

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

National Advisory Committee on Rural Health and Human Services

**Fall Meeting
Boise, Idaho
September 11-13, 2017**

Meeting Summary

The 82nd meeting of the National Advisory Committee on Rural Health and Human Services was held September 11th – 13th, 2017, at Springhill Suites in Boise, Idaho.

The committee members present at the meeting: Kathleen Belanger, Ph.D.; Kathleen Dalton, Ph.D.; Carolyn Emanuel-McClain, MPH; Kelley Evans; Barbara Fabre; Constance Greer; Octavio Martinez, Jr., MD; Carolyn Montoya, PhD, CPNP; Chester Robinson, DPA; Mary Kate Rolf, MBA, FACHE; Mary Sheridan, RN, MBA; Benjamin Taylor, Ph.D., DFAAPA, PA-C; Donald Warne, MD; Peggy Wheeler, MPH.

Present from the Federal Office of Rural Health Policy: Tom Morris, Director; Paul Moore, Executive Secretary; Steve Hirsch, Administrative Coordinator and Sahira Rafiullah, Senior Advisor.

Truman Fellows present from the Office of Rural Health Policy: Alfred Delena and Victoria Maloch.

**MEETING DAY 1 – SPRING HILL SUITES – BOISE, IDAHO
Monday, September 11, 2017**

The meeting was convened by The Honorable Ronnie Musgrove, Chair.

WELCOME AND INTRODUCTIONS

Governor Musgrove welcomed the committee members and stated that the topics of the meeting are Suicide in Rural America and Modernizing Rural Health Clinics.

MEETING OVERVIEW AND NACRHHS KEY PRINCIPLES

The rate of suicide in rural America is higher than in urban America. It is important to understand the underlying causes and ways to better assist rural communities with suicide prevention.

Rural Health Clinics were established in the 1970's and there are about 4,000 in the United States. This is an opportunity for the committee to hear from local stakeholders about the key issues facing rural health clinics.

Dieuwke A. Dizney-Spencer, RN, MHS
Deputy Administrator, Public Health Integration
Division of Public Health

Dieuwke A. Dizney-Spencer welcomed the committee to Boise, Idaho. It is great to meet a diverse group of committee members from different areas of the United States. Mary Sheridan is at the Bureau of Rural Health and Primary Care, in Boise, Idaho, and it is a huge honor for her to be on the committee. Thank you to Mary Sheridan and her staff for organizing the meeting.

IDAHO ORIENTATION

Anthony Parry
Interpretive Specialist
Idaho State Historical Society

Anthony Parry said he would share with the committee about Northern Idaho which is separated by mountains and is more isolated than some of the other areas of Idaho. Counties in Northern Idaho include Benewah, Bonner, Boundary, Clearwater, Idaho, Kootenai, Latah, Lewis, Nez Perce and Shoshone. Major Cities are Coeur d'Alene, Lewiston, Moscow, Post Falls, Hayden, Sandpoint, St. Maries and Bonners Ferry.

Native groups to the south are Nimipu (Nez Perce), in the middle are Schee-Chu-Umsch (Coeur d'Alene), and to the north are Kootenai (Pend Oreille). In the 1800's French fur trappers met with the Native American tribes renamed them with French names. Missionary groups traveled to the area and began meeting with the Native Americans resulting in mass conversion. Cataldo Mission, the oldest structure in the State of Idaho, was built in 1842 by Jesuit Priests and the Native Americans.

After the civil war, there was conflict between the Native Americans and settlers so the government sent the military to build a fort along Coeur d'Alene, where western groups moved in and built cities. Gold and silver were discovered during this time and railroads were built. In 1898, there was a land survey that led to the discovery that Northern Idaho was rich in timber. The abundance of timber became the biggest draw to the area and still remains the backbone of the economy.

Recreational activities in Northern Idaho include hiking, backpacking, camping, boating, and kayaking. Other attractions in the area are Silverwood Theme Park, Silver Mountain Resort, and Raptor Reef Indoor Waterpark.

Northern Idaho has 20% of Idaho's total population. There is an estimated population of 338,143. Forest products, mining, and agriculture are an important part of the economy.

There is also manufacturing, healthcare and tourism in the area. Economic development also includes a large corporate headquarters and five large call centers. There are three Native American Reservations with casino hotels at the Coeur d'Alene Reservation, Kootenai Reservation, and the Nez Perce Reservation.

The University of Idaho is located in Moscow, Idaho. There is a United States navy base located at Lake Pend Oreille. Lewiston, Idaho has the farthest inland port east of the west coast of the United States.

Amber Beierle
Historical Sites Administrator
Idaho State Historical Society

Amber Beierle said the vast expanse of Central Idaho was inhabited by the Native populations for a long time because they were the only people who could survive in the area. It is mountainous, with prairies, deserts, canyons, and farmland. Louis and Clark traveled through the region but went further north because of the unforgiving terrain. There was not much settlement in the area until the discovery of gold which led to an influx of agriculture and ranching in the area. Irrigation became a necessity because of farming in the south-central area. The region is mountainous and there is the Camas Prairie which was very important to the Native Americans. During the Bannock War of 1878, the Camas Prairie was being destroyed and taken over by the United States military. In the far south, there is the deserts and the canyon areas.

Sun Valley, Idaho, is a location where celebrities visit often and it was the nation's first destination ski resort. There is white water rafting in very remote locations. There is fishing, hunting, hiking, biking, snowmobiling and ATV activities that draw people to the state.

The regional population is around 200,000 people and they are spread throughout a large land mass. Mining in the area is mainly for silver, lead and cobalt. Sheep and cattle are vital in the region as well as farming and dairy. Chobani has the world's largest yogurt manufacturing plant in Twin Falls, Idaho, as well as Glanbia Foods, the world's largest American cheese manufacturer. The Idaho National Laboratory is the leading scientific research laboratory in the area.

The White Clouds Wilderness was designated as a wilderness area in 2015. The bill allows some land to be used by off-road vehicles and snowmobiles while also having roadless land for the wilderness purists. Idahoans worked together and made compromises to settle differences of opinion on how the land should be used.

