

**Health Resources and Services Administration
Office of Rural Health Policy**

National Advisory Committee on Rural Health and Human Services

**Beaufort, South Carolina
April 18-20th**

Meeting Summary

The 79th meeting of the National Advisory Committee on Rural Health and Human Services was held April 18th -20th, 2016, in Beaufort, South Carolina.

Monday, April 18, 2016

The meeting was convened by Governor Ronnie Musgrove; Chairman of the Committee. Governor Musgrove opened the meeting stating that the two topics for the meeting are: Alternative models to preserving access to emergency care and prescription painkiller and opioid abuse. The subject of opioid abuse was presented as a main issue during previous meetings in Kentucky and Minnesota. The committee recognizes the impact that opioid abuse has on every aspect of the health and human service delivery system so this is an important topic to be examined at the Beaufort, South Carolina meeting.

Governor Musgrove thanked Eugenia Cowen, Karen Madden, Wayne Myers and Roland Gardner who served previously on the committee for their outstanding contributions. He stated that the national advisory committee has a direct channel to the Secretary of Health and Human Services. The work that the committee does is respected and appreciated.

The committee members present at the meeting: Kathleen Belanger, PhD; William Benson; Ty Borders, PhD; Rene Cabral-Daniels, MPH, JD; Christina Campos, MBA, FACHE; Kathleen Dalton, PhD; Carolyn Emanuel-McClain, MPH; Kelley Evans; Barbara Fabre; Constance Greer; Carolyn Montoya, PhD, CPNP; Maria Sallie Poepsel, MSN, PhD, CRNA; Mary Kate Rolf, MBA, FACHE; John Sheehan, MBA, CPA; Mary Sheridan, RN. MBA; Benjamin Taylor, PhD, DFAAPA, PA-C; Donald Warne, MD; Peggy Wheeler, MPH.

Present from the Office of Rural Health Policy: Tom Morris, Director; Steve Hirsch, Executive Secretary; Paul Moore, Senior Health Policy Advisor; Mary Jane Mallos; Sarah Young, Public Health Analyst.

Truman Fellows present: Pierre Joseph and Donya Nasser.

Beaufort Orientation
Billy Keyserling, Mayor
Beaufort, South Carolina

Mayor Keyserling thanked the committee for visiting Beaufort, South Carolina. He stated that there needs to be good hearts and souls to face the challenges in rural communities. The population in Beaufort, SC is around 13,000 and most are living in moderate to lower income. Regardless of the large homes that are visible in the area, the majority of the people are poor.

The southern part of Beaufort County, including Hilton Head, has the 5th highest concentration per capita of millionaires in the country. However, this does not reflect the reality of the majority of the population in Beaufort County, South Carolina.

Mayor Keyserling shared with the committee that his father, who was a physician in Beaufort County, most often worked from eight am to at least midnight making home visits and rounds at the hospital. Many of the homes during that time had no indoor plumbing, no transportation, and had a great need for comprehensive healthcare. While there has been progress, many of these issues still remain prevalent today in rural South Carolina.

Mayor Keyserling shared that after the Civil War, reconstruction began, and slave owners fled South Carolina. Freed slaves acquired land where they fished, planted crops and maintained an internal economy.

FEDERAL PERSPECTIVE: PERSCRIPTION PAINKILLER AND OPIOID ABUSE

Nisha Patel
Director
Community Based Division
Federal Office of Rural Health Policy

In 2014, opioids were involved in 28,647 deaths in the United States. Half of those deaths were from prescribed opioids. Rural communities are disproportionately affected by drug related deaths. Use of naloxone is 22% higher in rural. Drug related deaths are 45% higher in rural areas. Rural has a greater prevalence of risk factors and fewer options for treatment. There is an older population in rural areas, more low income families and heavy labor occupations such as mining so painkillers are prescribed more frequently. Rural communities also have a shortage of psychiatrists and do not have detox centers. There are a minimal number of primary care physicians who have received waivers to prescribe buprenorphine in rural communities.

Opioid-related overdose deaths have increased over the past 15 years in both rural and urban, with exponential increases in rural areas from 2013-2014. Rural states are more likely to have higher rates of overdose death, particularly from prescription opiate overdose. Men in rural areas are using more opioids than women in rural areas but more women are dying from opioid overdose.

The opioid initiative was launched by Secretary Burwell in March 2015. Three priority areas of the opioid initiative are: Improved monitoring and guidelines of opioid prescriptions, increased use of naloxone to reverse opioid overdose and expanded use of Medication-Assisted Treatment for opioid use disorders.

There are cross government collaboration efforts around addressing this public health opioid abuse epidemic and it has become a top priority for the administration. Every agency is stepping up to address this issue and is proactively working with one another to align efforts and expertise.

The National Institute on Drug Abuse continues to support research on the health aspects of drug abuse and addiction. The Food and Drug Administration developed an action plan to reduce the impact of opioid abuse on families by being more transparent in the approval process for this category of drugs, improving communications with medical community about the drugs, improving the information that's available about opioid use and focusing efforts on approving drugs that have the potential to mitigate the crisis.

The Centers for Disease Control produce data and guidelines for prescribing opioids for chronic pain including recommendations for improving patient safety and care for those with chronic pain. The scope is limited and doesn't address prescribing to youth or long-term care, but mostly to middle age and pregnant woman and people with a history of substance abuse. The Substance Abuse and Mental Health Services Administration is leading the efforts with Medication-Assisted Treatment as well as regulatory oversight of medications.

Health Resources and Services Administration efforts to address opioid abuse include: funded research, the Rural Opioid Overdose Reversal Grant Program, the Health Care for the Homeless Demonstration Project, and the Behavioral Health Workforce and Education and Training Program, 2016 Substance Abuse Service Expansion, Substance abuse warm line, Project Extension for Community Healthcare Outcomes and the Secretary's 50 State convening focused on preventing opioid overdose.

