

July 17, 2020

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Dear Rural and Underserved Communities Health Task Force Co-Chairs:

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, thank you for the opportunity to respond to the Ways and Means Committee Rural and Underserved Communities Task Force (Task Force) Request for Information (RFI) regarding the delivery and financing of health care and social determinants in urban and rural underserved areas. Improving access to high-quality emergency care, especially in rural and underserved communities, is a priority for ACEP and a critical need within our health care system.

As you well know, addressing the needs of these communities presents its own unique set of challenges and considerations, so we greatly appreciate your thoughtful inquiries into how Congress can develop new strategies to help ensure patients in rural and underserved areas have access to the high-quality care they need and deserve. Our responses to the questions laid out in the RFI follow below:

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?

Health care-related factors

- **Rural emergency department staffing is highly variable.** Some rural emergency departments (EDs) are staffed by board-certified (BC) emergency physicians (EPs), with others staffed by advanced practice providers (APPs). While APPs are an important part of the health care team, their training and experience is not equivalent to that of a physician and care should still be physician-led. The Indian Health Service (IHS) also has its own unique difficulties in recruiting high-quality physicians, including pay rates, loan forgiveness, and ways to attract residents to IHS sites to improve the physician pipeline within the IHS system. Additionally, there is not generally easy access to skill training or quality improvement initiatives in rural areas if not affiliated with a larger health system.
 - To help address gaps in physician staffing, collaborative models between family medicine and emergency medicine should be developed, since both specialties play a key role in rural emergency medicine (EM).¹
 - APP oversight can be provided by local on-call EPs or tele-emergency medicine services (e.g., Avera ECare or Mayo Clinic's telemedicine program).

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¹ [https://www.annemergmed.com/article/S0196-0644\(17\)30788-6/fulltext](https://www.annemergmed.com/article/S0196-0644(17)30788-6/fulltext)

- **Academic training does not generally prepare for rural practice.** Providers trained in highly academic settings are more technology dependent, and more reliant on specialists. The tools (clinical skill set) required to work in rural areas are unique. EM residents who are not trained in rural EM are hard to recruit, and many leave when they get to rural areas.
- **Transfers are complicated and fragmented.** State EMS services are highly fragmented, often poorly funded in rural areas, and lack centralized oversight. Emergency transport in rural areas (including air ambulance) is sometimes unavailable due to weather or unable to be staffed with the appropriate level medics. Additionally, some have noticed a recent trend of transferring air ambulance contract companies failing to fulfill their obligations. Lack of a designated tertiary referral center may increase mortality due to delays inherent to the complexity of identifying an accepting facility.
- **Primary care access is limited.** Inadequate access to other physicians in rural areas, including primary care, may also factor into increases in rural ED use, highlighting the need for physician in rural areas needs to have both primary care and emergency skills. Collaborative training is essential. Limited access to ongoing primary care, either from fewer providers numbers or other financial barriers (insurance coverage, Medicaid access, etc.) may also play a role.
- **Specialty care access also limited, either in follow-up or at the local hospital.** Conditions that are easily treated at larger facilities can quickly consume personnel time and resources in smaller facilities that have fewer overall resources and unpredictable transport. Telemedicine can help fill these gaps, but requires significant investment in broadband – something that Congress could address at the federal level.
- **Limited technological resources, including broadband.** Adoption of new technology is usually very expensive and strains already-limited resources for rural and underserved facilities. Policies acknowledging that rural EM is often less technologically sophisticated may be helpful for training providers (as well as for medico-legal reasons).

System or Community-level factors

- **Social and behavioral factors.** Factors outside the direct domain of the health care industry that contribute to poor rural health outcomes include isolation and lack of economic development. Social and psychological factors may make the rural patient population unique, and innovative models for preventive care may be needed. Health literacy also varies depending on access to quality primary care.
- **Environmental factors.** In many rural and underserved areas, occupations are often higher risk (agriculture, mining, etc.), drive times between locations are longer, and common hobbies such as snowmobiling or all-terrain vehicles are high risk.

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):

- **Transportation.** Transportation is a major determinant of health. Some rural communities have transportation which is organized by towns or counties, but this is highly variable. It is important to maintain non-emergency Medicaid transport and expand this to Medicare. With appropriate physician supervision, models like Medicare's Emergency Triage, Treat, and Transport (ET3) model could be beneficial to rural communities as well.
- The Native Nuka System of Care² has shown a great deal of promise for managing chronic conditions and improving health outcomes, addressing all of these factors (transportation, housing, food insecurity).
- The Alaska example of home and community-based waivers to pay for care in place, rather than nursing homes and similar facilities, has kept costs down and allows individuals to remain in their homes without large infrastructure investments.