A growing refugee population in the region is due to industry jobs with a lower skill set. There is a diverse socio-economic group in the area that includes the very wealthy who live in Blaine County and the working class who live in the outlying counties because they can't afford to reside in Blaine County.

Jacey Brain
Interpretive Specialist

Idaho State Historical Society

Jacey Brain stated that he would share information about Eastern Idaho. The population is around 366,000 with 91% Caucasian. Eastern Idaho is heavily populated by The Church of Jesus Christ of Latter-day Saints and most of the cities were founded by Mormon settlers.

Franklin is both a county and a city and is well known as the oldest permanent non-native settlement. The Bear River Massacre took place in 1863 in Franklin County. About 300,000 Shoshone Indians were killed by civil war troops including many women and children. Patrick Connor, a union general, was anti-Native American. The casualties were downplayed but later the immensity of the number of fatalities was discovered. There were two dozen union troops killed. What ultimately brought the settlers to the area was the Oregon trail, stage lines, and railroads. The Union Pacific was supported by the Church of Latter-day Saints in 1900.

Brigham Young, who was the leader of the Church of Latter-day Saints, named Montpelier, Idaho in Bear Lake County. In Montpelier, there was a well-known heist by Butch Cassidy. Philo Farnsworth, the inventor of the television, grew up in Utah but moved to Jefferson County in Eastern Idaho.

The SL-1 nuclear reactor melted down on January 3rd, 1961, killing three operators. There weren't any lasting environmental problems as a result. It was built in 1951 in Idaho Falls and was the first successful nuclear reactor to produce electricity. The reactor was part of a prototype nuclear plant designed for the military.

Eastern Idaho is mountainous but not as mountainous as Central Idaho. There are hiking trails, biking and all-terrain vehicle travel in the area as well as hunting and fishing. It is a modernized area but without many cities. The main source of recreation is community and family gatherings.

The Fort Hall Indian Reservation is in Eastern Idaho. The Shoshone-Bannock tribes are in four counties in the region. The annual payroll in their casinos is 32 million dollars and 75 million dollars comes from agriculture in the reservation. Pocatello has one of the largest African American populations percentage-wise in the state. Railroad contracts to help build the railroad west brought African Americans to that area.

This part of Idaho is staunchly conservative, with a large Church of the Latter-day Saints populace and influence. Brigham Young University is located in Idaho Falls.

Suzanne Squires

Education Outreach

Idaho State Historical Society

Suzanne Squires shared that Southwestern Idaho is the largest region in Idaho. There are ten counties and over 765,000 people in the area. The area was primarily settled by the Shoshone, Bannock and Paiute Indians. They were nomadic people traveling between Southern Idaho, Northern Nevada and Eastern Oregon. The French trappers were influential in the area as well. It is believed that the French trappers named Boise after the French word for trees. The Oregon Trail came through Southwestern Idaho and many travelers located in the area. In the 1800's

travelers were looking for gold and many settled in Idaho City. The mining also brought Chinese miners from the San Francisco area and a large population of Basque people. The Chinese and Basque people were not as successful with gold mining so they took on other jobs. The Basque people raised sheep and there is still a large Basque population in Idaho. The native populations formed the Duck Valley Reservation and that is where the Shoshone and Paiute tribes live today.

The terrain consists of high deserts, rural farmland, mountains, rivers, streams, lakes, and reservoirs. Recreation includes skiing, kayaking, fishing, bike riding, boating, water skiing and white-water rafting. It is a high desert area around Boise. Bogus Basin Mountain Recreation, Bruneau Sand Dunes, and Hells Canyon Recreation are in this region of Idaho.

Boise State University, Northwest Nazarene University, and the College of Western Idaho are also in the region. There are many job opportunities including farming, agricultural, cattle ranching, and dairy farming. There is a Micron Technology Center that employs thousands of people. J.R. Simplot Company, Amalgamated Sugar Company are other major employers in the area. St. Lukes and St. Alphonsus are two large regional hospitals with outreach programs in all of the smaller communities.

This is the most populated area in the region and is one of the more liberal areas in the State of Idaho. There is more access to transportation in Southwestern Idaho and a major airport. The Basque community has festivals, restaurants and is a thriving part of the area. There is also a large refugee population that has opened restaurants and assimilated into the community very well. Boise is always in the top 100 places to live.

Q&A

Octavio Martinez asked if the committee could hear more about the low employment rate in Idaho compared to the national average.

Amber Beierle stated that many of the jobs are low-paying jobs. It is more difficult to find high-paying jobs for those who graduate from college with a bachelor's or master's degree. Many are non-degree jobs such as construction that are dependent on the economy. There is an issue with underemployment and people not making a living wage.

Kathleen Dalton asked where the immigrants are from and how they ended up in the remote area.

Suzanne Squires said there was an influx of refugees from Bosnia that were sponsored by churches. They were able to come to Idaho and were given the assistance needed to find jobs and become part of the community.

Dieuwke A. Dizney-Spencer responded that Idaho is a resettlement state. Boise and Twin Falls accept refugees. There is around a 14% Hispanic population and some people come due to agriculture as migrant workers.

Ben Taylor asked how the diversity is spread throughout Idaho.

Amber Beierle said that Idaho is not very diverse and is around 96% Caucasian. Boise, Pocatello and Twin Falls have more diversity than other areas of Idaho.

SUICIDE RATES IN RURAL AMERICA

Governor Ronnie Musgrove shared that rural areas have seen a divergence from urban areas in suicide rates. From 1970-1990, urban areas saw a decline in male suicides while rural areas saw an increase. Since 1999, the suicide rate in America has increased. Some of the factors that affect the rate of suicide are social isolation, limited economic opportunities and poverty. After 1999, the United States suffered two recessions. The first panel discussion will be speakers from Idaho on the issue of suicide. The second panel will speak about national trends related to suicide.

