June 12-14, 2005, Johnson City, Tennessee

Health Resources and Services Administration
Office of Rural Health Policy

Johnson City, Tennessee
June 12-14, 2005

Meeting Summary

The 50th meeting of the National Advisory Committee on Rural Health and Human Services was held on June 12-14, 2005 in Johnson City, Tennessee.

Sunday, June 12, 2005

David Beasley, Chairman of the Committee, convened the meeting on Sunday afternoon. He and Dr. Joellen Edwards extended thanks to Bruce Behringer and Marcia Donaldson for their work in arranging the meeting.

The members present were: Evan Dillard, FACHE; Joellen Edwards, Ph.D.; Michael Enright, Ph.D.; Bessie Freeman-Watson; Julia Hayes; Joseph Gallegos; Leonard Kaye, D.S.W.; Michael Meit, M.P.H.; Arlene Jackson Montgomery, Ph.D.; Sister Janice Otis; Larry Keith Otis; Patti J. Patterson, M.D.; Heather Reed; Thomas C. Ricketts, Ph.D.; and Tim Size. Members unable to attend were: Senator Raymond Rawson, D.D.S.; Susan Birch, RN, MBA; and Ron Nelson, P.A. Present from the Office of Rural Health Policy (ORHP) were: Tom Morris, MPA; Jennifer Riggle, J.D.; Karen Stewart, M.P.H.; Deanna Durett; and Anjali Garg. Dennis Dudley attended representing the Administration on Aging, U.S. Department of Health and Human Services (DHHS), and George Greenberg represented the Office of the Secretary. Nikki Bratcher-Bowman attended representing the Office of Intergovernmental Affairs, DHHS and Lisa Park represented the Substance Abuse and Mental Health Administration, DHHS.

Welcoming Remarks

Paul E. Stanton, Jr. M.D.; President, East Tennessee State University

Dr. Stanton reviewed the geography and history of the Tri-Cities area. The area has a history of health professional shortages and a population heavily dependent on Medicare and Medicaid. TennCare, the Medicaid program in Tennessee, serves 35% of the region's population. East

Tennessee State University, in Johnson City, is working to solve community and regional health issues. The University has a strong rural mission and a long history of community partnerships to address health care issues. It has a College of Medicine nationally ranked in rural and primary care, a College of Nursing, and a College of Public and Allied Health. The University is proposing to establish a College of Pharmacy in 2006. Then, Dr. Stanton described changes at the University since 1989 and the evolution of academic programs at the school. The University is known for its interdisciplinary programs, emphasis on rural health, responsiveness to regional needs, and a high percentage of graduates locating to rural areas. Dr. Stanton also discussed health disparities in the Appalachian Region where there are high mortality rates (from all causes, especially cancer) relative to national data, as well as negative trends in cancer, diabetes and heart disease. He noted the University's efforts to better understand the reasons for excess mortality in the Region. The University has identified rural data issues and is promoting new disparities research in partnership with Federal, local, and private agencies. Dr. Stanton identified a huge need in the region for pharmaceutical assets.

Dr. Ricketts asked the speaker why more focus has not been placed on regional health disparities, as opposed to racial and income differences. Dr. Stanton replied that fewer people are aware of regional disparities and that more research is needed on the reasons for them.

Access to Pharmaceuticals and Pharmacy Services in Rural Areas

Paul Moore, D.Ph., Atoka, Oklahoma
Mr. Howard Chapman, Jr., Executive Director, Southwest Virginia Community Health Systems
Ronald Franks, M.D., Vice President, Health Affairs, East Tennessee State University

Dr. Moore: Dr. Moore spoke about access barriers to pharmaceutical services in rural areas. Only 12% of all pharmacies nationwide are located in rural areas. They serve 25% of their local population. There is a disproportionate share of older pharmacists in rural practice and large numbers of them are approaching retirement. There is a pressing need for younger pharmacists to replace them. Yet, his data showed that fewer newly trained pharmacists are choosing to practice in rural areas. He explained that the recent emphasis on clinical training for pharmacists could be a disincentive to rural practice because there are fewer sites in rural areas where pharmacists can fully utilize their clinical skills. Dr. Moore also highlighted the economic realities faced by rural pharmacies, noting that low-volume pharmacies are predominant in rural areas and are most vulnerable to Medicaid budget reductions. He explained that Medicare Part D might also increase the financial risks of rural pharmacies. He provided financial data for his pharmacy to show that even small increases in third-party drug payments and small reductions

