National Rural Health Association

March 29, 2023

The Honorable Bernard Sanders
Chair
Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, M.D.
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

Dear Senator Sanders and Senator Cassidy,

RE: Request for Information on the Pandemics and All Hazards Preparedness Act

The National Rural Health Association (NRHA) appreciates the opportunity to provide formal comments on the Senate Health, Education, Labor and Pensions (HELP) Committee request for information (RFI) regarding the reauthorization of the Pandemics and All Hazards Preparedness Act (PAHPA). NRHA applauds the work Senator Sanders, Senator Cassidy and the rest of the committee are doing to protect our nation, including the 60 million Americans that reside in rural areas, from future disasters and public health emergencies (PHE).

NRHA is a national nonprofit membership organization with more than 21,000 members, and the association's mission is to improve the health of rural Americans and provide leadership on rural health issues through advocacy, communications, education, and research. NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common goal of protecting rural health.

Legislative packages, such as PAHPA, are necessary to ensure that rural health care and public health infrastructures are prepared to combat the next pandemic. Historically, rural communities and their providers have faced obstacles to providing health care services. Many of these challenges were exacerbated by the COVID-19 PHE, making it critical that rural communities and providers are represented in the next iteration of the Pandemics and All Hazards Preparedness Act.

National Health Security Strategy

Increase rural representation in the National Health Security Strategy for 2023-2026. The Administration for Strategic Preparedness and Response's (ASPR) National Health Security Strategy (NHSS) establishes a framework for our nation to prepare for and respond to disasters and emergencies. As Congress gears up to assemble the next NHSS, NRHA believes it is important to consider unique challenges rural areas face during health emergencies such as underdeveloped health information systems, limited preparedness training and equipment, and the maldistribution of response personnel.

Health Information and Cybersecurity: Interoperability is a rural health disparity that needs to be addressed before the next PHE. Easy access to electronic health records (EHR) was essential during the COVID-19 pandemic. Due to funding restrictions and suboptimal internet access, rural providers often use outdated methods to transfer clinical information leading to gaps in care. As of 2017, only 27% of rural hospitals and Critical Access Hospitals (CAHs) were able to participate

in all four domains of EHR interoperability compared to 41% of hospitals nationwide.[1] Differences in rural and urban health information systems underscore a growing digital divide. As recently as 2021, four of the five counties with the lowest levels of broadband access in the United States — below 40 percent — are in the country's most rural areas.[2]

Although Congress has provided support to rural providers for EHR adoption, that is not analogous to interoperability. Additional funding opportunities are needed to improve rural health information systems, but these programs are only helpful if they reach rural providers on the ground who may have the resources or the technical support to apply for grants at the same rate as their urban and suburban counterparts. Without rural-specific set-aside language in these grant programs, rural providers will fail to compete against larger health systems. As rural providers are responsible for providing the health care services for 20 percent of the nation's population, NRHA believes Congress allocates an equal amount to address health care in our rural communities.

Many rural areas also lack secure internet access. According to the Department of Agriculture, approximately 22.3% of rural Americans and 27.7% of Americans in tribal areas do not have access to fixed broadband services.[3] Historically, broadband companies have neglected rural areas and there has been little investment in cybersecurity. Due to reasons previously listed, a scarcity of resources and outdated systems, make rural providers prime targets for cyberattacks. As Congress looks to revamp the National Health Security Strategy to account for mistakes made during COVID-19, it is essential that rural providers have the capacity to streamline health information and protect against cyberattacks.

Rural Disaster Planning: Efforts should focus on building up access to communication infrastructure to counteract barriers to receiving accurate and timely information, such as access to transportation and socioeconomic status. Congress should support the development of disaster plans that address the unique culture of rural communities. Resources should be allocated to identify best practices and innovative models that encourage rural residents to actively participate in disaster planning, response, and recovery, as well as research and outcomes metrics of emergency preparedness exercises, emergency preparedness response, and post-disaster assessment for recovery in rural communities.

Rural Response Personnel: It is equally important that the National Health Strategy incorporates a plan to train and mobilize a robust cohort of response personnel to care for underserved populations during times of crisis. Congress should support funding to improve the education and multidisciplinary training of rural health care workers to collaborate with local and state organizations and residents. The COVID-19 pandemic underscored a greater need for emergency preparedness training and public health professionals in rural areas. Due to a limited capacity for care and fewer response personnel, rural health outcomes continued to worsen as other parts of the country saw a downward trend in COVID-19 cases and deaths.[4] Nationwide, communities are grappling with the health care workforce crisis, but none are so affected like rural communities who were already facing pre-pandemic shortages. As of 2017, AAMC reported that an additional 14,100 to 17,600 physicians were needed in nonmetropolitan areas in order to give underserved populations the same access to care.[5] By 2030, AAMC predicts that the demand for physicians will outstrip the supply and that the United States will experience a shortage of 121,300 physicians.