IMPACT OF SUICIDE IN RURAL AMERICA: AN IDAHOAN PERSPECTIVE

Kim Kane, MPA
Manager, Suicide Prevention Program
Idaho Department of Health and Welfare

Kim Kane stated that she would share suicide statistics, a history of prevention efforts and talk about a new suicide prevention program.

In 2015, Idaho had almost one suicide per day with a suicide rate of 21.9% and was ranked 5th in the nation. A lack of effective, affordable and accessible mental health services is among factors that contribute to the high suicide rate. The stigma of seeking help and a rugged individualism mentality adds to the challenges when dealing with mental health. There is also easy access to firearms which is the most lethal means of committing suicide. There is a correlation between states with the highest suicide rates and states with the highest percentage of gun owning households. Eighty-eight percent of all firearm deaths in the State of Idaho, in 2016, were suicides and 97% of all self-inflicted firearm deaths were suicides.

In the mid to late 90's, there was a youth suicide task force but it did not reach full potential because of it lacked a collaborative effort to support suicide prevention. In 2002, The Suicide Prevention Action Network (SPAN) Idaho was incorporated. The Suicide Prevention Action Network Idaho was all volunteers until 2004 when a few part-time employees were hired. There was a \$50,000 a year budget with two part-time employees and continued support from volunteers. In 2016, the Idaho Suicide Prevention Program at Idaho Department of Health and Welfare was established. Since 2010, there has been collaboration built between the police department, schools and the Department of Health and Welfare. A school suicide intervention and prevention best practice protocol was put into place with data collected from Wisconsin, Maine, and California.

Since 2010, there has been a large number of programs established related to suicide prevention. In 2011, Olympian Speedy Peterson was lost to suicide and the Speedy Foundation was established. The new Idaho Suicide Prevention Hotline was reestablished in 2012 after a lack of funding caused the previous program to end. In 2015, the American Foundation for Suicide

Prevention Chapter was established in Idaho. In 2016, the Idaho legislature allocated nearly a million dollars for suicide prevention.

The Idaho Department of Health and Welfare now has four full-time members on staff. The program implements strategies that are part of the state plan. The state office takes a comprehensive statewide approach to suicide prevention in Idaho. The Idaho Lives Project created Sources of Strength; an upstream suicide prevention program. Sources of Strength lost federal funding so the state is providing funding. Schools that want to implement the program do so through the Idaho Lives Project. Fifty schools have been trained and there is an 86% retention rate. Another thirteen schools will be training in the fall.

Rock Your Role Campaign is a new public awareness campaign through The Idaho Department of Health and Welfare. The campaign includes collateral materials being distributed throughout the community including posters, table tents, tear pads and coasters. This campaign is based on friends and family playing an important role in assisting those who are suicidal. Everyone is a gatekeeper and has a role to play in suicide prevention. An example is a public parking garage that had a higher percentage of suicides. The public parking garage is now putting up physical barriers so it is more difficult for people to commit suicide and also are placing signs in the garage with information on how to contact the suicide helpline.

Dotti Owens, MA, D-ABMDI

Coroner

Ada County, Idaho

Dotti Owens shared that the coroner's office services all of the cities in Ada County and provides forensic services, autopsies, and toxicology to thirty-three counties and two tribes. In 2016, in Ada county there were 104 suicides; 62 were gunshots and 22 hangings. Communities need to be utilizing the coroner medical examiner resources. Each case has a full, extensive investigation performed by examining medical, mental health and pharmacy records. There is a complete review of what occurred in the individual's life leading up to the suicide. This helps get an understanding of what is happening related to suicide in rural counties. Many times, statistics can be skewed. Different jurisdictions are classifying deaths with various processes. If there is an officer-involved shooting it can be classified as a homicide versus a suicide by police officer. If a person attempts suicide with different methods and is eventually successful, it can be classified as an undetermined cause. There are cases of Russian roulette that are classified as accidental or an undetermined cause, but when the history of the individual is reviewed it is an obvious case of suicide. Coroners do extensive research into the investigation of deaths so it is important that their records be utilized as a resource.

Jeni Griffin

Executive Director

Suicide Prevention Action Network of Idaho

Jeni Griffin thanked the committee for inviting her to speak. She stated that she is a survivor of suicide loss. She lost her sixteen-year-old son, Todd, fourteen years ago. It turned her world

upside down and she decided to do something positive with his death and get involved in suicide prevention. Ms. Griffith was the first chapter president of Suicide Prevention Action Network (SPAN) Eastern Idaho and is now the executive director. Suicide Prevention Action Network (SPAN) Idaho was implemented in 2002, and in 2004, The Idaho Prevention Plan was implemented and allowed SPAN Idaho to do projects across the state.

There are nine chapters across the State of Idaho which is unique because of the vast and rural land mass. The Fort Hall Chapter implements and does Native American specific suicide prevention efforts. The mission of SPAN Idaho is to reduce suicide through statewide advocacy, collaboration, education and best practices. The vision is that Idahoans will choose to live. SPAN Idaho is comprised of a ten-member board with people from all over the state that meets annually. The board members discuss awareness programs and what will work in different areas of the state in a collaborative manner. The chapter presidents are all volunteers that have a passion for suicide prevention because they are a survivor or work in the mental health profession.

SPAN Idaho collaborates with other suicide prevention groups and administers the Garrett Lee Smith Suicide Prevention Grant through the Idaho Lives Project implementing The Sources of Strength Program. Schools can apply to be selected as Sources of Strength facilities. Many of the regional chapters have robust groups. In Northern Idaho, there has been a memorial walk for the last ten years with about 25-30 people attending. The most recent memorial walk had 400 people who attended. The chapter had struggled because of the stigma of suicide and people not wanting to join a suicide group. The leadership of the group has been amazing and it is powerful to go from 25 to 400 people attending a walk to prevent suicide.

Some of the training programs through SPAN Idaho are safe storage for lethal means including guns and pharmaceuticals. There are programs supporting the placement of hotline materials and memorial walks. There are also support groups in most of the regions and SPAN Idaho produces a survivor packet. Other cities nationwide are implementing survivor packets similar to the ones created in Idaho. They contain survivor information, support group information, and seeds of hope that people can plant in memory of their loved one. This gives survivors hope that they will be able to recover from their loss and be able to live healthy, happy lives.

