



SORH COVID19 Learning Community Notes

Call Date: May 21, 2020

National Organization of
State Offices of Rural Health

NOSORH Updates

- FORHP announced \$225 million for RHCs/ comes out to a little less than \$50K for each facility. Tammy shared information on the FAQ and terms and conditions.
 - IN noted that a few RHCs in their state had used a system EIN instead of individual EINs, and some were showing as duplicates.
- J-1/Conrad 30 update – May 11th guidance came out; Telehealth is allowed (May 11th forward) if providers are located in a HPSA or providing care to a HPSA, and those who were unable to maintain 40 hours are exempt from penalty during the emergency declaration. Providers may **NOT** be transferred to a high need area during the pandemic.
- Our partners at the Telehealth Resource Centers pulled together a great [Cardiac Telerehabilitation Weblogography](#) full of links to lots of information.
- FMT will be soon releasing a survey for Flex programs; please be on the lookout for that and be sure to complete one response per state.
- [Data Resources for Responding to the COVID-19 Pandemic in Rural Communities](#) listening session from yesterday is now on the NOSORH website under Past Event Materials

Rural Challenges and Concerns

- RHCs concerns on July 1 funding will dry up; ratio of those not returning for routine care out of fear will reduce revenue
- ND – rural nursing director call; reliability of testing is a concern; some may only have a 50% efficacy rate; IN has seen this as well. Noted that on the CMS call this is a systemic issue, not just rural
- OH is pushing out studies related to the various testing mechanisms. Some tests are better than others – SORH noted that it's partly whose producing it, the reagent and even how far back the swab is put into the nasal cavity.

Identified Rural Strategies

Of the regulatory changes that have occurred, what do we recommend regulators consider extending beyond the pandemic to enhance access to care for rural communities?

- Several offices noted the continuation of payment for telephone consults, as this has been tremendously helpful to rural primary care providers. In RI, BCBS has extended this out until the end of July.
- Increasing joblessness and reduced access to health coverage, particularly in non-expansion states. What does this mean for social safety net programs and/or Medicaid expansion?
- NH commented on how FORHP was helping programs get ahead of vulnerable hospitals that may be at-risk of closure. Appreciate FORHP taking this proactive step!
- Productivity standards in RHCs – cost reports are going to be off and may create penalties. ND noted they were talking with CAHs and RHCs about the issue and plan to move forward with a proposal to their legislators
- Scope of practice expansion for NPs and PAs



- Provider licensing reciprocity across state borders for telehealth
- RI noted that they still have a large number of solo and duo primary care practices, they're concerned that this may cause the collapse of the primary care system in the state if support isn't provided.
 - Age of the providers is a concern – how many would rather retire than have to change everything they do? How has the pandemic changed their minds?
 - And will this impact recruitment? If a provider can get out to rural now, and offer telemedicine/work from home, will this help us?!

Needed Rural Resources

How do you see your office needing to shift future work to focus on the 'vulnerabilities' exposed in your state?

- CO noted that for some programs, funding is just gone. So, they're looking at ways to fund programs, increase revenue and provide virtual options.
- ND is looking at different ways to identify need/provide TA to RHCs (most in the state are provider-based already); reaching out and networking more with rural public health (early stages)
- MT is taking their annual meeting virtual but concerned about how that will continue to be a revenue generator – especially with sponsors; and how does a loss impact other programs for the office?
- OH noted that the relationships have been key to their success – quick responses from CAH administrators because they'd built close ties over time. Was beginning to build with rural LHDs and RHCs but now that they can't do site visits it's harder to cultivate those relationships. Need to figure out how we build that strong relationship without the face-to-face piece.
- NV noted a crisis is an opportunity; as rural communities struggle with joblessness, loss of health coverage, etc. are we ready to be at the table?
 - ND added that the old focus of SORH on community development and community engagement may be re-emerging as a major theme.

What support might you need in accomplishing this? (not financially limited)

- SORH discussed the importance of some new partners and affiliations, including:
 - Relationships with the SBA
 - How to build relationships with LHDs when the SORH isn't in the state health department; and vice versa – how can state-based SORH support academic/non-profit partners.
 - VT noted that it's a strategy of NOSORH's Board to be building these connections. Teryl has been making those connections to partners; if you have connections with pertinent groups, please pass along contact information.

Concerns about federal programs



- SORH are stating that the issues are not so much about federal programs, but about the uncertainty within each state. Lots of the strategy will be about capacity/resources but depends on how COVID-19 is done.

Next week: discussion on those state-based issues people are dealing with – bring your topics and see if other states have found a way to navigate them.