

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

National Advisory Committee on Rural Health and Human Services

**Albuquerque, New Mexico
September 14-16, 2016**

Meeting Summary

The 80th meeting of the National Advisory Committee on Rural Health and Human Services was held September 14-16th, 2016, in Albuquerque, New Mexico.

The committee members present at the meeting: Kathleen Belanger, PhD; William Benson; Ty Borders, PhD; Rene Cabral-Daniels, MPH, JD; Christina Campos, MBA, FACHE; Carolyn Emanuel-McClain, MPH; Kelley Evans; Barbara Fabre; Octavio Martinez, Jr., MD; Carolyn Montoya, PhD, CPNP; Maria Sallie Poepsel, MSN, PhD, CRNA; Chester Robinson, DPA; 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 Federal Office of Rural Health Policy: Tom Morris, Director; Steve Hirsch, Executive Secretary; Paul Moore, Senior Health Policy Advisor and Aaron Beswick, Public Health Analyst.

Present from Rural Policy Research Institute: Jocelyn Richgels, Director for National Policy Programs.

Present from the U.S Administration for Community Living Region IX Office: Dennis Dudley, Aging Services Program.

Truman Fellows present: Pierre Joseph and Adam Cohen.

Wednesday, September 14th, 2016

The meeting was convened by Governor Ronnie Musgrove; Chairman of the Committee. Governor Musgrove welcomed the committee to the 80th meeting of The National Advisory Committee on Rural Health. The topic of the meeting deals with Rural Relevant Social Determinants of Health. Health consists of far more than just the healthcare a person may receive through a doctor's visit and prescription. Addressing other determinants needs to be a priority and will be the focus of the meeting.

Governor Musgrove thanked committee members, Christina Rivas Campos and Carolyn Montoya, for hosting the meeting and also thanked everyone who assisted in the planning of the meeting.

New Mexico Orientation

Dolores Roybal
Con Alma Health Foundation, Executive Director
Santa Fe, New Mexico

Dolores Roybal welcomed the committee and thanked them for coming to New Mexico. She told the committee that she would share with them the New Mexico that she knows. People have many different perspectives depending on life experiences, biases, ignorance and a whole array of other reasons. Not many people can see the whole picture. New Mexico is statistically near the bottom of the list regarding social determinants of health and health disparities but with all of these challenges it is a land with incredible beauty, diversity, history and culture.

Ms. Roybal is a 5th generation New Mexican and grew up and lives in Espanola, which is predominately Hispanic and Native American. She grew up in a rural area of Espanola and didn't know she was poor until she went to graduate school at the University of Denver. Her family had food, a house, used the barter system and knew the value of family and community. When her sister couldn't care for her sons, she and her husband, without hesitation, raised them along with their own three children. It never even occurred to them for the children to be placed in foster care or adoption.

Con Alma is an equity foundation with the belief that everyone is entitled to a healthy life. Some health disparities are not inequitable for example biological differences between males and females. Health equity is framed around social justice. Con Alma focuses on broad policy and systems change. New Mexico is approximately 70% people of color but there are only 12% nurses of color. An initiative is to get more people of color to go into the nursing field to increase ethnic and cultural diversity. Con Alma partnered with the University of New Mexico on a pilot program with children as young as middle school to get more students of color into nursing.

Culturally diverse rural and tribal communities with a broad definition of health includes: primary health, behavioral health, oral health, environmental health and spiritual health and wellbeing. Con Alma examines culture, tradition and community for existing strengths. Rural health is not viewed in a negative perspective but as a focus on strengths. There will be a large increase in the percentage of the elderly so there has been a village model created. This is not a new model for those who were raised in a village. Neighbors and families have always been helping each other in villages and rural communities. In closing, we continue to view the challenges from the perspective of the communities and people most impacted.

Carolyn Montoya, PhD, CPNP
Associate Dean of Academic Affairs
College of Nursing, University of New Mexico
Albuquerque, New Mexico

Carolyn Montoya shared that she is native and grew up in the southern part of the state. Her parents are from a farming community called Jarales. Originally her family is from Spain and settled in the valley to farm. Ms. Montoya's said that her mother was the youngest of sixteen and

would roast chiles with her sister. When she walked into the door from school, the first smell was the roasting of chiles.

Ms. Montoya stated that she would speak to the committee about primary care providers and patient perspectives of rurality. There are 2.1 million people in New Mexico but most of the population is centered in metropolitan areas. There is a very large land mass with a great number of frontier and rural areas.

The shortage of primary care workforce includes primary care providers, nurse practitioners and physicians, and is mainly in the frontier and rural areas. Increasing the number of primary care providers is essential. The University of New Mexico's College of Nursing has been pleased that state legislatures have increased funding to double the number of nurse practitioners that can attend.

Ms. Montoya shared a film documenting a family practice in a rural community. It focuses on people waiting until they are very sick before they come to the doctor and other patients that come in with a deep wound who won't go to the city for assistance because they need to go back to their farm to care for their animals. Patients are also coming in and using the family practice as a counselor because there is nowhere else to go for counseling services.

Project Extension for Community Care Outcomes has been a great benefit to rural communities in New Mexico. It is an internet based link between primary care clinics in rural areas and the University of New Mexico's School of Medicine in Albuquerque. It is a successful way of training rural doctors so that people can stay in their community to receive treatment.

Christina Campos, MBA, FACHE
Administrator, Guadalupe County Hospital
Santa Rosa, New Mexico

Christina Campos shared that she is a first generation New Mexican; her family came from Mexico. Her husband's family came to New Mexico in the 1600's.

