

## **Frontier and Rural Expert Panel**

### **Annual Meeting Hotel Santa Fe, Santa Fe, New Mexico April 14, 2005**

#### **Background**

In 2004 the federal Office of Rural Health Policy (ORHP) issued a Request for Proposals for a Frontier Rural Health Care Information Project. The Frontier Education Center bid on this project and was subsequently awarded the contract. Among the tasks contained in the contract are the following four, which pertain specifically to the development of the Frontier and Rural Expert Panel: 1.) Submit 7 names for Frontier Issues Group; 2.) Host an annual meeting for Frontier Issues Group, notify the group via email and send summaries of meeting to PO; 3.) Host periodic conference calls for Frontier Issues Group, notify the group via email and send summaries of calls to PO; and 4.) Prepare Reports on Health Care Issues in Frontier Areas.

By early 2005, seven experts in the field were named to the Frontier and Rural Expert Panel and committed to provide leadership to the task of providing guidance to the Frontier Education Center as it identifies and addresses frontier and rural health issues for the Office of Rural Health Policy. The Panel represents a variety of frontier and rural health care experts and expertise in economic development, as well as representing an array of geographical areas.

An orientation packet was sent to all the members of the Panel prior to the first meeting.

#### **First Annual Meeting**

The first annual meeting of the Frontier and Rural Expert Panel took place in Santa Fe on April 14, 2005.

Members in attendance included Patricia Carr, Alaska; Gar Elison, Utah; Caroline Ford, Nevada; Rebecca Slifkin, North Carolina; and Karl Stauber, Minnesota. Martin Bernstein, Maine, and Peter Beeson, Nebraska, participated by conference phone. Emily Costich, federal project officer, attended, as well as Frontier Education Center staff members Carol Miller, Executive Director; Tess Casados, Assistant Director; Jill Sherman, Researcher; and Karen Sweeney, Administrative Assistant. A list of Panel members and their affiliations is attached.

#### **Introductions**

Carol Miller, Executive Director of the Frontier Education Center, welcomed the Panel members and outlined the topics to be discussed during the meeting, which included: The Impact of the Medicare Modernization Act on Frontier Areas, Maintenance of Health Care Infrastructure in Frontier Areas Subject to Seasonal Variations in Population;

**Technology for Training the Health Care Workforce in the Frontier; Frontier EMS – Staffing Services with Volunteer and Paid Workers.**

Miller then introduced Gar Elison, Frontier and Rural Expert Panel member and also the President of the Board of Directors of the Frontier Education Center. Elison provided a brief introduction to the contemporary frontier movement of the past 25 years and then greeted all those in attendance and asked all participants to introduce themselves. Panel members did so, and reflected on their interests and experience in Frontier:

- Peter Beeson has worked in Nebraska state government on rural mental health and has done extensive research on the impacts of farm crises and mental health. He is a past president of the National Association of Rural Mental Health. In addition he is a talented essayist and photographer.

In his introductory comments Beeson reflected on changes in rural Nebraska where young people leave, the elderly population grows and physicians retire and are not replaced. There is growth in immigrant populations, related in Nebraska to the meat packing industry. These demographic shifts cause language problems and new residents unfamiliar with the health care system. These factors strain local public health infrastructure.

- Martin Bernstein has 30 years of health care administration experience. He is CEO of the Northern Maine Medical Center in Fort Kent Maine, which provides a full range of health care services to St. John's Valley. The hospital is licensed for 49 inpatient beds, 45 nursing home beds, and satellite facilities. The Center also provides ambulance service, public health nursing, two small psychological units, and home health care for the community.

The rural health center has reimbursement, recruitment and retention issues and is looking at "grow your own" strategies to supply and retain healthcare workers.

- Patricia Carr, director of the Alaska Department of Health and Social Services' Primary Care and Rural Health Unit, focuses on Alaska rural health care issues. She looks at disparities in populations, linkages with tribal systems and has worked with developing community health systems from two to more than 60 sites.
- Gar Elison is executive director of the Utah Medical Education Council, which tackles healthcare workforce issues and works to equip healthcare workers to practice in small rural communities. Elison is also president of the Frontier Education Center Board of Directors.
- Caroline Ford is Assistant Dean and Director of the Center for Education and Health Services Outreach at the University of Nevada School of Medicine's Office of Rural Health. Ford cited the importance of international work experiences broadening her exposure to problems of getting an adequate healthcare workforce.

