THE AMERICAN HEALTH QUALITY ASSOCIATION
7918 Jones Branch Drive
Suite 300
McLean, VA
www.ahqa.org

The Honorable Danny Davis
Co-Chair, Rural and Underserved Communities Health Task Force
Committee on Ways and Means
U.S. House of Representatives
2159 Rayburn HOB
Washington D.C. 20515

The Honorable Terri Sewell
Co-Chair, Rural and Underserved Communities Health Task Force
Committee on Ways and Means
U.S. House of Representatives
2201 Rayburn HOB
Washington, D.C. 20515

The Honorable Brad Wenstrup
Co-Chair, Rural and Underserved Communities Health Task Force
Committee on Ways & Means
U.S. House of Representatives
2419 Rayburn HOB
Washington D.C. 20515

The Honorable Jodey Arrington
Co-Chair, Rural and Underserved Communities Health Task Force
Committee on Ways and Means
U.S. House of Representatives
1029 Longworth HOB
Washington, D.C. 20515

November 29, 2019

Dear Representative Davis, Representative Sewell, Representative Wenstrup, and Representative Arrington,

Thank you for the opportunity to respond to the House Ways and Means Committee's Rural and Underserved Communities Health Task Force Request for Information soliciting input on priority topics that affect health status and outcomes in these communities.

Our organization, the American Health Quality Association (AHQA), represents Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) and their quality improvement organizational partners operating throughout the United States, Puerto Rico, and the Virgin Islands, to make health care better, safer, and available at a lower cost. All of our members serve communities in rural and underserved areas.

As Medicare-funded organizations charged with working with providers, beneficiaries, families, and stakeholders to improve quality for our nation's seniors across the continuum of care, QIN-QIOs are keenly interested in improving quality, access, and delivery of care in rural and underserved communities.

Below are our comments for each of the questions outlined in the Task Force's Request for Information:

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Access/ hours, cost and coverage, provider recruitment and retention, health service provider shortage areas.

Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

There are a number of compounding factors that influence patient outcomes in rural areas associated with the healthcare system. A large issue in rural communities is provider recruitment and retention. There have been significant healthcare staffing shortages and turnover. This leads many healthcare organizations to try to staff with locum providers or agency staffing, which increases costs. In addition, these providers do not know the patients or the community, which can often lead to decreased patient satisfaction and outcomes. Across settings there continue to be closures, including critical access hospitals, home health agencies, and nursing homes. This creates challenges for patients who no longer have access to services in their own community and must travel great distances to seek care. If there are healthcare services available in a community, patients still often face barriers to access due to hours, cost and healthcare coverage.

Additionally, social determinants of health (SDOH) are a leading factor in poor health outcomes of patients living in rural communities. There has been a lack of standardization and screening to identify and address social determinants of health. Patients have difficulty managing their health conditions when their most basic needs are not being met such as food, housing, medications, and transportation. The QIN-QIOs supported many community interventions to address these SDOHs. However, most were volunteer based or lacked payment/reimbursement for sustainability.

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?

We offer the following suggestions for successful models and criteria that will be necessary for any model to succeed:

- Successful models will need to include initiatives that allow aging in place, which requires a selection of resources and services. These might include volunteer ride transportation, food programs, workforce development, including community health workers and behavioral health technicians.
- Most importantly, these initiatives need consistent reimbursement mechanisms.
- Additionally, programs that increase hospital reimbursement for low-wage hospitals to assist with reimbursement and workforce recruitment could be successful.
- Legislation allowing providers to work at the top of their license is needed to stretch the limited provider resources.
- Connecting the public to more to school-based clinics and other community organizations in rural areas.
- Expanded coverage of services and technologies, assistance with start-up costs of telehealth, coverage of providing telehealth at the patient's site of care, including the home.

