



CHHS
Community Hospitality Healthcare Services

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Rural and Underserved Communities Health Task Force Request for Information

My name is Ben Cirka, I am the founder and Executive Director of Community Hospitality Healthcare Services (CHHS), a national business that focuses exclusively on investing in healthcare businesses in rural and underserved communities nationwide. Our business model was my practicum at Johns Hopkins University and developed to overcome health disparities and access to capital issues experienced by businesses serving these communities. We have a very unique perspective on these issues, as we literally travel throughout the entire country visiting the most severely distressed rural and urban communities that have the most acute health access and service issues, and see common reimbursement, oversight, and planning shortfalls and opportunities in many different states. We are very passionate about our mission of service and offer any additional resources that you may require as you tackle these issues of severe importance. Over the past seven years we have invested in over \$1 Billion in healthcare businesses in rural and severely distressed communities and have yet to have a loss or default. We have offices in Florida and Baltimore, and I am regularly in Washington and would be happy to be involved as I am passionately devoted to these issues. I may be reached at (941)662-0139 or bcirka@communityhealthcde.com and look forward to your leadership and progress. Our responses follow, and although we have taken great pains to keep within the limits provided, we are pleased to add greater insight as needed in the future, along with some additional questions that you may consider asking:

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?

The main factors that influence patient and health outcomes in rural and underserved communities are the availability and access to modern healthcare facilities, trained medical personnel, and trusted guidance and programming regarding lifestyle (nutritional, exercise, and preventative health practices) regimen that includes coordination of resources, outcome tracking, and accountability. The main obstacle is access to capital for investments that address each of these factors on a sustainable basis, not simply increases in ongoing revenue or reimbursements for existing services and outdated infrastructure. In short, investment now in facilities and technology that effectively coordinates resources; and preventative care and wellness programming will

create long-term operating efficiencies, healthier and better informed individuals, families, and communities. We have seen nearly every capital structure and source under the sun, and have found the New Markets Tax Credit to be extremely effective for a multitude of reasons. The New Market program offers a shallow subsidy to cover financing gaps. The sponsorship of investments are required to source additional capital from philanthropic or market commercial sources for the projects, which encourages vetting of the project by experienced underwriters and investors that focus on verifying the need and sustainability for/of the investment, which are both critical aspects when considering efficacy and efficiency of capital outlay.

Finally, the state needs the data, period. We should know what we are paying for and cannot legislate in the dark. We also need better coordination of services and resources to plan prospectively for investments, and efficiency.

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 have seen some very promising and successful programs such as Pathways Community HUB and Care Transitions Interventions. These are two proven, evidence-based models that deliver on determinants of health matters including transportation, housing instability, food insecurity, multiple chronic conditions, and broadband access, and could be expanded to include telehealth and telemonitoring business models.

The models create Community-Clinical linkages to better serve patients and clients and are enabled through Community HUBs, an integrated network of community agencies and community health workers/coordinators delivering community-based care coordination, beyond the clinical walls but still technologically-linked as care team members with provider involvement. Telehealth may also be beneficially integrated with Community HUBs as the coordinators deliver community-based care coordination and risk reduction for patients/clients.

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

The committee should strongly consider investment in technology that allows for coordination of resources and meaningful data collection. Such technology enables enhanced communication by a wider group of stakeholders to identify needs and efficiently coordinate service delivery. This reduces duplication, adds efficiencies, and provides better health outcomes. Most importantly, having access to relevant data is

critical for state and federal oversight and legislation. On the data side, we (the state) need to see exactly what is being spent for what, and be able to get to a place where we can conduct real long-term planning of healthcare infrastructure investments.

In the short term, reduction in red tape around pharmaceutical prescriptions and fulfillment should be pursued along with installation of a “health curriculum” that provides access roadmap, practical nutritional and exercise guidelines and strategies, and encourages accountability through participation and cost sharing/reductions that make their way to the state and consumers.