- Rebecca Slifkin is director of the North Carolina Rural Health Research and Policy Analysis Center. She is a lead researcher from the University of North Carolina on the FLEX Monitoring Team; a consortium of North Carolina, Minnesota and Southern Maine Universities She is a member of RURPRI Health Panel, which studies the rural impacts of the Medicare Modernization Act.

- Karl Stauber is president of the Northwest Area Foundation where he works on economic and rural leadership development in eight northern states, which includes much of the frontier. As a financial program officer in a WWAMI study (based at University of Washington) with Mountain States Health Corporation, he looked at 150 rural hospital communities to help assess the future delivery of health care in these communities.

Stauber noted his foundation does not accept grant requests; they instigate all of their work, much in economic development. They offer a rural leadership development program in communities of 5000 or fewer residents. They are currently implementing an intensive ten-year effort in 15 communities in which they invest an average of \$10 million and learn from the successes and failures of these communities.

- Emily Costich, federal Project Officer, is Lead Medicare Policy Analyst at the Office of Rural Health Policy (ORHP) in the Health Resources and Services Administration, US Department of Health and Human Services. Costich advised that a goal for the Panel is to help the Office of Rural Health Policy understand current issues in frontier areas and help guide their research and policy agenda to make sure they address the issues. She anticipates that the panel and papers will help strengthen ORHP efforts in research and policy development on Frontier issues.

### **Overview of the Contemporary Frontier**

Carol Miller gave a brief presentation on the geography and demographics of the enduring American frontier. Current concern about the frontier dates to the 1980 census. A catalyst to this re-assessment of the contemporary frontier in the early 1980s was a series of papers published by land use professor Frank Popper and geographer Deborah Popper. Their analysis of the continuing de-population of the Great Plains was considered controversial at the time, even though twenty years later it has been proven accurate.

Miller presented maps showing Frontier counties and the impact of federal lands in Frontier areas and resulting policy effects. The group discussed the domination of the federal government on the economies of frontier communities' economies and looked at maps of USDA Economic Research Service typologies as well as patterns of land ownership. Federal lands are also often areas of persistent poverty. The local tax base is replaced by federal Payments in Lieu of Taxes (PILT) which are projected to be cut this year to an all time low of about 30% of land value.

Panel members cited characteristics of Frontier areas:

Dominated by agriculture and ranching, often open lands;

High rates of uninsurance and underinsurance;

Often includes recreation counties that impact health care services;

Depopulation – youth leave to find employment;  
Growth in elderly population; retirement of physicians;  
Growth of immigrant populations in some areas, with attendant issues --  
language barriers, unfamiliarity and distrust of health care system, transient  
population – overwhelms local public services;  
Difficulty in maintaining hospital or health care workforce;  
Difficulty in meeting federal policy demands, such as creating x number of jobs or  
providing x number of services per unit.

### **Developing the Scope of Work of the Frontier Rural Expert Panel**

Many of the issues raised by the group are similar to or overlap rural and urban problems. Several questions were raised: How do you translate frontier differences to public policy? When are frontier issues unique? When are frontier differences a matter of degree or outlier to general rural issues?

### **Unique Frontier Characteristics**

Panel members brainstormed these issues and listed many factors that relate to frontier communities, including:

Age distribution

Race distribution

Large areas of persistent poverty

Indian trust lands and reservations

Large expanses of ranch and farmland

Transportation issues

Hazardous occupations – mining, fishing, forestry, agriculture.

Recreation areas and high risk activities

Military and WMD installations

High degree of federal control

### **Regionalization of planning**

Stauber noted the Northwest Area Foundation often works with neighboring geographical areas such as counties, which individually dwell on past divisions with each other. He finds by grouping entities you can change the scale of the discussion and free people to work on issues. He suggests using the same approach in distributing federal services.

### **Federal Issues**

#### **• Cost Basis**

Federal health programs often look at cost per unit or encounter. In small and sparsely populated communities, it is frequently difficult to reach the federally mandated levels; yet the services are still needed. Another way to calculate costs needs to be developed. For example, looking at federal hospital regulations, perhaps services in low population areas could be calculated as the number of procedures per population base rather than the number of procedures per hospital. Otherwise it might take aggregated data from several clinics or hospitals to achieve the levels stated in regulation or policy.

- **Volume**

Bernstein spoke to this issue, noting how federal policy looks at volume. While volume may indicate one specialist for a certain population, it is difficult to retain a solo service provider. Without the availability of relief, burnout and retention issues surface. One solution he recommends is to provide services in a different way. For example, in his community in northwest Maine, family practitioners provide the routine OB/Gyn care. While the population might be able to support one OB/Gyn, a solo OB/Gyn practice is not viable.