² <https://www.southcentralfoundation.com/nuka-system-of-care/>

b. Multiple Chronic Conditions

- **Project ECHO** at the University of New Mexico has shown impressive outcomes in assisting rural providers in managing complex and chronic illness.³ Mobile health units may also show promise.⁴

c. Broadband Access

- Increased broadband access is an essential component for improved health care delivery in rural communities. Some states (Alaska, for example) have a rural supplement program aimed at supporting more broadband in rural areas. 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.

d. The use of telehealth/telemedicine/telemonitoring?

- Ideally, there should be minimal standards on what ED volume requires 24/7 EM staffing as opposed to a low volume for which APP staffing with telemedicine oversight by EM (or FM) physician is available.
 - As referenced previously, the Mayo Clinic system uses telemedicine to monitor and assist at their critical access hospitals that are staffed by APPs and other non-EM trained providers. APPs should practice under physician supervision in rural ED's, and thus telemedicine is still helpful. Some of these physicians, such as those trained in family medicine, are ideal providers for rural EDs but lack critical care and trauma training and/or skills. Providing these physicians access to specialists in emergency medicine and critical care via telemedicine may be an ideal alternative.
 - Avera Ecare is the emergency telemedicine program of Avera Health (Avera McKennan Hospital and University Health Center) located in Sioux Falls, SD, which provides a 24/7 connection to approximately 150 rural and critical access hospitals, primarily in the upper Midwest, with Avera Ecare's Emergency Medicine Board Certified physicians and other supportive staff. This brings emergency medicine expertise to smaller EDs and thus advances the quality of care available to rural/remote communities which are unable to staff their EDs with board-certified physicians.
- A highly integrated system where small rural facilities have an established relationship and workflow with larger referral centers (e.g., the New Zealand model).
- Telepsychiatry can be a very valuable resource in decreasing length of stay. Often, psychiatric holds are unable to be admitted locally and experience very long lengths of stay while awaiting placement into more specialized treatment. South Carolina has a model that merits the Task Force's consideration.⁵
- Alaska has head trauma guidelines where head CTs with intracranial hemorrhages are sent to neurosurgery to review and help keep many people in the community. New Mexico has a similar model (Project ACCESS). Northwest Arctic Alaska makes extensive use of telehealth visits between patients, either in their homes or at the local clinic in remote villages, and primary care doctors, medical specialists, and mental health professionals. Alaska Native Medical Center has an outstanding tele-orthopedic model where all referral centers send a brief HPI, Exam, and Images and an orthopedist responds within an hour with a plan, guidance on how to do more complicated reductions or splints, and reviews post procedure films. This is a huge benefit for patients and massive educational benefit for general practitioners in the ED and walk-in clinic.
- **The CALS (Comprehensive Advanced Life Support) Program.** The CALS Program is the emergency medicine education program specifically designed to meet the emergency training needs of provider teams

³ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0278>

⁴ <https://www.aha.org/news/headline/2018-01-05-case-study-calverthealth-medical-centers-efforts-address-transportation>

⁵ <https://scdmh.net/dmhtelepsychiatry/ed-telepsychiatry/>

which staff rural and remote emergency departments which by location are resource and personnel lacking in much of the expertise and equipment available in larger medical facilities. Originally developed in Minnesota to address many of the rural emergency training needs, the CALS Program is now being taught in many states and some foreign countries.

The CALS education program specifically addresses the development of effective emergency provider teams which maximizes the organization and function of whatever resources the rural/remote team may have. The education emphasizes the needed knowledge and skills to diagnosis, treat (stabilize), and as needed, safely transfer critically ill/injured patients who have a wide variety of critical conditions including serious trauma, CVA, respiratory compromise, shock, OB, cardiac, and other critical conditions.

The CALS Program has been endorsed by both ACEP and American Academy of Family Physicians (AAFP) as appropriate and valuable emergency training for those provider teams who practice in regions lacking in many of the resources of personnel, equipment and specialists taken for granite in more populated regions of our country and the world.

Additionally, ACEP has developed a proposal for a Medicare alternative payment model (APM) called the Acute Unscheduled Care Model (AUCM), which we strongly believe has the potential to transform the way emergency care is delivered both in rural and urban areas. Structured as a bundled payment model, it allows emergency physicians to accept some financial risk for the decisions they make around discharges for certain episodes of acute unscheduled care. It would enhance the ability of emergency physicians to reduce inpatient admissions and observation stays when appropriate through processes that support care coordination. Emergency physicians would become members of the continuum of care as the model focuses on ensuring follow-up, minimizing redundant post-ED services, and avoiding post-ED discharge safety events that lead to follow-up ED visits or inpatient admissions. For the first two to three years, the model focuses on episodes related to four high-volume ED conditions – abdominal pain, altered mental status, chest pain and syncope. Starting in year 3, the model will expand to include additional diagnoses. The model also includes payment waivers for ED acute care transition services, telehealth services, and post discharge home visits.

