

May 28, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: Request for Information Regarding Maternal and Infant Health Care in Rural Communities***

Dear Administrator Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide input on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) Regarding Maternal and Infant Health Care in Rural Communities. The RFI solicits comments on the barriers and opportunities to improving maternal care access, quality and outcomes in rural communities; initiatives in the field that have shown positive impact on addressing barriers or maximizing opportunities; and ways that the Department of Health and Human Services (HHS) and CMS can support such efforts.

Maternal health is a top priority for the AHA and our member hospitals and health systems. Through our ongoing efforts, we seek to eliminate maternal mortality, reduce maternal morbidity, increase access to comprehensive care and address persistent racial disparities in health and health care. As hospitals work to improve health outcomes for mothers and babies, we are redoubling our efforts to improve maternal health in rural communities across the country.

Efforts to improve rural maternal health care can be impeded by a number of persistent barriers including lack of available of transportation, workforce shortages, inadequate housing and food insecurity. While there is no one-size-fits-all approach to addressing these barriers, rural hospitals around the country have implemented several promising



strategies to improve maternal health including establishing partnerships in their communities, creating multi-disciplinary maternal health care teams and increasing efforts to recruit physicians and other providers. Beyond existing hospital initiatives, additional opportunities to address current barriers include: expanding support of the Alliance for Innovation on Maternal Health (AIM) maternal safety bundles, increasing rural representation on state Maternal Mortality Review Committees, and utilizing new technologies and advanced training for multi-disciplinary care teams.

**As CMS and HHS implement the Rethinking Rural Health Initiative to support the health of Americans living in rural areas, we urge the agencies to support the following public policy improvements:**

- **Bolster the maternal care workforce through supporting current scholarship and loan repayment programs, lifting Medicare Graduate Medical Education residency slot caps, and providing flexibility for co-located providers;**
- **Explore and disseminate Medicaid reimbursement and health care delivery strategies to support maternal care;**
- **Increase telehealth opportunities for maternal care in order to boost access to care and support clinician training;**
- **Enhance opportunities for obstetrics simulation training to support care team readiness;**
- **Improve coverage for maternal care, including extending Medicaid coverage for pregnant and postpartum women;**
- **Support efforts to reduce disparities in maternal care services and outcomes, including utilizing demonstration authority to explore how community-based organizations can improve maternal mortality and morbidity; and**
- **Facilitate the public/private collaboration of social agencies, providers and other community stakeholders through grant-funded projects to address social determinants of health for mothers.**

We appreciate your consideration of these issues and look forward to our future collaboration in addressing maternal health. Our detailed comments follow. Please contact me if you have questions, or feel free to have a member of your team contact Erika Rogan, AHA senior associate director for policy, at (202) 626-2963 or [erogan@aha.org](mailto:erogan@aha.org).

Sincerely,

/s/

Robyn Begley, DNP, R.N.  
Senior Vice President and Chief Nursing Officer

## AHA DETAILED COMMENTS

### **BARRIERS IN RURAL COMMUNITIES IMPACTING ACCESS, QUALITY OF CARE AND OUTCOMES IN PRENATAL, OBSTETRICAL AND POSTPARTUM CARE**

The Request for Information (RFI) outlines a number of the barriers existing in rural communities that impact access, quality of care, and outcomes in prenatal, obstetrical, and postpartum care. Our hospital members have acknowledged and expressed those same barriers in their communities. They also have highlighted a number of additional barriers in their communities, which are described below.

Access. Access to pregnancy and infant-related health care in rural communities is limited for a variety of reasons. For example, hospitals and obstetric units are closing due to low volumes, reimbursement and financial challenges, and the availability of health care providers, among other reasons. According to the [University of Minnesota Rural Health Research Center](#), the percent of rural counties without obstetric services rose from 45% to 54% between 2004 and 2014; and only 30.2% of the most rural counties had continual access to obstetrics services. As a result, women must leave their communities and travel greater distances for prenatal, obstetrical and postpartum care.

