Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Traverse City, Michigan
June 15-17th, 2011

Meeting Summary

The 68th meeting of the National Advisory Committee on Rural Health and Human Services was held on June 15-17th, 2011 in Traverse City, Michigan

Wednesday, June 15, 2011

The meeting was convened by Tom Morris, Director, Office of Rural Health Policy.

The Committee members present at the meeting were: Governor Ronnie Musgrove (Chair); Graham Adams, Ph.D.; April M. Bender, Ph.D.; Maggie Blackburn, MD; John Stewart Cullen, MD; Phyllis A. Fritsch; Donna K. Harvey; Thomas E. Hoyer, Jr., MBA; Todd Linden, MA; Robert Pugh, MPH; Shane H. Roberts; John Rockwood, Jr., MBA, CPA; Maggie Tinsman, MSW; Roger Wells, PA-C. Mr. Dennis Dudley attended representing the U.S. Administration on Aging.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Steve Hirsch, Paul Moore and Aaron Fischbach. Truman Fellows present were: Catherine Koozer, Natasha Scolnik, Aaron Wingad and Nicholas Lillios.

SETTING THE CONTEXT FOR MICHIGAN
Jeff Taylor, Ph. D., Executive Director and CEO, the Michigan Public Health Institute

Jeff Taylor thanked the committee for visiting Michigan and shared information about the Great Lakes watershed. He stated that Michigan has 3,200 miles of coastline which is the 2nd largest coastline next to Alaska. The Great Lakes are 21% of the world's surface freshwater and 90% of North America's surface freshwater.

Dr. Taylor stated that thousands of years before the arrival of the first Europeans, eight indigenous tribes lived in Michigan including the Ojibwa, Menominee, Chippewa, Miami, Ottawa, and Potawatomi. In the 1600's there were about 15,000 indigenous people. There are 11 federally regionalized tribes that remain in Michigan.

Dr. Taylor said that he can not talk about Michigan without talking about Henry Ford. Henry Ford was a watch repairman at age 15 and a Westinghouse steam engine repairman. Manufacturing grew rapidly after the 1900's with the automobile industry in Detroit. The Model T was manufactured in 1908. Assembly line production and a five

dollar a day wage were wonderful things as well as a franchised system of dealerships. Labor unions grew after 1935 and became a major presence in large factories.

Dr. Taylor said that today Michigan is the only state in the union that is losing population. Michigan's growth was the 10th slowest in the first half of the decade. People relocated to Florida, Texas, Arizona, Georgia and North Carolina. He stated that the city of Detroit once had 1.8 million people but has declined to just over 700,000. The city of Marquette has gained 1,300 people in the past decade and that is due to a diversified and well educated population and a high-tech economy.

Dr. Taylor said that Michigan lost over 800,000 jobs in a ten year period and there are over half a million people unemployed. Many of the 800,000 jobs lost were connected to the auto industry and manufacturing. Government, education and healthcare are now the top job producers in Michigan. Problems in the economy are due to jobs being heavily tied to a single industry. In a new economy there needs to be diversified industry.

Job growth is occurring in larger cities such as Lansing and Grand Rapids. Across the globe there are super cities developing so Michigan is competing with the world. Rules are changing with a global economy and there needs to be a good infrastructure and better partnerships between government and business.

Dr. Taylor spoke about the rebound of Michigan. He stated that auto sales recovered from hitting rock-bottom just two years ago which is a big factor in the manufacturing rebound that is driving the nation's economic recovery. According to federal data, the economy grew at an annual rate of 1.8% in the first three months of 2011 but manufacturing grew four times faster at 9% benefiting both output and hiring.

Michigan Agriculture is the second most diverse in the nation, leading in the production of dry beans, blueberries, tart cherries, cucumbers, flowering hanging baskets, geraniums, impatiens, and petunias. 1.05 million people are employed in the agri-food system which annually accounts for $60.1 billion in economic activity.

Dr. Taylor said that University of Michigan economist George Fulton predicts Michigan will gain 64,000 jobs this year; more than double the 24,500 jobs he had forecasted in November. The biggest job gains will come from business and professional services, health care, and manufacturing. However, he anticipates more job cuts in government.

Dr. Taylor spoke about the Public Health Institutes in Michigan. There are 34 in the national network that are generally smaller organizations and sometimes university-based and are positioned between community, academia and government. The Michigan Public Health Institute is setup to enable communities to apply state-of-the-art community health practices. Their mission is to maximize positive health conditions in communities through collaboration, scientific inquiry, and applied expertise. This mission includes carrying the voice of communities to health policy makers, scientists, purchasers, and funders and also advancing the application of scientific health practices in communities. Advancing community capacity to improve health and reduce disparities among

population groups and geographic areas is also included in its mission. Dr. Taylor added that the core business of the Public Health Institute is Health Information Technology, Federal Health Care Reform, Public Health, Human Services Systems Reform and Interactive Electronic Communications.

Dr. Taylor closed by asking the National Advisory Committee on Rural Health and Human Services what should the National Network of Public Health Institutes do to foster emerging institutes in rural areas. He also asked what should the National Network of Public Health Institutes do to stimulate more collaboration across member institutes on rural health issues and as National Network of Public Health Institutes pursues a cooperative agreement with HRSA –how should it promote a rural health focus.

Lonnie Barnett, Manager, Health Planning & Access to Care Section, Michigan Department of Community Health

Lonnie Barnett began by thanking the National Advisory Committee on behalf of the Michigan Department of Community Health. He gave an overview of the Department of Community Health and their organizational structure. He stated that it is a large department that includes public health, mental health and Medicaid are all a part of the Department of Community Health. Mr. Barnett said that he is part of the policy and planning administration in the department. The Department of Community Health was created in 1996 when separate departments of public health, mental health and Medicaid were combined into a single agency and now has over 4,000 employees.

Mr. Barnett stated that over 2 million Michigan residents will receive services in 2011 with either total or partial support provided by the Department of Community Health. The total state population is around 10 million people so approximately 20% of the State of Michigan is directly impacted by the Department's programming.

Mr. Barnett is the Manager for the Health Planning and Access to Care Section. The programs within his section are the Provider and Recruitment Retention Program, the National Health Service Corps, the State Loan Repayment Program, the International Medical Graduate Program and the Student and Resident Experience and Rotation in Community Health Program. Mr. Barnett stated that they manage a free clinic program and work closely with the Michigan Center for Rural Health on a state rural health plan.

Mr. Barnett spoke about the health of Michigan with a focus on rural Michigan. He stated that they look at the data by metropolitan, micropolitan and Rural Counties. For planning purposes they consider anything that is not metropolitan as rural. Population does not determine whether a county is metropolitan, micropolitan or rural. He noted that there are 83 counties in Michigan and 26 are metropolitan, 23 are micropolitan and 34 are rural counties.

Mr. Barnett shared information on population distribution by age for metropolitan, micropolitan and rural Michigan. The older age groups are higher in the rural counties and the younger age groups have a larger population in metropolitan areas. There is a

migration out of rural areas by the younger population.

