Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Bozeman, Montana
September 4-6, 2013

Meeting Summary

The 74th meeting of the National Advisory Committee on Rural Health and Human Services was held September 4th – 6th, 2013 in Bozeman, Montana.

Wednesday, September 4, 2013

The meeting was convened by Governor Musgrove, Chairman of the Committee. He shared that the meeting is being held in the home state of two of the committee members, Shane Roberts and Pamela DeRosier. Governor Musgrove stated that the primary focus of the meeting is on two topics: 1) The rural implication of outreach, enrollment and education in rural areas for the health insurance market places of the Affordable Care Act and 2) To examine the intersection of poverty and human service delivery in rural areas. Governor Musgrove welcomed Rene Cabral-Daniels, Christina Campos and Ginger Carpenter to the committee.

The Committee members present at the meeting: Governor Ronnie Musgrove (Chair); Rene Cabral-Daniels, MPH, JD; Christina Campos, MBA, FACHE; Ginger Carpenter, MSN, RN; John Stewart Cullen, MD; Pamela DeRosier; Barbara Fabre; Phyllis A. Fritsch, MS; Roland J. Gardner, MS; David Hartley, PhD, MHA; Thomas E. Hoyer, Jr., MBA; Michele J. Juffer; Karen Madden, MA; Barbara Morrison; Wayne Myers, MD; Shane H. Roberts; Roger D.Wells, PA-C; Christy Whitney, RN, MS.

Present from the Office of Rural Health Policy: Tom Morris, Director; Steve Hirsch, Executive Secretary; Deepti Loharikar, Public Health Analyst; Paul Moore, Senior Health Policy Advisor. Truman Fellows present: Kristen Lee and Shoshana Shapiro.

MONTANA ORIENTATION

John Russell
Executive Director
Montana Pioneer Museum
Bozeman, Montana

John Russell welcomed the committee to big sky country and to the Gallatin Valley. It is great to have a group of people from across the Country meeting in the Gallatin Valley where the Blackfeet Tribe referred to as "many coming together country". It was called this because of the array of tribes that came to the Gallatin Valley to hunt. Louis and

Clark came to the Gallatin Valley in 1805 and named the three rivers that formed the Missouri: Madison, Jefferson and the Gallatin. Fur traders John Colter and Jim Bridger passed through the area. The fur trade died out around 1840 resulting in a quiet period for about 10 years.

In the 1850s and the early 1860s there was the discovery of gold. There were many mining camps established. A mining camp to the northwest of the Gallatin Valley called Crabtown is now Helena, Montana. The Gallatin Valley was fertile also where farms and ranches were established to sell food to the neighboring mining camps. One of those who led in the first wagon trains in 1864 was John Bozeman. Bozeman, Montana was named in his honor.

In 1864, during the civil war was, the town of Bozeman was a pro-Union, pro-Republican and John Bozeman was a Democrat from Georgia. The town was almost renamed Montana City but it failed by one vote. John Bozeman was killed in 1867. History says he was killed by Blackfeet Indians but evidence shows he may have been killed by an acquaintance named Tom Cover.

In the wake of John Bozeman's death, the US Army established a fort in Bozeman. The railroad arrived in 1883 and when Montana became a state there was a contest to see where the state capital would be held. Bozeman was confident that it would be the state capital but Helena prevailed and Bozeman was given the state college. The Montana College of Agricultural Sciences is now Montana State University. The college helped stabilize the valley and helped it to grow.

Recently the economy has diversified but agriculture is still the key. Tourism and Montana State University have been a huge influence on the growth.

Hank Hudson
Former Economic Security Services Branch Manager
Montana Department of Public Health and Human Services
Helena, Montana

Hank Hudson welcomed the committee and said he was fascinated that the committee members are from rural areas from states throughout the United States.

Mr. Hudson worked for 26 years for state human services agencies. He moved from Greenbelt, Maryland where he worked for NASA to Montana to begin work in human services. While working for state human service agencies, he experienced huge system changes. There was a change from an aging service program with nursing homes; many were county operated nursing homes, to diversifying with a range of options for elderly people to remain independent and live in their homes or home-like settings. The transition took about ten years to move the system to a more respectful and principle driven service program.

Children's health insurance changes and child welfare changes were also implemented during his time with the department. Instead of putting children in foster care there were resources used to help their families succeed and protect the children.

Montana is a state of around one million people and for a public administrator that is the perfect size. It is big enough that there are adequate resources but small enough that you can work with counterparts and can easily have conversations. There were four human service agencies when he came to Montana. The state created an umbrella human service agency, the Department of Public Health and Human Services. Every community in Montana has a DPHHS Office. Montana is fortunate to be a human service system driven by principle and one of the principles is that human services must grow out of communities and reflect the needs of the individual community. The respect and dignity of individuals and respect for communities is priority in Montana.

Cost effectiveness is another key principle in Montana. Prevention is a focus so that children are not removed from homes and less people are treated for chronic illnesses. Communities are asking for prevention programs. The power of principle decision making is very important and articulating those principles to make human service agencies work is vital.

The Department of Public Health and Human Services was created because there were creative partnerships and ways to bring programs together. An example of a successful partnership is the mental health system and vocational rehabilitation system coordinating efforts. The goal is for every public health office or public assistance office to sign up a child for Children's Health Insurance Program. There is a good system in Montana of public employees and contractors working for the Public Health and Human Services. The Affordable Care Act is an opportunity to mobilize all the people in human services who have an interest in the health of Montanans and to help people understand the principles of universal coverage, participation, prevention and cost effective health care delivery.

