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U.S. House of Representatives
Committee on Ways & Means
Rural and Underserved Communities Health Task Force

Submitted electronically via Rural_Urban@mail.house.gov

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

Dear Task Force Co-Chairs,

Thank you for the opportunity to submit a response to the Rural and Underserved Communities Health Task Force Request for Information. Community Catalyst is a national, non-profit advocacy organization dedicated to quality affordable health care for all. Given our mission, we write to offer input on how to improve health outcomes for rural adults and children and work toward reducing health disparities among rural residents.

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?

Approximately 47 million adults,[1] and more than 13 million children[2] live in rural areas. Unfortunately, rural Americans face significant health disparities[3] compared to their urban counterparts and even within rural communities there is substantial variability in health outcomes based on race and ethnicity.[4] Overall, rural residents tend to be older and sicker than residents of urban settings,[5] and fare worse on most measures including mortality, health status, access to

[1] U.S. Census Bureau, New Census Data Show Differences Between Urban and Rural Populations, retrieved from: https://www.census.gov/newsroom/press-releases/2016/cb16-210.html.
[2] *Id.*
[3] Centers for Disease Control and Prevention, About Rural Health, retrieved from: https://www.cdc.gov/ruralhealth/about.html.
4 James CV, Moonesinghe R, Wilson-Frederick SM, Hall JE, Penman-Aguilar A, Bouye K. Racial/Ethnic Health Disparities Among Rural Adults — United States, 2012–2015. MMWR Surveill Summ 2017;66(No. SS-23):1–9, retrieved from: http://dx.doi.org/10.15585/mmwr.ss6623a1.
[5] Centers for Disease Control and Prevention, About Rural Health, retrieved from: https://www.cdc.gov/ruralhealth/about.html.

care, and use of preventive services.[6] Rural children also face significant health disparities including higher mortality rates with unintentional injury and suicide ranking as the top two causes of death.[7] Additionally, kids in rural areas with mental, behavioral, and developmental disorders experience more challenges than children with similar health issues in urban areas.[8]

Many aspects of rural life contribute to the poorer health outcomes experienced by residents of these communities. These factors include but are not limited to: the ability of rural residents to obtain adequate employment, geographic isolation exacerbated by a lack of transportation options, workforce shortages and limited availability of culturally competent providers, and stigma related to accessing mental and behavioral healthcare.[9] Despite these challenges, we know that rural communities have assets that more urban and populous locales may lack: a tightly knit sense of community and local pride.[10] The importance of the strength of community ties should not be underestimated and is one facet of how we can improve health outcomes in rural regions.

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?

Establishing robust systems for providing health services in schools can be an effective tool for addressing health outcomes and social determinants of health in rural areas. A larger share of rural children relies on Medicaid coverage for health insurance than their urban counterparts.[11] Since 2014, the Centers for Medicare and Medicaid Services have permitted schools to bill for health services provided to any child enrolled in Medicaid.[12] Creating access to health services where children already spend a majority of their day will reduce barriers to care such as a lack of transportation and also allowing caregivers to remain at work. Recently, states have made

[6] Henning-Smith, Carrie, et. al., Differences in Preventive Care Among Rural Residents by Race and Ethnicity (2019), retrieved from: https://3pea7g1qp8f3t9ooe3z3npx1-wpengine.netdna-ssl.com/wp-content/uploads/2019/11/UMN-preventive-services-disparities-policy-brief_11.8.19.pdf.
[7] Janice Probst, Whitney Zahnd, and Charity Breneman, Declines In Pediatric Mortality Fall Short For Rural US Children, Health Affairs, retrieved from: https://doi.org/10.1377/hlthaff.2019.00892.
[8] Centers for Disease Control and Prevention, About Rural Health, retrieved from: https://www.cdc.gov/ruralhealth/about.html.
[9] Rural Health Information Hub, Healthcare Access in Rural Communities, retrieved from: https://www.ruralhealthinfo.org/topics/healthcare-access.
[10] Hardy, Jean., How Rural America Is Saving Itself (2018), retrieved from: https://www.citylab.com/perspective/2018/12/rural-america-us-economic-future-new-york-times-wrong/578740/.
[11] Jack Hoadley, Joan Alker, and Mark Holmes, Health Insurance Coverage in Small Towns and Rural America: The Role of Medicaid Expansion (2018) at 1, retrieved from: https://ccf.georgetown.edu/wp-content/uploads/2018/09/FINALHealthInsuranceCoverage_Rural_2018.pdf.
[12] Centers for Medicare & Medicaid Services, Dear State Medicaid Director Letter: Medicaid Payment for Services Provided without Charge (Free Care), retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

progress toward implementing this policy.[13] Additional information is available on Community Catalyst's website.[14]

