THE TEXAS A&M UNIVERSITY SYSTEM

November 29th, 2019

Ways and Means Committee
Rural and Underserved Communities Health Task Force
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515
Submitted via email

RE: Request for Information: Rural and Underserved Communities Health Task Force

The Texas A&M University System (TAMUS) welcomes the opportunity to submit comments responsive to the House Ways and Means Committee's request for information on the delivery and financing of health care and related social determinants of health in underserved and rural underserved areas. Established in 1876 under land-grant college funding, TAMUS has evolved into one of the largest systems of higher education in the nation, providing rich and culturally diverse educational programs, innovative outreach and community enhancement services as well as robust research that delivers solutions, drives the economy and improves lives of Texans, the nation and the global community.

TAMUS' RFI submission incorporates comments from multiple entities within the System.

The Texas A&M Health Science Center, established in 1999, now has campuses across the State of Texas. Its six colleges are the Texas A&M College of Dentistry (formerly Baylor College of Dentistry), the College of Medicine, the College of Nursing, the Irma Lerma Rangel College of Pharmacy, and the School of Public Health. Other units include the Institute of Biosciences and Technology, the Coastal Bend Health Education Center, and the A&M Rural and Community Health Institute (ARCHI).

Health access for rural and underserved populations is a health science center priority, as demonstrated through several of its components. The A&M Rural and Community Health Institute (ARCHI) is a health extension center offering programs that promote safe, effective health care practices. ARCHI serves as a bridge for health care professionals and their organizations with academic centers, policymakers and researchers to improve the quality and safety of patient care to rural and underserved populations. In 2018, the Health Resources and

Services Administration awarded ARCHI the sole designation as a technical resource center under its Vulnerable Rural Hospitals Assistance Program. The grant has funded the creation of ARCHI's Center for Optimizing Rural Health to actively help rural communities maintain their hospital or create other means of access to care after hospitals close. Other rural-focused centers include the Southwest Rural Health Research Center at the Texas A&M School of Public Health, funded as one of just seven rural health research centers in the United States, and the Center for Community Health Development, twice funded as a Prevention Research Center by the Centers for Disease Control and Prevention, (CDC).

As a historical land grant institution, Texas A&M AgriLife is a statewide, diverse organization that supports research and extension activities that connect agriculture, food, and health to drive discovery and promote improvements in public health and economic prosperity. By partnering with members of the System, state agencies, and other public and private entities, AgriLife focuses on addressing the production concerns of farmers and ranchers, protecting the environment and producing nutrition-dense foods for healthier urban and rural communities, and serving people of all ages and backgrounds through teaching, research, extension, laboratory, and service facilities. Agrilife is the U.S. Department of Agriculture's Cooperative State, Research, and Extension Service, with a presence in 250 of the state's 254 counties. Texas A&M AgriLife and the Texas A&M Health Science Center are working collaboratively on several projects focused on public health initiatives.

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?**

   A. Distance to care

   B. Healthcare workforce shortages across virtually all professions and a failure to adequately address these shortages through training and deployment of health care professionals to rural areas;

      a. Only 9% of doctors and just 16% of registered nurses practice in rural areas (CSG, 2011; HRSA 2012).
      b. Rural America also has a severe shortage of nurse practitioners, dentists, pharmacists, and other health professionals (Council of State Governments, 2011).

c. Lack of specialty care has long been an issue for rural communities, including general surgery and obstetrics.

C. Lack of health insurance options; less penetration of third party insurance coverage

d. There is a significant small employer culture with the attendant implications for acquiring group insurance.

e. More individuals employed part-time, seasonally, or self-employed, resulting in no insurance or underinsurance.

D. Limited payer mix to support care with a higher penetration of Medicare, Medicaid, and uninsured.

E. Rural hospital closures, especially in the South, have left many rural counties without a hospital. Successful recruitment of health professionals is often tied to the availability of a hospital facility.

F. Poor infrastructure and scarce resources, especially the **lack of telecommunications** infrastructure for most rural regions. Addressing/providing reliable broadband connectivity would allow the use of telemedicine to address some/many of the shortages.

G. Cultural mindset that does not address community health access until it is not available or health status until it becomes an emergent issue.

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?