The three communities that the subcommittee members will be visiting are Laguna, Santa Rosa and Cuba and are very different from one another. The north is mountainous with trees; the west is more desert and to the east are more mesas. There is rich spiritualism in New Mexico and combining nature, home and health is essential.

The New Mexico flag has the Zia Sun symbol in red that is part of the Pueblo tribe. Four is a sacred number and symbolizes the Circle of Life: the four directions, the four times of day, the four stages of life, and the four seasons.

Ms. Campos told the committee that she also grew up poor but didn't know that her family was impoverished. The people of New Mexico are very resilient. In Guadalupe County, for a while the factors were really bad but the outcomes were really good. There is so much support among

the people; people across the different systems and parts of the state know one another and work together.

Ms. Campos shared the following statistics on the areas that the committee members visited and overall statistics for New Mexico:

- The population of Laguna (Cibola County) has a population of 1,241. 96.45% of the residents are Native American, and the median age is 38. Per capita income is \$10,980 and 28.6% of families are under poverty level.
- The population of Santa Rosa (Guadalupe County) is 2,848. 81.16% of the residents are Hispanic, and the median age is 36. Per capita income is \$11,168. There are 18.9% of families under poverty level.
- The population of Cuba (Sandoval County) is 736. 60.34% of the residents are Hispanic and 26.7% are Native American. The median age is 32 and per capita income is \$11,192. There are 36.5% of families under poverty level.
- The population of New Mexico is 2,085,109. Forty seven percent of the residents are Hispanic, 9.4% Native American, and 2.6% are black. The median age is 37.2 and per capita income is \$37,091. There are 20.6% persons in poverty.

What the committee will be discussing throughout the week is health factors, behavior, clinical care, social and economic factors and physical environment. The distance to the doctor's office, housing situations, health conditions, stress and depression are all connected when discussing social determinants of health. In parts of northwestern New Mexico, a pregnant mother will have to travel 120 miles to deliver her baby.

As an advisory committee and in terms of national policy, the focus is what can or should be done with a focus on rural social determinants of health. The committee needs to discuss the barriers, what is and isn't working, the challenges and what we need to address.

Q&A

William Benson said that the per capita income in Santa Rosa, Cuba and Laguna was less than a third of the statewide per capita. Is that similar to most of rural America?

Steve Hirsch said that median income in rural America is consistently lower but New Mexico is lower than the national median.

Government Musgrove stated that Mississippi and other areas have between \$11,000-14,000 median incomes. It is probably fairly normal across the country but it is interesting when it gets compared to the state average. Regardless of the state average if the average income is somewhere in that area, it is poverty level income regardless.

Octavio Martinez asked if they have a percentage of the undocumented individuals in New Mexico and if it affects how resources are accessed by individuals.

Christina Campos replied that in Santa Rosa there are very few undocumented workers but in smaller areas of the state there are more. Farms and the ranches attract migrant populations. Many of the poor, undocumented workers aren't in the census or numbers related to income.

Donald Warne said that income is an important measure of poverty but so is land ownership and home ownership. There was a long standing history of displacement and enslavement and loss of control and ownership. A big challenge is less control of land. Historically, there was not a concept of land ownership. Measurements of poverty are not just related to income.

Barb Fabre stated that in early childhood they are looking at the adverse childhood experiences (ACE) factors. Children are living in situations that may not be healthy. This has an ultimate effect on children and their outcomes.

Terry Brunner
State Director
USDA Rural Development
Albuquerque, New Mexico

Terry Brunner said that many of the issues the committee is discussing are discussed on a regular basis at USDA. The Secretary's strike force effort is working to get to the roots of persistent poverty across the United States. USDA rural development program adjusts housing, rural utilities, rural business and economic development. In the State of New Mexico, over seven years, they have invested about 2 billion dollars. Two of those years they invested more than the entire state appropriations budget. He asked the committee to keep in mind that USDA is ready to assist with many of the issues, and is looking at more efficient ways to get resources to grassroots needs. In Cibola County, there was a 26 million dollar investment in the waste water system. The money was reinvested in new market tax credits and added an additional 8 million dollars to the project.

In Grants, New Mexico, there are issues with their economy. There was a young woman in Grants who was going to have her children removed from the home by the Children, Youth and Families Department. Her attorney called to find ways for her to keep her children. Mr. Brunner tried to get her into a multifamily apartment complex but she has a criminal record due to drug abuse and she has a bad credit score. These types of issues are dramatically affecting people. She can't get her credit cleaned unless she drives one hour to Gallup, New Mexico for classes. She doesn't have a way to get to a drug treatment program. This young woman will probably end up back on the wrong track and lose her children. The lack of service and access is a cause of persistent poverty in rural America.

The Community Facilities Program was used to finance the hospital in Santa Rosa. The loan rates are now the lowest they have ever been at around 2% up to 40 years. Around the nation this is helping with regional medical centers and clinics. There is a distance learning and telemedicine program which is up to \$500,000 in grants.

Rural communities that are succeeding at overcoming issues have strong leadership who make things happen. Leadership building is an important topic and how the federal government can support this type of program.

Framing Social Determinants of Health from the Federal Perspective

Tom Morris
Associate Administrator
Federal Office of Rural Health Policy, HRSA, HHS

Rockville, Maryland

Tom Morris asked the committee to focus on the rural relevance of social determinants of health throughout the meeting and site visits. A person's quality of life is determined outside of the medical office and moving toward value-based payment has given a broader view to the health community about what is happening outside of the clinic. Social determinants of health will be seen in the coming years in the allocation of grant dollars, payment policy, and what is done regarding risk adjustment of payment policy. This topic brings both sides of the committee together, health and human services, but it is difficult because it is a broad topic. The challenge is that the committee needs to be specific and beyond the conceptual so that there is a concise, tight policy brief with a focus on rural issues. There are social determinants that play out across the country but issues like geographic isolation are specific to rural.

