September 8-10, 2002, Pray, Montana

Health Resources and Services Administration
Office of Rural Health Policy

Pray, Montana
September 8-10, 2002

Meeting Summary

The 42nd meeting of the National Advisory Committee on Rural Health (NACRH) was held on September 8-10, 2002 at the Chico Hot Springs Resort in Pray, Montana.

Sunday, September 8

Call to Order

The Honorable David Beasley, Chair

Governor David Beasley convened the meeting by welcoming members and guests and by explaining the purpose and function of the Committee. He then introduced Committee Member Jim Ahrens who welcomed the group to Montana.

Governor Beasley also introduced three new members of the Committee: Joellen Edwards from Johnson City, Tennessee; Michael Enright, Ph.D. from Jackson Hole, Wyoming; and Evan Dillard from Jasper, Alabama. The other members present were: Jim Ahrens; Stephanie Bailey, MD, MSHSA; David Berk; Steve Eckstat, DO; Keith Mueller, Ph.D.; Sally Richardson; and Mary Wakefield, Ph.D. Those not in attendance were: Glenn Steele, M.D., Ph.D.; Raymond Rawson, D.D.S.; Rachel Gonzales Hanson; Monnieque Singleton, M.D.; and Dana Fitzimmons, R.Ph. Present from the Office of Rural Health Policy (ORHP) were Marcia Brand, Ph.D., Tom Morris, MPA; Michele Pray-Gibson, MHS and Amy Elizondo, MPH.

After acceptance of the minutes from the June 2002 meeting of the NACRH, Governor Beasley provided an overview of the Montana meeting, explaining that it would focus on the report on quality that will be sent to the Secretary, Department of Health and Human Services (DHHS) in March and the white paper on rural workforce issues. He then introduced the first speaker, Kip Smith, who spoke about the Rural Hospital Flexibility Grant Program (Flex) and Small Rural Hospital Improvement Grant (SHIP) Program.

Working with Providers: The Flex and Ship Programs

Kip Smith, Program Director, Montana Health Research and Education Foundation

Mr. Smith began his presentation by reviewing the Federal statutory requirements for the Flex Program and its operations in Montana. Created by the Balanced Budget Act of 1997, the program provides grants to states to plan and implement rural health networks and designate small rural hospitals as Critical Access Hospitals (CAHs). The CAHs receive cost-based reimbursement from Medicare and six states, including Montana, provide cost-based payments through their Medicaid Programs. The program also supports the expansion of emergency medical services (EMS) in rural areas. Mr. Smith reported that as of August 1, 2002, 1178 eligible rural hospitals had been identified nationwide and 657 had been certified as CAHs. An additional 129 hospitals are pending certification. The program is funded at $25 million and a reauthorization for the next five years has been approved in the House and the Senate. The program has its origins in the Montana Medical Assistance Hospital Demonstration, Medicare's first major experiment with the concept of rural critical access hospitals.

The Flex grantee in Montana is the Montana Department of Public Health and Human Services. It contracts the majority of program activities to the Montana Health Research and Education Foundation. These activities include technical assistance to hospitals and their communities in the CAH designation process, educational meetings and other support functions. Strategic Planning and continuing education in rural EMS are done in coordination with the Critical Illness and Trauma Foundation of Montana. There is a mini-grant program, which provides funds directly to the CAHs for local use. Mr. Smith emphasized that the Flex program also supports quality of care activities through collaborations with the CAH Quality Improvement Network and the Montana Quality Assurance Organization. These efforts to improve quality of care in the CAHs were addressed in detail by the second two speakers at the meeting.

In response to a question from Dr. Bailey as to why the program seemed to be working so well in Montana, Mr. Smith explained that rural hospitals in Montana were independent-minded organizations that responded well to the facilitative (rather than prescriptive) approach taken in the administration of the program. The State does not mandate specific networking arrangements, but relies on communities and hospitals to make these decisions. Dr. Bailey also asked if the mini-grants were competitive and was told they are.

In the second part of his presentation Mr. Smith described the SHIP grant program, which helps small rural hospitals pay costs related to PPS implementation, compliance with the Health Insurance Portability and Accountability Act (HIPAA), and quality improvement activities. It is

anticipated that grants will be awarded by September 30, 2002 in estimated amounts of $11-18 thousand per hospital. The response to this new Federal program, administered by the Office of Rural Health Policy, has been overwhelming. Almost 1500 hospitals have applied, many more than anticipated. Most of the money goes directly to hospitals, but a small portion will be used by some State Offices of Rural Health for expenses to administer the program in their states. The House has appropriated $20 million for the program in 2003, but the Senate is yet to act.

