



FORMER US SENATOR MARK BEGICH

November 29, 2019

Rural and Underserved Communities Health Task Force
Committee on Ways & Means
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To Whom It May Concern:

During my time serving as U.S. Senator from Alaska, I had many opportunities to travel to every kind of health care facility from state-of-the-art cancer treatment facilities to simple clinics with community members trained as dental assistants in rural Alaska. Because of the large geographic size of my home state and less than a million people throughout, delivering preventative medicine, acute care, elder care and everything in between is challenging. The good news is that some of the most innovative models for wrap-around services and comprehensive care have been tried and proven here in Alaska, under challenging conditions and our providers are constantly developing even more ways to serve people. I have always said, if something can work in Alaska, it can work anywhere.

I commend this committee for working to gather some of the most innovative methods for tackling healthcare delivery challenges in rural America. Requests like this one are important for gathering innovative and creative ideas to tackle the most pressing problems.

In this summary I have highlighted several programs and concepts that deserve consideration as national models. Some already exist but risk funding cuts. Some are pilot programs that deserve review and implementation. There are still people suffering financially and health wise all-over rural America due to lack of access or affordable care even though the U.S. has the ingenuity and means to do better.

My team here at Northern Compass Group and I are eager to be part of this national conversation and development of and concepts that will better serve rural and underserved communities across the nation. If there are any organizations or concepts from Alaska you wish to further explore, I will be more than happy to work to connect them with this committee.

Sincerely,

A handwritten signature in blue ink that reads "Mark Begich".

Mark Begich
Former U.S. Senator for Alaska

RURAL AND UNDERSERVED COMMUNITIES HEALTH TASK FORCE REQUEST FOR INFORMATION

Submitted by:

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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?

Alaska has the highest health care costs in the U.S. as well as the fastest-rising costs.

Observers have offered more than half a dozen explanations for Alaska's extra-high health care costs.

The list includes:

- Our state's relatively small population and isolation from larger markets
- Distribution of a substantial percentage of Alaskans in a variety of remote areas, including off the road system
- Limited numbers of providers of medical services
- Limited competition among providers, especially specialty physicians
- Particularly high compensation for providers, especially specialty physicians who perform procedures (such as orthopedic surgeons, cardiologists, and neurosurgeons)
- Hospital profit margins in urban Alaska that are higher than national averages
- Particularly risky and/or antisocial behavior by patients
- Regulation by the State of Alaska, particularly the "80th percentile rule"
- Absence in Anchorage—the state's largest community—of government-operated and/or teaching hospitals that are open to all patients
- Alaska doctors often charge and collect 500 percent—or more—than the costs for obtaining the same service outside the state. These higher fees appear to be mostly charged by specialty physicians. Some specialist procedures cost 10 times as much in Anchorage as they do in Seattle.
- A survey of more than 300 Anchorage businesses and organizations identified health insurance as one of the two top barriers to their organization's growth, behind only the condition of the state economy.

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?

Nuka System of Care

Alaska health care delivery systems include those offered through a series of Alaska Native-owned, nonprofit health care organizations for each region of the state. One such group is the Southcentral Foundation and their Nuka System of Care. The Nuka system is a relationship-based, customer-owned approach to transforming health care, improving outcomes and reducing costs. The Nuka System of Care is very unique and receives increasing national and international recognition for its effectiveness.

Southcentral Foundation's Nuka System of Care is recognized as one of the world's leading models of health care redesign. "Nuka" is an Alaska Native word that means strong, giant structures and living things. It is also the name given to Southcentral Foundation's whole health care system, which provides medical, dental, behavioral, traditional and health care support services to more than 65,000 Alaska Native people. Nuka is built upon the simple, yet revolutionary belief that the relationship between the primary care team and the patient (known as the customer-owner) is the single most important tool in managing chronic disease, controlling health care costs, and improving the overall wellness of a population. Recognizing that individuals are ultimately in control of their own lifestyle choices and health care decisions, Nuka focuses on understanding each customer-owner's unique story, values and influencers in an effort to engage them in their care and support long-term behavior change.

