Washington State Hospital Association

November 27, 2019

The Honorable Danny Davis
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Terri Sewell
U.S. House of Representatives
Washington, D.C.

The Honorable Brad Wenstrup
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Jody Arrington
U.S. House of Representatives
Washington, D.C. 20515

Dear Representatives Davis, Sewell, Wenstrup and Arrington,

Thank you for the opportunity to respond to the Ways and Means Committee's Rural and Underserved Communities Health Task Force request for information.

The Washington State Hospital Association (WSHA) represents 108 hospitals throughout the state of Washington, including 45 rural and critical access hospitals. These facilities provide the full range of health care services, including inpatient and outpatient hospital, physician, long-term care, emergency and EMS, home health, hospice and other services.

WSHA's members face a variety of challenges in their efforts to serve the health care needs of their communities. Our state's rural hospitals are especially vulnerable. We appreciate the Committee's interest in addressing these challenges.

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?**

   Providers in rural and underserved areas face unique and varied challenges in their efforts to provide access to high quality and affordable medical treatment. Patients in these areas tend to be older and sicker, thus requiring more intensive care. Persistent shortages of providers, inadequate reimbursement, the lack of behavioral health services, and the opioid epidemic are among the challenges facing these areas. In rural Washington, travel distances can be extensive. These communities often face inadequate housing, transportation and broadband services.

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?**

   Telehealth is one tool that can help ease the shortage of providers – especially specialty physicians and behavioral health professionals – in rural and underserved areas. Hospital-to-hospital telehealth services have been available for some time and are especially critical in rural communities. Among these services provided in Washington State, tele-stroke, tele-radiology and tele-pharmacy services are the most common. Telehealth could be an especially important tool in diagnosing patients with behavioral health symptoms.

In addition, recent technological advances in personal devices can enable in-home monitoring of chronic care patients, thus removing the burden of traveling potentially long distances to a provider. Unfortunately, Medicare reimbursement policies for telehealth services have impeded realizing their full potential and limits on originating sites prevent further adoption of some services. In addition, some communities lack adequate broadband capabilities to fully utilize telehealth.

A number of rural hospitals in Washington State are developing systems to better coordinate care, and, thus, better manage chronic conditions. Unfortunately, despite their ability to reduce overall health care costs and improve community health, there is minimal reimbursement for these services. Similarly, efforts to address social determinants, such as transportation assistance, are hamstrung by lack of funding.

Health care in rural communities is often a mini-integrated delivery system in which the hospital is the hub for inpatient, outpatient, clinic and post-acute care services. Often this local system provides a variety of other social and public health services. We support development of these kind of delivery systems. Unfortunately, Medicare payment policies do not provide that opportunity. Developing demonstrations that refine how an integrated rural delivery system might operate are important to ensuring continued access to care in rural areas.

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

Because of the low number of people living in rural counties, low patient volume is a fact of life for rural community hospitals. WSHA believes that every resident of Washington State should have access to essential services, regardless of the size of the community in which they live, and that public policies should be shaped to achieve that goal. Rural hospitals are integrated community health systems. Providers and staff often perform a variety of roles, for example, an orthopedic surgeon in a rural area can also provide vital trauma coverage. Volume standards often have unintended consequences to access to care.

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

The National Health Service Corps and Teaching Health Centers programs and other workforce development programs at the Health Resources and Services Administration are examples of programs that have demonstrated that placing physicians in rural and underserved areas improve access to care for patients in these areas.

State-based loan repayment programs for physicians and other providers also have proven to be effective in recruiting and retaining physicians and other providers to shortage areas. Expanding federal loan repayment policies could make these even more effective. We also recommend expanding eligibility to repayment programs for behavioral health providers and nurses.

Studies show that physicians tend to locate permanently near where they do their residency, so creating more opportunities for residents to practice in rural and underserved areas will result in more access to physician care in these communities. The Rural America Health Corps Act aims to advance this goal. The recent Medicare inpatient hospital prospective payment system rules provision to make it easier for

residents to work in critical access hospitals is also a positive step. But far more needs to be done to encourage residency programs in rural and underserved areas.

5. **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?**

   Telehealth is an important tool in helping communities address substance use and behavioral health needs. Behavioral health providers are especially scarce in rural areas. Telehealth enables ER providers in remote communities to link to behavioral health specialists elsewhere to diagnose patients. Washington State recently began allowing rural health clinics to provide dental services, leading to increased access, however, a shortage of providers has limited expansion.

6. **The availability of post-acute care and long-term care 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?**

   A number of communities have initiated coordinated care projects aimed at more effectively coordinating care for patients with chronic and disabling conditions. Again, the issue is reimbursement for these services.

7. **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?**

   Data is a sore subject for providers in rural and underserved communities. A number of critical access hospitals, for example, submit data to Hospital Compare, however because their volumes are so low, it is statistically insignificant. In addition, the data elements measured are often irrelevant to these hospitals.

   Developing data elements that reflect the realities of rural care delivery should be a top priority for the Centers for Medicare & Medicaid Services. These might include time to transfer, for example.

Again, thank you for this opportunity to provide input on this important topic. Do not hesitate to contact me or my staff if you would like additional information.

Sincerely,

Cassie Sauer
President and Chief Executive Officer
Washington State Hospital Association