June 14-16, 2010, Charleston, South Carolina

Health Resources and Services Administration
Office of Rural Health Policy

Charleston, South Carolina
June 14-16, 2010

Meeting Summary

The 65th meeting of the National Advisory Committee on Rural Health and Human Services was held on June 14-16, 2010, in Charleston, South Carolina.

Monday, June 14, 2010

The meeting was convened by Larry Otis, Vice Chairman of the Committee.

The Committee members present at the meeting were: Governor David Beasley (Chair); Larry K. Otis (Vice Chair); Graham Adams, Ph.D.; April M. Bender, Ph.D.; Maggie Blackburn, MD; Deborah Bowman; B. Darlene Byrd, MNSc, APN; Larry Gamm, PhD; Sharon A. Hansen, Ph.D.; David Hartley, Ph.D., MHA; Donna K. Harvey; Thomas E. Hoyer, Jr., MBA; Todd Linden, MA; A. Clinton MacKinney, MD, MS; Robert Pugh, MPH; John Rockwood, Jr., MBA, CPA; Maggie Tinsman, MSW. Mr. Dennis Dudley attended representing the U.S. Administration on Aging. Lana Dennis of the Centers for Medicare and Medicaid Services Atlanta Office attended. The Administration for Children and Families' Senior Policy Advisor, Jeffrey Capizzano, also attended.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Jennifer Chang; Heather Dimeris and Paul Moore. Truman Fellows present were: Ben Able; Catherine Koozer; Laura Merritt; Natasha Scolnik and Kai Smith.

Setting the Context for Rural South Carolina

Graham Adams, CEO, South Carolina Office of Rural Health

Graham Adams opened his presentation by welcoming everyone to Charleston, South Carolina. He described, the South Carolina Primary Care Safety Net, which includes 115 Rural Health

Clinics, 20 Federally Qualified Health Center Entities, 5 Critical Access Hospitals, 11 Rural Hospitals with less that 50 beds, and 33 Free Health Clinics. Mr. Adams said that there are 34% of children considered obese in South Carolina. Mr. Adams noted that in 2009 to 2010 the number of South Carolinians on food stamps jumped 17% and is due to the problems with the economy.

Tom Morris spoke about the topics that will be the focus of the 2011 Report to the Secretary of HHS. The three topics are: Childhood Obesity or healthy weight for children in rural communities, Early Childhood Development place-based initiatives for children in rural communities and the rural implications of key quality related payment changes in the Affordable Care Act. These are namely Accountable Care Organizations, payment bundling and the value modifier. He advised the committee members to use the information that they learn to identify issues in the report in the context of how HHS programs can best address the challenges.

Childhood Obesity in Rural Communities

Jan Probst, Ph.D.- Director, South Carolina Rural Health Research Center and Associate Professor, University of South Carolina

Jan Probst noted that childhood obesity is linked to adult obesity. The consequences of childhood obesity can result in type 2 diabetes, hyperlipidemia, hypertension, metabolic syndrome, asthma, hepatic steatosis and psychological issue due to victimization and depression. Children at or above the 95 percentile for BMI for age and sex are considered at risk for obesity. She noted that what used to be unusual top percentiles in 1977 have become common.

The basic premise of understanding obesity in children is that it is fairly simply calories in verses calories out. Rural children 10-17 year old are more likely to be obese. This is true across races. Children in poverty face a higher risk of obesity. She noted that the Southern diet tends to consists of rice, grits, potatoes and fried food. Even the green foods seemed to be cooked with meat or in unhealthy ways.

Dr. Probst talked about rural barriers as pertaining to diet and exercise. The lack of recreation areas and sidewalks in neighborhoods is an issue. There are not as many playgrounds in rural communities. Barriers also include fewer stores and higher prices and people in rural communities have longer commuting times. The quality of school foods is an issue and having soft drinks in schools as a way of revenue is an issue. Dr. Probst stated that ways to improve the problem of obesity in rural communities is through reducing barriers in policies and improving nutrition and physical activities in schools.

She noted that interventions need to be focused and that one goal attained is better than 5 missed. Dr. Probst said that there are things that can be done in rural communities that don't take much money such as: creating walking tracks, playgrounds and park revitalization. Dr. Probst closed by saying that the problems can be fixed slowly, one solution at a time and one rural community at a time.

