

Kristine Sande: Good afternoon everyone, I'm Kristine Sande, program director of the Rural Health Information Hub. I'd like to welcome you to today's webinar the National Advisory Committee on Rural Health and Human Services Policy Briefs on Emergency Care Models and Rural Opioid Misuse Implications.

Our first speaker today will be Ronnie Musgrove, who has served as the chair of the National Advisory Committee 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 two 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 Kelley Evans about alternative models to preserving access to emergency care. Ms. Evans is the CEO of the Beartooth Billings Clinic. Her responsibilities include the overall administrative management and operation of the clinic. Beartooth Billings Clinic is a private, not for profit 501C3 located in Red Lodge Montana. It is an integrated provider based clinic with a ten bed critical access hospital.

Our final speaker will be Paul Moore, who will discuss the policy brief Families in Crisis, The Human Services Implication of Rural Opioid Misuse. Paul currently serves in Washington DC as senior health policy advisor to the Federal Office of Rural Health Policy. Through this position he brings experience related to rural healthcare of more than 30 years in community and hospital pharmacy. His career reaches beyond just pharmacy as he has served as the CEO of a county healthcare authority consisting of one of the nation's earliest critical access hospitals, the county EMS, a physician clinic, and a home health agency. He also serves as the executive secretary for The National Advisory Committee for Rural Health and Human Services.

With that I will turn it over to Governor Musgrove.

Gov. Musgrove: Thank you Kristine. I want to say welcome to everybody to the webinar of The National Advisory Committee on Rural Health and Human Services. There are 20 committee members drawn from a variety of backgrounds, all with some expertise in rural health and human services. The charge of the committee is to serve as an independent advisory body to The Department of Health and Human Services on issues related to how the department and its programs serve rural communities.

The committee was formed in the late 1980s after a large number of rural hospitals closed. The committee is not just supposed to wait for problems to occur, and only then offer the secretary advice on how to solve a problem. The committee can also alert the secretary to issues that are on the horizon and to try to head off a crisis before it occurs.

The committee meets twice a year to examine issues in depth and to hear directly from rural providers in healthcare and human services. Our last three meetings have been in New Mexico, South Carolina, and Minnesota. The committee used the meeting in Beaufort, South Carolina to examine the issues of what kind of services should remain available in rural communities that have seen hospitals close or which cannot support a hospital. The committee also heard about the problem of prescription painkiller use and opioids in rural South Carolina and elsewhere.

After every meeting the committee prepares a report to the secretary. When I was appointed chair of the committee I wanted to be able to quickly respond to issues that may have impacted implementation of the ACA in rural areas so that we have chosen to write quality briefs after every meeting and send those with recommendations on policy or regulatory matters under the secretary's purview. These briefs are also available to the public on the committee's website.

Today we'll hear from Kelley Evans, a member of the committee, who runs the Beartooth Billings Clinic in Red Lodge, Montana. She will speak about the committee's policy brief on alternative models. Kelley.

Kelley Evans:

Thank you, Governor, for your introduction and your ongoing leadership. Good morning to all and welcome. The committee met in South Carolina, which is a state that has seen four rural hospitals close in the last several years. In response to the closures South Carolina has examined alternatives that will allow some of the services connected to a rural hospital to remain in place even after a hospital is closed. We heard from representatives both nationally and the state hospital associations, along with CEOs from hospitals there. This is the first page of our brief, policy brief, and that is available on this website and at the end of this presentation.

The committee's concern has always been with the availability of medical care in rural areas. Since the committee's first issued recommendations, the landscape and financing of healthcare has changed a great deal. New hospital designations have been developed that did stabilize rural health hospital's financial picture for a period of time. However, we've seen a recent increased wave of critical access rural hospitals closing over the last six years. As you can see, one recent estimate found 180 rural hospitals at risk of closure.

Rural hospital closures have been widely featured in the media but what does a rural hospital closure mean to a community? This community is made up of a broad spectrum of professional backgrounds and perspectives. We strive to understand access issues not only on health but socioeconomic and cultural impacts as well. A recent article in The Journal of Health Affairs found that hospital closure had no measurable impact on local hospitalization rates or mortality rates. However, it mostly examined urban hospital closures.

Studies of rural hospital closures in the '80s and '90s showed declines in the access to care and increased distance rural residents had to drive to access services, including emergency care. Certainly a hospital closure can have an impact on the economy of a small town, on employment, and on the availability of many health services and providers which rely on the hospital, even if they aren't located in the hospital. As you can see from the slide, 47 recent hospital closures affected 1.5 million people. There's disparities amongst non-whites, blacks, whites, in geographic areas along with geographic distance.

