June 9-11, 2009, Rapid City, South Dakota

Health Resources and Services Administration
Office of Rural Health Policy

Rapid City, South Dakota
June 9-11, 2009

Meeting Summary

The 62nd meeting of the National Advisory Committee on Rural Health and Human Services was held on June 9-11, 2009, in Rapid City, South Dakota.

Tuesday, June 9, 2009

The meeting was convened by Governor David Beasley, Chairman of the Committee. Governor Beasley thanked the members who had organized the meeting and spoke about the process for developing recommendations to the Secretary.

The Committee members present were: Larry K. Otis (Vice Chair); April M. Bender, Ph.D.; Maggie Blackburn, MD; Deborah Bowman; B. Darlene Byrd, MNSc, APN; David Hartley, Ph.D., MHA; Donna K. Harvey; David Hewett, MA; Thomas E. Hoyer, Jr. MBA; Todd Linden, MA; A. Clinton MacKinney, MD, MS; Robert Pugh, MPH; John Rockwood, Jr., MBA, CPA; and Maggie Tinsman, MSW. Mr. Dennis Dudley attended representing the U.S. Administration on Aging. Members unable to attend were: Sharon A. Hanson, Ph.D.; Graham Adams, Ph.D.; and Karen R. Perdue.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Jennifer Chang, Executive Secretary of the Committee; Michelle Goodman; Sherilyn Pruitt; Jenna Kennedy; Meghana Desale; and Laura Merritt;

Jennifer Chang, Office of Rural Health Policy, announced that the 2008 Report to the Secretary will be released in July, 2009. She noted that over the years about 37.5% of the Committees' recommendations have been implemented. A compilation of these recommendations is available. Tom Morris, Director, Office of Rural Health Policy, added that the current

administration is interested in rural issues and is looking for recommendations that can be implemented quickly.

Setting the Context for Rural South Dakota

Sidney Goss, Ph.D., MS, Professor, South Dakota School of Mines and Technology.

Dr. Goss established a context for the meeting by presenting demographic information on the State and significant demographic trends that influence the delivery of health care and social services. South Dakota has a total population of about 804,000 people. In recent years there has been a slight increase in population after years of out-migration. The Sioux Falls area is growing, as well as communities in the Black Hills region of the State. Population loss is greatest in the farming areas. Birth rates are increasing in the Native American counties. Overall, the population is aging. Dr Goss presented maps showing that population changes and distribution patterns in South Dakota are similar to those of other areas in the Midwest. There are wide variations in population growth and density among counties in the State. These variations have enormous implications for the labor force and economic growth. For example, the farm population is aging and younger population groups are in decline. The State loses a large percentage of its college graduates and high school graduates and there is decline in the population of that age group. The aging of the health care workforce is a real challenge and the majority of SD counties are classified as underserved areas.

Mr. Rockwood asked about mortality rates for the Native American population. Dr. Goss replied that while mortality rates are improving, life expectancy on the Reservations is low relative to other areas.

Dr. Hartley asked about the college-age population in SD. Dr. Goss said that there are six universities in the State and that population trends in this age group were leading to excess capacity. There are no community colleges in the State.

State Office of Rural Health Welcome

Josie Petersen, Primary Care Program Coordinator, SD Office of Rural Health.

Ms. Petersen described the mission of the South Dakota State Office of Rural Health and the programs administered by the Office. The Office administers the Medicare Rural Hospital Flexibility Program, the Critical Access Hospital Program, Health Professions Shortage Area designations, a Workforce Center, and the Small Rural Hospital Improvement Program. She

provided a brief description of each program and the additional services in the Office to assist rural communities in obtaining grants to develop healthcare services.

Rural Primary Care Provider Workforce Panel

Bruce Vogt, MD, Chair of Family Medicine and Medical Director of Physician Assistant Studies, Sanford School of Medicine, University of South Dakota.
Charles Hart, MD, MS, President and CEO, Regional Health System.
Josie Petersen, Primary Care Program Coordinator, Office of Rural Health, South Dakota Department of Health.