Jeffrey K. Rupp
President/CEO
HRDC District IX, Inc.
Bozeman, Montana

Jeffrey Rupp shared that he is the resident of the Human Resource Development Council. He welcomed the committee to Montana. The local community action agency is one of ten nonprofits in Montana. The Human Resource Development Council addresses local community needs. HRDC is governed by local community members and elected officials. One third of the board members are consumers of services provided by Human Resource Development Council.

Montana is the fourth largest state with around 147, 000 square miles and one million people. Montana became a state in 1889 with three standard metropolitan service areas: Great Falls, Billings and Missoula. The five micropolitan areas in the state are Bozeman,

Havre, Butte, Helena and Kalispell. Seven counties out of the fifty six have most of the population. Eastern Montana is prairie and dominated by agriculture and that area is losing population. The western part of the state has mountains, resources and tourism and is heavier populated.

Mr. Rupp thanked the committee for the work they do on behalf of rural communities. Those who labor in rural America have done so by choice. There is something special about working in a community where you know people by name and the partners needed to solve community problems live in the town.

HHS UPDATE ON MARKETPLACE AND AFFORDABLE CARE ACT IMPLEMENTATION

Deepti Loharikar, J.D.
Public Health Analyst
Federal Office of Rural Health Policy, US DHHS
Rockville, MD

Deepti Loharikar said she would be sharing information about the Affordable Care Act with a focus on how it sets up the marketplace. The Affordable Care Act was signed into law March of 2010 and the goal is to provide affordable health care to Americans. This will happen through the marketplaces and through Medicaid expansion. Marketplaces are a structure that creates a place where insurance can be sold and purchased. There will be one marketplace in each state. Types of consumers include: individuals, families and small businesses. The three models that the marketplace can follow are federally facilitated model, state partnership model and state based model. Each state marketplace will offer qualified health plans.

Originally when ACA was signed into law Medicaid expansion was mandated for each state. The Supreme Court made Medicaid expansion a choice for each state. There is no time limit on when a state can decide to expand Medicaid so some states are still in the process of deciding. Medicaid expansion means that anyone under the age of 65 with household incomes at or below 138% will qualify. The federal government will pay 100% for the first three years and it phases to 90% by 2020.

If a state does not expand Medicaid, the current Medicaid recipients keep their benefits. Individuals not eligible for Medicaid can buy a plan in the marketplace. Incomes under 100% of the federal poverty level will be eligible for financial assistance.

Matt Heinz, M.D.
Director of Provider Outreach
Office of the Secretary, US DHHS
Washington, D.C.

Matt Heinz said that the initial goal of the marketplace during the open enrollment period is to get 15 million people into some type of coverage option. It is projected that 7 million of those people will be covered by a plan on the marketplace and the other 8 million are anticipated to qualify for Medicaid/Children's Health Insurance Program. All of the 50 states have their own marketplace based on that state's benefits. The plans are being treated by region and by state.

In June, the Healthcare.gov site re-launched. Healthcare.gov is a consumer friendly site where starting October 1st people can find costs, plans and options in each state based on a person's particular circumstances. In July and August, training for consumer assistance began. Health and Human Services and Centers for Medicare & Medicaid Services partnered with national, regional and state based organizations to provide education campaigns. Free online training courses were provided for people to become certified application counselors or to receive navigator training. Navigator grant funding went out to organizations to help fund employees and counselors to assist people.

Community health centers received assistance to employ people and do outreach so that people have access to information. Medical loss ratio requires insurance companies to use 80% of the insurance premiums they collect to care for the population they are covering. Consumers are receiving checks due to the Affordable Care Act from their insurance company because the company did not meet the 80% goal.

The Affordable Care Act is a huge priority of the President and will benefit millions of Americans who will be able to get health insurance coverage. January 1st, the marketplaces go live and insurance coverage can be purchased as soon as October 1st. A plan can be purchased up to December 15th and have it go into effect January 1st.

The application has been streamlined and it takes about 10-12 minutes for a person to fill it out. The consumer can submit the application online, by phone, meet with a navigator or a certified application counselor or mail in their application. The toll free number was available beginning in June in 150 languages, 24 hours a day/7 days a week and will only be closed for 5 holidays. There are also fact sheets on the website that can be printed to share and educate consumers.

Q&A

Roger Wells said that people are speaking about increased prices in private healthcare because of Obamacare. Private health insurance companies are trying to talk people into getting health insurance now because they are saying it will be more expensive when the Affordable Care Act is in place. Is that a reality?

Matt Heinz said that what they are seeing in state-based marketplaces is the numbers are far lower than expected. The numbers for health insurance through the Affordable Care Act are averaging about 20% lower than expected. The provider networks have not yet contracted with CMS in the federally facilitated states but in the state placed marketplaces there are impressive numbers. In New York the rates have dropped 50%.

David Hartley said that a graduate student did a project about Maine's co-op program and found out how little people know about looking at an insurance policy and assessing the value. When people chose a product, price is the deciding factor but people don't do the calculation of premium verses out-of-pocket cost. Does the website help people understand that there is more to the price than the price of the premium?

Matt Heinz responded that there is a cost comparison plan tool with bronze, silver gold and platinum plans that describes the degree of cost sharing and premium information. The tool will give the consumer detailed information and allow them to compare different plans. Depending on the person who is applying, the premium may not cost more than before for a better plan because they may qualify for a credit due to their income.

ACA OUTREACH AND ENROLLMENT PANEL: PAYERS AND PROVIDERS

Dick Brown
President
Montana Hospital Association
Helena, Montana

Dick Brown welcomed the committee to Montana and said that he appreciates that the Committee visits different states because each rural state is unique. He shared that he lives in Liberty County with 1.2 people per square mile and there are more cows than people. He was raised on a farm in northern Montana and went to college at Montana State University.

