Getting Connected: Can the ACA Improve Access to Health Care in Rural Communities?
Alliance for Health Reform
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ED HOWARD: Good afternoon. I'm Ed Howard with the Alliance for Health Reform. I want to welcome you on behalf of our board, on behalf of Senators Rockefeller and Collins to a program on how the recent reform law and related legislation are going to affect rural America. It's a topic, as a matter of fact, that both Senator Rockefeller and Senator Collins have a very close personal and professional interest in given their constituencies in Maine and West Virginia. They know, I suspect that most everybody in this room knows, that rural communities have for a long time had a number of special challenges in health and health care.

Patients are sometimes forced to travel long distances to get to the right care. Rural residents are more often uninsured and have lower incomes than their urban counterparts. There are shortages of key health personnel in many rural areas. High speed Internet access, which is obviously an essential component of improving quality and efficiency is really only a dream in a lot of part of rural America. Both the Affordable Care Act, which is how I'm going to refer to the recent reform law, and the earlier stimulus bill had provisions that are aimed directly at helping rural residents improve the health care system.

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Today we're going to be taking a look at some of those more important provisions in the new laws. Our partner in sponsoring today's briefing is the United Health Foundation, program of the UnitedHealth Group, which has been a leader in promoting higher quality and more efficiently delivered care.

In the interest of full disclosure, the Executive Vice President of United Health Group is Reed Tuckson. Reed's a charter member of the Alliance Board of Directors and here today from United is Catherine Anderson whose responsibilities include policies affecting Medicare and Medicaid beneficiaries especially those so-called dual eligibles who are enrolled in both those programs. So she'll be sharing moderator chores with me today. Let me call on her at the moment. Catherine?

CATHERINE ANDERSON: Thanks Ed. Thank you for the opportunity to be here. UnitedHealth Group currently serves more than 75 million Americans through our broad array of products and services. In our mission as helping people live healthier lives, we are constantly addressing issues around access, affordability, and quality.

Access to quality medicine in rural areas and other geographies like inner city areas are very important to us whether it's from our commercial perspective serving people like my family and me. We live in a very rural area and we see diminishing access to health care and even in the four years

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that we've been there, dramatic shift and it's not improving. So we have to address, from UnitedHealth Group's perspective, issues related to rural medicine for our commercial members.

Similarly for our Medicare members and Medicare beneficiaries as a whole. Many Medicare beneficiaries have no access or ability to choose from multiple health plans based on the fact that health plans can't build adequate networks to allow them to operate in rural areas. So Medicare beneficiaries are often limited with original Medicare, which may be fine for them but they don't have the choices that are available to people who live in more urban settings.

Then from a state Medicaid perspective, the states I speak to on a regular basis, this is a very important issue to them. They have many Medicaid beneficiaries, as Ed pointed out, a lot of the folks in rural areas are reliant on the Medicaid system. Today, there's limited access to health systems, even transportation in order to get to adequate or quality health care. So there are real issues that we, at UnitedHealth Group, are trying to address.

Some of the things that we've done, you might have spent some time in Connected Care or seen it. I know it spent some time on the Hill but it's our mobile state-of-the-art medical system that we can take from location to location to provide access to high quality care, other things around

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telemedicine and other technologies, and access to personal health records, and that sort of thing.

So there are a lot of things that we're working on to address some of the rural issues that our members see. There's a lot, yet, to be done -- clearly. We look forward to an opportunity to help shape that and to support initiatives to improve access and improve access to quality care. Thank you very much for the opportunity to be here.

ED HOWRAD: Great, thank you Catherine. Let me do my logistical chores if I can before we get to the rest of our program. You already have the packets with very important information including the slide presentations of our speakers, biographical information beyond what I'll be able to describe. There's also a list in there of a bunch of other materials we didn't run off to save trees. They're posted on our website so that you can go click on them and get a lot of background information that you don't have directly in front of you right now.

There's also, probably sometime tomorrow, a webcast of this briefing will be available as a courtesy on the Kaiser Family Foundation, on their website kff.org. You'll find all of the background materials in your kits and the rest of them on our website as well at allhealth.org, which is also where you can find a transcript of this briefing in a few days.

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If you've been to these briefings before, you probably are sick of hearing me say there are green question cards you can write a question on at the appropriate time and there's a blue evaluation form that we'd appreciate you filling out at the appropriate time.

Now, I'm not sick of saying it, because they're both very important to improving the quality of the briefings overall and making sure that your questions get addressed and that's really the point of these briefings in the first place.

So we've got a great panel. We're going to let them address you for a relatively limited period of time and then we'll get started on an interchange that we hope will supplement those presentations. We're going to start with Tom Morris who's the associate administrator for rural health policy at the federal agency with the widest portfolio of rural health-related programs, the Health Resources and Services Administration within HHS.

Tom oversees HRSA's Office of Rural Health Policy, which means he directs something like 16 different and distinct programs aimed at building rural health capacity. He's been serving in the Office of Rural Health Policy for a dozen years now. Before that he was a newspaper reporter and editor covering health issues, among other things, in North Carolina, which I understand has a few rural parts as well. So Tom,

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thank you for being with us and we look forward to your remarks.

TOM MORRIS: Well, good afternoon. Thank you for having us. At its core, I think the Affordable Care Act really is about getting health coverage for folks who need it the most. I think you make a pretty compelling argument that rural communities are going to benefit from that as much as anyone. When you consider that rural communities tend to have a struggle in terms of finding coverage in both the individual market and the small business market, as studies from the University of Southern Maine and University of North Dakota indicate, the opportunity to get affordable health insurance to these communities is going to be important.

The bill actually lays out a fairly straightforward roadmap for improving that coverage. It starts with what we've already seen, the pre-existing conditions pool, which was the high-risk pool that's available now at the state level.

Young adults can get coverage up to age 26 as a dependent on their parents' policies. There'll be the early retiree and reinsurance program for folks 60 to 65. We know that about 18-percent of rural residents fall into that category. Then beginning in 2014, the larger coverage provisions will kick in.

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The first of these that's worth noting is the Medicaid expansion up to about 133-percent of the federal poverty level. The reason that's important for rural communities is there used to be a fairly significant gap in terms of the uninsured, number of uninsured in rural areas compared to urban. That's lessened over the last 10 years primarily because of expansions in Medicaid and CHIP. So the public programs play an important role in terms of addressing the challenges of this market and that's not surprising given sort of what we know about socioeconomic indicators in rural communities, higher rates of poverty, etc.

So all that sort of leads up to then the exchanges becoming operational in 2014 and there'll be subsidies for low-income individuals and for small business, all with an eye towards not only improving access but improving affordability of insurance coverage across the country.

In terms of other provisions, I think, speaking to particular needs in rural communities, there's a heavy focus on prevention and public health. I think that's important when you consider that rural residents tend to have higher rates of chronic disease. So there'll be significant investments in that with the hoping that we can keep these folks healthier, we can not only improve outcomes but also reduce costs.

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So this starts with the provisions and the law that will allow private insurers and Medicare to cover more than preventive health services. You couple that with the legislation's provisions to expand the number of community health centers, $11 billion over five years. This is both for their existing operation of health centers, expansion of existing health centers as well as new starts and then also some construction of health center facilities. Right now about 33-percent of community health centers are physically located in rural areas but 60-percent of our health centers actually could take care of rural patients.

You can't really improve access unless you also address some of the workforce challenges. That's why the investments in the National Service Corps with $1.5 billion over the next five years, and that's on top of the $300 million that was in the Recovery Act, are going to play important roles. Sixty-percent of the National Service Corps placements are in rural communities. So this is a key program in terms of addressing recruitment and retention.

