November 29, 2019

Submitted via email to **Rural_Urban@mail.house.gov**

To: Ways & Means Rural and Underserved Communities Health Task Force
Attn: Task Force Co-Chairs, the Honorable: Danny Davis, Terri Sewell, Brad Wenstrup, Jodey Arrington

Re: Request for Information dated November 15, 2019

Thank you for allowing us to share our perspectives from the trenches as a safety-net primary health services provider and the lead member of a primary care Teaching Health Center Graduate Medical Education Safety-Net Consortium (GME-SNC) in rural Northeastern Pennsylvania – the largest HRSA-funded GME-SNC in the United States. Our feedback perspective is framed by decades of experience in primary care physician and inter-professional workforce development through and within our FQHC Look Alike NCQA Level 3 Patient Centered Medical Home, School Based and Primary Care-Behavioral Health designated locations, which are Ryan White service providers and a leading Pennsylvania Opioid Use Disorder Center of Excellence (OUD COE) that also serves as a Pregnancy Recovery and Coordinating Center for Medication Assisted Therapy initiatives. We have great faith that disciplined leadership by the federal government will optimize inclusive stakeholder contributions and propel us toward Quadruple Aim achievement in rural areas.

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 significant factor negatively affecting health outcomes in rural areas is affordable, timely access to primary care services (including mental health and addiction services). Health service provider shortages are enormous challenges - there are simply not enough primary care physicians and mental and behavioral health providers in rural areas to care for the population responsibly. Enhancing the numbers of primary health teams (physician-led inter-professional teams) and developing team skill sets to be responsive to the needs of the rural population will greatly improve access for ongoing, timely and preventative care, reducing the number of acute events requiring hospitalizations.

In our experience, poverty is a key driver of the rural population's lack of access to additional factors that impact health outcomes, including lack of access to: transportation, functional broadband, water quality, and affordable and convenient access to food. Moreover, the type of work most available to the majority of the population requires hard labor, leading to high

physical demands and unintentional injury. Other factors include racial injustice, chemical exposure (farming, fracking), and cultural challenges with seeking and identifying resources to assist in gaining access to the services and products listed.

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?

Federal and State designations such as Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs) and Federally Qualified Health Center (FQHC) designations have positively impacted rural community health outcomes by opening the door to focused and proven programs and funding addressing rural health needs and gaps. To date, the U.S. Health Resources and Services Administration (HRSA) programs targeting rural communities have been incredibly effective, most notably the Teaching Health Center Graduate Medical Education (THCGME) program to address primary care physician shortages in rural and underserved areas. The THCGME Program has delivered physician workforce at unprecedented rates in underserved populations as compared to traditional CMS and VA-funded GME programs. Moreover, the NACHC-inspired Hometown Scholars Program adopted and implemented by the A.T. Still University School of Osteopathic Medicine in Arizona (SOMA) is particularly successful in retaining primary care physicians in underserved settings; data shows that physicians are more likely to “train in place,” i.e., practice where they grew up. SOMA collaborates with safety-net clinics across the country to train physicians for medical school as well as for residencies in underserved areas.

ACOs and Health Information Exchanges (HIEs) also provide powerful engagement platforms for rural communities. Pennsylvania's Coordinated Centers for Medication Assisted Treatment program has enabled rural providers to become "spokes” connected to "hubs" of OUD COEs to provide addiction services. ECHO networks also offer opportunities for rural health providers to get connected to peer learning networks to improve the quality of care. HRSA's Peer Learning Networks and Rural Health Coordinating Center for GME Development and federal efforts to address OUD in rural communities offer promise.

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

The Committee should consider population size/primary health services provider ratios, to ensure that the population has adequate access to high quality well/prevention services as well as to timely sick visits/acute care. To improve outcomes, it is imperative to build disciplined and coordinated primary care and subspecialty relationships, coverage and referral networks, with timely and effective health information exchanges to promote timely and equitable access to care and health information.

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?

Travel distance and access to transportation for basic primary health services impacts health outcomes, along with routine versus high risk hospitalizations.

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

Fortunately, such investments improve general public health and reduce the need for hospitalizations for ambulatory sensitive conditions. There is, however, a glaring deficiency of proportionate investments in these arenas, especially in the prevention domain, which would clearly improve all outcomes while reducing costs. Intentionally increasing investments in prevention would pay force-multiplied dividends, particularly in the arenas of mental and behavioral health and infectious and chronic diseases.

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

Approved provider networks are often established by insurers without taking into account the lack of access, transportation barriers, and lack of convenience to patients from rural communities.