Something else to consider is: if there is a policy that works great for the inner city, could it be a determinant in rural communities? It is important to consider these issues as well because the department is designing national policies that tend to be urban centered. The RHHS NAC can voice the implications on rural and what the HHS leadership needs to be taking into account as these are incorporating these policies into operation in the coming years.

Aaron Beswick
Public Health Analyst
Federal Office of Rural Health Policy, HRSA, HHS
Rockville, Maryland

Aaron Beswick said that while considering social determinants of health that affect rural communities; it is important to know how social determinants of health are already being incorporated into health and human service programs and policies. This information will assist in making decisions how to move forward and/or how to make changes when necessary.

Health and Human Service program and policy topics include: departments of priorities, place-based initiatives, cross-sector collaborations, workforce development and innovations, data collection and quality measurement, patient safety and cultural competence and research and analysis.

Public Health 3.0 is an update to Healthy People 2020. It is a framework that brings together business leaders, community leaders, and policymakers at the state and federal level to incorporate health into all areas of governance, emphasizing cross-sector, systems-level actions that directly affect the social determinants and advance health equity.

The National Partnership for Action to End Health Disparities (NPA) is a national initiative that convenes federal agencies and programs to create a platform for strategic cross-sector collaboration and coordination. This is an opportunity to bring together, for example, the Department of Transportation, Department of Education and Health and Human Services to talk about policy and how they are all affecting health.

The White House Rural Council convenes partners to streamline federal programs serving rural places and promote private-sector partnerships, including a partnership with rural philanthropies. A chosen initiative of the rural health philanthropy partnership is bringing together foundations to advance health equity in rural places, in partnership with select federal partners (FORHP). Dr. Delores Roybal is working on the health equity initiative to find ways to partner with private foundations to invest in rural communities and health equity.

Place-based initiatives include coordinated, interagency federal support that coordinates and organizes federal support for local, cross-sector, area-specific efforts to build healthy people and healthy communities. These programs include Promise Zones and Rural Impact.

Public-private partnerships including the Healthy Futures Fund are experimental efforts to leverage federal resources. These use federal resources in order to bring together health and human services.

Enabling services and cross-sector collaborations provides local community health centers with the resources to attend not only to patients' health concerns, but also those social and economic barriers that keep patients from care. Some of these barriers include: child care, transportation, and medical-legal partnership along with health insurance issues.

The Accountable Health Communities demonstration is to connect healthcare and community service providers to understand if this will reduce Medicare and Medicaid costs for patients with health-related social needs, primarily by increasing patients' awareness of community services, using healthcare visits as a method of screening and referral for community services, and building alignment between local healthcare and community service sectors (CMS).

Workforce development and innovations includes the patient centered medical home, which introduces new members of the care team whose role it is to guide patients through the healthcare system while making the necessary connections to allied social services (CMS). Community health workers and non-healthcare personnel can be vital supports in rural communities and improve patient outcome. The benefit of employing members of the community is their understanding and familiarity with the community and also job opportunities within their community.

Data collection and more relevant measurements for social determinants and healthcare's effect on social services are being developed. The federal government is working on risk adjustment and how Medicare should account for socioeconomic factors in risk adjustment.

Patient safety and cultural competency is being examined by the Agency for Healthcare Research and Quality (AHRQ). Governmental reports and academic research continue to indicate discrimination and bias in healthcare service provision according to race and income level. This is something that the committee could consider looking at through a rural perspective. The National Institute on Minority Health and Health Disparities is doing research and analysis to study social, economic, and environmental factors and their impact on differential health outcomes for certain racial and ethnic groups, lower-socio economic status groups, and rural populations.

The Rural Health and Human Services National Advisory Committee is on the ground level and can share specific recommendations regarding social determinants of health and what will best benefit rural communities.

Harvey Licht
Senior Associate with Varela Consulting Group
Albuquerque, New Mexico

Harvey Licht stated that there are lessons from rural New Mexico that can inform what happens in other rural communities. The communities that the committee members will visit are ones with multiple generations of the same families in the same place. The Native American communities and Hispanic communities over the course of the long history have experienced incredible trauma and loss. There has been loss of land, resources (mineral, water, timbering rights, grazing rights) and loss of family. There have been generations of people brought to boarding schools and put into foster homes. There is a history of enslavement. There is the loss of language that is the bucket of culture. There is a refusal of the schools to respect the birth language – including Native American and Hispanic language. There is a loss of autonomy with traditional governance. Beyond that there has been loss of life, including genocide. This is the historical piece that leads to the current social inequalities and inequities that exist in the rural communities. These are incredibly resilient and surviving communities. When visiting these communities, ask them what their health issues are and how they have been addressed historically. This is a unique opportunity because there is no other place where there is such a concentration of communities that have gone back so many years. From a health perspective related to loss, there is a behavioral side of multigenerational trauma. This is an actual, psychological diagnosis that leads to behavioral issues that need to be recognized. Epigenetics is how environmental traumas show up in subsequent generations in the expression of the genetic basis. Periods of famine and different types of abuse change the mitochondrial expression of genetic health. This type of history in minority, rural communities leads to today's social determination of health.

During the visits, there will be a chance to hear about family histories and how families and these communities have begun to deal with the issues themselves without reliance on the human and health services system. That is a unique New Mexico perspective that gives you the opportunity to explore.

