

U.S. Department of Health & Human Services

Health Resources & Services Administration

# OFFICE OF RURAL HEALTH POLICY

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2005 Annual Report



# Office of Rural Health Policy FY 2005 Annual Report

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# Office of Rural Health Policy FY 2005 Annual Report

## Vision, Mission and Strategic Goals

### ORHP Vision

ORHP's vision is to improve the health of Americans by providing national leadership in increasing access to quality health care in rural America.

### Mission

The mission of the ORHP is to sustain and improve access to quality health care services for rural communities. In addition, the office coordinates access to quality health care activities along the U.S.-Mexico border.

### Goals

In order to measure its accomplishments, the office has established the following three long-term goals:

**Goal 1: Improve the health and wellness of people living in rural communities and in the U.S.-Mexico border region**

**Goal 2: Improve the financial viability of small rural hospitals, rural health clinics, and other rural providers**

**Goal 3: Sustain and improve access to outpatient, inpatient, pharmaceutical and emergency room care for rural communities and along the U.S.-Mexico border**

# Office of Rural Health Policy

## FY 2005 Annual Report

### ORHP Overview

The Office of Rural Health Policy (ORHP) coordinates rural health policy issues within the U.S. Department of Health and Human Services. In FY 2005, ORHP administered 13 grant programs with a focus on capacity building at the community and State levels. While located within the Health Resources and Services Administration, the office has a department-wide responsibility to analyze the impact of departmental policy on rural communities.

ORHP is both a policy and programmatic resource for rural communities. The office's policy role is created by Section 711 of the Social Security Act, which charges the office with advising the Secretary on rural health issues. In that role, the office examines issues such as the effects of Medicare and Medicaid on rural citizens' access to health care, specifically on the viability of rural hospitals and the availability of rural physicians.

The office's programs also provide funding at both the community and State levels to support improved rural health care delivery. Through its community-based programs, the office supports projects that improve access to health care services, encourage network development among rural health care providers, enhance delivery of emergency medical services and place and train people in the use of automatic external defibrillators.

In addition, the office assumes responsibility for managing HRSA's border health activities. Much of the 2,100-mile U.S.-Mexico border is rural and the urban regions face health care delivery challenges similar to rural areas, such as limited health workforce capacity and a fragile infrastructure.

#### Authorizing Legislation for ORHP Activities:

##### **Rural Access to Emergency Devices Grant Program**

Authorization: P.L. 106-505, Title IV – Cardiac Arrest Survival Act, Subtitle B, section 413 of the Public Health Improvement Act 42 U.S.C. 254c.

##### **Public Access to Defibrillation Demonstration Projects**

Authorization: Section 313 of the Public Health Service Act 42 U.S.C. 245 as amended by section 159(c), P.L. 107-188 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.

##### **Rural EMS Training and Equipment Assistance Program**

Authorization: Section 330J of the Public Health Service Act 42 U.S.C. 254b as amended by section 221, P.L. 107-251 of the Health Care Safety Net Amendments of 2002.

##### **Rural Health Research Centers Program**

Authorization: Section 711 of the Social Security Act 42 U.S.C. 912 and Section 301 of the Public Health Service Act 42 U.S.C. 241 as amended by section 432, P.L. 108-173 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

##### **Policy Oriented Rural Health Services Research Program**

Authorization: Section 711 of the Social Security Act 42 U.S.C. 912 and Section 301 of the Public Health Service Act 42 U.S.C. 241 as amended by section 432, P.L. 108-173 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

##### **Frontier Extended Stay Clinics Demonstration**

Authorization: Section 301 and 330A of the Public Health Service Act 42 U.S.C. 241 and 254c.

##### **Medicare Rural Hospital Flexibility Grant Program**

Authorization: Section 1820(j) of the Social Security Act 42 U.S.C. 1395 as amended by section 4201(a), P.L. 105-33 of the Balanced Budget Act and section 405(f), P.L. 108-173 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

**Small Rural Hospital Improvement Grant Program**

Authorization: Section 1820(g)(3) of the Social Security Act 42 U.S.C. as amended by section 4201(a), P.L. 105-33 of the Balanced Budget Act and section 405(f), P.L. 108-173 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

**Rural Health Outreach Grant Program**

Authorization: Section 330A of the Public Health Service Act 42 U.S.C. 254c as amended by section 201, P.L. 107-251 of the Health Care Safety Amendments of 2002.

**Delta States Rural Development Network Grant Program**

Authorization: Section 330A of the Public Health Service Act 42 U.S.C. 254c as amended by section 201, P.L. 107-251 of the Health Care Safety Amendments of 2002.

**Network Development Grant Program**

Authorization: Section 330A of the Public Health Service Act 42 U.S.C. 254c as amended by section 201, P.L. 107-251 of the Health Care Safety Net Amendments of 2002.

**State Offices of Rural Health Grant Program**

Authorization: Section 338J of the Public Health Service Act 42 U.S.C. 254r as amended by section 301, P.L. 105-392. The program was first authorized in 1991 and awarded its first grants in 1992

**Network Development Planning Grant Program**

Authorization: Section 330A of the Public Health Service Act 42 U.S.C. 254c as amended by section 201, P.L. 107-251 of the Health Care Safety Net Amendments of 2002.

# Office of Rural Health Policy FY 2005 Annual Report

## Financial Data

Labor-Health and Human Services-Education and Related Agencies (Amounts in thousands)				
<i>Rural Health Programs</i>	FY 2004 Final Appropriation	FY 2004 Amount to Program	FY 2005 Final Appropriation	FY 2005 Amount to Program
Rural Outreach grants	39,601	38,397	39,278	38,005
Rural Health Research	8,902	8,827	8,825	8,751
Rural Hospital Flexibility Grants	39,499	39,167	39,180	39,180
Rural and Community Access to Emergency Devices	10,933	10,841	8,927	8,852
Rural EMS Training and Assistance Equipment Program	497	482	496	480
State Offices of Rural Health	8,391	8,136	8,321	8,044
Denali Commission	34,793	34,793	39,680	39,680
<b>Total, Rural Health Programs</b>	<b>142,616</b>	<b>140,643</b>	<b>144,707</b>	<b>142,992</b>

*Chart 1.*

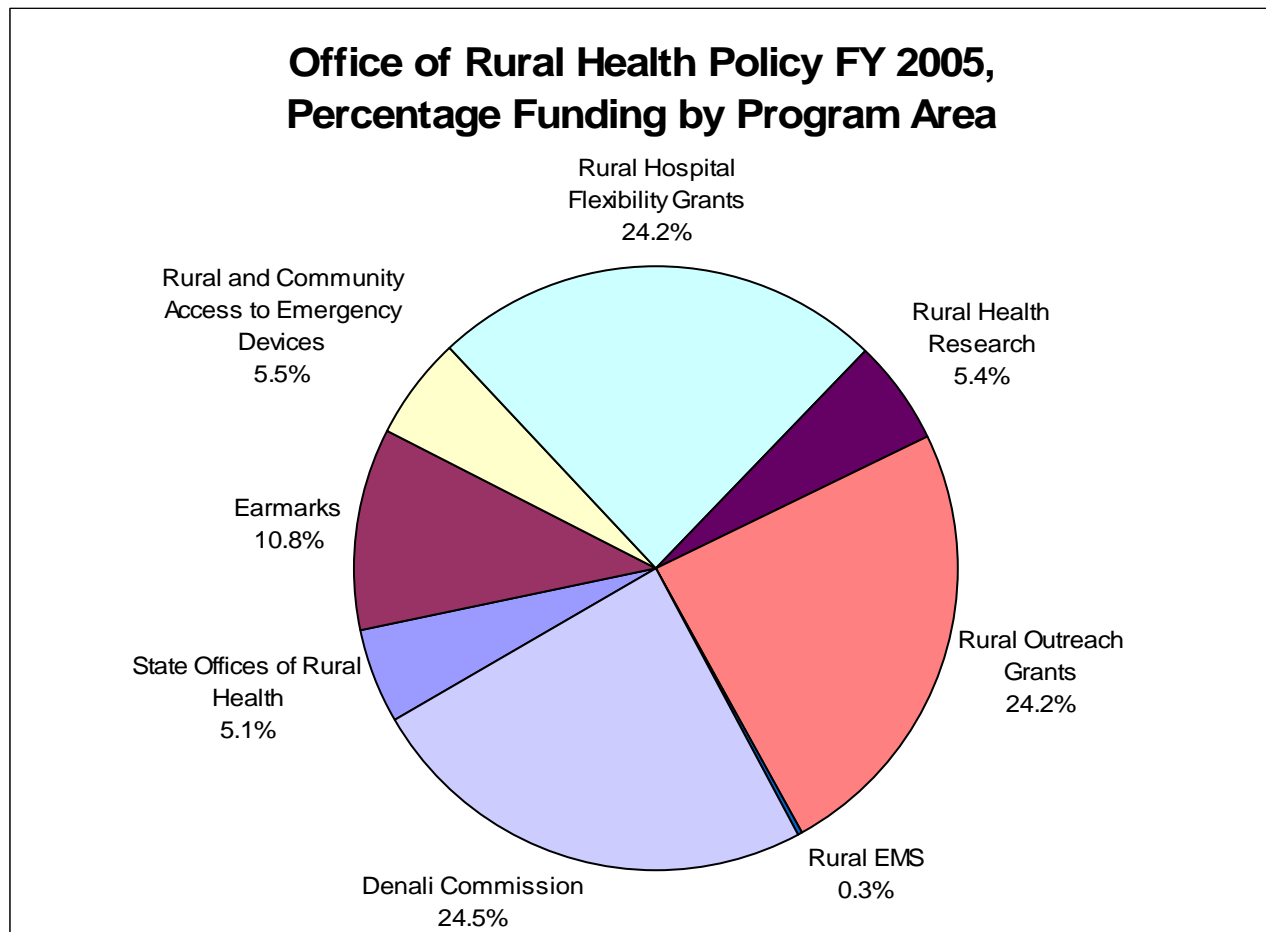


Chart 2 - Total number of ORHP grants and amounts by State, in FY 2005.

