NACRHHS Update: Emergency Medical Services (EMS) and Integration of Behavioral Health and Primary Care Services – 1/24/2023

Kristine Sande: Hello everyone. I think we'll get started. I'm Kristine Sande and I'm the program director of the Rural Health Information Hub, and I'd like to welcome you to today's webinar. We are delighted to be partnering today with the National Advisory Committee on Rural Health and Human Services to provide an update on their recent work on emergency medical services as well as the integration of behavioral health and primary care services.

Before we begin the webinar, I'll quickly run through a few housekeeping items. We have provided a PDF copy of the presentation on the RHIhub website, and that's accessible through the URL on your screen.

Jeff Colyer is the Chair of the National Advisory Committee on Rural Health and Human Services. He is a physician and former Governor of Kansas. As governor, he made Kansas the first state to privatize its entire Medicaid program into KanCare, saving $2.5 billion, expanding services and acting as the basis of many other states programs. A surgeon known for volunteering in 25 war zones from Rwanda to Syria, he provides trauma reconstruction in Kansas City. Originally from Hayes, Governor Colyer has degrees from Georgetown, Cambridge University, and KU Med.

Our next speaker will be Shannon McDevitt. She's a board certified family physician working to promote innovative and effective primary healthcare. Dr. McDevitt currently serves as a physician in the Bureau of Primary Healthcare at the Health Resources and Services Administration, where she conceptualizes how funding may be used to enhance the impact of the Health Center Program.

Next, we'll hear from James Werth Jr, who received his PhD in counseling psychology from Auburn University and his Master of Legal Studies from the University of Nebraska Lincoln. He is a licensed clinical psychologist in Virginia and is the Chief Executive Officer for Tri Area Community Health, a federally qualified health center, headquartered in Laurel Fork, Virginia.

Next is Yvonne Jonk and she is an associate research professor in the graduate program in public health at the University of Southern Maine's Muskie School of Public Service and is the deputy director of the Maine Rural Health Research Center. As a health economist, Dr. Jonk has over 20 years of experience working within the field of health services research. Dr. Jonk's areas of specialization include rural health, access to care, health insurance coverage, program evaluation, and cost and cost effectiveness analyses.

And our last speaker will be Kari Bruffett. In May 2022, Ms. Bruffett was appointed as the President and Chief Executive Officer of the Kansas Health Institute, KHI, a non-profit, nonpartisan educational organization focused on health policy and research. Prior to that, she was the Vice President of Policy at KHI. Before joining KHI, Ms. Bruffett worked in state government serving as Secretary of the Kansas Department of Aging and Disability Services. She also served as the Director of the Division of Healthcare Finance at the Kansas Department of Health and Environment, playing a key role in the development of the state's Medicaid managed care program, KanCare.

And now I'll pass it over to Dr. Colyer for your opening remarks.

Jeff Colyer: Thank you for the kind introduction, Kristine, and thanks to everyone at RHIhub who made this event possible, and I want to thank you for joining us here today.

Today's webinar will explore two pertinent topics regarding Rural Health and Human Services. As Kristine mentioned, our first speaker will be Dr. Shannon McDevitt, who will provide some context on behavioral health and primary care integration in rural health facilities. Our second speaker will be Dr. Jim Werth, who will discuss the National Advisory Commission's work regarding behavioral health and primary care integration. His marks will be followed by a question and answer session.

Then we're going to shift topics to Rural Emergency Medical Services with Dr. Yvonne Jonk, who will provide some context on Rural Emergency Medical Services. Our final speaker will be Kari Bruffett, who will discuss the committee's work regarding EMS. Her remarks will be followed also by a question and answer.

But before I get started, I would like to take this time to share a couple of updates. First, the National Advisory Committee on Rural Health and Human Services will partner with RHIhub to host a webinar in March. This will explore two other pertinent topics regarding rural health. The first is childcare need and availability in rural areas and the Programs of All-Inclusive Care for the Elderly, also known as the PACE Program. We'll send out more information regarding this webinar next month.

Second, the next meeting of the committee will be in April in Bend, Oregon with the topic of home visiting.

Third, the committee is very pleased that the Centers for Disease Control and Prevention is joining us in establishing an Office of Rural Health. The committee has had the benefit of working with Diane Hall and Scott Miller as ex-officio members of the committee from the CDC and helping advise our work. We're very pleased that CDC is taking the step.

At this point, I would like to provide some background information on the National Advisory Commission on Rural Health and Human Services. The committee is a federally chartered committee composed of 21 citizens from across the United States. The members' experience and expertise span a wide variety of health and human service issues focused on their rural aspects. The committee typically meets twice a year to examine issues of importance to rural areas. And for each topic, the committee engages with a number of rural stakeholders and subject-matter experts, and subsequently, we will submit a policy brief containing recommendations to the Secretary of the Department of Health and Human Services. Our policy briefs can be found at the committee's website, and that link is in the chat and also is going to be on the board in front of you.

The commission has a vision, and that is described on our next slide, that we see rural America as diverse communities of healthy people, and that we want them to succeed in achieving their American dream, that their health resources are supporting them so that they have the diversity, vibrancy and resiliency that is needed. We are going to be recommending several public policies that should have some bipartisan consensus to advance these rural ideals.

As mentioned, the first topic we'll explore today is behavioral health and primary care integration in the rural setting. Integrating behavioral health and primary care can result in improved clinical outcomes and reduced financial costs, it's a win-win for everyone. Additionally, behavioral health and primary care integration can lessen travel time for rural patients as well as lessen the fear of stigma in seeking behavioral health assistance. Now, this integration faces many challenges in rural America, such as a lack of service providers and a lower volume of patients. So it's very important that we discuss this topic today.