Community Health Resource Centers (CHRC) are - “one-stop-shop” facilities that co-locate ancillary health and social services in single regional place providing space and office management for organizations to utilize as a remote hub on a regular basis, (e.g. weekly, monthly) thereby allowing for local organizations to affordably extend service delivery to underserved communities. While they operate under different governance and financing models, dictated by individual community characteristics, they are all community-led and driven and are supported through a variety of mechanisms such as county and/or hospital district tax funds, service contracts, grant funding, and donations. Services offered vary based on community needs, support, and resources Services may include comprehensive case management, senior meal programs, tele-mental health counseling, volunteer transportation

systems, chronic disease self-management programs, low-cost medical and dental services (for CHRCs co-located with Federally Qualified Health Center [FQHC] clinics), substance abuse and domestic violence counseling, and information/referral navigation..
https://srhrc.tamhsc.edu/rhp2020/rhp2020-v1-download.html

The Texas A&M Telebehavioral Care Program (TCP) has implemented telehealth counseling services in 6 rural counties in Texas. Psychology doctoral students provide evidence-based psychological service to rural communities. Over 65% of clientele are uninsured, and 90% of clients in rural areas report they would have gone without services if not for the TCP program. **Identified access points in each of the communities** lessen the distance to care; home services can be provided. Partnering with the Centers for Community Health Development allows assessment for social determinants of health such as housing, utility assistance, food insecurity, transportation difficulties, etc. and connection to other social services. This program can serve as a national model for academic-community partnerships to address rural health challenges.

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

Population density must be calculated along with distance in order to best plan for and respond to the healthcare needs of rural areas. The impact of distance may mean that there is a need for providers despite not having adequate population density to fully support their presence.

A provider can reasonably care for 1200-2000 people. Thus a town of 3000 would likely need three providers; having only two would mean each had a panel of 2500 patients and limited coverage for time away. However, three providers would be mean relatively anemic patient panels and likely a negative impact on income and ability to retain the provider in the community.

While many look for every community to have a hospital, many rural cities may not be able to support even a scaled-down critical access hospital but rather must focus on how to support components of access to care such as emergency response that includes stabilization and transfer to tertiary care. Ideally, these communities would at least have access to acute and chronic care and some form of emergency service.

In some rural areas, organizations end up duplicating services and competing for the small patient volume forcing hospitals and clinics to compete for funding and staff. There is a need to coordinate healthcare across federally supported programs so that CAH, RHC, and FQHCs can collaborate in the best interest of the community.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where:

patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?

there is broader investment in primary care or public health?

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

Recent research out of California demonstrated that closure of rural hospitals led to a 6% increase in mortality (closure of urban hospitals had no impact on mortality.) Major changes in policy or regulation impacting rural hospitals should be made cautiously.

Alternatively, rural hospitals that reduce/eliminate service lines, but focus on investment in primary care, prevention programs, ***and*** supporting/partnering with community health centers and FQHCs, appear to be resulting in healthier communities. Atrium Health's approach in redesigning care (Atrium Health, Anson Hospital, Wadesboro, NC) has garnered national attention for not only turning around the financial health of the hospital but the health status of the community.

Research is currently being done at TAMU to evaluate/create innovative means of accessing care as well as enhancing emergency access, stabilization, and transport for critical situations. Delineating the continuum of care, the time/distance to access different points on the continuum, and seeking new ways of meeting care needs seems essential. The continuum should include identified processes to enhance population health and deal with social determinants of health (see CCHD above), but also the importance of recognizing the circle of care – the patient who goes to tertiary care should be returned to the community when his/her needs may be met locally.

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?

The creation of health networks is becoming increasingly common to achieve cost savings for hospitals by sharing costs, such as administrative staffing, equipment, providers, and specialty care costs through mechanisms like telemedicine. The Northwest Rural Health Network, a non-profit, multi-county network of critical access hospitals in eastern Washington State, appears to be a successful model thus far.

The challenge in creating these types of networks of rural hospitals is the fear of the system being perceived as a violation of anti-trust or Stark laws. The creation of a network creates substantial legal costs to ensure that the network does not unintentionally violate these federal laws. ARCHI has initiated efforts to study the various network models to determine which are most promising for replication as well as piloting a network model in a Texas region.

Telemedicine networks that have been created, and it is our understanding that the University of Mississippi has established a broad network to serve rural areas with specialty care. However, to have a system upon which a rural area can depend requires nearly universal broadband access and then the development of a telemedicine network. Ideally, the network would connect the rural area with those physicians and hospitals that also provide tertiary care when it is needed to support continuity of care.

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

WAMI (Washington, Alaska, Montana, and Idaho) Medical School, South Dakota North Dakota, and Minnesota have all developed programs that provide some or all of their medical students training in smaller, rural towns. These programs have demonstrated success in training students who are more likely to practice in small towns.

The Texas A&M Family Medicine Residency in Bryan, Texas, is one of a relatively small number of training programs that emphasize training for full-scope family medicine including endoscopy skills and operative obstetrics. These programs not only attract individuals who have a desire to practice in small towns, but they provide the breadth of training needed to practice fully in relatively isolated areas.