The focus of his discussion is the Montana Hospital Association and what they do, the impact of the Affordable Care Act on Montana, and about Montana Health Association's outreach and enrollment regarding the Affordable Care Act.

The Montana Hospital Association advocates for all the hospitals and members which also include physicians, long-term care and are the home health and hospice organization for the state. There are 65 hospitals in Montana and only 11 prospective payment system designated hospitals. There are 48 critical access hospitals and 3 Indian health services.

Approximately 21% of Montana's nonelderly are uninsured and 100,000 could obtain insurance through the Montana marketplace exchange. There are 80,000 eligible for Medicaid. The nonelderly uninsured is projected to drop to 10% after the reform.

Medicaid expansion was missed by one vote in Montana. In 2015, legislation will be reintroduced to try and move forward with Medicaid expansion. Montana Hospital Association strongly supports expansion and believes there needs to be reform in the Medicaid delivery system. They want to reinvest savings from the expansion to pay for future costs.

There is an active accountable care organization project in the Billings, Montana clinic. Two Billings hospitals are participating in bundling demonstrations and other hospitals are experimenting with bundling programs. State legislation has set standards for care coordination and Blue Cross Blue Shield has a care coordination project underway with providers. There is a Montana Hospital Association grant to provide care coordination in critical access hospitals.

All prospective payment system hospitals have met meaningful use criteria for electronic medical records. 34 of 84 critical access hospitals have received Medicare incentive payments. 25 met criteria for Medicaid payments and 7 met criteria for meaningful use. There was $15.5 million paid to critical access hospitals.

There are $571 million dollars in cuts for the Montana Medicare program. In rural states, $571 million is a large amount. Additional cuts under consideration total $229 million dollars. The state and health care providers will be facing this loss over the next ten years unless there is a change.

Hospitals are financially vulnerable in the future due to a loss of money on patient services, uncertain revenue outlook and pressure to reduce costs. Several of Montana's hospitals were county run and are now stand alone. They still receive a county subsidy and that is how most of the small rural hospitals make up their losses. The healthcare delivery system is transforming from the old model of paying for quantity of services to the new model of paying for quality of care, promoting wellness and coordinating care. In rural areas, small hospitals cannot stand alone and will have to partner with larger organizations in order to survive. Providers are assuming more risks since they are not just paid for care.

There may be a rough transition from the old model of delivering and paying for medical services to the new models based on quality and value. There are 26 small hospitals with 10 beds or less and if they close the nearest hospital is hours away. It is a tough situation for small hospitals and many are concerned that they could have to close.

Montana's exchange is federally run and the insurance commissioner will regulate plans. The insurance commissioner will hold town hall meetings in late September and early October. The navigator will provide broad outreach about enrollment options. Three Montana groups received federal navigator grants and community health centers have separate grants.

Hospitals and other providers can become certified application counselors and assist people in finding coverage. The Montana Hospital Association's goal is to have certified application counselors in every hospital. The Montana Hospital Association has developed an outreach and enrollment manual and will convene webinars for training. The association will assist the insurance commissioner with town meetings and collaborate with insurance companies to distribute information about the exchange.

The Montana Hospital Association members will provide leadership in helping Montanans enroll, educate staff on the insurance exchange, and will create a kiosk in the facility to assist the community.

John Doran
Director of Strategic Marketing Services
Blue Cross Blue Shield Montana
Helena, Montana

John Doran said that it is nice that the committee chose big sky country to talk about rural delivery challenges of the health care system. It is less than thirty days until the exchanges begin across the state. Key questions about the Affordable Care Act are the federal readiness, how to maximize outreach potential and who the target populations are in Montana. There is a wide range of readiness on a technological level, but most of the IT projects on a federal level are underway. Montana will have a federally facilitated exchange and Blue Cross Blue Shield Montana always planned to participate in the exchange while some other insurance companies have chosen not to participate.

In Montana, 96% of businesses are small employers. The employer mandate has been pushed to 2015 so businesses have an extra year to comply with the requirement that they provide their workers with insurance. Employers need more time and clarification on requirements and it is important to implement in a careful and thoughtful manner. Blue Cross Blue Shield has been working closely with groups to determine a strategy.

The three navigators in Montana are Planned Parenthood, Montana Primary Care Association and Montana Health Network. Navigators are not the only entities that will disseminate information and educate the public. Insurance providers are also actively educating the public.

Rural challenges include explaining how the subsidies work because most people do not understand the subsidies. Blue Cross Blue Shield has been working with Montanans to explain how insurance works and the value of insurance. The subsidy eligible population in Montana is between 138% - 400% of the federal poverty level. The average household income in Montana is just under $50,000 so there are a large number of people in Montana who potentially qualify for subsidies on the insurance marketplace.

The penalties for the individual mandate in the first year are low but in 2015 and 2016 the penalty will be comparable to a plan. The penalty will be an incentive for the people to get insurance. The insurance commissioner in Montana is pleasantly surprised with the marketplace rates. The rates are well below where they have been in the past.

The top three strategies of outreach in Montana are building an effective education, outreach and enrollment structure, using multiple channels and vehicles to reach the uninsured and provide technical assistance to outreach and enrollment partners. Blue Cross Blue Shield Montana has had a yearlong marketing campaign, public seminars and created the Health Care Reform and You website and education center.

