Franklin Regional Council of Governments

TO: Rural and Underserved Communities Health Task Force
FROM: Phoebe Walker, Director of Community Services and Linda Dunlavy, Executive Director
DATE: December 3, 2019
RE: Request for Information

Thank you very much for the opportunity to address the important issues this Task Force is addressing. The Franklin Regional Council of Governments (FRCOG) is a voluntary membership organization of the 26 towns of Franklin County, Massachusetts. FRCOG serves the 725 square mile region with regional and local planning for land use, transportation, emergency response, economic development, and health improvement. FRCOG serves as the host for a number of public health projects including the Franklin County/North Quabbin Community Health Improvement Plan Network. Other coalitions hosted by FRCOG include the local emergency preparedness committee, the Western Regional Homeland Security Advisory Council, the Region 1 Health and Medical Coordinating Coalition, two local substance use prevention coalitions -- one for the City of Greenfield and the regional Communities That Care Coalition. We also host a regional health district serving 14 towns. FRCOG also provides additional shared local municipal government services on a regional basis, including building inspections, accounting, and purchasing. To ensure the future health and wellbeing of our region, FRCOG staff are also active in state and federal advocacy.

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?**

Rural areas have less access to transportation, healthcare, government public health protections and other government servcies, education, employment, broadband, good housing, opportunities for exercise, and healthy food. Along with the impacts of historical racism, these factors known as the social determinants of health, all have a profound impact on health outcomes. With fewer tax dollars, because most federal and state programs use population as a primary factor in distribution formulas, rural areas have less capacity to fund programs that positively impact health.

Rural areas struggle to attract healthcare professionals, and as a result have fewer healthcare providers across the board. Access to rapidly available and highly qualified Emergency Medical Services (EMS) and Advanced Lifesaving Services (ALS) is limited, creating longer wait times and more complicated emergency transports. Rural areas are aging faster than urban areas, bringing an increased need for medical services. The smaller dispersed populations result in fewer hospitals and closure of these facilities has an enormous impact on both services and the regional economy.

In addition, rural areas have some of the lowest rates of childhood immunization, leaving communities vulnerable to outbreaks, while at the same time often having less robust local public health departments due to the above-mentioned fiscal constraints (and in the case of Massachusetts – no state funding for local health).

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?**

   - **Collective Impact Coalitions** bring together varied stakeholders to tackle complex issues that no single policy, government, organization, or program can independently solve.[1] Examples of effective Franklin County coalitions include the Communities That Care Coalition and the Opioid Task Force in Western Massachusetts.

   - **Rural Community Health Workers** are front-line healthcare professionals that are trusted members of the community with understandings of their clientele.[2] The Hilltown Community Health Center uses Community Health Workers to reach out to isolated rural elders, and provide domestic violence support. [3]

   - **Rural telehealth programs** allow healthcare professionals to connect providers with patients when factors like distance are a barrier to care. Heywood Healthcare in Athol, MA uses its Rural Tele–Behavioral Health Network to allow school children to meet with therapists and psychiatrists remotely. Lack of broadband in rural areas, however, limit use of telehealth.

   - **Regional public health districts** allow communities to share public health professionals and resources, thereby providing needed help and reducing municipal costs. The Franklin County Cooperative Public Health Service serves 14 rural communities, providing credentialed health agents and nurses, wellness clinics, and public health code enforcement. Other rural MA health districts include Tri-Town, Quabbin Health District and the Berkshire Public Health Alliance.

   - **The Population Urban and Rural Community Health (PURCH) Program** is a collaboration between UMass Medical School (UMMS) and Baystate Health System, which allows medical students to complete all there clinical work in rural Western Massachusetts, in connection with health improvement planners. The UMMS also has a **Rural Health Scholars program.**

[1] https://www.ruralhealthinfo.org/toolkits/networks/2/collective-impact
[2] https://www.ruralhealthinfo.org/topics/community-health-workers
[3] https://www.hchcweb.org/connect-to-services/service-we-offer/community-programs/

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

Be sensitive to the reality of rural areas when developing grant programs and volume standards. Programs need to be flexible on requirements for the number of patients, participants, or deliverables in recognition of sparse population density in rural areas. Travel challenges and distances to deliver service and receive required training and certifications should also be recognized. The FRCOG's Regional Public Health Nurse travels thousands of miles a year, with the related travel time, to serve the 20,000 residents of her 14 rural communities. Many certification and re-certification programs only offer trainings in Boston, which is 200 miles from Franklin County.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities

N/A -- The FRCOG has no experience with this question.

