



**Katherine E. Levins, JD, MBA**  
**Associate Vice President**  
**Public Policy & Government Affairs**  
Temple University Health System  
3509 North Broad Street  
Philadelphia, PA  
215-707-4851

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The Honorable Richard Neal  
Chairman  
House Committee on Ways and Means

The Honorable Kevin Brady  
Ranking Member  
House Committee on Ways and Means

Re: Request for Information-Rural and Underserved Communities

Dear Chairman Neal and Ranking Member Brady,

I commend you for forming the Congressional Task Force on Rural and Underserved Communities. Thank you for the opportunity to provide our insights and suggestions on caring for these vulnerable populations. I provide our response to questions below. At the outset, however, I provide a brief overview of Temple University Hospital (TUH) and its important public service mission.

Last year, TUH provided about \$63 million in free and under-reimbursed care to the indigent population we serve. Furthermore, with 88% of our patients covered by government programs, we are in a relentless fight for financial survival.

TUH was founded in 1892 as "Samaritan Hospital," with the mission of caring for patients with limited incomes and ensuring access to medical care in its surrounding neighborhoods. As the chief academic teaching hospital of the Lewis Katz School of Medicine at Temple University, TUH is a 722-bed non-profit acute care hospital that provides a comprehensive range of medical services to its low-income communities, and a broad spectrum of secondary, tertiary, and quaternary care to patients throughout Southeastern Pennsylvania. TUH is accredited as an Adult Level 1 Trauma Center by the Pennsylvania Trauma Systems Foundation and is a major penetrating trauma service for the Commonwealth.

In addition to its main campus in North Philadelphia, TUH operates at its Episcopal and Northeastern campuses, both of which are in economically distressed areas within three miles of the TUH main campus. Within our immediate service area, approximately 45% of individuals live below the federal poverty level. Approximately 64% of community residents received a high school education or less, 23% are unemployed and 76% self-identify as Black or Hispanic.

Virtually all Temple physicians care for patients covered by Medicaid in both the inpatient and outpatient setting. About 88% of TUH's inpatients are covered by government programs: 40% by Medicare and 48% by Medicaid. Patients dually eligible for both Medicare and Medicaid comprise about half of our Medicare inpatient base. About 70% suffer from one or more chronic conditions and 41% of our total inpatient cases include a behavioral health diagnosis.

TUH serves as a critical access point for vital public health services. Last year we treated more than 130,000 patients in our Emergency Department including 2,300 trauma activations, nearly 12,000 patients in our Psychiatric Crisis Response Center, 2,100 discharges from our inpatient Behavioral Health unit and 300 patients in our Burn Center. We delivered approximately 2,400 babies of whom almost 90% were covered by Medicaid.

TUH is also "ground zero" of Philadelphia's opioid epidemic. We are a critical partner with the Commonwealth of Pennsylvania and City of Philadelphia in its effort to combat the crisis through prevention, education and research. With our TRUST Clinic (Temple Recovery Using Scientific Treatment) central to Pennsylvania's sole urban-based "hub-and-spoke" model, we are coordinating services among our emergency departments, local health centers, physician offices and outreach organizations.

TUH is an indispensable provider of health care in the largest city in America without a public hospital. Among Pennsylvania's full-service safety-net providers, TUH serves the greatest volume and highest percentage of patients covered by Medicaid. Furthermore, among integrated academic medical centers, Temple University Hospital ranks #1 in America in terms of the share of hospital discharges covered by Medicare and Medicaid. In the absence of a public hospital, TUH provides a critical, albeit fragile, safety-net for one of America's most vulnerable populations.

## **Temple Health Response to Information Requests.**

### **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?**

Chronic Diseases, including hypertension, diabetes, COPD, asthma and obesity affect patient outcomes in our community. These are influenced by chronic behavioral health conditions such as persistent mental illness ranging from depression to psychosis. Developmental, disruptive and adjustment disorders are lead issues related to behavioral health. Health care outcomes are also influenced by poverty and literacy. The lack of sufficient ambulatory primary care leads to over utilization of emergency departments for low acuity care and influence admission rates associated with ambulatory sensitive conditions.

The following social determinants also affect outcomes:

- Housing: The availability of temporary housing and long term permanent housing is limited. Temporary facilities are typically full, and are unable to manage individuals with medical needs. Furthermore there are limited medical respite centers for underserved

communities given limited funding. The dearth of housing options affects health care cost through frequent utilization and placement of individuals in more costly levels of care.