Another important tool for creating positive impacts on health outcomes in rural areas is prioritizing collaborations among a variety of stakeholders. While there are examples of the importance of these collaborations throughout the country, we would like to highlight the achievements of one such effort in Shelby, North Carolina. Sparked by conversations made possible by the Partnership for Community Prosperity[15] (P4CP) coalition, local organizations worked with a local pediatric provider group to launch a pilot telehealth program in their elementary school. This pilot telehealth program resulted in reduced emergency room visits, increased attendance in school and parents able to remain at work. For additional information, see Community Catalyst's video[16] about this pioneering program.

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

Since 2010, 119 rural hospitals have closed.[17] This data shows continuing evidence of what the Government Accountability Office characterized in 2018 as a worsening trend.[18] One bright spot is the growing evidence that Medicaid expansion can help prevent further closures.[19] Research shows that expanding Medicaid is associated with improved hospital financial performance and substantially lower likelihoods of closure.[20] While patient volume is an understandable concern for hospitals given the history of closures, the reality is that rural Americans still need access to health care services. We recommend that the Committee encourage the 14 states[21] that have yet to expand Medicaid to do so immediately.

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

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[13] Community Catalyst, Healthy Schools Campaign and Trust for America's Health, State Efforts to Implement the Free Care Policy Reversal, retrieved from: https://docs.google.com/document/d/1u0j1so-se8ohhyl7AcHaaXlGX5l3s0PN2cuIDejXZQw/edit.

[14] Kyle Marie Stock, On the Road for Expanding Medicaid Services in Schools, retrieved from: https://www.communitycatalyst.org/blog/on-the-road-for-expanding-medicaid-services-in-schools#.XdbrRNVKh1s.

[15] Partnership for Community Prosperity, retrieved from: https://www.partnersbhm.org/partnership-community-prosperity-cleveland-county/.

[16] Community Catalyst, Communities Lead the Way on Health Care Solutions (2019), retrieved from: https://vimeo.com/345749907.

[17] NC Rural Health Research Program. (2019). 95 Rural Hospital Closures: January 2010 – Present. The Cecil G. Sheps Center for Health Services Research, University of North Carolina, retrieved from: www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

[18] Government Accountability Office. (2018 August). Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors. Report to Congressional Requestors, retrieved from: https://www.gao.gov/assets/700/694125.pdf.

[19] *Id.* at 26. *See also*, figure 5 at 27.

[20] Lindrooth, R. C., Perraillon, M. C., Hardy, R. Y., & Tung, G. J. (2018). Understanding The Relationship Between Medicaid Expansions And Hospital Closures. *Health Affairs*, *37*(1), 111–120, retrieved from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0976.

[21] Kaiser Family Foundation, Status of State Medicaid Expansion Decisions: Interactive Map, retrieved from: https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

There are several successful models of addressing workforce shortages including different types of care support and delivery system models. Community health workers[22] (CHWs) and doulas[23] have been shown to improve health outcomes and reduce disparities. CHWs are trusted members of the community and serve as a link between individuals, health care providers and social services.[24] CHWs contribute to addressing rural health by increasing health literacy through community education, informal counseling, and social support.[25] These activities help individuals manage chronic health conditions and reduce gaps in access to care.[26] Doulas fill a similar role by offering support before, during, and after labor and birth.[27] Given the disturbing statistics on infant[28] and maternal mortality,[29] particularly for Black women[30] and American Indian/Alaska Native women,[31] it is imperative that we increase access to and payment of doulas.