of cash purchases for prescription drugs can have a significant negative effect on net profits. Dr. Moore described the changing demographics of the pharmacist work force including the gender shift toward more female pharmacists and the increasing focus on clinical training that may be robbing pharmacy of its entrepreneurial spirit. He repeatedly emphasized the need to protect, and expand, access to the full range of pharmacy services in rural areas, not just the dispensing of drugs. Pharmacists play a key role in the health care of their communities and are even more important as prescription drug therapies grow exponentially and the cost of drug-related problems increases. Dr. Moore pointed out that the rural elderly use medications at a higher rate than their urban counterparts. Pharmacists can reduce the rate of drug-related problems and improve outcomes. They need to be part of the healthcare team in rural areas. In rural areas, they are the most important source of information on medications and often the patient's first contact with the health care system. Dr. Moore spoke about the economic value of rural pharmacies and emphasized the need to create pharmacy education and practice site opportunities in rural communities. He ended his presentation by calling for a more level playing field for rural pharmacies and their patients in reimbursements, formulary considerations, application of any willing provider policies, and 90-day drug supplies.

Mr. Dillard asked about the involvement of rural pharmacies with rural hospitals and Rural Health Clinics. Dr. Moore said that rural pharmacists are likely to act as consultants to these entities and are often the sole local source of advice and assistance on medications and the management of drug therapies.

Mr. Meit asked about the potential for changing reimbursement policies that focus only on the dispensing of drugs, rather than the full-range of pharmacy services. Dr. Moore replied that the lack of provider status is part of the issue for pharmacists and agreed that services must be divorced from products.

Mr. Chapman: Mr. Chapman spoke about pharmaceutical programs developed by Southwest Virginia Community Health Systems, Inc., a network of Federally Qualified Community Health Centers serving Southwest Virginia. In 2002, their system received a grant of $200K to pay patient advocates to complete patient applications for free medications available from pharmaceutical companies. In a 10-month period, they served 2,536 patients with prescriptions valued at $3.1 million. The success of this program resulted in financial support from the State. Over the last 3 years, the program has supplied $8.8 million worth of free medications. The return to the State on its investment (savings to the Medicaid program) has been significant over the past 3 years. There will be a further increase in State funding for the program in 2006. The System has developed software programs to help process the applications for free medications. A major reason for the success of the program is the availability of paid staff responsible for completing the applications for pharmaceutical assistance programs. Program benefits include

improved availability of drugs, greater patient compliance with drug regimens, less frequent trips to the doctor, and financial savings to the patients. The program is an excellent example of what can be achieved with relatively small amounts of money. Mr. Chapman also described the 340B program implemented by this system. The program provides discounted drugs for eligible entities such as Community Health Centers. He discussed several different models for implementing the program, including in-house pharmacies, contracted pharmacy services, and repackaging programs. Under repackaging programs, clinics pay for medications directly to the wholesaler and also a dispensing fee or repacking fee per prescription. The two models presented - prescription drug assistance and 340B - would be replicable in other rural provider settings.

Dr. Edwards asked about barriers to participation in the 340B program because the Committee had received testimony that many eligible organizations were not participating. The speaker responded that he was unaware of any major barriers or reservations from patients. Other speakers mentioned staffing shortages and the lack of expertise in pharmacy services.

Dr. Franks: Dr. Franks spoke about the new pharmacy school that will be created at East Tennessee State University. The School has been approved as a result of the dramatic increase in demand for pharmacists nationwide, especially in rural areas of Tennessee. Currently, Tennessee only educates one-quarter of the pharmacists it licenses each year. The University has innovative interdisciplinary, rural-focused health science programs that will collaborate with the new school of pharmacy. The school will recruit from underserved regions and graduate practicing pharmacists for rural communities and hospitals. Rural networks will be tapped for teaching, service, and research opportunities. Dr. Franks discussed the University's philosophy in approaching rural needs and issues, and the integrated programs that have been designed to meet these needs. Moreover, a significant percentage of the School's medical and nursing graduates decide to practice in rural underserved areas of the State and Region.

