Rural Health Coordinating Council (RHCC)

April 21, 2016, 8699 SW Sun Place, Wilsonville, OR

Roll Call & Introductions

Andrea Fletcher, Chair, began the meeting at 10 AM.

Members in Attendance

Linda Callahan, PhD, PMHNP, Oregon Nurses Association; Bruce Carlson, MD, Oregon Medical Association (OMA); Wayne Endersby, Oregon Emergency Medical Services (EMS) Association; Andrea Fletcher, Consumer - Eastern Oregon HSA #3; Craig Hostetler, Oregon Primary Care Association; Kim Lovato, PA-C, Oregon Society of Physician Assistants; Candye Parkin, Oregon Association for Home Care (OAHC); and Judy Peabody, ND, Oregon Association of Naturopathic Physicians.

Oregon Office of Rural Health (ORH) Staff

Scott Ekblad, Robert Duehmig, Meredith Guardino, and Eric Jordan.

Guest

Diane Lund-Muzikant

Q = Question, **A** = Answer, **C** = Comment

Approval of April 2016 Agenda

The April 2016 Agenda was moved by Ms. Callahan, seconded by Mr. Endersby, and approved unanimously as written.

Approval of January 2016 Minutes

The January 2016 minutes were moved by Ms. Callahan, seconded by Mr. Endersby, and approved unanimously as written.

Old Business

Bylaws Amendments

Mr. Ekblad reviewed the bylaws changes discussed at the last couple of RHCC meetings: updating the standing committees in Article VI to reflect the current work of ORH and the RHCC, and change the date of the annual RHCC meeting in Article IV from fall to spring.

These changes to the bylaws were moved by Ms. Fletcher for vote by attending members, and approved unanimously.

Apple A Day (AAD) Fundraising Update

Mr. Ekblad provided an update on the AAD Fundraising Campaign. As previously

mentioned, instead of the annual fundraising dinner held in conjunction with the annual Rural Health Conference, ORH will be putting all of its efforts into assisting the Glow XC 7k fun run out of Dexter, which will be held on the evening of Saturday, May 28. ORH investigated the idea of holding a golf tournament fundraiser as well, but there is not dedicated staffing necessary to successfully pull that off at this point in time. ORH also spoke with a professional fundraiser about growing the AAD effort. Mr. Ekblad reminded the assembled RHCC that sponsorship is always welcome.

Federal Legislation: EMS/Controlled Substances

Mr. Endersby provided an update on federal legislation regarding EMS and the use of controlled substances. The Drug Enforcement Agency's (DEA) language on the use of controlled substances on ambulances dates back to 1970, so is greatly out of date. Federal Bill HR 4365 has been introduced to update these rules. US Representative Greg Walden has already taken this up and is working to gather more support for it. What the bill aims to do is:

- Allow EMS agencies to directly register with the DEA. Currently it is the agency's supervising physician who registers. It also specifies that only one registration is required per agency, rather than one for each of the agency's locations.
- Require each agency to have a Medical Director. Mr. Endersby's reading of this is that there must be agencies elsewhere in the nation that do not have Medical Directors.
- Authorize the Medical Director to issue standing orders that allow the agency's EMTs to administer controlled substances.
- Standardize the protocol and forms for control of these drugs on the ambulances.

Q: [Mr. Duehmig] Do they specify what that process will be?
A: [Mr. Endersby] Not that I've seen. I have not gotten a lot of information from those that I've asked about this.

Overall this is a good piece of legislation because it brings the federal rules up to speed with what some states are already allowing. It would remove the threat to EMS personnel of arrest by DEA officers, as well as the risk to supervising physicians of revocation or suspension of their DEA license.

ORH Updates

RHCC Member Recruitment

Mr. Ekblad expressed kudos to the current Governor's office in recruiting a new consumer member, Steve Rubin, MD, from Enterprise. Dr. Rubin will replace Mr. Molinari. The previous Governor would not renew Mr. Molinari's appointment, so he kindly continued to serve without appointment for almost three years. Reappointment requests were

submitted by both Ms. Lewis and Ms. Fletcher, and both were reappointed. Mr. Ekblad also recently heard from the Board of Pharmacy that they will be replacing Mr. Patrick, who retired a short while ago.

