Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Sioux Falls, South Dakota
September 24 – 26, 2014

Meeting Summary

The 76th meeting of the National Advisory Committee on Rural Health and Human Services was held September 24- 26, 2014, in Sioux Falls, South Dakota.

Wednesday, September 24th, 2014

The meeting was convened by Tom Morris, Associate Administrator for Rural Health Policy. Governor Ronnie Musgrove, Chairman of the Committee, was unable to attend. Tom Morris stated that the primary focuses of the meeting are: 1) Telehealth and how it can support Affordable Care Act goals around access, improving the value, quality improvement and healthcare redesign 2) Intimate Partner Violence as it is experienced in rural areas.

The Committee members present at the meeting: Rene Cabral-Daniels, MPH, JD; Eugenia D. Cowan, PhD; John Stewart Cullen, MD; Barbara Fabre; Phyllis A. Fritsch, MS; Roland J. Gardner, MS; David Hartley, PhD, MHA; Michele J. Juffer; Karen Madden, MA; Barbara Morrison, MS; Wayne Myers, MD; Karen R. Perdue; Shane H. Roberts; Roger D. Wells, PA-C; Christy Whitney, RN, MS. Dennis Dudley was present from the U.S. Administration for Community Living.

Present from the Rural Policy Research Institute: Jocelyn B. Richgels, Associate Director of the National Policy Programs.

Present from the Office of Rural Health Policy: Tom Morris, Director; Steve Hirsch, Executive Secretary; Aaron Fischbach, Policy Coordinator; and Sherilyn Pruitt, Director, Office for the Advancement of Telehealth. Truman Fellows present: Catherine Fontenot and Charity Porotesano.

SOUTH DAKOTA ORIENTATION

Kim Gillan
Director, Region VIII
U.S. Department of Health and Human Services
Denver, Colorado

Kim Gillan thanked the committee for the opportunity to give a presentation about Region VIII. South Dakota, North Dakota, Montana, Colorado, Wyoming and Utah all comprise Region VIII. Ms. Gillan stated that she is from Montana and has some boots-on-the-ground experience that

helps her to understand the dynamics, challenges and opportunities of living in rural areas. Rural areas present particular challenges for healthcare, the economy and education. People living in states in Region VIII experience considerable driving time because they live a long distance from medical providers. She stated that she traveled long distances between towns in South Dakota when taking her children to sporting events.

The Affordable Care Act (ACA) in the rural areas is increasing access, affordability and over the long-term there will be an increase in quality. With the exception of Colorado and Utah, most of the states are under 1 million people. People are spread out over very long distances. She shared a story about a family driving 4 hours one way to take their children to the orthodontist. There are challenges for people who are running a farm and having to drive very long distances to access basic services.

There were Affordable Care Act navigators, local coalitions and community groups assisting people with enrollment on the Marketplace. The numbers indicate that there was success. In South Dakota, 13,104 selected a Marketplace plan. 89% of people in South Dakota selected plans with tax credits.

South Dakota has some of the poorest counties in the nation. There is a connection between the economy and healthcare. Poverty is a significant challenge. If people are healthy then there is a healthier economy. It is difficult when there are no jobs and there is a work requirement attached to Medicaid expansion. Utah has not expanded Medicaid and there are the working poor people who need it and would be eligible.

With the exception of Colorado in Region VIII, Montana, Wyoming, North Dakota, South Dakota and Utah all had federal marketplaces. Health and Human Services in Denver played a significant role supplementing local efforts. There was a local or statewide coalition and HHS communicated with them on a monthly basis. There were vast territories that had to be covered and much was done by telephone. Because there are over 30 tribal nations in the region, they were made a sub-target market. It Montana, Wyoming and South Dakota, there were telephone calls to navigators focusing on the tribal areas.

North Dakota and Colorado were the two states that expanded Medicaid in the region. For the people who fell within 100% - 138% range of poverty in states without Medicaid expansion, there were few opportunities that the navigators could offer. People in the non-Medicaid expansion states did not get the education to know that via CHIP and Medicaid for children there are opportunities. This is information that needs to be explained to people in rural areas facilitated by outreach and education. Medicaid expansion is needed in all of the states in the region.

In Colorado, Affordable Care Act enrollment navigators took an RV around the state servicing the rural areas. One of the biggest challenges facing rural areas enrolling people is that people have to travel for outreach and education. They have to do it on a systematic schedule requiring at least five or six visits for people to actually enroll. People would show up for one or two events and then outreach was provided via a phone call. There was no way to know if residents were actually going online to enroll. It is important to have trusted local entities working in the

community assisting people with enrollment. The privacy aspect is very important with people who live in rural areas and working with those who are trusted in the community makes a difference. Navigators are currently in place and health and human services are committed to getting people enrolled during the next period.

The Affordable Care Act outreach in tribal areas faces some institutional barriers, especially in states without Medicaid expansion. The materials for outreach have been customized for Native American. There will continue to be more outreach and education in the Native American tribal communities.

Michele Juffer
National Advisory Committee Member
Rural Health and Human Services
South Dakota

Michele Juffer welcomed the committee to Sioux Falls, South Dakota. She welcomed the committee on behalf of the Evangelical Lutheran Good Samaritan Society as well.

South Dakota is named after the Lakota and Dakota Sioux Native American Tribes. The state population is approximately 800,000 people. The state is divided through the middle by the Missouri River and is referred to as East River or West River. East River is where Sioux Falls is located. West River is ranch related and very rural. South Dakota is the 5th least populated state and the 17th biggest state measured by square miles. A huge challenge in the state is the amount of time it takes to travel through the state. Sioux Falls is the largest city with about 159,000 people with the next biggest city being Rapid City with around 70,000 people. The capital, Pierre, is in a central location and has about 14,000 people.

In the summer the temperature can be 110 degrees in the summer while in the winter it can be 20 degrees below zero. This adds to logistical difficulties when discussing travel. There can be 15-30 inches of snow and the eastern part of the state experiences about 30 tornadoes a year.