Mr. Smith complimented ORHP for creating an application process for the program that was both effective and easy to follow. He also complimented ORHP and the States for keeping the program overhead expenses so low. He urged more support from the SHIP for network development activities and the creation of a Technical Assistance Center for the Program.

Statewide Quality Efforts in Montana

Janice Connors, Deputy Director, Montana-Pacific Quality Health Foundation (MPQHF) and Cathy Pfaff, Director, Montana CAH Quality Improvement Network (QIN)

Ms. Connors began the presentation by describing the roles and responsibilities of the Montana-Pacific Quality Health Foundation which is the Quality Improvement Organization (QIO) (formerly known as the PRO) for Montana. The Foundation is a nonprofit organization that has Federal and state contracts for quality improvement. Its largest contracts are with Medicare and the State Medicaid agency. It also serves as the QIO for Hawaii and Wyoming. The Foundation has an ongoing collaboration with the Montana Hospital Research and Education Foundation to improve the quality of care in CAHs.

After describing the special challenges of collaborative efforts in Montana caused by the widely scattered and extremely rural population of the State, Ms. Connors outlined the current scope-of-work for Medicare QIOs. It includes quality initiatives aimed at nursing homes, home health agencies, hospitals, physicians and underserved rural beneficiaries. She presented specific activities undertaken to address the needs of each group of providers. The Committee was particularly interested to learn that the first publication of statewide quality data on nursing homes will be published soon.

In the hospital arena, QIOs are focusing on the collection and analysis of data on acute myocardial infarction, heart failure, pneumonia and the prevention of surgical infections.

In the outpatient arena, the QIO is working with physicians on electronic systems to improve care for chronic disease patients and is promoting increased use of preventive services.

The QIO has begun to identify disparities of care between CAHs and urban hospitals in the state and will develop interventions designed to eliminate the disparities. Unlike most states, the focus is not on racial or ethnic groups, which are not significantly represented in Montana, but on disparities between urban and rural populations in the State.

The QIO is also promoting public dissemination of performance data. Releases of hospital and home health data are planned over the next two years. Finally, the QIO is providing outreach to consumers on quality initiatives and handling beneficiary complaints.

At the end of her presentation, Governor Beasley asked Ms. Connors whether she anticipated any litigation from the release of quality data on nursing homes. She replied that the data was of high quality and that litigation was not expected. The QIO will provide technical assistance to facilitate the use and interpretation of the data.

Mr. Morris asked whether the four hospital measures of quality required by the Medicare Program were relevant to CAH hospitals in Montana. Ms. Connors replied that the measures are relevant to the Medicare population and that participation in these studies by the CAHs, while not required, has been increasing.

Ms. Conners indicated that funding for QIOs has been reduced 15-20% over the past few years. The Federal Office of Management and Budget did not provide additional funding to the Medicare QIOs for including CAHs in the hospital studies or for other rural activities required under the QIO contracts. Ms. Connors also explained that QIOs get no credit in the Medicare contract award process for efforts to work with Critical Access Hospitals, and those more appropriate credits and incentives would be helpful in the future.

Dr. Enright asked about the electronic system to help physicians manage their patients with chronic diseases and learned that 142 physicians are already participating in this new endeavor.

In response to a series of questions from Dr. Wakefield, Ms. Connors described the 800 number managed by her organization and other systems for dealing with beneficiary complaints in Montana. She also described the work that is being done to review the quality of care received by Medicare transfer patients.

Ms. Cathy Pfaff, Director, Montana Quality Improvement Network (QIN), was the second speaker for this segment of the meeting. Her presentation focused on quality improvement activities undertaken by the Montana CAH Quality Improvement Network. The Network is funded through the Flex program and currently has 29 CAH members. Ms. Pfaff described the typical CAH member as a community-based organization that usually includes a swing bed

program, skilled and intermediate nursing home beds and ambulatory clinics. Some CAHs also include home health services, wellness services and public health programs.

Each QIN is charged with developing quality assurance and education programs for its members, including statistical reports to hospital boards, annual program evaluations to satisfy CAH requirements, medical staff credentialing systems, and peer review programs. A typical first project is to develop a rural model for a comprehensive, integrated approach to quality improvement in CAH settings. In pursuit of this goal the staff developed some general principles and recommendations to guide their work. The overall approach to quality holds that it must be a system-wide function, that all levels of staff should be involved, that Quality Improvement needs to be action oriented in CAH facilities and that CAHs must begin to move toward a data driven decision-making process.