Health Information Technology (HIT) in Rural Areas

Ms. Liesa Jenkins, Project Director, CareSpark, Kingsport, Tennessee

CareSpark is a Regional Health Information Organization working to improve health care in the central Appalachian region through collaborative use of health information technology. It is a community partnership with roots going back to 1991, and includes both public and private organizations in Tennessee and Virginia. Ms. Jenkins described regional health issues that her organization is working to solve and gave a brief history of the organization. She spoke about their strategic planning process and the overall mission of the organization to target health issues related to diabetes, hypertension, cardiovascular disease, lung disease, and preventive

health. The specific goals and objectives of the organization are in conformance with the strategic framework for HIT developed by the Office of the National Coordinator for Health Information Technology. Their goals are to: (1) provide health information on demand at the point of service (including necessary support for transition to an electronic record keeping system); (2) encourage use of evidence-based guidelines; (3) provide selected aggregate data for regional improvements; and (4) enable individuals to access personal health information through a secure Internet interface. Ms. Jenkins provided data on health expenditures in the Region and the projected economic impact of CareSpark over the first three years of the project. Information sharing will create opportunities for savings in the use of medications, improvement of diagnostic services, and reduction of adverse drug events. She reviewed the criteria for a Regional Health Information Organization, as well as HIT initiatives in Tennessee and Virginia. She also spoke about potential policy changes that will impact HIT programs.

Mr. Otis noted similarities between law enforcement and HIT with respect to the development of compatible information systems. Ms. Jenkins mentioned that some large companies are beginning to look at standards for compatibility.

Dr. Kaye said that he was impressed by the level of collaboration in the project and asked about their methods. Ms. Jenkins said that they were able to identify project benefits for all parties to the collaboration and listened to their concerns. She further stated that everyone has to be a winner and there must be a fair distribution of financial returns from the project.

Mr. Size noted the challenges in HIT created by competitive health care systems seeking to gain an advantage through their individual systems. He asked how the project dealt with this issue. Ms. Jenkins responded that her organization was giving systems a chance to collaborate and was making a "moral appeal" based on the community and regional benefits from electronic information sharing.

Family Caregiver Support for Rural Elderly

Ms. Nancy Peace, Executive Director, Tennessee Commission on Aging and Disabilities
Ms. Kathy T. Whitaker, Director, First Tennessee Commission on Aging and Disabilities

Ms. Peace: Ms. Peace described a program for rural caregiver support funded by the Administration on Aging and administered by the Tennessee Commission on Aging and Disability. Local administration is through the Area Agencies on Aging and Disabilities. Service components include information dissemination on available services, caregiver training and support, respite services, and supplemental services such as homemaker services, meals, and

adult day care. Caregiver support groups are in place throughout the service area. Rural family respite programs began in 2004. Caregivers for persons with dementia can hire their own respite provider and be reimbursed for part of the expense. Ms. Peace illustrated the successes of the program and its development of a single point of entry for services. Supplemental services in some areas now include minor home modifications; some forms of financial assistance in the purchase of needed devices and supplies for the home, and personal emergency response systems. She presented statistics on the growing number of caregivers in the region, where nearly one out of every four households is involved with the care of people aged 50 or over. She noted that more people lose work time from elderly care giving than from child care.

Mr. Size asked if there are any emerging programs involving elderly persons providing care for children. Ms. Peace replied that her organization is seeing more of this and the system needs to look at legal issues that occur when caregivers for children are deceased. The system also needs to consider the disabilities of elderly persons caring for children.

Ms. Whitaker: Ms. Whitaker discussed issues faced by rural caregivers, including isolation, transportation, and separation from extended family. She said that women who are daughters or daughters-in-law provide the majority care for elderly persons. The common problems of rural caregivers include strain, anxiety, fatigue, depression, and perceived stress. Feelings of guilt and financial strains are also important issues for caregivers. Distance and isolation are major barriers to educational programs for caregivers. Further, young people are moving away from rural communities, leaving fewer caregivers for the future. This raises doubts about the widespread assumption that strong family ties in rural areas assure that someone will always be available for a person in need. Policy makers also assume that the costs of care giving in rural areas will remain low, but they fail to account for transportation problems and limited family resources. Ms. Whitaker said that many families with caregivers lack basic amenities such as indoor plumbing, transportation, and a source of routine health care. In many instances, spousal caregivers are equally frail and impaired. Caregiver support programs are often poorly publicized and frequently require too much red tape. Ms. Whitaker presented some excellent success stories in the care of elderly persons supported by her program. The lessons they have learned include the need for community involvement; early education of caregivers; seamless and flexible delivery systems; honesty about programs and services; avoidance of medical terminology in contacts with clients; confidentiality; and acknowledgement of cultural issues through appropriate dress and use of language.

