goal was to create a broadband network dedicated to healthcare to link to national "backbones" and internet. Also the network was used with disaster preparedness and to leverage investments in telehealth. There was a 22.1 million award from the FCC. There was a commitment from United Health Care to expand the network and provide training. Mr. Nesbitt noted that he had to become the agent for each site in order to apply for federal funds. They were concerned that they wouldn't get required 320 and they got 1,000 wanting them to be their agent. There were 860 sites that qualified. Ideally all of the patients would have a medical home and portable electronic medical records. Some of the challenges are that there are credentialing issues. There are anti-kick back laws and the equipment is considered "giving someone something of value to induce referral." There are also concerns with Stark issues. In summary Mr. Nesbitt closed by saying that advanced information technology and telecommunication have a central role in transforming the healthcare system.

Q&A

Todd Linden commented that another benefit of telemedicine is that there are a small number of doctors who take care of patients in ICU in rural communities and telemedicine gives physicians the ability to actually go home and get a night of rest. This will also give patients the ability to be actively managed twenty four hours a day. He stated that it has been transformational for their organization.

Maggie Blackburn asked if telemedicine is cost efficient. She also asked if there is a service issue with the robot who is legally responsible. Tom Nesbitt responded that it keeps dollars in the rural communities. It keeps money from lab work, x-rays and hospital stays in the community. People don't have to leave the community to and spend money in other cities or states. The service provider will monitor and manage the care of the patient and not just rely on the telecommunications. Mr. Nesbitt said that the service providers have very strict penalties for service outages. Kevin Urich noted that they actually offer faster access to care through telemedicine because if you have to call a doctor at home it may take them twenty minutes or more to get to the hospital. Through telemedicine there can be a physician on-line within minutes.

John Rockwood stated that the margins on the technology are higher in an urban area than a rural area. Technology doesn't need to be duplicated. Should there be a system that requires that before you put an expensive piece of technology in an urban hospital that the hospital has the responsibility to extend it to rural areas in the region.

Tom Nesbitt responded that the regionalization of certain types of high end equipment is needed. There is also the expertise that comes along with the equipment and they need to be responsible for providing that also.

David Hartley asked if there will be competition manifesting in telehealth like there is helicopter services. David Hartley said there is not that type of competition. In fact, it is difficult to get a doctor to do a consult because there is a shortage of physicians. The physicians through telemedicine don't make as much money because they aren't doing the procedure. They try to train the local doctors so that they don't have to refer to them as often.

Larry Ortis thanked all of the participants and the meeting ended with Jennifer giving logistics for the site visits.

Public Comment

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

Thursday, September 10, 2009

Thursday morning the Subcommittees departed for sites visits as follows:

Health Care Provider Integration Subcommittee: Sutter Amador Hospital, Jackson, CA and Sutter Health eICU Sacramento Hub Operations, Sacramento, CA.

Primary Care Workforce Subcommittee: Sutter Amador Hospital, Jackson, CA and Pioneer Heath Center, Pioneer, CA.

Home and Community Based Care Options for Seniors Subcommittee: Madelyn Helling Library, Nevada City, CA.

The Subcommittees returned to the hotel on Thursday afternoon. Subcommittee meetings were convened to continue work on the annual report to the Secretary.

Friday, September 11, 2009

HHS Update

Tom Morris started the meeting with the HHS update. He began with information on The Recovery Act, particularly related to rural programs. He noted that Health Resources and Services Administrations received $2.5 billion in recovery act funds and 20% went to health professions training. Most of the $2 billion was for community health centers. This included new community health centers, expanded capacity of community health centers, electronic health records and construction and equipment funding for community health centers. He noted that they are one of the few agencies that have met the target for getting the money distributed. There is also Department of Labor funding for high growth occupation areas and transitioning workers from declining fields to high growth areas. Nursing, health care and human service positions are high growth areas. Some will be workforce investment money and some will go to nonprofit groups. They are waiting on HIT incentive payments. These are incentive payments for health information technology and they are working on the rules for the payments. He stated that it is going to be important for rural people to review the rules and comment on them. Physicians, rural health clinics and federally qualified health centers can elect to get the funds through Medicaid incentive payments or Medicare but can not do both. Hospitals and Critical Access Hospitals will also get incentive payments.

