NOSORH and National Center for Frontier Communities
FRONTIER PARTNERS GROUP
Minutes and Notes
July 27th, 2017
Bellingham, WA

Attendees: Ben Rasmussen, Susan Wilger, Victoria Cech, Jody Ward, Teryl Eisinger, Kassie Clark, Harvey Licht, Owen Quinonez, Kristi Martinsen, Julie Frankl, Pat Justis, Lynette Dickson, Rachel Moscato, Scott Carlson, Michael Meit, Cari Garcia Hanson.

I. Introductions. All participants introduced themselves and stated their expectations for the meeting.

II. Who are frontier Americans? Presenter: Benjamin Rasmussen

Why Define Frontier?

Demographic and socioeconomic analysis; and, Rural health system policy/program development.

Frontier areas are different, and may require a different approach to assure adequate health service.

Identifying frontier areas highlights populations that will likely require public intervention to assure a core set of health services.

Assure the geographic equity of the health service system.

Establish a standby capacity of key services where low volume makes market solutions unlikely.

Remoteness bestows highly-cherished benefits, but also persistent economic and social challenges.

There is a need to better understand the effects of remoteness on job creation, population retention, and service provision.

Frontier and remote area classifications have the potential to contribute to ERS research on several policy-relevant issues :

- Demographic trends
- Food deserts.
- Health care accessibility.
- Farm program impacts.

Frontier Definitions:

- Frontier Health Professional Shortage Area- 1980:
- Frontier Health Care Task Force (NRHA
- HRSA/BHCDA – Regional Program Guidance Memorandum 86-10: June 10 1986
- Office for the Advancement of Telehealth: Frontier Definitions- 2006
- Frontier Health Professional Shortage Area- ACA

- BPHC Criterion: BPHC uses a population density criterion to identify Frontier service areas eligible for funding priority.
- CMS Super Rural: CMS identifies rural Zip Codes with the lowest population density as Super Rural. CMS selects the bottom quartile of rural Zip Codes for this designation. Payment bonuses are contingent on this designation.
- USDA Frontier and Remote (FAR

At this point the presentation took a look at several maps of frontier definitions and discussed.

Frontier Demographics:

Population decline of 39 % in FAR 2 Areas between 2000 and 2010

In the United States, the population has increased by 9.7% between 2000 and 2010

In- depth look of various maps and charts related to demographics of frontier Americans. Please see slide show for details.

Frontier Economies:

In addition to various maps related to economic indicators as related to FAR II designation, we took a look at a case study for each of the major types of frontier economies. Farming, mining, manufacturing, state/government, services and non-specialized communities and how their demographics and economic indicators compare.

III. What did the ACA do to Frontier Communities? Presenter: Harvey Licht

Harvey used the narrowest frontier definition to get a sense of what happened in the most remote areas of the nation.

In general, the data is really bad when looking at the ACA. Monitored how many people by zip code signed up on the exchange. Data from counties with less than 100 people who signed up was suppressed. This may be intentional or not- but it makes assessing the impact in less populated areas very difficult.

When they are talking about repealing the ACA it is important to understand which part(s) of the Act they are talking about.

Market failure of ACA. If you need to assure services to a large number of Americans you can't always rely on the market to work. Frontier areas as well as remote areas are at most risk in terms of having the market fail under ACA-- more so than other counties. **46 counties would not have and insurer under the proposed Better Care Reconciliation Act.**

Uninsured numbers are some of the best numbers we have. There was a drastic reduction in the number of uninsured in the frontier since ACA was implemented; the change in uninsured population under age 65 from 2013 to 2015 was about 26% in frontier. The change was much higher in rural, and urban (33% and 34.74% respectively). Some states may have more drastic decrease than the overall numbers. **With ACA, Frontier had lower change in the number of uninsured than rural and urban. It is**

still behind on closing the gap of uninsured. The numbers for uninsured and for those who are insured for frontier are small. The fight is to get people to care about this small amount of people.

In ACA non-expansion states, the percentage of uninsured decreased slightly, from 20.89% in 2013 to 16.26% in 2015. Expansion is really important in frontier areas of the nation, especially for populations that cannot buy insurance on the exchange and are not eligible for Medicaid.