There are positive initiatives focusing on patient navigation innovations to assist with the opioid crisis. The domestic AIDS network in Maine focuses on treating patients with dignity and respect and addresses the harms associated with addiction. Integration of behavioral health into the primary care system is accomplished through training and technical assistance for providers. The network utilizes peer navigators to establish trust with patients, connect patients to care, schedule appointments and make travel and childcare arrangements.

Another effective example of integration between health and human services is the Armstrong Indiana Clarion. The program serves people with substance abuse addiction and has expanded to cover numerous counties. There is a coordinated team approach that makes it possible to deliver high quality care to patients, build trust with the patient and involve the family in the treatment program.

The Rural Experts Opioid Roundtable is collaboration with the National Governor's Association. The National Governor's Roundtable convened with state leaders and national experts to suggest strategies for addressing heroin and prescription drug abuse in rural communities. The association is refining its strategies for addressing drug abuse in communities and with specific populations such as pregnant women, veterans and youth. The data will also be a roadmap too for states to highlight evidence-based practices for addressing opioid abuse in rural communities and for specific populations.

Collaboration is the key to success when responding to the opioid crisis. A patient centered focus is vital with the support of lawmakers, law enforcement, providers and families.

Gina Capra
Director
Office of Rural Health
Veterans Healthcare Administration

Gina Capra thanked the committee for the inclusion of the veterans in the discussion of opioid abuse and stated that there are approximately 9 million veterans enrolled in the Veteran Administration's healthcare system, 3 million of those veterans are in rural communities. The Veterans Administration wants to offer the same services to rural veterans as those veterans who live in urban areas.

The Veteran's Administration has a resource rich environment. Ms. Capra shared that she visited Mississippi State University in Starkville. They are doing great work to serve student veterans. On the way back from Jackson, there was a stop at the Meridian community based outpatient clinic. A veteran came into the clinic that was in crisis. He was a single father of two young children and a gulf war veteran and he wanted his prescription refilled. The director of the clinic interacted with the veteran and offered him support and counseling. The veteran was frustrated and agitated and not satisfied with the response. They offered for him to go to Jackson, Mississippi for services and he said that he was driving a borrowed car that he had to return the same day and also has two young children to care for so going to Jackson for services was not possible.

If the Veteran's Administration and a resource rich environment can not equal the playing field for the veteran's in rural communities, then there is a huge problem with access to healthcare that needs to be addressed. Dr. Drexler's presentation will share important information about telehealth and its importance in rural areas regarding the Veteran Administration's comprehensive system for substance abuse disorder.

Karen Drexler, MD
Deputy National Mental Health Program Director, Addictive Disorders
Office of Mental Health Services
Veterans Healthcare Administration

Karen Drexler thanked Governor Musgrove and the Office of Rural Health Policy for the opportunity to share the strategies that the Veteran's Administration related to addictive disorders.

Dr. Drexler stated that the opioid safety initiative is an approach to improve safe opioid prescribing while improving treatment for substance abuse disorders. She shared a case presentation with the committee. A veteran that she has been treating for several years was already stabilized with Suboxone when she began treating him. He was still struggling with many issues. He was a young, fit, active duty marine with a new bride when he developed a life

threatening lung disease. Doctors did not expect him to live and he was treated aggressively. Because nearing end of life, they treated him liberally with opioid pain medication because at that time that is what doctors were told to do. The treatment for the lung condition caused other medical complications so he was in and out of the hospital. During this time, his wife filed for divorce which added emotional pain as well. As he was transitioning out of the military into the Veteran's Administration he felt that his life was falling apart and he only had months to live so he decided just to get high because it didn't matter. He progressed into doing cocaine and heroin and his substance abuse disorder spiraled out of control. He was still keeping his doctor's appointments and the doctors saved his life from the lung disease but he was now an addict. The Atlanta Veteran's Administration gave him treatment options including: medication, attending an intensive outpatient program, attending a twelve step program and start depression medication. The veteran agreed to everything but the twelve step meetings. He stayed engaged and his opioid abuse dissolved pretty quickly with the medication. Addressing the depression and putting his life back together is taking years. It has been a long struggle for him to pull his life back together but he is now involved in the VA vocational rehab program to go to school and is pursuing a career in computers. He is making progress, attending his mental health visits every month and is staying on medication.

In 2001, doctors were not concerned about opioid prescriptions leading to addiction. From 2001 to 2014 the number of overdose deaths from prescription drugs elevated from around 10,000 to around 26,000. The number of deaths due to heroin addiction has taken a steep jump from 2010 to 2014. The black market has very cheap and potent heroin and people's tolerance to prescribed opioids gets so high that they can no longer afford the prescriptions so they are turning to cheaper heroin on the streets. As prescription opioids are cut back, physicians need to be educated in order to deal with the repercussions. Sales of prescription opioids, deaths due to opioids and people seeking treatment for opioid disorders are all rising together.

The Opioid Safety Initiative was developed to make the totality of opioid use visible at all levels in the Veteran's Administration. The initiative educates providers about the risks of opioid prescribing, prevents initiation of new opioid prescriptions, and reduces levels of the highest opioid prescriptions.

The Opioid Safety Initiative practices have decreased high-dose opioid use by more than 50 percent. The Opioid Safety Initiative integrates the team approach of reducing opioid use by relieving a Veterans' pain using non-prescription methods. There is an emphasis on patient education, close patient monitoring with frequent feedback. The benefits of the initiative are an increase in the number of enrolled veterans and a decrease in the number of veteran's receiving opioid pain medications. The initiative has decreased the number of veterans receiving opioid and benzodiazepine as well. For veterans on long-term opioid therapy, the long-term prescriptions have been reduced.