Deborah Bowman asked if as a committee they could comment on the proposed rules. Mr. Morris said that he would find out whether they should do it officially such as sending in a public commit or if it could be done informally. He noted that they could certainly have input. There

would be quite a bit of work involved. Mr. Morris then spoke about a large solicitation for HHS that is 650 million in prevention and wellness and it will be interesting to see how it will be used. It is a significant investment to try and improve wellness and it will hopefully be an opportunity for rural communities. He noted that they are waiting to hear if it will be run through CDC or through the health department for communities to apply, or if communities can apply directly.

Robert Pugh asked where in HRSA the program will be administered. Mr. Morris responded that it won't be in HRSA and that he doesn't know where it will be in HHS. It may be a CDC program but they are waiting to hear. Mr. Pugh asked if it will have a rural focus and Mr. Morris stated that he didn't know that answer yet. Deborah Bowman noted that it was really important in what department it ends up. Mr. Morris said that the last thing that is out is that there is money for the HIT Resource Centers through out the country. People are concerned about the Critical Access Hospitals. They were mentioned in legislation but there aren't in solicitation.

Mr. Morris said that the health preventions money was put into equipment purchases, simulators and nursing scholarship loan repayment. Every part of Title 7 got a little bit of money. They are hopeful that the money makes it into the rural communities.

Mr. Morris then touched on health reform and said they have been pleased that the HHS Office contacted them to help make a case for health reform from a rural perspective. Their research centers have produced about 30 products that would be put into one big document to go to the rural assistance center. There has been work done on the uninsured that is a particular interest. He stated that there are a lot of great products and they could be viewed on the research gateway. In May there was a Whitehouse meeting on health reform and farmers, ranchers and fisherman access to insurance was discussed and the meeting went well. He said that in Louisiana they were part of a rural listening tour with the cabinet secretaries from VA, USDA, HHS and Labor. Mr. Morris said that it was significant that there were four cabinet secretaries talking about rural health. He noted that The Department of Labor was interested to see that the money gets distributed. HRSA and the Department of Labor have formed a group to discuss how to coordinate workforce efforts. He said that he thinks they will pass something this year and it will play into the discussion about topics for next year.

Mr. Morris said that the 2010 President's budget was the first time that their budget hasn't been cut in the past 8 years. In the budget there was also language about an improving rural heath care initiative. The administration are asking them to rethink everything that is being done in programs and move towards more of an evidenced base and focus on recruitment and retention of health care professionals. The Office of Rural Policy has a variety of community based and state based programs and they are changing those in the next year and beyond to create an evidence base on what works in rural communities. They will invest in grants to try out ideas

and go back and use the findings the next time. When investing in future health promotion grants they can state that “what they know works” has to be used. Mr. Morris noted that that want to do the same thing on the hospital side with the flex program.

Maggie Tinsman stated that during the Home and Community Based site visit it was voiced that instead of investing in new projects that there should be focus on things that we know work. There is no need to be innovative all the time and looking for new things. Mr. Morris said they just led a contract to do outreach, tracking evaluation and best practices. They asked the contractor to look at what the foundations have funded and what other communities have done and see what was successful about those so that they are not operating in isolation. He said that there needs to be flexibility for rural communities to tailor to their particular needs. Mr. Morris said that the budget for the Office of Rural Policy is about 168 million dollars which sounds like a lot of money but if you consider the need in rural America it is not so much money. Mr. Morris stated that the best thing to do is find out what is working and disseminate the findings.

Mr. Morris said that workforce was always a challenge. In the 2010 budget they have been asked to do things in workforce and are taking steps. The Primary Care Conference in Washington was the first time HRSA worked across all of its bureaus on a common issue and it was a good model for the future. Mr. Morris noted that HRSA is investing in a new software package for the State Offices of Rural Health to do more active recruitment and retention. Only 25 of the 50 States are using the software. We are going to use training to help them do better. SEARCH is a program that HRSA funded but stopped about a year or two ago. It gets students into rural hospitals and clinics. The program will be started again this year through the Primary Care Association and maybe expanded. HRSA has gotten increases in outreach funding in the past two years. He stated that HRSA is considering using a couple of million for a Rural Network Workforce Program as a pilot. Mr. Morris welcomed ideas from the committee on how it would need to be structured. An example of what the program would do is if there is a rural residency program started and it is expensive to get money upfront. It is expensive to go through the accreditation and pay the salaries also. They can do a demonstration to create a residency.

A committee member asked about the SEARCH program and if it will still be run through the PCA’s and Mr. Morris answered, “yes it will.”

