



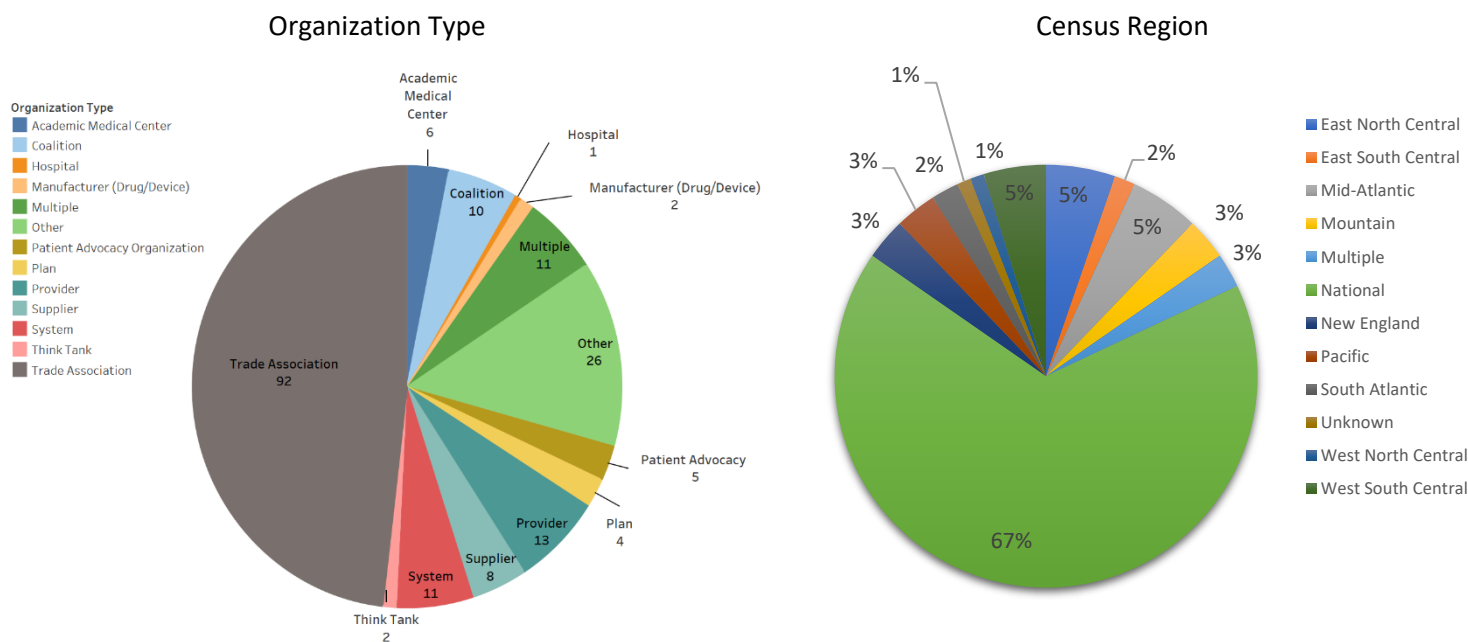
COMMITTEE ON WAYS AND MEANS
Bipartisan Rural and Underserved Communities Health Task Force
Summary of Responses to November 2019 Request for Information (RFI)
July 2020

OVERVIEW OF RESPONSES

The Ways and Means Committee’s Rural and Underserved Communities Health Task Force’s November 2019 RFI solicitation (see Appendix B) generated 194 submissions from a range of stakeholders representing national, regional, and local health care perspectives.¹ Nearly half (92) represented trade associations – other respondents ranged in perspective, from individual providers groups (13), health systems (11), academic medical centers (6), medical equipment suppliers (8), patient advocacy organizations (5), and health plans (4) (see Figure 1).

