

Supportive Services and Caregiving for Older Rural Adults from the National Advisory Committee on Rural Health and Human Services -12/17/19

Kristine Sande: Good afternoon everyone. I'm Kristine Sande, the Program Director of the Rural Health Information Hub. I'd like to welcome you to today's webinar on Supportive Services and Care Giving for our Rural Older Adults. We are happy to be collaborating with the National Advisory Committee on Rural Health and Human Services on today's webinar. And I will quickly run through some housekeeping items before we begin.

We hope to have time for your questions at the end of the webinar. If you do have questions for our presenters, please submit those at the end of the webinar using the Q&A section that will appear on the lower right hand corner of the screen following the presentations. We've provided a PDF copy of the presentation on the RHHub website. That's accessible through the URL on your screen and we also have put the link in the chat function.

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Now to tell us a bit more about the National Advisory Committee on Rural Health and Human Services and give us some background on today's speaker. I would like to introduce Paul Moore. Paul Moore currently serves as the Executive Secretary for the National Advisory Committee on Rural Health and Human Services. He's also a Senior Health Policy Advisor at the Federal Office of Rural Health Policy. Paul brings a lifetime of experience related to rural health care from both his family heritage and more than 30 years in community and hospital pharmacy. His experience reaches beyond pharmacy, as he was also the CEO of the County Health Care Authority consisting of one of the nation's earliest critical access hospitals, the County EMS, a physician clinic and a home health agency. Paul is also a past president of the National Rural Health Association. With that I'll turn it over to Paul.

Paul Moore: Thank you Kristine. I'd like to take this opportunity to welcome our audience again to today's webinar on Supportive Services and Caregiving for Older Rural Adults. By the National Advisory Committee on Rural Health and Human Services. In this webinar we will provide an overview of the committee, highlight rural urban disparities across aging and health. Discuss rural community infrastructure and hear about the committee site visit and policy recommendations. But first I'd like to provide some brief background on the committee, especially for those joining today's webinar who may not know who we are.

The Committee chartered back in 1987, is an independent citizens panel whose charge is to advise the Secretary of the U.S. Department of Health and Human Services on healthcare challenges that affect rural Americans. The committee consists of 21 members, including the chair. The experiences and expertise they bring reflects a wide variety of rural issues in public health, medicine, nursing, human service delivery, hospital administration, childcare, research, finance, law and business.

Since 1987, the Committee has continued its work to address and examined pertinent issues that affect the health and wellbeing of rural Americans. To also hear directly from rural stakeholders. Then following its meetings that committee produces policy briefs for the secretary of Health and Human Services with recommendations on policy or regulatory matters under the secretary's purview. For its 85th meeting in April, 2019, the Committee met in Sacramento, California and focused on supportive services and caregiving for older adults in rural areas as one of the two topics.

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During the meeting, the Committee examined the availability, accessibility and acceptability of supportive services for older adults in rural communities, in addition to some of the federal programs currently being leveraged to address this issue. On the first day of the two and a half day meeting, the entire committee heard firsthand from organizations and experts on the subject. Just as you will hear from during this webinar.

On the second day, the subcommittee tasked with this issue conducted a site visit at Sierra Nevada Memorial Hospital located in Grass Valley and Nevada, California. Now we have hyperlink to the brief that you will click on the cover. I'll get that for you there. You'll click on this cover, it will take you to the policy brief or you can also find it along with others at the link provided at the bottom of the slide.

You might say why supportive services and caregiving? Serving the rural elderly as a topic was the first human services topic taken on after the Secretary expanded the committee's charter to include human services way back in 2004. Life expectancy in the United States has risen since the 2004 report was sent to the Secretary bringing with it new challenges in providing both short and long-term care for an aging nation.

The effects of these challenges are especially pronounced in rural America where the proportion of older adults, those ages 65 years and older, has been steadily increasing and outpacing to proportion living in urban areas. The aging of rural America has been well documented, including the fact that rural areas have higher rates of poverty, multiple chronic conditions and age adjusted mortality for all causes. Understanding of the current supportive service and caregiving policies affecting the care of older adults, especially rural older adults, will be helpful for those a friend for the Federal Office of Rural Health policy, within Health and Human Services and other stakeholders to address issues of healthy aging. To transition us into learning more about this disease, I want to briefly introduce the experts presenting on today's webinar.

First, we will hear from Marcus Escobedo. He is Vice President of Communications and the Senior Program Officer at the John A. Hartford Foundation. Where he develops and implements the foundation's communication strategy. Joining the foundation in 2006 as a member of the program team, he maintains a grants portfolio of initiatives to improve hospital care of older adults, including in the emergency department and surgical settings. He served as a member of the Community Advisory Board of the geriatric emergency department innovations through workforce, informatics and structural enhancements, a project at Mount Sinai Medical Center.

