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NACRHHS Policy Briefs on Telehealth and Intimate Partner Violence

November 5, 2015
1:00 p.m. CT

Kristine Sande, Moderator

Presentation

- Q & A to follow – Submit questions using chat tab directly beneath slides
- Slides are available at https://www.raconline.org/webinars/nacrhhs-telehealth-intimate-partner-violence
- Do not close webinar window
- Technical issues: 701.777.6305

Presenters

NACRHHS Committee Chair

Ronnie Musgrove

Committee Members

Eugenia (Geni) Cowan

Karen Madden

National Advisory Committee
On Rural Health and Human Services

The National Advisory Committee on Rural Health and Human Services (NACRHHS)

Rural Assistance Center

Webinar

November 5, 2015

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National Advisory Committee
On Rural Health and Human Services

What is the NACRHHS?

- An independent advisory board to the Department of Health and Human Services (DHHS) on issues related to how the Department and its programs serve rural communities

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National Advisory Committee
On Rural Health and Human Services

What Does the NACRHHS Do?

- Serves as an independent, external voice to DHHS Secretary
- Prepares an Annual Report and/or Policy Briefs to the Secretary on key rural issues
  - In the past five years the Committee has sent twenty Policy Briefs to the Secretary

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National Advisory Committee
On Rural Health and Human Services

Committee Background

- **1987** Established by the Secretary of HHS
- **2002** Secretary Thompson expanded the focus to include human services
- **2010** Ronnie Musgrove, former governor of Mississippi appointed as Chair

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National Advisory Committee
On Rural Health and Human Services

Meetings

- Meets in the spring and fall, usually in the field
  - Members hear presentations from national and regional experts on the selected white paper topics
  - The field visits include site visits to rural locations and panel discussions around the selected white paper topics

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Field Meetings

- Mahnomen, MN
  - September 9-11, 2015,
- Slade, KY
  - May 27-29, 2015,
- Sioux Falls, SD
  - September 24-26, 2014
- Omaha, NE
  - April 28-30, 2014

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Rural Challenges

- Rural America has almost 20% of the Total Population
- Rural America has 10% of the Nation's Physicians
- The Physician Shortage is Especially Acute for Specialists

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Rural Challenges - 2

- Higher rates of chronic illness and poor overall health are found in rural communities when compared to urban populations
- In 2010, 22.3% of non-elderly rural residents were uninsured, compared to 21.4% of non-elderly urban residents.

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Policy Brief Topics

- Telehealth in Rural America
- Intimate Partner Violence in Rural America

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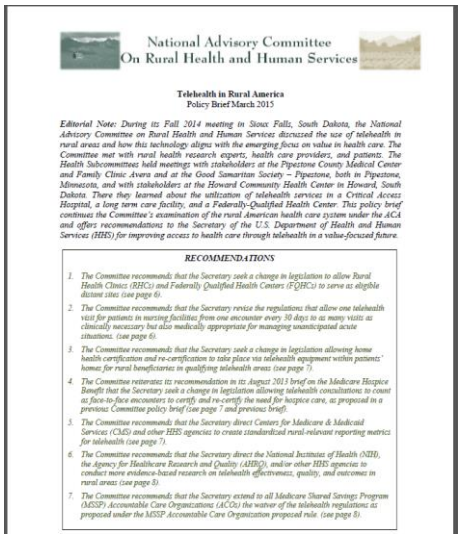
Telehealth in Rural America



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Telehealth in Rural America
Policy Brief March 2015

Editorial Note: During its Fall 2014 meeting in Sioux Falls, South Dakota, the National Advisory Committee on Rural Health and Human Services discussed the use of telehealth in rural areas and how this technology aligns with the emerging focus on value in health care. The Committee met with rural health research experts, health care providers, and patients. The Health Subcommittees held meetings with stakeholders at the Pipestone County Medical Center and Family Clinic Avera and at the Good Samaritan Society – Pipestone, both in Pipestone, Minnesota, and with stakeholders at the Howard Community Health Center in Howard, South Dakota. There they learned about the utilization of telehealth services in a Critical Access Hospital, a long term care facility, and a Federally-Qualified Health Center. This policy brief continues the Committee's examination of the rural American health care system under the ACA and offers recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) for improving access to health care through telehealth in a value-focused future.