The Network has started a benchmarking project involving 12 facilities and 13 quality indicators. The indicators include admissions, returns to the ER, Medicare and Medicaid days, length-of-stay and other basic measures. Many CAHs were challenged to collect even this level of data and overall progress has been slow. New measures such as infection rates and mortality rates have been added as the CAHs acquire more experience. The network is also trying to identify some industry-wide data that can be compared with the Montana experience. Reports are provided to the CAHs on a quarterly basis. They include both facility specific data and peer group data for groups of like facilities. It will be at least a year before any significant results will be available.

The Network has established a 7-member physician Peer Review Panel composed of Physicians who practice in CAHs across the state. Their enthusiasm for the work has been high. Their agenda calls for 5 emergency room studies and 6 inpatient studies. The inpatient studies include stroke management, dehydration/volume replacement, OB issues, chronic heart failure and others. The emergency room studies include chest pain, abdominal pain, trauma mortality and respiratory distress.

Ms. Pfaff reported several important lessons learned from the first year of activity by the network. First, quality time together for the network members is important and has intrinsic value beyond the scope of network activities. Second, a flexible program structure for the Network members with continuous ongoing refinements seems to work best for most members. Third, the Network must find a way for continuous support after the Flex grant expire. Fourth, frequent communication between the member and the involvement of top leadership at the CAHs are essential.

The presentation covered a lot of ground and generated several comments and questions from the Committee. Dr. Enright stated that he would like to see more attention to quality issues in mental health and substance abuse in rural hospitals. Ms. Pfaff responded that mental health resources were scarce in Montana and that CAHs had only a limited ability to deal with these issues. Behavioral health was not in the top 20 issues identified by the hospitals.

Ms. Richardson asked about CAH facility characteristics that differentiate success and failure with quality activities. Ms. Pfaff replied that success seems to depend largely on leadership by the hospital CEO and board members. She also stated that success depends upon a willingness to examine substantive issues rather than simply dealing with paper requirements. Mr. Smith then highlighted the tremendous resource differences between CAHs in dealing with quality issues.

Mr. Morris asked for specific recommendations on statutory or other changes that may be needed in the quality arena. Ms. Pfaff responded that legislative requirements imposed without resources to carry them out are a particularly great detriment to quality improvement programs. Ms. Connors added that a greater investment in information technology should be part of the solution. Mr. Smith supported her, noting that some hospitals and nursing homes have old computers or no computers, as well as limited phone lines. His office has bought computers for some facilities.

Dr.Mueller asked whether quality improvement has community value beyond the hospital setting. Ms. Pfaff mentioned the Network Physician Peer Review Panel as one starting place for greater value in the community.

Governor Beasley ended the presentation by asking the speakers to send any further recommendations they might have to the staff.

Report Updates

Tom Morris, ORHP Staff: Quality Report; Michele Pray-Gibson, ORHP Staff: Workforce White Paper

Mr. Morris began with a review of the draft report on quality that was circulated to the Committee. He asked for comments and suggestions from the Committee on material to include in the report.

Mr. Dillard questioned whether accrediting organizations like the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) should be asked to think about different and

lower threshold guidelines for their surveys of small rural hospitals. Mr. Morris answered that the Secretary, DHHS has little authority over these organizations, but that the Centers for Medicare and Medicaid Services (CMS) does work with them and the states on survey guidelines and issues. He asked for specific examples of requirements that do not fit small rural hospitals. Evan agreed to provide some examples.

Dr. Mueller recommended that the Secretary develop a models-that-work program to showcase best practices in quality, based on the Models That Work program run by the Health Resources and Services Administration. He also advocated for a regulatory framework that is more collaborative and less prescriptive in its approach to quality assurance. Other members of the Committee strongly endorsed this recommendation. Dr. Mueller also asserted that quality is a "bottom-up" activity, which means that DHHS needs to strongly increase its emphasis on investigator-initiated research.

Dr. Eckstat supported Dr. Mueller on the need for a more facilitative approach to quality assurance and urged the development of specific examples of how it might work.

Dr. Bailey questioned whether some of the resources to combat bio-terrorism might also help develop information systems related to quality. She endorsed the network approach to quality adopted in Montana and emphasized that quality must be part of every job.

