Rural and Underserved Communities Task Force
Ways and Means Committee
U.S. House of Representatives

November 29, 2019

Dear Colleagues:

I am pleased to provide responses to the Task Force solicitation of comments on various topics affecting rural and underserved communities. These comments are from the Health Panel of the Rural Policy Research Institute (RUPRI). We are happy to continue providing further information and analysis to the Task Force as you continue your important work. Thank you for your dedication to assuring accessible and affordable essential health services to people living in rural and underseved areas.

Sincerely,

Keith J. Mueller, Ph.D.
Director, Rural Policy Research Institute
Chair, RUPRI Health Panel

# 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 i**n .docx or .pdf format**, to: **Rural_Urban@mail.house.gov**.

**INFORMATION REQUESTS (Limit each response to 250 words - Total submissions should not exceed 10 pages, 12 pt font):**

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?

- **Health care-related factors include:**
    - Less rural access to employer-sponsored health insurance thus restricted access to comprehensive health care. In addition, rural/underserved residents are more likely to covered by public insurance plans (Medicare, Medicaid) and are more likely to be uninsured or underinsured

- Affordability of care for those with and without insurance in rural/underserved areas. Being uninsured or underinsured compounds other access to care obstacles faced by these groups.
- Fewer rural primary care practices operating as teams coordinating care locally with distant providers and proactively addressing patient and community health concerns. Extending additional support for primary care teams in payment and medical education and regulation would jumpstart a transition to better and more efficient care.
- Inadequate rural health services research funding to identify which models/processes and public health programs deliver high-quality, person-centered and const-effective healthcare
- Underdeveloped telehealth options to improve access to care

- **Systems or factors outside the health care industry include:**
  - Insufficient preventive programs and public health efforts to reduce suicides, traffic accidents, smoking related illnesses, opioid overdose deaths, and other preventable causes of death and disability.
  - Insufficient protections for occupational and environmental threats to reduce agricultural accidents, pollution-related illnesses, and other preventable causes of death and disability.
  - Limited availability of early education programs
  - Absence of affordable day care (for children and for older adults)
  - Underdeveloped transportation resources to help close access to care and other resources
  - Limited housing for the long-term care services and supports population

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?

- **Successful models include:**
  - **Farmington Experiment:** Community engaged primary prevention and primary care program that connect health and social services, mobilize community resources and pool funding to create greater flexibility in programming
  - **Toledo, OH:** ProMedica, including its rural facilities, went beyond investing in community organizations by creating a nonprofit of its own, the ProMedica Ebeid Institute for Population Health, which has a food market with affordable and fresh options, a classroom kitchen, and employment opportunities for local residents.
  - **Health Care Collaborative of Rural Missouri:** The Health Care Collaborative of Rural Missouri, composed of 55 member organizations including area FQHCs, works to meet the clinical and social needs of community residents.. To address

health disparities, the Collaborative has hired community health workers that work both in the community and in local FQHCs.

- **Columbia Gorge, OR:** Hospitals came together with community clinics, public health departments, and other community organizations to create the Columbia Gorge Coordinated Care Organization and a collaborative CHNA process that focuses on topics including chronic disease, mental health, and health care access.
- **Marriottsville, MA:** Bon Secours Health System in Marriottsville, Massachusetts, has provided financial support since the 1990s to organizations that improve access to affordable food and housing and help support the local community.

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

- **Considerations with respect to patient volume adequacy include:**
  - *Patient volume issues exist because of payment systems built on a fee-for-service platform.* As long as that remains the dominant payment paradigm, adjustments are needed in places with insufficient service volume to generate total payment that covers all costs (fixed and marginal). Therefore, essential community services (especially those that provide time-sensitive care such as emergency services) require a different payment platform. Firefighting and law enforcement represent a common good and are funded as such. Rural/underserved emergency services should be considered similarly. Investment is needed in public infrastructure that includes fixed costs of core services such as emergency medical care, and ongoing support in addition to FFS payment should be considered (the Medicare Payment Advisory Commission has made such a recommendation for emergency room services).
  - Performance measurement and reporting should specifically consider low volume situations with special statistical, such as rolling averages, volume-appropriate confidence intervals, and pooled data.
  - Promotion of collaboration between health care providers has the potential to improve health system efficiency.

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?

