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Kristine Sande, Moderator
September 29, 2016

# NACRHHS Policy Briefs on Emergency Care Models and Rural Opioid Misuse Implications

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**NACRHHS Committee Chair**
Ronnie Musgrove

**Committee Member**
Kelley Evans

**Executive Secretary**
Paul Moore



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

Ronnie Musgrove, Chair
Webinar
September 29, 2016

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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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# 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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# 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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# 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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# Recent Committee Meetings

- Albuquerque, NM
  September 14-16, 2016
- Beaufort, SC
  April 18-20, 2016
- Mahnomen, MN
  September 9-11, 2015

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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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**Kelley Evans -** Chief Executive Officer Beartooth Billings Clinic Red Lodge, MT



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Alternative Models to Preserving Access to Emergency Care

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**Alternative Models to Preserving Access to Emergency Care**
Policy Brief July 2016

*Editorial Note: During its April 2016 meeting in Beaufort, South Carolina, the National Advisory Committee on Rural Health and Human Services (the Committee) examined some alternative for provision of emergency care and ancillary services in the light of the recent surge in rural hospital closures. The Committee was concerned with how a rural community could maintain timely access to emergency and other care healthcare services in communities too small to support a full-service hospital but needing more services than offered by a typical primary care clinic. The Committee heard from government officials, rural health services researchers, and hospital administrators to get a broad view of the issue.*

RECOMMENDATIONS

1. *The Committee recommends that any model for Rural Free-Standing Emergency Departments must include a supplemental base payment, separate from fee for service payments for Emergency Department visits (see page 6).*
2. *The Committee recommends that the Department seek comment on use of a combination of distance and demographic or social determinants of health such as poverty and health outcomes when setting eligibility criteria for any demonstration project or alternative models (see page 9).*

INTRODUCTION

Concern over access to health care is usually heightened when a rural hospital closes, since these facilities often serve as the focal point for care in their communities. As a result, the closure of rural hospitals is a long-standing issue that this Committee has addressed repeatedly since it was created in 1988. The Committee first sent a report to the Secretary in 1989 and the first recommendations the Committee issued dealt with Medicare payment policy for rural hospitals. The implementation of the Prospective Payment System (PPS) during the 1980s was linked to the closure of approximately 400 rural hospitals by the early 1990s.

Over the past 30 years, Congress and a number of Administrations have created new hospital designations, revised Medicare payment formulas and created grant programs to support rural hospitals. These policy changes were largely effective and stabilized rural hospital financial operations until 2013, when a new wave of rural hospitals closures began. In the past six years, 75 rural hospitals have closed or ceased operations[1], prompting new concerns about access to essential services in rural communities.

[1] as of 6/30/2016 http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

1

http://www.hrsa.gov/advisorycommittees/rural/publications/alternatemodel.pdf

# The Committee's Concerns

- The Committee has been deeply concerned with Rural Hospital Closures since its inception in the late 1980s
- Congress created some new hospital designations (such as Critical Access Hospitals) that stabilized the Rural Hospital financial picture for a period
- Around 2010, a new wave of Rural Hospital Closures began with at least 75 Rural Hospitals closing over the last 6 years
- One recent estimate found 180 Rural Hospitals at risk of closure

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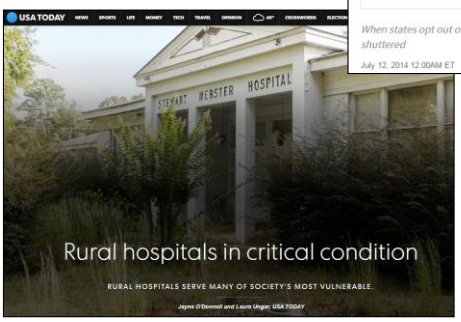



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# Effects of Hospital Closure

- Studies on the 1980s closures showed declines in access to care and increased distance rural residents had to travel to access services, including emergency care
- One recent study examined 47 recent hospital closures and found that
  - 26 hospitals no longer provide any health care services ("abandoned")
  - 21 continue to provide a mix of health services but no inpatient care ("converted")
  - These closures affected approximately 800,000 people in the markets with abandoned hospitals and 700,000 people in the markets with converted hospitals
  - The abandoned hospitals served a higher proportion of non-Whites (26%), particularly Blacks (14%), compared to converted rural hospitals (11% and 2%, respectively) and were located farther away from other hospitals
- News reports from areas with closed hospitals have blamed greater travel time for deaths that have occurred, but these are individual cases and not reflected in broader data