Human and health service policy is important because it helps us familiarize health impacts of inequity and inequality. It can assist in reducing impacts of social determinants of health. Generally health and human service policy will not eliminate the inequality or inequity. There needs to be social policy to make these types of changes. What can health agencies and programs do to better coordinate and have an effect on the health status of people who are harshly affected by factors beyond their control. It will take generations of social policy needed to have true equity. People's life experience and how they respond to their realities in their environment is important to understand when trying to find answers. There is an incredible vitality and ability to survive the difficult environment.

There are programmatic interventions but it needs to be done in collaboration and partnership with local entities. When visiting these communities, the committee needs to ask how the health and human service system can work in partnership with communities regarding health status.

Q&A

Donald Warne thanked Harvey Licht for the comments and stated that it was wonderful to hear a holistic perspective that is not often heard from federal and state agencies. Historically the holistic impact of trauma on health inequities has not been discussed. Education on this topic could be improved across HHS. If it is not addressed on a social perspective it will not be resolved.

Harvey Licht spoke about Jack Geiger, a physician in Mississippi, who worked in one of the first community health centers. The health center included: health, economic development and community based engagement. Jack Geiger wrote a prescription for groceries for someone who was malnourished. The community action agency has a community cooperative farm that produced basic nutritional supplements for the local population. He didn't write a medical prescription, but was engaged with community development efforts to try and resolve their issues.

Carolyn Montoya said that resilience is not well understood. For Hispanics there is a paradox regarding health. There is a high rate of diabetes and hypertension but a higher life expectancy. The survivors of the Bataan Death March were largely made up of New Mexicans who managed to survive these horrific war conditions. It is important to draw on the strengths of the communities and resilience after a long history of suffering.

Barb Fabre thanked the USDA representative for talking about the families and the horrible cycles. Drug use is prominent in rural areas and children are growing up in unhealthy situations. White Earth is trying to do a holistic approach. There are families who want to get better but can't pass the background checks to get a job, can't get housing or a driver's license. These families are vulnerable and Health and Human Services and U.S. Department of Housing need to take this into consideration.

Octavio Martinez said related to the trauma and intergenerational aspects, he is reminded of the meeting in Hazard County, Kentucky and a learned helplessness of a community. From a behavioral stand point, how can there be interventions when communities who have resilience cannot move forward due to current policies. There needs to be an acknowledgment of trauma and those aspects that need to be considered.

Social Determinants of Health, the safety net, and the Intergenerational Economic Mobility: Are Different Factors at Work in Rural America?

Bruce Weber, PhD
Department of Agricultural and Resource Economics
Oregon State University
Corvallis, Oregon

Bruce Weber spoke to the committee about Social Determinants of Health, the Safety Net and Intergenerational Economic Mobility. There is a link between place, upward mobility and health and place-based policies that can affect upward mobility. Dr. Weber referred to Chetty et al. (*QJE* 2014) "Where is the Land of Opportunity", comparing the national income rank of adult children with the national income rank of parents in 1990s to identify the places where children have the greatest absolute and relative upward mobility.

Intergenerational mobility is shaped by the environment and therefore may be manipulated. Family structure, spatial job matching, inequality and social capital are all related. More local economic development policies can have local affects. Place-based policy may be more effective in rural areas. Non-metro counties have higher mobility in part because they have favorable conditions for upward mobility: Better spatial match between jobs and workers, Lower income inequality, higher social capital and lower shares of single-mother families.

Health policy affects economic mobility. Increased Medicaid payments in the 1980s and 1990s reduced infant mortality and low-weight births. Reduced low-weight births are linked with upward economic mobility. Social safety net programs increase upward mobility by reducing poverty and having positive health benefits. Health and economic opportunity reinforce each other in a circular and cumulative way. There are intergenerational benefits of place-specific policies that improve both health and mobility.

Family structure, the percentage of single mother families, is the single most important predictor of upward mobility in both metro and non-metro counties. The quality of spatial job matching is strongly associated with non-metro upward mobility. Income inequality is a small but significant predictor of upward mobility in both metro and non-metro counties. Social capital is significantly correlated with upward mobility only in non-metro counties.

There can be positive health outcomes from non-health interventions at the local level. Health policy could support localities in having a holistic approach when considering the health of a person. In Oregon the coordinated care organizations are looking at the broad social context and considering the possibility that the health care system could pay for interventions that are not specific to health interventions.

Q&A

Chester Robinson said that when examining babies with low birthweight along with upward mobility if there was also the consideration of low birthweight and education. There was a study in Memphis about low birthweight and it found that most of the low birthweights were from teenage mothers. In Memphis, they were linking this to education. Is low birthweight really a determining factor?

Bruce Weber responded that the study doesn't assert that if low birthweight rates decrease, upward mobility will increase. There are many factors that are interconnected. This research tries to choose possible factors that can be linked to causes but it does not state that it is the cause.

Keith Mueller, PhD
RUPRI Center for Health Policy Analysis
University of Iowa
Iowa City, Iowa

Keith Mueller thanked the committee for inviting him to speak about rural healthcare delivery with a focus on social determinants of health. How change policy from a 50 year focus on delivery of clinical services to a model that incorporates the social determinants of health is difficult.

Healthcare delivery system transformation includes: mission, vision and payment policy changes. Slightly less than three trillion dollars is the total healthcare expenditures. The number spent on social services is very minimal. If investment in services, programs and communities is going to improve health, there needs to be more investment in social determinants of health from those who budget the three trillion dollars. Thought needs to go into how to design a system that incorporates social determinants of health and how to influence the vision of healthcare organizations, policy leaders and program administrators and how to influence their visions so that investment follows.