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?

N/A -- The FRCOG has no suggestions in response to this question.

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

State legislation that allows Nurse Practitioners to practice without the oversight of an MD exists in 37 states but not MA. Could a national version be passed to extend this important role's capacity to serve underserved populations?

Creating a fully funded a rural Student Loan Forgiveness and Repayment Discretionary Fund and adjusting eligibility rules to allow rural health care organizations to use this incentive for employee recruitment. Currently student loan forgiveness cannot be guaranteed by employers, which limits the ability to recruit personnel.

Provide incentives and reduce barriers to access workforce training for all levels of rural healthcare workers. Take advantage of local community colleges and medicals schools to partner and provide this training.

Designate rural healthcare practices as "Critical Access Providers." Similar to the Critical Access Hospital designation that the U.S. Congress developed to reduce the financial vulnerability of rural hospitals, State Offices of Rural Health should determine how best to designate rural health care practices in Massachusetts as "critical access providers" to ensure sustained access to quality healthcare.

As noted above, the [Population Urban and Rural Community Health (PURCH) Program] is a collaboration between UMass Medical School (UMMS) and Baystate Health System, which allows medical students to complete all their clinical work in rural Western Massachusetts, in connection with health improvement planners. The UMMS also has a Rural Health Scholars program. Programs like this that expose medical students to the benefits of working in rural areas are vital for convincing future physicians to move to rural 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?

- Federally qualified Community Health Centers are often the only dental provider in underserved regions. Addressing their recruitment needs and stabilizing their funding is a vital way to solve the challenge.
- It is of utmost importance to change the outdated federal regulations that govern Methadone treatment. This medicine is a critical tool in addressing the nation's opioid crisis, but the rules for those who wish to become providers create an unrealistic burden and are based in fifty-year old stigma of those with substance use disorder.
- The Commonwealth of Massachusetts funded a demonstration project in 2007-2009 called the BEST Oral Health Project which connected mobile oral health services to children in preschool and K-2 settings. It was deemed a best practice by the Association of State and Territorial Dental Directors and could be emulated.
- Behavioral health is another area in which tele-health could provide significant access improvements for rural residents.
- The Federal government should require the development of robust annual "prescriber report card" from all state Prescription Drug Monitoring Programs – some states still do not have them. Similarly, national leadership on facilitating the inter-operability of state PDMPs would be a good step forward.
- Many rural areas have implemented transportation alternatives to get rural residents to healthcare in urban settings: volunteer carpool programs; utilizing Uber and Lyft to supplement public transportation; transporting cancer patients to chemo via small planes. These innovative programs should be incentivized and formalized.

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?

- Rural Public Health Nurses: https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/PublicHealthNursingPolicyPaper.pdf.aspx?lang=en-US
- Community Health Workers: https://www.apha.org/apha-communities/member-sections/community-health-workers
- The Village Model: https://www.vtvnetwork.org/
- Robust Regional Senior Centers, supported through state, federal and local dollars will also be a vital part of ensuring that our rapidly aging rural population can stay in their homes as long as possible. They are also an important foundational institution for all of the above bullets, not an alternative.

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?

A limitation frequently hindering data collection and reporting in rural areas is the problem of small numbers. When the number of cases of a particular characteristic or condition is small, it is usually withheld from public reports, to protect confidentiality. The Massachusetts Department of Health will report on suspected opioid overdoses by town if there are five or more in the given time period. If fewer, the report indicates <5. This is common practice in reporting public health data, and Congress could help by setting a national standard that addresses the “small numbers” suppression challenge.