Academic detailing is clinical pharmacists working with providers as consultants and giving providers information about their panels of patients. It is difficult for doctors to know which patients' needs extra attention. The academic detailers also work with the providers to hear about barriers and how to reduce high risk patients. The provider gets education on resources that are available to them via academic detailing coaching.

The Veteran's Administration clinical practice guideline for management of substance use disorder recommendations is evidence-based. There are guidelines around screening and determining what type of treatment setting and specific treatments for the top four substance abuse disorders. The Veteran Administration promotes group mutual help involvement, and addressing co-occurring mental health conditions and psychosocial problems, follow-up and continuing care, stabilization and withdrawal.

Veteran's Administration telehealth services include clinical video telehealth, home telehealth, store and forward telehealth. Clinical Video telehealth is a real-time video consultation that covers over 45 clinical specialties. Home telehealth is care and case management of chronic conditions and provision of non-institutional care support to patients. Store and forward telehealth includes: TeleRetinal imaging, TeleDermatology, TeleWound Care, TeleSpirometry and Tele-Sleep studies.

In 2015, there were 2.14 million telehealth episodes of care to 677,000 veteran's administration patients. 282,000 patients used clinical video telehealth services, 6,300 received clinical video telehealth, 156,000 patients received case management by home telehealth and 298,000 used store and forward telehealth technology. The outcomes of the Veteran's Administration telehealth services include the reduction of hospital admissions and reduced acute psychiatric bed days of care.

Q&A

Ty Borders asked about medication assisted treatment and if physicians need access to counselors to assist with medication treatment. Isn't it a requirement that when a physician prescribes medication that they also have to connect that person to behavioral therapy counseling?

Dr. Drexler responded that it is a requirement that the person has access to counseling but it can be provided by the prescriber but has to be structured and monitored with urine drug testing. A doctor in Montana treating the whole state is partnering with community-based outpatient clinics. There is mental health available at all of the community-based outpatient clinics.

Dr. Sallie Poepsel asked how best to connect rural veterans with Veteran Association physicians? Many of the rural veterans are not able to travel to a VA medical facility due to distance or lack of resources.

Dr. Drexler stated that telehealth is very important and the VA has the ECHO project that is a web based consultation for providers at the outlying clinics. This is not available at every clinic but there is a national training program. There are a couple of hundred people participating twice a week and people can ask questions via chat. There is also consultation available. There is a Buprenorphine consultation service and doctor responses to individual requests. There is web based training for providers in outlying areas as well as patient care through telehealth.

STATE PERSPECTIVE: OPIOID ABUSE

Robert Toomey
Director
Department of Alcohol and Other Drug Abuse Services

Robert Toomey shared with the committee that the agency has a mission to mitigate the negative economic and social consequences of alcohol and drug abuse on individuals, families and communities in the state. This is a critical role of state government.

Mr. Toomey stated that he is a person in long-term recovery and recently celebrated 30 years of being alcohol and drug free. He said that he is indebted to people who support systems across the county and help people move from addiction and despair to a place of service, joy and recovery. A mission at the state level is to support the network of the providers who deliver the services on the ground every day. It is not an easy task and takes collaborations of many agencies with a focus on an individual, family and community.

When someone moves from addiction to recovery there are two principles that need to be considered. Every portfolio has a risk structure and there are multiple risks that occur in the same person. Some risks are easily reducible and others need a longer term focus. When clients approach recovery, they have a set of assets that are important to their recovery that may include housing, family or a job. A supportive network is important for those working towards recovery. Opioid use disorder treatment occurs in a larger framework of addiction and treatment. Medication assisted treatment, is treatment. Blood pressure treatment is not called medication assisted treatment, but just treatment. Addiction is a disease and needs to be treated like all other diseases.

Educating prescribers of opioid is vital. The Prescription Drug Monitoring Program is a database in which every filled prescription is recorded and the database can be used to track and assess outliers. Pharmacists input data into the prescription drug monitoring program system. Reimbursement policy in a state is connected to the treatment model. If there is not reimbursement, then there may not be as much treatment available. Law enforcement is an important part of the solution connected to the disease of opioid abuse. To intervene with the disease by giving medicated treatment to a person who has overdosed and then leaving them to go back on the streets is a moral failure.

Data and analysis is an important way to keep track of outcomes of the client but this information is very difficult to track. Once a person leaves treatment there is no follow-up. This data needs to be available. There are federal laws and regulations in place that prohibit the sharing of information and this is a huge barrier. In this field, there is a stigma and discrimination regarding those who are battling the disease of addiction. Addiction is another chronic illness and information has to be shared in order to serve those who are battling the disease.

Sara Goldsby
Program Director
Department of Governmental Affairs
Department of Alcohol and Other Drug Abuse Services

Sarah Goldsby said that South Carolina has been her home for many years but she was born in Wyoming and appreciates the committees work to eliminate rural disparities. South Carolina is a very rural state. Myrtle Beach, Charleston and Greenville have grown in the past 16 years but the other areas are growing more rural as farming and manufacturing jobs are declining.

From July 2014 to July 2015 over 4 million prescriptions for opiates were dispensed to 1,225,000 individuals in South Carolina. There were a total of 291,438,514 pills dispensed. There were 4,832,000 people who resided in South Carolina in 2014. The individuals receiving prescriptions and the number of opiate prescriptions dispensed are trending downward but the quantity of pills dispensed is trending upward. In South Carolina there are at least 63 opiate pills per individual which is alarming.

