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Thank you for joining today's webinar. We will begin promptly at 12:00 pm Central.

NACRHHS Update: Emergency Medical Services (EMS) and Integration of Behavioral Health and Primary Care Services

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Your *First* **STOP** for *Rural Health* **INFORMATION**

NACRHHS Update: Emergency Medical Services (EMS) and Integration of Behavioral Health and Primary Care Services

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Housekeeping

- Slides are available at www.ruralhealthinfo.org/webinars/nacrhhs-update-011023
- Technical difficulties please visit the Zoom Help Center at support.zoom.us

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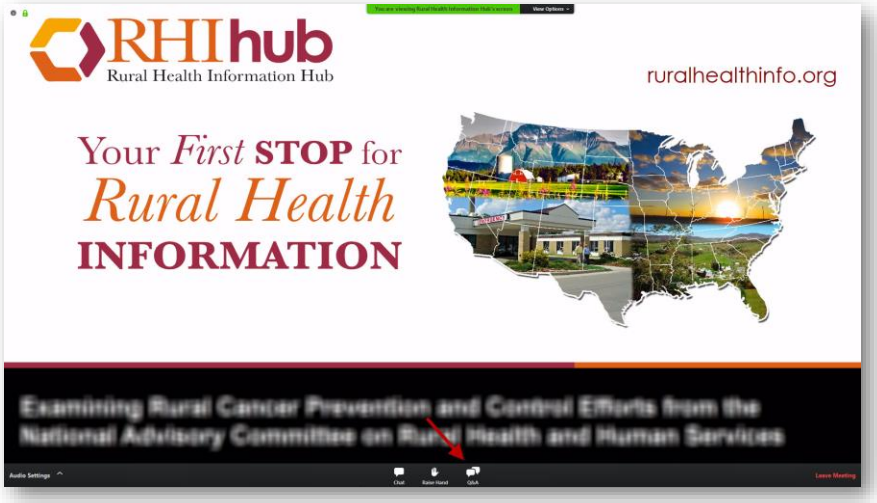
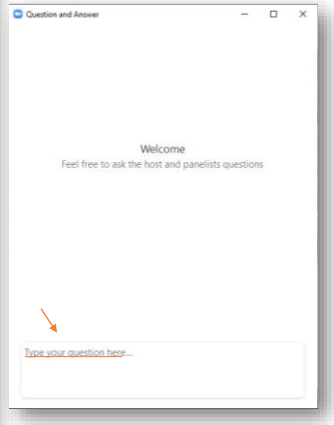
If you have questions…





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Featured Speakers

Jeff Colyer, Chair, National Advisory Committee on Rural Health and Human Services; Former Governor of Kansas

Yvonne Jonk, PhD, Associate Research Professor, Deputy Director, Maine Rural Health Research Center, University of Southern Maine

Shannon McDevitt, MD, MPH, Physician, Bureau or Primary Health Care, Health Resources and Services Administration

Kari Bruffett, President and Chief Executive Officer of the Kansas Health Institute (KHI)

James L. Werth Jr., PhD, ABPP, Chief Executive Officer, Tri-Area Community Health

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Behavioral Health and Primary Care Integration in Rural Health Facilities
&
Rural Emergency Medical Services

Policy Brief Webinar
January 24, 2023

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Webinar Schedule

Introductory Remarks
Jeff Colyer, MD
Chair, National Advisory Committee on Rural Health and Human Services (NACRHHS)

Behavioral Health and Primary Care Integration in Rural Health Facilities
Shannon McDevitt, MD, MPH
James L. Werth, Jr., PhD, ABPP

Rural Emergency Medical Services (EMS)
Yvonne Jonk, PhD
Kari Bruffett

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Updates

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National Advisory Committee on Rural Health and Human Services

- A 21-member citizens' panel of nationally recognized rural health experts
- Represents the diversity of rural health care, policy, and research
- Convenes twice a year in a rural part of the country
- Produces policy briefs with recommendations to the Secretary, HHS

NACRHHS Vision Statement

We envision rural America as diverse communities of healthy people, places, and providers, who access world class care and human services by capitalizing on continued innovation and rural values – places where people have the greatest opportunity to live their American Dream.

NACRHHS Mission

We will advance our Vision for rural America by:

- Examining rural health care and human services innovations
- Highlighting opportunities that integrate health care services, human services, and non-health sectors
- Recommending public policies that advance rural community diversity, vibrancy and resiliency
- Engaging science and evidence during our deliberations

Behavioral Health and Primary Care Integration in Rural Health Facilities

HHS Supports Behavioral Health and Primary Care Integration

NACRHHS Webinar on Rural Behavioral Health and Primary Care Integration and EMS Access in Rural Areas

January 24, 2023

Shannon K. McDevitt, MD, MPH
Physician, Office of Policy and Program Development
Bureau of Primary Health Care (BPHC)

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Rural Communities Experience a Variety of Challenges that Affect Access to Needed Health Care and Health Outcomes

People in rural areas **live 3 fewer years** than people in urban areas, with **rural areas having higher death rates for heart disease and stroke.**

Rural women face higher maternal mortality rates

Rural residents face **higher rates of tobacco use, physical inactivity, obesity, diabetes and high blood pressure**

Rural populations face greater challenges with **mental and behavioral health** and have **limited access to mental health care.**

Rural hospitals are closing or facing the possibility of closing
+
Increasing shortages of clinicians

Long distances and lack of transportation make it difficult to access emergency, specialty and preventive care.

Rural populations are more likely to be **uninsured and have fewer affordable health insurance options** than in suburban and urban areas.

U.S. Department of Health & Human Services HRSA Federal Office of Rural Health Policy

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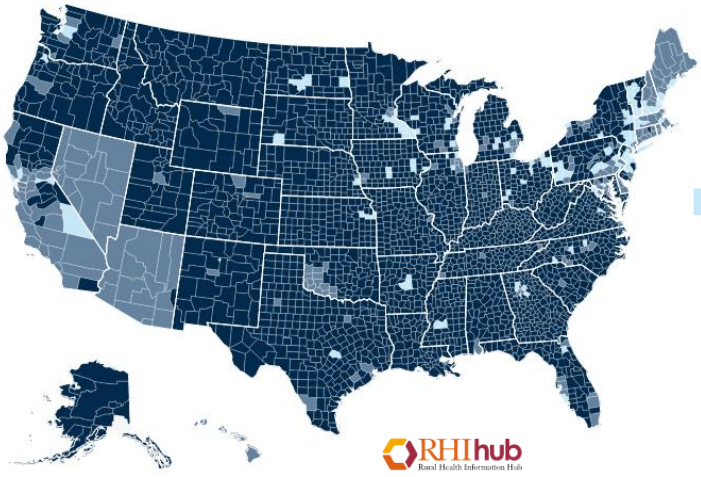
Access to Mental Health Services in the U.S.

