

November 29, 2019

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

Submitted electronically via email: Rural\_Urban@mail.house.gov

RE: *Rural and Underserved Communities Health Task Force Request for Information*

Dear Chairman Neal and Ranking Member Brady,

OCHIN applauds the Ways and Means Committee for their extensive work to improve care for underserved patients. We are grateful for the opportunity to supply the Rural and Underserved Communities Task Force with thoughtful responses to your request for information.

OCHIN is a 501(c)(3) not-for-profit community-based health information technology (HIT) collaborative, and a national leader in promoting high-quality health care in underserved areas across the country. Our extensive experience supporting safety net providers has given us great insight into substance use disorder and its treatment, as well as how to better serve this vulnerable population. We support over 500 health centers including public health, corrections, mental health, and youth authority. We continue to innovate and advance virtual care and telehealth within the safety net through our collaborative and the California Telehealth Network (CTN). The patients OCHIN members care for face significant challenges to acquiring high quality and easily accessible care. We utilize innovative strategies to expand capacity to ensure underserved and geographically isolated patients can remain in their communities while gaining access to care they need.

**INFORMATION REQUESTS:**

*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?*

We believe a major factor for underserved areas continues to be access—a barrier exacerbated by the myriad of barriers in reimbursement and costs related to telehealth and virtual care.

Our members serve patients in historically underserved areas where environmental and social factors have been shown to have outsized impact on health outcomes. Some of these factors include food insecurity and other social risk factors such as lack of economic prosperity. It is possible to combine the health and social support systems through the adoption and implementation of social service resource locators (SSRLs) into electronic health records (EHRs). SSRL providers create and curate lists of resources in the community to help make appropriate referrals for patients with an identified social need. Integrating this information into the EHR allows providers to act on their patients' social determinants of health (SDH), and connect them to services to help address social needs affecting their health and well-being. SSRLs also allows patients to receive closed-loop referrals for social services, increasing provider awareness of non-social factors.

To create more opportunities for economic prosperity, communities require broadband access to improve access to education and remote employment. Deploying broadband to schools, community centers, libraries, and directly to homes is critical for health care, education, and economic opportunities to help transform lives for the better.

*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?*

Significant investments in broadband, certified EHRs, telehealth, and virtual care have a strong impact on health outcomes in rural and underserved communities. It extends specialty care to communities relying solely on primary care, primary care into the home, allows for continuous contact and monitoring of chronic conditions, and can provide interoperability between services which otherwise remain siloed.

A current emerging model requires interconnectivity between health care and social service providers, especially where they are all connected into interoperable electronic health records, as this allows for providers or care coordinators to facilitate access. To reach this level of connectivity, behavioral health providers and other social service provider would require onboarding assistance to 2015 or newer EHRs to facilitate this level of data exchange. Use of SSRLs can coordinate transportation, housing, food, and more. By ensuring all of these services can communicate, a full, integrated record gives the provider or coordinator a clear picture of what services are available and being utilized, and how it impacts the health of the patient.

Similar interoperability between providers can help patients with multiple chronic conditions to better coordinate treatment efforts to prevent duplication. Where the patient is supplied broadband, it gives them access to methods of care or support, which may otherwise be

unavailable because of their location. These include nutrition counseling, virtual physical therapy, remote patient monitoring, and the opportunity for virtual appointments with primary care or specialty providers.

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

The Committee should consider the potential of increasing use of virtual care and eConsults to extend physician resources to underserved areas, improving reimbursement rates, as well as overhauling the state licensing laws to simplify the certification process allowing providers from other states to deliver care to underserved areas. Preference should be given to providers with bandwidth and availability over those within a particular state, especially where the patient is close to a state line, making access to the out-of-state provider easier than the in-state provider.

*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?*

Increase use of telehealth and allow patients to utilize it from within their homes, especially through Medicaid programs. This will reduce hospital visits by prompting patients to seek a consultation, preferably with their primary care provider or through a federally qualified health center (FQHC), for their illness or injury and can then be referred to an alternative care site rather than seeking care at a hospital. Ensuring all care providers are interoperable will allow for a seamless transition wherever the patient is seen, which reduces avoidable return visits and facilitates follow-up care outside of the hospital.

*b. there is broader investment in primary care or public health?*

Invest in patient engagement to promote patients to seek and establish relationships with primary care providers. Invest in methods to connect patients to a primary care provider and expand EHRs to serve patients in their native languages. This will ensure primary care providers are the first point of contact, allowing the provider to care for the patient directly, refer them to an urgent care clinic, or in rare or extreme cases, direct them to a hospital. Delivering online patient interaction in a patient's native language reduces repeat visits, allows telehealth and virtual care to serve them, and can deliver important health information to them without them having to be seen, increasing strain on an already stressed system.