Points of interest in the state include Mount Rushmore, Badlands National Park, Crazy Horse Memorial and Custer State Park and Black Hills National Forest. There will be a buffalo round-up in the National State Parks and it is an amazing experience. The Corn Palace in Mitchell, South Dakota is a popular tourist attraction. It has murals and designs made from corn and other grains. Sturgis, South Dakota is known for the Harley Davidson Rally held there once a year. De Smet, South Dakota is where Laura Ingalls Wilder grew up and the town does a great job of reenacting her life. Falls Park is located in Sioux Falls and it is rich in history as the location of the water falls of the Big Sioux River.

Michele Juffer shared her experience about going with her husband to a doctor's appointment due to a detached retina. They drive to Sioux Falls every week for the doctor's appointment. Her husband came out of the appointment and talked about a young, Native American couple who were in tears because the procedure the young woman needs is $16,000 and they have no way to pay for it. They traveled a much longer way to get to Sioux Falls for the appointment which

compounded the hardship. If she doesn't have the surgery, she will not be able to see. These are the types of problems that people are facing in rural communities.

Michele concluded by saying that she is delighted that the committee is in Sioux Falls, South Dakota. There is a great healthcare network in the South Dakota and the committee site visits will be extremely informative.

Q&A

Roger Wells asked if there was a large difference between the opportunities of insurance programs in rural areas verses metropolitan areas during enrollment.

Kim Gillan responded that in South Dakota there are 3 plans while Utah has quite a few plans. Wyoming has 2 plans and Montana has 3 plans and is gaining another plan this year. The offerings were not as diverse in the rural areas. The feedback is that the types of offerings were acceptable and that there are robust and affordable plans. Most people in the rural areas of the states qualified for lower out-of-pocket costs and were able to choose the Silver Plan.

Eugenia Cowan asked when working with tribes, has Health and Human Services Region VIII done any work with Administration for Children and Families (ACF) because they are trusted in the community.

Kim Gillan stated that they recently met with Administration for Children and Families (ACF), Health Resources and Services Administration (HRSA), Temporary Assistance for Needy Families (TANF) and established a work group to target how they could better serve the community.

Michele Juffer asked what are Region VIII challenges within the next year and if the challenges are different than other regions.

Kim Gillan responded that Region VIII challenges are that while there are navigators in place and it is still difficult to get statewide coverage. South Dakota has 2 navigators for the entire state. The resources to provide enough coverage are a challenge. The mileage reimbursement alone in such a spread out area will be challenging. Another challenge will be the resistance of people in rural areas to sign up via the marketplace. There needs to be more education in these rural communities and it has to be done through local, trusted entities.

TELEHEALTH PANEL – HEALTH SYSTEM PERSPECTIVES

Deanna Larson
Senior Vice President, Quality and eCare
Avera
Sioux Falls, South Dakota

Deanna Larson began by thanking the committee for visiting South Dakota. She stated that telemedicine cannot be a stand-alone solution. However, Avera has a lot of passion about what they are able to do and appreciates the opportunity to share their success stories with the committee.

Avera is a health ministry rooted in the gospel. Their mission is to make a positive impact in the lives and the communities served. Telemedicine is a way to make an impact on healthcare services received in rural communities and the local economics. Telemedicine is an example of how Avera lives its mission. Avera's history goes back to the frontier medicine of the Benedictine and Presentations Sisters, who began providing health care in Dakota Territory in 1897.

Avera sponsorship supports 31 hospitals including 5 Prospective Payment System (PPS) hospitals and 26 Community Access Hospitals (CAH) across a 4 state area. Twenty one nursing homes are supported and about 100 outpatient clinics. 110,000 home health visits have been supported as well.

Avera makes sure there is good, quality care in their critical access hospitals. It is important to have quality care so that people will not have to drive long distances for care or move out of the area in order to receive good quality care. Avera eCare not only provides better access to care but also better outcomes for patients, lowered costs and rural workforce sustainability.

Workforce and sustainability can be difficult in rural areas. It can be difficult to recruit new residents to rural areas because they may be on call every night with no colleagues to work with when they need assistance. Telemedicine can provide them with colleagues to call on when they need assistance reducing the feeling of isolation. An example of the benefits of telemedicine is a new resident having to insert and chest tube and having a physician walk through it with them.

Avera has had eCare services for over 20 years and the focus from the beginning was on providing specialty visits to rural clinics. The 24 hour service, eICU, makes an intensivist and critical care nurse available to any remote location. There are still local intensivists and nurses with support via the eICU physician. There is an infrastructure that alerts physicians if there are changes occurring. The local physician may be busy with another patient so eICU gives the physician back-up support. Many rural communities cannot afford to have specialists. A hub can provide quality of care in a rural community and raise the quality of care to what it would be in urban settings by providing specialist.

In 2008, Avera started the 24 hour ePharmacy service. Dispensing automatically provide medications with much less chance of error than if nurses have to pull them off the shelf. In 2009, the 24 hour service eEmergency was started. It is a way that rural hospitals can leverage emergency physicians via the hub. Many times, eEmergency physicians can be accessed before the local physician. When the local physician arrives, they work as a team. Having the eEmergency physician gives the local physician the ability to be hands on while the eEmergency physician is assisting with logistics. In 2012, eAccess began for people in long-term care facilities so they often can be cared for without being transferred to a healthcare facility. eAccess is also available in correctional facilities.

Recommendations to Health and Human Services include: eliminating credentialing requirements for telemedicine in provider based clinics; reducing credentialing requirements related to sub-specialty, peer to peer consults; allowing therapists, nurses, and other clinicians to bill for applicable telemedicine services; allowing for Nursing Home Recertification visits to be completed via telehealth; providing telemedicine-waivers for Center for Medicare and Medicaid Innovation (CMMI) & Accountable Care Organization (ACO) projects; providing more opportunities for rural networks to participate in CMMI funding.

Statutory issues include: multi-state licensing hurdles: inconsistent reimbursement across payers-public and private; policy that does not keep up with technology; broadband funding inequity for long-term care; inadequate reimbursement for originating sites.