While absolute numbers are better in terms of program investment in the urban areas, relative numbers are better in frontier areas- this is what we have to get people to realize. The ACA had less impact in the frontier. Further data on this would make for a clearer case.

Example: Washington was in pretty good shape after three years of ACA. It is estimated to be much worse in terms of number of uninsured if the 2016 reconciliation bill passes. Changes due to the ACA does not add up to more than 25% of the population- this is important to remember. ACA did not lead to insurance being pulled out of these counties- at least not in Washington, where about 50% of the insurance plans are employer based.

However, this is not representative of the frontier areas. Some of the proposed adjustments to the ACA were based on data that is not reflective of the actual population because it excludes certain groups that are ineligible for ACA, such as undocumented immigrants.

The economic impact of ACA repeal is exponentially more severe in frontier communities because the hospitals, etc. are such big economic drivers in those communities.

Harvey talked about the **KEY ACA Market Provisions**. Under ACA, State regulations required insurers to offer plans in all counties of a state and required a certain level of provider network adequacy. The latest federal repeal bills only require insurers to be in one county unless there is a state regulation indicating otherwise and reduced network adequacy requirements from ensuring 30% of each area's essential community providers were in the network to only 10% of providers.

Other potential changes to health care market if ACA is repealed include **risk reduction and stabilization measures** that were put in place to protect insurance companies. Under ACA 12% of financial loss by insurance companies who were in the exchanges was covered under ACA.

Conclusions:
What's the bottom line for frontier if ACA is repealed?

- Increase in underinsured
- Increase in insurance premiums
- Increase in cost sharing
- Decrease in choice of insurance plans
- Decrease in services available

Goal for frontier communities in the face of ACA repeal: Maintain existing Medicaid expansion.

How NCFC, NOSORH and States can to respond to ACA repeal and impact on Frontier?

- NCFC would be a good place to figure out advocacy mechanisms for ACA issues and get this to policy makers. Equip frontier communities to express what is at stake. Educate and empower

frontier communities. Learn what is most important to the frontier communities regarding their healthcare systems.

- NCFC can develop policy positions to protect frontier areas from being disproportionately impacted be any reforms.
- NCFC can advocate for better coordination among various healthcare systems and services and the necessary infrastructure support (e.g. telehealth or transportation)
- Educate the public and decision makers about what is happening in frontier healthcare and the impact of ACA and other policies.
- Research what models are working in frontier and integrate these into funding and other program initiatives.
- Encourage rural research centers to partner to evaluate impacts on frontier.
- Deeper assessment of the actual level of coverage, provider accessibility, cost and number of uninsured.

IV. Frontier Community Health Integration Project (F-CHIP) - A History and Update
Presenter: Victoria Cech

Project goal is to determine how to improve frontier healthcare and the financing mechanisms. Four prong waiver system- entirely around reimbursement payments—for home health, telehealth, bed expansion and/or ambulance service.

Cost-based reimbursement to the originating site for telehealth services (original reimbursement waiver offer also included asynchronous "store-and-forward" services per the model already conducted in Alaska and Hawaii, but this was withdrawn). F-CHIP waived the 35-mile rule for cost-based reimbursement of ambulance services and permitted an increase of 10 swing-beds in a critical access hospital. Offered enhanced payment for mileage for home health service.

Hospitals can apply for any one or a combination of these waiver packages and 13 hospitals from 3 states applied. The three hospitals selecting the home-health waiver were denied, leaving 10 sites in three states MT (3), ND (3) and NV (4).

The "tyranny" of small numbers. In terms of frontier communities.

Implementation challenges:

Telehealth: distant/specialty site challenges; billing and coding complexities; unfamiliarity on both ends of the process; provider resistance. ND and MT were ahead of NV in telehealth infrastructure. Hospitals want telehealth referrals to go to them. Fear of damage to hospital's current partner network.

Swing bed: Information/marketing to inform families that they can now receive care in their community.

Ambulance: regulatory/legal impediments to creative use of ambulance service (e.g. it is not legal in MT for paramedics to do preventative services like well child exams).