So next, I am going to turn it over to Dr. Shannon McDevitt to start us off with some content. Thank you, Shannon.

Shannon McDevitt: Thank you, Governor. To provide context for the committee's recommendations to improve health in rural America through the integration of behavioral health and primary care, I'll describe aligned actions at the US Department of Health and Human Services, or HHS, and its agencies are currently taking. In the version of my slides that are posted on the RHIhub website, there are additional slides and an appendix that present graphic information in ways that may be accessed by individuals using assistive technology.

About one fifth the people in the United States live in a rural area. They experience a variety of challenges that affect their access to needed healthcare and negatively impact their health outcomes, such as having higher rates of maternal mortality, tobacco use, obesity, diabetes, high blood pressure, and behavioral health conditions. Individuals in rural areas have lower life expectancy and are more likely to be uninsured and have fewer affordable insurance options. Access to needed health services is a complex issue that is determined in part by multiple factors.

One of the most critical is healthcare workforce supply. On this map, the dark blue indicates whole counties that are mental health professional shortage areas. And the middle blue shade indicates counties that just have portions that are mental health professional shortage areas. Clearly there's a nationwide problem.

The Biden administration recognizes the growing need for mental health and substance use disorder care, and the far-reaching consequences of these conditions. During his first State of the Union address, President Biden announced a national strategy to prevent and treat mental health conditions and substance use disorders. The president's strategy outlines numerous initiatives within three pillars. The Strength and System Capacity Pillar will expand the supply and diversity of the behavioral health workforce and ensure that the full continuum of behavioral healthcare is available. The Connect Americans to Care Pillar will bridge the gap between services that the system offers and people's ability to get the care they need. And the Support Americans by Creating Healthy Environments Pillar will support a whole of society effort, recognizing the importance of culture and environment in promotion, prevention and recovery.

Along with other federal departments, HHS has a significant role in implementing and advancing the president's strategy. HHS defines improving behavioral health as the promotion of mental health, resilience and wellbeing, the treatment of mental health and substance use disorders, and the support of those who experience and/or are in recovery from these conditions along with their families and communities.

Integration is an HHS priority as it is critical to transforming care for individuals with mental and substance use disorders. While integration often refers to inclusion of behavioral health services in primary care settings, HHS approaches it more broadly to also include integration of physical healthcare into behavioral health settings, and integration of behavioral healthcare with other specialty areas such as obstetrics and gynecology, social service and other settings.

Some of the many major initiatives led by HHS to improve behavioral health are the HHS Overdose Prevention Strategy, the US Surgeon General's Advisory on Protecting Youth Mental Health and implementing 988 as the new National Suicide Prevention lifeline, along with linking 988 to mobile crisis services.

Following the president's call to action and his State of the Union address, HHS examined what further steps the department could take to build upon these significant initiatives and transform the delivery of behavioral healthcare in the US. HHS engaged in a department-wide effort to identify first the most significant challenges to behavioral health integration, and secondly, come up with a short list of the most transformational policies to overcome those challenges. The result was the HHS Roadmap for Behavioral Health Integration, often referred to as the HHS roadmap. The URL for the roadmap is included on slide seven.

Another department-wide effort launched in September 2021 to establish a new initiative to strengthen primary healthcare. The initiative aims to provide a federal foundation for the provision of comprehensive, coordinated, whole person primary healthcare for all. The initiative supports the integration of primary care at behavioral health, as well as with public health and social services. Watch for the publication of the first action plan this spring.

As the governor mentioned, the Centers for Disease Control and Prevention, or CDC, have been appropriated $5 million to establish an Office of Rural Health, which will be an important partner in ensuring that patients are connected to needed healthcare services. The Health Resources and Services Administration, or HRSA, Health Center Program supports nearly 1400 health centers operating more than 14,000 service delivery sites that serve more than 30 million patients each year. With the assistance of federal investments over a number of years, health centers have increased access to integrated behavioral health services.

Health centers increased total full-time equivalence by 7% since 2020. With behavioral health increasing by 603 full-time equivalent. Nearly all health centers provide mental health services using both virtual and in-person care modalities. In 2021, 2.7 million health center patients access mental health services over a total of 15 million mental health visits.

In that same year, health centers also provided substance use disorder services to 286,000 patients. There were commensurate increases in the number of health center patients receiving screening, brief intervention, referral to treatment services and medication assisted treatment. There was also an increase in the number of health center providers eligible to prescribe medication assisted treatment. The Health Center Program provides technical assistance grounded in evidence-based interventions and promising practices on a variety of topics that support the integration of behavioral prevention and treatment services in primary care settings. Various teaching modalities are used to meet health centers where they are in their transformation journey.

Telehealth is not only an important tool for delivering integrated behavioral health services, but also for supporting provider to provider communication so that access to needed services can occur consistently in primary care settings. The National Institutes of Health, or NIH, Office of Disease Prevention Pathways to Prevention Program promotes the use of evidence-based practices to address complex public health issues by identifying research gaps and needs and specific topic areas.

In October 2021, an independent panel developed recommendations for advancing the use of provider to provider telehealth in rural areas. Subsequently, a meeting was held with representatives from the Agency for Healthcare Research and Quality, CDC, HRSA and NIH to identify strategies to address and implement the recommendations. The recommendations that were addressed are to develop one definition for rural provider to provider telehealth to make it easier to know how much it is used, how it is used, and whether it works, and to share information about provider to provider telehealth programs, compare different rural provider to

provider telehealth services. Then involve patients and providers in the development and evaluation of rural telehealth services, and finally, capture context and research such as demographics, state laws, and internet access.

Following the strategic vision and framework laid out by President Biden to improve behavioral health for the nation, HHS is building upon and supporting the president's strategy by addressing each of the three pillars, adopting an inclusive definition of behavioral health integration and launching diverse substantial initiatives to improve mental health and overcome the substance use disorder crisis.

