OCHIN

A driving force for health equity

Transmitted via email

October 5, 2023

The Honorable Jason Smith
Chairman, House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

Re: *Request for Information on Improving Access to Health Care in Rural and Underserved Areas*

Dear Chairman Smith,

On behalf of OCHIN, we appreciate the opportunity to provide recommendations in response to the Request for Information on *Improving Access to Health Care in Rural and Underserved Areas*. OCHIN is a national nonprofit health information technology innovation and research network that offers technology solutions, informatics, evidence-based research, and policy insights. OCHIN serves nearly 2,000 community health care sites with 30,000 providers in 39 states, reaching more than 8 million patients. For over two decades, OCHIN has advanced health care solutions by leveraging the strength of our network's unique data set and the practical experience of our members to drive technology innovation for patients and providers in rural and other underserved communities. OCHIN's network includes Critical Access Hospitals (CAHs), rural health clinics (RHCs), local public health agencies, and the largest network of federally qualified health centers (FQHCs).

Examining the Need for Improved Access to Health Care in Rural and Unserved Areas

Across the nation, rural and underserved communities face a variety of access barriers. Health care provider shortages, inadequate or unaffordable broadband, financial barriers, and physical access to care and services create disparities among patients in these communities. Revitalizing the economic health of Rural America and addressing the persistent health disparities communities in geographically remote areas continue to face is interrelated. CAHs and RHCs that are provided resources to modernize their health IT infrastructure and train and develop their workforce to optimize new health IT systems have pathways to financial sustainability while offering individuals in rural communities improved health outcomes and rewarding careers that will fuel growth and relieve key health related social needs. Financial independence and self-determination are essential to ensure rural providers can continue to be reliable and trusted care providers. In summary, we urge Congress to support targeted funding to support virtual specialty care access, modernized health IT, and health IT workforce development and training programs for CAHs and RHCs.

OCHIN RECOMMENDATIONS

Ensuring rural patients can seek and receive care within a reasonable distance from their home, and with primary care and specialist equipped with the knowledge and resources to offer the full array of clinical care (including prevention, urgent/emergency, and specialty services) advance the quadruple aim of bending the cost curve, improving population health, patient outcomes, and the resiliency of the broader care team. Sustainability and keeping the doors open means rural providers need the infrastructure to optimize care delivery leveraging 21st Century tools that are specifically tailored to meet the unique clinical, operational, and financial sustainability challenges of rural healthcare.

OCHIN urges Congress to advance the following policies:

- Invest in a virtual specialty network that integrates and coordinates with rural providers and increases access to specialty care to ensure that whole patient care is in rural communities whether at a patient's home or at school.
- Invest in health IT workforce development and training programs for rural communities leveraging virtual learning modalities and placement opportunities with local rural health care providers to optimize care delivery, establish local career opportunities, and strengthen rural communities.
- Congressionally authorized and appropriated funding to modernize public health information technology and infrastructure in response to the COVID-19 public health emergency should not be limited to public health agencies, but prioritize CAHs and RHCs due to the disparate, adverse impact of public health emergencies, including disasters on rural communities, that also lead to long-term health disparities and economic decline.
- Provide sufficient financial support and incentives so that rural providers can modernize their health IT systems with the flexibility to select options that are designed to meet their patient population needs and optimize their financial sustainability. Currently, many rural providers remain dependent on incentives that compel them to use large systems' health IT systems that do not meet rural patient or provider operational/financial needs.
- The Federal Office of Rural Health Policy in the U.S. Department of Health and Human Services' Health Resources & Services Administration should receive substantially increased funding to support CAHs and RHCs health IT modernization and technical assistance.
- Ensure additional funding for to support ongoing heath IT hardware and software updates, technical assistance, and staff training needed for readiness and mitigation measures to address mounting cybersecurity challenges and other disaster events (including fires and floods) that rural communities have unique challenges addressing.
- Improve payment and delivery models to account for and address adverse social drivers of health including housing and transportation insecurity that allow funding to expand benefit coverage to address these issues, standardized quality measures related to social drivers of health, and other payment enhancements to account for social drivers of health.
- Continue to prioritize investments in broadband expansion to rural areas that do not have access while also prioritizing enhanced speed for rural health care providers in communities that are connected.