The focus on relationships extends beyond health care delivery. To ensure whole system transformation, each key work system was redesigned – including workforce development, compliance, human resources and finance – to ingrain an organization-wide focus on relationship-building and shared decision-making.

They offer health care organizations value-based solutions for data and information management, integrated care, behavioral health, workforce development, improvement, innovation and more. Attend a Nuka Conference, request a speaker, participate in trainings and consult with Nuka experts on varying elements of whole system transformation.

This information is from the SCG website: <https://scfnuka.com/our-story/#toggle-id-2>

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

No matter the population of a region, access to health care should be available. Regulations should not be the reason there is no delivery of services and creative, alternative, innovative technology and services should be quickly developed, approved and implemented.

Networked technology has the power to transform the administration of rural and remote healthcare administration. From aging in place to providing faster or more convenient access for those in need of healthcare and those providing services. In one commercial example being developed in the Northwest, a tablet application has been developed that incorporates repetitive or on demand patient surveys, reminds patients to take medications according to a fixed

schedule, allows for social interactions with patient families, and provides for video conferencing connections directly to care givers and other medical providers. The product has specific applications within hospice, palliative, and managed care settings, including for “aging in place” settings where seniors choose to remain at home. While this technology offers the opportunity for faster intervention, longitudinal monitoring, more convenient access options, and a substantially more efficient and cost-effective model of care, Medicare and Medicaid billing does not presently incentivize uptake of the technology vs. more traditional models, and as a result the technology is not broadly adopted in practice. In short, the technology and process innovations are presently available in the marketplace today, but require modification to billing incentives in order to align for provider adoption.

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?**
- b. there is broader investment in primary care or public health?**
- c. the cause is related to a lack of flexibility in health care delivery or payment?**

Funding for Prevention Programs

The work of building a healthy rural population involves a comprehensive array of promotion, prevention and early intervention approaches that focus on getting and keeping people as healthy as possible. Although much of our personal health outcomes involve individual choices, health prevention and promotion involves community or environmental strategies to improve systems and services that make healthy choices easier and unhealthy choices less attractive. While prevention of sickness and disease could have the most impact on long term cost to the states and federal government, it has the least understanding and funding.

Some Examples: reducing youth access to alcohol, prevention, or increasing the safety of local parks. Prevention theory assumes that issues such as substance abuse, mental health, physical fitness, violence, and other issues are interrelated. The foundation of prevention whether for families, communities, or larger areas must connect these issues, partner and collaborate with a variety of stakeholders, develop a strategic plan of action, and be able to focus on what it will take to achieve identified community health and wellness goals. Effective efforts that prevent diseases and other social problems or promoting physical health and community wellness promotion will have clearly defined processes and qualitative performance outcomes.

Veterans Access to Health Care

While veterans are spread all over the US, many reside in rural areas including Alaska.

Transportation is expensive and many vets are unable to travel long distance to receive care.

A military veteran "Choice Card" would allow the veteran user to seek care at non-VA hospitals or clinics under certain conditions. It would allow the state's veterans to go to community providers for their care by expanding the pool of providers available to veterans by enabling them to access Indian Health Service, or IHS facilities such as hospitals and clinics.

A pilot project was launched in Alaska in 2012 and included 26 total agreements, which covered the geographical area of the entire state to include the Aleutian Chain. According to the VA, 62 veterans took advantage of IHS healthcare when agreements began taking effect in 2012. In 2013 the number had jumped to 279. As of June 6, 2014, the figure was 273.

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?