State	# Grants Awarded	FY 2005 Funding
AK	7	\$ 1,382,481
AL	7	\$ 1,869,934
AR	8	\$ 2,557,735
AZ	6	\$ 1,284,805
CA	10	\$ 2,254,120
CO	8	\$ 2,074,835
CT	3	\$ 449,238
DE	3	\$ 406,091
FL	13	\$ 2,671,343
GA	13	\$ 2,998,538
HI	4	\$ 734,060
IA	13	\$ 3,198,800
ID	6	\$ 1,408,119
IL	11	\$ 2,761,183
IN	6	\$ 1,466,719
KS	5	\$ 1,933,249
KY	11	\$ 2,710,553
LA	11	\$ 2,799,906
MA	6	\$ 692,051
MD	7	\$ 1,283,385
ME	7	\$ 1,864,798
MI	16	\$ 3,211,774
MN	12	\$ 3,398,934
MO	11	\$ 2,812,174
MS	7	\$ 2,552,848
MT	9	\$ 2,370,735
NC	8	\$ 2,316,071
ND	8	\$ 2,563,383
NE	9	\$ 2,946,884
NH	6	\$ 1,148,969
NJ	2	\$ 258,531
NM	9	\$ 1,629,220
NV	7	\$ 1,535,217
NY	8	\$ 1,544,933
OH	4	\$ 1,187,642
OK	4	\$ 1,544,766
OR	7	\$ 1,532,270
PA	6	\$ 1,069,843
RI	1	\$ 145,753
SC	8	\$ 1,773,599
SD	7	\$ 1,937,950
TN	6	\$ 1,745,615
TX	7	\$ 2,586,660
UT	4	\$ 792,804
VA	11	\$ 1,907,100
VT	7	\$ 1,182,235
WA	10	\$ 2,747,795
WI	7	\$ 1,929,478
WV	6	\$ 1,283,895
WY	4	\$ 816,023
Guam	1	\$ 72,842
Puerto Rico	1	\$ 9,340
<b>Total</b>	<b>378</b>	<b>\$ 91,357,226</b>

# Office of Rural Health Policy

## FY 2005 Annual Report

### Policy Activities

*Project Coordinator:* Emily Cook

*Rural Health Policy Analyst:* Carrie Cochran

#### **REGULATIONS AND KEY POLICY ISSUES:**

In its policy role, the office focuses on issues related to access to care for residents of rural areas. Because many of the policy levers at the Federal level are related to the Medicare program, Medicare policy review and analysis comprise much of the office's policy work. However, significant time and attention are also devoted to other policy areas including Medicaid, the State Children's Health Insurance Program, workforce and quality.

The specific Medicare regulations that come through ORHP for review vary somewhat from year to year, however the major Medicare payment system regulations generally come through for review during both the proposed rule-making and final rule-making cycles. Recently, regulations relating the Medicare Advantage, Medicare Drug Benefit and various quality reporting programs also have been received in the office and reviewed for comment.

Medicaid and SCHIP are State-based programs and much of the discretion for these programs is left to the States. However, ORHP does participate in the departmental review of Medicaid and SCHIP waiver proposals to assure that the interests of rural Medicaid beneficiaries are considered. Our role in workforce policy encompasses a wide variety of issues including Graduate Medical Education, J1-Visa Waivers, the National Health Service Corps and Title VII programs that provide support to rural providers. Quality issues are relatively new to the office, as they are to Federal programs in general, but review and input into quality measurement and reporting programs has become a regular and important activity.

#### ***Key Policy Accomplishments***

During Fiscal Year 2005, the policy staff in ORHP reviewed more than 44 draft Federal regulations and policies to determine how they might affect rural providers and the individuals they serve. Of these regulations only six included provisions ORHP staff felt had the potential to adversely affect rural providers or for which staff felt additional language should be added to benefit rural providers.

The creation of the Medicare Advantage Regional Preferred Provider Organizations by the Medicare Modernization Act (MMA) was intended to give a beneficiary living in a rural area the advantage of having a choice of methods through which he or she can receive Medicare benefits. As such, we felt it was important to assure that the regulations for the new program allowed this goal to be met. Through the comment process, we worked with the Centers for Medicare and Medicaid Service (CMS) to revise some proposed restrictions on "essential hospitals," assure that rural providers without access to the Internet could receive important documents from Medicare Advantage Plans, and revise language concerning cost-based providers.

During the establishment of the Medicare Prescription Drug Benefit, ORHP provided multiple comments to CMS regarding how their proposed regulations might better account for the needs of rural providers and beneficiaries. We were successful in obtaining a change in the network access standards that allows for certain closed-access pharmacies, including those operated by Rural Health Clinics, to count toward meeting the required access standards in areas that lack a sufficient number of open-access pharmacies.



ORHP often identifies issues of particular concern to rural providers during its review of the Medicare payment system regulations. We had many concerns about a proposal in the FY 2006 IPPS regulations to restrict the circumstances under which Critical Access Hospitals (CAH) could relocate their facilities and retain their CAH designation. We submitted multiple comments explaining our concerns and the potential affects that the proposed policy might have on rural communities. CMS ultimately revised the regulations and we supported its final policy. During the FY 2006 IPPS regulations process, we also worked closely with CMS to revise several definitions of rural used for both CAHs and other rural hospitals. These revised definitions will assure that hospitals in areas considered rural under several different definitions will continue to be considered rural for purposes of Medicare payment.

The CY 2006 Outpatient Prospective Payment System (OPPS) regulations offered us the opportunity to provide assistance to CMS in developing a payment add-on for certain rural hospitals. We worked with CMS to review data and payment policies that ultimately resulted in a payment add-on for a subset of rural hospitals that were determined to have the most need.

## SPECIAL PROJECTS AND PARTNERSHIPS:

One of the unique aspects of the Office of Rural Health Policy is its entrepreneurial nature. Since its inception, the office has put an emphasis on working with key partners and organizations to develop projects to address long-standing rural health problems. The office uses a portion of its funding in the Policy/Research line to support these activities. The emphasis of these special projects is either to highlight an issue or work with key rural partners to develop services or resources that fill an identified need.

Some of these “special projects” are focused on the needs of all rural communities, such as the need for general information on rural health. Others may focus only on a specific issue such as the recruitment and retention of health workforce or the role of economic development in health care. Still other activities focus on a particular type of health care providers. In each case, however, the projects and initiatives supported by the office meet an identified rural health care need.

The *Rural Assistance Center* (RAC) is one of the best examples of this investment. In its authorizing statute, the office was charged by Congress with establishing and maintaining “a clearinghouse for collecting and disseminating information on rural health care issues, including rural mental health, rural infant mortality prevention, rural occupational safety and preventive health promotion, research findings relating to rural health care and innovative approaches to the delivery of health care in rural areas.”<sup>1</sup> The need for such a resource was further heightened by the findings of “One Department Serving Rural America,” a report by the Rural Task Force of the U.S. Department of Health and Human Services to the Secretary.<sup>2</sup> This report identified the need for a single coordinated point of contact on rural issues for all the HHS programs that affect rural communities. The RAC was established in December 2002 as a rural health and human services “information portal.” RAC helps rural communities and other rural stakeholders access the full range of available programs, funding and research that can enable them to provide quality health and human services to rural residents. Services provided include RAC’s Web site ([www.raconline.org](http://www.raconline.org)), electronic mailing lists, and customized assistance. The site has had 586,589 hits since inception and has an average turnaround time of less than 24 hours for individual requests. In FY 2005, the RAC continued to expand the level and breadth of information and services for rural residents. In addition, the project also added new sites and information resources related to border health issues and health disparities in the Delta region of the country.

Another long-standing effort of the office examines the important link between economic development and health care in rural communities. The health sector is often one of the top employers in a rural economy, a role and relationship that often is not fully understood. The *Center for Rural Health Works* (RHWks) is an ongoing program that works to strengthen local systems of health. As the national focal point, it provides technical assistance, tools and training to help States measure the economic impact of the health-care sector on local, regional and State economies. It also develops feasibility studies for new health care services. During FY 2005, Center for RHWks activities included conducting two regional workshops, responding to more than 300 requests for technical assistance, developing models for measuring the economic impact of a CAH and a FQHC on local communities and sharing the results of their studies/activities at 16 regional and national conferences.