Dr. Vogt presented on "Getting Students into Primary Care and Primary Care Providers into Rural America: A Challenge for Academic Medicine." He described the factors influencing student selection of family medicine including personality traits, the influence of role models, student debt, salary expectations, and life-style issues. He cited survey data showing that personality, interests and skills exert a moderate influence on specialty choice. Research on student debt has not shown a convincing relationship with specialty choice, but 28 percent of medical school graduates nationally have said that debt had a moderate to strong influence on specialty selection. The same survey showed that salary expectations played a larger role than debt, and that salaries of family physicians are lower than for other specialties. The gap in salaries is increasing. Primary care tends not to be a 9:00 a.m. to 5:00 p.m. job, and 45 percent of graduates surveyed said that this had strong/moderate influence on specialty choice. Dr. Vogt spoke about the characteristics of family physicians. They tend to have broad interests; small town backgrounds, a strong motivation toward direct patient care, strong interpersonal skills, humanistic interests and values, and are community oriented. They also are more likely to have attended a public college or public-funded medical school. Women are more likely to practice primary care, but half as likely as men to practice in rural areas. Dr. Vogt discussed strategies to increase interest in primary care/family medicine in rural areas including early identification of interested students, admission policies that consider motivation and the characteristics listed above, and strategies to increase payments for primary care. Some specific strategies he offered were rural tracks in medical schools; community partnerships with physicians; debt counseling; and efforts to promote family medicine by being honest about the challenges and dispelling the myths about rural practice. Dr. Vogt concluded by saying that national health care reform must address income disparities in physician specialties, and create more opportunities for students to trade debt for service through programs such as the National Health Service Corps.

Dr. Hart identified some of the vital issues for health care reform in rural areas of the country. He began by saying that the aging of medical staff in rural areas is a critical issue that must be

considered. He argued that Medicare funding caps for graduate medical education must be lifted. He also said that we are defining “ever narrowing” technical requirements for practitioners that pose unique challenges for the recruitment of providers in rural areas. He noted the danger of Medicare funding reductions, and said that it will become impossible to recruit practitioners for some rural communities. He made the important point that socio-economic factors in rural areas must change our methods for risk adjustment and that rural areas should not be penalized for their less affluent populations. Payment incentives for physicians are not properly aligned with the needs of rural communities, and if universal access is achieved rural physicians cannot possibly keep up with the demand. He concluded by emphasizing the need for payment reforms, greater use of allied health professionals, changes in funding for graduate medical education, and new models for health care delivery.

Ms. Petersen discussed SD health workforce issues. She presented maps that showed that the vast majority of counties are designated as Health Professional Shortage Areas. Only five counties are not designated as mental healthcare shortage areas. She spoke about the SD Healthcare Workforce Center and eight programs administered by the Center to address healthcare workforce issues. These include programs that focus on healthcare career awareness for youth, hands-on health career experiences for high school students, distance learning opportunities in rural schools, high school student focus groups on health, and related projects. She also discussed incentive programs for health care professionals involving tuition reimbursement for physicians, dentists, and midlevel professionals such as Physician Assistants and Nurse Practitioners. Communities that qualify for these incentive payment programs must have a population of 10,000 or less (5,000 or less for mid-level tuition reimbursement) and have been assessed by the SD Department of Health on the basis of need and the inability to retain practitioners. The State also has loan repayment programs for health professionals and there is an incentive program that provides payments to health professionals after two years of full-time service in an eligible entity. The State Office of Rural Health administers the Rural Recruitment and Retention Network for the State and operates the “Community at A Glance” program that provides the means for rural communities to present their practice opportunities to health professionals.

Dr. Blackburn asked about reauthorization of Title VII of the Public Health Service Act and how the program can be improved. Dr. Vogt replied that we need to look at innovative programs such as rural training tracks for physicians and other providers.

Mr. Rockwood asked how we can create a better practice environment for rural primary care providers. Dr. Vogt said that we must get students comfortable with the rural environment during their training years, encourage community involvement, and support technologies that assist rural providers. Practice models other than solo practice are also important.