Thank you for your attention. I welcome Jim to the stage. Congratulations on the publication of the committee's report, Jim.

James Werth: Thank you very much. As both Governor Colyer and Dr. McDevitt discussed, behavioral health and primary care integration faces many challenges in rural communities. Recognition of these challenges is what led the committee to examine behavioral health and primary care integration in the first place. But we are particularly interested in how federal programs can support such efforts in rural America.

The committee heard from state and federal officials from the Arizona Center for Rural Health Substance Abuse and Mental Health.

Officials from the Arizona Center for Rural Health, Substance Abuse and Mental Health Services Administration, Centers for Medicare and Medicaid Services, as well as Dr. McDevitt from HRSA. The committee also learned from staff at Gila River Healthcare, Mariposa Community Health Center, local organizations that are making integration work in their communities. After engaging in discussions with these experts and stakeholders, the community decided to focus on four major challenges: Barriers to access, workforce shortages, lack of broadband access and reimbursement issues. Then we work together to craft recommendations to address these challenges. The first bucket of recommendations that we'll discuss today is access to care. People living in rural areas can place multiple barriers when accessing behavioral health services. One barrier is lack of insurance. Americans living in rural areas lack health insurance at higher rates than Americans living in urban areas. To increase the number of rural patients with health insurance coverage, the committee recognizes the role of both marketplace insurance plans and public coverage to achieve this goal.

This led the committee to recommend that the Secretary of support targeted outreach efforts to enroll appropriate rural residents eligible for Medicare dual eligible benefits, Medicaid, CHIP, and the national state-based health insurance marketplaces. HRSA has various programs that promote the integration of services such as its health center program, which aims to expand behavioral health services in current and new health center service sites. Moving forward, HHS could consider offering support for other health providers such as rural health clinics, critical access hospitals, and other rural primary care providers. This brings us to the next recommendation. The committee recommended that the secretary support behavioral health startup grants or loans to help offset the initial cost of integration, including integration of electronic health records, acquisition of telehealth equipment, and recruitment of behavioral health providers into primary care practices. Over 60% of rural America is considered a mental health professional shortage area. Many rural primary care facilities hoping to integrate behavioral health and primary care face difficulties when recruiting behavioral health clinicians.

This issue is exacerbated by the reality that burnout among rural primary care providers is prevalent, especially given the added responsibilities of providing behavioral health screening and services. Burnout often leads to the clinician leaving the practice. When the committee spoke with state representatives, learned of the need for long-term solutions to address shortages of virtually all provider types, such as behavioral health clinicians, family medicine providers, and more. In rural areas, smaller rural focused academic training programs often compete with larger urban focused training programs. Given that rural communities face a larger shortage of needed behavioral health providers, the committee believes that a more targeted approach may be needed for behavioral health and primary care integration efforts in rural America. Thus, the committee recommended that the secretary support rural specific grant towards, within its title, seven and eight health professional training programs to increase the number of clinicians in rural areas. Within HHS, the Rural Residency Training Program and Teaching Health Centers program administered by HRSA focused on training physicians who practice in rural communities.

The committee suggests that these programs expand to new rural residency programs and rural training tracks for other provider types that work in family medicine, internal medicine, and psychiatric settings. For this reason, the committee recommended that the secretary increase the number of rural residency plan grants in teaching health center rewards to support rural primary care and psychiatric residencies. Another issue of concern to the committee is the need for substance use disorder and opioid use disorder care in rural America. The committee believes that as many primary care providers as possible should be able to prescribe buprenorphine, which would in turn increase the number of practitioners that can offer specialized SUD and OUD care in rural areas. As of 2016, 60.1% of non-metropolitan counties lacked a provider who was approved to prescribe buprenorphine, over double that of metropolitan counties, which are only at 26.2%. To help alleviate this issue, the committee recommended that the secretary fund grants to increase the number of providers who can prescribe buprenorphine in rural practices.

In a move that is consistent with the committee's recommendation, the Substance Abuse and Mental Health Services Administration recently announced that it will no longer require applications for the DATA 2000 waiver previously needed to prescribe buprenorphine for the treatment of opioid use disorder. All practitioners with the current DEA registration, that includes prescribing authority for Schedule Three substances, may now prescribe buprenorphine for OUD if permitted in the state where they practice. Furthermore, the committee was concerned that under Medicare, there have been statutory restrictions regarding who can bill for behavioral health services, which was limited depositions, psychiatrists, psychologists, licensed clinical social workers, and psychiatric nurse practitioners. In some states, other clinicians such as managing family therapists and licensed professional counselors can bill for services under Medicaid. The committee believed that it would be beneficial to expand the pool of available clinician types. This relates to the next recommendation. The committee recommended that the secretary support research regarding the impact of expanding the range of behavioral health providers eligible for Medicare reimbursement.

The committee's recommendations was consistent with what other groups were thinking. And in late December, Congress passed the Mental Health Access Improvement Act that allows professional counselors and marriage and family therapists to bill as Medicare providers. The third bucket that we'll briefly discuss is telehealth technology and broadband. Prior to the pandemic, rural communities already had been using telehealth to increase access to behavioral health services. Use of telehealth increased during the pandemic. Due to the declaration of the public health emergency, some regulatory flexibility in building for telehealth services was

granted. Before the pandemic, around 8000 Medicare tele-mental health visits occurred every week. That number searched over 200,000 per week during the pandemic. Moving forward, the committee believes telehealth is an essential tool for integrated behavioral health and primary care in rural communities. The extent to which telehealth can be successfully implemented in rural areas will depend on several factors, such as the availability of high speed, reliable broadband internet.