The *National Association of Counties* (NACo) has established a partnership with Center for Rural Health Works to help county elected officials take the lead in conducting a comprehensive community engagement process for health and economic development. The purpose of this project is to help communities recognize that improving their health care system has a direct and positive impact on local economic growth. This is a new initiative for FY 2005. During this first year of the program, the NACo Project produced three county-level reports on economic impact, community need, health services directory and data/information. The reports were provided to each county and placed on the NACo website. NACo also disseminated information about this project through workshops at its Western Regional and Annual Conferences and through articles in NACo’s publication “County News.”

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<sup>1</sup> Section 711 of the Social Security Act.

<sup>2</sup> “One Department Serving Rural America,” February, 2003.

The provision of emergency medical services in rural areas represents a particular challenge. Toward that end, the office in 2005 provided funding support for the final year of a contract that created the *Rural EMS and Trauma Technical Assistance Center (REMSTTAC)*.<sup>3</sup> This center served as the focal point for the dissemination of information on rural emergency medical services and trauma care. Through the provision of technical assistance, this continuing program promotes local and regional integration of rural EMS within existing EMS, trauma, healthcare, mental health, public health, public safety and disaster responses systems.

With FY 2005 funds, REMSTTAC was able to conduct a wide range of activities. The center provided technical assistance to rural communities relating to EMS and trauma systems. It also represented and provided a rural voice for EMS and trauma in various meetings sponsored by national associations, State governments and Federal agencies. Funding supported the development and dissemination of the “Rural EMS Agenda” for the future. REMSTTAC sponsored a Town Hall Meeting in Park City, Utah. In addition, it began the development of written products that will assist EMS and trauma rural providers.

### Provider-Focused Technical Assistance

ORHP works to develop and provide technical assistance and information sharing for rural health care providers to strengthen and expand their ability to provide quality health care. ORHP’s provider-focused TA and information sharing efforts in 2005 involved Rural Health Clinic TA Conference Calls, 340B TA for Rural Hospitals, the Delta Rural Hospital Performance Improvement Project and the Alaska Rural Hospital Performance Improvement Project.

New in FY 2005, *Rural Health Center TA Conference Calls* focused on providing Rural Health Clinics (RHCs) with four national technical assistance conference calls each year. These calls were the only federally funded technical assistance provided specifically to RHCs. The topics were determined about one month before each call by an advisory group comprised of experts in the area of RHCs. FY 2005 funds supported the cost of phone lines, speakers and administration of four to six hour-long calls. The topics covered included billing and coding, shortage designation application, health information technology and cost reporting, among others. The calls attracted an average of 175 participants each.

As a result of a change in the law in 2003, more than 250 rural hospitals may now qualify to participate in the 340b Discount Drug purchasing program. To assist these facilities in signing up for the program, the ORHP provided supplemental funding to the HRSA Pharmacy Services Support Center (PSSC) in FY 2005 to assist rural hospitals in understanding and applying for participation in the 340b discount drug purchasing program. The PSSC is a resource established in 2002 to assist HRSA grantees and eligible health care sites to optimize the value of the 340B Program and provide clinically and cost effective pharmacy services that improve medication use and advance patient care. The PSSC operates under a contract between the American Pharmacists Association (APhA) and the Office of Pharmacy Affairs (OPA), in the HRSA Healthcare Systems Bureau. To date, 140 rural hospitals are taking part in the 340b program as a result of this assistance.

The *Delta Rural Hospital Performance Improvement Project (RHPI)* is designed to increase access to quality health care services in the Mississippi Delta by improving the financial, operational and clinical performance of its small rural hospitals. On-site technical assistance is available to 122 hospitals in eight States. This project is also developing and implementing a performance improvement strategy based on the Balanced Scorecard (BSC) technology. In 2005, the Delta RHPI Project carried out a range of activities. It delivered TA to 17 unique hospitals, including 11 Performance Improvement Assessments (PIAs), 10 Targeted Consultations and Balance Scorecard (BSC) consultations in three hospitals. Additionally the project made tools available through the project Web site, conducted sustainability meetings in four States, surveyed all assisted hospitals regarding project success and made numerous presentations about this project. The project has conducted both process and outcomes evaluations.

<sup>3</sup> This activity had received funding through the Trauma/EMS line in the annual budget due to a rural 10 percent set aside in this line item in the budget line authorized under Title XII of the Public Health Service Act. However, the funding in this line item was eliminated in the FY 2006 budget.

The *Alaska Rural Hospital Performance Improvement Project*, new in FY 2005, provided on-site technical assistance to hospitals in Alaska that request assistance. The TA was targeted at helping these hospitals improve their financial, clinical and operational performance. FY 2005 money funded three on-site TA visits to Alaska hospitals, as well as follow-up services to provide assistance during the implementation of recommendations made during the site visits.

## Health Information Technology

There is an established link between the benefits of health information technology (HIT) adoption and quality improvement. There also is an emerging need for support for rural providers to make informed decisions about their HIT futures, as well as processes and business tools to help them make decisions. Therefore, in an effort to work toward rural equity of HIT adoption, ORHP will hold a national rural HIT meeting, *Health Information Technology: A Provider's Roadmap to Quality*, in September 2006. This meeting will provide an opportunity for rural providers to learn about the basic components of HIT, focus on the initial steps of strategic planning for HIT investments and share best practices and lessons learned about HIT implementation. The meeting will bring together 300 rural providers to discuss strategic planning for HIT investments.

In planning for the 2006 meeting, the HIT External Planning Team, made up of a group of 13 rural HIT experts, met in Washington, D.C., on Nov. 7-8, 2005.

In other efforts to further the adoption and implementation of HIT by rural providers, ORHP provided funding to the *Technical Assistance and Services Center* to develop key expertise, partnerships and tools for critical access hospitals (CAHs) to consider as they look to invest in HIT. This is an ongoing project. With 2005 funding, the Technical Assistance and Services Center for the Rural Hospital Flexibility program (TASC) will deliver tools and a customized portal. The tools will identify key areas of expertise needed to assist CAHs in their clinical, financial, leadership and staffing domains, most likely in the form of a primer on HIT. The portal will be a customized space for knowledge sharing, access and workspace on the AHRQ HIT portal site for the CAHs and other rural health care providers.

## Health Care Workforce

The Office of Rural Health Policy also sponsors two projects meant to support improved access to quality health care services by supporting the Nation's health care workforce.

The *National Rural Recruitment and Retention Network* (3RNet) works to increase the number of providers practicing in rural America. The project consists of 43 State-based, not-for-profit organizations that encourage and assist physicians and other health professionals in locating practices in underserved rural communities. Members include State Offices of Rural Health, Primary Care Offices, Primary Care Associations and Area Health Education Centers and other not-for-profit entities.

During FY 2005, 3RNet helped States improve their retention and recruitment (R&R) activities especially for primary care physicians, RNs, dentists, pharmacists and mental health professionals. Members placed 715 medical professionals in 622 communities and 568 of those were in HPSAs and MUAs. 3RNet also maintained a toll-free phone line to assist providers interested in serving rural America. The Network continues conducting workshops, training, and presentations for those interested in recruiting and keeping providers in rural communities. In addition, 3RNet is working with HRSA programs to promote effective R&R into areas served by these programs.

A new project, *J1 Visa Report WWAMI* (Washington, Wyoming, Alaska, Montana and Idaho) focuses on analyzing data to determine the contribution of J1-visa waiver physicians to the rural physician workforce. There have been multiple changes to the various programs that approve these waivers. These changes have influenced those applying for waivers in certain programs. This has led to confusion over the actual aggregate numbers of physicians applying for waivers in exchange for agreeing to practice in rural areas. This project seeks to analyze existing data sources to better understand the supply of J1-visa waiver physicians and determine placement trends. With FY 2005 funding, the University of Washington Rural Health Research

Center, which has a heavy focus on rural workforce issues, will analyze various data sets to determine where J1 visa waiver physicians are practicing in rural communities.

## Rural Health Policy

The ORHP funds a number of projects in its efforts to influence rural health policy to make quality, affordable health care accessible in rural areas.

One of these endeavors, the ongoing *Policy Analysis Cooperative Agreement*, supports the performance of research and analysis on key policy issues affecting rural communities. The 2005 funding supported several activities. This includes working with rural community colleges on health workforce issues. The cooperative agreement also supports ongoing work of the Rural Policy Research Institute (RUPRI) Rural Health Panel. The RUPRI Rural Health Panel provides science-based, objective policy analysis to Federal policy makers. Panel members come from a variety of academic disciplines and create documents that reflect the consensus judgment of all panelists. The grant also provides staff support to the Rural Hospitals Issues Group, a panel of small rural hospital administrators and rural hospital finance experts from across the country to discuss issues such as the MMA, Medicare Advantage, and other policy issues affecting small rural hospitals.

