



## IDAHO PRIMARY CARE ASSOCIATION

November 29, 2019

House Ways and Means Committee  
Rural and Underserved Communities Health Task Force  
U.S. House of Representatives  
1102 Longworth House Office Building  
Washington D.C. 20515

RE: Rural Access to Health Care Services Request for Information

*Submitted via: [Rural\\_Urban@mail.house.gov](mailto:Rural_Urban@mail.house.gov)*

Chairman Neal and Members of the Committee:

Thank you for the opportunity to provide information to the committee. We appreciate your commitment to improving the health care outcomes within underserved communities across the nation. We hope to positively contribute to this discussion by providing responses to your questions from the perspective of a geographically large and mostly rural state.

IPCA is the state membership organization for Idaho's federally qualified health centers (FQHCs). FQHCs are a critical part of the healthcare system in Idaho. In 2018, FQHCs served 198,332 people – or 1 in 9 Idahoans. These clinics provide comprehensive medical, dental, and behavioral healthcare in 91 clinic sites across the state. An additional 30 clinics provide care in school based clinics. FQHCs provide life-saving primary care to residents, regardless of insurance status. They are locally operated healthcare systems offering affordable care to improve the wellness of individuals and families. Many FQHC patients are medically underserved, and having access to healthcare allows them to take responsibility for their health so they can be an engaged community member. Last year 32% of all FQHC patients in Idaho were uninsured and the majority live below the Federal Poverty Level.

Idaho has a population of 1.7 million and is the 14<sup>th</sup> largest state in the nation, yet the 12<sup>th</sup> least populous state. According to the 2018 America's Health Rankings Report, Idaho ranks 50<sup>th</sup> for ratio of primary care physicians to population. This provider shortage is likely to worsen with implementation of HRSA's Shortage Designation Modernization Project which updates the Health Professional Shortage Areas (HPSA) scores on February 1, 2020. The new HPSA scores, currently in its final stages, will negatively impact rural health centers and their ability to access

National Health Service Corp funding. The intent of the SDMP is to “give greater transparency, accountability, and uniformity to the HPSA designation and scoring process,” but like many policies and programs that seek uniformity, inevitably the uniformity fails to account for the vast differences in rural and frontier services and needs. For example, an ideal rural practice could be composed of 3 clinician FTE’s even though the HPSA score has a benchmark of 1 FTE to 3,500 Medicaid patients. In our opinion, the HPSA score for a rural area trying to sustain a practice is more likely to burn out a clinician rather than build and sustain a viable practice. This program should be correcting for rural/urban inequities in Graduate Medical Education spending rather than exacerbating the underlying problem of medical professionals being disproportionately trained in urban environments.

*Question #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 health-related factors impacting patient outcomes in rural areas include workforce shortages, lack of healthcare insurance, long driving distances, minimal specialty care, and lack of emergency medical services.

Idaho, like many states is experiencing a shortage of physicians, nurses and other trained clinicians. It’s more difficult to recruit and retain providers in rural or frontier areas than in urban areas and without a skilled workforce, rural residents will suffer the most in terms of access to healthcare. Too many Idahoans lack health insurance (11%), although this number is expected to decrease with the rollout of Medicaid expansion coverage starting January 1, 2020. People in rural areas are accustomed to driving farther for essential services than those in urban areas. However, this factor can negatively impact health outcomes when accessing care is inconvenient or inaccessible. Not surprisingly, rural residents have less access to specialty care and emergency medical services are minimal, if they exist at all.

*Question #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 integrated care (medical, dental, behavioral health, pharmacy) provided by our nation’s FQHCs is a very good model for delivery of primary care.

- a) Idaho FQHCs understand the importance of social determinants of health (SDOH) and do their best to address barriers to care. Depending on the needs of the local community, this could include bus passes, Uber rides, access to a clinic food pantry, and information about community services the patient may need.
- b) Idaho FQHCs are very skilled at providing care for patients with multiple chronic conditions. Through engagement with care coordinators, social workers, or community

health workers, patients are supported with health education and medication management.

