



November 29, 2020

To: The Rural and Underserved Communities Health Task Force (Task Force)

From: Integrative Medicine for the Underserved (IM4US)

RE: Request for Information

Integrative Medicine for the Underserved (IM4US) has outlined its response to The Rural and Underserved Communities Health Task Force (Task Force) Request for Information (RFI) for input on priority topics that affect health status and outcomes for rural and underserved populations below. This is a compilation of responses from individual providers practicing in several unique areas that are both rural and underserved.

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?

- Lack of access to care occurs in rural areas because there are a limited number of providers. In urban areas, there are a limited number of providers who take patients without insurance or Medicaid. This applies to both primary care providers and specialists.
- Underserved patients face extra burdens tied into unmet social needs or factors associated with the social determinants of health. These include food insecurity perhaps due to living in a food desert, transportation issues, lack of affordable housing, violence in their communities, lack of access to broadband internet, poor schools, lack of job opportunities, the effects of racism and discrimination, etc. These are often due to larger structural issues, such as policies that keep certain communities marginalized with a lack of appropriate resources.
- In certain rural areas, provider retention is one of the largest issues. This is a complex issue that tends to not be resolved by legislation. Poor schools, violence in the community, etc. are dynamics that deter or drive providers away from these communities, as well as impacts patients, however there are certain structural changes that might be helpful:
 - Revision of reimbursement patterns to provide higher reimbursement in health provider shortage areas – in our area, overhead costs are higher because of lack of trained support staff, poor infrastructure locally requiring more staff time for follow-up and facilitation of visits, etc.

- In far outlying areas such as Hawaii, shipping costs of medical equipment and heavy reliance on locums' providers further increases health care costs, yet Hawaii's reimbursement rates are in the bottom tier.
- Revision of reimbursement to allow greater use of telehealth and distance visits even for primary care – gasoline costs limit visits for many of my patients, and although I provide a tremendous amount of telephone and Internet care in order to take care of these people, the lack of reimbursement for this care makes it burdensome
- Alternatives to electronic MACRA reporting for small, independent offices - without a large staff and IT support, safety net providers are being penalized even though quality metrics may be well met in their practices
- Flexibility in case management support for low income patients – for a number of my patients, it is as simple as lack of reliable telephone service which makes it nearly impossible to schedule needed care; provision of a flip phone and a few hours of service per month could make a huge difference, but instead Partnership has offered case managers 3 hours away in Redding who can provide no material support beyond what my own staff can offer.
- Native Hawaiians have some of the poorest health outcomes in the US. A major health determinant is the heavy psycho-socio-political reality that Hawaii is illegally occupied by the US - this has been acknowledged by former US President McKinley and the United Nations. Hawaiians are culturally and politically subjugated in grave ways, and this reality is very much present in Hawaiians' psyches, contributing to this population's widespread depression, substance abuse, unemployment, domestic violence, and disenfranchisement and distrust of health providers and government. This is the same reality plaguing Native American communities across the country. Hawaiians were a vigorous and healthy population and had abundant healthy local food, until the arrival of outside influences that shifted the economy and lifestyle, such as free or cheap distribution of army rations like spam, and ecologically devastating industries such as sugarcane. Now most of the food is imported, and the average diet is very poor, contributing to the highest rates of diabetes and cardiovascular disease in the nation.

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?

- Social Determinants of Health
 - Partnering with outside organizations helping to connect patients to social needs (e.g. [Aunt Bertha](#), [Health Leads](#))
 - Many FQHCs offer in-house services to meet the needs of their patients. These include creating food access programs by working with food banks or food justice organizations; creating safe spaces for patients to exercise; group visits to address loneliness and isolation; [Medical-Legal](#)

[Partnerships](#) which can address housing rights issues, employment issues, and other health harming legal needs; programs to help patients with [tax preparation](#) which allows them to keep more of their income; allowing people to register to vote on-site; etc.