He has previously served on the board of One Stop Senior Services in the upper West side of Manhattan. As well as the Regional Health Equity Council, as part of the Office of Minority Health, national partnership for action to end health disparities, that's in region two. Following Marcus will be Dr. Octavio Martinez, Jr, a former National Advisory Committee Member. He is fifth Executive Director to lead the Hogg Foundation for mental health since its creation in 1940, some 79 and 80 years ago.

The foundations' grants and programs support mental health services, research, policy analysis and public education projects in Texas. The Hogg Foundation is part of the division of diversity and community engagement at the University of Texas at Austin. Dr. Martinez holds an appointment of Associates Vice President within the division. He's also an affiliate faculty member with an appointment in the University School of Social Work. He holds an adjunct

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professor appointment at the University of Texas Health Sciences Center at San Antonio School of Medicine's, Department of Psychiatry. He's formerly served on the Institute of Medicine's Committee on the governance and financing of graduate medical education and on the committee on the mental health workforce for geriatric populations. With those two introductions, let me turn it over to Marcus. Marcus, thank you for being here today.

Marcus Escobedo:

Thank you Paul. It's a real pleasure to be on this webinar and I applaud the National Advisory Committee on Rural Health and Human Services for thinking about and trying to address issues related to rural aging. I grew up in a very small town outside of Corpus Christi, Texas. My dad's 81 my mom is 76. The issues related to making sure they get quality healthcare and supportive services in their community is both personal and a professional interest to me. So thank you.

It's great to be here. I'll dive in and again, very excited to be here with you all. Let me tell you first just a little bit about the John A. Hartford Foundation. We were established in 1929 by the family owners of the A&P grocery store chain. For more than three decades, we've had one singular focus which is on improving care for older adults. That remains our mission today. We have three priority areas in which we try to meet that mission. We work to create Age-Friendly Health Systems.

That's both a broad concept and a specific initiative which I'll dive into in more detail today. We support family caregivers of older adults and we work to improve serious illness and end of life care. These are all interlocking areas with lots of overlap. We give out about \$20 million a year to excellent nonprofit organizations and academic institutions that are working in these three areas. Why do we focus on aging and older adults? Part of that is demography. If you can see here on the left hand side, we've a radical changing both in the United States and around the world in terms of our makeup of people by age group. As you can see here in 1960, older adults were just a sliver of the population in this country. As we proceed to 2060 you can see in particular how the 75 and up the 85 plus group, it's going to expand quite dramatically in a very short period of time.

That means that we... all of us in society need to think about how we better meet the needs of that aging population. On the right you see a response that we've seen happen... again, both globally and here in the United States. That has worked to create what we call Age-Friendly Social Movement or an age friendly ecosystem. That includes that we need age-friendly policies at the center of all of this, we need our regulations, our laws, everything that we're doing in society to really have a focus on meeting the needs of the growing population of older adults.

It means we need age-friendly cities and communities and we give good credit to the WHO and to AARP for establishing a movement to have cities and communities become age-friendly. Even States now are becoming age-friendly. That means redesigning the environment, having services in place and just rethinking the way that we have our communities, cities and States designed to better meet the needs of older adults.

It also means having public health that is age-friendly and I'll say a little bit more about this at the end but it's another important area for this audience, I think to be aware of. That there is a movement in public health to think more about older adults in the context of what that field can do. Then what I'll dive into today is the role of the health system and how it can be more age-friendly for all of us as we get older. I'll dive into that specific initiative. Age-Friendly Health

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Systems now. I'm so glad to say that the framework that I'll be talking about that is the foundation for Age-Friendly Health Systems was embedded into the policy report from the Advisory Committee that you'll hear more about today. The concepts and the framework that we'll be discussing really do apply broadly not only to healthcare delivery but to the supportive services delivered by community based organizations, by public health.

There's really here something for everyone. But the specific initiative Age-Friendly Health Systems is led by the John A. Hartford Foundation and the Institute for Healthcare Improvement, a terrific national quality improvement organization based in Boston. We work in partnership with the American Hospital Association and the Catholic Health Association of the United States. But what I will say is that this has really grown beyond an initiative. We really have a movement and you'll see in a moment many more partners and stakeholders involved and we hope you will join us.

But why Age-Friendly Health Systems? I've talked a bit about demography driving a lot of our reason for why the healthcare system needs to better meet the needs of older people. With aging comes complexity and our healthcare system right now doesn't do a great job in addressing that complexity. You think about layering on issues in rural settings and it becomes even more important. A third reason is really disproportionate harm that we see in our healthcare settings and we're doing everything we can to reduce that harm. Finally, we know we have a know-do gap. We have many evidence-based geriatric models of care, yet they only reach a very small portion of the older adults in the family members who could benefit.

We looked at that challenge of why we weren't having these evidence-based models more available to older adults in need. One of the key drivers behind not having that dissemination is really that healthcare is still complex and there's so many things that healthcare providers have to do. We challenged a group of experts in Geriatric Care along with the Institute for Healthcare Improvement, our foundation staff and health systems themselves to think about the common elements of the evidence-based models that we've seen out in the field that really do work. They identified 90 discreet core features in these evidence-based models. We challenged them to find redundancies and similar concepts and to streamline those models and they came out with 13 core features that were really essential. We challenged this group even further. We said in healthcare 13 is even too much to do.