- Food: Individuals with SNAP benefits often remain food insecure as they commonly need supplemental food from other sources. Food pantries and meal facilities generally offer foods high in carbohydrates and sodium, which have a negative effect on individuals with chronic conditions such as heart failure and diabetes.
- Transportation: Public transportation systems are not designed for those with disabilities or health conditions influencing ambulation. Consequently, patients with such conditions are unable to keep scheduled appointments and receive follow up care.
- Substance use disorders and gun violence. Individuals suffering from substance abuse disorder have limited options for sub acute care and housing. Growing gun violence is a public health threat, with victims more likely to be low-income, uninsured members of minority groups.

**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?**

- Federally Qualified Health Centers (FQHC's): These provide wrap around services, such as social services and dental care. Typically programs are broad based and provide primary and behavioral health care and behavioral health care. FQHC patients tend to have better outcomes related to potentially preventable admissions, lower emergency department utilization, and improvement in health screenings (breast cancer, colorectal).
- Housing First Models: Housing with care management oversight, in both rural and urban settings, have been successful in managing individuals with chronic conditions and those who are homeless. Such programs pay for themselves through cost reduction and health outcome improvement. A program of the University of Illinois demonstrates a reduction in hospitalization and emergency room utilization.
- Food as Medicine: There is a growing movement among Medicaid MCOs and other third party payers recognizing food as an influencer of health outcomes. *Manna* in Philadelphia has food “prescriptions” to address diabetes, heart failure and other chronic conditions. These programs reduce care utilization and improve outcomes related to hemoglobin A1C and weight.
- Telehealth Technology: This has demonstrated that early intervention can reduce the use of acute care resources. Telehealth products with central oversight demonstrate the ability to reduce heart failure and COPD emergency department utilization.
- Telemedicine: Remote access to limited resources such as specialty care and behavioral health services demonstrate value for consultative and ongoing care reducing the need to

move individuals to distant settings to access specialty care. (e.g. Temple Stroke Program, Diabetic Eye Examinations).

**3. This question related to rural communities is not applicable to Temple Health.**

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

Philadelphia has seen a variety of hospital closures over the past 20 years as well as the reduction of services line access such as obstetrical services. Most of the hospitals that closed served low-income communities and had a high percentage of patients covered by government programs. The following lessons can be understood as it relates to service reorganization:

- Individuals who have the knowledge and ability to change providers will move to other community based resources and transition care. An example is the closure of maternity care services in Philadelphia. Maternity care has transitioned to large teaching and academic facilities due to the cost of malpractice coverage. Community based maternity care services largely exist in more affluent areas. Such service line change results in patients needing new sources of care, which are often in a different geographic location with limited public transportation.
- Patients who are affected by one or more social risk factors have difficulty finding new providers. For example, those who struggle with health literacy and those who have difficulty managing the transportation system become disconnected until they face a health care crisis.
- The uninsured and underinsured are more likely to become disconnected from care when a service interruption occurs.
- Closure of hospital based services places a higher burden on municipal health centers and FQHCs.
- Service Elimination has not resulted in a change in the payment process or in health care delivery. Within the current framework, remaining health care providers, which are often major safety-net providers with slim operating margins, attempt to absorb those who have been disrupted.

**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?**

- Temple Clinically Integrated Network: This quality improvement initiative serving North Philadelphia's underserved community has reduced cost and improved quality outcomes. Over the past year the network has been able to improve outcomes related to ED utilization and 7 day office visits, while reducing cost. The program has generated a \$ 1.5 million savings for the network, enabling the investment in provider incentives and care management infrastructure.
- Additional examples of regional networks of care are Geisinger Health System, Intermountain Health and Kaiser Permanente, all of which are integrated health care providers and insurers. These networks, which have a more balanced payer mix and which manage both premiums and expenses, are advantaged in their ability to use innovative health care solutions to drive delivery system change. Their models are built on employed physician salary models, use of bundled payments, quality outcomes and the use of EMR systems to reduce cost associated with duplicated testing.

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

Temple University Health System's (TUHS) ability to achieve its mission is intertwined with a three-part initiative of positively impacting workforce shortages in a sustaining manner.

- TUHS partners with local schools, community groups, and labor organization to provide current high school students with the skills – academic, technical, and work-readiness – to enter the healthcare workforce. Presently, our programs are *Bridge to Employment*, which focuses on practical work experience (partners include City of Philadelphia high schools, 1199C labor union, and Temple University) and has resulted in permanent employment, and *Steppingstone Scholars*, a new program that focuses on career development and internships (partners include City of Philadelphia high schools, Lewis Katz School of Medicine at Temple University, and the Lenfest Foundation).
- The TUHS workforce plan is directed to up-skilling and employing unemployed and underemployed workers. Examples include (i) training and employing dislocated workers who reengineered their careers to registered nurses; (ii) working closely with and partially (but significantly) funding the Training and Upgrading Fund of the 1199C union, which prepares underemployed Philadelphians with training from GED to licensed practical nursing; and (iii) development of apprenticeships (so far: community health worker) to combine training with practical experience. Each of these initiatives results in full-time, benefitted, permanent employment.
- TUHS continues to ensure entry-level workers have the ability to progress into family-sustaining positions by creating career ladders (workers in the areas of nursing, various labs, respiratory, operating room, environmental services, dietary, and others).