According to a 2020 Federal Communications Commission report, 22.3% of rural Americans lack broadband coverage compared to 1.5% of urban Americans. For this reason, the committee recommended that the secretary work with the Department of Commerce, Federal Communications Commission and Department of Agriculture, to coordinate broadband investments. The fourth and final bucket that we'll discuss is reimbursement and sustainable revenue. This really gets at the question of whether it is financially feasible for a rural primary care clinic to integrate behavioral health services. The current fee for service or FFS payment model poses potential obstacles toward integration. Specifically, FFS reimburses physicians and behavioral health clinicians for services rendered to the patient. So non-billable tasks like acquiring and setting up telehealth technologies, training providers, and integrating electronic health records aren't funded.

The Centers for Medicare and Medicaid services, or CMS, supports primary care and behavioral health through the administration of Medicare, Medicaid, and the Children's Health Insurance program, in addition to its oversight of the healthcare marketplace. The committee recognizes that CMS has taken an important step in encouraging integrated care with new Medicare billing codes for behavioral health integration. The committee recommended that the secretary conduct an educational campaign for rural primary care and behavioral health providers, explain how they can apply the Medicare behavioral health integrations.

CMS also has incentivized integration through some value-based payment models. Samples are the Comprehensive Primary Care and Comprehensive Primary Care Plus programs, which are demonstration programs administered by the CMS Innovation Center. The integration of behavioral health into an existing primary care practice was allowed under CPC and required under CPC Plus. Between the two programs, close to 3000 primary care practices began providing some behavioral health services. It is important to note however that rural health clinics were ineligible and rural representation of among awardees and the two cohorts was under 10%. Thus, it will be critical for future demonstration projects to consider the unique barriers that rural healthcare facilities face when seeking to integrate behavioral health and primary care. This brings us to the final recommendation. The committee recommended that the secretary developed payment model through the CMS Innovation Center, to focus on an integrated behavioral health primary care payment methodology.

Kristine Sande: Dr. Werth, have you implemented primary care integration and behavioral health integration in your own facility?

James Werth: Yes. I worked at a federally qualified health center and was behavioral health director before becoming CEO. And in both organizations, we had behavioral health integration with psychologists and psychiatrists and utilized other professionals as well. In both places, having the medical providers and behavioral health providers able to work together and provide holistic care made a real difference in the quality of life for the patients.

Kristine Sande: Okay, so we do have a question. Do the recommendations include to ensure nurse practitioners and physician assistants can bill for behavioral health?

James Werth: We didn't specifically focus on whether medical providers could bill for behavioral health. There are aspects of what they do that lead to being able to indicate that they are providing behavioral health services through prescribing and so forth. But we didn't specifically look at other coding issues beyond what was in the recommendations themselves. Dr. McDevitt, I don't know if there's anything that you want to add to that from an overall perspective.

Shannon McDevitt: Well, the physician fee schedule has attempted to expand the types of behavioral health services and what providers can bill for them. And so I encourage you to go back, the audience, and look to see what those revisions are for this current version of the physician fee schedule.

Kristine Sande: Another question regarding reimbursement for behavioral health is for licensed clinical social workers and other mental and behavioral health providers and support staff. So same recommendation in terms of changes in reimbursement to look at the fee schedule?

Shannon McDevitt: Absolutely. Certainly, community health workers, clinical social workers, marriage counselors and therapists were all included in updates to this version of the physician fee schedule. And those of course are addressing Medicare. We're aware that the FQHCs and RHCs, the rural health clinics, have their own Medicaid arrangements, so you'll want to just take a look carefully at their regulations and requirements as are specific to those unique settings.

James Werth: And if I could just jump in for one second. LCSWs already were able to be reimbursed by Medicare prior to the recent revisions, so they're similar to psychologists and psychiatrists and others. So LCSWs, there wasn't really a change in what we recommended, the committee recommended or Congress did, because they were already included in the reimbursement packages.

Kristine Sande: So another reimbursement question is can you speak a little more on the legislation regarding LMFT and LPC billing to Medicare?

Shannon McDevitt: No, I'm going to have to pump that over to your local Medicaid office.

James Werth: I'll just say that it was passed in December, and there's been a lot of discussion by advocacy groups about what this means and the steps that are involved and the timeline involved. So there is a timeline here before things get implemented. So definitely as Dr. McDevitt said, check with your local and any group that may have been advocating for this, for more information.

Kristine Sande: Okay. Do any of the recommendations specifically target adolescents?

James Werth: We did not make a distinction between behavioral health for adolescents or behavioral health for adults or for children. We were just looking more broadly at behavioral health integration as it stands, and how those services could be useful across the lifespan.

Kristine Sande: All right. Next question is: Can you talk more about the integration of EMS? So EMS and behavioral health.

James Werth: I will defer a bit to the next speakers, but I'll say that one possible way of integrating the two would be through community paramedicine activities, where there's an opportunity for there to be some cross referrals or utilization of expertise on the medical side and on behavioral health side and on the EMS side, in terms of providing some services for people who may not be able to get them otherwise. But that may be an opportunity, a question that also can be addressed by the EMS folks.

Shannon McDevitt: And I'll just add that I know the Department of Transportation is aggressively pursuing their data programs, and so consistent reporting and interoperability between the state-based data programs on EMS runs, will certainly provide us with a lot more information about the types of calls and the disposition of those patients that are serviced by our paramedicine services.

Kristine Sande: Were there recommendations regarding utilizing community health workers?

James Werth: We talked about community health workers and the supportive role that they can play in integrated care and helping people access services. But the recommendations themselves were focused on the items that I reviewed in the slides. Community health workers certainly are a big part of what health centers and others can do, in order to help make sure that people get access to the care that they need. But we didn't specifically look at them with the behavioral health integration recommendations.

