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November 29, 2019

The Honorable Richard Neal
Chairman
House Ways & Means Committee

The Honorable Kevin Brady
Ranking Member
House Ways & Means Committee

Re: Rural and Underserved Communities Health Task Force Request for Information

Dear Chairman Neal and Ranking Member Brady:

Founded in 1897, the American Gastroenterological Association (AGA) is the trusted voice of the gastroenterology community that has grown to include more than 16,000 members from around the globe who are involved in all aspects of the science, practice and advancement of gastroenterology. AGA appreciates the opportunity to provide comments on the Rural and Underserved Communities Health Task Force's request for information on priority topics that affect health status and outcomes for rural and underserved communities.

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?

Workforce shortages

For gastroenterology and other specialties, one of the main health care-related factors that influence patient outcomes in rural areas are workforce shortages. A 2014 study[1] on physician shortages impact on colorectal cancer care found that the number of gastroenterologists per 100,000 people has significant variation between rural (.39) and urban (2.55) U.S. counties and this variation is correlated with an increase in colorectal cancer mortality rates in rural counties.

[1] Aboagye, J. K., Kaiser, H. E., & Hayanga, A. J. (2014). Rural-urban differences in access to specialist providers of colorectal cancer care in the United States: a physician workforce issue. *JAMA surgery*, *149*(6), 537-543.

Furthermore, there is a shortage of healthcare professionals with specialized training to deliver clinical care. This workforce shortage impedes patients access to clinically appropriate treatments, procedures and diagnostic testing and ultimately leads to higher negative health outcomes.

Variability in access and outcomes

With workforce shortages, there is also marked variability in access and quality of screening colonoscopy. In areas like rural South Dakota, most patients undergo colonoscopies in small critical access hospitals where a general surgeon or primary care physician with little GI specialized training is performing the procedure. Only 10 percent of screening colonoscopy in South Dakota is performed by a board-certified gastroenterologist. The results of screening colonoscopies in critical access hospitals vary and quality reporting on the outcomes is inadequate. The same can be said for other rural areas across the U.S. In Maryland, rural area patients are not receiving standard of care diagnostic testing, such as pH monitoring and high-resolution manometry. There is also constant need for coverage at rural area hospitals for advanced endoscopy and basic therapeutic procedures like ERCP. From these challenges comes delays in diagnosis, treatment and potential harm from misdiagnosis and inappropriate treatment.

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?

Social determinants of health

Transportation plays a large role in patient access and outcomes. Some of our members indicated that they are the only GI practice offering advanced endoscopic procedures in over a 100-mile radius. When traveling great distances, many patients are unable to secure reliable transportation or have the financial means for other transportation methods. To remove this barrier, community-based and public-sponsored transportation programs have been successful in giving patients more flexibility in scheduling appointments and receiving timely care.

Use of telehealth/telemedicine/telemonitoring

Telemedicine services have assisted in alleviating some of the access issues to specialized care. For rural health centers and critical access hospitals, telemedicine is used for second opinion consultations, chart review or videoconferencing. However, according to the Federal Communications Commission (FCC), 34 million Americans still lack access to adequate broadband. Many of these are located in rural areas. Without reliable high-speed internet, patients are unable to communicate with a healthcare provider via telemedicine. As a remedy, some patients drive to their local health care facility to obtain access to telemedicine options. FCC is in the process of developing the Connected Care Pilot Program to support the delivery of advanced telehealth services to low-income Americans, especially those in rural areas.

Moving forward, greater incentives for expanding technology infrastructure as well as improvements in reimbursement for remote consultation are necessary to ensure the adoption and development of advanced telehealth programs.

What should the Committee consider with respect to patient volume adequacy in rural areas?

In certain regions, low population density has led to hospitals scaling back to cover high fixed operating costs. For specialists, like GIs, this translates into a reduction in the dedicated number of physicians and support staff at the facility. This in turn creates an imbalance in the specialty physician-patient ratio and leads to shortages, access issues and worsening health care outcomes. Furthermore, even if there was enough population density to support bringing on an additional physician, there is such a broad shortage of GI's across the US, that recruitment efforts in rural areas are failing.

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?

Hospitals and physician practices in rural areas have begun to establish partnerships with rural health systems to utilize telemedicine. Physicians in rural Georgia cite that partnerships exist between their hospital and rural health systems to adopt telemedicine but has had some hardships in establishing a formal process that would alleviate some of the patient volume issues that currently exist. Specifically, physicians have cited a lack of manpower to further establish an official telemedicine protocol that is just as effective as in-person consults.

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

Telemedicine

Expansion of telemedicine has offset workforce shortages as it expands access to services that may not otherwise be sustained locally due to provider recruitment/retention difficulties, low patient volume, or inadequate local resources. Among rural Medicare beneficiaries, the number of telehealth visits increased from 7,015 in 2004 to 107,955 in 2013[2] and continues to rise. However, the following barriers still restrict the widespread use of telemedicine: regulatory restrictions on Medicare coverage and reimbursement of telehealth services; lack of adequate broadband connectivity; state licensure hurdles for practitioners; and high cost of acquiring and maintaining necessary equipment.[3]

Healthcare practitioners

Nurse practitioners and physician assistants have increased their role to help address rural workforce shortages but are also susceptible to downsizing and need to more specialized training in GI to ensure the delivery of quality patient care.