Now some other provisions in the law that aren't necessarily rural-specific but will help rural have to do with what we're doing around residency programs. There's a redistribution of unused residency slots, with an emphasis on putting those unused residency slots into new programs that

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will expand primary care training and there's an emphasis on rural primary care training within that.

Then our agency, HRSA, recently put out $168 million to expand to 82 accredited primary care residencies -- to expand 82 accredited primary care residency programs. The reason I mention the family medicine portion is because that's the backbone of the rural health care delivery system. The bulk of the physicians that are out there are trained in family medicine. So it's important that in terms of bolstering access, you also have to address the workforce challenge.

Now the bill also played an important role in sort of shoring up the rural health infrastructure. There were a number of provisions in the law that basically extended or created new payment provisions. They're an extension of increased lab reimbursements for rural hospitals extension of hold-harmless payments under Medicare outpatient prospective payment. It also extended the Medicare Dependent Hospital Program.

There are temporary bonus payments for primary care physicians of 10-percent and, for general surgeons, 10-percent in health professional shortage areas. There's a provision for $400 million in increased reimbursements in states where you have low cost per beneficiary. These are folks that, one could make the argument, they've been historically underpaid under

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the Medicare system and this gives them a temporary boost in the next two years. There's also a provision in the law for states that are primarily frontier that will get increased physician reimbursement and increased hospital reimbursement.

The legislation also made some temporary changes to a low-volume adjustment under Medicare hospital payment. The reason that's important is because when you talk about rural health care, it tends to be a low-volume environment. Most of our payment system is built on paying on a system of averages. So rurals tend to struggle with that.

So the low-volume adjustment is important because it recognizes the unique characteristics they face. So for two years, there'll be some relaxed standards in terms of who will qualify for that. There's also the expansion of the 340B discount drug program to critical access hospitals and solo community hospitals.

Now as we move forward, I think the Affordable Care Act really recognizes that we've got to change the way we pay for care with more of an emphasis on quality and less emphasis on just a procedure-by-procedure billing system.

So there's the Center for Medical Innovation created within the legislation where they're going to try out new things. One of the main things the bill does is move a lot of Medicare payment into what's called value-based purchasing

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where your payment is adjusted by how you score on that quality score.

Now one of the things they've done is they've realized that any dramatic change like this can be challenging in rural communities. So there's a demonstration program for critical access hospitals and low-volume prospective payment system hospitals so that as we move forward, as we do the right thing about linking to quality, we do it in a way that helps ensure that if there are any unintended consequences, we find out about them beforehand. So those demos are important.

We'll be working with our colleagues at CMS on frontier payment integration. These are for the very small facilities, five patients or less in the hospital. They have a home health agency, a rural health clinic. What are some of the special regulatory challenges they have? We'll be doing that over the next few years.

Then there's been a lot of discussion about accountable care organizations. I think Clinton (MacKinney) will speak to this in a little while but our hope is that critical access hospitals, rural health clinics can really be a key part of this and this is all part of the shared savings programs you might have heard about.

I'd like to close by just talking a little bit about health information technology because I think it really does

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underpin so much of what we're talking about in terms of health care reform, the Recovery Act had $19 billion to create incentive payments to move health care providers towards meaningful use.

We felt like the final rules issued for meaningful use standards -- they came out late this summer -- took into account many of the key considerations for rural providers. We thought that was a positive step forward.

We recently announced increased funding for the regional extension centers. These are the resources that are going to help providers, hospitals, physicians move towards meaningful use. They realize the critical access hospitals, small rural hospitals needed some extra help so there's additional funding for them.

Then Ed mentioned broadband access, obviously that's a very important thing. There are still gaps in this country where you can't get access to portable broadband. We've made some inroads in terms of the U.S. Department of Agriculture and the Commerce Department, Recovery Act funding that was focused on broadband.

We've also been encouraged by the FCC's recent rule making related to their universal service program. They have about $400 million a year they have available to assist rural health care providers. So they've, as part of the national

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broadband plan, have looked at ways they can refocus that money towards broadband expansion and making that broadband access more affordable. We think some of their proposals really make a lot of sense.

I also think telehealth can play a very important role in what we're talking about, both in terms of reducing costs and improving quality, and in our agency we operate the telehealth programs and we have 26 telehealth network grants that we currently operate. What we're finding with those folks is that they actually can improve patient outcomes. It's not just about access but it's about improving patient care. For instance, we're seeing some very positive results on diabetic control with those 26 networks.

Now the other thing we know is that telehealth has become a lot more affordable over recent years and therefore, we want to promote the technology as much as we can. So we have nine telehealth resource centers around the country. These are folks with a proven track record in using this technology to improve patient care. So they're out there to help anybody who's interested in telemedicine learn more about it and help them set up those systems. So I'll stop with it right there and turn it over to Clinton and Mario.

ED HOWARD: That's great. Thanks very much Tom. Let's turn first to Clint if we can. Dr. Clint MacKinney who's been

working in health care in rural areas for the past 25 years or so, most of that time he's a family physician, more recently as an emergency department doc in rural Minnesota. Dr. MacKinney's also a member of the health panel for the Rural Policy Research Institute, RUPRI, that's the group that did the analysis of the ACA's impact on rural people, places, and providers, the executive summary of which is in your materials. We're very pleased to have you. Clint?

CLINTON MACKINNEY: Thank you very much and while the clicker's coming down, I wanted to comment a little bit about that bio. I think you may read the bio and Ed, thank you very much for the introduction, you may kind of say to yourself well la-di-da, Institute of Medicine or RUPRI. But I'll tell you I want to say I'm most proud about being a rural doc. I'm also very honored to be here advocating for rural people and places. So thank you, Catherine. Thank you, Ed, for inviting me and thank you all as well too.

I don't want to actually jump exactly to the end but I think I can answer that first question that's the title of the briefing. The answer is "yes" but the question is how and how much? So what I'd like to do is talk a little bit about how we reviewed the ACA and try to get at the how and the how much.

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This is a big honking piece of legislation as you all know. If you all have your hands around it better than I do, congratulations, because it's really tough and I've spent a lot of time trying to understand it.

But I think there's some overviews that you can get there as I've listed on the screen. But the key is really not so much in the legislation. The angel as opposed to the devil, the angel is going to be in the details of implementation and rural writing and regulations.

So what I believe is what's going to be fundamental to success is how do we analyze, how do we research the impact of this legislation moving forward. And how can we be nimble and flexible with our implementation or even our legislation as we run into the unintended consequences that are inevitable in something like this?

So here's some implicit expectations. You all probably know them. So what I'd like to do is try to help you understand how the ACA can get us to these implicit expectations, first of all coverage and more affordable care and as Tom talked about, purchasing value.

Now, value may seem kind of like a complex notion but actually it's pretty simple math in my opinion. It's quality plus service divided by cost. That's what we need. We need quality plus service divided by cost. So what I would like to

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do is talk a little bit about those provisions of the ACA that tend to impact rural people, places, and providers but then also add some cautions as we move forward over probably the next decade with implementing this plan.

We've broken this out into about six different categories or themes in the ACA. So let's start. Health insurance coverage, this is the big kahuna. This is what we really want to get at with the ACA, but as Ed and Tom alluded to, rural's different. We're older. We're poorer. We're more disabled. We're less insured and we work more for small businesses.

So because of those provisions in the ACA, small business provisions, we think it's going to be a positive benefit for rural but we need to be cautious to understand what the net effect of small business will be moving forward. We don't know exactly what will happen when some of the tax breaks sunset.