Another way to address provider shortages, specifically related to mental health care, is through a health care delivery model called psychiatry access programs. These programs give primary care providers direct access to specialists in psychiatry who provide consultations on diagnosis and treatment. Massachusetts has long operated a psychiatry access program focused on children,[32] and more recently has offered support related to maternal mental health.[33] Research has shown that child psychiatry access programs have increased primary care providers' ability to meet the needs of individuals with mental health issues.[34] Further research demonstrates that

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[22] Kyounghae Kim et al. "Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review", *American Journal of Public Health* 106, no. 4 (April 1, 2016): pp. e3-e28, retrieved from: https://doi.org/10.2105/AJPH.2015.302987.

[23] Bey, Asteir et. al., Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities, at 8 (2019), retrieved from: https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf.

[24] National Rural Health Association, Community Health Workers: Recommendations for Bridging Healthcare Gaps in Rural America, retrieved from: https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Community-Health-Workers_Feb-2017_NRHA-Policy-Paper.pdf.

[25] *Id.*

[26] *Id.*

[27] Bey, Asteir et. al., Advancing Birth Justice at 5.

[28] *See* Centers for Disease Control and Prevention, Infant Mortality, retrieved from: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm.

[29] *See* Centers for Disease Control and Prevention, Pregnancy Mortality Surveillance System, retrieved from: https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

[30] *Id.*

[31] *Id.*

[32] Massachusetts Child Psychiatry Access Program: Overview, Vision, History, retrieved from: https://www.mcpap.com/About/OverviewVisionHistory.aspx.

[33] MCPAP for Moms, retrieved from: https://www.mcpapformoms.org/About/About.aspx.

[34] Barry Sarvet, et. al., Improving Access to Mental Health Care for Children: The Massachusetts Child Psychiatry Access Project, Pediatrics Nov 2010, peds.2009-1340, retrieved from: https://pediatrics.aappublications.org/content/early/2010/11/08/peds.2009-1340.

such programs are "a collaborative, scalable, and cost-effective model".[35] Additional information and recommendations are available on Community Catalyst's website.[36]

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?

More than 56 million people in the U.S. live in areas without enough dental providers to meet their oral health needs;[37] more than half of those people live in rural areas.[38] This misdistribution of dental providers has left pockets of rural and underserved areas where people cannot access dental care, resulting in poor oral health outcomes and persistent disparities.[39] To address these gaps, about a dozen states and communities have authorized dental therapists – highly trained mid-level oral health practitioners that provide oral health education, prevention, and common dental procedures in underserved areas.[40] Research shows that dental therapists improve oral health outcomes – increasing access to preventive care and reducing the need for tooth extractions.[41] They also enable dental practices and clinics to see more patients with Medicaid coverage, reduce the amount of time patients wait for a dental appointment, and provide a cost-effective way to get dental care into underserved communities.[42] Dental therapists primarily work in underserved settings and often work in their home communities, allowing them to establish a high level of trust with patients, which improves their experiences and outcomes. In just over a decade, leaders in Alaska Native communities have built a group of highly skilled American Indian/Alaska Native dental therapists who share the language and culture of the more than 45,000 people they serve.[43] For additional information, see the National Partnership for Dental Therapy website.[44]

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[35] John H. Straus and Barry Sarvet, Behavioral Health Care for Children: The Massachusetts Child Psychiatry Access, Health Affairs, 33, no.12 (2014):2153-2161 at 2161, retrieved from: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0896.

[36] Kyle Marie Stock, Addressing Trauma and Children's Mental Health through Child Psychiatry Access Programs: An Introductory Guide for State Health Advocates, retrieved from: https://www.communitycatalyst.org/resources/publications/document/PAPS-Report-KMS-FINAL-2.pdf.

[37] *See* Health Resources & Services Administration, Health Workforce Shortage Areas, retrieved from: https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[38] National Advisory Committee on Rural Health and Human Services, Improving Oral Health Care Services in Rural America: Policy Brief and Recommendations, retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2018-Oral-Health-Policy-Brief.pdf.

[39] *Id*.

[40] Community Catalyst, Dental Therapists: Expanding Access to Oral Health Care, retrieved from: https://www.communitycatalyst.org/resources/publications/document/DT-101-One-Pager_FINAL.pdf.