Health Professional Shortage Areas: Mental Health, by County, 2022



None of county is shortage area | Part of county is shortage area | Whole county is shortage area

Source: data.HRSA.gov, November 2022.

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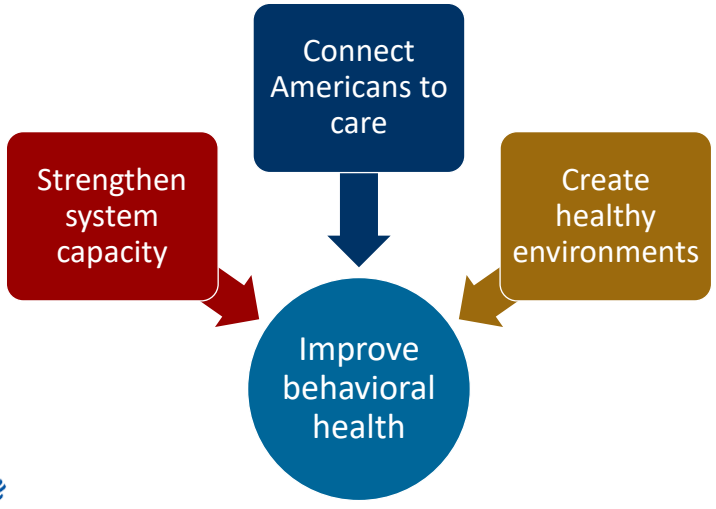
President Biden's Strategy to Address our National Mental Health Crisis Pillars



To view the Fact Sheet announcing President's Strategy, visit https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

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U.S. Department of Health and Human Services (HHS) Goal Statement to Support and Build Upon the President's Strategy

The full spectrum of behavioral health care will be integrated into health care, social service, and early childhood systems to ensure all people have equitable access to evidence-based, culturally appropriate, person-centered care.

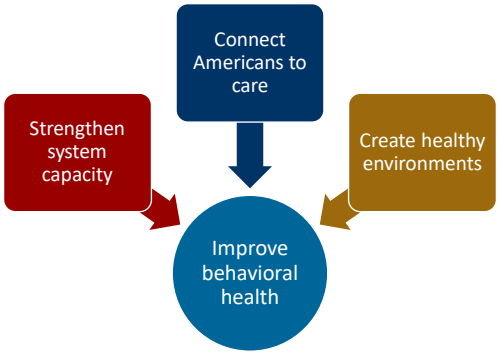
Source: Assistant Secretary for Planning and Evaluation. Issue Brief. "HHS Roadmap for Behavioral Health Integration." https://aspe.hhs.gov/sites/default/files/documents/84a701e0878bc26b2812a074aa22a3e2/roadmap-behavioral-health-integration.pdf

Sample of HHS Activities Supporting the President's Strategy

HHS Overdose Prevention Strategy	• To learn more, visit https://www.hhs.gov/overdose-prevention/
9-8-8 Suicide & Crisis Lifeline	• To learn more, visit https://www.samhsa.gov/find-help/988
U.S. Surgeon General's Advisory on Protecting Youth Mental Health	• To learn more, visit https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf
HHS Roadmap for Behavioral Health Integration	• To learn more, visit https://aspe.hhs.gov/sites/default/files/documents/84a701e0878bc26b2812a074aa22a3e2/roadmap-behavioral-health-integration.pdf

HHS Roadmap for Behavioral Health Integration

President's Strategy Pillars



Major Challenges to Behavioral Health Integration

- Structural support for siloed care
- Stigma and mistrust
- Limited adoption of technology
- Inconsistent use of data and evidence
- Insufficient investment in promotion and prevention
- Insurance and financing limitations
- Workforce challenges
- Inequitable engagement of underserved populations

Source: Assistant Secretary for Planning and Evaluation. Issue Brief. "HHS Roadmap for Behavioral Health Integration." https://aspe.hhs.gov/sites/default/files/documents/84a701e0878bc26b2812a074aa22a3e2/roadmap-behavioral-health-integration.pdf

HHS Initiative to Strengthen Primary Health Care

- Aim is to provide a federal foundation
  - For the provision of comprehensive, coordinated whole person primary health care for all
  - To improve the health of individuals, families, and communities
  - To improve health equity
- First action
  - Develop an initial action plan of prioritized, new steps to be taken by HHS and across HHS agencies under current statute and funding

Primary Health Care Goal State

Supports health, well-being, and resilience through sustained partnerships with individuals, families, caregivers, and their communities

Equitably provides first contact access to all, as well as whole person, comprehensive care over time, using multidisciplinary teams

Coordinates and integrates care across the primary health care components

New Funding for Centers for Disease Control and Prevention

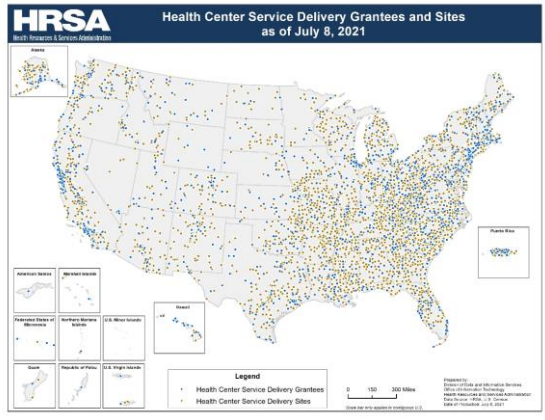
FY2023 Omnibus Appropriations Bill

- $5M for CDC to establish an Office of Rural Health
- "The Office of Rural Health will enhance the implementation of CDC's rural health portfolio, coordinate efforts across CDC programs, and develop a strategic plan for rural health at CDC that maps the way forward both administratively and programmatically."