Michael Byrd- Director, Bureau of Community Health and Chronic Disease Prevention, South Carolina Department of Health and Environmental Control

Michael Byrd spoke about the progression from 2000 to 2008 of the obesity epidemic in South Carolina. In 2000 there were 3 counties where 70% of the adults were obese in South Carolina. By 2009, 19 counties in South Carolina had 70% of the adults considered obese in South Carolina.

Most of the money spent in medical care in the state is on chronic disease and obesity is an underlying factor in chronic disease. He noted that there is no budget in his office for childhood obesity but billions of dollars are spent on treating the diseases that are a consequence of obesity. Mr. Byrd stated that there is funding put into medical care but not enough is focused on prevention.

Key challenges in addressing obesity in rural settings is poor access to health care, population diversity, economic transitions, low-population density, cultural and social networks. Counseling, education and clinical interventions are important but don't have a lot of impact on the health of populations. Long lasting, protective interventions have long lasting protective health on a population because you can stop the spread of disease on a population. The context needs to be changed to make the healthy choice the easy choice. Mr. Byrd stated in closing that the battle against childhood obesity is a winnable battle.

Francis Rushton, MD, FAAP- Community Pediatrician and American Academy of Pediatrics District Chair

Francis Rushton said that obesity disproportionately impacts people in the lower socio-economic populations. There are contextual factors like access to playgrounds, the ability to be able to walk to school and the soda machines in the schools. More money needs to be spent on preventative services.

The epidemic of obesity is growing fast but the turn around will be much slower. He said one reason is because of epi-genetic factors. Epi-genetic factors means that socio- environmental

factors influence a person's genes that are passed on and incorporate the DNA. It takes several generations to get rid of the genetic propensity of being obese.

Dr. Rushton gave recommendations for addressing rural obesity, such as: Identifying those at risk, continue funding and promote Safe Routes to School in rural communities, support legislation that promotes healthy food choices in schools, support rural communities in providing better access to farm-fresh foods, and promote youth activity programs. He also added that there needs to be support of pediatric office interventions to address both prevention and treatment of obesity. Supporting rural communities in increasing and sustaining breastfeeding rates is an important factor in addressing rural obesity. Dr. Rushton said that it is important to have home visitation programs for families at risk during the pre-school period

Q&A

Maggie Blackburn asked Jan Probst how they measured physical activity, and, if when looking at nutrition, they looked at food availability and food deserts. Jan Probst responded that in the 2003 and 2007 national survey, parents were asked how many times a week did your child engage in activities that made them sweat. In the second studies the teens were given a list of activities and asked if they did any of the activities and how much time they spent doing them.

Deborah Bowman asked if South Carolina has looked at child abuse and neglect, smoking, and early sexual behavior related to obesity. Is there a way to deal with all of the socio-economic factors together? Francis Rushton responded that it depends how you define child abuse and neglect because it is a spectrum. There are a lot of children who have some attachment disorders that are from families that are less able to give the physical and emotional support. This can cause them to have self-esteem issues later on. He said that if you look at child abuse from a narrow standpoint then he doesn't see the correlation.

Deborah Bowman said that money needs to be put into looking at the issues as a whole. She asked if they had looked at food stamps and the contributory factor. Michael Byrd said that they are looking at this as a systems approach. The home visitation programs that address early childhood development are multi-faceted interventions.

David Hartley said he had been engaged in active living research. They found that the issue about having sidewalks in rural areas was irrelevant. After school programs seem to be what will work. Low income children can't attend after school programs because the low income children have to leave on the bus. Transportation is a problem. Michael Byrd said that there are no grocery stores within 50 miles of some communities and transportation is a real issue. Accessibility of and transportation is a challenge.

Rural Early Childhood Development Place Based Initiatives

Mary Lynne Diggs – Director, South Carolina Head Start Collaboration Office

Mary Lynne Diggs stated that there is Head Start in each of the 46 counties in South Carolina. Head Start is a part of the war on poverty and the last intact program of the war on poverty. There is a presence in each of the counties but that doesn't mean that they are fully served. When talking about collaboration it means working together. Ms. Diggs talked about the Head Start Collaboration Office, and about Head Start as a comprehensive readiness school program.