Where we came out with were the vital few and the four M's of age friendly care, which I will go through now. If any... if you take anything from this presentation, here's what I hope you will take away. It's the four M's framework that this amazing group of partners have developed and are... it's now rolling out across the country. The four M's are what matters, medication, mentation and mobility. What matters, when we say that in healthcare... and again this is about supportive services as well about public health, about everything we're dealing with older adults. We want to know and align care with each older adults, specific health outcome goals and their care preferences. This does of course include end of life care but we're thinking beyond end of life care. This is not just about advanced care planning but really about understanding the goals and preferences of every older adult in every care setting and having all care aligned towards what matters.

On medication, we always say if medication is necessary and that if is very important. We know that too many older adults are on too many medications, which cause a number of harms and

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potential problems. But if a medication is necessary, we ask in our healthcare systems that are age-friendly to use age friendly medication that does not interfere with what matters, mobility or mentation across the settings of care. Mentation is about preventing, identifying, treating and managing dementia, depression and delirium across settings of care. In primary care and outpatient setting, we focus primarily on dementia, depression. In the hospital we focus on delirium, which is an acute state of confusion that is incredibly dangerous and harmful to older adults and is also very costly to the system. Finally, mobility is moving beyond just falls prevention to ensuring that older adults move safely every day in order to maintain their function and do what matters.

Those are the four M's of Age-Friendly Care. I hope this will stay with you. Why do we have these four M's? One to build on a strong evidence-based? As I mentioned, pulling from the literature, they do address older adults core health issues. They are about simplifying and reducing burden in health care around implementation and measurement. Very importantly, these four M's are reinforcing of one another. What's novel and unique about this approach and this framework is that we're asking every healthcare setting every time with every older adult to think about all four M's together. We're finding that most healthcare systems are actually addressing the four M's with evidence-based practices. But this is a way to organize that thinking, organizing the work so that we get the best outcomes possible for older adults. Because we know these four M's impact key quality and safety outcomes for people who are aging.

We have a bold aim as part of this initiative mean we're trying to build a social movement so that all care with older adults is age-friendly. That means it's guided by this essential set of evidence-based practices, these four M's that it causes no harms. That it's consistent with what matters to older adults and their families. We have bold aims in terms of how many healthcare practices and hospitals we want to reach. We are well on our way to meeting our goal of a thousand hospitals and practices being age-friendly by the end of next year.

Then by 2023, we hope to be in 2,500 hospitals and practices and I should say we will be there because this movement is taking off. I want to give credit to the healthcare systems who are pioneers in helping us develop the four M's model. Anne Arundel Medical Center in Maryland, Ascension, Kaiser Permanente, Providence St. Joseph Health and Trinity Health, were amazing partners at the outset, helping us crystallize these four M's and identifying the evidence-based practices that are feasible, that are implementable, that are now being spread across our Age-Friendly Health System sites.

There are many gateways into Age-Friendly Care and support. I'm primarily focusing today on institution based care in hospitals and in long-term care settings as well. But ambulatory primary care is another important area that I'll reference, that's including retail pharmacy. We have an exciting partnership with CVS MinuteClinic and Case Western Reserve Nursing that we'll be rolling out Age-Friendly Care through that network. Then again, I want to emphasize the role of community-based organizations and public health and thinking about the four M's.

But you may be wondering how does this get operationalized? What happens on the ground? Here is an example that I won't go into too much detail about. But the key elements are taking those four M's which we know are evidence-based, which we know have great impact. It's about two things, assessing those four M's and then acting on them. Here you can see some of the

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activities that a hospital or primary care practice would take in asking what matters, documenting it or reviewing medications, screening for delirium immobility and then very importantly acting on those screens to actually put in place evidence-based practices that can make a difference in the lives of older adults based on those four M's.

Same thing in primary care, you can see this very feasible, implementable way to address the four M's in care. Even further to the right if we extended this out would be a list of a menu almost of evidenced-based practices that you can easily implement in your healthcare setting to get to those four M's. Measurement is a huge deal in healthcare. I will not go into details about this but just to say that in any healthcare system that's involved, we are not trying to add to the measurement burden but rather using existing measures for both outcomes and processes. Mapping those to the four M's in Age-Friendly Care to make this as easy to implement as possible. What's a vehicle for health systems either hospitals, clinics, long-term care settings wanting to become more involved? One mechanism is through action communities. These are seven months learning opportunities that are freely available to healthcare teams around the country and we are encouraging rural healthcare teams very much to be involved.

The opportunity includes monthly interactive webinars where there's education around the four M's and those evidence-based practices. There's opportunity to share progress and learnings with your peers in other healthcare settings. There's in-person meetings as well as ways to submit data and get feedback on the approach to care being used at different healthcare settings. There's ongoing coaching. It's a great opportunity that we're getting very good feedback from teams who are joining this learning collaborative.

