



TEXAS TECH UNIVERSITY  
HEALTH SCIENCES CENTER™

November 25, 2019

Committee on Ways and Means  
Rural and Underserved Communities Health Task Force  
1102 Longworth House Office Building  
Washington, DC 20515

Dear Committee Task Force Members,

On behalf of our students, faculty, and staff, I wanted to thank you for the opportunity to participate in the Rural and Underserved Communities Health Task Force's Request for Information (RFI). Health care research, education, and patient care to a predominately rural constituency is a core component of TTUHSC's service mission to West Texas.

In the 50 years since our inception, TTUHSC has trained more than 30,000 health care professionals and meets the health care needs of almost 3 million people in 108 counties including those in the Texas Panhandle and Eastern New Mexico. TTUHSC is comprised of five schools with campuses in Abilene, Amarillo, Dallas/Fort Worth, Lubbock, Midland, and Odessa. This unique infrastructure has made the delivery and financing of health care to rural areas both a challenge and focal point in the implementation of our programs.

The Task Force's questions provide a good starting point as an introduction of our programs and the unique approaches currently being developed with health care service in a rural setting. We have collectively addressed the Task Force items that were the best fit for our mission and tailored our responses to the challenges and outcomes presented in our rural service delivery area.

We appreciate the opportunity to participate in this endeavor and look forward to working with you on the Task Force's ongoing efforts. Please do not hesitate to contact me at [smiley.garcia@ttuhsc.edu](mailto:smiley.garcia@ttuhsc.edu) or 806-743-2095 if I could be of further assistance.

Sincerely,

Smiley Garcia  
Senior Director, Government Relations

**a. 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?**

Societal determinants of health are conditions in the social, physical, and economic environment in which people live, learn, born, live, work, play (Healthy People, 2020). These determinants are different for rural and urban populations. Rural Residents often suffer “triple jeopardy,” a combination of growing older, residing in a remote setting, and managing chronic health problems at a distance from specialty medical centers. The average per capita income for Texans is \$46,274, rural per capita income is \$37,629; the poverty rate is 8.1% compared with 15.3% in urban areas; 21.5% of the rural population has not completed high school, compared to 17.1% of the urban population; unemployment in rural Texas is 4.8% while in urban Texas it is 4.2%.

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

Rural residents prefer to stay and be treated where they live; rural clinicians prefer to receive continuing education where they work.

There is a national shortage of rural physicians (especially family medicine physicians and general internal medicine physicians) and rural physician specialists. In addition, allied health specialists are also lacking, especially registered nurses, physical therapists, and pharmacists. Access to medical care is a problem for rural residents, but access to the latest information is a problem for local health care providers.

A significant barrier to educational mobility for health care professionals who work and live in rural communities is geographic distance from metropolitan areas where institutions of higher learning tend to be located. These professionals may have obtained their educational training from technical, vocational, and two-year colleges in locations accessible to their places of residence. They continue to work and live in their rural communities, where the geographic barriers to educational mobility continue to be a reality. However, the geographic distance and relative isolation of these rural communities do not insulate these health care workers from the demands of a changing health care system. Many of these rural professionals are thrust into health service delivery situations demanding high levels of skills, competencies, and creativity, particularly because rural health institutions are faced with resource and technology limitations that are not usually typical of urban health systems.

New paradigms require new skills and competencies. The knowledge base underpinning these new paradigms is best obtained in organized, structured and well-planned interdisciplinary educational programs. Models which encourage “growing our own” have the greatest chance of success because healthcare providers born and raised in a rural environment often return to a rural environment. It is an environment they understand and feel comfortable providing care for their friends and family. This is why Area Health Education Centers (AHEC) are important because they provide a pipeline of future healthcare providers who live in rural communities. In addition, models which involve community leaders/planners in identifying community needs and best local answers have the greatest chance of success.

**c. 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?**

These challenges are addressed by a strategic partnership between communities and state/federal components to utilize existing programs and health care infrastructure, as noted below. The approaches or existing resource serves as a bridge to address the gaps of social isolation and care accessibility.

a) Approaches for rural care delivery:

Interprofessional education through Health Related Institutions (HRIs)  
Addition of Community Health Workers into the healthcare team  
Telemedicine  
Area Health Education Centers (AHEC)  
Federally Qualified Health Centers (FQHC)  
Community Partnerships  
Support for Critical Access Hospitals  
Clinics affiliated with healthcare specialists  
Hospice/Palliative Care  
Home health  
Long Term Care options  
Transportation

b) Approaches to gaps in rural health care typically address:

Accessibility: Where do I go? How far is it from where I live? How can I get there?

Acceptability: Would I go there? Is there a provider who will take my insurance? If I don't have insurance, how will I be treated?

Affordability: Who will pay? Even if I have insurance what will I pay?

Availability: When can I be seen?

**d. 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?**

Despite their comparatively sparse population, rural communities experience similar rates of mental illness and substance use disorders to urban areas, and rural communities often rank mental health amongst their top health priorities. Notwithstanding the similarity in need to their urban counterparts, rural communities must overcome unique barriers in accessing appropriate care such as workforce shortages, geographic distance, deficits in information technology infrastructure, and a lack of anonymity when seeking care. As with physical health, the delivery of mental health services in rural settings is important to maintaining their social and economic vitality. Rural communities have taken several approaches to overcome the challenge of access. These include:

- **Leveraging technology and collaborative partnerships to “shrink” the distance between patients and providers:** Patient access has been improved through telehealth services and in some instances rural communities have shared resources across wide multijurisdictional areas. Leveraging more traditional technology like a dedicated phone line has also proved beneficial in such instances as crisis response with law enforcement.

