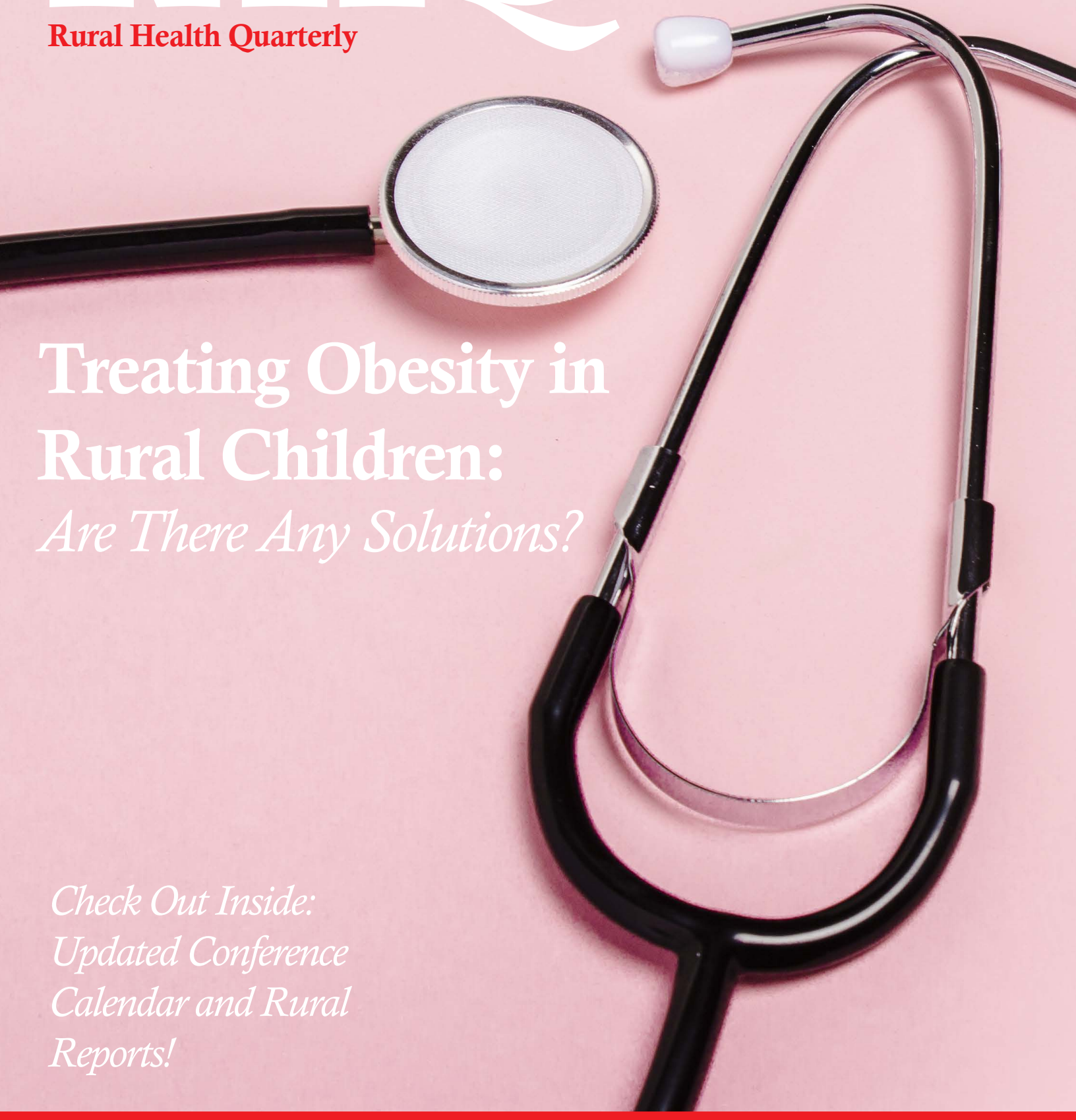
Spring 2022

RHQ

Rural Health Quarterly



Treating Obesity in Rural Children:

Are There Any Solutions?

Check Out Inside: Updated Conference Calendar and Rural Reports!

A Publication of the F. Marie Hall Institute *for* Rural and Community Health

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RHQ
Rural Health Quarterly

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Publisher
Billy U. Philips, Jr., Ph.D., executive vice president and director of the F. Marie Hall Institute for Rural and Community Health, Lubbock, TX

Editor in Chief
Candice Clark

Section Editors
Catherine Hudson—Health Education

Copy Editor
Candice Clark

Data Analyst
Miguel Carrasco

Research Associate
Debra Curti

Web Developer
Miguel Carrasco

Designer
Candice Clark

Contacts and Permissions
Email RHQ at *RHQ@ttuhsc.edu.*
For more contact information, visit *www.ruralhealthquarterly.com*

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Innovation in Times of Hardship: What the Ukriane Crisis Means to Rural West Texas

In the years that I have been publisher of the *Rural Health Quarterly*, the editors each have had a unique philosophy regarding the way the publication portrays themes in each issue. Many look forward to the U.S. Rural Health Report Card issue which is in preparation for the upcoming winter, as it awaits the issuance of complete data for various parameters of our method. For each issue, the editor will tell me the theme and I usually write my column to reflect on that as uniquely as I can. Often, they have had to remind me of deadlines as I have a heavy workload from other duties at the University.

BILLY U. PHILIPS, JR.

PUBLISHER
Executive Director, F. Marie Hall Institute for Rural and Community Health at the Texas Tech University Health Sciences Center

Nevertheless, I enjoy writing this more than any other type of writing that I do. For this issue, we have covered many topics so it is hard to put a title to our theme for this one. My editor put it nicely, "you can write about whatever you like as long as it touches on rural!"

The unjust war in Ukraine has been much on my mind of late. Unlike other wars, we have seen almost moment-by-moment scenes on social media and have even spoken or communicated in one fashion or another with people we know there. We know that when they go silent, that is not a good sign for their wellbeing or ours. Sometimes that's only because they have been moving and lost connectivity and sometimes it's far worse.

