Summary Report
from
Rural Public Health: A Path Forward Oversight Hearing

Friday, October 18, 2019, 11:30 a.m. - 3:30 p.m.
The John W. Olver Transit Center
12 Olive Street, Greenfield, MA 01301

Hosted by
Joint Committee on Public Health
Rural Caucus
Franklin Regional Council of Governments
Baystate Health
Cooley Dickinson Health Care

Summary provided by
Maria Polino, MPH candidate, UMass Amherst

View the full hearing:
https://senatorjocomerford.org/rural-public-health-a-path-forward-oversight-hearing/

This is not a verbatim report, but a summary of remarks made at the oversight hearing. If you have any edits or additions, please email Sam Hopper at samantha.hopper@masenate.gov.
Opening Remarks

Welcome and thank yous

- Senator Jo Comerford, Hampshire, Franklin, Worcester district, Senate Chair of the Joint Committee on Public Health

Senator Comerford welcomed all to the rural public health hearing and emphasized how happy she is with the dedicated focus and large turnout regarding an important topic such as rural health. Senator Comerford recognized and thanked Representative John Mahoney, Chair and public health partner on the Joint Committee on Public Health. Rural health is critically important in western Massachusetts and in the Commonwealth, and by holding today’s event, the leadership in the House and Senate in Boston can focus on ideas and challenges facing western Massachusetts. This forum provides a lens to which the appropriate governing bodies can use to focus on rural public health in western Massachusetts. The Senator thanked all who travelled to Greenfield as well as those who were watching in Boston. Referring to the Agenda for this meeting, Senator Comerford introduced all panelists, discussed the format of the forum, and introduced Linda Dunlary and Phoebe Walker.

Introduction to the Rural Policy Plan

- Linda Dunlavy, Executive Director of the Franklin Regional Council of Governments (FRCOG), Chair on Rural Policy Advisory Commission (RPAC)
- Phoebe Walker @FranklinCOG, Director of Community Services, Franklin Regional Council of Governments

Linda Dunlavy & Phoebe Walker: Why are we here? There are 170 rural communities in the Commonwealth with the Massachusetts Rural Commission contributing to the Rural Health Policy Plan. Rural health hearings like this help aid in making decisions on what we hear today. Even though western Massachusetts might be small in numbers, questions asked and collaboration among the panelists will make a mighty impact in Boston. All questions and comments are welcomed, and the five panels will be live streamed from the Senate page and on social media platforms such as Twitter. The discussion will involve the Rural Advisory Commission and the Rural Platform.

Linda Dunlavy: The Rural Policy Plan prepared by the Rural Policy Advisory Commission has been created to enhance the economic vitality of rural communities. According to the USDA, “rural” is defined as space consisting of open countryside with population densities less than 500 people per square mile and places with fewer than 2,500 people (ers.usda.gov). Berkshire County, Franklin County, and the Cape all have declining populations in the state and the median household income is higher in the eastern part of the state. Franklin County has the lowest average wages in the state and the housing costs are lower. Rural costs are higher for transportation, where rural households spend about 54% of their total income on housing and transportation in comparison to the rest of Massachusetts. The Rural Plan describes assets, challenges, and best practices in Massachusetts along with action oriented recommendations for policy.
13 regional planning agencies received funding to create this Rural Policy Plan, where 25 stakeholders met across 15 different focus areas. The Rural Policy Plan was released in the State House on October 2nd.

Rural Health Assets:
- Outdoor recreation, tourism
- Small scale farming, rural agriculture
- Local food and craft beverage production
- Strong small businesses and local economy

Rural Health Challenges:
- Demographic trends, population decrease, aging in western Massachusetts
- Reliance on road and bridge infrastructure
- Funding formula the state uses (based on population) does not accurately represent the areas served
- Lack of accessible career centers
- Limited, older rental/housing stock
- Lack of municipal state funding
- Difficulty being competitive when applying for state grants
- Not all rural communities face the same challenges

For complete information on the Rural Policy Plan, please refer to:

Phoebe Walker: Confirmed the above list of assets and challenges in rural areas. There is a major shortage of healthcare providers along with a quickly aging population and an increase in opioid use in this area. There is a higher rate of opioid overdoses in Franklin County than in Boston, with the opioid crisis hitting the area harder than the eastern part of the state. There are challenges in infrastructure and funding for improvements. Emergency medical response is a crisis in some rural areas. There are higher rates of mental health issues, substance abuse and domestic abuse in rural areas. There is a higher suicide rate in western Massachusetts compared to the eastern part of the state. The public health recommendations from the report were discussed at length, and consist of a number of steps:

1. Pass currently filed state legislation to improve rural health and healthcare
2. Fund initiatives to improve the healthcare infrastructure and public health of rural residents
3. Allow Nurse Practitioners to practice without the oversight of an MD
4. Fully fund a Rural Healthcare Workforce Student Loan Repayment Fund (for example, it is difficult finding medical providers to move to rural communities)
5. Provide incentives and reduce barriers to access workforce training for all levels of rural healthcare workers
6. Designate rural healthcare practices as “Critical Access Providers”
7. Reduce the cost of DPH Community Paramedicine certification
8. Encourage towns to increase the use of Community Compact funds to begin Age-Friendly Community Planning (for example, Deerfield is creating age-friendly planning and is trying to find ways to make the community better for its older residents)
9. Be sensitive to the geography and population density of rural areas when developing public health grant program requirements (have greater flexibility when holding trainings/meetings with proximity in mind for those travelling from rural areas)


Panel 1: Addressing Rural Health Disparities, Part 1

Speakers

- **Clare Higgins**, Executive Director, Community Action Pioneer Valley
- **Dr. Kinan Hreib**, Chief Medical Officer, Baystate Franklin Medical Center
- **Heather Bialecki-Canning**, Executive Director, North Quabbin Community Coalition
- **Ilana Steinhauer, FNP-BC**, Executive Director, Volunteers In Medicine Berkshires
- **Cheryl L. Dukes** (we, us, ours; she her, hers)@UMASSWalker, Director of Healthcare Outreach and Community Engagement, UMass Amherst College of Nursing

**Clare Higgins:** Discussed the Franklin County forum on homelessness. There is disparity that leads to challenges that affect community health outcomes. The cost of housing and transportation is a big issue, where 64% of income in Franklin County is spent on those costs alone per household (compared with 45% in Suffolk County). What is left per month when most of your money has to go to housing and transportation costs? western Massachusetts is home to the 4 poorest counties in Massachusetts; Franklin, Hampden, Berkshire, and Hampshire. An increase in funding allocation is needed at the state level to address the cost of transportation and services. Most people are 20 miles from the nearest WIC program and public transportation is not accessible by many in Franklin County. In Suffolk County public transportation is accessible to many for work. There are public health implications due to transportation issues. Due to the lack of public transportation, there is an increase in greenhouse gases. There also needs to be a focus on carbon neutral transportation.

**Dr. Kinan Hreib:** There is a general consensus among the medical community that people in rural areas suffer from lack of access to healthcare. It costs $1,000 extra in rural communities where incomes are lower. There is increased poverty and a decrease in access to food. How do we provide access to rural areas? There are rural models that have been tested based on outreach programs that are successful. There are many reasons why people are unhealthy, and smoking happens to be the leading cause of preventable death in Massachusetts. Massachusetts is one of the wealthiest states in the Union and is ranked second in health care outcomes except in rural Massachusetts.
**Heather Bialecki-Canning:** As the Executive Director of the North Quabbin, Ms. Bialecki-Canning thanked emergency services for all that was provided during the recent bad weather. 6 out of 9 towns were still without power, but the people of western Massachusetts are strong and have a pioneering spirit. Listen to the constituents because they know what works for their communities. Using a local example to highlight the challenges people face out here, a young mother was described as having a young school aged child and a toddler. She has no car, pays for her apartment with a housing voucher and works at Market Basket in Athol but it doesn’t pay well. She does not earn a living wage, but is grateful for the employment because she was formerly incarcerated for drug use. She attends recovery meetings, and works nights and weekends to make ends meet. Transportation is a barrier to getting to work because she doesn’t have a car, and relies on a nurse who volunteers to drive her so she can provide for her family and attend recovery support. She, like many others, has a tough quality of life. There needs to be better infrastructure around working people like her to improve their quality of life. Transportation is crucial and is sparse or non-existent in these areas.

**Ilana Steinhauer, FNP-BC:** Volunteers in Medicine in Berkshires, where there is a staff of 10 and about 60 volunteers. Free medical/dental/optical/social determinants of health programs are offered. Described rural health as it relates to undocumented immigrants, which is the only growing population in these areas. There has been an increase over 50% of patients who are immigrants who have lower education, and their health is impacted by being uninsured. 18 and older do not qualify for healthcare in the state. There needs to be more flexibility among providers, and the broad based community needs greater funding. There is a critical access designation but the community's health has to be based off of preventative healthcare. State investment needs to be on working models with the implementation of new programs to decrease poor health outcomes. Data collection has been hindered due to “no show rates” because of fear of driving while undocumented. The Berkshires are also seeing an increase in elderly retirements. There is an urgent need for free services for the uninsured and there needs to be more money invested in these areas. Make it easier for those who want to volunteer in regards to licensing. Increase funding for interpretive services. Support legislation for MassHealth and licenses.

**Cheryl L. Dukes:** Cheryl L. Dukes was invited to present for Panel 1, and “is present but not here.” Ms. Dukes will be represented as “Death” for the purpose of this discussion. There is a lack of diversity in this forum on Rural Health, with few people of color included in the discussion. Race and time is a social construct and structural concept created by historically white male landowners. Racism exists because we continue to allow it to exist. Indigenous Native people should be included in discussions such as this. There needs to be more people of color included and leading the discussion on how we can help care for the rural health of people of color in these communities. The question needs to be asked “how can we expand on culturally informed care in rural areas?” Diverse, underrepresented groups have been historically excluded from discussions on healthcare. If we want to address health disparity, we must have all groups represented.