Almost two-thirds (126) of respondents had a national presence. Others represented regional or local areas – the East North Central Census Division (10), Mid-Atlantic (10), and West South Central (9) accounted for the majority of the remaining responses. A majority of respondents (111) represented both rural and urban interests, while 45 came from a solely rural catchment area. Only seven respondents spoke from experiences working in an entirely urban area.²

Figure 1. Task Force Respondents, by Organization Type and Census Region



Summary of Information from Request for Information
Bipartisan Rural and Underserved Communities Health Task Force
July 2020

The analysis (see Appendix A for a description of the methodology and limitations of this analysis) yielded several key themes that fit into three larger buckets: health care factors, non-health care factors, and promising models. Given the small sample size of the data, we present findings below across these themes in broad terms, rather than providing responses to each of the RFI questions. In many cases, themes crossed questions – and many answers did not directly respond to the questions at hand. Thus, to provide robust results, this report aggregates responses and presents them by major theme below. Individual response letters, by organization, are provided on the Ways and Means Committee website: <https://waysandmeans.house.gov/responses-ways-and-means-rural-and-underserved-communities-health-task-force-request-information>.

Health Care Factors

Across responses, organizations described a number of common and interrelated health care factors that affect the health of rural and underserved communities and impact health system characteristics.

Population-based factors. Organizations characterized the populations of both rural and urban underserved areas as having a disproportionate burden of disease relative to other areas of the country. Such diseases include: diabetes, obesity, cardiovascular disease, mental illness, and substance use disorders, among many others. In many instances, these individuals do not have the health care coverage to financially afford health care services that help to manage these conditions – and frequently, even if individuals possess coverage, they often do not have access to the providers they need, respondents explained. “Dwindling populations and an uptick in the number of small rural hospital closures often result in fewer local providers, which can significantly reduce availability of both primary care and certain critical services in rural communities, such as maternal care,” the Bipartisan Policy Center said. In such instances, the lack of access to care inhibits prevention and exacerbates preexisting health conditions, creating a cycle of chronic conditions from one generation to the next, respondents said.

Health system factors. In many instances, the configuration of health resources in underserved rural and urban areas is intertwined with the health status of the population. Respondents frequently described the low patient volumes in underserved areas – particularly rural – which often results in either hospital service line reductions or closures. Low demand, stemming from small population sizes and low rates of health care coverage (i.e., access to affordable health coverage) results in low supply, which, in turn, creates further disparities in population health. While few commenters offered solutions to service line elimination and hospital closures, many noted the need for additional research into alternative sites of care and non-traditional delivery models, given the challenges of keeping hospitals afloat in many rural and underserved areas. Many emphasized that the low patient volume in isolated communities makes it nearly impossible for providers to operate in a traditional fee-for-service environment – where payments are dependent on volume – and suggested that alternative payment models also be considered. Still, some cautioned that limited resources frequently pose issues with data collection to support these alternative value-based models of care – and even in cases where resources allow for the robust collection of data, small sample size can be an issue (see Non-health care factors section below).

Summary of Information from Request for Information
Bipartisan Rural and Underserved Communities Health Task Force
July 2020

Respondents specifically discussed the challenges of primary care and mental health care provider shortages. Others discussed “obstetric deserts” and the impact these workforce shortages have had on maternal mortality rates in certain communities. While many commenters noted significant workforce shortages in the areas of oral and behavioral health, few responses offered many concrete ideas to address gaps in care delivery. Some highlighted the promise of non-physician mid-level providers (including dental therapists), funding for mobile clinics, and expanding screening for behavioral conditions into and across primary care settings to mitigate shortages in rural and underserved areas to the extent primary care is available. “Home care services led by nurse practitioners (NPs) in states that allow prescription authority is a promising model that can enhance access for homebound residents in rural areas” the Fitzhugh Mullan Institute for Health Workforce Equity said. Others touted the use of telehealth – particularly in the mental health space – as an option for filling gaps in provider availability if infrastructure issues – particularly access to broadband – can be addressed for this to be widely successful.

