

**Health Resources and Services Administration
Office of Rural Health Policy**

National Advisory Committee on Rural Health and Human Services

**Hattiesburg, Mississippi
September 26-28th, 2011**

Meeting Summary

The 70th meeting of the National Advisory Committee on Rural Health and Human Services was held on September 26-28th, 2011 in Hattiesburg, Mississippi.

Monday, September 26th, 2011

The meeting was convened by Governor Musgrove, Chairman of the Committee.

The Committee members present at the meeting were: Governor Ronnie Musgrove (Chair); Larry Otis (Vice Chair); Graham Adams, Ph.D.; April M. Bender, Ph.D.; Maggie Blackburn, MD; Darlene Byrd, MNSc, APN; John Stewart Cullen, MD; Phyllis A. Fritsch; David Hartley, PhD, MHA; Donna K. Harvey; Thomas E. Hoyer, Jr., MBA; Todd Linden, MA; Karen Perdue; Robert Pugh, MPH; Shane H. Roberts; John Rockwood, Jr., MBA, CPA; Maggie Tinsman, MSW. Mr. Dennis Dudley attended representing the U.S. Administration on Aging.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Steve Hirsch, Paul Moore and Megan Meacham. Truman Fellows present were: Aaron Wingad and Nicholas Lillios.

SETTING THE CONTEXT FOR MISSISSIPPI

Mary Currier, MD, MPH, Mississippi State Health Officer

Mary Currier began setting the context for Mississippi by sharing with the committee that the entire State is medically underserved and the entire state has health professional shortage areas. There are major health problems in the State of Mississippi including ranking first in heart disease death rates and cancer death rates. One reason the cancer death rate is high is because people are not screened in a timely manner. The State is has a high accidental death rate and part of this is attributed to the danger of the rural roads.

The HIV disease rate is very high in Mississippi. The African American population is disproportionately affected. The State of Mississippi's infant mortality rate is first in the country. The African American population has almost double the rate of infant mortality than Caucasians. There is a large disparities issue. The State of Mississippi has a very high teen birthrate and infant mortality is higher among teens. Another reason the State has the highest infant mortality rate is because it has the highest very low birth weight

rate in the Country.

The obesity epidemic in the Country is growing rapidly and the rate in Mississippi is 34%. More than one third of the population in Mississippi is obese. Diabetes is an issue related to obesity and the rate of diabetes in the State is 12%. The State of Mississippi is second highest in the Country in the rate of diabetes.

Dr. Currier stated that a huge issue with dealing with the health issues in communities is that the State has one of the lowest rates of physicians per population in the Country. There are major access issues and some areas of the State do not have physicians or nurse practitioners. Dr. Currier stated that even some of the areas attached to metropolitan areas have access to care issues. She noted Tunica is part of the Memphis metropolitan statistical area and there is not a physician or clinic in Tunica and it is a very rural county next to a metropolitan area.

Health care access, community health centers and physicians clinics are a great need in the State of Mississippi. Public health assists in meeting needs but it is not the same as access to healthcare. There are 9 public health districts in the state and clinics in every county. The public health portion of health care gives the areas a way to follow-up on communicable disease cases, treat patients and work on prevention. The public health sector also attends to issues related to infants and infant mortality and chronic diseases due to obesity.

In summary, Mississippi is a rural State covered with medically underserved areas. The life expectancy in Mississippi is shorter than the rest of the Country. Issues such as poverty, obesity and lack of access to care are risk factors in rural Mississippi.

Q&A

John Rockwood said that Medicaid and Medicare make a difference in success in many states and he wanted to know if that is the case in the rural areas of Mississippi.

Mary Currier said that one of the efforts they are trying to work on is a patient centered medical home model to improve access to care, health, education and patient medical plans as opposed to managed care.

John Cullen asked about infant mortality and if mothers are getting prenatal care.

Mary Currier said that 97% of pregnant mothers are getting prenatal care, mostly in the first trimester. There is a Delta infant mortality elimination project to provide inter-pregnancy care. Medicaid does not cover inter-pregnancy care which is an important asset to keep women healthy before becoming pregnant again.

Maggie Tinsman asked if the high rate of mortality, risk factors and less than optimum care is related to being rural.

Mary Currier responded that it is related to poverty and that she thinks that the poverty is due to rural issues.

Maggie Blackburn asked about issues around oral health and noted that oral health is connected to other health issues.

Mary Currier said that the State has a new dental director who is getting grants related to oral health and also educating students in the school system on ways to promote positive oral health.

David Hartley stated that Mary Currier had spoken about the disproportionate numbers related to higher rates of health issues and infant mortality in African Americans in Mississippi. He asked if other rural areas than the Delta in Mississippi are showing disparities.