We also need to be sensitive to the rural realities. It's already been mentioned, some of the Internet connectivity in rural isn't what it is in Washington, D.C. So how will the health insurance exchanges really work well? How will we do risk ratings from an insurance perspective with a group of people that are more disabled, more ill, and more elderly? How do we set up our provider networks when there's not really a

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provider there? How will we ensure that rural citizens have the same plan choices that they do elsewhere? These are all things to consider moving forward.

How about payment? Well you know about every provider in this country who just touches health care is going to be affected by the ACA. Let me just use one example. I'm a family physician by training and there's some really great stuff for family docs and primary care in the ACA. Here's one of them. There's a 10-percent bonus for primary care physicians and providers who provide primary care services that represent 60-percent or greater of their practice.

Now take the rural doc. She's out in rural Wyoming and she purposefully provides a lot of procedures in her practice because you got to drive 100 miles to get those procedures otherwise. And because she provides more procedures, she isn't eligible for that 10-percent bonus because she doesn't reach that threshold of 60-percent of her practice being primary care services. Was that the intent of the legislation? We also recall that the legislation does not include preventive health services under that 60-percent bonus. So we're not sure if that's the intent.

We also, Tom alluded to, a lot of influx of funding for community health centers, which is wonderful. Community health centers are essential safety net providers in this country but

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they're not the only safety net provider. In many, if not maybe most, rural communities the critical access hospital and the private practice physicians or nurse practitioners or physician assistants are the safety net.

So we would encourage collaboration with FQHCs, the CHCs, and current providers in communities to ensure that we're developing collaborations with this funding through the ACA not competition.

I'm just thrilled to see quality coming to prominence. I've been working at quality improvement for years and to be honest with you, it's sometimes hard to get the ear of hospital CEOs when talking about quality. So now we're getting some of that.

That quality demands two things. It demands measurement. You all have heard you can't improve it unless you measure it and that's true. It also demands transparency, which equates with accountability. So when people talk about what accountability is, it's transparency. So with measurement, we need to make sure that the measures are relevant for rural providers.

Let me give you a quick example. If I'm working in a rural hospital and every time an acute heart attack patient comes into my ER I transfer them to the nearest tertiary care facility but yet I'm being asked to assess or to demonstrate my

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quality for inpatient care of heart attacks, how do I do that? How do I do that? So we got to make sure that the measures are relevant for rural providers.

Next, if we're going to put quality measures out on the web, which is important, that's transparency they also need to be accurately reflect the care provided there and Tom alluded to low volumes. I'm not a statistician but I'm smart enough to know that you increase the numbers of what you report and measure, you increase the reliability of repeatability. So we need to make sure that we're dealing with low numbers as well too. Rural should not be excluded but we need to be treated fairly in the quality measurement and transparency.

How about public health? We have probably been behind much of the developed countries in our emphasis in public health. So isn't it neat to see the formation of the new National Prevention Health Promotion of Public Health Council, which brings together upper levels of government together to talk about what really should be essential to all of our concerns, which is the health of this country.

Now that group does have an advisory council so I think it will be important that we have rural expertise and rural experience on that. When we also talk about public health, you'll hear a lot about disparities and indeed, unfortunately, there are significant disparities of health in this country

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especially around racial and ethnic basis but there are also geographic disparities. So we would encourage continued interest and focus on geographic disparities when we look at public health research and programs.

The workforce -- Tom alluded to workforce and as Tom said, primary care is the backbone of the rural health care workforce. It's very encouraging to see such great support for rural health and primary care in the ACA. But we can use Massachusetts as an example where you've seen, as we've increased health insurance coverage in Massachusetts, demand for primary care has gone up. So access potentially goes down. So we need to ensure that as we approve the rural health workforce, it's meeting the demands of rural people and places but that's not yet a given.

Also while we're ginning up the workforce, we can also use the current professionals more effectively and the medical home. You may hear a lot about the patient-centered medical home. One component of that is how do we use teams to provide better care for our patients and more efficient care for our patients.

Lastly long-term care. The rural are elderly. They deserve dignity and respect in their elder years. It's again encouraging to see the ACA address long-term care. In fact, not just addressing long-term care but in helping support people move from long-term care back into the community, which is absolutely essential.

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So we want to ensure that these great programs are equally available to rural residents as to urban. We need to reach out and ensure that that outreach occurs.

We also know that rural residents are less wealthy than urban. So having long-term care insurance premiums that may be needs based would help in that regard.

To finish up, I'm going to leave you with some questions. I'm not going to read them and in fact, if I could ask you, maybe what you could do is kind of take these on a Post-It note and kind of stick them somewhere, because these are the questions to ask yourselves as you all participate in implementation of this great legislation.

These are the questions that we want to be able to get at and also recall -- recall that health care providers, the health care system is undergoing overwhelming change right now. I think it's going to be positive change but one of the great opportunities in the ACA is its ability to leverage change elsewhere in the health care system.

The government, admittedly, is the largest purchaser of health care in this country and it's probably the largest purchaser of health care in the world. But if we can leverage that, the power of the ACA, to impact positively the rest of the health care system, the entire health care system, all of us will be successful.

Because all of us will need health care, all of our families will need health care, and all of us want to look

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forward to a future in which our health care's secure, safe, affordable. Thank you all very, very much.

ED HOWARD: Great, thank you. Thank you, Clint. And finally we hear from Mario Gutierrez, who's the policy advisor at the Center for Connected Health Policy in Sacramento, California. The Center is a relatively new non-profit organization that works to remove barriers preventing the best use of telehealth technologies, as Tom was talking about, in California's health care system.

Before he joined the Center, Mr. Gutierrez was a Senior Program Director for the California Endowment where he was responsible for all of its rural and agricultural worker health activity. Like Dr. MacKinney, he has a close connection to RUPRI, chairing the RUPRI Human Services Advisory Panel. So glad to have both the RUPRI people here and Mario, especially glad to have you.

MARIO GUTIERREZ: Thanks so much, Ed, and thanks for the invitation. Much like Clint, the best way to sum up who I really am is a real advocate -- no matter whether it's in the foundation, working in a community health center, volunteer, or now at a policy center. We look at the world through the eyes of rural communities.

I think what we both bring here as well is a sense of how health and human services really described the human

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experience of individuals, families, and communities. One of our great hopes is that the ACA will help build healthier communities not just for more access to health care but through access to social services and other needs and looking at the broader needs.

I'm going to focus on the experience in California. We have over 25 years of experience in telehealth. I think if we think of California as a nation-state, there's much to be learned from our experiences.

This is my view of California, not necessarily everybody else's view, particularly on the East Coast. We are a rural state and I promised my friend Tom Morris I wouldn't get into the definition of rural but suffice it to say that most of the state is rural, one of the largest populations of rural people in the country.

It's really three states. If you look at the far north, which tends to be forgotten, it's mostly frontier, the size of the state of Washington and the central part is the Great Central Valley where much of the agricultural products come from in this country. It's been called the Appalachia West because of the conditions of poverty and the human experience that exists there.

Then in Southern California, which is dominated by that little red dot called Los Angeles, is actually one of the

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largest rural areas in the state. One county alone, Riverside County, is 20,000 square miles. You can fit the state of Massachusetts and Delaware and maybe Rhode Island and squeeze them into that one county.

So with 25 years of experience of working in telehealth, I think we can infer from there what the rest of the country may be learning.