**Panel 1 Question/Answer**
● Comments from Senator Comerford: Thank you to all the panelists. We need to be representative and inclusive, and there have been issues that have been siloed in the past. We need to be more clear about whose land we are on, and it is not always easy to occupy space. Thank you again for leading this discussion.

● Question from the audience: Rural healthcare costs about $1,000 more?
  ○ Answer from Dr. Hreib: 1) Out of pocket expenses add to this, because the insurance market is different in rural parts of the state which affects coverage. 2) Most patients don’t reach out for medical help until time goes on and the disease has progressed. The cost is 6 times higher to visit the emergency department (ED) than it is to go see your primary care provider. Patients go to the ED because they can’t get to their primary care provider. Transportation and proximity is a real issue.
  ○ Answer from Heather Bialecki-Canning: Access to primary care instead of specialty care is an issue. It is very difficult to reach your primary care provider because they are rarely accessible. Travel costs and overall logistics are high.

● Comment from Representative facing the Panel: Thank you for sharing with us this information. The presentations about transportation issues, perspectives and stories gives us information as legislators on how to best advocate for rural health in Boston.

● Comment from Senator Comerford: Currently, there is a Bill that is addressing changing the State Seal. Immigrants should be able to work with their license at the best of their ability. Mindy Domb has cosponsored a Bill on practicing healthcare and licensing with immigrants, and we need advocacy from western Massachusetts to make it happen.

Panel 1 Common Themes
There is a problem with accessibility to healthcare in the rural areas in western Massachusetts. It is critical that more funding is put into rural areas for transportation and healthcare. There are a lack of accessible providers, high transportation costs with little to no bus service, and low incomes. western Massachusetts has 4 out of the 6 poorest counties in the state and require more funding. Communities in the western part of the state deserve the same access to services and providers that the eastern part of the state has. State funding is currently inequitable based on population and geography. Infrastructure needs to be a priority out here with increased state funding.

Panel 2: Addressing Rural Health Disparitie, Part 2
Speakers
● Kat Allen, Co-Coordinator, Communities that Care Coalition
● Debra McLaughlin, Coordinator, Opioid Task Force of Franklin County and the North Quabbin Region
● Ed Sayer, Chief Executive Officer, Community Health Center of Franklin County
● Peg McDonough, Planner, Berkshire Regional Planning Commission, Age-friendly coordinator
Kat Allen: There are strengths in these rural communities. The Communities that Care Coalition has been operating for the past 17 years, where the group was formed with the mission of improving the health and wellbeing of the area youth, by increasing nutrition and decreasing drug and substance abuse. There is a vaping epidemic and the area has an opioid crisis along with high marijuana use. We impart healthy decision making and follow evidence based programs to reduce youth violence and substance use. There has been a reduction in substance use among the youth over the years, and that is community driven along with effective policies and programs. We utilize working groups and evidence based strategies based on local data and national research. Our work involves collaborating with schools, providing a life skills curriculum, evidence based parenting programs, and we participate in social norms marketing campaigns. The coalition hosts a variety of programs and practices by range of institutions in the community. There has been a dramatic decrease in youth substance abuse across the region, and we are helping to reduce disparities. Massachusetts is one of only six states that spends none of its' own state money on prevention. Of the $240 million in the Bureau of Substance Addiction Services budget, only $8 million is spent on prevention. All of this $8 million that the state spends on prevention is from the federal Substance Abuse Block Grant. Massachusetts only spends the 20% minimum of the Block Grant required by the federal government. Massachusetts also has no statewide prevention association, which is a significant gap and means that prevention is often left out of important state-level conversations. The new Medicaid Waiver will cover treatment services that are currently being paid for out of the federal block grant. This means that now is a very good time to increase (at least double) the amount of money from the block grant that goes to prevention, in order to fund existing community coalitions at higher levels, to fund more community coalitions in Massachusetts, and to fund a statewide coalition association.

Debra McLaughlin: Opioid use is a big issue out here. There have been a record number of overdose fatalities in the region. There is intersection between public health and community health in relation to recovery. There are multiple stages to recovery and relapse. Even with multiple attempts over the years, people still need housing and jobs. There are methadone deserts in the region, and methadone clinics are closed to new patients. There needs to be access in alignment with funding and services, and we need to examine insurance and regulatory services. We can provide specific recommendations on how to do this. If patients are provided for, there will be a reduction in emergency department visits which will save money overall.

Ed Sayer: In rural areas, there is a smaller tax base, lower incomes, and an increase in suicides and domestic violence. There are problems specific to rural areas, such as physician shortages and fewer hospitals. There are fewer people out here. Allow Nurse Practitioners to practice at the top of their license without physician oversight. We need to attract and retain healthcare staff out here, and we can do this if we have student loan forgiveness. Family Medicine Residents at Baystate Medical Center did not get the funding for student loan forgiveness to work in rural Massachusetts. Telehealth will become important to primary care physicians, and there needs to be a big commitment to rural healthcare and oral health care. Baystate Medical Center is concentrating on oral health as the demand for oral healthcare is high in this area.
The large majority of oral health patients are underinsured or on Medicaid. People with the means to do so find treatment, but the rest cannot. There needs to be a focus on building on the capacity of what we have, and a way to expand supplemental health care services.

