



NHPCO'S Response to Ways and Means Committee Rural and Underserved Communities Health Task Force Request for Information

- 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?**
 - a. Rural families have less access to hospice care programs than people in more concentrated populations, according [to a 2015 study](#). Rural counties are less likely to have a Medicare-certified hospice than urban counties, and the service area of the nearest hospices may not extend far enough to reach some rural patients.
 - b. Although death is one of the few certainties in life, very few Americans spend time considering their wishes for their life when they become ill, incapacitated, and face death. Moreover, minority communities have cultural and historical reasons why they may push for aggressive interventions, even if they are futile, to make up for years of receiving substandard care from a systemically unequal healthcare system. Transportation and healthcare literacy can be a hurdle in both urban and rural communities, and the absence of a local or live-in caregiver compounds difficulties with activities of daily living. However, many of these symptoms could be addressed if Americans were empowered and incentivized to consider their mortality before a crisis occurs; having important conversations with family members, spiritual guides, and their healthcare team could allow Americans in all situations to understand their options, and have a clear plan that respects their beliefs, wishes, and priorities.

- 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?**
 - a. The Hospice model; that is, an interdisciplinary team of community-based physicians, nurses, social workers, chaplains, physician assistants, certified nursing assistants, and volunteers, has forty years of success in the United States providing care to patients facing serious-illness and the end of life without regards to their ability to pay. This team-based approach addresses more than the medical needs of the individual patient, but also addresses the caregiving needs of their family, including training on how to be a caregiver and respite support. Hospices manage the care of complex patients, many with multiple co-morbidities, by facilitating important conversations about quality of life, patient wishes, and personal beliefs. Palliative Care has the potential to take this model, focused on end-of-life care, and provide it to a wider, non-terminal but still seriously-ill population, thereby improving outcomes while decreasing costs and reliance on emergency rooms.

3. **What should the Committee consider with respect to patient volume adequacy in rural areas?**
 - a. Hospice and palliative care providers in rural America struggle to keep their doors open. They must maintain a sufficient daily census to pay their staff, but also must travel many hours and miles to visit patients in far-flung corners of their region. They struggle with workforce issues including recruitment and retention.

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?**
 - i. As the National Association of Rural Health Clinics has indicated, Millions of rural Americans receive high-quality care from local Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs). Unfortunately, when these patients want to access hospice services, they are unable to continue to receive hospice care from their RHC/FQHC physician because RHC/FQHC physicians are not reimbursed for Medicare hospice services. This is a reason why rural and frontier Medicare decedents are less likely to use hospice services than their urban counterparts and the number of rural hospices is decreasing. We support the increasing use of RHCs and FQHCs, however we must ensure that patients at those providers have the same access to hospice services as other patients.
 - b. **there is broader investment in primary care or public health?- NA**
 - c. **the cause is related to a lack of flexibility in health care delivery or payment?**
 - i. FQHCs and RHCs are paid through a bundled payment system that current does not permit payment for hospices services. In every other part of the healthcare system, a patient can keep their regular primary care provider and that provider works with the hospice team in tandem to ensure patient comfort and continuity of care. Due to this lack of flexibility in the FQHC and RHC payment system, patients at these centers are not afford the right to their attending physician of choice. We urge the Taskforce to consider the Rural Access to Hospice Act (H.R. 2594), a bi-partisan, bi-cameral, non-controversial bill that would fix this issue. This bill was introduced by Ways and Means Members Reps. Kind and Walorski and benefits from being cosponsored by Ways and Means Members; Reps. Blumenauer, DelBene, Sewell, A. Smith, Reed, J. Smith

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?**
 - a. Project ECHO® (Extension for Community Healthcare Outcomes) is a movement to demonopolize knowledge and amplify the capacity to provide best practice care for underserved people all over the world. Launched in 2003, the ECHO model™ makes specialized medical knowledge accessible wherever it is needed to save and improve people's

lives. By putting local clinicians together with specialist teams at academic medical centers in weekly virtual clinics or teleECHO™ clinics, Project ECHO shares knowledge and expands treatment capacity.ⁱ The result: better care for more people. The University of Kansas is a Project ECHO hub and leverages technology to educate providers in rural areas that face workforce shortages especially in certain types of care including hospice and palliative care.

- 6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?**
 - a. Resolution Care, a Eureka, Calif., palliative care provider operates a virtual hospice program that enables clinicians to support patients and families in real time where workforce shortages exist. Resolutions has a number of tablets with data plans in circulation and other ways to support those with limited access in the rural communities they serve in the northern part of their state.
- 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?**
 - a. NA
- 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?**
 - a. Community-based hospice and palliative care services specifically address gaps in care delivery and the challenges of social isolation by providing person-centered, wrap around services that care not only for the patient's medical needs, but their spiritual and social needs as well as the needs of their family and caregivers. The Medicare Hospice Benefit mandates the use of community volunteers, many of whom provide patients with a sense of community and social support. In order to address social isolation, health decline, and trips to the emergency room, we need to further prioritize person-centered, wrap around services in the community, like hospice, and free hospice from the restrictions that require a diagnosis of terminal illness for eligibility, and bring palliative care services to the chronically and seriously ill populations that would benefit from such services in rural areas.
- 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. [CMS recently released a report highlighting the rural-urban disparities in healthcare.](#) This report found that rural residents, regardless of race or ethnicity, often received worse clinical care than urban residents. It also notes that future research is needed to understand whether this pattern reflects poorer dissemination of clinical practice guidelines to rural areas, poorer translation of those guidelines into clinical practice, difficulty accessing care in rural areas, or some other cause. These would be good data elements to focus on to help researchers better identify the causes of health disparities in rural areas.

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?

- a. An easily achievable improvement for rural and underserved patients would be the passage of the Rural Access to Hospice Act, a bi-partisan, bi-cameral bill that fixes a barrier in current law that prevents patients at Rural Health Clinics and Federally Qualified Health Centers from keeping their primary care provider when they elect hospice. This bill also received technical assistance from CMS in 2018 and this has been incorporated into H.R. 2594. This is a non-controversial, technical fix that would remove this statutory barrier and allow these patients to have easier access to the supportive services of hospice. We know that continuity of care and patient choice are important indicators of quality, and we know that hospice improves outcomes for patients and families. This legislation if passed would accomplish all of these goals.

ⁱ http://www.kumc.edu/Documents/telemed/ProjectECHO_flyer5-19.pdf