The problem is more complex than perhaps when first mitigated by CMS in the establishment of critical access hospitals and the mileage. Again, when we looked at data and news reports from areas with closed hospitals blame greater travel time for death that occurred. We have not been able to find data reflected in the broader data to support that.

What did we look at in the recent alternative models that have developed? The Frontier Extended Stay Clinic, or FESC, I won't read these exact points, this was a model that could provide emergency access and has been tested in frontier areas. It's called The Frontier Extended Stay Clinic. These were located mostly in Alaska. I'd like to stress here that in these alternative models, and at the beginning of this presentation, this was access to emergency services and there was quite a bit of discussion about how would we stabilize emergency access and the other service lines that come into play in order to make that occur. While the Frontier Extended Stay Clinic was successful at reducing transfer costs, each one required a million dollar subsidy, approximate, along with expenditures on new equipment to prepare the clinic to handle cases that would previously been transferred to a hospital.

Another model is called a Rural Freestanding Emergency Department. The Georgia Department of Community Health adopted rules in 2014 that allowed rural hospitals to reduce the scope of service provided and operate as a rural freestanding emergency department. This provides an alternative to closing down all operations for rural hospitals. To date no rural hospital in Georgia has been designated as a freestanding emergency department. Upon closer examination it was clear that some obstacles in moving to this model are that emergency departments are expensive to operate and without a hospital to admit patients to the cost would outweigh the payment that the emergency department could generate. Particularly in a low population density area.

A recent report from the University of North Carolina's Rural Health Research Center examined the finances of rural freestanding emergency departments, or RFEDs, and found that rural freestanding emergency departments currently do not receive any rural specific designation under federal regulations. They must be owned by a hospital to be eligible for reimbursement by CMS. The annual total cost to operate a low, medium, and high volume RFED is estimated to be between 5.5, 8.8, and 12.5 million. Unsurprisingly, the average visit cost per patient declines with greater volume, or 600, 370, 347 for low, medium, and high

volume rural freestanding emergency departments. Low patient volumes, high rates of uninsured patients, minimum staffing requirements, provider shortages, federal reimbursement policies, and other real factors must be considered in assessing the financial viability of an RFED.

Medicare Payment Advisory Commission, or MedPAC, had listed a couple options for rural freestanding emergency departments. The rationale behind this approach is to keep standby emergency capacity, which Medicare would support through a fixed supplemental plan. The second option is for communities too small to support a 24 hour ED. This would create a primary care clinic that would be open eight to twelve hours a day with an adjacent ambulance service operating 24/7, creating a clinic by day and stabilization and transfer model by night.

Other options that the committee discussed and recent proposals have suggested other models for hospitals with 50 or fewer beds would allow receiving enhancement reimbursements of 110% of reasonable cost for Medicare services. You can see going through the slide other policy proposals to alter hospital services and provide increased payments. The committee believes that certain services must be included under any option that is chosen and stressed the flexibility for these communities to make these decisions.

Essential services might be described as emergency services, extended hours for EDs, diagnostics, radiology lab, possibly CAT scanning, full service primary care, including serious attention to patient centered medical home models, giving a nod to value based purchasing in rural areas, ambulance transport support, tele-health, specialist behavioral health, as well as tele-ED for emergency rooms that may be supported by mid-level capacity. Other services that could be optional, again, depending on the community, the need, and the ability to fund, would be dental, behavioral health, home health, hospice, and post-acute. Many of the rural facilities are fairly integrated and providing these services is found to be beneficial for their communities. We did stress, again, the flexibility of community choice.

Recommendations to the secretary. The committee included a strong recommendation to the secretary that any option must include a supplemental base payment separate from fee for service payments for low emergency department visits. Low volume. There is a need to formally build into payment the reality of low volume and high fixed costs. The secretary must insure that any model has the flexibility to offer those services that meet the community's unique needs.

During our discussions on these models there was skepticism by the members the CMF would get the amount of the base payment correct. We didn't necessarily think the difference between current cost based reimbursement and the various PPS payments would be enough to support the new model. As we discussed the notion of low volume and high fixed cost and the need to think

differently about how to pay for these models we kept the example of The Frontier Extended Stay Clinic model in mind. It didn't take a high fixed cost into account at all and was not sustainable.

As you can see in this second recommendation, I'll give you a minute to look at that, the committee was concerned that using a mileage threshold seems to lock in a vision of an upper United States, Midwest, or quasi-frontier provider, when most of the hospital closures that are occurring are in the southeast where mileage is often not as big a factor. The committee had some suggestions that we made to the secretary beyond the two recommendations. Any new model must be aligned with current delivery system reform, which is shifting from quantity of service to providing value based purchasing and patient centered medical home model. These new models can provide quality care in rural settings and that is what the committee believes is the most important.