[41] Donald L. Chi, et. al., Dental Therapists Linked to Improved Dental Outcomes for Alaska Native Communities in the Yukon-Kuskokwim Delta, Public Health Dentistry, 78, no. 2 (2018): 175-182, retrieved from: https://doi.org/10.1111/jphd.12263.

[42] *See* Midwest Dental: Dental Therapist Case Study, https://www.wilder.org/sites/default/files/imports/DeltaDentalRenvilleAddendum_5-17.pdf.

[43] *See* Dental Health Aide Therapist (DHAT), retrieved from: https://www.nihb.org/docs/05212014/Dental%20Health%20Aide%20Therapists%20Presentation%201.pdf.

[44] *See* National Partnership for Dental Therapy, retrieved from: https://www.dentaltherapy.org/.

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?

States have taken various approaches to expand LTSS services in rural and underserved areas. These include:

- Increasing wages for direct support workers. States including Tennessee, Washington, Massachusetts, Mississippi and Montana have used different strategies, including policies setting minimum wages, using funding from the Balancing Incentive Program, and increasing payments to managed care companies (MCOs) and requiring those payments be passed along to providers.
- Building requirements into MCO contracts to expand training programs and recruitment for direct care workers. States include NY, MS and MT.
- Expanding Rural PACE Provider Grant Programs. A 2011 evaluation found this eased establishment of PACE in rural areas, particularly when implemented in conjunction with Area Agencies on Aging (ASAs).
- Supporting family caregivers. Washington State uses an 1115 waiver to run the Medicad Alternative Care program that provides supports through AAAs, including respite care, to unpaid caregivers of older people who qualify for Medicaid LTSS but choose not to seek typical home services. Another program, Tailored Supports for Older Adults, serves those likely to need future Medicaid LTSS services. It either supports their family caregivers or taps local home care providers.
- Linking primary care and LTSS in the home. Georgia started the Medicaid-funded Service Options Using Resources in a Community Environment program through an 1915c waiver and AAAs. It provides in-home services to adults with physical disabilities and those over 65 with functional challenges. Services include personal care, adult day health and meals, as well as access to case manager and PCP.

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?

Given the interest in identifying the causes of health disparities in rural areas, Community Catalyst encourages the Task Force to consider focusing on a core set of rural-relevant measures. In 2018, the Measure Applications Partnership Rural Health Workgroup identified a set of such measures and provided recommendations on assessing and improving access to care in rural areas.[45] In developing the core set, the Workgroup prioritized measures that are endorsed by the

[45] *See* National Quality Forum, A Core Set of Rural-Relevant Measures and Measuring and Improving Access to Care: 2018 Recommendations from the MAP Rural Health Workgroup, retrieved from: https://www.qualityforum.org/Publications/2018/08/MAP_Rural_Health_Final_Report_-_2018.aspx.

National Quality Forum, cross-cutting, resistant to low case-volume, and address transitions in care.[46] The Workgroup also supported measures that address specific conditions or services that are important to rural individuals' health. These included mental health, substance abuse, medication reconciliation, diabetes, hypertension, and chronic obstructive pulmonary disease (COPD), and hospital readmissions, and perinatal and pediatric conditions and services.[47] The Workgroup recommended 20 measures for the core set: nine for the hospital setting and 11 for the ambulatory setting.[48] We encourage the Task Force to foster utilization of this rural core set and ensure that data collected using the recommended measures is disaggregated by race and ethnicity. We further urge the Task Force to monitor the work of the Measure Applications Partnership Rural Health Workgroup[49] to continue learning from their ongoing efforts to collect relevant rural health outcomes data.

Community Catalyst greatly appreciates the opportunity to provide input on the Rural and Underserved Communities Health Task Force Request for Information. If you have additional questions, please reach out to Eva Marie Stahl (emstahl@communitycatalyst.org).

Sincerely,

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Associate Director of Policy
Community Catalyst

[46] *Id*. at 9-11.
[47] *Id*. at 10.
[48] *Id*.
[49] *See* National Quality Forum, Measure Applications Partnership Rural Health Workgroup, retrieved from: http://www.qualityforum.org/MAP_Rural_Health_Workgroup.aspx.