This is some of the earlier developments. 1996 was a watershed year in California. Two critical things happened. One was the passage of the Telemedicine Development Act, which is the first of its kind, a trailblazer for a state establishing the parameters for reimbursement and for how telehealth will be treated in the context of services. It allowed, for example, teledermatology and teleophthalmology to be reimbursed without the face-to-face visit and had other elements to it. It was amended over a number of years until recently but it really opened the door for the expansion of telemedicine.

I joined the California Endowment in 1996 when it first started. Without going into a lot of details, it was a conversion foundation, which established essentially two foundations from the conversion of Blue Cross. One was the California Endowment with over $3 billion in resources, which put us in a pretty challenging but wonderful position of

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distribution $150 million a year for communities that are underserved for health.

The other foundation was the California HealthCare Foundation, which focused on health care policy. Much like the experience of the ARA funds, the stimulus funds, when we joined the Endowment, we wrote cards and made grants immediately and to chunk out large amounts of money. We're looking for so-called shovel-ready projects as the stimulus funds.

Prior to joining the Endowment, I was with Sierra Health Foundation and worked with one of our real leaders in rural health, Dr. Tom Nesbitt, of the University of California-Davis School of Medicine. We had funded a study to look at the needs of telemedicine and telehealth in California. That was the basis on which we were able to convince our board to set aside $10 million over five years, which was then again renewed for another five years to build capacity in rural health providers throughout the state to begin to become familiar with this technology and to incorporate it into community health centers, rural hospitals, and to establish a training center at U.C. Davis to bring practitioners in to learn how to use the system.

Other events that occurred during that year, another part of that investment was the creation of the California Telehealth Education Center, CTEC, which by establishing that

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early on that became one of the resource centers that Tom alluded to so that we now have a resource center in California.

Other events include, as a result of the merger of some of the telecomm giants, funds were available to create the California Emerging Technology Fund with $60 million in 2006. U.C. Davis, again under Dr. Nesbitt's leadership, created what I think is a unique program in the country thinking about the question of workforce in rural areas, to establish a five-year program with a specialty in rural health practice, which would incorporate the use of telemedicine and telehealth throughout the experience of the medical training.

So today, we have the groundwork established for what we never would have imagined would be the huge infusion of resources for the expansion of high-speed broadband throughout the state and the creation of the opportunities through the California Telehealth Network, which received one of the largest FCC grants, to connect all of the, what is now 900 community health centers and rural clinics throughout the state, including some urban centers as well, to low-cost, high speed, high-definition broadband throughout the state. We have great hope and promise for that network.

I know that a number of communities and states throughout the country are having great difficulties and challenges with implementing those. The fact that we had this

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history already in place allowed us to really get the system up and running and I think we'll be a model for the country.

A few words about what we're doing at the Center for Connected Health Policy. The other foundation that was created, the California HealthCare Foundation, funded this center with $4 million over three years to dig deep into the issues related to policy. This is a rapidly developing field that affects a number of issues related to reimbursements, to workforce, to scope of practice, etc. So I'm going to touch on three of the programs that we're working on.

As I mentioned earlier, the telederm program is a project that we have underway right now. Given the fact that in 1996, reimbursements were now allowed under telemedicine for teledermatology, we want to assess what's been the impact of that, how many dermatologists actually are using telemedicine in their practices so that we can infer that for other specialties as we develop.

One of our major programs is the specialty care safety net initiative. Our goal here is how do we bring the resources of the University of California and the five campuses of the school of medicine to provide resources and support to the safety net providers throughout the state, community, FQHCs, and rural hospitals, and the critical care access hospitals?

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By providing them with equipment, providing them with training and connections and also providing them with access to free specialists. This is a demonstration project. The jury is still out. One of the things that we're learning very early in this whole process, however, is that we have very different cultures at the community health centers and at the university medical centers and changing the way practices operate.

In an FQHC setting to be able to adapt and adopt telemedicine, even when it's made available for free for specialty care has really been a challenge. So this project runs through 2012 and you can see from this map, we have centers all over the state but predominantly rural with a few urban centers down south.

Our biggest project right now, which we're really excited about is the development of what's called the model statute. If you're not familiar with this process, it's a technique by which you take a particular policy and look at it from 360 degrees to determine what changes, if any, can be made in the legislation that we passed in 1996.

So out of this we hope to see recommendations for state legislation, federal legislation, changes in practice, changes in regulatory both at the state and federal level. It will not be one bill but we'll look at all aspects related to that.

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We started this process by initially doing a literature search and looking to see what other states have done with legislation related to telemedicine, learning from their experiences after our initial legislation in '96. We brought together an expert panel, which includes Dena Puskin from HRSA as well as practitioners, policy experts, and such to help advise us on the development of these changes. We hope that this will result in several bills moving forward depending on what happens with our elections and such in California.

So what are our challenges moving forward? Well, we do have elections going on in California. One thing about our current Governor Schwarzenegger, he has been a strong advocate of telehealth in rural communities and that backing has really allowed us to do a lot of things in the state that ordinarily we wouldn't have had that opportunity.

We're not sure, depending on who gets elected, what the future will be. Of course the state is always broke. So we go through constant battles. We have legislation to change the way the budget is being, we're actually an initiative on the ballot that hopefully will simplify things and not require a two-thirds vote for a budget every year so that we'll be able to have a much better normalcy in terms of how we operate.

I think at the federal level, as we've heard, there's a real need for fresh thinking and how we approach the rapidly

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changing world of delivery of health care. The creation of the Center for Innovation is a major step forward to allow communities -- particularly rural communities -- who are known for innovation and resourcefulness…. We've learned an awful lot with very little in rural communities and I think there's a lot to learn there and as Clint has indicated, I think we have an opportunity here to learn from them.

Another lesson that we've learned is that even with all the investments that we've made over the last 20 years, too much change too fast is a real problem and adapting and changing of the cultures is very difficult. Also I think a major problem is -- the paper in your packet that highlights this -- is how do you bring together the issues of emergency medical records, health information systems, and telemedicine altogether so that you have the capacity and the ability to do a seamless approach to treating patients?

It doesn't matter if you have the most sophisticated telemedicine program in the world. If you don't have an electronic medical record to be able to see simultaneously then it's just like not having it at all.

Just very quickly, the benefits that I see for rural, certainly it strengthens the safety net and the medical home. The idea of prevention, public health, continuity of care, keeping communities healthy, as I mentioned earlier one of our

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efforts at the RUPRI panel is how do we look at integration of medical and social service and human needs?

I think the ACA provides us a real vehicle by which we can build access to other social services and treat the whole family that benefits the whole community. I think ultimately this is about building healthy communities and allowing practitioners to stay home and if we can't have access to all the specialists and all the resources, it does provide us a lifeline to the rest of the world.

I think as we've learned from the BTAP program and the so-called Beacon Communities, it's a way of allowing communities to build those resources virtually by having access to education, prevention, and other services that will allow this to be implemented successfully. Thank you.

ED HOWARD: Great, thank you very much Mario. Now it's your turn. If you would come to a microphone and assuming that the microphone works, and/or hold up the green card as the young lady in the back is doing, someone will bring it forward. Steve is that the only floor mic? There we go, a floor mic and a floor mic person. We'd ask that if you do have a question to ask in oral form that you identify yourself, keep it as brief as possible, and direct it to one or another panelist if that's appropriate. Yes go ahead.

ANDRE SHAUFSKEN: Thank you very much for the

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presentations. My name's Andre Shaufsken [misspelled?]. I'm a fourth year medical student at Boston University and I plan on practicing in primary care and that's kind of, I guess, a default decision. A lot of my friends and colleagues are specializing and for the ones practicing primary care like myself, I'll be working in the inner city as opposed to a rural setting.

