

INFORMATION REQUESTS (Limit each response to 250 words - Total submissions should not exceed 10 pages, 12 pt font):

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 healthcare related factors that influence patient outcomes in rural or underserved areas is the lack of access to stable housing paired with access to stable services for adults who struggle with symptoms of serious mental illnesses such as schizophrenia and dementia. The factors that influence outcomes outside the industry is the inability to navigate the complexity of the community based systems, fragmentation of state agencies in the rural communities and the failure of safety net and first responders to ensure that those with chronic disabilities or aging can self preserve when living arrangements are failing. Often the system is so complex and overwhelming it is difficult to know how to respond and many people are left in inappropriate settings without appropriate care.

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?

The most successful models to ensure access and management of care for adults with serious mental illness and seniors with dementia are state licensed Assisted Living Facilities that are inspected by the state agencies. These facilities offer care coordination, access to primary care, psychiatric care, balanced diets, internet access, transportation, benefit restoration/ optimization, assistance with transition to more independent living arrangements when requested and often can link with a whole array of community based services. These community based living arrangements offer oversight of chronic disease conditions, allow for adequate follow up and coordination of appointments for improved management of chronic disease conditions such as schizophrenia, COPD, heart disease, diabetes, cancer, stroke, dementia, it is possible to customize a care environment around almost any specific set of parameters. These licensed settings offer protections under a resident bill of rights which is enforceable through civil actions. There is real accountability in these settings as opposed to other settings.

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

There should be greater focus on ensuring that physicians have higher reimbursement rates for patient visits in rural counties. The patients in rural counties are at higher risk of institutional care.

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?

We should expand the FQHC in the rural areas, these have been a positive way for the counties to expand access to care. The congress should create incentives for local communities to invest in the FQHCs and make these more widely available.

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

There should be a broader investment in primary care through the expanded use of incentive payments via the Medicare Advantage plans to the physicians. The modernization of the Medicare Advantage plans should be expanded to allow for payment of personal care services to the state licensed Assisted Living Facilities for persons who meet certain income eligibility requirements tied to the FPL.

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

The complexity of the payment system and then the inability to get paid is at the core of why so many providers have decided to move towards direct primary care. The reality is that the reimbursement system for care is overly complex and needs to be changed so as to reduce its complexity and create a more straight forward simply approach to payments that alone would reduce costs and drive more dollars to the direct care of patients.

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?

The large systems seem to be so bureaucratic and complex to navigate that patient care is often getting lost in these “mega” systems of regional care. The move towards smaller emergency rooms that then feed the larger hospitals have blown up the ambulance system and created shortages and long wait times for private ambulance services and increased ambulance expenses as the ambulances now must transport patients between the smaller stand alone ER to the larger “mother ship” bigger hospitals at the regional system. The main challenges in the regional system is access to medical information and creating a smooth link between the hospital and community based providers so that when patients are being discharged that the discharge is smooth. The most problematic issue right now facing the system of care is hospital discharge planning and how patient care is often mishandled in the management of discharges and how discharges result in breakdowns and readmissions to the hospitals or poor outcomes. This is a huge and under appreciated issue and needs greater focus.

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

There are very few working models addressing the workforce shortages, what is happening organically is that hospitality workers are seeking jobs in health care, they often seek their first job at the Assisted Living facility and then once they get the training will move on from there to the nursing home and then into the hospital. We need to recognize the natural migration flow of labor and workforce trends and then work to support, improve and develop and help facilitate the development of these workers along the route so they are retained and do not leave the workflow and remain in the workforce and go on to achieve higher education credentials to become a nurse or respiratory therapist. We need tax credits and incentives to help with this professional development work being done each day on the frontlines.

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 provision of onsite care is a growing trend that improves access to services. The FDA in 2017 approved the WX100 Sysmex CLIA waived CBC hematology analyzer. The use of Clozaril is the most effective medication to manage Schizophrenia is recommended as first strategy in an effort to control symptoms. The medication requires a weekly CBC to test the white blood cell count as a matter of law before the medication can be dispensed and often adherence with the blood test can make use of Clozaril complex treatment option for patients with a history of non adherence. The ability to provide the blood test on site and reduce the stress associated with this test changes the entire set of barriers completely and substantially improves the ability to expand the use of Clozaril to patients who before would not comply as readily with the blood

test. It is estimated in Florida of the 55,000 adults with Schizophrenia only about 9% of these patients are being treated with Clozaril. This explains why Baker Act costs remain high and why Schizophrenia is the #1 diagnosis seen in the ER and why forensic admission continue to rise. Improvements in technology and use of medications known to gain better control of symptoms create a major change in the use of crisis driven systems of care.

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 development of new technologies through [www.onsyte.com](http://www.onsyte.com) that allows for the management of waste water through a new treatment approach will allow residential treatment facility operators to create residential housing projects in rural areas that are not connected to municipal utilities or water and waste systems. The fact is that new technology is now available that allows for the construction and development of Assisted Living Facilities that are good quality and affordable that are not connected to a municipality. What needs to happen is to create federal support for these new system and to ensure there is federal funding to help maintain these systems to encourage the development of these systems. The systems at my facility in Florida was the first to be developed of any of the 32 rural counties in Florida not connected to a municipality. My assisted living facility is operating today as a model and example of what can be done from the private sector.

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?

The data gathering is happening within the Assisted Living Facilities inside the electronic health records right now. Point Click Care has over 21,000 long term care facilities in the United States. They have massive amounts of data right now on all issue imaginable. The reality is that what needs to happen is federal grants and incentives are needed to help create studies that allow Assisted Living Facilities to help lead and organize studies in their communities. The Assisted Living Facilities are community centers often in the area and if allowed to become a part of a study with students this could help gather data and allow data to be gathered and then reported into a larger study over the long term. The committee should really talk with Mike Wessinger at Point Click Care as they likely already know a great deal of what the committee desires to know about many parts of the system of care as they have the data.

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?

\* Medicare Advantage Plans – need to allow them to pay Assisted Living Facilities for personal care for persons who meet certain income criteria.

\* Pharmacy Copayments – The PBMs appear to be violating the “safe harbor” rules under Section 42 CFR related to the pharmacy copayments. They are demanding that pharmacies go to unreasonable lengths to collect copayments or they will claw back these amounts under the notion the pharmacy has reduced the price of the medication. Residents who are Medicaid and Medicare eligible and live in an Assisted Living Facility must pay copayments or they will not get life saving medications and residents who are Medicaid/ Medicare who live in a nursing home are exempt from copayments – this is a violation of the equal protection clause.

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