Mr. Morris said that the committee has said that they need to do more on leadership development. He said that they recreated the leadership program this year. They brought in about 25-30 grantees together for a 2 ½ day meeting on Health Policy and Leadership Development. The first day they talked about how policy works and the second day they talked

about Community Based Leadership skill development. The participants were very pleased and there will be money in the budget to continue the program.

Mr. Morris then discussed the definition of “rural” issues. He noted that California shows how the national definitions don’t work. He said that it is a function of the size of their counties and even the size of their census tracks. In the Office of Rural Policy they also reach into the census tracks to identify rural areas. There were census tracks in California that are bigger than counties in the East. There is a consideration of building a definition of frontier. They are working with USDA’s Economic Research Service to come up with a proposed definition for frontier. The definition will likely be a scale and have population density and consider travel distance by road to the next largest area that can provide services. He stated that when it comes out there will be a public register notice. He also said that hopefully this will be in place to target resources in frontier areas that get left out in the definition of rural.

David Hewett stated that the solution isn’t a new definition but an exceptions process. Mr. Morris said that they had an exception for California to address Shasta and Imperial County. It was written in a way that didn’t cause problems to the east. The problem is with CMS and Medicare, both of which haven’t adopted the exception. Mr. Morris stated that there is still a need for the frontier definition because the one that gets used doesn’t tell much.

Mr. Morris gave an update on things of interest this year. This included Regional Commission Meetings where stakeholders from the areas are invited to learn from the other commissions. These groups are involved in healthcare and this is a forum for people to share with each other. There will be a 340B Rural Hospital Meeting. He noted that there is legislation pending that would make Community Medicare Dependant and Critical Access Hospitals eligible for 340b and if it gets part of health care reform the meeting may get larger. Mr. Morris noted that there is the Workforce Network Demonstration that may happen. There will be around 75 awards of Quality Improvement Grants. An FQHC-CAH Collaboration Manual, HIV AIDS Best Practices Manual and Mental Health Best Practices Manual will also come out.

Subcommittee Reports

Home and Community Based Care Options for Seniors

Tom Hoyer reported for the Subcommittee. He said that Donna Hartley had put together an outline and analysis of the chapter and it would be submitted to Jennifer Chang. The subcommittee felt that the problems that were shared on the site visit were problems due to either action taken by the State, State Programs or misunderstandings by the people giving the presentations. The presenters were suggesting federal mandates to reverse state decisions,

needing more federal money for programs they administer, and wanting more flexibility. They also wanted benefits for programs like Reverse 911 and different telehealth programs. He noted that the programs were complicated and that most of the people running them don't know where the authority lies and what the options are because they have come in the middle of things and have to move forward. He said that the people giving the presentations were looking at their local situation and not doing a thoughtful analysis of the system. He stated that there are a lot of people doing hard work but it wasn't much help in writing the chapter. He said that they would forward the outline by Donna Hartley and list of recommendations. The subcommittee did recommend that some of the descriptive material about programs be removed from the report and noted that they would be prepared to review and edit the next draft.

April Bender noted that she thought that descriptions of the program were helpful especially with new people in the administration. Jennifer Chang said that the subcommittee agreed that they wanted it in a more blunt fashion. Tom Hoyer said that he thought that people should be able to go from idea to idea. Ms. Bender said that she thought that about integration too and when "barriers" were being discussed. She noted that specifying where a barrier is in legislation and then talking about it made it easier. Tom Morris said the problem should be sited, then talk about a possible solution, and then recommendations will be in the back.

Health Care Provider Integration Subcommittee

John Rockwood reported for the Subcommittee. He started by saying that they talked about the format for the paper and wanted to set the context for some of the recommendations they were going to make. He said that he agreed to re-write some of the first part. Mr. Rockwood read the following, "The committee finds that achieving integration can align rural health services that provide clinical quality, provide cost reduction and increase access. Specifically the quality of patient care in rural areas will improve. Policy makers and regulators promote coordination by seamless patient and information flow among and between providers along a continuum of care. The achievement of this goal will approve the health status of people in rural areas by offering enhanced healthcare quality service and efficiency. There is not a single or rigid structure for the integrated model that would fit all rural areas nationally. However, the committee anticipates that such a model would encompass logic geographical areas that would deliver the full range of health services necessary for the rural population it serves and large enough to achieve significant economies of scale. This integrated structure model should be inclusive as to all types of health care providers in the region affected. In addition to hospitals and physicians it should help coordinate the efforts of community health clinics, home health agencies, mental health services and other health professionals as appropriate to serve the full range of needs of the client population. Elements of this structure would be fair and adequate reimbursement for health care providers and could be paid on a bundle basis similar to Accountable Care