ACEP presented the AUCM proposal before the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on September 6, 2018. The PTAC recommended the AUCM to the Secretary of the Department of Health and Human Services (HHS) for full implementation. The AUCM met all ten of the established criteria, and the PTAC gave one of the criteria (“Scope”) a “Deserves Priority Consideration” designation since the PTAC felt that the model filled an enormous gap in terms of available APMs to emergency physicians and groups. The PTAC submitted its report to the Secretary in October 2018. On September 27, 2019, Secretary Alex Azar responded to the PTAC’s recommendation by stating that he believes that core concepts of the AUCM should be incorporated into APMs that the Centers for Medicare & Medicaid Services’ Innovation Center (CMMI) is developing. We look forward to working CMMI to advance emergency patient care through the implementation of this model.

Since it is unknown how long it will take for CMMI to begin incorporating the AUCM into the Medicare APMs it is developing, we have started our own initiative to promote participation in emergency medicine-focused APMs being offered by other payers like Medicaid and private insurers. As Medicaid and private payers move away from fee-for-service contracts with providers towards value-based payment arrangements, a non-Medicare version of the AUCM would be an ideal APM construct for these payers to pursue.

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

- **Patient volume and provider-type**

- Ideally, there should be minimum standards on what ED volume requires 24/7 EM staffing vs. a low volume for which APP staffing w/ telemedicine oversight by EM (or FM) physician is available. With adequate training (knowledge and skills), an experienced APP can function well in this environment, with telemedicine support and access to high level continuing education such as procedure labs and simulation. However, APPs need at least several years of clinical experience before they can safely function in this setting. In these models, an EM trained/boarded physician can staff several departments simultaneously.

- If EDs are significantly low-volume, consider transitions to 24/7 paramedicine and outpatient clinic, but hospitals will need assistance in this transition.

- **Patient volume and clinical skills**

- Explore hub & spoke models where personnel from urban & rural EDs are incentivized to trade places enough to teach/learn and share perspective.
- Identify new and innovative ways for rural providers to stay up-to-date on skills and new technology.

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?

- For RHCs and FQHCs that have acute care capacity:
 - Provide support for unscheduled care, including billing for EMS to deliver to a FQHC
 - Telemedicine support
 - In some locations, 24/7 paramedics/ambulance and FQHCs could be a viable alternative instead of rural hospitals.

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

- In rural areas, many patients use the ED for primary care as there may be no other options. Critical access hospitals often provide the only access to health care in remote areas. Co-located primary and emergency care⁶ can make better use of the ED space, increase the overall number of patient contacts, increase continuity between primary care and emergency care, and optimize admissions in small hospitals.

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

- It is not feasible or cost effective to try to keep a rural hospital open or financially solvent by providing routine or even emergent surgery at that facility. Rural patients in need of surgery should be transported to larger institutions where those procedures can be performed more safely and cost effectively. Instead, patients need to have access to quality emergent patient care and observation units for short term, low acuity admissions (a truly critical access hospital).
- The current lack of delivery and payment models makes it very hard serve rural communities. This could be bolstered via more rural-specific opportunities through the Center for Medicare & Medicaid Innovation (CMMI), as well as efforts to build up the FQHC model to offer more emergent care.
- Another limitation on payment models is that the variety of payments with few people make any program harder to sustain. Some emergency physicians have noted that the Pennsylvania rural hospital global budgeting model shows promise in this area.

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 largest barriers are infrastructure, stakeholder engagement, and reimbursement. Examining trauma systems nationwide can provide great examples on how systems of care can be built, or states with cardiac emergency programs, such as North Carolina's "RACE" model.⁷ Other good examples of systems of care in states that support rural facilities

⁶ <https://atriumhealth.org/locations/atrium-health-anson>

⁷ <http://www.nccacc.org/race/race.html>

include Alaska’s trauma head guidelines, the New Mexico Project Echo model, and the Ground Medical Transport Model in Alaska, Washington, and several other states.