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

Rural providers may not be able to obtain statistically reliable results for some performance measures without meeting certain case thresholds, making it difficult to identify areas of success or areas for improvement. Quality programs require reporting measures that are not relevant to the low-volume, rural context. A new model of care would be the establishment of an emergency medical center designation under the Medicare program for rural hospitals. This designation would allow existing facilities to meet a community's need for emergency and outpatient services without having to provide inpatient services. In addition to having emergency services, communities would have the flexibility to align additional outpatient and post-acute services with local needs and receive enhanced reimbursement. Policymakers should protect access to care in rural areas by providing relief from outdated/unnecessary regulations. Surveyors should be provided guidance related to rural-specific circumstances, including low patient volume and limited capacity. CMS also enforces a policy for CAHs and small (i.e., fewer than 100 beds) rural hospitals, requiring "direct supervision" for all outpatient therapeutic services (with some exceptions). This policy requires that a physician be immediately available for even the lowest risk outpatient therapeutic services, such as the application of a splint to a finger. Without adequate numbers of health professionals in rural communities to provide direct supervision, some hospitals may limit their hours of operation or reduce services due to their inability to meet this requirement.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where –

a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?

b. there is broader investment in primary care or public health?

c. the cause is related to a lack of flexibility in health care delivery or payment?

Rural/underserved acute care (inpatient) beds are difficult to maintain with low volumes. The growth of outpatient, prevention, and wellness services will continue to impact acute volumes even in more populated areas. Traditional hospitals have high fixed costs due to minimum staffing requirements and are not sustainable in rural/underserved areas. Additionally, continued reliance on acute models will not prepare communities/providers for future payment incentives. However, any reductions in service lines must be part of a larger community needs assessment about essential services and the ability to meet expected standards of care rather than a standardized approach to care delivery. While some services are duplicated between hospitals and RHCs/FQHCs, not all services currently provided to rural/underserved communities can be replaced by an RHC/FQHC as rural hospitals see more than 21.5 million emergency visits annually. Rural communities are seeing patients seek complex/specialty care outside their local communities, but they continue to expect local access to emergency and primary health services. Current reimbursement models only support the two extremes; primary/ambulatory care or a full-service hospital. Alternative payment models that support the delivery of urgent/emergency care, transportation services, transitional care, outpatient and ambulatory services, and leverage mid-levels and/or telemedicine are needed. Lessons gleaned from QIO experience supporting rural and underserved communities include:

- emergency/transitional/transportation/diagnostic services (i.e. community defined core services) need to be maintained to support rural populations; shift focus from inpatient to outpatient/primary/emergency care
- payment models need to support new models of care, including combination of fixed/global payments versus volume-based FFS payments

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?

Critical Access Hospital (CAH) networks were originally structured to leverage resources and support from tertiary hospitals. In Kansas and Montana, these networks worked to increase broadband access and upgraded telemedicine technology, but payment methodologies never caught up. Those CAH networks now primarily provide networking/education support, and some clinical improvement support. Local services need to be a gateway to a larger health delivery system to be sustainable. Collaboration and affiliation will be essential as small/resource constrained markets cannot sustain all health services without significant financial support. There are barriers keeping such organizations from implementing telemedicine systems. Distance, isolation, and constricted resources are the most common barriers. The cost of health IT to support regional networks of care can be intimidating, making

it one of the most common barriers. Providing physicians with access to reliable broadband connectivity is also key to ensuring a telemedicine program is utilized to its fullest potential. Health care professionals must feel confident in the care they can provide, with a reliable connection.

Some locales are already successfully testing models. The University of Vermont Health Network Critical Care Transport services, known as "Healthnet", provides rapid access to tertiary care and units are positioned strategically to provide optimal geographic coverage across Vermont. Carle Foundation Hospital is an integrated, not-for-profit regional health care provider that supports many CAH and regional hospitals throughout east-central Illinois. Avera eCare is a telemedicine network supporting providers across multiple states. These are examples of successful system/network models, but some reimbursement challenges prevent further proliferation.

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

Addressing healthcare workforce challenges continues to cause critical concern for our rural communities. We would like to highlight a few programs that are proving to be effective in this area. One such program is the Community Paramedicine Program (CP), which has been implemented in several states. The focus is to teach patients early in their illness/injury to seek care, reduce unnecessary transports, conserve emergency resources, and take advantage of rural EMS providers. Maine noted that in addition to the success of the program, they forged stronger relationships in their community along with a referral process for patients and primary care providers. Another proven model that is addressing the reality of workforce shortage is that of the Community Health Worker Program (CHW), which has also been implemented in several states. The CHW program engages CHWs to work alongside health professionals to provide information and support to community members of various socioeconomic backgrounds. New Hampshire noted that their CHW program added additional community support around focused education for target populations and/or health conditions that often present challenges in the primary care setting. There is a real urgency to test models and programs that will positively impact these shortages as we forecast the retirement of baby boomer physicians and health professionals. We recommend further review of the CP and CHW programs as potential solutions to improve community relationships and resources through further development of these models in an effort to address the rural workforce in rural and underserved areas.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

