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NATIONAL RURAL HEALTH ASSOCIATION

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November 26, 2019

The Honorable Danny Davis
U.S. House of Representatives
2159 Rayburn House Office Building
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The Honorable Terri Sewell
U.S. House of Representatives
2201 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup
U.S. House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Jodey Arrington
U.S. House of Representatives
1029 Longworth House Office Building
Washington, DC 20515

Submitted Electronically to Rural_Urban@mail.house.gov

Re: Rural and Underserved Communities Health Task Force (Task Force) Request for Information

Dear Task Force Co-Chairs Davis, Sewell, Wenstrup, and Arrington:

The National Rural Health Association (NRHA) appreciates the opportunity to offer our comments and concerns on a range of topics which affect health status and outcomes for consideration and discussion in future Member sessions of the Task Force. NRHA is a non-profit membership organization with more than 21,000 members nation-wide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses and patients. We work to address the healthcare needs of rural America through government advocacy, communications, education and research. NRHA appreciates your continued commitment to the needs of the 62 million Americans residing in rural and underserved areas and looks forward to collaborating with you to improve health care access and quality in rural America.

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 Americans—who make up 20% of the U.S. population—face inequities that result in worse health care than that of urban and suburban residents. These rural health disparities are deeply rooted in economic, social, racial, ethnic, geographic, and health workforce factors. That complex mix limits access to care, makes finding solutions more difficult, and intensifies problems for rural communities everywhere.

Rural communities—from Appalachia and the Deep South to the Midwest and western states to Alaska and Hawaii—share common risks for poorer health. These challenges, including few local doctors, poverty, and remote locations, contribute to lack of access to care. Compared with urban areas, rural populations have lower median household incomes, a higher percentage of children living in poverty, fewer adults with postsecondary educations, more uninsured residents under age 65, and higher rates of mortality, according to a 2017 report by the North Carolina Rural Health Research Program (NC RHRP) at The University of North Carolina at Chapel Hill.

Physician shortages contribute to many rural health difficulties. Primary care doctors are stretched thin, and specialists, including mental health and substance abuse providers, are a rarity. Distance to care and transportation needs are key issues for rural residents when considering access to care. People who live in frontier areas often must travel long distances to obtain even basic healthcare, but distance may also be a factor for other rural residents when obtaining specialty clinician or hospital care. The lack of transportation also can challenge rural residents, regardless of distance to providers (although longer distances can worsen barriers to access when there is lack of transportation). Causes of potential sources of difficulties with transportation for rural residents: lack of public transportation options; income challenges that make it difficult to afford a reliable means of transportation; and decreasing numbers of family caregivers who can provide transportation (for example, due to age or job responsibilities that make it difficult to take necessary time off).

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?

Telehealth has tremendous potential for improving access to health services for patients in rural settings. However, there are several barriers and challenges regarding its use. For example, to utilize telehealth services under Medicare and for some Medicaid programs, patients must travel to the medical practice in order to use the telehealth arrangement, and this can be a barrier to access. Depending on the payer, fees may be associated with the service, and some third-party payers do not cover telehealth services. Such fees may result in additional out-of-pocket cost to the beneficiary. There may be licensing or other regulatory barriers to providing or receiving telehealth. A glaring need for education regarding telehealth services among rural patients is in order to help them become more comfortable with the idea of obtaining healthcare via telehealth.

The first challenge to utilization is a lack of infrastructure in place to achieve the expansion of telehealth – primarily the scarcity of broadband internet in rural America. Broadband is used throughout rural communities from agriculture to education and is needed to expand access for rural Americans to reliable internet service capable of delivering quality health care through technology. Policymakers at federal, state and local level should work to encourage deployment of broadband in rural areas nationwide. Every American should have access to quality health care, and broadband is an important step to achieve that goal for rural communities.

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

1. **Geographic isolation. Many, though not all, rural health providers are geographically isolated, which can limit patients' access to healthcare providers and specialists. Isolation is also frequently associated with patient transportation issues and limited broadband, hindering information technology capabilities.**
2. **Small practice size. Small rural hospitals and clinician practices often have limited time, staff and finances available to dedicate to quality improvement efforts. Additionally, the staff in rural areas frequently lack the specialized technological skills required to measure, calculate and drive quality improvements.**
3. **Heterogeneous setting and patient population. Rural areas tend to have disproportionately vulnerable residents who are socioeconomically disadvantaged and in poor health. This heterogeneity affects healthcare performance measurement and may mean quality measures have to be adjusted for patient characteristics.**

4. **Low case volume. Some rural providers do not have enough patients to achieve reliable and valid measurement results, a challenge which can be particularly relevant for certain condition-specific measures and for providers in more isolated rural areas.**

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

The population of rural America constitutes about 20 percent of the total population, or nearly 62 million people living outside metropolitan statistical areas. In 2005, only 11.4 percent of physicians practiced in rural locations. In recent years, shortages of non-physician providers including nurses, midlevel providers, dentists, pharmacists, radiology and laboratory technicians, and mental health professionals have also become more apparent. Problems with the distribution of physicians and other health professionals, as well as recruitment and retention issues in general, are ongoing for rural areas, especially those that compete with urban areas to maintain an adequate workforce.