The Department of Health and Environmental Control in South Carolina has done a great job of preventing clinics from prescribing medication without high quality treatment. Additionally, the Bureau of Drug Control representatives are pharmacists and also law enforcement officers that identify prescribers who are outliers and prescribing high numbers of opiates. They also identify individuals who are prescribed the high number of opiates.

Drug trafficking and accessibility is an important issue for rural areas. Law enforcement data states that traffickers of heroin know to stay off of I-95 because there is high drug intervention. Drug traffickers are taking I-85 and other small interstates which is leading to drugs being available in rural areas. This trafficking is causing higher numbers of overdoses in these rural communities.

A rise in the number of pain pill deaths in Anderson County, South Carolina is a great concern. In the past 14 months, 31 people have died of overdoses. Twenty nine of the deaths were accidental. Stanley Shaw, age 17, was found dead in his bedroom due to an overdose of prescribed drugs mixed with other drugs. His parents said that he was struggling with anxiety and taking medication and he also struggled with drug abuse. Stanley Shaw was getting ready to finish high school and marry his girlfriend.

The stigma of drug related deaths is such a stigma that people are ashamed and family members do not want the cause of death on the death certificate. This should be a disease that is addressed as a community instead of trying to cover it up. The stigma has to be removed.

Opiate abuse and use is not being identified in our senior population. When seniors pass away in a nursing home, there is no death investigation. When there is a senior on a huge list of prescription drugs, they may be suffering from respiratory failure due to opiates. Some seniors may have trouble eating and swallowing due to the opioids and that can cause aspiration and pneumonia.

Environmental risk factors are characteristics in a person's surroundings that play a part in a person's risk of developing substance abuse disorder include: family, friends, work, schools and community. There is one rural county that agencies have been working with that says illegal drug use and alcohol abuse are the top two concerns. There is a culture of apathy and fatalist attitudes

combined with high unemployment, isolation and the stigma of mental health issues. It is important to understand that these things are all related.

There are very few publicly funded treatment agencies with opioid based treatment services in rural communities. Abstinence-based treatment services are more widespread and there is evidence-based data that supports the need for opioid based treatment services. There are people who can not drive two hours to a methadone clinic or they do not have transportation so they are not getting the services. If methadone treatment is not available then people will go back to the drugs to maintain stability.

From the first time a person misuses prescription drugs or uses heroin it is about 8.2 years until they seek treatment. In 2015, over 1,000 individuals who were seen had a primary problem of heroin and over 4,000 individuals had a primary problem of prescription drugs. Of the people using heroin, almost all of them had injected in the past 30 days. The other risks for those injecting is infectious disease. Hepatitis C and HIV are co-occurring in the injecting users. Needle exchange programs would be beneficial in many communities.

In South Carolina, there are 230 physicians that are waived to treat opioid dependency with buprenorphine. There were about 72 of the 230 that were maxed out for the number of patients that they could see last year. The federal government is considering allowing more than 100 patients per physician that can be seen for opioid dependency medication treatment and that would be incredibly beneficial. These individuals need to be seen often and monitored and they need to be given the best care possible.

There needs to be permanent, year around sites for unused prescription drugs. Dispensing pharmacies to become sites has been a challenge, especially in rural areas. The hospital association has been helpful in getting receptacles in pharmacies but the pharmacy association said that pharmacists are being held at gun point and robbed. They do not want to collect unused prescriptions because they will be a target. Larger hospitals are engaged and the public needs to be aware and take their unused drugs to safe places to be disposed of in rural communities.

Law enforcement agencies have been trained with naloxone in order to respond to those who have overdosed. Law enforcement officers are exhausted from seeing people die and are really ready to have a way to respond. South Carolina has incorporated the Emergency Medical Systems database with the law enforcement related to overdose reversals. There is a distinct tracking system and the officer can upload information about the overdose reversal that can be shared with EMS. This leads to more intervention and connecting treatment counselors and peer recovery specialists to those who have had an overdose.

In Chesterfield County it takes about 40 minutes for a deputy to respond to an accident on the other side of the county. It would be too late for a person who has overdosed. Family members, loved ones and volunteer firefighters need to have Naloxone on hand for those who experience an overdose. Mothers, sons, girlfriends or anyone close to a person struggling with an opiate abuse disorder need to have naloxone on hand. People are fearful to ask for the prescription so there is a lot of work to do but engaging with law enforcement is the first step.

People who recently lost their lives because of opiate abuse in South Carolina include a single father, two students at the same community college who overdosed separately but with the same batch of laced heroine. It is probable that all of the South Carolinians that were lost could have been helped if there was more done through prevention, intervention and treatment.

A success story is Katy Austin who says that she found prison before she found treatment. She kept using opiates so she wouldn't go through withdrawals. After intensive inpatient treatment she is in her third year of recovery. She is working and going to school and is an advocate of inclusive recovery. Group support systems in communities are abstinence based and do not embrace individuals on medication. There are many paths to recovery and those who are assisted with medication treatment need to be included. Recovery communities in rural areas and stigma can have seriously negative consequences for those who are especially vulnerable and need that support.

Fred Leyda
Director of Human Services
Beaufort County Human Service Alliance

Fred Leyda shared the success of collaboration between human service organizations through the Beaufort Human Service Alliance. Collaborative Organizations of Services for Youth was formed in the 1990's in Beaufort. Collaborative Organizations of Services for Youth created a platform for agencies to sit at the same table so everyone could learn about each other's services. Collaboration Organizations of Services for Youth lead to The Human Services Alliance which began in 2002 including 85 government agencies, non-profits, faith leaders and citizens that meet quarterly. There is now a system of over two dozen collaborative groups in Beaufort County to address quality of life: economy, education, social wellbeing and health and environment.

The Human Services Alliance became a collective way to have an impact in the community. A state education report was done for Beaufort for the education oversight committee and the raw data showed that 98% of children entered kindergarten on grade level last year. The same was true for Jasper County, which is very poor. Collaboration is making a huge difference regarding successful outcomes.