There will be more coming out over the next year and I'll at the end show you how you can stay involved and learn about more action communities. The movement's growing. We're very excited. I mentioned we're trying to get to a thousand hospitals and healthcare practices by the end of next year and already we have 446 teams in 49 States engaged with us. Wyoming is the one place that we did not have a team but we soon will.

I'm happy to announce that we'll have a presence in Wyoming over this next year. Here are the levels of designation for Age-Friendly Health Systems initiative. We have 247 teams and sites across the country that have described how they are meeting the four M's and that allows them to designate themselves as a participant even further. We have 117 that have gone the extra step of providing data around the numbers of older adults and how they're being reached with four M care.

I mentioned that this movement is growing. We have many stakeholders engaged with us and this just gives you a snapshot of some of the many partners who have joined in the movement and we encourage each of you in your respective roles to join us as well. With HRSA, the Health Resources and Services Administration, we've been terrific partners with us and what's called their Geriatrics Workforce Enhancement Program, which has many rural sites around the country that are engaging directly in the Age-Friendly Health Systems work.

They are training primary care clinicians in geriatric care using the four M's doing outreach and training and it is exciting partnership that I hope you all can learn more about. Basically Age-Friendly Health System is really about beginning and ending at the kitchen table. I want to go back and reemphasize. I did not talk much about community-based organizations of supportive

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services, public health, the role of other kinds of stakeholders in delivering Age-Friendly Care but it's absolutely a component to the initiative and becoming more and more important. But this is a worldwide health and social movement that again, we hope you all will join and here's how you can do that. Visit ihi.org/age-friendly. You can learn more about these action communities. I know for some of you, you're not in a healthcare setting but please share this information with your local healthcare organizations and invite them to join.

We are also now having organizations run their own action communities in New York State. We will actually have a hospital association running an action community and if your state or region is interested, we can help you learn how to facilitate your own action community for healthcare teams wanting to become age-friendly. We have free resources that are available. Again on this site, you can download guides to using the four M's, guides for the return on investment.

Then finally, what I would encourage each of you to do is to find out for our friends at age-friendly quarterly update calls. These are great ways to stay engaged in the initiative, learn more about what's happening. We have many different kinds of stakeholders who join those calls. I'm going to end slightly veering off from Age-Friendly Health Systems but just noting a few other areas that the foundation is focused on rural aging as was presented by Paul early on, this incredibly important area where we will be investing more resources in over the next several years.

I've mentioned our Age-Friendly Health Systems that we've worked on expanding other models like PACE, Programs of All-inclusive Care of the Elderly, which helps keep older adults out of nursing homes. We've worked to expand depression care models in rural communities. I mentioned the Geriatric Workforce Enhancement Program, which 30 of those sites around the country are rural. I encourage you to check that out and learn more about what's happening in your community.

We have other initiatives as well. Finally I do want to end on the Health Affairs special theme issue that just came out in December, 2019, which we at the John A. Hartford Foundation helped to sponsor, just an incredible resource of research and policy recommendations around rural issues broadly and about rural aging as well. I encourage you to take a look at that theme issue and learn as much as you can. I know we will here at the foundation and be continuing to focus on the needs of rural older adults. With that, let me thank you. This is our vision across all of our priority areas that we want accessible, affordable healthcare for all older adults, including those in rural communities that deliver high quality, high value services that matter most. I really appreciate being here with you all today and let me turn it right over to Octavio Martinez, who will now take it from here. Thanks very much.

Octavio Martinez: Great presentation, Marcus. To everyone on this webinar, this is Dr. Martinez. Welcome and thank you for tuning in today. I'm delighted to present the committee recommendations as a former member of the committee myself. Before we go over the recommendations, I would like to talk more about the site visit that we took on the second day of the National Advisory Meeting. Grass Valley is a rural community in Nevada County, California, located in Gold Country in the Sierra Nevada mountain range. Grass Valley has a population of approximately 13,000 residents, according to the United States, census data. It's designated as a medically underserved population in primary care health professional shortage area and a high needs geographic mental health, health professional shortage area.

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The committee site visit to Grass Valley was hosted by Sierra Nevada Memorial Hospital, which has operated in Nevada County since 1958. Services provided by the hospital range from family medicine to cancer care and emergency services. But they also provide outreach programs on Alzheimer's disease and caregivers support. The California area Agency on Aging planning and services area four as well as the FREED Center for Independent Living. Were also instrumental in recruiting service providers and consumers to attend the site visit. Including Gold Country Community Services, Helping Hands Adult Day Program, Chapa De Indian Health, Hospitality House, Hospice of the Foothills, Elder-Care Providers, Coalition with Nevada County, Falls Prevention Coalition with Nevada County and Partners in Care. Stakeholders from the California Area Agency On Aging, Gold Country Community Services, Chapa De Indian Health partners in care and Hospice of the Foothills, all expressed transportation as a significant barrier for older adults who wish to receive their services.