Source: FY 2023 Omnibus Appropriations Bill. "Explanatory Statement." https://www.appropriations.senate.gov/imo/media/doc/Division%20H%20-%20LHHS%20Statement%20FY23.pdf

Health Center Program Fast Facts

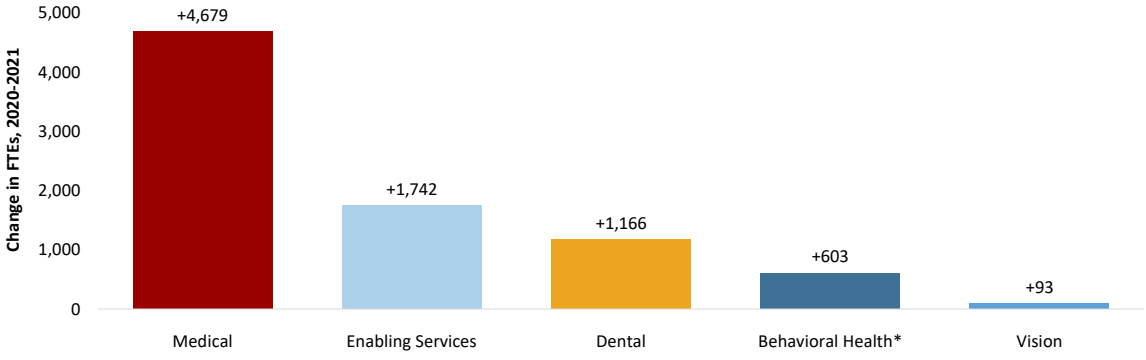
- Nearly **1,400** health centers operate more than **14,000** service delivery sites
- More than **30 million** patients
- Health centers provide **patient-centered, comprehensive, integrated care** by offering a range of services:
  - Primary medical, oral, and mental health services
  - Substance use disorder and medication-assisted treatment (MAT) services
  - Enabling services such as outreach, case management, health education, interpretation services, and transportation



Source: Uniform Data System, 2021

Health Center Workforce Growth

Health centers *increased total FTEs by 7% or nearly 17,000 FTEs since 2020,* leveraging COVID-19 funding to maintain and expand services.



Source: Uniform Data System, 2020-2021, Table 5.
*Behavioral Health is a combination of Mental Health and Substance Use Disorder (SUD) service categories
Note that the net 17,000 increase in FTEs since 2020 includes FTE categories not displayed in the bar graph.

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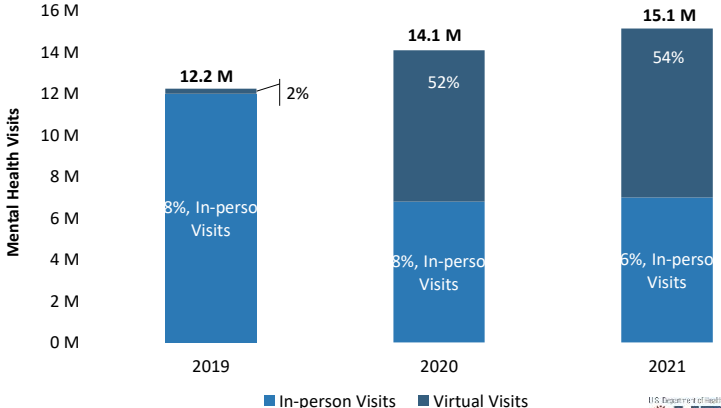
Health Centers Responding to Increasing Mental Health Needs

In 2021, health centers responded to increasing demand for mental health services and expanded care by providing screenings and virtual services.

- More than 15 million mental health visits conducted
- Served **2.7 million** patients seeking mental health services and **286,000** patients seeking substance use disorder services in 2021



Source: Uniform Data System 2019-2021 – Table 5, Table 6B
Virtual visit data first reported in UDS in 2019

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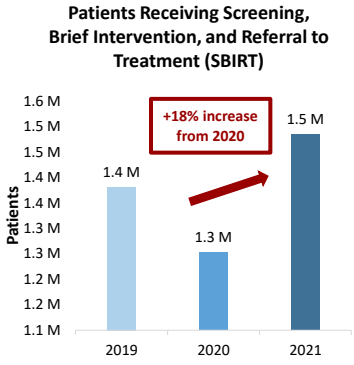
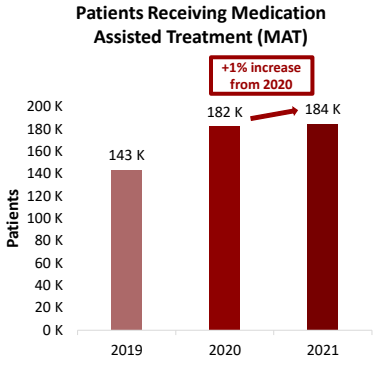
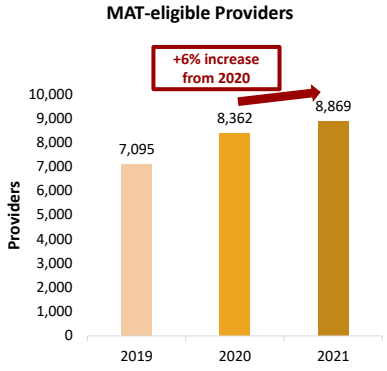
Health Centers Addressing Substance Use Disorder Needs

Health centers provided substance use disorder services to 286,000 patients in 2021, **representing a similar proportion of total patients to past years.**







Source: Uniform Data System, 2019-2021 - Table 6A, Appendix E: Other Data Elements
Definition of MAT providers expanded to include physician assistants & certified nurse practitioners in 2017
Please note, as of October 2022, the number of MAT-eligible providers changed due to a correction in the UDS dataset from 16,769 to 8,869.
Percent increase calculations are based on actual reported numbers, not the rounded numbers presented in the charts.

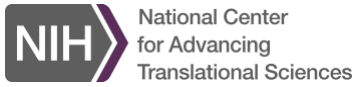
Integration Technical Assistance for Health Centers

- Communities of practice
- Virtual office hours
- One on one coaching
- Social determinants of health roundtables
- Virtual site visits – program assessment
- Webinars

- Medication-Assisted Treatment
- Pain management
- Screening Brief Intervention and Referral to Treatment
- Pediatric mental health
- Pregnancy and substance use disorder
- Tele-behavioral services
- Workforce well-being
- Depression screening
- Social determinants of health
- Care coordination and case management

Pathways to Prevention (P2P): Improving Rural Health Through Telehealth-Guided Provider-to-Provider Communication

Workshop Aim
Assess the effectiveness and timeliness of telehealth-guided clinical decision making as a means of improving rural health outcomes



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P2P: Independent Workgroup Recommendations

- Develop one definition for rural provider-to-provider telehealth
- Compare different rural provider-to-provider telehealth services
- Involve patients and providers in the development and evaluation of rural telehealth services
- Capture context in your research

To view the Panel's Final Report, visit https://journals.sagepub.com/doi/10.1177/1357633X221139630.
To view the resultant federal action plan, visit https://prevention.nih.gov/.