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

- There are a number of factors that make such models successful. These include:
 - Specifically recruiting medical students from rural communities.
 - Recognizing the difficulty of practicing rural EM, increasing pay, supporting providers with access to reliable transport and specialty care correlates to better job satisfaction.
 - Supporting loan forgiveness for EM physicians inclined to explore rural EM (such opportunities exist for primary care but not for emergency medicine).
 - Providers with a history of rural experience are shown to be more willing to practice in rural areas.
 - Residency programs should offer rural rotations and be incentivized to do so.
 - Addressing staffing challenges for rural emergency departments by setting up provider groups with physicians willing to work at multiple sites and creating redundancy. Rural emergency departments are very likely single coverage with longer shifts, and covering shifts when providers are unable to work or there are holes in the schedule is difficult.
- Hub and spoke models show promise. Providers work a percentage of their hours at one main site and some other percentage at a few smaller sites creates a larger provider pool and allows for better stabilization of schedule irregularities. Loan forgiveness can be based on where the provider chooses to do most of their clinical shifts. Setting up “sister sites” where an urban area regularly staffs a rural one on a rotating schedule can provide some stability to the work force.

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?

- **Substance Use Disorder**
 - Some few rural EDs have practitioners who can prescribe an onset bridge of medication-assisted treatment (MAT) with follow-up at a central MAT clinic – dependent upon agreements and transportation.
 - Tele-medicine and ECHOs (Project ECHO) are proving very useful for education and support in this gap in care.
 - The rules around 42 CFR Part 2 make this especially hard in rural communities. It causes a duplication of services and siloing that prevents good care. Between the “x-waiver” for prescribing buprenorphine and 42 CFR Part 2, federal regulations stand in the way of high-quality care in rural areas.
- **Behavioral Health**
 - Statewide tele-ED networks are hard to set up as they require significant investments; however, they work very well. South Carolina’s Tele-ED model⁸ is a good example that the Task Force should examine.

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

⁸ <https://scdmh.net/dmhtelepsychiatry/ed-telepsychiatry/>

disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

- Post-acute and long-term services are what keep many CAHs open, so finding ways to promote rural solutions could be greatly beneficial. As noted previously, home and community-based services also can work well in rural areas.
- The federal “four walls” policy that does not include care furnished outside the four walls of a clinic makes delivery of care in rural America much harder, and focuses payment to institutions rather than the direct care.

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?

- **Variables**
 - Most publicly available datasets only have metropolitan statistical area (MSA) vs. non-MSA as a variable of geography, when much more granular designations could be more helpful (e.g., Rural-Urban Commuting Area (RUCA) codes).
 - Linking census data to administrative datasets (Medicare, National Health Interview Survey (NHIS), etc.) would save a substantial amount of time for researchers.
 - Making datasets such as Medicare available at low-cost to rural researchers would be of great benefit. It is difficult to access Medicaid data, but very critical to understanding rural outcomes – states could make this process much easier.
- **Gaps in rural research**
 - Rural providers often do more with less, and rural EM is not very well studied in the US. There is a perception among some that patients are less sick or have a lower acuity level; however, this is not well documented. The percentage of patients discharged to home as opposed to admitted or transferred may not reflect true acuity levels, as rural patients often do not want to be transferred out of their communities but are unable to be admitted at local CAHs.
 - Basic tools needed for provider success and causes of provider frustration in rural areas are unclear and should be evaluated.
 - Aligning quality tools and payment models across different payers would make this easier to understand or track.
- **Quality and Safety**
 - Many rural hospitals lack the staff and funding to have a dedicated ED quality and safety point person, and even if they had such an individual, there is often no one to send this data to or discuss it with. Providing a few hours a month of paid, protected time for a rural ED physician to review their small ED’s census, transfers, codes, and deaths within 72 hours of admission and transmit this data to their referral center would be an incredibly high yield source of information and quality improvement.

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?

- **Research**

- Promote research that shows rural applications or even require research to have rural sites and rural implementation.
- **Clinical**
 - Minimum standard for providers (non-EM trained physicians and APPs) to work in rural EDs.
 - Telemedicine support (and federal efforts on broadband access) for a broader population of rural ED patients.
- **Models**
 - Highly integrated health systems or contracts with prearranged referral plans for all serious patient conditions.
- **Workforce**
 - Create Accreditation Council for Graduate Medical Education (ACGME) approved rural emergency medicine electives, particularly for IHS – using the way the U.S. Department of Veterans Affairs (VA) does as an example.
 - Increasing rural physician workforce through programs such as medical school scholarships to students from rural areas to incentives.

Once again, thank you for the opportunity to respond to the Task Force's RFI. As you continue this important effort to improve health care delivery and outcomes for rural and underserved communities, we look forward to working with you to effect real, tangible improvements that will ensure our patients have access to the high-quality emergency care they need and deserve. Should you have any questions or require any additional information, please do not hesitate to contact Ryan McBride, ACEP Senior Congressional Lobbyist, at rmcbride@acep.org.

Sincerely,



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