This war, unlike any others, has been as much fought on social media as in the harsh and deadly reality of the field. Just today, I learned of the existence of "deep fakes", someone posing to be Ukraine President Volodymyr Zelenskyy telling the people to surrender. I think that was easy to spot since he seems to be fearless, very brave and an amazing leader.

Amazingly, new fighters from places other than Ukraine have been inspired and went to fight alongside these amazing people. In fact, recently the enemy triangulated on the cellular traffic of a particular sniper to identify a previously unknown military training center. It was destroyed and the Ukrainians have used similar tactics, most notably in the sinking of a ship filled with ammo.

Here's my point, Ukraine is mostly a rural country with a stamina and grit that is remarkable. That's very much what one could find in West Texas. These people are plainspoken, resourceful and they make formidable foes when you try and take what's theirs.

The simplest reason is theirs is a rural culture. What I have observed in over a dozen years working in West Texas and because I come from that culture, I know that liberty is much more ingrained among people who are accustomed to scarcity in nearly every aspect of life from internet bandwidth to health care access.

When your days start and end with the rising and setting of the sun and what you do to make a living is produce food, fuel or fiber for others, then there's a certain singularity to your life that produces a hardened self-reliance. One gets accustomed to deciding what to do in every kind of situation and for every kind of need and living with the consequences. Anyone or anything that poses a threat to that is likely to meet stiff resistance from people who are hardened, tough and strong.

And like we have seen in Ukraine, these are people who have grown accustomed to using all kinds of tools, including firearms. The culture of rurality is different and substantial. I worry that, like the Ukrainian enemy, that rural culture is being lost with urbanization.

Urban dwellers must learn accommodation because there are too many people in too little space and compromises go with that – like the form of transportation and schedule is dictated by the greater needs of the many rather than the individuality of the one.

A collateral matter is that the ingenuity and innovation often required to prosper in rural areas is much more profound a factor than in urban settings – like enduring weather extremes in part because one must be prepared in order to survive them in rural areas where the fashion, learning and lore are oriented that way. Self-reliance produces an expectation, perhaps even a preference to be with other such hardy souls.

Taken together, when such people are thrust into a war, they are going to be formidable opponents because they will be unconventional, they will act decisively, they will improvise and they will be unrelenting.

I am sure you can look at the Ukrainian people and see many of these traits and perhaps others that inspire you.

With all this written, what about the specter of nuclear or biological annihilation. There are two things I've noticed in the times I have lived a rural life – one, is an unspoken understanding that some things are beyond control and you just take it as it comes. The other is more important; making such a threat gives license to adapt the idea and use it. Let me illustrate.

There's a story that Henry Ford popularized the "pickup" vehicle because the proprietor of a dairy that sold milk to the Ford family admired the Model T car, but remarked that it wouldn't be easy to carry milk tins in it. This provoked a modification in the Model T where a longer wheelbase and heavier axle replaced the back seat, thus making hauling and transporting goods much easier.

Soon factories were buying large numbers of the Model TT, and many farmers quickly adopted them to carry many other things to market. The rest makes up the history of the evolution of the most popular vehicle in America, especially in rural regions. The point is that history turns on the hubris of such threats.

I know that Mr. Putin has misunderstood and miscalculated the response he has gotten in Ukraine. I wonder if he might regret that as he realizes how quickly and dramatically things might change merely because someone decided that was too good an idea not to adopt and use. If it were so, the realization would be illuminated in a flash of light with a suddenness that someone beat him to it! ●

RURAL REPORTS

RURAL HEALTH REPORTING

FROM ACROSS THE NATION

AND AROUND THE WORLD

What's news in your neck of the woods? Let us know!

Email: Email your rural health news to RHQ at **RHQ@ttuhsc.edu**

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F. Marie Hall Institute for Rural & Community Health,
5307 West Loop 289, St. 301
Lubbock, Texas 79414

Voicemail:
Prefer to call? Leave us a message at (806) 743-3614

FAX:
(806) 743-7953

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ALABAMA //

The University of Alabama in Huntsville (UAH) has a research team working on rural healthcare delivery by drone.

The program, a partnership between UAH's College of Nursing and RSESC-UAS, is testing the delivery of medications to rural hospitals.

uah.edu | 02.22.22

ALASKA //

Dr. Murray Buttner of Unalaska was named a 2021 Community Star by the National Org. of State Offices of Rural Health.

Dr. Buttner has worked in rural Alaska since 1997, and received the award for organizing statewide workshops on medical trauma.

alaskapublic.org | 12.08.21

ARIZONA //

Cochise County, Arizona was left reeling in Feb., as the county's board of supervisors rejected $1.9 million in pandemic funds, citing pandemic fatigue.
Local doctors and residents protested the descision, as county health care continues to be swamped by COVID patients.

www.nytimes.com | 02.11.22

ARKANSAS //

The Delta Regional Authority has added 11 healthcare facilities to the DRCHSD, a program designed to enhance healthcare in the Delta Black Belt region. Dallas County Medical Center in Fordyce and T.W. Wagner, INC in Manila were chosen to participate in the program.

dra.gov | 02.09.22

CALIFORNIA //

Project Homekey, a state program that helps counties convert motels into housing for the homeless, has made a big impact in northwest California. In rural Del Norte County, county funds are used to house people at risk of becoming homeless, providing a safe space to live and access needed medical care.

Del Norte County received $2.4 million from the state to convert an old motel in Crescent City into housing. The Legacy Motel can house roughly 17% of the county's homeless residents.

www.ijpr.org | 02.19.22

CONNECTICUT //

State lawmakers are working on a number of bipartisan bills to improve mental health care for children in rural and urban communities. Proposals for permanent telehealth services and extra funding for school social workers are on the table.

usnews.com | 02.18.22

FLORIDA //

The governor of Florida awarded $11 million in infrastructure funds to Madison, Suwannee, and Putnam counties in North Florida. The funds are through the Florida Dept. of Economic Opportunity.

