Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Mahnomen, Minnesota
September 9-11, 2015

Meeting Summary

The 78th meeting of the National Advisory Committee on Rural Health and Human Services was held September 9th -11th, 2015, in Mahnomen, Minnesota.

Wednesday, September 9th, 2015

The meeting was convened by Tom Morris, Associate Administrator; Federal Office of Rural Health Policy. Governor Ronnie Musgrove, Chairman of the Committee, was not able to attend the meeting. Governor Musgrove opened the meeting via satellite and stated that the two topics of the meeting are Poverty among Children in Rural Areas and Delivery System Reform.

Poverty among children in rural areas is always a concern of the committee. This meeting will give the opportunity to look at the issue from a tribal perspective. The experience at White Earth can provide insight from both the Native American perspective and also for the wider population. Rural childhood poverty is also a focus of The White House Rural Council whose members are from across all federal departments.

Delivery System Reform is an issue coming to the forefront of the healthcare system in this country. This is an opportunity to stay ahead of implementation of reforms and to anticipate problems that may arise for rural providers. This is an opportunity to help shape change in healthcare and make the changes appropriate to rural healthcare.

The committee members present at the meeting: Ty Borders, PhD; Rene Cabral-Daniels, MPH, JD; Christina Campos, MBA, FACHE; Eugenia Cowan, PhD; Kathleen Dalton, PhD; Kelley Evans; Barbara Fabre; Roland J. Gardner, MS; Karen Madden, MA; Octavio Martinez, Jr., MD; Carolyn Montoya, PhD, CPNP; Barbara Morrison, MS; Wayne Myers, MD; Chester Robinson, DPA; John Sheehan, MBA, CPA; Donald Warne, MD; Peggy Wheeler, MPH.

Present from the Office of Rural Health Policy: Tom Morris, Director; Steve Hirsch, Executive Secretary and Paul Moore, Senior Health Policy Advisor. Truman Fellows present: Pierre Joseph and Donya Nasser.

CHILD POVERTY: FEDERAL AND STATE PERSPECTIVE

Jeannie Chaffin
Director
Office of Community Services

Administration for Children and Families, US DHHS

Jeannie Chaffin told the committee that she would focus on child poverty from a federal perspective and share some of the topics reflected in the Administration for Children and Families strategic plan. The goal is to assist the committee in making policy recommendations to the Secretary of Health and Human Services.

More than 26.2% of children in rural areas were poor in 2014. For American Indians and Alaskan Natives the child poverty rate is 36.3%. These statistics are very concerning and there needs to be an urgency to think in new ways to address the issue. Some of the answers may be at the intersection of health and human services. The committee can be pioneers in addressing rural child poverty in new ways. Ms. Chaffin shared that she is from a rural area in Southwestern Missouri and understands the challenges of child poverty and values the strengths in rural America.

The Office of Community Service at Administration for Children and Families allocates money to different tribal entities through the Low Income Home Energy Assistance Program Community Services Program and Community Services Block Grant. The Community Service Block Grant funds around 1,000 agencies and is flexible, allowing communities to address poverty based on local needs.

Integration of human service delivery is important and there is a need to provide holistic services to families through bundled services. The impact of early brain development shows the need for integrated, early services. Linking Head Start, Temporary Assistance for Needy Families, Food Stamps and Medicaid is an example. The Administration for Children and Families is creating a bundled service model called the Tribal Early Learning Initiative. This bundled service model is taking place in White Earth Nation. Administration for Children and Families has been piloting the Tribal Early Learning Initiative since 2012. Tribal Early Learning Initiative includes tribes that have: Head Start, Early Head Start, childcare development funds, tribal maternal/infant and early childhood home visiting. There has been great innovation around coordinating assessments, data collection and holistic case management.

Administration for Children and Families is also funding the Maternal and Early Childhood Home Visiting Program at White Earth Nation. The program provides grants to tribal entities to develop, implement and evaluate home visiting programs in American Indian and Alaskan Native communities. Administration for Children and Families is working on a research project based on a two-generation approach for serving families. The Office of Planning, Research and Evaluation offered four grants to head start programs and will be evaluating the benefits of serving parents and children over a period of time.

Local Initiative Support Corporation has a seventy five site demonstration and are bundling employment services, income support and coaching. They are finding that the families who get services for an extended amount of time, have more success achieving goals, improving credit, maintaining a job and reducing stress.

Administration of Children and Families is looking at how to bring the issue of adverse childhood experiences into many of the ACF programs. How to imbed the learning and science into many programs is a focus. The Adverse Childhood Experience Study is one of the largest studies ever conducted to assess associations between childhood maltreatment and later-life health and wellbeing. The study is collaboration between the Centers for Disease Control and Prevention and the Kaiser Permanente's Health Appraisal Clinic. The study found that when children have traumatic childhood experiences it produces poor outcomes later in life. The assistant Secretary for Planning and Evaluation is developing a toolkit for trauma-informed care that practitioners can use to address adverse childhood experiences.