So my question is what in the ACA specifically could incentivize someone like myself to practice in the rural setting as opposed to inner city setting. I know 10-percent pay increase and National Health Service Corps but it's not really that much of an incentive considering that at least in the city I have potentially access to more resources. So what incentive is there for people like myself to abandon Baltimore, D.C., or New York, and go out to the rural setting and Appalachia?

ED HOWARD: Or California Appalachia [Laughter]?

ANDRE SHAUFSKEN: Or California. Thank you.

ED HOWARD: Very good question. Anybody want to take that? Clint?

CLINTON MACKINNEY: I can take a stab. Thank you very much and also congratulations to you for considering primary care. Parenthetically, I feel blessed by my opportunities, by my education and my opportunities since then and even though many of your colleagues are considering specialty, I think primary care is wonderful. Like all people, I mean docs like kudos and to take care of an elderly lady and she brings you in

zucchini from her garden and she gives you a hug after an office visit is really wonderful. You'll enjoy that.

Now your question specifically was what's in the ACA that will help me consider rural as opposed to Baltimore or D.C., Tom could speak better than I could around some of the workforce issues and you already actually touched on a couple.

A lot of times, I hear people say well the reason why I'm not going into primary care is because I have such a high debt load coming out of medical school. Well the National Health Service Corps eliminates that debt load and actually I was a National Health Service Corps scholarship recipient and I started in practice and had to stay three years in rural Iowa and I stayed 14 and I loved it. I just loved it. So if that's an issue, there's help there.

I already mentioned the 10-percent bonus for primary care. Now that's not rural-specific and in fact, we have concerns about how widespread rural practices will be eligible. We just don't know yet but for going into health professional shortage areas, HPSAs, there's an additional 10-percent bonus. Now these are Medicare payments and I agree with you, the real question is, is this 10 or 20-percent bonus going to outweigh the lure of a half a million dollar suburban gastroenterology practice? We don't know yet but to simply have legislation, such powerful and comprehensive legislation that highlights the

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importance of primary care in the system will start a cultural shift.

As a way of background for that, you all may remember in the early 1990s when President Clinton said every American should have a family doctor and even though the Health Security Act was never passed, family medicine had its greatest interest or maturate in the residencies in the early 1990s when the President said every American should have a family physician and we were very interested in managed care and we really needed good clinicians, primary care clinicians to help not simply manage the cost but manage the care of patients. I think cultural, if you move back that way, I hope we'll see a resurgence in primary care that will facilitate or support some of the early changes in reimbursement.

MARIO GUTIERREZ: Let me just add a couple of points on this point as well. Two things, one of the real beauties and I think advantages of what telemedicine, telehealth has provided is that our experience now working with primary care physicians in very isolated rural areas, by connecting them to the specialists in the medical schools, they don't feel so isolated. In fact, they're receiving CME credits and becoming more and more specialized primary care physicians or primary care plus as we're calling it because they can do more in their

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practice. It allows you to be much more of a true family physician in those communities.

The second thing, there's a real beauty also about rural communities. I believe it's section 3013 in the ACA that talks about health information systems and efficiency and equality, I think you can do a lot more in a rural community to understand the community health and the population health and then you can, in large urban areas, you can really see your work come alive as a physician.

ED HOWARD: Is it true they don't hug you in Baltimore [Laughter]?

CLINTON MACKINNEY: I don't know but no zucchini.

CATHERINE ANDERSON: There's a question on a green card and it's a question that's of interest to me as well. So it's good to see. How does the growth and the removal of the Medicare Advantage program impact seniors in rural areas and how does this impact providers?

I'm interested in the panelists' view on this but it is point of discussion for us as well as we look at the future of our Medicare products and how we can serve folks in rural areas and non-rural areas quite honestly as Medicare Advantage changes. Some of the things that Medicare Advantage does offer is care management and additional value-added services. So with the absence of that, how does that, Clint, I don't know if

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you have thoughts or the other panelists have thoughts on how that will impact Medicare beneficiaries.

CLINTON MACKINNEY: I can try. I'm not an insurance expert but I don't think we know how the change in reimbursement for Medicare Advantage plans is yet going to affect rural. We know that rural citizens disproportionately, when they do use Medicare Advantage plans, use private fee-for-service plans. We also know that they tend not to have the same amount of choice as urban Medicare beneficiaries.

So we would worry that as market forces tend to make Medicare Advantage plans more competitive with traditional Medicare because, again recall that what's essentially happening is the Bush administration reimbursement strategy, which was to pay certain Medicare Advantage plans more than fee-for-service in hopes of developing competition and providing more service gets ratcheted back to fee-for-service levels.

We wonder what will happen to those plans in rural areas and will therefore insurance organizations choose not to offer those plans for rural areas but I don't think we know yet. As I commented earlier, a lot of what we really need to do going forward really, essentially over the next decade, is to monitor for unintended consequences. I think this is potentially one.

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ED HOWARD: Mario?

MARIO GUTIERREZ: The only thing I would add is I'm not the expert in the insurance side of this work but one of the things that we're really learning is a great potential of telehealth is in-home support of services where you can have home monitoring for elder care and keep people out of nursing homes. So in terms of cost savings and keeping people independent is going to have a great advantage and hopefully the reimbursement systems will be reformed to do that.

ED HOWARD: Okay. Another green card question talks about sophisticated health care systems like Mayo and Geisinger. How will they or will they expand the accountable care organization concept in rural communities? Will they be able to take advantage of other ACA provisions to grow with their own kind of organization and take better care of folks?

CLINTON MACKINNEY: I'd like to take a stab at that but also follow by Tom because Tom will be able to speak to how the ACA and his office will be able to support rural providers and ACOs. In brief, ACO is an accountable care organization. It's not specifically a demonstration program in the ACA. It's actually a new program in which provider organizations contract with Medicare to receive a gain share and what you agree to do as a group of providers is to provide care at or lower than a certain benchmark cost. We don't quite know what that

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benchmark cost is yet. Then if you're able to provide that care less expensively than that benchmark then you will share in those gains with Medicare.

There's a lot of unknowns about this concept but theoretically it makes a whole lot of sense that suddenly the government is interested in paying not for widgets, not for fee-for-service but actually paying for an entire life of care over a period of time. That includes both Part A and Part B and I assume Part D of Medicare but I'm not sure about that but the real issue is exactly what the questioner said is how do we translate this concept of integrated care systems like Mayo or Geisinger into one that acceptable and works in a rural area of that's not integrated or isn't currently collaborating or currently doesn't have contractual affiliations with the larger system because recall that we need to care for these patients for all of Part A and Part B of Medicare.

So first, how do we even set those systems up in rural areas and then how do we make it work? So because the system, a good one in my opinion, a good one, really is born of the current integrated systems, which are generally an urban-based model or at least took decades to develop the cultures, the patient care cultures and the reimbursement strategy cultures to develop. How do we make that happen in a rural area? Remember these rural areas represent 25-percent of our

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population. The critical access hospitals represent about 25-percent of all the acute care hospitals in the country.

This is not insignificant but yet there isn't really a mechanism for us as rural to get engaged. So we'll be looking to the ACA and the people who write the rules and regulations around ACOs to ensure that rural has skin in the game. There's no reason why a quarter of this country should be excluded for what I think has great potential to improve the quality and hopefully to use a vernacular of the times, bend the cost curve. We want to make sure rural is engaged.

ED HOWARD: Tom you want to add to that?