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?

a. FQHCs work very well as a low-cost setting and are inherently accountable to their communities through their structural requirements. Many rural and critical access hospitals are equally committed and accountable, but both could be better wired into local, regional, state, and federal resources through better (and existing) data and care coordination technologies. Any such hospital eliminations often create efficiencies by reducing costly overhead, and can increase clinical outcomes by having fewer, more focused specialty service practices. As you will hear, communities generally abhor hospital closures but they often lead to efficiencies or opportunities to consolidate some local practices into a more efficient/updated regional practice (current example In Rochester, NY).

b. When looking at service line reductions or eliminations, considerations must be undertaken to identify which base level services are critical and necessary, which can be expanded upon via technology, and what types of low-cost preventative programming may be readily adopted. Efforts should also be taken to avoid and reverse perverse incentives that exist in certain reimbursement systems that incentivize resources and services to shift away from areas of need into geographies and communities that are simply more profitable. In many cases this involves recruitment and retention of doctors (discussed below). We believe that some such eliminations are warranted, especially when there has been a broader investment in public health, and adequate need and resource planning.

c. Lack of flexibility in healthcare delivery and payment can largely (and efficiently) be overcome through proper investment. Many rural and underserved areas are operating hospitals or buildings that are 40 or 50 years old (or more) and were designed during times when physicians practiced medicine differently, solely as hospital employees.

These structures are obsolete and now have a hard time recruiting doctors. In many cases the needed fix is simply to fund construction of a medical office building. The newer, more efficient space is a relatively inexpensive proposition to attract and retain talent and offers the hospital operator flexibility in letting physicians maintain their own independent practice while also serving in the hospital. In many rural areas these new facilities (properly scaled and designed) are viable as there is adequate need and revenue opportunity but proper capital investment is needed (i.e. the New Market Tax Credit). Example in Spruce Pine, N.C.

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?

Sustainability for community-based care coordination is a challenge. We feel it may be solved by adopting value-based payment contracts with Community HUBs that provide community-based care coordination. Capitated or fee-for service contracts minimize care-coordination. Contracts with Community HUBs and value/performance based payment should be strongly considered and explored.

The Community HUBs network and unite highly-fragmented, community service organizations and healthcare systems to streamline and develop community-clinical linkages. Together, they identify and develop care resources and policy based on real-time community needs data collected by care coordination. The HUBs network is connected technologically with the healthcare system and health information exchanges, insurance companies, and local and state government to provide better health for the populations, reduction in healthcare costs, and faster, data-driven decision and policy-making. The best and most promising service provider that we have seen with respect to managing community health and population data and resource coordination among various agencies and parties has been Care Coordination Systems.

States such as Ohio and Texas both have Community HUB initiatives. Ohio has 10 HUBs, regionally distributed. Texas has one innovative and expansive Community HUB in San Antonio. Both have strong community health worker resources. Both have been able to establish value-based payment/performance contracts on a limited-basis with payers and providers. Both are able to show very strong results in their initiatives.

Washington State created has nine accountable community of health regions serving the entire state (islands, rural, semi-rural, suburban and urban). Telehealth initiatives have been planned but not implemented.

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

Many rural areas (especially critical access hospitals) operate very old and physically obsolete facilities that were designed in an era when the doctors were simply hospital employees that showed up and performed their work. In today's world, doctors are willing to perform at hospitals but need space to also run their private practice. We have seen multiple rural projects dramatically overcome recruiting challenges by simply building a low-cost medical office building. Again, capital from New Markets Tax Credit has been extremely valuable to allow an existing facility with very narrow margins create long term value, increase capacity and overcome hiring and operating budget challenges with relatively shallow and small federal subsidy. Also, we have seen examples of extremely rural health centers overcome what they knew was to be their biggest challenge of recruitment up-front by using a top design-build firm to build a state-of-the-art medical facility with great aesthetics. The added cost for the initial build was very small considering the levels of top talent that they have been able to recruit into their town. Good example in Othello, WA—is now considered one of the best family health centers on the West Coast and doing well financially.

Additionally, greater efforts should be undertaken to recruit college students from these communities who are willing to come back to work within them (we also see outcome efficiencies where this is achieved). We would also recommend work incentives such as tuition reimbursement for medical school for Doctors who make commitments to serve in these 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?