A lack of transportation was also noted as a limitation on seniors' food and nutritional choices. Social isolation for some older adults to walk significant distances to receive certain services. Representatives from Hospitality House and the Helping Hands Adult Day Program said the community used to have a centralized Senior Center but it closed years ago and inhibited the ability to provide services from a low accessed and centralized location.

They noted the uptick in people who are homeless as a growing issue in the community, as over 30% of the homeless population are 55 years of age or older. Attendees representing Chapa De and Hospice of the Foothills, none of that primary care, dental, behavioral health and nutrition assistance were some of the most utilized care offerings in the area. But other important services, for example, case management and patient navigation were provided without reimbursement.

Individuals who worked for the FREED Center for Independent Living, discussed the effects of recent wildfires in the region as particularly detrimental to older adults and those living with disabilities. Those who were affected that lost their homes, had no other options other than going to an assisted living facility. The Elder-Care Providers and Falls Prevention Coalitions of Nevada County, mentioned that the area has still not recovered from the economic effects of the 2008 recession, particularly a resource center dedicated to providing training and respite care services for caregivers was forced to close. They noted stigma and accessing services as a great barrier to care for their older adults. Person-centered planning programs for those aging in their area had been introduced to combat stigma and improve participation in local agent services but they are understaffed and require additional services to be more effective.

Over the course of the meeting and site visit, the committee developed a sense of the importance of a complete care continuum focused on improved health outcomes for older adults living in rural areas. Although, traditional definitions of supportive services and caregiving generally fall under the human services category of long-term services and supports programs, the committee recognized that both health services and human services have an interconnected role, the provision of care for older Americans. This idea is reflected in the following recommendations to the Secretary. The national and state policy experts that presented to the committee emphasized the difficulties caused by fragmentation of care across multiple funding streams and programs.

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Disjointed care systems for older Americans places the burden of navigating the options on the individual and their family and it limits the possibility of optimizing resources. On the final day of the meeting, the committee concluded that health and human service programs should be designed to allow rural older adults to age in place in a manner that is accessible, available at acceptable to the needs of each individual. These themes laid the framework for the committee's first three recommendations of providing access to the Older Americans Act, resources, expanding telehealth services and promoting age-friendly communities and health systems in rural health initiatives at the federal level.

For the first recommendation, the committee recommends the Secretary create a comprehensive resource on the aging and long-term services and supports available to older adults in rural areas. The administration on aging offers information, on long-term services supports programs through its approximately 30 national resource centers. However, a recent GAO report on rural service providers noted that these resources are dispersed across many platforms and could be difficult to locate for service administrators, caregivers and those receiving care.

This was evident during the committee site visit in rural Northern California, where local health service providers expressed that community members did not know what services are available. They are not getting the assistance they need to plan for aging in their community. Additionally, the GAO report reported that the administration for community living does not currently offer a resource specifically for older adults in rural areas nor is there the ability to search for rural caregiving options across existing programs and resources. The committee agrees with the GO Analysis as it aligns with their observations during its meeting and suggest that information barriers could be addressed by synthesizing the administration for community living program offerings into a coordinated and more accessible resource tailored to the unique needs of rural older adults.

For the second recommendation, the committee recommends the Secretary continued to expand flexibility in Medicare telehealth billing and provide a comprehensive resource of telehealth offerings in rural areas. Medicare reimbursement for telehealth services remains a barrier in rural settings, particularly in the fixed rate facility fee paid to originating site providers. For calendar year 2019, the payment amount for the telehealth originating site facility fee is 80% of the lesser of the actual charge or \$26.15. The Committee believes the Secretary should consider a cost-based reimbursement approach, which would alone align with the payment model for rural facilities such as critical access hospitals.

There is precedent for this. For providing cost-based reimbursement for telehealth in the Frontier Community Health Integration Project demonstration, where participating critical access hospitals received a reimbursement through Medicare at 101% of the cost of the telehealth services provided. The 2018 interim report to Congress on the Frontier Community Health Integration Project noted a 70% increase in telehealth for distance site providers across multiple specialties only one year after this reimbursement change. The Frontier Community Health Integration Project participants did note however, that the greatest implementation challenges were due to credentialing specialist, pointing up another barrier the Secretary should address to improve access to rural telehealth services.

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Navigating and accessing telehealth options in rural settings is difficult due to the lack of a complete geographic inventory of telehealth services offered. Registries such as the Telehealth Connect and the Telehealth Service Provider Directory do exist but they are not comprehensive and rely on voluntary reporting and registration. They also require provider consent. In order for these services to be effective rural, older adults and patients must know where to find them.

For the third recommendation, the Committee recommends the Secretary ensure the promotion and encouragement of age friendly concepts within rural health grant programs. The Committee heard from experts on national aging policy with stress that Age-Friendly Care results in contorted care, improved health and cost effective services. Health and Human Services Systems should align care with the health goals and preferences of the older adult. Including whether or not they wish to age in place and receive care in their community.