The White House Rural Council is focusing on rural child poverty. Health Resources and Services Administration, Administration of Children and Families, the Department of Labor and many other departments are working with the White House Council on rural childhood poverty. Rural Integration Models for Parents and Children to Thrive is a two generation effort to provide services. Ten communities will get intensive technical assistance from the federal government on how to integrate a two generation model. Forty communities applied and the applications are being reviewed and the communities will be announced before the end of September. Trends are not in the right direction related to child poverty but there are some creative and innovative opportunities to pursue.

Jim Koppel
Assistant Commissioner for Children and Family Services
Minnesota Department of Human Services

Jim Koppel thanked the committee for the opportunity to speak. He shared that the meeting is in the heart of rural Minnesota and the heart of rural poverty. Mr. Koppel oversees Child Protection, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families, Child Support and Child Care. Grant funding is given to targeted recipients.

Mahnomen County has a 40% poverty rate. The child poverty rate is high in all but one county for children in Minnesota. The issue of poverty is difficult because statistics or topics are isolated. When working on an issue like child health, it is important to consider the whole family. The whole child approach is needed so health, education and housing have to be considered. Consistent wellbeing and stability are vital for children to have healthy outcomes not only during childhood but as adults.

Policies shape family options and are underpinnings to what children can achieve. The policies have yet to impact poverty so there needs to be a conscious effort to address poverty. The War on Poverty had a great impact but was not quite the success that was expected. Poverty itself should not be the only focus but family stability has to also be considered. This means that a family should not have to be highly mobile because it is highly disruptive in children’s lives. High mobility is usually a symptom of income instability or other types of instability. Self-sufficiency is the goal and a person can be self-sufficient in poverty if they have housing, enough nutrition, access, transportation and the basic needs. Housing is the most important element of a family’s life and predictability is vital. Predictability means that a person knows what is approaching in the future and not having to worry that if they make an extra one hundred they will lose services.

Child care assistance needs to be given for twelve months so that families do not have to worry about child care being taken away if a parent gets a raise and becomes ineligible. The more adverse childhood experiences a person accumulates, the more likely the bad outcomes. Stability reduces the likelihood of children experiencing hopelessness due to stress and no access to healthcare.

It is important to look at population outcomes not just programmatic outcomes. This doesn't show what is happening to the Temporary Assistance for Needy Families population and how they are doing. When evaluating for food stamps, the families need to be asked how they are doing and what is occurring in their lives that is impeding their ability to meet their goals.

Q&A

Dr. Donald Warne said that most block grants go to the states and he is intrigued by the Community Service Block Grant. Can it go directly to a tribe and is it competitive?

Jeannie Chaffin replied that there the Low Income Assistance Program Grant and the Community Service Block Grant which can go from the Federal Government to the tribes. Minnesota has a history of working with the tribes to co-fund grants using state money so many tribes have gotten the funding from the state because they can get more funding.

Carolyn Montoya asked how much substance abuse plays a role in lack of stability for rural children living in poverty.

Jim Koppel responded that it is a major issue and from a tribal perspective abuse during pregnancy is at a crisis level. Babies are being born addicted. There is a methamphetamine problem resurfacing in Minnesota and many children are being removed from homes because of this issue. There needs to be a system that knows how to treat addiction and related trauma and there needs to be a system to eliminate what leads to drug addiction. The circumstances that lead to addiction need to be addressed like hopelessness and mental health problems. It is important for preventative measures to take place. Every time you remove a child from a home, they experience trauma. Substance abuse and the effects of poverty are the two major reasons that children are removed from households.

Barbara Fabre shared that the state and tribes need to focus on the rising numbers of people addicted to heroin and address it immediately. Block grants are important because they can go directly to the local entities instead of through the state. This allows communities to address problems on a community level. Dental care for children is also a barrier interconnected to rural poverty. Rural residents have to travel long distances for dental services. Grandparents who are raising their grandchildren also need to be a consideration when providing assistance. This is becoming more prevalent in rural communities.

Jeannie Chaffin said that the rural impact demonstration will be broad and be able to include grandparents and other family members as well. Opioid abuse and other social conditions are being discussed at the individual level but also have to be addressed as institutional and systemic problems.

CHILD POVERTY: LOCAL AND TRIBAL PERSPECTIVE

Leah Pigatti, PhD
Executive Director
Mahube-Otwa Community Action Partnership, Inc.

Leah Pigatti shared that Mahnomen County is part of the Community Action Service Area and is entirely on the White Earth Reservation. Dr. Pigatti said that she has been involved in working with child poverty for almost 40 years. She remembers when President Johnson issued the War on Poverty. The issue is different now and there is more known about child poverty but there has not been much progress made since the War on Poverty. Almost 40% of children in Mahnomen County live in poverty and many are in working family households. Parents are working three and four jobs and not making enough money to get them out of poverty.