Mr. Barnett said that the leading causes of death in Michigan are heart disease, cancer, strokes and Chronic Lower Respiratory Disease. There are higher crude death rates in rural counties than in metropolitan or micropolitan counties. The rural health systems have to address the burden of disease and disability and respond. Behavioral risk factors in Michigan include overweight adults and substance abuse. Obesity is an issue throughout the State and Michigan is ranked 41st in the country in terms of high obesity rates. The Governor has indicated that dealing with the issue of obesity is a priority. Another health risk behavior is substance abuse. There are higher rates of people who smoke and more heavy drinking in rural areas than in Metropolitan areas.

Mr. Barnett spoke about health professional shortage areas where almost every rural area in Michigan is designated a health professional shortage area. Almost 20% of the state's population is designated a primary care shortage population. Most rural areas are also designated as mental health care professional shortage areas. The vast majority of licensed physicians and physician's assistants are located in metropolitan areas. Additionally, 46% of physicians indicated in a survey that they will retire in the next ten years and 42% of nurses indicated that they plan to practice for only one to ten more years. This creates a looming problem that the state will have to address.

Mr. Barnett spoke about The National Health Service Corps. There has been a 116% increase in Michigan in National Health Service Corps Providers from January 2010 through June 2011. The increase has been more in metropolitan areas than in rural areas where the rural increase has been 85%.

Mr. Barnett closed by stating that he would be glad to take questions and thanked the committee for visiting Michigan and taking part in site visits.

John Barnas, Director, Michigan Center for Rural Health

John Barnas began by giving an overview of the Michigan Center for Rural Health. In 2007 there was a decision to create a state rural health plan. There was an advisory committee that included many organizations that looked at the critical indicators in rural communities and did a survey of rural providers. They also went to twelve rural communities to find out what was important to them pertaining rural health. Access to care, recruitment and retention of providers and healthy lifestyles were the most important factors. It was addressed through measurable objectives with implementation strategies attached to them. Internally, at the Center for Rural Health, they decided to increase education and metrics.

Mr. Barnas said that they are considered an affiliate at Michigan State. They provide programs that are needed and have video-conferencing sites through the telehealth network. There are sixty sites and providers receive their education while staying in their hometown. There were thirty nine video conferences in 2009 which has increased education opportunities for providers and contact hours from 1500 to 3400.

Mr. Barnas spoke about quality improvement and a network started through the Medicare Rural Hospital Flexibility Grant Program. It includes 36 critical access hospitals and 1 prospective payment system hospital. He and his colleagues decided on measures to use that improve quality in their communities. This past year the Michigan Center for Rural Health looked at AMI/Chest pain and Emergency room transfers. A software program was purchased to gather data from the hospitals involved and the data is reviewed on a quarterly basis. This is an efficient way for hospitals to share best practices.

Mr. Barnas shared information on the community access hospital financial improvement network. There are 29 critical access hospitals participating. They collect rural relevant data on quality and finance. They merge their financial data into one system and the acute care cost per day is compared. Hospitals share their best practices on financial improvement within this network.

Mr. Barnas spoke about the Healthy Lifestyles Community Matching Grant Program. It is a program for the Healthy Lifestyle section of the State Rural Health Plan. $5,000 grants are matched by each community to create a $10,000 healthy lifestyle project if the communities address any of the objectives in the state rural health plan. In 2010, 1,088 rural residents were involved in various healthy lifestyle programs. 262 children received health screenings and 800 people attended health fairs. Examples of healthy lifestyle programs started by communities include an after school program at Eaton Rapids, a health fair in Gratiot County and a farmers market in Sault Ste Marie.

Mr. Barnas spoke about an Osteopathic high school rural recruitment program called OsteoChamps. It is a two week program for high school juniors and seniors who are taught by faculty and medical students and receive increased education in organic chemistry and experience everything needed to become a health care provider. The program cost per student is $2,000. Between the years 2000 through 2007 there was only 1 student out of 140 from rural Michigan in the program. In order to get more students from rural areas they created grants for rural students to attend by increasing the vender fee. Every student who has attended the program has gone into a health care field. This year there will be 6 students sent from rural communities which are crucial because the students tend to go back to the rural communities to work.

Q&A

Robert Pugh asked if he could get more information about the restructuring of the Public Health Department in 1996.

Lonnie Barnett responded that he thought in 1996 the idea was that bringing public health, mental health and Medicaid together into a single department would help to bring down silos that separated the operation and administration of the programs. It was to improve quality and efficiency.

Larry Gamm said that when working with critical access hospitals on meaningful use, quality and financial data reporting, to what extent are the critical access hospitals in Michigan looking toward accountable care organizations or bundled payments.

John Barnas answered that it depends on the facility. Many of the critical access hospitals in Michigan are parts of systems and tied together. Many of the administrators are cautious because it is new and they are not sure where it will lead the quality of care and affect their financial performance.

Jeff Taylor stated that he could address electronic health records and that critical access hospitals are highly involved. The regional extension center program has great incentives. It is a 90% match and was initially a two year matching but has been extended to four years. There are also Medicare and Medicaid incentive programs. There are penalties if there is not meaningful use by 2014. Critical access hospitals want to have broadband so they can share information through health information exchange. Michigan has 14 million dollars to build the platform and set up a non-profit to manage the process. Broadband initiatives and electronic health records are important initiatives in Michigan.

John Barnas stated that they are concerned about Rural Health Clinics because they do not have the resources to get to meaningful use.

Maggie Tinsman asked Lonnie Barnett if the Michigan Department of Community Health is the State Health Department. She added that they want to combine all of their departments together in Iowa. She asked what the responsibility of Michigan Department of Human Services is.

Lonnie Barnett responded that the Michigan Department of Community Health is the state health department. He also stated that Medicaid enrollment is done through the Department of Human Services.

John Cullen said that the Michigan infant mortality rate has counties with high infant mortality rates adjacent to counties with low infant mortality rates. He asked if they had any data to explain why.

Lonnie Barnett said that there are two issues the new Governor has identified where he would like to see progress. Infant mortality rate in the state in the past 15 years has been flat. Things have not gotten worse or better. There is a huge racial disparity issue where the African American infant mortality rate is 2 – 2 ½ times higher than the white infant mortality rate. In rural areas there were higher infant mortality rates than metropolitan areas. There has not been a county by county review of the numbers. A number of delivery sites have closed in the Northeastern part of Michigan. There is a state summit being planned to look at infant mortality to develop a state plan.

John Cullen asked if there is a relationship between critical access hospitals and obstetrical services and if that is something that critical access hospitals are doing.

John Barnas said that out of 36 critical access hospitals there are 7 or 8 with obstetrical services but they do coordinate so that physicians or physician assistants are traveling and delivering prenatal care but there are still a few delivered in emergency departments.

Maggie Blackburn asked if, for recruitment and retention of physicians, the state loan program is currently funded and if it has made a difference.

Lonnie Barnett said that the Michigan State Loan Repayment Program, until recently was the largest or second largest in the country, depending on if it was measured by funding or number of placements. In October of 2009 the state funding ended. State funding was approximately $500,000 used to match federal funds of $750,000. There was also local funding to provide the additional match to get the full federal award. Now it is a local match program so the employer or community has to provide the match in order to get the federal funds. When the state funding was lost there was the extension of the National Health Service Corps and available funding. The field strength increase in the National Health Service Corps has helped since the state loan repayment program field strength decreased. Since the National Health Service Corps is implementing score thresholds, in the past month there have been calls from communities through Michigan expressing interest in the local match program.