We have worked with several rural communities to address these issues effectively using New Markets Tax Credits for new community health facilities. This is very efficient use of capital, and creates long-term savings within the overall system. One example was the Peace River Medical Center in Polk County, FL that was actually led by the somewhat famous Sheriff Grady Judd who realized that he had a crisis on his hands with mental health and substance abuse issues, and the local center constantly beyond its licensed capacity. Another example was the recently opened Comprehend Health Facility in rural Maysville, KY (recently visited by Rand Paul), which has been one of the epicenters of the opioid crisis. Both are critical to their communities, and both were funded utilizing New Markets Tax Credits. We have invested in many such rural and underserved markets and projects and can provide additional detail or examples. As far as gaps, traveling doctors for routine care can be very effective. Examples include

Family Health Centers of SW Florida who provide a variety of mobile health services to schools and populations with barriers to transportation, and doctors and dentists in AK.

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?

The Health HUB model implemented by Care Coordination Systems has been effective and is promising as it can recruit and incorporate individuals from any organization (churches, Meals on Wheels, etc.) to be referral sources for medical, social, and transportation services for individuals that may otherwise “fall through the cracks” and engage them into the broader network of services and activities while maximizing efficiency, follow-ups, and choosing lowest-cost programming. From a standpoint of long-term care, health HUBs also allow for less institutionalization and more aging at-home with community health worker visits, transportation coordination and case management. The local community members themselves can be resources within such a system providing visitation, food and library deliveries, etc. Community Health Centers have done an excellent job of getting at oral health issues, and the “Greenhouses” model of long-term care has been a very successful alternative to nursing homes.

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?

Standard data is available but needs to be adopted for the social determinants of health--specifically those that identify social health risks in a community for its members. Pathways Community HUB and Care Transitions care models Define individual and household risk factors for reduction through establishing community-clinical linkages with community-based care coordination. Both models standardize data elements and enable compliant sharing of patient/client information for better data-driven decision making. Great and effective policymaking is also enabled by data-driven decisions and flexibility.

A Community HUB network of community agencies and providers provides training, jobs, structure, process and information-gathering for successful, sustainable community-clinical linkages in rural, semi-rural, suburban and urban settings.

The data elements of these models are standardized yet allow communities the flexibility to apply them in addressing and implementing solutions for community population and health issues that are most important to each community. Care Coordination Systems has the best technology we've seen to provide health agencies,

and stakeholders meaningful data while supporting Community Health HUBs, care models, and actionable, sustainable community-clinical linkages.

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?

I would strongly recommend expansion of the New Markets Tax Credit programming for investment in rural and underserved healthcare facilities and businesses. The latent private-public partnership structures provide incentive for innovation and expanded services to vulnerable populations, but also incentive for proper underwriting of investment for sustainability and avoidance of waste or over-spending, and due to the structure and shallow nature of the subsidy are extremely cost effective for the federal Government. Unfortunately, we (Community Hospitality Healthcare Services) have a valid pipeline of \$1 billion of such projects annually, and are lucky to be at the top of the industry with an annual allocation of \$50-\$70 Million. Programmatic changes should be considered to make larger, longer-term NMTC allocation available to participants solely focusing on healthcare investments in rural and underserved markets nationwide.

Additionally, for improved health for patients and reduced healthcare costs, health systems need to expand continued community-based care and transitional care to Community HUBs and the HUB's network of partners including community agencies, FQHCs, dentists, SUD and behavioral health providers and area for aging administration (AAA) providers. Community-Clinical linkages should be both technological and collaborative between the HUBs and the healthcare system. Information-gathered should be compliantly-shared among the community-clinical care team for whole-person health. Information-gathered should be standardized and shared through evidence-based care models such as Pathways and Care Transitions Intervention. These efforts require value-based payment/performance contracts for economic sustainability and expansion. All geographic areas will benefit--especially the rural and semi-rural areas due to sustainable Community HUB and community health workers successfully reducing social health risk.