Kristine Sande: All right. Where will we find the reimbursement rate for Medicare and Medicaid for LACSW, LCSW, in rural health clinics specifically?

Shannon McDevitt: Certainly, your Medicaid rates are going to be determined by your state. And so again, I would go back your technical assistance advocacy organizations. If you're a federally qualified health center or HRSA supported health center, certainly looking at your primary care association. They may be able to help guide you through that. Your state office of rural health and certainly your state Medicaid office could be useful. The physician fee schedule provides the guidance for Medicare and does not necessarily specify the rates.

Kristine Sande: Our next question is: These initiatives focus on delivering behavioral health to primary care patients in FQHCs. This is primary mild to moderate severity conditions. What programs and provisions have been considered to integrate primary care into behavioral health settings? Agencies serving the severely and persistently mentally ill, which is an underserved population, including the unhoused that has difficulty navigating usual primary healthcare?

James Werth: Well, let me clarify one thing. We talked about health centers, and we included health centers in some of the slides in discussion. But the recommendations are to be applied broadly, so not just for community health centers. There are some differences in the way community health centers and rural health clinics are treated by Medicare. And so we wanted to make sure that the recommendations were broad enough and not just narrowly focused on these kinds of organizations, because there are some differences under Medicare and Medicaid rules. In terms of the other piece, the integration with community mental health centers or the CCPHC's, we, the committee, didn't specifically look at that component because we are focused on the primary care integration aspects. However, and Dr. McDevitt mentioned this in her presentation, there certainly are some important considerations around not just behavioral health into primary care, but primary care into the behavioral health settings.

And certainly with, there are some health centers, just as an example, who have special work, who have special grants to work with people who are unhoused.

And so those folks maybe have some additional ideas about how to reach those populations. But we as a committee didn't focus on special populations like that.

Kristine Sande: And the next question, it looks like Sahi might want to answer this one. It says, do you know of any successful programs with developing rural transportation, as this is a very significant barrier? Sahi?

Sahira Rafiullah: I didn't mean to answer it live, but I did want to just mention that the Department of Transportation does have dedicated programming for rural programs related to health-related transportation. And I can share that information with you, Kristine, and you guys can put it on RHIhub, if that's okay.

Kristine Sande: Yes, certainly. And we do have resources on RHIhub related to transportation, both a topic guide and a toolkit that folks can check out in terms of developing transportation programs in rural areas. So I would encourage you to do that.

All right. So it looks like that's the end of the questions for our behavioral health speakers, so we can move on. I'll turn it over to Governor Colyer.

Jeff Colyer: Thank you.

And I want to say, say thank you to Dr. McDevitt and Dr. Werth for a very interesting discussion. The second topic we're going to discuss today is EMS. Emergency Rural Medical Services provide essential care to remote and isolated communities.

But one of the key things is, they're often overstretched, understaffed, and underfunded. In particular rural areas, they're faced with greater physical distances when responding to calls, difficulties in recruiting and retaining its workforce, and higher fixed costs. These aren't only in rural areas, but they are amplified in our rural situations.

So now we're going to turn this over to Dr. Yvonne Jonk, who will be talking more about her research into the issues of EMS services in rural areas.

Yvonne Jonk: Thank you, governor. And I'd like to thank the committee for the opportunity to present our work on identifying ambulance deserts today.

We'd also like to acknowledge the Federal Office of Rural Health Policy for funding this work, as well as the members of our team from the Maine Rural Health Research Center at the University of Southern Maine. We'd also like to thank the members of our EMS expert panel, Gary Wingrove, Kevin McGinnis, and Nick Nudell.

So today, we'll re-review the study rationale and purpose, the definition of ambulance deserts. We'll share our methods. And finally, we'll share a few of our maps illustrating the prevalence of ambulance deserts.

So in terms of study rationale, the declining numbers of rural hospitals and ambulance services implied that remaining ambulance services are being tasked to play a greater role in delivering emergency services in expanded-service areas.

So compounding the issue is the fact that the delivery of ambulance services has not been systematically integrated, particularly in rural areas.

Unfortunately, this lack of systems planning has led to gaps in the provision of ambulance services, also known as ambulance deserts, which are exacerbated across larger geographic coverage areas. So to document these gaps, this project employs a systematic methodology within a GIS framework for identifying ambulance deserts and addressing access.

Our study aims were to build a database of transporting ambulance service locations, create maps of ambulance deserts within each of the 50 US states, characterize who lives in ambulance deserts, and understand the healthcare landscape for those living in ambulance deserts.

Our research questions included what areas of the state are ambulance deserts? What percentage of each state's population lives in an ambulance desert? And how does this differ by rural urban location or census region?

Who lives in ambulance deserts? And for those living in ambulance deserts, are there other access barriers to obtaining care?

First, we'll address some definitions. In this study, we define an ambulance station as the physical location of a ground-transport-capable EMS service. An ambulance service area is defined as a geographic area encompassing all roads that can be accessed within a 25-minute drive time from an ambulance station.

An ambulance desert is a populated census block with its geographic center outside of a 25-minute ambulance service area.

So next we'll address our methods. In terms of our methods. We created our state maps in ARC GIS by taking the following steps. So from the list of ambulance locations that we received from each state EMS office, we first geo-coded ambulance station addresses. We then estimated 25-minute ambulance service areas using the road networks available in ARC GIS.

Next, we identified populated census blocks with geographic centers outside of a 25 minute ambulance service area, and we color coded them in our maps to designate the ambulance deserts.

We also included locations of healthcare facilities, hospitals, FQHCs, and RHCs. We address county level differences in ambulance access by rural urban location, using rural urban continuing codes or the RUCCs. And we're currently working to compare the demographic and socioeconomic characteristics of counties with better or worse ambulance access.