Panel One: The Impact of the Affordable Care Act's Value-Based Purchasing Demonstrations for Rural Hospitals.

Brian Peters, Executive Vice President, the Michigan Health and Hospitals Association

Brian Peters began by setting the context for the discussion on value-based purchasing. He said that term budget neutral does not mean more funding but redistributing existing funds. The value-based purchasing program is identified as a budget neutral program. There will not be new funds to award hospitals for performance but taking existing dollars and putting them at risk. The Michigan Health & Hospital Association supports the concept of value-based purchasing and thinks it is the right approach based on value and quality.

Mr. Peters said that health care is going to become more integrated and more transparent. In Michigan there are many small rural hospitals linking up with multi-hospital systems and physicians are becoming employees of hospitals and health systems in the state. This speaks directly to value-based purchasing. Performance, patient satisfaction, quality and cost will be measured and will be incentivized, rewarded and broadcast to the public.

Mr. Peters shared with the committee that there are 140 hospitals with a total of 49,369 beds in Michigan and they are all members of the Michigan Health and Hospital Association. In the 1980's there were 236 hospitals in the state of Michigan with 24,617 beds. The number of beds has been cut in half. Almost, all of the 236 hospitals in the 1980s were independent facilities and not a part of a system. Today out of the 140 hospitals, 100 of the facilities are affiliated with 20 systems and 5 of the 20 systems are

headquartered outside of the State of Michigan. There is an evolution from independent hospitals joining hospitals system to multi-hospital systems creating relationships with each other and larger multi-hospital systems that may or may not be in the State of Michigan.

Mr. Peters stated that how value-based purchasing will work in hospitals depends on what state you are in. Federal healthcare reform did not deal with many of the factors at the state level. State level market factors that play a role include Certificate of Need laws, medical liability reform protections, existing insurance market dynamics, physician culture, unions, population characteristics, economic realities, politics and provider taxes. Mr. Peters said that Michigan has significant liability reform protections and their existing insurance market dynamics are very different than many other states. There is a Blue Cross plan in Michigan that has a higher market share than any other Blue Cross plan in the United States. In regards to physician culture, Michigan has one of the highest concentrations of osteopathic physicians in the country. There is very robust union presence in Michigan that impacts hospital employees. The population of Michigan is comparatively unhealthy when looking at the rest of the country. The challenges with accountable care organizations, value-based purchasing and bundled payments are that they can put providers at risk for negative outcomes when there is an unhealthy population. There is a greater challenge with chronic disease management.

Mr. Peters said that Michigan has a robust provider tax program for hospitals, nursing homes and Health Maintenance Organizations. There are federal matching funds through the Medicaid program and through the hospital provider tax program. Not all states are doing this and not every state is doing it the same as Michigan. It will have a serious impact on hospitals' financial standing and will initiate discussion on value-based purchasing and their willingness to move forward towards something like an accountable care organization.

Mr. Peters spoke about rural characteristics of value-based purchasing. Rural hospitals have a higher percentage of Medicare patients. They also have a higher percentage of outpatient, home health and skilled nursing where Medicare margins are smaller. There is a higher percentage of chronic disease in rural communities and smaller hospitals. A challenge for health information technology in rural communities is access to capital. Health professional shortages are more prevalent in rural communities.

Mr. Peters said that the population growth in the State of Michigan has stagnated. A large percentage of the population is aging quicker than the rest of the country. Young people are leaving Michigan. Medicare will be a larger share of the rural hospitals bottom line and policy changes will greatly impact rural Michigan.

Mr. Peters spoke about the Michigan Health and Hospital Association's 5 principles regarding value-based purchasing. Any proposal for value-based purchasing should be developed collaboratively. Incentives should be aligned across providers. There should be rewards provided to motivate change. Both improvement and performance should be rewarded. Hospitals that are already high performers today should not be penalized if

they do not show as much improvement as their colleagues. Unintended consequences should be avoided.

Mr. Peters shared how the hospital community can take value-based purchasing and make it work. A focus on quality, patient safety and community health improvement is essential. The Michigan Health and Hospital Association is operating a three part strategy for quality and patient safety. There is a federally certified patient safety organization that has been collecting adverse event data from all of the hospitals for the past two years. Examples of the data being collected are medication errors, patient falls and wrong site surgery. The data will help inform the work that is done in the Michigan Health and Hospital Association Keystone Center for Patient Safety which is an entity that has been in operation for seven years and is very successful on a national level. The MI Hospital Inform website is a website developed to share with the public the hospital outcomes in terms of cost, quality and patient satisfaction.

Mr. Peters stated that when a hospital CEO takes on the new dynamic of value-based purchasing that it is important for them to know the steps that will get them to the level of performance that is required in their region. The Michigan Health and Hospital Association is helping physicians with these steps through the Keystone Center and Patient Safety Organization and other collaborative efforts.

Dean Smith, Ph.D., University of Michigan School of Public Health

Dean Smith opened by stating that whatever Medicare does regarding value-based purchasing; it should be cognizant that it is one of many payers and look at the payer's side of the equation. The relationship that patients have with hospitals and the types of choices that they make has to be considered. There has been a debate in this country about economic policy and whether it should be supply side policy or demand side policy and have come to no resolution and healthcare may be the same. When thinking about options about supply side initiatives, the demand side needs to be considered as well.

Dr. Smith said that The Affordable Care Act strategy tries to extend health insurance to most U.S. citizens and legal residents and to alter health insurance coverage from available services to valued services. Another strategy is to transform financing of the delivery system from pay-for-procedures to paying for quality. There is a hope that innovations work to bring efficiencies, higher quality outcomes, and cost containment.

Dr. Smith spoke about the value-based insurance design and that the Affordable Care Act gives authority to the Departments to develop guidelines that utilize value-based insurance designs. While there is demonstration projects around value-based purchasing there are also demonstration projects being done around value-based insurance design. It would be ideal to do demonstrations on the supply changes with value-based purchasing and the demand changes to collect information on what patients and consumers are looking for regarding insurance policies. The value-based insurance designs include provisions of information and incentives for consumers that promote access to and use of higher value providers, treatments, and services.

Dr. Smith said once the decision is made that a service is going to be provided and paid for, there needs to be assurance that the right amount is being paid to the providers. They should be doing it in a way that is appropriate in providing quality outcomes. A danger is that there is an overall grade for a hospital for quality outcomes but there is a lot of variation in the grading. If a hospital does well for one type of surgery they should get a grade for that type of surgery instead of overall.

Dr. Smith stated that the University of Michigan has decided that services for diabetes are essential so there are no co-pays for diabetes patient services. Medicaid programs in most states are now co-pays. They pay mothers to bring their children in for immunizations because the rates of immunization were too low. There are many insurance programs in the country where providers are given strong encouragement and good payments for providing preventative care services but the same insurance company charges high co-pays when no one uses them. There are hospitals that get good payments because they provide high quality care, there should be something on the insurance side that steers patients to go to those hospitals. Dr. Smith said that it has to be a tangible incentive to make that happen.