Mary Currier said that there are also great needs in the southeastern part of State and disparity.

Rozelia Harris, Mississippi State Office of Rural Health

Rozelia Harris spoke to the committee about the Mississippi State Office of Rural Health activities. She first thanked the Office of Rural Health Policy and the committee members for their service.

Ms. Harris stated that Mississippi has 3 metropolitan areas that include 17 counties. The other 65 counties are rural. The Mississippi State Office of Rural Health is responsible for assuring that rural health issues are attended to in the State. Mississippi State Office of Rural Health has at least two workshops a year for rural health clinics. They also produce a quarterly newsletter. She said that they also assist with recruitment needs and utilize the National Service Corps Programs. Because the majority of the counties are rural, the National Service Corps is an important tool. They also pay for the Rural Recruitment and Retention Network which is a web-based recruitment tool.

Medicare Rural Hospital Flexibility Program is a program that is used to meet the objectives of the Mississippi State Office of Rural Health. It allows acute care hospitals in rural areas to apply for critical access hospital designation. Those hospitals have requirements regarding average length of stay and are required to have network agreements with larger health systems. There is a community grant program for those facilities so that they can apply for grants to assist them in areas of operational improvement, adoption of electronic medical records, meeting meaningful use, and with their financial performance and quality initiatives.

Ms. Harris also spoke about The Small Hospital Improvement Program. There are 47 hospitals that qualify for the program in the State.

Rozelia Harris closed by thanking the committee for their work and for visiting Mississippi.

HEALTH DISPARITIES

Therese Hanna, Executive Director, Center for Mississippi Health Policy

Therese Hanna said that the Affordable Care Act will provide opportunities and challenges when addressing health disparities. When addressing health disparities there are many different dimensions including ethnicity, income, education and geography. There are inter-relationships between these dimensions and they also have independent disparities.

Ms. Hanna presented data from the Commission to Build a Healthy America that detailed health disparities across the nation and one focus was life expectancy. It showed the interface of all of the dimensions of disparities. Life disparities are very closely related to income and people with lower income levels have lower life expectancies. The same is true for health status. A Centers for Disease Control Behavioral Risk Factor Survey shows that low income populations show much higher rates of poor health status regardless of race or ethnicity. Lower education levels also have poorer health status not related to race or ethnicity. Rural residents are more likely to be uninsured, have poorer health status, report chronic disease such as diabetes and less likely to be physically active. Rural residents are also more likely to be obese.

Ms. Hanna said that to address disparities, the policy side needs to be addressed. Policy to address the social determinants of health is also important. In the Affordable Care Act there are broad approaches to improve disparities and address the multi-dimensions of disparities.

There are opportunities in the Affordable Care Act to expand coverage to many low income populations. There is Medicaid expansion and the implementation of state based health insurance exchanges to improve the available and affordability of health insurance coverage. There are tax credits for small businesses with up to 25 employees. There are provisions in the Affordable Care Act to ensure culturally competent outreach to eligible populations and assistance of navigators to help navigate the system. In Mississippi, they expect the Affordable Care Act to improve access to coverage. For adults ages 19-64 the uninsured rate is expected to drop from 20% to 7%. Facility expansions will also improve access to care. There have been grants for expansions of community health centers and for additional community health centers. The Affordable Care Act has authorized up to 11 billion dollars to support and expand community health centers. There are also provisions to expand school based health centers. The Affordable Care Act offers technical assistance to providers to enable them to develop the capacity to provide quality care and this should prepare them for quality based care.

Section 4201: Community Transformation Grant provides grants to state and local governments to implement evidence based strategies to reduce health disparities and

improve health. Not less than 20% of the funds should go to rural and frontier areas. The applications for the grant were due July 15th. The strategic directions supported by the grant include tobacco free living, active living and healthy eating, community based and evidence based services, social and emotional wellness.

Ms. Hanna said that data collection is important because you cannot improve what you do not measure. One of the Affordable Care Act requirements for federal health programs and surveys is to collect data and help standardize categories so that there can be comparisons between agencies and help monitor health disparities over time.

Ms. Hanna said there are opportunities and challenges related to the Affordable Care Act. There is the opportunity to reduce the number of uninsured but providing healthcare coverage does not insure access to care so the healthcare workforce will need to assist with the supply. In The Health Insurance Exchanges, the Qualified Health Plans are allowed to have geographic ratings and that could be an issue for some of the rural areas with high rates of chronic disease. In the guidance for the Community Transformation Grants, any area that was smaller than a state had to have a population of 500,000 to apply so the rural areas could not qualify. It will be up to the states to assure that funding gets to the rural areas. There are opportunities in the act to improve coordination of care but rural areas will not have the capacity to implement some of the advantages and will not see the results and outcomes. There will be a need to have access to health information technology in particular electronic medical records in order to enable rural areas to take advantage of improved coordination of care.