Jesse Tischer
Chief Operating Officer
Sanford Health Network
Fargo, North Dakota

Jesse Tischer thanked the committee for coming to South Dakota. He stated that he was a critical access hospital CEO and there have been much advancement in technology since he left the hospital. There used to be mobile carts with the 36" televisions that no one wanted to move because it was so physically difficult. Now virtual care can be done on cellphones which is pretty remarkable. He shared that he is also a flight paramedic. Providers are now much more comfortable with emergency care since working via telehealth with physicians.

Sanford Health is headquartered in the Dakotas. It is the largest non-profit, rural healthcare system in the nation and serves 9 states. It serves 2.3 million people in over 132 communities. The service area equates to the fifth largest state in the United States. They cover 9 states and 3 countries. The primary service area is very similar to Avera's service area. There are over 41 hospitals in the network and 7 are PPS. They are a fully integrated network with over 80 subspecialty practice areas. Sanford Health Network has nearly 1,500 physicians and about 26,000 employees. There are 8,600 births a year in their facilities and 32 long-term care facilities in the network.

Sanford Health Network believes in integrated services. They utilize telehealth and virtual care as a supporting service for their integrated delivery network. They understand that the best care happens closest to home. When the patient's family does not have to drive, there are better patient outcomes. The objective is to not have patients go to tertiary facilities unless it is absolutely necessary. Avoiding unnecessary transfers is very important. There needs to be shared information in order to have success and create a seamless environment. Full integration means having employed physicians, providers and fully integrated hospitals, clinics and long-term care facilities providing the best quality and efficiency.

Virtual care is viewed by Sanford Health Network as more than telemedicine. Virtual care does not replace bedside care but supplements it and also provides tools to providers and an additional point of access for patients. It will never replace human interaction. There are no plans to place an individual access point where there is not a healthcare system or local provider located.

Sanford One Connect is the traditional telemedicine services via Sanford Health Network. Sanford One Call is a point of access for primary care providers and Sanford One Chart is the electronic medical record that allows clinical decision making. In the integrated services, all the information is utilized via the One Chart system.

Virtual Care's triple aim is improving patient experience, improving population health and reducing per capita cost. Best Practices in virtual care include: delegating credentialing and Centers for Medicare and Medicaid Services and Emergency Medical Treatment and Active Labor Act clarification. There was conflicting information around CMS and EMTALA so they came out with a joint statement related to emergency calls and it opened the doors in rural settings to be able to use virtual care to provide back-up coverage in rural facilities.

Opportunities for policy include: infrastructure, licensure and reimbursement. Infrastructure opportunities include expanding bandwidth and creating consistency in rural communities to allow access. Bandwidth is nearly non-existent in many rural communities while some rural communities have faster lines that major metropolitan areas. There needs to be consistency. Equipment costs are a significant barrier regarding bandwidth. Many rural communities would not have telehealth if it were not for grant funds.

Many midwest health systems have consistently been at the table and are generally supportive of Health Care Compact adoption that will allow physicians to be licensed in one state and have a reciprocal license in one of the compact states. It is still in the development stages but it is hopeful there will be broad-based support. Health Care Compact adoption will allow tele-psychiatry to be utilized in rural locations. Reimbursement opportunities include states with parity laws for private insurance coverage of telemedicine. Parity is important and allows telemedicine to be reimbursed like a face-to-face visit.

Q&A

Phyllis Fritsch asked about the Joint Commission and Health Care Accreditation hospitals and how they are getting around the restrictions that the joint commission puts on accrediting.

Jesse Tischer said that the Joint Commission is usually the distant site instead of the originating site so they rely most on the Centers for Medicaid and Medicare Services (CMS).

Deanna Larson responded that Avera are compliant with both the joint commission and the CMS rules. With ICU most are Prospective Payment System (PPS) hospitals and many are joint commission. Avera has to be compliant with licensure for both.

Barbara Fabre asked if there is a possibility for children's services especially regarding psychiatry. There are not many therapists and specialist in rural areas for infant and toddler care. It would be a great asset via telemedicine. Also, is telemedicine working with tribes and Indian Health Service?

Deanna Larson said that the efforts to work with tribes are ongoing. There have been grants with reservations to use telemedicine. It is needed and there has to be a relationship built with Indian Health Service and the tribe in order for the service to work consistently.

Jesse Tischer responded that Sanford Health Network has been to White Earth Nation a couple of times. Sanford has the service capability but not a funding source. When services are available, to add additional volume does not create a lot of additional expense once the base product is developed. Adolescent psychiatry is very difficult for the system, even in an urban community. Adding behavioral health in rural communities has been successful. In one rural community in Minnesota they have been approved for some dedicated behavioral health beds. It is a rural community that could not support psychiatric and psychological assistance on an in-patient basis. Sanford Health Network created behavioral health outreach from that community to other communities. It allows them to have enough volume to support their practice.

TELEHEALTH PANEL – OVERVIEW AND NATIONAL PERSPECTIVE

Rashid L. Bashshur, PhD
Executive Director of eHealth
University of Michigan Health System
Ann Arbor, Michigan

Rashid L. Bashshur thanked the committee for the invitation to speak. Mr. Bashshur said that he is excited to talk to a group who is willing to discuss the merits of telemedicine and addressing the nation's health problems of access, quality and cost. There was a time, around 1974, when only 5 or 6 people would attend meetings related to telemedicine. In 1975, Mr. Bashshur stated that he published the first book on telemedicine. The future of telemedicine is bright.

There are many myths regarding telemedicine including: that telemedicine is new; telemedicine was developed for rural areas; it was driven by technology; and that the future of telemedicine is uncertain.

Telemedicine evolved with the human experience. In Indian tribes information was sent by smoke signals. In Australia, the Aboriginal people used message sticks to share information. Wealthy people in the 17th century would send urine samples to distant physicians who used uroscopy charts to diagnose illnesses.

