Kristine Sande: Good afternoon everyone. It looks like it's 1:00 pm. Let's go ahead and get started. I'm Kristine Sande, and I'm the director of the Rural Assistance Center. I'll be your moderator today. I'd like to welcome you to today's webinar covering the National Advisory Committee on Rural Health and Human Services' policy briefs on telehealth and intimate partner violence. I will quickly run through some housekeeping items, and then we'll get right to their presentations.

We hope to have time for your questions at the end of today's webinar. If you do have questions for our presenters, we ask that you submit those towards the end of the webinar using the Q&A section of the screen that is directly beneath your slides. We have provided a PDF copy of the presentation on the RAC website, and that's accessible through the URL that's on your screen or by going to the RAC webinar page. That's at www.raconline.org/webinars and then clicking into today's presentation. If you do decide to go and download those slides during the webinar, please don't close this webinar window or you'd have to log back into the event.

If you have any technical issues, please contact our support area using the phone number listed on the information screen. If you're not seeing that screen, that number is 701-777-6305. Once again, for technical issues the number is 701-777-6305.

Our first speaker today will be the Honorable Ronnie Musgrove who has served as the chair of the National Advisory Committee for Rural Health and Human Services since 2010. He previously served as the Governor of Mississippi from 2000 to 2004, serving as the Lieutenant Governor prior to that. For more than 2 decades he's taken a leading role in the state of Mississippi to improve education and expand economic development. Governor Musgrove will give us an introduction to the work of the National Advisory Committee.

Following Governor Musgrove we will hear from National Advisory Committee member Karen Madden regarding the committee's brief on telehealth. Karen is the director of the Charles D. Cook Office of Rural Health within the New York State Department of Health. Karen has expertise in statewide rural health policy development, implementation and analysis, health planning, program planning in administration systems development and hospital conversion. She is the past president of the National Organization of State Offices of Rural Health and currently serves on its board of directors. Karen has also served on the National Rural Health Association board of trustees and the advisory committee of the Technical Assistance and Services Center for the Rural Hospital Flexibility Program.

Our final speaker will be Geni Cowan who will discuss the committee's brief regarding intimate partner violence. Dr. Cowan is a professor at California State University Sacramento in educational leadership and policies. She has worked as a trainer and facilitator for the Center for Human Services at UC Davis Extension

since 1996 specializing in issues such as working with Native American clients, HIV AIDS in the workplace, the Indian Child Welfare Act, alcohol and substance abuse, mental health issues, domestic violence, and dual diagnosis. Dr. Cowan has more than 20 years of experience in community based social services and organizational leadership and development.

Also joining us on the call today is Steve Hirsch, a longtime staff member of the Federal Office of Rural Health Policy who works with the National Advisory Committee.

Now we're ready to hear from our first presenter, Governor Musgrove.

Gov. Musgrove: Kristine, thank you very much. It's a pleasure to be with you today, to all of you. If you're looking at your screen, you see the National Advisory Committee on Rural Health and Human Services. It's probably the only committee I've been a part of where the acronyms are as long or longer than the name itself, and it's harder to pronounce than the name itself. Some of you may be very familiar with the committee, others may not. What exactly does the committee do? It's an independent advisory board to the Department of Health and Human Services, which we just all, of course, call HHS, for issues related to how the department and its programs serve rural communities.

Our effort is never to take away from what is going on in the urban areas, but to always highlight those things that are happening in rural areas and if there is unwanted consequence or a downside to rural areas, we certainly want to be able to point that out to the secretary. We believe we serve as an independent external voice to the HHS secretary. We also prepare an annual report or we do policy briefs to the secretary on key rural issues. In the past 5 years the committee has sent 20 policy briefs to the secretary.

A lot of our work has focused on the Affordable Care Act, and in that regard as various aspects were coming online, we went to policy briefs more than the annual reports to make sure that the secretary and HHS were both getting input from the advisory committee on the various aspects of the Affordable Care Act.

The committee was established in 1987 by the secretary. Then in 2002 Secretary Tommy Thompson expanded the committee to focus also on human services. As Kristine told you, I was appointed in 2010. I probably would take the position that I didn't have as much grey hair in 2010, but my wife and others assure me that I did. That hasn't changed a lot. I very much enjoyed the time that I've had to serve and had the privilege to serve as chair to work with a lot of people and to make sure the voice in rural healthcare is heard by the secretary.

We typically have 2 meetings, 1 in the spring and the fall. They're usually in the field, which all of the members believe is of great benefit. We hear presentations from national and regional experts on selected whitepaper topics. The field visits include site visits to rural locations and to have discussions

around the selected whitepaper topics. The interesting point about the visits is that sometimes you can visit and you can see how well things are doing and what great care has been provided. In other situations you see the really great challenges that rural areas are having in meeting the delivery of quality healthcare in rural settings.