The same philosophy that helps address training physicians, recruiting from rural areas, and training in rural areas, works for other professions as well. Nursing schools and programs that train nurse practitioners and are located in small towns are more likely to graduate professionals interested in serving in small towns. Likewise, having high schools or community colleges offer programs for certified nursing assistants, EMT's and licensed vocational nurses means recruiting from the local population and providing a skill set that can be used locally.

Some models expose K-12 students who reside in rural areas to health careers. These models include holistic review criteria that include rurality, or commitment to rural health for admissions into health professions programs. There is a need to evaluate rural clinical education models and financial support of students through scholarships, traineeships, fellowship, and residencies across many health professions, federal student loan repayment models for rural practice, incentivizing innovation in the care models co-created with communities, and integration of technology in the delivery of care.

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?

Texas A&M has utilized an academic-community partnership model to address unmet behavioral health needs in rural Brazos Valley through telehealth. The University provides foundational supports in grant and financial management, information technology, legal

oversight, etc. and Texas A&M psychology doctoral students provide behavioral health counseling via telehealth. The communities offer support through the resource centers, which provide the physical space within the rural community and a staff member to coordinate the activities.

The Texas A&M College of Dentistry offer support of local general dentists by consulting via telemedicine on difficult diagnoses or procedures. This allows a larger portion of the community to remain local for their care even while accessing state of the art interventions.

Many emerging telemedicine support systems are being developed; Avera is a South Dakota based model that currently serves over 30 states with a wide array of services. Perhaps the one that gets the most attention is backing up emergency departments that are staffed with advanced practice providers or physicians not trained in emergency medicine. From thousands of miles away, they talk teams through care to stabilize a patient and prepare them for transport to the nearest tertiary facility.

Much less sophisticated but equally important in terms of access are the emerging school-based clinics that bring dental care and primary care to school children who have no other access.

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?

In many ways, rural areas are solving this better than urban. In addition to often having nursing facilities with or without rehabilitation services, small CAHs offer excess beds that are called into use when beds are not available in urban areas. While underserved urban areas may suffer social isolation, the very nature of small towns suggests that people who return to their communities for rehab or nursing services fare better because they often surrounded by family and friends of long duration. One of the challenges is to assure that the tertiary center sends the patient back to their origin rather than encouraging them to remain the city for their longer-term care; families and aging friends are often not able to make frequent trips from their small town to the more populous urban center for reasons of unreliable transportation, costs, or demands of jobs and family at home.

The excess beds available across rural America may offer a partial solution to the lack of beds for chronic and disabling conditions in the city. The use of swing beds would enhance the average daily occupancy of small hospitals while allowing access to tertiary beds for more complex and acute care. Care will need to be used to assure that the complex rules regulating CAH beds are met, but both urban and rural would benefit from more planned and coordinated use of existing facilities.

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?

For rural and underserved urban areas, one of the challenges is the cost of acquiring and supporting adequate computer systems. While most large systems have become highly computerized, underserved and underfinanced systems often have outdated, inadequate systems and virtually no information technology support either to clean the data that may be in an old system or to troubleshoot problems with keeping old systems functioning.

Collecting data is often challenging in rural areas. The CDC does not collect rural county and city level data for the Behavioral Risk Factor Surveillance System.

One of the greatest challenges to data for rural areas is what is referred to as the "tyranny of small numbers." That is, even when small hospitals are able to collect data, it is subject to the impact of small numbers. For example, if a hospital has 50 discharges per day, 18,000 discharges per year, but has 200 patients who get readmitted within 30 days of discharge, they have a readmission rate of just over 1 percent. However, if a rural hospital has an average of 0.5 discharges per day, 219 discharges per year, and has only ten patients readmitted within 30 days of discharge, they have a readmission rate of 4.5 percent. When numbers are small, a numerator of only one or two can change percentages tremendously; this means that comparing data from urban and rural facilities is relatively meaningless.

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?

Perhaps the single most impactful change would be meaningful and ongoing investment in assuring reliable and universal broadband connectivity. This would allow telemedicine to grow and become more sophisticated; it would enhance educational efforts to "grow your own" professionals and would allow better information technology support in a virtual manner.

Continued efforts to encourage primary care and broad scope training are necessary. While there are some successful programs, perhaps the most powerful inhibitor of recruiting students into primary care is the ongoing national lack of appreciation for and investment in the power of good primary care. It is virtually always one of the least well-paid specialties despite repeated research demonstrating that a strong primary care base leads to better health outcomes and less costly total health care costs. And primary care is truly the only specialty of adequate breadth to be able to serve more isolated geographic areas.