When all of the agencies sit together at the table, all agencies can work together as one. The core elements that allow this type of collaboration are trust and respect. It is all about relationships and directors sometimes get so focused on the responsibility of their agency that they can't step back and see that they are a part of something much larger. The directors have one meeting a week instead of multiple meetings and collaboration makes their jobs easier. When people work together they become a team and have shared information on the people in the community. It gives a sense of community because everyone is one group working together for the better of the community. Money should not be the motivator to bring organizations together in collaboration. Agencies need to be there because they recognize that working in collaboration will better the community, the money will be available.

Collaborative Organization of Services for Youth has been in operation for 20 years. Twelve agency directors began to work together because it was more efficient. The average length of

time that a child was kept out of their home in a therapeutic placement was over 477 days. Last year in Beaufort County it was 24 days. It was costing the state \$300,000 to provide services and last year it was decreased to \$24,000. This is possible because families are being served more efficiently. The whole community is wrapped around that family so that their needs are met.

The Early Childhood Group has been working together since 2000 and modeled after the Collaborative Organization of Services for Youth concept where the family meets with all of the agencies at one time. Agencies meet with the families in the prenatal stage or when they have newborns to get information about the family so that agencies can create a plan for the mother without her having to attend. The group decides which agency would be most appropriate to work with the mother. There is a universal staffing team who talks to mother about her concerns in order to connect her to agencies that can best assist her.

The building of relationships between the faith community, government, for profit and non-profit to support families has been the reason for success over the past 40 years. This has been the most effective way to impact social ills in the community. It is very possible to have a public, private, non-profit partnership.

Q&A

Benjamin Taylor asked if there has been consolidation of agencies.

Fred Leyda said that the Child Abuse Prevention Association, Citizens Apposed to Domestic Abuse and Child Advocacy Center has formed the Coalition of Abuse Prevention.

Barb Fabre stated that confidentiality laws make it difficult to share information between agencies. How are they dealing with that issue?

Fred Leyda replied that the parents are voluntarily attending the group meetings and they sign a waiver allowing the information to be shared between agencies.

ALTERNATIVE MODELS I

Thornton Kirby
President and CEO
South Carolina Hospital Association

Thornton Kirby welcomed the committee to the palmetto state. He also welcomed the committee on behalf of Rick Toomey, the CEO of Beaufort Memorial Hospital who was not able to attend the meeting.

There are pressures on small rural hospitals nationally. The increasing specialization in large hospitals is driving people to go to urban centers for specialized treatments. It is difficult for small hospitals to build subspecialties. People are also bypassing their small rural hospital because the 2008 recession caused job loss in rural communities. Many people in rural areas had to find work in urban settings. People who are working in urban areas decide to have their

physicians there as well. The general reimbursement and utilization forces are moving towards outpatient care. Small rural hospitals have challenges keeping a hospital census when many services move to outpatient. It is difficult to have a viable hospital when there are very few inpatients.

Longstanding funding challenges are an issue with small hospitals. Many rural hospitals in rural South Carolina were built in the 1960's or 1970's and haven't been renovated. The urban centers have modern hospitals and it is drawing people who have insurance to the urban hospital. When there are uninsured patients depending on Medicaid, the rural hospitals do not have money to reinvest into the facilities. The small rural hospitals have a heavy dependence on one or two physicians. The rural hospitals that have a surgeon are doing well but hospitals without surgeons are struggling. There are usually only surgeons that come one day a week. There is a tug of war between what the community needs from the hospital and what the reimbursement system favors. Many of the rural hospitals are in areas that are close to urban hospitals so they don't need a surgical center or advanced imaging. The rural hospital needs emergency care, primary care, basic diagnostics, lab and x-ray. There is not a need for advanced surgery. The CEO wants to meet the needs of the community but also needs to have surgical and advanced imaging revenue to keep the doors open.

Another challenge for rural hospitals is a difficult time recruited physicians. There are not amenities in small communities and the cities are also paying well. The physician has to really want to be in a small community in order to live and work there. Whether or not states expanded Medicaid is a big issue related to rural hospitals. Expanding Medicaid is a priority when it comes to stabilizing rural hospitals. There are many people in rural communities who cannot afford to pay for services.

South Carolina legislature created the South Carolina transformation fund in July 2014. The transformation fund assists qualifying hospitals to transition to more sustainable models of service delivery that meet the needs of their community and reduce reliance on inpatient admissions, surgery, or high-tech diagnostics. This includes encouraging new long-term partnerships between rural hospitals and community, tertiary and teaching facilities to ensure seamless, timely and high quality clinical care for patients in rural parts of the state.

The South Carolina Department of Health and Human Services is tasked to fund and manage the program. A 15 million state appropriation was matched with 25 million of Disproportionate Share Hospital funds to create a 40 million pool. Transformation projects cannot exceed 4 million for this pool. South Carolina Department of Health and Human Services contracted with South Carolina Office of Rural Health for 1 million from the pool to allow target hospitals to access consulting services to develop sustainability plans. The hospitals training programs allowed flexibility for hospitals to design partnerships that would be beneficial to the community. Beyond an acquisition or lease partners may include primary care, emergency care, post-acute care, and/or long-term care. The use of telemedicine can also be used to create opportunities.

Nine target hospitals have sustainability plans completed. The plans are individualized but all include a combination of identifying prospective partnerships as well as opportunities for

rejuvenation. Depending on the hospital, some of the planned activities were carried out in conjunction with an advising hospital either during the planning or proposal phases.

There have been three projects approved by the state. Seven placeholder applications were submitted on behalf of target hospitals to the state by April 1st. The state will approve or deny all projects and expense resources by 9/30/16.