## **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 Pennsylvania, the substance use crisis has been addressed in the following ways:

- In collaboration with the Commonwealth and medical schools, *Temple developed curriculum to educate providers to screen and refer patients for substance use disorder*, to focus on pain management and multimodal treatment and to develop core competencies and prescribing guidelines.
- Pennsylvania's online *Prescription Drug Monitoring Program* helps providers identify drug seekers and link them to treatment programs.
- Pennsylvania's *drug-return program* enables safe return of unused prescriptions.
- The Secretary of Health established an *Emergency Standing Order* for the dispensing of Naloxone for rescue of individuals who have suffered from a drug overdose.
- The Department of Human Service's *Center of Excellence for Opioid Treatment*, such as *Temple's for women of childbearing age*.
- The Department of Health collaborated with SAMHSA for \$ 12.7 million in grant funding to develop Medication Assisted Treatment programs using a hub and spoke model. Of seven sites across the Commonwealth, *Temple is leading the only urban-based hub and spoke model*.
- \$55 million in SAMHSA funding for treatment and recovery services. *Temple collaborates with the Single County Authority and ProACT for the placement of Certified Peer Recovery Specialists* at its hospitals.

**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?**

- *Temple University Hospital Post Acute Collaborative*. This is a collaboration of 22 providers with the goal of achieving quality outcomes for the patients who use skilled services. The program is focused on readmission reduction, and care management of patients back to their community based primary care provider.
- *Community Health Worker Programs (CHW)*: These programs, built on an age old model of community support, have become a staple in supporting individuals in the community. Programs originating at Temple University and other educational institutions develop culturally sensitive teams to provide safe home support for vulnerable patients and link them with social supports they need to heal. These programs are shown to avoid over utilization and to align patients with primary care.
- *Programs for All inclusive Care for the Elderly (PACE)* enable individuals to age in place. Services include primary and specialty medical care, nursing, social services, therapies

(e.g. occupational, physical, speech, recreation) pharmaceuticals, day health center services, home care, health-related transportation, minor modification to the home to accommodate disabilities, and other services the program determines is medically necessary to maximize a member's 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?**

- Coding. Currently, social factors are not coded consistently, which results in underrepresented data. There should be consistent guidance for coding for social condition that directly relates to the reimbursement system. ICD-10 provides for “Z” codes to which can classify the factors that influence health.
- Community Specificity: In general, current data is geographically based using zip codes to represent the needs of a patient population, which may not entirely represent the specific needs of individuals within the community. To address the need for a specific community, the Lewis Katz School of Medicine at Temple University is conducting its “Block by Block “ community-based participatory research project. Its aim is to better understand and address the health concerns and needs of North Philadelphia by engaging local residents and gathering general and specific health 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?**

- Congress must recognize the need to provide adequate and stable funding for major safety-net hospitals serving an extraordinarily high percentage of patients covered by Medicare and Medicaid. In general, federal payment policy considers hospitals as a homogenous group with the ability to cost-shift across all payers. It does not contemplate hospitals such as Temple with an exceptionally high caseload of low income patients covered by government programs, including high-cost high need patients dually covered by Medicare and Medicaid.
- Although not a public hospital, Temple effectively functions in this role. Most other hospitals are able to absorb losses on Medicare and Medicaid with surpluses from commercial payers. Consider that the RAND Corporation recently issued a research report indicating that commercial payers reimburse on average 241% of Medicare rates. In contrast, The Medicare Payment Advisory Commission (MedPAC) reports average Medicare margins of -11%. These massive disparities between private and public reimbursement are generally acknowledged by policy-makers, though not reflected in payment policy.
- Individuals in underserved populations often have multiple comorbid conditions influenced by social determinants. In light of this, data related to quality needs to be organized for like populations.

- Risk Adjustment for establishing baselines is an essential factor for creating equity in establishing incentives for improvement or for understanding environmental factors that influence health outcomes.

Thank you for the opportunity to comment on the important issue of healthcare delivery in rural and underserved communities. Please advise if you have questions or wish to discuss further.

Sincerely,

A handwritten signature in blue ink that reads "Katherine C. Lewis". The signature is written in a cursive style with a large initial 'K' and a distinct 'C' for the middle name.