Similarly, in the post-acute care (PAC)/long-term services and supports (LTSS) space, most commenters noted the myriad issues related to PAC and LTSS shortages but provided few demonstrated solutions. Some topics respondents put forward for the Task Force’s consideration included: funding for community-based collaboratives and social support services, increasing the use of remote monitoring, developing a geriatrics workforce enhancement program, and maximizing Medicaid home- and community-based waiver services. Ultimately, though, the majority of responses either ignored the RFI’s question on PAC/LTSS or provided few details.

Given the RFI’s prompt to discuss “successful” models, nearly all commenters mentioned the need to expand all Graduate Medical Education (GME) programs, including rural training tracks and loan forgiveness programs, such as Health Resources & Services Administration (HRSA)-funded programs like the National Health Service Corps. Loan forgiveness was noted as a tool to address provider shortages, and some respondents suggested that initial training and continuing education should incorporate cultural competencies to help mitigate implicit bias. Some respondents mentioned the role of medical schools and Fitzhugh Mullan Institute for Health Workforce Equity cited research on the topic: “Medical school rural programs have been shown to be effective in increasing the rural physician workforce... [Researchers] estimated that if 125 medical schools had just 10 students per class in rural training programs, it would more than double the number of rural doctors produced over the next decade.”³ Others discussed the importance of models that include early recruitment from rural and underserved areas and the elimination of restrictions on physician and non-physician scopes of practice in these underserved areas.

“Firefighting and law enforcement represent a common good and are funded as such. Rural/underserved emergency services should be considered similarly.”

– Rural Policy Research Institute

Non-health Care Factors

Across responses, submissions described a number of non-medical health care factors that disproportionately plague many underserved rural and urban areas – compounding issues with accessing health services and maintaining health. Figure 2 lists many of the factors respondents highlighted.

Figure 2. Examples of Non-Medical Factors Presenting Health Challenges in Underserved Rural and Urban Communities	
Transportation	Poverty/Unemployment
Food deserts	Structural Racism and Xenophobia
Education/literacy	Social isolation
Air quality	Physical Violence
Geography/Topography	Infrastructure (e.g., Broadband)
Housing	Classism
Language Preference	Homophobia

Though respondents recognized how difficult it is to address non-medical factors, they emphasized the importance of programs that seek to address these larger forces as they intersect with health. Respondents repeatedly identified these larger social forces as the true root cause of inequitable access to care and differential outcomes.

Health fairs and community-based screenings were suggested as approaches seeking to address a historical lack of response in the face of need in marginalized communities. Franklin Regional Council of Governments also noted, “rural areas have some of the lowest rates of childhood immunization, leaving communities vulnerable to outbreaks, while at the same time often having less robust local public health departments due to fewer tax dollars, because most federal and state programs use population as a primary factor in distribution formulas.”

The lack of broadband access is important to note, a few respondents said, given the focus on the potential for telehealth to alleviate provider shortages in underserved regions. In many areas, the absence of reliable broadband service makes it impossible for residents to rely on telehealth as a viable form of health care, emphasizing the interplay between health system and environmental factors in many of these communities.

In addition to environmental and structural factors, respondents also discussed data limitations. On the one hand, they noted the absence of data to measure differences across communities and appropriate quality measures that quantify the differences in underserved areas, both of which ultimately limit insights policymakers and providers might

“Increased broadband access is an essential component for improved health care delivery in rural communities... Federal investments to expand broadband access would be a substantial improvement for America’s rural communities and would provide exponential positive downstream effects on health care delivery and outcomes.”

– American College of Emergency Physicians

have in the most beneficial interventions for a particular community. On the other hand, commenters cited deficiencies in resources and sophistication needed to perform quality reporting and participate in value-based design are often out of reach for providers in these communities.

They also mentioned data siloes across agencies and institutions that preclude integrated responses. “The escalation of public sector service utilization (criminal justice, first responders, human services, mental health and substance use treatment, individualized education plans) often predates the increase in downstream healthcare cost & utilization,” the University of Illinois at Chicago said. “Data about individuals who frequently utilize public sector systems remain locked away in isolated silos. This limits the ability for identification and intervention earlier in a person’s life, when trauma, injury or mental illness first occur.”