Telemedicine did not develop in the United States. In 1905, in the Netherlands there was an article published about using the telephone to transmit EKG images. In the 1970's, the United States began to excel in telemedicine. In the late 1970's, the federal funding for telemedicine disappeared and there was an anti-technology sentiment in Washington based on analysis made by economists. The claim was that the major driver of costs in healthcare was technology.

In the late 1980's and early 1990's there was a renewed interest in telemedicine. The country has had inequitable access to care, uneven distribution of quality and cost inflation. Telemedicine is a

way to address these three issues disturbing the phenomenal advances in information technology and declining prices.

The future in healthcare drivers is: demographic transition due to low birth rates and increased life expectancy, disparities in health care opportunities, the significance of chronic diseases and accountability for outcomes. There is a need for efficiency in the healthcare delivery process. The acute care model is obsolete and patient-centered care is necessary. Consolidated and integrated health systems are a requirement and information technology is a necessity.

There has to be a focus on chronic disease management. Chronic disease is expensive and prevalent in the United States. There is evidence of benefits if patients manage their health with a medication regiment, healthy lifestyle and informed decision making. Continuous monitoring, early detection, timely responses and education are important. Regional networks can be used for research related to patient health and chronic disease management.

Keith Mueller, PhD
Director
RUPRI Center for Rural Health Policy Analysis
Former NACRHHS Member
Des Moines, IA

Keith Mueller said that it is a pleasure talk about the topic of advancing effective use of telehealth in rural communities. Telehealth is becoming mainstream in the delivery of healthcare services. Public policy can help accelerate the trend. When telehealh becomes part of the mainstream and is part of the delivery system, it can be regulated the same as everything else in the healthcare delivery system. It is continuously evolving into how to handle an integrated delivery system.

There are many opportunities for accomplishment via telehealth. Existing services can be done through the use of telecommunications. The technology can be used as a tool for delivering and enhancing services within sites. Telecommunications can extend services to new sites for example tele-ICU, tele-emergency and tele-pharmacy. Services can be extended into a person's home or other sites.

Through the RUPRI Center's work, published literature and expert testimony, there have been lessons learned about eICU. There are challenges to implementation and expansion of telemedicine technology which include: physician and nurse resistance, slow process of showing significant improvement in care, high initial capital investment, lack of reimbursement and difficulty marketing services and developing community awareness. Some other challenges to implementation and expansion are: the effects on human resources, the protection of patient confidentiality, implementation and operational costs, a need to develop trust and shared decision models and concerns about depersonalization of care.

Lessons learned from a RUPRI Center examination of hospital-based application of telehealth, specifically tele-emergency. Critical access hospital staff are valuing the applications of eICU. It is a benefit to patients who cannot be moved due to special circumstances and need to be treated

effectively in the rural location. It is valued where the staff is multi-tasking and a patient can be monitored via the telehealth ICU hub to assist the physicians and nurses.

Tele-emergency care has led to better care coordination for patients, providers and the community as well as improved coverage and consultation. Tele-emergency care is leading to new and regulations that recognize what is now possible. The new delivery system is better connecting healthcare to all the resources of the system. Local services are more highly valued with implications for more sustainable services, greater patient satisfaction and more loyalty to care givers.

Telemedicine is part of an evolving healthcare system. It keeps patient care in rural communities where patients live and need services. It is integrated care utilizing care teams and linked facilities. The rural primary care provider has a support system increasing his value and lowering medical costs.

General RUPRI policy implications include: telehealth as patient-based or service-based decision instead of a place-based decision, allowing Medicare patients to be considered as in a region for telemedicine, with licensing as regional matter, bundled payment for chronic condition therapies, extension into other places such as workplaces and schools.

Q&A

David Hartley said that over the last 10 years he has been teaching a course on health information management. He and his students had looked at the electronic health record with much emphasis on adaption and acceptance by primary care givers and the specialists. As specialists become more engaged in teleheatlh they also need to be using the electronic health records more and part of the overall system.

John Cullen said that most of the telemedicine systems have been created without anyone with medical training and that is frustrating. Things are starting to change and be more usable. So much money was going into developments of projects that could have gone into training providers.

Keith Mueller replied that the models of success have been models that have been physician driven or with heavy physician involvement. Everybody sees this as a wave of the future and it gives the clinician the ability to do their job more effectively.

DOMESTIC AND INTIMATE PARTNER VIOLENCE PANEL

Moderator: Jocelyn B. Richgels
Associate Director
National Policy Programs
Rural Policy Research Institute
Washington, DC

Jocelyn Richgels stated that during the meeting in Omaha there was a conversation about rural homelessness that reinforced the link between homelessness and intimate partner violence. Many challenges faced in rural communities are compounded by intimate partner violence. Lack of access to services and the paradox of isolation are issues in rural communities. High density of acquaintanceship in rural areas makes it more difficult for victims to feel comfortable getting assistance.

Marylouise Kelley, PhD
Director
Family Violence Prevention and Services Program
Administration for Children and Families
U.S. Department of Health and Human Services
Washington, DC

Marylouise Kelley thanked the committee for the opportunity to share information with them on the subject of family violence prevention and services. Family Violence Prevention and Services Program were first authorized as part of the Child Abuse Amendments of 1984, the Family Violence Prevention and Services Act has been amended eight times.

According to the CDC's National Intimate Partner and Sexual Violence Survey, 3 in 10 women and 1 in 10 men have experienced physical violence, rape and/or stalking by an intimate partner. Households with incomes under $25,000 see higher rates of intimate partner violence. Most impacted are African American, Alaska Native, American Indian and multi-racial women and men.

There is a prevalence of intimate partner violence in rural communities. Women in rural areas have higher severity of physical abuse than women in urban communities. Rural survivors of intimate partner violence are twice as likely to have severe physical injuries. They also experience forms of economic abuse at higher rates than in their urban counterparts.

Service accessibility is a challenge in rural communities. The distance to a domestic violence shelter is three times greater for women in rural communities than in urban. Rural intimate partner violence programs serve more counties and have fewer shelters. Over 25% of women in rural communities live more than 40 miles from the nearest program.