A new project, the *CAH/Hospice Financial Report*, was created to analyze and predict the financial impact that providing general inpatient and respite hospice services will have on Critical Access Hospitals (CAHs). FY 2005 funds supported the development and analysis of a financial model that depicts the likely financial impact of the provision of hospice services on CAHs with various cost structures.

Funding for the *National Conference of State Legislatures* (NCSL) supports an existing cooperative agreement through the Bureau of Primary Health Care which provides funding support to the NCSL for an annual meeting focusing on a key rural health issue of interest to rural State legislators. With 2005 funds, NCSL convened a day-long conference to examine the relationship between health care and economic development in rural areas, and identify strategies and resources available to help rural communities thrive.

## Best Practices and Emerging Issues in Rural Health

The ORHP also funds public health efforts and a program of all-inclusive care for the elderly as part of its work on communicating best practices and addressing emerging issues in rural health.

This ongoing *Public Health* funding supports an existing cooperative agreement with the National Association of County and City Health Officials (NACCHO) through the Bureau of Primary Health Care which provides technical assistance to community and migrant health centers. The Office of Rural Health Policy supplements this cooperative agreement to ensure that key rural issues are addressed in the public health arena and information on rural activities is communicated. Fiscal year 2005 funds supported several activities including: the creation and maintenance of a rural listserv; an issue brief on workforce development; rural sessions at the NACCHO Annual Conference; six scholarships for rural Local Public Health Agencies (LPHAs) to attend the NACCHO Annual Conference; two skills building scholarships for rural LPHAs to attend a social marketing public health conference; the creation of an internal NACCHO Rural Health workgroup and updates on rural health resources and issues in the NACCHO Exchange and the Public Health Dispatch.

The purpose of the *Program of All-inclusive Care for the Elderly* (PACE) model, a Medicare demonstration project, is to expand community-based long-term care options for seniors through comprehensive coordination of preventive, primary, acute, and long-term care services. It is a unique capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity that features a comprehensive medical and social service delivery system. There is little or no penetration of this model into rural areas. What is not known is how many rural providers are interested in the PACE model and how viable this model might be for meeting the needs of frail elderly in rural communities.

FY 2005 funds supported a range of activities related to PACE. The project offered consultation with potential providers and a two-day meeting for all PACE Providers to determine progress in the development of rural PACE sites. Discussion between ORHP and the National PACE Association (NPA) has begun on

evaluation component. In addition, NPA provided technical assistance to providers on ways to receive start-up PACE site funding.

## Women's Health Issues

The ORHP created a new project in FY 2005 to address women's health issues. The mission of the Bright Futures for Women's Health and Wellness Initiative is to plan, develop, implement and evaluate a variety of culturally competent consumer, provider, and community-based products to increase awareness and use of preventive health services for all women across their lifespan. The objectives of this project are to aid rural women and adolescent girls in the following ways: 1) providing information to rural women on recommended preventive health services so that they seek care based on their individual needs and share in the decision-making about their health services and 2) providing tools for rural practitioners to use in making all health care visits an opportunity to offer preventive care. FY 2005 funding used to modify an existing set of physical activity and healthy eating tools for consumers and health care providers in rural settings. The final version of these materials is expected on Aug. 30, 2006

## Frontier Health

Funding for a frontier health project supports the Frontier Education Center, which provides technical assistance to individuals seeking information on frontier health care issues and produces 3-4 issue papers on frontier health-specific topics. Funding supported papers focusing on topics including the use of health information technology for public health activities in the U.S.-Mexico Border region, the applicability of the Frontier Extended Stay Clinic model to sites in the "lower 48," and developing baseline information to analyze the impact of the Medicare drug benefit on frontier communities with a sole pharmacy.

## Collaboration with the National Rural Health Association (NRHA)

The Office of Rural Health Policy collaborates with the National Rural Health Association (NRHA) on several fronts to identify, analyze and address rural health needs.

The purpose of one of the collaborative efforts, the *Rural Medical Educators' Conference and Technical Assistance*, is to share innovative ways to get more medical professionals into rural areas as well as discuss new issues in rural health education. This is an ongoing program. FY 2005 funds supported the planning and execution of the Rural Medical Educators Annual Conference in May 2006. The conference will bring together about 50 physicians, students, residents and professors who strive to bring medical professionals (including doctors and nurses) into rural environments.

Additionally, in response to issues brought to the forefront by the Institute of Medicine's 2005 rural health quality report "Quality Through Collaboration," a new *Rural Hospital and Community Technical Assistance* project seeks to improve quality of health care in rural communities. Funding supports in-depth technical assistance through three to five site visits. These visits are designed to promote health care quality in rural areas. In addition, funds are used to collect best practices and rural needs in quality improvement as well as create a rural quality focus group.

Another *Quality* project, new in FY 2005, was funded to support several activities including planning a quality conference, writing a rural health quality best practices manual and bringing in four speakers to the Quality Conference in July 2006. In addition, funds will provide National Quality Forum Membership for the National Rural Health Association to provide input and have a "rural vote" in the forum.

The Office of Rural Health Policy also collaborates with the NRHA to hold several *policy forums* throughout the year for key stakeholders to discuss various issues, such as Medicare, acute care, etc. The forums educate participants about rural community-based health models and begin developing reports on best practices.

Another joint endeavor by ORHP and the NRHA, the *Cooperative of Health Networks*, will develop a series of performance measures in order to measure progress of the Rural Health Network Grants. In FY 2005, the first year of funding, money was used to identify possible measures.

The *Regional Meetings – Best Practices* is a new project meant to improve rural health quality and promote the use of best practices by working with State Rural Health Associations. Technical assistance will be delivered through a series of presentations and site visits. In addition to technical assistance, this program will collect quality improvement models that work. This collection of best practices will be distributed nationally.

Further, an ongoing *Annual Meeting Support* project supports various parts of the National Rural Health Association's annual meeting. The annual meeting brings together the broad rural health community for continuing education and networking. FY 2005 funding was provided to support eight sessions on topics such as rural Health Information Technology, the National Advisory Council, Rural Voices, mental health and substance abuse, a committee on rural health and human services, improving systems collaboration, updates from ORHP and BPHC and a Medicaid update.

Another collaborative effort between ORHP and NRHA brought about *State Rural Health Association Grants* to support the rural health community at the State level through a variety of different activities. It is a continuing project. With FY 2005 funding, 34 grants of \$9,500 were administered to support activities such as rural health newsletters, conferences, educational activities, skill building, etc. In 2005, 20 of the State Rural Health Associations (SRHAs) devoted portions of their annual meeting to educating rural citizens about the findings in the Institute of Medicine's "Quality Through Collaboration" report on rural health quality issues. Other SRHAs used their meetings to share information about the new Medicare drug benefit while others focused on issues such as health information technology.

Other collaborative efforts with the NRHA resulted in the *Ag Health* program that provides technical assistance in order to raise awareness of health and safety issues associated with agriculture, decrease the number of related accidents and illnesses, and improve treatment. It is a new program in FY 2005. The Ag Health program provided agriculture health training, such as farm safety, to health professionals who have patients working in agriculture.

## Border Health

ORHP also facilitates intra-agency border health activities that cut across the Bureaus and Offices of HRSA.

In FY 2005, funds supported the *Border Health Clearinghouse in the Rural Assistance Center*, which aims to develop a border Website within the RAC ([www.raconline.org](http://www.raconline.org)) for health and human services information. This bilingual site serves as a clearinghouse for information on border health issues. The border health website was launched on schedule in January 2006.

ORHP also supported the *U.S.-Mexico Border Health Association Meeting* to further educate clinicians and community workers about HRSA programs and the progress toward achieving U.S.-Mexico Border 2010 Health Objectives. ORHP supported the annual U.S.-Mexico Border Health Association Meeting in Laredo, Texas, through the provision of logistical support for educational seminars for providers.

The purpose of the *Pan-American Health Organization Immunizations* program is to further educate clinicians and community workers in the appropriate use of vaccines and to facilitate the vaccination of children and adults in local clinics and community health centers along the US-Mexico border. FY 2005 funding provided logistical support for Immunization in the Americas Week.

In FY 2005, ORHP supported a new Border Environmental Coordination Research Program is to fund research to test the hypothesis that environmental education and training is an effective intervention tool for improving public health. The target population is lay community health workers, or *promotoras*, residing along the U.S.-Mexico border and the communities they serve. This project, jointly sponsored by EPA and HRSA, supports larger border health efforts including, but not limited to, the U.S.-Mexico Border 2012 program ([www.epa.gov/usmexicoborder](http://www.epa.gov/usmexicoborder)). Funding from FY 2005 supported the development of a research protocol to examine pesticide exposure in rural border areas by Texas A&M University.