J. Robert Polk, MD, MPH, FACP
Former Chief Quality Officer and Vice President, Quality and Patient Safety
Saint Alphonsus Health System

Robert Polk stated that he would speak about systems and how to approach suicide prevention in a rural setting. To change outcomes, it has to be through infrastructure and process.

A healthcare parallel to suicide prevention is infection prevention. Tuberculosis rates are lowered by clean water and sanitation, not from anti-tuberculosis medications. Education is essential but you have to have systems in place to go above the 90% rate of prevention. When suicidality is present, what do we do to keep it from progressing? A low sense of belongingness and perceived burdensomeness are two ingredients of suicidality. There has to be an appreciation of the innate

value of all human beings and the value of our differences. Bad thoughts stay with us and we have to teach ourselves how to handle our thoughts and treat ourselves with love when others are critical of us. There has to be a system of care in place with a diagnosis, treatment plan and coordination of care. The myths and stigma of suicide have to be addressed.

Zero Suicide is a system of care around suicide prevention. It includes suicide screening for all patients who enter a rural medical facility. If the screening is positive then a comprehensive risk assessment is done the same day. If the risk assessment is positive, a safety plan and lethal means counseling is done and a follow-up appointment is scheduled.

Rural clinics vary in staff and resources. In a small clinic, there may be one physician, a medical assistant, and a receptionist. In a robust clinic, it may include community health workers, social workers, lab and imaging services. Rural health clinic designation dollars are usually capped at \$80 per visit but if the clinic is part of a community access hospital there is no cap per encounter. The funding inequity needs to be examined to provide the infrastructure and resources to follow the process of Zero Suicide. Many behavioral health clinicians are not trained in comprehensive suicide assessment and management.

Two major obstacles of assisting people who are suicidal are a lack of trained staff and funding. Where resources and funding are scarce, a principle to follow is to concentrate the resources centrally, ensure widespread access, and grow a decentralized capacity over time. Public health districts can concentrate resources centrally by using staff trained in suicide assessment and management, and by means of telemedicine. Capacity can be expanded over time by changing reimbursement models, funding trained individuals in clinic sites and putting telemedicine at the frontline clinics. Clinics should have a combination of community health workers and registered nurses that are well trained in suicide assessment and management.

Q&A

Paul Moore asked Dotti Owens if researchers are accessing the coroner reports. There is so much detail in the reports so they are a valuable asset to a committee.

Dotti Owens said they have not had researchers access the reports and all of the data is available. The investigations are a great resource.

Octavio Martinez stated that according to suicide statistics the rate is increasing in Idaho. Can you identify why the slope not going down?

Kim Kane said that until efforts can be ongoing, sustainable and statewide the rates will not decrease. If the efforts are scattered it doesn't work so Idaho is initiating a comprehensive approach.

Donald Warne shared that he is a family physician and the Chair of the Department of Public Health at North Dakota State University. He is involved in the Sources of Strength Program and a trainer for Zero Suicide and hopes to see Zero Suicide in all the clinics and Sources of Strength in all of the schools. Something that is prevalent in tribal populations in the Dakota's is the

significant adverse childhood experiences, unresolved trauma and a lack of trauma-informed care. Are you trying to address some of those challenges?

Kim Kane said that Sources of Strength addresses those issues and the program began with Native populations in Alaska and the Dakotas. Trauma-informed care is part of every training. The teacher training is focused on viewing unwanted behavior through the lens of trauma. It is all taught through the Sources of Strength model. Sources of Strength believes that if we want kids to stop being at risk that we have to stop telling them that they are at risk. That doesn't mean to not be cognizant of their traumas and make them aware of it, but they can't be left in that position of vulnerability.

Chester Robinson asked if the panel has been able to put a face on suicide.

Kim Kane said that the face of suicide could be anybody across the country. The highest rates are in middle age to older males. In the past five years, there has been 105 school age children commit suicide with a rate of 6.7%. The middle age male rate is 35-50 per 100,000. In 2016, males over the age of 85 have rates of 75 per 100,000.

IMPACT OF SUICIDE IN RURAL AMERICA: NATIONAL TRENDS

Holly Hedegaard, MD, MSPH
Injury Epidemiologist, Office of Analysis and Epidemiology
National Center for Health Statistics
Centers for Disease Control and Prevention

Holly Hedegaard told the committee that she would speak about national trends in rural suicide. Dr. Hedegaard shared that she worked at The State Health Department in Colorado for close to 20 years. Colorado typically ranked in the 7th or 8th position in suicide rates. Colorado was one of the first states to have an office of suicide prevention. The work being done in Idaho is fascinating and if the rural states work together on best practices, they can learn from each other's successes.

The National Vital Statistics System Mortality Data is compiled from death certificates. It includes all U.S. resident deaths. This includes demographic characteristics, the cause of death, geographic information and other variables.

The suicide rates have been increasing in the United States. From 1999 to 2015, the rates have been higher in rural than in urban counties. The disparity in 2015 is a 40% increase from 1999 in rural versus urban. There hasn't been much change in the rates in the most urban areas between 1999 and 2015, but the micropolitan and non-core areas have increased substantially.

The National Center for Health Statistics did small area analysis statistical techniques to create models researching county-level suicide rates from 2005 to 2015. In the models, there were a variety of factors that might influence the suicide rate. The county-level median age, poverty levels, divorce rates, mental health issues and other factors were considered. The areas of Oklahoma, Arkansas, Kentucky and the Appalachian States started to show high prominence in

suicide rates in 2015. The counties with the biggest change between 2005 and 2015 were mainly in non-core areas. Almost half of those counties had an increase in suicide rates in at least 30% or more.

