1. **What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?**
    a. Inside the healthcare industry in rural areas, the main factors driving patient outcomes is the ongoing availability of consistent, qualified, and aligned providers. The absence of providers results in rural patients being transported long distances and patient care is delayed or eliminated entirely.

2. **What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/ telemedicine/telemonitoring?**
    a. We are a physician group that has successfully implemented a rotating physician model in 45 rural and critical access hospitals in 16 states over the past decade. This model consists of formally contracting with the local hospital for our group to provide a dedicated 24x7x365 “core team” of physicians (hospitalists or general surgeons) for that hospital. Our physicians live anywhere in the country, but each month they travel and work an assignment at a rural hospital that is 7 to 10 days in duration. To manage costs, they live in the hospital itself or reside in housing on/near the hospital campus. During their assignment they are responsible to be available to provide all the patient care that is needed for their specialty. They don’t work 24 hours a day because there is typically not enough patient demand, so they are able to be busy without having the demand of a 24x7 model in an urban hospital. Our group bills patient insurance to collect professional fees for the services our physicians provide.
    b. Our goal is to keep as many appropriate rural patients local where they are close to their homes, families, friends and social support rather than transport them hundreds of miles to large urban medical centers. In cases where patients are very sick and need dedicated, extended specialist care, a large urban center is best for patients, but we find that with the right model and the right fit providers, many patients can be kept locally.

3. **What should the Committee consider with respect to patient volume adequacy in rural areas?**
    a. The committee should consider ways to incentivize rural care supply against rural patient volumes. In urban centers, the quantity of patient demand for care is high and dense enough to fully utilize the services of a specialist and to enable efficient office staff and infrastructure. In rural communities, there may only be one or two local needs a month for the services of a given specialty. In high volume environments like urban and

suburban cities, population density aggregates higher volumes and allows the creation of efficient offices that can spread the costs of delivering care across more patients. In rural environments, the lower volume of care episodes prevents care efficiency on the same level of an urban center. The committee should consider the need to provide greater support to care delivery in rural markets than in urban markets. This could take the form of slightly higher professional fee revenues for rural markets than in urban markets.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —
a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?
b. there is broader investment in primary care or public health?
c. the cause is related to a lack of flexibility in health care delivery or payment?

The lesson we learn is that rural patients and rural communities are *not* well-served when patient care delivery is driven out of the community to urban centers. We reject the move to transform critical access hospitals to "urgent care" centers, and we believe this is a short-sighted and potentially harmful approach toward supporting the health of rural communities—both from a clinical and economic standpoint. In many rural communities, health services are an essential part of the economy and provide well-paying jobs for educated local citizens. When rural hospitals close, patients lose their access to convenient care. Getting care in big cities is costly for rural patients and for their families due to transportation to and from the city, the time lost away from their local jobs, as well as the cost of food and overnight accommodations in the city. Additionally, the local family and friend support network doesn't exist for rural patients in the city. When local service lines close, the economic activity from healthcare declines, the rural hospital closes, and now the rural community is left *poorer* than they were already.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?
No answer

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?
Our model of formal, long-term programs to bring providers 365 days a year to rural communities have shown a positive impact to our 40+ rural hospital partners. Our model is successful for several reasons:
-It addresses the challenge of remoteness / travel time by spreading the cost of travel and travel time over 7 to 10 days.
-The long-term / permanent model avoids the costs of temporary coverage / "locum tenens" models that can extract high costs due to the desperation of rural hospitals

-It avoids the risks and high costs associated with long-term physician employment contracts that often times do not workout.
-It allows a wider number of providers to work in rural communities by reducing the "friction" of having to move to a rural community permanently. Many providers would love to work in a rural environment, but they or their family not ready to commit permanently to living rurally.
-It improves care continuity by having the same 3 or 4 physicians rotating through each month.
-It addresses the long-term demographic trend of fewer providers moving permanently to rural communities. We do not believe that trend will reverse in the near term, so new approaches to delivery must be introduced.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?
No Answer

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

In the 40+ plus Critical Access Hospitals we work in, we help to grow their swing bed programs for post-acute and long-term care. It is a critical resource for rural communities and allows the patient to receive the much needed observation and care before being sent back home. We work with tertiary and surrounding facilities to send patients back to their local communities to be treated. This allows for family and friends to visit more often, improving the patient experience.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?
NO ANSWER

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

-Allow for the inclusion of provider (Physicians, PA/NP) transportation costs in a critical access hospital's cost report.

-Consider HRSA program funding changes such as other organizations (not just non-profits) such as physician groups in order to encourage more providers to work in rural markets.