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November 29, 2019

Ways and Means Committee

Subject: Rural and Underserved Communities Task Force RFI

Dear Task Force Members,

Thank you to the Committee on Ways & Means Chairman Richard E. Neal and Ranking Member Kevin Brady for pursuing commonsense legislation to improve health care outcomes within underserved communities. Qsource appreciates the opportunity to provide comments related to priority topics that affect health status and outcomes for consideration and discussion in future Member sessions of the Task Force.

Qsource is a not for profit 501 C 3 healthcare consultancy dedicated to improving healthcare delivery across multiple states including Arkansas, Alabama, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Missouri, Nebraska, Ohio and Tennessee. In addition to provider directed quality improvement program support, we empower communities in expanding access to care, addressing social determinants of health (SDOH) and building coalitions to create innovative solutions to rural health challenges. Many of our efforts are funded wholly or in part by legislative priorities that are created by you. Without your support, many of our most innovative, value driven programs could not be undertaken.

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas?

In our region, we believe that insurance availability and affordability, access to affordable preventive and restorative care, healthcare provider workforce shortages (especially related to primary care physician availability in rural areas), and lack of community-based care services like rehabilitation and behavioral health are the primary health care-related factors that influence patient outcomes. This is especially true in extremely rural areas such as the Appalachian regions and the mid-South.

Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

In addition to the healthcare related issues; safe housing, access to healthy food options, clean drinking water, exercise opportunities, transportation (especially in rural areas), and health literacy all contribute to poorer health outcomes. Disparate access to broadband services may also limit telehealth availability.

The biggest factors that contribute to poor health outcomes in the elderly are related to the increase in frail elderly "aging in place". Often living along or with a similarly fragile spouse, these elderly patients struggle to meet normal activities of daily living. Frequent hospital admissions may result. Moreover, if there are no community supports, poor outcomes or placement in long term care facilities may occur.

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);

Qsource is working within multiple communities to create a healthcare ecosystem to support improved outcomes, but funding for such programs is a challenge, especially in rural communities. For example, in rural Hazard County, Kentucky, the community's focus has been on educating community health workers to outreach to rural patients with limited transportation options. In Memphis, Tennessee, Regional One Health has created a front line model where an onsite food pantry delivers food boxes to underserved patients. In Crawfordsville, Indiana, a community paramedicine model was deployed, whereby community paramedics conduct home visits to elderly patients to monitor patient vital signs and deliver medications. Models like these represent modest community investments but are in need of sustainable funding and a backbone organization to expand them.

b) multiple chronic conditions;

Qsource has developed and supported programs for patients with chronic conditions and the underserved by relying heavily on patient engagement. For example, working with sickle cell patients in Memphis, TN, we were able to help patients frequently seen in emergency departments find a medical home. Throughout the mid-south, diabetes educators were able to provide diabetes education to over 10,000 patients and demonstrated significant improvements in measures of hypertension, obesity and acute care hospitalizations.

c) broadband access; or

d) the use of telehealth/telemedicine/telemonitoring?

Project ECHO (Extension for Community Healthcare Outcomes) is a model that aims to improve the care of patients in underserved areas by building partnerships between primary care providers and specialists. With the specialists serving as the "hub" and primary care providers as the "spokes", Project ECHO utilizes videoconferencing technology to spread knowledge among the healthcare community. Multiple versions of the model exist, including those that address older adult health or chronic pain.

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

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?

We have seen a continued decline in healthcare availability in rural areas. In fact, in many rural counties, the hospital represents not just the only access to acute care, but also the economic engine for the community. When these facilities close or reduce service lines, alternative care sites are not always available, especially in rural areas. Alternatives don't address acute and trauma care needs of rural communities. As a result, patients must often travel several hours for their care. In instances of trauma, where the golden hour is critical to provide prompt medical and surgical treatment, this lack of availability may lead to preventable mortality . Unintended costs associated with supplemental transportation services (ground and aeromedical EMS transport) may also exist.

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

We believe that widening programs for primary care physician loan forgiveness initiatives for residency in rural/physician shortage areas are helping to address the needs of underserved communities. Expanding residency programs to rural hospitals willing to take on the educational burden is also a good example of how rural communities are addressing healthcare provider shortages.