In 2015, the suicide rates for rural females was 20% higher than urban females. The pattern is not the same for rural and urban. There is a single peak for rural and urban but the peak is not at the same ages. The peak is higher for younger rural females than urban females. Rates have risen for rural males and in 2015 the difference between rural and urban is about 40%. The pattern of suicide rates by age group for rural males versus urban are about the same but the rates are higher in rural. In rural areas, there is an increase in the rate at ages 50-54, then a decline and another increase at the age of 70 and older.

Rural versus urban suicide rates by race and ethnicity show the highest rates in rural American Indian/Alaskan Natives. The white, non-Hispanic rural individuals are the second highest rates. Rates are higher for every race in rural except for the African American suicide rate. It is the same in rural and urban.

Percent by selected means statistics show that firearms are used more than any other means of suicide. In rural communities, about 60% of suicide deaths are committed by a firearm and in urban areas about 47% are committed by firearm. In urban areas, the percentage of suffocation and hanging are higher.

In conclusion, there is increasing the disparity between rural and urban suicides. The highest suicide rates are for rural males. There are similar age patterns in suicide rates for rural and urban males. The age group with the highest suicide rate is younger for rural females (45-49 age group) compared to urban females (50-54 age group). Among race/ethnicity groups, rates are highest for rural American Indians and Alaskan Natives. Compared to urban suicides, a higher percentage of rural suicides (60%) involve the use of a firearm.

Richard T. McKeon, PhD, MPH
Branch Chief, Suicide Prevention Branch
Centers for Mental Health Services
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Richard McKeon said he would speak to the committee about national suicide prevention efforts. Suicide in the United States has been increasing. More than 44,000 Americans died of suicide in 2015. Suicide is the 10th leading cause of death among all Americans and 2nd leading cause of death among youth and young adults. For adults 25 years and older, 38,000 to 44,000 are deaths by suicide. Most of the national efforts have focused on youth suicide and not on suicide across the lifespan.

Adult visits to emergency departments related to suicide ideation are increasing. From 2006-2013, the rate increased 12% annually. By 2013, there was 903,400 emergency department visits

related to suicidal ideation. If and an individual makes a suicide attempt, there is a 3.2% they will die of suicide within the next year. Males have a higher rate of suicide than females.

State suicide prevention coordinators face unique challenges in rural communities. There are workforce shortages and closings of community mental health centers and rural hospitals. There is a lack of psychiatrists and psychiatric beds in rural communities and long waits at emergency rooms. Care coordination is also an issue in rural communities. Economic disadvantages, geographic issues and a lack of transportation are also barriers to access.

Rural suicide prevention must include crisis services and coordination of care after discharge. When a person leaves the emergency room or treatment, there is still a risk of suicide so follow-up care is vital. Telepsychiatry would be beneficial to rural communities so people don't have to be transported a long distance for a suicide risk assessment. Partnerships with gun shops and shooting ranges, and working collaboratively with firearms groups as part of suicide prevention is important. Faith communities are another important partner as part of the collaborated effort to prevent suicides.

The 2012 National Strategy for Suicide Prevention provides a comprehensive approach to suicide prevention. Most states are using the national strategy to revise and update their state plans. The potential for having a measurable impact is variable. The absence of state, tribal, and community infrastructure hampers successful suicide prevention efforts. There are states with a suicide prevention coordinator but they have many other responsibilities and a small amount of time to focus on suicide prevention. The effort to integrate and coordinate suicide prevention is not standard practice in most states. There needs to be sustained focused community and healthcare efforts. The efforts must be data-driven, coordinated by a public-private partnership, with a strong state infrastructure.

The Garrett Lee Smith Suicide Prevention Program on youth suicide is making a difference but not long term. The impact is only lasting one year after activities conclude. The positive impact was largely driven by small to medium size counties.

The Zero Suicide approach is about making suicide prevention a core priority in healthcare systems. Healthcare clinicians need the training, supervision, and support to work with suicidal people. The elements of Zero Suicide in a healthcare organization are to create a leadership-driven, safety-oriented culture and create a pathway to care. The pathway to care identifies and assesses the suicide risk and uses evidence-based care to create a safety plan, restrict lethal means and treat suicidality and mental illness. A competent, caring workforce will provide continuous support as a pathway to reducing suicidal behavior. There has to be a significant means of follow-up and support.

Improving post discharge safety is important. The White Mountain Apache tribe has shown almost a 40% reduction of suicides. They routinely follow-up with youth at risk when they leave emergency rooms and when they come back from inpatient units. They meet with the youth in their homes and connect them to Apache Behavioral Health Services. Follow-up is an important component of their comprehensive effort.

Some of the Substance Abuse and Mental Health Services Administration (SAMHSA) suicide prevention programs include Garrett Lee Smith State/Tribal Youth, Garrett Lee Smith Campus, Suicide Prevention Resource Center, National Suicide Prevention Lifeline, Native Connections, National Strategy for Suicide Prevention and Zero Suicide.

Q&A

Kathleen Dalton asked about the suicide rates of females regarding rural versus urban. Could there be a reporting issue because women may be less likely to commit suicide with firearms so it could be easier not to report those deaths as suicide.

Holly Hedegaard responded that more are by drug overdose or poisoning compared to men. There is more investigation happening and perhaps deaths that previously may have been termed accidental could actually be suicide.

Donald Warne asked about the correlation between poverty and suicide and if there a difference between rural and urban. A challenge in Indian country is identifying evidence-based practices that are culturally relevant. What are your thoughts regarding the need for more resources to do evaluations of programs?

Holly Hedegaard replied that data sets at National Center for Health Statistics don't include poverty levels so there is not a way to address the question of poverty being a risk factor and correlation.

Richard McKeon stated that African Americans have lower suicide rates so some of the issues were masked in terms of matters around poverty and education. African American women have the lowest rate of suicide of any ethnic/racial groups. It is important to understand why because it is not the absence of stress that contributes to the lower rates.

Regarding evaluation and evidence-based practices, it is particularly important in tribal communities to support tribal sovereignty in making their own decisions. There is literature from New Mexico and The White Mountain Apache Tribe and a group of American Indian/ Alaskan Natives has collaborating centers doing suicide research.

