



General Membership Meeting

MINUTES

March 23, 2011 at 6:15 pm
Seven Seas Hotel & Waterpark, Mandan, ND

In attendance:

Christian Albano, NDSU College of Pharmacy
Mary Amundson, Center for Rural Health
Denise Andress, SW AHEC
Jaclyn Bugbee, St. Alexius Medical Center
Thomas Cooper, Oakes Community Hospital
Gwen Halaas, UND SMHS
Kristine Henke, Center for Rural Health
Keith Johnson, Custer Health

Daniel Kelly, McKenzie County Healthcare System, Inc
Mitch Leupp, Mountrail Medical Center
Dave Molman, Altru, UND SMHS Advisory Council
Kylie Nissen, Center for Rural Health
Ann Rathke, NDSU College of Pharmacy
Roger Schauer, UND SMHS
Joshua Wynne, UND SMHS

Welcome and Introductions

Lynette Dickson, Board Member

Lynette Dickson provided background on the ND RHA which was formed four years ago, with the kick-off meeting held at the Seven Seas during the 2007 Dakota Conference on Rural and Public Health. The focus/size/operation of Rural Health Associations in every state is different. North Dakota was a latecomer in to establishing a Rural Health Association; all but 6 or 7 states have a RHA.

Due to the weather conditions, the majority of the people on the meeting agenda were unable to make it.

Approval of Minutes

The minutes from the 2010 Membership meeting were included in the packet which was distributed to those in attendance. Kristine Henke moved to approve the minutes and Kylie Nissen seconded. Minutes approved.

Current Board Members

Lynette Dickson

- Pete Antonson, Administrator, Northwood Deaconess, Northwood
- Darrold Bertsch, CEO, Sakakawea Medical Center, Hazen
- Cathy Swenson, Administrator, Nelson County Health System, McVillie
- Buzz Benson, CRNA, Medcenter One Health System, Bismarck
- Tim Cox, CEO, Northland Healthcare Alliance, Bismarck
- Lynette Dickson, Program Director, Center for Rural Health, Grand Forks
- Carol Goodman, Executive Director, Cavalier County Job Development Authority, Langdon
- June Herman, Senior Director, Public Advocacy and State Health Alliances, North Dakota American Heart Association, Bismarck
- Keith Johnson, Administrator Custer Health Unit, Mandan
- Dan Kelly, CEO, McKenzie County Health System, Watford City

- Fred Larson, Bismarck
Jim Restemayer, NREMT-P/EMS Education Coordinator, Grafton
Michael Schwab, Executive Director, North Dakota Pharmacy Association, Bismarck
- Bev Voller, Executive Officer, Emmons County Public Health, Linton
- Kurt Waldbillig, Outreach Director, St Alexius Medical Center, Bismarck
- Don Warren, Program Director, USDA, Bismarck

Board members are currently being asked if they would be willing to serve another 3 year term. Some Board member positions may come open. The Board will discuss those openings at their next meeting and decide on areas that need to be filled.

Administrative/Technical Support to NDRHA

Lynette Dickson

The NDRHA entered into an agreement with the Center for Rural Health (CRH). The services provided, (at no charge to NDRHA) will be supported by State Office of Rural Health grant funds through the CRH. Kylie Nissen, project coordinator, will provide support for the organization. Since the NDRHA has a volunteer board, accomplishing things within the association presents a challenge. Kylie will assist with facilitating NDRHA efforts going forward. The NDRHA initially established a Board of Directors, developed by-laws, attained 501C3 status, and developed and maintains (through CRH) a website.

Discussion & Reports

NDRHA Activities over the past year

Lynette Dickson

1. NDRHA has been a supporting partner of Dakota Conference since 2008.
2. NDRHA conducted a survey via Survey Monkey to see what other organizations were doing legislatively within North Dakota.
3. NDRHA supported the CAH bill (HB 1152) as the primary sponsor.
4. Initiated Rural Health Day at the Capitol and exhibited.
5. Supported the Governor's Proclamation of Health In Partnership with Education (HIPE) Week and exhibited during HIPE Week at the Capitol.
6. Brad Gibbens created a facts sheet that was branded as a CRH/NDRHA joint creation. That sheet is included in the packet that has been given out to those in attendance. (The facts sheet is attached to the minutes but it is a very low resolution – if you would like a copy for distribution, please contact Kylie at kylie.nissen@med.und.edu and she can email you one of higher quality.)

