



National Rural Task Force

# Rural Health Workforce Issues: Challenges and Opportunities

2010 Meeting Summary





National Rural Health Association

National Rural Task Force  
RURAL HEALTH WORKFORCE ISSUES:  
CHALLENGES AND OPPORTUNITIES

Meeting summary  
July 14 - 15, 2010  
Arlington, Virginia

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## Executive Summary

The National Rural Task Force (NRTF) is part of the National Rural Health Association. The task force was established to fulfill the mission to “discuss rural issues, communication strategies, and build partnerships to promote the long-term growth and sustainability of rural community and migrant health centers.”

This summary covers the fourth annual meeting of the task force. The task force engages in six conference calls and one face-to-face meeting every year. When NRTF convened its first meeting in 2007, members established concrete goals and selected its leadership team. Additionally, each year the group develops a work plan, which includes setting the meeting and conference call topics and speakers.

The success and accomplishments of the National Rural Task Force are considerable. From its beginning, members committed to each other and to setting and meeting goals. In 2009, NRTF achieved consensus on a vision statement.

From the initial meeting, the group set its most important goal to be raising its concerns and sharing its ideas with the highest levels in the Health Resources and Services Administration (HRSA). Every year, the HRSA administrator was invited to the meeting, and although HRSA staff attended each of the meetings, the administrator had not been available to attend.

This year, Mary Wakefield, Ph.D., HRSA administrator, attended along with Tom Morris, HRSA Associate Administrator for Rural Health Policy. These two leaders spent a half of a day with the task force. There were presentations by both, each followed by wide-ranging discussions with the task force members. This is a positive advancement and fulfilled the most important goal of the National Rural Task Force. A description of these discussions follows.

Having fulfilled this goal, the task force selected new leadership, updated of the 2009 vision statement, and set parameters for the 2011 work plan.

## Background

The National Rural Health Association (NRHA) is dedicated to assuring access to high quality health care in all rural and frontier communities of the United States. In an effort to support this goal, NRHA established a multi-disciplinary National Rural Task Force (NRTF).

### **NRTF mission:**

To discuss rural issues, communication strategies, and build partnerships to promote the long-term growth and sustainability of rural C/MHCs.

The purpose of the task force follows:

To help rural communities move toward the improvement and expansion of access to health care, it is important to continue partnering with other organizations in order to expand and improve access to culturally competent, quality health care and to ensure services are appropriately available to rural and frontier patients, including primary and preventive services, as well as enabling services.

Through collaboration, task force members develop common goals. Additionally, members share their varied work and life experiences and then as a group develop policy recommendations. The end result is to advance the national goal to ensure access to a “health home” for all rural Americans.

NRTF had its fourth annual meeting July 14 and 15, 2010, in Arlington, Va., and this meeting summary describes the discussion and outcomes of the meeting.

## Day 1 - July 14, 2010

### Opening, Marilyn Kasmar, NRTF chair

Kasmar thanked NRTF members for their commitment and expressed her appreciation for the good attendance on the six teleconferences held between annual face-to-face meetings. The topics and presenters for the 2009-10 teleconferences came directly from the recommendations made at the 2009 annual meeting. The group's ideas were presented to task force members who set the priorities among the topics and recommended presenters. (NRTF co-chair Mike Samuels was unable to attend the meeting.)

### Welcome, Alan Morgan NRHA CEO

Morgan stressed the importance of the National Rural Task Force to NRHA and its partner organizations. He said he was looking forward to NRTF's policy recommendations to help support the work of NRHA and its government affairs activities.

### Meeting goals, Carol Miller, facilitator

Miller stated the goal of the meeting is to develop

a hard-hitting, one-page policy statement to be completed quickly and integrated into current health reform discussions.

Miller thanked the group for the respect members show each other, coming together from different types of organizations and parts of government. She said since the group has worked together for years and has grown strong, the only ground rule is that everyone must participate. She explained that there would be three "round robins" during which everyone around the table would be asked to comment and that they also might breakout into small groups to further discuss select topics.

### Introductions and individual goals

Task force members and guests introduced themselves and stated their individual goal for the meeting. As the group went around the table, ideas and key points were raised. The ideas fell into several categories, but threading through all are the concepts of networking, local flexibility and a rural and frontier voice in policy development.

#### Flexibility

- Recognize the differences among the states when making federal policy. Some policies will work well in some states but be impossible in others.
- Identify and promote successful models.
- Simplify licensure: align Medicare, certifying organizations and workforce.
- Requirements for EHR and/or NCQA certified medical home need flexibility to reflect the on-the-ground reality and to work for rural and frontier providers.
- New types of providers are needed within primary care practice to address health issues; for example, dieticians and exercise professionals.
- Policy must be based on the best, most accurate and current data.

#### Networking

- Reform brings opportunities.
- The task force should become a catalyst for bringing people and systems together.
- Bridge the gap between NRHA and NACHC.
- Service area changes are coming. How do we get from where we are to where we need to be to guarantee universal access?

#### Policy voice

- Participate in negotiated rulemaking, frontier HPSA and other changes.
- Encourage transition to needs-based decisions.
- Grant process is too random, those with "entrepreneurial spirit" or resources get the programs.
- Align reforms to what CHCs do and do well instead of changing everything.

### ***Participants' individual goals were stated:***

- **Carol Miller:** We have met our goal to address workforce with a short policy statement. We have an excellent two-page vision statement, short enough that a policy maker will read it and find both data and concrete proposals.
- **Aurelia Jones-Taylor:** Workforce, alternative providers, dieticians (loan repayment), exercise therapist regarding health status in rural communities. Influence policy/teaching health centers in rural communities. School of medicine into rural to influence policy.
- **Kris Sparks:** Licensure, certification, registration related to reimbursement. How to influence policy, states right, federal setting policy. Bands of excellence with services provided, look at things differently, health profession demand.
- **Bob Bowman:** Get the right information out; there are distortions from the government and lot of misinformation.
- **Alan Morgan:** Guidance from the task force with expertise to position NRHA.
- **Tom McWilliams:** Networking and learning from others. Identify potential opportunities under health care reform, ideas on better addressing positioning CHCs and rural practicing physicians, CHC and practicing rural providers, smooth relationships.
- **Lathran Woodard:** Clarify what the task force is and its purpose. What to focus on, not duplicate what's going on in health care; AHECs and NACHC talk about workforce also. How to work together as providers for rural health, systems, dollars not being competitive. Task force should be the catalyst of bringing systems and people together.
- **Wagih Michael:** The first meeting was to bridge gaps between NACHC and NRHA and come up with what works in coordinating health services. Come up with something to get everyone on the same page.
- **Graham Adams:** Identify successful models of collaboration between CHCs, CAHs and RHCs. Help states collaborate with the health system.
- **Patricia Tarrango:** Service area and provider model. Need to facilitate models that work within states. Address the opportunities health care reform is bringing to the table. The costs of long-term care for states and develop roadmaps and paths.
- **Charlie Alfero:** National Health Care Workforce Commission. Can the task force be advisory to that group? Collaborative approach in the short term, workforce model. Need dollars for entrepreneurial GME payments. Align Medicare with systems and align goals of health care reform with what the task force does.
- **Susan Walters:** Take back information on the task force to NACHC. How to move forward with health care reform. Develop principles/work plan to influence policy makers. How to fund health profession education/training. National credentialing would save dollars and promote system change.
- **Greg Dent:** Create blueprint for collaboration. Opportunities for collaboration with partners not at the table. Larger hospital system could be partners. Continue strengthening the relationship between NACHC and NRHA.
- **Marilyn Kasmar:** Make recommendations that help address conflicts within health systems. By 2014 CHCs must have EHR on board. NCQA model doesn't lend itself to rural areas. Workforce regarding rural C/MHCs. Need different type of workforce model for rural and frontier centers as well as specific EHR solutions for rural/frontier.

### **HRSA update**

The National Rural Task Force was honored that HRSA Administrator Mary Wakefield took time out of her schedule to speak to the group. This was an exciting and informative opportunity for the members.

#### **Mary Wakefield, HRSA Administrator**

*The following is a summary, not an exact transcription of the presentation.*

Wakefield shared activities HRSA is involved in, first implementing the ARRA funds and now the PPACA law. "We are collectively all in it together and it is exciting to have such good partners... We could not do it without having so many partners."

HRSA has primary responsibility for a number of the

ACA provisions and also many in the second year of the recovery act. (Note: PPACA is now referred to as the Affordable Care Act or ACA.) These two pieces of legislation advance an agenda focused on meeting the health care needs of underserved areas and vulnerable populations more than any other laws in recent memory. The laws will help address the populations all of us in the room are dedicated to serving.

These also create daunting challenges, whether we come from the CHC world or the rural world. There is also a unique window of opportunity. We will be able to look back in the future and see that we really made a difference. The unique challenge for rural is the need to build a health care workforce in a substantive way with tremendous need going forward.

We know there is more work to be done and there will be more resources rolling out. There is a lot of work being done on the state and local levels, and it will take all levels to address the workforce issue.

A goal is to develop “a continuum of care that transcends geography.” This is now a time for us to think big because we are not talking about incremental change any more. The CHC funding under ARRA helped to blunt the effects of the recession on families.

The theme for HRSA is the integration of health care systems, within providers, within systems and even within and across regions.

MCHB often delivers services at CHCs; \$800 million in block grants. Ryan White program with \$2.3 billion for medications, half of all people with HIV/AIDS get their meds through the Ryan White program’s 900 clinical locations, many of which are CHCs. 340B has 1,400 safety net providers, many of which are FQHC and FQHC look-alikes.

HRSA rarely goes it alone without partnerships, we can’t afford to, because we don’t have all the expertise or resources.

#### **Key HRSA initiatives:**

- ACA programs from the Public Health Trust Fund, \$250 million: \$158 million for primary care residency slots, community-based. The goal by 2015 is to add 500 providers. \$32 million to train 600 new PAs; \$30 million to train 600 new NPs; \$15 million

for nurse-managed health clinics and other providers including social workers; \$5 million for state and local health care workforce needs, primarily for planning efforts.

- These investments come on the heels of the Recovery Act, half a billion dollars of workforce investment.
- President’s 2011 budget has a new rural health care initiative, and the cornerstone of this will address workforce.
- Recruitment and retention Rural Health Care Initiative. ORHP will work more closely with NHSC and the national Rural Recruitment and Retention Network (3RNet). 3RNet is a 49-state matching service that placed 1,025 clinicians in rural communities last year.
- ORHP is providing technical assistance to 22 rural training tracks focused on minorities and to 40 rural workforce training tracks.
- 2,500 rural physicians, the backbone of care in many areas, need help with implementing HIT.
- Partnerships in HIT, HRSA is working with foundations as partners.
- Rural HIT. There is a new rural HIT task force that will work with David Blumenthal (HHS OHIT) and staffed by ORHP to engage the rural HIT issue.
- In May 2010, HHS chose 15 beacon community HIT projects.
- The birthplace of HIT on many levels has been rural.
- HIT creates tens of thousands of new jobs and an expansion of community college training programs to produce the technicians needed.
- CHCs, with 19 million users, have the largest patient base of any health care system in the U.S., public or private, and it will double users to 40 million by 2014-16.
- Rural-urban definition is a blurring of distinction through HIT, rural people served at urban sites, satellites, mobile clinics and the like.

- HRSA recently published a CHC-CAH manual for collaboration.
- NHSC is 60 percent rural, and 50 percent are at CHCs. The Corps is now ramped up to recruit, place and support many additional providers.

**Questions/comments:**

Task force members joined in an informal and open discussion with Wakefield.

Bob Bowman stressed the need for a much larger investment in primary care training to meet the years of disinvestment and insufficient investment. Bowman expressed frustration because we know rural primary care works for cost, quality and access. Why not take evidence-based rural successes and make them the model for the nation; otherwise there is a rural tier and an urban tier. Wakefield agreed, but HRSA can only take the funds which are appropriated and try to catalyze additional investment by foundations, state and local governments.

Wakefield promised that the National Health Service Corps in a very few years, is not the Corps that anyone has experienced before. There is explosive growth in loan repayment and scholarships, hand-in-hand with the training expansion. “We are trying to leverage every way we can. Many of us have been banging on the workforce drum for a long time and now we have an opportunity, but we can’t do it overnight.”

Aurelia Jones-Taylor asked about the new “blurring of rural and urban” care, the proliferation of telehealth, but was wondering about reimbursement. It is common that “patients move” among primary care providers, to specialists, to centralized sites for technological procedures. Jones-Taylor asked if there is an adverse impact of this blurring. In response, Wakefield said “we will always pay special attention to underserved areas, across HRSA... Wherever we’ve got underserved, that’s our mission.”

Patients go between urban and rural, and specialists go between urban and rural “can harness the technology and resources to augment what a local primary care physician or local social worker is providing, that’s what I am talking about. Don’t hear in what I said to mean we are not going down the line for rural

underserved... rather hear, how do we really capitalize on networks and integration,” Wakefield said. CMS has a new Center on Innovation that is looking at system design and reimbursement, and there is a lot of potential change coming through that with new strategies.

Graham Adams asked two questions: How will HRSA incentivize collaboration instead of competition on the state level? And the HPSA committee has left out some key players, will others be added? Regarding local collaboration, there are meaningful ways to “guide, encourage and award points for” demonstrated collaboration. HRSA is gearing up the regional offices as facilitators for collaboration. Just as there is a need for a neutral partner to come in, just as we are here having this conversation with NRHA and NACHC, there is a need for a “facilitating role to be played at the local level.” There are things that should be solved purely on the local level and collaboration between CAHs and CHCs is a step in that direction.

Michael and Kasmar asked what is happening after ARRA for CHCs that have hired/matched with ARRA funds. Wakefield stated we try to pay attention internally to funding that is facing a cliff and hope the CHC trust fund dollars will help. It is starting to roll out with mandated spending. The patients that health centers have been so good at serving, the uninsured, under the ACA will have coverage which will change the revenue stream.

Wakefield asked Morris if he had any comments of clarifications. Morris clarified that 33 percent of health centers have a physical location in rural zip codes but that undercounts the rural impacts. More than 50 percent of health centers serve rural populations.

Alfero said this is an incredible time, and the task force is here to help. Wakefield agreed and said there is latitude with how resources are rolled out. Anything that is not bound by statute is being looked at for better ways to get the resources out. “The last things we need are silo mentalities.” HRSA cannot do this alone.

The task force was specifically asked to send ideas to Wakefield, who left the meeting carrying the packet containing all task force products to date.

## **Tom Morris, HRSA Associate Administrator for Rural Health Policy**

*The following is a summary, not an exact transcription of the presentation.*

*The slides that accompany this presentation are Attachment C.*

The Office of Rural Health Policy (ORHP) has been busy, and the staff has doubled to 50. Morris presented the organization within the office. The budget is \$168.4 million and ORHP now manages the black lung and radiation exposure compensation programs.

HRSA has a new publication on collaboration between CAHs and CHCs, "A Manual on Effective Collaboration Between Critical Access Hospitals and Federally Qualified Health Centers." Due to the expansion of CHCs and CAHs there are places where both are now in the same neighborhoods and they should be natural partners; oftentimes they are but not always. Both have a legislatively charged safety net role. Collaboration is an easier thing to promote than making it happen. Morris asked task force members to help distribute the manual since it presents three diverse case studies for successful collaboration and shows dollars saved to both organizations.

The Office for the Advancement of Telehealth began at ORHP and had spun off but now is back. There are three primary programs within this office.

- Telehealth Network Grants showing improved outcomes and clinical effectiveness.
- Telehealth Resource Centers, initiated by Congress, provide technical assistance to all entities no matter the structure, private, USDA-funded or HHS.
- Licensure and Portability Grant is working with states and licensure boards. Examples of the issues they are working on include licensure, reimbursement and referrals across state lines.

Morris asked the NRTF to help get the word out on these programs since it doesn't help to have resource centers if no one knows about them. The lead person is Sherilynn Pruitt, and Morris suggested Pruitt would love to participate in a future NRTF meeting.

## **HHS Improving Rural Health Care Initiative**

This shows a significant commitment on the part of the administration with \$79 million in the President's budget request.