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# Recent Alternative Models

- Frontier Extended Stay Clinic (FESC)
  - located at least 75 road miles away from the nearest hospital, or the nearest hospital was inaccessible from the clinic by public roads
  - In addition to normal clinic services, FESCs were authorized to keep patients for extended periods of time (up to 48 hours) and deliver 24-hour emergency and after-hours care not otherwise available in remote areas
  - A preliminary assessment of the FESC model conservatively estimated that the FESC consortium saved almost $14 million in transfer costs by avoiding nearly 1,800 medical evacuations between August 2005 and September 2010
  - However, each clinic required an estimated additional $1 million per year over that same five year span to provide services

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# Recent Alternative Models

- Rural Free-Standing Emergency Department (RFED)
  - The state of Georgia adopted rules in 2014 that allowed rural hospitals to reduce the scope of services provided and operate as a rural free standing emergency department
  - No organization has applied for the new designation as a rural free standing emergency department, with stakeholders citing the financial viability of the model as a major concern
  - Rural Hospital Emergency Departments have very high fixed standby costs of coverage
  - In full-service hospitals, the ED's operations are subsidized by the hospital's other operations
  - An additional financial benefit that rural hospitals receive from operating their EDs is the admissions that come through the ED

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# Recent Alternative Models

- The Medicare Payment Advisory Commission (MedPAC)
  - In a 2015 report, *Models for Preserving Access to Emergency Care in Rural Areas*, MedPAC proposed 2 option:
    1. Paying isolated hospitals outpatient PPS rates and a fixed supplemental amount to preserve their emergency department (ED) and ambulance service along with ancillary services such as telemedicine
       The local community could also be required to provide some of the funding for the emergency department and other services
    2. For a community that is too small to support a 24-hour emergency department
       Create a primary care clinic that would be open 8-12 hours a day with an adjacent ambulance service operating 24/7, creating a clinic by day, and a stabilize-and-transfer model by night

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# Other Options

- Recent proposals have suggested other models for hospitals with 50 or fewer beds allowing them to convert to Rural Emergency Hospitals (REHs)
  - These would provide emergency and outpatient services, but not inpatient care.
  - REHs would receive enhanced reimbursement rates of 110% of reasonable costs for Medicare services.
- Another proposal would enable rural hospitals with 50 or fewer beds to convert to a for a Community Outpatient Hospital (COH) model
  - These would offer 24/7 emergency care and observation services and transfer patients requiring acute inpatient care
  - They could offer other outpatient services, telehealth, and post-acute care using swing beds
  - Medicare payment for services provided by a COH would be 105% of reasonable cost

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# The Committee's Conclusions

- Essential Services
  - Emergency
    - Extended hours of service
    - Extended duration for ED visits
  - Diagnostics (radiology, lab, possibly CT)
  - Full Service Primary Care (including serious attention to Patient Centered Medical Home model)
  - Ambulance transport support
  - Telehealth – specialists and behavioral health
- Optional Services
  - Dental
  - Behavioral Health
  - Home Health
  - Hospice
  - Post-Acute Care

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## Recommendations to the Secretary

1. *The Committee recommends that any model for Rural Free-Standing Emergency Departments must include a supplemental base payment, separate from fee for service payments for Emergency Department visits*
2. *The Committee recommends that the Department seek comment on use of a combination of distance and demographic or social determinants of health such as poverty and health outcomes when setting eligibility criteria for any demonstration project on alternative models*

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**Paul Moore** - Executive Secretary National Advisory Committee on Rural Health and Human Services

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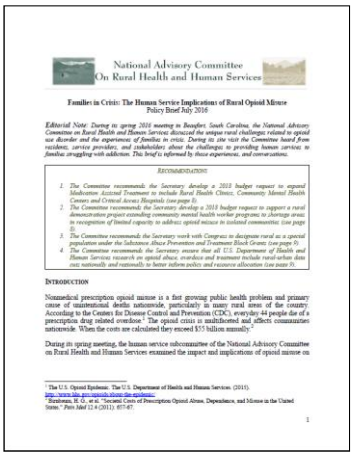
Families in Crisis:
The Human Service Implications of Rural Opioid Misuse