Dr. Smith said the specified conditions that have been targeted for evaluation like pneumonia and heart failure are not very meaningful on the value-based insurance design side because patients do not make choices about these issues. If there are specified conditions with designation of hospitals, the list should be expanded to procedures that patients do make choices about. There is an incentive to want to measure things that are easy to measure.

Dr. Smith said that he has not seen overlap between value-based insurance design and value-based purchasing demonstrations. Part of the reason is because most of the highly valued services are the primary care services that happen outside the hospital. To integrate value-based purchasing and value-based insurance design, measures need to be applied in hospitals beyond the patient that has heart failure or a much broader set of conditions to quantify outcomes. High value services should be encouraged and low value services should be discouraged. Provider selection can only happen where there are choices. A concern about value-based purchasing is that if you give consumers greater incentives to use providers that they can not access then it is not meaningful. If you try and differentiate between providers that are 50 miles apart by how much they are being paid, it will not work. Value-based purchasing should be able to be applied anywhere but with thresholds that can be difficult to achieve.

Dr. Smith closed by stating that rural hospitals can do well and noted that ICU's in Michigan sustain zero blood stream infections for up to 2 years and smaller hospitals sustained zero infections longer than larger hospitals.

Q&A

John Rockwood said that he is curious about the measurements and the emphasis on hospitals and outcomes when starting with a very sick population. There are not good metrics to evaluate that. Can it be looked at from a stand point of if a hospital is following best practices or how is the outcome? The outcome can be affected by many things once a patient leaves the hospital. This is particularly true in rural areas where the provider may be 50 miles away. Rather than concentrate on best practice, did the system do everything it should have done instead of just looking at the outcome. It seems immeasurable. There are so many other outside factors that can cause a successful outcome or unsuccessful outcome.

Dean Smith said that measuring quality of care is difficult. A measuring model of care is structure, process and outcome. Structure is if there are the resources and appropriate people to be able to provide the services. Many of the recent efforts have been on process and following steps of a checklist. This works well in the institutional setting because there is control over what is happening in the process. When looking at re-admission within 30 days, the hospital can not control what happens in a person's home. Getting positive outcomes is the key element. There has been a push towards getting at outcomes. If the hospital was appropriately certified and the surgeon did everything they could and the surgery went well but the patient died then there is a missing element. When measuring outcomes, structure and process need to be counted as well.

Brian Peters said that Peter Pronovost, a John Hopkins physician who worked in Michigan would say that there is no conceptual framework accounting standard when talking about quality measures in healthcare. Hospital boards have been accustomed to looking at financial outcomes because there is a common format and institutions can be compared easily but in the quality realm that has not happened yet. In Michigan, some boards and leadership teams look at their own experience and feel positive because they have reduced blood stream infections by 72% in the last 18 months. If they compare their rate to other Michigan hospitals performance their performance does not look as positive. There needs to be real time access to data that can be compared.

John Cullen said that he is concerned about looking at metrics but not really looking at patient care. It is easy to check a box that says you spoke to a patient about smoking but it is much more difficult to have an impact on the patient. In rural hospitals there is a problem with metrics because one bad case can really throw off the statistics and have an impact on payments to the hospital.

Dean Smith responded that providers discount the impact they can have on patients by what they say. Providers are discouraged because physician counseling is brief and telling someone to quit smoking only increases their likelihood of quitting smoking by 10% points. A 10% chance is really a large percentage if you compare to other areas. Sometimes it is good to have check boxes even though it is not perfect to make sure patients are reached that will respond.

Tom Hoyer said that he spent a lot of time writing regulations on utilization reviews. Mr. Hoyer said these ideas have been in the Medicare policy making process since the early 70's. It takes a long time for an idea to have its' time come.

Todd Linden said that he would like to hear more about the value-based insurance design. Potentially, this could be a place where people can select the correct services or providers and maybe there is some incentive in the design. Iowa is similar in many respects to Michigan. He said that because of the re-imbursement issue, his hospital in Iowa has had to become much more efficient and they were disappointed that the efficiency piece was not included in year one. In rural areas there is a challenge with quality measures and they are beginning with the efficiency piece a year late.

Dean Smith responded that one way to go, scientifically, is to be precise enough to withstand the challenges. The preventive services that we want to encourage are not the battle. The provision that there is no patient cost sharing for the preventive services is a concern. Just because they are a preventative service does not mean they are high value. How to pay less for low value services is becoming a challenge. It is important to be precise about when care is appropriate to repose cost sharing on patients for not having unnecessary procedures.

Brian Peters added that the efficiency of the Michigan hospitals was looked at by a healthcare consulting practice and they had a positive analysis. The data was taken to the payer community to show that on a unit cost basis the hospitals were extremely efficient. The response was that because of the unhealthy population the quality volume is higher than it may be in other states. At the end of the day the aggregate cost of the system is still high.

Tom Morris said that there is a unique opportunity for a demonstration and it does not have to align with what Medicare has proposed already.

Brian Peters stated that the conceptual framework that has been established is important. When looking at value-based purchasing at this point and the five principles that the hospital association identified, Centers for Medicare & Medicaid Services would not score 100% but they still have done a lot of things right. Rural hospitals are different but the focus and expectation should be increased on value and reduced focus on volume.

Larry Gamm said that 10 or 15 years ago he was on the Texas Advisory Committee and they looked at a cost and quality comparison. Even though there was a lot of good data collected, it really did not reach the consumers and they did not change their behavior by finding the hospitals that were efficient and high quality hospitals. Dr. Gamm stated that he is concerned about this happening with the current approach. Looking at community based partnerships is important particularly if you are looking at preventable hospital readmissions or quality improvement. Sometimes the focus is on the one organization to blame or praise for success instead of looking at the larger picture. It may be worthwhile to look at rural hospitals that are parts of health systems verses more independent, critical access hospitals. Some of the critical access hospitals may have rural clinics associated

with them and there may be more integration. On the one hand there are policies to demonstrate overall accountability but there is not anything that matches up the information and social technologies that occur among the providers and organizations within the system. Is there a possibility for demonstration programs in rural hospitals that take in consideration electronic medical records and how effectively they are used?

Dean Smith stated that it is not just having the electronic medical records but how you use them. There are a series of research projects on having electronic medical records in place with meaningful use. The concern is getting too much into the mechanics and maybe getting small answers but not the big picture.

Brian Peters said that the reality is that even within a state like Michigan, there is such tremendous variability in rural settings. There may be a true independent hospital that may not have a health clinic affiliation. In other communities the hospital is part of a multi-hospital system with a tertiary care center in a city whose medical staff is entirely different. The question becomes if the pilot initiative is tailored for one community or is there an over-arching principle or goal of where the system should gravitate. Then the hospitals in a very different arena will have to do what they need to do to gravitate to that model.

John Rockwood stated the level of care in institutions is assumed to be the same for all physicians and that is not true. It is implied that there is a requirement for hospitals to do a better job to bring physicians to the same level. In a small hospital in a rural setting there may be one orthopedic surgeon who may not be the best. Is it better to keep a sub-standard physician in a small community or not have the physician there requiring people to travel long distances for care. It is difficult for rural areas to recruit the new physicians because they are going to metro areas. There can be some unintended consequences and it is a problem.