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Conclusion

- President's Strategy provides a federal framework for improving behavioral health for the nation
- HHS is building upon and supporting the President's Strategy
  - Addressing the President's Strategy 3 pillars
  - Defining integration broadly
    - Behavioral health into primary care
    - Physical health care into behavioral health settings
    - Behavioral health integrated into other specialties and social service settings
  - HHS Roadmap for Behavioral Health Integration provides a whole-of-HHS approach to advancing the President's Strategy via behavioral health integration
  - HHS Initiative to Strengthen Primary Health Care conceptual framework is based on integrated services
  - HRSA Health Center Program investments and technical assistance have increased access to mental health and substance use disorder services
  - NIH Prevention to Practice workshop identified recommendations and federal actions that may support provider to provider telehealth in rural areas

Thank You!

Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)

Health Center Program Support

877-464-4772, 8 a.m. to 8 p.m. ET, Monday - Friday (except federal holidays)

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Summary of NACRHHS Discussions

- Access to care
  - Distances to care, lack of insurance, lack of mental health specialists, etc.
- Workforce
- Telehealth, technology, and broadband
- Reimbursement

NACRHHS Recommendations - Access

Support targeted outreach and enrollment efforts to rural communities to enroll appropriate rural residents eligible for Medicare Dual-Eligible benefits, Medicaid, etc.

Support behavioral health start-up grants or loans to help offset the initial costs of integration.

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NACRHHS Recommendations - Workforce Recruitment and Retention

Support targeted, rural-specific grant awards within its Title VII and VIII health professional training programs to increase the number of clinicians practicing in rural areas.

Expand the number of Rural Residency Planning Grants and Teaching Health Center Awards to support rural primary care and psychiatric residencies.

Fund grants to increase the number of DEA-waivered providers who are approved to prescribe buprenorphine in rural practices.

Support research to assess the impact of expanding the range of behavioral health providers eligible for Medicare reimbursement.

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NACRHHS Recommendations - Telehealth, Technology, and Broadband

Work with the Department of Commerce, the Federal Communications Commission, and the U.S. Department of Agriculture to coordinate broadband investments to address access gaps in rural communities.

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NACRHHS Recommendations - Reimbursement and Sustainable Revenue

Conduct an ongoing campaign to educate rural primary care and behavioral health providers on how to apply the Medicare behavioral health integration codes.

Develop a payment model through the CMS Innovation Center to focus on an integrated behavioral health-primary care payment methodology to expand access, coordinate care, and enhance outcomes through a range of primary care providers.

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If you have questions…

Rural EMS

Ambulance Deserts: Addressing Geographic Disparities in the Provision of Ambulance Services

NACRHHS Webinar on Rural Behavioral Health and Primary Care Integration and EMS Access in Rural Areas
January 24, 2023

Maine Rural Health Research Center

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service

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Acknowledgements

This work was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), Grant CA#U1CRH03716, Rural Health Research Center Cooperative Agreement to the Maine Rural Health Research Center.

The information, conclusions and opinions expressed are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.

Maine Rural Health Research Center

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Team Members

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- Carly Milkowski, MPH, Research Associate
- Zachariah Croll, MPH, Research Associate
- Karen Pearson, MLIS, MA, Policy Associate
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Maine Rural Health Research Center

EMS Expert Panel

Gary Wingrove, FACPE, CP-C

- President and Chief Innovation Officer, The Paramedic Foundation, Duluth, MN

Kevin McGinnis, MPS, EMT-P

- Program Manager, Community Paramedicine - Mobile Integrated Healthcare, NE Mobile Health Services, Scarborough, ME
- Rural Emergency Care, National Association of State EMS Officials (NASEMSO), Falls Church, VA

Nick Nudell, MS, MPhil, NRP, FACPE, PhD Candidate

- Research Manager, UCHealth
- Paramedic Scientist, The Paramedic Foundation, a 501(c)3 non-profit charity
- President, American Paramedic Association
- Treasurer, National EMS Management Association
- Board Member, Colorado Chapter of NAEMSP
- Board Member, EMS Association of Colorado

Agenda

- Study rationale and purpose
- Definitions
- Methods
- Preliminary results

Study Rationale & Purpose

Rationale

- Declining numbers of rural hospitals and ambulance services:
  → remaining ambulance services are being tasked to play a greater role in delivering emergency services, and
  → their service areas are expanded.[1-5]
- Delivery of ambulance services has not been systematically integrated, particularly in rural areas.[6]
- Lack of systems planning has led to gaps in the provision of ambulance services, also known as "ambulance deserts".
- Lack of data on ambulance service locations at the national level.
- To assist state and regional policymakers in formulating strategic plans to address these gaps, this project employs a systematic methodology within a geographic information system (GIS) framework for identifying ambulance deserts and addressing access.

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Study Objectives

Study aims were to identify geographic disparities in accessing ambulance services by

1. Building a database of ambulance service locations
   - preferably broken out by transporting/non-transporting
   - focused on mapping transporting service locations
2. Identifying and creating maps of ambulance deserts within each of the states
3. Characterizing who lives in ambulance deserts
4. Understanding the health care landscape for those living in ambulance deserts

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Research Questions

1. What areas of the states are ambulance deserts; how prevalent are they?
2. What percentage of each state's population lives in an ambulance desert? Are there rural-urban or regional differences in the share of residents living in these deserts?
3. What are the demographic and socioeconomic characteristics of people living in ambulance deserts?
4. For those living in ambulance deserts, are there other access barriers to obtaining care?