Committee reports

Nominating Committee

Lynette Dickson

Lynette announced that the current officers are Pete Antonson as President, Darrold Bertsch as Treasurer, and Cathy Swenson as Secretary. Pete said that he will be stepping down as President. The Secretary and Treasurer positions will also be voted on. Additionally, a President Elect position will be elected. According to the by-laws, the nominating committee solicited nominations from the members 3 weeks prior to the meeting. These new officers will be voted on electronically by the Board in the next couple of weeks.

The following were nominated:

President:

- Darrold Bertsch
- Tim Cox

- Lynette Dickson
- President Elect:
- Fred Larson
 - Mike Schwab
- Treasurer:
- Don Warren
- Secretary:
- June Herman
 - Cathy Swenson

Policy Committee

Lynette Dickson

National Policy Update – See Attached.

State Policy Update - Mike Schwab has been very active with NDRHA. He is with the Pharmacist Association. He was unable to make it tonight, so we do not have a full legislative report. NDRHA supported the CAH bill as the main sponsor. The bill was initiated through NDRHA (Cathy Swenson). It is a bill to provide for Medicaid supplemental payments to critical access hospitals; a legislative management study; and to provide an appropriation. If this bill passes, the NDRHA needs to thank Maggie Anderson (ND Medicaid Office) for all the support and assistance. It appears that this year Rural Health issues seem to radiate more strongly amongst the legislators. The bill is currently sitting in Senate Appropriations. Currently, they are in the process of getting it out of committee and on to the Senate floor to be voted on before any big bills are brought forward to be voted on.

Dakota Conference – supporting partner

Kylie Nissen, Executive Director

NDRHA is a supporting partner in the Dakota Conference (NDRHA, ND Public Health Association, Center for Rural Health, Family and Community Medicine, Altru Health System). Many states Rural Health Associations conduct their state-wide rural health conference. Karen Larson (Community HealthCare Association of the Dakotas) serves on the Dakota Conference Planning Committee as the NDRHA representative.

Finance

Dan Kelly, Finance Committee

The PNL that was handed out to all of those in attendance starts from the date of inception to the present date. The first two years we received \$9,500 from the National Rural Health Association Technical Assistance grant and the 3rd year we received \$3,800. Current balance is \$10,459. The finance committee intends to create a budget soon so that the association. We just received notification (Year 4) that we were approved for \$9,500. Questions: What are the best activities for us to take on?; What is the best use of our funds?; and How can we be effective and not be redundant of other organizations we are already a part of?

It was suggested that we use some of the funds to support the travel for the current President, if he/she is available, to attend the NRHA Annual meeting (May, 2011) and Policy Institute (January, 2012) so we have consistent representation at these very important meetings. If the President isn't available, then other officers/members will be offered the opportunity.

Membership/Community Relations

Lynette Dickson

A membership recruitment push has not been made since the initial kick-off of the association. It is the Board's intent to wait until a strategic plan has been finalized so that members can join knowing what value they can expect to receive with their membership.

It was suggested that the NDRHA look into applying for a Bremer foundation organizational development grant. They are awarded to groups to engage more people and hold regional meetings to gauge interest/awareness. These grants are given out to any location in the state.

Future Activities

Lynette Dickson

Lynette asked each person in attendance for their thoughts as a member/potential member as to what they see as the purpose this association should serve in ND:

- Rural is different – how is that going to be reflected in the policy we develop/support; who is our audience, who do we want to affect and how?
- Need to reinvent ourselves, the mission has petered out and we need to find out what our niche is.
- As a health care community we are not cohesive. We tend to not come in together as a group to present issues across the board as a united front.
- We need to keep in mind the term “umbrella” and use this organization to do that in North Dakota.
- Look to the other RHAs that have strong organizations and get advice from them. Learn from those that are successful at being that umbrella. Take what can be useful for our state.
- Facilitator of policies for all of those associations/organizations.
- Everybody (other associations, trade org.) goes in their own direction and don't know if everyone hears each other – this group could be the convener to get us all to work together.
- There is a need to get people to Bismarck to testify during the legislative session. Seems like many organizations are really struggling – everyone is so busy, we see the same people in every organization/boards/etc.
- Connection to the NRHA which is a great resource for its members.
- New models of health care delivery and inter-professional collaborative care. Communities are where health care delivery happens and the needs of every community are different. Not all the systems are working very effectively. We could all learn from each other and become experts in inter-professional health care delivery.