Dr. Graham Adams
Chief Executive Officer
South Carolina Office of Rural Health

Graham Adams thanked the committee for the invitation to speak and shared that he enjoyed his time as a member of the committee. Dr. Adam shared that the trend of small rural hospital closures is alarming. There have been 107 small rural hospital closures since 2010. There is a linkage between states that did not expand Medicaid and rural hospital closures. There have been three closures in South Carolina and one that has temporarily suspended service due to damage from a storm. Most of the small rural hospitals in South Carolina are within 45 miles from another facility. The Low Country and Pee Dee portion of South Carolina are the poorest areas and struggle with negative outcomes.

Bamberg County Hospital closed in 2012. It was a small rural hospital and did two analyses to see if the Critical Access Hospital Model would work for them. The CEO could only focus on the negatives of Critical Access Hospital Reimbursement and not the potential. Different consulting firms came in to assist. There was a thriving nursing home in the hospital. There were two towns that wanted to build a new facility but they could not come to an agreement so the hospital closed. A neighboring, larger facility has opened an urgent care, extended hour clinic in Bamberg County. That has provided some enhanced care at the local level. Some of the local physicians and the local surgeon left Bamberg County.

In the spring of 2015, the Marlboro Park Hospital closed. There were two small rural hospitals owned by the same real-estate investment trust. They had a contract with a company to operate the hospital. The contract company decided to no longer operate the facilities. A large health system from Florence, SC manages one of the two facilities and the other closed. The surviving facility has done a great job of reaching out into the rural community.

Southern Palmetto Hospital closed January 2016. There were many leadership changes throughout the years. They were looking at building a regional facility but were purchased by a for profit company. The company had been successful in other ventures but not healthcare related ventures and eventually went bankrupt. Another investor ran the hospital for about a year and a half but closed abruptly. The building is now owned by a bank in Tennessee and not available for local use. There is a Federally Qualified Health Center that has served the county for the last 40 years and is working with the county to do an extended care model.

Williamsburg Regional Hospital is included on the federal map as closed but the hospital considers it as temporarily suspended services due to flood damage. The plan is that they will reopen. It is a critical access hospital and has a modular emergency department unit onsite and is awaiting approval from Federal Emergency Management Agency to open. They have a 24 hour rural health clinic that has been opened since the closure of the hospital. There is lab, physical therapy and surgery is being done at a nearby facility. The hospital is doing all that they can to maintain service at a local level and plans to reopen.

There are more rural hospitals at great risk. The margins are very thin and the model they operate under is the same as 40 or 50 years ago and it is difficult to transition into the new model.

Q&A

Mary Kate Rolf asked how much community involvement there was in the decision making process related to the community hospitals.

Graham Adams said that besides the board there was not much community input. Part of the reason hospitals are closing is because the census is low and people are choosing not to go there.

Thornton Kirby stated that many of the hospitals are outdated and people in the community have a difficult time supporting a hospital that is out of date. It is difficult for people to sacrifice their family's wellbeing by keeping a hospital facility that is out of date. Whatever new model there is it needs to be called a hospital. Communities need to feel that they are not losing a hospital but it is being converted to a more modern version.

Peggy Wheeler asked why there were sixteen hospitals with the criteria to apply only ten hospitals were funded.

Graham Adams said that the state allowed all rural hospitals to apply for the sustainability plan. There was \$14 million available. Three projects are approved but didn't have a sustainability plan done because they were being acquired by larger facilities.

John Supplitt Senior Director of the Section for Small and Rural Hospitals American Hospital Association

John Supplitt stated that he would be discussing Innovative Models of Health Care Delivery across Rural America. It is a pleasure to talk about the things that members' and member hospitals are doing that are innovative and everyone should know more about. Three things that are motivations are Department of Health and Human Services goals for alternative payment models, Medicare Payment Advisory Commission report on alternative delivery models and rural hospital closures.

Health and Human Services value-based payment plan calls for: 30% of Medicare fee-for-service payments to alternative payment models and 85% to quality or value by 2016. By 2018 the plan calls for 50% of Medicare fee-for-service payments to alternative payment models and 90% to quality or value. The Health Care Transformation Task force is committed to moving 75% of its businesses to value-based arrangements by 2020.

The Center for Medicare and Medicaid Services Innovation Center demonstration projects include the Frontier Community Health Integration Project, Frontier Extended Care Clinic, Rural Community Hospital Program, Centers for Medicare and Medicaid Innovation Challenge Grants and State Innovation Models and State Innovation Models.

The Center for Medicare and Medicaid Services Innovation Center Alternative Payment Models include bundled payments and the accountable care organization investment model.

ALTERNATIVE MODELS II

George Pink
Humana Distinguished Professor
Department of Health Policy and Management
UNC Chapel Hill

George Pink thanked the committee for inviting him to speak and stated that he would share data regarding rural hospital closures and free-standing emergency departments. The Rising Rate of Rural Hospital Closures Study defined closure as a hospital that is no longer providing inpatient care. A hospital has to provide inpatient care according to Medicare.

There have been 110 hospitals close between January 2005 and January 2016. Many of the hospitals that have closed are in the southern United States. There seems to be a statistical correlation between states that did not expand Medicaid and hospital closings. Most of the states in the south that have not expanded Medicaid have community hospitals that have been struggling for many years.

When hospitals close in rural communities, people are forced to travel to larger communities for services. Over half of the rural hospitals that close, the people in those communities will have to drive 15 miles or more. In some rural areas, people will have to drive 30 or even 100 miles to get to the nearest hospital.