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Definitions

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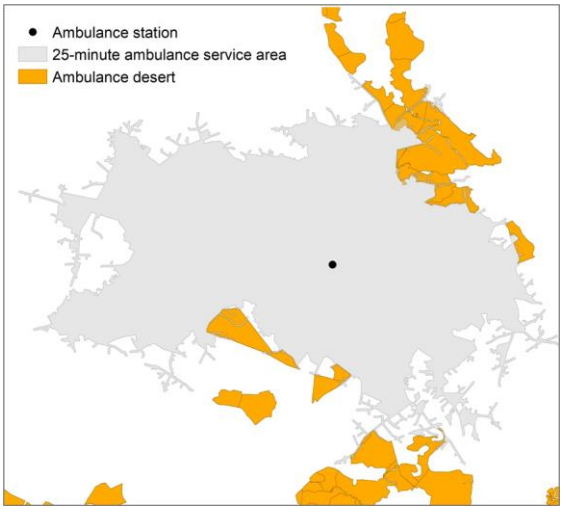
Definitions

- **Ambulance station:** The physical location of a ground transport-capable EMS service
- **Ambulance service area:** A geographic area encompassing all roads that can be accessed within a 25-minute drive time from an ambulance station
- **Ambulance desert:** A populated census block with its geographic center *outside* of a 25-minute ambulance service area



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Methods

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Methods

- **Ambulance deserts** were defined as populated areas of the state that are not within a *25-minimum minimum access standard* of an existing ambulance service.
- Created state maps in ArcGIS Desktop ArcMap version 10.8.1
- Geocoded ambulance station addresses using Esri World Geocoding Service
- Estimated 25-minute ambulance service areas using ArcGIS Ready-To-Use Services (Generate Service Areas tool)
- Mapped ambulance deserts in relation to ambulance stations and healthcare facilities (hospitals, Federally Qualified Health Centers, Rural Health Clinics)
- Analyzed county-level differences in ambulance access by rural-urban location using Rural-Urban Continuum Codes (RUCCs)

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Methods

By stratifying the percent of county populations living in ambulance deserts (ADs) into quartiles:

- We identified counties with a high (top quartile) and low (bottom quartile) percentage of their populations living within an AD.

- Comparing high AD (H-AD) rural county populations and low AD (L-AD) rural county populations
  - the socioeconomic profiles and
  - differences in their access to health care providers and facilities.

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Data Sources

- **Census block-level ambulance desert data** compiled by the Maine Rural Health Research Center
- **Cartographic boundary files** (states, counties, census tracts): US Census Bureau
- **2020 Census block-level population data:** Esri, US Census Bureau
- **Road network data**: Esri, ArcGIS Online Ready-To-Use Services
- **Rural-urban continuum codes (RUCCs):** USDA, Economic Research Service
- **Healthcare facility locations:** Health Resources & Services Administration
- **American Community Survey** five-year estimates (2016-2020)
- **County Health Rankings** (Robert Wood Johnson Foundation)
- **Area Health Resources Files** were used to describe socioeconomic and market factors associated with counties lacking adequate access to ambulance services.

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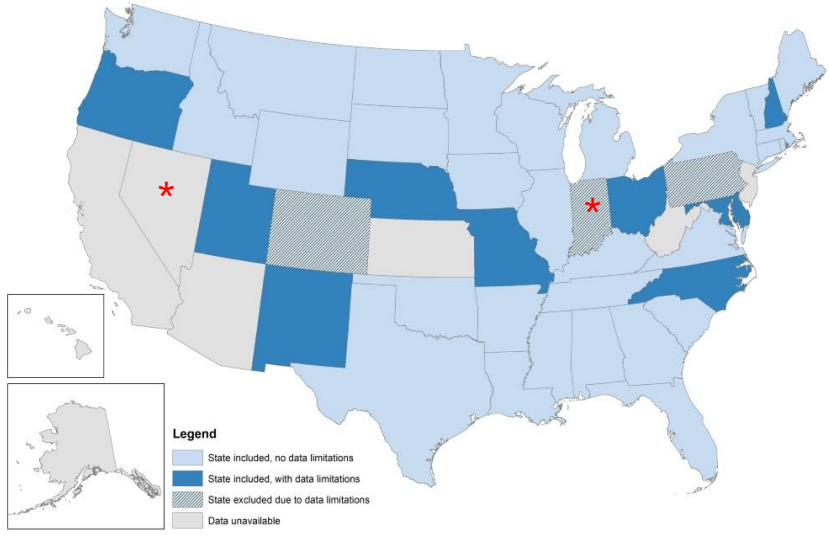
Data Collection

Data requests sent to all 50 state EMS offices.

- Data provided by 39 states
  - 29 - filled the request
  - 10 – minor data limitations
- Remaining 11 states
  - 3 - major data limitations
  - 8 - data unavailable or request denied



* Ambulance location data are now available

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Preliminary Findings

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TABLE 1. Prevalence of Ambulance Deserts in Rural and Urban Counties Across 39 States, 2021-2022

	Rural Counties	Urban Counties	All Counties
Number of counties (in 39 states)	1,662	955	2,617
Number (%) of counties with at least one AD at the census block level	1,416 (85.2%)	747 (78.2%)	2,163 (82.7%)
Percent of population living in ADs:			
Average across all counties	9.4%	3.5%	7.2%
Average across counties with ADs	11.0%	4.5%	8.8%
Total AD populations (n)	2,217,325	2,089,238	4,306,563

Notes: AD = Ambulance Deserts; All counties in these analyses are populated; only populated census blocks were included.
Population Data Source: United States Census Bureau, American Community Survey, www.census.gov/surveys/acs

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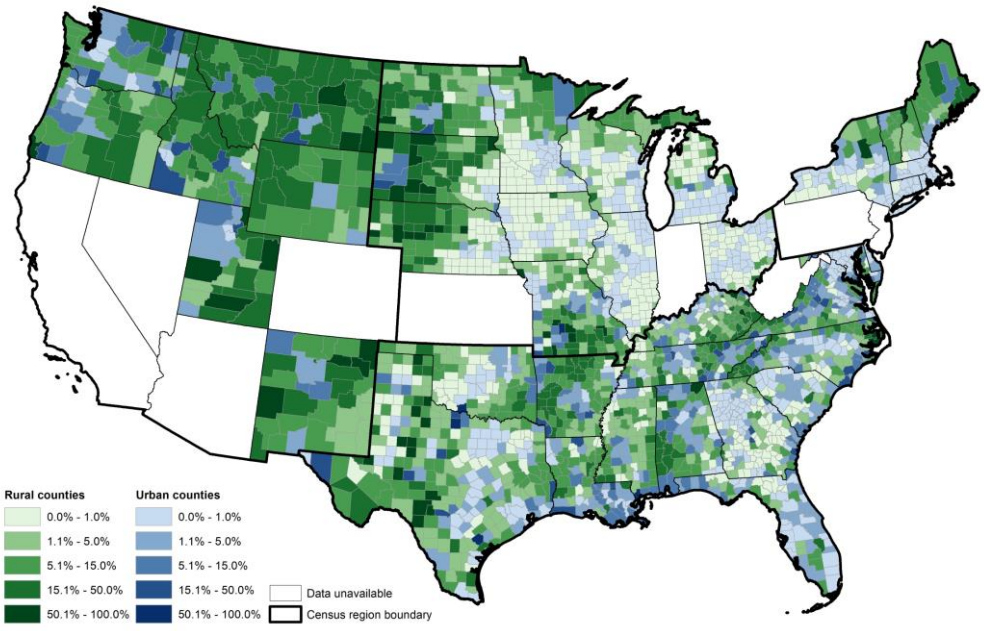
Figure 2. Percent of Rural and Urban County Populations Living in Ambulance Deserts, 2021-22