# Office of Rural Health Policy FY 2005 Annual Report

## Grant Programs

### Medicare Rural Hospital Flexibility Grant Program (Flex)

*Project Officer:* Steve Hirsch, MSLS

The Rural Hospital Flexibility Program is a Federal initiative that provides funding to State governments to stabilize rural hospital economics, integrate emergency medical services (EMS) into the health care system and improve quality of care. Flex funds support the conversion of small rural hospitals to Critical Access status, which allows them to receive cost-based reimbursement from Medicare for inpatient and outpatient services. Flex funding to the States also encourages the development of collaborative systems of care in rural areas, including the CAHs, EMS providers, clinics and other providers of high-quality, necessary health care services.

The CAH program requires participating States to develop rural health plans, and funds the States to support and implement community-level outreach and technical assistance. Although focused on very small, rural hospitals, this complex intervention operates on the national, State, community and facility levels and covers a broad range of health service issues.

### *Changes to the Program*

There were no significant changes to the Flex Program.

### *Key Program Accomplishments*

Since the inception of the Flex Program, more than 1,200 hospitals have converted to Critical Access status. Most of these hospitals have seen an improvement in their financial status. Most hospitals have offered new, needed services to their communities. More than 80 percent of CAHs report engaging in activities to improve the quality of care provided to patients.

The Program has also stimulated the development of dozens of rural health networks in the participating States. Network types have ranged from small, hospital-based networks to Statewide networks involving all CAHs to multi-State networks devoted to improving quality of care.

### At A Glance

#### Amount Awarded:

2004: \$ 22.4 million

2005: \$ 22.2 million

2006: \$ 22.3 million (anticipated)

#### Grants Awarded:

2004: 45 continuing awards

2005: 45 continuing awards

2006: 45 continuing awards

#### States:

ORHP awarded 45 grants to 45 states in  
FY 2005



## Small Rural Hospital Improvement Grant Program (SHIP)

*Project Officer:* Keith J. Midberry, MHSA

The purpose of the SHIP grant program is to help small rural hospitals do any or all of the following: 1) pay for costs related to implementation of prospective payment systems (PPS); 2) comply with provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996; and 3) reduce medical errors and support quality improvement (QI) efforts.

State Offices of Rural Health help rural hospitals to participate in the program. In FY 2005, \$14.7 million was awarded to 1,523 eligible hospitals in 46 States and Puerto Rico and each hospital received approximately \$9,700.

### *Changes to the Program*

Since FY 2002, the first year of the program, the number of participating hospitals has increased by 73 hospitals or 4.8 percent.

The use of SHIP funds for reduction of medical error and quality improvement activities increased from 49 percent in FY 2003 to 53 percent in FY 2004 while the use of SHIP funds for HIPAA activities decreased from 46.5 percent in FY 2003 to 39.5 percent in FY 2004. The use of grant funds for PPS activities remains relatively constant at 6 percent.

### *Key Program Accomplishments*

Key program accomplishments for FY 2005 have yet to be evaluated. The project period, Sept. 1, 2005 to Aug. 31, 2006, began too late in the year for the information to be available from the consultant who provides the report at the end of the period.

During FY 2004, 53 percent of the funds (\$7.8 million) were expended for projects and initiatives related to quality improvement. HIPAA activities received 40 percent of the funds (\$5.9 million) and PPS activities received 7 percent (\$1 million) of the funds. Of the 1,523 participating SHIP hospitals, 1,095 or 72 percent used some or all of their grant funds to invest in health information technology (HIT). Seventy percent (771) of the hospitals used SHIP funds to secure new or upgrade existing hardware and software infrastructure that serve as the foundation for business office, security and quality improvement functions. Twelve percent (127) of the hospitals expended funds on hardware or software related to business office functions such as coding, billing or accounting software. Forty percent (436) identified their HIT expenditures as specific to compliance with the HIPAA security rule and 58 percent (634) invested in HIT for quality improvement activities.

#### At A Glance

##### Amount Awarded:

2004: \$ 14.7 million  
2005: \$ 14.8 million  
2006: \$ 14.5 million

##### Grants Awarded:

2004: 49 continuing awards  
2005: 47 new awards  
2006: 47 continuing awards

##### States:

ORHP awarded 47 grants to 46 states and Puerto Rico in FY 2005

## Rural Health Outreach Grant Program

Project Officer: Eileen Holloran

The purpose of the Rural Health Care Services Outreach (Outreach) Grant Program is to provide funds to expand the delivery of health care services in rural communities. The history of rural health care in the United States is one of underserved people and under-resourced providers. Many factors contribute to the story: geographic isolation, low incomes, lack of insurance and too few caregivers, to name a few. The Outreach Grant Program encourages the development of new and innovative health care delivery systems in rural communities that lack essential health care services. Programs funded vary greatly and have brought care that would not otherwise have been available to at least 4 million rural citizens across the country.

The emphasis of the grant program is on service delivery through creative strategies requiring the grantee to form a consortium with at least two additional partners. The consortium should include local providers and other organizations that support the delivery of health care. The Outreach projects are based on demonstrated community needs. The population to be served should be included in identifying and planning for the services that will be provided. All projects need to be responsive to the unique cultural, social, belief and linguistic needs of the target population.

Applicants may propose to deliver different types of services, including primary care, dental care, mental health services, home health care, emergency care, health promotion and education programs, outpatient day care and other services not requiring inpatient care.

In fiscal year FY2005, 30 new and 72 continuing grants (102 total grants) were awarded, totaling \$18,821,464.

### *Changes to the Program*

Through the FY 2005 grant cycle the maximum amount of grant funds that could be requested by applicants was \$200,000 per year for up to three years. For the FY 2006 grant cycle, Outreach applicants could request \$150,000 in the first budget period, \$125,000 in the second budget period and \$100,000 in the last budget period.

### *Key Program Accomplishments*

Rural communities have managed to create hospice care, bring health check-ups to children and provide prenatal care to women in remote areas. The Outreach program projects allow rural populations to receive a wide variety of health services. In FY 2005 some of the project focuses were: primary care, 27 percent; mental health, 26 percent; diabetes, 12 percent; oral health, 8 percent; obesity, 5 percent; and others types of services, including health education and disease prevention, totaled 24 percent of the projects emphasis. The majority of the population served is made up of adults (51 percent), but infants, children, adolescents and the elderly also receive health services.

Outreach program grantees successfully expand health services delivery each year, by increasing the number of people served in rural communities. Two examples of Outreach grantees that have received national recognition for projects that were conceived and developed using Outreach Grant Program funds are the Sickness Prevention Achieved through Regional Collaboration (SPARC), which focused on breast cancer detection in older women in a contiguous rural area at the junction of Connecticut, Massachusetts and New York, as well as the Diabetes Lay Educator Program in Morehead, Minn. that provided services for migrant Hispanic farm workers who have diabetes.

### At A Glance

#### Amount Awarded:

2004: \$ 19.9 million  
2005: \$ 18.8 million  
2006: \$ 17.9 million

#### Grants Awarded:

2004: 96 continuing awards, 13 new awards  
2005: 71 continuing awards, 30 new awards  
2006: 43 continuing awards, 65 new awards (anticipated)

#### States:

ORHP awarded 102 grants to 39 states in FY 2005

## Delta States Rural Development Network Grant Program

*Project Officer:* Lakisha M. Smith, MPH

The purpose of the Delta States Rural Development (Delta) Grant Program is to support community organizations in the development and implementation of projects to address local health care needs in the rural Delta Region. A single grant is awarded to one organization within each of the eight Delta States (Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri and Tennessee) collectively known as the Delta Regional Authority (DRA). The eight states are comprised of 207 eligible counties.

ORHP provides support for the counties within the DRA through activities designed to strengthen the safety net and small rural hospital performance, demonstration projects for improving collaboration across counties among existing grant programs and providing technical assistance and outreach funds to small rural communities.

In fiscal year 2005, eight grants were awarded to the DRA totaling \$5,090,751.

### *Changes to the Program*

In FY 2005, the program implemented a major shift for grantees from single-county networks to multi-county consortia. This will help to achieve greater financial impact across the Delta counties/parishes for the program.

### *Key Program Accomplishments*

Each of the eight Delta grantees is unique as is its accomplishments.

The Alabama Delta grantee has garnered the buy-in of two counties, which previously opted to not be involved in the grant program, to become active participants in the Delta grant and have received funding for health implementation projects. Alabama's partnership with the Southern Rural Access Program has provided an opportunity for the grantee to engage in the practice management model by providing technical assistance to primary care providers throughout the region. This represents the first multi-county effort ever initiated by Alabama's Delta States project.

Through TA, several grantees, including Arkansas and Louisiana, were able to leverage additional grant funds in excess of \$1.35 million to assist in other initiatives within the various Delta States.

Local projects in Illinois were able to develop school based health centers in three sites and a coordinated referral service for patients of an established volunteer free clinic.

Kentucky initiated a pharmaceutical access program assisting low-income adults to take advantage of low cost pharmaceuticals in 10 Delta counties. Grantees in Kentucky and Missouri have also been involved in pilot project targeting to the ARC and DRA region regarding a new pharmaceutical web-based pharmaceutical system.

