

January 30, 2023

**Testimony to Senate Human Services
SB 2155
FQHC and Study**

Chairman Lee and members of the Committee. Thank you for accepting my testimony on SB 2155. I am Brad Gibbens, MPA, Acting Director and Assistant Professor, Center for Rural Health (CRH), UND School of Medicine and Health Sciences. The role of the CRH is to work with rural communities to improve access to community health services, improve population health, and to assist rural communities in building their capacity to meet local needs. Rural health is vital to rural community independence and survival as it contributes not only to the health of individuals and overall population health, but also as a significant factor in the economic, social, and cultural dynamic of the rural community. While we operate through a number of programs two primary program areas are the State Office of Rural Health (SORH) and the Medicare Rural Hospital Flexibility Program (Flex) which also includes the Small Hospital Improvement Program (SHIP). These are supported by federal funds from the Health Resources and Services Administration. Flex works directly with Critical Access Hospitals (CAHs) providing technical assistance, education, assessment and planning, resources, and other services. This now includes an education process to explore a new federal hospital category called the Rural Emergency Hospital. Under Flex, we have created the CAH Quality Network (all 37 CAHs belong) to improve patient quality and safety and a separate Rural Health Clinic Network meeting the needs of the states 54 federally certified RHCs. The SORH provides necessary resources to CRH to facilitate our work with a range of health and community organizations including public health, EMS, CHC, nursing homes, schools, economic development, tribal health, aging services, and others. The CRH also has programs and services to address health workforce, behavioral and mental health, and Native health and aging (e.g. the National Resource Center on Native American Aging). We work closely with the ND Department of Health and Human Services on behavioral health, community care services development, and health workforce, to name a few. Much of our work is in the area of service development (including grant development), assessment, planning, facilitation, education, and connections to other resources. CRH is also home to the national Rural Health Information Hub (RHI Hub) which is essentially a national resource center for rural health and the Rural Health Research Gateway (both HRSA supported)

The rural health landscape has numerous provider groups/organizations, some private and some public that are viewed as “safety net” providers which includes community health centers, rural health clinics, Critical Access Hospitals, and public health. Rural EMS is a particular focus. In general, virtually all rural health organizations exist in a turbulent and fast changing environment. We recognize the American health system is changing as we move from a volume-based system (i.e., payment associated with delivered services) to one based more on value (payment associated with outcomes and performance). This is a significant and complex change. CRH is actively engaged with others in developing a pathway to value for rural providers. There are population/demographic, financial, workforce, regulatory, and other environmental factors that influence organizational viability. Thus, they also impact the entire rural community. Ultimately, all of these community organizations strive to provide the best services they can to improve the health of their populations. Building local capacity to make rational decisions is fundamental.

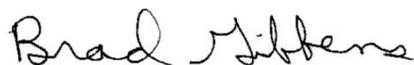
Community Health Centers are essential providers and it is positive to stabilize their viability. On a personal note, I have had the opportunity to work with our local Grand Forks CHC, Spectra Health on their commendable work to be part of our Grand Forks efforts to address homelessness. My church has been able to provide emergency funds to Spectra to help keep some families in their homes. That is a good example of addressing population health and the social determinants of health. For my church this is an opportunity to be a partner to a worthy community effort. CHCs expand their impact via community partnerships. I greatly appreciate and admire the use of a sliding fee scale as a way to provide primary care, oral health, and mental health services to financially vulnerable individuals and families. Community Health Centers are critical providers.

I do have some concerns with the legislation. While CRH works with and supports CAHs, RHCs, and CHCs it is clear they are different models and the needs of one may conflict with the needs of others. We must acknowledge this. Sometimes there is collaboration and an understanding to work together for the good of the community; however, there have been times where there has been organizational conflict. Some years ago, CRH worked with a few communities to build consensus as there was turbulence involving CAHs and CHCs. Please understand it is natural that some providers (e.g. hospitals and RHCs) question the use of state funds to support one type of health organizational structure (CHC) in expansion into their traditional markets. This perspective has been presented to me. Health care is by nature a competitive operation and we have witnessed this with larger health systems expanding into a community that has its own health system. We accept this as it is part of how private health organizations expand. It is an example of health care capitalism and we tend to view competition as positive. The difference may be that that competition is part of the private market and does not involve public dollars supporting one of the structures. We risk duplicating services in small markets that struggle to maintain what is already present. We are at a juncture nationwide where we now see non-health organizations (e.g. Walmart, Amazon, Target, and others) entering and providing direct patient services. Many traditional health systems feel that pressure. The world is changing.

I am offering these insights less as objections than as additional factors to consider. Cautionary considerations. In my almost 38 years in health care I have seen many successful efforts (and failures) to improve access to care. By-in-large collaboration between groups is the best means to meet community health needs. I think we all want to avoid unnecessary conflict. All the provider groups are sincerely committed to improving access, improving health status, and community viability. In terms of assessment activities, I would recommend “put the community first.” That is the goal. Different structures can work together when offered the opportunity to do so. An assessment process that is inclusive of all local providers and community representatives, having them at the table for discussions, considering their unique contributions, taking time to understand different positions, and considering overall implications can make a significant community contribution.

In conclusion we hope and trust that a process can be developed that is based on collaboration and inclusivity rather than competition to meet unmet community health needs and to avoid duplicative effort.

Thank you,

A handwritten signature in black ink that reads "Brad Gibbens". The signature is written in a cursive, slightly slanted style.

Brad Gibbens, Acting Director and Assistant Professor