Two superintendents' in the district were concerned about the high numbers of children being retained in kindergarten and what to do to solve this problem. The statistics showed that in those two districts, that 100% of children in one district live in poverty and 90% of the children in the other district live in poverty. The parents were working but they were not making enough money to elevate them out of poverty. These children were being read to less than their peers, didn't have appropriate interactions in their household and had less vocabulary than their peers. All children need to be enrolled in a high quality, early childhood preschool program. If parents are working two minimum wage jobs and have two children they may not qualify for Head Start services. There are school readiness programs but they are offered half a day with no transportation so that is a barrier. There are high quality child care programs and there are Early Learning Scholarships for providers to access a scholarship to enhance their services and receive up to $7,500 per child per year. Programs need to be aligned so they are all using the same curriculum. Programs cannot be siloed and expect children to begin school and be successful.

Many children are hungry when they attend school and cannot focus on learning. Dr. Pigatti shared a story about a parent training event where there was food available. At the end of the session, a young boy was piling a paper plate with chicken. He told the parent coordinator that he wanted to take it home to give to his mother because sometimes she did not have enough to feed the family. All families need to be able to access Supplemental Nutrition Assistance Program but also parents need to be educated on how to shop for food. Spending Supplemental Nutrition Assistance Program money on convenience food does not extend the money enough to last throughout the month. Parents need to receive nutrition education, wise food shopping and cooking education so they can stretch their food dollars. Schools do a great job of offering reduced lunches but there are still children who are not being fed at school because their parents did not fill out the application. Children should not go hungry for this reason.

Another huge risk factor is homeless youth. Last year the agency provided services to 490 children and youth who were homeless. In rural areas, homelessness is hard to see. There aren't people living under bridges and there aren't many shelters. There are people living in tents, in camper trucks or moving from one house to another, sleeping on friends' couches. There was an instance where a woman was living in a chicken coop. Rental assistance, transitional housing and

long term homeless assistance is great for the emergency need but intense case management is needed to maintain success.

Almost 100% of children in Head Start and child care programs in the area have not been to a dentist. There is a grave shortage of dental clinics that will serve public pay patients. Lack of access to dental care for low income people in rural areas is an important issue. There needs to be more dentists in rural areas and dentists that accept public pay patients.

There has to be integrated services, coordination and cooperation. Community action is great but there is a need to reach out to community providers for health, dental and mental health. All organizations need to be aligned so that they can truly make differences in the communities. This has to be done on the local level to make it work.

Thomas Schreiner, MD
Indian Health Service

Thomas Schreiner shared that Indian Health Services is clinic based and it is the responsibility of the tribal partners for outreach into the community. One of the advantages of the clinic is that they offer a variety of services. Adult services include: a family physician, geriatric nurse practitioner, women's health nurse practitioner and family nurse practitioners. Pediatrics is also offered in the clinic and there is also prenatal care. The clinic also has a podiatrist and optometrist including a JVM machine for diabetic eye exams. Contracted medical specialties at the clinic include: OB-GYN, orthopedics and an infectious disease specialist. There is a physical therapist and an occupational therapist at the clinic. The occupational therapist focuses on upper extremities, fine motor patients and autism spectrum disorder. There is also a nutritionist, audiologist and radiologist on staff. Ultrasound, mammography, a mobile MRI and CT, and laboratory services are offered through the clinic. The clinic does have vacancies and has difficulty recruiting physicians to the area.

The dental department houses three general dentists, a pediatric dentist and two dental hygienists. It is difficult recruiting and keeping dental hygienists. There are satellite clinics but they are often closed because there is not enough staff available. There is a pharmacy that includes a tobacco sensation clinic. There is a full time patient benefits coordinator to assist patience in signing up for assistance. Agency funds only provide 40% of the budgeting needs so the rest has to come from a third party so it is critical to have this service available.

Purchase and referred care funds are for patients who have to go outside the Indian Health Service System for services that are not available. There are strict rules as to who qualifies. There are clinic based mental health providers available and community based mental health services in the clinic. Challenges to providing health care by Indian Health Service are the distance people have to travel because the reservation covers a large area. The satellite clinics have limited services and days opened, and there are staff shortages. It is important for rural Minnesota to have access to medical care for children with chronic disease problems like asthma, hypertension and diabetes in rural Minnesota. Parents have to understand that preventative care is vital. Type 2 diabetes is an increasing problem and trying to convince children to take medications when they don't feel sick, is difficult.

Dr. Schreiner gave an example of a patient that visited the clinic. A sixteen year old girl was screaming in pain with a large abscess. They referred her to the emergency room where the abscess was opened and packed. She walked to the clinic the next day to have the packing changed without her parents. Home health visited her to help with the additional packings. This brings up the issue of toxic stress which is frequent activation of stress without the buffering protection of adults. Most parents would never send their child to the doctor with a large abscess without going with her.