Almost two thirds of the people in Montana will qualify for subsidized health insurance. The total population of nonelderly in Montana is 847,000. Over 100,000 people are projected to participate in Montana's marketplace and 70% will be subsidized. There is an expected 50% decrease in the number of uninsured in Montana, post Affordable Care Act implementation. The people participating are going to be across the health spectrum, it will not only be the unhealthy people rushing to the marketplace. There will be self-employed people who could not afford insurance for themselves or their employees.

Q&A

Roland Gardner asked if community health centers received navigation grants and if they were working with the hospitals to enroll people and do community outreach.

Dick Brown said that community health centers did receive funds across the state for enrollment and outreach.

Tom Hoyer asked if a coverage expansion may help achieve equilibrium between what services people want and what they really need and receive.

Dick Brown said that in the last 3 or 4 years in Montana, hospitals have been looking at how to reduce cost and manage services that are provided. Healthcare providers need to consider the care they provide and what is really necessary. Electronic health records with help reduce duplication of services because information will be shared.

ACA OUTREACH AND ENROLLMENT PANEL: CONSUMER ASSISTANCE

KaiEllen Bucher
Partner
SwiftCurrent, Healthcare Consulting Group LLC
Kalispell, Montana

KaiEllen Bucher said that she has over 20 years of experience in commercial health insurance and has worked with Medicare education and enrollment as well as assisting people in receiving subsidies. She worked with the community of Libby, Montana which is a superfund site and was deemed a public health emergency in 2003. Benefits were designed specific to their community.

Ms. Butcher stated that physical presence is important to patient buy-in so Affordable Care Act navigator physical presence in the community is important. It is also important for the navigators to know the income statistics, percentage of uninsured and the industries in the community. The best place to meet with people is a place that they are familiar with and comfortable meeting. Places that are good meeting places include: hospitals, universities, schools, restaurants and libraries. Outreach can include: radio, television, newspaper and billboards. Not everyone in rural communities has access to the internet so it is not as effective to include outreach via e-mail or the internet.

Montana has a total area of 147,164 square miles. In the winter months of the year it is very difficult to travel long distances in Montana. There are no in-state flights. Travelling would be in excess of 6,000 miles to reach all 56 county seats to hold an Affordable Care Act marketplace meeting one time. Open enrollment will be held during winter months and it will make travel difficult. There are major logistical challenges but physical presence is important for sharing information with people in rural communities.

Montana has 7 Indian reservations. The Little Shell Tribe of Chippewa Indians is a landless tribe. There are approximately 66,000 Indians and 35% of the Indians in Montana reside off a reservation. It is important for the Native Americans to know what Affordable Care Act program benefits they can receive. This population of people is going to take serious, intensive outreach and education while working through cultural barriers.

Choosing the appropriate benefits should be determined due to a person's medical needs but many times there are financial restraints. People need to be educated so they know that the insurance with the lowest premium does not mean it will be the most cost effective coverage. Finding out details about a consumer's health and their family will assist in helping them choose the correct coverage. Most people choose the lowest premium so the navigator has to have the knowledge and ability to help a consumer determine their needs. The navigator can also determine if the consumer is eligible for advance payments of the premium tax credit and cost-sharing reductions.

Ms. Bucher talked about going to Libby, Montana with money that was received from a W.R. Grace lawsuit due to asbestos related illnesses in the community. She thought that people would be glad to receive this money for testing and treatments but they were not. The people in the community were leery of a person offering money and were not trusting of a representative coming from outside of the community. It was important for her to meet with people one-on-one and to have small group meetings in order to gain their trust. Involving community leaders that are trusted by the community is also important. This is the same approach that will be needed when presenting the affordable care act marketplace to communities. Direct mail, phone calls and state-wide media campaigns did not work in Libby, Montana.

Chris Hopkins
Vice President Strategy and Business Development
Montana Health Network
Miles City, Montana

Chris Hopkins thanked the committee for visiting Montana. Montana Health Network was established in 1987 and was a group of Eastern Montana small critical access hospitals. Even though the hospitals are competitors they realized they need to work in collaboration.

It is important to reach eastern Montana ranching, farming and reservation communities. There is a declining population in eastern Montana due to younger people leaving the area and an aging population.

Montana Health Network is primarily critical access hospitals which are the center point of the town. In rural Montana, critical access hospitals are the largest employer. There are wellness programs offered by the critical access hospitals and they are always looking for outreach opportunities. The providers and staff have personal relationships with the patients and are aware of local needs. Critical access hospitals and physicians are the best resource to operate the navigator grants in rural towns.

Montana will train 32 navigators who will cover 28 counties. Montana Health Network was notified August 15th about the grant and they will utilize people who are already employed at the critical access hospitals to be navigators. The navigators will have 20 hours of online training and due to state requirements they will be fingerprinted, have a background check and a certification test.

The Montana Health Network is creating a common marketing plan. There has been a press release announcing that navigators are available. There are perception challenges regarding the affordable care act. Remote agriculture families, Native Americans and oil field workers need to have access to navigators so they can be educated on what is available and have their needs met.

Doug Rauthe
Director
Northwest Montana Community Action Partnership
Kalispell, Montana

Doug Rauthe shared that they are the community action agencies for all 56 counties in Montana. He thanked the committee for visiting Montana and for being interested in their thoughts and what they have to offer.

The challenges of conducting outreach, enrollment and consumer assistance with the affordable care act in rural Montana have been discussed by other speakers. Trust is the key when working with people in rural communities. It is difficult to meet face-to-face with individuals in a large state like Montana. The navigator funding averaged to about $3.10 per person who needs access to coverage. That is not much funding to cover 56 counties in a state as widespread as Montana. There needs to also be press releases, television coverage and literature available to hand out.