Some of the reasons for rural hospital closures include small declining populations, the number of insured patients, competition, deteriorating facilities but the most common reason is the financial factors. Most of the hospital closures are community access hospitals and prospective payment system hospitals. There is little research on the impact of rural hospital closures. There is an economic cost of rural hospital closures because rural hospitals are usually one of the top two employers.

The Rural Hospital Closures and Health Disparities Study looks at the effects of rural hospital closings. The findings disclosed unobservable consequences of rural hospital closures. There

were two categories of hospitals that have closed: permanently closed hospitals and hospitals that became another kind of healthcare facility. There is a difference between these two categories. The abandoned hospitals served a higher proportion of minorities and were located further away from other hospitals. This shows that there are some health disparity issues that are not obvious from secondary data that needs further exploration.

Dr. Pink stated that The NC Rural Health Research Program did an article for The Journal for the Healthcare of the Poor and Underserved. They tried to decompose racial composition for the hospital markets and there is a higher percentage of the population being black and Hispanic in the hospitals that permanently closed. They also found a higher premature death rate in the counties where hospitals permanently closed. There needs to be more careful research relating health disparities in rural areas.

There are two examples of rural hospital closures that occurred in very different ways. One is in Belhaven, NC, on the east coast of North Carolina in a poor, economically deprived area with a high percentage of a minority population. The other was in Blowing Rock, North Carolina, in the western part of the state with a primarily Caucasian community. Blowing Rock is seven miles from a large medical center and the people in eastern North Carolina have a 30 mile drive to get to the nearest hospital. In Blowing Rock, when the hospital closed, there was an immediate ground breaking for new facilities and services to replace the acute care hospital. The Chamber of Commerce was actively involved; the transportation secretary gave 3 million for new roads. In Belhaven, North Carolina, there was not the same response. This brought together the republican mayor of Belhaven, North Carolina, and the head of the NAACP, Reverend Barber, and they walked to Washington, DC to protest the closing of the hospital. The mayor stated that closing the hospital is an outrage and the Vidant system which closed the hospital made 100 million in profits and closed a critical access hospital. These are examples of two totally different outcomes due to hospital closures in rural North Carolina.

The North Carolina Rural Health Research Program policy brief on the estimated costs of rural freestanding emergency departments first considered the legislation that is already in place. This was entirely based on costs. The legislation states that rural freestanding emergency departments should provide 24/7 access to care, be affiliated with a hospital or health system, have newer facilities, be conveniently located and have shorter wait times than the traditional emergency department.

Independent Freestanding emergency departments tend to be located in wealthy, suburban areas with a large payer mix. Most of them do not have contracts with insurance companies but have patients that can pay for care. Rural freestanding emergency departments do not exist. If there were freestanding hospitals in rural communities, they would be further from a close hospital, have lower volumes and a higher percentage of Medicare and Medicaid.

The Rural Health Research Program considered with the existing legislation on freestanding emergency department, what is the lowest volume of patient care that could be established under the current legislation. There were three models established: 6 beds, 12 beds and 18 beds at 6 million, 9 million and 13 million cost.

The Rural Health Research Program posted a spreadsheet to their website so hospitals can download the spreadsheet and put in their data to get an estimate of what their freestanding hospital would cost for their volume.

MedPAC expressed an interest in pursuing this further because the models and cost are great for existing legislation but if there were an opportunity for different legislation that did not require 24/7 medical coverage but the conditions of participations for the critical access hospitals. This would allow for smaller levels of patient volumes. This is feasible because many small communities have physicians in privately owned clinics that could double as the medical director and a consultant pharmacist available and other supports in place.

Three models were created for low, medium and high volume hospitals. When looking at the models for freestanding hospitals and how many hospitals would be interested in the models, there was a graph constructed comparing net patient revenue to distance to the next hospital. Every proposal that MedPAC developed in the past years has had distance as a criteria. The hospitals less than 5 million in net patient revenue and greater than 25-35 miles from the closest hospital may be potential hospitals. This includes about 240 hospitals as a maximum.

It would be beneficial to have panel of advisors on freestanding hospitals in rural communities, considering state laws, services that should be offered, patient volume, different medical models and the importance of distance. The results from the panel will be beneficial when considering staffing and costs estimates and if this is a viable model for freestanding hospitals in rural communities.

Q&A

Kelley Evans said that in addition to focusing on the closing of rural hospitals is that a focus on critical access hospitals that are doing well and emulating their models?

John Supplitt replied that high performing community access hospitals have specialty care and surgery. Post-acute services are more realistic and will continue to be a need.

PUBLIC COMMENT

There was no public comment.

Tuesday, April 19th, 2016

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

HEALTH SUBCOMMITTEES

Rural Hospital Alternative Models

Keyserling Cancer Center

Subcommittee members: Kathleen Belanger, Christina Campos, Kathleen Dalton, Carolyn Emanuel-McClain, Kelley Evans, Mary Kate Rolf, John Sheehan, Mary Sheridan and Peggy Wheeler.

Staff Members: Tom Morris and Donya Nasser.

HUMAN SERVICES SUBCOMMITTEE
Prescription Painkiller and Opioid Abuse

Beaufort County Social Services

Subcommittee members: William Benson, Ty Borders, Rene Cabral-Daniels, Barbara Fabre, Constance Greer, Carolyn Montoya, Maria Sallie Poepsel, Benjamin Taylor

Staff Members: Steve Hirsch, Jocelyn Richgels and Pierre Joseph.

The subcommittees' returned to Keyserling Cancer Center in Beaufort, South Carolina to discuss site visits.

PUBLIC COMMENT

There was no public comment.

Wednesday, April 20th, 2016

The Meeting was convened by Governor Ronnie Musgrove, Chairman of the Committee.