**Peg McDonough:** An action plan is currently being created for the aging in Berkshire County. Berkshire is the second oldest county in the state under Cape Cod. Transportation has always been an issue, as is access to health care. There has been a cultural shift within the north and south parts of the county. There is a collective community impact model involving many across the county, with various community meetings at the local level. Unfortunately, “age-friendly” is not included in the collective impact model. There needs to be more transportation and more transit providers, but there are challenges due to legislation. Rural transportation has to be a priority in legislation.

**Linda Sarage:** Discussed the Recovery Coach Program: What are Recovery Coaches and how the providers are trained? Recovery Coaches are trained according to a specific model and the program is given through Westfield State University. Recovery principles were discussed along with ethics training. Recovery Coaches can volunteer or be hired, and can be certified in Massachusetts. The certification program involves 60 hours of training and 500 hours of supervised Recovery Coach experience to be certified in Massachusetts. There is a lot of opportunity in rural Massachusetts, including the cities of Springfield, Northampton, and Pittsfield. There is a Recovery Coach program in North Adams, where Recovery Coaches “train the trainers” and is a peer to peer recovery model. There are programs that are HRSA (Health Resources and Services Administration) funded, and in rural Massachusetts, there are funding requests that are not receiving funding due to not matching all of the requirements. These programs do not need the full funding to be operational in these rural areas. The peer recovery centers in rural western Massachusetts can operate with less money.

**Panel 2 Question/Answer**

- **Question from member on panel:** Why is DCF in a white bubble (referring to visual slide graphic)?
  - **Answer from Linda Sarage:** Because DCF is so involved in all that needs recovery, we need them to be an ally and not be seen as the enemy.
  - **Answer from Debra McLaughlin:** I am on the Board of DCF and can tell you we would like more support.

- **Comment from legislator:** We have a vehicle we all identify in each session.
  - **Senator Comerford interjects in agreement, “the Governor just put out his Health Plan Policy today”**
  - **Legislator nods in agreement, and continues:** We should use this moment and use this vehicle to have real opportunity on what we want to change.

- **Question from panelist:** To what extent do we need to shift the formula for DCF funding or a clear agenda for adding a rural agenda? We need to be clear.
○ Answer from Debra McLaughlin: Thank you for looking at the education formula. It would be great if the same attention was given to looking at rural health services and the population for funding. Set aside money to be more considerate of rural funding.

○ Answer from Peg McDonough: There are grandparents raising grandchildren...some are losing their senior benefits because they are raising children. The formula needs to be reassessed.

○ Answer from Kat Allen: Rural areas are leading the way with primary prevention, as with prevention coalitions. We can’t do everything, and we need better state funding and state services.

○ Answer from Heather Bialecki-Canning: We (Community Connections) are largely funded by DCF. There is funding for the social determinants of health, but people aren’t educated within these areas of DCF. Most do not know there is funding available. There are 3 tiers and there is some money available for more. There should be less statewide pushes and more pushes by local communities. There is a kinship navigation program; we need to identify additional support around extended kin. This is a newly developed program that is a huge step forward in tangible policy work, moving forward to ensure success.

● Statement from the audience: Community coalitions used to get money from the state. Each coalition ran out of money, but they worked really well together.

● Statement from Greenfield School Committee member: There are isolation issues that impact suicide, depression and anxiety. All of these are increased in rural communities. Please take on isolation as an issue. Raise it as a possible framework for rural communities.

Panel 2 Common Themes
The state budget needs to be reanalyzed and rural areas need to have greater consideration. There are unmet needs in the rural communities in western Massachusetts which require more funding. The state does not fund substance abuse prevention using only the minimal federal money to do so. Communities are doing all they can but it is not enough. There is a higher rate of opioid overdoses, suicide, depression, transportation issues and lack of medical providers in this area. Community coalitions are doing all they can to bridge the gaps and provide services for rural communities, but they need help. They cannot provide for all who need assistance, and there needs to be a state budget that reflects the needs of the communities in rural Massachusetts.

Panel 3: Improving Health Care Access and Infrastructure
Speakers
- **Eliza Lake**, Chief Executive Officer, Hilltown Community Health Center
- **Dr. Estevan Garcia**, Chief Medical Officer, Cooley Dickinson Health Care
- **Dr. Sarah Perez McAdoo**, Population Health Clerkship Director, University of Massachusetts Medical School at Baystate
Eliza Lake: Thanked the panelists and attendees for housing the listening session in western Massachusetts and not Boston. Hilltown Community Health Center has been in western Massachusetts since the 1950’s and is the only provider of all community health services in the region. The lack of public transportation is a huge issue in this area. Over 65% of community members are also patients of the health center. The Rural Policy Plan has a comprehensive list of recommendations to aid this area. There needs to be critical access providers in these rural areas. There are provider shortages, where health centers out in rural Massachusetts operate in the negative. When a health center loses one provider, the impact is tremendous. The loss of one provider can result in about 1,000 patients losing access to care. Small sites try to fill gaps with existing staff and there is an increase in inefficiency. This affects revenue and stability of the center, and decreases the ability to attract providers to the area. Please support the Health Center Transportation Fund, and thank you for your support of rural communities.

