

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?

Due to low volumes and high poverty levels we have major issues with adequate reimbursement to support operations. We are a CAH in Sutton County, Texas with over 1,450 square miles and a population less than 3,000. We are also the only hospital within a reasonable driving distance for Edwards and Crockett counties that are both without a hospital (another 4,400 square miles). Medicaid utilization is very low and we also must deal with a very large uninsured, indigent, and undocumented percentage of our population. There is not even a clinic in Edwards County.

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?

We believe the Chronic Care Management program is eventually going to be successful but start up costs have been difficult due to our limited qualified population. Cost based reimbursement in the CAH and RHC has also been very helpful but the shift to Medicare Advantage and Managed Medicaid has been devastating for most rural healthcare facilities.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Please understand that our patient volumes will never support all of our necessary services to even provide emergency care, let alone needed primary care services to the indigent and elderly population.

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?

People do not have that option here. Closest facilities of this type are 80 to 120 miles away.

b. there is broader investment in primary care or public health?

There does need to be more investment in primary care that takes into account our lower volumes and higher costs to attract the necessary providers. The ACA has also created a dire situation with patients that do have insurance due to much higher deductibles a co-pays that patients are not able to pay because premiums are also much higher.

c. the cause is related to a lack of flexibility in health care delivery or payment?

The more managed care that is forced on rural healthcare, the more problems you are going to see. MCOs use any and all excuses to delay or deny payments and many are just ridiculous preventing us from being paid for services that we must provide their customers. How can they justify not paying us for emergency services we have delivered to their insured based upon a discharge code after the fact. Our providers must treat any patient that comes to our ER because of EMTALA. The term “medical screening exam” is so ambiguous and we must still call in that provider to do the exam and have support staff there.

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?

None in this area that I am aware of. Telemedicine is used only to support our providers in the ER because without the ER compensation for physicians, we can't pay enough to attract a physician.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

Now we are forced to overpay to attract these providers. It is also very difficult to attract qualified personnel to bill claims and manage denials. These are not traditionally high paying jobs in urban areas but here we must pay higher wages or outsource local jobs out to off site companies. The most successful programs to train local workers are through tuition and certification programs for current employees but that takes time to have an impact and there are no guarantees that you can retain them once they are trained.

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?

This is one area that I truly believe telemedicine may be very helpful, especially with behavioral health. Local therapists and counselors can get necessary physician support to manage patient care effectively on an outpatient basis. More emphasis needs to be put in this area but again, most of these patients do not have any type of payor source.

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?

This problem is very evident in rural communities because there is such a high dependency on Medicaid and Medicaid does not reimburse enough to cover the costs of long term care that

the regulations require. Supplemental programs such as QIPP in Texas help but still do not cover real operational costs. That is why most corporate owned nursing facilities limit their Medicaid beds to 20-30% of total beds. They can't afford to take on too many Medicaid residents that they will lose money on.

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?

Current data does not truly reflect the indigent and uninsured population. We generally do not see these patients until there is an emergency or condition that has gotten out of control. This isn't something that you don't already know but there has never been an adequate answer to address this. Primary care is imperative to manage these populations and how to get them covered.

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?

We have great quality systems in place that are getting more manageable through the use of electronic medical records and more education on best practices. The information we now see is almost overwhelming and can be difficult to implement but we are getting better as our staffs learn to adapt to best practice changes. What you need to keep in mind is that we must have resources available to work effectively and many of the mandates we must adapt to are costly to implement. Services need to expand in rural areas, not contract further.

Please look at areas that can help us eliminate costs that have very little to do with patient care. Over 45% of our operating budget has very little to do with patient care and more to do with compliance issues, data reporting, liability exposure limitations, and just trying to get paid for the services we provide to our communities.

**Thank you for your interest,
Andy Kolb, CEO
Sutton County Hospital District**