### **The initiative has four pillars:**

1. Health workforce recruitment and retention
2. Building a programmatic "evidence base"
3. Telehealth/HIT coordination
4. Cross governmental collaboration

Much of what ORHP does is demonstration, putting money out for one to three years. They never looked at what worked and what didn't work but can bring more science to what they are doing. They are working with RAC and NORC to do an evaluation, and it will be put up on RAC, on what worked and what didn't to guide applicants to successful models rather than reinventing the wheel every time.

They are also reaching out to USDA, VA and working within HHS to collaborate in ways we haven't before.

The National Rural Recruitment and Retention Network (3RNet) is successful. Twenty-five states use the practice sites software which automates the whole recruitment process, and ORHP put money into updating the software. They have challenged other states to use the software because they know what works. But you can't just post jobs; you have to work with the community.

## **Rural Workforce Resources and Opportunities**

### **• Rural Training Track Technical Assistance Center**

There are currently 22 rural residency training sites. Over the years not all sites have been stable, some come and go. This technical assistance center is part of a solution to provide technical assistance and flexibility to see what might make these more successful. For example, if funds are needed to fly a resident to a training site, that would be allowable. If a site needs a T1 line so residents can participate in grand rounds at

their academic health center, that might be funded.

Note: Subsequent to the meeting, NRHA was awarded the grant to operate this TA Center.

#### • Rural Network Training Grants

Similar to the SEARCH program, which no longer exists, they get two to three unsolicited projects a year related to rural training. So using network authority they developed a program to fund 20 projects, evaluate them and maybe, if successful, this could become a part of the community-based programs within the office.

They wanted to pick up on some of the ACA provisions by redistribution of PC residents to have the opportunity to move some of the unused slots to rural.

Rural Residencies are not subject to the Medicare GME cap.

How do we work together to maximize the funds? We have an opportunity for the next five years to make an impact to change the culture of how we train providers. How do we assure that rural gets its fair share? CMS bonus payments help on the retention side, also reducing uninsured and uncompensated care under ACA should help with retention.

They are pushing for rural communities to take more advantage of Title VII and Title VIII programs. A lot of people do not know or understand programs like HCOP or how to get more rural applicants for HCOP. A state will get \$800,000 grants with Title VIII to open a nurse managed clinic, nurse traineeships to go from associate degree to BSN to advanced practice. States can use funds to pay for rent, transportation costs, etc. They have a huge educational challenge fostering campus partnerships.

BCRS-NHSC is underutilized by rural hospitals; it's not clear that hospitals are even eligible. It is harder to get to the required 32 hours of primary care if the doctor is going to the nursing home in the morning, maybe covering ER and hasn't been eligible for loan repayment. Now with the part-time option, this might change, but better articulation of the program is needed. Need to update the definition of primary care with a more modernized definition of the 32 hours requirement.

#### **HPSA**

Sixty-nine percent of Health Professional Shortage Areas (HPSAs) are rural, and the HPSA work is critically important. The meetings will be open to the public, and this must be done right. ORHP asked RUPRI to put together a primer on HPSA before the process begins on how you count, what works in the current system, what works about HPSA, and how to update HPSA and MUAs without upsetting the current infrastructure.

#### **Questions/comments**

Charlie Alfero stated the HPSA discussion is critically important to CHCs and when combined with MUA, exponentially so. He then posed the idea of a primary care HPSA that recognized systems of care and the providers needed. That would avoid needing new types of HPSAs; pharmacy HPSA, hospitalist, nutrition, etc. For example, if it is required for a CHC to have pharmacy services it should be included in the HPSA. He cautioned against the over bureaucratization of HPSA because of the expansion of funding and expansion of definitions.

Morris responded for the purpose of stimulating further discussion, saying that one open question is why combine the process? HPSAs have their faults, but we know what they are and we know how to do them. HPSAs were created for the NHSC and MUAs for health centers. One of the first questions the committee will have to resolve is whether or not they should be combined into a single designation.

#### **Projects with USDA**

Facilities: ORHP hospital staff is working with USDA developing an MOU.

Broadband: USDA just fund equipment, it's not a grant program. ORHP brings the telemedicine/distance learning piece.

#### **Project with VA**

The VA Office of Rural Health has a lot of funding which brings challenges. It is a new environment for them, and they are learning more about collaboration. The advisory committee to the VA ORH has issued a report with recommendations, but it is not public yet. The VA is very concerned about security and confidentiality.

### **ACA provision on CHC collaboration**

The ability to contract out, do rules need to be written for this? BPHC feels it is the same as existing practices and agreements. Maybe a PIN is needed to clarify, or may just operate under the existing rule.

### **Future funding**

They have a large sum of money for the next few years and then will face some austere, tough budget times.

### **Medical home in rural**

The National Advisory Committee in its 2009 annual reports included a whole section on medical home and NCQA from a rural perspective.

The report is Attachment F.

### **Workforce needs**

Bob Bowman addressed the primary care shortage crisis. The magnitude of the shortages creates a disconnect between policies encouraging primary care and reality of the workforce available now, or in the training pipeline. Jones-Taylor raised the issue of shortages of oral health providers, dentists and hygienists. Morris agreed it is a huge challenge, but the greatest success in expanding oral health has been through health centers. NHSC made more progress recently than in years past, especially with the part-time provider provisions. Miller informed the group of the NOSORH Oral Health Project and the work state offices are doing. It is clear that almost across the board there is inadequate infrastructure and facilities. Even if people can recruit oral health professionals, in many places there is nowhere for them to work.

Variability of AHECs was raised by Tom McWilliams; some are terrific, others not and even diverting resources. Morris said Wakefield would like more information about the ones that might need more direction or guidance.

There was discussion of a USDA paper by Rick Reeder about targeting resources to the places with greatest need; persistent poverty and completely rural counties. A shift from grants and loans to more guaranteed loans will hurt the neediest communities the most.

Miller cautioned that even though there has been a huge increase in resources for health care this is occurring at the same time that other departments and

agencies are cutting resources for rural communities. It is unclear if the ultimate effect will be a net loss, despite the increase in health funding. Because ORHP is engaged in the interdepartmental work, Miller asked if the office could be attentive to cutbacks in other departments and let the rural health community know of changes as well as opportunities. Morris said Bridget Ware is the person to contact within ORHP.

Alfero agreed saying that it is an alignment issue. We can train people for rural practice but if there aren't facilities for them to practice in, we will lose them.

NRTF Chair Marilyn Kasmar thanked Morris for making time to meet with the task force and leading a very informative discussion.

## **Workforce updates**

### **Developing the Future Health Care Workforce**

Kenneth Heiles, D.O., American College of Osteopathic Family Physicians president

*The following is a summary, not an exact transcription of the presentation.*

*The slides that accompany this presentation are Attachment D.*

Heiles has been a family physician in rural Arkansas for 25 years, director of medical education and family practice residency director.

The presentation began with an overview of the osteopathic profession in the U.S.; 70,000 D.O.s currently in practice, 15,000 students currently enrolled at osteopathic schools. More than 60 percent of D.O.s are in primary care. At the current rate of growth, there will be more than 112,000 D.O.s in practice by 2020.

Currently, one out of every five physician graduates is a D.O. With the growth of new medical schools and larger class sizes by 2014 two out of every five graduates will be a D.O. Most people practice within 50 miles of where they train.

Heiles suggested a number of policies that will improve the health care system and address workforce:

- Equitable payments for primary care
- Create economies of scale for rural providers

- Support new delivery models; accountable care, medical home
- Implement team-based care
- Increase training capacity
- Recruit students that reflect the workforce desired, maybe 3.2 GPA is better than 4.0
- Train rural in rural for rural
- Currently 60 percent of all residents are trained in 10 states
- Increase non-hospital ambulatory care training
- Use tax policy, loan repayment and other incentives to recruit to rural

### **Questions/comments**

NACHC stepped in to help the new osteopathic schools qualify for NHSC scholarships. Originally a school had to already have graduated a class before their students were eligible for the NHSC. NACHC helped change this policy, and now students at new schools are eligible.

Timing of federal funds is problematic; residencies start in July, but funds don't start until August.

Miller stated one of the most telling slides (slide 20) is the one where various entities estimate provider shortages between now and 2025. COGME and AAMC have the lowest estimates for the future shortages, much lower than HRSA's estimate. This is important because in the 1980s these same groups predicted a physician glut, which led to the shrinking of the National Health Service Corps and a movement away from primary care toward specialty training. And now this data shows that they still don't get it.

Heiles thinks the aging physician issue is somewhat different now with the downturn in the economy, many have lost retirement funds and are deciding to work longer.

McWilliams identified the insufficient residency slots as a bottleneck; it doesn't help to have a degree if there is not a residency. It doesn't matter how many new

schools there are if there are not enough residencies in primary care. For example, in Arizona there were seven family medicine residency programs, but the state lost two in the last two years; we are going in the wrong direction.

Alfero noted that the cap was supposed to lower health care spending but had just the opposite effect and led to more subspecialty training. New Mexico had three rural residencies start in 1996, and the next year the cap went into effect. They started small and are still small, all of them would like to grow, and they can't. The cap on residencies is "the most reverse impact I have ever seen implemented, this one thing."

Bowman provided the equation that he says best predicts rural practice; mid-to low-range MCAT schools (n = 140 schools), older age at medical school graduation, zip code of origin and zip code of training leads to higher probability of rural family medicine career choice.

## **Teaching Health Centers and Health Reform**

### **Krystal Knight, National Association of Community Health Centers**

*The following is a summary, not an exact transcription of the presentation.*

*The slides that accompany this presentation are Attachment E.*

Within the ACA there are two parts to the Teaching Health Centers (THC) program. The first part is Title VII Section 749 A and provides for the development, including capital, for starting a new THC. It is expected that this section will probably be run out of the Bureau of Primary Health Care. The second part, Title III, covers direct and indirect costs of being a THC, the actual payments to health centers.

Under the Affordable Care Act, a Teaching Health Center is "a community-based, ambulatory care center that operates a primary care residency program." The program is not limited to community health centers and includes, but is not limited to, the following:

- FQHCs
- Community mental health centers
- Rural health clinics
- Indian health centers
- Title X recipients

Primary care residency is broadly defined to include all internal medicine, all pediatrics, internal medicine-pediatrics, psychiatry, general and pediatric dentistry and geriatrics.

The development Title VII provision does not have an appropriation, and NACHC is hoping for an appropriation for FY2012.

### **Title III, new Section 340H**

This title is not funded through Medicare; it will be new money, \$250 million for five years.

Payments for direct and indirect expenses will be made directly to “qualified THCs.” The most important provision for health centers is language that requires the THC must be the “sponsoring institution” as determined by the relevant accrediting body (ACGME and AOA).

- Direct expense is calculated using a formula written in the statute. The formula is similar to the one used for children’s hospitals.
- Indirect expense formula calculation is delegated to the secretary to establish.

Currently there is only one health center that is a sponsoring organization. At the other existing THCs, the hospital is the sponsor. NACHC is encouraging all new THCs to apply and be certified as the sponsoring institution.

HRSA will set the limit on the number of trainee FTEs that will be established. If a hospital is receiving GME for a resident, the THC will not receive payments for the time the resident is at the hospital. This is in the statute to prevent “double dipping” or overpayments. To recoup overpayments, the secretary can reduce payments by up to 25 percent until repaid.

Community-based RHCs can also become THCs. It is unclear until regulations are promulgated whether the eligible RHCs will be not for profit or both for profit and not for profit. If large hospital systems can have one or more of their RHCs apply to be Teaching Health Centers, the result may be different from the intent of the legislation.

### **Questions/comments:**

Concern was raised about priority given to THCs with relationships with their AHEC. There are such differences among the states regarding AHECs it contributes to an unfair advantage.

Another concern is language about payments being in the form of reimbursements. What funds will CHCs have available to use for the teaching and residency costs, while waiting for reimbursement? Concern was expressed that HRSA has not had experience with reimbursement programs and might want to consider a joint powers agreement with CMS to manage the actual reimbursement and cost reports.

NACHC is collecting information now on specific types of training currently underway at health centers.

NRHA is hoping to work closely with NACHC on this to assure there are THCs in rural areas. This would make a good joint project specifically for the task force. There is a lot of brainpower in the room, a lot of experience already participating in training, and maybe we can come up with some best practices among task force meeting attendees.

There was a concern that the program may not be widespread in rural CHCs because there is a minimum population and capacity base at which it is possible to become a THC. Therefore, the THC is not a rural-friendly model.

The benefits to the health center are not financial, frequently all costs are not covered. However, anecdotal indications are that there are recruitment and retention benefits for CHCs that train residents.

Community economic benefits are very great. There is \$512 billion in economic impact per year from medical training programs. A few dozen zip codes in six states get 50 percent of that economic impact. Twenty-five states share less than 10 percent of that economic impact.

This results in a situation where Alaska gets basically no economic impact from medical education while Massachusetts receives a huge impact. The large training institutions also receive the majority of International Medical Graduates (IMGs). This perpetuates the later recruitment of the IMGs to the same urban areas where they train.

Concern was raised that this program is only established for five years without a reauthorization. It needs language that guarantees that if this THC program is not reauthorized, the THC is grandfathered into the Medicare GME payment system. No rational resident will choose a program that is not assured for the length of the residency.

Knight explained that some members of Congress see this as a demonstration program; however, realistically it needs to become permanent to truly succeed.

When the regulations and guidance are developed for the THC program, it is important to assure the money is available for the entire training period of a resident. This will assure that a resident beginning in years four or five will be supported for the term of the training, not the five-year life of the authorization.

ORHP also has funds for developing rural residency track training, which is another good place to encourage collaboration.

HRSA has already pulled together staff to begin planning for this new program, and they have committed to holding “stakeholder” meetings. The NRTF is urged to participate and bring its expertise to the process.

The funding calendar is off cycle. Funds are to be released in October of FY2011, but residency programs, which begin in the summer, will already be underway for that year. A recommendation of the NRTF should be that funds follow the residency, a July-June calendar, not the federal fiscal year.

Actually a THC must be guaranteed the funds at the time of the residency match process, earlier than November of the year before the residency is to begin. Otherwise, how can a site recruit and interview medical students for a residency program if they cannot guarantee that the slot will be funded?

The new THC will not solve the overall workforce crisis, but it is a good step that hopefully will improve health center recruitment and retention.

## **NRTF discussion of HRSA updates**

This part of the meeting was used to collect reactions to the HRSA updates and all ideas that the task force wants to send forward to Wakefield and Morris.

Rosemary McKenzie was recognized for her success at having Wakefield attend the task force meeting. With all of the intense work going on inside HRSA and how extraordinarily busy Wakefield is, it is an especial honor for all of us that she attended and not only presented but was able to stay for an open and mutually beneficial discussion.

Wakefield, by attending our meeting, demonstrated HRSA’s commitment to the task force and our success bringing together CHCs, PCAs, PCOs, SORHs, NACHC and the NRHA. The Task Force was also able to demonstrate to Wakefield how well we work together. Through consensus, our diverse members have established a unified goal for meeting the health needs of rural and frontier communities.

### ***Follow-up: NRTF commits to help HRSA succeed***

NRTF allocated the next two hours to brainstorming ways the task force can help HRSA succeed in its implementation of health reform. Doubling the number of people served each year to 40 million, 10 percent of the population, is a very large assignment. But as Wakefield challenged us, we are working hard to achieve success.

The unfiltered results of the brainstorming follow. The group ranked them as priorities, and these recommendations are presented later.

### **Alignment within HRSA, breaking through silos**

- All of the various new programs in HRSA are going into different offices. We need to urge that resources within HRSA programs be aligned. If health centers are expected to double the number of patients, that will take 100 percent more providers.
- HRSA thinks they have done this alignment, and the task force wants to support them.

- For example, if all the money for loan repayment goes to support independent loan repayment in urban areas versus funding going to rural CHCs, not much has changed.
- Because of the large infusion of ARRA funds NHSC stopped prioritizing HPSA scores. Many slots went to urban and private sites. There needs to be a policy for prioritizing HPSA scores based on need.
- BCRS is developing a matrix based on systems of care to help with this in the future.
- This is the first time members of the task force have heard someone high up in HRSA refer to silos and the negative effects. The task force wants to support HRSA in its efforts to reduce the silos.