Northwest Montana Community Action Partnership applied for navigator funding. There are 31,000 people in the area that are eligible to apply for insurance via the marketplace. It cost Northwest Montana Community Action Partnership $8,000 to submit the grant and they did not receive the funding. Even without funding, there will need to be outreach provided and citizen assistance with the marketplace.

The agency is applying to become a certified application counselor agency and they are currently training their employees. The staff is familiar with the Healthcare.gov website and has the telephone number available so that they can talk to every customer they meet about the marketplace. They will print information and create outreach materials specific to the programs and do their best to assist their citizens even though there are limited resources. If funding is made available to more of the community action partnerships to provide necessary assistance, Health and Human Services would have a large network to assist Americans with the marketplace.

Q&A

Shane Roberts asked how much the grant pays the navigators**.**

Chris Hopkins said that they are covered for about 140 hours.

Barb Fabre asked if any if the navigators are in an Indian Health Services Agency.

Chris Hopkins said they are not but the hospital in Hardin and the hospital in Wolf Point work in conjunction with the two HIS agencies and the intent is that both those facilities employ Native Americans and they are encouraging them to designate Native Americans as navigators.

RURAL POVERTY AND HUMAN SERVICES PANEL

Jeffrey Rupp
President/CEO
HRDC District IX, Inc.
Bozeman, Montana

Jeffrey Rupp shared that the community action network was formed in 1964 as part of the war on poverty. The Economic Opportunity Act was signed into law by President Johnson and that created the Community Action Network. In 1981, the community action network was changed to a block grant given to governors and local states to handle the responsibility of community action. Funding is flexible and agencies can choose how to use the money. An agency in rural America may use funds for transportation for people to get to work and in an urban area an agency may use the funds for a community garden so residents can have healthy food choices.

Bob Buzzas
Director
HRDC Director's Association
Bozeman, Montana

Bob Buzzas welcomed the committee to Bozeman and said he would provide background information and describe the setting in which the ten community action agencies work to address poverty using mostly publicly funded programs.

Montana is slightly larger than Japan. It is 615 miles to drive from Missoula to Sidney, Montana which is comparable to driving from Washington DC to Atlanta, GA. Montana struggles to provide services to the large land mass with few people.

Montana has ten community action agencies and each provides a variety of programs depending on the needs of the community. Districts I, II and III are a single agency called Action for Eastern Montana. It covers 290 miles north and 180 miles across. 65% of Montana's population lives in rural areas.

Montana's poverty rate is comparable to the national poverty rate. The poverty rate is slightly higher in rural Montana than in urban Montana. 19.4% of all persons in poverty are children which is slightly lower than the national average. Over the past 6 years, hunger and nutrition issues have increased following a brief downturn in food insecure homes. Very low food security increased slightly, where food intake was reduced during the year because of the lack of money or resources.

In Montana, Native Americans account for a disproportionate share living in poverty. More than one-third of all Native Americans in Montana live in poverty. There are seven reservations in Montana but 63% of Native Americans live off of the reservations and are largely concentrated in cities.

The number of women as head of household in Montana is significantly higher than the United States average. In Montana, 42% of the female headed households have children under the age of 18.

Montana's population is aging at a higher rate than the rest of the nation. The number of persons 64 or older increased in Montana more than 21% in the last 10-year census compared to 15% for the rest of the country. The number of people 85 and older has also increased in Montana at a higher rate than the rest of the nation. This has implications on the cost and delivery of health services, public health services and programs. Having affordable housing for seniors is a concern.

Approximately 25,000 families in Montana live in poverty. There is a 36 month waiting list for 13,000 people with housing vouchers. Currently, there are 3,300 units available though all families do not want or need subsidized housing it is still an issue.

Jim Morton
Executive Director
Human Resource Council
Missoula, Montana

Jim Morton shared that he began working in community service in 1970 with Project Medicare Alert. It was formed to inform 19 million seniors of their right to sign up for medical coverage under the Medicare act. Thousands of staff members were hired to have one-on-one discussions with seniors to dispel myths associated with Medicare and it is very similar to what is happening today with the Affordable Care Act.

Mr. Morton asked the committee to think about driving 200 miles in any direction from where they live and the services available in the area. In Montana, you can drive 200 miles in any direction and not have a hospital, specialty care facility or a residential treatment center. In Missoula, the second largest city in the state, they just got a residential treatment center. If a person has a problem with addiction they are sent to a state facility away from their support group or family.

In 1970, when Mr. Morton graduated from high school, there were one million people living in Montana which is the population of Montana today. 17% of America's population is in rural areas where as in 1910 it was 72%. Much of rural America is becoming poor and elderly. Native Americans make up a small percentage of the population but over 50% of Native Americans who are poor live in only 5 states. These states are Arizona, New Mexico, South Dakota and Montana.

The Human Resource Council administers programs starting with the community services block grant to put together a plan looking at long-term needs. The Human Resource Council manages the 211 information referral line which receives about 8,000 calls a year. They analyze the calls and find what the most requested needs are in the community. Lack of shelter, rent affordability and energy assistance are at the top of the list. Energy assistance is a necessity because landlords will evict people who cannot pay their power bills leaving those people to become homeless.

Young people are leaving rural areas because there are no opportunities. This causes a shortage of service technicians and people who can do in-home care and this is a barrier in the state of Montana. Transportation, access to resources, health care and nutrition are also issues in rural Montana.