Committee learned of two frameworks that could be used for age-friendly capacity building in rural settings. You already heard from Marcus of the four M framework of mobility, medication, mentation and what matters. Another one is the CDC, Healthy Brain Initiative created by its Alzheimer's Disease and Healthy Aging Program. The Committee is of the opinion that the principles of these frameworks should be incorporated into Federal Rural Health Grant funding initiatives and notes that Health and Human Services has precedence for including age friendly concepts into notice of funding opportunities within HRSA Programs.

For the fourth recommendation, the Committee recommends the Secretary explore the entry of Medicare Advantage Dual-Eligible Special Needs Plans into rural areas, identify potential barriers and work with States to adopt policies that encourage or expand the reach of these plans to rural beneficiaries. Currently delivery of healthcare and supportive services in rural communities is a fragmented system spread across multiple organizations and funding streams.

Because federal and state level programs are often not person-centered and because Medicare does not cover long-term services supports, people have difficulty navigating and financing services on their own. The traditional fee for service model is shifting to promote better organization and care navigation through integrated managed care based programs. However, the shift has primarily occurred in urban areas where insurance and service options are more readily available.

Dual-eligible individuals living in rural areas are the most effected by the urban rural discrepancy. They are often the sickest and most vulnerable individuals in the population. Dual-Eligible Special Needs Plans were created as a Medicare advantage option to integrate Medicare and Medicaid for dual-eligible enrollees. Despite the fact that Dual-Eligible Special Needs Plans are the most common form of integrated plan for dual-eligibles, there is a lack of published research on their availability of Dual-Eligible Special Needs Plans in rural areas and Medicare Advantage enrollment as a whole has lagged in rural areas compared to urban.

The Committee believes, further research is needed on the role of Dual-Eligible Special Needs Plans and integrating care for rural enrollees. The Committee also believes that adjustments, the federal and state policies regarding Dual-Eligible Special Needs Plans could promote expansion into rural settings. Issues that the Committee felt were more general or not rural-specific, have also been included within the policy considerations portion of the brief. In addition to the

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specific recommendations above, the committee offers the Secretary the following policy considerations.

Number one, collaborating and integrating strategic efforts across federal agencies. Number two emphasizing the importance of non-emergency medical transportation. Number three, supporting the reauthorization of the Older Americans Act. Number four, including social isolation within the healthy people 2030 framework. Number five, valuing the need for peer navigators in the care delivery process and number six, promoting and expanding unpaid caregiver support programs. With that, I want to thank you all for listening about the Committee's experience, Sierra Nevada Memorial Hospital and the policy recommendations and considerations put forward. I will now turn things back over to Paul to provide his closing thoughts. Paul.

Paul Moore:

Thank you Octavio and Marcus, both of you for the information that you've shared. A lot to digest there. But those are the Committee's recommendations that Octavio shared with us. I now encourage you to read the Committee policy brief and full for further details. There's our website right there. You can access this brief along with additional information about the Committee at the link on this slide. I can answer any questions that you may have or maybe our experts will. Our presenters will help me with this at the end of this webinar. Let's just move into that section right now. Thank you for all for listening through the course of the webinar and let's begin the Q&A. Kristine.

Kristine Sande:

Great. Thanks so much Paul and to our speakers. That was excellent information. We will open the webinar up for questions at this time. Hopefully the Q&A box has shown up on everybody's screen in the lower right hand corner. Go ahead and enter your questions there for our panelists. We do have one question that came in via chat during the webinar and it's for Marcus. The question is, have you found any issues with internet availability and connection when implementing... implementing action communities in rural areas? How many of the communities is currently involved, they're considered rural, and how might you define rural? Three-part question.

Marcus Escobedo:

Sure. Great questions and something that we're looking at much more closely. As of right now I have not heard specifically about issues related to internet connection, broadband and how the connectivity issues might be playing out. Of course, we know that's an issue. It just came from a wonderful presentation at the IHI, the Institute for Healthcare Improvement forum that wasn't on Age-Friendly Health Systems but with this terrific group called Last Mile Health.

They really highlighted how here even in the United States we have such remote areas that are facing challenges related to technology connectivity that it's almost as if you were in a country more in the developing phase. We have those issues to work with. I have not yet heard of specific examples but I anticipate we will come up against that. It's an issue that we'll have to think about from a policy standpoint and from just an access standpoint. In terms of how many of our age-friendly sites are technically rural and or how do we define rural.

I don't have those numbers yet but I know that as these action communities are rolling forward and we're in the middle of one right now, the Institute for Healthcare Improvement and the American Hospital Association, which is also running the actual community are collecting that

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kind of information. We need to be able to tell the story of who's involved, how rural or not they are and their particular challenges.

I will note that I mentioned the Geriatrics Workforce Enhancement Program funded by HRSA. There are 44 sites, 33 of those are rural, at least designated by HRSA as such. They are actually officially now coming into the Age-Friendly Health Systems initiative as an action community focusing on those four M's and doing the training. I think we're going to learn a lot from those 33 rural what we call GWEP, Geriatric Workforce Enhancement Programs. The last thing I'll say is I just want to connect into what are the policy recommendations that Octavio was mentioning.

