College of Healthcare Information Management Executives

November 26, 2019

The Honorable Richard Neal
United States House of Representatives
House Office Building
Washington, DC 20515

The Honorable Kevin Brady
United States House of Representatives
House Office Building
Washington, DC 20515

The Honorable Danny Davis
United States House of Representatives
House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup
United States House of Representatives
House Office Building
Washington, DC 20515

The Honorable Terri Sewell
United States House of Representatives
Office Building
Washington, DC 20515

The Honorable Jodey Arrington
United States Senator
722 Hart Senate Office Building
Washington, DC 20510

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

Dear Chairman Neal, Ranking Member Brady and Task Force Co-Chairs:

The College of Healthcare Information Management Executives (CHIME) is pleased to respond to your request for information (RFI) concerning opportunities to improve health and care for those in rural and underserved communities.

CHIME is a professional organization that represents more than 3,200 Chief Information Officers (CIOs) and other senior healthcare IT leaders. CHIME enables its members and business partners to collaborate, exchange ideas, develop professionally and advocate for the effective use of information management to improve the health and care in the communities they serve. CHIME members are responsible for the selection and implementation of clinical and business systems that are facilitating healthcare transformation through technology. Our members represent some of the earliest and most prolific adopters of electronic health records (EHRs) and other health IT resources like telehealth and RPM for clinicians and patients. Our mission is, “To advance and serve healthcare leaders and the industry improving health and care globally through the utilization of knowledge and technology.”

We appreciate the opportunity to share our thoughts on how technology can improve care and outcomes for those in rural and underserved communities. We have selected to answer a subset of your questions that will prominently feature healthcare technology.

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?**

Access to care is a primary concern when evaluating the factors that influence patient outcomes in rural and underserved communities. Provider shortages, negative margins and facility closures have only exacerbated access challenges. Providers struggle to sustain themselves financially or draw quality talent due to low volumes and lack of insured populations. Social determinates of health (SDOHs) such as community resources, poverty, literacy, access, have significant impacts on rural and underserved communities. We implore the Task Force to recognize that the ability to leverage SDOHs may vary greatly between rural and urban communities simply due to the lack of community and/or social services/agencies.

Healthcare providers have begun to leverage telehealth (provider to patient) and telemedicine (provider to provider) capabilities everywhere, but especially where it has proven to be the most realistic way to provide care to those communities facing the greatest access challenges.

Robust healthcare data exchange will be paramount as the industry seeks to serve disparate communities. Meaningful data exchange is nascent today, but with the passage of the 21st Century Cures Act (Cures), Congress committed to nationwide healthcare interoperability. It will be critical for the Administration, with Congressional oversight, to ensure that the policies generated out of the Cures Act spur data exchange that is reliant on solid data standards. Traditional clinical care data will be necessary for healthcare transformation, but also SDOH data capture and exchange, which will ultimately facilitate better access to the care an individual patient actually needs.

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?

c.) Broadband access

Last year the Federal Communications Commission (FCC) unanimously approved to establish a new $100 million Connected Care Pilot Program. Under this pilot, the agency plans to create a Universal Service Fund pilot program to promote the use of broadband-enabled telehealth services among low-income families and veterans, with a focus on services delivered directly to patients beyond the doors of brick-and-mortar healthcare facilities. CHIME was pleased to offer our support of the FCC's efforts to improve access to healthcare services through broadband and other advanced technologies to low-income Americans, including those in rural areas and our nation's veterans. It's critical that the infrastructure be in place to facilitate technology-driven efforts to improve access and outcomes for those in rural and underserved communities.

A member from a rural state who served as the CIO of a community hospital detailed how his organization formed a relationship with a large academic medical center in the state and served as their regional hub, leveraging telehealth to offer additional services into their community. Through grant funding they were able to extend their reach and offer additional capacity into even more rural areas, including into elementary schools. Unfortunately, not all of the schools and small practices had broadband, and thus could not benefit from the additional services that were being offered through the partnership between the community hospital and the academic medical center.

5G

In considering the best way to reach rural and hard-to-serve communities (which include urban areas), we highlight the promise of 5G. The ultra-low latency and high-speed capability of the 5G networks may not only remove existing access barriers but also unlock the ability for the world's best doctors and specialist to diagnose and treat patients in these areas. Simply, 5G may connect patients

with healthcare providers in ways not possible today and redefine every aspect of healthcare. The possibilities include video visits, patient monitoring, remote diagnostics, prescription adherence, connected internet of things (IoT) sensors and more. Thus, CHIME encourages the Task Force to pursue policies to enable the proliferation of 5G.