Housing is an issue in rural Montana. Without affordable housing it is hard to attract industry to an area. 33% of renters in rural communities are poor and large majorities have high rent burdens. They are not able to access health care because they cannot pay copays. When looking at healthcare and housing there is a relationship and that has to be considered when working with communities.

Brian Steffen
Chief Executive Officer
Action for Eastern Montana
Glendive, Montana

Brian Steffen shared that Action for Eastern Montana covers 17 counties with a service area covering 47,945 miles. In 2012, $190,000 was spent on travel due to the vast service

area. This includes going to homes to weatherize them and client visits. Travel distances can be 5 hours one way. The geographic distance that has to be covered is the reason that community action is such an important benefit to rural America. There is a 15 member governing board made up of local people in the service area. The board members come from counties and communities in the service areas and offer important information about their community.

In Broadus, Montana, Action for Eastern Montana held a presentation on programs available in the community. The presentation was about workforce development and finding employment in a town with only a few businesses and most of them are family owned. At the meeting there was a local rancher who asked if Action for Eastern Montana would pay for a youth to work on his ranch if he trained them to operate equipment and taught them to work with livestock and drive a tractor. These types of meetings are helpful in making connections.

In a recent community assessment the number one need was assistance paying for utility bills and the next need was assistance paying for medical and dental bills. When an organization is 5 hours away from a community, it is difficult for people to know how to receive assistance. There has to be innovative ways to get information to the communities because it is a huge burden on staff and resources to travel to remote locations.

Action for Eastern Montana helped nearly 750 seniors and individuals with disabilities receive home delivered meals. 215 individuals received in-home health care. Last year Action for Eastern Montana provided over 7,600 rides to people for such things as doctor's appointments, grocery shopping and picking up prescriptions.

The Bakken area has been impacted by the oil industry. The strongest wage growth and lowest unemployment has been in the Bakken area. The negative impact of the oil industry has been the increasing rates of rental properties and higher cost of living. Elderly people with fixed incomes are having a difficult time affording to live in their home community. The essential workers like teachers and firefighters are struggling because the cost of living is rising but they are not able to afford the cost of living on their salaries. Action for Eastern Montana is trying to do housing development to help with the rental situation but the lots are $300,000 where they used to be $10,000. Rural America is facing significant needs and there has to be housing available.

Q&A

Christy Whitney said she was intrigued with the presentation about the impact of the oil industry. Is there an answer regarding corporate responsibility and the cultural and social impact of these projects?

Brian Steffen said they work with housing developers in rural America where the oil industry is located who say that in rural America there are investors who will charge the top of the market pricing or tax credits through government funding for housing. The only real solution is to build and saturate the market.

David Hartley stated that he did a project in Sweet Grass County and Stillwater County, Montana. Stillwater Mining was turning hotels into barracks for workers. The mining company worked with the hospital and hired a healthcare worker to be onsite at the mine in case of injuries. There has to be pressure to support all local services including healthcare, education and law enforcement. Is that happening in the mining communities?

Bob Buzzas said that oil representatives attended the last two statewide housing conferences and said they are willing to assist with the local impacts. Legislature occurred and there is a holiday on oil and gas taxes. Because of the holiday the opportunity was missed to get the tax money.

Karen Madden said that in New York there is a moratorium on hydrofracking and a lot of people want it to expire so they can make money. People are talking about the environmental impacts but not the social and cultural impacts.

Thursday, September 5th, 2013

Thursday morning the subcommittees' depart for site visits as follows:

HUMAN SERVICES SUBCOMMITTEE
Human Resource Development Council
Bozeman, Montana
Subcommittee members: Ginger Carpenter, Pamela DeRosier, Barbara Fabre, David Hartley and Barbara Morrison.
Staff Members: Tom Morris and Shoshana Shapiro.

HEALTH SUBCOMMITTEES
Wheatland Memorial Hospital
Harlowton, Montana
Subcommittee members: Phyllis Fritsch, Tom Hoyer, Michele Juffer, Roger Wells and Christy Whitney.
Staff Member: Kristen Lee and Deepti Loharikar.

Community Health Partners
Livingston, Montana
Subcommittee members: Rene Cabral-Daniels, Christina Campos, John Cullen, Roland Gardner, Karen Madden, Wayne Myers and Shane Roberts.
Staff Member: Steve Hirsch and Paul Moore.

The subcommittees' returned to Bozeman and attended break-out sessions for discussions.

PUBLIC COMMENT

Chris Hopkins

President
National Cooperative of Health Networks Association

I am speaking to you during the public comment section under a different hat I wear, as President of the National Cooperative of Health Networks Association, or NCHN as we call ourselves. Our Executive Director, Rebecca Davis provided comments during this point in your agenda at the April Committee meeting in Grand Junction, CO. I would like to follow-up on her comments and provide some more information on the important work that rural health networks are doing across the country.

Again, I would like to add my welcome and thank you all for coming to the Big Sky country of Montana from the membership of NCHN. And thank you for providing time for public comment.

Montana Health Network is a founding member of NCHN. The professional membership organization is comprised of health network organizations across the country. Montana Health Network's CEO, Jan Bastain, along with being among the founding members, also served twice as President, in the formative years, 1997 and again in 2004. And nine years later, Montana Health Network is again providing leadership for NCHN, as I serve as President for 2013. Montana Health Network has supported NCHN since its inception.