- In Hawaii, incredibly heart-warming local movements are working to regain food sovereignty and cultural vitality.
- Silver sneakers as part of many Medicare Advantage plans and paid for health club membership for a number of Medicare patients, but these plans have pulled out of some areas. This is a low-cost high-yield intervention to decrease sedentary lifestyle, much cheaper than PT
- Additionally, since social determinants of health are caused by specific policies that have created or exacerbated health disparities, FQHCs have been very active in advocacy efforts to help change laws and policies in order to benefit the health of their patients. FQHCs are starting to collect data on social determinants and social needs of their patients and using this to inform which legislative and policies they need to target.
- On Hawaii island, the hospital system is partnering with the fire department and EMS in a pilot program to make house calls to frequent flyers of the emergency rooms. The preliminary data are very encouraging in terms of decrease ER use by these people, and the patients seem to really welcome the visits even though they are unannounced surprise visits!
- Nationwide, the majority of new physicians tend to stay and practice close to their residency site, so establishing medical residencies in underserved areas is a high yield solution. The fairly new family medicine residency on the Big Island of Hawaii is training new providers, almost all of whom are staying in Hawaii (although a good number are going to Oahu where pay is higher.) However, the inherent limitations of resources in these areas present great hurdles. The residency here has strong community support, but it took 3 starts over more than a decade to get it off the ground, due to funding and political challenges. Hence, underserved communities who are motivated to start a new residency program should receive national support to do so.
- *CULTURAL CONCORDANCE* between providers and patients greatly enhances health outcomes. When patients see that their provider is from their same culture or at least is informed and respectful of the culture, then these patients are much more likely to show up for visits, communicate openly, and trust their provider's recommendations:
 - On Big Island of Hawaii, there is a strong representation of culturally concordant mid-level providers and staff who speak pidgin and honor the local culture, making Hawaiian patients feel comfortable and respected.
 - Culturally concordant physicians are still lacking in Hawaii, but there are scholarships that address this gap by paying for 100% of medical school training for a few native Hawaiians each year, with some required service in the local region after completion of training.

- Some community health centers are integrating traditional practices and inviting traditional elders to come teach workshops.
- Multiple Chronic Conditions:
 - For multiple chronic conditions, integrative pain management programs that follow the [HHS Best Practices for Pain Management](#) and take a biopsychosocial approach with a larger toolkit that may include acupuncture, chiropractic, mental health services, substance use services, yoga, etc. These often have to be created in-house due to lack of access of these services in underserved communities for various reasons (no practitioners, lack of payment by insurers, etc.).
- Broadband
- Telehealth/Telehealth/Telemedicine/Telemonitoring:
 - Telehealth is an effective approach in rural areas, but even in urban areas where there is a lack of access to specialists. One model that has been particularly effective is [Project ECHO](#), which allows PCPs to become specialists in their communities in particular areas through online education.
 - Allow telehealth reimbursement for primary care and for homebound patients

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

- For solo practitioners in a rural area, reporting for MACRA taxes can over stretched staff and may run the risk of being penalized in reimbursement even if quality goals are met, simply because of the inability to report on these in the way requested. See file:///C:/Users/fullc/Downloads/rural_final_report.pdf. In rural areas, there is the risk of frequently practicing beyond the scope of many urban family doctors because of the lack of specialty care accessibility, however this is not recognized by reimbursement or by reviewers (in recent Medical Board issues)
- On Hawaii island the existing shortage of providers is expected to worsen in near future years because the physician workforce is aged, with many providers having recently retired or about to retire. However, the existing dearth of providers until recently was not reflected in the rosters of active licenses, because many active licenses are maintained by retired or partly retired practitioners, or by locums practitioners who are not even on the island. For this reason, most of Hawaii island did not qualify as underserved, until a community panel completed a years-long project of phoning up practitioners on the roster one by one to verify their active status. There are likely other underserved areas like ours who need assistance to demonstrate their underserved status.

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?

- Offering patient primary care is great, but often a big barrier is getting patients access to specialty care if they need it. [FQHCs do provide excellent care, often better than the care provided in other clinics](#), and they can provide a lot of services including primary care, behavioral health services, and dental, but

sometimes patients require a higher level of care, and may not have access to this due to either a lack of practitioners, or practitioners that accept public insurances.