### ***Improving outcomes for rural grant applications***

- It was recommended that ORHP consider a simplified application process for small projects, a “letter of intent” process for grants with a two-step process. The review process should also accommodate projects from the smallest rural communities. This will increase funding opportunities for the least resourced areas.
- Community self de-selection occurs where people do not have the resources to apply or find the expectations unrealistic.
- Some of the barriers are very basic for proposed new rural sites:
  - The requirement to open in 120 days is a barrier in communities with no facilities and infrastructure.
  - It takes longer to recruit providers to small, remote communities.
  - The need for assistance worksheet needs further improvement. It should have more weight so that funds can be targeted to the places with the greatest need. It is important to look at need in rural communities versus those with access to good grant writers. This will help target resources based on need.
- Pre-application letters might be good in conjunction with the planned revitalized role of regional offices

(grant writing). HRSA is allocating resources for technical assistance to rural communities and ways to improve the review process.

- The task force must speak up about the importance of targeting aid to rural.
- BPHC is funding PCAs to provide community development and grant writing technical assistance. Using the PCA gets the right kind of help within a state rather than national technical assistance contracts.

### ***Service area concerns***

- Overlapping service area applications are a serious problem; politics play a major role in funding.
- Concern for fair competition for rural applicants, lack of capacity of rural organizations and lack of resources to apply and lack of resources inhibit applications.
- Politics is politics, and it is not always fair.
- Can't completely be passed along to the state where it gets into state and local politics.

### ***Building partnerships among PCAs, PCOs and SORHs***

- With HRSA regional offices, work together to level the playing field. Some states have succeeded in working together, and others have not. There should be more sharing of best practices by the states where collaboration has demonstrated the best outcomes.
- Funding should encourage and reward collaboration. Maybe as basic as just requiring documentation of working together in the annual reports to HRSA.
- Support PCOs to work with organizations other than FQHCs. PCO funding comes from the Bureau of Health Professions. It should be more inclusive of NHSC, BPHC and ORHP.
- PCAs are required to support communities, not just its members as a trade association, which is the community development role of the PCA. The bureau expects the PCA to identify access issues within a state and help develop resources to bring services to places where they are needed, to be more than a trade association, which is a difficult role.

- PCO/PCA need relationships with academic training centers: plan, implementation and link. PCOs need to build strong links with in-state training programs.

### ***Increase use of cooperative agreements***

- Strongly support the development of more cooperative agreement relationships. There should be reduced reliance on grants, which are required to be competitive, at least periodically. Categorical grants increase silos by their very nature.
- NRTF recommends HRSA use cooperative agreements and/or memoranda of agreement to sustain existing relationships as well as to develop new relationships focused on maximizing limited resources, to reduce duplication, to encourage collaboration and voice and to make improvements that work.

### **How can NRTF help HRSA be successful in implementing health care reform?**

- As HRSA looks at its structure; we are well positioned to help best meet the needs of rural communities.
- There will be between 7,000 and 10,000 new CHC locations to meet the goal of serving an additional 20 million people. HRSA is to add an additional 15,000 NHSC providers. Where will these Corps providers come from? It will take many partners, old and new, to achieve this goal.
- How can we help leverage available funding? We are headed to tight economic times. How do we meet the large goals with little money? Can some of the functions merge or is there a better allocation of resources to eliminate duplication?
- There are issues of trust but there is also confusion about what each of the parts of the system does. Need to bring in other partners such as public health and work towards better collaboration.
- The task force can help organize alignment. Most important, just as we have built trust among

ourselves as a task force, we commit to help build trust more broadly among the different members of the FQHC family. Some steps are as simple as inviting dialogue to learn what each of us does and then work to fit the pieces together.

Concern was expressed about the distribution of ARRA workforce resources, much of which went to urban. The more remote areas are not getting NHSC resources; there was too much money to move so quickly. Stopped looking at HPSA score, allowed more than two loan repayers at a site, relaxed existing policy to use all the ARRA funds. Some sites received help even if they were not completely ready to move on short notice.

The task force also expressed its interest specifically in helping the bureau get out the much-increased resources. BPHC is adding 100 new project officers, most of who have not previously worked in the health center program. It will take a lot of work to help get the ACA implementation under way. The task force can help assure appropriate distribution of these resources to rural centers.

How is the task force going to choose its focus from among all of the ideas and brainstorming? How will we set our priorities? A lot of workforce issues have come up today. Since we have done the vision statement last year, are we done with workforce and ready to move on, or are there still workforce items to address?

Asked for HRSA's goals for the group, McKenzie read the description of NRTF included in the current ORHP-NRHA Cooperative Agreement. The two prior years had been funded by the BPHC-NRHA Cooperative Agreement.

### ***The purpose of the task force is:***

To help rural communities move toward the improvement and expansion of access to health care, it is important to continue partnering with other organizations in order to expand and improve access to culturally competent, quality health care and to ensure that services are appropriately available to rural and frontier patients, including primary and preventive services, as well as enabling services.

### **Mission of the task force:**

To discuss rural issues, communication strategies and build partnerships to promote the long-term growth and sustainability of rural C/MHCs.

The vision statement was sent to all NRHA members in the e-newsletter. NACHC sent the vision statement to members of its rural committee and all of their V-Ps.

The history of the predecessor Joint Task Force was that there was tension between the two associations, and BPHC felt it was important to create a place for rural NACHC members and staff to get together with NRHA members and staff. It was very beneficial for both associations.

It is important for NACHC and NRHA to elevate the task force among their members. There are a lot of talented people who could be helping us in our work who don't realize we exist. Tomorrow we will discuss who needs to be in the room for our next meeting. Outside groups recognize the importance of the task force. We have been able to have presentations from the National Council of State Legislators, the National Governors Association, Medical Education Futures, leaders from most of the HRSA bureaus, ORHP, National Association of State Medicaid Directors and others.

The focus of this task force is to work inter-organizationally for the benefit of rural and frontier health centers and improving access. There are steps NRHA and NACHC can take to work more closely together. For example, NACHC can encourage rural centers to become NRHA members, and NRHA can focus some of its activities on rural health centers. NRHA members from health centers think NRHA is too hospital focused. They feel that some people in NRHA are "unfriendly" to health centers when they are at NRHA meetings.

Members suggested NRHA change the website to make it easier to find the task force meeting and conference call summaries, the compendium, reports and policy statements.

The group recommends NRHA present at NACHC conferences and NACHC present at NRHA conferences. This used to happen in the past and should be re-established by the two associations. McKenzie will follow-up on improving the website and starting an e-group.

Kasmar asked everyone to look at the NRHA website and come back tomorrow with suggestions.

### **Day 2: July 15**

Miller began the meeting suggesting the group prioritize the ideas it raised yesterday as well as review the progress on the workforce goal set at the first task force meeting. Next, the group will set the goals and work plan for 2011. Among the next steps would be several organizational and membership changes, these changes will be informed by the survey completed by members of the task force.

Miller reminded members that from the beginning, they made it clear they did not want to be a member of the NRTF just to go to one more meeting or participate in the conference calls. At the first meeting, members agreed that the purpose was to come together to develop policies, to reach consensus across professional, geographic and organizational diversity for the purpose of the mission: To discuss rural issues, communication strategies and build partnerships to promote the long-term growth and sustainability of rural C/MHCs.

The task force has made it clear it wants to set tasks, complete the tasks, impact policy, and move on to new tasks. Its members have committed to be a work group with the emphasis on work.

### **Survey discussion**

A survey was sent to members of the task force in preparation for the discussion today. The group reviewed the results together. All are very happy and honored that high-level people from numerous national organizations have made time to present in person at the annual meetings and/or participate in the conference calls.

Wakefields's participation this year demonstrates her recognition of the task force at the highest level of HRSA, which is very significant. It elevates the status of the task force within HRSA and accomplishes our highest priority goal: to bring the concerns and issues of the task force to the attention of HRSA.

We accomplished the goal of bringing people together to hear the latest research and the policy efforts of other organizations. Overall, members felt that their expectations for the task force had been met.

There was unanimity in response to the statement that "the work of the task force is important to my organization."

Miller asked the group to help focus some time on the areas where members indicated their expectations were not met so that could be improved as the group moves into the new year. For example, should there be subgroups to focus on particular areas and report back? Are there other ways to better meet expectations?

The group was reminded that each year, they set the topics of the teleconferences and suggested presenters. McKenzie then arranged the conference calls and lined up the specific speakers. It is a testament to McKenzie that no one has turned down the opportunity to present, which is why our presenters have been at such a high level.

### **Future membership**

As we set the future tasks, we should ask "who needs to be in the room as we move forward." We did ask NOSORH for a representative, and they appointed Graham Adams from South Carolina. We had invited AHEC but did not get the participation we had hoped. The current co-chairs were thanked for their wonderful support of staff and great leadership to the group.

### **Next steps**

As the discussion progresses, ideas will be written on a flip chart for later review and prioritization. It is okay to critique our past work because we really want the next phase of the task force to advance an important policy agenda for rural migrant and community health centers. There is a lot on the table. With the increased funding comes increased responsibility.

Greg Dent reminded us that in the early meetings we were disappointed that HRSA leaders did not attend the meetings to meet with the task force. Now we just had the head of HRSA, which is a major accomplishment.

Adams asked about linking the task force to either a NACHC or NRHA meeting. This is difficult for those who do committee work, but for many people those are already long meetings, but we will look at that. McKenzie reminded the group of all the extra meetings in conjunction with the NRHA annual meeting. Lathran Woodard pointed out that in addition to time constraints, it would be difficult to have the quality of speakers in conjunction with another meeting. That is another reason for holding the meeting in D.C. Others agreed that it should remain a free-standing meeting.

Alfero recommended presentations on the task force at both the NACHC and NRHA meetings, and we should share our products. Others agree this would increase the impact of the work we do.

Woodard followed up with the idea that the task force should also report to the leadership of both organizations, giving visibility to the task force and showing accountability from the task force to NACHC and NRHA. Flow the work up through the organizations' policy systems which would impact both organizations. Also have the task force report to the NACHC Rural Committee.

Feedback requested from NRHA

Request that NRHA report how they see the value of the task force and what we are doing or what NRHA will do with the work and recommendations. Having Kris Sparks, NRHA president-elect, as a member of the task force also creates a much stronger link to NRHA leadership, which elevates NRHA participation. This is currently NRHA's only task force that holds face-to-face annual meetings and has ongoing funding.

Wakefield is detailed-oriented; she referred to our paper; she has used our vision statement. Wakefield spoke our work back to us. And importantly, she short-circuited the layers to get to her, asking us numerous times as individuals and as a task force to send her

our ideas and recommendations. Members feel the recommendations of the task force as a whole should follow a “chain of command” to NRHA and then NRHA share the work with Wakefield.

Wakefield has made it clear at several meetings attended by task force members that she has delegated to her bureaus and office directors, that they have a lot of responsibility and decision-making authority, that everything does not need to come to her. They have more flexibility than in the previous administration, so everything does not have to come to her.

Jones-Taylor said we should come up with a list of questions to answer within the broad topic areas. For example with HIT, what are the rural issues? Is it infrastructure, ability to staff, what are the specific challenges for rural health centers? Workforce, what policies do we want to impact? Our discussions should focus on those.

As an example, Bowman raised the excess workforce costs involved in recruiting to remote centers, such as in Alaska. The cost of securing workforce even through contract or other short-term solutions is different; this is something the task force might address.

Crux of the meaningful use is whether it is possible to recruit or hire staff that can run the system and/or do the analysis to provide information, which will improve health outcomes, the practice or delivery system.

### **Task and next steps**

Take on the issue of alignment. For example, there are multiple new initiatives all within BHPR. How do these align, coordinate generally as well as regarding CHCs?

Become official advisory to HRSA.

NACHC Rural Health Committee Chair Sip Mouden wants more involvement. That committee has 63 members, and they should have a presentation from the task force at the next meeting. Last year for the first time in years, both Tom Morris and Alan Morgan presented at the NACHC P&I. Focus on strengthening links between NACHC, ORHP and NRHA. NRHA should exhibit at NACHC meeting and have NACHC

and the task force present a session at the NRHA Policy Institute.

HRSA needs to know what is going on in the field, and this group is a place to help. ORHP has been highly elevated in this administration, and we should seek a liaison role for the task force.

Medical home and what it means to rural in particular. Free clinics have defined it as sickness care since that is how people they serve get help. It is more episodic than a CHC model.

Task force members like the health home concept. Legislators are confused with the multiple terms. We should define the elements and not have them defined for them. Alaska is working with their state Medicaid program to define this for Alaska.

Physician assistants (PAs) are excluded from meaningful use. Unless the PA is the medical director, a site will not get meaningful use incentive payments. There should be a policy to address this.

Define products and the best venue for moving them forward and then disseminate.

Should we bring AHEC back to the table? AHECs are not universally effective; some states do much, much better than others. If the priority is not workforce, would AHEC still have a role? Steve Shelton of Texas was suggested as an active NRHA member and AHEC leader, also Caroline Ford of Nevada.

Develop recommendations on meaningful use, medical home and accountable care organizations. Of the many criteria contained within each, which make the most sense and also which are doable in rural America? Including the impacts of health reform would match with the top four interests of the NACHC Rural Committee.

The group agreed to send the NACHC Rural Committee survey to the members of the NRHA’s Community Operated Practices Constituency Group. If the results are similar, it begins to create priorities for the two organizations.

The group is aware and concerned that NCQA has patented the term patient-centered medical home and

has created a business out of certification. There will be a summit in the fall about NCQA and medical home. Stevens at NACHC is hosting an invitational meeting, with support of Kaiser, to discuss this topic. NRHA will be at that meeting. The rural implications for medical home are especially important to the group, costs of certification to small organizations, etc.

### **Finalizing next steps**

The full membership of the task force will be asked to prioritize goals, tasks and topics for conference calls, as has been done in the past.

Medical home has important political implications. NCQA has self-serving agenda, possibly no rural involvement.

We need to dig into one topic this year to be effective, not spread thinly with too many tasks.

A concern was raised about the impact of the growth of 330's budget on comprehensive services in rural. PINs on map mentality without regard to quality, readiness, community leadership/ownership. Quality and improved outcomes require additional resources. It is important to support existing providers well and fund additional services. That goes against the PINs on the map approach. Is it all about adding new users, or better care and services to existing patients? Rural will never win the numbers game.

What about adjustments to the base. Especially important for sites which are maxed out with users and market share. ARRA adjustments helped but will they continue? Until the ARRA help, some health centers hadn't had an adjustment to base since 2003.

Jones-Taylor wants the task force to elevate the issue of quality over widgets. The President's Initiative (Bush) set unfair competition and moved resources from the southeast towards California which could provide the numbers.

Patient-centered should be the focus, improving health outcomes and reducing disparities.

Seeing a shift in the business model from one based purely on volume to outcomes focus with incentives for quality and chronic disease management. What does quality mean? Addressing chronic health conditions

doesn't happen in a 10-minute office visit; it requires a primary care team, not only medical interventions.

### **Update vision statement**

*The vision statement is Attachment G.*

Miller read from the vision statement. We said this to support workforce last year. We might want to restate it for quality and outcomes. Health centers are the model, chronic disease collaboratives were created by our movement. NCQA is trying to capitalize on what health centers created. We are really talking about building on the foundation of the vision statement. The NRTF has raised the social and political determinants of health.

Update the vision statement based on the passage of the ACA. Last year was a whole different world; several of the things we called for are done, such as increasing the NHSC. Let's take credit for that.

Take the next conference call or two to update the vision statement. Send as a document with columns for the group to indicate the individual items done, not done, on the table, etc. See if we have consensus on what has been done. Expansion alone of Corps didn't always meet our purposes of improving rural and frontier CHCs. Disparities among patients is important.

The task force members would like the various products as hard copy. Not just an e-mail link or PDF.

Bureau and ORHP staff should be on all of the calls.

Task force members should be charged with sharing all the products with their organizational contacts and networks. McKenzie thought this was already happening, but it has been clarified that the members' role is to help NRHA disseminate.