Ms. Tinsman commented on the great demand for geriatrics in Iowa and the difficulties in recruiting these specialists. Dr. Hart responded that the volume of patients is there to attract physicians, but Medicare payments are far too low. Also, there is a huge demand for other specialists that deters students from geriatrics.

Dr. Bender asked for recommendations to help consumers take more responsibility for their health. Dr. Hart said that there is a lack of responsibility on the part of patients and physicians alike because the payment incentives are misaligned.

Home and Community Based Care for Rural Seniors

Ms. Deborah Bowman, Secretary, South Dakota Department of Social Services.
Senator Jean Hunhoff, MHA, MSN, Corporate Compliance Officer and Home Care Services Director, Avera Sacred Heart Hospital.
Ms. Cindi Slack, RN, MBA, Vice President, Sioux Valley Clinic Management, Sanford Health.

Secretary Bowman presented on the South Dakota Department of Human Services. She first talked about the geographic challenges in SD in terms of population distribution and the delivery of services to elderly populations. South Dakota is one of a few States with a single State Unit on Aging. There are 25 field offices across the State and most services to the elderly are provided under contracts with her agency. She provided data on the number of individuals receiving services in nursing facilities, personal care, assisted living centers, respite care, etc. A study of the need for long-term care services in SD was completed in 2008. It showed that the over 65 age group will double by 2025, requiring an expansion of home health care services, community-based services, and the development of a single point of entry system for long-term care services. The economic downturn is having a major impact on reaching these goals, but several task forces have been established and are working hard on the issues. She said there are reasons for optimism because thousands of individuals are being served every day and living independently in their own homes. Support is provided for telehealth services and there are some exceptional voluntary programs on the delivery of meals.

Senator Hunhoff spoke about Avera Sacred Heart Home Care Services. The service area covered by Avera Sacred Heart is over 5,000 square miles with a population density of 14 people per square mile. She recounted the history of programs developed by Avera Sacred Heart and provided data on the number of units of care that clients have received. There have been increases in service utilization for home health visits, hospice days, hospice visits, and especially homemaker services. The strengths of the system are its working relationships with local Department of Social Services providers, a focus on keeping elderly in their homes, and local access to health care. Weaknesses include staff shortages, low reimbursements, and

regulatory requirements. The average age of Licensed Practical Nurses is very high and there are major challenges to stay compliant with applicable regulations. Senator Hunhoff identified opportunities to improve services through regulatory changes, single point of entry, interdisciplinary case management, and telehealth. Some threats to these changes are physician control of patients, eroding reimbursements, and bundling of services that could potentially damage home care.

Ms. Slack spoke about Sanford Home Health Services, an integrated system with hospitals and tertiary care centers that has geographic coverage across the State. The system is facing tough workforce issues, especially nursing staff shortages. She discussed the overall environment in SD for long-term care and home health services and provided a portrait for patients served by Sanford Home Health. Most patients are connected to family and friends in their communities and wish to remain in their homes. Ms. Slack endorsed the programs and State activities presented by Secretary Bowman, including a single point of entry for services and reduction of paperwork burdens. Other issues of concern involve State scope-of-practice provisions that limit to the ability of nurses to delegate appropriate nursing tasks.

Governor Beasley asked how the Department of Health and Human Services responds to State requests for Medicaid waivers. Secretary Bowman replied that it is a nightmare process that is to be avoided. The Committee needs to have further discussion about this process.

Mr. Hewett inquired about proposed payment reductions and paperwork burdens. Secretary Bowman said that proposed Federal payment reductions would have a devastating effect on home health in SD, and that they don't make sense if we want to keep people in their homes. Senator Hunhoff commented on Federal hospice regulations and what they demand in the way of paperwork.

Dr. Tom Dean, who was scheduled to speak later in the day and is a member of the Medicare Payment Advisory Commission, said that he will take information back to the Commission on the potential effects of payment reductions.