TOM MORRIS: Well I would agree with everything Clint said. I think the challenge is will the new rule making in the next couple months that sort of set out the larger parameters for ACOs and it will be important for folks to read that and to comment on them and to look at them from a rural perspective but the hope is that it would not be a geographic-specific thing that any Medicare beneficiary, regardless of where they live, would be able to take advantage of the benefits of being part of an ACO. Certainly the thing it's modeled after is the Medicare group practice demonstration and that had rural partners as well as urban. All of them were able to achieve shared savings as a result. I'm optimistic.

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CLINTON MACKINNEY: Tom, I think and the physician group practice model, all of them improve quality but only like two or three out of the 10 actually saved any money. So that's a struggle. We want to improve care obviously but remember my simplistic equation for value, quality plus service divided by cost. So we need to improve quality. We need to improve service. We need to reduce costs and that's how we get value. The one demonstration project that we had was not universally successful at least driving down the cost. That's a challenge for us.

TOM MORRIS: The one difference is that was just Part B services. So with an ACO, you're talking about post-acute, Part A, Part B the full continuum of care. The hope is that you'll be able to really drive the savings from that but that's why it's part of the new approach and the Center of Medical Innovation with the idea being we have to try out these new approaches, find out what works, find out what doesn't, what rules make sense to be the most inclusive, and go forward from there.

CLINTON MACKINNEY: Absolutely.

ED HOWARD: If I may, I'm just a poor country lawyer here but Geisinger already has an enviable record of costs, of moderation, and high quality and yet their geographical area is primarily rural right? People think of Pennsylvania as

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Philadelphia and Pittsburgh but there's this great Appalachian-like space between them. What is there in the ACA or what is there in HRSA independent of that or anywhere else that is going to allow us to clone or at least graft Geisinger in other parts?

TOM MORRIS: Well I don't know that there's an easy answer to that. The integrated delivery systems like Geisinger are fairly unique. Geisinger and Marshfield are probably the best examples I can bring to mind that have significant rural territory but there's going to be a lot of changes in the health care system in the next couple years as people respond to the new incentives. We've been operating a network development grant program in HRSA for probably 15 years now with the understanding being that rural providers have limited economies of scale. You have to work together both in horizontally and vertically in order to get those economies of scale.

So the hope is that by using those funds that we can get providers to build sort of virtual integrated delivery systems. They don't all have to be under the same ownership mantle to do that. I think telehealth can play an important role there. It hasn't been built yet, that's true but that doesn't mean it can't be. We also operate the, we have $50

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million in grants that goes out to the states for small rural hospitals.

In the ACA, they reauthorized one program with the explicit eye towards using that funding to prepare rural hospitals for payment bundling and taking part in value-based purchasing in accountable care organizations. I think there's enough stuff out there to help people along the way as just a question, I think ultimately is going to come down to leadership.

ED HOWARD: Catherine you have a question there?

CATHERINE ANDERSON: A major issue in rural health care is access to quality behavioral health specifically veterans, older adults, folks with illness, mental illness, substance abuse. What does the panel recommend regarding ACA implementation with respect to behavioral health?

TOM MORRIS: That is a tough one. You get it at every single rural meeting. It is a real challenge but I'm encouraged that the expansion of the community health centers offers at least a step in that direction because part of that expansion will be for behavioral health. If you look at the expansion we've had in the health centers over the last 10 years, a significant part of that went for both mental health and oral health. So they've become, in essence, defacto medical homes because they offer the full range of services.

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now that's not going to address the whole problem that's raised there.

It's a larger issue of producing the kind of mental health providers that will go into these communities. I think telehealth can play a very important role. One of the things we do know is that it was one of the early clinical applications that really yielded benefits. I think of eastern Montana with one child psychologist in the entire eastern portion of the state.

If it wasn't for the Telemedicine Network out of Billings, they would have no access to children's behavioral health services. Again there's no one solution here but I think that there are a couple of different policy strings that might be able to tie together to begin to address the problem.

MARIO GUTIERREZ: I'll come at it from a different perspective. I think one of the challenges of national health reform is that it's limited to the delivery of health care and how it's paid for. I think from our perspective, we want to see how can we address the multiple issues that are faced by families and communities, whether it's veterans or low-income behavioral health problems and drug abuse, etc. as was alluded to. We have this incredible network of high speed broadband that's now being implemented throughout the country. if we can move to a system that addresses and makes it a national purpose

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of human services are just as important, in some cases more important than the access to clinical care and medical care. I think it'll be a big step forward.

Mental health, behavioral health is a huge epidemic in rural America. It's a hidden problem. Access to specialists and psychiatrists, and psychologists, and behavioral health counselors is virtually, as Tom alluded to, nonexistent. So to the extent that we can begin to think about national policy, not just by what the laws are passed but what's right in terms of integration of services and programs, I think we'll make a big step forward.

ED HOWARD: We got a couple of related questions here, one very straightforward. This person is asserting that physicians will never be able to provide all the care needed in rural areas to incent advanced practice nurses and physician assistants to move in and provide these services and concomitantly. This person observes that the ACA makes considerable investments in training non-physician providers, which is in partial response to the first card, which can help meet the growing demand for health care services and cites a recent IOM report that states that nurses need to be able to practice to the full extent of their education and training to help meet the demands for care. Many states have laws that limit the scope of their practice. Do you think that changes

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resulting from the ACA will place enough pressure on the health care system for states to lift those restrictions and the physicians' supervision requirements?

TOM MORRIS: That's a nice easy one.

CLINTON MACKINNEY: Straightforward.

TOM MORRIS: I should have said earlier when I said that family medicine was sort of the backbone of the rural health care delivery system. I should have said primary care is the backbone of the delivery system. The reality is it's not just docs. It's nurse practitioners, it's PAs, all of them play an important role. I think that in the Affordable Care Act, we were able to take some of the money from the public health prevention fund and put it into physician assistant and nurse practitioner training because I think we realize that there's not going to be enough primary care docs to fill the need if Massachusetts is any example.

So there are provisions to do that. If you look at the mix of providers covered by the National Service Corps right now, it's almost split fairly evenly between physicians, nurse practitioners, physician assistants, psychologists, the full range of providers are taking advantage both loan or payment and the scholarship. I think that's recognition that the rural workforce is diversified and we need to use every single professional that's willing to go into practice there to go do

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so. So again no easy answer there but I think all those disciplines are going to be important. I think there are provisions in the bill that are going to help move us in that direction.

CLINTON MACKINNEY: I agree with the question that there will never, well you never say never right? You never say never that there will be enough physicians. In our current system, the way health care's delivered currently, there will never be enough physicians. Now I would encourage all of you to take a peak, when you have a chance, at some of the information regarding the patient-centered medical home. This is team-based care of people and I wonder if we are really providing care based on teams that is and remember teams is the antithesis of independence, it's interdependence on a team, so our goal should not be independent practice. It should be how do we work together as a team to provide comprehensive care for our patients?

I wonder if that were really the case and if that really were going on everywhere, might our need for rural family physicians and also secondarily rural nurse practitioners and rural physician assistants be less acute. I don't know that yet but nonetheless, I would strongly argue, as we move forward, for caring for patients in a different way and

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using all of our resources to the full extent of their licensure, their experience, and their education.

MARIO GUTIERREZ: With the model statute, one thing that has been surfaced that's fairly controversial obviously is the whole notion of scope of practice but if we're truly going to get to a system that can serve all the people, we need to think about how we use everybody who's involved in the health care system as a team, as what's been alluded to, so that they are connected in a way that provides the best care and think differently. It's time to start thinking, even issues such as licensing across state borders, I mean the world is much smaller now that we should start looking at those opportunities.

ED HOWARD: Yes, Jim?