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Demographic and Socioeconomic Characteristics

After categorizing counties in high or low quartiles of their populations living in ADs:

- Counties flagged as having a high percentage (upper quartile) of populations living in ADs were more likely to be rural (83%).
- Residents in rural high AD counties tend to have higher rates of social vulnerability than residents living in rural low AD counties

Rural County Characteristics	High AD	Low AD
have smaller median populations	10,800	20,500
are more likely to be age 65 and older	23.7%	20.4%
have a larger percentage of people of color	23.3%	18.5%
have lower household incomes	$46,200	$56,300
have incomes below the federal poverty level	16.0%	14.2%
have higher rates of uninsurance	13.8%	10.0%

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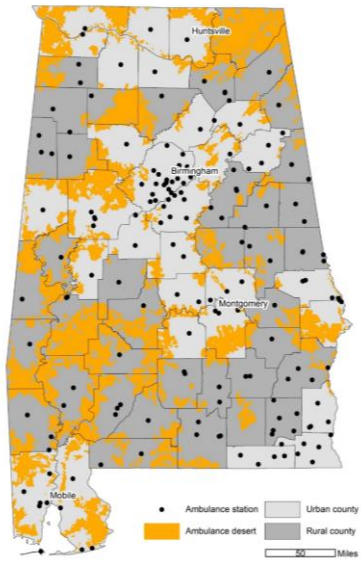
Alabama

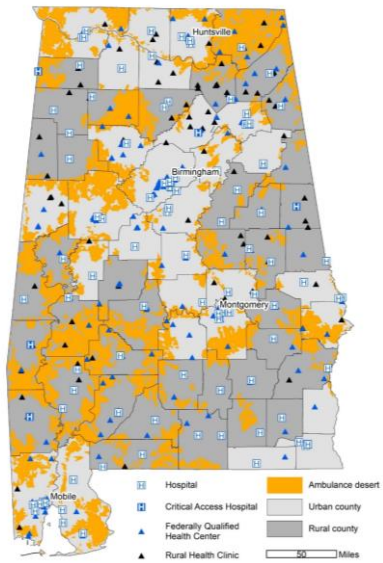
Ambulance stations	172
Estimated ambulance desert population	314,841
Total population in a desert	6.3%
Rural county desert population (% of total)	144,260 (45.8%)
Percent of rural population in a desert	12.6%

Data sources: Alabama Public Health - Office of EMS, Esri, US Census Bureau, Health Resources & Services Administration, USDA Economic Research Service

Ambulance Locations and Deserts



Healthcare Facilities and Deserts



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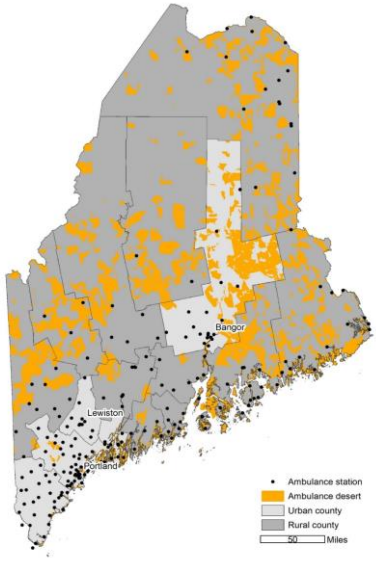
Maine

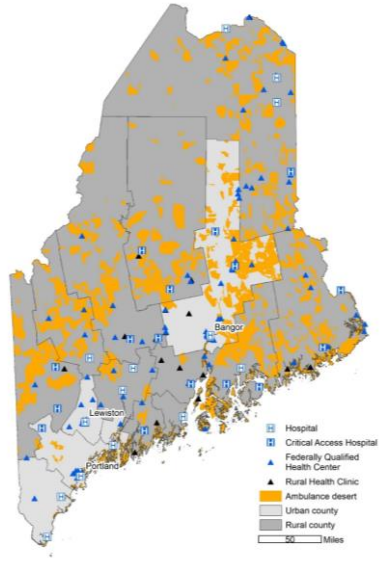
Ambulance stations	215
Estimated ambulance desert population	82,346
Total population in a desert	6.0%
Rural county desert population (% of total)	54,278 (65.9%)
Percent of rural population in a desert	9.9%

Data sources: Maine EMS, Esri, US Census Bureau, Health Resources & Services Administration, USDA Economic Research Service

Ambulance Locations and Deserts



Healthcare Facilities and Deserts



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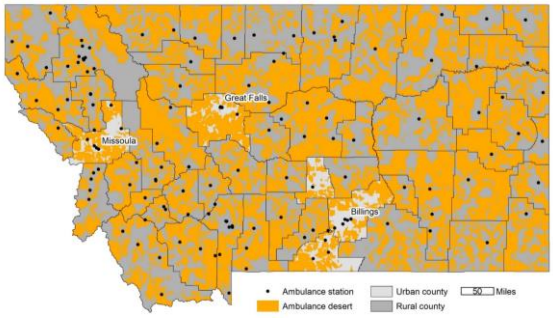
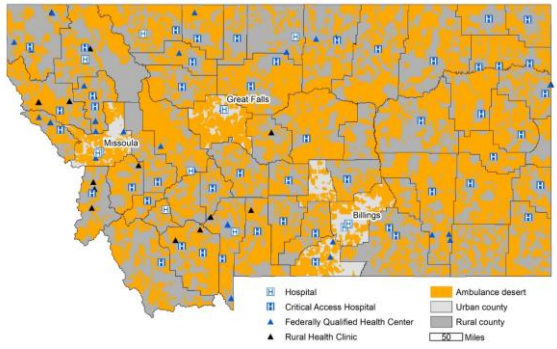
Montana