Thank you.

Paul Moore:

Thank you, Kelley. I appreciate you sharing the findings and the concerns and the conclusions, and then also the recommendations of the committee from our meeting back there in April with the public today. I appreciate you doing that. Governor, I appreciate your leadership in allowing and actually suggesting that we make these briefs public and draw attention, the public's attention, to the briefs and your leadership in that.

I had the privilege of visiting with you about the other topic listed during our April meeting in Beaufort South Carolina. That being the topic of the human service implications of the rural opioid misuse and the rural opioid crisis that we are experiencing. Over the past few years, regardless of where the committee met or the topic being addressed by the committee, whether rural mortality and life expectancy or intimate partner violence or child poverty, the conversation has led us back to substance abuse each time. Particularly prescription painkillers and heroin.

The committee felt the need to take on the human service implications of rural opioid misuse, particularly due to its effect on the family. No pun intended here but the statistics are truly sobering. 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 the years 2013 and 2014. Men in rural areas are using more opioids than women in rural areas but more women are dying from opioid overdose.

While this crisis has been building for a long time, it seems to have only arrived in the public consciousness over the last two years. One of the big jolts that garnered national attention, shining a light on the issue recently, was the story of a small town in Indiana that saw an HIV epidemic due to intravenous drug use. The committee's concerns reflect other embedded rural challenges, such as rural

poverty, lack of economic opportunity, lack of access to behavioral and substance abuse treatment, and the wider effects of substance abuse on rural families and communities.

All the barriers mentioned contribute to great difficulty in getting substance abuse treatment for rural residents, and to maintaining a family structure in the face of the limited human services access in rural areas. Much of the federal services funding is done through federal block grants to the states. Now block grants have advantages. They allow states to target funding to areas of greatest need, but they can also allow a great deal of variation from state to state. Large block grants are administered by the Substance Abuse and Mental Health Services Administration and the Administration for Children and Families.

While the Substance Abuse Prevention and Treatment block grant distributes 1.8 billion and is producing positive outcomes the concern is that funding has not kept up with healthcare inflation and has seen a 26% decrease in its real value. Another major source of federal funding administered to the states is the Community Mental Health Services block grant. This block grant has a budget of \$533 million. It provides comprehensive community based mental health services to adults with mental illnesses and to children with serious emotional disturbances.

Another resource, the Administration for Children and Families block grant, is worth about \$1.7 billion a year. It funds a variety of initiatives including substance abuse treatment and counseling along with, as you see there, other locally relevant social services. There is a real specific concern with block grants, in that block grant funding may not always go to the areas of greatest need as they are often concentrated in urban and suburban areas. This is a problem the committee has seen repeatedly over the years but not just with block grants. There's a propensity for funding to go to areas with a larger population, directed by the agencies because they're seeking the most bang for their buck, even though this can sometimes exclude rural areas with severe problems and very few resources to address those problems.

State governments play a critical role, not just because they administer the block grants. States also face the economic and social consequences created by substance abuse on individuals and families and even communities, increasing stress on programs such as education, housing, and other supports across the spectrum. The committee's recommendations include building on the rural health infrastructure that already exists, initiatives such as expanding medication assisted therapy to rural health clinics as a provider, to community mental health centers and to critical access hospitals.

The committee supports a rural demonstration project extending community mental health worker programs to shortage areas in recognition of the limited capacity to address this crisis of opioid misuse in these isolated communities. The disparity of resources providing substance abuse treatment in rural areas

calls for a change in how rural areas are treated, recognizing their unique challenges. States could be required to designate block grant funding, or at least some of the block grant funding, to help rural areas. Rural communities would be better served if all the research on opioid abuse, overdose, and treatment included a rural urban data cut.

You see, it's until we get that kind of data we don't have what we could use to head off future possible crises before they reach the level we see today in opioid misuse. Quite simply, the committee believes more attention and more resources are needed to face the crisis in rural areas and appreciates this opportunity to share this briefing, not only with Secretary Burwell but also with you, the public, in an effort to inform and encourage, not only HHS but the states and the communities involved, to implement solutions to prevent and treat opioid misuse and to mitigate, as much as we can, the effect on individuals, families, and communities.

With that information we'll just stop now and hopefully we can take any questions you may have.

Kristine Sande: All right, if anybody has questions you can enter those in the Q&A section there. All right, our first question is for you, Paul. The speaker mentioned that men in rural areas are using more opioids than women but women are dying more from opioid overdose. Do you know why that is?