McKenzie has distributed hard copies of the various reports under the BPHC Cooperative Agreement to all health centers. Adams pointed out that there are three members of the NRHA board at this NRTF meeting and none of them have seen, or remember seeing, any of the many publications. There is a breakdown somewhere within NRHA and its distribution of products. Dissemination will become a priority because the products are excellent. As a task force we are proud of the hard work, great reports, new friendships, increased interagency partnerships and

the future impact our rural voice will bring to the implementation of health reform.

Reform implementation and tracking the changes, rule making, regulations to read at the state and national level. Is anyone tracking the time? Isn't this all piled on top of all the existing work, not to mention doubling the number of sites and patients at the same time.

Miller specifically mentioned the importance of

assuring a covered benefits package robust enough to cover the whole team needed to meet the desired outcomes. The definition of "essential health services" will be key to the entire reform.

During the conversation of what the task force can change and improve to increase its effectiveness items were written on a flip chart at the front of the room. The following recreates the flip chart.

- What could be done better?
- Consider AHEC representative to NRTF
  - Use technology, Web-Ex (Go to meetings)
  - Presentations at annual meetings (NACHC/NRHA)
  - Produce written policies for NRHA and NACHC
  - Articulate workforce issues to align federal resources
  - NRTF will report to NACHC and NRHA leadership
  - Get feedback from NRHA, the value it adds to NRHA
  - Ambassadors to NRHA/NACHC committees (policy)
  - Advisory to HRSA, increase the connection
  - NACHC Rural Committee → collaboration with task force on agenda and presenters
  - Increase connection to ORHP Liaisons

### **Leadership transition**

Kasmar asked for nominations and volunteers to move into task force leadership. Being the chair has been a great experience. The vitality of organizations depends on refreshed leadership, so she retired from the chair position. She gave the responsibilities and then opened the floor to nominations. The task force applauded her as a sign of their appreciation of her leadership.

### **New officers**

Members present elected Mike Samuels and Greg Dent as co-chairs. The task force requested that there be an orientation: leadership, how to track members' roles, and feelings.

Kasmar recommended the leadership check in with members individually. It is better not to wait for a survey to learn more about the members' ideas of ways to work more effectively.

### **Communication plan**

- It was decided that the new and old chair and vice chair, together with McKenzie and Miller draft a communication plan to present to the members.
- Make it easier to find our publications online. Easy to find link on NRHA home page.
- Put all CHC publications under the COP CG link.

- Provide multiple hard copies of all publications to task force members.
- Members commit to disseminating the work of the NRTE
- Task force needs greater branding. The graphic designer is talented, so we can ask their help.

**New members**

Nominations will be based on geographic diversity and expertise for the FY2011 priority. In support of our mission, the primary involvement of CHCs, PCOs, PCAs and national organizations will be maintained. Names that were brought forward are:

- Steve Shelton (AHEC) – Texas
- Sip Mouden, Community Health Centers of Arkansas CEO (NACHC Rural Health Committee Chair)
- Kenneth Heiles, D.O. – ACOFP, Arkansas
- Carmela Castellano-Guarcia – PCA, California
- Scot Graf – PCA, Dakotas
- David Queckenbosh – CVHN
- Thomas Rauner, PCO director, Nebraska
- ASTHO
- National Association of Counties rural staff
- Kim Byas – American Hospital Association

Adams mentioned in some communities there is tension between hospitals and health centers and asked should there be AHA input on the task force? The tension may increase as health centers expand, and he mentioned John Supplitt or Kim Byas. There was agreement Byas would be good, also as a link to the NRHA Multiracial and Multicultural Health Committee.

**Geography of current members**

- Alabama (PCA)
- Alaska (PCA)
- Arizona (3) (two academic medicine and PCO)
- California (CHC)
- DC – NACHC (national)
- Georgia (CHC)
- Kentucky (academic public health)
- Mississippi (CHC)
- Missouri (staff)
- New Mexico (3) (CHC and SORH-retiree, facilitator)
- North Dakota (CHC)
- South Carolina (2) PCA, NOSORH representative
- Washington (SORH, NRHA president-elect)

<p><b>To do: Policy issues</b></p> <ul style="list-style-type: none"> <li>• Workforce (impact of health reform)</li> <li>• HIT (rural health center’s infrastructure)</li> <li>• Medical home (NCQA) – does rural have a definition? <ul style="list-style-type: none"> <li>○ T. F. policy paper</li> </ul> </li> <li>• Meaningful use (impact of excluding PAs)</li> </ul>	<ul style="list-style-type: none"> <li>• Impact of huge CHC dollars on comprehensive services in rural <ul style="list-style-type: none"> <li>○ NACHC survey : review, disseminate to NRHA COP CG</li> <li>○ Maintain quality: rural systems are different (patient-centered), health outcomes</li> </ul> </li> <li>• Update vision statement to current environment <ul style="list-style-type: none"> <li>○ One or two conference calls</li> <li>○ Third call: finalize the work plan for the year</li> </ul> </li> <li>• Review ACOP/AOA policy recommendations</li> </ul>
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## **Next steps**

Do you feel your ideas are reflected in our broad outline? If not, tell us how to better communicate that so we can reflect your ideas.

Miller: We have worked really hard. We are trying to hold up the flag for the underserved in the face of a big tidal wave that is coming. We won't even know some of the changes for years until regulations and policies are written and implemented.

1. Our goal is the people. Paradigm shift to patient-centered care with incentives to keep people healthy or improved health.
2. Who gets trained, who pays for the training to guarantee that there is access, providers where they are needed.

## **Compendium**

Members were reminded to submit models that work for the compendium part two. We are building a body of knowledge for wide dissemination.

## **Round robin**

The meetings always end with going around the table, a space for every member to share their thoughts. An abbreviated compilation of the comments follow. Numerous people expressed sincere appreciation to Wakefield, recognizing the significance of her attendance. McKenzie was also recognized by all for her work.

- Lucky to be a part of this group with all the hard work we have done, and a pleasure getting to know each other. Our vision statement is beautiful and forward thinking.
- I leave today with a clear vision, view of the work ahead. A lot of good ideas came forth. I will contribute more as we move forward, bringing out the issues affecting rural America.
- There is a lot of trust for the task force and among its members.

- This was time well spent.
- Leave with a lot of knowledge from these meetings. Learning from each other, from different professions.
- It is important to have the SORH perspective included, appreciate being the NOSORH rep.
- Very productive meeting. I am glad that we have developed concrete deliverables.
- Appreciate setting an action plan.
- Let's also consider what is it that we accomplish and how we will rate our effectiveness.
- We can be proactive and not reactive. Say this is what we seek for policy. Not just react to policies as they come up.
- See the context, what is the big picture and where do we fit in. This was an important meeting.
- Look forward to a closer collaboration with NACHC, especially the Rural Committee.
- Teaching Health Center presentation was very helpful.
- The next year and a half is critical for success of the implementation of all of the workforce initiatives.
- NRHA staff will see that there will be more impact within NRHA and will take knowledge of the NRTF to the Government Affairs Committee.
- Individuals need to feel productive with a group, that their role and purpose for being there is essential to the group effort. The new action plan will help assure our members are productive.

## **Meeting evaluation**

Task force members were reminded to complete their meeting evaluations. The evaluations are important to the current and future work of the NRTF.



## Attachment A

**National Rural Health Association  
National Rural Task Force meeting**  
July 14 – 15, 2010  
Hotel Palomar, Arlington, Va.

Rural workforce issues: Challenges and opportunities

### AGENDA

#### Tuesday, July 13, 2010

7:00 p.m.

**Optional, informal group dinner**

Meet in hotel lobby

#### Wednesday, July 14, 2010

8 – 9 a.m.

**Networking breakfast**

9 – 9:15 a.m.

**Opening**

Marilyn Kasmar, NRTF chair

**Welcome**

Alan Morgan, NRHA CEO

9:15 – 9:30 a.m.

**Goals of the meeting, background, outline,  
ground rules**

Marilyn Kasmar, NRTF chair

9:30 – 10:15 a.m.

**Introductions and round robin**

Participants introduce themselves and briefly describe their top goal for the meeting.

10:15 – 10:30 a.m.

**Break**

10:30 a.m. to noon

**HRSA update**

Mary Wakefield, Ph.D., HRSA administrator, will discuss the Administration's efforts on behalf of rural C/MHCs.

Tom Morris, HRSA Office of Rural Health Policy associate administrator, will discuss ORHP's workforce initiatives, the impact of OAT within ORHP and rural HIT issues.

Noon – 12:30 p.m.

**Question and answer period**

12:30 – 1:30 p.m.

**Lunch**

1:30 – 2:30 p.m.

**Workforce update**

Kenneth Heiles, D.O., American College of Osteopathic Family Physicians president

2:30 – 3:30 p.m.

**Teaching Health Centers**

Krystal Knight, National Association of Community Health Centers public policy associate

3:30 – 4 p.m.

**Question and answer period**

4 – 4:15 p.m.

**Break**

4:15 – 4:30 p.m.

**Small groups 1**

Carol Miller, facilitator

4:30 – 5 p.m.

**Reports from small groups 1**

5 – 5:15 p.m.

**Open discussion**

5:15 – 5:30 p.m.

**Day 2 overview, task force feedback**

Carol Miller, facilitator

7 p.m.

**Optional, informal group dinner**

Meet in hotel lobby

## Thursday, July 15, 2010

8 – 9 a.m.

### **Networking breakfast**

9 – 10 a.m.

### **Next steps**

Carol Miller, facilitator

Small groups 2

10 – 10:30 a.m.

### **Reports from small groups 2**

10:30 – 10:45 a.m.

### **Break**

10:45 – 11:45 a.m.

### **Open discussion, consensus on next steps**

11:45 a.m. – 12:45 p.m.

### **Forum: Brief comment by each participant**

### **Task Force member “assignments”**

12:45 – 1 p.m.

### **Complete evaluations**

1 p.m.

### **Box lunches available**

## NOTES AND BACKGROUND

### **PARTICIPANT GROUND RULES:**

- This is a task force, and everyone is expected to be an active participant.
- Small groups will be assigned by the facilitator to mix it up as much as possible.
- The closing forum is similar to the opening introductions because we will ask every person to provide a closing comment.

## Attachment B

### National Rural Health Association National Rural Task Force 2010 meeting participants

July 14 – 15, 2010

Arlington, Va.

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**Robert Bowman, M.D.**

**Professor of family medicine**

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**Greg Dent**

**President and CEO**

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**Program Services vice president**

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**President**

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**Aurelia Jones-Taylor**

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**Krystal Knight (speaker)**

**Federal affairs public policy associate**

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**Rosemary McKenzie (staff)**  
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**Executive director**  
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**Tom Morris (speaker)**  
**Associate Administrator**  
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**Bureau chief**  
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# National Rural Task Force Meeting

## Office of Rural Health Policy Update

July 14<sup>th</sup>, 2010



- What's New at ORHP?



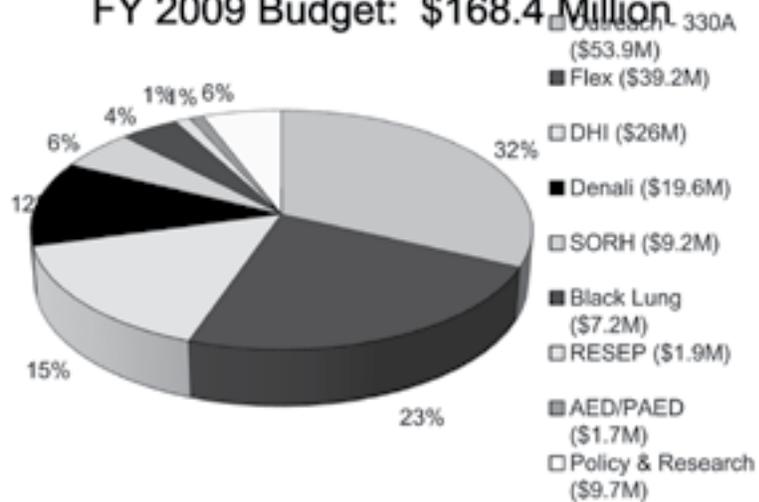


# ORHP Structure



## ORHP & Key Rural Program

FY 2009 Budget: \$168.4 Million





## FQHC-CAH Collaboration Manual

- Just released and now available at:  
<http://www.hrsa.gov/ruralhealth/about/news/index.html>



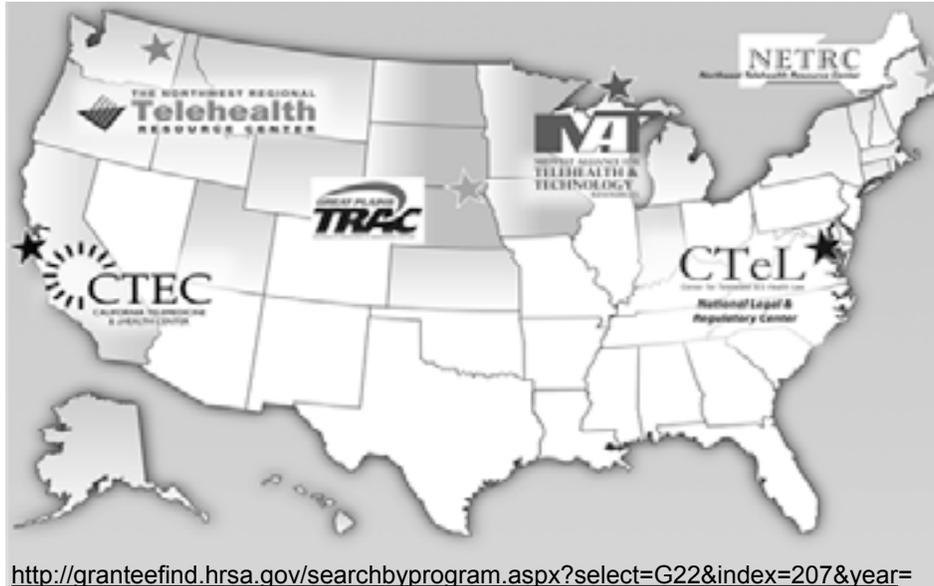
## Office for the Advancement of Telehealth

- New Addition to ORHP ...
  - Telehealth Network Grants
  - Telehealth Resource Centers
  - Licensure and Portability





# Telehealth Resource Centers



“Within the total amount requested for Rural Health activities, the Budget includes \$79 million to continue the President’s initiative to improve rural health. The goal of this initiative is to improve the access to and quality of health care in rural areas.