Ambulance Locations and Deserts



Healthcare Facilities and Deserts



Ambulance stations	142		
Estimated ambulance desert population	140,365	Rural county desert population (% of total)	112,824 (80.4%)
Total population in a desert	12.9%	Percent rural population in a desert	16.0%

Data sources: Montana Department of Public Health and Human Services, Esri, US Census Bureau, Health Resources & Services Administration, USDA Economic Research Service

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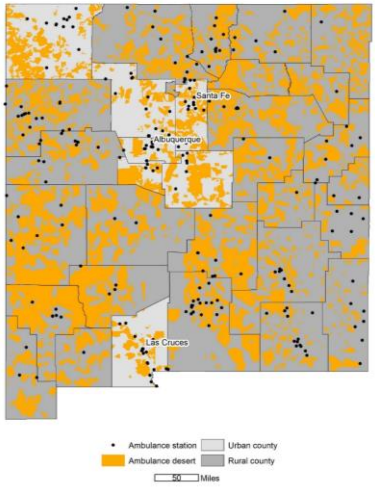
New Mexico

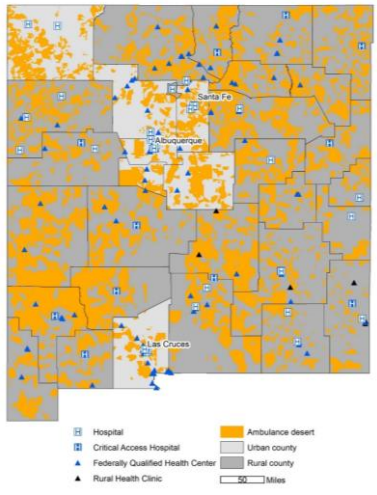
Ambulance stations	246
Estimated ambulance desert population	119,854
Total population in a desert	5.7%
Rural county desert population (% of total)	81,399 (67.9%)
Percent of rural population in a desert	11.6%

Data sources: New Mexico Department of Health, Esri, US Census Bureau, Health Resources & Services Administration, USDA Economic Research Service

Ambulance Locations and Deserts



Healthcare Facilities and Deserts



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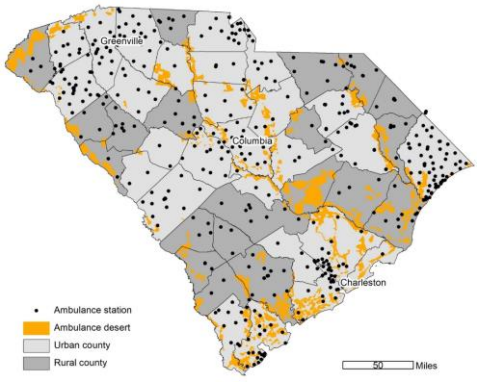
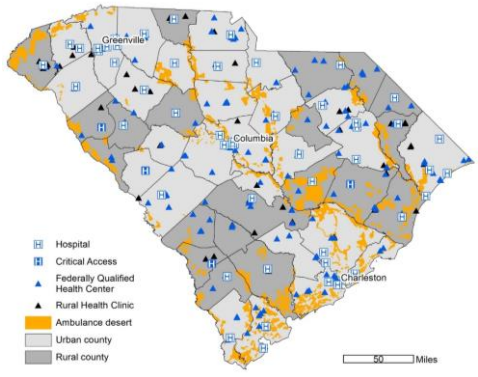
South Carolina

Ambulance Locations and Deserts



Ambulance Deserts and Healthcare Facilities



Ambulance stations	461		
Estimated ambulance desert population	83,587	Rural county desert population (% of total)	24,569 (29.4%)
Total population in a desert	1.6%	Percent rural population in a desert	3.4%

Data sources: South Carolina Department of Health and Environmental Control, Esri, US Census Bureau, Health Resources & Services Administration, USDA Economic Research Service

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Discussion/Conclusions

- A substantial majority of counties in the 39 states contained ambulance deserts at the census block level (85% in rural; 78% in urban), 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, over 56% (range 56% - 96%) of state populations living in ambulance deserts were living in rural counties.

Ambulance Desert Chartbook – tables illustrating state rankings:

- 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.

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Discussion/Conclusions

In summary:

- In the Western and Midwestern states, the prevalence of ambulance deserts appears related to sparsely populated rural areas, making it challenging to provide adequate ambulance service coverage.
- The relatively high percentages of their county populations living in ambulance deserts (e.g., 100% for all the Western states) stands in stark contrast to the relatively high number of ambulance stations per capita.
- Because the counties in these states are large (in terms of square miles) and their populations are spread out (i.e., population densities are low), ambulances are likely traveling long distances, contributing to high rates of their county populations living in ambulance deserts.

Discussion/Conclusions

- Alternatively, the relatively low number of ambulance stations per capita and high population densities are factors contributing to high numbers of people living in ADs in the South (e.g., North Carolina, Alabama, Texas, and Tennessee).
- Although the Southern states tend to have relatively low percentages of their AD populations living in rural counties, the exceptions include Kentucky (81%), Oklahoma (73%), Arkansas (66%), and Texas (56%).

Finally, the national maps highlighted the following geographic areas of concern:

- Southern states (particularly within the Appalachian region);
- Western states with difficult mountainous terrain;
- 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 ADs.

Policy Implications

- This study is the first known to document coverage gaps in the provision of ambulance services across geographic areas in the U.S.
- In light of the current funding and reimbursement challenges associated with the provision of ambulance services, policymakers may need to consider the appropriate availability of ambulance services within the existing fabric of the health care system.
- Given the higher prevalence of ambulance deserts in rural areas and the persistent threat of rural hospital closures, the need to develop funding and reimbursement strategies capable of sustaining rural ambulance services and ensuring access to emergent health care is of pressing importance.

Thank You!

Any Questions?