There are 4 migrant Head Start Programs. Sponsorship includes CAAPS and mission agencies. The issue of non-English speaking workers and people who had been migrants and may become farm workers or disappeared is an issue in early childhood in a Health and Human Services perspective. There are 8 Early Head Start programs providing services to children age 0-3. By the end of the summer there will be 16 Early Head Start Programs. Head Start in South Carolina includes: Head Start, Early Head Start, Native American Head Start and Migrant Head Start.

Ms. Diggs said that there is a Head Start Collaboration Officer in each state who assists Head Start when collaborating with agencies and entities involved in state planning, assists agencies in coordinating activities with the Childcare Block Grant, works to align curriculum and promotes linkages. Head Start focuses on children who are 100 percent poverty. They serve just over 50% of those who are eligible in the state. This means they need expansion but also partnerships.

Ms. Diggs spoke about some of the programs in the state that deal with the problem of obesity and health care. Some of the programs included: Color Me Healthy Program, I'm Moving, I'm Learning and the Oral Health initiative. Ms. Diggs stated that food is very expensive in an institutional setting. South Carolina has a food buying alliance so that public schools, juvenile justice centers and Head Start can come together and purchase food on a bid. This saved 400,000 in one of the counties. This also cuts the cost of transportation.

Ms. Diggs closed by asking the committee to look at Title 1 administered by the Department of Education. It was signed 6 months after Head Start in 1965. It goes up to 3rd grade and can go up to 21. Title 1 says that if the funds are used for early care and education that Head Start education performance standards must be used. Quite often that part of the legislation is not recognized. Title 1 funds can also be used for homeless programs and inclusion, and special services.

Sharon Hansen- Director, Community Action Partnership Head Start

Sharon Hansen shared with the committee some information from the Rural Early Childhood Institute meeting that she attended in Kansas City. Dr. Hansen stated that key ideas about community change are comprehensive efforts, sustained efforts overtime and data driven decision making. Ways to measure success in communities is through healthy pregnancies and births and children who are thriving at age three, eager and ready at five and successful in school and well rounded at age eight.

Dr. Hansen spoke about what to consider when looking at The Place Based Initiative for Young Children. There needs to be examples of communities who have developed a coordinated system that includes a governance structure. This structure includes parents, schools and community based organizations, Head Start and Early Head Start, health and mental health systems, child welfare and family support and disability services.

Data collection is very important to justify what programs are doing. Place Based Initiative is communities coming together and finding ways to have continuous, comprehensive services that begin with expectant mothers and go through age 8. The public school and all agencies within the communities that work with children are involved.

Dr. Hansen stated that one of the most important subjects of the meeting was that family needs to be in the center of designing programs and that programs need to be developed that meet the needs of the local communities. It is vital to have the partnership with local school districts for many reasons. Dr. Hansen stated that federal government should model collaboration for states and local communities. She stated that there needs to be more focus on collaborations that are data driven, strength based, solution oriented and with strong outcomes. Communities can learn from each other through programs that have been implemented and are successful.

Q&A

Maggie Tinsman stated that people in the communities are saying that they spend so much time on data that they don't have time for the service. Sharon Hansen said that people complain about collecting data but people have to take time to reflect on practices. It has become a tool of reflection for practitioners and it is important to engage the people doing the data collection to embed it in their practices so that they see the value.

Larry Otis said that if you explain to people why they are collecting the data then they can see its value and it is not a burden. He said their program is using social security numbers and once

it is put in the system it becomes a ten digit identifier number. It can be translated to federal programs and the public school. This can track a child through college and the rest of their lives.

Tom Hoyer said that he spent his time in a policy organization and struggling with the operations people. The paradigm is that there is never time to do it right but always enough time to do it over. He said that the committee has always talked about needing more local leadership. He noted that if there were more people like Mary Lynne Diggs then everything would work.

Maggie Blackburn said that some of the outcomes they need to get is long term and hard to get data on. Head Start is great because it has been around for years. A problem is that some families are fractured and children are moved from person to person in a family. She said that they do summer programs with the migrant population but then they leave and there is no way of getting the data to where they are going.