Brian Peters responded that was one of the unintended consequences they had in mind on the list of 5 principles. The new pressure points may make the hospital decide that it is not worth the risk to offer a particular service line and get out of the business which threatens access for the community. It is happening in some cases and it is a serious issue.

John Cullen added that when looking at the metrics that you can not generalize best practices across communities. The health care systems in small communities are all very different. There are some communities that do not even have capabilities to meet what is in the metrics. There needs to be metrics for rural communities. There can not be an assumption that the metrics are the best practice for a particular hospital.

Paul Moore said that he would like to have more information to discuss with the value-based purchasing demonstrations subcommittee. Mr. Moore asked what the committee could do to inform the demonstration and if there were suggestions regarding catchment area and how to accomplish that. There are few small rural areas that are going to have 5 thousand and that is a problem. He also asked how to impact the re-imbursement.

Dean Smith responded that the reason to do the demonstration is because some aspects of the system may change if the demonstration is positive. If there are re-imbursement aspects that are not going to change then not much can be learned from the demonstration. Dr. Smith stated that if there are segments that the demonstration will not work for then exclude those segments and have the demonstration project in areas where there is a 5 thousand to 25 thousand range rather than make it 'one size fits all".

Brian Peters said that when looking at catchment area it may be possible to look at regional variation. Each region may have a different number in terms of population because of the population density and referral patterns. There are 25 or 26 hospital referral regions in Michigan. Every state has hospital referral regions so that may be an option to consider.

Paul Moore said in terms of the hospital referral regions, small hospitals and critical access hospitals have limited resources and will need resources from the large hospitals. Mr. Moore questioned how it will work with contract agreements and will it be large hospital driven. This is concerning the non-owned hospitals.

Brian Peters stated that the majority of the 36 critical access hospitals are owned or have a close affiliation with a multi-hospital system and they are required by law to have a referral arrangement with a tertiary care hospital. For the non-owned it is a good question and unclear how it will work but the answer is clear for the owned. For the non-owned it will probably be different for each institution due to their experience in managing risk.

Part Two: Primary Care Training and Placement

Aron Sousa, M.D., Associate Professor of Medicine and Senior Associate Dean for Academic Affairs, Department of Medicine, Michigan State University

Aron Sousa began with background information on Michigan State University College of Human Medicine. It was founded in the 1960's to be a medical school that focused on producing practitioners. The school was founded as a school interested in community-based education with a focus on primary care. There is also a focus on rural populations. The Upper Peninsula Campus has a rural physician program that began in the 1970's and it was one of the first rural physician projects in the country. There was also the Kellogg Project in the 1980's to train physicians in rural areas in hopes that those physicians would return to those rural communities. The college of human medicine was founded with the notion that they were not about illness but about people. The college follows a biopsychosocial model of medicine, that illness and health is not just about bacteria but a whole person and the community in which they live. Medicine is an eco-system with a support system of nurses and other providers as a group. There is a focus on underserved populations. The college was founded with the idea that it was about education and not about being a large clinical center. It was also founded on the idea that students would pay tuition and the State of Michigan would provide general funds support. Dr. Sousa said that this is a difficult model to uphold as a medical school.

Dr. Sousa stated that the college is still a community-based school and runs its admissions process based on this mission. Primary care is still the focus of the college but they recognize that underserved communities need surgeons. They try to encourage their students to stay in state and about 45-50% stay in the State of Michigan.

Dr. Sousa said there are new campuses with strong rural experiences in Traverse City and Midland. The college has a partnership with Munson Healthcare in Traverse City. The addition of the Traverse City campus and the Midland campus will increase the number of people who will train in a rural setting. There has been an expansion of the Upper Peninsula campus as well.

Dr. Sousa stated there are new certificate programs with core rural experiences. One certificate program is Leadership for the Medically Underserved. The students have about 100 hours of diagnostic and 80 hours of required service as part of the certificate. Students learn to do needs analysis for a community organization like a soup kitchen or county office on aging. They do a project based on the needs assessment. They also study overseas for two months as part of the program to gain broader experience. It is a successful program. The other certificate program is Compass which is a wilderness and sports medicine certificate. This is based in the Upper Peninsula.

Dr. Sousa said that there are a large percentage of students that go into rural practice but they are a small school so fewer physicians are produced. There are clinics where students attend and there are pipeline programs through other universities. Institutions that Michigan State University partners with work with students in their school that are interested in working with underserved populations. These students get advanced advising and in their junior year they can apply through a special process and get conditional admission into the college if they maintain their academics through their final year. It is a successful program. The pipeline programs bring in about a quarter of the class.

Advanced Baccalaureate Learning Experience is a pipeline program for students who apply to the college and are well suited to medical school but do not have the academics to thrive. The students take about four medical school courses and a variety of preparatory courses. The students tend to go to underserved areas and the students tend to come from underrepresented populations in medicine and have a high likelihood to stay in Michigan even if they are from other states. The integrative program is another pipeline program and is relatively new. Students in their fourth year of medical school apply to a community for a residency and receive a scholarship. If all goes well the student and residency choose each other for the match.

Dr. Sousa said the university has a holistic admissions policy with two phases. The mission fit is the student’s likelihood to stay in Michigan and work with underserved populations and an academic bar. If a student clears the academic bar then the student’s mission fit is considered. The college has a higher rate of minority students in the class and a higher rate of non-traditional students. The university has been pleased with the admissions criteria, policy and outcomes.

Dr. Sousa talked about the Geriatric Education Centers of Michigan. The centers are in many communities and are there to educate health professionals. It is a very important resource for the state and geriatric populations. Geriatric populations are the most at risk rural population and are underserved.

Dr. Sousa said that 14-15% of the College of Human Medicine students end up practicing in rural communities. 45-50% of the students come from a disadvantage background.

Dr. Sousa stated that about 232 people have graduated from the Rural Physician Program. 41% of the people in the program come from a rural community. Within residency, the rural physicians are about 10% more likely to go into primary care and are twice as likely to go into family medicine. Students in the Rural Physician Program are a bit more likely to go into surgery also. 42% of the Rural Physician Program students end up practicing in rural areas verses 14% of the entire class.

Dr. Sousa said that admissions is the key to producing rural physicians and the University's mission based admission policy is what makes them different than other places.

Dan Webster, M.D., Assistant Dean, College of Human Medicine, Michigan State University

Dan Webster opened by sharing with the committee that he received his undergraduate degree from Michigan State University and went to Northwestern Medical School for his residency. He said that he will discuss the Munson Medical Center, Munson Healthcare system, the northern Michigan Service Area, the undergraduate medical education and the graduate medical education and will touch on four other topics that the committee requested.

Dr. Webster said that Munson Medical Center is a rural referral center. There are 391 acute care beds and 422 medical staff. Dr. Webster said that when he came to town in 1979 there was about 80 medical staff. Munson Medical Center has received numerous awards including ranking in the 100 Top Hospitals. The culture of Munson is quality and patient safety. Dr. Webster stated that the service area covers 11,000 square miles.