YKHC

The Yukon-Kuskokwim Health Corporation, commonly referred to as YKHC, is a Tribal Organization that administers a comprehensive healthcare delivery system for 58 rural communities in southwest Alaska. Each of the communities in the service area is home to a federally-recognized Tribe, whose governing council has authorized YKHC to provide health services on behalf of the federal Indian Health Service (IHS). YKHC's healthcare delivery system includes community clinics, sub-regional clinics in five of the area's larger communities, a regional hospital, dental and optometry services, behavioral health services, substance abuse counseling and treatment, health promotion and disease prevention programs, and environmental health services. This information is from the YKHC website: <https://www.ykhc.org/>

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

Rural Human Service (RHS) Program

The Rural Human Service (RHS) Program, [College of Rural and Community Development](#), is a [34-credit certificate University of Alaska academic program](#) developed for Alaska village-based human service providers. It is intended for rural residents who are natural helpers and healers in their communities, and it is designed to help further develop skills and credentials in the helping profession. RHS offers a culturally appropriate training program designed for rural, village-based human service workers. Skills and training are provided in services such as crisis intervention, suicide prevention, community development, and counseling in mental health, substance abuse, interpersonal violence, grief, and healing. Students are often employed full-time and return to work after the intensive classes. Students are supported by numerous [partnerships and collaborations](#) throughout Alaska. The program curriculum, built over the course of ten years, has an active [advisory council](#) from across the regions. This above info is from this website: <https://uaf.edu/rhs/>

Dental Health Aide Therapists (DHAT)

For over 15 years, in an effort to increase access to dental care for residents in the Yukon-Kuskokwim Delta, Yukon Kuskokwim Health Corporation (YKHC) has sponsored the training of Dental Health Aide Therapists (DHAT). The rigorous, two-year training program equips local Alaskans to become mid-level dental practitioners who provide essential oral healthcare as close to our patients' home as possible.

As students prepare to become practitioners in rural Alaska, a rural-based training location is vital for the long-term success of our DHATs. During the second year, DHAT students receive training in a local cultural model and gain a working knowledge of common logistical barriers in rural Alaska. Prospective DHATs train alongside a network of current dental providers and work directly with the patient populations they will serve upon graduation, forming personal relationships with patients. Students experience life in a rural service area firsthand, helping to reduce attrition upon graduation. Local training for high wage, professional employment, allows DHAT students to train closer to home and builds local role models for our youth.

Community Health Aide Program

The Community Health Aide Program (CHAP) consists of a network of approximately 550 Community Health Aides/Practitioners (CHA/Ps) in over 170 rural Alaska villages. CHA/Ps work within the guidelines of the *Alaska Community Health Aide/Practitioner Manual* in assessing and referring members of their communities who seek medical care and consultation. Alaska CHA/Ps are the frontline of healthcare in their communities.

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?

Comprehensive Integrated Mental Health Program Plan

Alaska has a long-established Alaska Mental Health Trust authority. The beneficiaries served are those who experience mental illness, intellectual or developmental disabilities, chronic alcoholism or drug dependence, or suffer from a traumatic brain injury or Alzheimer's disease or related dementia.

This early intervention model is based on the idea that Alaska has a comprehensive behavioral health system with the necessary resources and funding behind it to provide a full continuum of care of prevention, treatment, and support services across the lifespan. The Alaska Mental Health Trust Authority has worked with the State of Alaska to establish a method to strengthen existing systems called *The Comprehensive Integrated Mental Health Program Plan*. This is an online working document that is available online along with a list of complementary resources where anyone working to promote behavioral health services can review the information and use it to guide their work. It will be revisited annually to monitor progress and assess impacts to the health and safety of Trust beneficiaries.

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?

Medicare Rural Add-on

The longstanding Medicare rural add-on for home health services will be phased out over the next 2-4 years, threatening the provision of the benefit in rural areas. This three percent payment modifier to reimbursements for services provided in rural areas continues to be crucial to maintaining access to care. Rural agencies face higher overhead expenses due to increased travel time between patient visits and demands for extra staff. This payment modifier is imperative so that rural agencies will be able to keep their doors open and provide necessary care to homebound patients. Congress has repeatedly determined, with bipartisan support, that the home health rural add-on is needed to maintain care access and quality in rural areas. Dating back to 2000, the Congress has continually extended the rural add-on with only minimal gaps. As initially applied to the Medicare Home Health Prospective Payment System, the add-on was set at 10%, and then decreased to 5%, followed by 3%. Most recently, the Bipartisan Budget Act of 2018 called for phasing the add-on out over the next 2-4 years, leaving many providers questioning how they will be able to stay in business. [Fact Sheet](#)