- In some communities, the FQHCs are not accepting new patients, or are excluding patients with specific health conditions, most particularly chronic pain, and they freely acknowledge that they are challenged to provide care to complex patients with multiple chronic illnesses. There is frequently a lack of access to physicians, with the provision of care primarily by mid-level practitioners, who may not be well trained or adequately supervised in managing these complex and seriously ill patients.
- Patients with transportation issues or inability to pay will not seek preventative care, then when they are critically ill, they go by ambulance to the emergency room, which is a highly inefficient use of already limited health care dollars.

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?

UCSF has recently been offering a lot more follow-up visits by telehealth for patients, after initial specialty consultation, which has been tremendously helpful - not sure what has changed in reimbursement in the last year that makes this possible.

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

- The National Health Service Corps and State Loan Repayment programs. One point I'll make about these are that they are limited to MDs/DOs/NPs/PAs/BH practitioners/dentists. However, with the aforementioned HHS Best Practices for Pain Management, it is recommended we start including other types of providers who can address patients' pain and help keep them off of opioids, such as acupuncturists and chiropractors. Loan repayment should be expanded to include other integrative health practitioners who can help clinics meet these best practices.
- Additionally, calling for increasing diversity within health professional schools, to include more students from underserved communities who may be more likely to work in their communities when their schooling is completed.

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?

- Partnering with outside organizations. For example, partnering with a local recovery and addiction organization to bring in a substance use counselor into our clinic (we used opioid grant money from HRSA to add this service). Or, partnering with a local Chinese Medicine school who bring students that can perform acudetox using the [NADA protocol](#) for patient with substance use. Some states allow for BH practitioners or nurses to get trained in NADA, and that's another way to provide this service to patients.

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?

- Group Medical Visits group visits can address social isolation. Improvements in reimbursement for group visits/shared medical visits that would allow for paying facilitators in addition to the healthcare provider would make this more feasible for more providers
- [Redwood Coast Village](#) is a program in one area for seniors to volunteer and benefit from services to help each other
- Peer led support groups like the Chronic Disease Self-Management Program developed at Stanford are sponsored by our local IPA (https://www.cdc.gov/arthritis/marketing-support/1-2-3-approach/docs/pdf/provider_fact_sheet_cdsmp.pdf) - legislative support for funding for meeting spaces and for facilitator training might be useful

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?

- Health literacy and overall literacy is an issue in our community, and I'm not sure that that is measured
- Shame and suspicion of authority are significant barriers for patients – many will not accept home health services or other visitors due to concerns about loss of autonomy if government representatives witness their substandard housing, safety issues, etc. There is a large burden of undiagnosed or underreported mental health dysfunction as well.
- Are there measurement metrics for patient perception of discrimination or stigma? There are a number of people who will not access healthcare services even when they have the financial resources because of this – having limited choices in healthcare providers (for instance only a single FQHC for the area, or only a single drug treatment program) can be particularly problematic if people have had a single bad experience. Some sort of metric for number of options to access care might be useful for this reason.

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?

- More of an investment in infrastructure for rural and underserved areas (affordable housing, transportation, education, sustainable food systems, etc.) to help mitigate some of the social determinants which impact health.
- Alternative payment models which allow for the expansion of practitioners that can focus on wellness and whole person health. E.g. HHS Pain Management Best Practices which recommend the use of acupuncture, chiropractic, yoga, tai chi, etc. There is a strong need for nutritional education in our area as well. In rural areas, there is a lack of resources such as diabetic educators for the community,

as well as nutritionists/dieticians for other conditions which are known to be responsive to diet. Reimbursement for visits with these providers would make a significant difference in making that care available

- Investment in the implementation of group visits - will address loneliness and isolation, improve chronic health conditions, cut costs, keep patients out the ER, and improve patient and provider satisfaction (others can help expand upon this). This will require a change in how groups are currently billed as well.

Cordially,

A handwritten signature in black ink, appearing to read "Rhonda Smith", with a stylized, cursive script.

Rhonda Smith
Interim Executive Director