NASDOH
NATIONAL ALLIANCE TO IMPACT THE SOCIAL DETERMINANTS OF HEALTH

The Honorable Jason Smith
Chairman
Committee on Ways & Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, DC, 20515

Chairman Smith,

On behalf of the National Alliance to Impact the Social Determinants of Health (NASDOH) we appreciate the opportunity to respond to the Request for Information on addressing chronic disparities in access to health services in rural and underserved communities. We are pleased to offer our recommendations on ways to use innovative care models and technology to improve patient outcomes.

NASDOH is a group of stakeholders working to systematically and pragmatically build a common understanding of the importance of addressing social needs as part of an overall approach to health improvement. We seek to make a material improvement in the health of individuals and communities and, through multi-sector partnerships, advance holistic, value-based, person-centered health care that can successfully impact the social determinants of health. NASDOH brings together stakeholders from different geographic regions with health care expertise, public health and social services expertise, local community experience, community-convening competence, business and financial insight, technology innovation, data and analytics competencies, and policy and advocacy acumen to assess and address current regulatory frameworks, funding environments and opportunities, and practical challenges to implementing and sustaining social determinants of health efforts. Our website lists all of NASDOH members.

People living in rural areas are more likely to have chronic diseases such as heart disease, obesity, and diabetes, in comparison to non-rural residents,[1] and face additional challenges in accessing health care and improving health outcomes. Issues such as hospital closures, transportation barriers, food insecurity and access to healthy foods, and availability of broadband all impact health disparities in rural communities.[2] For example, people living in rural areas often have to drive further to receive care. A study from the University of Washington found that median travel to access care for rural Medicare beneficiaries in small rural communities was 22.5 miles (31 minutes), whereas urban Medicare beneficiaries traveled 9.2 miles (18 minutes).[3] This is a substantial barrier for beneficiaries who do not have access to reliable transportation as missed appointments can result in adverse health conditions

[1] Need for Addressing Social Determinants of Health in Rural Communities: https://www.ruralhealthinfo.org/toolkits/sdoh/1/need-in-rural.
[2] Need for Addressing Social Determinants of Health in Rural Communities: https://www.ruralhealthinfo.org/toolkits/sdoh/1/need-in-rural.
[3] Ensuring Age-Friendly Public Health in Rural Communities: Challenges, Opportunities, and Model Programs: https://www.tfah.org/wp-content/uploads/2023/08/Rural_Healthy_Aging_Brief_FINAL.pdf.

and transportation can also impact decision-making about whether to make an appointment out of town or to see a specialist.[4]

Additionally, the prevalence of food insecurity, which is associated with obesity in adults and children,[5] in rural areas was 10.8 percent in 2021.[6] Although this is similar to the prevalence of food insecurity in urban areas, healthy food is less accessible in rural communities.[7] Rural populations also tend to be older, yet seniors in rural areas are less likely to be covered by innovative payment models[8] or Medicare Advantage that can provide services to address health-related social needs that are not covered by traditional Medicare.[9]

NASDOH supports the Chairman's goal of increasing access to health care services, and we also believe that reshaping our nation's health care system to reduce health disparities in rural communities must include addressing the health-related social needs and underlying drivers of poor health outcomes.

The use of community health workers (CHWs) and similar professionals is one important approach for addressing these drivers of health and improving health in rural communities. CHWs serve as the link or intermediary between health and social services, facilitating access to services for individuals and improving the quality of service delivery. This can be especially impactful in rural communities, which often face a shortage of health care providers. Research has highlighted links between clinician burnout and the ability to address patients' social needs.[10] Having a CHW to help patients with health-related social needs can reduce provider burnout, support morale, and improve quality of care for patients.[11]

CHWs not only serve as a linkage to trusted community-based organizations (CBOs) that can provide critical services that are necessary to supporting improved health outcomes, CHWs can support the work of overburdened health care providers. The Rural Libraries and Health Cooperative Agreement is one innovative model for utilizing CHWs to support improved health outcomes. The pilot program involved hiring social workers and CHWs at libraries to provide consultations, care management, and referrals.[12]

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[4] Ensuring Age-Friendly Public Health in Rural Communities: Challenges, Opportunities, and Model Programs: https://www.tfah.org/wp-content/uploads/2023/08/Rural_Healthy_Aging_Brief_FINAL.pdf.
[5] Healthy People 2030: Food Insecurity: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity#cit21.
[6] USDA Household Food Security in the United States in 2021: https://www.ers.usda.gov/webdocs/publications/104656/err-309.pdf.
[7] Food Insecurity in the Rural United States: An Examination of Struggles and Coping Mechanisms to Feed a Family among Households with a Low-Income: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9785039/.
[8] CMS Innovation Center Strategy Refresh: https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper.
[9] Medicare Advantage Enrollment, Plan Availability and Premiums in Rural Areas: https://www.kff.org/medicare/issue-brief/medicare-advantage-enrollment-plan-availability-and-premiums-in-rural-areas/#:~:text=In%202023%2C%20a%20smaller%20share,and%2053%25%2C%20respectively
[10] Annals of Family Medicine: Capacity to Address Social Needs Affects Primary Care Clinician Burnout: https://www.annfammed.org/content/17/6/487.full.
[11] Annals of Family Medicine: Capacity to Address Social Needs Affects Primary Care Clinician Burnout: https://www.annfammed.org/content/17/6/487.full.
[12] Center for Rural and Primary Healthcare: https://www.scruralhealth.org/libraries.