Promising Models

SPOTLIGHT:

Better Health Through Housing (BHH)

“BHH is a partnership with the Center for Housing and Health... the Flexible Housing Pool, a collaborative alliance of 28 supportive housing agencies across Chicago and Cook County focused on addressing the gaps between the housing and health care sectors. It includes other hospitals, state and local entities, and public and private funders... Through its partnerships, the network helps provide permanent supportive housing across Chicago and offers support and wrap-around health services to its clients... It has reduced costs for UI Health by 21% and reduced hospital utilization by 67% per patient.” – University of Illinois at Chicago

Responses ranged in the level of detail provided on existing models of care delivery in underserved rural and urban areas that have exhibited positive outcomes – and many responses did not address promising practices at all. Among those who did, they emphasized the importance of relying on community-driven models tailored specifically to the individual community and needs of the population receiving the intervention. National or regional models of care were not the focus of responses. For example, the State of Arkansas formed a network to screen and do early referrals of high-risk pregnancies to care centers capable of providing an appropriate level of care.

Respondents noted the need for flexibility in provider network standards, including federal support for interstate compacts and other means of allowing health practitioners to engage in cross-border practice.

Examples of programs that directly targeted social determinants focused on such areas as: access to food, peer-to-peer and community health worker (CHW) services, transportation, and unemployment training. “CHWs have a proven record in better understanding multicultural populations, gaining trust in the community, and providing the next level of care delivery to assist patients with chronic or disabling conditions” the American Health Care Quality Association said. “The CHW program demonstrates how to effectively impact these areas and improve social isolation.” The Rural Policy Research Institute further noted, “ProMedica [located in Toledo, Ohio], including its rural facilities, went beyond investing in community organizations by creating a nonprofit of its own, the ProMedica Ebeid Institute for Population

Summary of Information from Request for Information
Bipartisan Rural and Underserved Communities Health Task Force
July 2020

Health, which has a food market with affordable and fresh options, a classroom kitchen, and employment opportunities for local residents.”

Examples of models focused more on addressing chronic health needs appeared to rely on care coordination, CHWs, community health centers, and housing-based interventions, among others. The Association of State and Territorial Health Officials cited a “review of 13 randomized controlled trials involving CHW interventions [, which] showed a modest reduction in levels of hemoglobin A1c (a common indicator of diabetes) compared to usual care.”⁴

DISCUSSION AND CONCLUSION

Overall, RFI respondents presented a bleak picture of rural and underserved communities that grapple with similar challenges ranging from population health and coverage barriers, to massive health system deficiencies, to social and structural determinants that adversely impact health. Respondents also emphasized the challenges in collecting data that appropriately quantifies and highlights these differences in a meaningful way for researchers and policymakers to better understand – and ultimately propose interventions to address – these inequities. While the responses the RFI generated came from a narrow subset of organizations primarily representing national trade groups, they uniformly echoed the trends evident in the extant literature – namely, that a multiplicity of factors impact the health and delivery of care in our nation’s underserved communities. While these factors may manifest differently in each community, urban and rural underserved areas alike contend with a range of both health care and non-health care factors that drive the configuration of a given area’s health resources and, ultimately, the health characteristics of its population.

Although the RFI specifically requested submissions focus on examples of “best practices” and “lessons learned,” the submissions provided to the committee offered few concrete data-driven solutions, and even those that were put forth appeared limited by questions of their scalability. Perhaps this gap in data across submissions is a reflection of the truth that “silver bullet” policies do not exist when attempting to address phenomena that are varied, intertwined, and have historic routes dating back hundreds of years. The plight of rural and urban underserved communities is complex and implicates many principles seen to reflect the nation’s conscience. In these circumstances, where structural changes inform social advancements, it is extremely difficult to develop one-size-fits-all solutions to satisfy every stakeholder. In many instances, community-tailored interventions, like some of those highlighted above, have proven and may continue to be the most promising approaches to tackling our underserved communities’ challenges – even if they do not represent the most efficient solutions from a scalability perspective.