Family Violence Prevention and Services Program network of services includes 2,600 programs across the country. Three hundred thousand children are receiving assistance through domestic violence programs each year. Services available for women survivors include: housing, crisis response, advocacy, legal assistance, counseling, and safety planning and support groups. There has been a huge spike in the number of calls to domestic violence programs since there has been so much news about the NFL and domestic violence cases. There needs to be the resources available to assist those who request help.

Region VIII receives state formula grants via the Family Violence Prevention and Services Program. There are state domestic violence coalitions that provide coordination, training, education and technical assistance to those who will be working with survivors. Domestic

Violence 101 is a new online learning tool that teaches the basics about Domestic Violence. Domestic violence advocates need the education and tools to provide safety planning and support to survivors.

The National Health Resource Center on Domestic Violence is a designated resource center that has improved the health response to domestic violence survivors. They provide training resources, model strategies and personalized technical assistance and web-based and in-person training. There is a national conference on health as well as nationwide model programs. There has to be a comprehensive response to domestic violence. Not everyone who is experiencing domestic violence will go to a domestic violence center. Those experiencing domestic violence will be walking into their childcare center, head start center or health care provider. All health and human service providers need to know how to identify possible victims and respond in a compassionate way. When a woman reveals that she is living in a home where domestic violence is occurring, the provider has to have an assistance plan in place.

Suzanne Kramer-Brenna
Rural Outreach Specialist
Council on Abused Women's Services North Dakota
Bismarck, North Dakota

Suzanne Kramer-Brenna shared that she is with the North Dakota state coalition office supporting the 20 domestic violence programs around the state. She works with the rural outreach and organizing project and it is funded through the Department of Justice Office on Violence against Women. Through the grant, they receive $300,000 per year. There is a pressing need for services in the western part of North Dakota so that is the current emphasis. Training and technical assistance with rural crisis intervention centers concentrate on ways to better serve the victims, including the adults and children. There is an emphasis on strengthening identification and assessment and the appropriate response to victims through collaborative efforts and multi-community task forces. Increasing safety and wellbeing of rural victims through enhanced awareness and education, particularly strategies for primary prevention, is another focus. This is being achieved through evidence-based curriculums that have been proven in other areas. Assisting youth and teens early to have safer and healthier relationships is important so they do not have issues with domestic violence as adults.

North Dakota has over 700,000 people in the state. This is the 2nd highest population in the state's history. There are 53 counties spanning 68,000 square miles. The rise in population is due to the energy development, technical and manufacturing jobs and an increase in the immigrant population. There is a large Native American population in the state. There are 4 Indian reservations in one service area. North Dakota also has one of the highest aging populations in the country.

The Bakken formation is in the western part of the state where fracking taps into the 7.5 billion barrels of oil. There will be about 1,800 new wells added each year. The fracking activity is expected to last about 15-20 years. There are thousands of new jobs filled by thousands of men coming to the state from all over the country. Even though not all men are perpetrators of domestic violence; there are a large percentage of these men arriving who have the risk factors

and violent behaviors. The domestic violence rate in the area has greatly increased where about 90% of the victims are from out of state.

There are about 20 domestic violence programs in the state. One issue is that there are large service areas serviced by very small programs. Two advocates in on program are covering a 5 county area. Law enforcement has to travel one half hour to one hour away when responding to a domestic violence call.

In North Dakota in 2013, there were 4,801 new victims receiving services from crisis intervention and 90% were women. At least 77% of the victims were physically abused. 52% of the victims suffer from mental illness that is often related to the domestic violence. In almost half of the cases, the abuser had a prior history.

The face of domestic violence in rural North Dakota defines of what it means to be rural. There is a lack of transportation and during winter months many roads can be closed due to severe weather. There is nowhere to go in the short-term for a woman trying to leave an abusive relationship as well as an absence of child care. The societal norms and patriarchal structure continues to hold violence against women as an acceptable behavior in rural communities.

There is a rise in the number of extreme cases of severe physical violence such as women being choked, beaten, shot and stabbed. There is a need for increased health and human services, medical and mental health services. There are very few professionals in small communities to address the need. Sex trafficking, gang and drug activity is becoming more prevalent. Health care professionals have no training in this in rural communities.

Phone advocacy is available in the counties that have crisis intervention centers. Medical personnel are asking for a more dependable way to deliver health and services to domestic violence victims. There is a greater need for training for health professionals and better screening for victims. If a patient tells her provider that she does not feel safe in her relationship, the medical professional needs to have a plan in place.

The Council on Abused Women Services is working with the rural communities through an outreach project to find ways that advocacy programs can better combine services with hospitals and clinics. Collaboration is critical among hospitals and clinics working closely with the advocacy program. It is very vital to have combined resources with people working together in rural communities.

Brenda Hill
Native Co-Director
South Dakota Coalition Ending Domestic and Sexual Violence

Brenda Hill said that she appreciates the invitation to address the committee. She shared that she is Siksika Blackfeet and she is also a woman who has been has been in relationships with men who chose to be violent. In 1989, she started the Women's Circle Advocacy Program on the Lake Traverse reservation.

Ms. Hill said that she would like to give the context and perspective from the advocate's view. There are not many people in rural communities that have understanding about domestic violence. Many of the communities in South Dakota have 300 – 600 people living hundreds of miles away from other populated locations.

A challenge is finding people with grant writing, management or administration in small communities. She said that she did not have that knowledge when she started her job. Many advocates work more than 40 hours a week and many times they give women in need money out of their pocket. Advocates do not make great salaries and have to use their own vehicles. Advocates have a high rate of burnout from working so many hours and the stress of lack of funding. Shelters do not have funds for repairs such as plumbing issues, cracks in buildings and painting. Advocates need more education on how to deal with victims with mental health and substance abuse issues.

Many times, victims of domestic violence have to give up their homes and jobs in order to relocate to a safe place. It is also difficult to maintain confidentiality in small, rural areas because everyone knows one another. In South Dakota, native women have to leave their homeland for extended periods of time due to domestic violence. When women come to shelters in South Dakota, they may stay from three months to a year. It is important to not only to assist the victim of domestic violence but to hold the offender accountable.