Other

There is a Membership form in the packet that each attendee at the meeting received. Membership options are available for both individual memberships and organizational memberships. For those that work with students you can encourage them to join.

Adjourn

ND RHA Policy Committee Report

Submitted 3-22-2011

by Brad Gibbens, Center for Rural Health

Budget/Appropriations:

- For FY 11, the year we are in, we do not actually have a budget
- Congress has been passing a series of short CR's (Continuing Resolutions) which in effect mean funding is at the FY 10 level.
- So far no one seems real serious about having a government shut down, and we are seeing a lot of political positioning
- House Republicans had originally (early January) put up a call to cut \$100 billion, but they have been hovering around \$50 billion. This would be cutting the remainder of FY 11 (March through September, by \$50-100 billion.
- NRHA has proposals for either keeping rural health funding at about level funding or slight increases; NOSORH had supported keeping it even and no increases
- Rural Health Programs account for about \$131 million a year (FY 10 budget). This includes the following:
 - Flex/SHIP (\$41 million)
 - SORH (10 million)
 - Research line (research centers, RAC,) (10 million)
 - Rural Health Outreach line (Rural Health Outreach Grants, Network Development Grants, and Network Planning grants) (56 million)
 - Rural and Community Access to Emergency Devices grant (\$2.5 million)
 - Telehealth (11.6 million)
- NRHA also lists the National Health Service Corps on their list as \$142 million a year
- AHEC is \$33.3 million
- The President's budget for FY 12 was released and while the major rural health programs (e.g., SORH, Flex, Outreach line, research line) were basically left alone (one cut would be to eliminate SHIP), the President's proposal did call for large cuts in the DHHS, including HRSA (cuts in CHC spending for example)
- We have a ways to go. Basically all released budgets are DOA until they work through compromises
- It is hard to not think that there will be proposed rural health cuts; they just have not materialized to date. When they do then NDRHA will have to step up along with others and advocate.

Left on the Table after the ACA (NRHA agenda)

- Allow RHC to participate in 340B Discount Drug program
- Eliminate unfair treatment of CAHs in the ARRA
- Ensure continued support for SORHs (Flex was reauthorized in and the ACA and given a formal role for CAHs with regard to Accountable Care Organizations, bundled payments, and other system changes; but SORHs need to be reauthorized)
- Reinstate Necessary Provider for CAH (this is not a significant issue in North Dakota)

- Allow CAHs flexibility in their bed counts
- Increase Medicare Payment cap top RHC
- Eliminate CAH isolation test for ambulance reimbursement
- Ensure rural representation on MedPAC
- Ensure fair payment rates for rural
- Protect access to care for most geographically remote Americans
- Improvements to Meaningful Use Incentives for RHC professionals
- Problems with CMS physician supervision (hospital outpatient therapeutic staff)
- Creating access to capital for CAH equipment and workforce deficits
- Improving REC outreach to CAHs
- Fixing Medicare incentive formula for RHC
- MedPAC study on adequacy of Medicare payments for Health care professionals serving rural areas
- Support rural health appropriations

Re-introduction of R-HoPE (Rural Hospital and Provider Equity Act) – in many respects this is a “fix-it” bill to the Medicare Modernization Act of 2003

- Big rural health bill previously sponsored by Senator Conrad
- Idea would be to get much of this incorporated in larger bill – some of this was picked up in ACA but much was not; in other cases it is extensions of current law (capital loans have not been included in other pieces so that could be a significant change)
- Addresses the following:
 - Equalize Medicare Disproportionate Hospital Payments
 - Reinstate the Hold Harmless for Rural Hospitals under the outpatient prospective payment system
 - Assistance for low volume hospitals (non-CAHs with less than 800 discharges and more than 25 miles from another hospital – could be eligible for an adjustment of up to 25% of the otherwise applicable PPS rate)
 - Re-classification of wage index
 - Reasonable cost reimbursement for clinical lab test extension
 - CAH clinical lab services
 - Capital infrastructure loan program (mortar and brick loans)
 - Medicare incentive payments for physicians in scarcity areas
 - Increase RHC reimbursement
 - Home health and PA, NP, and clinical nurse specialist and ability to prescribe

(VERY IMPORTANT) CBO recommendations on the budget deficit calls for eliminating cost based reimbursement for CAH, Sole Community Hospitals, and Medicare Dependent Hospitals (VERY IMPORTANT)

I have had two phone calls with Ingrid Sell, health LA for Senator Hoeven

- Positive calls
- She is interested in learning more about rural health

- Provided her copy of North Dakota Rural Health Impact Statement (can be found at <http://ruralhealth.und.edu/topics/17>)
- Interested in “fixes” to ACA, either things that were left over or things to make ACA work better
- Sent her information on CBO recommendation and also to Conrad’s office

I was told Congressman Berg has hired a Health LA, and I am trying to reach her.

