

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?

Many rural areas lack services that are taken for granted in more populated areas. Fewer providers live in rural areas and are often located further from patients than in urban areas, necessitating additional travel. This problem is exacerbated in terms of specialty care, mental health services and substance use disorder services. Many rural areas have a complete lack of such providers. Further impacting these access issues is a lack of health literacy, especially in terms on managing care between multiple providers. This problem also affects urban areas, but the lack of resources available and distances to providers make it even more impactful in rural communities.

Once services are scheduled, transportation is often a major barrier, especially for those in poor health who have to visit multiple providers. Public transportation systems in rural areas are less comprehensive and often do not run at needed times. Increased travel times utilizing these systems is a barrier to care as low income individuals already struggle to find time for healthcare due to often inconsistent work schedules and a lack of paid personal time off to attend appointments.

Low-income individuals everywhere face many issues that directly impact health outside of the healthcare system, including lack of quality food sources, insufficient or substandard housing, lack of employment, and exposure to violence. This general dysfunction within low income communities can lead to significant substance use disorder rates, including abuse as well as the continued proliferation of drugs like meth and increased alcohol abuse.

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);

Models to provide care in rural communities include Integrated Community Health Centers that include partnerships or direct delivery for: ride services, social service agencies, mental health services, pharmacy services, housing support, food access, care coordination and workforce development. Of particular importance is care coordination, giving patients a single point of contact when they have questions concerning their health. This model also allows patients to

receive a variety of services at a single location, further reducing barriers to care from transportation.

b) multiple chronic conditions;

This model also allows for patients to travel to a single location to receive care for multiple chronic conditions. While specialty care has only grown in importance over time, there are still many chronic conditions that can be directly addressed through primary care providers at a health center without having to seek out additional services. Once a patient has stabilized their condition and embarked on regular, long-term care, many chronic conditions, from hypertension to diabetes to asthma can be addressed directly through primary care.

c) broadband access; or

Broadband access varies greatly between individuals with access being more difficult to locate and more expensive than in urban areas. Access can generally be obtained for provider offices but it is not always possible to rely on private individual's access broadband services from their homes.

d) the use of telehealth/telemedicine/tele-monitoring?

Thus, the most promising telehealth models for rural communities generally still require a visit to a health facility to access. These models are a means of delivering services otherwise unavailable in their communities and often focus on behavioral health services, which are more easily delivered through telehealth models and which are often less available within rural communities.

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

With low patient volumes the norm in rural areas, it is important to develop systems of care utilizing integrated models to most efficiently deliver services. Community health centers allow for integration with behavioral health, substance abuse treatment and specialty services, making them ideal candidates to serve rural communities. These efficiencies can be increased further through the use of telehealth options, where closer to standard reimbursement rates could allow for sustainably increased access. Similarly, telecounseling services that allow the use of LCPCs would make these services more affordable to deliver. Multiple tiers of patient

volume models can be developed and supported with a combination of direct face-to-face and tele-medicine, working together to provide complete patient care by providing primary care through CHC's with supported consultations via telemedicine for specialist care.

In order to fully meet patient needs, these models would also need to include some sort of allowance for rural transportation. Additional transportation issues could be lessened by imbedding care within regional schools systems, seeking to provide health services where students already go every day. Confidentiality issues are often concerns in small rural areas, but could be addressed through tightly controlled telehealth networks, making this close collaboration model ideal to serve 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?

Community Health Centers are well-positioned to provide care in place of many hospital visits. While severe emergencies are still best handled at hospitals, many individuals still visit hospitals when they have minor health issues, including issues that are best handled at a primary care office. However, there are often reasons patients continue to visit hospitals for non-emergency issues, with lack of availability when patients can attend appointments or long wait times for appointments being two leading causes. Health centers are able to meet these needs by scheduling evening and/or weekend hours and providing creative scheduling systems to allow for a limited number of same day appointments.

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

The more primary care services are available, the lower the overall health costs are for a patient seeking service. More primary healthcare helps lower need for hospital visits, especially with creative scheduling to allow for same day appointments and appointments outside normal business hours. Health centers are already the most utilized service providers in many underserved and rural areas.

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

Current state and federal models justify payment on face to face visits and for specific services offered, leading to health services more focused on delivering and billing individual services

than overall patient care goals. If providers were assigned to provide comprehensive care for individuals on a per member per month (PMPM) basis and held accountable for outcomes, increased creativity could allow for improved care delivery systems. This would require increased provider support for alternative delivery options such as tele-triage centers and other emerging methods, many of which could be linked to normal primary care providers within Community Health Centers.