Rural Implications of Payment Bundling and Accountable Care Organizations

Paul Moore, with the Office of Rural Health Policy, gave an overview of the discussion of payment bundling and Accountable Care Organizations. These are provisions that don't exist in statute now but have been talked about for a long time and have the potential to dramatically change the way care is delivered and organized. Accountable Care Organizations and bundled payments are conceptual so the discussion around them is abstract. Specifically, he noted that he would like to hear the committee and presenters thoughts on how this will affect rural providers and their patients.

Ed Sellers - Chairman & CEO, BlueCross BlueShield of South Carolina

Ed Sellers started by saying that he wanted to set the context for the ACO and bundled payment discussions. There is a mixture of quality and economics. Quality is getting things done better and avoiding negative things. He cautioned trying to sell ACOs and bundled payments on the basis of economics. Quality will be a terrific outcome if it is done well.

The health insurance bill has three or four slightly disconnected things that in combination are going to be a tsunami of inflation in the commercial health insurance market. This is going to be a problem because it is the cash flow that is the life line of every hospital in the state. Anything that affects the fundamental structure of the commercial insurance market is going to hurt the cash flow to the provider systems. Guaranteed opened enrollment means that anyone can call the insurance company and get coverage which is good. In isolation it can destroy an insurance market. Subsidies on exchange and the age slope matter. He stated that the individual mandate is worthless. An open enrollment environment is a strong mandate that keeps the pool healthy.

The mandate penalty is $95 annually during the first year. Above 50 the premium is 3 times higher, illness is higher and the cost of the subsidy is higher and these people may leave in large numbers.

Robby Kerr – Past Director, South Carolina Department of Health and Human Services

Robby Kerr started by saying that bundling was the same as DRG systems. It is all the same and is trying to control cost. Mr. Kerr said that most of his experience is in Medicaid. The bulk of the premiums in the private sector are paid by employers.

There are five components when thinking about bundling. You want an accountable provider. He asked, “Who will be the primary person who is capable of taking the bundled payment? Do they have the coordination and administrative capacity?” Most bundling is around an episode of care. You have to look at what is the scope of services, how long the episode is going to last, what is the objective, how to monitor the outcome and how to price the services.

Patient choice may get compromised. Service capacity and primary care availability is going to be an issue. The primary care physician used to follow their patients throughout the entire episode of care. Today a patient in the hospital does not see their primary care physician. There is a lack of coordination of care. The primary care doctor who monitored everything has been substituted with specialist, hospital staff and the patient is expected to navigate the system. Now Accountable Care Organizations are supposed to do that for the patient and Mr. Kerr stated he doesn’t think it is feasible.

Mr. Kerr said he is worried about how Critical Access Hospitals and rural hospitals with reimbursed cost are going to be involved in the Accountable Care Organizations.

Q&A

Todd Linden said that he runs a middle sized rural hospital in the Midwest. He is concerned about a 157 billion reduction in Medicare to help pay for this in 10 years. He mentioned the reimbursement they would get, but he said that the math doesn’t work in his state. Are payment rates going to be a geographic variation or a national payment rate when ACO starts? Ed Sellers said that geographical variation is the classic “where you sit determines how you feel”. In most cases the studies suggest that the profitability for Medicare doesn’t vary that much across the country.

John Rockwood said that he thought the DRG system has worked pretty well. To assume that the federal government is going to solve this problem doesn’t make sense. He said that there can’t be 3 or 4 different payment systems and expect practitioners to make any rational

decisions because everyone who comes through the door is treated the same but have different requirements. Why not start with best practices. It is about how the components are priced and we are all going to pay for the same components. Doesn't that work? Ed Sellers said that it works on paper. He said he thought it would work but you can't get agreement. Today it is impossible to get agreement on physician fee adjustments inside a law that is on the books.