Rural communities also struggle to recruit and retain health care providers. Generally speaking, there is a shortage of providers needed to provide maternal and infant health care. This includes, but is not limited to, obstetricians/gynecologists (OB/GYNs), anesthesiologists, family practice physicians, pediatric specialists, nurse practitioners, certified nurse midwives, physician assistants, mental and behavioral health providers, EMS providers, community health workers and doulas. For example, from 2009-2016, the number of family physicians providing [high-volume labor and delivery services](#) decreased 50%. Moreover, the percentage of family practice maternity care providers providing [low- and medium-volume obstetric services](#) also continues to decline. This, coupled with the nationwide shortage of obstetricians, significantly reduces access to care for pregnant women in rural areas.

In addition to recruitment challenges, training is another obstacle in rural communities. For example, in communities without obstetric units, it is challenging to train and build the workforce necessary to address obstetric emergencies, including potential complications for mothers and infants. [Maintaining training is costly](#), both with regard to time and financial resources. Rural health care providers often are trained to respond to routine medical emergencies. However, they often have less training and practice experience in areas like labor and delivery and, therefore, are less prepared to recognize or respond to obstetric complications.

Outcomes. As indicated in the RFI, women living in rural communities have increased health risks, including chronic diseases such as hypertension, cardiac disease, obesity and asthma. Rural residents also experience higher rates of obesity and hypertension. Opioid

use also is higher in rural counties leading to maternal opioid use disorder, which increases the risk of medical complications and fetal death. These risks are further exacerbated by the social determinants of health, which play a critical role for rural residents who may have fewer economic resources and lack access to transportation, housing, food or other resources necessary to improve health before, during and after pregnancy.

All of these factors contribute to women in rural communities accessing prenatal and postpartum care less often than their non-rural counterparts. It also contributes to more rural women choosing to have elective deliveries to reduce the risk going into labor when they may be hours from the nearest hospital. This includes induction and cesarean sections – procedures that increase the [risk of complications](#). As a result, maternal health outcomes in rural communities, including maternal morbidity and mortality, are worse than in other communities across the country.

With regard to infant health, the [rates of neonatal mortality](#) also are higher in rural areas. It is challenging to recruit and retain neonatal specialists to rural communities, which leads to shortages of both neonatal specialists and neonatal intensive care units (NICU). About 40% of pre-term births in rural areas occur in [hospitals that do not have a NICU](#). This means that newborns may be transferred to another hospital up to 100 miles away. The separation of mother and baby has shown long-term neurological and physical effects. In addition, we have heard from rural hospitals that they feel ill-equipped to treat severe complications in newborns, including neonatal resuscitation, because they lack the training, resources or most up-to-date protocols.

#### **OPPORTUNITIES TO IMPROVE ACCESS, QUALITY OF CARE AND OUTCOMES IN PRENATAL, OBSTETRICAL AND POSTPARTUM CARE**

There are many opportunities to improve access, quality of care and outcomes in rural communities. Below are five examples:

1. Expand support of the Alliance for Innovation on Maternal Health (AIM) Bundles. AIM is a national partnership funded by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau. It includes provider, public health and consumer groups that work at the state level to develop maternal safety bundles that include evidence-based practices. These [standardized maternal safety bundles](#) have been shown to improve quality, safety and outcomes, including reduced rates of maternal mortality and severe maternal morbidity. Rural hospitals have benefited from participating in statewide collaboration, for example in California and Texas, around AIM maternal safety bundles.

While rural hospitals are engaging in AIM maternal safety bundles, widespread adoption in rural settings has been limited. The administrative requirements associated with participation, such as data tracking and the costs of additional staff to implement

maternal safety bundles, are a hurdle. In addition, rural hospitals may not have the volume and training opportunities necessary to standardize care and outcomes. There are opportunities to overcome these barriers by increasing training of rural service providers, at the state level, to implement safety bundles for treatment of obstetric hemorrhage, opioid use disorder and severe hypertension in pregnancy. In addition, telemedicine offers an opportunity to increase participation, tailor the maternal health bundles for emergency department (ED) providers in rural communities, and incorporate ongoing interactive or simulated training tools to optimize efficacy for rural hospitals performing fewer deliveries.