- **Categorization and Wording**

Similarly, Ford emphasized the important of wording. By design or default, the use of words is critical. How do words help or hurt rural and frontier populations? Ford noted that the more someone is engaged in the issues of small and isolated populations, the more they understand how words help or hurt frontier and rural populations. She raised the question: How do we create options from which people can choose those that will help them get accessible, high quality care?

Another issue that was raised was that of urging "special consideration" for frontier issues rather than looking at exceptions to the rule. The point is to make certain that frontier communities achieve parity. There should be opportunities on the front end of program design to allow participation and language that acknowledges special consideration.

Slifkin referred to her service in Africa designing a health care system from scratch. The question they had to wrestle with was: What is the highest reasonable level of care you can provide in villages of a certain size?

These points suggest that an underlying issue is determining the minimum level of care that should be provided relative to age, sex, race, economy, available transportation and other variables.

### **Reports to the Office of Rural Health Policy**

The discussion turned to the four specific areas of ORHP interest for which the Frontier Education Center is to prepare written reports by August 2005. The topics are: Volunteer Versus Paid EMS Workers in Frontier/Rural Areas; the Healthcare Needs of Seasonal Population Communities; the Effect of Technology on Training Frontier and Rural Health Care Workers; and the Impact of the Medicare Modernization Act of 2003 on Frontier/Rural Areas.

### **REPORT TOPIC: Volunteer Versus Paid EMS Workers in Frontier/Rural Areas**

Karen Sweeney presented the preliminary results of the EMS study. Frontier Education Center contacted state EMS directors for available statistics. Most states do not separate rural and frontier EMS workers, and many do not track paid versus volunteer workers. A June 2003 study by the National EMSC Data Analysis Resource Center (NEDARC) supplemented the information gathered.

Panel members discussed important issues related to Frontier EMS needs and suggested direction for the report. They cited anecdotal evidence relating to problems encountered by frontier and rural EMS systems and their workers.

Education requirements have increased, necessitating a greater time commitment from volunteers.

A national standardized test has been established -- many people fear failure and reject the need for extensive preparation for the test.

Lengthy diversions of EMS crews from local service --

- a. Long transports
- b. Lengthy waiting times to transfer patients at receiving, often urban hospitals
- c. Growing trend to responding to primary health care calls.

Costs for low volume paid and volunteer systems cannot be recouped in current federal reimbursement or other per run payment systems.

Volunteers must be retired, unemployed or in interruptible jobs.

Increased National Guard and other military service call-ups have impacted the EMS workforces in some communities.

In addition, the group discussed the question of whether EMS is a health or public safety function. Funding opportunities may be different depending on where the service is "housed." One suggestion was that EMS should be brought under the umbrella of a local primary health care provider or hospital.

#### Policy Issues

Is it possible to determine what decisions communities and EMS agencies need to make to determine if they staff with volunteers or paid workers?

How does the paid versus volunteer staffing affect Medicare reimbursement and can these impacts be addressed through changes in payment to staff?

Slifkin added: What are the federal level policies that affect whether you staff with volunteers or paid workers?

The initial information collected by the Center found several states that use only paid workers; others are primarily staffed by volunteers. Would it be useful to know how they arrived at those choices? The answer was yes, look at the reasons for the type of staffing.

The panel suggested looking at best practices. Ford referred to the Owyhee Indian Reservation in Nevada where support staff employed by the tribe have EMS training and serve that function when needed. She suggests doing a rough sampling in frontier counties: how do they determine cost and how do they bill.

An outline of the projected study will be supplied to the Project Officer before proceeding.

**REPORT TOPIC: Maintenance of Health Care Infrastructure in Frontier Areas Subject to Seasonal Variations in Population**

Jill Sherman reported on Phase 1 of the Seasonal Population Fluctuations paper completed in June 2003. Two issues that arose in the discussion for Phase II were the impacts of delivering adequate health care in frontier areas with fluctuating populations and how to meet the needs of year-round residents and visitors. Questions/issues that were raised include:

Are year round residents' health care needs displaced by seasonal population influx? If so, how often and to what effect?

What is the impact on local health care of urgent care visits versus the ongoing care of long-term residents?

Visitors expect level of service provided at home; locals are more accepting of what is available. Providers take the heat.

Frontier/rural providers sometimes bear the disproportionate costs of providing care to nonresidents.