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?

SIHF utilizes a transportation system developed through a partnership with TRH to ensure transportation needs of low income individuals are met within the urban portion of our service area. However, this has not yet been replicated in a rural community due to the much larger distances involved and a lack of transportation providers for partnership.

Collaborative networks that support shared data and care models can advance outcomes through patient-focused care and cooperation. SIHF Healthcare is currently designing such a model that imbeds specialist from a local university system, behavioral health services from a local community mental health provider, tele-medicine, Inpatient and Outpatient services with a safety net hospitals, pharmacies imbedded by local providers, labs and point of care testing on site, and targeted case management. This project has benefited from a long history of collaboration and continuous community engagement necessary for successful partnerships.

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

Workforce issues are always difficult in areas with low populations and fewer attractions for than in more populated areas. In order to bridge some of this employment gap, programs such as the National Health Service Corps Loan Repayment Program can attract providers with a tangible benefit. Other models can improve workforce deployment by more fully utilizing nursing staff and physician assistant staff to minimize the amount of physician time is required.

Outside the healthcare system, STEM and trade education programs developed in concert with local employers and reflecting their workforce needs can ensure local residents are able to qualify for jobs actually needed in the community. Programs that link participants back to

regional employers from the start and ensure they complete their education ready to work are of benefit to both local residents and businesses needing labor.

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?

In order to ensure these services beyond primary care are available to patients, it is necessary to create systems of care with shared resources through partnerships. Community Health Centers and other primary care providers can provide screening and referral for additional services that may be necessary. Screening patients when they receive primary care allows their primary care physician to track additional services patients receive through formal referral arrangements and helps to break down the barrier created by the stigma of reaching out for services such as mental health and substance use disorder, which are often difficult for individuals to seek on their own.

In one rural health center, SIHF Healthcare has partnered with a local community mental health center to provide more intensive counseling services for patients in need. This has resulted in a provider becoming trained and licensed to provide Medication Assisted Therapy and allows patients to receive this service much more easily than more disjointed systems of care where patients must seek services outside of the formal referral process. A new pain management program is underway that will deliver services through tele-consultation and nurse practitioners.

Provider incentives for dentists are necessary to drive access in rural and underserved areas. Current reimbursement rates for dental services are low and expenses for providing dental care are high, making this a difficult service to sustain in rural areas with fewer patients. States must consider scope of service and reimbursement improvements to improve dental care in rural areas.

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?

Social isolation often affects seniors living alone and to fully address this problem, housing must be addressed. The use of Low-Income Housing Tax Credit (LIHTC) to construct and operate

independent senior housing and assisted living has become a key initial step to address this question with lower cost. SIHF already operates two senior living housing facilities in its urban service area and these same types of housing facilities are needed for rural seniors as well.

Additional means of addressing this issue include emerging models for “Aging in Place,” where seniors remain in their homes and services are provided directly in the home. These services often include efforts like meals on wheels in addition to medical care and general home health.

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 biggest issue with data is that most all data is available only at a state level when doing analysis of rural counties. In most cases, populations are too low to calculate rates accurately and due to privacy concerns most raw data is suppressed. If we could access raw data, it would be at least useful to compare to others, but with raw data often suppressed due to low numbers, it makes looking at rural areas very difficult.

Additional issues include a lack of capacity to track and report data on uniform conditions for many small entities already working with limited resources. Coupled with often skeptical mindsets of rural residents when answering questions or being asked to fill out surveys, this makes gathering primary data difficult.

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?

Some of the most difficult barriers to offering services in rural areas are strongly affected by uncertainty over time and the lack of long-term support with federal funds often uncertain until the last minute and occasionally being frozen altogether for periods of time. Long term funding for FQHC's would allow for longer term planning and more stability in services offered.

Moving states to APM models that fund a network of providers under a lead entity that ties the investment back to lives and outcomes appears to be an ideal model for rural service delivery. For example SIHF is a lead entity with a controlled safety net hospital, community mental health, substance abuse treatment, focused case management and housing. New ventures to expand specialty access, workforce development, teleconsultation and others are underway

and will strengthen this system of care, allowing patients to receive holistic services from a central point of contact.

Additional help could maintaining rural providers could be helped by increased loan forgiveness payments of providers serving these areas.