Organizations already proposed by congress. It wouldn't be limited to that. It could include leveraging technology that would permit more care being provided locally such as telemedicine networks and specifically eICUs and other applications." Something interesting that the subcommittee learned at Sutter was that they are running eICU and that a byproduct is not just the ability to provide efficient oversight of intensive care patients but also to create a huge amount of data. They were able to pinpoint where the H1N1 virus is most prevalent and some mutations of the virus that everyone should be concerned about. They know it before every one else. This kind of data allows them to get ahead of the curve and understand what the public health issues are and also looking at patients and making sure that get the right kind of care. Other components that he mentioned were centralization of services, credentialing and financial functions. Mr. Rockwood ended by saying that it would promote continuity of care and encourage preventative care.

David Hewett commented in reference to the report. He noted that as you work through the narrative it gets in the way of the ideas. Quite a bit of that could be put in appendices and made reference to because the report doesn't flow. Tom Morris said that they want the chapters to have a similar look from chapter to chapter and since they are recommending back to the secretary that they need to get into the specific issues and if it is buried in the appendix that no one would look at it. He recommended keeping it in so that it would be a smooth transition from one section to another. Deborah Bowman said that she thought that the key is that the secretary sees the recommendations. She said that the Secretary can then question why it has been recommended. Mr. Morris said maybe they could switch to having a vision paragraph, then the recommendations and the rest of the chapter is used to explain why these were recommended. The committee agreed that this was a good idea.

Primary Care Workforce Subcommittee

Robert Pugh reported for the Subcommittee. He stated that they visited Amador Sutter Hospital and one of its clinics. Mr. Pugh said that California is in a state of crisis but that some of the crisis is unique to their state and that puts it in a unique place. Some of the California problems don't apply to the rest of the nation. Some of the things covered in the draft workforce report are right on target. One of the main things that was recognized is that resources are stretched, especially for personnel. Mental health is a huge problem and primary care physicians have to provide mental health and behavioral health services. Sometimes this is happening without the physicians having the adequate training or reimbursement for these services. Mr. Pugh noted that this part of California has become a popular place for retirees and they are moving to the rural areas where there are limited resources. He said that the PRIME program was the highlight of the visit. The PRIME program is a great project and is a great benefit when addressing workforce issues. These type of programs help address workforce challenges and

barriers that the country is facing. There is not a federal strategy to these types of programs. In California the PRIME program is run by the UC University system but is not supported by the State. He then noted that in some of the remote areas there is only one practitioner. This is a real issue and there may be some ways that technology can help with that or other resources. One of the PRIME students confirmed that the National Service Corp Program should be more flexible and that is part of the draft chapter. It would enhance the tailoring of programs to local rural needs around the nation. Telemedicine and technology has a role to play to allow more cooperative arrangements between provider institutions and larger markets in outlying rural areas. Technology can be a potential retention tool and it can be a way to recruitment. Mr. Pugh stated that overall the message is that the intervention of technology and incentives around distribution of workforce into rural areas is a way to increase access of needed services to rural residents.

Deborah Bowman asked Robert Pugh if he heard about the problems of broadband in the area. She said that if they promote telehealth they have to understand that there has to be the infrastructure in place and it isn't. Mr. Pugh agreed and said that they were in Pioneer and the doctor said that his cell phone wouldn't work there.

Larry Gamm added that when looking through their report that what is missing is a relationship between various residency programs and funding from the National Health Service Corp. Each of these contributes to the supply of rural physicians but various points are weak within the system and are losing people along the way. Have people put together a system flow to find where in the "pipeline" people are being lost and the weak points are so that it can be fixed to make sure that people go to rural settings. Tom Morris said that he doesn't believe that information exists in one place. There is nothing comprehensive like that. David Hewett said that it is relevant to recruitment and retention and that it took nine months to get licensure cleared for a recruit and that the corporate practice of medicine is also an issue. Those pose a huge barrier to recruitment. They are state issues but in some way they should be acknowledged. He asked how those issues could be dealt with in the chapter of the report. Tom Morris said that they will state that the biggest problems in California are the corporate practice of medicine and delay in licensure but that they are state issues and beyond the scope of the committee. Until they are addressed there are going to be problems. Tom Hoyer said that the words "corporate practice of medicine" rang a bell with him and that there may be areas where the federal government might want to intervene to establish national policy if there are issues in enough states that relate to it. A committee members said that they had been told that there were five states with that issue. Darlene Byrd said that delay of licensure was not unique to California because she heard it during a Critical Access Meeting in Arkansas and that some of the hospitals lost its recruits due to delay. Robert Pugh noted that the committee did discuss these issues and there is a lot of

stress around the subject. He noted that licensure can be contentious because you get into constitutional and states rights issues. These need to be looked at and there needs to be a policy as regards to this issue. A committee member said that the CHCs can employee doctors in California.