Government programs and incentives

[2] Mehrotra A, Jena AB, Busch AB, Busch B. J., Souza J., Uscher-Pines L., Landon E. B. (2016 May 10). Utilization of telemedicine among rural Medicare beneficiaries. JAMA. Retrieved from: https://doi.org/10.1001/jama.2016.2186

[3] American Hospital Association. (2018 April). Fact Sheet: Telehealth. Retrieved from: https://www.aha.org/system/files/2018-04/fact-sheettelehealth-2018.pdf

Offering incentives for specialty providers to practice in rural areas such as loan forgiveness and increased salaries have in the past been strategies to help recruit expertise but have not been as effective in recent years in recruiting enough highly specialized gastroenterologists to meet the need across all rural areas.

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?

Quality reporting

As rural healthcare facilities, like critical access hospitals operate with workforce shortages, it is necessary to ensure that quality care is still being delivered to patients, especially with non-specialized physicians performing procedures outside of their scope. AGA recommends creating a reporting mechanism for low-volume, critical access facilities to disclose specialty care procedural outcomes to monitor quality of clinical care.

Reimbursement

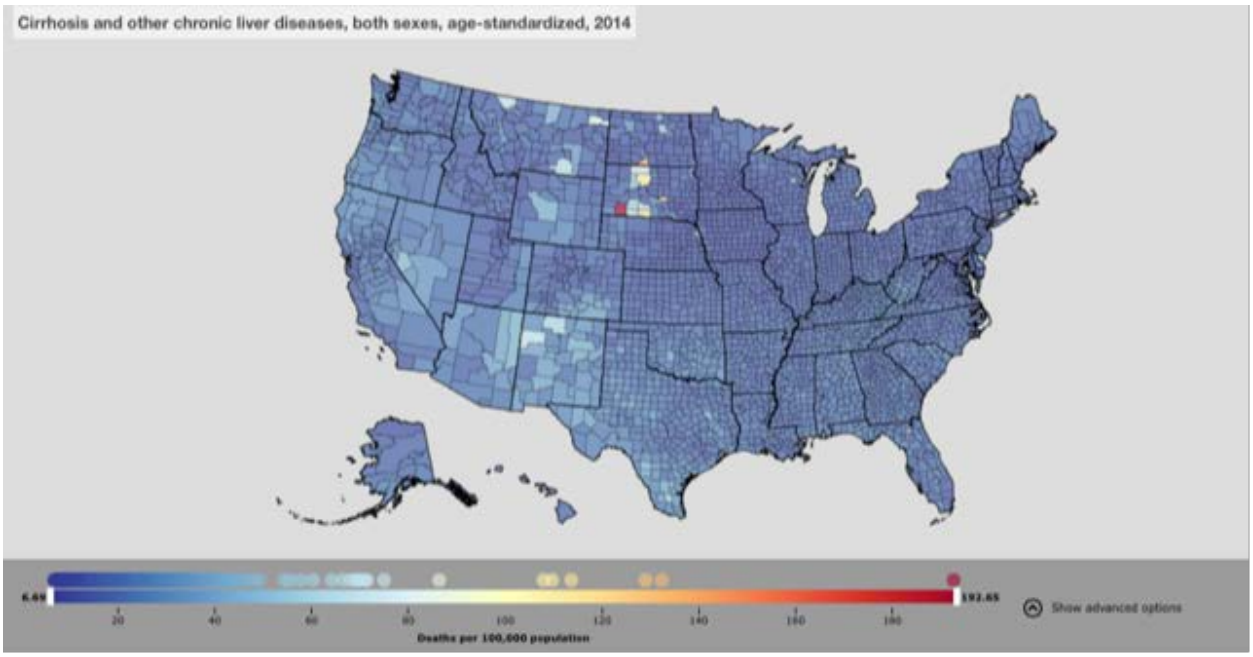
Reimbursement for telemedicine services and advance endoscopic services is inaccurate and serves as a barrier to addressing workforce shortages. Misvalued professional reimbursement rates based on time, training, and effort of the advanced endoscopist has led to a greater deficit in the recruitment of GI's with specialized training to provide the appropriate clinical care.

While Medicare has increased its coverage of telemedicine services in rural areas, statutory and regulatory restrictions on how Medicare covers and pays for telehealth still prevent further adoption and growth on this workforce shortage and patient access remedy.

Preventative care to at-risk populations

To address systemic substance abuse disorders for at-risk populations in rural communities, there needs to be adequate capacity for inpatient treatment of alcoholism and other substance abuse disorders. The resources available to effectively intervene and identify early signs of disorders have been unsuccessful.

Based on physician input, the heat map below displays the incidence of cirrhosis and chronic liver disease across the U.S. In red is Shannon County, where most of the Pine Ridge Indian Reservation lies. Surrounding regional hospitals in the area admit young patients with acute alcoholic hepatitis daily, many of whom will die within the next few years from alcoholic liver disease. Due to the lack of preventative and screening resources coupled with the inadequate capacity to provide treatment for this growing at-risk population, patients in Shannon County and other rural areas with high incidences of substance disorders will continue to observe worsening health care outcomes.



Thank you for the opportunity to provide comments on the Rural and Underserved Communities Health Task Force request for information. If we may provide any additional information, please contact Megan Tweed, Director of Government Affairs at 301.272.1607 or mtweed@gastro.org.

Sincerely,

Hashem B. El-Serag, MD, MPH, AGAF

President