The future high performance delivery system vision is accessibility, affordability and person centered. Shifts being made to accomplish this vision are: considering the total wellbeing of a person, making goods and services accessible and affordable, and having an integration of services across sectors. Nutrition and proper food are a necessity when considering social determinants of health. Services to the home should also be considered. As an example, going to the house of a child who has been discharged with asthma to evaluate what may be triggering their asthma in the home. Dealing with the root causes in the home and doing the home repair if necessary. Spending a minimal amount of money to do home repairs could save an enormous amount of money that would be spent if the child continued to be admitted to the hospital.

Rural healthcare providers' mission is to consider the health and wellbeing of the community. They are a source of leadership to secure the use of other resources. They can help address the problems because they know the community and see the end result. Healthcare service integration is the core to affecting social determinants of health. There will be extended activities beyond just seeing patients in the office and will include integrated services from other community-based organizations. A robust data sharing system is necessary for care coordination. A change in payment policies to include integrated services is necessary. Care coordination and healthcare coaches need to be incorporated into the workforce. Training local people to be care coordinators is an economic benefit to the community as well.

Centers for Medicare and Medicaid Innovation provide a screening tool to identify areas of immediate need in rural areas. Rural communities need to develop process measures indicating progress toward improved community health, perform and gap analysis and develop a quality improvement plan based on gap analysis.

In conclusion, the system is moving from population health management to health communities. This requires moving beyond Health and Human Services. The White House Rural Council is a great platform. This will be require policy adjustments and is best accomplished in an all payer environment or collaboration.

Q&A

Ty Border said that there are good examples relating community health workers and cost savings and telemedicine increasing access, but it is still up to the states to adopt things under the Medicaid plan. Even between North Dakota and South Dakota there is a huge difference. North Dakota expanded Medicaid and South Dakota didn't expand. Much of the language from the legislature is a social discrimination against Medicaid expansion rather than a cost savings or quality of care. Is there anything Centers for Medicare and Medicaid Services can do to give incentives to include community health workers as a reimbursable provider type for example? Is

there a way to improve motivation for states to participate in these creative ways to improve population health management?

Keith Mueller said not at the state government level. Regarding health workers and compensations, the payment goes to the healthcare organization instead of creating new workers. The organization takes the payment and uses it differently and can help pay for the health workers.

Carolyn Montoya is on the Medicaid advisory committee for the State of New Mexico. New Mexico did expand Medicaid but the Medicaid Advisory Committee has been charged by the legislature to cut \$50 million from the Medicaid budget. The advisory committee cannot seem to suggest anything that will not harm patients.

Keith Mueller said they are going through something similar in Iowa. There is no good answer.

Kelley Evans said that the advice to reallocate some of the 3 trillion health funds instead of expecting expansion of the spending. Less than three percent of the 3 trillion is rural spending.

Keith Mueller said that as an example reallocated at the level of Accountable Care Organizations or those who provide services through the new bundled payment demonstrations.

Mary Sheridan said that healthcare in rural Idaho is mainly through Critical Access Hospitals and most of them own Primary care clinics. One of Idaho's rural communities is on the leading edge and embracing population health in their community. They are embracing the concept of the medical health neighborhood and are successful in keeping patients out of the ER and reducing admissions and readmissions. The payment and reimbursement has not yet caught up to them. Healthcare has been destabilized in rural communities as they are embracing the right things. Can we get your feedback for states that an all payer system is not a reality?

Keith Mueller said to push for Medicare innovation in those communities and move the payment policy under a demonstration authority. There needs to be payment demonstrations that change the revenue stream coming in. This would be a great recommendation for the committee. There needs to be a focus on region and not necessarily population.

Governor Ronnie Musgrove asked Keith Mueller what would be his recommendation regarding social determinants of health.

Keith Mueller said that income is the immediate issue but more difficult to solve and the second is condition of housing.

Social Determinants of Health: A look at Community Health Workers & Medicaid Managed Care in New Mexico

Art Kaufman, MD
Office of Community Health
University of New Mexico, School of Medicine
Albuquerque, New Mexico

Art Kaufman thanked the committee and said he would speak about the role of academic health centers and the challenges they face in New Mexico. Compared to all western countries, the United States spends close to the same total amount on health and social services. The difference is the amount the United States spends on medical services is huge and social services are very little. The United States is close to the bottom of every health measure.

In New Mexico, the Native Americans have the best screening rates and interventions of service for diabetes but the worst outcomes. Medical services have a very small impact on health, maybe ten or fifteen percent and the social determinants have the most impact. Social determinants of health include: housing, transportation, educational attainment, nutrition. Unless social determinants of health are addressed, there will not be improvement in health and this has a big impact on cost. The question is how an academic center and the health system address this issue.

The University of New Mexico researched other universities that invest in social determinants of health. The community health office asked focus groups how they could improve health. The community response was that the university would come in when there was a grant and then disappear. The University of New Mexico, Office of Community Health, realized that they had to move the control out of the university and into the communities. It has to be a physical and an organizational change that has to happen which can be difficult. The university established the health extension rural offices (HEROs) with agents all over the state. Their role is to link community health priorities with University of New Mexico resources, primarily around social determinants of health.

Affordable Care Act: Section 5405 (“Primary Care Extension Program”) is a University of New Mexico and the University of Oklahoma model. Health extension is being used in the model in New Mexico. For example: The impact of having kids graduate from high school, would save as many lives and have as few cardiovascular events as stopping everyone from smoking.

Physicians know that social determinants of health are as important as medical needs. They understand that their social needs make their medical conditions worse. This is not just true for poor people but for everyone. The University of New Mexico Health Science Center created a social determinants of health prescription pad so that patients in clinics can be asked questions. The prescription pad included: employment assistance, education assistance, inability to pay for utilities, transportation assistance, daycare assistance, safety assistance, domestic violence assistance. The number one social determinant was the inability to pay for utilities.