So by stratifying, we stratify the percent of county populations living in ambulance deserts in a quartiles. So we identify counties with a high being the upper quartile and low being the lower quartile. So high and low percentages of their populations living within an ambulance desert.

We then compared the socioeconomic profiles and access to healthcare providers and facilities for rural counties with high concentrations of their populations living in ambulance deserts, to counties with low concentrations of populations living in ambulance deserts.

So here's a list of our data sources. In addition to the 2020 census block level population data, we're using the ACS, the American Community Survey five-year estimates, the Robert Wood Johnson Foundation's County Health rankings, and the Area Health Resource file to describe socioeconomic and market factors associated with counties lacking adequate access to ambulance services.

So ambulance data were requested from each of the 50 states. Of the states that responded, 39 provided ambulance location data with no limitations, and 10 provided data with minor limitations. So three states responded, but were excluded from the current report due to major data limitations, and data were unavailable or not received from eight states.

You'll see that since this chart book was submitted to our funders, the Federal Office of Rural Health Policy, two other states did come in with data, and those are Nevada and Indiana, which are highlighted in this map.

So the states that had major data limitations included not being able to distinguish transporting from non-transporting services. So services that consist of first responders, for example, that do not have a ground transporting ambulance were not included in this study.

Some minor limitations included the provision of incomplete information on ambulance station locations. So for example, some states were only able to provide agency mailing addresses, which may or may not correspond with actual station locations or agency headquarter addresses. And that this could potentially result in the overestimation of ambulance deserts. But any data limitations are listed in the footnote of the state maps.

So in terms of our findings, across the 39 states included in these analyses, 4.3 million people lived in ambulance deserts. Of the 4.3 million living in ambulance deserts, 2.2 million lived in rural counties, and 2.1 million lived in urban counties. We just wanted to note that this question has come up numerous times, that because we use counties as our unit of analysis here, some counties contain a mix of rural and urban places. And so some urban counties contain communities that are ambulance deserts.

But we did find that rural counties were more likely to have at least one ambulance desert at the census block level, 85% of rural counties, and that was higher than urban counties at 78%.

However, because rural counties are less densely populated than urban, just over half or 52%, 2.2 million people were living in ambulance deserts located in rural counties.

And finally, rural counties had higher percentages of their populations living in ambulance deserts, 9.4% on average, compared with urban counties, 3.5% on average.

So here we have a national map illustrating the percent of rural and urban county populations living in ambulance deserts. The national map highlights the following geographic areas of concern. You see the southern states, particularly within the Appalachian region. The western states, with difficult mountainous terrain. And then the jagged coastal areas and the rural mountainous areas of Maine, Vermont, Oregon, and Washington had high percentages and or high numbers of people living in ambulance deserts.

So after categorizing counties as having low or high concentrations of their populations living in ambulance deserts, counties flagged as having a high percentage of populations living in ambulance deserts were more likely to be rural, approximately 83%.

So focusing just on rural counties, residents living in rural counties with a high concentration of ambulance desert populations tend to have higher rates of social vulnerability than residents living in rural counties with a low concentration of ambulance desert populations.

More specifically, rural counties with large concentrations of ambulance desert populations tend to be more sparsely populated, their populations tend to be older. They have a higher percentage of people of color. They have lower incomes and higher poverty rates, and they're more likely to be uninsured compared with rural counties with low concentrations of ambulance deserts.

I'm going to skip over some of these state-level maps. They were presented last year when we presented to the committee, but you see that the ambulance stations are the dots.

The deserts are the yellow highlighted areas in the state. And then on one side you see the healthcare facilities overlaid on the desert so that you can kind of see proximity to healthcare facilities for those people living in ambulance deserts.

So here we have Alabama. Next slide, we have Maine. The next slide we have Montana. The next slide is New Mexico, and the last slide is South Carolina.

In conclusion, we saw that well over three quarters of counties in the 39 states contained ambulance deserts at the census block level, demonstrating the gravity of the issue of ensuring access to ambulance services. Rural counties were more likely to have ambulance deserts, and in 22 of the 39 states, well over half of state populations living in ambulance deserts were living in rural counties.

We'd like to refer you to the chart book that the Federal Office of Rural Health Policy will be releasing soon, and probably most available if you search on the RHIhub or the Rural Health Research Gateway.

For more information on how the states rank on the following measures; population densities, ambulance stations per-square-miles, ambulance stations per-capita, the prevalence of ambulance deserts, and the number of people living in ambulance deserts in each state. Next slide.

The additional tables that can be found in the chart book will help explain some stark differences across the census regions. We saw that the sparsely populated rural areas in the Western and Midwestern states make it challenging to provide adequate ambulance service coverage.

A hundred percent of all the counties in the Western states, for example, have ambulance deserts. But they also tend to have high concentrations of ambulance stations per-capita. This is because they have a lot of ground cover. Populations are spread out, ambulances are driving long distances, and that's why you see high rates of county populations living in ambulance deserts in these states.

Alternatively, in the south, we have the opposite issue. In that there are relatively low numbers of ambulance stations per-capita, and high population densities, that are driving high numbers of people living in ambulance deserts.

Although these ambulance desert populations in the South are largely concentrated in urban counties, a few of the southern states have high concentrations of their ambulance desert populations living in rural counties. And those are Kentucky, Oklahoma, Arkansas, and Texas.

And finally, the national maps highlighted the geographic areas of most concern, the Appalachian regions, the western states with their difficult mountainous terrain and the jagged coastal areas and rural mountainous areas of Maine, Vermont, Oregon, and Washington.