The money will go to extend water and sewer service in Madison County, and expand lift stations in Putnam County.

floridajobs.org | 02.21.22

GEORGIA //

The Georgia State Senate recently approved SB338, if passed it will extend Medicaid coverage for low-income postpartum women.

The coverage will now extend to a year, with the hope that this will help lower the state's high maternal mortality rate. Rural women in Georgia are at higher risk of dying post-childbirth.

georgiahealthnews.com | 02.07.22

HAWAII //

On Lāna'i, Hawai'i's smallest inhabited island, the locals have received funds from CEI to build a new community health center. Located in Lāna'i City, the facility is another step towards culturally appropriate medical care.

dailyyonder.com | 02.17.22

IDAHO //

The Idaho House of Representatives has a new bill to consider that affects the state's medical school. HB 718 would require medical school graduates to practice in the state for four years, or pay back tuition that was subsidized by public dollars. The bill would affect students enrolling in WWAMI at the U of Idaho or U of Utah.

idahobusinessreview.com | 03.07.22

CANADA

The Canadian government has announced an investment of $2.2 million to three health organizations in the country, in order to increase access to healthy activities for older adults. The Sinai Health System, McMaster University, and Cowichan Green Community Society will work towards expanding services for older adults to better maintain healthy habits.

newswire.ca | 03.08.22

UGANDA

Rocket Health, a startup founded in 2012, is working to bring medical care to Ugandans via telemedicine technology, with the main goal of making healthcare easily accessible across Africa.

Rocket Health offers services such as online medical consultations, sample collection, and medicine delivery. After receiving $5 million in funding, the startup will expand further into East Africa and other regions in the country over the next two years.

techcrunch.com | 03.07.22

FRANCE

France will suspend COVID-19 vaccination pass requirements on March 14.

Currently, a COVID vaccine passport is required in order to access all venues in the country.

But as infection spikes die down, the government is relaxing COVID health protocols, including wearing a face mask indoors.

Vaccine passes will still be needed to access elderly care centers.

france24.com | 03.03.22

AUSTRALIA

The Royal Victorian Eye and Ear Hospital is the first hospital in the country to adopt the Pharmacist Shared Medicines List, the newest initiative from the Australian Digital Health Agency.

PMSL is a list of a patient's prescription and non-prescription medicines, and will help providers manage their patient's medicines and prevent medication-related incidents.

It will also help patients who have chronic diseases and multiple medications.

healthcareitnews.com | 03.07.22

SOUTH KOREA

Medical Korea 2022, a medical conference for the global healthcare market, will be held in Seoul from March 10 to March 15.

The conference will discuss the future of healthcare in the wake of the COVID-19 pandemic.

businesswire.com | 03.08.22

SCOTLAND

The Scottish Government is starting a trial project to look at community health groups possible integration into the NHS. Community health could make a big difference overall in the country, where deprivation has led to shorter life-spans.

heraldscotland.com | 03.07.22

ILLINOIS //

U.S. Sen. Dick Durbin (D-Ill) has introduced a bipartisan bill called the Rural America Health Corps Act. The bill would build a National Health Service Corps, to improve retention of rural healthcare workers in medical shortage areas.

annanews.com | 03.03.22

INDIANA //

In Seymour, Indiana, Schneck Medical Center admin reached out to the community to get locals vaccinated. Creating a task force, the town and employed interpreters to reach residents new and old to get the shot.

As a result, 400 more people were vaccinated against COVID.

wfyi.org | 03.03.22

KANSAS //

In rural counties across the state, patients are dying waiting to receive care. According to state data 80 patients have died, exposing the consequences of rural hospital staffing shortages in the state.

kwch.com | 01.23.22

KENTUCKY //

In Lawrenceburg, Kentucky, the local police have teamed up with an ex-addict in a new effort to help those struggling with drug addiction. Andrew Hager has helped the police in treating addicts instead of jailing them, lowering incarceration rates.

dailyyonder.com | 01.18.22

LOUISIANA //

In the wake of Hurricane Ida, a program called Louisiana Just Recovery Network has helped hundreds of people in the southeast part of the state recover from the storm.

Working as volunteers, the group has tarped roofs and cleaned out homes for free, assisting rural residents waiting on relief funds from FEMA and the state.

southerlymag.org | 02.22.22

MARYLAND //

The University of Maryland Extension has partnered with three mental clinics to help struggling farmers on the Eastern Shore. The clinics will offer more acces sibility to mental health treatment and resources, where 46% of farmers say its hard to access treatment.

delmarvanow.com | 02.10.22

MINNESOTA //

The University of Minnesota, Mankato, has opened a new Center for Rural Behavioral Health, to address mental health shortage areas in rural parts of the state. The Center will focus on workforce development and research.

keyc.com | 03.04.22

MISSOURI //

In rural Missouri, the definition of "rural" has led to funding issues.

Rural towns have struggled to apply for projects, but they don't count as rural for some grant opportunities. The USDA is revising their definition, but could take years to conclude.

news.stlpublicradio.org | 01.18.22

MONTANA //

Montana State University is now offering a new doctoral program in Indigenous and Rural Health.

The program is designed to meet workforce needs across the state, as well as address health disparities. Students will be trained to develop health systems and new policies, as well as train new health professionals.

greatfallstribune.com | 02.10.22

NEBRASKA //

The University of Nebraska at Kearney has received a $100,000 gift from Healthy Blue Nebraska to support a project bringing broadband to rural parts of the state.
The Rural Measures project provides resources to keep patients connected to health care. They also address health disparities.

unknews.unk.edu | 03.07.22

NEW YORK //

Xochitl Torres Small, USDA undersecretary for rural development, met with students from the College of Agriculture and Life Sciences at Cornell University for a Q&A.
Highlighting challenges still impacting rural areas of the U.S., Torres Small discussed the food supply chain, access to resources, and climate change with the students.

news.cornell.edu | 03.08.22

NORTH CAROLINA //

The Resilient Leaders Initiative, started in rural North Carolina, helps local communities implement trauma-informed practices.