Montana Health Network continues to support NCHN and I encourage you as a national committee to be aware of NCHN and any resources it can provide to this group.
In the beginning there were a handful of pioneers in the rural health network movement! This handful of folks were forward thinkers that saw the need, particularly in rural communities, to bring together healthcare providers to collaborate and seek ways to share resources in an effort to ensure access to quality health care services. Early network leaders understood the importance and benefits of networking and collaboration among potential competitors. And, these pioneer network leaders understood the isolation of their job – not many network leaders in their local area! By forming NCHN, a platform was developed for network leaders to come together to share their success stories and their challenges. NCHN is a learning environment for network leaders.
And this is why Montana Health Network is a founding member and has continued to support our Association – NCHN!

From our early days of 5-7 members, meeting in a room and discussing what we do and how we do it and asking how we can do it better, we have grown to an Association of over 50 network members that represent a variety of healthcare providers in rural communities from Maine to Alaska.

Repeatedly when asked why join NCHN or what is the major benefit of NCHN membership, we hear – Networking, Networking, Networking! So, as a National Advisory Committee, I ask you to also to look for ways to support NCHN, the professional membership organization devoted to supporting and strengthening rural health networks as they support their rural healthcare organizations.

Before I close, I would like to share with you some examples of what NCHN does to support our members:

- An Annual Educational Conference – Our last conference in New Orleans went very well and we are busy planning for the 2014 Annual Conference that will be held in June in St. Louis. We are pleased that the HRSA Rural Health HIT Network Development Grantees will be joining us in St. Louis.
- Our Leadership Summit will be October 1-2, in Austin, TX. The Leadership Summit Committee has put together a great agenda and we will be kicking off our 2013 Leadership Learning Community – which is a 8 month program following the Summit focused on assisting our members develop their leadership skills. I am also happy to report that Dr. Thomas Klobucar, Deputy Director, of the Veterans Health Administration – Office of Rural Health, will be attending the Summit and discussing potential collaborative models for NCHN members with rural veterans.
- Our monthly Coffee/Tea Chats with Dr. Mary Kay Chess are very popular with both the NCHN membership and the HRSA Rural Health Network Development Grantees – it is like a monthly "hot line for network leaders" – a place they can come to ask questions, offer advice, share successes and cry over unexpected outcomes!
- Executive Coaching Program – NCHN members volunteer to serve as a mentor/coach to new and beginning network leaders – we know of no specific program that teaches one how to be a rural health network leader – so we are so excited that our experienced and successful network leaders are willing to work with new network leaders. We also offer this service to the current HRSA Rural Health Network Development Grantees.
- Business Partners Program – NCHN has developed a Business Partner Program over the years that provides discount pricing for NCHN members for products and services for both the network and its members. One of our most used partners is GrantStation – an online subscription program that we are able to offer to our membership for $65/year – GrantStation's average annual subscription rate is $695 – so this is a tremendous savings to the NCHN membership and to their members.
- HCAHPS Breakthrough Series – "Transforming the Patient Experience – 1 webinar at a time" -- this summer we partnered with Custom Learning Systems Group in the delivery of a dynamic, high impact, innovative, practical educational series, designed to enable our network members to assist their hospital members to achieve breakthrough sustainable improvements in their HCAHPS patient experience survey scores. MHN took advantage of this NCHN program and I can tell you that our members are excited about the service and are using it to educate their staff. We have 13 NCHN members that have subscribed to the program to

date and through this approximately 250 rural, mostly Critical Access Hospitals, are enjoying the benefit of this NCHN Educational Program.

Jessica Lipnack one of the foremost researchers on network organizations was our opening speaker at the 2013 NCHN Annual Educational Conference. Jessica discussed the long history of organizations—"beginning when we first formed small tribes to survive—the network is the newest, the most powerful, and, at the same time, the oldest form of organization. Networks motivate people and organizations to take risks and do what they cannot do alone. Networks become powerful magnets to attract others and spur participation. Members of networks compete and cooperate at the same time."
NCHN is the learning community that brings rural health networks leaders together – as a membership organization, our programming and services are developed and designed by network leaders, who bring both a varied background and experiences to the table.
Thank you for your time today. Thank you to Tom Morris and his staff at ORHP for all the work they do to support rural health care programs. We look forward to working with ORHP and this Advisory Committee, as everyone moves forward with the implementation of the Affordable Care Act; and the shared overarching goal of ensuring that rural citizens have access to quality healthcare. Rural health networks can assume an important leadership role in these activities. Research supports that one of the critical success factors for a network is its leadership, both network leader and board members (O'Sullivan, 2009; NCHN 2011). NCHN supports the leaders of these networks and we invite you to support us in our efforts.

If you would like more information or to discuss rural health networks, feel free to ask. Thank you.

Friday, September 6th, 2013

The meeting was convened by Tom Morris.

REVIEW OF SUBCOMMITTEE VISITS

HUMAN SERVICES SUBCOMMITTEE
Human Resource Development Council
Bozeman, Montana
Subcommittee members: Ginger Carpenter, Pamela DeRosier, Barbara Fabre, David Hartley and Barbara Morrison.
Staff Members: Tom Morris and Shoshana Shapiro.

Barbara Fabre shared key points and concerns from the Human Resource Development Council site visit. The topic is the intersection of poverty and human service delivery in rural areas.

- Visit showed a great example of intersecting poverty and human service delivery. Bozeman may not be an example of every rural community.

- The program has a great infrastructure. There is a food bank, community café, apartment complex, a transitional house and homeless shelter called the Warming Center.
- There are 407 partners involved with the Human Resource Development Council.
- There is an impressive transportation program with free services available to the community.
- There is an effort to get out of silos and integrate services.
- Human Resource Development Council has received funding to build condominiums and to assist families in rebuilding their lives. It would not be done as easily in a county based system. A non-profit has much more flexibility to be able to accomplish this.
- Many of the services are structured so that people who are not in the lower income strata can make use of them. Anyone can ride the bus for free. There is a brand being developed across all of the services that does not say welfare system but a system of services. It raises the visibility and includes the entire community.