Kathleen Belanger said that she is intrigued by the suicide prevention coordinators engaging in the state-tribal and community infrastructure issues and challenges, and coordinating community and healthcare efforts. Can you expand on the challenges and community efforts? What needs to exist in a rural community to get the funding?

Richard McKeon responded that on a state level there has to be a nexus to focus on suicide prevention because it doesn't happen automatically. Every state has a suicide prevention coordinator but some are really underpowered. Suicide crosses multiple sectors so there has to be a connection between the broader health system, mental health system, substance abuse system and the justice system. Gatekeeper training is important but to ensure coordination requires more work.

Octavio Martinez stated that the economic impacts of suicide are often overlooked. Investing in programs can prevent huge expenses. There needs to be an economic analysis of cost. Investing in programs can make a difference in expense. It affects the family and community when a person is lost.

Richard McKeon responded that he is not aware of an economic analysis on the effects of suicide. There has been analysis on direct medical costs. It is also important to look at the cost of suicide attempts and suicidal ideation. Productivity may be another cost that needs to be researched because there are people who are on disability or employed but their effectiveness could be diminished due to suicidality.

MODERNIZING THE RURAL HEALTH CLINIC

Governor Ronnie Musgrove stated that the afternoon sessions focus on how the rural health clinic program can adapt to the changing healthcare system. The rural health clinics destination was created in the late 1970's. Now there are around 4,000 Rural Health Clinics. The program remains very close to what was initially included in the legislation.

MODERNIZING THE RURAL HEALTH CLINIC PROVISION, PART 1

Teresa Cumpton

Regional Office Rural Health Coordinator, Region X (Seattle)

Center for Medicare & Medicaid Services

U.S. Department of Health and Human Services

Teresa Cumpton stated that she would share history of Rural Health Clinics with the committee. RHC's were established in 1977 to address the inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas and to increase the utilization of nurse practitioners and physician assistants in these areas. RHC's are paid an all-inclusive rate for medically-necessary primary health services and qualified preventive health services furnished by a rural health clinic practitioner. Rural Health Clinic services are defined as a physician, nurse practitioner, certified nurse midwife, a clinical psychologist, and clinical social worker services. Rural Health Clinics must be in a nonurbanized area as determined by the census bureau. Federally Qualified Health Clinics can see any patient that comes through the door and have sliding fees. They receive grants to support their work and to offset the cost of the requirements of being an FQHC.

Commingling prohibitions affect rural health clinics that are not provider-based. Commingling is when a rural health clinic shares a space with a specialist. Because the all-inclusive rate is based on the cost of providing care, Centers for Medicare and Medicaid Services is specific about the definition of primary care versus other services. In order to define this, there is a prohibition to commingling. Some rural health clinics are open three days a week during the day and is a dental clinic the other days a week. This prevents commingling since the services can't be in the same space at the same time.

There are differences between independent rural health clinics and provider-based health clinics. Independent rural health clinics are free-standing clinics that are owned by a provider. They may be owned by a larger healthcare system, but do not qualify for, or have sought provider-based status. Provider-based rural health clinics are owned and operated as an essential part of a hospital, nursing home, or home health agency participating in the Medicare program. The provider-based rural health clinics have no payment cap if the clinic is provider-based to a hospital of fewer than fifty beds or has an average daily census of under forty and is a sole community hospital or essential access community hospital.

Rural health clinic payments by Medicare are an all-inclusive rate for services determined by the cost report. The 2017 all-inclusive rate limit for independent rural health clinics with fifty beds or more is \$82.30. The rate is adjusted each year based on the Medicare Economic Index.

All state Medicaid programs are required to recognize rural health clinic services. The states may reimburse rural health clinics under one of two different methodologies. The prospective payment is when the state calculates a per visit rate based on the reasonable costs for an RHC's first two years of operation. For each succeeding year, this per visit baseline rate is increased by the Medicare Economic Index Factor. Alternative payment methodology is when there are only two requirements. The clinic must agree to methodology and the payment must at least equal the payment received under the prospective payment system.

John A. Gale, MS

Senior Health Policy and Services Researcher

Maine Rural Health Research Center, University of Southern Maine

John Gale stated that he would be examining the rural health clinic's role in the healthcare environment and discuss some of the challenges and opportunities that are available. There are approximately 4,200 clinics serving rural residents in forty-four states. The rural health clinic program was created to improve access for Medicare beneficiaries living in rural areas. It expanded the use of midlevel providers in a team based environment in a time that very few payers were reimbursing directly for those healthcare professionals.

The challenge of primary care is that primary care physicians have lower incomes and higher practice overhead than most specialists. They are expected to take on care coordination and population health without adequate reimbursement or IT support. Despite the challenges, primary care demand is increasing. Long-term sustainability of hospitals and health systems depends on the strength of their primary care systems. Primary care plays a central role in many health systems and practices transformation initiatives. Primary care physicians provide services that specialty providers are not delivering in rural communities including mental health services, substance abuse services and dental services.

The clinic program is at a crossroads and it is necessary to make modifications to continue improving access and serving vulnerable populations. In 1977, there were access barriers, inadequate supply of rural providers, rural populations were older, sicker and poorer. All of these issues are still true today. Rural residents have higher rates of uninsured and underinsured.

Data collection is necessary in order to make decisions about improving the program. Safety net challenges facing rural health clinics are greater demands for free or discounted care and reductions in provisions of care by private physicians. Provision of charity care draws costs away from Medicare on the cost report. Rural residents are less likely to be employed and more likely to be low-income, face significant access barriers and are less likely to have employer-based coverage. Rural health clinics are part of the safety net in rural, underserved areas by providing services to the uninsured, elderly and Medicaid and Children's Health Insurance Program recipients.

It is important for rural health clinics to adopt health information technology. It is necessary for patient-centered medical homes, accountable care organizations, pay for performance and other transformation initiatives. The adoption of health information technology leads to improved access and service to vulnerable populations. Electronic health records are in use in 72% of rural health clinics. There are 11% of RHC's that are establishing implementation of electronic health records. Approximately 18% of rural health clinics do not have electronic health records.