The availability of data and the problem of small numbers affect the reporting of data by race and ethnicity. For example, in our region, because the population of Franklin County and the North Quabbin is 91% non-Hispanic White, statistics for the population as a whole are typically very close to statistics for the area’s non-Hispanic White population alone. Statistics for the region’s Latinos, Blacks, Native Americans, Asians, or other groups may be quite different, with the difference obscured by the overall statistic. For example, the poverty rate for Franklin County is estimated to be 11%, but the estimate for Blacks is quite different – 48% (with a large margin of error). Having a standard way to address this – by aggregating five years of data, for example, would allow us to far better understand our rural areas. We are unable to explore differences among smaller groups with the quantitative data available. [4]

We would also recommend meeting with the Robert Wood Johnson Foundation’s County Health Rankings Team, as they have an important perspective on the challenges of capturing the spectrum of health data for every county in the US.

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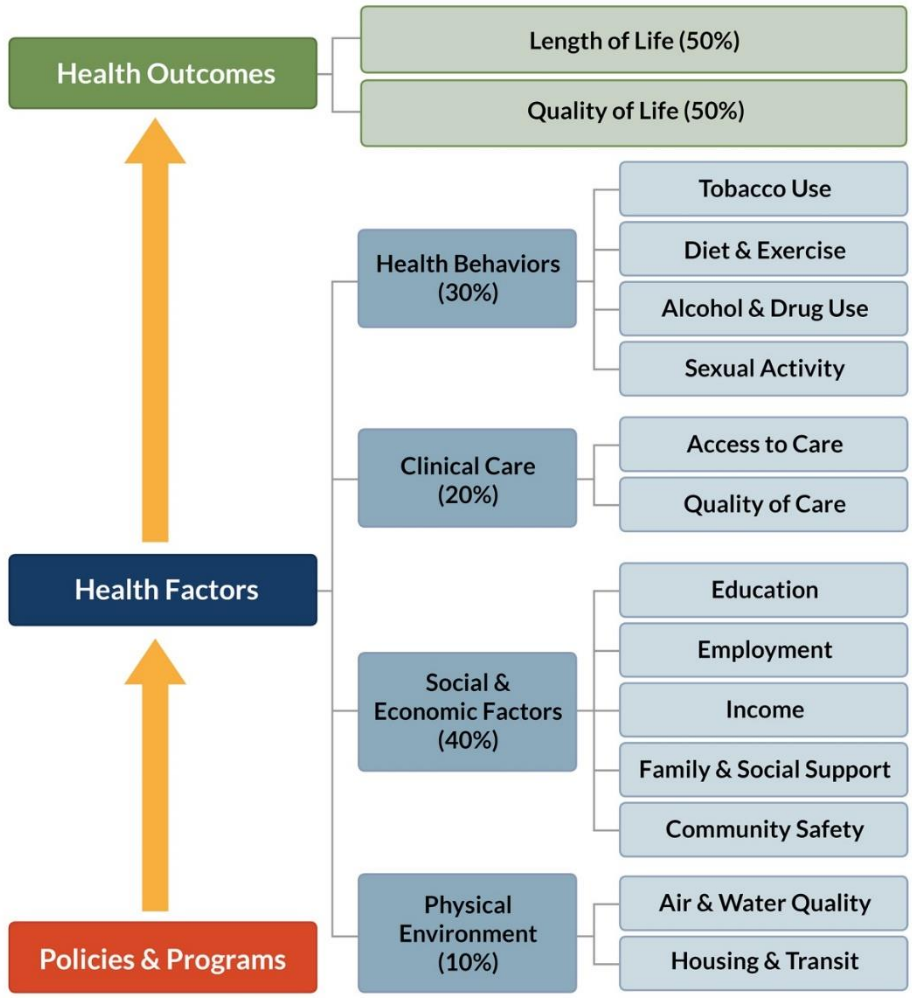
[4] Baystate Franklin Medical Center Community Health Needs Assessment, 2019

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?

- We need a commitment on the part of federal and state funders and healthcare systems to understanding and addressing the social determinants of health (see picture -- model of health factors from the Robert Wood Johnson Foundation's County Health Rankings).

- We need a national cultural humility training for healthcare systems.

- We need more behavioral health training for medical, NP, and Physician Assistant students to ensure that rural healthcare providers can treat the whole patient – especially in areas where behavioral health supports are scarce.



County Health Rankings model © 2016 UWPHI