

**2005 NEW ENGLAND RURAL HEALTH ROUNDTABLE SYMPOSIUM**  
**PUBLIC HEALTH SYSTEMS Constituency Group**  
**October 27, 2005**

**PRESENT:**

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**HIGHLIGHTS:**

**1. Rural-specific concerns that differentiate you from urban/suburban counterparts?**

- As defined in IOM report (technology, workforce, population health, finance/sustainability)

**Is there potential for NERHRT to impact any of these issues?**

- Yes re: data collection (comparable data across region; not reinventing wheel in each state)
- Yes re: workforce development (a forum to address it collaboratively, with less competition between segments within health care; a forum to learn from one another—e.g. 2 rural health scholars programs never met prior to this conference)

**2. What association groups currently represent your interests?**

- Trade associations (home health, hospital, Bi-State PCA, etc)
- Offices of rural health bridge disparate interests, esp. MA (though divided east/west) and VT
- Coalition of public health networks (created for bioterrorism/emergency, but broader)

**Is there a clear rural focus within those groups?**

- Sometimes, but interests may be different/conflicting (e.g. rural hospitals vs. rural CHC's)

**How can NERHRT collaborate with these groups?**

- Outreach to make rural issues & NERHRT more visible, look for synergies, and stir interest in NERHRT membership. Mostly NERHRT members can do, occasionally staff.
- Prime for outreach: long-term care (home health plus); EMS; oral health; telehealth. Also Rural Development Councils (it has been difficult to get health care on agenda in NH).
- Identify interstate political barriers (e.g. difficult to collaborate across state lines because of provider licensing & Medicaid policy) and collaborate to solve once for all.
- Identify & spread successes (e.g. performance improvement, oral health, mental health).

**3. How does the composition of this group feel?**

- Much support for suggestion that we merge public health systems & social/community health & consumers (leaving just 2 other groups, hospitals and primary care).

**4. Would you be interested in this constituent group having an ongoing presence?**

- Yes: email listserve.
- Yes: rotating policy-oriented conference calls.
- Not much comment on other two ideas.

**Other:**

- Suggested: divide membership list by organizational type; then when constituency group takes lead on some issue, inform/invite relevant members to participate.
- Concern about staff/volunteer time needed to maintain constituency groups.
- Interested in seeing at next year's Conference, presented in way that reaches across segments within the sector: Telehealth; Workforce; Financing (across hospitals, CHC's, EMS, etc); Economic Development (show economic impact of hospitals, CHC's, etc).
- Discussed NRHA model of constituency groups (the rabble-rousers) and issues groups (policy folks), who work together to bring things to issue papers. Consider taking an issue addressed at the conference, and have it worked on in both issue & constituency groups.