Part 2 (3-23-2011)

I just spoke to Kate Spaziani, Senior Policy Advisor, to Senator Conrad. She handles budget issues. Dana also participated on the call.

High points

- Nothing specific to rural health right now
- Conrad “will fight to see rural health is not unfairly targeted or treated.” –but “buckle up”. Landscape has changed and anything is possible.
- Conrad feels the approach of taking stabs out of domestic spending like the House has looked at is not big enough as we need significant reform for entitlements, defense spending, and the tax code.
- Senator Conrad and Senator Durbin (both Democrats) and Senator Coburn (OK) and Senator Crapo (ID) (both Republicans) were all members of the President’s Deficit Reduction Commission and all four voted in favor of the Commission’s recommendations. In other words, Democrats and Republicans supported ideas that took on two sacred cows: 1) cut entitlements, and 2) raise taxes. There are six Senators (these four) and two others who are working in a Senate deficit compromise.
- FY 11 is a significant issue as it sets the stage for the FY12 budget. How things end for FY11 will set the boundaries for FY12. If things are cut in FY11 hard to get back in going forward. We really won’t know until see how things work out between the White House, the Speaker, and the Senate Dems. Where will be the compromise?
- Next year appropriation process could be as unsettled as this one has been
- Final note was on the CBO report (i.e, ending cost based reimbursement of CAHs and others)- Kate said this is just a review of options by CBO. Any serious look at this would have to go through Senate Finance where we have strong rural health advocates like Grassley (IA), Chairman Baucus (MT), Senator Conrad, Senator Roberts (KS), Senator Rockefeller (WV), Senator Crapo (ID), and others. This is not likely to get support.

11.0346.02000

Sixty-second
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1152

Introduced by

Representatives Devlin, Vigesaa, J. Nelson, Kaldor

Senators Christmann, Robinson

1 A BILL for an Act to provide for a critical access hospital grant; and to provide an appropriation.

2 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

3 **SECTION 1. CRITICAL ACCESS HOSPITAL GRANTS.**

- 4 1. During the 2011-13 biennium, the state department of health shall contract with a third
5 party, such as the North Dakota hospital association, to administer a grant program for
6 critical access hospitals. The administrative costs of the party administering the grant
7 program may not exceed the lesser of actual direct costs or five percent of the grant
8 program appropriation. The party administering the grant program may establish a
9 committee to review grant applications and to make grant award determinations.
- 10 2. In order to qualify for a grant under this section, an applicant must be a critical access
11 hospital in the state which has not previously received a grant under this section. A
12 grant application must specify how grant funds will be utilized by the recipient, include
13 requested fiscal and demographic information, and include any supporting
14 documentation required by the party administering the grant program.
- 15 3. Grant funds must be used for quality of care issues, which may include facility
16 improvements, patient care needs, and patient care equipment needs and for
17 implementation of health information technology and electronic medical records.
- 18 4. A grant award may not exceed five hundred thousand dollars per recipient. As a
19 condition of receipt of a grant under this section, a recipient shall agree that during the
20 2011-13 biennium the recipient will provide the grant administrator with periodic
21 reports on the status and use of the grant funds distributed. The grant administrator
22 shall provide the state department of health with status reports on the grant program
23 and on recipient postaward reports. A grant award may be distributed to a qualified
24 recipient over the course of the 2011-13 biennium as may be provided under the terms

Sixty-second
Legislative Assembly

1 of the grant award. If the state department of health determines a recipient has used
2 grant funds in a manner inconsistent with the terms of this section or of the grant
3 award, the recipient shall return that portion of the award to the state department of
4 health.

5 5. The name of a grant applicant, the name of a grant recipient, the amount of grant
6 funds awarded, and the amount of grant funds distributed are public information.
7 However, material in a grant application or postaward report may be exempt or
8 confidential under section 44-04-18.4.

