THE UNIVERSITY OF IOWA

RURAL POLICY RESEARCH INSTITUTE
COLLEGE OF PUBLIC HEALTH
Department of Health Management and Policy
145 N. Riverside Drive, N200 CPHB
Iowa City, Iowa 52242-2007
319-384-3830
Fax 319-384-4371

October 9, 2019

Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857
hrsacomments@hrsa.gov

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide evidence-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments in response to the inquires posed by HRSA. The discussion below is meant to speak to the notions itemized below each of the following questions:

Question 1: What are the core health care services needed in rural communities and how can those services be delivered?

- Core health services warranting priority will vary from rural community to rural community, based on population size, characteristics that drive health care needs (e.g., age, social determinants), and proximity to services elsewhere. The continuum of potential core health services spans: Primary care, Psychiatric and substance use treatment services, Emergency Department and observation care, Prenatal care, Transportation, Diagnostic services, Home care and Dentistry services.
- Potential service delivery should consider innovative and alternative pathways in combination with traditional ones. Innovations that bring services to the population deserve special consideration, which in turn requires local access to requisite technology. Expansion of broadband services to rural homes enhances abilities to monitor health conditions and assure appropriate follow up to acute care services. Technology, specifically telehealth, assists in assuring timely and local access to services across the care continuum, including engaging providers located in distant urban centers.
- The process a community uses to determine their most appropriate combination of core health services should parallel the measures suggested to evaluate community healthcare access discussed in Questions 2 & 3.

Question 2: What are the appropriate types, numbers, and/or ratios of health care professionals needed to provide core health care services locally for rural populations of different compositions and sizes?

- Setting numerical targets or ratios of professionals to population should be a process using several building blocks: defining the service area, particularly for primary care (we suggest using established primary care services areas); assessing the health needs of the community using population and health data (e.g., age distribution, prevalence of health conditions); access to services in the region beyond the local community; and projections of demand based on changes driven by underlying economic and social conditions expected to change the size and characteristics of the local population.

THE UNIVERSITY OF IOWA

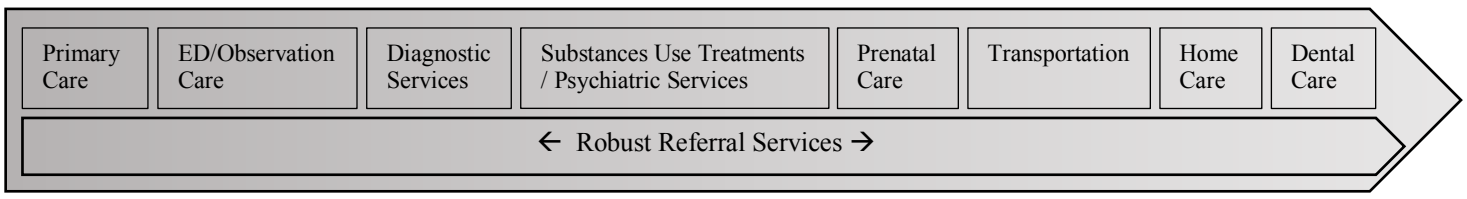
RURAL POLICY RESEARCH INSTITUTE
COLLEGE OF PUBLIC HEALTH
Department of Health Management and Policy
145 N. Riverside Drive, N200 CPHB
Iowa City, Iowa 52242-2007
319-384-3830
Fax 319-384-4371

Question 3: What other factors are important to consider when identifying core health services in different rural communities, such as current and projected population size, distance to the nearest source of care, availability of telehealth, and sustainability of services?

- Current statuses and anticipated trends of population characteristics, community properties and attributes of existing area healthcare professionals should be included in efforts to determine what core healthcare services and related workforce/infrastructure presence are ideal for a rural community to host. For example, the age distribution of the existing healthcare workforce should be used to forecast immediate and short-term future needs.
- Population characteristics crucial to include may be age distributions, underserved subpopulations, and population susceptible to adverse health conditions based on at-risk employment. Effects on demand for services can be assessed using claims data and disease registries.
- Community properties crucial to include may be geographic service area, geographic distance from service providers, location-specific health risks and seasonal health risks, physical environmental factors and social environmental factors.
- Existing core healthcare services and related workforce/infrastructure presence should be evaluated using claims data and disease registries to identify care gaps and surpluses. Trends in provider retention, provider participation in public programs, policies surrounding reimbursement for alternative care delivery means and anticipated community needs should also be assessed.