The QIN-QIOs provided technical assistance and resources to reduce adverse drug events due to opioid medications such as overdose and deaths. They recently conducted environmental

scans across rural communities to determine current initiatives and challenges surrounding improved access to behavioral health and substance use treatment. By providing office-based medication assisted treatment in primary care settings, patients can access lifesaving opioid use disorder treatment in their communities eliminating many of the access barriers. The continued challenge is provider volume to meet the patient demand due to panel limits. There needs to be continued training and support to providers to increase the number of buprenorphine prescribers to meet this need. Additionally, care coordination across agencies can be difficult with 42CFR limitations and reforms would help providers to better coordinate and care for patients.

8. The availability of post-acute care and long-term services and supports is limited across the nation but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

Often, when a patient is discharged from a hospital, they are not fully ready to return home and resume daily activities. The need for post-acute care and long-term service support is high while the available resources to fulfil the demand is low in our rural communities due to workforce shortages, lack of funding for transition programs, and the inability to bill for certain services that would benefit post-discharge patients. To address this gap in care delivery, we once again highlight the recommendation and potential to enhance the Community Health Worker Program (CHW). They deliver value to the community by serving as a conduit between the patient and health care team during transition of care processes. CHWs have a proven record in better understanding multicultural populations, gaining trust in the community, and providing the next level of care delivery to assist patients with chronic or disabling conditions. Patient safety, reducing avoidable readmissions, and increasing overall community engagement are all issues at the forefront of improving healthcare. The CHW program demonstrates how to effectively impact these areas and improve social isolation. However, with limited funding and/or reimbursement from Medicaid and Medicare, the programs are challenged with further development and sustainability. Delivering home health services, phone calls etc. is currently cost-prohibitive in rural and frontier areas. We strongly encourage further consideration and review of the CHW program as post-discharge processes heavily impact a successful transition of care for patients and provide the best possible outcome for both patient and doctor.

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

Currently, it is optional to include most of the SDOH codes in electronic health records, so there is a need to partner with top EHR vendors to make that standard or at least make the process of adding them easier and less costly. Especially if you're talking about small rural and medically

underserved practices. Many of these are still on paper. Many specialists and independent providers are also still using paper.

Additionally, data definitions and the need to suppress are a problem because with such a small patient volume in rural areas, there are not enough numbers making up the numerator and therefore not enough to be able to make good decisions. We have some models to measure medical complexity, but not social complexity. We need to move towards incentivizing or mandating the collection of social complexity data, like SES, deprivation. The option of race used to be optional and now its mandatory; we need to move in that direction with other SDOH elements. Data elements that are needed to help identify causes of health disparities in rural and underserved population besides what we might typically see in an electronic health record are school ratings by zip code, uniform screening on access to nutritious foods, uniform screens for safe housing, transportation, health insurance, clean water, and air quality screening in homes.

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?

There needs to be measure harmonization across all payers to create uniformity and eliminate opposing objectives. This would also reduce burden on providers because currently measures are based on the different payer contracts. In Rhode Island, the state works with providers to harmonize the data sets so providers can work on shared data platform across the state to operate like a regional network of care. Additionally, multiplayer initiatives need to include paying for uniform services for SDOH across each state. It is also critical that we move towards outcome-based measures and an emphasis on patient satisfaction like the latest alternative payment models, such as the direct contracting model by CMS that focusses on chronic disease, seriously ill population, and primary care capitation. These payment models need to continue to offer an increasing flexibility for providers in rural communities in order to participate.

We thank the Task Force for the opportunity to comment on rural health and the strategies to address the challenges that contribute to health inequities in rural and frontier areas. We stand ready to provide additional information and assist in implementation of state-of-the-art quality measurement and improvement initiatives to ensure quality in these underserved areas.

Sincerely,

Alison Teitelbaum, MS, MPH, CAE
Executive Director