The clinics realized that if they ask these questions, they have to address the problems. The clinics were responding that they did not have enough expertise to deal with these results and they weren’t being reimbursed to do this type of work. Community health workers were hired to work with Medicaid managed care to reduce costs. Community health workers take the burden off the primary care doctor to deal with patients’ social problems.

The conclusion is that there should be a patient centered medical home with community health workers as part of the clinical system it would be a major benefit.

Charlie Alfero, MA
Executive Director,
The Southwest Center for Health Innovation
Silver City, New Mexico

Charlie Alfero stated that the four core primary care services in rural health integration are: medical, dental, behavioral health services and family support services. Each of the directors of the core services is equal in the organizational chart. The community health worker and medical director share the same position in the organization.

Each of the four areas focus on different aspects of healthcare: prevention, diagnosis, treatment and management. Historically what is paid for in healthcare is diagnosis and treatment. Payment units in healthcare are structured for diagnosis and treatment services. If there is going to be equity in the system then there is going to have to be a payment system that supports community health. A payment model was designed with University of New Mexico that would separate the support of individuals in community health from the medical office visit in terms of payment. All four could be done with community health workers: prevention services, diagnose social issues, support access to social services and help manage clinical and other issues. Community health workers are like any other primary care provider but doing non-clinical work.

The reason this needs to be done in healthcare is because the social system is not working. Minority health programs, categorical disease specific programs and affordable education has not worked and these are the underlying problems that support ill health in the population. Things are viewed from a safety net perspective, but a net is a trap. What can we do so that all American's benefit proportionally? If we subsidize food rather than give people food stamps, then everyone could afford the food. The safety net programs are naturally discriminating and the healthcare system does the same with policies. Medicaid is in two different layers, states that have expanded and states that have not expanded; everyone who isn't on Medicaid now is being discriminated against. There are 50 different approaches in the 50 different states in how the country works with Americans and it is a serious problem that has caused loss of money, illness and suffering. Prior to the 1980's, people could petition the government on national issues; once you have the issues decentralized there is not the ability to have that argument or address the problem.

When thinking about rural modeling, there are basic things that need to happen in an expanded access environment or without an expanded access environment. There have to be core services including: medical, behavioral, dental and family support. There must be community engagement in what is important beyond basic primary care. There has to be hospital care participation.

There has to be a three part strategy to address health: comprehensive patient support, intensive care coordination and population health strategies. Comprehensive patient support is managing a person's health issues before they are complex or expensive and people are linked to social services early in the process.

A community health worker is an enhancement of a medical model. There are about seven or eight states that have certification. In New Mexico, there will be six months of training and six months of practical training. There has been a delay but two of the community colleges are starting to train until the Department of Health develops its curriculum. The training is with one or two weeks of intensive training and the real training is on the job. It takes about 4 -6 months for a beginning community health worker to work under the supervision of a seasoned community health worker until they are prepared. They learn about all of the resources in the community and they develop personal relationships. They learn from each other and there is also continuing education.

There needs to be workforce development to support the rural service delivery system. The Center for Health Innovation has Forward New Mexico and Frontier and Rural Workforce Development programs. They are working with children in junior high school with after school programs in math and science and take kids twice a year to Albuquerque from rural communities. They visit the medical school, dental hygiene program, nursing college and college of pharmacy. Some of these children have never left their rural community.

There is also an affiliation with the University of Utah and they will accept three students a year from Western New Mexico University. There is housing in the community for students and residents. In Silver City, there are loft style apartments in the clinic for people to live in when they are doing rotations in the community. As a result of the work in health careers, there is now a frontier based family medicine and residency program. A statewide primary care training approach is being developed to decentralize physician residency training in New Mexico.

Octavio Martinez asked if they are tracking numbers to find out if people in the workforce development program are staying in the area.

Charlie Alfero said that they work in the junior high school program with about fifteen hundred kids a year. As they go further in their education, we try to maintain contact with them and support them. Students who come from outside of the community to attend undergraduate school are supported also so they may decide to stay in the area. In the family medical residency programs, the vast majority of the people who finish the programs are still in New Mexico or working in underserved populations elsewhere.

Art Kaufman stated they are not doing a good job of increasing the diversity of the physician level. It still remains mostly white and increasingly higher income families. The data from New Mexico shows that if a person is from rural New Mexico, an ethnic minority and goes to medical school and residency in New Mexico, the likelihood of staying in the area is very high. To increase rural, ethnic minorities is difficult because they are recruited by out of state universities. The University of New Mexico started a program to retain students in the state because if they leave, most likely they will never return. Twenty five percent of the student body now comes from this program. The majority of these students are going into family medicine. If a physician is African American, Native American or Hispanic, the likelihood of seeing a patient of that ethnicity is five times as high.

Ona Porter
Prosperity Works, President and CEO
Albuquerque, New Mexico

Ona Porter welcomed the committee to New Mexico and thanked them for the opportunity to speak. Solutions come from within a community which makes it possible to implement programs and reach a community's goals. The lack of money is often discussed, the lack of money is not the issue but where the money resides. Moving forward this needs to be considered. Everyone knows about the disparities between rural and urban America. There are many positives in rural America including strong social networks, lower crime rates, natural resources and higher levels of two parent families.