# The Improving Rural Health Initiative: Key Elements

▪ Health Workforce Recruitment and Retention	
▪ Building a Programmatic "Evidence-Base"	
▪ Telehealth/HIT Coordination	
▪ Cross Governmental Collaboration	



## Rural Workforce Resources & Opportunities



The Rural Recruitment and Retention Network  
www.3rnet.org



## Rural Workforce Resources & Opportunities

- The Rural Training Track Technical Assistance Center
- The Rural Network Training Grants



A Family Medicine resident in Idaho

Awards Expected by  
September, 2010



## Health Reform & Workforce: One Possible Scenario for Rural

- Linking the Key Provisions
  - Medicare GME
  - Residency Expansion Funding
  - Teaching Health Centers
  - Rural Training Track TA Center





## Health Reform & Workforce: An Indirect Benefit ...

- Bonus payments for primary care docs and ge surgeons
- Reduction of uncompensated care



## How to Help Rural Connect the Title VII and VII Dots ...

- Title VII:
  - Area Health Education Centers
  - Primary Care Training Grants
  - Dentistry
  - Health Careers Opportunities Program



- Title VIII
  - Advanced Education
  - Traineeships
  - Nursing Workforce Diversity

- BCRS
  - NHSC
  - Nursing Scholarships
  - Nursing Loans
  - SEARCH



## The Rural Challenge in Health Workforce

- Getting Existing Dollars and Programs to Focus on Rural Challenges
  - Making Sure Programs Accessible
  - ...
  - Getting Institutions to Include Rural in their Applications
  - Creating Partnerships between Rural Providers and Health Profession Schools



## Contact Information

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Associate Administrator for Rural Health Policy  
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<http://ruralhealth.hrsa.gov>

# Developing the Future Health Care Workforce

National Rural Health Association  
National Rural Task Force Meeting  
July 14, 2010

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Meeting



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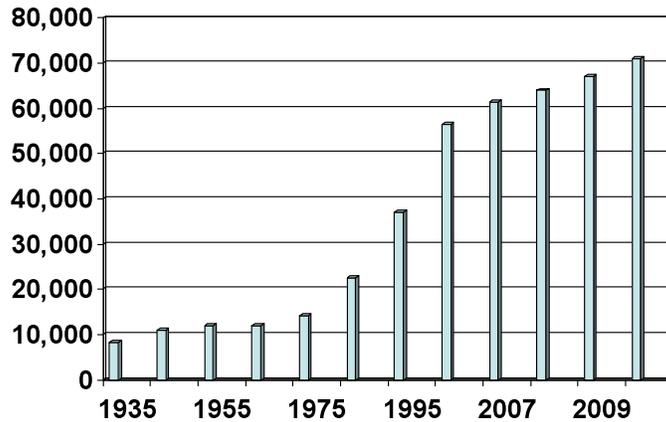
## Overview of the Osteopathic Profession

- 70,480 osteopathic physicians in practice
  - 697,800 allopathic physicians
- 29 Colleges of Osteopathic Medicine
- 15,000+ students enrolled in colleges of osteopathic medicine (2009-10)
- 60.5% practice in primary care specialty
  - Family medicine, internal medicine, pediatrics, OB/Gyn
- At current rate of growth, it is estimated that at least 110,000 osteopathic physicians will be in active practice by 2020

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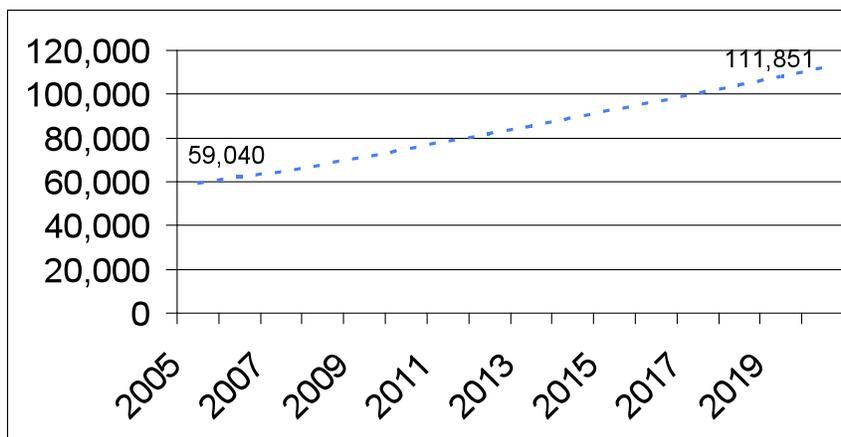
# Growth of Osteopathic Profession 1935 to 2009



National Rural Task Force Meeting



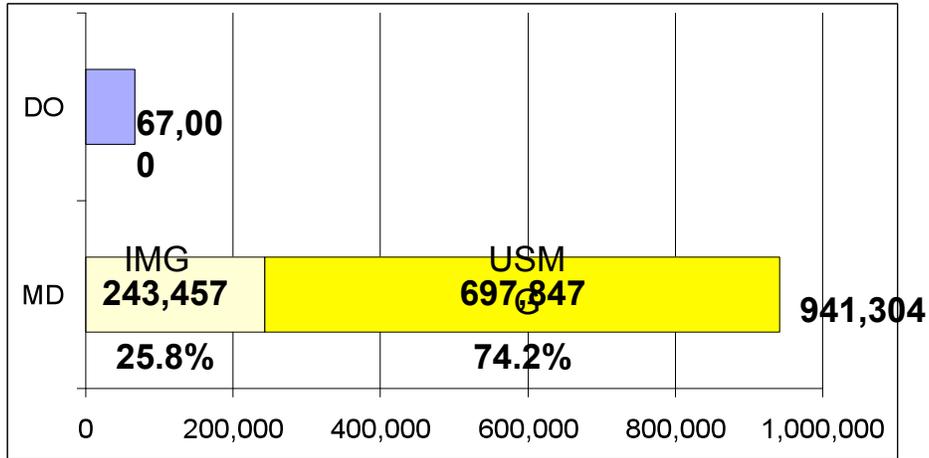
# AOA's Projected Number of DOs



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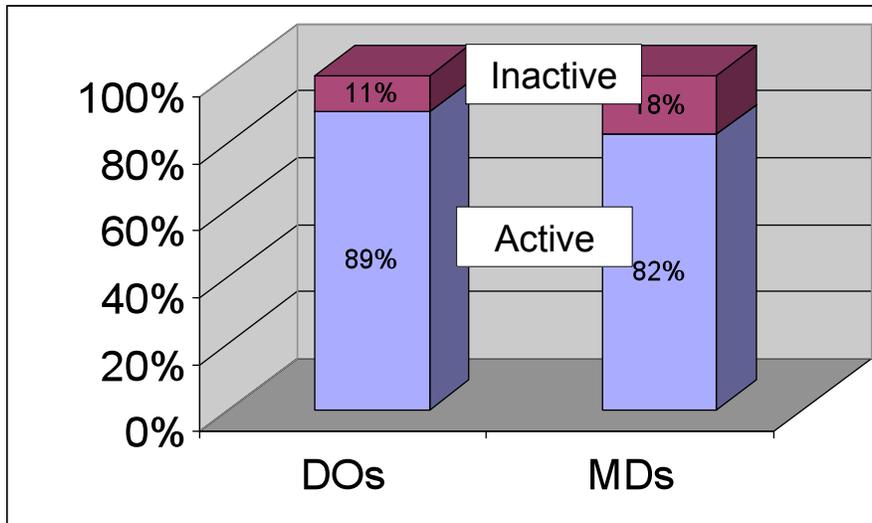
# DOs and MDs



National Rural Task Force  
 Sources: American Osteopathic Association, 2009  
 AMA Physician Characteristics and Distribution 2009



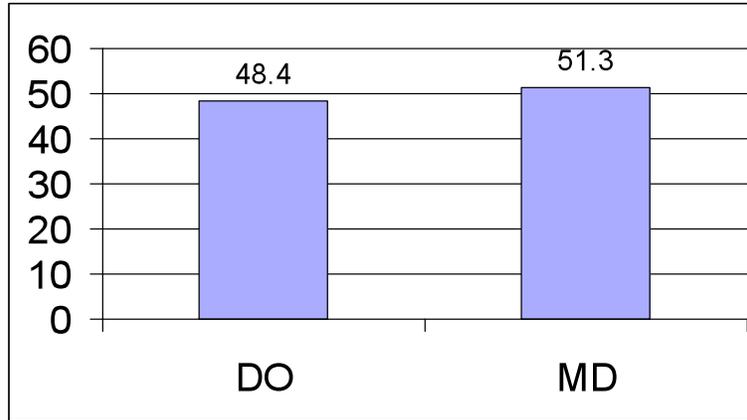
# Physician Pool



National Rural Task Force  
 Sources: American Osteopathic Association, 2009  
 AMA Physician Characteristics and Distribution 2009



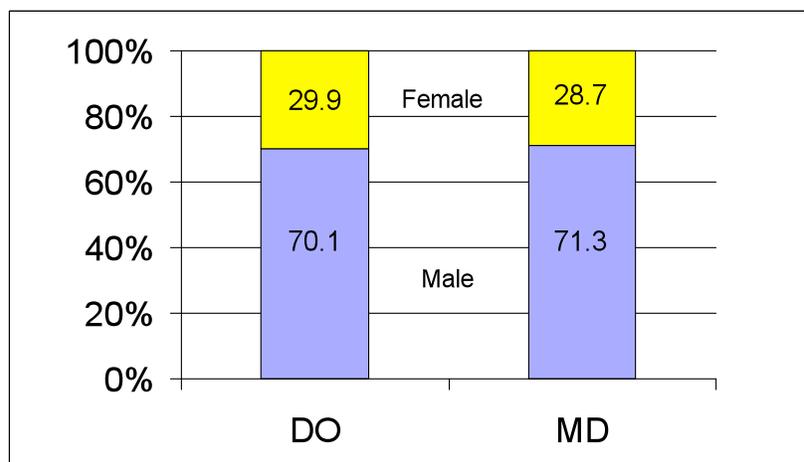
# Mean Age



National Rural Task Force  
Sources: American Osteopathic Association, 2009  
AMA Physician Characteristics and Distribution 2009

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Osteopathic  
Family Physicians  
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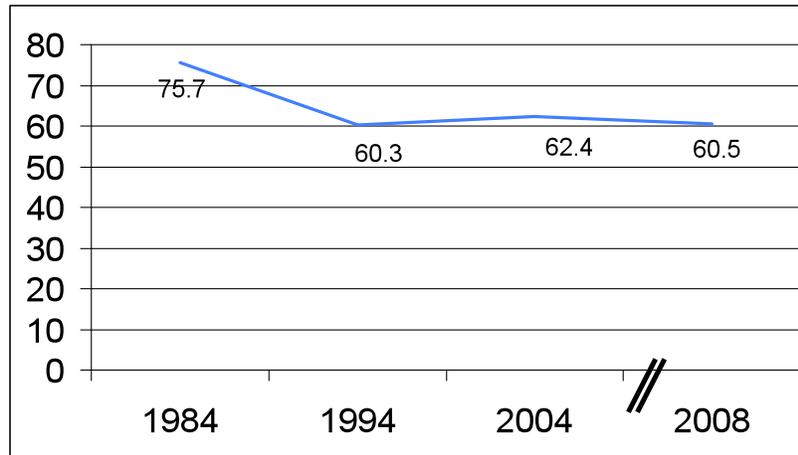
# Gender Distribution



National Rural Task Force  
Sources: American Osteopathic Association, 2009  
AMA Physician Characteristics and Distribution 2009

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# Percent of DOs in Primary Care



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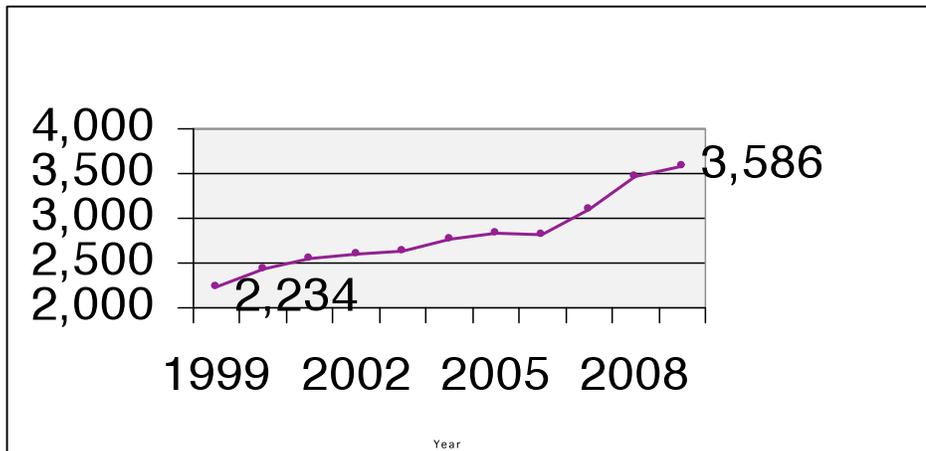
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# Osteopathic Graduates

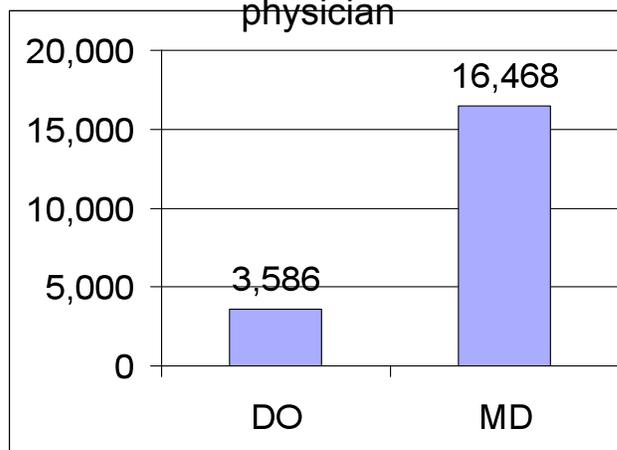


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# 2009 Graduates: DOs and MDs

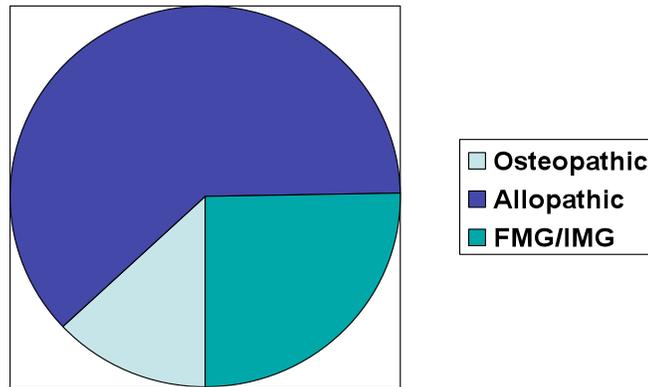
1 in 5 physician graduates is an osteopathic physician



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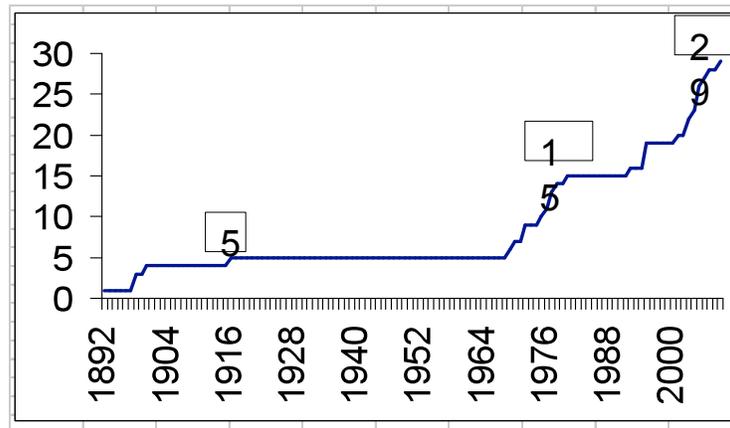
# 1<sup>st</sup> Year Residents - 2009



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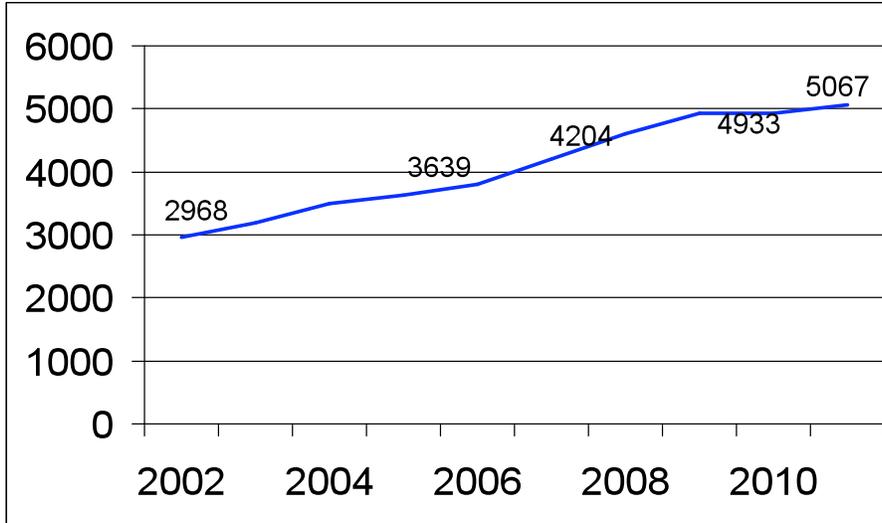
# COMs and Branch Campuses