Dr. Webster shared information on the undergraduate medical education which includes the Michigan State University College of Human Medicine, Michigan State University College of Osteopathic Medicine, Nurse Practitioner students and some Central Michigan Physician Assistant students.

Dr. Webster said that the graduate medical education involves one residency. There are three campuses for the Michigan State University College of Human Medicine and they are Midland, Traverse City and Marquette. Each one has one family medicine residency. It is a dually accredited residency and is fully accredited on the osteopathic side and the allopathic side. The graduate medical education has a rural mission to train physicians to practice in North Michigan or a rural setting elsewhere in the country. They have a rural

curriculum. There is an ambulatory clinic where they see patients that are up to a 30% uninsured or underinsured payer mix. They offer a service mission centered approach. Dr. Webster said that since they started the residency they have had about 68 graduates and a placement in Northern Michigan rural settings of 60%.

Dr. Webster talked about Michigan Rural Health Clinics and said there is one in Kalkaska that some of the committee members will visit. There is a federally qualified health center in Traverse City that is a migrant clinic and is population based rather than physician shortage based. There is a federally qualified health center in Antrim County and Traverse City Health Clinic is considering applying to be a federally qualified health center. As a residency, they do not have an affiliate with a federal qualified health center, rural health center or a teaching health center.

Dr. Webster spoke about the nursing graduate medical education demonstration program. There are challenges to nurse practitioner training in a rural setting. Scheduling and preceptor availability are issues. Many of the programs are down state and people are working as nurses who want to further their education. There is not the infrastructure that there is for medical school training but there remains a huge rural need for nurse practitioners. There is a need for team collaboration and access to care for people through primary care offices and that is the role that nurse practitioners have assisted with.

Dr. Webster said that at Munson Healthcare the credentialing process to bring in a nurse practitioner is difficult because there is not a structure to make it happen. There are benefits to nurse practitioner training such as teaching teamwork with residents and medical students and they have a valuable outreach within the community.

Dr. Webster said that Health and Human Services can insure that the demonstration meets the needs of training nurse practitioners in rural settings with support, planning, implementation and infrastructure.

Dr. Webster stated that educational challenges for Northern Michigan are preceptor availability, faculty development, consistency of curriculum delivery, the availability of distance learning, patient mix availability, money and accreditation hurdles. Accreditation hurdles do not change as fast as the need in the community changes.

Dr. Webster said that some problems with placement for providers practicing in rural settings are that providers want to have access to colleagues to share information and be able to have a referral process. New graduates want to be able to share information through electronic medical records. They are also concerned about reimbursement, loan repayment and retention and which are major issues when practicing in a rural setting. Providers want access to virtual information updates which may not be available in rural settings.

Q&A

John Rockwood said that the needs in rural communities are changing and with fewer physicians there needs to be physicians with a broader range of skills.

Maggie Blackburn shared that she is a family physician and the director of rural health at Florida State University College of Medicine. She asked Aron Sousa to give his definition of primary care for his outcomes.

Aron Sousa responded that he uses family medicine and internal medicine and pediatrics as part of primary care for his outcomes.

Maggie Blackburn asked if there is a way of training medical students and residents to use resources to foster a more integrated training team concept.

Aron Sousa said that it would be wonderful to get students into federally qualified health centers and it would be the perfect place to train well rounded physicians but he can not get students in. He said that the practitioners are the most productivity driven people he has ever seen. They are numbers driven because that is what keeps the place going and it is required. He said that having it as an educational opportunity is a struggle. He said that in Kalamazoo, the medical education consortium has an interlocking board with the federally qualified health centers and they are starting to get residents in but not students. Dr. Sousa noted that the sponsorship is such a daunting effort that they struggle with it as a medical school.

Dan Webster said that in Traverse City program, they have been able to place a few students in a federally qualified health center in Cadillac, Michigan and one graduate works in a local federally qualified health center.

John Cullen said that when he is looking for physicians to join their practice, he is looking for a broad spectrum physician. He asked if the students are going to be able to get broad spectrum training through a teaching health center.

Aron Sousa responded that the strength of the federally qualified health center is the integration and the multiple disciplines. Students get mental health training in those organizations and mental health needs to be integrated into the rest of the medical healthcare system because it is currently a struggle. A federally qualified health center is a special place to train people because of the integration.

John Cullen said that one of the things that determine if a physician is happy in a rural environment is whether they have the skills to do well.

Aron Sousa said that he does not know if the federally qualified health center will encourage people to enter rural settings or help people to be happier in rural settings or want to go to rural areas. He said that he thinks it depends more on where people are from that makes the difference. You have to have students that want to be in rural areas or they will not be happy.

Tom Morris said that a lot of the money that comes through the National Service Corps is for scholarships and loans but a portion is set aside for site development. Mr. Morris asked if they had been able to take advantage of site develop and if not what needs to be done towards site develop so when there is a scholarship or loan that it is a successful match and leads to long-term success and retention.

Dan Webster said that he did not have any experience with site development and there would be people available at the site meeting to speak further about that.

Robert Pugh said that he was impressed with the pipeline program and as an effective way of growing and sustaining adequate workforce. Mr. Pugh said a problem is that policy leaders will not invest in pipeline projects because return on investment is not immediate.

Mr. Pugh said there are 11 certified teaching health centers across the country, 9 and 2 are in rural areas. The issue around the productivity focus of the federally qualified health centers is understandable because of the sliding fee scale pressures and the need to generate other third party revenues. He asked if they had looked at options of working with the health centers in terms of how to overcome the challenge related to placing preceptors and those who would be training residents for primary care who come from rural areas and want to stay in those areas.

Dan Webster said that he only had the experience of placing students in the Cadillac federally qualified health center. There is a federally qualified health center in East Jordan and they have taken University of Michigan students and incorporated them into their system so there are success stories but they are few and far between. Dr. Webster said that the question is what has worked for them and if it could work for other people. He said that a major issue is that they have spent many meetings talking to federally qualified health centers about joining. There is a lot of talking, relationship building and trust that needs to happen before there can be a joint venture. There has to be two willing parties before moving forward.

Tom Morris said that if Cadillac or Kalkaska wanted to apply for a residency program and received some of the redistributed slots, the first hurdle is the medical education slot that has not been approved yet. The cost of entry for the people who need it the most is often too high to take advantage of the provision.

Robert Pugh said that rural workforce development and rural citizens access to care are very important issues for the committee. The teaching health center model is very important to the committee as they advise the Secretary. The Director of the Michigan Primary Care Association, Kim Sibilsky, is at the meeting and it would be great to hear from her on this subject.

Maggie Blackburn stated that as the committee discusses the issues, are there any accreditation regulations that the committee should be aware of.

Dan Webster responded that the Accreditation Council for Graduate Medical Education work duty hours is affecting them on the graduate medical education side. The first year residents can not work more than 16 hours straight and they have to have time off. To run an efficient residency in primary care there has to be a minimum of an 18 FTE residency. First year and second year residents have to be in house every night and that affects the FTE count.

SUBCOMMITTEE BREAKOUT SESSIONS

The subcommittee's met for discussion prior to site visits scheduled for Thursday, June 16th.

Subcommittee breakout groups: Aging Stakeholder Meeting Planning, Value-Based Purchasing Demonstrations and Primary Care Training and Placement.