Dr. Estevan Garcia: Cooley Dickinson serves many community members in Hampshire County and southern Franklin County. It is a hospital that serves rural areas and small cities. Discussed staffing at the hospital and affiliated medical groups, and reiterated that there is a significant challenge recruiting physicians to western Massachusetts. It is a beautiful area, but people need to have a reason to move here, such as ties to the area. The Association of American Medical Colleges predicts a physician shortage of 40-100,000 by the year 2030. By the year 2030, there will be one third less access to primary care providers in rural areas than in urban areas. There needs to be more funding and incentive for primary care because new physician recruits are concerned about student debt. There is a need for exploring different ways to help patients, such as through telemedicine. Telemedicine with the eastern part of the state along with proxy credentialing can help increase access. All of healthcare is a challenge in this area and we need better workforce recruitment.

Dr. Sarah Perez McAdoo: Described UMass Baystate and the medical school’s student track that provides training in health care disparity. The residency program has taken a special interest in the social determinants of health and equity. This type of training is augmenting traditional medical education with an emphasis on empathy and equity. There is a focus on longitudinal healthcare training in rural areas with an emphasis on community needs assessments. Community immersion and training students in various health care areas is important, as is focusing on the social determinants of health, culture, and equity training. UMass Baystate campus has a family residency program in Greenfield where they specifically focus on the social determinants of health. Healthcare training should be innovative with a focus on empathy an equity.

Ruth Blodgett: Described the Department of Public Health (DPH) and how data driven studies monitor the state of public health. There is a focus on the social determinants of health along with health inequity and disparity in rural areas. The special DPH commision is set to focus on efficiency and effectiveness in
regards to health shared services. There is funding for new and expanding services in rural areas, such as the community health worker program, the community health fund, and the community aging fund. These programs show promise through new certification programs, investment in the local population, and innovative focus on the social determinants of health.

**Kirby Lecy:** The State Office of Rural Health was created in 1994 to bridge access to services and health care partnerships by linking rural health networks and resources to improve the health of rural communities. There are local partnerships with soft match programs with the DPH. The rural communities served are vibrant and resilient and have an entrepreneurial spirit. These rural communities are comprised of problem solvers offering expertise regarding their communities. The challenges of rural communities is that the population tends to be older, sicker, poorer. Out of 58 rural towns in Massachusetts, 20% are 65 and older. These areas pay more for services which are much more difficult to access. Rural communities in western Massachusetts rely on tourism and have low wages, and these communities are affected by the rapid pace of hospital closures. Mid-level practitioners are filling the medical gaps in these areas, and the population relies on federally qualified health centers. Telehealth is needed in these areas to help bridge the gap in health coverage. Social services need support in rural areas and not regionalization. Urban development receives two to five times the amount of federal money than rural areas do. One third of all resources are spent on rural areas. Rural Massachusetts needs more meaningful representation on committees. Rural advocates and experts are needed on panels as all the underrepresented need a voice. There needs to be more investment in rural communities, and holding hearings like this will help achieve equity.

**Panel 3 Question/Answer**

- Comment for Representative Paul Schmid: Let’s collaborate!

- Question in reply from Senator Welch’s office: Can you speak to local health agents?

- Question from Sameen Ansari (audience): I am a fourth year medical student and Public Health Fellow in Senator Comerford’s office. It is nice to hear from the panelists about the push for primary care. I am disheartened that Boston as a whole does not care about primary care. For example, Harvard doesn’t have a primary care residency, and here in Massachusetts there is a primary care physician shortage. Funding hasn’t increased for federally-funded graduate medical education. How can Massachusetts increase funding for graduate medical education, and how can we ensure these funds will be used for primary care? How can we push for a culture shift in Massachusetts that allows for primary care physicians to be as essential as specialty physicians?

  - Answer form Eliza Lake: 4% of spending goes to primary care, and 96% of Healthcare spending goes to specialties other than primary care. With the high cost of education it is financially difficult to come out of medical school and go into primary care. The state needs payments on loans….the loan repayment program is very important. There’s no guarantee there will be funding for it though. There needs to be a culture change with
accountable care organizations, and really recognize that primary care can bring down healthcare costs.

○ Answer from Ruth Blodgett: I agree with the focus on primary care. Healthcare costs are high due to preventable chronic disease.

○ Comment from Dr. Estevan Garcia: Primary care, prevention and a focus on the social determinants of health is crucial.