The Initiative also provides resources for rural communities and schools.

publicnewsservice.org | 03.07.22

OKLAHOMA //

The Oklahoma State Dept. of Health is offering at-home HIV test kits to residents for free, in an effort to diagnose and treat faster. The state is one of seven with the highest number of rural residents with HIV. The test kits can be ordered by calling 405-426-8400.

tahlequahdailypress.com | 03.03.22

PENNSYLVANIA //

The AgriStress HelpLine, a new pilot project for mental health, has launched in Pennsylvania. Created for rural farmers and workers in the state's agriculture industry, the pilot is funded by the USDA.

The HelpLine is available 24/7, and can be reached at 833-897-AGRI (2474).

newsfromthestates.com | 02.11.22

SOUTH DAKOTA //

The Great Plains Epidemiology Center, located in Rapid City, is one of 12 tribal centers focused on epidemiology and tribal public health needs. The center serves 18 communities in four states, providing public health programs in schools and beyond.

newscenter1.tv | 02.09.22

TEXAS //

No Kid Hungry Texas and the Texas Rural Education Assoc. have awarded $150,000 to five rural schools to assist their nutrition programs, a step towards reducing child hunger is rural Texas.
The school districts used the funds to improve their food distribution and run curbside and delivery services.

keranews.org | 03.03.22

UTAH //

In southwest Utah, National Guard members are being deployed to hospitals struggling with patient overflow and tapped out ICUs. With COVID-19 still an issue for rural hospitals in the state, St. George Regional Hospital will get 11 National Guard members to help out in non-clinical duties. Most rural facilites are operating at capacity.

sltrib.com | 02.11.22

VIRGINIA //

Eastern Shore Rural Health, Inc. is expanding their services to the community by opening a new urgent care center in Onley, and adding a pharmacy at the Onley Community Health Center. The projects are in the planning phase.

shoredailynews.com | 03.08.22

WASHINGTON //

The Washington Legislature has passed a new bill that will increase access to affordable health care for the state's residents. HB1616 will expand the state's charity care law, requiring hospital systems to provide greater financial assistance to patients.

atg.wa.gov | 03.08.22

WYOMING //

The Wyoming Senate has approved five more appropriations from the American Rescue Plan Act funds, giving $33 million to state health initiatives.
The funds will go towards suicide prevention, community health centers, and broadband projects.

wyomingnews.com | 02.20.22

COVER

STORY

Treating Obesity in Rural Children: Are There Any Solutions?

DR. STANLEY SACK

PEDIATRICIAN

Dr. Stanley Sack, MD, is a pediatrician in Key West, Florida and is partnered with Lower Keys Medical Center.

Whenever we have a public health crisis, so much is revealed about the status of all aspects of health care. We've certainly seen this with the recent COVID-19 epidemic. While much of what's good about medicine has come to the forefront—the speed with which vaccines emerged, the dedication of those on the front lines, families and businesses coming together are just a few examples—so have a lot of challenges that are still with us.

One such challenge involves our youngest patients. We've known about this problem for a while, yet our successes in preventing and treating it have been limited. And yes, the epidemic has created new hurdles in addressing it. That's right: I'm talking about childhood obesity.

Why We're Concerned: The Scope of the Childhood Obesity Problem

In recent years, a lot has been written regarding the prevalence of childhood obesity, and a few statistics are worth reviewing. According to the Centers for Disease Control and Prevention, obesity (body mass index, or BMI, above the 95th percentile on standard growth charts) was present in 19.3 percent of children and adolescents in the United States in 2017-2018. And in the United States, the prevalence of obesity, particularly severe obesity, appears to be increased in children residing in rural areas.

Why do rural kids suffer disproportionately from this weighty issue? One way of looking at this is through the lens of food insecurity. One study, for example, found that children from food-insecure households were 5 times more likely to have obesity than their food-secure counterparts. And we're well aware that rural Americans are more likely to suffer from food insecurity. But knowing these increasingly well-established facts, is there anything else we can glean about the problem by looking at the affected populations?

In order to answer that question, I wanted to go to some individuals with some firsthand knowledge of the issue: pediatricians who see and treat those affected kids. (As a pediatrician, I myself have practiced in a rural area in recent years. But as a provider who feels he could use a little help in successfully managing the problem of childhood obesity, I wanted to hear from others.) Dr. Claudia Preuschoff, a pediatrician in Poplar Bluff, Missouri, offers some insight into how parents might inadvertently contribute to the problem: "People get into a routine of buying food, and they think they're doing a good job because they are feeding their children. But they might be eating at a fast food place several times a week, they might be giving juice because they heard juice is healthy." Dr. Elisa Rosier, who has worked in both urban Detroit and rural Ketchikan, Alaska, cites "lots of food deserts" and "limited availability of fresh produce" where food insecurity is a problem.

Indeed, there is a lot about rural life, particularly in populations prone to food insecurity, which provides a setup for childhood obesity. There can be less access to proper food. A lack of walkable neighborhoods and interschool sports can mean less opportunities for exercise. Communities may lack support services such as nutritionists who could provide guidance. Oftentimes, the major source of intervention comes from the pediatric office—but there are some seemingly insurmountable barriers in treating this population. What's a pediatrician to do?

Treatment Frustrations

Drs. Peuschoff and Rosier, like virtually all of us who practice pediatrics, work with a substantial number of families of children whose BMIs are elevated. And treating these kids is a challenge no matter what the setting. Urban and rural providers alike don't really have a large selection of road maps to lead them to a good treatment plan. Much of the existing pediatric literature is focused on documenting the scope of the problem rather than providing guidance on solving it. There is a lot out there regarding what wisdom to impart to parents and patients: "Eat when hungry, stop when full, avoid soft drinks, get more exercise," and the like. Certainly, many of us adults are very familiar with advice on what to do or not do to optimize our own health, and we know that hearing and doing are two very different things.