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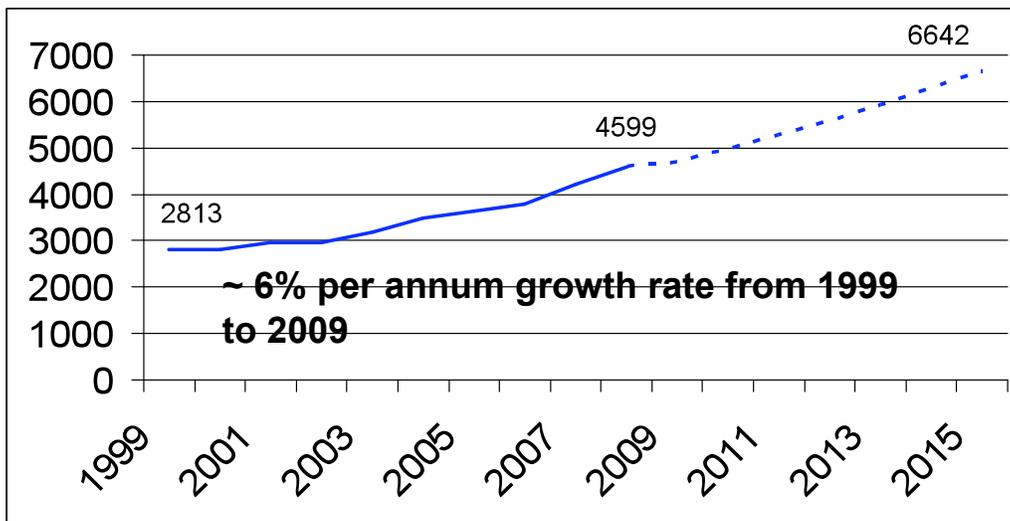
# Approved COM Class Size



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# Approved Class Size Projection

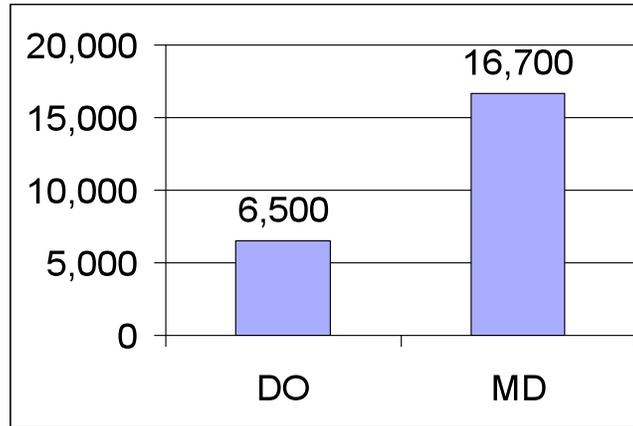


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# 2014 Graduates: DOs and MDs

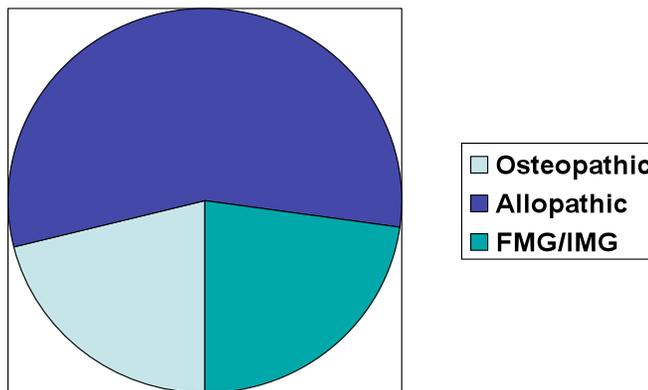
Nearly 2 in 5 physician graduates are osteopathic physicians



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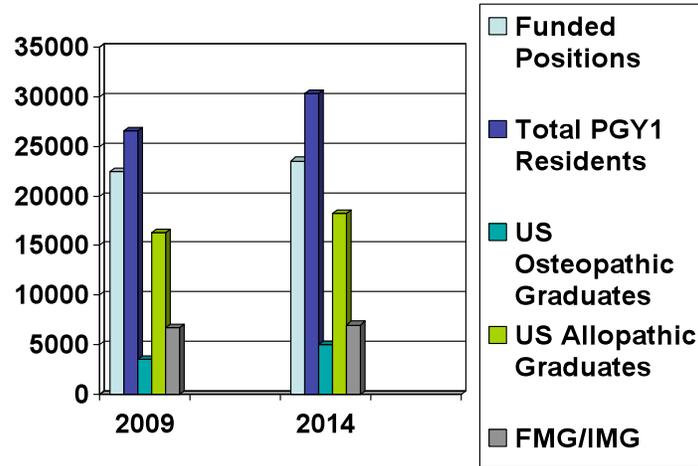
# 1<sup>st</sup> Year Residents - 2014



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# Teaching Capacity 2009 & 2014



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## Projected Physician Shortages

- Cooper 200,000 by 2020-25 11/04
- COGME 85,000-96,000 by 2020 1/05
- HRSA 110,000 – 245,000 by 2020 10/06
- AAMC 124,400 - 159,300 by 2025 11/08

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# Policy Questions

- Shifting demographics
  - Population is aging and growing
  - These are not “baby-boomer” physicians
  - These are not “baby boomer” patients
- What is the health care delivery system of the future?
  - Patient-Centered Medical Home/Accountable Care Organizations
- What is the desired physician-to-patient ratio
- What is the role of primary care physicians
- Team-based healthcare
  - How do we maximize health care workforce
- Public health vs public dollars

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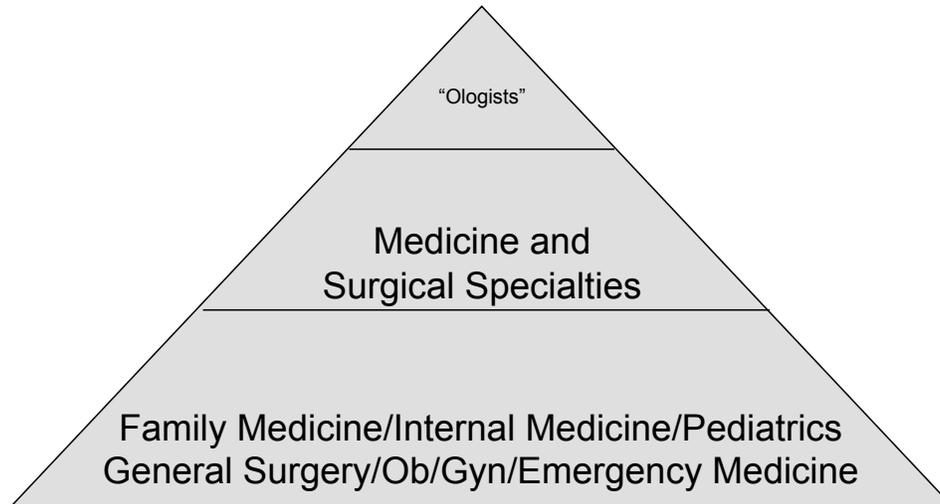
# Policy Questions

- Does every town need a full-time physician?
- Does every town need a hospital?
- Can technology create a virtual tertiary care system?

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# Health Care Workforce Should be Established on Solid “Generalists Foundation”



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## Key Objectives to Improving Rural Health Care Workforce

- It's the economy
  - Payment rates for all physicians, but especially primary care physicians must become equitable as compared to the overall market
  - Create economies of scale for rural providers
  - Create new delivery models such as medical homes, accountable care organizations
  - Stop talking about team-based care and start implementing team-based care

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# Key Objectives to Improving Rural Health Care Workforce

- Input equals output
  - Recruiting and admissions must reflect desired workforce
  - Maybe 3.2 is better than 4.0?
  - If you are from Boston, are educated in Boston, and train in Boston, guess what.....

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# Key Objectives to Improving Rural Health Care Workforce

- Increase training capacity
  - Eliminate BBA97 limits on funded residency slots
    - Currently 22,000 funded PGY1 positions
    - MD/DO graduates in 2015 will exceed 24,000
    - Currently 5,000 IMG's PGY1 entering system
  - Create new teaching programs
    - 60% of all residents are trained in 10 states
    - Utilize community hospitals
  - Create new teaching environments
    - Community health centers
    - Teaching consortiums

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# Key Objectives to Improving Rural Health Care Workforce

- Increase opportunities in desired practice settings such as rural communities
  - Increase non-hospital ambulatory training
  - Enhance loan and scholarship programs
- Use the tax code to provide incentives
- Physicians for America
  - Think “Teach for America”

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America's Voice for Community Health Care

## Community Health Centers Today

- **Proud History** – 45 years of bringing good health to underserved communities, giving people served ownership & control of delivery system
- **Largest national network** – 20 million people served, 40% uninsured, 37% Medicaid/SCHIP, 63% people of color, 92% low-income individuals
- **Record of Achievement** – cited by IOM, OMB, and GAO for excellence in care, disparities reduction, cost-effectiveness, and community benefit
- **Bipartisan support** – Congressional majority and key Presidential candidates praise work, mission of health centers, call for continuation & growth

### **The NACHC Mission**

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

## **Teaching Health Centers and Health Reform**

Krystal Elaine Knight, MPH  
Public Policy Associate, Federal Affairs  
National Association of Community  
Health Centers  
July 14, 2010



## Overview

- The Affordable Care Act (ACA) contains a new teaching health centers provision
  - Title VII: Development grants
  - Title III: Payments for Direct and Indirect Costs



## What is a “Teaching Health Center”?

Under the Affordable Care Act, a “**Teaching Health Center**” is:

- A community-based, ambulatory care center that operates a **primary care residency program**.
- Includes, but is not limited to, the following:
  - FQHCs
  - Community Mental Health Centers
  - Rural Health Clinics
  - Indian health centers
  - Title X recipients

**Primary care residency** is broadly defined to include all internal medicine, all pediatrics, internal medicine-pediatrics, psychiatry, general and pediatric dentistry, and geriatrics



## Title VII Development Grants

- Development grant program authorized under Title VII (Sec. 749A)
    - Awards of up to \$500,000 for up to 3 years
    - Made to teaching health centers to establish “new accredited” or expanded primary care residency training programs
      - Under language, technically, development grants can only go to “teaching health centers.”
    - Funding could also cover technical assistance provided by an AHEC
      - Also a preference for THC’s that document an existing relationship/affiliation with a THC
  - *Authorized to be appropriated* \$50 million in FY11 and FY12
    - Would not be created until appropriators allocated funding
    - Discretionary funding will be tight the next few years
- 



## Title III Payments

- Authorized under Title III, new Sec. 340H.
  - *Is not funded through Medicare*
- Payments for direct and indirect expenses to “qualified THC’s”
  - Suggests THC’s will be the “sponsoring institutions” by the relevant accrediting body (ACGME and AOA)
  - Direct expenses calculated using a formula written in statute
  - Indirect expense formula left to Secretary’s discretion
- *Appropriated* \$230 million for FY11 - FY15
  - The law does not outline how much money will flow annually
  - Unknown how many THC’s will be ready in the early years, so may be smaller funding year 1 then grow over time.



## Title III Payments

- Funding limit of FTE residents
    - HRSA will be able to set FTE limit to ensure payments do not exceed amount appropriated
  - No “double dipping”
    - THC cannot receive payment for time a resident spent in a hospital **if** that hospital is also counting that resident towards its FTE
    - “Reconciliation” process under which the Secretary may recoup overpayments
- 



## Title III Payments

- Annual Reporting
  - Types of approved training programs
  - Number of resident positions
  - Number of residents who completed residency training
  - Other information Secretary deems necessary
- THC audits
  - Secretary may audit a THC for accuracy/ completeness of reporting
  - Payments can be reduced by at least 25% for failures to provide accurate annual report



## Issues to Watch

- Interpretation of Title III-eligible “teaching health centers”
    - Could possibly limit eligibility to one model of teaching health center, those that are the sponsors of the residency program
    - No existing FQHC residency program fits the mold of this new model
  - THCs would still need to contract with hospitals for inpatient training time, paying them for time resident spends in hospital.
    - Law indicates THC residents will not count against hospitals’ Medicare cap, so possible opportunity for collaboration.
- 



## Alternative Funding Option

- Primary Care Residency Expansion (PCRE) Program
  - Funded through ACA’s Prevention & Public Health Fund
  - \$168 million from FY2010 to FY2014 for Title VII, Section 747 grants to increase primary care residency slots
  - \$80,000 per resident per year for a total of 3 years per resident
  - Grant applications are due **July 17<sup>th</sup>**

# QUESTIONS?



**For further information about NACHC and  
America's Health Centers**

Visit us at [www.nachc.org](http://www.nachc.org)



## Attachment F

### THE 2009 NACRHHS REPORT

# Creating Viable Patient-Centered Medical Homes in Rural Areas

## Rural Significance: Why the Committee Chose this Topic

As discussions to reform the health care system continue to gain traction, the development of a patient-centered medical home for all patients has been widely promoted by many policy experts. This concept, in which a team of providers works together to coordinate a patient's care, holds great potential for patients, particularly for rural residents who face significant, unique challenges in accessing comprehensive health care services. The Committee seeks to ensure that rural considerations are taken into account in the ongoing discussion about medical home.

Medical home is a term that represents a combination of care management, primary care, quality

improvement, information technology and social work. The concept emphasizes sharing of information among providers with a goal of improving quality of care and health outcomes. The idea of a medical home surfaced in the literature more than four decades ago and has since been extensively written about; however, the concept is still evolving, and large-scale implementation remains a challenge. Demonstration projects on various scales have delivered care in a medical home model to limited population groups thus far.

The Committee believes that this concept has great value for rural America and has identified important issues that specifically pertain to rural areas. Site visits to rural areas in North Carolina and Minnesota enabled the Committee to observe medical home implementation in rural communities and to discuss the operation of the model with providers and State health officials.

### Community Care of North Carolina

North Carolina administers one of the first State-wide efforts of medical home implementation within its Medicaid program. Community Care of North Carolina (CCNC) began in 1998 as a quality improvement demonstration project to advance primary care case management for North Carolina Medicaid enrollees. The demonstration evolved into regional systems of care that currently serve more than 800,000 patients across the State in both rural and urban areas.

Building on strong local networks of physicians at the county level, larger groups of physicians united to form relationships that would promote local empowerment and materialize into an organizational structure.<sup>64</sup> Case managers work with primary care providers to assist patients in managing chronic conditions, such as diabetes, asthma, and heart failure.

North Carolina Medicaid compensates physicians at a rate of \$2.50 per member per month, for each Medicaid patient enrolled in the program. In addition, Medicaid compensates regional networks, the entities that employ the case managers, at a rate of \$3.00 per member per month. CCNC has just launched an enhanced care management program for aged, blind, and disabled Medicaid recipients, under which networks will receive an additional \$5 per member per month payment, and physicians will receive an additional \$2.50 per member per month payment, to help support the care needs of these more complex and costly patients.

Source: Willson, C. (June 3, 2008). "Evolution of the Primary Care Medical Home in Eastern NC." Remarks to the NACRHHS, June Meeting.

### Patient-Centered Medical Home: A Quality Initiative

Leading advocates of the medical home model believe that care associated with a medical home should be patient-centered, accessible, continuous, comprehensive (whole patient), integrated, compassionate, and culturally effective.<sup>65</sup> The concept was first developed and published by the American Academy of Pediatrics (AAP) in 1967.<sup>66</sup> The Health Resources and Services Administration's (HRSA's) Maternal and Child Health Bureau (MCHB) partnered with AAP to continue to develop and implement the concept. In fact, a number of HRSA's programs in rural and urban areas have embodied the principles of a medical home in their approaches to caring for patients (Table 1).

#### Medical Home Infrastructure

While the concept of the patient-centered medical home is still being refined, common structural components can be observed in demonstration

projects that have been established by public and private health care payers. Case management is a defining element of the model. Although there is no single standard or universal definition of a medical home, most of the models and prototypes focus on some common elements. Medical homes operate on a team-based structure led by a primary care provider and supported by case managers, specialists, pharmacists, and other practitioners and providers. Primary care providers may include physicians, physician assistants, and advanced practice nurses. Case managers may have a wide range of educational backgrounds and can include nurses, social workers, and other trained individuals to help the patient with coordination of care and implementation of chronic care management plans. One of their primary duties is to connect patients and providers, although some variation in day-to-day roles and responsibilities will vary from one demonstration project to another. Patients communicate with their provider or case manager through commonplace technologies, such as phone and email.