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**Families in Crisis: The Human Service Implications of Rural Opioid Misuse**
Policy Brief July 2016

*Editorial Note: During its spring 2016 meeting in Beaufort, South Carolina, the National Advisory Committee on Rural Health and Human Services discussed the unique rural challenges related to opioid use disorder and the experiences of families in crisis. During its site visit the Committee heard from residents, service providers, and stakeholders about the challenges to providing human services to families struggling with addiction. This brief is informed by these experiences, and conversations.*

RECOMMENDATIONS

1. *The Committee recommends the Secretary develop a 2018 budget request to expand Medication Assisted Treatment to include Rural Health Clinics, Community Mental Health Centers and Critical Access Hospitals (see page 8).*
2. *The Committee recommends the Secretary develop a 2018 budget request to support a rural demonstration project extending community mental health worker programs to shortage areas in recognition of limited capacity to address opioid misuse in isolated communities (see page 8).*
3. *The Committee recommends the Secretary work with Congress to designate rural as a special population under the Substance Abuse Prevention and Treatment Block Grant (see page 8).*
4. *The Committee recommends the Secretary ensure that all U.S. Department of Health and Human Services research on opioid abuse, overdose and treatment include rural-urban data cuts nationally and regionally to better inform policy and resource allocation (see page 9).*

INTRODUCTION

Nonmedical prescription opioid misuse is a fast growing public health problem and primary cause of unintentional deaths nationwide, particularly in many rural areas of the country. According to the Centers for Disease Control and Prevention (CDC), everyday 44 people die of a prescription drug related overdose.[1] The opioid crisis is multifaceted and affects communities nationwide. When the costs are calculated they exceed $55 billion annually.[2]

During its spring meeting, the human service subcommittee of the National Advisory Committee on Rural Health and Human Services examined the impact and implications of opioid misuse on

[1] The U.S. Opioid Epidemic. The U.S. Department of Health and Human Services. (2015). http://www.hhs.gov/opioids/about-the-epidemic/.
[2] Birnbaum, H. G., et al., "Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States." *Pain Med* 12.4 (2011): 657-67.

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http://www.hrsa.gov/advisorycommittees/rural/publications/opioidabuse.pdf



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# The Opioid Crisis

- Over the past several years, the Committee has repeatedly heard of increasing use of Opioids and prescription painkillers in rural areas
- Since 1999, the rate of overdose deaths involving an opioid has nearly quadrupled
- Drug related deaths are 45% higher in rural areas than in urban areas
- Opioid-related overdose deaths have increased over the past 15 years in both rural and urban areas, with exponential increases in rural areas from 2013-2014
- Men in rural areas are using more opioids than women in rural areas but more women are dying from opioid overdose

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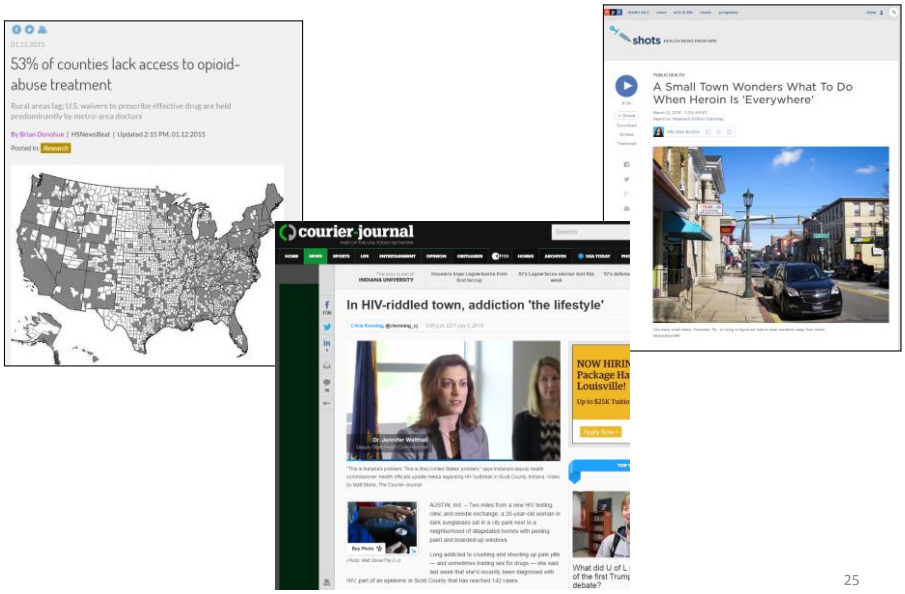