Commendably, there's emerging literature on how to foster obesity prevention in the pediatric population. Too often, however, we're too late and are playing catchup; we already have a large population of children with elevated BMIs. Finally, we often read about innovative, multidisciplinary programs designed to manage pediatric obesity—yet due to time and financial constraints, they may not be available even in metro areas and can be virtually impossible for rural families to access. Notes Dr. Preuschoff: "Many treatment options are not available because family resources are limited"; these can include issues with transportation and getting time off from work to attend regular obesity clinic appointments.

Lacking specialty services for most affected children, pediatric providers look to provide treatment for the condition in their own offices. Yet the roadblocks to doing so go beyond having to navigate the lack of direction. Treating obesity properly is labor intensive, requiring regular appointments; this is difficult to accomplish in a busy pediatric office. In addition, health insurers often will not pay practices for a diagnosis of obesity unless a co-diagnosis such as diabetes is present. One provider who's well aware of these frustrations is Dr. Sandra Hassink.

A past president of the American Academy of Pediatrics, Dr. Hassink is former director of the Obesity Clinic at Nemours Children's Hospital in Wilmington, Delaware, a program which she started in 1988. "People didn't understand what I was doing, I was laughed at initially," Dr. Hassink notes. "There is a stigma around obesity" which has often precluded its consideration as a serious medical issue. "Obesity needs to be seen more as the chronic illness that it is."

What Small Offices Can Do

Just like any symptom that a patient can walk in with, it's helpful to know the reasons behind obesity in order to drive treatment. Says Dr. Hassink: "Every child lives in their own microenvironment, and you have to understand where they're coming from." Clinicians may have some surprises in store if they just ask what's going on. Is the child getting breakfast both at home and at daycare? Has physical education been reduced or eliminated at school? Is there a corner store where everyone congregates after school? Sometimes the child needs to be questioned: Is there a family member giving snacks in the middle of the night?

In addition to asking what's happening, it's worth knowing how the family feels about the child's weight. There's no question that different cultures bring different attitudes literally to the table. Dr. Hassink has a spin on this that makes it quite understandable: "Realize that when you come from a place where a child is malnourished with chronic diarrhea, the ability to have food and maintain weight takes on a different meaning. The problem is largely when it continues through subsequent generations who have access to the American diet, which isn't good for anyone." Cultural considerations and values may come into play during weight management counseling: "The parent may think: 'If I make these changes, my child will go hungry.'"

Dr. Hassink finds it useful to consider affected children in a practice collectively. Often having a "weight management day" in the office is helpful to get perspective and provide a tailored approach to treatment; developing a list of children suffering from obesity to track treatment and connect to community resources is another tactic. She also recommends a family focus group, bringing families in together and getting a sense from the group of how they can be better assisted in tackling the problem. If an office group meeting is not feasible, perhaps leading a meeting at, say, a local church or Rotary Club would have a similar effect.

As with any seemingly daunting task, addressing childhood obesity is sometimes made easier by breaking things down. "Focus on one office initiative at a time," notes Dr. Hassink. "As an example, can there be a 'no soda' initiative—no one drinking soda at their desk in the office, 'no soda' posters, perhaps even a 'no soda pledge' that kids can sign?"

Finally, it's important to realize that rural areas have their advantages when it comes to preventing and treating obesity, and all three interviewees can speak to examples. Dr. Preuschoff notes there is an outdoor culture in her area: "People often hunt, and there are beautiful waterways. There are many farmers' markets with fresh produce in the summer." Whale Pass, Alaska, where Dr. Rosier now resides, has a one-room school where "they keep their own chickens and collect eggs to use for their lunch. They have a big greenhouse, and each student has their own plot in the greenhouse. If children catch fish over the weekend, they are encouraged to bring some fillets in for the cook to use for lunch prep." Certainly, involving children in procuring and preparing food is one tactic that has been suggested to foster healthy eating.

One thing that's universal to rural living was brought up by Dr. Hassink: "Everyone knows everyone, and everyone knows you. It's easy to get the word out there" if, say, a focus group or other initiative is being planned.

At the end of the day, there is no one solution to the problem of obesity in rural children. But the lesson here seems to be to embrace each family's unique situation and help them come up with a workable plan. It's popular nowadays to talk about "shared decision making" in treating patients, and perhaps nowhere is it more relevant than in treating obesity. And although children who suffer from severe obesity or have medical complications probably do need specialist care, rural practices, with their potential for close relationships with patients, families, and the community, just might have a thing or two to teach their urban counterparts in managing this condition. ●

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The Case for Community: Exploring Solutions for Mental Health Care Inequity in Rural Georgia

ALEX ANTEAU

JOURNALIST

Alex Anteau is a Master of Health and Medical Journalism student at the University of Georgia.

Sunlight streamed through large glass panel windows into the library, illuminating walls lined with artwork and bookshelves. In the center of the room was a large wooden table filled by attendees taking notes, facing a presentation screen that read, "Welcome to QPR: Question, Persuade, Refer."

Volunteers receive QPR training at the Nuci's Space library on Nov. 30, 2021 (Photo/Alex Anteau)

"The topic we're gonna talk about may be triggering for some people," Lesley Cobbs, the social worker leading the presentation, said, "It may become difficult for you at any point during the day. If that's the case, feel free to leave…This is a safe space." Cobbs is a counseling advocate at Nuçi's Space, an Athens, Georgia based organization focused on suicide prevention, delivering the first round of Question Persuade Refer, or QPR, training to the organization's volunteers.

The goal of the course is to teach members of the community how to identify signs of suicidal ideation in their peers, start conversations about mental health, persuade at risk individuals to not attempt suicide and refer them to resources that can help.

While Nuci's Space was just beginning to administer the course to their staff in late November 2021, Cobbs plans to make the course free and available to the public through the organization in the near future.