Paul Moore: That is a mystery. There have been a number of ideas that have been put forth. Number one, the overall mortality rates, as we saw in a previous study with the National Advisory Committee, is disparate toward higher mortality rates in women in rural areas. Or, the rate is not improving as much as it is with men. There's an overall thing happening there that is adverse to women in rural areas. There's been a lot of physiological things raised, issues raised, about the increased vulnerability, the stresses that are placed on women, and then particularly in rural areas. It's a mystery to me but I know that there are a lot of folks that are looking at both clinical data and social data to see why that may be the case.

Kristine Sande: All right, thanks Paul. It doesn't look like we have any other questions at this time. We'll give it just a minute and see if anyone else has questions for you all. We do have a question. Are there any successful rural models you could present? I'm assuming that's dealing with the opioid issue but I don't know that for sure.

Paul Moore: I will tell you that as we were able to visit in Beaufort, South Carolina we did see some models. The committee, when we go out on these site visits, or when we visited different places in different states, we try to always include some site visits to providers or to social services. There were a couple that I just recollect. I don't even remember exactly where the clinic was but there were a couple of promising and actually impressive models where folks were dealing with this

issue in their own community. Through the mental health services that were available, through the community efforts that were going on.

Then you see the faith community get involved and you see a number of situations. Yes, there are some bright spots out there. The problem is the bright spots are usually cropping up in the darkest areas but there are promising practices out there. If the questioner wants more specific information, drop me an email and I will get you the names of the places that you could check on.

Kristine Sande: Okay. On that topic as well I would just mention that on the RHHub we have a Rural Health Models and Innovations section. If you look under the topic of substance abuse there are several successful models on this topic. We've also featured the opioid abuse in our Rural Monitor. Those stories have had some successful models as well.

Paul Moore: Kristine, it just became obvious to me also, let me invite the viewers to access our website with the National Advisory Committee and access the actual briefs because there are drop down text boxes and things like that that will highlight those bright spots.

Kristine Sande: All right. Next question. If the committee is requesting the expansion of CHWs to combat this issue, what is being done to develop a recommendation on a national scope of practice for community health workers?

Paul Moore: There's a reluctance, I've found, as scope of practice is usually a state matter. Again, this is just a personal observation that, since I've been in federal government, to notice that there's a tendency to be reluctant to deal with scope of practice issues on the federal level because they are the purview of the state. However, we are more than happy to highlight places where it's working well, or where there's the ability for community mental health workers to be engaged in a greater capacity and to show where those good practices are taking place.

Kristine Sande: All right.

Paul Moore: That's a poor answer, just to say it's a state issue, but, in large degree, it really is a state issue.

Kristine Sande: Thanks Paul. Next question. I'm interested in knowing how a community coalition in northwest Colorado would approach the USDA to get access to empty properties to convert into safe and sober transitional living facilities.

Paul Moore: That sounds like the viewer read the same article in The Washington Post that I did this week, where it highlighted that that is happening. I encourage folks to read that article if they can access it. It highlighted USDA Secretary Tom Vilsack and his personal passion on this issue of addressing this and other disparities in rural America. I, along with you, will go and learn more about that. The

information is out there. I would access the USDA website and I promise to go look and learn more with you.

Kristine Sande: Paul, I wonder if contacting the state USDA Rural Development Office might be a first step for folks.

Paul Moore: I would say that they will know soon. If it hasn't made it down to their level yet, it will be soon. There's nothing like a good inquiry to get the ball rolling.

Kristine Sande: Right. I know as well sometimes in the federal register they list federal properties that are suitable for helping the homeless so that might be another place to watch for some of those properties that might be available.

Paul Moore: Mm-hmm (affirmative).

Kristine Sande: Another listener wrote in suggesting using the state rural development offices through USDA or the National Office for Housing.

Paul Moore: Absolutely.

Kristine Sande: All right. Any other questions at this time? All right, I guess, seeing no other questions, that brings us to the close of the webinar today. On behalf of the Rural Health Information Hub I'd like to thank the National Advisory Committee for all the work that they've done on behalf of rural communities. Thanks especially to our speakers, who've shared great insights with us today. Thanks to all of our participants for joining us. We will email a survey to you and I hope that you'll all take a minute to fill that out. That helps us as we host future webinars. Once again, the slides used in today's webinar are available at www.ruralhealthinfo.org/webinars.

In addition, a recording and a transcript of today's webinar will be made available on the RHHub website. Those will also be sent to you by email in the near future so you can listen to us again or share this presentation with your colleagues. Thanks so much and have a great day.