Toxic stress is seen in children who are abused, neglected, have parental drug use, and whose parents are not emotionally present. An MRI shows change in the brain architecture due to toxic stress. These changes include: hyperactivity, anxiety, impulse control and problems with memory. Toxic stress also causes a decreased ability to fight infection and tendency for obesity. Examining children gives a physician a good idea if a child knows attachment. Normal attachment is when the physician is looking in the child's ears they are holding close to their mother. Children, who just scream without finding security from their mother, don't have that attachment to their mother. This could be from a mother who is on drugs and not there for their children. These children grow up having difficulty in their relationships and being able to relate to their children. If a parent is a bad role model, the child will mirror their actions. There is an increase in the number of grandparents raising their grandchildren. Many grandparents do a great job but other grandparents cannot provide the discipline and limits that need to be applied.

Samantha Beauchman, PhD
Sanford Health Mahnomen Clinic

Samantha Beauchman said that she is a psychologist at the Sanford Clinic at Detroit Lakes. She did her residency at the Tribal Mental Health Program and worked in the Circle of Life School, which is a tribal school in White Earth.

A Prevalence of mental health issues are depression, anxiety, PTSD and trauma. There is a lack of resources in the area including transportation, mental health providers and a lack of culturally competent providers. Collaboration is so important when there are children with chronic problems that receive multiple medical procedures to diagnose a problem so mental health becomes the last consideration. Integrated care, including more mental health providers in clinics, is important.

Most children are referred through primary care or schools. The school year is the most stable time for the children. During the school year, children have meals, transportation and consistency. The school system administers the children's medication during the school year while during the summer parents may be abusing their children's medication so the children go without. Mental health visits only take place during a crisis in rural, impoverished areas. If there could be preventable care available, the crisis could be avoided. Another issue is that medical assistance requires specific guidelines for a diagnostic evaluation and if they are not done, the visit may not be covered. The patient has to answer a list of questions instead of being able to talk to the psychologist for assistance. This is a major hurdle in delivery of care.

People who are poverty stricken want immediate gratification and that leads to adverse experiences and trauma. People with poor coping skills have unhealthy ways of getting gratifications like smoking, drinking or doing drugs. If it takes two or three weeks for a person with poor coping skills to see a therapist due to administrative paperwork, they will probably not come in. Involving mental health providers in the schools and teaching coping skills is important. Many schools cannot afford it and do not bring in mental health providers. Holistic care and working with the integrated model needs to include a spiritual or religious belief support as well. It can be very therapeutic to have those connections. For tribal children this could include attending pow wows and feeling a cultural connection. There needs to be a sense of identity.

Q&A

Kelley Evans asked if there is access related to telemedicine. If not, what are the barriers?

Thomas Schreiner said that they have not done telehealth at White Earth. Getting the Memorandums of Understanding is quite an involved process. Tribal mental health does do some telehealth with a psychiatrist.

Leah Pigatti stated that another barrier is connectivity and that many areas do not have high speed internet.

Carolyn Montoya asked if community health workers are used.

Thomas Schreiner said that the tribe runs a large home health program and have about fifty nurses. There are community health workers in addition that are utilized.

CHILD POVERTY: INNOVATIVE DATA SYSTEMS

Jennifer Stevens, RN, BSN, PHN
Home Health Manager
White Earth Nation

Jennifer Stevens welcomed the committee to White Earth Reservation. The topic of her presentation is the WE CARE system which stands for White Earth Coordination, Assessment, Resources and Education. WE CARE was created because of duplications of services. There was a need for a more efficient way to work with people. Decreasing duplication increases resources, communication and coordination of programs. The Tribal Early Learning Initiative funding brought different agencies together to discuss what services they were offering. Clients were becoming confused and overwhelmed due to a lack of communication between agencies duplication of paperwork and assessments.

The WE CARE development team was assigned by program directors to develop a universal assessment for clients. The team met monthly to develop the WE CARE model and developed the universal intake form, the confidentiality form and the WE CARE plan. There was also a WE CARE curriculum developed for staff training. The WE CARE development teams worked with

White Earth Economic Development staff on a public relations campaign to educate people on how WE CARE can provide greater access to programs and improve Tribal services overall.

The client is the center of the WE CARE model. The model is around how to meet their mental, spiritual, physical and emotional needs. This goal can be met with the inclusion of tribal programs, non-tribal programs, community and family. Family inclusion is very important in the success of a patient centered plan. When teaching a mother about newborn care, you may also be including the grandmother. When serving the client, programs have to be able to overcome barriers and work together as a team to meet all of the needs of the client.

WE CARE allows the White Earth Nation to own and regulate data that is submitted, assess program outcomes and assess the needs of the people. It assists the White Earth people to inform Tribal programs of their needs and forms a central data base that allows real time reports to be run based on data that is entered. The model works for White Earth because it is customized by the Tribe and it can be used by all Tribal programs. There are various levels of security set by the tribal administrators. There is the ability to generate email alerts or referrals based on the clients' needs. WE CARE collaborative case management was developed by White Earth to meet the needs of the community.

