



House Committee on Ways and Means
Rural and Underserved Communities Health Task Force
Request for Information

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Submitted Via Email Rural_Urban@mail.house.gov

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The Big Cities Health Coalition (BCHC) is a forum for the leaders of America's largest metropolitan health departments to exchange strategies and jointly address issues to promote and protect the health and safety of the nearly 62 million people they serve.

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WASHINGTON, D.C.

The Big Cities Health Coalition (BCHC) is pleased to submit the following in response to the House Ways and Means Rural and Underserved Communities Health Task Force Request for Information. BCHC is a forum for the leaders of America's largest metropolitan health departments to exchange strategies and jointly address issues to promote and protect the health and safety of the nearly 62 million people they serve.

We appreciate the inclusion and acknowledgment that "underserved" does not always mean "rural." While rural locations are underserved in ways dictated by geography, urban areas are often underserved due to challenges around racial and ethnic diversity and disparities, and an assumption that cities have all the resources they need. In fact, residents in many of our BCHC communities suffer from a lack of access to healthy food and not enough *safe* places for them and their children to be outside on a regular basis, not to mention long standing substance use disorders that started long before the current opioid epidemic. Many of these challenges need to be addressed with different policy levers than are currently being implemented.

Below we primarily share answers to those questions that address the public's health and prevention, as this is our focus. Thank you for the opportunity to share this information on our members' behalf. Please do not hesitate to reach out to Chrissie Juliano, Executive Director, with questions (Juliano@bigcitieshealth.org or 301-664-2989).

Q 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?

So much of what affects our health happens outside the four walls of a doctor's office. While the provision of clinical health services are an important factor impacting health outcomes, governmental public health departments work each day to create the environment and systems that allow residents in a community to get and stay health and safe. They focus on prevention – helping to provide vaccines, for example, for those most in need – but also thinking about how to help the entire community through access to healthy food and safe, well lit parks and recreation centers, as well policies that might affect active living as it relates to transportation and commuting to and from work or school. In short, all of those factors outside the clinical setting are what public health practitioners focus on and are the things that *most* address health outcomes.

Q 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?

Because of gaps in care delivery, particularly as it relates to substance use needs, as well as sexually transmitted diseases, governmental public health departments are often "gap fillers" or safety net providers. Being deeply rooted in the community, they know, for example, that many of their residents who are experiencing homelessness aren't going to leave their belongings to travel to a clinic.

Our member cities work incredibly hard to meet residents in need where they are sometimes using mobile vans or public health nurses or other health department staff, sending them into the community. This is incredibly resource intensive, and it can sometimes be difficult to get such services reimbursed if they don't occur in a formal clinic. Our members, however, have found that these are some of the best approaches to addressing those most in need.

Q 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?

Local data, i.e. at the city level, is incredibly hard to gather and find. It is resource intensive and often forgotten about. Having key health data available at the level of political jurisdictions is incredibly important to give local elected leaders information about their population. This is a shift in how we think about data, which are primarily available at the state and county level.

Data need to be able to be disaggregated to look at local jurisdictions, but definitions also need to be consistent at the national, state, and local levels so that comparisons can be made, and disparities better addressed.

One area where this has been particularly problematic is in how opioid overdoses (ODs) are captured – and by whom (i.e. a medical examiner and/or an epidemiologist). Further, building upon such uniform definitions, the next level would be to start to capture “near misses” of ODs to work to prevent them from occurring in the first place. Given the level of epidemic we have now, we need to do more to address the factors that lead to substance use and misuse.

Q 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?

Most important in thinking about next steps in addressing underserved communities is the importance of supporting prevention, not just response or care. It is far more efficient to prevent disease or addiction or homelessness than to treat or respond to it. It is also important to identify who in a community can and should be funded to address these challenges. Finally, all too often federal requirements dictate how a certain provider can be reimbursed and/or who that provider should be. Innovation – such as mobile vans to treat people experiencing homelessness – should be rewarded and mobile care should be reimbursed at the level as if that person walked into a clinic. Helping underserved or hard to reach communities demands thinking outside the box and the flexibility to make such innovation successful.