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December 6, 2019

The Honorable Richard E. Neal
Chairman
Committee on Ways & Means
U.S. House of Representatives
2309 Rayburn H.O.B
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways & Means
U.S. House of Representatives
1011 Longworth H.O.B.
Washington, DC 20515

Dear Chairman Neal, Ranking Member Brady, and Members of the Rural and Underserved Communities Health Task Force:

On behalf of the more than 82,000 members of the American College of Surgeons (ACS), thank you for your leadership and interest in exploring solutions to address the challenges faced in rural and underserved communities. The ACS looks forward to collaborating with the bi-partisan Task Force on solutions to address health disparities, particularly the growing shortage of general surgeons in rural America.

To reflect the ACS' commitment to assure quality surgical care for 60 million rural patients, the Advisory Council for Rural Surgery (ACRS) was established in 2012 with a mission to identify, investigate, and rectify the challenges of rural surgical practice. The development of broad-based rural residency training tracks as well as support for rural surgeons including recruitment, retention, mentoring, and post-residency education are inherent in the ACRS' endeavor to assure quality surgical care for rural patients.

Background

General surgery is an essential element of the care of a community or region. The addition of general surgical care allows a majority of the local population's health care needs to be served without the expense of transfer, time away from employment, and travel and hotel costs. Given that some safety net hospitals in urban areas are running well over capacity, patient transfer does not automatically assure quick access.[1]

A general surgeon contributes substantially to the local economy, both in terms of hospital revenue and creation of jobs, which are critical to the hospital and the

[1] https://www.todayshospitalist.com/Hospital-capacity-and-adverse-events-Is-there-a-connection/

community it serves.[2] Loss of surgical services and their associated revenues can contribute to hospital closures which can be catastrophic to the local community.[3] **Primary care physicians cannot close this gap in rural surgery. Patients in need of care must therefore travel to a place with surgical capabilities, leading to delay in care and potentially suboptimal outcomes**. Patients transferred to safety net hospitals in another region or state, for example, may wait up to four days to be placed in a hospital room and undergo treatment in emergency departments which is neither patient centric, nor optimal for care.

In 2016, the Health Resources Services Administration (HRSA) issued an analysis entitled "National and Regional Supply and Demand for Surgical Specialty Practitioners: 2013-2025," recognizing the current and future workforce shortages facing surgical specialties.[4] However, it only breaches the surface. In the study, baseline demand for all surgical specialty practitioners was assumed to be equal to 2013 supply because no consistent national/regional data sources are available to estimate base year shortages or surpluses. Unfortunately, these data do not tell us if the supply of all surgical specialists nationwide is adequate to provide access to the surgical services demanded by the population today.

A shortage of general surgeons is a critical component of the crisis in health care workforce because surgeons are the only physicians who are uniquely trained and qualified to provide certain necessary, lifesaving procedures. Unlike other key providers of the community-based health care system, general surgeons do not currently have a formal workforce shortage area designation.

RFI Question #1: *What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional systems or factors outside of the health care industry that influence health outcomes within these communities?*

ACS Response: Nationally, disparities in surgical care are a combination of complex patient, social, and institutional factors. There are two main factors that adversely affect access in rural underserved areas: the availability of specific services and distance to needed medical care. The relative contributions of access and timeliness of surgical care and surgical evaluation to these disparities is not clear. Access to surgical care is affected by socioeconomic status, age, gender,

[2] https://digitalprairie.ok.gov/digital/collection/stgovpub/id/24192
[3] https://www.beckershospitalreview.com/finance/the-rural-hospital-closure-crisis-15-key-findings-and-trends.html
[4] https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/surgical-specialty-report.pdf

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level of education, race, ethnicity, health care availability, and geographic distance. While insurance status proves to be the most reliable surrogate for prediction of outcome differences, underuse, and delay of surgery, rural location and limited access to high volume hospitals are additional mechanisms that lead to inequities in surgical outcomes. Despite these factors, several studies have shown that where access to care is equal, outcome disparities become indiscernible[5]. Further, while excellent surgical care can be provided even in very small hospitals for common surgical procedures, the lack of a complete surgical team—anesthesia, nursing and technology— can prevent this from occurring. Given the complexity of health care disparities, the ACS believes that a multi-pronged approach to eliminate disparities in surgical care, from access to outcomes, is necessary.

RFI Question 2: *What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?*

ACS Response: To ensure demonstrable, positive impacts on health outcomes for rural and underserved communities, the ACS believes that systems and resources must be in place to ensure that patients receive the highest quality of care, regardless of where the patient is seeking treatment. To that end, the ACS supports facility and educational accreditation as well as verification programs for surgical knowledge. Improving the quality of surgical care leads to greater access for patients, fewer complications, and better outcomes.