Data Usage Limitations
While broadband access may be a challenge in rural areas, where our members are leveraging remote patient monitoring (RPM) technologies that are internet-enabled, patients on limited data plans may also be prohibited from taking advantage of the services. One children's hospital CIO from a large metropolitan area offered the example of a child outfitted with a Cochlear implant, a surgically placed electronic device, which can be transformative for a child's development and future. But it's not a one-and-done event. Because recipients haven't always been able to have the same speech-teaching interactions that hearing children do, life with a new Cochlear implant can involve significant, specialized speech therapy requiring weekly visits. One of the key questions when evaluating a child as a Cochlear implant candidate is whether he or she will be able to attend these visits. The innovative use of telespeech to bring speech therapy into patients' homes breaks down barriers to care for patients in remote areas who previously would have been denied access to Cochlear implants, or whose families would have had to make enormous sacrifices to travel for their therapies. However, if these families lack access to the internet for these telehealth visits, they too would be precluded from receiving the implant.

d.) Use of Telehealth/telemedicine/telemonitoring
Our members strongly support connected care technologies that can help reach patients who would otherwise be underserved, as well as expanding the use of these technologies to help drive down healthcare costs. Hospitals, health systems and other providers are embracing the use of telehealth technologies because they offer benefits such as the ability to perform high-tech monitoring without requiring patients to leave their homes. This can be less expensive and more convenient for patients, as well as improve access to specialists and expand care to patients in remote locations. Telehealth services come in many forms, from post-discharge remote monitoring programs resulting in reduced hospital readmissions, to emergency departments using remote video consultations to enable patients to receive a telepsychiatric screening.

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?

With the continued market consolidation and persistent workforce shortages, it will be incumbent on smaller providers to leverage technologies, such as telemedicine and remote monitoring, to augment services rendered with arrangements with larger healthcare providers. Grants or subsidized access to high speed internet and telemedicine platforms at rural facilities would help smaller providers build these relationships.

As outlined above, community hospitals and physician practices are forming networks or partnerships to leverage telehealth for access to services that are offered at larger institutions that may be hundreds of miles away. Additionally, building telehealth capabilities in Critical Access Hospitals (CAHs) and schools, have been viewed as ways to help prevent high-cost visits and hospital admissions.

Persistent Challenges

Whether public and private payers cover telehealth services and adequately reimburse hospitals and other healthcare providers for providing those services, is a complex and evolving issue. As a result, reimbursement is often a barrier to standardizing the provision of these valuable services. Additionally, the payer requirements associated with these services pose challenges. The relationship outlined above was only possible because the academic medical center received grant funding to extend their telehealth offerings, both the provision of technology and services. Unfortunately, since the relationship was established, the funding stream ended and much of the programming has ceased.

Today many of our members provide telehealth services at a financial loss to their organizations. Our members emphasize that providing telehealth at a loss, meaning they often do not get reimbursed for it, actually saves payers money because it prevents what would become more costly procedures or admissions. Additionally, it can reduce strain on the already depleted healthcare workforce.

Further, issues with scope of practice and medical staff credentialing/privileges pose challenges to healthcare organizations. This also includes the inability for physicians to treat patients across state lines, which ultimately limits how some telehealth arrangements may scale.

It is again important to reiterate that the lack of reliable access to high-speed internet has been a persistent challenge to extending telehealth networks.

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?

Telehealth has been viewed by CHIME members as a means to combat the lack of access to specialty care providers that face higher-than-average shortages. One of the services that our members tend to be offering most broadly is telepsychology programs. There are shortages of behavioral health and addiction service providers across the nation, but especially in rural areas that have been devastated by the opioid epidemic.

We applaud the language included in the SUPPORT for Patients and Communities Act passed in 2018 that eliminated the geographic restrictions placed on services "to an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder;" and requires a report from the Department of Health and Human Services (HHS) within five years on the effectiveness of telehealth and telemedicine programs in treating people with substance abuse issues. But we can, and must, do more to meet patients wherever they are most comfortable and ensure that their zip code does not predispose them to poor outcomes.

Additionally, CHIME members have begun leveraging regional hubs with high-volume needs (as outlined above) and mobile integrated teams that are technology-enabled to especially focus on the homeless and indigent population.

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?

Long-term and Post-Acute Care facilities are increasingly seeing patients with more complex healthcare needs. Often rehabilitation hospitals must bring patients to post-surgical appointments by ambulance for routine follow-up, a very costly and disruptive process. Ideally, telehealth could be leveraged from the LTPAC facility to the clinician with which the patient has an appointment rather than needing to leave the facility. In a study published by the American Burn Association, the use of telehealth in a rehabilitation hospital was found to not just improve outcomes, but to also save money.