Ms. Richardson recommended that QIOs receive some sort of credit in the CMS contract renewal process for working with CAHs in their states. She also highlighted the need for greater flexibility in reimbursement systems that will allow facilities to better address their quality issues.

Dr. Wakefield mentioned that CMS is spending a considerable sum on consumer education in quality and stated her hope that some of this would reach rural consumers. She also wants to make sure that the Agency for Health Research and Quality in DHHS includes a rural component in its forthcoming report on quality. Further, she noted that the National Quality Forum is coming out with hospital performance measures and needs to look at them from a rural hospital perspective. Finally, she suggested that CMS could work with the State Survey Agencies to help rural hospitals better address quality assurance requirements.

Ms. Edwards stressed the need for approaches that will increase leadership capacity on quality improvement issues in rural hospitals.

Ms. Michele Pray-Gibson and Ms. Amy Elizondo provided an update on the Workforce White Paper, which the Committee plans to send to the Secretary in March or April 2003. Ms. Pray-Gibson explained that the White Paper is a vehicle which gives the Committee more latitude to

address some global workforce issues that are not under the immediate purview of the Secretary. She would like to have a draft in January 2003 that is almost complete and ready for final review by the Committee.

Dr. Wakefield recommended that pharmacy technologists be included in the list of occupations covered by the report since there is a widespread need for them in rural areas of the country. She also suggested that staff look at data from the National Association of County Health Officials on the staffing of public health facilities in rural areas. She further suggested that rural shortages of emergency medical technicians should be addressed in the report.

Ms. Richardson asked that Clinical Social Workers be included in the report. She also mentioned that the role of vocational schools in the health professions should not be overlooked in the report.

Dr Eckstat cited the deplorable state of both dental health and mental health in rural communities and urged that the white paper call attention to needs in these areas.

Mr. Berk mentioned that in the nursing profession and other health care disciplines there are few educational or career ladders for workers. Many of them have to start all over again with their education if they wish to move to the next level.

Dr. Mueller spoke about the role of cost-based reimbursement in recruitment and retention of health professionals and the need for progress is recruiting from immigrant populations that reside in rural areas.

Mr. Dillard described gender issues that effect career choices in health care, citing the example of male workers who object to being called nurse.

HHS Update

Marcia Brand, PhD, Director, Office of Rural Health Policy

Dr. Brand briefed the Committee about the rural initiative recently announced by the Secretary, DHHS, at a ceremony at which both she and Governor Beasley were present.

In keeping with the Secretary's goal to make DHHS the federal focal point for rural programs and initiatives, he announced that a cooperative agreement will be awarded to establish a Rural Assistance Center. The Center will provide information on Federal funding opportunities; information on rural policy and legislative issues; a web-based grant application process; an 800 number for inquiries and information dissemination; and will include all DHHS programs, not just

those involving health. The Secretary also announced that rural issues will receive more specific attention in the Department's legislative and performance management processes and urged all agencies in the Department to try to better quantify their ongoing investments in rural programs. In addition, he mandated the creation of a permanent departmental workgroup on rural health and the development of new demonstration programs to help rural communities.

Dr. Brand announced that the Secretary has decided to expand the scope of the National Advisory Committee on Rural Health to include human service programs and issues. Nominations for an additional five members of the Committee will be solicited soon using the same process as for current members. The new members will attend the March 2003 meeting. Since this will be a major expansion of the Committee's responsibilities, Dr. Brand ask the Committee to be flexible as questions about Committee structure and operations are addressed.

Dr. Brand indicated that the Department is working to define a new type of provider called Frontier Extended Stay Clinics. These will be facilities that can provide short over-night stays for patients who need observation or who are unable to travel due to weather conditions. She announced that in FY2003 there is Senate language for a demonstration of these new providers. Mr. Ahrens warned about the dangers of keeping people who need to be in a real hospital in a clinic overnight.

Governor Beasley closed the day's meeting by asking for public comment. None was offered.

Monday, September 9

The Committee departed for site visits to the Livingston Memorial Hospital in Livingston, Montana and Pioneer Medical Center in Big Timber, Montana.

Qualified of Care in Rural Hospitals

Mr. Sam Pleshar, Administrator, Livingston Memorial Hospital and Ms. Sandi Harker, Community development Director, Livingston Memorial Hospital

Following a tour of the hospital, Mr. Pleshar introduced Ms. Sandi Harker who spoke to the Committee about quality of care at Livingston Memorial. The hospital was designated a CAH in March 2001. It provides a comprehensive array of services including acute care, a Rural Health Clinic, a second ambulatory clinic, home care, home oxygen, hospice care and a wellness center. The CAH receives no tax support and has lost money over the past four years. After losing staff, they hope to break even this year. Most of the physicians and nurses are board certified and average tenure of staff is excellent.