Conference Planning

Mr. Ekblad and Mr. Duehmig provided an update on planning for the 33rd Annual Rural Health Conference. The planning committee is well underway with the agenda. The opening plenary session will be part two of the Blueprint for Rural Health in Oregon that began at last year's conference. Other sessions will spotlight oral health, data usage in Coordinated Care Organizations (CCO), opioids, recruitment and retention, and federal policy. We are also considering a session on community paramedicine.

Q: [Ms. Fletcher] Will the recruitment and retention session be led by ORH Staff?
A: [Mr. Duehmig] Yes, and we might bring in others as well. We also hope to have a networking event Thursday night for students and residents to interact with potential sites. We did one of these one year when the conference was in Salem, and it was successful. We bused students to the event at Champoeg Park. Tying this to the conference in Portland makes it easier for the surrounding students to attend. We've been in conversations with the sites and schools with rural training tracks to build excitement for this event.

C: [Ms. Parkin] We recently did something like this with Providence Home and Community Services, and the response was amazing – there were over 150 attendees. The meet and greet portion of recruitment is really important. This was in February, and we are still pulling candidates from that pool.

Q: [Ms. Parkin] On the paramedicine session, can you provide more detail?
A: [Mr. Ekblad] We had a session on community paramedicine a couple of years ago, but I hope to keep this subject on people's mind. I think the angle of this session is shaping up to be on the training of Paramedics for community paramedicine. So as far as specifics, I am not sure what it will look like at this point.

We will also have a session on aging issues. The Director of Portland State University's Institute on Aging will provide a 30,000 foot overview on what can be done to create "age friendly" communities, then a physician from Hood River will focus on scaling that to a rural community. This might be a plenary session.

And finally, we have decided to keep the conference in central Oregon for the next few years. After the one in Portland this year, it will move to Bend. We have outgrown the available coastal conference centers, and a central Oregon location makes the travel more equitable for all.

Apple A Day Awards Update

Mr. Ekblad reported that so far this year the ORH has conducted one cycle of awards for

individual volunteers and one for agencies. This leaves approximately $3,000 available for the last cycle of individual volunteer awards later in the summer.

ORH Staff Update

As previously reported, Maeve Trick took a position with National Rural Accountable Care Organization. We are currently hiring for that vacancy. The position has been reconfigured to better serve the needs of the Field Services team and our constituents.

The Blueprint for Rural Health in Oregon webinars have been going well, but we would like to see more people participating in the pre-webinar surveys. There is good attendance on the actual webinars. Harvey Licht, the contractor helping us with the Blueprint, has noted that these numbers are to be expected, but we want them to be as large as possible. We hope to have a draft of this Blueprint to present at the conference in September.

C: [Dr. Carlson] Related to ongoing issues in rural Oregon, I've noticed that transportation is huge. The Confederated Tribes of the Umatilla Indian Reservation received a federal grant to run six bus routes that are reaching into neighboring communities, as well as Morrow county.

Q: [Mr. Ekblad] I've heard of communities in other states running volunteer drivers out of churches or some other non-profit entity. Does anyone know of anything like this in Oregon?

A: [Ms. Lovato] As a one-off, we recently had a patient who had some transportation issues, so our clinic coordinator was able to locate a church that had a volunteer drive her to her appointment.

A: [Ms. Parkin] I think the Veterans Administration (VA) has a stable of veterans who drive other veterans in need to their appointments. Some small communities have organizations such as Love in Christ and Love, Inc. which provide transportation, yard maintenance, and visitations to other community members.

A: [Ms. Fletcher] Morrow County has a transit service like this that is funded, but volunteer run.

Q: [Mr. Ekblad] I assume the grant the Tribe received is time limited. What are the plans to continue it after its funding cycle?
A: [Dr. Carlson] I am not sure at this point, but it looks to be very popular, so I assume they will continue it somehow.

Q: [Dr. Carlson] What can we do to look at transportation solutions?
A: [Mr. Ekblad] That will certainly be one of the points of the Blueprint.

RHCC Elections

Ms. Fletcher opened up nominations for Chair, Vice Chair, and Executive Committee members at large.