DRAFTING OUTLINE OF POLICY BRIEFS

HEALTH SUBCOMMITTEES

Rural Hospital Alternative Models

Keyserling Cancer Center

Subcommittee members: Kathleen Belanger, Christina Campos, Kathleen Dalton, Carolyn Emanuel-McClain, Kelley Evans, Mary Kate Rolf, John Sheehan, Mary Sheridan and Peggy Wheeler.

Staff Members: Tom Morris and Donya Nasser.

Subcommittee considerations/ possible recommendations

- Annual base payment, separate from fee for service and visits, will be necessary to support a low volume facility providing emergency services
- Traditional cost-based payment model will not reliably cover operating costs
- New facility type would be required, based on either freestanding ED or primary care clinic
- Facility must have a limited set of required (core) services, plus optional services depending on community need
- The CAH ED Conditions of Participation provide appropriate base level of staffing and service requirements (appropriate flexibility with staffing type and call coverage)
- Eligibility based on combination of isolation as determined by driving distance to existing EDs and community demographics showing high need and limited access to care

HUMAN SERVICES SUBCOMMITTEE
Prescription Painkiller and Opioid Abuse

Beaufort County Social Services

Subcommittee members: William Benson, Ty Borders, Rene Cabral-Daniels, Barbara Fabre, Constance Greer, Carolyn Montoya, Maria Sallie Poepsel, Benjamin Taylor

Staff Members: Steve Hirsch, Jocelyn Richgels and Pierre Joseph.

Subcommittee considerations/possible recommendations

- Difficulties related to prior authorization for prescribing medications for opioid abuse
- The Importance of Telehealth for therapy and specialists who can prescribe medications
- Financial mechanisms for rural physicians to encourage behavioral health services
- Training and education for healthcare professionals
- Expanding medical authority to physician assistants and nurse practitioners
- Research on opioid abuse in older adults
- Innovative programs tailored to rural areas
- Transportation issues in rural communities is a barrier for people seeking medical assistance
- Financial assistance for grandparents who are caring for grandchildren who have been removed from a home (kinship care)
- Housing for people transitioning from substance abuse treatment
- Requirement that physicians provide counseling when prescribing medications for opioid addiction

FEDERAL UPDATE

Tom Morris

Associate Administrator

Federal Office of Rural Health Policy, HRSA, HHS

Rockville, Maryland

Tom Morris stated that the rural funding for the President's FY 2017 budget include the Federal Office of Rural Health Policy Programs, National Health Service Corps, primary care training, area health education centers, teaching health centers, healthy start and home visiting.

Some considerations for the fall Rural Health and Human Service National Advisory Committee meeting are that it is a transition year; key national trends are Medicare merit-based incentive payments and alternative payment models. Other key issues are health information technology, rural population health payment considerations and rural considerations related to mental health reform. Rural Considerations in the Medicare Access & Children's Health Insurance Plan Re-Authorization Act is another key issue that can be considered.

The White House Rural Council reinforces that collaboration is a key part of initiative and the White House Rural Council collaborates with Health and Human Services and with other Fed programs this has greatly enhanced their outgoing work. The White House Rural Council is now

in its third year, it's been the longest Executive Branch focus on rural issues ever and health care remains front and center for the council.

Other focuses include the National Health Service Corps, community access hospitals, Health IT training and capital and using telehealth and the health information exchange to enhance care for rural veterans. Working with rural focused Foundations and Trusts to learn from each other, share information and inform our future efforts is also a priority.

Gina Capra
Director
Office of Rural Health
Veterans Healthcare Administration

Gina Capra told the committee that she would give an overview of rural veterans and the Veterans Association increasing access to care and strategic partnerships.

There are 22 million veterans in the United States and 5.3 million live in rural areas. There are 9.1million veterans enrolled in Veterans Administration health care and 3 million are rural veterans. Thirty three percent of enrolled Veterans live in rural areas. Twelve percent of veterans served in Iraq or Afghanistan and typically have multiple medical and combat-related issues. Eight percent of veterans are minorities and 6 % are women. There are 167 Veterans Administration Medical Centers. There are 771 Community Based Outpatient Clinics and health care centers, 287 other outpatient and/or residential service sites which include mobile medical and telehealth units. The Veterans Administration has 300 readjustment counseling centers and 80 mobile veteran centers.

The Veterans Administration is engaging community providers by establishing community-based outpatient clinics, patient-centered community care contracts and by launching The Veterans Choice Program. The Veterans Choice Program provides greater access to community health care for eligible Veterans and coordinated care.

The Veterans Choice Program allows eligible Veterans the choice to receive pre-authorized health care in their communities from community Veterans Choice Program providers, rather than waiting an extended time for a Veterans Administration appointment or traveling a significant distance to a VA medical facility.

The Veterans Administration Budget and Choice Improvement Act calls for improving veteran access to care by consolidating community programs into one and standardized New Veterans Choice Program. The new program will standardize access to community care through a high-performing network with robust care coordination and timely provider payment. A transformation of this scale and impact will require phased implementation and a systems approach. The Veterans Administration submitted a proposal to Congress on October 30, 2015.

The Veterans Administration Secretary of Health Priorities are open access to care, improved employee engagement, consistency in best practices and quality, a high-performing network and restored trust and confidence. In 2006, Congress passed legislation to create the Office of Rural

Health. The Office of Rural Health was established in 2007. The Office of Rural Health works across the Veterans Administration and with external partners to develop policies, best practices and lessons learned to improve care and services for rural Veterans.

COMMITTEE BUSINESS

Topics to consider for the September meeting in Albuquerque, New Mexico are:

- Impact of block grants in rural America
- Social determinants of health having the highest poverty rate for children
- Health disparities
- Chronic care management
- Telehealth being developed as rural outreach in telemedicine
- Joint social determinants of health including health and human services

PUBLIC COMMENT

There was no public comment.