Maggie Blackburn said that when you look at Accountable Care in rural areas then you need to look at if from a quality level. If people are sent to a larger urban center then we are back to sending them home with a ventilator and a house without electricity. The community based care aspect works well and controls cost well and needs to be brought into what is done with Accountable Care. Ed Sellers said that in their experiments they came to the conclusion that you have to start with quality. There has to be quality to get provider buy in and patient buy in. If quality is first then the economics will follow. He also stated that it is dangerous to say that these two sets of ideas are going to do anything with inflation and health care costs within the first 3-4 years.

Clint MacKinney said he is concerned about how Accountable Care Organizations will work in dissociated rural areas. Have you seen examples of how rural systems may develop contractual relationships with tertiary care systems that might make the idea of ACO happen without ownership requirement? Ed Sellers said that South Carolina has gone through some of that. They have watched tertiary care centers in South Carolina pull out of semi-rural areas. If you start with a cost structure that is designed to serve that type of demand, you can make it work.

Public Comment

There were no public comments and the meeting was adjourned until Tuesday morning.

Tuesday, June 15, 2010

Tuesday morning the Subcommittees departed for sites visits as follows:

Rural Implications of Payment Bundling and Accountable Care Organizations Subcommittee: Clarendon Health System – Manning, South Carolina

Childhood Obesity in Rural Communities Subcommittee: Eat Smart, Move More - Walterboro, South Carolina

Rural Early Childhood Development Place-Based Initiatives Subcommittee: Rural Mission – Johns Island, South Carolina

Wednesday, June 16, 2010

The meeting was convened by Governor Beasley, Chairman of the Committee, who called for reports from the three Subcommittees.

Review of Subcommittee Visits

Rural Implications of Payment Bundling and Accountable Care Organizations Subcommittee: Clarendon Health System – Manning, South Carolina

The subcommittee includes: Graham Adams, Darlene Byrd, Larry Gamm, David Hewett, Tom Hoyer, Todd Linden, Clint MacKinney, John Rockwood.

Graham Adams presented for the Subcommittee. He started by saying that Clarendon hospital is a 56 bed hospital but is not an average small hospital. The CEO has been at the hospital for 20 years or so. The hospital has home health, hospice, own three nursing homes, several rural health clinics and have onsite pharmacy and wellness. The hospital owns and runs EMS for the county. The people who attend the subcommittee visit were hospital leadership and the executive director from the Community Health Center. The discussion was about what it would look like in a rural community to have an ACO and is it feasible to have it in a small community. Is bundled payments something that would be for everything or specialized cardiac or orthopedics or around specific disease states?

The subcommittee learned that this can't work in a community that is struggling. If a hospital is struggling then they can't hypothesize what it would be like to lead an ACO. A larger rural hospital with more resources that can serve as the anchor and bring in other smaller rural counties is needed. Then many of the services can be provided.

The subcommittee talked about the need to encourage CMS to have a certain number of rural pilots. Also, the subcommittee thinks that rural physicians, nurse practitioners and physician assistants need to be included in the discussions about the Accountable Care Organizations. Identifying the characteristics that an Accountable Care Organization would need to work was discussed. The subcommittee discussed recommending to CMS that the program be done incrementally.

Childhood Obesity in Rural Communities Subcommittee: Eat Smart, Move More – Walterboro, South Carolina.
The subcommittee includes: Maggie Blackburn, David Hartley and Robert Pugh

David Hartley presented for the Subcommittee. He said that the Eat Smart, Move More Program was funded by Blue Cross Blue Shield. The group they met with were people representing the

community, funders, the Department of Agriculture, health department and the hospital. There was a great partnership between them and they are committed to fighting childhood obesity. The program hasn't been implemented yet. Mr. Hartley said that the battle against childhood obesity includes the nutrition people and physical activity people and they are in silos. The subcommittee is suggesting holistic approaches instead of silo approaches to the problem.

Dr. Hartley said that schools need to be a source for intervention with nutrition and physical activity for children. Incorporating more physical activity in the school day and looking more closely at school lunches and vending machines in schools is a priority. Many children in the community are eating two meals a day in the school. He noted that parents are also a place for intervention. Educating parents and also looking at what food is available to buy in the community. There are also churches that can be considered for intervention. In the community there have been efforts to offer healthier foods at church suppers. Many people in rural communities are more likely to get messages from the church then from other places. There also may be an opportunity for an intervention with transportation. Children don't live close enough to walk to school and are being bused. This causes problems for after school activities because they have to take the bus home right after school.