Telehealth becomes incredibly important. I was talking to MaineHealth, a system in Maine that is in the Age-Friendly Health Systems initiative. While they are based in Portland, their catchment area reaches out into rural New Hampshire and they have patients that are trying to access care. They're right now piloting telehealth as a way to implement some of the four M's screens that they're are focused on. That's going to be incredibly important. This recommendation from the Committee about telehealth in making that viable for as many sites as possible is going to be really important.

Kristine Sande: Great. Thank you. I think this next question is also for you. Are there efforts to have the Joint Commission support and include standards and specifications tied to Age-Friendly Hospital Systems as a mandated part of their accreditation requirements?

Marcus Escobedo: It's a great question. I will say that conversations are ongoing right now with accrediting bodies like the Joint Commission to explore the possibility of baking in standards related to four M's, Age-Friendly Care. There's still ways to go and how that might be operationalized. We want to... as I mentioned, make sure that we are not overburdening or making an initiative that's not feasible. That's why their focus is really on a framework and a way of organizing the care rather than being a specific model. But I will say stay tuned to join friends of age-friendly. You'll be kept up to date on how this conversations are progressing and how we might move towards a recognition and accreditation program around Age-Friendly Health Systems.

Kristine Sande: Thank you. The next question is, can you talk more about promoting health care workforce recruitment in rural areas such as rural residency programs? What are the Advisory Committee's recommendations in that area?

Paul Moore: Kristine, I'll take that one being part of HRSA. Workforce is a big part, what to grow health workforce in the health resources and services administration. It has been mentioned on the webinar about the HRSA's Geriatric Workforce Enhancement Program and the idea of... we're not just going to have more geriatricians and more aging elderly specialists out there, it's going to be a matter of bringing it up through the workforce planning and also through our medical schools and so there are efforts underway.

When you look at the... what's happening to demographics, I'm hoping that the efforts can hopefully keep up with the demographics, the changing demographics but those are the things that are going on. I was encouraged to hear that 30 of the 44 sites that are being funded are in rural areas. That's not always the case. So many times the Committee's dealt with this before and things like Block Grants, how they... funding goes to States and then it goes to where the

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biggest bang for the buck is and that's not always in the smallest rural communities. So very encouraged by that statistic that was shared.

Octavio Martinez: I was just going to add Paul into the great question but also the recommendation too on the telehealth. It really ties into that is recognizing the need to really take advantage of technology. Right now telehealth, telemental health, telepsychiatry as well as the Intel pharmacology. But thinking about it for the needs of our elder population in rural areas where we know it's going to be very difficult to increase geriatricians or physicians concentrating on rural adults where we can really utilize other resources through technology and telehealth right now is really one that we need to maximize. As well as we continue to look at alternative and additional resources. Back to you Marcus.

Marcus Escobedo: I know that's great Octavio and really great answers from both you and Paul. I'll just add in just so people are aware, there is a national coalition that's focused on these issues as well. It's called the Eldercare Workforce Alliance. It's an organization of about 32 different organizations that have come together and they are very broad and diverse. They represent both health professionals associations but also family caregiver groups, consumer groups, unions and just to add in, rural is on their radar and the coalition is at the federal level really trying to support HRSA's efforts and on the rural front as well as more broadly.

Octavio Martinez: Let me add one other thing because this is such a rich, I think question because the workforce really is a rate limiting factor for our ability to respond to our communities but it's also the consideration of really expanding and thinking about what... who is part of the workforce and hence the reason we wanted to let the Secretary know that peer support individual's lived experience but also individuals that can be elders themselves who can in fact be part of the solution and really help their colleagues, their neighbors and their friends. Is something that we really also need to maximize because the studies are showing that it really elevates and increases the ability for navigation and for understanding our complicated healthcare system.

Kristine Sande: All right. Great point. The next question is what is the thinking of accepting scientifically supported programs and recommendations from the National Prevention Councils when creating continuums of health education programs, Age-Friendly Health Systems and community programs in rural communities? Anyone wants to weigh in on that?

Paul Moore: I'm not real familiar with that particular questioner's point of... or perspective on that. What I am familiar with is in any case, whether you're talking about the Joint Commission and with health care facilities or whether you're talking about like the National Quality Forum, when you're looking at quality measures or any of these bodies. When there's an evidence-base that there is there and that you build your programs and your supports around that, you're a lot more likely to get the attention of payers. It just becomes something that they're more open to supporting when those evidence bases and that certification, I guess if you could call it, is there. It includes the educational areas that you're talking about that the question raised.

Kristine Sande: Great. Thank you. Next question-

Marcus Escobedo: And this is Marcus... I'm sorry, I'll just had a quick... I actually, I'm not quite sure what the National Prevention Councils are but I'm going to look that up. But I will mention just a reference to our Age-Friendly Public Health Initiative. We're working with an organization called

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the Trust for America's Health. They are tightly connected to the US Preventive Services Task Force and other efforts. I'll say through that initiative we are trying to think about prevention wellness as a component here on Age-Friendly Care.