### At A Glance

#### Amount Awarded:

2004: \$ 5.1 million  
2005: \$ 5.1 million  
2006: \$ 5.1 million (anticipated)

#### Grants Awarded:

2004: 8 new awards  
2005: 8 continuing awards  
2006: 8 continuing awards

#### States:

ORHP awarded 8 grants to 8 states in FY 2005

## Network Development Grant Program

*Project Officer:* Erica Molliver, MHS

The purpose of the grant is to “expand access to, coordinate and improve the quality of essential health care services, and enhance the delivery of health care in rural areas.” These grants support rural providers who work together in formal networks, alliances, coalitions or partnerships to integrate administrative, clinical, technological and financial functions across their organizations. The funds provided through this program are not used for the direct delivery of services. The ultimate goal of the RHND Grant Program is to strengthen existing health care networks in order to achieve business (network partner return) and social (community return) competencies that increase access and quality of rural health care and, ultimately, the health status of rural residents.

Nine new grants and 28 continuing grants were funded in FY 2005 (37 total grants) totaling \$6,974,893.

### *Changes to the Program*

There were 10 new awards made in FY 2005. There were no changes to the program in FY 2005.

### *Key Program Accomplishments*

**Agrisafe Network** in Iowa began a series of distance continuing education courses for local providers. Network members initiated discussions with the Iowa Farm Bureau Federation and Wellmark Blue Cross Blue Shield of Iowa regarding the coverage of preventive health services for farmers. They also developed protocol referral guidelines to measure changes in clinical outcomes in four different content areas.

The **Upper Peninsula Health Care Network** in Michigan adopted and endorsed a cooperative pharmacy formulary management system. The network then used the combined volume of their 15 hospitals to leverage Performance Discount/Rebate Agreements in the purchase of prescription drugs. In the case of one particular drug, the network expects annual net savings for the network hospitals to be as much as \$74,000 from this drug alone.

In addition to continuing grant-funded work in the adaptation and implementation of a web-based information management software program to link rural safety net providers, the **East Texas Health Access Network (ETHAN)** was able to provide significant aid to victims of hurricanes Katrina and Rita. Network members provided direct patient care and medication assistance to hundreds of evacuees, obtained donations of insulin, food, clothing and hygiene supplies, and conducted door-to-door search and rescue activities in two eastern Texas counties. Two days after Rita hit, network staff reopened the ETHAN Office using a generator, and kept updated information on the location of open hospitals, food distribution sites, etc. for evacuees.

**North Country Health Consortium** in New Hampshire leveraged additional funds to support the Molar Express, the network’s mobile regional public health dental clinic, which provided screenings to over 500 Medicaid-eligible North Country children between April and December of 2005.

**Grand Traverse Regional Health Care Coalition** of Michigan signed a contract with the State to operate the Adult Benefit Waiver I (ABWI) program in three target counties. The network’s participation in this program allows access to Federal matching dollars for other local programs.

### At A Glance

#### Amount Awarded:

2004: \$ 6.6 million  
2005: \$ 7 million  
2006: \$ 4 million (anticipated)

#### Grants Awarded:

2004: 29 continuing awards, 5 new awards  
2005: 27 continuing awards, 10 new awards  
2006: 15 continuing awards, 23 new awards (anticipated)

#### States:

ORHP awarded 37 grants to 22 states in FY 2005

## Network Development Planning Grant Program

Project Officer: Michele L. Pray-Gibson, MHS

The purpose of the Rural Health Network Development Planning Grant Program is similar to the Network Development Grant Program in that it seeks to “achieve efficiencies; expand access to, coordinate and improve the quality of essential health care services; and strengthen the rural health care system as a whole.” These grants support rural communities needing assistance in planning, organizing and developing a health care network. Funds cannot be used for direct delivery of health care services. The grant supports one year of planning to develop a network and help them become operational.

Nineteen new grants were awarded in fiscal year 2005 totaling \$1,563.49.

### *Changes to the Program*

In FY 2004, the grant cycle began on Dec. 1. For FY 2005, the cycle was changed to March 1.

### *Key Program Accomplishments*

#### Hopi Regional Health Care Network, Kykotsmovi, AZ

The Hopi Tribe received grant funding in 2004. The goal of the network was to “develop a formal networking system that would foster true partnership and collaboration between the two major hospitals which provide medical health services to our Native American population.” As a result of the grant, the network developed and adopted bylaws and a governing board. Two additional hospitals, Flagstaff Medical Center and the Northern Arizona VA Hospital, have requested to join the network.

#### Alaska Small Hospital Performance Improvement Network (ASHPIN), Juneau, AK

The Alaska State Hospital and Nursing Home Association received grant funding in 2004. It was a network of 10 small frontier hospitals focusing on three things: (1) network development; (2) strategic planning to address network member clinical and operational communications issues, including a telehealth/telemedicine system; and (3) performance improvement. This network was successful in securing a Network Development Grant in fiscal year 2005 to continue its activities and is still operational.

#### Planning Equals Access for Louisiana (PEAL), Napoleonville, LA

The Louisiana Rural Health Association received funding in 2004. The goal of PEAL was ultimately to identify strategies to increase adult immunizations and adult vaccinations while addressing chronic illness. The network proposed to develop a strategic plan addressing the health needs of twenty-nine parishes. As a result of the grant funds the network grew into an emerging coalition called Progress Equals Access for Louisiana (PEAL) and network membership increased to include the regional CMS Office and the LA Department of Insurance, Senior Health Insurance and Information Program. This network was successful in securing a Rural Health Outreach Grant in fiscal year 2006 to address the access issues identified during the planning grant process.

#### At A Glance

#### Collaborative Action for TAOS County Health (CATCH), Taos, NM

The Taos Health System (Holy Cross Hospital) received funding in 2005. The goal of CATCH is to evolve from a horizontal to a vertical network. The project proposed to create a single point of entry to existing services and develop a *Promotoras* program. As a result of the grant, the network is now a vertical network that includes emergency medical services, a community foundation and an herb company. The network secured a Rural Health Outreach Grant for fiscal year 2006 to continue the development of a single point of entry and the lay *Promotora* Program. The focus is on providing education on diabetes, linking patients to appropriate programs and securing prescription assistance.

#### Amount Awarded:

2004: \$ 1 million  
2005: \$ 1.6 million  
2006: \$ 1.1 million (anticipated)

#### Grants Awarded:

2004: 12 new awards  
2005: 19 new awards  
2006: 13 new awards (anticipated)

#### States:

ORHP awarded 19 grants to 16 states in FY 2005

## State Offices of Rural Health Grant Program

*Project Officers:* Jennifer Riggle, JD & Jennifer Chang, MPH

The purpose of the State Offices of Rural Health (SORH) Grant Program is to assist States in strengthening rural health care delivery systems by creating a focal point for rural health within each State. The program provides an institutional framework that links small rural communities with State and Federal resources to help develop long term solutions to rural health problems.

There are three core functions of the SORH: (1) to serve as a rural health clearing house of information and innovative approaches to the delivery of services; (2) to coordinate State activities related to rural health in order to avoid duplication of efforts and resources; and (3) to identify Federal, State, and nongovernmental programs regarding rural health and provide technical assistance to public and nonprofit private entities regarding participation in such programs.

In fiscal year 2005, 50 non-competing continuation grants were awarded for a total of \$7,401,171. The maximum level of funding awarded was \$150,000, which 46 of the 50 States requested and received. Each State is also required to match the SORH Federal funding at a minimum 3:1 ratio; a unique leveraging component for the program.

### *Changes to the Program*

The program continued its performance improvement initiative at the programmatic and grantee level. The Government Performance and Results Act (GPRA) measure for the program was updated and the peer-to-peer mentor program was used to improve the effectiveness of strategy implementation and planning at the State level.

### *Key Program Accomplishments*

The three core functions of the SORH program were well illustrated during the response to the devastation caused during the 2005 hurricane season. The SORHs in the afflicted and neighboring States were key partners in information gathering, coordination of activities and in providing technical assistance after the immediate crisis. Given the rapidly changing nature of the crisis, there was an urgent need to share information and the SORH served as a valuable asset to ORHP and HRSA in determining the magnitude of the effect on rural areas.

The program encourages each State to promote rural recruitment and retention efforts of health professionals. The SORHs are the primary dues-paying members to the Rural Recruitment and Retention Network (3RNet) which in 2005 recruited 742 health professionals of which 450 of these were primary care physicians.

State Offices continue to leverage significant partnerships with the goal of improving rural health. In 2005, an example of the impact of these partnerships is seen through the Rural Hospital Performance Improvement project (RHPI). SORHs in MS, LA, AR, AL, TN, IL, KY, and MO are worked collaboratively with their State Hospital Associations (SHAs) to provide input and expertise. In particular, the SORHs worked with the contractor to ensure that the on-site technical assistance was well-managed and appropriate to the needs of each hospital. The SORHs and SHAs also continue to follow up with the hospital after technical assistance is rendered.