HEALTH SUBCOMMITTEES
Wheatland Memorial Hospital
Harlowton, Montana
Subcommittee members: Phyllis Fritsch, Tom Hoyer, Michele Juffer, Roger Wells and Christy Whitney.
Staff Member: Kristen Lee and Deepti Loharikar.

Phyllis Fritsch shared key points and concerns from the Wheatland Memorial Hospital site visit. The topic is the rural implication of outreach, enrollment and education in rural areas for the health insurance market places of the Affordable Care Act.

- The group attending the meeting was better informed than expected overall.
- The hospital is training two people initially to provide education and information about the enrollment process.
- One concern was how the Country would pay for the Affordable Care Act.
- The health care facility is going to sponsor a community enrollment fair that will include the three major insurers and will have navigators available to assist people with enrollment at the fair.
- There needs to be a study done on provider density and type in rural areas. There is a concern about a shortage of providers.
- There needs to be an inclusion of cost sharing and explanatory information needs to be available.
- The website needs to include information about the value of having insurance for people who do not think it is necessary.
- There is a recommendation that critical access hospitals are able to include the enrollment process as a community benefit and claim it on the 990 form and there is directive relating to the providers so they know to start tracking the information.
- Recommend an evaluation based on critical mass to find out where the best place is to provide care, how to continue to have access and what is really needed in the rural area to get the enrollment process accomplished and then provide the care.

Community Health Partners
Livingston, Montana
Subcommittee members: Rene Cabral-Daniels, Christina Campos, John Cullen, Roland Gardner, Karen Madden, Wayne Myers and Shane Roberts.
Staff Member: Steve Hirsch and Paul Moore.

Karen Madden shared key points and concerns from the Community Health Partner site visit. The topic is the rural implication of outreach, enrollment and education in rural areas for the health insurance market places of the Affordable Care Act.

- The enrollment process needs to be kept simple and there needs to be as many people trained as possible to assist with enrollment.
- Pent up demand may lead people to enroll while healthier people do not enroll, those who do may get immediate care and then drop out.
- Preparation for filling out the online form may be time consuming.
- Need more pricing information in order to educate the public.
- Mental health provider concerned that they will be overrun with people coming in and there will not be enough capacity to serve them.
- There are people who qualify for Medicaid but will not apply because they do not want to be dependent on the system.
- This is healthcare insurance but there needs to be consideration of healthcare access.
- There are allies that want to help people but need more information and training.
- The employer coverage is not ready and the employer mandate being delayed was a problem for employers who want to cover everyone.
- There was a positive outlook and the realization that it will take time and patience until the Affordable Care Act is fully implemented to work through the process.

Waded Cruzado, PhD
President
Montana State University
Bozeman, Montana

Waded Cruzado welcomed the Committee and shared that she is the President of Montana State University and is from Puerto Rico, a tropical island that is 3,515 miles with 4 million people. Montana is a state with 1 million people with over 147,000 square miles.

Dr. Cruzado shared that the Morrill Act was signed into law by President Lincoln on July 2, 1862. Until then there were only universities in urban areas but this allowed for a public college in each state and territory of the union. During a time with difficult circumstances due to the civil war, elected officials were able to envision a brighter future and open doors to educate the populace.

Montana State University has 4 campuses, 7 agricultural centers and county extension offices that touch every rural community in Montana and every tribal nation. The college

forged an alliance with the University of Washington and provides incentives for medical students to start their first year of medical education in Bozeman and complete their studies at the University of Washington. Every summer those students come back to Montana and work in the rural communities.

Care for Our Own is a coop that was established in the college of nursing and is configured for Native American students. In the Native American communities, they prefer to have their own people taking care of the elderly and the children but they do not want the students to leave the reservation. The students come to Montana State University for the education and go back to the reservation for summers to apply what they have learned.

Extension programs are a powerful tool at Montana State University. The extension programs need to be relevant. Their extension programs are tackling some of the most difficult issues in rural areas such as grandparents raising grandchildren and obesity problems.

There is an international extension program called engineers without borders. This program includes students majoring in nursing, sociology and pre-med. The students go to rural schools in Kenya and help build wells so that the schools can have fresh water for the children. The social impact is incredible. Only boys were allowed to go to school when the program started. The girls were walking for miles to bring water for the community. Now the boys are pumping the well and the girls are holding the pail and they all attend school. Inspired by that model, students from a Helena, Montana high school have raised $10,000 in order to have water projects for the Native American reservations.

Dr. Cruzado closed by saying it is an honor to have the Committee visit the State of Montana.

ORHP/HHS Update
Tom Morris, M.P.H.
Associate Administrator
Federal Office of Rural Health Policy, US DHHS
Rockville, MD

Tom Morris shared information with the Committee on what Health and Human Services is working on at this time. He spoke about regulatory actions taking place related to rural issues. Mr. Morris also gave an update on White House Rural Council activities.

Committee Business
The Committee discussed Omaha, Nebraska and Sioux Falls, South Dakota as possibilities for future meetings. There was also discussion about having virtual meetings between field meetings in order to prepare and discuss topics.

PUBLIC COMMENT

Kristin Juliar
Director
Montana Office of Rural Health

Kristin Juliar thanked the Committee for visiting Montana. She reiterated that distance is a big issue in Montana and something they deal with on a daily basis. It was a great experience having the Committee in Montana and listening to the conversation during the meeting. The dedication and wealth of knowledge of the Committee is inspiring.