Scaling the scope of services to optimize available providers has also been successful, such as expanding utilization of pharmacists to provide care to patients in underserved areas. For example, Tennessee law recognizes pharmacists as providers (https://bit.ly/33nfItN), though pharmacists' services are currently underutilized, partially due to lack of reimbursement.

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

Telemedicine is not always pursued as an option for care delivery due to the inflexibility of certain provider reimbursement mechanisms.

CMS' recent change to allow health professional shortage area (HPSA) bonus payments for all mental health specialties is an example of a policy change leading to positive health outcomes.

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?

Health information technology companies such as Cerner and Allscripts are partnering with rideshare companies such as Lyft and Uber to provide non-emergency medical transportation. Partnerships like these reduce transportation barriers and increase access to medical care.

Medicaid beneficiaries can access transportation to and from providers when necessary under most non-emergency transportation programs yet states have different rules about when rides are necessary, and some federal rules regarding consistency would be helpful. Finally, while non-emergency transportation providers are contracted to serve every area of the state, there is still very few companies or services that reach rural and underserved areas.

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

One successful model is workforce development programs. These programs may include loan forgiveness for working in underserved areas. Two examples in Qsource states are the Tennessee Center for Health Workforce Development Community Incentive and the Kentucky State Loan Repayment Program. These programs succeed because they reduce the cost of obtaining education for healthcare professionals and improve workforce shortages in underserved areas.

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?

Coordinated care with fully engaged communities is a best practice toward shifting patient volumes, though not something easily accomplished.

Telehealth/virtual health mentoring, peer navigator programs, and FHQC programs (including preventive and restorative dentistry for uninsured students, expectant mother support, and support for patients experiencing homelessness) are other proven approaches. For example, Church Health in Memphis offers specialty dental care to low-income and uninsured individuals. They utilize a 3D printer which can create a crown in one hour, shortening the time required for this appointment at a cost of about $200.

One approach to address opioid use disorder and comorbidities such as depression and anxiety is Project ECHO. Indiana University coordinates one such ECHO hub and scope partnership.

In Tennessee, the Department of Mental Health & Substance Abuse Services has developed a faith-based recovery network. This network actively engages faith communities to increase outreach, educational activities, access, and visibility to people seeking substance abuse services.

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?

Community asset mapping and outreach to develop community ecosystems of care is a productive first step to creating partnerships with community-based organizations and not for profits to deliver care and services to vulnerable populations such as the homeless and frail

elderly. These programs typically exist in urban areas, but they could be piloted and developed in rural communities as well.

Community paramedicine and pharmacists can fill gaps in both post-acute care and long-term services and supports by helping patients to navigate the healthcare system and connect to community resources.

Qsource has also worked with IT developers such as CreateAbility Inc. who provide interactive health and safety monitoring software solutions to help caregivers monitor physical and mental well-being of loved ones at home 24/7.

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 most obvious data needs for the underserved population are the accurate capture of race, ethnicity and socio-economic status among patients. Enforcing and incentivizing the collection of primary language and health literacy is also needed. More recently, measures of medical and social complexity have been developed but are inconsistent and used only by a handful of providers. Focusing on data capture for these elements consistently would be a good starting point.

The National Quality Forum[1] has published recommendations to address low case volume performance measures for healthcare providers in rural areas. Recommendations include pooling data across time to derive more actionable information.

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?

Expanded payment programs that pay for non-traditional services and support such as food vouchers, patient navigators, temporary housing, and expanded programs to support SDOH in rural communities is one such effort.

Greater support is also needed for people with multiple chronic conditions who are high repeat utilizers of healthcare services, such as self-management programs and coordination of care specifically for this high need population.

Expanded and more flexible payment policies with incentives for virtual healthcare provision at the patients' home and virtual provider mentoring is another example.

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1 https://www.qualityforum.org/Publications/2019/04/MAP_2019_Recommendations_from_the_Rural_Health_Technical_Expert_Panel_Final_Report.aspx

Harmonization of measures across different payers and quality programs would reduce opposing objectives and provider burden for receiving payment. Fewer measures would also allow for a more intense focus on high priority patient care issues.

Thank you again for the opportunity to provide our comments.

Sincerely,

Dawn M. FitzGerald

CEO, QSource