- **Increasing capacity within existing settings/programs:** Since most patients receive their care in a primary care setting, efforts have been taken to increase the capacity of primary care providers to address the complex needs of patients experiencing mental health challenges. Primary care capacity have been improved through the increased practice of integrated care and in providing new tool or trainings to primary care providers.
- **Targeted messaging to reduce stigma in rural areas:** The lack of anonymity in rural areas is often cited a barrier to seeking help. Some rural communities have taken on more open discussion on mental health challenges and have spent time to address some populations who are at increased risk. For example, access to lethal means such as firearms have been linked to a higher suicide rate in rural areas so some communities have made it a priority to address this issue.
- **Grow your own and increased financial incentive:** The challenge of recruiting to rural areas often makes it necessary to identify community members with an interest in healthcare and providing opportunities for that person receive training with the intention of staying in community upon completion. The use of loan repayments for practice in rural areas has also been an effective strategy used by states such as Texas.

**e. 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?**

There is an extensive literature that health disparities persist despite improvements in medical care and in disease prevention strategies. There is a developing literature that suggest that deaths attributable to chronic conditions such as cardiovascular diseases, cancer, stroke and even deaths from trauma are as much related to where people live, learn, work and do life, often called social determinants of health. The focus of intervention research that produces models has been on three main clusters or factors: 1) poverty and employment, 2) access to health care, especially high quality care, often correlated to workforce shortages, insurance or lack of it, and transportation, and 3) poor and unstable housing and food supply, and limited safe and healthy environmental conditions.

One thing that has proven effective is education and early childhood interventions that are locally focused, closest to the problem and are products of community initiatives. Notable, there is a developing understanding that government run programs are not as effective as those that build from local concern and engagement. This is likely why things like the 1115 waiver programs have been so successful. Moreover, avoiding adverse childhood events across the board reduces the cumulative impact on overall health status across the life-course.

Employment and income supplemental programs have proven effective with some caveats. First, employment must lead to reducing poverty. Programs that showed income gains and raised the socioeconomic status at every age in the life-course increases life-expectancy and provides resources for stabilizing access to health care, safer housing and better nutrition. So if the focus is only on employment then typically disparities continue, exemplified by mortality higher for people of color and greater for men than women independent of ethnicity. So lifting people out of poverty is why employment is important. Income supplementation programs work best at the end of the continuums of life-course, very young (largely due to improved nutrition and more stable housing and education) and the very old (largely leading to access to better health care and better overall quality of life). Two keys here are conditional cash transfer programs (those that limit the cash for only approved uses such as nutrition) they work best; and second, that are applied to populations where the poorest receive the largest cash amounts. Bottom line is employment must reduce poverty and cash transfers must be targeted and reduce poverty.

Health care programs are effective if they address more than shortages, insurance or mode of delivery. The literature suggests that team based care is best when it is focused on higher quality and better outcomes. That is the basis for value based payment systems. In the communities of west Texas team-based care is the standard and scope of practice issues are largely irrelevant. This is one of those occasions where policy should prevail over politics, as Representative King said many times in the forum. We know that rural and some underserved populations have far fewer choices in insurance options than their urban counterparts and that needs to change because the limits, access to team-based care and value-based payments which produce the best outcome and cost-effectiveness. System size is a factor here and the bigger health care systems afford the best infrastructure to report metrics tied to payments. So again, government run initiatives favor big systems of care. Incentives for creating consortiums of rural providers seems to be one answer. On telehealth and telemonitoring the answer is simple get all payers on the same page relative to parity? That is these are effective stratagems and should be paid equivalent to flesh to flesh visits, start with reforms at CMS within Medicaid and Medicare that will filter to the state level.

Stable housing, food supply and safe neighborhoods are givens. They have been politicized by both predominant parties at the national and state level. The principle here is local investment, engagement and control. One size does not fit all communities thus what works in San Antonio, Texas does not necessarily work in Lubbock, Texas. What's needed is more evidenced-based research that is population based and focused on outcomes that are upstream social determinants that focus on children within family units within local areas and economies.

**f. 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?**

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

Hospital emergency departments are a major source of primary care in many rural areas, so rural hospital closures—often attributed to high uninsured rates and high shares of public paying patients—can have a significant impact on rural health. However, alternative care sites can mitigate some of these challenges. Studies have found that uninsured individuals living near FQHCs are less likely to have unmet health needs, to visit an emergency room or to have an inpatient stay, and community health centers have spread steadily over five decades following studies showing their effectiveness. Other public health initiatives like community health worker programs—liaisons that connect underserved patients with available health services—have also been successful.

For additional models of healthcare innovation that slow spending growth, consider the work done by “Centers for Excellence” across the country. These centers are typically dedicated to key service lines within healthcare organizations and distinguish themselves due to high clinical quality, patient satisfaction, innovative offerings, and lower-cost approaches.

For instance, Stanford University’s Clinical Excellence Research Center focuses on “ambush points,” critical but often overlooked junctions in a patient’s care. One example is when chronic kidney disease worsens to the point where patients need dialysis. CERC found that by ensuring patients get home-based versus center-based dialysis, as appropriate, providers and payers can dramatically reduce costs while also improving the patient experience. CERC estimates that the U.S. would save \$63 billion a year by switching to home-based dialysis and ensuring effective management of early-stage kidney disease.