The purpose of this paper is to help ORHP see where different types of seasonal variations need different solutions for maintenance of infrastructure. Areas with very large population swings were suggested as a focus. Miller suggested looking at one state, such as Arizona with "snowbird" issues that might have implications for another state, such as Florida. Bernstein suggested Mount Desert Island, Maine. Other suggestions are Sturgis, South Dakota and Daggett County, Utah, home of Flaming Gorge Recreation Area and other popular federal lands recreation areas.

Several in-depth community case studies could be done to delve deeper into the various categories of problems caused by seasonal population fluctuations. These could then help the panel develop policy recommendations to the ORHP.

An outline of the projected study will be supplied to the Project Officer before proceeding.

**REPORT TOPIC: Technology for Training the Health Care Workforce in the Frontier**

There was consensus among the members of the group that this topic is too broad and needs a narrower focus in order to produce an effective document. Suggestions included limiting the types of training looked at, levels of training and areas of training.

The overriding issue is: What will help recruit people to rural health careers?

Issues that surfaced during the discussion included the fact that urban training can sometimes defeat the goal of producing workers who will serve and stay in rural areas. Training in rural and frontier places may yield a better supply of rural workers, but there is no known data on this.

As examples of technology used in training, Stauber recommended looking at e-North Carolina led by June Patterson, at the North Carolina Rural Economic Development Center. A second example is Hayfork CA, where a community foundation set up a technology network including the county, hospital, and community college branches. He cautions that if you have a technology strategy you also need parallel training and promotion strategies.

Ford recommended finding people or organizations that can connect education, training and technology and their application in a community. Success in all of these areas is key. Is there one state that has done it well? She suggests identifying model programs, particularly in frontier areas, that have been successful as a way to bring innovation to the table. She notes that ORHP is interested in recruitment and retention issues.

Carr suggested models around country that provide training or academic preparation of health care providers. She says the University of Alaska, Southeast has a major commitment to distance education. Their program might be an example – they offer classes with live audiences, as well as cameras at remote locations shown on public television.

The group agreed that it is important to keep the information frontier-focused. In frontier areas it may be difficult for students to get together or for an instructor to come to them. Alaska, for example, offers programs that are designed around the needs of frontier communities – when people are available, etc.

Nursing was discussed as a possible field to focus on because there has been considerable emphasis on distance learning for nursing education. There have also been some successes with technology as a training tool for nursing education. Initial training might be looked at first, but examples of successful programs involved in continuing education and re-licensure might also be examined.

An outline of the projected study will be supplied to the Project Officer before proceeding.

#### **REPORT TOPIC: The Impact of the Medicare Modernization Act on Frontier Areas**

The discussion turned to the report on the impacts of the Medicare Modernization Act (MMA) on Frontier areas. Bernstein offered the comment that for the frontier hospital he directs, the MMA resulted in a 6% increase in Medicare reimbursement. In addition, they were given a two-year exemption from the Ambulatory Payment Classification groups (APC's), which are also referred to as Outpatient PPS (prospective payment system). Rural hospitals are concerned about APC's on the outpatient side because it is volume-



driven. The impacts of these provisions affect different rural hospitals differently, while they result in improvements for some (including the Northern Maine Medical Center), they may cause problems for others.

Slifkin noted that the RUPRI health panel recently put out a document looking at the MMA impact in rural areas. The study might provide information that could be reviewed for frontier areas. Slifkin also cautioned that this is a huge topic and one that several large university-based rural health research centers as well as the RUPRI Health Panel are already studying. She cautioned that the topic might in fact be too large for a small organization like the Frontier Education Center to tackle alone.

The group then focused on the prescription drug benefit section of the MMA. The prescription benefit plan will offer a mail order option for seniors. While this may be financially beneficial for consumers in remote areas, it is not clear what it will do to small pharmacies located in rural areas. If loss of business means they cannot remain open, their substantial service to the community will be lost. Among the serious implications:

Pharmacy Benefits Managers (PBM's) have primarily been used by employer-based insurance plans and are somewhat untested for public payers. PBM's often hold costs down through offering a limited formulary and using mail order services.

Mail order pharmacies do not offer all retail drugs.

Rural health clinics, community health centers and other providers are required by law in some states to have a consulting pharmacist available and in some states on site from time to time.

Patients, especially those in the Medicare population of the elderly and disabled, benefit from the expertise of a pharmacist to review drug interactions, allergies and other quality of care issues. Loss of these services could result in more emergency room visits.

Computerized tracking of a patient's drug profile is offered as a side benefit of mail order prescriptions. Whether that would be accurate and sufficient is unclear, although some tracking may be better than no tracking.