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UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service

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5. Wishner J, Solleveld P, Rudowitz R, Paradise J, Antonisse L. *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies*. Henry J Kaiser Family Foundation;2016.
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Summary of NACRHHS Discussions

- Ambulance service transport issues
- Business mode versus medical mode
- Low volume
- EMS deserts and impact on outcomes
- Medicare payments
- EMTs and paramedics
- Volunteer workforce
- Grant opportunities for EMS training

Discussion Areas & Virtual Site Visits

Discussion Areas

- Federal EMS Programs
- State Perspectives on EMS Access
- Tribal Perspective on EMS

Virtual Site Visits

- Provider Panel on EMS Reimbursement and workforce
  - State Perspectives on EMS Access
  - Tribal Perspective on EMS

NACRHHS Recommendations - Access to EMS

Support ongoing research on ambulance deserts and their impact on health care outcomes.

Ensure in regulations that community paramedicine providers can deliver services to Medicare beneficiaries "incident to" the services of a physician/non-physician practitioner.

Support analysis of the use of on-site and en-route telehealth in EMS for appropriate triage care to identify future policy options.

NACRHHS Recommendations - EMS Workforce

Consider CMS ground ambulance data collection in future rulemaking on the Ambulance Fee Schedule. Also consider the MedPAC study on standby costs to help inform future policy making.

Support analysis of the use of on-site and en-route telehealth in EMS for appropriate triage care to identify future policy options.

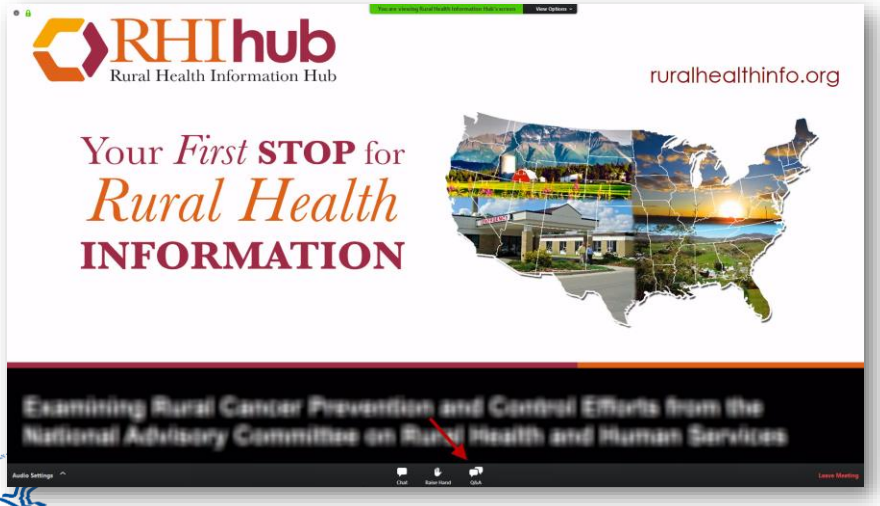
Additional Considerations

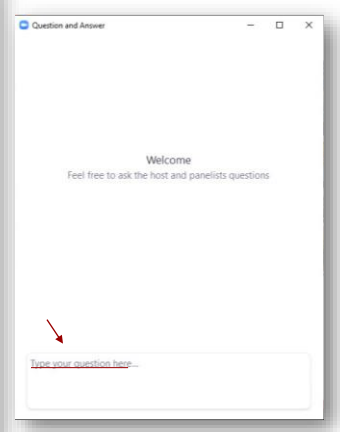
The Committee recommends that the Secretary work with Congress to…

1. Expand EMS areas into ambulance deserts.
2. Allow community paramedicine programs in rural communities to bill Medicare directly for basic chronic care management, prevention, and screening services.
3. Close the remaining 911 gaps in tribal areas.
4. Provide emergency medical service training grants.
5. Make the rural and super rural add-on payments in the Ambulance Fee Schedule permanent and give the Centers for Medicare and Medicaid Services the ability to increase adjust them in the future.

Q&A

If you have questions…





Thank you!

- Contact us at ruralhealthinfo.org with any questions
- Please complete webinar survey
- Recording and transcript will be available on RHIhub website

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Thank you!

NACRHHS website:
hrsa.gov/advisory-committees/rural-health

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Appendix

Rural Communities Experience a Variety of Challenges that Affect Access to Needed Health Care and Health Outcomes

People in rural areas live 3 fewer years than people in urban areas, with higher death rates for heart disease and stroke. Rural women face higher maternal mortality rates. Rural residents face higher rates of tobacco use, physical inactivity, obesity, diabetes, and high blood pressure. Rural populations face greater challenges with mental and behavioral health and have limited access to mental health care. Rural hospitals are closing or facing the possibility of closing and have increasing shortages of clinicians. Long distances and lack of transportation make it difficult to access emergency, specialty, and preventive care. Rural populations are more likely to be uninsured and have fewer affordable health insurance options than suburban and urban areas.

Health Center Program Fast Facts

Health Center Service Delivery Grantees and Sites as of July 8, 2021

Map of the United States and U.S. territories with blue and brown dots showing the locations of health center grantees and health center delivery sites. The map includes pull-out boxes for Alaska, Hawaii, American Samoa, Marshall Islands, Federated States of Micronesia, Northern Mariana Islands, U.S. Minor Islands, Guam, Republic of Palau, U.S. Virgin Islands, and Puerto Rico.

Legend:
Blue - Health Center Service Delivery Grantees
Brown - Health Center Service Delivery Sites

Prepared by:
Division of Data and Information Services
Office of Information Technology
Health Resources and Services Administration
Data Source: HRSA, U.S. Census
Date of Production: July 8, 2021

Data Table: Responding to Increasing Mental Health Needs

Year	In-person Visits	Virtual Visits	Total Visits	Percent In-person Visits	Percent Virtual Visits
2019	11,989,271	247,297	12,236,568	98%	2%
2020	6,795,990	7,289,339	11,328,094	48%	52%
2021	6,988,621	8,146,660	15,135,281	46%	54%

Source: Uniform Data System 2019-2021 – Table 5, Table 6B
Virtual visit data first reported in UDS in 2019

Data Table: Addressing Substance Use Disorder Needs

Category	2019	2020	2021
Patients receiving Screening, Brief Intervention, and Referral to Treatment (SBIRT)	1,381,408	1,253,127	1,484,857
Patients receiving Medication Assisted Treatment (MAT)	142,919	181,896	184,379
Providers Eligible to Prescribe MAT	7,095	8,362	8,869

Source: Uniform Data System 2019-2021, Table 6A, Appendix E: Other Data Elements

U.S. Department of Health & Human Services HRSA Federal Office of Rural Health Policy

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