For Chair, Mr. Endersby was nominated by Ms. Fletcher. Dr. Carlson moved to close nominations and the motion was unanimously approved. Ms. Fletcher opened voting for Mr. Endersby as Chair, and he was elected unanimously.

For Vice Chair, Ms. Parkin was nominated by Dr. Carlson. Dr. Carlson moved to close nominations; the motion was seconded by Ms. Lovato, and it was approved unanimously. Ms. Fletcher opened voting for Ms. Parkin as Vice Chair; she was elected unanimously.

Mr. Ekblad noted that Chair and Vice Chair are two-year terms.

For the Executive Committee, Ms. Fletcher opened nominations for two at-large members. Ms. Fletcher and Ms. Lovato each offered to serve. There were no further volunteers or nominations. Dr. Carlson moved to close nominations and the motion was seconded by Mr. Endersby. Ms. Fletcher opened voting for herself and Ms. Lovato as at-large members of the Executive Committee, and they were elected unanimously.

Mr. Jordan noted that this is a one-year term.

Home Health

ORH Report – Meredith Guardino

In Fran Molinari's absence (Ms. Molinari was to provide a local Fossil, Oregon first-person perspective on this issue), Ms. Guardino provided background information on Asher Home Health's experience with the Star Rating system, an overview of the Star Rating system, Oregon's aging demographics, and her own findings from querying home health agencies in rural Oregon.

Ms. Molinari has brought to the RHCC's, ORH's, and US Senator Ron Wyden's field representative's attention the issues Asher Home Health is facing with the Centers for Medicare and Medicaid Services' (CMS) Star Rating system for home health agencies. This system is based on quality outcome metrics that are difficult for a small, rural agency to meet and advance to higher ratings. For instance, one measure is distance from urgent care. This can be a problem for rural agencies and most certainly is for Asher Home Health. This rating system is being used by at least one major insurer to determine reimbursement rates.

ORH's Stacie Rothwell spoke with Harney Home Health, who seconded Asher Home Health's concerns, but pointed out challenges specific to Asher Home Health: having a small (1.5 FTE) staff, and not having an electronic medical record system (EMR) to make documentation and billing easier and quicker.

Ms. Guardino was able to survey a handful of the 32 rural Oregon home health agencies, and found they faced common challenges:

- The scale needed to meet administrative and regulatory requirements
- Operational efficiency to meet administrative and regulatory requirements
- Regulations versus patient focused
- Issues with and avoidance of the VA
- Focus and concerns with Star Rating
- Payment models
- All agencies reported being in the red financially. The only ones which are profitable are those that include hospice care

Q: [Dr. Carlson] Rural Health Clinics (RHCs) can do home health. Can Federally Qualified Health Centers (FQHCs) do home health?
A: [Mr. Hostetler] It depends. If a provider leaves the four walls of the clinic, they are no longer covered for medical malpractice, which is an issue being worked on. How is it that RHCs can do it?
A: [Dr. Carlson] The first thing is the clinic must be in a home health agency shortage area, which our RHC in Christmas Valley received as a dispensation from CMS. We were also able to fund a home health nurse separate from the clinic staff and we had a lot less paperwork than a home health agency does. This all hinged on the CMS dispensation.

OAHC Report – Candye Parkin

Ms. Parkin feels Ms. Molinari's concerns are very legitimate, as she knows the Fossil community and their needs well.

Ms. Parkin noted that it is said that home health is the second most regulated industry in the nation, right after nuclear energy. All of that regulation stems from the frail nature of the patient population. For instance, the OASIS forms that need to be completed for each patient at intake, every 60 days, and on discharge are 18 pages long. For Asher Home Health that is true paperwork that they must keep up with.

A lot of these payment changes are being driven by the Affordable Care Act (ACA), as well as shifting demographics in the United States. We are facing major demographic changes, so we have to adjust a lot for that – we have to make changes, we can't deny it.

The face-to-face visit requirement is one of the major reasons for payment to be held up. What often happens is the referring physician (who often receives zero training on these

forms) incorrectly fills out the form, and the agency is denied payment.

Another reason for a lower Star Rating is that agencies without hospice in the area are penalized as a result of their patients not improving. The rating system is based on quality improvement, which will not happen with a dying patient.

There are nine states doing a pilot project on payment methodologies, one of which is Washington. The rest of the states will have the payment roll-out in 2017.