- **Care site alternatives include:**
  - Independent Practice Clinic: provides outpatient primary-care
  - Hospital-Owned Primary Care Practice: provides outpatient services in during limited days/times
  - Provider-Based or Independent RHC: provides outpatient primary-care

- FQHC and CHC: provides community-based primary, dental, behavioral health care (rather than 24/7, emergency or inpatient services)
- Urgent Care Centers: provides outpatient primary care
- Off-Campus Emergency Department: providers emergency care on a limited or unlimited schedule as a remote hospital department
- Free-standing Emergency Department: providers emergency care on a limited or unlimited schedule as a non-hospital affiliated entity
- Clinic and Ambulance: independent clinic-, RHC- or FQHC-affiliated 24/7 ambulance service
- Frontier Extended Stay Clinic: outpatient clinic with extended hours of operation and emergency care capacity offering comprehensive medical, dental and mental outpatient services and minimal inpatient services
- Rural Emergency Hospital: providing emergency services but no inpatient care; would offer/expand to include outpatient clinic-based services
- 12-or 24-Hour Primary Health Center: Provides care similar to FQHCs for 12- or 24-hours per day every day with support from an EMS plan and a larger partner organization

- **Examples of transitions to alternative care sites include:**
  - **Urgent Care Services in Douglas, AZ:** Copper Queen Community Hospital from Bisbee (27 miles from closed Cochise Regional Hospital) opened Douglas Medical Complex Quick Care facility, an "urgent care clinic on steroids." *http://valuehealthcareservices.com/education/cochise-regional-hospital-closes/*
  - **24-hour Emergency & Outpatient Services Center in Cheboygan, MI:** 24/7 emergency room and other expanded services: adult and pediatric primary care, imaging, laboratory, specialty and rehabilitation services, sleep center, and outpatient surgery clinic. *http://articles.petoskeynews.com/2012-05-04/emergency-services_31577169*

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

- Lessons from the Accountable Health Communities (CMMI) participants that include rural sites should be the basis for further rounds of the demonstration
- Lessons can also be drawn from the experiences of communities participating *The Culture of Health* program funded by the Robert Wood Johnson Foundation

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

- Follow through on appropriate reforms to Stark provisions that inhibit investments in delivery system reform by regional systems supporting rural providers (e.g., small rural hospitals)
- Encourage more rural-specific demonstrations under CMMI authority

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? **(WORDS: 214 of 250 max)**

- **Examples of regional networks of care:**
    - **Franklin County, Maine:** Community-wide programs targeting hypertension, cholesterol, and smoking, as well as diet and physical activity, sponsored by multiple community organizations, including the local hospital and clinicians. Sustained, community-wide programs targeting cardiovascular risk factors and behavior changes to improve a Maine county's population health were associated with reductions in hospitalization and mortality rates over 40 years, compared with the rest of the state. Further studies are needed to assess the generalizability of such programs to other US county populations, especially rural ones, and to other parts of the world. See *JAMA*. 2015;313(2):147-155. doi:10.1001/jama.2014.16969 for more information.
    - **Rural Maine:** Physiological and behavioral risk factor reduction programs offered in a rural county included reductions in leadership, staff, institutional resources, data monitoring, and the programs themselves. When analyzed, the gains associated with population health interventions may be lost when the interventions are reduced. Adjusting outcome measures for socioeconomic status may allow quicker and more sensitive monitoring of intervention adequacy and success. The increasing trend of age-adjusted mortality in Maine and nationally to correlate inversely with incomes may warrant further community interventions, especially for poorer populations. See *JAMA Network Open.* 2019;2(6):e195877. doi:10.1001/jamanetworkopen.2019.5877 for more information.

- **Challenges that persist:**
    - Payment system that rewards increased volume and market share competition
    - Absent facility designations that allow right-sizing rural health system
    - Inadequate payment and regulatory policy to promote collaboration
    - Distinct health care and social services payment systems

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful? Payment policies that specifically and substantially address provider type and geographic area workforce shortages.

- **Elements of models successful in addressing workforce shortages:**
    - Expanded opportunities for professional membership and collegiality, additional time away, part-time work, and more requires consideration.
    - Community health workers and community paramedic and other innovative position.
    - Consideration of emergency medical services (EMS) as essential public services (as firefighting and law enforcement) and funding as such.