To summarize, this study is a first to document coverage gaps in the provision of ambulance services across the US. Policymakers need to consider how best to address these coverage gaps within the existing fabric of the healthcare system.

In terms of next steps, we hope this study helps inform the work of policymakers interest in addressing the pressing issues underlying the reasons why we're seeing high concentrations of ambulance deserts in rural areas. Just want to thank you for your time, and here's my contact information.

Thank you.

Kari Bruffett: Well, good afternoon. I'm Kari Bruffett. I am a member of the National Advisory Committee on Rural Health and Human Services, and I'm going to talk about the committee's recommendations, and some of the considerations from our discussions on rural EMS.

And that presentation by Dr. Jonk was really helpful, both in our meeting. And then I think it adds extra flavor to the recommendations that we'll be discussing this afternoon.

So I'll be going over, again, those recommendations and considerations. We were able to go back and forth and talk about language, and try to take what we were learning in our own home states, or what we learned from the presenters and in our communities, and really contributed to the development of those recommendations.

Those recommendations and considerations resulted in a policy brief, which is then sent to the secretary of HHS. So the April, 2022, National Advisory Committee meeting focused on EMS in rural United States. So many of the issues that you've heard just presented in the research before were the front and center of the conversations we were having.

The committee's discussion covered a lot of ground though, including other issues. Including the volume issues, Medicare payments reimbursement issues. You'll see that in the recommendations and the considerations that follow.

For example, we heard that EMS response times are longer in rural areas, more than twice as long on average, per a 2017 study. And rural providers respond to higher acuity calls at a higher rate than urban and suburban colleagues. So while frontier areas, so real low density population area providers, receive fewer calls than the urban providers, the proportion of those calls that are critical is over twice that of the providers in urban areas. So fewer calls, but a higher proportion of critical calls and higher acuity calls in general. So those are examples of some of the things we heard about.

So after hearing from the subject-matter experts and those working on EMS issues in their states, the committee then came up with the five recommendations and five considerations to improve EMS in rural communities. And I think Jim touched on this a bit, but I'll just point a quick point of clarification, what's the difference between a recommendation and a consideration? It doesn't mean that one is more important than the other. A recommendation is something that the agency itself HHS can act on, whereas a consideration tends to be something that the agency or the secretary would do by working with Congress or perhaps some external partner or some other federal agency. So that wouldn't be a direct agency action, but it's still something that the committee felt rose to the level of importance where it was necessary to include it in the brief. Again, doesn't mean considerations are less important. And as you'll see, many of the considerations are related to the recommendations. It's just a different way to present issues that we think are important.

So given the virtual nature of the April meeting, site visits were replicated through breakout rooms, and they focused on EMS reimbursement and workforce topics were sort of the key

areas for the breakouts, and those included both perspectives from individual states and tribal perspectives as well. In the tribal session, for example, we discussed some of the challenges of providing quality emergency medical services in communities, such as the lack of 911 services and lack of integration with local level organizations. The provider panel also included a discussion of problems like lack of regional integration with EMS services, insufficient payment by insurers to cover standby and fixed costs that ambulance service providers have, and insufficient state and federal policy coordination across oversight agencies.

The committee received input from representatives of national organizations and federal agencies such as the Paramedic Foundation, the Federal Office of Rural Health Policy, the National Highway Traffic Safety Administration, in addition to Dr. Young's pre-research. We also heard from local EMS providers from across the country, from Pafford Medical Services from Hope, Arkansas, Rutland Regional Ambulance Services in Vermont, Lafayette County Wisconsin EMS, and Dysart Ambulance Services in Iowa. In the next part of the presentation, I'll talk about the recommendations and considerations that the committee generated from those discussions.

A quick note, and you'll see this if you look at the brief, while the committee acknowledged that air ambulance services have an important role in the provision of emergency care, the meeting was focused on ground ambulance services. And so the policy brief and the recommendations and the considerations you're going to hear about, those are all focused on ground ambulance issues.

Okay. So we're going to start here with the discussion of the committee's recommendations. The committee's first set of recommendations focus on access to EMS in rural areas. The recommendations center on principles of improving our understanding of existing EMS capacity funding services in areas where EMS is most inaccessible and supporting new innovative models of care that can utilize EMS as a resource for rural communities.

So therefore, the recommendations were, first, was that the secretary support ongoing research on ambulance deserts and their impact on healthcare outcomes. The innovative work that Yvonne shared with us was the first of its kind to look into ambulance deserts, but there's much more to learn and more states and more information and data points. So we really wanted to encourage the continuation of research on ambulance deserts.

Next, the next recommendation was the secretary should work to ensure the regulation and guidance that community paramedicine providers have the ability to deliver services to Medicare beneficiaries, quote unquote, "Incident to," the services of physician, non-physician practitioners, and encourages that such policies allow for community paramedicine providers to practice under general rather than direct supervision. And some of this issue is also related to make sure that it's clear how those services can be billed, even to the extent that they are already allowed to be billed. But we'll talk about a consideration in a moment that's similar or is related. Community paramedicine programs can already bill for their services by utilizing this, "Incident to," billing rules. But we believe, the committee believed, that there could be additional benefits from enabling them to directly bill Medicare for their services. That was a consideration or a discussion point to expand upon that recommendation.

Third, the recommendation was that the secretary's support analysis of the use of onsite and on route telehealth and in emergency medical services for triage care to identify future policy options. There was some discussion of the interrelationship with that and the new rural emergency hospital model, for example. There's a similar consideration in the area of access to EMS that we touched about on a bit earlier, which is that we heard from members of Indian

Health Service staff that residents on some tribal lands are not able to dial 911 and reliably get a response. So the committee recognizes that, and again, developed a recommendation, or a consideration, as a key impediment to accessing ambulance services and really needs to be better understood and addressed across agencies.