Q: [Ms. Fletcher] Is that taking away the rural add-on payment? What is the change in the methodology?
A: [Ms. Parkin] They will be paid by their Star Rating.

For Asher Home Health, something that might be a strength is that, with their smaller staff and smaller census, they might be better able to educate their staff about things like the OASIS forms.

On the issue of home-bound status – it is really very vague. It is measured on the taxing effort that it takes one to complete a task. This is something which is open to a lot of interpretation. For instance, blindness. There are a wide range of tasks that a blind person can perform.

The Oregon Association for Home Care is very well aware of Asher Home Health's situation and is working closely with them and Representative Greg Walden to overcome this. We are trying to help CMS understand the burden of the face-to-face policy. We are also pushing to make the add-on payment for rural agencies permanent.

CMS has made things difficult for home health agencies that do not have an EMR. Since Asher Home Health is still paper-based, we would recommend they contract with an electronic billing service.

Q: [Dr. Carlson] Under payment modes, you mention some agencies are trying to steer more towards Medicaid, rather than Medicare. Is that right?
A: [Ms. Guardino] I would not say some, it is only one. One has switched over as a result of its CCO involvement.

C: [Dr. Carlson] Well that could be the start of a trend. I could see this becoming a crisis down the road, since you cannot make up repayment that way by volume. I would suggest that OAHC speak with the state AARP. It is the second largest organizational lobbyist in the US.

Q: [Mr. Ekblad] Was there Internet at the home health office in Fossil?
A: [Ms. Guardino] Yes, it is connected physically to Asher Clinic.

Q: [Mr. Ekblad] What would it cost them to go EMR?

A: [Ms. Guardino] It depends on which hospital's EMR they are trying to match to. Estimates range from $5,000 – $50,000. Another angle is that an umbrella organization could step up to assist these smaller home health agencies with their EMR needs. But which organization would that be?

Q: [Dr. Carlson] I bet this is not a problem unique to rural Oregon. Has anyone contacted the National Rural Health Association to see if there are others in the US already working on this?
A: [Ms. Parkin] I've heard that there are other states with these concerns.

C: [Ms. Fletcher] I spoke with our agency in advance of this meeting, and in Morrow County, which is adjacent to Wheeler County, staff burnout in home health is a concern. The home health/hospice agency there is highly regarded. Payment is by prospective payment, because they are provider-based, so they might be a bit better off as a result of that. There is some overflow of services into neighboring counties, which increases and impacts the service area. Their prominent payer is Medicare, so everything is highly scrutinized. In regard to durable medical equipment, there is not any real competition on the market, so they have to pay what they have to pay, which is usually high. Lastly, pockets of no Internet access are also barriers, since you cannot set up home monitoring if you do not have Internet access.

C: [Dr. Carlson] You can use a cell phone or a hotspot device for monitoring, providing you can get a cell connection. Also to note: the senior poverty level has gone down since about 1965.

C: [Ms. Lovato] Being a PA with indirect supervision, I'm getting a few things a week to sign, which I cannot sign. This is a real barrier to care. With many aging patients in my census, home health will be in their future. I did some research and found a policy paper by the NRHA from 2008 which addressed this very issue that we are discussing today. I really do not know what is holding up the legislative changes to this.

C: [Ms. Parkin] Home health has been working on this for some time. Some of this legislation dates back to the 1960s, so is desperately in need of change.

C: [Mr. Duehmig] Relating to changing healthcare legislation at the federal level, all of American health care is now viewed through the ACA lens, so any changes to legislation, no matter how non-political it may be, has become something that *is* political.

C: [Ms. Guardino] We could add something to the upcoming Flex grant to hire an intern to look into this situation in depth. If anyone is interested or has any suggestions, please let me know in the next week.

RHCC Member Reports

Judy E. Peabody, ND, Oregon Association of Naturopathic Physicians

The Oregon Association of Naturopathic Physicians is not too focused on rural currently, so not much to report there.

On a personal note, my husband and I became my mother's primary caretakers this past fall and, since moving in with her, we've noticed a tremendous overall improvement in her well-being. It's a testimony to the power of positive human interaction.