There is an assets approach to the work that is being done locally. New Mexico has the highest level of child poverty in the nation. There is an underinvestment in the families, children and the future. There are some critical policies in the nation that can work well or can present barriers. Work support such as Medicaid, Medicare, CHIP and the Affordable Care Act are critical in rural communities. Without these programs in rural communities there would not be doctors, dentists

or hospitals. Transportation, child development and head start programs are major issues in when discussing work supports. Temporary Assistance for Needy Families (TANF) is twenty years old and it is time to consider changes. There are fewer people on welfare which was the goal of Temporary Assistance for Needy Families (TANF) but more people in poverty.

Temporary Assistance for Needy Families (TANF) recommended revisions include making decently waged jobs, with access to union protection and available to those who under TANF are often directed into poverty-level “workfare”. The minimum wage needs to be raised and higher education needs to be accessible and affordable. There has to be enforcement of the anti-discrimination provisions of Title VII of the Civil Rights Act to end gender and race based pay disparities. Child care has to be accessible for everyone, with no cutoffs for those with earned income or for families who hit arbitrary time limits. Basic income to caregivers needs to be provided to those who are outside the labor market or unable to get market work that pays enough to support their families.

A safety net is needed but not sufficient. The vast majority of people in poverty get out in 3 years; after 3 more years 30% fall back into poverty and after 5 years 50% fall back into poverty. There is a constant cycle in and out of poverty that shows the fragility of economic progress for low and moderate income (LMI) families. Changing the system instead of programs allows low-income families to be viewed through the lens of their resourcefulness, rather than their need. There has to be an investment in the strengths, capacities, and initiative of low-income families and communities. This change in the system will strengthen the social and economic mobility that enables everyone to have the ability to create a life of security and well-being.

There is the mantra, “If it is what we need to do, we need to find a way. Don’t tell me no, tell me how”. Prosperity Works vision is that every New Mexican will have the opportunity, knowledge and relationships needed to achieve economic security and prosperity. Prosperity Works focuses on a social justice framework for structural change to increase the opportunity of those less fortunate politically, socially and economically. There is a focus on the root causes and strive for systemic and institutional change.

Financial assets that Prosperity Works focuses on include: access to banking, child’s savings accounts, emergency savings accounts, individual development accounts, secured credit cards and citizenship loans. Personal assets include: civil and citizenship legal services, financial capability training and coaching. Education, child development and community leadership training are also assets that are provided.

A credit score and a driver’s license are essential for people to have upward mobility. Many of the large organizations are using credit information as the primary screening of employment when they are hiring. Low income people and people of color who don’t have the opportunity to build credit are marginalized. Prosperity Works has services that build these assets and one is individual development accounts which are matched savings accounts. People complete ten weeks of financial capability training, and when they reach their goal, they match them four to one for the purchase of the first home, to capitalize a small business or for post-secondary education. The system was designed about ten years ago for rural first.

It is a three-legged stool of personal, social and financial assets that allows people to thrive. If rural people leave their homes, networks and land for a job in Albuquerque two of the three legs of the stool have been removed.

There is a household strategy that frees people from poverty in eighteen months. It is also a community economic development strategy. There is more mortgage money in the mortgage companies and banks. It also adds money to institutions of higher education. These individuals have increased their annual aggregate income by almost four million dollars and that money is all spent in local communities. They have grown six hundred and sixty locally owned businesses and created almost twelve hundred jobs. When rebuilding communities, it is necessary to support local business owners because care about the people doing business with them.

Prosperity Works opened accounts for people enrolled at Central New Mexico Community College. Their data shows that 84% of the students who got an individual development account were retained. The national retention rate is in the 30th percentile. All of these students have taken a positive step to better their lives, they should be given the opportunity to succeed and change their lives. This is part of the asset for independence initiative. It takes one local dollar for every federal dollar and recruiting local dollars is very difficult.

Prosperity Works looks at assets across the life span and looked at children and what happens when they graduate from high school. New Mexico has one of the worst graduation rates in the nation. Dr. Willy Elliott, at the University of Kansas, has found that kids that have a savings account in their own name are four times more likely to go to college and three and a half more likely to complete college. The amount of money that these kids had in their accounts was five hundred dollars or less. This was creating a future identity and getting kids and parents engaged early in their education. If they invest at birth they have higher social development than their peers.

Prosperity Works took a much more comprehensive approach of collective impact. Prosperity Kids is a program that was created with a shared agenda, focus, resources and measures. Parents complete ten weeks of child development and community leadership training. When they have completed the training, their children from birth to eleven, are eligible for a savings account that is opened for one hundred dollars. They match parent money up to two hundred dollars for ten years. The expectation is that after ten years there will be five to seven thousand dollars in the accounts. At high school graduation, the students can use the money for post-secondary education or training. If they don't use the money by the age of twenty three they can use it for a stable transition into adulthood. Parents also get an emergency savings account with about ten dollars and there are incentive deposits in their accounts for five years to support healthy outcomes for their children. They have a credit card attached to the accounts so they can build credit and use the financial system without risk. There is also assistance for civil legal services and legal services for citizenship. This approach is a way to break the cycle of poverty.

The biggest difference between low-income families and upper class families is the level of personal, social and financial assets at their disposal, not their intelligence or resourcefulness. Assets would allow low-income families to exercise choice and get control over improving their lives. Look at the people of rural America as assets and help them build those assets.

PUBLIC COMMENT

There was no public comment.

Thursday, September 15, 2016

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

SOCIAL DETERMINANTS OF HEALTH SITE VISITS

Santa Rosa, New Mexico

Guadalupe County Hospital

Subcommittee members: Bill Benson, Christina Campos, Kelley Evans, Sallie Poepsel, Mary Kate Rolf and John Sheehan.

Staff Members: Paul Moore and Adam Cohen.