> "At the rehabilitation hospital, 146 ambulance transports were averted during the study period, resulting in a cost savings of $101,110. In addition, assuming a weekly 3-hour visit to the burn center, which includes travel and prep time on both ends, the rehabilitation hospital saved an average of 2 to 3 days per hospital admission secondary to unnecessary travel and improved throughput. Throughout the study period, the rehabilitation hospital estimated an average of three rehab days saved per patient, totaling 87 bed days gained.[1]"

In some care settings, like rehabilitation hospitals or other post-acute providers, other care providers may be as valuable to improving patient outcomes as the physician. Thus, CHIME recommends that the Task Force ensure that the qualifying professional considered for reimbursement for virtual visits must not be limited to physicians alone.

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?

Improvements to clinical data capture and exchange as well as SDOH data standardization are necessary. There is a significant lack of standardization across clinical data, which has hindered interoperability efforts. Data can be the differentiator. If clinicians have access to patient data when and where needed and can access it even if the patient is receiving care via telehealth, we will see an improvement in outcomes.

Our members also cite the need for consistency in definition of social determinants of health. Each health system may define something like "financial challenges" differently, thus negating the ability to have a larger view of care across different communities.

CHIME supports Congressional efforts to modernize the nation's public health data systems and core infrastructure. The nation's public health departments are at the frontlines and often lack the technological capabilities to quickly and accurately portray the health status of their communities.

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?

Broadband Access
Technology has the potential to fundamental address healthcare access challenges, but if we lack proper infrastructure necessary to leverage technology, it will all be for not. It is critical that a

[1] "Urban Telemedicine: The Applicability of Teleburns in the Rehabilitative Phase," by Yuk Ming Liu, MD, MPH, Katie Mathews, BA, Andrew Vardanian, MD, Taylan Bozkurt, MBA,* Jeffrey C. Schneider, MD, Jaye Hefner, MD,† John T. Schulz, MD, PhD, Shawn P. Fagan, MD, and Jeremy Goverman, MD, 2017, Journal of Burn Care & Research, Copyright © 2016 by the American Burn Association

concerted effort be taken at a national level to equip all Americans with reliable, high-speed internet access.

Telehealth Reimbursement
Many CHIME members are providing telehealth services to ensure better patient outcomes and are doing so at a financial loss. It's time for Medicare and Medicaid policies to adapt, acknowledge patient preferences and recognize the value of enabling technology to address the current shortcomings of our healthcare delivery system. The reimbursement paradigm should reward the providers that are seeking to provide better, more timely healthcare that is resulting in healthier, happier patients.

CHIME calls on the Task Force to encourage CMS and payers to reconsider and redefine what constitutes a telehealth visit. A CIO of a large health system said that her physicians get reimbursed for a telehealth visit if they spend 30 minutes with a patient. However, in leveraging telehealth the doctor often does not need to spend 30 minutes with the patient as they are likely to have their health history and, if combined with remote monitoring, access to additional data points to augment the patient consultation. Telehealth visits should not be defined by the length of the visit, but instead, by the services provided.

The Task Force should consider other ways to use virtual services to address some of the health disparities before they end up with an admission such as allowing care coordinators to bill for their services provided to patients managing their chronic disease(s).

Cross-state Licensure for Providers
The Task Force should consider how to address cross-state licensure concerns, often imposing troublesome legal barriers to a physician wishing to offer telehealth services to a patient in another state. CHIME supports policies to allow licensed healthcare providers to offer services to patients, using telemedicine, regardless of what state a patient resides in, notwithstanding whether the patient is within a traditional care setting or in his or her home.

One member gave the example of a patient being monitored for inflammatory bowel disease and is traveling. While a virtual visit may be appropriate, the provider licensing restrictions will hinder that encounter from happening. Instead the patient will likely seek more expensive care at an urgent care facility and be subject to unnecessary additional imaging and diagnostics.

CHIME commends the Committee and Task Force for its willingness to engage stakeholders to pursue policies to improve healthcare access and quality in rural and underserved communities. We hope our comments are useful and look forward to a continued dialogue regarding legislative solutions for improving healthcare for patients through the use of technology. Should you have any questions or if we can be of assistance, please contact Leslie Krigstein, Vice President of Congressional Affairs, at *lkrigstein@chimecentral.org*.

Sincerely,

Russell P. Branzell, CHCIO, LCHIME
President and CEO
CHIME