PUBLIC COMMENT

Kim Sibilsky, Executive Director, Michigan Primary Care Association

Kim Sibilsky addressed the committee**.** Dr. Sibilsky said that Community Health Centers and Rural Health Clinics are in an odd situation. They have been excluded from attribution of lives in a model that was supposed to start to shift how cost was being accrued and move attention into primary care systems in rural areas. They can participate in accountable care organizations but the fear is they will turn into dumping grounds for patients that do not give the right kind of performance. Accountable care organizations, if they have Federal Qualified Health Centers included, get additional percentage points. They are a valued commodity being designed to plan the margin in some way.

Dr. Sibilsky said that she worked for the Rural National Health Association and they were looking for rural demonstration graduate medical education programs and the idea was to move resources from training programs in historic training centers into rural hospitals and more remote sites. She thought it was a good idea to move some of the capacity closer to the community where there was scarcity. Dr. Sibilsky said that they have received calls from programs interested in teaching health centers including Dr. Pickett from Marquette. There had to be a training program with a community based organization or in a consortium including a community based organization. By design, it limited the number of applications moving to teaching health centers. There was interest in the state but no one who actually qualified. It takes a residency program that is interested in leaving its current location or reaching out, in a substantial way, to consort. It is going to take willing partners and it is an expensive investment in politics as well as money for it to happen.

Dr. Sibilsky said that she has shared the state directory of health centers with the committee staff and each health center has listed the academic programs with whom they participate in rotation. She said that when talking about patient centered medical home and interdisciplinary training, there are a lot of people participating in training rotations within health centers and they are ready for more.

Teresa Wehrwein, Ph.D., RN, CNEA-BC, Associate Professor and Associate Dean for Academic & Clinical Affairs, College of Nursing, Michigan State University

Teresa Wehrwein stated that she appreciates the opportunity to talk about the demonstration project which may allow them to see the potential to support graduate nursing. Nursing education is fundamentally different in structure then medical education. Nurses are educated as generalist at the bachelorette level and then in a specialty at the graduate level. A person coming into the program is identified as primary care family nurse practitioner or primary care adult gerontology nurse practitioner at the time they enter and all of their training is geared toward that and all of the training hours are in primary care settings.

Dr. Wehrwein said that when looking at the demonstration project, it is crucial that the primary care fields are impacted and that the money be able to flow through to those fields. The deans of the colleges of nursing in Michigan have met and are looking at trying to design a collaborative model. They use the same clinical facilities. They have found a partner to work with them if the wording of the proposal will allow the pass through of the funds to the site where the education is occurring. If the funding has to stay within one organization then they can not reach out across the state. She said that they need the committee's assistance to allow them to spread the money through to all of the sites.

Marylee Pakieser MSN, RN, NP, President, Michigan Council of Nurse Practitioners

Marylee Pakieser thanked the committee for meeting in Northern Lower Michigan. She stated that she represents a growing nurse practitioner association of approximately 900 full members and 200 graduate nurse practitioner students where about 40-50% of their members live and work in rural areas of Michigan.

Ms. Pakieser said that she lives in rural Michigan and has practiced in a variety of settings since 1995. She stated that she would like to comment on issues regarding education for Advanced Practice Registered Nurses in rural areas.

Ms. Pakieser shared that there is a need for academic programs for a post masters certificate for psychiatric nurse practitioners and gerontology nurse practitioners so that programs are designed to be a combination of distance learning and onsite instruction. Most nurse practitioners are initially educated in the family and adult tracks but over time may gravitate to specialized practices. They need the appropriate education to take the national specialty exam to qualify for the nurse practitioner certificate at the state level.

Ms. Pakieser expressed the need for designated preceptor sites for graduate nurse practitioner students during their clinical rotations. She stated that most programs put the burden on the student to find preceptors and preceptors who work with graduate students

do it as a professional responsibility and without any stipend. This can negatively impact the nurse practitioner's work schedule and limit billable hours. Preceptors would also benefit from a structured format on how to be more effective.

Ms. Pakieser said that there are artificial barriers for being an Advanced Practice Registered Nurse in Michigan need to be removed. She said that she realized this was not the responsibility of the Committee but the current restrictions could interfere with their recommendations. Michigan's Advanced Practice Registered Nurses are in the process of working towards legislative changes that would allow practice to the full extent of education, licensure and scope. The barriers are felt in Michigan's rural communities in which some nurse practitioners are the sole health care provider which can limit access to care.

Thursday, June 16, 2011

Thursday morning the Subcommittees departed for site visits as follows:

Value-Based Purchasing Demonstrations Subcommittee: Cadillac, Michigan
Mercy Cadillac Hospital

Primary Care Training and Placement: Kalkaska, Michigan
Kalkaska Rural Health Clinic

Aging Subcommittee: Rural Stakeholder Forum, Traverse City Michigan
Munson Medical Center

The subcommittees returned to the hotel Thursday evening.

PUBLIC COMMENT

There were no public comments and the meeting was adjourned.

Friday, June 17, 2011

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

REVIEW OF SUBCOMMITTEE FINDINGS

Value-Based Purchasing Demonstration
Key Points and Timelines
Subcommittee members: John Rockwood (chair), Larry Gamm, Tom Hoyer, Todd Linden and Shane Roberts. Staff members: Paul Moore, Tish Scolnik and Aaron Wingad.

John Rockwood presented for the subcommittee. The subcommittee visited Mercy Cadillac Hospital in Cadillac, Michigan. He stated that value-based purchasing relates to a

demonstration project for smaller hospitals and critical access hospitals. He added that critical access hospitals are important to their community or they would not be critical access hospitals and the first priority is not to do harm to the hospitals but to make them better. The subcommittee discussed scoring the hospitals without financial consequences initially, but to raise the bar for everyone. Getting hospitals to join the demonstration projects, be involved in peer groups and use best practices from the peer groups is a way to accomplish this goal. There are a number of area critical access hospitals that are doing this and they have made progress in improving quality care and reducing costs.

The cost of maintaining, gathering and analyzing the data is expensive. The subcommittee discussed that quality improvement organizations in each state may be able to take the lead and take on some of the cost. They would be an independent third party as well.

The measurements for the larger hospitals are clinical measurements where the emphasis is on clinical improvement, but for the smaller hospitals, cost improvement should also be considered. The Critical Access hospitals should also have a focus on cost control. The volume problems of the smaller hospitals were discussed by the subcommittee and the low volume is statistically significant to draw wrong conclusions and that is an issue.

Primary Care Training and Placement
Key Points and Timelines

Subcommittee members: Maggie Blackburn (chair), John Cullen, Phyllis Fritsch, Robert Pugh and Roger Wells. Staff members: Aaron Fischbach, CJ Koozer and Nick Lillios.

Maggie Blackburn presented for the subcommittee. She said that areas they were looking at on the site visit were: residency, graduate medical education and the re-allocation of resident slots. The subcommittee would like for the Secretary to monitor the slots and make sure the slots were going to primary care. The slots should be monitored to assure that some are in rural areas. The residents who have those slots should be monitored to see if they go into primary care after the residency and use the slots as a stepping stone towards their cardiology scholarship.