RECOMMENDATIONS

1. *The Committee recommends that the Secretary seek a change in legislation to allow Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to serve as eligible distant sites. (see page 6).*
2. *The Committee recommends that the Secretary revise the regulations that allow one telehealth visit for patients in nursing facilities from one encounter every 30 days to as many visits as clinically necessary but also medically appropriate for managing unanticipated acute situations. (see page 6).*
3. *The Committee recommends that the Secretary seek a change in legislation allowing home health certification and re-certification to take place via telehealth equipment within patients' homes for rural beneficiaries in qualifying telehealth areas (see page 7).*
4. *The Committee reiterates its recommendation in its August 2013 brief 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 re-certify the need for hospice care, as proposed in a previous Committee policy brief (see page 7 and previous brief).*
5. *The Committee recommends that the Secretary direct Centers for Medicare & Medicaid Services (CMS) and other HHS agencies to create standardized rural-relevant reporting metrics for telehealth (see page 7).*
6. *The Committee recommends that the Secretary direct the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), and/or other HHS agencies to conduct more evidence-based research on telehealth effectiveness, quality, and outcomes in rural areas (see page 8).*
7. *The Committee recommends that the Secretary extend to all Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) the waiver of the telehealth regulations as proposed under the MSSP Accountable Care Organization proposed rule. (see page 8).*

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Telehealth

- In rural areas, access to health care remains a challenge.
- Telehealth is defined as "the use of electronic information and telecommunications technologies to support long-distance health care, patient and professional health-related education, public health and health administration."
- Can Telehealth help rural areas realize "The Triple Aim" for the American health care system: improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations?

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Telehealth Reimbursement

- Medicare reimbursement for Telehealth services is conditional on the originating site being located in a non-MSA county or a geographic HPSA located in a rural Census Tract. Originating sites are paid approximately $25 and the 20 percent beneficiary coinsurance applies.
- Distant site providers are paid the same reimbursement rate as non-telehealth equivalent services.
- Rural Health Clinic (RHCs) and Federally Qualified Health Centers (FQHCs) are not considered distant site physicians or practitioners and are not reimbursed.
- Currently, 21 states and the District of Columbia require telehealth coverage by private health insurance plans.

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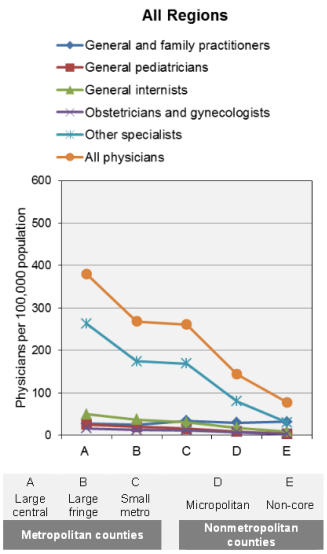
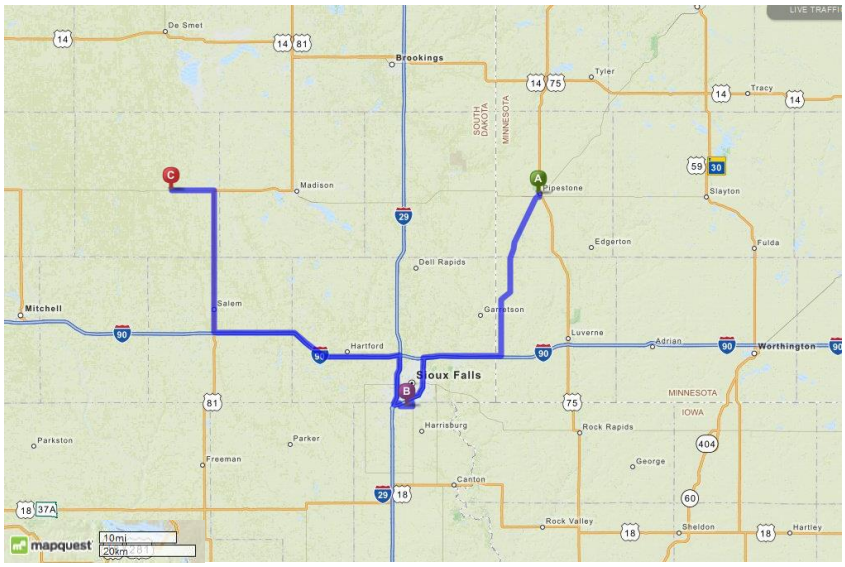
Figure 27(a). Active physicians per 100,000 population by physician specialty and urbanization level: United States, 2010