There have been successful programs that can be drawn upon when discussing this issue within the Task Force. NRHA supports legislation that aims to attract and train the next generation of physicians, especially through establishing and expanding teaching health centers. The teaching health center program draws upon current Federally Qualified Health Centers (FQHCs) to establish medical residency training programs. Further, many physicians do not choose to come to rural practices due to the lack of resources offered and the many expectations of a rural doctor. There needs to be increases in pay, benefits, and flexibility for physicians to stay in rural areas. Lastly, NRHA supports changes to the National Health Service Corps (NHSC). The NHSC provides scholarships and loan repayment to physicians and other health care professionals that agree to work in an underserved or rural area. There has been issues with the number of professionals from the NHSC choosing rural areas, and we support tailoring the program to encourage more physicians to choose rural communities to serve in.

5. 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?

There are grave disparities in access to oral, behavioral and substance use needs in rural areas. Focusing on oral health, 56.1% of rural adults age 18-64 visited a dentist in the past year, compared to 65.7% of non-rural adults. Seniors in rural areas were even less likely to have a dentist visit in the past year. Rural adults aged 18-64 are twice as likely to be edentulous as non-rural residents and have higher untreated dental decay (32.6% compared to 25.7% of urban residents). Limited access to oral health care correlates with poor overall health, lower level of employability, and decreased school performance.

NRHA has launched a Rural Oral Health Initiative and is working with the OPEN Network on solutions to rural oral health needs. Policy makers are encouraged to work with NRHA on these efforts. Also, the Task Force should review the recommendations of the National Advisory Committee on Rural Health and Human Services report, "Improving Oral Health Care in Rural America," December 2018; we encourage the implementation of the recommendations. The Task Force should urge action to expand the oral health workforce and scope of practice, in conjunction with States. There needs to be growth in the support for coverage of dental care through Medicare, which covers the often-older rural population.

6. 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 patients are on average older, sicker, and poorer than their urban counterparts with higher rates of chronic disease and higher rates of lifestyle choices detrimental to health, such as tobacco use and opioid addiction. A 2017 Center for Disease Control (CDC) study found that "[t]he death rate gap between urban and rural America is getting wider" as a result of the fact that the rate of the five leading causes of death- heart disease, cancer, unintentional injury, chronic respiratory disease, and stroke – are all higher amount rural patients. Additionally, risky lifestyles, environmental factors, and mental health issues leading to suicides, negatively impact rural life expectancy. A plethora of other studies demonstrate similar indications of sociodemographic risk. These factors are not fully accounted for by the disparity between rural and urban Medicaid rates (21% rural vs. 16% urban).

According to the CDC, causes of chronic disease health disparities range across numerous factors of rural life:

- **Health Behaviors:** Rural residents often have limited access to healthy foods and fewer opportunities to be physically active compared to their urban counterparts, which can lead to conditions such as obesity and high blood pressure. Rural residents also have higher rates of smoking, which increases the risk of many chronic diseases.
- **Health Care Access:** Rural counties have fewer health care workers, specialists (such as cancer doctors), critical care units, emergency facilities, and transportation options. Residents are also more likely to be uninsured and to live farther away from health services.
- **Healthy Food Access:** National and local studies suggest that residents of low-income, minority, and rural neighborhoods often have less access to supermarkets and healthy foods.
- **Demographic Characteristics:** Residents of rural areas tend to be older, with lower incomes and less education than their urban counterparts. These factors are linked to poorer health.

Solutions to the increasing percentage of chronic conditions and isolation must address these factors.

7. 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 care providers serving in rural areas face many challenges in reporting quality measurement data and implementing care improvement efforts. Due to geographic isolation or small practice size, rural providers often have limited time, staff, and infrastructure for internal quality improvement efforts or effective participation in performance reporting and value-based purchasing programs. The result: Rural health is often left out of the quality measurement and improvement discussion. This continues to be a persistent challenge for the US health care system.

NRHA's 1998 paper, *Facilitating the Use of National Surveys in Rural Health Research*, identified confidentiality and sample size as two challenges faced by researchers interested in studying rural populations. Unfortunately, this situation has not changed since the paper was published. An individual with a particular diagnosis might be identifiable based on their condition, either alone or in combination with other data collected, such as age, gender, or date of service. Typically, this type

of data is not publicly available, so a researcher who needs access may face barriers or extra steps to get the data. The sample size collected in rural areas by national surveys may not be adequate to allow for meaningful comparison of the rural area to more populous regions.

Identification of rural and underserved-specific issues is important and necessary as glaring health disparities continue to exist in rural communities. Thank you for the opportunity to offer our perspective on this topic, and we thank you for your consideration of our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality of and access to care in rural areas. If you would like additional information, please contact NRHA Government Affairs and Policy Manager, Max Isaacoff at misaacoff@nrharural.org or 202-639-0550.

Sincerely,

Alan Morgan

Chief Executive Officer

National Rural Health Association

cc: The Honorable Richard Neal, Chairman, Committee on Ways and Means

The Honorable Kevin Brady, Ranking Member, Committee on Ways and Means