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?

- **Examples of state/community approaches to addressing behavioral/substance use gaps in care delivery:**
    - **Rutland, Vermont*:*** Project Vision began in response to heroin and other drug use in Rutland, VT, a community located in the rural southwestern part of the state. See http://projectvisionrutland.com/ for more information.
    - **Wyoming:** The Wyoming Trauma Telehealth Treatment Clinic serves survivors of domestic violence and sexual assault using telehealth to connect them with psychology doctoral students who have been trained in trauma intervention theory and techniques provide services under the supervision of doctoral-level psychologists.
    - **West Virginia:** Hub-and-spoke networks have been implemented for MAT delivery to support treatment access for rural persons with OUD. See https://www.sciencedirect.com/science/article/pii/S0740547219300595 for more information form more information.
    - **Cherokee Health Systems:** Primary care providers screen all patients for BHDs and co-manage those who screen positive with the BH consultants, often via the telephone or telehealth.. See https://www.cherokeehealth.com/patient-services/adult-primary-behavioral-care and https://www.careinnovations.org/resources/lessons-from-cherokee-health-systems-a-truly-integrated-and-inspiring-model-of-care/ for more information for more information.
    - **Michigan Upper Peninsula:** The Marquette Peer Recovery Drop-In Center provides peer recovery support services including peer mentoring and coaching, resource connecting, facilitating recovery groups, and building a safe community for members. See https://www.greatlakesrecovery.org/ for more information.

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?

- **Examples of state/community approaches to addressing gaps in LTSS care delivery:**
    - **Rural PACE Provider Grant Programs** utilize an integrated care model to assist adults aged 55 years and older, most of whom are considered dual eligible, to keep adults in their communities rather than in an institutional setting, and provide coordinated, integrated care.
    - **Primary Care-Led LTSS Models** build on the principles of the patient-centered medical home model creating networks of primary care practices linked to an

accountable care organization to manage the full range of medical and LTSS services.
    - **LTSS Provider-Led Models** for delivering care and support that an individual may need in a rural setting incorporate integrated care using an LTSS provider rather than a traditional medical provider.
    - **Medicaid Testing Experience and Functional Tools (TEFT)** builds and tests various combinations of four components to support and improve community-based LTSS for Medicaid beneficiaries: (1) the use of personal health records, (2) experience of care surveys, (3) functional assessments, and (4) quality measurement.

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?

- **Needed data elements/definitions to identify causes of health disparities:**
    - Greater accessibility to de-identified clinical care data (e.g. CMS claims data) for established researchers would allow better analyses, identification of care delivery gaps for rural/underserved areas, more informed decision-making regarding new models of care for rural and urban underserved areas.
    - Data from national surveys need to be available with the smallest possible geographic identification (protecting confidentiality with sufficient sample size).

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?

- **Suggestions from http://www.rupri.org/wp-content/uploads/TAKING-STOCK-2018.pdf#page=23:**
    - **Support development of rural-relevant quality measures**. Policymakers should support development of measures recommended by the NQF expert panel on rural and low-volume measures. The panel recommended 9 areas for consideration and creating a workgroup, which is active and advising CMS on the selection of rural-relevant measures.
    - **Develop a comprehensive cross-agency approach to rural health care quality improvement technical assistance (TA).** Policymakers should consider a comprehensive and aligned program of rural-focused quality improvement TA, coordinated through contracting, management, and oversight across agencies of HHS with responsibility for health care and rural health.
    - **Offer quality initiatives specifically designed to meet rural needs and opportunities.** Policymakers should advocate new health care quality pilot programs designed specifically to test methods to improve quality and value for

the unique rural environment, and address the barriers to participation by CAHs and RHCs.

- **Technology-related items:**
  - EHRs technology is an important foundation for addressing quality and safety and is now essentially universally available in rural communities.
  - There is growing interest and use of tele-health in rural, particularly in the ED, and increased utilization of remote pharmacy resources, both of which can improve access and safety.

- **Other items:**
  - **Transparency:** As of May 2019, 1,339 CAHs signed MOUs to report quality data and 99% reported on at least one domain.
  - **Leadership and Culture:** There has been increasing focus in quality improvement programs on the community as the unit of improvement, breaking down the silos of care delivery to improve quality and safety.