The SORHs are continuously working with Federal, State and local partners to improve the collaboration among safety net providers in rural areas of their States. In particular, 18 SORHs applied with their State partners to an ORHP initiative to "Improve Collaboration Between Critical Access Hospitals (CAHs) and Federally Qualified Health Centers (FQHCs)." Funding was available to provide technical assistance to four of the States; those were Louisiana, Texas, New Hampshire and Arkansas. In each of these States, the SORH took the lead in bringing together the State-level partners (PCO, PCA, SHA). The technical assistance was provided through consultants to the State teams to assist them in better understanding the roles and relationships

between CAHs and FQHCs. As a result of the leadership from the SORHs, each of the States has developed plans and strategies for improved collaboration between the CAHs and FQHCs in their States.

At A Glance

Amount Awarded:

2004: \$ 7.4 million

2005: \$ 7.4 million

2006: \$ 7.2 million (anticipated)

Grants Awarded:

2004: 50 continuing awards

2005: 50 continuing awards

2006: 50 continuing awards

States:

ORHP awarded 50 grants to 50 states in  
FY 2005

## Rural Access to Emergency Devices

*Project Officer:* Sheila Warren

The purpose of the Rural Access to Emergency Devices (RAED) Grant Program is to provide funding to rural community partnerships to purchase automated external defibrillators (AEDs) that have been approved, or cleared for marketing by the Food and Drug Administration; and provide defibrillator and basic life support training in AED usage through the American Heart Association, the American Red Cross, or other nationally recognized training courses. The legislation that created this program states that awards will be made to community partnerships. A community partnership is composed of local emergency response entities such as community training facilities, local emergency responders, fire and rescue departments, police, community hospitals and local non-profit entities and for-profit entities.

Forty-eight non-competing continuation grants were awarded in FY 2005 totaling \$7,252,903.

### *Changes to the Program*

No changes to the program in 2005.

### *Key Program Accomplishments*

In 2005 approximately 8,110 AEDs were placed and approximately 24,830 lay persons and first responders were trained in their utilization. There were approximately 1,500 AEDs uses, which resulted in approximately 850 patients having their cardiac rhythm restored. AEDs have been placed in colleges, universities, community centers, local businesses, law enforcement and ambulance vehicles, fire trucks, 911 dispatch centers and offices to name a few. The grant creates opportunities to educate the public on AEDs via advertisements, news media, schools, churches, shopping malls, restaurants, home owner associations, businesses, local government bodies, security firms, etc. The RAED Program has resulted in an increased public awareness, increased number of AEDs available and an increase in persons, first responders and lay persons trained in their utilization in the event of sudden cardiac arrest.

#### At A Glance

##### Amount Awarded:

2004: \$ 9.2 million

2005: \$ 7.4 million

2006: \$0.3 million (anticipated)

##### Grants Awarded:

2004: 49 continuing awards

2005: 48 continuing awards

2006: 3 new awards (anticipated)

##### States:

ORHP awarded 48 grants to 47 states and 1 territory in FY 2005



## Public Access to Defibrillation Demonstration Projects

*Project Officer:* Sheila Warren

The purpose of the Public Access to Defibrillation Demonstration Project (PADDP) is to award grants to political subdivisions of States, Indian tribes and tribal organizations to develop and implement innovative, comprehensive, community-based public access defibrillation demonstration projects that provide cardiopulmonary resuscitation (CPR) and automated external defibrillation (AED) to cardiac arrest victims, provide training to community members in CPR and AED usage, and to maximize community access to AEDs.

In fiscal year 2005 four non-competing continuation grants were awarded totaling \$930,663.

### *Changes to the Program*

No changes to the program in 2005.

### *Key Program Accomplishments*

In 2005 approximately 1,077 AEDs were placed and approximately 7,593 lay persons and first responders were trained to use them. AEDs have been placed in colleges, universities, community centers, Indian reservations, local businesses, law enforcement and ambulance vehicles, fire trucks, 911 dispatch centers, sporting events, major tourist attractions and offices. The grant has created methodologies to educate the public on AEDs via advertisements, news media, schools, churches, shopping malls, restaurants, home owner associations, businesses, local government bodies, security firms, etc.

The PADDP Program has resulted in increased public awareness, increased number of AEDs available and an increase in persons, first responders and lay persons, trained in the utilization of AEDs in the event of sudden cardiac arrest.

#### At A Glance

##### Amount Awarded:

2004: \$ 0.9 million

2005: \$ 0.9 million

2006: \$ 0.9 million

##### Grants Awarded:

2004: 4 new awards

2005: 4 continuing awards

2006: 4 continuing awards

##### States:

ORHP awarded 4 grants to 3 states in FY 2005

## Rural Health Research Centers

*Project Officer:* Joan Van Nostrand, DPA

The Rural Health Research Centers (RHRCs) Program is designed to help policy makers understand the problems that rural communities face in assuring access to health care for their residents. The RHRCs study issues facing rural communities in their quest to secure adequate, affordable, quality health services for their residents. This is the only Federal program that is dedicated entirely to producing policy-relevant research on health care in rural areas. The work done by the Centers is also critical to helping the Office play its policy role within the Department. The research done by the RHRCs help provide important data and findings to the office's policy staff which they bring to bear in their annual review of key Departmental regulations.

Eight Centers in eight States were competitively awarded cooperative agreements for the period FY 2005-2008.

The eight RHRCs conducted 25 research projects and wrote 25 policy briefs and technical reports about their results. All RHRCs have websites which highlight their rural research results.

### *Key Program accomplishments:*

Research Centers create policy briefs that provide clear, simple summaries of legislation affecting rural areas, e.g., the Medicare Modernization Act, and possibilities for effective implementation, e.g., the new prescription drug benefit. The following are examples:

- A report on the impact of Medicaid cuts on rural communities, especially on the disabled and the elderly
- A report on rural teens that found that rural teens are just as likely to be exposed to violence and more likely to use illicit drugs than urban or suburban teens
- Policy briefs that showed the benefit of Federal loan repayment scholarship, and special recruitment programs to staffing rural Community Health Centers
- A report on certification and training of Community Health Workers to study the certification activities in States with formal programs
- Program changes in FY 2005 included increasing the number of RHRCs from six to eight and having each RHRC identify a topic of concentration for its rural research.

### At A Glance

#### Amount Awarded:

2004: \$ 4 million  
2005: \$ 4.4 million  
2006: \$ 4 million

#### Grants Awarded:

2004: 8 new awards  
2005: 8 continuing awards  
2006: 8 continuing awards

#### States:

ORHP awarded 8 grants to 8 states in FY 2005

## Rural Emergency Medical Service Training and Equipment Assistance Program

Project Officer: Blanca Fuertes, MPA

The purpose of the Rural Emergency Medical Service Training and Equipment Assistance Program (REMSTEP) is to assist entities to develop improved emergency medical services (EMS) in rural areas by improving the recruitment, training, certification and retaining of volunteer and paid EMS personnel with a special emphasis in the use of technology-enhanced education methods. The grant also funds the purchase of EMS and personal protective equipment.

The office provides support to these grantees through the EMS and Trauma Technical Assistance Center and by requiring the use of community partnerships and the involvement of the grantee's State Office of Rural Health program.

In fiscal year 2005 three grants were awarded as continuation grants to the REMSTEP program totaling \$356,313. Fiscal Year 2006 the Congress chose not to fund this program. Grantees will complete the current funded year and will be instructed on how to close the program.

### *Changes to the Program*

No changes were made to the program.

### *Key Program Accomplishments:*

**Arizona:** Northland Pioneer College (NPC) in partnership with the authorized State EMS council for Northern Arizona, 14 Northern Arizona fire departments, 12 hospitals and two other community colleges created Project ROPE (Rural Outreach Paramedic Education). The project provides high-quality, accessible and cost-effective training opportunities for certification and recertification of paramedics, and continuing education for EMS providers in Northern Arizona using a mobile hand-on critical care skills lab, using NORMAN, a human patient simulator.

**Washington:** Inland Northwest Health Services (INHS) in collaboration with Spokane County EMS and the Spoke County Medical Director, created EMS Live At Night! (EMS Live). EMS Live provides monthly education forum using interactive video conferencing broadcasts to rural communities throughout eastern Washington. The grant funds have been utilized to expand the program to more than 300 EMS agencies not only in the State of Washington, but also to Northern Idaho, North Central Oregon, and the Eastern Aleutian Tribes of Alaska. The success of the program prompted the State of Montana to request, and was accepted as a partner State.

**Wisconsin:** In partnership with six hospitals, four are CAHs, 10 ambulance services from Sandusky and Huron counties, the Sanilac Medical Services in Sandusky, Michigan developed an EMS program to increase access to EMS training, reduce barriers when accessing EMS training or services, increase awareness of the value and importance of EMS volunteers, and increase the incentives to increase EMS volunteers.

### At A Glance

#### Amount Awarded:

2004: \$ 3.8 thousand  
2005: \$ 3.6 thousand  
2006: \$ N/A

#### Grants Awarded:

2004: 3 new awards  
2005: 3 continuing awards  
2006: N/A

#### States:

ORHP awarded 3 grants to 3 states in FY 2005

## Frontier Extended Stay Clinic Program

Project Officer: Emily Cook

The purpose of the Frontier Extended Stay Clinic (FESC) Cooperative Agreement Program is to examine the effectiveness and appropriateness of a new type of provider, the FESC, in providing health care services in certain remote locations.