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What are Barriers to Telehealth in Rural Areas?

1. Infrastructure
   - Access to Broadband Internet Connections
2. Licensure
   - Licensure is a State not Federal responsibility
   - Licensure by each distant site professional in each state can be time consuming and expensive
3. Credentialing and Privileging
   - Practitioners providing services via telehealth often must be credentialed and receive privileges to practice at each patient location, particularly if the originating site is a hospital.
4. Payment
   - The range of services that are reimbursable is somewhat limited and are limited to Part B fee-for-service,
   - the geographic limitations of eligible originating sites also hinder broad use of telehealth

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Key Recommendations

1. The Committee recommends that the Secretary seek a change in legislation to allow Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to serve as eligible distant sites
2. The Committee made several recommendations on allowing Telehealth to be used in home health certification, and allowing more than one Telehealth consultation per month in nursing homes

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Key Recommendations

3. The Committee 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 re-certify the need for hospice care
4. 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.

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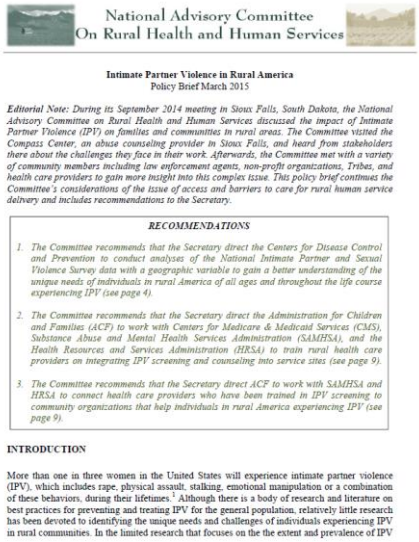
Intimate Partner Violence in Rural America



National Advisory Committee
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Intimate Partner Violence in Rural America
Policy Brief March 2015

Editorial Note: During its September 2014 meeting in Sioux Falls, South Dakota, the National Advisory Committee on Rural Health and Human Services discussed the impact of Intimate Partner Violence (IPV) on families and communities in rural areas. The Committee visited the Compass Center, an abuse counseling provider in Sioux Falls, and heard from stakeholders there about the challenges they face in their work. Afterwards, the Committee met with a variety of community members including law enforcement agents, non-profit organizations, Tribes, and health care providers to gain more insight into this complex issue. This policy brief continues the Committee's considerations of the issue of access and barriers to care for rural human service delivery and includes recommendations to the Secretary.

RECOMMENDATIONS

1. *The Committee recommends 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 a better understanding of the unique needs of individuals in rural America of all ages and throughout the life course experiencing IPV (see page 4).*
2. *The Committee recommends that the Secretary direct the Administration for Children and Families (ACF) to work with Centers for Medicare & Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Resources and Services Administration (HRSA) to train rural health care providers on integrating IPV screening and counseling into service sites (see page 9).*
3. *The Committee recommends that the Secretary direct ACF to work with SAMHSA and HRSA to connect health care providers who have been trained in IPV screening to community organizations that help individuals in rural America experiencing IPV (see page 9).*

INTRODUCTION

More than one in three women in the United States will experience intimate partner violence (IPV), which includes rape, physical assault, stalking, emotional manipulation or a combination of these behaviors, during their lifetimes.[1] Although there is a body of research and literature on best practices for preventing and treating IPV for the general population, relatively little research has been devoted to identifying the unique needs and challenges of individuals experiencing IPV in rural communities. In the limited research that focuses on the the extent and prevalence of IPV

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Intimate Partner Violence

During 2014, the NACRHHS The Committee visited the Compass Center, an abuse counseling provider in Sioux Falls, and heard from stakeholders there about the challenges they face in their work. Afterwards, the Committee met with a variety of community members including law enforcement agents, non-profit organizations, Tribes, and health care providers to gain more insight into the issue of Intimate Partner Violence..