In addition to enhanced communication between patients and providers, another key component of the medical home is continuous care coordination between

#### Lakewood Health System

Lakewood Health System near Staples, MN is a rural hospital that is ahead of the public policy curve when it comes to incorporating the medical home model. At the urging of one physician who saw the model primarily as a better way to provide coordinated care, Lakewood began its Medical Home program in August of 2008. Guided by the "Joint Principles of the Patient-Centered Medical Home,"<sup>67</sup> Lakewood's Medical Director, Dr. John Halfen, pushed for the initiative. Lakewood is implementing the model without additional Federal or State funding—this initiative is their effort to improve quality of care, increase patient safety, reduce the health care costs associated with chronic conditions, and ultimately gain a competitive advantage through patient satisfaction.

The support of Lakewood's administration and hospital board has been essential in moving forward with medical home implementation, allowing Lakewood physicians to provide medical home care to more than 250 patients. To enroll in the Lakewood Medical Home program, patients may qualify by meeting one of the criteria, including multiple diagnoses (three or more), multiple medications (four or more), chronic illness, or a physician identifying a patient as a "good candidate."

Lakewood officials hope to eventually use their electronic health record system to identify additional patients who are eligible. Once enrolled, patients continue to see their regular doctor and have additional access to the RN Medical Home Coordinator. This Coordinator sends reminders and educational materials to enrolled patients. Physicians are responsible for coordinating referrals and specialty care that patients receive. Lakewood Health System estimates that the program's startup costs were approximately \$200,000 and will be \$100,000 annually in future years.

Source: Halfen, J. (September 25, 2008). "LHS Medical Home." Remarks to the NACRHHS, September Meeting.

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HRSA	Program	Description
Bureau of Primary Health Care	Health Centers	Health Centers are community-based and patient-directed organizations that provide the types of care and services that fulfill many components of a medical home. For more than 40 years, HRSA-supported Health Centers have provided comprehensive, culturally-competent, quality primary health care services to medically underserved communities and vulnerable populations. <sup>66</sup>
Maternal and Child Health Bureau (MCHB): Division of Services for Children with Special Health Care Needs	Medical Home for Children with Special Needs	MCHB has supported implementation of the medical home concept for children with special health care needs for over two decades through grant, quality improvement, and measurement initiatives. Medical home is now central to the MCHB mission for the entire MCH population. <sup>67</sup>
Center for Quality	Health Disparities Collaboratives	In the late 1990s, the Collaboratives began as a quality initiative aimed at improving the quality of health care and eliminating health disparities. The Collaboratives encourage the evolution and greater adoption of a comprehensive medical home, and the related systems and support infrastructure for continuous quality improvement. <sup>70</sup>
Center for Quality and Healthcare Systems Bureau's Office of Pharmacy Affairs	Patient Safety & Clinical Pharmacy Services Collaborative	By training organizations to coordinate services for their patients, this Collaborative has goals of improving health outcomes, reducing adverse events, and improving patient safety. This 18-month initiative began in 2008. <sup>71</sup>
Office of Rural Health Policy	Delta Health Initiative (DHI)	Two aims of the program are to address the health needs of the Mississippi Delta region by increasing access to care and health education. In 2008, the grant began to support Health Centers and hospitals in the Delta region to reduce emergency department use by providing medical home-type care to patients. <sup>72</sup>

members of the health care team. This includes referral tracking, the documentation and tracking of the handoff of care from local providers to referred specialists and then back to local providers, which is used to improve the quality of care provided. This process is especially relevant for rural practices, as fewer specialists work in rural areas and the geographic distances can make patient care coordination more challenging. Centralized records, management of chronic conditions, and reporting and quality improvement measurements are other commonly incorporated components in a medical home model. There are many components to the medical home model; however, it is not an all-or-nothing proposition. In some situations, transitional implementation toward an ideal model over time could make it more feasible to implement.

The Committee has found that electronic health records (EHRs) and other health information technology (HIT)

are not essential initial components of a medical home. However, a comprehensive understanding of a patient's health history is necessary for providing high quality care. EHRs can enhance the medical home because they facilitate providers' access to a patient's health history and allow for better coordination of a patient's care based on that information. In addition, population health may benefit from EHR implementation because non-identifying, disease-specific data can be generated and analyzed so that a community's providers can respond to community needs. In practice, the Committee has learned that inclusion of HIT and EHRs is not necessary at the beginning stage of a medical home implementation. During the June 2008 site visit, administrators in North Carolina said they focused first on establishing basic components of the medical home. It has been 10 years since North Carolina developed its Community Care Networks and they have yet to require an EHR or rigidly prescribe any IT

requirements. Because most rural practices do not already have the necessary HIT infrastructure, this flexibility may be the most realistic option for many rural health provider groups interested in transitioning to a medical home model.

### Expected Outcomes

Many of the potential advantages of medical home implementation would accrue to anyone seeking health care, not just rural patients and providers. Medical home implementation has the potential to improve quality and performance in health care.<sup>73</sup> Implementation of the medical home could make comprehensive care more efficient, less costly in the long-term, and allow for more preventative services. Proper care coordination should also reduce the number of diagnoses lost to follow-up, adverse drug interactions caused by polypharmacy from multiple providers or patients receiving conflicting information from multiple providers. In addition, medical home implementation may result in patients being better able to understand and follow medical instructions received and to schedule follow-up visits in a timely manner.

The Committee emphasizes that cost-savings should not be expected as an immediate outcome. An overemphasis on early cost savings could serve as a barrier to ideal practice redesign. However, medical home implementation does have the potential to reduce costs in the long-term for the health care system by concentrating on preventative care and better health

outcomes.<sup>74</sup> Preventative care will be provided with the aim of minimizing the future development of more serious or more costly ailments, creating less strain on the health care system. Cost-savings may take longer to realize in rural areas with a disproportionately high number of disadvantaged populations, such as the elderly, those with chronic diseases or those who are living in poverty. This is because reducing service deficits for these patient populations may initially require a higher level of care.<sup>77</sup>

The primary question facing policymakers is how a medical home system would be structured and compensated. Several current demonstrations are aiming for budget neutrality, meaning that within the defined demonstration period, medical home implementation must produce sufficient savings to the payer to offset the additional costs for care management. The Committee believes that savings should be a longer-term goal because the time it takes to realize it is dependent on where and how the model is implemented. On the individual practice level, increased start-up costs are always a concern in small or low-volume practices, a model which dominates the rural landscape.

### Implementation to Date

The considerable attention to the medical home model at all levels of health care has led to the development of a number of projects demonstrating variations on the model.

#### Cost Savings from Medical Home Implementation

Whether cost savings will accrue from medical home implementation will vary depending on the patient population, services provided, and diseases targeted. One study of Community Care Plan of North Carolina, an early medical home implementation effort for the North Carolina Medicaid population, reports cost savings from the implementation of chronic care management and other medical home components.<sup>75</sup> Of particular importance for rural communities, medical home efforts have reduced duplication, strengthened human services connections, and enhanced the quality of care for the Medicaid population. Networks of providers have focused on evidence-based practices and have experienced success in assisting patients in better managing conditions such as diabetes, asthma, and heart failure. Patient education and training help patients adopt best practices and connect with community resources to help patients achieve better health outcomes. However, many health experts caution against using near-term cost savings as a measure of the model's success and claim that "the medical home may be best served by promising *value* rather than near-term cost savings."<sup>76</sup>

### Pharmacy Home

Rural pharmacists in several States have started to take a more active role in managing a patient's medications to increase patient safety. In North Carolina, Community Care of North Carolina leaders recognized that patients with an increased number of providers and an increased number of prescriptions were more at-risk to experience drug interactions. This prompted them to develop a pharmacy home program in which patients who were given 24 or more medications over three months, or saw three or more providers over six months, are eligible to enroll. In Minnesota, Lakewood Health System's Medical Home has adopted a similar program. Patients with 10 or more medications are referred to the hospital's pharmacist for Medication Therapy Management. These cognitive pharmacy services are covered by Medicare Part D and Minnesota's General Assistance Medical Care.

Sources:  
Simmons-Kornegay, T. (June 3, 2008). "Network Pharmacist Program." Remarks to the NACRHHS, June Meeting.  
Moriak, J. (September 25, 2008). "Medication Therapy Management." Remarks to the NACRHHS, September Meeting.

Several provider groups have incorporated pieces of the model into their practice. To make it work, several States with rural populations, including Minnesota, Pennsylvania, and Vermont, now use a blend of public and private funding to compensate providers for coordinating patients' care.

In addition to State-level initiatives, the medical home model is being explored at the Federal level. The Tax Relief and Health Care Act of 2006 (TRHCA) authorized Medicare to establish a Medical Home Demonstration program. This demonstration must include physician practices of varying sizes serving metropolitan, rural, and underserved areas.<sup>78</sup> The original funding appropriated to the Secretary for the project was \$10,000,000 and the demonstration was expanded by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), providing additional funding in the amount of \$100,000,000 toward the project.<sup>79-80</sup> The expansion beyond the original demonstration may only occur if the demonstration can improve the quality of patient care without increasing spending or if there is reduction of spending without decreasing the quality of patient care.

### How the Medical Home Can Benefit Rural America

One of the Committee's frequent findings has been that existing components of health and human services systems do not relate effectively to one another,

share information about patients, or coordinate their services. The Committee has looked for effective ways to build an infrastructure necessary to achieve the coordination of services that will lead to better efficiency and higher quality of care. The need for integration of services among communities and programs was cited in the Committee's 2008 report to the Secretary. The Committee believes that adopting the medical home model may advance such coordination.

### Medicare Medical Home Demonstration

In early 2009, eligible physician practices in participating selected States are scheduled to begin applying for the Medicare Medical Home Demonstration. Physician eligibility is limited to board certified primary care physicians and some board certified specialists. Medicare Fee for Service beneficiaries with at least one eligible chronic condition are eligible for medical home care under the demonstration. Practices that can meet the first-tier standards will become certified to receive monthly payments for each Medicare Fee for Service beneficiary to whom they provide medical home-type care. These values were established by the Relative Value Scale Update Committee and are based on the complexity of care provided to patients. Submission of data to qualify for the two tiers of medical home certification in the demonstration will occur through the National Committee for Quality Assurance's (NCQA's) Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) survey tool, as modified for the Medicare demonstration. The demonstration and payment period will run for a three-year period. It is expected that the demonstration will begin on or about January 2010.<sup>41</sup>

### Managing Specialty Referrals a Key Advantage

Medical specialists practice primarily in urban areas; therefore, rural health care providers often must refer their patients who need specialists to tertiary hospitals, so those patients must travel to distant urban areas for specialized care. The geographic handoff of care is one of the realities of rural practice and the lack of coordination when it occurs presents one of the biggest challenges in terms of assuring continuity of care. Without effective coordination of patient and treatment information, by both the primary care provider and the specialist, the patient may experience delays in receiving proper treatment, which can often result in additional complications, poorer health outcomes, and increased costs. The medical home model can strengthen relationships and facilitate coordination and information sharing between primary care providers and specialists.

As the medical home concept develops, policymakers and providers should remember the importance of managing the care handoff for rural patients. Emphasis should be placed on how the sharing of information between local primary care providers and distant specialists will occur in practice. There are many factors to consider. When patients are discharged from tertiary hospitals and return home to rural areas, their

discharge plans need to be communicated to the local provider for the handoff of care to be effective. For example, with post-operative follow-up, discussions need to occur between the local primary care providers and surgeon specialists. If a local primary care provider could counsel the patient through rehabilitation and physical therapy, this can save the patient from the necessity of traveling back and forth to a distant surgeon specialist's office. The medical model also can minimize transportation-related access problems for rural patients by scheduling multiple referrals and appointments into a comprehensive medical visit using care coordination.

Rural America has a larger share of the nation's geriatric population; in 2004, 15.0 percent of non-metropolitan residents were 65 or older, compared to 11.7 percent of metropolitan residents. This difference is expected to increase, as rural elderly "age in place" and others move to rural retirement destinations.<sup>83</sup> This statistic is significant for rural areas because elderly patients tend to require more services, and are more likely to be disabled or have one or more chronic diseases for which care is not well coordinated.<sup>84</sup> The additional diagnoses often require different specialists, and as a result, care for an elderly patient is more likely to be fragmented.<sup>85</sup> Thus, coordinating care for rural America's elderly citizens could positively impact their health and lower their health care costs.<sup>86</sup>

#### PACE Embodies Medical Home Concept for Frail Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is an example of a viable long-term care model of a medical home for those over age 55.<sup>87</sup> PACE organizations serve nursing home-eligible patients with the idea of keeping them in a home-based setting. These organizations use a team approach to provide a full range of care to enrollees, including primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, transportation, and meals. PACE is an optional benefit under both Medicare and Medicaid; PACE teams receive a per-enrollee fee each month for services they provide.

The first PACE programs began in 1990, and PACE had been largely an urban-based model. In 2003, ORHP awarded a one-year contract to the National PACE Association that focused on providing technical assistance on the PACE model to rural communities. The purpose of the contract was to determine the rural interest in the PACE model, determine the viability of PACE in rural areas, and provide technical assistance to interested rural communities on ways to develop and implement a PACE site. The program generated great interest. Congress provided funding to the Centers for Medicare and Medicaid Services (CMS) for the Rural PACE Provider Grant Program. In 2006, CMS provided \$500,000 to up to 15 organizations for rural PACE expansion, which provided start-up funding for the development of PACE sites that serve rural residents.

Source: Personal Communication, National PACE Association. (November 2008).

## Building the Rural Health Care Workforce

In addition to benefiting patients, the rural health care workforce could also be helped by medical home implementation. Improved relationships and communication between staff could make care coordination and the use of health care teams more manageable. A stronger team environment can give primary care providers greater rewards and job satisfaction. This effect has the potential to improve retention and recruitment efforts in rural areas and, in turn, increase community development (further addressed in the Workforce and Community Development chapter).

### Provisions for Rural Implementation

The Committee's 2008 report, which summarized the last 20 years of key developments in rural health care, documented that the geographic, cultural, and economic dimensions of rural areas call for health care approaches specifically tailored to each community's needs. It is important that any State or national medical home initiative take into account such rural-urban and regional differences and seek input from rural practitioners during the planning and implementation stages, so as not to unintentionally harm rural practices or limit access to rural patients. For example, the Committee suggests that CMS and NCQA consult with a variety of rural experts to ensure that the criteria and performance measures used in the CMS Medical Home Demonstration and the final NCQA medical home definition are appropriate and relevant for rural practices.

### Small Practices: Lack of Capacity and Need for Support

The lower patient volume of rural practices can be associated with many of their challenges. Most small practices currently lack the personnel, technology

### Geisinger Health System Implements a Medical Home Model for Its Patients

Geisinger Health System, an integrated delivery system that operates many of its clinics in the rural areas of central and northeastern Pennsylvania, is offering a version of a medical home through its Personal Health Navigator program.<sup>47</sup>

In this program, patients are given increased access to primary and specialty care, a nurse care coordinator, and a personal health navigator who they can rely on to respond to their health questions. Patients' health information is maintained in their electronic health record system.

Geisinger has created incentives for providers by providing monthly payments to physicians for expanding the scope of their practice, stipends to support additional infrastructure and staff, and performance-based payments to those who meet quality measures.

infrastructure, space, capital, and purchasing efficiency to meet all of the medical home requirements currently being proposed by NCQA.<sup>48</sup> Depending on the requirements such practices would need to meet in order to be considered a medical home, significant upfront resources would need to be provided for HIT. The total incremental cost may be similar for rural and urban providers, but the per-patient costs will be higher for small volume practices. For example, in rural areas, there are a smaller number of patients and providers at each facility, so rural practices would incur higher costs per patient when the purchase of expensive equipment is involved, such as the hardware needed by an EHR system. High implementation costs of EHR implementation could be detrimental for many rural practices if an EHR system became a qualifying factor, because most rural practices lack information technology infrastructure.

### **Creative Adaptation and Workforce**

As a practical matter, the medical home concept can be implemented incrementally, transforming and gradually supplementing the existing rural health infrastructure.

The Committee believes that States offer the best setting to test this model. As the Committee saw during site visits to Minnesota and North Carolina, there are different ways to implement medical home. States will need to identify and implement creative practices to ensure the model works in rural areas. The initial focus in making the transition should be on building relationships between networks of providers and all members of the health care team, not on credentialing. Credentialing will eventually play an important role in rewarding providers for the quality and complexity of care they provide, but it should not be a barrier to practices in building a medical home workforce. "Virtual" medical homes that rely on external team members could be one example of how rural practices could creatively adapt to geographic challenges and strains on the workforce supply. There is also potential for new categories of health care workers to emerge. It is important that States recognize rural workforce limitations and allow flexible and creative use of human capital. Investment in the rural health care workforce can help small practices transition to the medical home model.