JIM FASULLIS: Hey Ed, Jim Fasullis [misspelled?] and I'm going to wear my hat initially as a pediatrician on the patient-centered medical home and then wear my hat as someone who provided subspecialty care to 80 different regional clinics. You've addressed the patient-centered medical home and primary care as a savior and yet as what I kind of said to Ed in Clinton reform that pushing primary care is going to be job security for the specialists.

How do you get the specialists in these teams, now I'll tell Tom I was the guy who went out to Billings, Montana to

cover all of cardiology for eastern Montana and there's one pediatric cardiologist in Billings as well, and did run 80 different regional clinics that we went to. So we've incentivized the family practice trying to be in the community but the same, if you look at what the parents want, the pediatric cardiologists, they want to talk to the cardiologist and not the primary care doc. That's why we got the calls at night.

How do we break that pattern? How do we incentivize, continuing to do the regional clinics because we're not getting any incentive to do that? Often the clinic is run, pretty much the clinic is run at a loss. So how do we match that up? The second and I'm going to ask this to Dr. MacKinney directly, do we think with the rules that are made now by the RRC and what's happening to residency training, are we going to be training them adequately enough to take care of the minor subspecialty problems that they should be that I was trained to do, you were trained to do but nowadays they get sent off for referral that I'm not sure payment's going to change that.

CLINTON MACKINNEY: I'll try the last one since it's directed to me. First all of you may know and kudos to the pediatrics and the American Academy of Pediatrics, 40 years ago coined the term medical home. So family physicians and internists are Johnny come latelys compared to pediatricians.

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I'm not in medical education. I really don't know what the RRC will do but—

ED HOWARD: Tell those of us who aren't even as close you are, what RRC is.

CLINTON MACKINNEY: Residency Review Committee, it's a group that accredits the training of young doctors and you may have a different experience but I don't see physicians being coming out of their training with the sense need to be interdependent. Instead, we're socialized to be autonomous and control freaks, which is again the antithesis of team-based care. So it really will take a wholesale change in the way we do education to start to get to this nirvana of team-based care. Now there's pockets of people who are truly enlightened about this and do it really well. It doesn't necessarily have to be the pediatrician or the family doc. Others can do it too but nonetheless I think that's the way we should be moving.

If there's a theme through the ACA, it's a need for coordination and integration. When you talk about ACOs, why do they look at Marshfield or why do they look at Geisinger or Mayo, well it's an integrated system? The Commonwealth Fund has done great research on quality of care in those systems compared to disparate systems and it's much better. So I think we need to be moving in that direction but how to change the medical education system to be able to do that, you're exactly

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right. It's key and you're right, I don't think that the reimbursement system will be able to fix that.

ED HOWARD: We won't be answering all those questions but we are going to address workforce issues, the ACA, and the relationship in a briefing sometime next month we hope. So keep your eye out for that.

ED HOWARD: Catherine, do you have any other questions?

CATHERINE ANDERSON: This one's directed to Tom. There's actually two questions. How will the $11 billion CHC funds be spent? I understand the first round has been announced. Are all the dollars for construction expansion or can it be used for provider payment reform?

TOM MORRIS: I don't actually know the answer to that. We have a competition right now for new access points and the construction for, I think school-based centers was recently announced but we'll be rolling things out over the next year in succession to address all the points that are in there but decisions on some of that is still being made.

CATHERINE ANDERSON: Then the second question, if you can comment how do you see potential changes in HPSA and MUP definitions impacting workforce development currently in rule making?

ED HOWARD: And what are HPSA and MUP?

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TOM MORRIS: HPSAs are health professional shortage areas and MUAs, MUPs are medically underserved areas and medically underserved populations. They're the designations we use to sort of allocate resources from a federal perspective. There's a provision in the bill that actually moves towards what's called negotiated rule making. We've tried three times over the last 15 years to update these regulations. It's been very challenging because any time you do that, there's winners and losers and folks tend not to like to lose.

So what happened was they went to this thing called negotiated rule making where you get all the key stakeholders in the room and they're actually meeting right now in Rockville, Maryland and they will, today, tomorrow, and then two days a month for the next three or four months, with the idea of being that they can get the stakeholders to come together around what the key concepts are then that will form the basis of a proposed rule that would go out for comment. The hope is that that process will work. If not, it will defer back to the department to do rule making regarding this.

ED HOWARD: If I can insert just a small commercial. We are about a week away from posting a new issue brief on the question of regulations and other ways of implementing the federal and state roles in the ACA. So keep an eye on our website and check back with that. Tom, I have one more quick

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one for you. Someone wants to know what division can one contact at HRSA or elsewhere in HHS to learn more about the resources available for expanding health care workforces in rural areas.

TOM MORRIS: Well in rural areas, well you can contact your office. We also support the Rural Assistance Center, which is a one-stop shop for all things rural. It's a clearing house, it's RAConline.org. They also operate a thing called the Health Workforce Information Center, which posts information about workforce programs but probably the best thing to do is call our office or call the Bureau of Health Professions in HRSA. All those numbers are up on our website. We'll be happy to tell you more about those programs.

ED HOWARD: Thank you. As we get to the final questions, I remind you that we'd love to have your comments on the evaluation form that you have in your packets. Here's a question that I've heard addressed in a number of different forums lately and I'd be very interested in the panel's reaction. It's raised by a graduate student attendee here. Racial disparities are even more pronounced, this person asserts, in rural areas. What mechanisms or provisions will help address this issue? First do you agree with the assertion?

MARIO GUTIERREZ: I think it's not just communities of color

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but it's also some of the poorest communities in the country are located in rural areas. I think one of the, if I can harp back to the work that I did with the Endowment, was to really focus on the notion of how we addressed the questions of disparities through language access, again the use of access to telemedicine, telehealth allows the ability to communicate in multiple languages without having to be in the room.

I think the use of what are called health navigators can be health workers from [inaudible] is a big movement around the country. There are some provisions in the bill that don't take effect until what 2019 related to that but I think that's one strategy that we have found to be extremely effective in bridging the gap between western medicine providers and language differences, cultural differences, working in rural areas whether it's farm workers in the central valley or Ethiopian refugees in rural San Diego County.

ED HOWARD: Anybody else?

CLINTON MACKINNEY: Though not specific to the ACA, I sound like a broken record with the patient-centered medical home so forgive me but I've been involved a bit in trying to design assessments for a medical home. Even though nothing is really out on the street for doing that other than the National Committee on Quality Assurance, or NCQA, we're actually designing questionnaires to assess cultural sensitivity. It's

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not just asking are you culturally sensitive but it's instead asking do you provide patient education materials in Spanish. Are you training your staff, have opportunity to have cultural immersion opportunities, etc? So at least as I and many others envision the patient-centered, and of course that's the key, patient-centered that honors cultural diversity, we would like to actually assess what behaviors are being done in that practice to do so.

ED HOWARD: There's one other aspect to that if I can jump in just on my own, don't hold me to what the before numbers were but certainly the after numbers. In Massachusetts, the affected access among non-Hispanic Whites before reform was passed was about 85-percent as measured by insurance status and about 65-percent among African Americans. In 2008, at the end of 2008, those numbers respectively were 95-percent and 95-percent. Stunning, not only were disparities reduced but at least in coverage not necessarily completely in access, they were eliminated and presumably once we roll out the major expansions in coverage that we have a very positive impact on the disparities.

MARIO GUTIERREZ: Just another quick comment on this, the movement toward patient outcomes is going to drive us to understanding the high incidence of diseases of poverty, of hypertension, diabetes, obesity that we find in such large

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numbers in communities of color. So that's going to be a major factor as well to help to become much more targeted in our approaches to services.