A lot of these waiver programs can mean that hospitals have a larger revenue pool to draw from which will make a big difference. The question is "could this project be easily replicated without technical assistance or support"? It depends on the capacity of the site; among the current 20 sites capacity varies widely. In general, telehealth requires some degree of technical assistance to get up and running in a remote community. Determination of readiness may include:

- Determine what the "critical mass" is (i.e. what number of patients need to be seen before the numbers really begin to increase?).
- What equipment is available? Is bandwidth at a level to ensure stable connections?
- What is capacity to operate equipment?
- Is there a trust level established between originating site and provider on the other end?
- Are they familiar with billing and coding related to the service provided?
- How are patient records managed to account for the service provided?

If these models are going to continue to just be tweaks of urban models, then they probably will not be all that effective- what does it take?

Recommendations:

- Review regulatory policies of FQHCs and Critical Access Hospitals and determine areas of conflict.
- Determine the structural, systemic and other barriers that prevent integration.
- Volume should not determine value.
- Take into account the cost of transfers as part of the fiscal analysis.

V. Utilizing CHWs in Frontier: Innovative Approaches to Training, Financing, Job Creation and Demonstrating Impact

Presenter #1: Scott Carlson, Office of Family and Community Health Improvement, WA State Department of Health

There is no state certification for CHW's in most states. In Washington state, there was a task force that put forth recommendations on developing the CHW definition, roles, skills, training requirements and funding sustainability.

WA CHW training program has required training in core competencies that can be done in person or online. Core competencies incorporate both community and clinical environments. Core curriculum is 30 hours of training over 8 weeks. An additional 75 plus hours of training in 20 health specific modules are also available online. Online trainings have teachers available to help the students. The literacy level is usually from 5th to 7th grade- so that it is applicable to the workers themselves. Courses are Free.

The vast majority of people in these classes are already employed and their employers send them as part of their job. They purposely have little to no barriers of participation because the aim is for this to be available to all communities.

Braided funding from: 1305/1422 CDC Chronic Disease Prevention Grants, Comp Cancer, PHBG, MCO and state funds. Recognize that training supports all CDC strategies. Funding is contingent year by year, which is a challenge for growing and sustaining the program. Programs support the development of health specific modules, costs and technical support as needed. It's really about reaching out into the most underserved communities and bringing them together and connecting them to resources.

Moving forward they plan to: continue expansion of training curriculum (Heath Specific Topics) as identified; expand in-person CHW training supporting blood pressure and hypertension self-monitoring

(available in Spanish); align core curriculum with Washington State Task Force recommendations; incorporate multiple language resources; implement regional Train the Trainer models; incorporate our electronic Community Health Assessment and Referral Tool (CHART); integrate CHWs into 6 clinical settings through the CHW Pilot Integration Project; and partner with colleges for continuing education.

The Pilot Integration Project is in partnership with the Foundation for Healthy Generations. CHWs will be placed into 6 diverse clinical settings, which are primarily FQHCs, one tribal, one free clinic and one frontier setting. They will identify best practices around hiring, supervising, integrating CHWS into clinical care teams

Presenter #2: Krisin Juliar, Montana Office of Rural Health/AHEC

Began exploring interest in CHWs in 2010. Periodic workforce assessments.

Community Health Integration Project – Care Coordination Pilot Project was funded by the Federal Office of Rural Health Policy and CMS and placed CHWs in 11 critical access hospital communities. Regional supervision by ADRN at MT Hospital Association. The project was heavily evaluated and found to be cost effective, improve patient outcomes.

Convening of stakeholder groups beginning in 2015, one of which is the Policy and Reimbursement Committee, Stakeholder Group and Curriculum Committee.

CHW system in MT has been hard to get organizations to fund.

Training – They are developing a curriculum and piloting with Mountain Pacific quality Health Foundation. Apprenticeships and distance training models are in the works. The CHW Fundamentals course has 8 core competencies that are similar to the ones other states have used. There are four 15-hour models broken down into 3-5 hour units. They are anticipating they will have a lot of individuals in small communities wanting to take the CHW Fundamentals course. They are also developing a behavioral health fundamentals certificate.

Employment of CHWs in MT - Trend is growing in Montana- more people are employing health workers. Increasing from 28% in 2015 to 32% in 2017, based on survey results.11% of those surveyed reported they are “highly likely” to employ CHWs in the future. The elderly, rural residents, low socio-economic households and American Indians are the top populations served by survey respondents in 2015 and 2017. Majority of CHW’s are employed elsewhere (have primary job).