Kim Lovato, PA-C, Oregon Society of Physician Assistants

Ms. Lovato's report was delivered in the preceding section on home health.

Andrea Fletcher, Consumer - Oregon HSA #3

Ms. Fletcher's report was delivered in the preceding section on home health.

Wayne Endersby, Oregon EMS Association

Mr. Endersby's report was delivered in the earlier section on Federal Legislation: EMS/Controlled Drugs.

Linda Callahan, PhD, PMHNP, Oregon Nurses Association

Linda presented to the RHCC on the Blue Zone Project, a community-wide well-being improvement movement designed to make healthy choices easier for everyone (healthways.com). The City of Klamath Falls has adopted this program, and had a very high turnout at the kickoff event in March after a year of planning. Overall, it's a very large national project which will last three years.

She does wonder how these outcomes will be measured. She also does not have a strong feeling for what the education and primary care components will be. Not to sound negative, as the overall kick-off was very strong and well managed. Notably, local restaurants, grocers and other businesses are already profiling their Blue Zone offerings so there is great local engagement.

Q: [Mr. Ekblad] What is the body that gets the award, or recognition?
A: [Ms. Callahan] In this case, the City of Klamath Falls.

Bruce Carlson, MD, Oregon Medical Association

About 99% of the Pendleton Clinic patient census is covered by Medicaid. One of our

employees is going to Community Health Worker training. She'll be looking at the patient roster to see who is going to the emergency room for something preventable. I'm also looking at hiring a nurse case manager. We are a level 3 patient-centered medical home (PCMH), so must have a live person on the phone 24/7, and now use an online virtual receptionist to triage the calls. The Independent Physician Association in Pendleton is working hard to recruit physicians into the city. We are looking at rural residency programs as well.

The Eastern Oregon CCO (EOCCO) is looking at patients with back pain. The Health Evidence Resource Commission (HERC) has been appointed by the Oregon Health Authority (OHA) to look at the treatment that the OHA will pay for, which currently consists of opioids. Last month, the CDC published a paper on alternative pain management One thing they looked at was cognitive behavioral therapy, which has been proven to be a big help. But you cannot get payment for it but now, with HERC's recommendation of alternative methods, the OHA is studying this method of therapy. The only downside is that our area is currently short 50 mental health practitioners.

Q: [Ms. Fletcher] What level of provider can do cognitive behavioral therapy?
A: [Ms. Callahan and Ms. Lovato] Psychiatric Mental Health NP, Marriage and Family Counselors, Psychologists, and a Master of Social Work.

Q: [Mr. Ekblad] Would the EOCCO be interested in training a Psychologist in the area?
A: [Dr. Carlson] Perhaps, but there are issues. Primarily, where would the training take place, and where would the proctor be? We have one PhD Psychologist already in Pendleton, but he does not belong to EOCCO.

C: [Mr. Ekblad] Let us know if there is a PhD Psychologist out there who would be interested in the establishment of a psychology internship program.

The EOCCO had a board meeting and the Pharmacy Director from our insurance company gave a presentation on the percentage of prescriptions used by different populations. Thirty percent of patients using commercial insurance are using prescription drugs. Fifty-seven percent of the people on Medicaid are using prescription drugs. About seventy percent of the people on Medicare Advantage are getting prescription drugs. Under the Medicaid program, the number one type of drug prescribed are pain killers, but the highest cost are antivirals.

The Hermiston clinic is now working towards becoming a level 3 PCMH. We are currently a level 2. This will allow us to do new things there. We have a new PA coming in on June 1, 2016. Good Shepherd Hospital in Hermiston, EOCCO in partnership with Oregon State University, and Northeast Oregon Network out of La Grande are all offering community health worker training. We will be able to bill for these services through EOCCO.

Q: [Ms. Parkin] What are the services that they provide?
A: [Dr. Carlson and Mr. Ekblad] They connect patients with resources for not only

healthcare, but also housing, transportation, etc.

The hospital in Heppner is admitting patients who are in recovery from procedures done elsewhere. This looks like a trend in rural hospitals.

Candye Parkin, Oregon Association for Home Care

Ms. Parkin's report was delivered in the preceding section on home health.

New Business/Public Input

There was no new business or public input.

Adjourn

Ms. Fletcher adjourned the meeting at 2:45pm.