VIRTUAL, INTEGRATED SPECIALTY CARE TO DRIVE ACCESS AND SUSTAINABILITY

The dearth of consistent and reliable access to specialty referral options among RHCs and CAHs patients is a key starting point to crafting a new paradigm of community resiliency. Providers and their patients in rural and underserved communities must have the option to use a range of modalities to increase ready access to specialty services along an integrated continuum from advanced clinical decision-support, peer-to-peer education, eConsult, telehealth, and remote patient management (RPM) and remote therapeutic monitoring (RTM). These virtual modalities must be integrated with in-person primary care. These integrated options strengthen care continuity and create surge capacity during environmental disasters and public health emergencies in rural communities and beyond.

Expanding access and optimizing virtual care services ensures that patients who face additional barriers to in-person care (such as geographic isolation and/or shortages) can access timely specialty referral services while also facilitating transitions to value-based payment models that support whole patient care. A dedicated virtual specialty network should offer care coordinated with a patient's primary care provider and leverage the capacity, where possible of CAHs. Currently, many rural patients have a higher prevalence of multiple chronic conditions, mental/behavioral health diagnoses, and unmet social needs. The goal is to enhance access to care coordination between primary and specialty care and community-based social services. A dedicated virtual network could offer specialty services conveniently and cost-effectively, improve medical outcomes, and prevent unnecessary emergency department visits and in-patient hospitalization.

OCHIN has proposed legislation establishing a virtual specialty network, the Equal Access to Specialty Care Everywhere Act of 2022. This would be a virtual specialty network demonstration that offers dedicated integrated services in rural and other underserved communities to test the scalability of access to specialty care and facilitating transitions to value-based pay to support whole patient care for patients in rural communities, particularly those with Medicare and Medicaid coverage and the under- and uninsured. While on-demand telehealth is available for individual willing to pay out-of-pocket or, in some instances, who are insured commercially or have Medicare (and extremely uncommon Medicaid coverage) there are few offerings at scale.

We urge Congress to consider:

- Lack of access to integrated specialty care for patients with Medicaid and CHIP coverage who live in rural and other underserved communities is a persistent challenge that will only deepen due to clinician shortages and demographic trends.
- OCHIN network data reflects local, regional, and national trends of limited access and delayed referrals to specialists, which drives health disparities in rural and other underserved communities.
- This reality was documented before the COVID-19 PHE and similar trends have continued during the COVID-19 PHE despite the availability of extensive telehealth flexibilities.
- In the OCHIN network, in 2019, the median referral wait time for cardiology was 38 days, psychiatry was 31 days, neurology was 74 days, and endocrinology was 57 days.
- Factors for these delays include specialist shortages, geographic mismatch, lack of transportation and other structural impediments as well as Medicaid and CHIP payment rates that are not competitive with Medicare and commercial health insurers.
- Further, models that only deliver to patients with Medicare or Medicaid insurance do not reflect the structural challenges faced by providers in rural and underserved communities that serve a mix of patients that include the under- and uninsured with fewer Medicare and commercially insured patients.
- Demonstrations and existing federal agency initiatives have not focused on sustainable delivery models among providers in rural and other underserved communities with a high percentage of Medicaid and under- and uninsured patients served. These are not scalable or sustainable models particularly with the movement to value-based payment.
- The proposed demonstration would test a virtual specialty network dedicated to providing a range of virtual modalities (including clinical decision support, eConsults, and telehealth, for example) in partnership with primary care clinicians in underserved communities.
- The purpose would be to ensure access to specialty care in rural and other underserved communities, reduce wait times, and improve care coordination while addressing major social drivers of health and medical complexity.

A dedicated network of specialists offering innovative services that are coordinated with primary care providers and centered where patients are located, is essential to overcoming disparities and moving to true value-based delivery and payment models.

MODERNIZED HEALTH IT SYSTEMS AND 21ST CENTURY WORKFORCE DEVELOPMENT AND TRAINING

Modernized health IT and health IT workforce development and training programs ensure rural communities and providers are able to address:

- Needed infrastructure to support new payment and delivery models requiring population health management, advance data analytics (for operations and clinical care) and tools to address health related social needs.
- Long-standing health inequities exacerbated by the convergence of the COVID-19 pandemic, the opioid epidemic, and mental health crisis that disparately impact rural and underserved communities.