Kim Turner
WE CARE Coordinator

Kim Turner said that the WE CARE is very user friendly. One hundred and seventy five assessments have been completed. The programs are contacting the clients and getting the information over the phone because many clients do not have internet availability. Another benefit of the system is monitoring referrals to make sure that the clients are being contacted. Some clients have a number of needs so they are prioritized by level of importance. The first week, they focus on three or four of the needs. The clients are very comfortable with the care plan and really enjoy the experience and feel satisfaction. The client gets a printout of dates of appointments and detailed information about their plan and what is expected.

Donna Richgels
Social Service Supervisor
Becker County Human Services

Donna Richgels supervises child welfare and child protection services for Becker County. On White Earth Reservation, White Earth Indian Child Welfare provides child protection services. Becker County Human Services provide to tribal members living off the reservation, children who are eligible for enrollment in other tribes and the Caucasian population.

When working with a White Earth family, Indian Child Welfare assigns a worker and they collaborate with the worker. It is a struggle with other tribes because there are huge caseloads and long distances to travel. If clients cannot come in person they may have to meet via speaker phone. On some occasions, home based workers transport families to appointments. A majority of the children are chronically neglected and have many healthcare needs. There are so many children who have rotten teeth which adversely affects their overall health. These children are

being transported to the dentist so that they can save enough of their baby teeth so they can learn to eat and speak. Children cannot learn, participate and play with a mouth full of rotten teeth. When children come into the system, they go to community health center for an exam to determine if there are immediate healthcare needs.

Many of the problems of child poverty are attributable to lack of transportation and chemical dependency of parents. St. Louis County has the highest level of pregnant women who are admitted to treatment for opioid abuse in the state of Minnesota, second is Hennepin County and third is Becker County. Opioid abuse is a real concern in rural areas. Becker County has by far the highest number of pregnant women entering treatment for methamphetamine addiction. A disturbing trend is that parents are abusing substances with their children at much younger ages. Recently there was a case of a 16 year old that was passed out on the table next to her mother with track marks all over her arms. She said she started using intravenously with her mother a year and half previously.

There is a Family Group Decision Making Program that is funded by the Minnesota Department of health and Human Services which is culturally appropriate to use for American Indian families. There is often multi-generations of the family, spiritual advisors, providers and elders that attend the meeting. A case plan is created for the family and they problem solve around barriers. This is also used for older adolescents that are in placement and have come out of placement but do not have skills for the transition. There is flex funding available so there is the chance to address the immediate needs of families. Some examples of immediate needs being met are filling the car with gas, purchasing a microwave or a bed. Housing is a huge issue, especially for people with felonies or histories of evictions.

The Department of Health and Human Services has allocated money to address disparities and out of home placement in the state of Minnesota. Specifically recruiting an American Indian social worker to engage families early on would be ideal. There is really not a community based, culturally sensitive support system. Young mothers need social activities with their peers. An American Indian social worker can setup culturally specific programming, activities and a social network off the reservation for American Indian families. Basic child safety and early interventions are needed and there just are not enough resources so that is a struggle.

Mathias Gardner
Presidential Management Fellow at Division of Public Health Services
The Assistant Secretary for Planning and Evaluation, US DHHS

Mathias Gardner said that Assistant Secretary for Planning and Evaluation is working on a project to address health disparities. Five health disparities that are part of the project: obesity, behavioral health, oral health, pre and neo-natal care and respiratory health. The finding has shown the importance of telehealth and home based services. There is solid evidence based findings on way communities are addressing health disparities and the finalized form will be available in the next few weeks.

DELIVERY SYSTEM REFORM I

Paul Moore, DPh
Senior Advisor
Federal Office of Rural Health Policy, HRSA, US DHHS

Paul Moore stated that an important issue is how Delivery System Reform will affect rural providers. In January, 2015, under Secretary Burwell's leadership, the Department has begun an effort to accelerate improvements to our health care delivery system. The overall objective of the initiative is improving care and spending our dollars more wisely across the U.S. Health care system. The objective will be achieved through aggressive coordinated management of three focus areas: incentives, care delivery and information. As part of the effort, there are goals for delivery system reform, an approach for achieving and tracking progress towards the goals, and policies critical to success.

The Secretary stated that if we find better ways to deliver health care, pay providers and distribute information, we can receive better care, spend dollars more wisely and have healthier communities, a healthier economy and healthier country. This will reward value and care coordination and there will be more transparency on cost and quality information.

The payment taxonomy framework includes four categories: Fee for Service (No Link to Quality), Fee for Service (Link to Quality), Alternative Payment Modules Built on Fee-for-Service Architecture and Population Based Payment.

Specific timelines and goals have been set. By next year, thirty percent of all payments will be in an alternative payment model and eighty five percent will be Fee for Service- Linked to Quality. In 2018, fifty percent will be in an alternative payment model and ninety percent will be Fee for Service- Linked to Quality.