2. Increase rural representation on state Maternal Mortality Review Committees (MMRCs). Currently, of the 46 states with MMRCs, only two require [rural representation](#). Given MMRCs influence on improving review processes and informing recommendations to improve outcomes for mothers and babies, it is essential that the voice of rural health care providers be included in these discussions to share the unique [needs and challenges of rural communities](#).
3. Utilize technology to improve access to care. Telemedicine is being used more frequently in rural communities where broadband access exists, and can help reduce the “distance” to a provider. It is an opportunity to provide pre- and post-natal care, specialty care for mothers and infants, and improve overall birth outcomes. During the COVID-19 pandemic, telemedicine is an integral tool in helping clinicians to continue to care for OB patients in a safe manner. In addition, there is a growing number of applications (apps) available to help monitor blood pressure, glucose levels, depression and other conditions remotely. Apps help maintain contact between providers and patients without requiring unnecessary trips to a hospital. When used in collaboration with in-person care, apps have been shown to increase engagement between mothers and providers.
4. Increase training for ED teams in rural communities. As mentioned above, in rural communities without obstetric units, it is challenging to train and build the workforce necessary to be prepared for obstetric emergencies, including potential complications for mothers and infants. An ongoing opportunity exists to support training of multi-disciplinary teams that can address pregnancy in rural EDs. In addition, there is an opportunity to provide technical assistance as those teams develop and implement standardized procedures and ensure that the appropriate emergency response supplies are available in the delivery room in the event they are needed.
5. Increase access to implicit bias training. More than 10 million women of color live in rural communities in the United States. And, those rural counties with large populations of black women have [higher rates of obstetric unit closures](#). Integration of ongoing implicit bias training to teach providers how to recognize and interrupt the unconscious stereotypes and assumptions that influence their actions and care has the potential to improve the quality of care and improve outcomes for mothers and babies in all

communities. Specifically, these programs may be used to address systemic and institutionalized racism in the health care system.

## **INITIATIVES THAT HAVE DEMONSTRATED A POSITIVE IMPACT IN ADDRESSING BARRIERS OR MAXIMIZING OPPORTUNITIES**

Rural hospitals have implemented a number of initiatives to promote access, quality of care and outcomes for mothers and babies in their communities. While there is no single, one-size fits all strategy, rural hospitals around the country are employing solutions that align their communities' needs with available support structures and resources. The AHA highlights successful efforts through its Better Health for Mothers and Babies initiative. More information is available at <https://www.aha.org/better-health-for-mothers-and-babies>. Some examples, specific to rural communities, are discussed below.

Partnerships between hospitals, health systems and community partners. Rural hospitals are partnering with other stakeholders in a number of different ways. They are partnering with larger hospitals and health systems to provide virtual training and consultations with specialists. Other rural hospitals have partnered with health systems to bring specialists to rural hospitals on a regular basis to address high-risk and complicated pregnancies. These relationships provide critical medical expertise and a learning opportunity for rural providers. In rural communities that do not offer obstetrics services locally, these partnerships provide women the opportunity to know and feel comfortable with the providers that will ultimately deliver their babies.

Rural hospitals also are [partnering with community organizations](#) to address social needs that are heightened in rural communities, including food insecurity, safe housing, domestic violence, health literacy, mental illness and substance use disorders. Specifically, they are partnering with health providers and community support systems, such as social service agencies, schools, libraries and mental health organizations to help identify and address unmet social needs of mothers and babies throughout the care continuum. These partnerships have the potential to improve overall health outcomes and lead to improved patient engagement and patient satisfaction.

Building multi-disciplinary maternal health care teams. Because many rural communities do not have access to a full-time obstetrician, our members recommend an increase use of midwives and nurse practitioners (NPs) and other clinicians in all aspects of maternal care (prenatal/surgical assist in obstetrics/postpartum). Hospitals identified this as an area of dire need. In particular, NPs' strong medical backgrounds make these clinicians very suitable, not only, to provide routine care but also address other issues, such as expediting subspecialty consults, which can be difficult to achieve in a timely manner. The [use of midwives](#), especially in underserved areas, can improve access and outcomes.