In summary, the loss of an independent pharmacy is the loss of a health care provider and would be a blow to the local health care system, one that might even unwittingly contribute to its demise.

Informed enrollment in a prescription drug plan by beneficiaries is also an issue. Choosing the best plan is complicated. Some states have different organizations charged with educating Medicare recipients on their choices. Slifkin thinks it is reasonable to assume that the more remote you are, the less likely you will have benefit from these education programs.

If individuals do not enroll at the first possible opportunity, they will be subject to penalties when they either choose or are required to enroll.

Stauber asked whether there is any similarity to the way the VA provides drugs. Slifkin noted that there is a huge difference. The VA negotiates with manufacturers on price whereas in the MMA, Congress expressly forbids Medicare to negotiate lower prices.

Ford suggested one approach would be to establish a baseline in frontier counties in terms of the locations of established retail pharmacies. With that information one could look at the size of the Medicare population and predict some outcomes. Slifkin noted that RUPRI is already funded to do that.

Is it possible to identify frontier communities where the single pharmacy has closed and then assess the effect of the closure on the community? An alternative would be to look at communities where there is one remaining pharmacy. This information might be available from the study Keith Mueller has done at the University of Nebraska.

Slifkin noted that since the impact has not yet been felt, the report could state these are the concerns and why we have them. There could be targeted case studies, which would be used to get some idea of the scope of potential impact. She suggested starting with a review of the RUPRI document to see if there is a Frontier differential. For one product, she thinks a case study on communities with sole pharmacies would be a useful body of work.

Staff will follow-up and report on discussions with Mueller.

Miller noted the influence on the health care system some state pharmacy boards have by regulation. Slifkin recommended doing case studies in different states in order to show how pharmacy boards operate and impact the system.

An outline of the projected study will be supplied to the Project Officer before proceeding.

#### **Next Steps**

Miller suggested a process for the next steps. Staff of the Frontier Education Center will work on drafts of the reports, which will be shared with panel members. Any panel member with a special interest in one or more topics will be encouraged to participate fully in the development of the report.

There will be quarterly conference calls of the group. In addition, an internal website has been established where members can easily review materials and make comments. Most communication with the group will take place by email.

In closing the meeting, thanks and statements of sincere appreciation for the support and hard work by the group members was expressed. All members of the Frontier and Rural Expert Panel are welcome to call staff with ideas, suggestions, and criticisms at any time.

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## **RESPONSIBILITIES OF THE GROUP**

### **Background**

As part of the Frontier Education Center contract with the Federal Office of Rural Health Policy, two tasks pertain to the Frontier and Rural Expert Panel. With the finalized membership of the group, Task 3 A. and B. are completed.

NOTE: While the contract referred to the Frontier Rural Health Care Issues Group, in recognition of the tremendous level of expertise of the group members, we have renamed this the Frontier and Rural Expert Panel.

The scope of the work plan is as follows:

### **Task 3            Formation of a Frontier Rural Health Care Issues Group**

A. In carrying out this contract, the Contractor shall form a group of experts on frontier rural health care issues composed of national and State level representatives. **Completed.**

B. The Contractor shall submit 7 names for the group to the Project Officer for review. **Completed and Approved.**

C. The Contractor shall prepare materials for 3 conference calls and 1 annual meeting for each period of performance of the contract. The purpose of the conference calls and meetings will be for discussion of issues in frontier rural health care and to identify key concerns on frontier rural health care with the input of the Frontier Rural Health Care Issues Group. Particular attention should be paid to how the Office of Rural Health Policy grants and other related HHS health programs work in frontier areas. **In Process.**

D. The Contractor shall submit the date and background information for the first conference call within 16 weeks after the EDOC. The Contractor shall notify group members via email and by sending summaries within 4 weeks of call. **In Process.**

### **Task 4            Prepare Reports on the Health Care Issues in Frontier Areas**

A. The Contractor shall research, by consulting experts in the field, **the members of the Frontier and Rural Expert Panel**, performing literature searches, and other means as necessary, the following subjects, then prepare reports to deliver to the Project Officer.

#### **1. The Impact of the Medicare Modernization Act on Frontier Areas**

- a. The impact of Medicare Advantage in the frontier.
- b. The impact of the pharmaceutical benefit in the frontier.
- c. The impact of Medicare payment changes on the provision of health care in the frontier.

#### **2. Maintenance of Health Care Infrastructure in Frontier Areas Subject to Seasonal Variations in Population.**

#### **3. Technology for Training the Health Care Workforce in the Frontier.**

#### **4. Frontier EMS – Staffing Services with Volunteer and Paid Workers.**