Richard deShazo, MD, University of Mississippi

Richard deShazo stated that obesity has become a prime driver of health disparities and health costs in the State. In Belzoni, Mississippi, the University of Mississippi has spent the past two years doing a documentary for public broadcasting on Mississippi's health issues. Dr. deShazo said that the problem is they have tried to deal with healthcare issues from the top down instead of bottom up. He said that the Affordable Care Act state match gives great opportunity to the State of Mississippi.

Dr. deShazo noted that Belzoni, Mississippi is surrounded by corn fields and soybean fields and other white crops that are subsidized by the present policy. There are no fruits and vegetables grown because there is no subsidy and it is a penalty to grow fruits and vegetables. Only 15% of the farmland is used for fruits and vegetables.

Dr. deShazo gave an example of a family that mirrors many families in rural Mississippi. The Edwards family has lived on their land in Belzoni for over a hundred years. They began as slaves, then tenant farmers and now they have a home in Belzoni. It is in the middle of a cornfield surrounded by catfish farms. There are twin 5 year old girls in the family named Takira and Nakira Edwards. The normal weight of a 5 year old is 39 pounds and Nakira is 50 pounds and Takira is 94 pounds. The family is concerned about Nakira because they are afraid she is underweight. The mother weighs 340 pounds and is an elementary school teacher, well-educated and a great mother. She is taking Nakira to

the doctor because she has sleep apnea, asthma and reflux all related to weight issues. This is the normal behavior in the State.

Belzoni, Mississippi has many fast food restaurants and there is only one supermarket in the small town. Many stores are closing but the most prevalent new businesses opening are home health agencies due to an overwhelming need. The community has large numbers of people with chronic disease and there are many cases of diabetes or health related issues due to overweight population. The cost of obesity in the small town of Belzoni is 1.6 million dollars per year. The drivers of health disparities in Mississippi have been racism, customs, geography, social class and education. An added driver of disparity in Mississippi is obesity. It is cheaper to eat fast food than to eat fresh food. If a person is working two jobs, has kids and want to do well at work, they probably will get something from a fast food restaurant before going to their second job. There is a huge obesity problem in the State of Mississippi and there is a need for training as many qualified physicians as possible to care for the growing number of sick people in the State. 69% of people in Mississippi are overweight or obese. 35% are overweight and 34% are obese and what is alarming is the number of children who are obese.

Dr. deShazo said there has to be a focus on the problem of obesity and what is driving the epidemic of obesity such as policy, the lack of availability of fruits and vegetables and the lack of available resources. Some examples of success in the Mississippi are the Healthy Schools Act and The Federally Qualified Community Health Centers movement. There are 157 rural community health centers that are federally subsidized and they are a life line for the people in rural areas.

Dr. deShazo talked about The Southern Remedy Action Plan that was created to help generate groups of individuals at the community level to work to eliminating obesity, hypertension and diabetes. Community health advisors are being trained to have events at Baptists and Methodists churches to do testing for rural residents.

There are many people in Mississippi who are getting involved at the community level to work on the problem of obesity. Reverend Michael Minor, with Oak Hill Missionary Baptist in Hernando, MS, has worked to get fried chicken out of every national Baptist church in Northern Mississippi. Dita McCarthy, set-up Farmers Markets in Ocean Springs, and people are able to use food stamps to purchase fresh fruits and vegetables. Anthony and Janelle Edwards, in Jefferson, MS, financed a program to educate children and young adults on how to grow and sell fresh fruits and vegetables. Pastor Clara Reed, in Belzoni, MS, started Mid-Delta Health Systems and is in charge of 14 home health units.

Dr. deShazo told the committee that Rural Health and Human Services can encourage interactions of the Rural Health Clinics and Federally Qualified Health Centers. There needs to be funded healthy schools legislation in all states to get fried foods and unhealthy habits out of the public school systems. There needs to be an obesity task force for each state, nutritional education initiatives and support for primary health provider training.

Q&A

Maggie Tinsman asked what is needed to get the patient centered medical homes operational.

Therese Hanna said that when the payment system changes there will be more movement but there is also work to be done to develop the infrastructure.

Maggie Blackburn asked what the percentage of African Americans are in the medical school class. She asked what the rate of physicians is who have participated in electronic health records.