Entities articulating the medical home idea and States currently implementing it need to recognize that advanced practice nurses and physician assistants can play a key role. Many associations, such as NCQA, have established best-case standards asserting that a medical home be led by a board-certified physician. Physician workforce shortages in many rural communities have left physician assistants and advanced practice nurses as the sole primary care providers there. The patients served by physician assistants and advanced practice nurses should not be excluded from receiving the benefits of a medical home. Therefore, it is essential that CMS, NCQA, and States develop a definition of a primary care provider that includes health care providers, other than primary care physicians, who are currently providing a similar level of care.

### **Payment Considerations for Medical Homes**

A fundamental challenge to medical home implementation is that the current payment structures are not designed for medical home reimbursement. Current payment is tied to procedures without incentive to provide care coordination; there is no differential payment for providers who coordinate care or better manage chronic conditions.

#### **Minnesota Health Reform**

Health care home\* legislation was passed in Minnesota, as part of a larger health reform package, in May 2008. The legislation created a program where people with complex conditions will be encouraged to select certified health care homes as their providers. Health care homes will be market-wide and available to enrollees of State health care programs, private health plans (HMOs), and to State employees. The legislation also requires the development of standards for certifying health care homes that include HIT use and patient registries. Minnesota also plans to provide per-person care coordination payments and quality incentive payments to participating providers. Of particular importance for rural areas, the legislation specified that certified health care homes are to be led by "personal clinicians," which can include physicians, physician assistants, and advance practice nurses. A workforce study, due in January 2009, will explore licensing and regulatory changes to ensure full utilization of all licensed health care professionals in the health care home model.

\*Minnesota uses the term "health care home" in legislation. For the purposes of this report, we treat it synonymously with "medical home."

Source: Leitz, S. (September 24, 2008). "Health Reform in Minnesota: Overview and Health Care Homes." Remarks to the NACRHHS, September Meeting.

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### Community Paramedic Program

The medical home model is based on patient-centered care. In some cases, that care begins with emergency medical services. No matter how healthy a population is, there will always be a need for emergent care. It is estimated that 46.7 million Americans cannot access a Level I or II trauma center within an hour, and many of these people live in rural areas.<sup>29</sup>

It is important to take emergency services into account when considering changes to the health care system. Just as advanced practice nurses and physician assistants are the only health care providers in many rural areas, the paramedic may be the only health care provider in some rural areas. While emergency services do not usually require a constant level of full staffing in rural areas, it is necessary to have the appropriate staff available when the need arises. With additional training, a paramedic can assist in delivering non-emergent health care services to rural Americans.

The Community Paramedic pilot project in Minnesota encourages innovative use of the workforce by providing opportunities to cross-train professionals. The community paramedic concept grows out of the need for health care services in rural America, and the need to reduce the stand-by cost for the emergency medical services, and the conviction that rural areas need to use this trained workforce. Flexible and creative uses of human capital are likely to emerge, due to rural workforce shortages. The Committee recognizes that there are issues to be resolved with respect to the Community Paramedic program but believes that it is worth further study.

Source: Wilcox, M. (September 24, 2008). "Community Paramedic." Remarks to the NACRHHS, September Meeting.

There has been some conceptual work on how medical home payment systems could work.<sup>30</sup> States will have an important role in the development of payment systems for care coordination because medical home implementation may likely expand from the demonstration stage at a regional level, through State Medicaid programs. While it is too early to specify which medical home components a reformed health care system would cover, the Committee notes that North Carolina has constructively led the way with its program by explicitly providing payments for case management and record-keeping functions while, at the same time, holding its initial focus on building relationships with individual practices in order to see improvements in quality care and health outcomes.

In order to account for rural providers, a payment system could involve the following components:

- A structure that adequately considers a fee-for-service component, a per-patient care coordination component, and a performance-based component.<sup>31</sup>
- Risk adjustment for performance-based components to account for case-mix differences, eliminating reasons that cause providers to turn away Medicaid, Medicare,

or chronic disease patients; and, risk adjustment for per-patient capitation rates.

- A method to account for rural practices' operating expenses, because lower volume rural practices incur higher costs per patient when implementing new systems.
- Reinvestment of a portion of any yielded cost savings in the health care system as an incentive to the providers; otherwise, overall savings to a payer could represent net revenue loss to the delivery system, which would adversely affect financial incentives for transitioning to a medical home.
- Payments to practices that act as medical homes for patients. A range of primary care providers, case managers, and specialists who coordinate chronic care management (e.g., cardiologists or endocrinologists) who can provide care coordination and other medical home services should be eligible to operate within the model. With the current shortages of providers in rural America, this flexibility is important to ensure access to quality health care.
- Payments related to quality, based partly on patient outcomes, to keep providers focused

on the model's patient-centered objectives. In designing payments based on rewards and outcomes, CMS and other payers need to consider the statistical problem of rural providers having too few data points to accurately represent true performance. This can sometimes prevent small, rural providers from participating fully in reporting initiatives.

## Summary

Medical home is an important model of care for rural practices because its patient-centered approach and focus on quality improvement could yield many benefits to rural patients, especially through case management and improved care coordination. Improving the handoff of care between primary care providers and specialists would enhance the care rural patients currently receive. Implementation could also yield benefits to the rural primary care workforce. Therefore, it is important that rural stakeholders ensure that the medical home model is viable in rural areas, not just in urban and suburban areas.

As the medical home model is currently proposed, implementation will not take place in rural practices without challenges. Specific rural complications include information technology limitations and a limited workforce. To aid rural providers with this transition, the Committee believes that HHS should create incentives to promote HIT adoption for rural practices. These can be created within the payment system or through new or existing grant programs, such as the Critical Access Hospital-Health Information Technology Network Program (CAHHIT) and the Small Rural Hospital Improvement Program (SHIP). Technical assistance should be provided with the resources for HIT adoption, to ensure successful implementation.

The Committee believes that the viability of the medical home model in rural communities depends on an honest acknowledgement of physician availability. The physician specialist may be the dominant model; however, the Committee believes that a broader

definition of primary care is necessary to accommodate the realities of rural practice. Nurse practitioners, other advanced practice nurses, as well as physician assistants, should be able to serve as medical home providers.

Because the model is still in early stages of widespread implementation, now is an important time for States to prepare rural providers and practices to be a part of the medical home model. The Committee believes that the Federal government should support State Medicaid and State Children's Health Insurance Plan (SCHIP) waivers for demonstrations that focus on creating medical homes for enrollees. The Committee encourages States to develop the concept with a view towards achieving a care model in which patient-provider relationships are strengthened and where patients benefit from case management.

Additionally, the Committee believes that CMS and NCQA should retain and refine their tiered certification systems. The definitions and benchmarks that are being developed by CMS for the Medicare Medical Home Demonstration should be examined to determine which are essential to providing quality care through a medical home and which may be adapted for use in rural areas for optimum implementation. CMS should adapt its quality of care goals to make them usable in rural practices.

The Committee believes that policymakers should not focus on cost reductions in planning and evaluating the medical home idea. Medical home implementation may not yield near-term cost savings. The Committee believes that HHS medical home demonstrations should not utilize near-term cost savings as a fundamental measurement of the model's success, to avoid jeopardizing the intent to improve patient outcomes. Demonstrations should continue to draw comparisons to a baseline year, prior to program implementation.<sup>97</sup> By taking these steps, HHS can help to ensure that the medical home model is viable for practices of all sizes and in all parts of the country.

The Committee believes that CMS should ensure coordination of their medical home demonstrations with ongoing initiatives related to pay-for-performance,

such as the Medicare Physician Quality Reporting Initiative and outpatient quality performance measure submission. It is essential for HHS to continue support of HIT adoption through ongoing policy activities via the National Coordinator's Office for HIT, in addition to providing funding for the grant programs that support HIT-related activities administered by HRSA, the Agency for Health Care Research and Quality and the National Institutes of Health's National Library of Medicine.

## Recommendations

As HHS deliberates on how to promote widespread adoption of medical home principles, the Committee would like to offer the following considerations regarding rural practices.

### *Recommendations related to the CMS Medicare Medical Home Demonstration Project:*

- The Committee recommends that the Secretary ensure that an appropriate number of rural practices, in each of the participating States, are selected for the Medicare Medical Home Demonstration for comparison with one another and with urban practices. The Committee recommends that these sites be located in varying regions of the country, to account for regional differences.
- CMS should include physician assistants and advanced practice nurses as primary care providers, for reimbursement purposes, in the Medicare Medical Home Demonstration project and in any future medical home implementation projects.
- CMS should ensure that the criteria and measures used for the Medicare Medical Home Demonstration are appropriate and relevant for rural practices. The Secretary should work with NCQA to bring their guidelines into the same framework.

### *Other Recommendations related to CMS:*

- CMS should work with the American Medical Association to develop Current Procedural Terminology (CPT) codes that describe the case management and coordination required for medical homes. The CPT codes should be priced so that Medicare and other payers can support implementation. CMS should also revise the RVRBS values to reflect billing under a medical home model.
- The Secretary should clearly identify for the States which CMS Medicaid waiver authorities are available to support medical home demonstrations at the State level.
- The Secretary should use Medicaid Transformation grants and Healthier U.S. grants to promote medical home implementation in rural areas.

### *Recommendations related to HRSA:*

- The Secretary should reauthorize and support funding for the Healthy Communities Access Program with revisions to support projects that focus on development and implementation of medical home components, e.g., incorporation of HIT and EHRs, chronic care management, medication management, etc.
- The Secretary should use existing Rural Health Care Services Outreach and Rural Health Network Development program grants to promote the medical home model in rural communities and use funding from these demonstrations to inform policymakers in developing medical home standards and regulations that take into account rural practice considerations.

## National Advisory Committee Annual Report 2009

For the NRHA National Rural Task Force 2010  
Excerpted Section on the Patient Centered Medical Home

### Subcommittee: Creating Viable Patient-Centered Medical Homes

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### Creating Viable Patient-Centered Medical Homes in Rural Areas

In the ongoing efforts to improve health care delivery and achieve better health outcomes many public policymakers are touting the use of the medical home model as a key strategy toward that goal.

Nationally, the medical home model has gained much popularity and is often regarded as a way to reduce the cost of medical care for people with chronic diseases, which accounts for 75 percent of medical care spending in the United States.

Many health experts also view the medical home as a way to improve the quality of care, especially for patients whose complex conditions would benefit from better care coordination. The concept of the medical home gained traction from the movement for quality improvement and increased focus on medical error reduction. Despite the extensive discussion and literature already existing on the medical home model, it is largely a theoretical concept at this point. The criteria for what a functioning medical home would entail are still being developed. Currently, there is no single consensus on what exactly a medical home is.

The Committee agrees that development of a medical home has potential for improving care coordination and outcomes. There are, however, challenges in creating a medical home model that will work equally well in urban and rural areas. The share of the elderly population that lives in rural areas is increasing and the rural elderly would stand to benefit from better care coordination and referral tracking through medical home implementation. Rural residents face challenges in accessing coordinated care across the health care continuum given that they often have to travel for specialty care. In addition, rural areas face shortages of primary care clinicians who would serve as the hub of any medical home. The Committee believes that the Department of Health and Human Services (HHS) should move carefully in any design of a medical home and allow for flexibility for reimbursement to also include physician assistants and advanced practice nurses as medical home providers.

The Committee visited two States where medical homes are either already implemented or getting started. The Committee observed that when rural physicians partner with their hospital boards and administrations, they can lead a successful small-scale implementation of the model. States can direct their Medicaid funding to drive quality improvement, using the medical home as a delivery model. To ensure that rural areas can be positively affected by medical home implementation, and to minimize adverse outcomes, the Committee has outlined several recommendations. The Centers for Medicare and Medicaid Services (CMS) Medical Home Demonstration is viewed as an important opportunity to determine the impacts of medical homes and the costs of implementation. The Committee recommends that CMS Demonstration sites include rural practices in several different States so that impacts in a variety of rural communities can be observed. The Committee also recommends that Relative Value Resource Based System (RVRBS) and Current Procedural Terminology (CPT) codes be modified so that providers can be reimbursed for care coordination and other services associated with a medical home.

The 2009 Report  
to the Secretary:  
Rural Health and  
Human Services Issues

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NACRHHS

The National Advisory Committee on  
Rural Health and Human Services

April 2009



## Attachment G



NRHA

### National Rural Task Force Vision Statement, September 2009

**The goal is better health for all.**

Call to action:

- Grow access to care in the United States through community-operated Community Health Centers (CHCs).
- Promote the CHC model with its well documented record for improved outcomes and health status.
- Encourage the expansion of the CHC model of chronic disease management, reduced use of emergency department services for non-emergency care, patient education, enabling services and other proven strategies for reducing Medicaid expenditures for CHC patients.
- Acknowledge the social and political determinants of poor health and commit to their elimination.

**Support rural care teams to meet the goal of better health**

Access to rural health care cannot survive in a purely market-driven system. The special considerations and support needed to serve small populations, higher percentages of elderly, disproportionate poverty and the challenges of isolation cannot be addressed by markets.

**Establish a national commitment to rural health care that must:**

- steadily improve financial and geographic access to care for rural populations.
- compensate and reward rural primary care providers through reimbursement enhancements.
- reward primary care providers who address a broad range of supportive services.
- directly support training programs that serve rural populations. This includes support for both the actual training that occurs in rural sites as well as those programs that graduate professionals who choose and remain in rural practice.

History repeats itself. If the nation returns to its 1960s and '70s level of commitment to health care for all, we already know what to do. Restore and build on the successful programs established then: including the National Health Service Corps, Community and Migrant Health Centers, Medicaid and Medicare.



## Enact policies to guarantee a rural workforce

*Success requires a multi-faceted, holistic approach.*

### Selection and admissions:

The process for improving a professional choice of rural practice begins with selection and admissions decisions made by medical schools, PA and NP training programs.

- Implement well-documented best practices for selecting students with the highest probability for rural primary care practice.

### Financial support and incentives for education:

- Expand National Health Service Corps (NHSC) scholarships for primary care. As well as being an attractive incentive to all students, this program has proven to increase recruitment and graduation rates of minority and low-income students.
- Increase the types of providers eligible for the NHSC and other training support to meet changing health needs, including pharmacists, optometrists, certified diabetes educators, a broader range of mental health practitioners, exercise physiologists and dieticians.
- Eliminate graduate medical education caps on programs that educate and train family medicine residents.

### Finance meaningful rural training to meet current and future needs:

- Provide financial support and incentives to students, rural residency/rotation sites and sponsoring training programs.
- Allow training dollars to follow the student/trainee.
- Provide incentives for training at rural Community Health Centers (CHCs).
- Train for the full breadth of family medicine required for rural practice.
- Train in the “health home” model of interdisciplinary care teams.

### Ongoing support for rural practice:

#### Improve NHSC placement in rural areas through policy and statutory changes:

- Eliminate the policy for determining Population Group Health Professional Shortage Area designations which requires 30 percent of the population be at or below 200 percent of the federal poverty level.
- Remove the language in U.S. Code which confines site-match opportunities for placement of NHSC scholars at a ratio that cannot exceed 2 to 1 (two sites per available scholar).
- Provide annual bonuses to sites that retain NHSC providers beyond the initial service obligation.
- Increase the loan repayment program to help assure the rural workforce.

#### Improve reimbursement for primary care; create additional recruitment and retention bonus payments:

- Make necessary changes to the reimbursement system to support low-volume providers. Current incentives reward volume and intensity, but rural practice is by definition low volume and less specialized.
- New models of care that require additional providers and/or provider types will need subsidies to compensate for low volume.
- Provide recruitment and retention bonuses to rural providers whether or not they are participating in NHSC scholarship and loan repayment programs.
- Provide incentives for documented quality of care and improved health status outcomes whether through CHC collaborations, health home or other outcomes-focused models.
- After five years retention in rural practice and every five years thereafter, provide a cash award to the training program and institutions where the rural primary care provider had trained.



## Attachment H

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