Policy and Reimbursement Committee- examines the role of CHWs in the models under consideration by the Governor’s Council on the Montana State Innovation Model Design and other Montana initiatives This committee evaluates the use of CHWs with Medicaid populations and care coordination models including PCMH, CMS funded care coordination projects and ACOs. Identify policies and reimbursement models that support the use of CHWs through Medicaid and private payer.

Funding is from MT HC Foundation, HealthCARE MT (Dept. of Labor project), MT Geriatric Education Center, and AHEC. Stakeholder group, curriculum committee, policy and reimbursement committee Staffed by MT AHEC/Office of Rural Health Creating curriculum and pilot with Mountain Pacific Quality Health Foundation project (RWJF and CMS funding) Apprenticeships and distance training models in the works Policy and Reimbursement Committee met in June

They think this could be a really powerful tool in these rural communities. This also includes supervised experience.

Presenter #3: Susan Wilger, NCFC and Southwest Center for Health Innovation
The US spends much less on social services than most other developed countries and spends much more on health care.

Role of Health Risk Assessment- upon enrollment, all new Medicaid members receive a Health Risk Assessment which leads to level assignment: Level 1: Generally healthy, ~85% of enrollees; Level 2: Mostly chronic diseases, higher need, ~10% of enrollees; and Level 3: Highest risk, highest cost enrollees, ~5% of enrollees. Those categorized as Level 2 or 3 receive a more comprehensive evaluation, face-to-face by a nurse or case manager and this leads to an intervention plan. Until now, focus of CHWs was on highest cost—Level 3.

The Integrated Primary Care and Community Support (I-PaCS) program aims to put more focus on levels 1 and 2.

Existing CHW intervention for Level 3 consists of intensive intervention and care coordination. With the I-PaCS pilot project, participating clinics that had contracts with MCOs to care for Level 3 enrollees assigned to CHWs remain unchanged. Each CHW handles a panel of 25-30 Level 3 members. Services provided for ~3-6 months until they are able to use resources appropriately, adhere to treatment plan, gain adequate health literacy, etc. Level 3s also receive added value from Community Health (Level 1) and Patient Support (Level 2) services The I-PaCS evaluation will include monitoring degree to which enrollees initially assigned to Levels 1 and 2 become level 3.

IPaCS can address the following problems in the current healthcare system: 1) MCO's profits are reduced due to high ER use, hospitalizations; 2) MCOs have trouble locating high users (top 5%) for their case managers Intervention; 3) MCOs contract with FQHCs who are responsible for hiring, training and supervising

I-PaCS Outcomes: 62% reduction in cost to MCOs (4:1 ROI); CHW programs expanded to all 33 counties in New Mexico; the CHW model replicated in 10 other states

Pilot: CHW Interventions with Levels 1 & 2 Enrollees

Clinically Integrated Patient Support (mostly affect Level 2) - The clinic will screen all patients at each visit for adverse social determinants of health. CHWs facilitate connection to needed community resources. CHWs teach health literacy, imparting skills in navigating healthcare and social service systems.

Community Health, Population Focus (mostly affect Level 1). CHWs work with community advocates to address the social determinants of health that are impacting Medicaid patients the most (e.g. build better community access to nutritious food, increase school graduation rates, access to transportation or housing, training and access to better paying jobs, etc.) Strengthen resource collaboration between primary care, public health, local government sectors.

I-PaCS Evaluation/What will be Measured?

Quantitative:

- Frequency of primary care, ED visits
- Frequency of hospitalizations for primary care sensitive diagnoses
- Medication costs
- Healthcare Effectiveness Data and Information Set (HEDIS) measures
- Uniform Data System (UDS) measures
- Chronic diseases-# newly diagnosed, Degree of control
- Self-reported health

Prevention

- Policy needs identified (ex. Transportation, Food, Housing)
- Policy actions taken (e.g. working with city/county policy-makers, creating and advocating for proposals; working with State Medicaid, MCOs, University and FQHCs creating and advocating for systemic changes that address SDOH, access, etc.)
- Community interventions-developed, outcomes recorded (e.g. setting up health fairs linked to intervention clinic communities; creating young children's' meals and nutrition programs in clinics, etc.)