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What we know about Intimate Partner Violence (IPV)

- IPV is prevalent in communities across the country and affects women and men of all ages
- Nearly half of all women and men in the United States have experienced psychological aggression from an intimate partner.
- Most people who experience IPV have their first experience with it before they are 25 years old.

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Impact of Intimate Partner Violence on Individuals

- A 2009 study found that 22.9 percent of women in small rural areas reported being victims of IPV compared to 15.5 percent of women in urban areas.
- Women living in rural communities reported significantly higher severity of physical abuse than women living in urban areas

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IPV in Rural Communities

- Rural persons experiencing IPV are 2.5 times more likely than those living in urban areas to have their property destroyed by an abuser.
- Additionally, women who have experienced IPV in rural America are more likely to be murdered by a partner than those living in cities.

Intimate Partner Violence and Families

- There are notable co-occurrences of IPV and child abuse; research indicates that "in an estimated 30 to 60 percent of the families where either domestic violence or child maltreatment is identified, it is likely that both are occurring
- ACE Study by the CDC shows that adverse childhood experiences have a direct impact on health outcomes later in life

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IPV is associated with a number of adverse health outcomes and are more likely to report frequent headaches, chronic pain, difficulty sleeping and poor physical health compared to those who have not experienced IPV

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Rural Human Service Infrastructure and IPV

- Those who have experienced IPV face the same challenges in accessing human services in rural America as the rest of the rural population
- Barriers to Service in Rural Communities
  - Transportation barriers
  - Isolation of clients in need of human services
  - Stigma
  - Lack of providers in some communities
  - Disparate levels of federal/state/local funding
  - Shortage of high quality, affordable housing
  - Lack of economic opportunities

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"In contrast to urban areas, less is known about human and social services conditions in rural areas, the social services rural residents need and use, and the effectiveness of those services."

-2006 Report on Rural Research Needs and Data Sources for Selected Human Services Topics by the Assistant Secretary of Planning and Evaluation, DHHS

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Knowledge Gaps on Rural IPV

- What we know is based on a limited evidence base
- While there is a body of research on best practices for preventing and treating IPV for the general population, little research exists for rural
  - Lack of rural identifiers in federal data collection
  - Difficulty including individuals who do not use services

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Recommendations on Intimate Partner Violence

1. The Committee recommends 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 a better understanding of the unique needs of individuals in rural America of all ages and throughout the life course experiencing IPV

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Recommendations on Intimate Partner Violence

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Recommendations on Intimate Partner Violence

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2016 Committee Meeting

- Beaufort, SC
  - April 18-20, 2016

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Uses for the Committee Reports

- Inform the policy decisions of the Secretary for HHS
- Resource for rural providers who can then share findings and recommendations with others in the field
- Resources for policy makers

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For More Information…

To find out more about the NACRHHS please visit our website at http://www.hrsa.gov/advisorycommittees/rural/ or contact:

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shirsch@hrsa.gov

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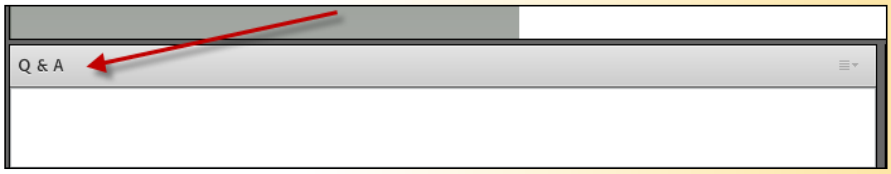
Q & A

- Submit questions using Q & A tab directly beneath slides.



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- Please complete webinar survey
- Recording and transcript will be available on RAC website

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