Respondents described a nation rife with disparities – economic, health care, environmental – that have only been exacerbated by the current COVID-19 crisis. Although organizations drafted RFI responses months before cities began social distancing practices, their observations ring especially true in 2020: provider supply, rampant chronic conditions, inadequate support services for the aging population, environmental barriers, differences in outcomes along racial and ethnic lines, and a paucity of sufficient data all seem to have come into microscopic focus in light of this current crisis. Mental health challenges, although deeply

Summary of Information from Request for Information
Bipartisan Rural and Underserved Communities Health Task Force
July 2020

engrained, have also emerged as a focal point, as Americans have been asked to stay home and isolate themselves in the face of uncertainty. Technology's potential to fill the space of our socially distant interactions has emerged as a bright spot for some – but primarily for those with access to a computer, smartphone, or broadband.

The responses received remind us how important it is to leverage the advancements in our health care in ways that address the clear disparities that exist between some communities and others that are underserved. As the Task Force continues to explore ways to address the complex and interwoven factors that create underserved communities – be they rural, urban, or somewhere in between – it will prioritize sustainable solutions that address the problem at its root, rather than mere symptoms. For example, while hospital closures have dramatic effects on communities, their occurrence is not a function of Medicare payment rates alone. There are many other factors, including population size, lack of population health coverage, and absence of public transportation that enables physical access to health facilities, among others, that contribute to a given hospital closure. The same can be said for workforce shortages, where telehealth may be beneficial in some circumstances, but in others, may not address the underlying issues related to recruiting providers with longstanding ties to certain communities or the limitations of our access to broadband. Without considering these other drivers, such a policy is merely a band aid on a gaping wound.

The Task Force recognizes that no federal policy alone will solve the challenges our most underserved communities face. To address health inequities, the health system must identify and distill which populations to target for interventions, incorporate input from targeted populations, and tailor interventions to communities to address the specific factors driving health inequities. Further, solutions must be multidisciplinary and support coordination across all levels of government, industries, and sectors. As the RFI responses underscored, a multi-level approach to interventions is crucial to addressing the many challenges summarized in this report. It is clear then, that long-term commitment from Congress and also state, local, and private-sector interests is not only important but crucial to the development of *sustainable* and creative solutions to the challenges many underserved communities have been battling for decades.

On the federal level, the members of the Task Force have identified four policy areas to concentrate on moving forward: addressing social determinants of health, enacting payment system reforms, strengthening technology and infrastructure, and reinforcing our health workforce. No one policy will solve the litany of challenges stakeholders highlighted for the Task Force, but progress in these areas can make a meaningful difference. In the coming weeks, the Task Force will begin to have focused discussions with stakeholders to help craft policies in these designated areas of focus. The members of the Task Force, Chairman Neal, Ranking Member Brady, and the broader Committee on Ways and Means stand committed to advancing solutions for the issues laid out in this report and tackling disparities and inequities in health across our geographically diverse communities.

APPENDIX A: METHODOLOGY AND LIMITATIONS

Below, we describe the methodology used to construct our analytic file and conduct the analyses for this study; we also present limitations.

RFI solicitation tool development. Committee staff created a broad series of questions to guide respondents, focusing on the range of issues raised both in the Task Force’s July 2019 kick-off meeting and extant literature. Similar to the kick-off meeting, the RFI sought to solicit opinions from stakeholders representing a broad range of perspectives (e.g., industry groups, patient groups, experts, etc.) across the continuum of care. Staff vetted the questions with independent outside experts to ensure questions were framed in an objective and relevant fashion, the inquiry did not have significant subject-matter gaps, and the tool was flexible enough not to limit relevant ideas.