Jennifer Lundblad, PhD, MBA
President and CEO
Stratis Health

Jennifer Lundblad said that what Paul Moore described about Delivery System Reform did not mention rural. The rest of the discussion will discuss what this means for rural. Examining Delivery System through a policy and practice perspective in rural America will support the committee's ability to make recommendations to the Secretary regarding rural delivery system reform.

Dr. Lundblad shared that she is the CEO of Stratis Health and their mission is creating collaboration and improving heath and health outcomes with a priority on rural health quality.

Dr. Lundblad is also a member of the Rural Policy Research Institute health panel that provides independent, scientifically based policy analysis for federal policy makers. The RUPRI Health Panel envisions rural health care that is affordable and accessible for rural residents through a sustainable health system that delivers high quality, high value services. A high performance

rural health care system informed by the needs of each unique rural community will lead to great community health and wellbeing.

Foundations of a high performance rural health system is affordability, accessibility, community-focus, high quality and patient-centered. Delivery System challenges in rural include statutory exclusions, lack of appropriate measures which account for low volume and narrower service mix, limited capital and financial resources and workforce shortages – both numbers and types.

Through Delivery System Reform, the public sector will have new payment models, patient-centered medical homes, state innovation model programs, community transformation grants, value-based purchasing and workforce initiatives. The private sector will have payer-provider contracts for Accountable Care, patient-centered care teams, evolving systems that combine providers and provider types as well as use of telehealth.

Lakewood Health System is a rural health care system which includes a critical access hospital and five primary care clinics. All clinics are certified Health Care Homes, have an extensive care coordination program and proactive palliative care and hospice initiatives, and became a Medicaid Accountable Care Organization this year.

Southern Prairie Community Care is a collaboration of twelve rural Minnesota counties which joined together to become a Medicaid Accountable Care Organization and a State Innovation Model Accountable Community for Health, focused on improving population health through integrating health care, behavioral health, and human services. They are using an e-Health grant to develop a health information exchange for their network.

The Rural Health Value Project has gathered and developed a comprehensive set of tools to support the transformation from volume to value. It is a value-based care strategic planning tool that assesses one hundred twenty one different value-based care capacities in eight categories, which results in a customized value-based care readiness report.

Measurement is important to assuring and demonstrating value. Payment models are changing for rural to value-based purchasing and alternative payment models. There will be a direct and indirect impact. Care delivery redesign with effective care coordination is essential for success, both for patient care and for new payment models. End-of-life care needs and impact are substantial in rural. Establishing palliative care programs and services, securing hospice care, and promoting advance care planning is necessary.

New governance approaches need to address patients and the broader community to participate effectively in alternative payment programs as well as leverage negotiating and purchasing power. The National Quality Forum Rural Health Project gives guidance on how rural measurement should occur. The twenty member rural expert committee convened to provide recommendations to Health and Human Services regarding performance measurement issues for rural and low-volume providers. The Performance Measurement for Rural Plow-Volume Providers draft was issued on June 1, 2015 for public comment.

The Rural Health and Human Services National Advisory Committee should consider what policy makers and rural care delivery leaders should be doing related to rural communities and Delivery System Reform. Policy questions include: How rural providers should be incorporated into value-based payment and quality. What kinds of protections should be added to value-based programs to protect rural. How can Health and Human Services design complementary, equally rigorous quality reporting and value-based programs to facilitate participation from rural providers omitted from Delivery System Reform initiatives? What should Health and Human Services do to ensure that quality measures are relevant for rural providers given their lower patient volume and other unique circumstances? How can Health and Human Services facilitate meaningful rural participation in its existing technical assistance programs for care delivery reform? How should the Secretary support rural providers to build needed infrastructure and capacity for meaningful use of electronic health records and health information technology?

Q&A

Octavio Martinez said that episode of care payments for integrated care includes physical and behavioral care issues and is time based instead of diagnosis based. Someone with diabetes and depression maybe needs an episode of care to last nine months. It is a system of care approach to care for a person over a course of time. This needs to be modified from a rural standpoint to build in complexities in rural like transportation. This will allow them to measure outcomes in a better manor instead of getting dinged for things they cannot control. He also asked if there has been consideration about a regional healthcare partnership, for example a critical access hospital, clinics and individual providers collaborating.

Jennifer Lundblad replied that episode of care payments would fall under the same category as bundled payments. There is a pilot project being contemplated focusing on a regional shared savings approach.

Kelley Evans talked about unintended consequences of cost reporting. The medical assistance facility followed by the critical access hospital program predated the Accountable Care Organizations. Throughout the Accountable Care Organizations there is emphasis of continuum of care. There is an imbalance of what is going to be rewarded and what is expected. The new era is not addressing the fixed cost of home health and hospice that can help reduce readmission rates.