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# The Committee's Concerns

- Many rural opioid users are more likely to have socio-economic vulnerabilities that put them at risk of adverse outcomes
- The Committee is concerned that the opioid crisis could exacerbate child abuse and neglect
- Opioid overdose deaths are contributing to increased rural mortality and a decrease in average life expectancy in many rural areas

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# Barriers to Treatment and Services

- The Committee has issued many recommendations over the years calling attention to the lack of Mental Health and Substance Abuse treatment providers and facilities in rural areas
- States with proportionally large rural populations compared to urban populations have greater shortages of mental health providers and fewer facilities to provide treatment services
- Rural areas lack basic substance abuse treatment services as well as the supplemental services
- The vast majority of rural residents live in counties that do not have detox services

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# The role of Federal Block grants

- To fund systems of care and delivery of human services, behavioral health, and substance abuse treatment and prevention, States rely on several HHS block grant programs administered through:
  - The Substance Abuse and Mental Health Service Administration (SAMHSA)
  - The Administration for Children and Families (ACF)

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# SAMHSA Block Grants

- The Substance Abuse Prevention and Treatment Block Grant (SABG), administered is distributed by formula to all States and Territories and is effective in:
  - producing positive outcomes as measured by increased abstinence from alcohol and other drugs
  - increased employment
  - decreased criminal justice involvement
  - Improving states' infrastructure and capacity
  - fostering the development and maintenance of state agency collaboration
  - promoting effective planning, monitoring, and oversight
- Funding has not kept up with health care inflation, resulting in a 26% decrease in the real value of SABG funding by FY 2015

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# SAMHSA Block Grants

- The Community Mental Health Services Block Grant (MHBG) provides funds and technical assistance to all 50 states to
  - provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances
  - monitor progress in implementing a comprehensive, community-based mental health system

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# ACF Block Grant

- The Social Services Block Grant (SSBG) enables each state or territory to meet the needs of its residents through locally relevant social services such as
  - support programs that allow communities to achieve or maintain economic self-sufficiency to prevent, reduce or eliminate dependency on social services
  - a variety of initiatives for children and adults including daycare, protective services, case management, health related services, transportation, foster care, substance abuse, housing independent/transitional living, and employment services



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# Concerns with Block Grants

- In the Committee's work over the past 10 years, stakeholders in multiple states have noted that allocated block grant funding may not always go to the areas of greatest need and often is concentrated in urban and suburban areas
- Changes in Block Grants require legislation in Congress

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# The Committee's Conclusions

- State governments play a critical role in mitigating the negative, economic and social consequences of substance abuse on individuals, families, and communities
- A key mission at the state level is to support the network of providers who deliver services to individuals with a substance use disorder (SUD)
- There is a great need to develop rural specific treatment models that meet the needs of individuals and families dealing with a SUD
- The Committee believes policy makers must consider, plan, and fund adequate support services within communities for those receiving treatment to avoid having to refer patients out, placing them far away from family

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# Recommendations to the Secretary

1. The Committee recommends the Secretary develop a 2018 budget request to expand Medication Assisted Treatment to include Rural Health Clinics, Community Mental Health Centers and Critical Access Hospitals
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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:

The Federal Office of Rural Health Policy
Rockville, Maryland
301-443-0835
shirsch@hrsa.gov

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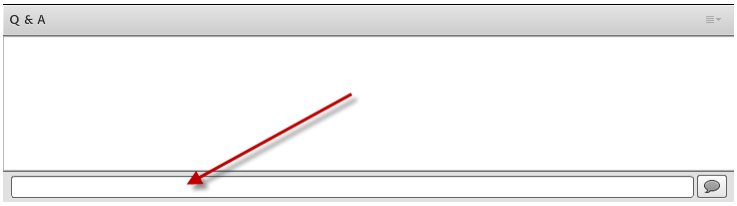

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