If you'll look at the next slide, you'll see the last 4 meetings that we've had and the timeframes. You take states like Minnesota, Kentucky, South Dakota, and Nebraska all of those meetings obviously had us going into rural areas. All the areas are different, and the challenges are different. The members of the committee have always felt like that it was very beneficial to see what was happening in different parts of the country.

Some of the notes ... quickly, some of the challenge, rural America has almost 20% of the total population. However, it only has 10% of the nation's physicians. The physician shortage is especially acute in the specialist areas. Also high rates of chronic illness and poor overall health are found in rural communities when compared to the urban population. I think you'll see the statistic there that in 2010 a little over 22% of nonelderly rural residents were uninsured compared to 21.4% of nonelderly urban residents. This is a statistical comparison you'll see over and over in almost every category that it's of greater consequence in the rural area on almost any category.

We've had the opportunity over the last several years to deal with some prior briefs such as primary care provisions affecting the rural elderly and reducing health disparities in rural America. As Kristine told you and as you can see on the screen, the policy brief topics that we'll cover today will be telehealth in rural America and intimate partner violence in rural America. At this time I will turn it over to Karen Madden to take the first topic. Thanks, Karen.

Karen Madden: Than you, Governor. Hi everyone. I'm going to discuss the brief that we did regarding telehealth in rural America. In rural areas access to healthcare remains a challenge as I think we all know. At least I hope we all know. Access to specialists is particularly limited in rural areas. We all saw in the 2014 update of rural urban chart book that in central counties in large metro areas there were 263 specialists per 100,000 population compared to only 30 per 100,000 in the most rural counties. Additionally there were approximately 6 times as many general pediatricians and general internists per 100,000 population in central counties in large metro areas as in the most rural counties.

Telehealth is defined as the use of electronic information and telecommunications technologies to support long distance healthcare of patients and professional health related education, public health, and health administration. The committee wanted to examine how can telehealth help rural areas realize the triple aim for the American healthcare system, which is to improve the individual experience of care, improve the health of populations, and reduce the per capita cost of care.

Payment policies both private and federal includes availability of services including telehealth services. Major reimbursement for telehealth services is conditional on the originating site, which is the place where patients are located, being located in a non-MSA county or a geographic health professional shortage area located in a rural Census Tract.

Originating sites are paid approximately $25, and the 20% beneficiary coinsurance applies. Distant site providers, which the distant sites are where the provider is actually located, are paid the same reimbursement rate as non-telehealth equivalent services. Rural health clinics and federally qualified health centers are not considered distant site physicians or practitioners and are not reimbursed. Currently 21 states in the District of Columbia require telehealth coverage by private health insurance plans.

This is a figure from the 2014 rural urban chart book showing how physician availability plunges the more rural a county is. Beginning with the most urban counties on the left and moving right to the most rural, the availability of all physicians decreases greatly as shown in the chart.

In order to examine the issues of telehealth the committee met in Sioux Falls, South Dakota and traveled to 2 originating sites, the places where the patients are, to see how telehealth works in greater detail. On the map you can see Sioux Falls is the letter B. One committee went to a federally qualified health center in Howard, South Dakota, which is represented on the map by the letter C, and the other went to the Pipestone Medical Center, a critical access hospital in Pipestone, Minnesota that is part of the Avera Health System and to the Good Samaritan Society Pipestone, which is a long term care facility. That's marked on the map by the letter A. Howard, South Dakota has a population of 858 people, and Pipestone, Minnesota is a town of 4,317 people.

This is a photo of the Avera Health System eHelm. The committee was also able to see how telehealth works at the distant site where the providers are. In Sioux Falls, Avera Health System has a facility called eHelm, which is the hub of their telehealth system. This is a photo of the eICU where providers are using telehealth to support care in multiple ICUs spread across several states, where eHelm also has ePharmacy, eLongTerm care, eEmergency, eConsult, and eCorrectional. At the Pipestone Medical Center Emergency Department the subcommittee saw a demonstration that showed how the specialists at the EeHelm could support ER staff in the hospital.

At Howard the subcommittee met with a veteran who received counseling via telehealth. Saving him a 140 mile roundtrip, which he probably wouldn't have been able to make. Without the telehealth capacity in Howard he would not have been able to receive services in his hometown, and likely would have had to go without those services.

There are barriers to telehealth in rural areas that still exist even though we've come a long way. Some of those are infrastructure, which is access to broadband Internet connection, alternative transmission technologies that do not require installation in fiber over significant distances like the same speed as broadband. It really is necessary to have broadband services in order to have telehealth. Licensure is a state and not a federal responsibility. Licensure by each distant site professional in each state can be time consuming and expensive.