Studies have shown that using doulas can improve outcomes for mothers and infants, especially for women at risk of adverse outcomes, including African American and Hispanic women, and those living in rural areas. [Doulas have demonstrated](#) a reduction in labor time, reduction of mother's anxiety, improvements in mother-baby bonding and improved breastfeeding success. However, barriers remain with respect to their accreditation given the absence of federal regulation to determine competencies. In addition, [coverage and reimbursement](#) for doula services can be challenging, making the work less financially viable for the practitioners unless it is [supported by a health care system or private grant programs](#). Despite these challenges, some rural hospitals are responding to workforce challenges by engaging doulas.

CenteringPregnancy. [CenteringPregnancy](#) is an approach that brings together women due at the same time for prenatal care appointments that last 90 minutes or more. The additional time with providers allows patients to be more engaged, better informed and ask providers more in-depth questions about their pregnancy. It also allows mothers to make friends and benefit from the support of other group members. While bringing together a volume of pregnant women of similar gestational age in rural communities is challenging, one rural, critical access hospital in the Midwest reports decreased pre-term delivery and postpartum depression rates.

Efforts to recruit physicians and other providers. Rural hospitals have taken a number of steps to increase access to the clinicians necessary to provide care to mothers and babies. Some of these include:

- Loan repayment programs that allow physicians to pay loans back over time rather than upfront have been effective at recruiting physicians for longer periods of time.
- One Kansas hospital recruits “mission-driven” physicians – clinicians who are drawn to missionary work in Third World countries – to come serve that community's large refugee population and the hospital is able to capitalize on the reasons that drew physicians to medicine.
- Some rural hospitals have focused on recruiting “home grown” health care providers. By staying in contact with individuals throughout their schooling, offering summer internships and appealing to their family connection in the area, the hospitals have been able to recruit clinicians back to their home community.
- Rural hospitals also are working with medical and nursing schools, residency program and other educational institutions to attract health care providers.

Neonatal Abstinence Syndrome (NAS) Programs. The rate of NAS increased six fold between 2000-2014, and rural counties [experience disproportionately higher rates of NAS](#) than urban counterparts. As a result, rural hospitals are responding to this growing need by implementing programs to care for babies born with NAS. The use of rocking programs has been effective in a number of rural hospitals. [Holding and rocking a baby with NAS](#) has shown to provide comfort, reduce tremors, regulate body temperature, increase hydration and have overall better outcomes. Some hospitals have recruited volunteers to

optimize the success of the rocking programs, freeing nurses and physicians to focus on critical medical care.

## **POLICIES TO SUPPORT RURAL PROVIDER EFFORTS TO IMPROVE MATERNAL CARE**

Bolster the maternal care workforce. Workforce shortages in rural areas are common across most types of care, including primary care and specialty services. Shortages in the rural maternity care workforce are particularly striking. Overall, rural communities have the lowest ratios of OB/GYNs-to-women and more than half of women living in rural areas have to drive over 30 minutes to a hospital that provides perinatal care. To fill these access gaps, initiatives should be expanded to incentivize OB/GYNs, family practitioners with interest in maternity, midwives and other professionals to practice in rural areas.

Some existing programs work to ameliorate rural workforce deficits by incentivizing clinicians to work in rural areas. These include the Conrad State 30 and the National Health Service Corps (NHSC) programs, which are administered by federal agencies with funding from Congress. **We urge HHS to work with Congress to help ensure continued support for these programs, which are important to address workforce gaps in rural areas.** Federal agencies, including CMS, also should explore additional incentives and training opportunities for practitioners in such programs that have interest in rural maternity care. In addition, according to the Congressional Research Service, less than 1% of NHSC clinicians are placed in critical access hospitals. **Given the important role of hospital-based services for not only deliveries but the full range of maternal care, further study would be useful to examine how recruitment programs, such as the NHSC program, can better recruit maternity care professionals to rural hospital settings in order to improve access to obstetrics care in rural communities.**

Despite the promise of current programs, with only 1% of medical residents and fellows indicating a preference for practicing in a small town or rural area, designers of rural recruitment programs will have to consider additional, unique ways to attract the next generation of clinicians. **We urge CMS and other agencies to support efforts to recruit and retain maternity care professionals – including OB/GYNs, family practitioners, midwives, nurses and other practitioners – to rural hospitals.**

Medicare graduate medical education (GME) funding is critical to maintain the physician workforce and sustain access to care, including maternal health services. The Balanced Budget Act of 1997 imposed caps on the number of residents for which each teaching hospital is eligible to receive GME reimbursement. **We urge CMS to support legislative efforts to lift the cap on the number of Medicare-funded residency slots, which would expand training opportunities and help address health professional shortages, including OB/GYNs and family practitioners.** Accordingly, AHA supports the Resident Physician Shortage Reduction Act of 2019 (H.R. 1763).