Recommendations to the committee include: Ensuring rural and Native advocates are integral to policy development and decision-making. Funding and appropriations need to be in line with grant expectations in the context of rural and tribal/native resources or lack thereof recognizing the reality of the lives of women and families in these areas. There needs to be inclusion of confidentiality policies that clarify information sharing on a need-to-know-basis in healthcare screenings and other initiatives. Healthcare screening should require explicit protocols and resources when there are positive responses, including collaboration with local advocacy programs. Intimate Partner Violence Healthcare initiatives should include training for all staff. Tribal jurisdictional issues, under-funded tribal programs across the board, need to be addressed across the board, prioritizing the safety of women and offender accountability.

Q&A

David Hartley stated that he wanted to ask about perpetrators of domestic violence and risk factors. To what extent can people be identified as being at risk?

Suzanne Kramer-Brenna said that there are attitudes and a belief system that violence is acceptable, whether it is against their female partner or as it plays out in society. It is a huge risk factor when young men witness their primary male figure physically and/or emotionally abuse their mother. The high risk factor relates to men who do not have strong support systems and foundations in their lives. Domestic violence has been in North Dakota for a long time. There have been hundreds of thousands of women over the years who are victims of domestic violence. The face of domestic violence in the rural communities is the friend, neighbor and the family member. People allow it to continue to happen and do not talk about it in rural communities.

John Cullen said that he is a physician and he tries hard to find those who are being abused. There was a young woman being held against her will in his community and nobody knew. Are there any good ways to screen and ways to do it better? They are screening and doing everything possible but are still not identifying some people at risk.

Suzanne Kramer-Brenna stated that there does need to be a better way to screen. Making it acceptable to talk about it is critical. Knowing that when a woman walks into your office and tells you, she needs to know that she will be taken seriously and it will not be minimized. She needs to know abuse is wrong and she did nothing to deserve it and that she is going to get help.

Brenda Hill said that educating staff on the dynamics of domestic abuse is very important. Victims of domestic violence want to know what will happen if they tell a physician that she is being abused. She needs to know that she will be provided safety for herself and for her children.

FEDERAL PERSPECTIVES ON TELEHEALTH

Aaron Fischbach
Policy Coordinator
Federal Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services
Rockville, Maryland

Aaron Fischbach shared he will speak to the committee about Medicare Telehealth Policy Issues and where Medicare is at this point. Social Security Act Sec. 1834(m) [42 C.F.R. § 10.78] is the telehealth requirement. It states that the telehealth services will be paid for on the condition that the physician or practitioner providing the telehealth is not at the same location as the beneficiary. Requirements are that the service has to be a Medicare covered service as well as an approved telehealth service. The patient must be a Medicare Part B beneficiary and telehealth is required to be an authorized clinician and patient site with an interactive audio and video system.

Eligible originating sites include: physician's office, rural health clinic, federally qualified health clinic, community mental health center, hospital, critical access hospital, hospital based ESRD clinic and skilled nursing facility. It has to be located in a non-MSA county or in a rural HPSA. Eligibility can be confirmed on a yearly basis using the Medicare Telehealth Payment Eligibility Analyzer.

Eligible distant sites depend on the location of the eligible physician or practitioner at the time of service. The distant site or practitioner submits a claim using the appropriate modifier. Physician or practitioner does not include a federally qualified health center or rural health center. Medicare provides a list of all the telehealth services that are covered on the Medicare.gov. Website.

There are quite a few potential barriers with the telehealth policy including that patients must travel to an eligible originating site. Home monitoring is not covered. Most of the U.S. cannot use store-and-forward to better utilize specialists' time. The originating site fee copay makes

telehealth more expensive for the beneficiary. The original sites cannot contract with specialists and bill for their services. The approved services list is minimal. There is an extensive approval process to add services. There is limited clinical outcomes data for some services. There are clinician state licensure limitations. Specialist credentialing is required at each hospital originating site. There is a RHC and FQHC distant site prohibition. Clinician-to-clinician consultations are not billable. There are different coverage policies than other payers. There are equipment costs involved and transmission speeds, reliability and costs are all issues.

There are telehealth resources via the FCC Health Care Connect Fund. There are telecom and internet subsidies for eligible providers. The fund provides a 65% discount on broadband services, equipment connection to research and education networks, and cost effective locally-constructed and owned facilities.

Tom Klobucar, PhD
Deputy Director
Office of Rural Health
U.S. Department of Veterans Affairs
Washington, DC

Tom Klobucar thanked the committee and stated that it is a great opportunity to talk about telehealth because of how the veteran's administration is evolving. Congress recently passed the Veterans Choice Act. Veterans who live 40 miles or more from a VA facility will receive a Veterans Choice Card. The card will allow the veterans to go to any service provider. This will have an impact on healthcare moving forward and will change the way the Veterans Administration does business. It is an important opportunity to partner with non-Veterans Administration partners to make sure that veterans are getting coordinated care that improves their healthcare and quality of life.

Veterans Administration has 150 medical centers, 985 outpatient clinics, 135 community living centers, 300 readjustment counseling centers and 103 domiciliary resident rehabilitation treatment programs. Eligibility for Veterans Health Administration care services depends on a number of qualifying factors including the nature of the Veteran's discharge, length of service, service connected disabilities, income level and available veterans administration resources.

26 Veterans Administration medical centers are located in rural areas, and 344 community based outpatient clinics are located in rural areas. There are more than 50 mobile clinics providing primary and specialty care to rural regions. 56% of veterans who live in rural communities are currently receiving care at urban Veterans Administration facilities.

More than 70% of VA enrolled rural veterans see both VA and community providers. This makes care coordination among physicians a challenge. 5.2 million Veterans live in rural areas. About 31% of Operation Enduring Freedom and Operation Iraqi Freedom are users of the VA health care system in 2012 reside in rural areas.