- - -

The Panel expresses its gratitude to HRSA and its collaborators for taking steps to develop policy intending to support rural communities. For said intent to be realized, it is crucial that policies in place in rural communities conceptualize core health services not as discrete categories, rather as a continuum of care services with discrete specialties and potentially discrete access points. In operation, if a rural resident accesses any one of these services, his or her collective needs should be kept in mind so as identify additionally needed care and to support him or her in accessing a needed service at a different point of the continuum.



The Panel recognizes that intent of core healthcare services are to meet fundamental wellness needs of a rural community. Before needs can be fulfilled, however, they must be accurately identified at the community level. The panels suggests that communities needs for core

THE UNIVERSITY OF IOWA

RURAL POLICY RESEARCH INSTITUTE
COLLEGE OF PUBLIC HEALTH
Department of Health Management and Policy
145 N. Riverside Drive, N200 CPHB
Iowa City, Iowa 52242-2007
319-384-3830
Fax 319-384-4371

healthcare service types, service volumes and related healthcare professional types and volumes be informed by current and anticipated population size and characteristics, community properties as well as attributes of existing area healthcare professionals and healthcare infrastructure. Anticipated population, community and healthcare trends stand to be ever more meaningful given the increasing availability of 'big data'. Supporting rural communities in collecting and analyzing their respective data appropriately has the potential to allow policy decisions to be more effective and more sustainable in the long term.

Current population characteristics accounted for should include concepts such as age distribution, cultural composition, poverty prevalence and severity, health literacy level, health statuses per claims data and disease registries and underserved population prevalence. Current community characteristics considered should include their geographic service area (rather than county location), geographic distance to existing direct service providers (rather than commuting patterns), associated seasonal risks, associated physical environment risks as well as known and foreseeable social environment risks. The existing local presence of core healthcare service and related workforce/infrastructures should be evaluated in the context of claims data, beneficiary surveys and disease registries to identify care gaps and surpluses. Trends in provider retention and provider participation in public programs, community capacity to support alternative care delivery modalities, policies surrounding reimbursement for alternative care delivery modalities, credentialing policies and anticipated changes in community needs should also be referenced.

Particular weight should be given to a community's capacity for alternative care delivery modalities as distance to a service provider in not a definitive access barrier if novel means to access these services (e.g., telehealth, community health transportation resources) exist; and if referral services are robust enough to connect patients to these innovations. It is worth noting, however, that a baseline infrastructure is necessary for some of these modalities to be used. Technologies with the potential to bridge many access challenges are dependent on the availability of consistent, efficient and sufficient broadband. Said availability poses an obstacle to many rural communities. Elevating broadband presence in rural communities may stand to elevate both access to services as well as community health literacy levels.

To evaluate the extent to which broadband expansion or any other access improvement effort was successful, the Panel endorses the utilization of measures that seek to gage the appropriateness of provider availability with identified population needs, the distance between rural communities' geographic service area and direct service providers in context of availability of alternative care delivery resources.

The Panel commends HRSA's continued work on these and other nuanced issues affecting rural residents. Again, the panel is very appreciative of the opportunity to submit comments to this policy discussion.

Sincerely,
The Rural Policy Research Institute Health Panel

THE UNIVERSITY OF IOWA

RURAL POLICY RESEARCH INSTITUTE
COLLEGE OF PUBLIC HEALTH
Department of Health Management and Policy

145 N. Riverside Drive, N200 CPHB
Iowa City, Iowa 52242-2007
319-384-3830
Fax 319-384-4371

Keith J. Mueller, PhD – Chair
Andrew F. Coburn, PhD
Alana D. Knudson, PhD
Jennifer P. Lundblad, PhD, MBA
Clinton MacKinney, MD, MS
Timothy D. McBride, PhD