Richard deShazo said they have a robust system in place to recruit minorities to their medical schools and have scholarships and pipeline efforts that begin in elementary schools. They have been unable to recruit above 5% because minority groups apply to many different universities such as Harvard and Brown and leave the state and do not come back. There are a number of traditionally African American colleges in the state including Tupelo and Jackson State.

David Hartley asked if they could expand on how they are dealing with healthcare workforce issues with community health outreach workers.

Richard deShazo said the Department of Health has an active initiative to train professionals to be community health workers and the largest growth is in nurse practitioners. There is a physician's assistant program that was just approved. There is an osteopathic school in Hattiesburg that will bring physicians to the workforce and the University of Mississippi is collaborating with that school.

Therese Hanna said that there is a project between the health department and primary care association to look at training and certification requirements and through the health department set up a certification program so community health centers can know that community health workers have met a certain level of training.

John Cullen asked what the percentage of graduates from the University of Mississippi medical school are going into family medicine and specifically going to rural areas.

Richard deShazo said that they are fortunate that about 50% are going into pediatrics or family medicine. Not many are locating in rural areas because they do not want to take their families to areas where schools are underperforming and also there are not the amenities in rural areas that are available in urban.

PHYSICIAN PAYMENT VALUE MODIFIER

Clint MacKinney, MD, University of Iowa

Clint MacKinney began by stating that the way to pay doctors is changing from a focus on volume to a value based system. The Institute of Medicine states that there should be six aims for improving healthcare and they are care that is safe, effective, patient-centered, timely, and efficient and equitable healthcare service. There is a huge variation in cost disparity across the country and in rural areas. He asked the committee to consider how to address the cost disparity issue as they inform the legislature. For example, does more money go to Minnesota because the quality is good or to Louisiana because the quality is poor.

Dr. MacKinney said that value equals quality plus service divided by cost. Value cannot be a code word for cost reduction. In this Country there is suboptimum quality and unsustainable cost that is much more expensive than the rest of the world.

Some systems of pay that have been attempted in the past include getting paid fee-for-service which means that a physician gets paid more for doing more to the patient whether it improves their health or not. Capitation is another system that was tried and that means that a physician gets paid the same no matter how hard they work and how much time is spent to improve the patient's health and quality of life. The Government has decided that pay for performance for value based purchasing is the best way to obtain quality healthcare.

The pay for performance pipeline progression is:

- Voluntary performance data reporting,
- Mandatory reporting,
- Publically available data,
- Payment for reporting,
- Payment based on actual performance
- Payment withholds with potential for "claw back".

Dr. MacKinney stated that the Centers for Medicare & Medicaid Services Value-Based Purchasing vision for America is patient-centered, high quality care delivered efficiently. The Affordable Care Act is changing the focus from volume driven revenue to value-based purchasing.

Value based modifier is a concept at this point but is detailed in the Affordable Care Act Section 3007 regarding the physician feedback program. It is a pay for performance pipeline which includes reporting data and money paid or held back due to performance data.

The Physician Feedback Program included 310 physicians in 2009 and 1,600 physicians in 2010 located in 12 metropolitan areas. The Centers for Medicare & Medicaid Services is going to expand the Physician Feedback Program to 4 more states in the near future.

A RAND study shows that if physicians are responsible for quality and how patients are attributed to the physician's performance it critically impacts the results. The Centers for

Medicare & Medicaid Services will get physician feedback on cost and quality. The patient is attributed to a single medical professional who bills for the largest number of office, emergency department, inpatient, or consult evaluation and management visits. Potentially the patient may be going to 6 different doctors and the single medical professional is only seeing the patient for 20% of the visits but they are still held responsible for patient quality and cost.

Dr. MacKinney spoke about 28 quality measures for physicians proposed in 2011. Physician quality will be measured and compared to peers within metro regions. Physicians will be measured on total costs, ED visits and hospitalizations and on 28 quality measures. Peer groups for comparisons will be medical professionals of the same specialty and in the same metro area but the rural comparisons have not been completed yet but it will be budget neutral.

Dr. MacKinney said it is not known how the physician value-based modifier will be implemented. There may be a differential rural impact. He noted that it may have similarities to the Prospective Payment System value-based purchasing program and it is a withhold and claw back payment system.

Dr. MacKinney spoke about the next steps for the physician value-based modifier program from years 2012 -2017. These steps include:

- Publishing the final value modifier quality and resource measures,
- Developing a system to convert measures,
- Scaling up feedback to include all applicable physicians,
- Completing value modifier through rule-making,
- Applying a value modifier fee schedule for specific physicians,
- Applying a value modifier to fee schedule for all applicable physicians.