Committee Guests:

Jocelyn Richgels, National Policy Director, RUPRI

Keith Mueller, Director of the RUPRI Center for Rural Health Policy Analysis

Charlie Alfero, Executive Director, Hidalgo Medical Services

Cuba, New Mexico

Cuba County Fairgrounds

Subcommittee members: Carolyn Emanuel-McClain, Octavio Martinez, Carolyn Montoya, Chester Robinson and Peggy Wheeler.

Staff Members: Tom Morris, Steve Hirsch and Aaron Beswick.

Committee Guests:

Harvey Licht, Former Director of the Primary Care / Rural Health Office in the New Mexico Department of Health

Genevieve Robran, Western Regional Director, Presbyterian Medical Services

Richard Kozoll, Doctor of Family Medicine, Presbyterian Medical Services, Cuba Health Clinic

Laguna Pueblo, New Mexico

Laguna Housing Development & Management Enterprise

Subcommittee members: Kathleen Belanger, Ty Borders, Rene Cabral-Daniels, Barb Fabre, Mary Sheridan and Ben Taylor.

Staff Members: Pierre Joseph and Shannon Wolfe

Committee Guests:

Ona Porter, Prosperity Works

Amber Carrillo, Tribal Communities Leader and Advocate, Prosperity Works

Dennis Dudley, Department of Health and Human Services, Administration for Community

Rodolfo Acosta-Perez, Southern New Mexico Community Action

PUBLIC COMMENT

There was no public comment.

Friday, September 16 , 2016

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

DRAFTING OUTLINE OF POLICY BRIEFS

Santa Rosa, New Mexico
Guadalupe County Hospital

Subcommittee members: Bill Benson, Christina Campos, Kelley Evans, Sallie Poepsel, Mary Kate Rolf and John Sheehan.

Staff Members: Paul Moore and Adam Cohen.

Subcommittee considerations/ possible recommendations

- Lack of ability for people to invest in their homes as a way of starting to build wealth.
- It is difficult for people in rural areas to get loans to start small businesses.
- There is a lack of labor supply.
- Social benefits system seems to keep people in poverty. There needs to be a way for people to move up economically while gradually losing benefits over time.

Cuba, New Mexico
Cuba County Fairgrounds

Subcommittee members: Carolyn Emanuel-McClain, Octavio Martinez, Carolyn Montoya, Chester Robinson, Donald Warne and Peggy Wheeler.

Staff Members: Steve Hirsch and Aaron Beswick.

Subcommittee considerations/possible recommendations

- Educational opportunities are an issue. There is not an opportunity for a person to get a GED if they don't graduate from high school
- There is a lack of broadband in the area
- Transportation is an issue so people can not get to doctor visits. Home health visits can be difficult because of the distance of travel.
- More accurate census information is needed
- Longer funding periods for grants would be beneficial

Laguna Pueblo, New Mexico
Laguna Housing Development & Management Enterprise

Subcommittee members: Kathleen Belanger, Ty Borders, Rene Cabral-Daniels, Barb Fabre, Mary Sheridan and Ben Taylor.

Staff Members: Pierre Joseph and Shannon Wolfe

Subcommittee considerations/possible recommendations

- Funding is not available for planning and carrying out projects
- There is a data barrier when applying for grants due to small population
- Distance and travel is difficult for employment
- Keeping clinicians is an issue

- There is a lack of quality mental health clinicians

FEDERAL UPDATE

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

Tom Morris stated that he would discuss the next two meetings. There could be a field meeting or a meeting in Washington DC since there will be a new administration.

For a field visits committee could consider:

- The new way physicians are being paid under Medicare
- The ongoing transition of value and providers: Federal Qualified Health Centers, Critical Access Hospitals and Rural Health Clinics not included
- Tribal issues with hospital viability and access to services
- TANF shortfall could be considered
- Marketplace issue with affordability and access
- The Reauthorization of the Older Americans Act could weigh in on principles

For a meeting in Washington:

- Invite career and political representatives to discuss the committee's work
- Get feedback from the Health and Human Service leadership to align what information is needed with the focus of the committee

COMMITTEE BUSINESS

Topics to consider for the April meeting are:

- Elder abuse and services
- Tribal health facilities
- Substance abuse and mental Health Treatment
- Data and Performance-Based Measures

PUBLIC COMMENT

Dr. Barbara Overman
Professor of University of New Mexico College of Nursing

For social determinants of health, education is extremely important and from a policy standpoint one of the most important parts of education is literacy regulations. The concept of "place" matters so much in rural areas and in New Mexico especially. The profiles of stakeholders that exist in a given rural place don't always match the same professional titles as the key stakeholders in urban areas. A lot of funding opportunities mandate these labels that don't exist in rural areas which discriminate against rural areas from receiving funding. A lot of funding

mechanisms make it very difficult for agencies to co-apply for funding opportunities. Because of small populations in rural areas, agencies often would benefit from co-applying for funding and making it easier for them to do so should be a priority of grant providers. There is not established mechanism to fund Community Health Workers and so they are often employed by managed care organizations. This is a contrast to them being funded by actual health and human service, which is needed to actually hold them accountable to communities.

Paula Cordova

University of New Mexico Nursing Student

One of the biggest problems facing rural areas is the lack of activities that engage children. The most effective way to make sure young people succeed is to make sure they are kept busy with a large number of sports and extracurricular programs that keep them engaged.

Emma Slachta

University of New Mexico Nursing Student

Access to contraceptive and family planning services is a huge factor in the social determinants of health. Maternal mortality has nearly doubled in Texas (reference below), and has been rising in other rural areas as well, as women's health clinics continue to close. Providing quality, evidence-based care for women and their families can help to break the cycle of poverty.