Rural Health Clinics have public reporting issues and do not typically participate in Center for Medicare & Medicaid Services quality reporting programs. Eligible professionals working in rural health clinics who perform non RHC services bill Medicare Part B and are not subject to merit-based incentive payment adjustments. It is a challenge to encourage RHCs to participate in quality measurement because there are few incentives or penalties for RHCs regarding reporting. There are barriers to RHC quality reporting that include difficulty extracting data and availability of staff time.

A Recommendation for modernizing the rural health clinic program is to support the development of a standardized RHC data set to monitor program performance. Team-based reimbursement models that encourage innovative use of clinical and non-clinical staff need to be explored. Incentives to encourage rural health clinic participation in practice transformation initiatives can be developed. Medicare and Medicaid reimbursement rates need to be evaluated and support given to RHC net initiatives.

Q&A

Kelley Evans said the critical access hospital program received funding based on the capital expense to allow for depreciation and interest. Rural health clinics started in the 1970's so they may need building improvements or IT assistance. Is there something similar to assist RHC's similar to the assistance offered to critical access hospitals?

Teresa Cumpton said that she is not aware of any new funding going to rural health clinics similar to the assistance for critical access hospitals.

Carolyn Emanuel -McClain said she is the CEO of a Federally Qualified Health Center. An FQHC look-alike program is something that rural health centers can do to get an enhanced reimbursement. The government doesn't allow a health center to use the federal money to subsidize Medicaid patients which are a state responsibility. In order to become a FQHC look-

alike the RHC must demonstrate need, have a required set of services, and have a consumer-driven board.

John Gale said there are greater administration burdens for an RHC to transition to look-alike status that may not be easily supported by small practices.

MODERNIZING THE RURAL HEALTHCARE PROVISION, PART 2

Bill Finerfrock
Co-Founder & Executive Director
National Association of Rural Health Clinics

Bill Finerfrock said he will address rural health clinic challenges and provide suggestions and ideas for moving forward. The Rural Health Clinics Program is the oldest federal program aimed at improving access to primary care in rural underserved areas. The Rural Health Clinic program was established in 1977 and today, there are approximately 4,100 federally certified RHCs in 45 states. Rural Health Clinics were created to encourage providers to move to rural areas. There is a higher percentage of Medicare and Medicaid patients in rural areas which makes it difficult for providers to have practices in rural communities. RHCs made it possible for physicians to be paid on a cost basis. The program has grown since the 1980's because of the changes made in payment methods to hospitals. In the mid-1980s hospitals were changed from a cost-plus system to a per episode based payment system.

There are forty-four million Medicare beneficiaries. Twenty-eight million are in the fee-for-service part of Medicare and sixteen million are in Medicare Advantage. The average age of a Medicare beneficiary is 75 years old. Fifty-five percent of Medicare beneficiaries are female and forty-four percent are male. Regarding race and ethnicity of Medicare recipients, there is eighty-two percent non-Hispanic, seven percent African American, five percent Hispanic and four percent other/unknown.

In 2007, Medicare costs to RHC/FQHC was .26% and it grew to .38% in 2015. The percentage of beneficiaries using RHC/FQHCs grew from 6.59% to 7.99% during that time period. In 2015, independent rural health clinics actual payment per visit was \$81.32 and the cost per visit was \$106.22. Provider-based to community access hospitals actual payment per visit was \$164.36 and the cost per visit was \$164.36. Provider-based to hospitals with less than 50 beds actual payment per visit was \$152.75 and the actual cost per visit was \$152.75. Provider-based with more than 50 beds actual payment per visit was \$81.32 and the cost per visit was \$148.97. The upper payment limit cap was set in 1988 and there has been medical inflation in the past 30 years. Providers are being asked to do data collection and reports in 2017 with a cost structure that is 30 years old.

The National Association of Rural Health Clinics continues to promote raising the RHC cap to at least \$110 per visit for those RHCs subject to the cap. The 2017 cap is \$82.30. The \$110 is the cost per visit is for RHCs that are subject to the cap. In 1993, Congress approved cost-based reimbursement for Medicare and Medicaid for FQHCs which was created after the RHC

reimbursement model. The RHC rate was determined by statute in 1988, prior to the adoption of the resource-based relative value scale and federally qualified health center rate that was set in 1993. The last year for the cost-based FQHC rate was 2015 and the rural rate per visit was \$112.56.

Rural health clinic policy issues that need to be addressed include raising the rural health clinic cap to \$110 per visit, eliminating the requirement that RHC's employ a physician assistant or nurse practitioner, allowing physicians working at RHCs to be the attending physicians for hospice beneficiaries and allowing RHCs to be the distant site of telehealth services. Other recommendations are to relax emergency preparedness rules, grandfather RHCs related to relocation and respond to the issue of regional offices lengthy time process for RHC certification. The lack of grant money for uninsured or capital improvement needs to be addressed. Rural health clinic lab testing requirements are outdated and should be modernized. There should be equality with the FQHSs for Medicare Advantage treatment or payment for RHC services.

Wakina Scott, MPH, PhD

**Policy Coordinator, Federal Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services**

Wakina Scott said that rural health clinics are struggling with the technical component and how to do value-based payment and quality reporting. Federally qualified health centers are more prepared to do quality reporting. Rural health clinics need a grant to provide skills and technical assistance funding. Data collection is a necessity in order for rural health clinics to prove their importance and demonstrate that they are providing quality services. It is necessary to have one source for RHCs to submit shared information for various sources to obtain.

The Center for Medicare and Medicaid Innovation is finding ways to assist RHCs and FQHCs to do more quality reporting and care coordination. There are not many RHCs participating in accountable care organizations because of lack of technical assistance. This is a timely and much-needed topic for the committee to examine and make recommendations of how it can be modernized.

A flex program that could provide dental services and mental health services and reimburse different types of providers would be beneficial. The 340B program would benefit rural health clinics.