Paul Moore said what they tried to do with the Frontier Community Health Integrated Project was to take it back to the fully integrated network that once existed in the small communities. The opportunity exists and it can be shown that bundled payments and integrated care existed once. There needs to be a consideration of not disturbing things that are working in small communities.

DELIVERY SYSTEM REFORM II

Mat Spaan
Agency Policy Specialist

Health Care Administration- Office of the Assistant Commissioner
Minnesota Department of Human Services

Matt Spaan thanked the committee for inviting him to take part in the meeting. He started with giving a definition of Accountable Care Organizations. Accountable Care Organizations are a group of healthcare providers with collective responsibility for patient care that helps coordinate services in order to deliver a high quality of care while holding down costs. Accountable care organizations are also flexible so that they can create a system based on the community needs. The integrated health partnership is the Medicaid Accountable Care Organization in Minnesota. The goal is lower cost and improved quality but how provider groups accomplish the goal is flexible. The requirements for providers who can participate in the Integrated Health Partnership model are: they must deliver the full scope of primary care services, coordinated with specialty providers and hospitals and have demonstrated how they will partner with community organizations and social service agencies to integrate their services into delivery.

Integrated Health Partnerships are accountable by total cost of care. Total cost of care comprises a set population including the general Medicaid population, Minnesota Care and special needs basic care. There are integrated and virtual model options. The integrated model is a more traditional health system that has a hospital and specialty care. The virtual model is the primary care only clinics and does not have an imbedded hospital. Southern Prairie is a good example of a virtual model.

Performance on quality measures impacts the amount of shared savings an Integrated Health Partnership can receive. It is phased in over a three year demonstration: Year One- twenty five percent of shared savings based on reporting only, Year Two- twenty five percent of based savings based on performance and Year Three- fifty percent of shared savings based on performance. The Integrated Health Partnership portal analytical reports give data to assist Integrated Health Partnerships to succeed. The report includes data on utilization, quality, care coordination and total cost-of-care.

Seven of the sixteen Integrated Health Partnerships include rural health clinics with four more joining in 2015. Integrated systems including rural and non-rural clinics are Essential Health and CentraCare. Regional rural collaboratives are Southern Prairie Community Care and Wilderness Health. Independent, integrated rural health systems are Lake Region Healthcare, Lakewood Health Systems and Winona Health. In 2013, the first six Integrated Health Partnerships providers saved $14.8 million dollars compared to their trended targets. The 2014 interim total cost of care savings was estimated to be $61.5 million dollars.

A challenge voiced by providers was that new programs may be financially challenging to sustain and it is difficult to control costs if patients are sent to a large, often costlier system. A benefit voiced by health care providers are that the Accountable Care Organization arrangement builds stronger relationship and creates stronger care and better coordination.

Mary Fischer
Executive Director

Southern Prairie Community Care

Mary Fischer said that Southern Prairie Community Care is a virtual Accountable Care Organization focused on the triple aim which is better health for the population, better care for individuals and lower costs through improvement. Minnesota has the Accountable Community for Health that includes ten identified communities that are focused on population health initiatives. Southern Prairie Community Care is part of one of those communities.

There are twenty seven provider members including: clinics, hospitals, public health, mental health centers, and area human service agencies. There are 185,000 people within the twelve counties. Strength of the model is connecting the community with the medical model which mobilizes community based services. Important partners are the Minnesota Department of Human Services, the Minnesota Department of Health and BlueCross BlueShield. The number one chronic condition within the population is depression so it will be a benefit to impact the mental health costs within that group.

Southern Prairie Community Care has an agreement with BlueCross BlueShield through 2016. The demonstration project and operation of costs are financed through BCBS. Southern Prairie Community Care can benefit BlueCross BlueShield by enhancing health plan relationships with local networks, developing locally driven care coordination and investing in a health information exchange.

In the first year, Southern Prairie Community Care served over eighteen thousand Medicaid patients and reduced the cost of care by 4 million dollars. The shared savings of 1.5 million dollars was reinvested to the provider network. Southern Prairie Community Care has learned in the first year that building relationships and creating a foundation is vital to success. Strong leadership and a commitment to the vision are also essential. Rural America is unique and requires its own solution to challenges.

Q&A

Rene Cabral-Daniels stated that people will come together to discuss care coordination but it is difficult to sustain interest over a period of time. This took a lot of planning. How were you able to do it?

Mary Fischer replied that the planning efforts for the project began in 2006 and the contract began in 2014. In Southwest Minnesota, county commissioners stay in place for a long period of time. The administrators at key agencies and the county commissioners had known each other for a long period of time. There are three mental health agencies that serve twelve counties. There can be three mental health administrators at the table to have a discussion. The topic may have changed, but everyone involved knew each other. This is a big part of how it worked well.

Carolyn Montoya asked what was done with the savings.

Mary Fischer said that the distribution was in July. They were asked to focus on prevention and early intervention. Some people had internal interface costs related to their health information

exchange, others had not invested in care coordination and decided to do that. There was investment in diabetes programs. There have been a variety of uses of the savings.