Home Health Care Planning Improvement Act S. 296/H.R. 2150

Medicare law requires that a physician certify a patient's eligibility for coverage of home health services. Much of the primary care provided today comes from highly skilled non-physician practitioners such as Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists. As a result, these professionals must "hand-off" their patients to a physician simply to comply with outdated Medicare certification requirements. Similar legislation allowing Non-Physician Practitioners (NPPs) to certify a patient's eligibility has been introduced in past Congresses, garnering broad bipartisan support. In the 115th, 46 Senators and 182 Representatives cosponsored the legislation.

[Fact Sheet](#)

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 use of distance technologies such as telemedicine can not only improve the quality of care for Alaskans, but also has the potential to drive down costs through increasing access and service in an individual's community of choice and reducing travel costs. To fully utilize telemedicine, rural America and Alaska must have affordable, dependable fiber-optic services.

Additionally, the US must optimize information technology investments to improve process efficiency and enable innovation such as with a new program in Alaska called the "Health TIE: Health Testbed for Innovative Enterprises." After events focused on defining the pain points and brainstorming the opportunities, plans have emerged to create an Alaskan-based Innovation Hub focused on creating an ecosystem that encourages start-ups and innovative entrepreneurs to tackle "wicked problems" specific to health and human services. While the current focus is direct support workforce, long-term the accelerator could catalyze a variety of projects in the healthcare realm.

- Explore utilization of innovative distance technology to increase access and cost savings.
- Evaluate potential technologies and solutions.
- Encourage a culture of data-driven decision-making that includes data sharing, data analysis, and management to link support services across Alaska Department of Health and Social Services (DHSS) divisions and other departments.
- Support innovation policies and collaborative planning efforts.
- Understand what data is available and streamline efficiencies.
- Enact purpose-driven data collection and data analysis
- Use the state Health & Human Services department's existing systems map and legal determination, create a data-streamlining and data-sharing plan.
- Obtain legal counsel for final determination on the opportunities and constraints of inter-divisional data-sharing.

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?

Telemedicine

1. Establish methods for delivery of more advanced Telemedicine, which allows doctors, nurses, local health aides, and patients to communicate about diagnosis and treatment through electronic means, avoiding the cost of travel.

In Alaska and across the country, one of the most pressing issues regarding telehealth is the issue of inter-jurisdictional – across state or country boundaries (across states' lines). This topic relates to situations where the practitioner (i.e., psychotherapist or counselor) and the client or clients are not in the same state or even the same country. The issues at hand are whether a psychologist in State A can treat a patient who is in State B via telehealth if the practitioner is licensed only in State A but not in State B. It is obvious to almost all practitioners and experts alike that some state licensing laws are archaic and do not match 21st century digital realities. While some attempts have been made to allow licensure mobility for psychologists and other professions, this allowance is far from the change that needs to take place. The above information can be found at the following website:

<https://www.zurinstitute.com/telehealth-across-state-lines/>

3. Mental Health First Aid

Since 2015, 20 states have made Mental Health First Aid a priority by enacting policies that allocate funding for trainings, require certification standards for public sector employees and establish statewide mental health training programs and mandates. The Mental Health First Aid Act of 2015 (S. 711/H.R. 1877) authorized \$20 million for Mental Health First Aid. Under this funding, participants could be trained in:

- Recognizing the symptoms of common mental illnesses and substance use disorders.
- De-escalating crisis situations safely.
- Initiating timely referral to mental health and substance abuse resources available in the community.

Training programs under this project would be offered to emergency services personnel, police officers, teachers/school administrators, primary care professionals, students, and others with the goal of improving Americans' mental health, reducing stigma around mental illness, and helping people who may be at risk of suicide or self-harm and referring them to appropriate treatment. Studies have shown that Mental Health First Aid successfully increases help provided to others and guidance to professional help, and improves concordance with health professionals about treatment.

This program should be fully funded every year and expanded to include high schools across America.