Q&A

Tom Morris said that in the statute there is the ability for skilled nursing facilities to have a provider-based rural health clinic. In communities where rural hospitals are closing could it be that there are regulatory barriers that make it hard under the current statute for a free-standing skilled nursing facility to also be a provider-based rural health clinic? What would it take to get the model developed and prove that it can be viable?

Bill Finerfrock responded that the Rural Health Clinic would be subject to the cap so from a financial standpoint it would be an issue. In the past there have been skilled nursing facilities with RHCs but there haven't been any in recent years.

Peggy Wheeler said a challenge in California with critical access hospitals is they cannot just convert to a freestanding facility and make the financing structure work.

Bill Finerfrock stated that the programs were created so long ago that they don't work for what people need at this time. There need to be new models to allow for a delivery system that meets the needs of the community.

Octavio Martinez said that graduate medical education should be expanded to include other providers like physician's assistants and nurse practitioners. If graduate medical education is paid by the government then the recipients should be required to work in underserved areas.

Bill Finerfrock responded that graduate medical education does cover nursing education and allied health. The problem is that the graduate medical education payment goes through the hospital. Most physician assistant and nursing practitioner programs are not in hospitals so that creates an issue with the money flow.

Carolyn Montoya stated that there are nursing education bills that go through Congress but are not funded at the level of graduate medical education. Some of the GME is tied to how the hospital receives funding. The advanced nursing education workforce grant provided \$22,000 to ten students in her area which were extremely beneficial.

The students need to have clinical rotations while they are in school because if they have exposure to rural communities they are more likely to work in these areas. Even better is to recruit students from rural communities because they are more likely to go back to the community to work.

PUBLIC COMMENT

There was no public comment.

Tuesday, September 12th, 2017

Tuesday morning the subcommittees depart for site visits as follows:

HEALTH SUBCOMMITTEES

Modernizing the Rural Health Clinic Provision (Gooding, Idaho)

North Canyon Medical Center

Subcommittee members: Kathleen Dalton, Carolyn Emanuel-McClain, Kelley Evans, Carolyn Montoya, Chester A. Robinson, Mary Kate Rolf and Mary Sheridan.

Staff Members: Tom Morris, Steve Hirsch, Wakina Scott, and Victoria Maloch.

HUMAN SERVICES SUBCOMMITTEE

Understanding the Impact of Suicide in Rural America (Emmett, Idaho)

First Baptist Church

Subcommittee members: Kathleen Belanger, Barbara Fabre, Constance Greer, Octavio Martinez, Benjamin Taylor, Donald Warne and Peggy Broussard Wheeler.

Staff Members: Paul Moore, Sahi Rafiullah, Alfred Delena and Shannon Wolfe.

The subcommittees' returned to SpringHill Suites in Boise, Idaho, to discuss site visits.

PUBLIC COMMENT

There was no public comment.

Wednesday, September 13th, 2017

DRAFTING OUTLINE OF POLICY BRIEF

IMPACT OF SUICIDE IN RURAL AMERICA: NATIONAL TRENDS

Subcommittee findings and possible recommendations include:

- Coordination between Health Resources and Services Administration, Federal Office of Rural Health Policy, and Substance Abuse and Mental Health Services Administration to leverage resources
- Federal agencies separate rural/urban data and research
- Targeting block grants based on need
- Find ways to better utilize community health workers
- Sustainability strategy for community health workers after funding ends
- More technical assistance and promotion of Patient Health Questionnaire 9

MODERNIZING THE RURAL HEALTH CLINIC PROVISION

Subcommittee findings and possible recommendations include:

- Payments need to be examined for rural health clinics
- Rural health clinics need a more value-based payment system
- Development of a Future Leaders Exchange Program for rural health clinic technical assistance
- Rural health clinics should be considered a distant site so they can deliver telehealth services
- Nurse practitioners and physician assistants should have the ability to order home health and hospice services
- Behavioral health clinicians that are licensed by state should be allowed to be a licensed provider of services in rural health clinics
- Lab requirements need to be modernized
- Relocation requirements need to be addressed
- RHCs must employ a nurse practitioner or physician assistant and there needs to be more flexibility

FEDERAL UPDATE ON DELIVERY SYSTEM

Tom Morris

**Associate Administrator, Federal Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services**

Tom Morris stated that the Health and Human Service Secretary's priorities are the opioid crisis, childhood obesity, and mental health issues. Those priorities need to be linked to the committee's priorities.

The interest level of telehealth continues to grow, particularly the Extension for Community Healthcare Outcomes project. Most divisions of The Department of Health and Human Services are investing in the ECHO model as an avenue for provider education. There are legislative proposals regarding telehealth being considered.

The 340B proposal to reduce Medicare outpatient reimbursement for hospitals that are getting 340B has generated concern for the future of the 340B discount drug program. Using the savings from the reduction and redistributing the funding around the outpatient system is being considered.

The Children's Health Insurance Program has been successful in rural areas and is up for reauthorization. When CHIP was implemented in combination with Medicaid, it lowered the uninsured rate among children. In rural areas, children are much more likely to be covered by CHIP or Medicaid than in urban areas. The reauthorization will be a vehicle to attach other pieces of legislation. Some Medicare payment extenders may be included. Marketplace discussions about ways to stabilize the insurance market will help inform the work of the committee at the next meeting in New York.

There are reinsurance proposals to the Medicaid Waiver Program that will reduce premiums. Alaska was the first one to pioneer the reinsurance proposal and Oklahoma is considering it.

Shortage designation requirements are being updated. The National Provider Identifier is being used instead of survey data to determine where there are health professional shortages. Rural Health and Health and Human Services is considering how to assist states that are going to lose the full county health professional shortage area designation to a partial county health professional shortage area so they don't lose the ten percent bonus. There are about 5 or 6 states that are more at risk than other states because they have more geographic health professional shortage areas.

Paul Moore announced that the next Rural Health and Human Service National Advisory Committee meeting will be held April 16-18th in Saratoga Springs, New York.

PUBLIC COMMENT

There was no public comment.