In remote, frontier areas of the country, weather and distance can prevent patients who experience severe injury or illness from obtaining immediate transport to an acute care hospital. For residents in some of those communities, providers offer observation services traditionally associated with acute care inpatient hospitals until the patient can be transferred or is no longer in need of transport. Provision of these services requires the staffing, equipment and quality assurance programs of an acute care hospital. However, extended stay services are not currently reimbursed by Medicare, Medicaid or other third-party payers. For several years, officials in the State of Alaska and several State Offices of Rural Health, Primary Care Offices and Primary Care Associations have explored the development of a new provider type, or other mechanism, that would enable reimbursement of these services through the FESC model.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) authorized the Centers for Medicare and Medicaid Services (CMS) to conduct a demonstration program in which FESCs would be treated as Medicare providers. Under MMA, FESCs are defined as clinics that are: 1) located in communities which are at least 75 miles away from the closest hospital or are inaccessible by public road and 2) designed to address the needs of patients who are unable to be transferred to an acute care facility because of adverse weather conditions or who need monitoring and observation for a limited period of time.

In a separate recognition of the extended care services provided by some frontier clinics, an additional demonstration program to be administered by the Health Resources and Services Administration (HRSA) was established by the Consolidated Appropriations Act of 2004.

### *Changes to the Program*

The ORHP Frontier Extended Stay Clinics Cooperative Agreement was the catalyst for a significant increase in the availability of quality health care in four frontier communities in Alaska and Washington. The Cooperative Agreement provided funding to the Alaska FESC Consortium for additional provider staff, equipment and facility upgrades. Each site meticulously recorded every extended stay via a detailed, web-based encounter log. In addition, the Alaska FESC Consortium worked closely with state and federal partners to craft standards, policies and procedures, regulations, and conditions of participation. They qualified the conditions under which patients can safely be monitored and observed, and when they must be transferred to a higher level of care.

### *Key Program Accomplishments*

Preliminary results of the first year of data collection indicate that the four clinics recorded 631 extended stays (two hours or greater duration). Only 7 percent of the stays were over 24 hours; 48 percent of the extended stays resulted in being discharged home, without further referral; 41 percent resulted in emergency transfer to a higher level of care; 12 percent were referred on a non-emergent basis.

#### At A Glance

##### Amount Awarded:

2004: \$ 1.5 million

2005: \$ 1.5 million

2006: \$ 1.5 million

##### Grants Awarded:

2004: 1 new award

2005: 1 continuing award

2006: 1 continuing award

##### States:

ORHP awarded 1 grant to 1 state in FY 2005

# Office of Rural Health Policy

## FY 2005 Annual Report

### ORHP Staff

Marcia Brand, PhD, <i>Associate Administrator</i>	Budget, personnel, Government relations, operations oversight, legislation, policy and administration issues, Secretary's Rural Initiative, tribal health, oral health
Tom Morris, MPA <i>Deputy Associate Administrator</i>	Budget, personnel, National Advisory Committee on Rural Health and Human Services, policy and research coordination, administrative issues
Jennifer Riggle, JD <i>Associate Director</i>	Grants Program Director (program oversight), guidance preparation, re-Authorization, Division of Independent Review liaison, liaison to Grants Management and Division of Grants Policy and Grants Tracking, State-based activities
George Brown, MPH, CHES <i>Public Health Analyst</i>	Delta Health Initiative Grant Program, Delta Small Rural Hospital Performance Improvement Initiative, <b>SOUTHEAST REGION LIAISON</b> (Project Officer for Southeast States in FLEX, SHIP, and State Office of Rural Health)
Jennifer Chang, MPH <i>Public Health Analyst</i>	Rural Health Care Services Outreach Grant Program Coordinator. Issue Areas: women's health, maternal and child health, domestic violence, school-based programs
Carrie Cochran, MPA <i>Public Health Analyst</i>	Single-Year Rural Research Grant Program. Rural health policy issues including: workforce, health information technology, Medicare payment policy, Medicaid payment policy, rural health clinics, HHS Rural Task Force, National Advisory Committee on Rural Health and Human Services.
Jerry Coopey, MPH <i>Strategic Planning</i>	Issue Areas: Rural Recruitment and Retention Network liaison, Access to Capital - <b>MIDWEST REGION LIAISON</b>
Emily Cook, MPH <i>Lead Medicare Policy Analyst</i>	Rapid Response for Requests of Rural Data Analysis Cooperative Agreement. Rural health policy issues, including: Medicare and Medicaid payment policy, critical access hospitals, rural hospitals, rural health clinic regulations, National Advisory Committee on Rural Health and Human Services, rural Medicare demonstrations including the Frontier Extended Stay Clinic model.
Lt. Heather Dimeris, MS, RD, CLC <i>Public Health Analyst</i>	Small Health Care Provider Quality Improvement Grant Program Coordinator. Issue Areas: health information technology, case management services, public health, dietary/metabolic syndrome issues
Nancy Egbert, RN, MPH <i>Senior Clinical Advisor</i>	Issue Areas: clinical advisor/evaluation, quality (especially hospital and primary care), nursing issues, influenza pandemic, State Hospital Team Leader. <b>NORTHWEST REGION LIAISON</b>
Steve Hirsch, MSLS <i>Public Health Analyst</i>	Rural Hospital Flexibility Grant Program coordinator, Rural Assistance Center Cooperative Agreement. Issue Areas: definitions of Rural (including Rural Urban Commuting Areas) <b>NORTHEAST REGION LIAISON</b>
Eileen Holloran <i>Public Health Analyst</i>	Grant Program Coordinator. Issue Areas: transportation (mobile clinics), chronic disease and Alzheimer's
Kristi Martinsen <i>Public Health Analyst</i>	Black Lung Clinics Program, Coordinator Rural Health Outreach Grants Issue area: mental health and substance abuse.

<p>Keith J. Midberry, MHSA <i>Public Health Analyst</i></p>	<p>State Offices of Rural Health Grant Program Coordinator, Small Hospital Improvement Program Coordinator and Human Resources Coordinator</p>
<p>Erica Molliver, MHS <i>Program Analyst</i></p>	<p>Network Development Grant Program coordinator. Issue Areas: pharmacy issues (coordination, prescription drugs and medication management)</p>
<p>Nisha Patel <i>Public Health Analyst</i></p>	<p>Rural Health Care Services Outreach Grant Program Coordinator. Issue Areas: cardiovascular health, diabetes, nutrition, obesity and elder care</p>
<p>Michele Pray-Gibson, MHS <i>Public Health Analyst</i></p>	<p>Executive Officer Liaison to the Office of the Administrator, Budget Coordinator, National Advisory Committee on Rural Health and Human Services logistics, SOUTHWEST REGION LIAISON</p>
<p>Elizabeth Rezai-zadeh, MPH <i>Public Health Analyst</i></p>	<p>Border Health Initiative, U.S.- Mexico Border Health Commission liaison, SOUTHWEST REGION LIAISON</p>
<p>Jacob L. Rueda, MPH <i>Public Health Analyst</i></p>	<p>Issues Areas: Rural EMS, Pharmacy, and Medicaid Project Officer for Network, Outreach, Black Lung, and RESEP Grants.</p>
<p>Lilly Smetana <i>Grant Programs Assistant</i></p>	<p>Grants Program Assistant, Electronic Handbook liaison, File Master. Issue Areas: earmarks grants, health professions education, health literacy and oral health.</p>
<p>Lakisha Smith, MPH <i>Public Health Analyst</i></p>	<p>Delta Network Development Grant Program Coordinator, Issue Areas: HIV/AIDS, minority health, Indian/Tribal liaison, agricultural health and safety, safety net collaboration, school-based programs, and health education/promotion and disease prevention (general)</p>
<p>Karen Stewart, MPH, CHES <i>Public Health Analyst</i></p>	<p>Acting Intergovernmental Affairs Coordinator (State Organizations: NGA, NACO, ASTHO, NCSL, NRHA, NACCHO, Commissions, Technical Assistance Coordination) and NHRA Liaison.</p>
<p>Sonja Carter Taylor <i>Staff Assistant</i></p>	<p>Administrative Team Coordinator, Inter/Intra Agency Agreements Coordinator, contracts backup. Issue Areas: primary care access (general)</p>
<p>Joan Van Nostrand, DPA <i>Research Director</i></p>	<p>Rural Health Research Centers Grant Program Coordinator. Issue Areas: aging, disability, long-term care and palliative care</p>
<p>Sheila Warren <i>Public Health Analyst</i></p>	<p>Rural Access to Emergency Devices/Public Access to Defibrillation Demonstration Grant Program Coordinator and Contracts Coordinator. Issue Areas: health education/promotion and disease prevention (general)</p>
<p>Support Staff</p>	
<p>Mary Collier, <i>Support Staff Member</i></p>	
<p>April Ward, <i>Support Staff Member</i></p>	