○ Answer from Dr. Sarah Perez McAdoo: We forget how the debt carries with you. There needs to be a shift at the national level and it will take awhile. There needs to be upstream strategies to meet the shortage. It is important to build relationships with the communities served, and to see how education impacts the health needs of the community. There needs to be a shift in medical schools regarding this.

○ Answer from Dr. Estevan Garcia: Look at exposure to the area. We have a relationship with an institute with a physician assistant program that allows them to serve their clinical rotations at our hospital. The PA’s do not have to compete with the Harvard PA’s in Boston for their rotations or fight for exposure with medical residents.

● Question from Joannah Whitney (audience): Primary care needs to be expanded. I have secondary MS, and deal with the challenges of negotiating a complex medical system and high turnover of primary care providers living in a rural area. There is no continuity of care in a rural area with physician and staff turnover.

○ Answer from Dr. Sarah Perez McAdoo: Moving from providers treating solo to a medical care team, using a team approach for your medical needs is optimal. There should be team based care for the population and also a partnership with community based organizations.

○ Answer from Dr. Estevan Garcia: We have struggled with it. There is a poor rate of employment and getting a consistent team is tough. Primary care practitioners (PCP) have a retention rate of around 28 months. There is an education piece for the community as far as preventative care. The expectations on PCP’s needs to change, and I am sorry we are in this system.

○ Answer from Kirby Lecy: We know best practices, but don’t have the funding. We operate on a shoestring budget. There needs to be a larger overall effort involving education and loan repayment. It is hard to compete with physicians in the eastern part of the state.

● Comment from Nurse Practitioner in the audience: The state needs to invest in nurse practitioner (NP) programs. There is no money going into the programs. Other states have implemented tax reductions. There are alot of NP students that are applying to these programs. NP’s have always been trained in this model. Shift the money, so instead of putting money towards physicians, put it towards nurse practitioners and physician assistants.

Panel 3 Common Themes
The Rural Policy Plan has a comprehensive list of recommendations to aid this area. There needs to be critical access providers in these rural areas, where transportation issues are critical and there is a provider
shortage. There needs to be a focus on the social determinants of health, health equity and disparity, and preventative medicine. Physician recruitment and retention is challenging in western Massachusetts. There needs to be innovative ways to connect providers, such as with telemedicine. The state should focus on loan repayment and incentives for primary care providers in rural areas. There should also be a focus on incentives for nurse practitioners and physician assistants. The health care needs of these rural communities are well known, and the communities, coalitions and providers are doing all they can to help. It is imperative that they receive assistance from the state. There is a discrepancy as to state funding in urban versus rural areas. Rural Massachusetts needs more meaningful representation on committees. Rural advocates and experts are needed on panels and their voice needs to be included in the process as they are the experts in their community and can represent them best.

Panel 4: Local Public Health Structure

Speakers

- Phoebe Walker @FranklinCOG, Director of Community Services, Franklin Regional Council of Governments
- Laura Kittross: Public Health Program Manager, Berkshire Regional Planning Commission
- Betsy Kovacs: Chair, Heath Board of Health

Phoebe Walker: There are 351 local health departments within Massachusetts. We have more than other states, but the do not function well.

Laura Kittross: Small towns are struggling, and there is variability in staffing and credentialing. There are shared services and there needs to be creative ways to handle them.

Phoebe Walker: There are 6 interlocking recommendations:

1. Workforce credentialing
2. Continuity of care
3. Set higher (state) standards
4. Collect and share data
5. Allocation of resources
6. Encourage shared services

Local boards of health rely on data reporting and analysis. We are not getting much data. There also needs to be higher quality of local public health enforcement. In the state data reporting, there is not one data point regarding public housing. There needs to be better data collection for public health. With the creation of regional health districts, there could be cross jurisdiction sharing. Funding public health departments regionally could be positive.

Laura Kittross: In regards to workforce qualifications, healthcare agents need less credentialing than a hairdresser. There are no statewide credentials which leads to inconsistency of local boards of public health and large variability across the state. Some are completely trained and credentialed while others are
not. There are pools of agents, and the issue is there is no training or school to learn how to be a local public health agent. It is difficult to find a fully trained and credentialed person to hire in a rural town. There should be workforce recommended credentials that board of health members should adhere to. If it’s not possible to be credentialed, there should be a waiver process, where education would be acceptable instead of certification. Training needs to happen in western Massachusetts and not Boston.

**Betsy Kovacs:** Heath is the poster child for everything that has been discussed. Public health is so important, not just healthcare. Public health deals with homes, safe water, the environment, air quality, etc. We need more funding, training, and additional personnel. Heath has a population of about 700, with a population density of 28 people per square mile. It is the 15th smallest town out of 350 in the state, and it borders Vermont. There are 65 miles of road, half of which are gravel. There are huge snowfalls and the people of Heath have to travel great distances. The population increases by more than 1,000 in the summer due to tourism. Heath may be small but we are still responsible for the community’s public health. Heath happens to be in the top 10 for highest tax rates in the state. There are no local businesses and the town consists of modest homes. Due to the decrease in population and students, the elementary school has closed down. Heath is financially strapped. There are 5 members on the board of health, and a part time clerk and staff. There are major gaps in the quality of public health workers, for example, no training or certification requirements, just conflict of interest training and no requirement to serve on the board of health. There is no funding for disease prevention or emergency support preparedness. The work done here would not be possible without the Franklin Region Council of Governments representative. There is a lack of infrastructure and staff. Heath was still out of power yesterday due to the recent storm, and it is just coming back on this morning. When the weather is bad, the town can be without electricity or heat for days, and many do not have internet. Due to the recent EEE critical risk designation, Heath should be getting help with mosquito control. Heath deserves what the rest of the state has.