Credentialing and privileging is also an issue. Practitioners providing services via telehealth often must be credentialed and receive privileges to practice at each patient location, particularly if the originating play is a hospital. Finally payment, the range of services that are reimbursable is somewhat limited and are limited to Medicare Part B fee-for-service. In addition, the geographic limitations of eligible originating sites also hinder broad use of telehealth.

In order to address some of these barriers the committee developed recommendations. The key recommendations that we'd like to highlight today are ... the first one is the committee recommends that the secretary seek a change in legislation to allow rural health clinics and federally qualified health centers to serve as eligible distant sites. Although the committee tends to avoid requesting legislative changes we felt this was especially important for making telehealth services in rural communities available. In one example the subcommittee heard in Howard, South Dakota a psychologist who works for a FQHC cannot receive Medicare reimbursement for telehealth consultations.

The second recommendation is the committee made several recommendations on allowing telehealth to be used in home health certification and allowing more than 1 telehealth consultation per month in nursing homes. Using telehealth for consultations in our nursing homes can reduce hospital admissions and aerial transport of patients, both of which are expensive and often unnecessary.

The committee has also reiterated an earlier recommendation on the Medicare hospice benefit that the secretary seek a change in legislation allowing telehealth consultations to count as face-to-face encounters to certify and recertify the need for hospice care. Finally, the committee made recommendations that the secretary assure use of appropriate measures for rural telehealth quality of care and that further research on the efficacy and efficiency be performed in rural areas.

Now I will turn this over to Geni Cowan.

Geni Cowan: Thanks, Karen. My task is to view what the committee's deliberations have been and our recommendations around the issue of intimate partner violence in rural America. We made 3 recommendations, but as background let me back up here to our 2014 meeting in Sioux Falls. Our visit to the Compass Center, which is an

abuse counseling provider in Sioux Falls, we were able to hear from stakeholders about the challenges that they face. After we met with them, then we met with a variety of other community members including law enforcement agents, nonprofit organizations, tribes, and healthcare providers to gain a little more insight into the issue of intimate partner violence.

What we know ... and we preface what we know with saying in general this is the data that we have. First, we know that intimate partner violence is prevalent in all communities across the country. No one is left unaffected. We know that nearly half of all the women and men in the United States have had the experience of at least psychological aggression from an intimate partner, and we know that most people who experience IPV have their first experience with it before they reach the age of 25.

We know that in 2009 a study found that in small rural communities almost 23% of women reported being victims of IPV, as compared to 15.5% of women in urban areas. We also know that women living in nonurban communities ... changing my language a little bit ... reported significantly higher severity of physical abuse. The physical abuse they experienced was much more and severe than women living in urban areas. That sounds like a lot of data, but the data that we have available on rural communities is much less.

Rural persons experiencing IPV are 2 ½ times more likely than those living in urban areas to have their property destroyed. A 20-year study of murder rates by the Department of Justice concluded that while intimate partner murder rates fell in urban areas between 1980 and 1999, they rose in rural areas in the United States during the same period. That same study found a strong relationship between geography and intimate partner murder. Non-intimate partner murder rates over the same period did not show any relationship with the condition of being in a rural community.

The conclusion we draw from that is that women who've experienced IPV in rural America are much more likely to be murdered by a partner than those living in cities. It's almost if you can kind of imagine IPV on a continuum, the end of the continuum might go as far as murder. In nonurban communities what our experience showed us was that the likelihood of women being murdered in those communities the same situation is greater.

You'll note that the co-occurrences of IPV and child abuse are notable. Research shows that 30% to 60% of the families where either domestic violence or child maltreatment is identified it is likely that both are taking place at the same time or that they're co-occurring. The ACES study by the CDC, the adverse childhood experiences, shows that those experiences have a direct impact on health outcomes later in a person's life.

IPV is associated with a number of adverse health outcomes. People who experience IPV are more likely to report frequent headaches, chronic pain,

difficulty sleeping, poor physical health in comparison with those who have not experienced IPV.

We're looking now at the rural human services structure and IPV. The literature suggests that social factors including traditional gender roles and a high degree of social cohesion in rural communities can make it difficult for women who are experiencing IPV to obtain assistance. Those that have experienced IPV face similar challenges, but their access to services is different in rural communities in that they face transportation barriers, isolation being those of them who need human services may be isolated, the stigma in some small communities, the lack of providers in those communities, and disparate levels of federal, state, and local funding to support services. There's also often a shortage of high quality affordable housing, which we saw directly in some of our visits, and the lack of economic opportunities for families.