PUBLIC COMMENT
There was no public comment.

Thursday, September 10th, 2015

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

HEALTH SUBCOMMITTEES

Lake Region Healthcare Cancer Care and Research Center
Fergus Falls, Minnesota
Subcommittee members: Ty Borders, Christina Campos, Kelley Evans, John Sheehan and Peggy Wheeler.
Staff Members: Steve Hirsch and Donya Nasser.

Sanford Health Detroit Lakes Clinic
Detroit Lakes, Minnesota
Subcommittee members: Rene Cabral-Daniels, Kathleen Dalton, Karen Madden, Carolyn Montoya, Wayne Myers and Chester Robinson.
Staff Members: Paul Moore, Aaron Beswick and Mathias Gardner.

HUMAN SERVICES SUBCOMMITTEE

White Earth Tribal Center
Ogema, Minnesota
Subcommittee members: Eugenia Cowan, Barbara Fabre, Roland Gardner, Octavio Martinez and Barbara Morrison.
Staff Members: Tom Morris, Pierre Joseph, Jeannie Chaffin and Jocelyn Richgels.

The subcommittees' returned to Shooting Star in Mahnomen, Minnesota to discuss site visits.

PUBLIC COMMENT
There was no public comment.

Friday, September 11th, 2015

The Meeting was convened by Tom Morris, Associate Administrator; Federal Office of Rural Health Policy.

FEDERAL UPDATE

Tom Morris

Associate Administrator
Federal Office of Rural Health Policy, HRSA, HHS
Rockville, Maryland

Tom Morris stated that the key activities for FY 2016 included: the third season of the Marketplace outreach and enrollment, implementation of the Medicare merit incentive payments, delivery system reform, addressing opioid abuse, meaningful use and interoperability, 4340B discount drug program outlines and continued expansion of community health centers. Key rural policy issues for 2016 are: rural hospital viability, marketplace plan affordability and next steps on rural child poverty.

Some of topics to consider for the spring Rural Health and Human Service National Advisory Committee meeting are: Medicare Access and Chip Reauthorization Act Sections 101 and 103 and specific rural previsions, opioid use, human/social services intersection with health status, continued work on two-generation or bundled services, meaningful use and interoperability and key elements of a new rural model to address closure-affected access.

DRAFTING OUTLINE OF POLICY BRIEFS

DELIVERY SYSTEM REFORM

Description of Delivery System Reform and priorities:

- An overhaul of current health system; not small adjustments
- Secretary's Initiative- Emphasize focus on Delivery System Reform
    - Provider payment incentives
    - New models of care delivery
    - Information sharing
- Challenges to rural Delivery System Reform
    - Special reimbursement systems for rural providers
    - Limited human resources
    - Lack of financial resources
    - Restricted health services
    - Interoperability issues and stringent privacy laws are a concern to community care coordination
    - Staff shortages and lack of opportunity to employ people from the local area
- Lack of Primary Care-Behavioral Health Integration

Recommendations discussed by the subcommittee include:

- Thinking broadly and taking holistic approach
- Looking at community demographics in terms of health improvement
- Providing technical assistance to support an understanding of options
- Focus on getting health data with more detail to manage healthcare delivery reform
- Focus on outpatient measures – payment incentives
- Consider a longer transition to alternative payment models
- Look at interoperability from a rural perspective
- Increase access to mental health services

- Workforce is changing in the delivery model so there also needs to be a change in type of education

CHILD POVERTY

Priorities/recommendations discussed by the subcommittee include:

- Stability needs to be the goal to serve children and their families living in poverty
  - Need strong anchor organizations which can be a challenge in rural communities
  - Housing, employment, transportation, early childhood services and youth programs are concerns
  - There is a need for shared data and case management
  - Need to emphasize leadership and breakdown silos
  - Need more flexibility in funding streams
- The rural poverty challenge includes small populations spread over large geographic areas, workforce and service delivery challenges
- Building on the White House Rural Council Work
  - More Federal partners to be engaged in the Two-Generation Bundled Services Approach
  - How can Federal Agencies model true collaboration for collective impact
- Health and Human Service Specific
  - Tribal Temporary Assistance for Needy Families- Assist tribes that are ready to meet goal
  - Have a broader Health and Human Service participation in Promise Zones
  - More Best Practices in Federal Program Coordination
  - Priority on preferences in Health and Human Service grants when applicants can demonstrate true collaboration
  - There are challenges for rural communities when applying for Federal funding based on population
  - Consider a rural version of the Collaborative Improvement and Innovation Network

COMMITTEE BUSINESS

The two topics for the April meeting being considered are: Key Elements of a New Rural Model to Address Closure- Affected Access and Opioid Use.

Locations considered for the April meeting are Beaufort, South Carolina or Santa Rosa, New Mexico.

PUBLIC COMMENT
There was no public comment.