Rural veterans' most common outpatient diagnoses are high blood pressure, post-traumatic stress disorder, type II diabetes, depressive disorder, high blood cholesterol and at least one service connected disability.

Telehealth will assist in getting healthcare to veterans via clinical video telehealth, store and forward telehealth and home telehealth. There are also many uses of clinical video telehealth in the VA for instance: cardiology, dermatology, intensive care, mental health, primary care and rehabilitation.

The Veterans Health Administration has built a technology infrastructure that supports broadband video conferencing. In 2013, the VA had 542,675 clinic video telehealth visits where 56% accounted as rural. The VHA will continue to extend telehealth services into veterans' homes but if broadband does not reach rural veterans, the option will not be available. Currently 557,560 VHA enrollees are not reached by broadband.

Priorities for 2015 are the Veterans Choice Act Implementation rural provisions. It is important to support new and continuing pilot projects across the VHA to impact rural access to care, including transportation. The VA will focus on a targeted technical assistance and analysis of care coordination, the rural healthcare workforce, targeted disease efforts and social determinants of health.

Sherilyn Pruitt
Director
Office for the Advancement of Telehealth
Federal Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services
Rockville, Maryland

Sherilyn Pruitt thanked the panel for their presentations. Paying for telehealth via Medicare is complicated and there are many restrictions. The VA does not have the same reimbursement restrictions.

It will be interesting to see how the veterans choice act card will work for those eligible through the VA. Being able to access services through community providers, the providers will need to know the best way to treat veterans. The health information exchange is going to be even more important than ever.

The Office of the National Coordinator for Health Information Technology is undergoing reorganization and the new director is Dr. Karen DeSolvo. The High Tech Act funds have expired and the emphasis on programs promoting Meaningful Use have come to an end. The focus will be on quality and interoperability and that is key to positive outcomes of people in rural communities. There will be a focus on policy and bringing stakeholders together. A strategic plan regarding health information technology is in development and there are references to telehealth and telemedicine in the plan. Including telehealth and telemedicine in the plan is important because health information technology needs to be looked at more broadly.

Throughout the day there have been discussions about the Federal Communications Commission, Veterans Administration, Health Resources and Services Administration, Centers for Medicare & Medicaid Services and U.S. Department of Agriculture. The federal government is working closely together regarding telehealth. FedTel is a cross governmental telehealth group that meets every other month to discuss telehealth development. All entities of the federal government with interest in telehealth are part of this group.

The VA is in a unique position because they are able to do innovative care that can improve the healthcare of veterans. The practice of providing direct care to the patient's home is very progressive. It will be interesting to learn from the VA and how they are implementing their programs.

Q&A

Roland Gardner said that 6 of their sites are in underserved areas where the mailing address is in an urban setting ½ mile from the county line. Because of this, the equipment has to be moved to a medically underserved area.

Aaron Fischbach stated that it is where the patient goes for services so if 5 of the sites are in rural or HPSA then you qualify. It is about where the patient is located so you would check eligibility for each of the 6 sites individually.

David Hartley said that the face-to-face interaction that takes place in the telehealth visit is about patient centered care which is not where he thought we were heading for population health and care for whole populations. How do we get the people who are doing non-VA telehealth to think about taking care of the whole population via telehealth? A key piece is home monitoring. This is not necessarily doing a treatment but monitoring a chronic illness in the home. Support groups via telehealth for chronic diseases are another take on a population health approach.

Roger Wells said that you cannot get reimbursed for home monitoring but can get reimbursed for care coordination. Can you utilize that service and use home monitoring as input? Many people who are trying to get to Stage 2 for medical health records are having difficulty because y fiber optic broad band speed is necessary to transfer data back and forth. Is there any activity to intertwine the interface between the systems?

Aaron Fischbach said that transitional care management service has been added to the telehealth services. When asked about home monitoring, it is bundled within some of the codes. Because it does not require a face-to-face visit they are also proposing the chronic care management code.

PUBLIC COMMENT
There was no public comment.

Thursday, September 25th, 2014

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

HUMAN SERVICES SUBCOMMITTEE
The Compass Center- Sioux Falls, South Dakota
Subcommittee members: Rene Cabral-Daniels, Eugenia Cowan, Barbara Fabre, David Hartley and Barbara Morrison.
Staff Members: Tom Morris, Charity Porotesano, Jocelyn Richgels and Dennis Dudley.

HEALTH SUBCOMMITTEES
Pipestone County Medical Center and Family Clinic Avera
Good Samaritan Society - Pipestone
Pipestone, Minnesota
Subcommittee members: John Cullen, Phyllis Fritsch, Michele Juffer, Wayne Myers, Karen Perdue and Roger Wells.
Staff Members: Aaron Fischbach and Catherine Fontenot.

Horizon Health Care, Inc., Administration Office
Howard Community Health Center
Howard, South Dakota
Subcommittee members: Roland Gardner, Karen Madden, Shane Roberts and Christy Whitney.
Staff Members: Steve Hirsch and Shannon Wolfe.

The subcommittees' returned to Sioux Falls and attended break-out sessions for discussions.

PUBLIC COMMENT
There was no public Comment.

Friday, September 26th, 2014

The Meeting was convened by Tom Morris, Associate Administrator for Rural Health Policy. Mr. Morris stated that he would like the committee to discuss the site visits and the policy brief and some discussion of potential recommendations. The next meeting will be held in Eastern Kentucky with a focus on life expectancy and mortality.

HUMAN SERVICES SUBCOMMITTEE
DOMESTIC AND INTIMATE PARTNER VIOLENCE

The Compass Center- Sioux Falls, South Dakota
Subcommittee members: Rene Cabral-Daniels, Eugenia Cowan, Barbara Fabre, David Hartley and Barbara Morrison.
Staff Members: Tom Morris, Charity Porotesano, Jocelyn Richgels and Dennis Dudley.

Barbara Morrison spoke for the subcommittee and shared the following concerns/possible recommendations:

- Who has the authority related to sovereign nations and are the protection orders still enforced outside of the sovereign nation if women leave their tribal communities.