Beyond physicians, it is important that all members of the health care workforce are trained in emergency preparedness including nurses, EMS, and community health workers. Community health workers are effective in improving health outcomes and they provide a range of duties such as connecting people within the community to health care. Rural communities are highly diverse with specific needs. Community health workers can act as a bridge between rural communities and health care systems, but guidelines for CHWs in disasters and emergencies would be helpful to maximize their support. NRHA believes integrating preparedness into standards of care is key to staying ahead of the curve before the next PHE.

Hospital Preparedness Program

Fully Fund the Hospital Preparedness Program (HPP) and prioritize assistance to rural health care coalitions. Since its original passage in 2006, funding for the Hospital Preparedness Program has decreased steadily, contributing to problems faced by hospitals throughout COVID-19. In FY 2023, Congress appropriated $474 million to help rebuild the program after years of underfunding. This budget will be used to increase funding to HPP cooperative agreements, improve the building capacity of HPP recipients, and address gaps in health care preparedness such as readiness of emergency medical services and medical transport systems. NRHA believes the Hospital Preparedness Program is an essential program that requires sustained funding to adequately prepare HPP partners for disasters and emergencies.

Rural health care coalitions (HCC) in particular stand to benefit from this increased funding. In 2022, the Government Accountability Office released a report that described unique challenges faced by rural HCC partners throughout the pandemic such as those related to staffing, supplies, information, and space. In general, rural hospitals struggle to remain financially viable because they tend to serve lower patient volumes and see more chronically ill patients, as well as higher rates of Medicare and Medicaid reimbursement. In the last decade, 147 rural hospitals have closed and close to 500 more are operating with negative or thin margins. Without additional support, rural facilities do not have the resources nor the capacity to respond to another PHE. NRHA urges Congress to set aside funds within HPP to ensure equity among all HPP partners, including rural HCCs. Additionally, NRHA encourages ASPR to work with state and local governments to provide technical assistance and guidance specific to rural HCCs through HPP.

Public Health Emergency Fund

Include funding for rural providers to improve their health care infrastructure.
Rural providers had their limits tested throughout the COVID-19 pandemic. One constant NRHA members expressed is the need for improved and updated facilities to accommodate safety requirements. NRHA urges the committee to include a section for hospital infrastructure so that rural providers can improve and expand their facilities. NRHA urges the Committee to model this proposed section after Section 40003 of H.R. 1848 in the 117th Congress, the LIFT America Act, which appropriates $10 billion to improve hospital infrastructure. NRHA would also request that such section be accompanied by a 20 percent rural carve-out methodology as described above.

Medical Reserve Corps

Provide flexibility for Conrad 30 J-1 Visa holders during emergencies and disasters. The Conrad 30 Program was established to address the issue of physician shortages in rural and other

underserved areas. The program admits 30 foreign-born graduate medical students to train and serve in Health Professional Shortage Areas (HPSA) or Medically Underserved Areas (MUA). To remain in compliance with their visa requirements, Conrad 30 J-1 visa holders must work 40 hours per week in direct patient care. During the pandemic, exceptions were made for telehealth visits. However, current program requirements prevent J-1 visa holders from volunteering with the Medical Reserve Corps during disasters or emergencies. J-1 visa holders are physicians with a proven interest in serving vulnerable populations, and yet they are unable to volunteer their services when the country needs them most. NRHA believes these physicians should be afforded flexibility to volunteer in the Medical Reserve Corps at times of national emergency.

Vaccine Tracking and Distribution

Conduct targeted public awareness campaigns to boost vaccination rates in rural communities. Throughout the COVID-19 pandemic, vaccination rates in rural areas were consistently lower than vaccination rates in urban areas. Evidence suggests low vaccination rates contributed to higher reinfection rates and higher death rates in rural areas during the pandemic. Rural folks are more likely to report feelings of vaccine hesitancy and they are more likely to experience structural barriers to care such as long travel distances and low vaccine supply. Misinformation and vaccine hesitancy is becoming a more significant problem within rural communities as it puts rural residents at higher risk for disease and endangers the wider population. Targeted public awareness campaigns that work in tandem with trusted community partners (I.e., school nurses, librarians, community leaders, etc.) could help to combat some of the misinformation being spread throughout rural communities.