- Barriers to the aspirations of rural communities to build careers in health care and the technology-driven economy of the future.
- Skills gaps in rural communities grappling with high turnover, clinician burnout, and growing demand for tech and linguistic/cultural competencies to care for the specific needs of rural populations.
- Rapidly evolving need for workforce upskilling in cybersecurity and technology methods and strategies to address climate change, natural disasters, and future public health emergencies that are disparity multipliers in rural communities.
- Federal and state health program mandates requiring accurate digital health care data collection, security, and interoperability.

Modernized Health IT Systems

The COVID-19 public health emergency (PHE) underscored a challenge in rural communities that persists even after the termination of the PHE: a widespread need to upgrade and regularly fund information technology and digital health capabilities to support health care access, sustainability, public health, and research reflecting the needs of Rural America. While over a decade ago government investments were made in provider health IT systems, in the intervening period several generations of technological revolutions have occurred. Yet, many CAHs and RHCs have faced ongoing financial crises and have not received resources needed to adopt new systems or to upskill or create a pipeline of operational and support staff able to optimize health IT systems. Far too many CAHs and RHCs continue to labor with obsolete systems without sufficient margins or upfront financial reserves needed to migrate off an antiquated system to upgrade to new health IT systems. Even when CAHs have the resources needed to transition to new systems, given their limited funding they may select poorly designed ones that do not support their operational and clinical needs and undermine their financial sustainability (particularly where they have had to rely on the health IT systems of large systems outside of their community). RHCs and CAHs need "right sized" health IT systems that meet their needs, challenges, and that expand their opportunities.

Health IT Workforce Development and Training

CAHs and RHCs face historically high turnover among operational and support staff. In rural communities there are few federal and state funding initiatives that prioritize Health IT workforce development and training for individuals in family-friendly careers that can be performed remotely and launched without student debt. Such programs can be part of a career ladder to upper financial mobility in health care and technology fields and engines of financial health in rural communities. Foundationally, health IT professional development and training programs would increase the quality of patient care and the accuracy of health care data while expanding the care team to include community health workers in addition to medical billers and coders, electronic health record support analysts and health information management specialists.

There are significant challenges obtaining funding to build a health IT workforce pipeline to meet today and tomorrow's needs from existing federal and state workforce development and training programs.

- Traditional workforce training programs do not match the existing workforce skills needed by RHCs and CAHs, frequently take place in brick-and-mortar settings, require college admission or diplomas, take too long, are cost prohibitive for individuals in rural and underserved and underrepresented communities, and challenging to navigate for individuals facing persistent structural inequality.
- Federal and state programs remain fragmented without a defined roadmap for technology and health care workforce development and upskilling for existing workforce and do not include robust, representative pipelines to address burgeoning demand for talent at the intersection of healthcare and technology.
- Federal and state funding are largely targeted to programs that do not account for the rapidly evolving technology and health care needs of community-based and public health providers and do not offer training for in-demand skills with practical real-world applications, that are modular and allow for quick progress.
- Many programs fail to provide a pathway to career opportunities and create barriers for many (by requiring high school diploma, college credits, or enrollment in costly programs).

Congress should support workforce programs that reduce the substantial time, money, and disruption borne by individual RHCs and CAHs to recruit, train, and retain employees with mission critical health IT skills through workforce development and training programs. Effective health IT workforce development and training programs include:

- Proactive and holistic learner support is critical for student retention and success, especially when recruiting and training non-traditional learners. This includes financial and practical support (e.g., stipends, computers, support enrolling, etc.) to reduce barriers to access as well as ongoing instructor/mentor engagement with the students.
- Upskilling existing staff, which represents opportunities to promote internally and drive staff retention.
- Do not include mandatory federal and state programs that require matching funds which delay program implementation/initiation and undermine the sustainability of program.
- Program requirements mandating adherence to traditional trade apprenticeship provisions (which may differ at the federal and state level) do not account for the training needs of health IT.

Thank you for your leadership and inclusive approach to gathering stakeholder feedback to develop solutions to address access to care for rural and underserved communities. Please contact me at stollj@ochin.org if we can provide any additional information to support your efforts.

Sincerely,

Jennifer Stoll
Executive Vice President
External Affairs