Additionally, there is growing evidence that telemedicine services are valuable in rural and remote settings in several ways. Telemedicine brings some aspects of subspecialty care to locations that would otherwise be without. Technology limitations, but also intrastate licensing barriers, anti-self-referral laws and reimbursement roadblocks currently prevent more widespread application.

RFI Question 3: *What should the Committee consider with respect to patient volume adequacy in rural areas?*

ACS Response: Hospital closures affect both rural and larger size facilities and are leading to a severe access problem for the 60 million patients in rural

[5] Haider AH, Scott VK, Rehman KA, Velopulos C, Bentley JM, Cornwell EE, Al-Refaie W. Racial disparities in surgical care and outcomes in the United Sates: A comprehensive review of patient, provider and systemic factors. J Am Coll Surg. 2013;216(3):482-492.

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America.[6] Urban and tertiary facilities struggle to absorb these additional patients, resulting in longer transfer times and higher death rates. Urban and smaller facilities need to work together to determine which patients can be safely and effectively treated locally, and which patients need transfer to a larger facility.

Traumatic injuries, including those resulting from car crashes, falls, head injuries, burns, and firearm injuries, are the leading cause of death in America for those ages 44 and younger and account for more years of life lost and disability than any other disease process, including cancer and heart disease. Individuals who live in rural areas with limited access to trauma care face critical delays. Just 24 percent of those who live in rural areas have access to a Level I or II trauma center within the "golden hour" during which treatment has the greatest chance of preventing death, compared to 86 and 95 percent in suburban and urban areas respectively. Despite progress toward optimal trauma systems in the US, more work remains to be done to insure injured patients in rural areas receive quick and efficient care.[7]

ACS encourages the Task Force to review the 2016 report by the National Academies of Science, Engineering and Medicine (NASEM) which outlines 11 recommendations for completing a national trauma system. Federal leadership, cooperation between military and civilian health leaders, strong collaboration between states and a national trauma research plan will reduce unnecessary death and delay of care in rural areas.

RFI Question 4: *What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where — patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers? there is broader investment in primary care or public health? the cause is related to a lack of flexibility in health care delivery or payment?*

ACS Response: Community health centers and federally qualified health centers serve as an excellent means of increasing access for routine healthcare, preventive care and outpatient services but are not a surrogate for care of traumatic injuries and acute surgical illnesses. There is an inverse relationship between death rates from motor vehicle accidents and the distance from where the accidents occurred to designated trauma centers.[8] Acute surgical resuscitation and stabilization locally

[6] https://www.americanprogress.org/issues/healthcare/reports/2019/09/09/474001/rural-hospital-closures-reduce-access-emergency-care/
[7] https://www.facs.org/quality-programs/trauma/tqp/systems-programs/trauma-series
[8] https://www.reuters.com/article/us-health-rural-autos-crash/car-crash-death-rates-highest-in-remotest-rural-areas-idUSKBN1CA2EW

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saves lives in surgical emergencies, even if transfer is later necessary for definitive care.

Unfortunately, rural trauma patients are already at a disadvantage. Trauma patients in rural locations are typically older, more severely injured, and more likely to die at the scene than urban patients. The fatal crash rate is more than twice as high in rural than urban areas.[9]

Similarly, the loss of an obstetrical service line would have a very negative effect. A lack of access to maternal health care can result in negative maternal health outcomes including premature birth, low-birth weight, maternal mortality, and increased risk of postpartum depression. Using maternal mortality as one proxy for overall maternal health, there are 29.4 maternal deaths per 100,000 in the most rural areas versus 18.2 in urban areas. Many rural hospitals have eliminated their maternity service line because of financial losses. The consequences have been numerous reports of increased maternal and fetal complications and deaths due to the lack of local care in emergencies.[10]

RFI Question 5: *If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?*

ACS Response: The best example of a regional network of care is that utilized by the U.S. military to treat those wounded during conflict. Stabilizing treatment begins close to the battlefield in resource-limited facilities, and patients are rapidly transferred to higher-level, better-equipped facilities in the region. If appropriate they can then be transferred back to the U.S. Several states have statewide trauma systems in place with varying levels of trauma centers (Levels IV to I) coordinating care and facilitating appropriate transfer when needed. Other systems of coordinated care involve large affiliated regional healthcare systems involving both small and large facilities.

Most states and many large health systems have formed regional networks, many of which are designed to capture patients from a large area, for which the system provides various levels of care with a goal of performing complex, specialized care at the major urban centers. Examples of effective regional networks include the

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1730169/pdf/v011p00024.pdf
[10] https://www.dailyyonder.com/legislation-seeks-to-decrease-rural-maternal-deaths/2019/11/05/

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Gunderson Health System in Wisconsin, as well as similar regional based networks in North Dakota and Montana.