Qualitative

- Enrollee perception of access to healthcare, to social services
- Clinic provider perception of impact on ease of practice
- Clinic administrators' perception of cost, benefit of CHW intervention on their "bottom line"
- MCO "ownership" of the Pilot
- MCO "satisfaction" with the outcomes of the Pilot
- HSD, Medicaid Centennial Care administrations' "satisfaction," actions on basis of Pilot

Implications of Pilot for Centennial Care (NM Medicaid)

- ~40% of New Mexicans are enrolled in Medicaid
- Currently, 2-5% of Medicaid enrollees, in Level 3, the highest use/cost category are touched by CHWs
- If the CHW Pilot with Level I (~85%) and 2 (~10%) enrollees improves quality and reduces cost, Medicaid will consider rolling out across state

Several studies showing the return on investment for this CHW model are available.

The I-PaCS project has developed a comprehensive toolkit that includes a readiness assessment, CHW training with core competencies for each level, documentation of CHW interventions, the Well RX (screening tool for social determinants) and screening of patient functionality, integration of CHWs into the clinical team, etc.

Full Group Discussion About Community Health Worker Models in Frontier

Q: Is there any issue about CHWs exceeding their scope of work or any concerns about liability?
A: This is a common concern we hear across the nation. CHW training programs typically emphasize ethics and scope of work (e.g. when it is necessary to consult a supervisor or other member of the treatment team). Additionally, CHW supervision training, policies and procedures are designed to ensure that CHWs stay within their scope of practice. There are mutually agreed upon skills, rules and definition that define the CHW scope of work. Documentation by CHWs is a core training area.

VI. Frontier Health Inequities: Challenges & Opportunities for Integrating Public Health & Primary Care
Presenter: Michael Meit, The Walsh Center for Rural Health Analysis, NORC at Univ of Chicago

All health departments, urban and rural have less flexibility than they did ten years ago. The ACA provided people with insurance coverage but not access to care. If you are a rural health department demand for your services started going up after ACA. The opposite was true in urban areas where there was more choice of providers.

Rural/Frontier Public Health Disparities
Updated *the Rural vs Urban Chartbook*, published by CDC in 2001 to understand trends and provide a baseline of rural and urban difference in health status and access to care prior to ACA implementation. Some of the health disparities for rural vs urban include: higher rates and disparities for COPD; overall youth smoking has decreased, yet rural youth smoke more; suicide rates are increasing with greater disparities for rural. Health access is worse in rural/frontier areas. The Regional Mortality Study revealed suicide and unintentional injury are highest in rural/frontier.

Rural/Frontier Public Health Infrastructure
Rural public health departments are closing. Public health cuts followed the 2007 great recession. How public health is financed varies by geography. We are seeing an increase in local funding by urban public health departments. However, small rural/frontier public health offices are much more dependent on state and federal funding and on Medicaid and Medicare payments.

Clinical services provided have gone down- but not in rural areas. If you are an urban health care provider but there are other services in the area it may be a good idea to divest from clinical services. In rural areas, the opposite is true; those services may be helping to bring in needed income.

Public health departments may shift clinical services provision to partners or other health care entities. This may allow Health Departments to increase focus on core public health activities and services (e.g., policy development/ support, assessment and surveillance, etc.) Public health departments may expand their provision of clinical preventive services. This is especially true in areas where there are health provider shortages. Local public health departments are also dependent on local ability to bill for services.

The National Association of County Health Offices (NACHO) recently started a rural health committee to address their membership going two different directions (financially and services). They are starting to be receptive to these talks.

Evidence Based Models Tookit Series:

- Conducted on behalf of the Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP)
- A compilation of evidence-based practices and resources that can strengthen rural health programs
- New toolkits each year on different topics that target FORHP grantees, future applicants, and rural communities
- Applicable to organizations with different levels of knowledge and at different stages of implementation
- Hosted by the Rural Health Information Hub on the Community Health Gateway

VII. Wrap Up

Final questions and comments.
Participants completed evaluations
Meeting adjourned at 4PM.