**Panel 4 Question/Answer**

- **Comment from Senator Comerford:** 7 of the top 20 towns are in the top taxed district. The PILOT program (payment in lieu of taxes) from the Department of Conservation and Recreation has decreased and there is not enough economic growth in these areas which as a result has pushed them into the top tax bracket.

- **Comment from audience, Deerfield Select Board of Health member:** There should be some kind of training offered to serve on the board of health. It is a volunteer organization that cannot be fully effective without training. The board is trying to form local coalitions with emergency management to aid this area. No one on the panel has brought up climate change. Climate change impacts diseases such as EEE and there is a line item for mosquito districts. There is data that shows where the mosquitoes are, but no funding so we can figure out how to handle this. The healthcare system is shifting down to Springfield which affects community members. Transportation is a critical issue here.
  - All panel members agree and emphasized there needs to be credentialed health staff.
Panel 4 Common Themes
Data reporting and sharing needs to improve and include data points on public housing for example. The current system does not work well, where rural public health departments are not getting the information they need. There was an emphasis on lack of credentialing and training for those serving on their town’s board of health. Community members who serve on the board are volunteers and are looking for training opportunities. There is a consensus that rural health workers are managing all they can with what little training they have. In order to provide a higher standard of care for the towns served, it is imperative that there is a credentialing and training process for public health boards to better serve the community.

Panel 5: Addressing Rural Social Determinants of Health
Speakers
- **Stuart Beckley**, Town Manager, Town of Ware, Quaboag Connector
- **Dave Christopolis**, Executive Director, Hilltown Community Development
- **Dr. Leo Hwang**, Dean of Humanities, Engineering, Math and Science, Greenfield Community College
- **Patricia Crosby**, Executive Director, MassHire Franklin Hampshire Workforce Board

**Stuart Beckley:** Thanked everyone who worked on the Rural Policy Plan which is a necessity in these areas. Transportation is a critical issue, as there is no bus service other than the PVTA which has limited lines. There is transportation around Worcester and around the 5 College area, but there is a void in between. Quaboag and South Quabbin are greatly affected by the lack of transportation. The Quaboag Connector provides transportation covering 10 towns. People in the communities out here rely on this to get to their medical appointments, and 67% of rides are to places of employment. The hours the rides are available are not practical. There needs to be extended hours as there is a critical need for transportation. The PVTA has dropped their number of services out here, and now they are running twice a day. There needs to be real in depth conversations around this issue, and not just with the policy makers.

**Dave Christopolis:** Discussed housing as a critical area of the social determinants of health. Housing development needs to take transportation into consideration. Housing issues directly impact the health of the community. Geography in rural areas dictate the opportunities and power of the people living in these communities. Around 60% of monthly costs of people living in rural communities goes to transportation and housing. There is an old housing stock which are far from services, and rentals and purchases of vacation/secondary homes are putting pressure on the people who live here. There continues to be zoning issues and a scarce labor force. Not one dollar from the state has gone into housing rehabilitation in the hilltowns. It has only been federal money and that needs to change. People need to know what is needed for a healthy home. Support rehabilitation needs, low income people and people of color, and look at regional solutions for housing. There needs to be flexibility in state funding for development in these regions.

**Dr. Leo Hwang:** Emphasized how communities in western Massachusetts matter. There is a critical opioid epidemic, low food security, homelessness, and a lack of basic needs that are being met out here.
Referring to Greenfield Community College (GCC): basic needs and security affect the academic outcomes of students. There needs to be an increase in access and support for students for their basic needs, because education changes lives for the better. An associate's degree will ultimately lead to an increase in tax revenue, an increase in the workforce, and a decrease in government support. It is imperative that the basic needs of students are met, and that they have expanded opportunities. Have a dedicated effort to provide for those on the fringe; those formerly incarcerated, recovering opioid addicts, adult learners, etc. Increase the health of the community by partnering with each other. Pre-K through grade 12 along with higher education needs greater support for better student health outcomes.

