

RURAL AND UNDERSERVED COMMUNITIES HEALTH TASK FORCE REQUEST FOR INFORMATION

The Committee on Ways & Means Chairman Richard E. Neal and Ranking Member Kevin Brady are committed to advancing commonsense legislation to improve health care outcomes within underserved communities.

The *Rural and Underserved Communities Health Task Force* (Task Force) is the Committee's forum to convene Members and experts to discuss the delivery and financing of health care and related social determinants in urban and rural underserved areas and identify strategies to address the challenges that contribute to health inequities. Reps. Danny Davis (D-IL), Terri Sewell (D-AL), Brad Wenstrup (R-OH), and Jodey Arrington (R-TX) serve as the Task Force co-chairs, and are working to identify bipartisan policy options that can improve care delivery and health outcomes within these communities.

This *Request for Information* (RFI) solicits input on priority topics that affect health status and outcomes for consideration and discussion in future Member sessions of the Task Force. Terms such as "initiative," "approach," "model," or "demonstration" generally refer to any activity that addresses issues impacting optimal health in these communities.

SUBMISSIONS: Individuals or groups wishing to respond to this RFI should email comments **by close of business Friday, November 29th, 2019** as attachments in **.docx or .pdf format**, to: Rural_Urban@mail.house.gov.

Dear Committee:

The following responses come from our collective work experience and research in rural health professions education and practice. Most recently we have worked together under the HRSA-funded Collaborative for Rural Primary care, Research, Education, and Practice (Rural PREP), whose mission is to improve and sustain rural health through community engagement and research in rural primary care health professions education.

<https://ruralprep.org/about/who-we-are/>

Our individual and collective approach to health disparities and workforce maldistribution even beyond the scope of this grant-funded project is to promote education and training in those places that are underserved. Our answers to the relevant questions below are bolded for clarity.

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?
 - **Availability of providers able to perform critically important services such as family physicians providing emergency care, obstetrical care and stabilization for transport.**
 - **Health care teams caring for populations able to educate communities for public health and prevention.**

- **Primary care services: First contact and continuing, comprehensive, and coordinated care of the individual in the context of family and community, particularly in the setting of multiple chronic illnesses.**
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?
 3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Adequacy of patient volume is the wrong question. If the committee is to consider the rural community's perspective, workforce projections solely based on patient volume will underestimate need in rural places and overestimate need in urban. Given the small numbers and long distances in some rural places, there should be at least some minimal level of access regardless of patient volume. An excellent example of an appropriate response to a rural community's need under the current system is Valdez, Alaska, where AAFP immediate past President John Cullen MD and 3 family physician colleagues staff a small critical access hospital that provides a spectrum of essential services – emergency care, maternity care including surgical obstetrics, endoscopy services, and others.

<https://alaska.providence.org/locations/p/pvmc> They have been able to do so because they employ comprehensive generalists in medicine, nursing, pharmacy, social work, and others for a population of 4,000 remote from specialty care. A similar model exists in Corydon, Iowa, where a broad scope family physician, a general surgeon, and a nurse practitioner form the core of a slightly larger hospital staff in a town that qualifies as FAR (frontier and remote) level 4.

In each circumstance, the presence of family physicians and other health care providers allow for critically important hands on and life saving measures. This can be supplemented through technology and telemedicine to support such providers but does not replace them.

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

Lack of flexibility is one thing. Lack of alignment is another and “alternative care site” options can be counterproductive. There are too many rural

places under current rules where an urban sponsored FQHC competes with a rural health clinic, and they both compete with the rural hospital. We should pay entities operating in population centers of smaller size and a rural designation in a way that encourages collaboration, not competition. One example of such collaboration is [Sakakawea Medical Center](#) and [Coal Country Community Health](#), the only example in the country of a CAH and FQHC sharing a CEO and board of directors.

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?

Although transportation is a major challenge in rural communities, a greater challenge in too many rural communities with excellent asphalt highways is lack of broadband access. There is better broadband access in many parts of Africa than in my own county of Athens, Ohio. Lack of broadband is another example of the downside of competition among large provider entities in rural places, an approach that operates against those individuals and communities located in the “last mile” of telecommunications networks.

Rural health professions education should be able to benefit from successful ECHO and ECHO-like approaches to remote education and training, but will be limited by lack of connectivity. Connectivity is essential to both education and practice.

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

Education and training that occurs in rural communities appear to be one very important piece of the puzzle. Rural residencies in medicine for physicians, now developing for nurse practitioners, have been shown to produce rural primary care practitioners with 2-3 times the likelihood of initially locating in rural practice and, according to research we have done and is not yet published, 2-3 times the likelihood of staying there. What makes rural residencies successful is the context in which its trainees learn, not simply the content of their training. The content of course is also important, as residents in rural contexts train to a broader scope of practice as rural generalists, a characteristic of practice now shown by research to decrease physician burnout.

Health professions education and training in rural places contribute to the retention of existing practitioners who serve as faculty, and both faculty and trainees provide critically important service to the community. Out of

necessity and in the face of limited resources, interprofessional education and training simply “happens,” whether or not it is planned, and if planned, tends to be more collaborative in nature than similar efforts in large urban centers, where professionals too easily operate in isolation.

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?

Under a single accreditation system in graduate medical education that calls for integrated care and training, rural residencies address gaps through broadened scope of training and practice. Less specialization in a setting that promotes collaboration across specialties and disciplines naturally results in less segmentation of care and fewer “gaps.” Incentives to coordinate care in order to be effective need to include meeting mental health and dental needs of clients, such as in the case of FQHCs, some ACOs, and other quality performance measure programs.

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?
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?

One of the greatest challenges in rural health professions education research is the lack of attention paid to geography by accrediting bodies and by systems of payment for education and training (e.g. GME from CMS). Accurate geographic coding of education and training experiences is essential to mapping the context of that training. For example, under the current system, neither the ACGME nor CMS have any idea of how much training occurs in rural places or in health professions shortage areas. The documentation that currently exists (ADS for accreditation; IRIS for CMS payment) is often anchored in hospitals or health systems that are counting FTEs for administrative purposes, not in the actual place of education and training. Geographic information regarding an ambulatory site of training is often incomplete or ascribed to the health system (often urban and neither rural or underserved) that employs the physician preceptors that do the training. A system of accreditation and payment for training based on geographic information rather than sponsoring hospital location or health system location would be an important step in further

building an evidence base for place-based education that addresses geographic disparities in health care and workforce distribution.

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?

- **Targeted place-based strategies for training and payment that increase the duration and quality of education and training occurring in rural and underserved communities (e.g. reauthorization and expansion of THCGME in rural and underserved urban places; S289 Rural Physician Workforce Production Act, which provides a payment mechanism for training in rural places in a way that differs from traditional GME, and in line with recommendations by the IOM Committee on the Governance and Financing of Graduate Medical Education in 2012).**
- **Continued and expanded funding for research in rural health professions education and training (e.g. renewal of the Academic Units for Primary Care Training and Enhancement program (AU-PCTE), supporting research in rural and underserved urban locations) to demonstrate program effectiveness.**
- **Renewal and expansion of Rural Residency Planning and Development grant program to include the planning and development of General Surgery and Obstetrics and Gynecology programs, as well as rural nurse practitioner and physician assistant residency training programs in rural and underserved urban locations. (There is currently very little if any other federal funding for planning and development in these specialties or disciplines)**

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Collaborative for Rural Primary care Research, Education and Practice



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