Provide regulatory flexibility to improve access to maternal care. Many hospitals share treatment space with other providers in order to offer a broader range of medical services and better meet patient needs. In rural areas, hospitals may lease space to visiting practitioners several days per month to make certain services locally available. These types of agreements are crucial for small and rural hospitals that may have limited clinical staff and/or rely on visiting physicians to provide services that would otherwise require patients to travel long distances in order to obtain such care. Last year, CMS issued draft guidance on co-location and sought public comment on that draft guidance. AHA submitted a [letter](#) in response to the draft guidance and encouraged the agency to make several revisions so that co-location arrangements can enable hospitals to serve their patients in a more efficient and effective manner. **AHA urges CMS to provide regulatory flexibility to providers who wish to share treatment space as a means to fill gaps in patient access to care.**

Explore and disseminate Medicaid reimbursement and health care delivery strategies to support maternal care. Medicaid pays for nearly half of all births in the U.S., including more than [half of all births in rural America](#). The closure of rural hospitals has resulted in a lack rural women's access to timely maternal health care, such that [nearly half of all rural counties in the U.S.](#) are without a hospital with obstetric services. Solutions to improving access to rural maternal health care will require a multifaceted approach for which the Medicaid program is uniquely situated. The federal/state program addresses access through expanding coverage, addresses delivery reform through innovative payment approaches, and addresses workforce shortages through payment for multidisciplinary care teams. Many states are leveraging their Medicaid programs to improve maternal health.

**We urge CMS to build on the capabilities of the Center for Medicare and Medicaid Innovation (CMMI) to further disseminate state innovations and best practices.** CMMI could further explore bundled care payment approaches that [10 states are currently pursuing](#). In addition, CMMI could examine how states are addressing workforce challenges with coverage for doulas or care delivery models through pregnancy medical homes or group prenatal care. CMMI also could develop payment or delivery models based on the lessons learned from these state experiments.

Increase telehealth opportunities for maternal care. Telehealth offers opportunities to improve access to maternal health care by connecting pregnant women to their providers through the use of telecommunications devices that allow for videoconferencing, remote monitoring and other communications. A Centers for Disease Control and Prevention (CDC) [2019 study](#) examining work done by 13 state MMRCs identified providing telehealth at facilities with no obstetric provider on-site as one strategy to address personnel issues at hospitals and prevent future pregnancy-related deaths. For rural women, utilizing telehealth for prenatal care can save long travel times and reduce in-person visits. Virtual prenatal visits can utilize home monitoring equipment to track fetal heart rate and maternal blood pressure.

Integrated virtual care models, such as [Mayo Clinic's OB nest](#), have shown promise in [reducing in-person visits](#) while maintaining patient-provider connection. Monitoring a mother's health status – including mental health – also is crucial to postpartum care, and telehealth offers more opportunity to monitor the mother's ongoing health and maintain patient communication. In addition, [tele-lactation services](#) allow mothers who may have difficulty breastfeeding to connect with lactation consultants from their homes.

Telehealth may also include provider-to-provider communications. For rural practitioners, this may include electronic consults with specialists, such as maternal fetal medicine physicians, who may not practice locally. For example, at [Dartmouth-Hitchcock Medical Center](#), two-thirds of deliveries with TeleICN (neonatologist) consult stay local. Support from other practitioners in this way is important for rural clinicians who may not see the same patient volume as larger communities.

**CMS policies should be updated to expand the types of technology that may be used for telehealth services and provide payment parity with services delivered in-person. We also urge CMS to support efforts to facilitate virtual care across state lines and allow eligible hospitals to test and evaluate telehealth services.** For example, CMMI could develop a demonstration model that tests integrated virtual care design for rural providers that includes prenatal care.