Analysis. Staff downloaded all relevant responses into a database and created an Excel-based analysis matrix for summarizing and analyzing results. This database sought to capture both quantitative elements of respondents (e.g., type of organization, location) and qualitative responses (i.e., narrative responses to the RFI questions). The analytic tool mapped to the questions in the RFI to facilitate cross-respondent analyses. One staff member culled and summarized each RFI response, inputting the summaries into the Excel database to create an analytic file. Once the file was fully populated, three Ways and Means staff members representing a range of expertise – clinical, legal, and research – independently reviewed the results to identify emergent themes. These three independent reviews were aggregated and reconciled to develop the results presented in this report.

Limitations. This study included several key limitations that ought to be noted. First, the sample of respondents is inherently limited to the organizations that heard about and had the resources to respond to the RFI in a timely manner. The Committee did not solicit responses from particular groups; thus, there are likely a number of organizations with experience relevant to the RFI that did not ultimately submit responses to the Task Force. Second, the Task Force opted to limit the length of responses as well as the questions it asked of stakeholders. The purpose of this directed approach was to facilitate cross-stakeholder analysis; yet, it had the potential to limit the types of information presented to the Task Force. Finally, given the breadth of information provided to the committee, the analysis required individual staff members to make a series of judgement calls when summarizing materials. While staff sought to employ an objective and standardized approach to its review of all submissions, there were likely some inevitable inconsistencies in approach.

APPENDIX B: RFI SOLICITATION

RURAL AND UNDERSERVED COMMUNITIES HEALTH TASK FORCE *Request for Information*

The Committee on Ways & Means Chairman Richard E. Neal and Ranking Member Kevin Brady are committed to advancing commonsense legislation to improve health care outcomes within underserved communities.

The *Rural and Underserved Communities Health Task Force* (Task Force) is the Committee’s forum to convene Members and experts to discuss the delivery and financing of health care and related social determinants in urban and rural underserved areas and identify strategies to address the challenges that contribute to health inequities. Reps. Danny Davis (D-IL), Terri Sewell (D-AL), Brad Wenstrup (R-OH), and Jodey Arrington (R-TX) serve as the Task Force co-chairs, and are working to identify bipartisan policy options that can improve care delivery and health outcomes within these communities.

This *Request for Information* (RFI) solicits input on priority topics that affect health status and outcomes for consideration and discussion in future Member sessions of the Task Force. Terms such as “initiative,” “approach,” “model,” or “demonstration” generally refer to any activity that addresses issues impacting optimal health in these communities.

SUBMISSIONS: Individuals or groups wishing to respond to this RFI should email comments **by close of business Friday, November 29th**, as attachments in **.docx or .pdf format**, to:
Rural_Urban@mail.house.gov.

INFORMATION REQUESTS (Limit each response to 250 words - Each total submission should not exceed 10 pages, 12 pt font):

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?
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?
3. What should the Committee consider with respect to patient volume adequacy in rural areas?
4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where—

Summary of Information from Request for Information
Bipartisan Rural and Underserved Communities Health Task Force
July 2020

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

Summary of Information from Request for Information
Bipartisan Rural and Underserved Communities Health Task Force
July 2020

¹ A few respondents submitted comments as individuals; to the extent these individuals identified with a particular organization, we incorporated that organization in the analysis.

² For some respondents, it was difficult to categorize urban vs. rural catchment areas; we categorized these as “unknown.”

³ Rabinowitz HK, Diamond JJ, Markham FW, Wortman JR. Medical school programs to increase the rural physician supply: A systematic review and projected impact of widespread replication. *Acad Med*. 2008;83(3):235-243. Available at:

https://journals.lww.com/academicmedicine/Fulltext/2008/03000/Medical_School_Programs_to_Increase_the_Rural_Physician_Supply.15.aspx

⁴ Palmas, W et al., Community Health Worker Interventions to Improve Glycemic Control in People with Diabetes: A Systematic Review and Meta-Analysis. *National Center for Biotechnology Information*, (2015). Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/25735938>