Deborah Bowman said that the nonprofits they talked to said that they run into budget issues because the Governor and legislature can't agree on a budget so the agencies can't get their federal pass through money for 3 or 4 months. She said that the agencies struggle to operate and have to get a line of credit and that costs them more money because they have to pay interest. They were asking for the Federal Government to mandate the money be passed through whether or not the Governor and legislature can decide on a budget. Tom Hoyer said that congress appropriates the four quarters of the Medicaid appropriation, 3 from the current year and 1 from the future year in order to get the program passed. He suggested that could be a type of recommendation that is made.

Tom Morris said that the corporate practice issue is something that NAC would have to decide what to do about. He said that they had heard from every speaker that it has creating problems.

2011 Report Topics Discussion

Larry Gamm said that the topic of rural public health is an issue and rural public health workforce. He stated that it had been an issue since 1999 and that was when it was last addressed. He nominated it for a 2011 topic.

Tom Morris said that health reform, whether it is big health reform or just insurance reform and Medicare, is still going to give opportunities and they could focus on that.
He stated that they should brainstorm ideas as back-up plans. Maggie gave Mr. Morris a list of topics that included Medicaid reform, having a sliding fee scale, mental health prevention and making long term care insurance mandatory.

David Hewett stated that he would endorse the Medicaid issue. Medicaid will be looked at when looking at long term care. Mr. Morris requested that they research what the rural angle is and how the issues are more important than the urban ones with Medicaid. David Hewett said that it has had a huge impact on the number of kids that aren't insured and the number of Medicaid expansions that have occurred. It removed the urban rural differential. Deborah Bowman said that all 50 states are so different in how they operate their Medicaid program. She stated that she struggles with that and wonders how such unique programs can be addressed on a global level. Mr. Morris said that the USDA came out with the most recent "Rural at a Glance" report and an interesting finding is the persistence of child poverty in rural areas relative to urban. He

said that they should take on the issue of how child poverty affects the continuum of health and human services. John Rockwood was concerned was that the topics of the report aren't focused enough. He stated that there are only 6 days that they meet and if they aren't picking the right topic that it demeans their input. It would be better to pick a couple specific areas of focus and ask what problem is that is trying to be solved and make sure that it is a problem that people think should be solved. He requested sending out information that has already been written and researched on the subject. It would help to use the site visits more effectively. Mr. Morris said being more focused is a good idea. He then stated that the committee may only have 6 days together but his office is putting in many more hours and work hard to pull all of the top research and glean it for the committee in a way that they can pick and choose. Mr. Morris then stated that they could be more focused. He stated that the challenge is that they have the health and human side and there need to be topics for both sectors. Health is a bit easier from a federal perspective than human services. He stated that they have become less specific to accommodate the new structure. He welcomed any ideas about finding a way to narrow the target.

David Hewett suggested the topic of best practices for the 2010 report. He said that it is a struggle in a system to implement best practices. He suggested discussing how to hold the providers and institutions accountable for implementing best practices. He requested looking at approaches that are successful and also look at failures.

Mr. Hoyer noted that they have persistently said that integration of programs through local leadership is the real advancement in Rural Health and Human Services and it would help to find places where it happens so that examples can be included. It is a way to express that you can't keep a program sustainable, even with funding, if you can't find a person to exert strong leadership.

Larry Gamm asked if there has been cross section work like education and healthcare. Rural schools and health are two dominate institutions in rural communities. In terms of Rural Health and Human Services should education be included under human services and if so should the committee take a look at collaborative ventures that are occurring? An example is school health clinics. Mr. Morris responded that it depends on what is considered the goal of the committee. This moves towards broader community development concepts. He said that he has always moved towards more specific program regulatory items. Mr. Morris said that it is your committee and we want to be responsive to you.