DAVID FINNEGAN: David Finnegan, I'm a second year internal medicine resident, Georgetown Hospital. I've had a lot of experiences where I'll have my patients either move to rural communities or people from rural communities move to the city where they've been lucky enough to have an electronic medical record but then because we don't use the same systems, of course, I can't get access to it. So as Google and Microsoft and everybody comes out with their own system in the next little bit and when all the rural communities start to get their own thing, so any talk of standardization of the underlying data so that we can talk to each other?

MARIO GUTIERREZ: Lots of talk [Laughter]. We recognize this as a [inaudible] of the inoperability of the system to be able to communicate. You have major providers out there and competition and we can't even get the systems within the University of California to talk to each other between the medical schools. So it really is a huge problem. In some ways, you wish you had that benevolent dictator to say that this is a system for the country and we're all going to be on it and that's in the best interest of people being served but that's not the case. it's one of the huge hurdles that we have to overcome.

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ED HOWARD: That is one of the jobs that David Blumenthal and his colleagues at the Office of the National Coordinator is supposed to be addressing. Okay. Yes, Bob?

BOB GRIST: Bob Grist with the Institute of Social Medicine and Community Health, we've been talking about rural areas as kind of shadows of the urban area. They don't have various resources that the urban areas have as if that was a deficiency that was a deficit that needed to be corrected. I'm wondering, because in those urban areas, we have so many resources and they're competing and ACA gives us an opportunity to get more competition over price and quality but to the extent that planning is the missing ingredient in rationally distributing resources to address needs, rural areas have to face that reality all the time.

I'm wondering if there are some innovations that you would like to see or are seeing now in innovations in rural health that would not only be solutions to the lack of excess resources in rural areas but would have implications for the way urban areas could be more efficiently operated. For example, when communities are market-driven, a lot of people go from rural areas to urban areas for the specialized care that the hospitals provide, many of those people could be treated as well in the rural area.

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That would strengthen the linkages to sustaining that rural area. It's not going to happen through competition in the market place but it could happen through more state planning around health systems, agencies, and organizations like that. Do you see any innovations coming from rural areas that could make health care delivery systems function better both in rural areas and in urban areas?

ED HOWARD: Be mindful of Dr. Fasullis' occupation that people often want.

MALE SPEAKER: [Inaudible]

MARIO GUTIERREZ: Rural areas are huge resources of innovation. It is what they do to survive and to use resources. One of the things that we are really focused on now with the RUPRI Human Services and the health panel both is looking at he whole question of regional integration of services and how can we impact federal policy to look at the notion of medical home not just being about medical clinical care but the whole needs of an individual and the family.

There's some great examples of that that we just did a site visit of the panel up in the far, far north of California in Delaware County up in the Oregon border is about as isolated as you can find where there are great examples of models of integration of health and human services down at the county level and also through the non-profits and the health centers. The health center there, also the open door clinic has become one of

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the first, what is called, hub centers for telemedicine rather than being dependent on the specialty care at a medical center or a specialty provider, they are now becoming the specialist in pediatric neurology and are consulting with urban areas down in southern California. So I think there's great potential and great examples out there and we hope to surface those as part of our work and to contribute to the policy along those regards.

ED HOWARD: Clint?

CLINTON MACKINNEY: We said for years that, by its small size, that rural can be nimble and can be innovative. If I want to change something, I've got a committee of three people that I talk to at a rural hospital rather than several hundreds of people to talk to and convince but that said, that said, if we really want to consider integration across the care continuum, we're going to need disparate providers to be working together. So it's not just the rural community. It's also the rural community plus the big city.

Now for better or for worse, the systems tend to follow the money and when there is money that rewards integration then I think that will start. That's where the accountable care organizations come in. So in the ACA, there are the accountable care organization programs, which I hope starts to drive some of the common sense planning that you're describing. In fact, I think you would probably agree that one of our

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challenges in this country is investing in technologies and services that are really duplicative because we need to compete with the guy down the street or down the road.

Well if we're in an ACO, I would like to think that that kind of competitive nonsense will no longer see those investments, see those investments and we'll be able to bring some common sense to at least the region that that ACO is covering with that opportunity to share the gains with Medicare. It's yet to be seen.

ED HOWARD: We're going to wind things up here in just a couple of minutes. There was a question that I was very interested in getting the panel's response to. This person writes that there are continuing closures in rural training programs such as the University of Iowa due to lack of interest. If that's so, how will increased funding change this trend and lure trainees from large centers to small training sites? If you want to try to address that, you might provide a little background and assess the accuracy of those assertions too.

CLINTON MACKINNEY: Tom, maybe you'll help with this. Let me just say whomever wrote that question, please talk to me afterwards. Part of my time, as you know I work as a rural ER doc but I also work for the University of Iowa as a contract

researcher, so I'd be very interested in kind of how that's happening in Iowa.

When I practice, I practiced in Iowa for 14 years in a town of 4,000 people and I regularly had medical students in my practice. That was all uncompensated and actually because remember for the most part, rural docs are paid on the number of patients that comes through the door, my income went down 15-percent every time I had a student with me because I purposely decreased the number of patients per day that we saw so I had some opportunity to teach. So not only was there no compensation, it cost me and my family whenever I had a student but I thought that I was a better doctor when I was participating in education. So that's why I continue to do that.

So I don't know if it's lack of interest, do we know that it's lack of interest in medical students or do we know that it's lack of opportunities? I don't know the answer to that but I would sure be happy to learn, like to talk about it further.

TOM MORRIS: Yes, I guess sometimes training programs, residency programs open and close for a variety of reasons. Sometimes it's lack of institutional support. Sometimes it's lack of interest of students. One of the things we do know is that if you can get kids exposed to rural practice, whether

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it’s physicians or physician assistants, nurse practitioners, and you can retain a portion of those because they see what it’s like to practice with a more autonomous nature if they’re predisposed towards appreciating the rural lifestyle and appreciate the young man earlier, I mean you want to go into primary care, I think that’s great.

Inner city needs docs just like rural areas do. The challenge, of course, is if we can just find a couple of kids who grew up in rural and want to stay in rural, you don’t need as many practitioners to achieve a big success there because there’s fewer folks. So the challenge is creating the sort of training programs that during the medical school or during nurse practitioner school, get them exposed to it a little bit. Then for physicians, when they get into residency training is making sure they have a chance to do some rural training. Right now we have about 25 rural training tracks around the country. These folks, they do one year in an academic health center, two years in a rural setting.

The last study showed about 70-percent of them practice in rural areas when they get done. Many studies show that you tend to practice near where you completed your residency training. So it shouldn’t be any surprise that if you complete your training in an urban area, you’re probably going to practice in an urban area. So it’s all about exposure. So

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we're going to put money, over the next three years, into supporting those 25 rural training tracks, try to get their fill rate of family medicine students up, and see if we can move that dial a little bit. If we can, we'll invest further in it, sort of a pilot program but I think those are the sort of things we need to do. We need to look at innovative ways to expose people to training and just try to get a portion of them to think about practicing there.

ED HOWARD: Excellent. Well my final admonition is to fill out the evaluation forms while you listen to my closing comment, which are really pretty simple and they consist almost exclusively of thanks. Thanks to Catherine and her colleagues at United Health for helping us settle on the topic and get a panel together and pull this thing off. Thanks to you for asking good questions and testing the panel and thanks for also helping me thank the panel for a very, very descriptive and useful discussion of a very complicated part of our health care system [Applause].

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