- c) Broadband access continues to be a challenge in the most rural areas of Idaho. However, Governor Brad Little has prioritized broadband improvements in the coming year as an outcome of his Broadband Task Force.
- d) Idaho FQHCs currently utilize telehealth and are interested in incorporating more in the coming year. One of the biggest challenge to providers utilizing telehealth is lack of support on the part of insurers.

*Question #3 – What should the Committee consider with respect to patient volume adequacy in rural areas?*

The primary care provider is critical in rural areas, but often has a greater overall responsibility to the patient given the lack of access to specialty providers and may be the only source of OB/GYN care, dermatology and pediatric care. This broad range of scope requires the provider to spend more time with each patient and therefore large panels are hard to sustain. This becomes more critical when primary care is responsible for chronic disease management like diabetics and others in their area. Therefore, sustaining a large panel without partners is challenging.

As an example, we are concerned that the current approach to health professional shortage areas (HPSAs) fails to account for rural realities and the burden placed on a single practitioner to deliver care to 3,500 individuals 24/7, 365 days a year. A rural community needs a minimum of three full time equivalents to manage emergency call and the range of services needed in a rural environment. The historic use of population-to-provider ratios to determine what constitutes access is fundamentally biased against rural and frontier healthcare providers because the population density is low, and providers cover a wider range of services.

*Questions #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?*

Idaho has formed a statewide primary care network comprised of FQHCs. The purpose is peer support and learning, in addition to resource sharing and group purchasing.

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

There is no easy fix for workforce shortages, however some existing models are worthy of increased investment.

Federal models/investment:

- The National Health Service Corps (NHSC) is critical for enabling rural clinics to recruit providers with the help of the loan repayment program. Increased funding for NHSC would be an investment that would pay dividends in rural communities. Rural residents cannot access care if a clinic cannot attract and retain physicians, nurses, and other clinicians.
- The Teaching Health Center Graduate Medical Education Program supports the training of physicians – many of whom serve their residency in a rural area and decide to stay in the community.

State models/investment:

- The University of Washington School of Medicine regional medical education program (a partnership between Washington, Wyoming, Alaska, Montana, and Idaho). As a state without its own medical school, partnerships such are very important.
- Graduate Medical Education funding through the state general fund enables Idaho to fund residency seats for state residents.

*Question #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?*

FQHCs continue to provide integrated care that includes behavioral health care, dental, and treatment for substance use disorder. Idaho FQHCs are on the front lines of responding to the opioid epidemic and have expanded their role in treating Substance Use Disorder (SUD) among medically underserved populations. FQHCs continue to integrate behavioral health into primary care and increase the services they provide.

Strengthening FQHCs by reauthorizing federal funding for five years, rather than two years would be an investment in rural health delivery in every state. Investments in infrastructure development and new access point funding would also go far to improve access to healthcare for rural residents.

*Question #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?*

An investment in electronic health information exchanges (HIEs) would allow for better care coordination between providers, and across geographic lines. HIEs allow physicians, nurses, pharmacists and others share a patient's vital medical information electronically. Uniform data collection would improve our state's understanding and utilization of data relating to the social determinants of health. Lastly, data collected from state Primary Care Offices (PCOs) that have a big impact on a state's facility HPSA score must be collected uniformly. In the current national

update of Auto HPSA scores, HRSA is forced to rely on data collected by each state's PCO and inconsistent data has culminated in vast disparities between states. The end result is lower HPSA scores for 80% of Idaho's FQHCs. This means that the majority of FQHCs in Idaho will not be competitive for loan repayment support through the National Health Service Corps. Left unaddressed, Idaho's FQHCs anticipate great difficulty recruiting physicians and nurses. This will have a negative impact on health outcomes for individuals and families in rural areas.

*Question #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?*

Federally qualified health centers are an integral part of our state's primary healthcare system. As such, the following investments in FQHCs would help strengthen the delivery of healthcare to rural patients and improve health outcomes:

- Reauthorized 5-year funding for the Community Health Center Fund
- Increased funding for the National Health Service Corps
- New access point funding to create new FQHC clinics
- Funding for infrastructure improvements for existing FQHCs

Thank you for your consideration of our comments, and please feel free to contact me directly if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Yvonne Ketchum-Ward".

Yvonne Ketchum-Ward, CEO

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