Investments should also be made into eConsult technology and networks in the form of improved reimbursement, training, and technology. These expand a physician's scope of practice and reduce unnecessary referrals for face-to-face visits, reducing patient travel, time off, child care, and extended wait times for appointments. Where the patient has a primary care physician and a complex issue requiring a specialist, the physician can be the conduit allowing the patient to forego seeking hospital care where the specialist can provide instruction or treatment.

*c. the cause is related to a lack of flexibility in health care delivery or payment?*

Health insurance programs must be required to incentivize seeking care in non-hospital settings or have hospitals require up-front payment in non-emergency situations where alternatives for care are available. Where telehealth does become available, it is critical to ensure payment parity for telehealth delivery, especially for safety net providers. Paying lower reimbursement amounts disincentivizes use of telehealth and telepsychiatry and prevents clinics from innovating through technology and workflows. State licensing laws must also be improved to expand resources across state lines. Arbitrary boundaries restricting access to care must be overcome.

In the movement towards value-based payment structures, SDH and risk stratification must be integrated so as to not put greater financial risk structures onto those caring for the most complex patients. The safety net must remain strong, supported, and independent, and not including social factors and high rates of comorbidities into the payment structure puts safety net providers at a great disadvantage.

*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?*

California has the California Telehealth Network, organized to increase care delivery to underserved safety net-patients using telehealth systems. A number of challenges existed or persist, which include lack of broadband connectivity in some areas and difficulty obtaining funding to build it out, and the prior lack of payment parity for telehealth services. These two issues strongly impact most states across the nation, hindering the innovation and delivery of telehealth.

Without reliable broadband, geographically isolated clinics and providers cannot reach other clinics to conduct eConsults or reach their patients in schools, community centers, or their homes. Many areas still struggle with this connectivity, often because of lack of funding for broadband buildout. Although payment parity for telehealth has been reached by many private

providers, it is lagging in publicly funded programs, especially Medicaid. States are slowly changing their policies to mandate payment parity, but in the meantime, it is preventing clinics that could benefit the most from telehealth from innovating to deliver it.

Reducing the reimbursement amount for provider services which require the same time and education to deliver through an alternative means disincentivizes its use, reducing adoption among clinics with slim margins. These clinics often serve safety net patients who are more complex and have fewer options for seeking care. Transportation, missing work, and childcare are common barriers that decrease their ability to seek care, all of which can be overcome or significantly decreased by telehealth delivery.

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

Telehealth and eConsult models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas. When paired with simple certification processes to allow providers to deliver telehealth across state lines, this redistributes resources to support underserved areas. Efforts must be increased to establish provider networks to facilitate the expansion of resources.

*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?*

Telehealth is the most commonly relied upon method for extending behavioral and substance use care to underserved areas. These can all be delivered virtually, allowing providers with bandwidth to extend themselves into rural areas to supply counseling as well as administer medication-assisted treatment (MAT).

*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?*

Post-acute and long-term care can be facilitated within communities allowing patients to heal in their homes using technology such as telehealth, remote patient monitoring, and patient portals with a focus on education. Telehealth allows patients to have follow up visits virtually,

increasing access between providers and patients. Remote patient monitoring uses technology to remain dialed in to a patient's vitals from within the comfort of the patient's own home.

Patient portals allow patients and providers to exchange information in real-time, providing access to health coaching, education, and reminders for patients to assist them in managing complex health conditions. For example, a patient with diabetes could receive medication reminders, alerts for lab work requests, and automatically set up periodic eye and foot exams. It can also provide nutrition assistance and work in tandem with remote glucose monitoring.

*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?*

To better understand health disparities in rural and underserved areas, it is necessary to standardize social determinants of health both in collection practice and in definition. Many of the health disparities are related to access, but this is often a byproduct of a social determinant – financial stability and access to insurance. Other social determinants that impact health disparities are food insecurity, physical inactivity, social isolation, and alcohol and tobacco use.

How these terms are defined and how the information is collected at point of care is critical to compiling the data necessary to study the interaction of complex health conditions and social determinants of health. The first factor to address is the tool of collection. Electronic health record technology is critical for successful data compilation, but the data is only as good as the information put in. Providers must be trained in their workflows and methods to ensure they are getting accurate data from patients. This requires the ability of the provider to obtain the trust of their patients, and to communicate the social determinants with clarity.

*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?*

The overarching efforts needed to expand and improve care to rural and underserved populations include funding broadband, reimbursement parity for telehealth, and expanding efforts to not only collect social determinants of health, but to address them as a functional part of the health care system. Their treatment should be covered under social programs or insurance, as social determinants of health impact health arguably as much if not more than medical

treatments. Health does not exist in a medical vacuum, and it is strongly impacted by social factors, housing, food, mental health, education, and more.

We appreciate your consideration of our comments. Please contact Jennifer Stoll at [stollj@ochin.org](mailto:stollj@ochin.org) should you have any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read "Jennifer Stoll".

Jennifer Stoll  
EVP, Government Relations and Public Affairs