As noted above, where one resides often determines survivability following traumatic injury. Today, trauma systems are driven by individual state and regional requirements with considerable variability and often with lack of coordination across state lines. ACS would encourage the Task Force to support the recommendations from the 2016 NASEM report and develop minimum trauma system elements in every state and support programs to coordinate care across regions. In addition, support for universal adoption of quality programs such as the ACS Trauma Quality Improvement Program (TQIP) which are used to measure trauma outcomes and system performance, will support optimal system development and provide a platform to improve patient outcomes. Programs such as these would help to facilitate the creation of a national trauma system, connect trauma centers across the nation, and standardize a complex and varied approach.

RFI Question 6: *What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?*

ACS Response: Health systems with some success emphasize a two-way relationship between their major facilities and their rural providers. The systems provide education and quality programs, shared electronic medical records, and call coverage to assist their rural providers. Most importantly, the system addresses regulatory burdens which are especially difficult for the provider in a rural or underserved practice to navigate.

These models are successful in part because of collaboration between large urban centers and rural centers based on mutual respect and personal knowledge of the capabilities and issues in each location. In states and regions in which urban surgeons have direct interaction with small, rural hospitals rather than simply accepting transfers from unknown surgeons and hospitals of unknown capabilities there develops a culture of mutual understanding of the needs and services required for success. Interhospital and surgeon-to-surgeon collaboration is key. Uniformity of EMS services also aids significantly in success of these models. States with centralized, coordinated transport systems have more success than those which use ad hoc approaches to urgent transfer.

RFI Question 9: *There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are*

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needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

ACS Response: The ACS strongly believes that building a solid foundation of accurate and actionable data is critically necessary to better understand the surgical workforce and begin to identify and define general surgery shortage areas. Currently, there is no standard definition of what constitutes a "shortage" of general surgeons for a given population, nor is there a standard definition of "rural" in this same context. Since there is no federally accepted definition of a surgical shortage, projections reset each year, and assume that the then current ratio of surgeons to population is the appropriate baseline rather than tracking the decline and growing shortage over time. Having federal shortage data and a surgical shortage designation would identify affected areas and would facilitate planning for the needs of rural patients. Collecting data on general surgery shortage areas would provide the opportunity to ensure access to care for all surgical patients.

Accordingly, the periodic, repetitive collection and analysis of workforce data on both a regional and national basis should be a top priority. This should be undertaken in consultation with relevant stakeholders to ensure accuracy of the data collected and its subsequent analysis. Data collection is necessary in order to better understand health care workforce supply and distribution and to project workforce demands for the future.

The ACS strongly supports the *Ensuring Access to General Surgery Act* (H.R. 1841/S. 2859), sponsored by Representatives Ami Beri, MD (D-CA), Larry Bucshon, MD, FACS (R-IN), Scott Peters (D-CA), and Markwayne Mullin (R-OK) and Senators Brian Schatz (D-HI) and John Barrasso, MD (R-WY), which would: direct the Secretary of the Department of Health and Human Services (HHS) to conduct a study to define a general surgery workforce shortage area; collect data on the adequacy of access to surgical services; and grant the Secretary the authority to provide a general surgery shortage area designation. Identifying communities with workforce shortages is critical in guaranteeing all patients have access to quality surgical care, regardless of geographic location. Establishing what constitutes and defines a surgical shortage area is an important first step in achieving this goal.

RFI Question 10: *Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?*

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ACS Response: ACS accreditation and verification programs such as the Surgical Quality Verification Program (SQVP), ACS Trauma, Bariatric, and/or Commission on Cancer accreditation can play an important role in promoting quality and patient safety. Verification programs pursue excellence and avoid system errors by ensuring that the resources, staff, and infrastructure are in place to provide the highest possible quality care to the patient. Patients benefit from this by knowing that for their condition or disease all necessary structural and process elements are aligned in a culture of continuous quality improvement throughout the care enterprise. The focus of care becomes team-based, patient-centered, and aims at improving outcomes that matter to patients. While relatively modest, the cost associated with participating in these programs can be burdensome for some rural facilities such as Critical Access Hospitals (CAH). Permitting expenses related to verification programs to be included on CAH cost reports would allow more of these facilities to participate, and thereby improve patient safety and quality.

Concluding Remarks

Access issues and a shortage of general and trauma surgeons, along with a loss of obstetrics service lines contribute to the growing crisis in access to health care in rural areas. Surgeons play a pivotal role along with other providers in the community-based health care system, but unlike primary care and mental health care, surgical care is lacking a formal shortage area designation.

The ACS appreciates the opportunity to respond to the Task Force's Request for Information and remains dedicated to working with Congress to address the challenges faced in rural and underserved communities. Please contact Amelia Suermann in the ACS Division of Advocacy and Health Policy at asuermann@facs.org if you have any questions or need additional information.

Sincerely,

David B. Hoyt

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Executive Director

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