NASDOH members are also involved in providing services in and resources for rural communities to address non-medical drivers of health and improve health outcomes. The following are resources, models, and technologies from NASDOH members to improve rural health:

NASDOH member, **Unite Us**, is supporting an innovative rural health care delivery model in Missouri. The Transformation of Rural Community Health (ToRCH) project led by the Missouri Department of Social Services is a new model of care to direct resources to rural communities committed to addressing the 'upstream' causes of poor health through integrating social care supports into clinical care. The model is designed to maximize existing social care funding, to create new pathways to sustainability for rural hospitals, and to ultimately improve clinical outcomes, reduce rates of avoidable hospitalizations, and lower ED usage by focusing on social challenges among Medicaid recipients. The ToRCH Model relies on robust partnership across three key players in the rural community: 1) The rural hospital 2) the primary care and behavioral health clinics; and 3) The community-based organizations providing social services. These partners form local community leadership boards that identify local priorities for population health improvement. The model is supported by Unite Us, a technology company powering cross-sector community care coordination. Participants use Unite Us technologies to send and receive referrals, track referral outcomes, report on referral activity, assist with gap analysis, and manage payments to CBOs for needed social services.

NASDOH member, **USAging**, represents and supports the national network of Area Agencies on Aging that help older adults and people with disabilities live with optimal health, well-being, independence and dignity in their homes and communities. According to the 2022 National Survey of Area Agencies on Aging, 43 percent of AAAs provide social engagement programming tailored to the needs of older adults living in rural areas. The Veteran Directed Home and Community Based Service Program in Missouri provides veterans with opportunities to self-direct their long-term services and supports and continue living independently at home.[13] Veterans in the program have a flexible budget to decide what mix of goods and services best meet their needs, and they can hire and supervise their own workers. An options counselor also provides ongoing counseling and support to veterans, their families, and caregivers.[14]

NASDOH Member, **Civitas Networks for Health**, is a national nonprofit collaborative comprised of over 170 member organizations working to use health information exchange, health data, and multi-stakeholder, cross-sector approaches to improve health. More specifically Civitas HIE members are often thought of as the last mile of health data interoperability. Increased data sharing and supporting rural providers and practices with more robust health data is critical in this effort to improve overall care and access to care. Additionally, many Civitas members serve as non-profit multistakeholder collaboratives that provide technical assistance to health systems, practices, payors, and providers on matters of health care quality, cost, delivery, and

[13] National Association of Area Agencies on Aging: https://www.usaging.org/Files/AIA2018Final.pdf#page=34.
[14] Veteran-Directed Care Program: https://acl.gov/programs/veteran-directed-home-and-community-based-services/veteran-directed-home-community-based.

payment. They provide critical infrastructure in efforts to improve health and have been effective in rural health settings.[15]

NASDOH Member, **Build Healthy Places Network**, released an action-oriented guide for health care organizations wanting to pursue partnerships with local community and economic development and other sectors in rural areas and small towns to create the community conditions that support improved community health. The report focuses on strategies to support economic opportunity as a non-medical driver of health, as well as co-locating services to improve access and supporting community hubs for health.[16]

NASDOH member, **Trust for America's Health**, recently released a report on challenges facing older adults who wish to age in place in rural communities and the role that public health practitioners can play to support an age-friendly environment in those places. The report highlights a model in Mississippi, the Healthy Aging Champion Program, in which older adults receive training on common health and chronic health conditions from their peers.[17]

We appreciate your focus on addressing chronic disparities in access to health care in rural and underserved communities and look forward to future legislative action on this topic. Please consider NASDOH a resource as you navigate the federal SDOH policy space. Should you have any questions or wish to discuss our comments further, please contact Laura Pence at Laura.Pence@LeavittPartners.com.

Sincerely,

Laura Pence

Laura Pence

Director, Leavitt Partners and Advisor to NASDOH

[15] Veteran-Directed Care Program: https://acl.gov/programs/veteran-directed-home-and-community-based-services/veteran-directed-home-community-based.
[16] A Playbook for New Rural Healthcare Partnership Models of Investment: https://buildhealthyplaces.org/downloads/Build-Healthy-Places-Network-Rural-Playbook.pdf.
[17] Ensuring Age-Friendly Public Health in Rural Communities: Challenges, Opportunities, and Model Programs: https://www.tfah.org/wp-content/uploads/2023/08/Rural_Healthy_Aging_Brief_FINAL.pdf.