Patricia Crosby: Discussed the social determinants of health and how it impacts communities. Roofs over people's heads and food on their table all affects social health and gives purpose. In rural areas, there are not a lot of job opportunities and people would like more options than just working at their local food store or driving a truck for example. People want access to better jobs and trainings and better transportation that will make this possible. There are critical travel issues due to the lack of public transportation. People also would like to navigate within a job, and need guidance as workforce professionals to navigate the system. MassHire is the largest workforce in the region, where wages are 65% lower than the state average. 70% cannot travel outside of Franklin County region to work. 20-25% do not have reliable transportation. There has been a 35% cut in funding in recent years because when the unemployment numbers go down in the state, so does the allocation. The community cannot get comprehensive services out here. MassHire offices have been consolidated to Greenfield and pushed further south, leaving Hampshire County with no office. The consolidation of offices has resulted in a loss of jobs. Improving transportation will be the way to move forward. There needs to be stable funding for career center services along with continued partnerships and allocation for rural factors to ensure these communities are provided for. We do not have a rurality factor, or a scale for the state to really understand the issues that these rural communities face out here.

Panel 5 Question/Answer

- Comment from Representative: I appreciate today's effort. I represent Westport and Freetown (near Fall River and New Bedford) and all this resonates. Especially the issues around transportation. It is very difficult for me to see the transportation money that is spent on the MBTA and what is not being spent for the rest of the state.

- Comment from Senator Comerford: The Regional Transit Authorities (RTA) serve a larger area and there is regional inequity (RTA vs Massachusetts Bay Transportation Authority [MBTA]).

- Comment from Representative: I would like to reiterate how we cannot be looking at a healthcare bill and ignore aspects like housing and transportation. I will think of ways to carry these issues forward.

- Comment from Senator Comerford: There are many social determinants of health. We have discussed access to services which is an issue out here. Massachusetts nurses (recognizing a group
of nurses in the audience)...there has been a closure of a mental health facility in the region. Are there Massachusetts nurses who would like to speak regarding this?

- Comment from Donna Stern (audience): I’m a full time psychiatric nurse and social worker in these rural communities. There is deep concern regarding the inpatient closure at Baystate Franklin Medical Center (mental health services). There is a lack of access to transportation, isolation, and poverty in this area. All these issues are amplified when combined with mental health issues. How can we make access to mental health services even more difficult by making patients travel to Baystate Medical Center (Springfield) which is 45 minutes away when there are critical transportation issues that currently exist? We cannot pretend that this is not going to happen and ignore this situation. We need to fight for those who are not here today, the vulnerable.

- Comment from Suzanne (audience): I work in the emergency department at Baystate Franklin Medical Center. Because of the closure at Baystate Franklin along with two other rural centers, members of these communities are affected by lack of access to services. People are stuck in the emergency department for days because there are no mental health psychiatric beds available. People are checking in for care, and walk to the medical center because they do not own a car. Local access is very important, and to move care 45 minutes away with no transportation is unacceptable.

- Comment from Tim Blake (audience): As a consumer of mental health services, accessibility is an issue. The proposal to shut down the mental health care services at Baystate Franklin Medical Center and move them to Springfield will impact many lives. Where is the plan for transportation? How can you close three psychiatric units, move the care south to Springfield, and not provide transportation for the patients that rely on these services here? We cannot go backwards in regards to accessibility and mental health care for those who are vulnerable, and we must have a more people centered approach.

Panel 5 Common Themes
The social determinants of health needs to be the focus of rural health at the state level. Affordable housing, transportation issues, access to jobs and trainings are of utmost importance in these areas. There needs to be an increase in state funding to provide for the communities out in rural Massachusetts. Transportation is a critical issue and impacts everything ranging from monthly income spent on transportation to accessing healthcare and job opportunities. The state needs to focus more on the issues that impact the daily lives of those living in rural areas.

Closing Remarks
Senator Comerford thanked all who made the journey to take part in this important discussion on rural health. We cannot go back, and must keep pushing forward for better health care accessibility in these areas. The focus must be on rural health and transportation in order to achieve regional equity. A special thanks to all who gave insight as to what obstacles rural health communities face, and what we need to focus on moving forward.
Addendum: Submitted Statements and Materials to be included in the Oversight Notes

The Rural Policy Plan for the Commonwealth of Massachusetts

The Massachusetts Health Gap Report:

Health Gaps Report:
Health Gaps Discussion Guide.pdf

Ruth Suyenaga Testimony:
20191017 Ruth Suyenaga Testimony.pdf

Illana Steinhauer, FNP-BC Remarks:
20191017 Ilana Steinhauer FNP-BC Panel 1 Testimony.pdf

Kat Allen Remarks:
20191018 Kat Allen Panel 2 Remarks.pdf

Ed Sayer Remarks:
20191018 Ed Sayer Panel 2 Full Remarks.pdf

Linda Sarage Remarks:
20191018 Linda Sarage Panel 2 Full Remarks.pdf

Ruth Blodgett & Kirby Lecy Testimony:
20191018 Ruth Blodgett Kirby Lecy Panel 3 Testimony.pdf

Dr. Leo Hwang Remarks:
20191018 Dr. Leo Hwang Panel 5 Remarks.pdf

Doug Selwyn Testimony:
20191018 Doug Selwyn Testimony.pdf

Patty Healy RN CM Testimony:
20191024 Patty Healey RN CM Testimony.pdf