Quality issues of concern to the hospital are average length of stay, proficiency of laboratory staff, error rates in the pharmacy, patient satisfaction and patient loyalty to the home oxygen service. The challenges they face in assuring the highest quality of care are staffing shortages at all levels, access to new technologies, an aging facility and regulatory issues such as laboratory and home care standards.

Governor Beasley asked if the hospital staff would provide the Committee with examples of regulatory burdens and Ms. Harker agreed to furnish some additional specific concerns.

Ms. Harker mentioned that the loss of funding for time-limited grant programs will pose major problems for the hospital. She cited a diabetes project, funded by a Rural Health Outreach Grant, and the Wellness Center, also funded by a grant. It will be difficult for the hospital to continue these programs after the end of grant support because there are no allowable reimbursement streams under Medicare.

The hospital is meeting its challenges in providing quality care by participating in the Quality Improvement Network for CAHs in Montana and through affiliations with larger facilities. The hospital is affiliated with the Deaconess Billings Clinic and receives support from them in such areas as visiting specialists and access to newer technologies.

When asked how government could help, Ms. Harker offered the following recommendations: 1) allow greater flexibility in reimbursement for home care and maintain the ten percent add-on for these services; 2) provide support for capital financing; 3) loan repayment programs for laboratory technicians and pharmacists; 4) better integration of regulatory requirements; and 5) longer-term grant support.

Pioneer Medical Center

Mr. Cody Langbehn, Administrator

Mr. Langbehn conducted a tour of the hospital and then spoke to the Committee about the facility. He said that CAH status is essential to its survival. After closing in 1995, the hospital was reopened in 1996 and attached to a nursing home. The facility now provides acute care, skilled nursing, hospice care and assisted living services. With help from the Montana Quality Improvement Network, the hospital is just beginning to develop measures of quality. Some of the biggest challenges they face are HIPPA costs, the need to pay more competitive wages, recruitment of nursing staff (they have developed an innovative program to recruit nurses from the Philippines) and shortages of Certified Nurse Anesthetists.

The Governor's Blue Ribbon Task Force on Health Care Workforce Shortage

Mr. Loren Soft, Chairman

Mr. Soft reviewed a recently completed health workforce study commissioned by the Governor of Montana. He summarized the major findings of the report as follows:

1. Funds for the education and training of health professionals are lacking
2. Health care workers often lack career ladders to foster their professional development
3. Job stress is increasing and patients are more difficult to handle
4. Paperwork burden is a huge issue for health professionals
5. Staff-to-patient ratios have become unmanageable
6. The workforce in healthcare is aging-out
7. Oppressive state and federal regulations
8. Long hours and overtime for health professionals
9. Lack of professional liability insurance
10. Zero tolerance for errors in an overtaxed system
11. Inadequate reimbursement
12. Worker-management conflicts need to be addressed

The report included a wide range of proposals to deal with these issues and will be sent to the Governor on September 26, 2002.

Tuesday, September 10

Governor Beasley reminded the Committee that the March meeting will be in Washington, D.C. He also announced that the June meeting will probably be held during the 1st or 2nd week of June in San Antonio and Uvalde, Texas. He suggested that Iowa and West Virginia be considered for the September meeting and invited members to e-mail Mr. Morris with their suggestions for the location of that meeting.

There was a brief discussion about the letter to the Secretary on the Montana meeting, which will be drafted immediately following the meeting and circulated to the Committee for comment. The letter will reflect the Committee's focus on quality and manpower issues.

Governor Beasley asked the Committee to begin thinking about topics to address after the manpower and quality papers are completed, keeping in mind the expanded charter for the Committee. He suggested the topic of AIDS in rural America because it is both a health and human services issue and would be a nice fit for the expanded Committee. He also mentioned telehealth as a possible issue. He and Mr. Morris also suggested that the Committee could focus on access to capital.

Dr. Mueller and Mr. Ahrens suggested that the Committee produce a white paper on community development because health care is often overlooked as an integral part of community and economic development.

Mr. Morris announced that he would send an E-Mail to the Committee on recent legislative developments.

In closing the meeting, Governor Beasley extended his thanks to Mr. Ahrens for making the arrangements and to all those who contributed to the success of the meeting.