Reinstate cooperative agreements with the border states part of the U.S. Mexico Border Health Commission. Since its passage in 1994, the U.S. Mexico Border Health Commission has experienced repeated cuts to funding and a general scale back in its authority. The commission was first created as a joint effort by the United States and Mexico to improve the health and quality of life for folks living at the border. In recent years, legislators representing border states have made efforts to revitalize this commission, especially during the COVID-19 pandemic to improve communication and resource sharing between the two governments. However, none of these efforts have been successful to date. Recognizing the disparate health outcomes experienced by folks at the border throughout COVID-19, NRHA urges Congress to reinstate cooperative agreements with border states part of the U.S. Mexico Border Health Commission.

Authorize the Office of Rural Health within the Center for Disease Control and Prevention (CDC).

NRHA applauds Congress for appropriating 5 million dollars to stand up an Office of Rural Health within the CDC in FY23. In recent years, CDC has acknowledged the health challenges and disparities routinely encountered by the 60 million Americans that call rural home. These obstacles have become increasingly evident as structural barriers to addressing rural health and safety needs have become more apparent. Prior to the passage of the Consolidated Appropriations Act of 2023, CDC did not have a dedicated Office of Rural Health to ensure rural communities are represented in their data collection and funding dissemination. NRHA strongly encourages that the Office of Rural Health will serve as the primary point of contact in the CDC on matters of rural health by:

- Assisting the CDC Director in conducting, coordinating, promoting, and disseminating data and researching public health issues affecting rural populations;
- Working across CDC to develop, refine, and promulgate policies, best practices, lessons learned, and coordinating successful programs to improve care, services, and social determinants of health for populations who reside in rural areas of the United States;
- Conducting, supporting, and disseminating rural health research, educational outreach, and evidence-based interventions to promote healthy behaviors, prevent death, disease, injury, and disability among rural populations;
- Identifying disparities in the availability and accessibility of health care and public health interventions for populations living in rural areas; and
- Administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support improved health and healthcare in rural areas.

Provide a rural set aside for all grant programs and supplemental appropriation funding included in the package.

Rural providers are responsible for providing the health care services for the 60 million rural Americans, accounting for 20 percent of the nation's population. NRHA believes it is imperative that Congress ensure funding be specifically allocated for the health care providers in our rural communities. As the Committee looks to equip health care providers with the resources needed to combat future pandemics it is critical that rural providers have adequate resources to address public health disparities.

Prioritize assistance to rural clinical laboratories at risk of closure.

Rural clinical laboratories face problems similar to rural hospitals, putting them at risk of closure. In 2014, Congress passed the Protecting Access to Medicare Act (PAMA) to update data reporting requirements and payment methodology for clinical laboratories. The data was collected to reform the Clinical Laboratory Fee Schedule (CLFS) to a single national fee schedule, but the data sampling came only came from 1,942 labs out of more than 250,000. The new schedule cuts Medicare and Medicaid reimbursement rates by 15% placing an undue financial strain on rural clinical laboratories who serve lower patient volumes and more patients enrolled in Medicare and Medicaid. Congress has delayed cuts to reimbursement twice during the COVID-19 public health emergency, but these cuts finally went into effect on January 1, 2023. These cuts to reimbursement will have devastating effects to rural clinical laboratories. As Congress looks to strengthen our nation's response to and preparedness for disasters and emergencies, it is essential that Epidemiology and Laboratory Capacity (ELC) grant program receives sustained funding and prioritizes assistance to rural areas. NRHA believes the flexible funding ELC provides to recipients can be used as lifelines for our rural laboratory facilities.

Rural Children's Health

Children are the most vulnerable population in society during an emergency. Natural and mad-made disasters have long lasting impacts on children's mental health and psychosocial well-being. While the U.S. invests billions of dollars to support emergency preparedness and response, very often children's needs are overlooked. Children and families living in rural America are more likely to face a climate related emergency and yet have less access to immediate and long-term

mental health and psychosocial support in their communities. It is crucial that adults who care for children at schools and childcare are trained in trauma informed care to provide supportive services before, during and after disaster rather than relying exclusively on the traditional clinical approach of triage and referral.

NRHA urges the House Energy and Commerce Committee to reauthorize the Children's Preparedness Unit (CPU) as it serves a key role in protecting the lives of children in an emergency. Additionally, NRHA recommends the full integration and utilization of the Technical Advisor to evaluate the impact of family isolation on displaced children and families during and following a disaster. Further, the association urges the House Energy and Commerce Committee to reauthorize the National Advisory Committee on Children and Disasters at the full amount and renew the statute for 5 years.

NRHA appreciates the work the Senate HELP Committee is doing to ensure the American health care infrastructure is prepared for the next PHE. NRHA looks forward to our continued collaboration to ensure rural providers are prepared for future crises. If you have any questions, please contact Kristen Batstone (Kbatstone@ruralhealth.us).

Sincerely,

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