"I think everybody should be fully aware of what goes on mental health wise. It just makes for a better community," Cobbs said.

Providing these types of services fills a desperate need in the state. Nuci's Space's home county, Athens-Clarke, is one of the 85 of Georgia's 159 counties designated Mental Health Professional Shortage Areas by the State Office of Rural Health in May of 2020. On average only 36.15% of rural participants surveyed felt fully confident that they could help someone who is very high stress or suicidal, indicating a majority of the population is not fully confident they are equipped with the tools to help someone in crisis.

While this is by no means a substitute for long term, clinical care, recognizing and responding appropriately to someone experiencing a mental health crisis, is the first line of defense when in comes to suicide prevention.

A Proposed Solution

Nuci's Space is one of many outreach organizations exploring community-driven solutions to the state's mental health care shortage and QPR is just one in a sea of burgeoning community intervention programs.

According to Vikram Patel, a Harvard researcher specializing in global health, community-based care models have a good track record in other countries. Patel is in charge of a research team in India that recruits members of communities and equips them with resources and training similar to what QPR gatekeepers receive.

The research team has developed a series of classes that teach participants to identify signs of mental health problems and use their positions in the community to have candid conversations about their peers' mental health needs.

The courses are entirely virtual but are designed to be completed without reliable broadband access, a necessity

"The idea…here is that you form a community of people who are supporting each other."

in regions with poor internet service. The trainees are certified through a combination of practical assessments, supervised casework and a roleplay-based exit qualification. They then receive continued support as they go out into the community.
So far these efforts have been well-received in India. Since then, Patel's team has partnered with the Wellbeing Trust, a mental health advocacy organization, to bring their work to the United States.

"[The trainees'] enthusiasm and engagement has been astonishing," Patel said, "I think it just reflects the desire to learn how to do mental health work and the convenience that digital learning offers."

Patel draws a line between crisis response and the early intervention that his team's trainings are designed to assist with.

"The idea really here is that you form a community of people who are supporting each other." Patel said.

Patel's efforts are primarily focused in Africa and Asia, where traditional mental health care doesn't exist for many people. Now that these interventions are showing promise, Americans have taken notice of their potential.

"It's, in a sense, Global Health coming to the U.S." Patel said.

Benjamin Miller, a psychologist and the president of the Wellbeing Trust, said this model has promise to improve the state of mental healthcare in Georgia. Though Patel's and Miller's work is still making its way to the U.S., the University of Georgia's Cooperative Extension is one such proving ground for how community driven care is reshaping the conversations around mental health in the rural south.

The Case for Community

The Cooperative Extension was originally created to bring agricultural research to farmers, but their mission has since expanded audience and scope. Recently they've embarked on an initiative to increase mental health care

access and education in rural Georgia.

Andrea Scarrow, director of the Extensions's southwest district said recently extension officers have started including content intended to raise awareness of mental health issues in their research presentations;
Staff members now offer blood pressure checks and provide health care information, from managing diabetes to how to recognize the signs of stress.

"We didn't want to create any other barriers. There's a stigma around mental health, talking about stress and even farmer suicide," Scarrow said, "So we just kind of soft pedal it and say we're concerned about the stress you're under, and if you need us, we're here."

In addition to the overall mental health care shortage throughout the state, farmers experience high levels of physical and emotional stress.

"You don't ever know what's going to happen," Rebecca Brightwell, Co-Principal Investigator of the office's Farm and Ranch Stress Assistance Network said. "And farmers are often very independent, that combination can really take a toll."

These efforts are done in conjunction with youth outreach through 4-H programs and ongoing efforts to establish a peer-to-peer mentorship network to increase community ties in isolated rural regions.

"If you're having a problem, you're going to probably benefit most by talking to someone who really understands your circumstance or where you're coming from," Brightwell said.
If a farmer comes to them with a direct need, Brightwell said the Office will seek out others who've had similar experiences and connect the two by way of a mentor-mentee relationship. Typically potential mentors produce the same commodity as the mentee. For instance, if they raise cattle, the office will seek out another person who raises cattle. Once a mentor is selected, they will receive mental health first aid and QPR training, focusing on how to access different resources in the area.
"The nice thing about the farming community is that it is a very generous community," Brightwell said, "Farmers are always looking to help other farmers. They may not want to help themselves, but they'll right away give you the shirt off their back."

Changing the Culture

Scarrow and Brightwell come from farming families, and their background puts them in a unique position to understand not only the needs, but the strengths of the farming community.

"[Farmers are] used to getting the job done, no matter what it takes, there's no whining, no complaining, you just do it," Brightwell said.

Unfortunately these same strengths can also be the reasons farmers are reluctant to reach out for help, especially if those equipped to help don't understand farming culture.

"You have to understand farming is not just a job to a farmer, it's their identity, it's who they are. Much more so than any other job," Brightwell said.

Brightwell's family owned a cotton gin for over 80 years. When cotton prices took a hit her grandfather, realizing he wouldn't be able to keep the machine, ultimately ended up taking his life.

"He really didn't share with anybody what kind of stress he was going through…" Brightwell said, "I just wish…he would have seen there was life on the other side of losing the gin"

According to Miller, implementing community initiated care models takes time because ultimately these efforts are changing the culture of the current healthcare model and the stigma surrounding mental health. However, despite the odds, Miller believes that in Georgia, the idea might just work.

"It allows for communities to begin to address some of these issues that the state is not," Miller said. "[Georgia] feels like a state that something wants to happen in." ●

EDUCATION

Two Illinois Medical Schools Focus on Healthcare Access in Rural Communities

CRYSTAL HAMMON

WRITER
Crystal Hammon is a freelance writer and storyteller.
Visit her website at crystalhammon.com/

It's no secret that COVID has taken a toll on healthcare workers, causing many to leave the profession through early retirements, layoffs, or illnesses, including long COVID recoveries. The Association of American Medical Colleges estimates that there will be 17,800 to 48,000 fewer primary care physicians than are needed by 2033. Who will cover that gap? That question is especially relevant in rural areas, where a shortage of healthcare providers was a persistent problem before the pandemic.