Enhance opportunities for simulation training. Simulation training allows clinicians to acquire and hone skills in a safe, realistic environment that poses no threat to patients. It has grown in use across many specialties, including obstetrics and gynecology. For example, simulation training can be utilized to practice pre- or postnatal care as well as both vaginal and caesarian births. As technology has progressed, simulator-based education and training have become more refined, including capabilities to practice variable scenarios and high-risk procedures. In addition to having life-like qualities, simulations also offers opportunities for team-based training (i.e., physicians, nurses and other staff can train together). Importantly, simulation training in obstetrics and maternal care offers a way to maintain maternity care quality for rural providers, which often have lower delivery volumes.

Because the cost of simulator technologies can be prohibitive, **the AHA urges CMS, as well as other federal health agencies, to provide more opportunities, including demonstration programs and grant funding, to rural providers to develop and maintain obstetric simulation training programs.** Both the HRSA and Agency for Healthcare Research and Quality have [previously granted funds](#) to rural providers for such initiatives.

Increase coverage for maternal care. According to the [CDC](#), an estimated 31% of pregnancy-related deaths occur during pregnancy, 36% during delivery or the week after, and 33% one week to one year after delivery. Adequate health care coverage is essential

for women to receive appropriate health care before, during and after pregnancy. While Medicaid currently pays for more than half of rural births, the program's limited postpartum coverage can leave women uninsured or underinsured during a crucial time in their lives.

**We urge CMS and other agencies to support legislative efforts to improve maternal care coverage.** For example, AHA-supported Helping Medicaid Offer Maternity Services Act (H.R. 4996) would give states the option to extend Medicaid and Children's Health Insurance Program coverage for pregnant and postpartum women from the current 60 days to one year after birth, with a 5% increase in the Federal Medical Assistance Percentage for the first year a state opts to extend the coverage. **We also urge CMS to consider ways to increase coverage for maternal care through its waiver authority.**

Reduce disparities in maternal care services and outcomes. The U.S. has the worst maternal mortality rates in the developed world and an alarmingly higher rate among black women. In addition, one recent study found that having a [higher percentage of black women in a rural county](#) is associated higher odds of the county lacking of obstetric care.

**In light of such extremely concerning evidence, we urge CMS and other agencies to support legislative efforts to address the disparities in maternal health care.** For example, AHA strongly supports the Black Maternal Health Momnibus Act (H.R. 6142/S. 3424), which would invest in community-based organizations, support care coordination and collect data on maternal mortality and morbidity in minority and underserved populations. The bill also would provide funding to diversify the maternal and perinatal nursing workforce to reflect the patient population served, create a perinatal care alternative payment model demonstration project and protect the health of pregnant incarcerated individuals. **We urge CMS to consider ways to use CMMI demonstration authority to explore how community-based organizations can improve maternal mortality and morbidity.**

In addition, successful quality initiatives, such as the California Maternal Quality Care Collaborative, can serve as an example for addressing disparities in outcomes. AIM continues to review access to care and implicit bias as potential causes of disparities, in addition to encouraging the use of its Reduction of Peripartum Racial/Ethnic Disparities Patient Safety Bundle, which provides guidance for organizations and clinicians regarding how to reduce disparities in maternal morbidity and mortality. The AHA and its members support investments in accessible technology, such as applications to help monitor blood pressure, glucose levels, depression and other conditions remotely, in order to reach women who are most at risk for negative outcomes. Such investment will help address high rates of adverse outcomes for all women, including those living in rural areas.

Facilitate the public/private sector collaboration with social agencies, providers and other community stakeholders through grant-funded projects to address social determinants of health for mothers. Addressing social determinants of health such as food, housing, transportation and social supports is key to [improving maternal health outcomes](#). Solutions will require collaborations with health providers, community stakeholders and government

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agencies. Provider-led initiatives, such as [Pioneer Baby](#) designed to improve the health of reproductive-age women in rural Kansas is one example of a public/private collaborative. **CMS and other agencies, such as the HRSA, could provide seed money to help develop and promote these public/private collaboratives to address the social needs of rural pregnant women.** The agencies could consider developing grants for community-based collaboratives; these funding opportunities could focus on fostering creating programs to address transportation needs, food insecurity and housing through collaboratives with providers, community groups and local government.