David Beasley brought up two ideas and the first one was the domestic violence issue and he would like to get it on the agenda. He said that the issue came up during the site visit at Sutter Amador. He stated that they were talking about mental health issues and immediately they

spoke about substance abuse and domestic violence. His next idea was to look at regional leadership programs in the country because some have remarkable success. He stated that if going to the best practices approach and making a statement about the relevance of local community leadership then it may be good to look at all of those different programs. Mr. Morris replied that when you are on your 4th year with the committee that you have seen the "good, bad and ugly" when you get out there. He said that by the 4th year people state that they could fix all of the programs but until there is a person in the community that can make it all work than it doesn't really matter. Tom Hoyer said that something that takes away committees credibility is to ignore the "leadership" problem and say that if they are given more of "this or that" then it would work. He stated that it tells the people reading the reports that they aren't looking past the mechanics of the program to anybody implementing it. Mr. Hoyer said that is a mistake and tends to make people lose faith in government. Larry Gamm stated that he had done a study on rural leadership around community health partnerships and one of the issues was the over burdening of local leaders in rural areas. The same leaders were on the cancer coalition, youth leadership and involved in many other programs. April Bender noted that in terms of leadership and community development that people should be looking at workforce development as economic development. She was impressed by the marketing materials from Sutter Amador Hospital. She said that they market their quality and successes and how much money is going back into the community. Maybe Health and Human Services can't directly address those but they can be used as criteria in solicitations. She stated that in a solicitation they can say, "here are the 5 things that we know will help you be successful" and requiring them.

Jennifer Chang noted that they will compile the ideas and if there are additional ideas to e-mail them and they will add them to the list. Ms. Chang said that they would probably take a vote in November.

Tom Morris said that they would go back 5 or 10 years and see what the topics were and they could make a conference call to discuss what the focus should be. He reiterated that they are there to staff the committee and they want consensus on what is the best way to go or how to merge together the "big picture" issues and the incremental issues.

Deborah Bowman asked how they address the human service issues in context with the people who bring the health perspective to it. She stated that she struggles with that as a fairly new committee member. She said she consistently hears about behavioral health issues in rural communities. How does that impact families and children and what could Medicaid do in that area? She wonders if that is something they should focus on. It does bring in the health and human services perspective. Rates of suicide in rural communities are related to lack of behavioral health services in those communities. There are mental health experts and behavioral health experts, so should this committee look at those types of things or has another

group look at that. Mr. Morris stated that behavioral health is the best way to cut across the two sectors and there is a lot of research to look at but also a lot of gaps. That would be a rich area to focus. David Hewett said it is a rich area in which very little progress had been made. John Rockwood said that he thinks it is a mistake to look at how to fix “what is right now” and that it is narrow thinking. If there is something that should be in legislation that isn’t we can suggest pilot projects. He suggested looking at newer concepts and if they aren’t in legislative form than it can be suggested that there is a pilot program or a way to test the hypothesis.

Jennifer Chang asked if they would like to have a conference call in a couple of months and the committee said that would be a good idea.

Letter to the Secretary

Mr. Morris suggested that the comments for the Letter to the Secretary be done by e-mail because so many of the committee members had left the meeting early to get to their flights in time.

Public Comment

John Rigg, Vice President of Regulatory Affairs, California Hospital Association thanked the Committee for coming to the State of California. He stated that they have seen a unique state with unique geographies and there are unique challenges. He appreciated that the committee is mentioning in their report to the Secretary some of the challenges that are unique to California. He brought to attention that California has uniquely large counties that affect the eligibility for CMS program services and reimbursement systems in the State. They also affect physician recruitment. Anything that is at the county level with the large counties disproportionately affects states in the west. In the state of Nevada because of the presence of Reno, is considered a metropolitan area. The entire Cascade Range in Washington State is considered metropolitan for the same reason. He stated that these are all areas with very large counties, low population densities and rural areas but because of the large counties are similarly affected. It is a big policy concern and would appreciate anything that you could include in your communications with the Secretary. Another issue is the physician employment issue through Corporate Practice of Medicine. This is not just a California issue. There is Texas, Colorado, California, Ohio and Iowa that have some type ban on Corporate Practice of Medicine on the books. It may have made sense in the 1930s or 1940s but it no longer makes sense. The last point is the reimbursement for telehealth. The benefits of telehealh for physician recruitment and retention in rural areas and expanding specialty services to rural areas and providing patient centered care in their local communities. Once again he thanked the committee on behalf of the California Hospital Association.