In the future the subcommittee wants to encourage the Secretary to work with Congress to make sure that the residency slots and positions go to residents that have evidence of doing a good job. Traverse City has 60% of their residents actually practicing in Northern Michigan.

Dr. Blackburn said they looked at the National Health Service Corps program and spoke to two practicing physicians who had taken part in the scholarship program. One physician was a loan participant who chose it because she wanted to have control. The people who received the scholarships wanted to insure that they could stay in a certain geographic area. A recommendation is to allow the recipients to choose the area where they go so that if someone is from Northern Michigan they can stay in Northern Michigan.

Dr. Blackburn said that another recommendation is allowing the Critical Access Hospitals be considered in the allocation of time. If someone is in a rural area and they cover the emergency room or some of the inpatient services that it be allowed as part of the time. The subcommittee suggests that time between the practice site and the critical access hospital be

allowed for loan repayment. The subcommittee wants nursing homes and long-term care facilities to have the same consideration. There may be a person who is the medical director of a nursing home and that time should be included in loan repayment time.

Dr. Blackburn said that people who come from rural areas should be considered for the National Service Scholarship program. They may already know when they go into medical school that they want to go back home to a rural area to practice. A pipeline program is a good way to access those students.

Dr. Blackburn stated that with advanced practice nursing students there should be an allocation for part time school as well as part time employment. Currently, to access the scholarship program students have to be fulltime. There are students who are employed while working on their degree and it would be helpful for those students.

Dr. Blackburn said that the nursing graduate medical education was another focus. The subcommittee recommends that the Secretary insure that the funds for the demonstration projects not just go to the hospital but also to the people involved with setting up the clinical sites. The coalition includes federally qualified health centers and rural health centers. For nurse practitioners the programs are mainly administered by the universities and community colleges and not by the hospital even though the hospitals are used as training sites. The entities responsible for placing students are the sites that should have access to the funds to administer the program and make sure the students get into the appropriate spots. The demonstrations need to focus on primary care and needs to be monitored to make sure that some graduates are going to rural areas and that there is data to provide that information.

Teaching health centers were a discussion with feedback from the people at Michigan State and the residency at Munson Healthcare. There is time and energy involved in the teaching health centers with many people involved. The current legislation is only for the implementation of the health center and the subcommittee would also like funds to go to planning and development of additional sites because so few are eligible.

There needs to be collaboration with the rural health centers and federally qualified health centers so that the coalitions could work together with the residency program. Currently, federally qualified health centers and rural health centers are not approved residency sites and they do not understand all of the graduate medical education guidelines.

Summary of Aging Stakeholder Meeting
Implications for Future Topics
Subcommittee members: Donna Harvey (not in attendance), Graham Adams, April Bender and Maggie Tinsman. Staff members: Tom Morris, Steve Hirsch and Dennis Dudley.

Steve Hirsch presented for the subcommittee. He noted that the panel discussion consisted of people from the Area Agencies on Aging, the Council on Aging, Hospice and other local agencies that work with the aging community. He stated that the stakeholder panel began by discussing the Community Living Assistance Service and Support (CLASS) Act. They agreed that CLASS Act would be important for rural people and would accumulate a pot of money that would help cover prevention, unskilled

nursing and long-term care. Small businesses are concerned with healthcare and if they can supply a benefit that does not cost the business the panelist believe that they will participate. The panel believes that it is important to educate businesses on the CLASS Act. CLASS will help convene people earlier with possible health problems and could bring down costs in the long run.

There was also a discussion about The Program of All-inclusive Care for the Elderly (PACE). PACE saves money but requires more covered lives than they have in the rural areas of Michigan. A problem in the rural setting is that the attending physician must be within 60 miles which is not possible in some areas. Using telehealth would be a great tool. There is an issue with assessment tools and different ways of evaluating. The panel suggested there being a standardized tool for making assessments.

There are issues with hand-offs due to silos and a problem with the flow of information among providers. Care transitions are an issue and there needs to be more coordination and shared information. Some nursing homes are acting as sub-acute care facilities and they need more shared information on patients.

Home health services for patients who are discharged from the hospital are important. Some people get home and just need help with getting medicines, food or having someone help clean dishes. Sometimes people are getting re-hospitalized due to issues that are avoidable if there were a homecare worker to help with things as basic as getting the patients medication or educating them on their medications and making sure that they have what they need in the home.

He noted that Hospice is very important because caring for people at the end of life is vital. A doctor with Hospice and Palliative care stated that the regulation for face-to-face meetings is an issue. There has to be follow-up with the patient after 180 days and then every 60 days which is difficult for the physicians. People are being discharged from Hospice and with the census going down it is difficult to meet the budgets. Referrals are coming into Hospice late and the patients are not getting referred soon enough. Many of the referrals come after hospitalizations from the hospital instead of from physicians.

Tom Morris added that having a forum with local stakeholders was an interesting way to gather information. He said that the committee voted to take on the CLASS Act but the rulemaking has not happened yet so it will be on the agenda for September. He noted that they may be able to add more Affordable Care Act proposals relating to aging.

Dennis Dudley said that the Aging Disability Resource Centers are within the Affordable Care Act and they are expanding. He said that the Rural PACE project is fine for the larger population but there is a need for it in smaller rural areas. If PACE is created like a satellite the rules are the same and it is unaffordable for smaller communities. If the regulations could be more flexible for a satellite then small, rural areas could consider it.

Dennis Dudley added that CLASS Act was something that everyone in the discussion agreed would be good. People need to be educated on CLASS because some people think

that CLASS Act is the same as long-term care insurance but it is not. CLASS is to keep people in their homes and provide them a stipend to purchase services. It is good for the agency, the individual and the community.

Mr. Dudley said that everyone on the panel agreed that home health agencies are very valuable and they are the last place there should be cuts but that is where cuts are happening.

LETTER TO THE SECRETARY

Tom Morris asked about the issues that need to be raised in the letter to the Secretary as follow-up to the meeting. The committee discussed the option to wait and send the Letter to the Secretary with the primary care and value-based purchasing white papers.

Governor Musgrove said that he would like to encourage the Secretary to consider the rural aspects when discussing health care while this issue is a major topic.

DISCUSSION ON SEPTEMBER MEETING TOPICS

Tom Morris said that focuses for the September meeting are some Affordable Care Act Provisions. There is an Affordable Care Act provision that requires the Centers for Medicare & Medicaid Services to create a value modifier for all physician services as a benchmark to measure their quality of services. Physicians will be re-imbursement based on quality of services. The Community Living Assistance Services and Supports (CLASS) Act and the Aging and Disability and Resource Centers will also be topics. Eliminating health disparities is another topic for the September meeting and a number of Affordable Care Act provisions relate to health disparities. There is public health money through the Centers for Disease Control with a data section that requires Health and Human Services to collect more information on rural populations and on health disparities.

Governor Musgrove added that the meeting will be held in Hattiesburg, Mississippi and the committee will be given the opportunity to view a number of various types of healthcare delivery systems in rural Mississippi. The committee will visit Delta areas and coastal areas that experienced the repercussion of Katrina as well as other rural areas that are in the heart of rural America.

PUBLIC COMMENT

There were no public comments and the meeting was adjourned.