Dr. MacKinney cautioned that there has to be a fair rural provider comparison group in order for rural physicians to get money back. Will rural providers have the systems to proactively improve quality is a question. There is also the question of how rural physicians will identify low cost hospital and specialist providers. Dr. MacKinney said that financial risk needs to promote change but not unfairly make rural practices vulnerable.

Dr. MacKinney's recommendations to the committee included:

- Assessing fairness of provider feedback comparison groups,
- Considering the difference of impact on rural compared to urban communities,
- Request that Health and Human Services makes technical assistance available that takes into account cultural change,
- The Office of Rural Health Policy design and implement programs with health care value improvement as an obvious goal.

Greg Oden, MD, Pioneer Health Services, Magee, MS

Greg Oden began by sharing with the committee principles of the Medical Home Model. Each patient has a personal physician with a whole person approach to care. A whole person approach to care is when the physician does not limit the visit to one issue but is concerned with the overall care of the patient. A team oriented approach to patient care has been demonstrated in several states. If there are a team of medical professionals seeing the patient, there is a greater possibility for quality care. Coordinated care with integration across all elements of the health care community is a way to share information between hospitals and doctor's offices. Increasing access of the patients to their healthcare and patient education including a higher level of communication with the doctors is important.

Dr. Oden stated that in regards to medical home model joint principles there needs to be a focus on quality and safety. The care is evidence based using support for optimal medical decision making. A key part will be the use of electronic health records and the use of electronic health prescriptions and e-prescribing. Performance feedback provided to physicians will be a part of the medical home model and each practice will be involved in quality improvement activities. Demonstrations of patient education and incorporation of feedback from patients into provider's decision making are important principles.

Dr. Oden spoke about concerns for physicians in small practices not being prepared to transition to electronic medical records, e-prescribing, data collection for quality measures and clinical decision support. Many small practices in rural communities do not have an action plan for quality improvement or plans to participate in a quality improvement collaborative.

Dr. Oden spoke to a group of rural providers. He conducted The Rural Health Care Physician Survey with the 18 family practice physicians. 1.6% of the providers have access to specialists and other hospitals, 1.6% have electronic prescribing, and 1.6% have access to chronic disease registries. 1% of the providers have electronic medical records. .5% have nurse care managers for chronic disease patients. 1.6% have a designated team to discuss defined groups of patients about care coordination. 33% of the providers have access to clinical information technology in the office.

Dr. Oden said that in rural communities the physicians are the cornerstone of care. If they force the doctors in rural areas to make too many changes, it could have very negative implications. There needs to be an incentive program to get technology into the rural providers' office and assistance for the physicians with developing health information technology. The physicians need to be educated on the changes so they can learn why they are important for value and a higher level of healthcare. Dr. Oden stated that it is an opportunity to educate new practices with physicians just coming out of residency so they will be educated from the beginning on the medical home model.

Tim Alford, MD, Kosciusko, MS

Tim Alford shared with the committee that there are 5 level 5 schools in his district of Kosciusko, Mississippi. The physicians in the community interact with the school district

because they feel that education is important and can be an important predictor of disease.

Dr. Alford shared that primary care physicians make up 32% of the physician workforce. This percentage is from the output of residents from medical school. He said the primary care workforce is an extremely fragile eco-system.

Dr. Alford said that the proposed rule is that physicians will be judged or pay adjusted on the 28 metrics in 2 years in advance to payments. He noted that modifying learned behavior based on an evaluation from 2 years previous to payment is an issue. He believes that the performance time needs to be closer to the payment reward time in order to be effective.

Dr. Alford stated that physicians in rural areas are aging and the State is losing physicians out of the primary care workforce. There is an aging population in Mississippi and it puts rural physicians in a disadvantage to urban physicians. In rural areas there is a higher percentage of chronic disease and patients have a difficult time getting to physicians due to lack of resources. He noted that there needs to be a different grading category for rural than urban.

Dr. Alford said that 28% of people in Mississippi are impoverished. There is a huge variance in the percentage of unemployment across county lines. Chronic disease is much higher in the counties with high unemployment. Sample sizes in rural populations are smaller and the methodology and attribution of risk will be critical. He recommends reducing the numbers of metrics to reflect the chronic disease that rural physicians are facing on a daily basis.

Dr. Alford said value based modifier will be implemented in a budget neutral environment so there will be winners and losers but added the losers should not be the patients. He reviewed some of the metrics and how they would apply to rural. An example of a metric that can be an issue in rural areas is colon cancer prevention screening. Will it be a reasonable screening test or a colonoscopy? A colonoscopy is expensive and takes special equipment. Some of the metrics require expensive equipment and some of the tests are expensive. The rural physicians may not have the equipment for these screenings. Dr. Alford said that with a 13.5% unemployment rate in Mississippi, people do not have the money for expensive tests. This is an issue with preventable care.