Dr. Montgomery commended the presentations and talked about factors that make some caregivers reluctant to use available services.

Dr. Kaye highlighted the stresses placed on caregivers and the effects on their health. Caregivers have high rates of mental illness, alcoholism, etc., and maintaining their health is a critical issue.

Call for Public Comment

Three people responded to the Chairman's call for public comments.

Ms. Kathy Wood Dobbin from the Tennessee Primary Care Association applauded the Committee's selection of topics and its interest in the Appalachian Region. She said that TennCare was dropping people and that Community Health Centers in the Region were looking at ways to help these newly uninsured. She noted that some providers do not use the 340B program because they lack adequate staff and pharmacy personnel. She said that small amounts of money can go a long way to improve access to pharmaceuticals and described several strategies that can be employed. Further, she stressed the need for outreach to people who can benefit from pharmaceutical assistance programs. Outreach is particularly important because many needy clients do not have a computer in their home.

Ms. Diane Goyette from the HRSA Pharmacy Services Support Center talked about the Pharmacy Services Support Center in HRSA. Technical assistance is available free of charge to organizations eligible for the 340B program.

Dr. Wallace Dicksen from East Tennessee State University talked about a new Ph.D. program in clinical psychology that was developed in response to acute shortages of psychologists in the region.

Monday, June 13, 2005

Governor Beasley convened the meeting at 8:15 a.m. There was a brief orientation to the site visits that would take place during the morning. The Subcommittees then departed for their respective site visits.

The Subcommittee on Access to Pharmaceuticals and Pharmacy Services in Rural Areas visited the Wilson Pharmacy in Johnson City, TN.

The Health Information Technology Subcommittee visited the Johnson County Health Center in Mountain City, TN.

The Family Caregiver Support for Rural Elderly Subcommittee visited Mountain Empire Older Citizens, Inc. in Big Stone Gap, VA.

On Monday afternoon, the Subcommittees returned to the hotel for Subcommittee meetings.

The Committee of the Whole was reconvened in the late afternoon for a brief discussion of Committee business and the opportunity for public comments. There were no public comments and the meeting was adjourned until Tuesday morning.

Tuesday, June 14

The meeting was convened at 8:45 a.m.

Dr. Ricketts announced the death of Dr. Jim Bernstein, one of the nation's great leaders in rural health. He reviewed Dr. Bernstein's outstanding career and suggested that the Committee find an appropriate way to recognize his work and legacy. The ORHP staff will draft a resolution that will be sent with the Committee's letter to the Secretary.

Governor Beasley asked for a report from each Subcommittee on this year's annual report to the Secretary.

Dr. Ricketts, reporting for the Pharmacy Subcommittee, said that the Subcommittee chapter would begin with clear statements of rural issues and the various forces at work that might affect access to pharmaceuticals and pharmacy services. Rural places are at risk of losing pharmacy services due to market changes, competition, workforce shortages, and other factors. The report will speak to these issues and will also touch on potential problems for rural areas in the design and implementation of Medicare Part D.

Mr. Meit reported for the Subcommittee on HIT. Its report will focus on the electronic health record and will be structured around the national strategy for HIT. The report will discuss rural issues and opportunities in the context of the national goals and objectives established for HIT. One of the biggest concerns is to create compatible information systems in the face of competitive pressures for providers to go their own way. Mr. Size reinforced the issue of system interoperability and stated that this issue goes to the heart of how rural health care will be structured in the future.

Dr. Kaye reported for the Caregiver Subcommittee. He said that the site visits had been extremely helpful in understanding rural issues. The Subcommittee report will focus on the need for increased funding of caregiver support programs; research on rural caregivers; cultural sensitivity in caregiver support programs; information dissemination; early intervention programs to assist caregiver; and other rural issues. Mr. Size mentioned the importance of faith-based groups in rural communities and this will be discussed in the report.

Following the Subcommittee reports, Governor Beasley asked for comments on the letter to the Secretary. There was a discussion on the need for feedback on the Committee's reports, and it was suggested that the Committee ask for the Secretary's guidance on future topics. Several members commented that the Committee should be more proactive in disseminating its reports. There were several suggestions on how this might be accomplished. ORHP will send the members a Power Point presentation on the Committee. Members were requested to e-mail the Committee's reports and recommendations to appropriate officials in their states. ORHP staff will draft some language for these messages.

Dr. Enright briefed the Committee on the next meeting to be held in Wyoming.

There were no public comments and the meeting was adjourned.