They're also less likely to seek out help and perceive the justice system as less helpful than urban women might. Individuals to whom the women might need to reach out for help such as a member of a law enforcement team, a judge, a primary care provider, or another service provider are potentially likely to have a personal relationship with the abuser. We heard that this was not an uncommon experience in rural communities. Actually in one study half of the primary care providers reported that lack of privacy is a huge barrier to care. Accessing human services is similar both in urban and nonurban communities then you add issues of isolation and stigma and the lack of privacy in rural communities.

Here's a quote from a 2006 report. "In contrast to urban areas, less is known about human and social services conditions than social services rural residents need and use and the effectiveness of those services." This is from an executive summary of a comprehensive 2006 report on rural human services research by the assistant secretary for planning and evaluation. Since this report 10 years ago, there's call for an additional rural data collection and research in human services, little has changed, and the rural human services evidence base remains limited. This report called for government and other human services researchers to incorporate rural sites into more evaluations, report rural findings when possible, and include rural populations in more studies.

What we know is based on a limited evidence base. You can see that when comparing the availability in data in urban communities. Although there's a body of research on best practices, little exists for rural populations. There's a lack of identifiers in federal data collection that would mark rural populations plus difficulty including individuals who don't use the available services.

Our recommendations, first we recommended that the secretary direct the Centers for Disease Control and Prevention to conduct analyses of the national intimate partner and sexual violence survey data with a geographic variable to gain better understanding of the unique needs of individuals in rural America of

all ages and throughout the life course experiencing IPV ... this in response to the limited availability of data.

Secondly, we recommended that the secretary direct the Administration for Children and Families, ACF, to work with the centers for Medicare and Medicaid services, substance abuse, and mental health services administration and HRSA to train rural healthcare providers on integrating IPV screenings and counseling in the service sites. During our meetings both in Sioux Falls and Omaha the committee heard about the difficulties of accessing human services in rural areas. Just being able to alert a healthcare provider that the patient is experiencing IPV can be difficult and sometimes dangerous. More training for providers to help them recognize and respond to IPV as needed.

We had further discussion about the difficulty of assessment when it comes to IPV screening tools. Though there are several with regard to IPV, their effectiveness is limited based on a number of different factors. In rural communities one of the issues that was presented to the committee from a provider was that some questions shouldn't be asked of a woman or a man who's experiencing IPV because it increases their risk. We also discussed the need to review and think about IPV screening and the service sites where it might be conducted. What strategies could be used that would ensure the safety of families as well as ensure their privacy and support?

Finally, recommended that the secretary direct ACF to work with SMSA and HRSA to connect healthcare providers who have been trained in IPV screening to community organizations that help individuals in rural America experiencing IPV. Making linkages from healthcare provider to human service provider would be helpful. To move from being aware of a problem to knowing how to intervene and assist is critical. Thus, I'm now going to turn this back over to Steve.

Steve Hirsch: Thank you, Geni. I just wanted to let people know that the committee will have a meeting in the spring of next year, and we're going to Buford, South Carolina on April 18th through the 20th. Committee meetings are always open to the public. About 6 weeks beforehand there will be a notice in The Federal Register. We'll post an agenda on our website. You can find the reports as well on our website, all the previously released policy briefs, and many of the annual reports going back about a decade or more are available whose address you can see now. Or you can contact me here at Health Resources and Services Administration's Office of Rural Health Policy, and I can email you a copy of the report or mail you a paper copy if you like.

I think now, Kristine, I'll throw it back to you and we could open the floor for any questions that the audience may have.

Kristine Sande: Absolutely. Thank you so much for those great presentations, and we will open it up for questions right now. You can see on the screen where to find the Q&A

box. It's directly underneath the slides on this screen. Please enter your questions for our speakers. While we're waiting to see if there are any questions, I would just mention that the next event that the Rural Assistance Center will be hosting will be a live webcast on National Rural Health Day. That will be discussing the name change of the Rural Assistance Center that will occur on December 1st. We hope that you will be able to join us for that webcast. You can register to listen in on that webcast on the main page on our website, raconline.org/webinars. We hope you will do that. I am not seeing any questions at this time.

Steve: Okay. Thank you. Is there anything else, Kristine?

Kristine: No. I guess if we don't have any questions, we can wrap it up. Just thanks again for those great presentations, and thank you to everyone who listened in today. The slides from the webinar are available on raconline.org/webinars, and a recording and a transcript of the webinar will be made available on the RAC website. We'll send that to our registered participants by email in the near future so you can listen in again and also share the presentation with your colleagues. Thanks everyone and have a great day.

Steve: Thank you, Kristine.

Kristine: You're welcome.