Q&A

Donna Harvey said that in human services there are the same conversations that Dr. Alford has spoken about. She said there need to be partnerships at the local level to address these issues. Now is the time to look at the systematic process and have discussions at the local level on how to blend limited dollars and to open communications

between the social support systems as well as the medical world. The barriers to making this happen need to be considered so that there can be progress.

Tim Alford said that in 8 weeks his clinic will begin a ½ million dollar electronic record project that includes 9 family physicians and 3 providers. It is a huge investment but it has to be done. The electronic record contains many of the metrics that are being considered and they have gone to great lengths to get the information from their charts. Rural physicians are busy taking care of patients and they do not have time to do the planning. They need leadership and do not need to be discouraged.

Graham Adams said that in South Carolina more than 50% of the physicians are employed by health centers, hospitals or larger practices. The employed physicians tend to be more up to speed on value based purchasing and pay for performance. He asked if Dr. Oden thought that it was a benefit if the physician workforce is employed by hospitals and health centers.

Greg Oden responded that many physicians will probably be employed in the next 18 months and electronic medical records will be available to them. The older, rural physicians will be lost because they will not want to deal with the cost of making the change. Value based purchasing is a successful program and has made hospitals improve their quality. But there needs to be resources to make it happen and doing it in the outpatient world will be a challenge.

John Cullen said there is disconnect between the ideas and language related to patient centered medical homes and what is being done in doctor's office. He feels that in the surveys it could be the language that is causing confusion. If you ask the physicians what they are actually doing that they are performing all of the elements of a patient centered medical home.

Greg Oden said that the key point is that if they are doing the elements of patient centered medical homes that they still have to know how to report the data.

AFFORDABLE CARE ACT PROVISIONS AFFECTING THE RURAL ELDERLY

Steve Farrell, MD, Chief Medical Officer, Forrest General Hospital

Steve Farrell began by stating that Forrest General had a discussion about reducing the readmission rate and they submitted an application for the Community-Based Care Transitions Program. Dr. Farrell stated that he wanted to give an overview of what their application included and how it related to the committee and an emphasis on rural health. Forrest General readmission rates are above average and worse than the national average because they need to be more adequately linked to the outpatient setting. He noted that they have numerous healthcare entities in the community and a robust health initiative and numerous nursing homes but needed to be more adequately linked to provide a continuum of care.

The Community-Based Care Transition grant enabled Forrest General to develop an application combining several community based organizations. They partnered with Hattiesburg Clinic, Southeast Mississippi Rural Health Initiative, nursing homes, Pioneer Healthcare and an analytical company that helped them assess data. They also met with the Area Agency on Aging to learn how they could more efficiently work together. Forrest General Hospital had already begun addressing readmissions with a nurse practitioner at Pioneer Healthcare that enrolled patients into an educational process and had them go to Pioneer Healthcare's clinic. When they need assistance but could not get to their local physicians, they could be seen by the nurse practitioner. The nurse practitioner does home visits so people can call him when they begin to have problems and he works with them before they have to be re-hospitalized. The nurse practitioner drives to the rural communities and takes equipment to take x-rays and draw blood so that he can take this information back to be examined. Many of the physicians do not have time in the day to see all of the patients so patients are not being seen before they have to be re-hospitalized. There has been almost a 90% reduction in readmission rates because people had access to care.

Dr. Farrell said that they met with the Area Agency on Aging to develop the Community-Based Care Transitions Program and discussed problems with transportation and nutrition issues. The Area Agency on Aging said that they have funding issues and that there is even a 5 year waiting list for Meals on Wheels. If there are patients with chronic diseases they would try to get them in a Medicaid waiver program to help them with medical problems but they probably could not help with nutrition or transportation.

Dr. Farrell said they have enlisted the help of nursing home companies and home health agencies and formed a community based not-for-profit organization to coordinate care however it has not been implemented yet. When patients come into Forrest General there will be data collection and patients will receive automated calls to their home and they will be asked 5 basic questions. If they answer incorrectly, the nurse practitioner will receive an automated message and the nurse practitioner has a time period to respond. He enrolls them further into the program and works closely with home health agencies and with the support of telehealth. Telehealth units have been placed in patients' homes to measure their weight, blood pressure, oxygen saturation and the data is sent to the home health agency. This monitoring allows managed care to be proactive.

Dr. Farrell said that the model is also in the nursing homes and they have given positive feedback on how it is benefiting care of their patients. Dr. Farrell stated that he feels the Community-Based Care Transitions Program holds promise in the future for lowering the readmission rates of patients and meeting their needs when possible before re-hospitalization.