Two medical education programs in Illinois—a new one at Southern Illinois University, and an established one at the University of Illinois—are making purposeful strides to improve healthcare in rural and remote areas of the state. Both universities are recruiting the next generation of physicians who will provide healthcare in underserved communities and training them for the unique challenges of rural settings.

Attracting Medical Students with Cultural Understanding of Rural Communities

Dr. Hana Hinkle serves as the interim director and heads the National Center for Rural Health Professions at the University of Illinois College of Medicine in Rockford, Illinois, where the Rural Medical Education Program (RMED) is a core program.

"Our goal, first and foremost, is to increase the quality and the types of physicians that are trained, and to improve the long-term distribution and supply of those physicians to rural communities," Hinkle said.

The RMED program started almost 30 years ago, but until 2015, only admitted about 15 students per year. In response to growing interest in rural health, the program has doubled in size, giving more students a chance to acquire the skills needed to practice in underserved communities.

"In the early years we were really focused on students who were committed to family medicine and primary care exclusively, but after talking to our hospital partners throughout the state and the country, it really became evident to us that rural healthcare needs go beyond primary care to other specialties like psychiatry, general surgery and emergency medicine," Hinkle said.

Nearly half the students who attend medical school at the University of Illinois College of Medicine commit to the RMED program. "They represent a number of different primary and specialty interests that will go back and populate rural communities across the state and the country," she said.

RMED students train longitudinally all four years of medical school with students in the university's rural pharmacy program, learning the pharmacist's role and responsibilities within the healthcare team. They collaborate on community-oriented primary care projects to get trainees comfortable with team-based care. "We're also working to bring in other disciplines like social work and nursing," said Hinkle, who adds that the shortage of healthcare workers spans the entire continuum of providers—not just physicians.

Two-thirds of RMED graduates end up practicing in the state of Illinois, and 90 percent of Illinois graduates practice outside Chicago in suburban counties and downstate communities, sometimes returning to their rural hometowns.

"A really important point about our program is that we are particularly designed to recruit students who are from a rural background and can demonstrate that they have intent to practice in rural communities even before they get admitted into medical school," Hinkle said. "Our outcome data show that if we can recruit a student who is from a rural or more remote area in the state and across the country, they're much more likely to go back and practice in a rural community."

Students from rural backgrounds bring cultural understanding to healthcare, according to Hinkle. They are aware of the need for resources because they've lived there, and they're eager to give back to people who have helped them along the way.

"We try to identify the students who resonate with the rural connectedness we're looking for in our admissions process," Hinkle said. "Our recruiter is a former bull rider and current part-time sheep farmer, and he lives in a very small town. Our faculty, our recruiter and our directors are from rural towns, so they understand the students and the deficits they may have coming from rural communities, where there may not be advanced placement classes and other academic opportunities."

The RMED program, the Urban Medicine Program and the National Center for Rural Health Professions at the University of Illinois also partner with statewide healthcare organizations to foster local talent by getting students interested in healthcare careers as early as junior high. That happens through nine centers throughout the state that make up the Illinois Area Health Education Center Network, funded by the Health Resources and Services Administration. "We start very early on with students to make them aware of the possibilities, and then work to mentor them in their educational pathway throughout the recruitment process right up to when they apply to medical school," she said.

An Emphasis on Early Clinical Experience and Teamwork at Southern Illinois University

South of Rockford, Illinois primary care physicians like former Assistant Dean J.D. Daniels, MD, MPH and his colleagues at Southern Illinois University School of Medicine (SIU School of Medicine) decided to address the shortage of physicians in southern Illinois through a novel approach to medical education.

In 2019 they launched the Lincoln Scholars Program, making room for eight additional medical students each year, all dedicated to becoming primary care physicians in underserved, rural and remote communities.

Medical students selected for the Lincoln Scholars Program complete the majority of their foundational science classes in the first year with a class of physician assistant trainees. Under the guidance of a practicing physician, both groups begin multidisciplinary collaboration and Problem-Based Learning (PBL) in a clinical context from the start.

The goal is to help medical students learn to solve real-world problems with the information they have and seek the information they don't have. "Health science is constantly in flux, so the ability to learn and relearn is a critical part of competency for physicians," said Jennifer Rose, MD, assistant professor of family and community medicine and director of the Lincoln Scholars Program at SIU School of Medicine. With fewer physicians in underserved areas, new providers must be team players, Rose says.

Rapid obsolescence of medical information has prompted many medical schools such as SIU to abandon the "memorize-and-regurgitate-facts" model of training. Instead, they emphasize critical thinking, problem solving, teamwork and relationships. SIU School of Medicine combines PBL with multidisciplinary collaboration and early clinical experience to prepare medical students for the realities of providing care in a rural setting.

Throughout medical school, Lincoln Scholars work with a mentoring family physician one day a week in southern Illinois clinics, where they address a gamut of needs—from chronic disease prevention and management, to mental health problems and opioid addiction. During the second year, they begin seven-week rotations through several specialties, including internal medicine, neurology, pediatrics, obstetrics and gynecology, psychiatry, surgery and emergency medicine.

Mimicking the RMED program at the University of Illinois College of Medicine, the Lincoln Scholars Program targets students with ties to rural communities and/or an innate passion for practicing in a rural area. Their strategy acknowledges what hasn't worked particularly well in the long haul: underserved communities sometimes attempt to draw new physicians

by offering generous pay and contracts. Money may draw new providers, but it doesn't always keep them, especially if rural healthcare isn't a passion or there is no real connection between recruited physicians and the communities they serve.

"[The Lincoln Scholars Program] is more of a big-picture solution of training physicians and providers in a way that they feel confident in providing service in underserved areas and recognizing their value to those communities," Rose said. "We're choosing people who aspire to that early on in their careers and helping them blossom into the providers those rural communities need."