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 state of Maryland has done an incredible job establishing a state-wide, government-endorsed HIE, overcoming the disruptive barriers of competition where regional HIEs are paralyzed to deliver the mission of interoperability because of the stakeholder dominance of integrated delivery systems linked to insurance companies (which historically consider insular system level information interoperability a competitive advantage). The lack of high integrity, inclusive governance of regional HIEs in other states is extremely detrimental to rural or even smaller urban communities where fundamental care needs necessitate that patients cross between competing systems that fail to engage in interoperable information flow.

As mentioned above, Pennsylvania's Coordinated Centers for Medication Assisted Treatment program has enabled rural provider "spokes' to connect to "hubs" of Opiate Centers of Excellence to provide Addiction services. Also, Penn State's OUD COE and PacMAT ECHO networks have powerfully engaged rural providers in peer learning networks. Finally, the VA Medical Center in Wilkes-Barre, PA is successfully implementing telepsychiatry services to improve access to its veterans and their families in rural areas or who face transportation barriers.

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

HRSA's THCGME program has delivered unprecedented graduate retention outcomes in rural and underserved communities, in spite of repeated challenges with federal funding strategies. SOMA's "Hometown Scholars Program" referenced above (for osteopathic physicians), along with its Central Coast Physician Assistant Programs offer amazing potential impact for rural health services provider pipelines. The Wright Center for Graduate Medical Education's GME-SNC model has effectively engaged rural FQHCs, both in Northeastern Pennsylvania and Ohio, in primary care GME, increasing the likelihood of primary care physician retention. Our GME-SNC's National Family Medicine Residency Network has successfully overcome the geographic accreditation barriers of the Accreditation Council on Graduate Medical Education with its unprecedented successful accreditation of a multi-state single Family Medicine Residency program. This program has enabled Health Source of Ohio, one of the largest rural FQHCs in America, to engage in Family Medicine Physician Residency training which they had not been able to actuate independently.

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?

The Wright Center for Graduate Medical Education's GME-SNC model, supported and partially funded through HRSA's THCGME Program, has evolved a sponsoring institutional strategy that converges community-based ambulatory training with the hospital-based experiential training in Family Medicine, Internal Medicine and Psychiatry for resident physicians. All residents also share exposure to a general curriculum related to population health, patient centered medical home delivery models, health disparities, poverty and SEDH realities, screening and address, recovery-oriented addiction services inclusive of Medication Assisted Therapy, basic oral health needs and services and continuous quality improvement initiatives responsive to community health needs. This approach to curriculum ensures that the primary care physicians and psychiatrists have had a broader education more responsive to community needs.

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?

Development and deployment of house-call service lines through community-based care teams in partnership with aging agencies and other home-focused social service agencies improves outcomes. Bluetooth and other technologies enhance community-based living and reduces social isolation.

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?

An interoperable, national HIE that powers a consensus-driven, simplified, transparent, well-publicized and iteratively evolving "Healthy America" Balanced Scorecard to unify all stakeholders in a collective impact strategy to improve healthcare and public health is ideal. This backbone platform should be stewarded at the highest level of government, inclusive of HHS and the VA, and supported by responsible and responsive updates of HIPAA and 42CFR legislation. All federal health and social service investments, inclusive of program support for Graduate Medical Education, inter-professional workforce development and accrediting agencies, should be linked to mandatory connection, engagement, and performance.

Claims of the impossibility of this innovation are myths disproven by the success of the Prescription Drug Monitoring Program initiative (PDMP). At some point, our government must stop entertaining the feigned outrage of large integrated health systems with insurance company ownership who resist change for the benefit of our country. The repetitive, outdated insistence on insulating information at the level of the regional exchanges with single stakeholder predominance is nonsense. The federal government tolerance of state and insurance company-level conversations about establishing additional, independent social services information exchanges that are – once again - unconnected to emerging health information exchanges simply defies common sense and inhibits progress.

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?

The unintended consequential block of information flow at the point of patient care resulting from outdated language of 42 CFR, HIPAA and Pennsylvania laws impose nuances that amplify the problem and continue to impair our nation's achievement of the Quadruple Aim. Chasing patient information creates enormous waste and distraction in the tranches where care is delivered, and patients in rural communities are disproportionately affected.

Fast, affordable, secure internet access must be a utility not a commodity, available to rural areas. Investing in primary care workforce development initiatives and programs will increase the pipeline and improve access. Programmatically supporting community-driven innovations whereby communities define their specific challenges and own their solutions is likely to yield surprising results.

Most respectfully,

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