- Training and technical assistance is needed regarding domestic and intimate partner violence. This relates to every public service representative that comes in contact with a victim (physicians, police officers, teachers, emergency room professionals, etc.)
- Screening tools need to be revisited. If a woman answers "yes" she is living in an abusive home, the provider needs to have a plan in place to assist the victim.
- The adverse effect on the children living in homes with domestic violence is a huge issue. It continues the cycle of domestic violence.
- There needs to be screening tools that are unique to rural communities, around the topic of anonymity because these are small communities and everyone knows one another.

HEALTH SUBCOMMITTEE
TELEHEALTH

Pipestone County Medical Center and Family Clinic Avera
Good Samaritan Society - Pipestone
Pipestone, Minnesota
Subcommittee members: John Cullen, Phyllis Fritsch, Michele Juffer, Wayne Myers, Karen Perdue and Roger Wells.
Staff Members: Aaron Fischbach and Catherine Fontenot.

Phyllis Fritsch spoke for the subcommittee and shared the following concerns/possible recommendations:

- Reimbursement and grants for equipment initially
- Strength is in having a strong organization to support telehealth. An offsite location with a dedicated staff is vital to success and expansion.
- Telemedicine is an addition and not a substitution
- Multiple state licenses and credentialing is an issue– the national practitioner data base needs to be more timely and needs to reflect what is occurring with the practitioner.
- Telehealth is saving patients time and money from not having to travel to a hospital.
- Telehealth is also saving time and money related to transfers.
- There need to be metrics that are related to the triple aim of improving the patient experience of care, health of populations and reducing the per capita cost of health care and how telehealth relates to accomplishing the triple aim
- Many rural areas do not have broadband and that makes it impossible to have telehealth capability.
- Federal grants need to be inclusive of staff and process redesign; moving from traditional healthcare into telehealth.

Horizon Health Care, Inc., Administration Office
Howard Community Health Center
Howard, South Dakota
Subcommittee members: Roland Gardner, Karen Madden, Shane Roberts and Christy Whitney.
Staff Members: Steve Hirsch and Shannon Wolfe.

Christy Whitney spoke for the committee and shared the following concerns/possible recommendations:

- Utilize telemedicine more for face-to-face requirements and recertification for hospice and long-term care.
- Looking at telemedicine as not being an add-on but a substitution in terms of an intervention regarding reimbursement.
- The fee provided to the originator is not sufficient to incentivize the use of telemedicine.
- Using telehealth to extend local staff to clinics where there is an extremely limited staff.
- Grant funding is a necessity for both the originator and provider.
- Relaxing regulations related to a qualified service, site and provider.
- Credentialing and licensing – multi-state licensing a burden.
- Veterans Association and Indian Health Service collaborating with local organizations.

ORHP/HHS Update
Aaron Fischbach
Policy Coordinator
Federal Office of Rural Health Policy, HRSA, HHS
Rockville, MD

Aaron Fischbach said that emerging questions and challenges include moving beyond fee-for-service, changing workforce dynamics, and the role of information technology.

There are 16 states & DC who have state-based marketplaces. 7 states have state partnership marketplaces and 27 states have federal facilitated marketplaces.

As of August 15, 7.3 million enrolled people had paid their Marketplace premiums, through July 31, 7.9 million people signed up for Medicaid and CHIP. As of Q1 2014, 13.1% of Americans (41 million) lacked insurance, a drop of 8% (3.8 million) from the previous year. (Source: CDC).

State Marketplace service and rating area decisions are particularly relevant to rural. Average 2014 monthly premiums are higher in less densely populated areas. Outreach and enrollment is particularly critical.

The rural uninsured is more likely to be eligible for coverage under the Marketplace and more likely to be eligible for coverage under the Medicaid Expansion.

Fewer rural states have expanded Medicaid. A Majority of rural residents live in a non-expansion state. A Variation among expansion states has led to a wider rural-urban disparity in insurance coverage than existed pre-Affordable Care Act.

Rural Health System Analysis and Technical Assistance (RHSATA) is a 3-year cooperative agreement with Rural Policy Research Institute (RUPRI). It was developed to increase

understanding of how new health care delivery and financing systems may affect rural communities and providers and raise awareness about what opportunities and challenges exist for rural health care providers and patients. It will also build and distribute a knowledge base of research, practice, and collaboration to help create high-performance rural health systems, and disseminate project findings to inform public policy and private action in a rapidly changing health care environment. The analysis will develop taxonomy of rural places and provided targeted direct technical assistance.

On July 14, Centers for Medicare & Medicaid Services published a proposed rule updating the Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems and other policy changes. A key provision focuses on collecting data on site-of-service for off-campus provider-based departments.

Regarding health information technology and meaningful use, Centers for Medicare & Medicaid Services reported in May that only 4 hospitals had attested to Stage 2. As a result, stage 2 has been extended one year, but full-year Meaningful Use is required in 2015.

PUBLIC COMMENT

Jane Lucas
Health Policy Council
Representing Senator John Thune
United States Senate
South Dakota

"I would like to thank the committee for coming to South Dakota to have this meeting. Senator Thune and I are both pleased that you saw some of the best of what South Dakota and this country has to offer when it comes to telehealth capabilities. Avera Hospital System, Sanford Hospital System, Horizon Health System, and the Good Samaritan Society are on the cutting edge of providing care to patients across rural and frontier settings.

Many of the Committee members have discussed various CMS payment policies that affect rural care, such as the Critical Access Hospital 96 hour rule and physician supervision requirements. I encourage you to make sure you are communicating your concerns to both CMS and to your members of Congress. The Congressional Budget Office determines the cost, or the "score," to the government of legislative payment policy changes and often the score of legislative fixes to CMS payment policies make it difficult to easily pass them. The more CMS and the Hill are aware of how these payments policies are affecting your ability to provide high quality care, the easier it is to find the needed political support to enact those changes.

Please feel free to reach out to me in Washington, DC, if you would like to talk more about rural health care. I value your expertise and thank you for your service on this panel. I look forward to your upcoming reports."