Mr. Hoyer commented that it has always been a problem for government to control bad actors in the system, and that the little guys always get hurt by paperwork requirements.

Health Care Provider Integration Panel

Tom Dean, MD, Family Practice Physician, Horizon Health Care.
Matt Michels, JD, RN, Health Care Law Attorney.
Scot Graff, MPA, CEO, Community Health Care Association of the Dakotas.

Dr. Dean presented on recommendations by the Medicare Payment Advisory Commission (MedPAC) and other Medicare issues related to the current focus of the Committee. He said that the big challenges in health care cost and quality relate to the projected insolvency of the Medicare Trust Fund by 2017; Medicare Part B premiums consuming a increasing portion of Social Security Payments; and Health outcomes that vary widely from place to place and are inferior to other developed countries. The MedPAC strategy is to use the Medicare payment system to restructure the health care delivery system; restructure provider payments; and to provide incentives for care coordination and more efficient use of resources. Medicare spending by region varies from $5,280 to $14,360 per beneficiary with no evidence of better outcomes in high cost areas. Patient satisfaction is actually lower in high cost areas. MedPAC is recommending the bundling of payments for hospitalization, physician fees, and post-hospital services. He noted that over 50 percent of hospital readmissions within 30 days took place when there was no bill for physician services during the post-hospital interval. Experts believe that roughly two-thirds of the readmissions are avoidable. He described MedPAC interest in Accountable Care Organizations in which hospitals and the physicians related to them would be accountable for costs and outcomes for patients assigned to them. Key design elements for these organizations are a defined group of beneficiaries, defined spending benchmarks, performance measures, and distribution of shared savings. Dr. Dean said that MedPAC has twice recommended increased payments for primary care physicians and measures to restructure the primary care delivery system. MedPAC is also concerned that current payment formulas for medical education are not sensitive to public need and should be changed. Other areas of concern are declining access to pharmacy services and the stability of rural home health programs. He concluded by saying that the present course in health care is unsustainable. In his view there is no alternative to pushing forward with constant vigilance for vulnerable citizens and systems.

Mr. Michels explained the Stark Anti-Self-Referral legislation and its impact on rural providers. He reviewed the history and purpose of the legislation and some of the “safe havens” available to rural providers. He discussed provisions on the employment of physicians by hospitals that may impose barriers to the integration of services in rural areas. He noted that the Stark regulations are voluminous. He also said that payment reforms may negate the Stark legislation (one example is bundled payments). The Stark provisions will not work if payments are reformed along the lines considered by MedPAC.

Mr. Graff talked about the evolution of primary care in SD. In the late 1970s and into the 1990s there was rapid movement to adopt the Medicare Rural Health Clinic model and there were a significant number of hospital conversions to Critical Access status under Medicare. Community Health Centers emerged throughout the State and look very different between

urban/rural/frontier areas. Some sites are the only provider in their communities. Mr. Graff presented maps showing the locations of Rural Health Clinics and Community health Centers throughout the State, noting that some facilities are managed by larger systems of care.

Mr. Linden conveyed his concerns about new payment incentives under health care reform and the damage to rural areas if the payments are based on current spending patterns. It could be a repeat of the mistakes made when the Medicare DRG system was adopted.

Dr. Gamm asked if we have enough primary care doctors for implementation of the medical home concept. Dr. Dean replied that MedPAC has called for Medicare demonstration of medical homes, but it will not work without more primary care physicians. We have no choice but to change this now. We are already expecting too much from our primary care physicians. Mr. Graff described a number of different training models for primary care in SD.

Mr. Rockwood expressed a caution about bundled payments for hospital and physician services, He does not think bundled payments will work because patients may go outside the bundled arrangement for services.

Overview of Site Visits

Ms. Chang reviewed the site visits plans for Wednesday, June 10.

Public Comment

Ms. Sandra Durick, Director, South Dakota State Office of Rural Health welcomed the group to South Dakota and talked briefly about the challenge of recruiting and retaining primary care providers.