Rural Early Childhood Development Place-Based Initiatives Subcommittee: Rural Mission- Johns Island, South Carolina

The subcommittee includes: April Bender, Deborah Bowman, Sharon Hansen, Donna Harvey and Maggie Tinsman. Maggie Tinsman was not on the site visit.

April Bender presented for the subcommittee. Dr. Bender said that they were fortunate to speak to ACF in a conference call before the visit. She feels that framing the findings around language and initiatives that ACF are already developing gives more meaning to them.

ACF are looking at indicators that include: healthy pregnancies and births, children that are thriving at three, eagerly engaged and ready at five and successful in school and well rounded at eight. The key elements they are looking for are: Governance structure, system of data collection, quality assurance systems and school systems. The subcommittee is going to look for these things and put it in language that ACF understands and it will have more practical meaning to HHS.

The Rural Mission's roots are faith based in the Methodist Church. They are all about comprehensive care. If the floor collapses in a person's home, it has to be fixed. There was a lot of information about comprehensive care and matching services with needs which is place-based. Some people on the committee were looking for more robust early childhood practices

but the committee did see the approach of the caring community. Research that had been collected showed that 5/6 of a child's time is spent at home with mom. So "place" is home with mom.

Every child involved in the Head Start Program on Johns Island is connected to a medical home. The relationship between public health and private practice was very strong. The subcommittee would like to follow up on faith in place-based in rural communities. Volunteerism is something else that the committee wants to follow-up on.

The subcommittee discussed that shared funding access across HHS and including incentives would be beneficial to better meet the holistic needs of children through a federal, state and local network. Dr. Bender also said they would like to look at natural partners on a rural level that would occur with funding from HHS. Flexibility needs to be built into legislation to give the ability to customize services.

HHS Update

Tom Morris presented the HHS update to the committee. He began by saying that they are doing the Recovery Act and healthcare reform implementation. Dr. Wakefield has a focus on public health and HRSA's investment in public health. The Recovery Act and Affordable Care Act have heavy investments in primary care and workforce.

Mr. Morris said that HRSA's larger role in healthcare reform is Community Health Centers and the expansion of health centers and capital projects. Workforce expansion and increased funding for National Health Service Corps is also included. HRSA and ACF will co-administer a newborn home visitation program. There are also expansions and changes to 340B program.

Mr. Morris spoke about how health reform benefits rural America. Insurance reform will expand access and will assist in affordability in rural communities. There will be an expansion of Community Health Centers. Investments in health care workforce will include: National Health Service Corp., Medicare GME changes and Teaching Health Centers.

Mr. Morris spoke about the Improving Rural Health Care Initiative which focuses on health workforce recruitment and retention, building a programmatic "Evidence-Base", telehealth and HIT coordination and cross governmental collaboration.

He also talked about the Flexi Multi State Quality Improvement Project that involves a large number of Critical Access Hospitals. It is an effort to show national quality improvement in Critical Access Hospitals through rural appropriate measures and processes.

2011 Report

Heather Dimeris stated that the timeline information for the 2011 report is located in the meeting binder under tab 7. She said that the 2011 rough draft was modified slightly and the rough draft will be provided to the Truman Fellows and advisory committee before the September meeting. At the meeting, the Truman Fellows will collect the information so that they can tighten up the chapters after the meeting. The 2011 report should be out around the beginning of the year. She stated they would like the report to be more concise this year and each chapter should be from 5-6 pages.

Letter to the Secretary

Governor Beasley stated that this will be his final letter to the Secretary. In the letter he will include the suggestion that the future chair, Governor Musgrove, and the Secretary meet to discuss upcoming initiatives. He said that there should be two letters. There should also be a letter to the FCC representatives about broadband and rural access of information.

Governor Beasley thanked Truman Fellows, Kai Smith and Laura Merritt, for all of their hard work. He stated that Laura Merritt will be leaving to attend Harvard University and Kai Smith will be leaving to attend Stanford University. The committee members thanked them for the great work they have done staffing the National Advisory Committee.

Public Comment

There were no public comments and the meeting was adjourned.