Kristine Sande: Great. Thank you. The next question is what did you uncover about caregiver availability and affordability or the lack of caregiver resources in the areas that you did your research?

Paul Moore: I might ask Octavio to talk about the framework that actually it was his, that he came up with the affordability, the accessibility and the acceptability around that question. Octavio.

Octavio Martinez: Sure. Thank you, Paul. Where that framework comes from and I think would really, it speaks to... and I love the question about what do we uncover about caregiver availability. What we uncovered is what juristically, I think the community really already knows, which is the majority of caregiving is being done by family and by community and it's not really being done in a formal fashion.

One thing we did discuss as a committee member during our site visit with our stakeholders that were present but we went afterwards as we were deliberating among ourselves and coming up with the recommendations to give to the Secretary, is the fact that so many of our caregivers, there is not a formal way of providing resources for instance, for example, to provide them and to give them a respite from taking care of their loved one or a community member.

That is woefully needed even more so in rural areas. As we noted, a lot of resources really unfortunately go to urban areas or suburban areas and we really need to include and have that rural lens in focus to additionally include the caregivers that we're seeing there. I have a feeling that the majority of folks that are online and listening to our presentation today are very much, very well aware of that. We want to know that... we want you to know that as a committee we take that also very seriously. That's why we've included and want to ensure that we're having this discussion and getting these recommendations to the Secretary. I know it's not a great answer to tell you the truth but it is definitely a part of the dialogue now, which I have felt historically really hadn't even been there on the radar.

Paul Moore: Kristine, I might add that it does add to that conversation about, it's not just about having Age-Friendly Policies and also Age-Friendly Health System. It really is about having age-friendly communities. As we see the changing demographics in our rural areas where the maybe... the younger generations are heading to the urban areas for employment opportunities that we see an aging of gray and of rural America where there is extra stress on the folks that are... if you will, left behind. It's about thinking of it is a community process.

Kristine Sande: For sure. Thank you. All right. The next question is; can you talk about how the Veterans Health Administration fits into this work?

Marcus Escobedo: This is Marcus. I can just briefly say that we are engaged with the VA. They're terrific... in fact for many years because they were such a source of great geriatric care. Geriatric is really... we think was incubated in the VA. We continue close partnership with them. They're engaged, we're exploring with them. How the VA system and healthcare can adopt the age friendly principles. I did not mention and won't go into too much detail but would say that we also have very interconnected initiatives around geriatric emergency department care and geriatric surgical

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care, that are age-friendly that are... that go deeper into those settings. There we have really deep partnerships particularly on the ED side with the VA who is actually going to be taking up some training soon.

Kristine Sande: Great. Thank you. The next question says, "We just started a project in Michigan regarding Age-Friendly Public Health System. How do we engage the local Health Department in the initial phase to determine level of participation, engagement with aging services in their communities and how do we make sure to implement it with a rural lens?"

Marcus Escobedo: That's a great question and while I can't answer it directly, I know exactly the people who can, so I mentioned in our Age-Friendly Public Health initiative, it's piloting right now in Florida and that's where right now on the ground we have a learning lab going on with exactly that kind of engagement happening specifically between the public health departments and aging services on the ground at the County level. Some of those areas are of course rural in Florida. I'd be happy to make a connection offline. I hope you've got my... or I hope you can be provided my email. I'd be happy to make connections to both the project team is working in Florida as well as some of those Florida state officials that are there so you can learn and go Michigan. You guys are doing all kinds of great age friendly stuff.

Kristine Sande: Great.

Paul Moore: Just a reminder of what my friends in Michigan already know is that what we know about rural areas, especially with the smaller rural areas, is it while they are resource-restricted, they are relationship-rich. In addition to what Marcus shared with you, I'd say, go at it from a relational impact or perspective, you know these folks. Reach out to them individually and let them know what you're working on and that you need their partnership. Many times that will then... they'll share with you what they know and you can share with them what you know and look at it from a national perspective but move in there on a local perspective from the relationships you already have.

Octavio Martinez: Can I add to Marcus and to Paul's answer? One I think that's fabulous what you're doing there in Michigan in your approach. I'm with Marcus, I know about the Florida Initiative. Marcus, I'm glad you're going to provide them with that or those contacts. But also don't forget the power of your local statistics and demographics in making this extremely irrelevant. Now, I know that sounds like very basic but too often we actually forget about utilizing local and statewide data. National data is great but if you can make it local and personal, then you really are able to engage your stakeholders at the local be it at the city or County or even State level to be able to advance your initiative.

Kristine Sande: Great. That sounds like some really good advice. At this point we're about at the end of our time. I think we'll wrap things up. On behalf of the Rural Health Information Hub, I'd like to thank our speakers for the great information and the insights that you've provided. Also, thanks to the National Advisory Committee on Rural Health and Human Services as a whole for doing this important work. Also, thank you to our participants for joining us.

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