Mr. Jay Maxwell, CEO of Wireless Broadband Provider in Wichita, Kansas advocated the growth of telecommunications services in rural areas and gave some examples of how home monitoring systems can contribute to disease management for rural citizens. He urged the Department to determine the extent of broadband access in rural areas and to coordinate stimulus funding for broadband coverage.

Wednesday, June 10, 2009

The Committee members and staff departed for site visits at 8:45 a.m. and returned in the afternoon for Subcommittee Meetings. Site visits took place at the following locations:

Primary Care Workforce Subcommittee: Hans P. Peterson Memorial Hospital, Philip, South Dakota.
Health Care Provider Integration Subcommittee: Custer Regional Hospital, Custer, South Dakota.
Home and Community Based Care Options for Seniors Subcommittee: Home Care and Hospice of the Hills, Rapid City Regional Hospital, Rapid City, South Dakota.

Thursday, June 11, 2009

Governor Beasley convened the meeting and called for reports from the three Subcommittees.

Mr. David Hewett reported for the Subcommittee on Health Care Provider Integration. At the site visit there was a general theme that current payment incentives are misaligned for service integration. Employed physicians can work well for hospitals in rural areas, but there is not enough information on how bundled payments will effect coordination. The Subcommittee is studying issues on: 1) How the Stark legislation will impact provider integration; 2) A moratorium on Medicare certification of specialty hospitals; 3) Critical Access Hospital access to the 340B pharmacy program; 4) Coordination of health information technology by the Department of Health and Human Services; 5) Extension of Critical Access Hospital payment methodologies to rural hospitals under the Medicare Prospective Payment System; and 6) Exceptions under the Stark rules for rural hospital ambulance services.

Ms. Blackburn reported for the Subcommittee on the Primary Care Workforce. She reported that recruitment and retention of the hospital workforce was not a problem at the hospital site, but that retirements may lead to problems in the future. The hospital has started a day-care center that has been a great help in the recruitment of nursing staff. It has a strong working relationship with community and close ties with other local providers in home health long-term care. The Subcommittee will be considering issues related to Federal designation of health professional shortage areas, telehealth, and paperwork burdens. Payment issues will also be addressed.

Ms. Harvey spoke for the Home and Community Based Care Subcommittee. The site visit facility was beautiful and has created a unique model for sharing pharmacy services between hospice and home care services and hospitals in the service area. Integration of services with community groups was impressive. There was a presentation from “The Community Service Connection,” a group that has developed a “Dial 211” telephone service that citizens can use to access home and community services. There was also a presentation on the use of electronic home-health monitoring technologies to assist seniors staying in their homes. The Subcommittee will make a recommendation in this area. There were also suggestions for improving current patient assessment tools to reduce the paperwork burden on both patients

and providers. The Subcommittee will also consider issues related to payment of travel costs for home visits, lack of broadband services, a uniform assessment tool for patient in-takes, and education on home and community-based services for both consumers and providers. In addition, the group will be studying home and community-based services as a policy option under Medicaid, rather that a waiver process.

Letter to the Secretary

The Committee members suggested several issues for inclusion in the letter to the Secretary. 1) A caution about the danger of unintended consequences for rural areas in the passage of health care reform; 2) Thoughts for rural initiatives that are funded in the 2010 budget; 3) Ideas on how we can support the Secretary in the coming years; 4) Broadband coverage in rural areas; 5) Plans for negotiated rule-making that may preclude participation by rural interest groups that lack resources; 6) The need to improve reimbursement for primary care services; and 7) Language asking the Secretary to oppose a reduction of funding for home and community-based services in the health reform package. The ORHP staff will send e-mails to solicit other comments on the letter and draft the document for approval by the Committee.

Administrative Issues

There was a brief discussion of plans for the September meeting in Sacramento, California.

Public Comment

Dr. Patrick Clinch, a practicing Chiropractor in SD, introduced himself and spoke about the demographics of chiropractic services in the State and his view of the importance of chiropractic providers. He urged the Committee to consider chiropractic workforce issues in its deliberations and to add one or more chiropractors to the Committee.

The meeting was adjourned.