9 **SECTION 2. APPROPRIATION.** There is appropriated out of any moneys in the general
10 fund in the state treasury, not otherwise appropriated, the sum of \$18,000,000, or so much of
11 the sum as may be necessary, to the state department of health for the purpose of providing
12 grants to critical access hospitals under section 1 of this Act, for the biennium beginning July 1,
13 2011, and ending June 30, 2013.

11.0346.05000

Sixty-second
Legislative Assembly
of North Dakota

**SECOND ENGROSSMENT
with Senate Amendments
REENGROSSED HOUSE BILL NO. 1152**

Introduced by

Representatives Devlin, Vigesaa, J. Nelson, Kaldor

Senators Christmann, Robinson

1 A BILL for an Act to provide for medicaid supplemental payments to critical access hospitals; to
2 provide for a legislative management study; and to provide an appropriation.

3 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

4 **SECTION 1. MEDICAID SUPPLEMENTAL PAYMENT - CRITICAL ACCESS HOSPITALS.**

5 The department of human services shall provide a medicaid supplemental payment to critical
6 access hospitals. The department shall seek federal medicaid funding to support the
7 supplemental payments.

8 **SECTION 2. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT**

9 **STUDY.** During the 2011-12 interim, the legislative management shall consider studying and
10 evaluating the positive and negative impacts of implementation of patient-centered medical
11 homes in the state, including consideration of whether implementation is resulting in North
12 Dakotans experiencing health care savings and improved medical results as well as whether
13 implementation is impacting North Dakota's critical access hospitals. The legislative
14 management shall report its findings and recommendations, together with any legislation
15 required to implement the recommendations, to the sixty-third legislative assembly.

16 **SECTION 3. APPROPRIATION.** There is appropriated out of any moneys in the general
17 fund in the state treasury, not otherwise appropriated, the sum of \$1,527,802, or so much of the
18 sum as may be necessary, and from federal funds, the sum of \$1,926,259, or so much of the
19 sum as may be necessary, to the department of human services for the purpose of providing
20 medicaid supplemental payments to critical access hospitals under section 1 of this Act, for the
21 biennium beginning July 1, 2011, and ending June 30, 2013.



Emergency Medical Services (EMS)

- Heavy reliance on volunteers combined with volunteer shortages
- Limited management structure
- Majority of rural ambulance have limited number of runs
- Distance, weather, and location
- Financing and funding

Finance and Funding

- Public and private reimbursement rates and levels
- Low volume and/or low utilization
- Reliance on a limited number of payment mechanisms
- Organizational structures/ownership structures
- Reimbursement not matching actual costs

Networking and Collaboration

- Focus on resource sharing and creating new sources of resources
- Increase capacity and ability to respond to local/area needs
- Improve efficiency and effectiveness
- Development of trust and sense of mutual benefit for all partners

Chronic Disease and Health Behavior

- Aging population is significant
- Majority of health costs associated with chronic disease
- Rates of chronic disease are higher in rural areas
- Limited resources to help manage disease

Delivery System Reform

- Viability of rural health facilities
- Supply and demand for health professional workforce
- Payment mechanisms
- Limited services and low volume
- Role of HIT and quality of care

Community and Economic Development

- Rural health facilities provide significant benefit to local community
- Viability of rural health facilities and of the community are intertwined
- Rural health facilities typically a top local/area employer
- Rural hospitals developing more hospital foundations and securing local tax revenue

Health Insurance

- Lower rates of coverage in rural North Dakota
- Self-employed and small businesses
- Uninsured and under-insured impact to rural hospitals

Access to Care and Availability of Services

- Physical access, financial access, and organizational access
- Supply and demand for health professional workforce
- Viability of rural health facilities
- Changing population and economic conditions, particularly de-population and aging

Health Infrastructure

- Health facility closures or concerns for future closure
- Limited number of options covering facility types or classification
- Supply and demand for health professional workforce
- Access to and costs of technology and quality of care measures
- Regulatory environment

Health Professional Workforce

- Shortage and/or maldistribution
- Growing incidence of chronic disease with demand for care and management
- Aging workforce
- Movement away from primary care
- Perceived issues toward rural, rural life style, payment and technology

Quality of Care

- Costs for adoption and training/education resources
- Movement toward linking quality with payment and performance
- Linkage of quality with health information technology
- Statewide and/or regional support for systems of care

Health Information Technology (HIT)

- Movement toward quality improvement and facility performance
- Costs associated with HIT conversion and maintenance
- Supply and demand for health professional workforce
- Access to training and costs of training workforce



Center for
Rural Health

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