Dennis Dudley, Aging Services Program Specialist, Administration on Aging

Dennis Dudley began by discussing the Aging Disability Resource Center (ADRC). He noted that about 9,000 people become age 60 or above each day in the United States. Sections 2401 and 2402 of the Affordable Care Act state that there should be a choice to live in the least restrictive environment for people who are aging. ADRC's community strategy includes home and community based services, nursing homes and risk pools including very frail and not frail aging and disability populations.

There is a vision of having an ADRC in every community in the nation. This will provide a full range of options of supports available in the state or county region and will help prevent premature institutionalizations. Navigating the system can be difficult because there are fragmented systems and eligibility criteria can be very different between different funding systems.

The number of long term support services has increased which has added confusion for the populations being served. ADRC will build a trusted single point of entry for the community to allow people to get information about aging and disability services. The goals of ADRCs is to raise the visibility of options that are available to the aging and disability populations, to better coordinate the disability systems and to provide objective information and assistance. The system that has been developed in the past 50 years began by giving information to a senior and then it progressed to giving referrals. From that there was a need for follow-up so case management was developed. How to empower people to make informed decisions and know the options that are available is important and having one single point of entry for information on public and private long-term care programs and support services will be extremely beneficial.

Mr. Dudley said that the rural implications of the ADRC are the same as the rural implications of many other services that include the lack of access and lack of technology. One question is whether there will be a need for more staff and funding to have the Aging Disability Resource Centers. Another question is whether or not agencies will be able to combine funding. Rural is not recognized in the models and that is an issue.

Q&A

Maggie Tinsman said that she thought that Agencies on Aging were supposed to be doing the same things that he discussed about ADRCs.

Dennis Dudley said that the issues in the aging community are the same as in the disability community and there needs to be more communication. The ADRC can frequently be located within the Area Agencies on Aging.

Paul Moore asked Dr. Farrell if they are partnering with smaller hospitals.

Steve Farrell said that they receive referrals from a 19 county area and they have 3 critical access hospitals and an acute care hospital that refer to Forrest General. They also have referral agreements with other critical access hospitals. They did not include them into the CCTP application because they were focused on the criteria that made them eligible to apply from their readmission rates.

Paul Moore stated that Section 3026 legislation leaves out critical hospitals and asked if they see a way to incorporate them.

Steve Farrell replied that they will be working with the critical access hospitals to reduce readmission rates and to deliver as much care as possible in the critical access hospital. Family physicians and internists can take care of problems like heart failure patients.

PUBLIC COMMENT

Mendal Kemp, Director, Center for Rural Health, Mississippi Hospital Association

Mendal Kemp shared that there are 92 hospitals in Mississippi with a 12 billion dollar impact on the economy. There are 90,500 people employed by hospitals with an average salary of \$42,193. Hospitals are in trouble of existence and threatened by cuts. If healthcare and education are not available in the communities then the communities cannot exist. The rural hospitals are not making money and cannot afford cuts. Electronic health records and other regulations requiring them to perform better are good for patient care and the economy but there needs to be support in place for the transitions required to meet regulations.

Meeting was adjourned.

Tuesday, September 27th, 2011

Tuesday morning the Subcommittees departed for site visits as follows:

Health Disparities: New Augusta FQHC in Perry County.

Physician Payment Value Modifier: Covington County Hospital (CAH).

ACA Provisions Affecting the Rural Elderly: Forrest General in Hattiesburg, MS.

The subcommittees returned to Hattiesburg and attended break-out sessions for discussions and drafting outlines of white papers.

PUBLIC COMMENT

There were no public comments and the meeting was adjourned.

Wednesday, September 28th, 2011

The meeting was convened by Governor Musgrove, Chairman of the Committee.

REVIEW OF SUBCOMMITTEE FINDINGS

Health Disparities Subcommittee

New Augusta Federally Qualified Health Center in Perry County

Subcommittee members: Robert Pugh (Chair); David Hartley; April Bender; Graham Adams, and Maggie Blackburn.

Staff Members: Steve Hirsch and Nicholas Lillios.

Robert Pugh reported for the Health Disparities Subcommittee. Mr. Pugh shared the subcommittee's thoughts from their site visit to New Augusta Federally Qualified Health Center. An issue for the hospital is the inability to obtain tertiary care for patients which affects their ability to build trust with patient populations. The physician at the New Augusta FQHC was very committed to serving the local population even though he did not have a connection to the area prior to his employment.