Now, we'll go to the recommendations that were related to the EMS workforce. Our next set of recommendations is regarding reimbursement and then a payment model. It's kind of similar to the final recommendation that you heard in the integration of behavioral health and primary medical care as well.

But first, we'll start with the recommendation about the way the reimbursement system currently recognizes or is calibrated to the realities of what EMS does. Basically, the belief that you'll see in the brief was that the current reimbursement is not accurately calibrated to the realities of what EMS does. So the committee recommends that the secretary consider CMS ground ambulance data collection in future rulemaking on the ambulance fee schedule. The secretary should also consider the forthcoming MedPAC study on standby cost to help inform future policy making on Medicare ambulance reimbursement, knowing that the Medicare ambulance fee schedule is a driver for many other reimbursement ambulance service reimbursement from other payers as well.

And then finally, the last recommendation was to, we believe that the Center for Medicare and Medicaid Innovation, CMMI is an appropriate place to test a new payment mode. So that final recommendation to the secretary was to direct the CMS Innovation Center, the CMMI, to develop a pilot payment model that is focused on addressing chronic disease and emergency medical service gaps from a population health perspective, and particularly one that would be inclusive of rural providers. We heard about some other innovative models, including CMMI models, that engage ambulance service providers, but require a certain volume of patients that tends to exclude rural ambulance service providers. So this recommendation would include those rural providers as well.

Okay, I mentioned that considerations, and some of these I've touched on already, but in addition to these recommendations, the committee offered several considerations outlined on this slide. As previously mentioned, they're not actions that necessarily going to be taken directly by the agency or secretary, but they would be done in collaboration with Congress or other agencies. So I think most of these are, would require working with Congress to create a grant program to expand EMS areas into ambulance deserts. Kind of looking back at some of the early establishment of EMS, the federal leadership that many decades ago that led to our current system, but really expand upon that in the ambulance deserts that the research we've seen has identified.

To also then work with Congress to allow community paramedicine programs in rural communities to build Medicare directly for basic chronic care management, prevention, and screening services. That was mentioned before. Also, to work with Congress to close the remaining 911 gaps in tribal areas. To provide emergency medical service training grants. We heard about some models including a SAMHSA program that provides training for EMSF and dealing with substance use disorder and behavioral health conditions in ambulance in EMS. But the recommendation was to expand that really to EMS generally across the country, and not just for rural EMS programs and services, but certainly inclusive of them.

And then finally, to make the rural and super rural add-on payment. And those of you who are ambulance service providers or familiar with it know what that means. It's extra payment that is

temporarily approved every few years by Congress that adds on for the ambulance fee schedule for rural and super rural, meaning very sparsely populated areas. To make that payment, add-on payment, permanent, and to give the CMS, that's Centers for Medicare and Medicaid Services, the ability to adjust them in the future as well.

So we learned that modern EMS is certainly relatively new and rapidly changing as a field. I mean, we've had EMS for a long time. We heard really great stories from some of the service providers that we met with about how much their services had evolved over decades, and particularly in recent years. Increasing professionalization and technology, or improving and expanding the type of care that EMS can provide. Despite those advances, we know there are barriers to unleashing the full potential EMS, which we've briefly described here. The committee believes it's possible and critical, essential, to improve upon the current EMS system by making investments that expand access to EMS in places that don't have adequate services by supporting the recruitment and retention in the next generation of professionals, and by aligning our reimbursement policies with the reality of the nature of modern EMS, particularly in rural America.

I'm happy to answer any questions you may have, and I know Dr. Jonk is as well. Thank you.

Kristine Sande: So these first questions are for Dr. Jonk. Did the study distinguish between volunteer versus fully funded EMS services?

Yvonne Jonk: We included both. The majority, a good majority, of very rural states, such as Maine and North Dakota, rely on volunteers. And so we did not address staffing in this project. It was fairly challenging to get the roster of ambulance service locations or identify them for all 50 states, but it is an ongoing conversation with the federal office to tackle that issue.

Kristine Sande: All right. And then there are a couple questions about whether the data in the maps will be available by state and where they can find those.

Yvonne Jonk: Yes, they will be available for each of the 39 states that we have data for, including the two that eventually we will update that chart book to include Nevada and Indiana. You'll be able to find them on the Rural Health Research Gateway, which you'll be able to find them through the RHIhub as well. And then of course from the Maine Rural Health Research Center's website.

Kristine Sande: All right. The next question is, have you identified any correlation between rural hospital closures and the creation of ambulance deserts?

Yvonne Jonk: Oh, that is coming up. That is part of our mission for this year is to take a look at that correlation. So stay tuned. We don't know the answer yet, but I'm quite sure there's a correlation. Yeah.

Kristine Sande: Yeah, it seems like there would be, so it'll be great to see that research. And then next question is, how will this data be used to determine the need and funding for rural beds for EMS to take people to, considering this needed resource for the EMS staff?

Yvonne Jonk: So part of what we're doing is looking at the distance that people who live in ambulance deserts have to travel, this is from their residential location, to get to a hospital or a clinic. And so that conversation will hopefully lead to other additional conversations, including the impact of the rural emergency hospital. There is a session at the National Rural Health Association meetings coming up that specifically looks at rural emergency hospitals and the impact of hospital

closures on EMS. That's part of that conversation. Don't have that answer yet, but definitely the conversation is ongoing.

Jeff Colyer: I want to thank everyone for joining us today, especially our friends at RHIhub for helping produce this, the many presenters, and the many staff of all of these multiple agencies that have been supporting the National Advisory Commission. You can see us on our website, which is on the slide, and see us also in the chat that will show you our website. Happy to visit with you anytime and we appreciate all of your support. Thank you very much.