Possible Recommendations

The subcommittee stated the possible recommendations should be considered:

- Aggregating data that looks at geographic regions with similar demographic characteristics.
- Incentives for states to develop infrastructure for data collection.
- Incentives for state offices of rural health to create and facilitate the data capacity.
- More emphasis on quantitative and qualitative characteristics – behavioral change and capacity to change culture.
- Focusing on identifiers: Distance to health food sources.
- Workplace, faith-based, and school based focus as places to promote healthy activity lifestyles

Physician Payment Value Modifier Subcommittee

Covington County Hospital (CAH)

Subcommittee members: John Cullen (Chair); Darlene Byrd; Tom Hoyer; Shane Roberts; Karen Perdue; John Rockwood and Todd Linden.

Staff Members: Paul Moore and Aaron Wingad.

John Cullen reported for the Physician Payment Value Modifier Subcommittee. He stated that the Physician Payment Value Modifier is a new reporting requirement for physicians and is intended as a way to improve primary care payments, looking at quality and decreasing costs. The initial phase is data collection and the second phase is implementation and payments or withholding payments based on quality measures. It is designed to make providers more efficient and also lower costs but it is unknown what the impact will be on rural communities because there have not been demonstration projects done in smaller communities.

The three primary concerns with the physician payment value modifier are:

- Physician Payment Value Modifier plan is highly dependent on highly functioning electronic medical records.
- Rural providers are behind in terms of starting and using electronic medical records.
- Electronic Medical Records may not have the ability to provide the quality needed in rural communities when there is not as IT support in rural areas.
- Rural providers are working at capacity and beyond and may not be able to reduce their workload enough to implement the program.
- Many rural providers are not comfortable using electronic medical records, especially the older physicians.

There are issues with the rural population because they tend to be more overweight, less educated and have poor habits such as smoking.

Rural physicians may be disproportionately harmed by the measurements for payment due to attribution associated with rural communities such as higher costs for transportation in an ambulance.

Possible Recommendations

The subcommittee stated the possible recommendations should be considered:

- Data collection component should be started at the regular timetable instead of having a two tiered system.
- There needs to be a rural modifier to take into account the higher costs associated with rural care.
- Decreasing the number of initial core value measurements until the process is operational and allowing more measurements to be added later.
- There is a lack of education among providers about the Physician Payment Value Modifier. There needs to be more education available.
- The rural modifier should be a yes or no answer and it should not be physician reported but rather based on demographics.
- The timeline for implementation should be deliberate.

Affordable Care Act Provisions Affecting the Rural Elderly Subcommittee Forrest General in Hattiesburg

Subcommittee members: Phyllis Fritsch (Chair); Donna Harvey; Maggie Tinsman and Larry Otis. Staff members: Tom Morris and Dennis Dudley.

Phyllis Fritsch reported for the Affordable Care Act Provisions Affecting the Elderly Subcommittee. She began with some suggestions from the subcommittee. One suggestion was to promote the Program of All-inclusive Care for the Elderly to take care of frail, elderly dual eligibles.

The subcommittee also discussed transportation issues and suggests promoting United We Ride and identifying ways to use existing siloed transportation resources across programs.

Information coordination and service referral is needed for the elderly across care transitions and also when they move in and out of Medicare and Medicaid. Another important issue is how to reap the benefit of the information in electronic health records in a manner that coordinates services beyond the health sector and informs direct human service providers serving the elderly.

There is a service gap for the newly discharged who are at risk for readmission but not eligible for home health or skilled nursing facility services. This can be particularly challenging in areas with primary care shortages since it can often be difficult to get the newly discharged patient back into the physician office in a timely manner.

Communities need to find ways to coordinate the many diverse sets of programs, services and strategies of care coordination. The Affordable Care Act provides significant changes to the aging service infrastructure but it has the potential to create a confusing patchwork of services across the community.

Possible Recommendations

The subcommittee stated the possible recommendations should be considered:

- Avoid disincentives in offering hospice in communities served by critical access hospitals by changing the cost reporting rules for critical access hospitals offering Hospice services.
- Patient safety challenges due to critical access hospital requirements to have a different account number for each level of care meaning orders have to be rewritten increasing the chances for errors or missed indicators.
- Waive the readmission penalty for small rural hospitals in a primary care health professional shortage area.
- Health & Human Services should examine the impact of the readmission policy on small rural hospitals and consider whether the time period should be reduced and should the penalty only occur on issues related to the original admitting condition.

LETTER TO THE SECRETARY

The white papers will be drafted, review and approved and then the Letter to the Secretary will be sent.

DISCUSSION ON FUTURE MEETINGS AND TOPICS

The next meeting will be in Washington DC mid to late February. The June and September meetings do not have definite locations set at this time but there are some locations under consideration.

PUBLIC COMMENT

There were no public comments and the meeting was adjourned.