The first two classes of Lincoln Scholars to matriculate through the program share some common traits. "From what I have seen, these students are really committed to their decisions," she said. "They're brave, and they have kind of a pioneering spirit because this is a new venture for the SIU School of Medicine. They recognize that this is a new opportunity, a new adventure and they've said, "Yes, this is what I want to do and how I want to be."

High Test Scores Aren't Everything

The Lincoln Scholars Program and the RMED program aim to disrupt a problem that has perpetuated physician shortages in rural and remote communities. Students typically attend medical school in urban areas where they see a high volume of patients and a wider range of conditions.

If they are from a rural area, they often develop a taste for urban lifestyles and amenities.

Facing ever-increasing student debt after graduation, future physicians are forced to think about where they can make the most money and enjoy the best lifestyle. "As their education progresses, more of our students became less interested in primary care and more interested in specialty care in urban areas," said J.D. Daniels, MD, MPH, former assistant dean of students at SIU School of Medicine.

The advent of electronic medical records may have exacerbated the physician shortage by shifting a disproportionate amount of work to primary care physicians who see a high volume of diverse patients. Daniels says this unequal burden diminished job satisfaction among primary care physicians and made primary care less attractive to students drawn to healthcare for altruistic reasons.

"We try to select people who are organized, thoughtful and good on documentation, but it's not like we're hiring a bunch of accountants. We want them to focus on, 'How am I going to diagnose this person? Not 'What's the best way to document?'"

At SIU School of Medicine, Daniels and his colleagues have studied various ways to improve community health by making primary care practices more effective, more satisfying to healthcare providers, and more appealing to the next generation. "A lot of people end up not going into medicine because they're discouraged or not exposed to it," Daniels said. "It might be because of race, gender, or it might even be because of where you're from and what you're exposed to."

Faculty at SIU School of Medicine sought to offset some of those factors by getting younger healthcare providers engaged in filling the talent pipeline through partnerships with local health departments in southern Illinois. They found that high school students are more receptive to pursuing healthcare careers when they see someone like themselves already there.

Lincoln Scholars get involved in community projects where they interact with high school students in rural parts of southern Illinois. "That's probably the most powerful tool we have to introduce healthcare careers," Daniels said. "The students see our medical students and say, 'I can do this.'"

Attracting healthcare providers to underserved areas also required SIU to revise its thinking about who gets accepted into medical school. "Once you hit a certain level on your MCAT score, any higher than that doesn't necessarily make you a better doctor," Daniels said. Since interpersonal skills are the hardest to teach, SIU School of Medicine focuses less on attracting students with the highest test scores, and more on how applicants handle themselves in interviews.

A Private Practice in Greenville, Illinois Based on Trust

Practicing as a primary care physician in a rural or underserved community can be mentally and physically exhausting, which is why many healthcare systems and medical schools emphasize work-life balance among physicians. For many graduates of medical schools with rural education tracks, the opportunity to make a difference in an underserved community offsets the drawback of a heavy workload.

"The entire background of what it's going to take to be successful, to be a leader, to try to change healthcare, to better the community and be a resource—that's the kind of information the RMED program starts infusing from day one," said Kelsey Hopkins, MD, a 2007 RMED graduate and family physician who runs a private practice with a partner in Greenville, Illinois, a town of 7,000 people. He also serves as assistant clinical professor for the University of Illinois College of Medicine Department of Family and Community Medicine.

The fourth child in a family of eight siblings, Hopkins grew up in a northern Illinois community where the nearest neighbor was a mile away. His high school served six small communities and offered no advanced classes that might have given him a leg up on getting into medical school, but a strong work ethic proved to be a competitive advantage.

Hopkins has been a primary care physician since 2010, and also served as chief of staff and board member at a local hospital. He and another primary care physician started a family practice in 2016, buying land and renovating a 1970s farmhouse to realize their dream of improving access to healthcare in their small community. It's a labor of love that requires the duo to work up to 100 hours a week.

Proof that a private practice is almost impossible from a financial point of view: they've taken on substantial debt and given up salaries for extended periods. "The flipside is that it's unbelievably rewarding at times," Hopkins said. "People are so appreciative that you are able to help them, and that you're not part of a system that says you have to do this or that."

Hopkins and his practice partner believe that independence enhances their credibility at a crucial time in healthcare. For now, their relationships with over 6,100 patients matter more than personal prosperity. "There are a lot of trust issues in the world right now, especially with medicine, with COVID, and people not believing doctors anymore, and not believing science," he said. "If they trust that we are looking out for them, they're more likely to believe what we say."

Like many graduates of the RMED program, Hopkins' training prepared him to go beyond primary care to make an impact and solve healthcare problems in Greenville. He performs office surgeries, makes house calls, and visits local assisted care and nursing facilities. When the pandemic struck, he and his partner initiated a telemedicine program, set up a tent where they performed outdoor visits, and created a drive-through flu shot clinic. Their renovated office now has a separate wing where patients with coughs and respiratory problems can come for treatment without exposing other patients.

"You can do as much as you want as long as you're trained and prepared to do it," he said. One of their biggest challenges is getting appropriate care and services for the nearly 25 percent of their patients on Medicaid. In Illinois the Medicaid program has several different insurance plans, but for various reasons, many of the closest providers and hospitals don't accept them.

"When a big system like a hospital or a pharmacy puts a big X and says no on access to care, it creates a real issue for us to get them care," he said. "If there's something I can't provide, like a stress test, and the hospital or the cardiologist that comes here once a month or once a week doesn't take that [insurance plan], these patients, who are on Medicaid because they have financial issues, are no longer able to go anywhere that's less than 60 miles from Greenville."

Despite many obstacles, Hopkins says he sleeps well at night because he feels good about what he is doing. "This is what I feel I was meant to do," he said. "It's not a job. It's not an occupation. It's a lifestyle to meet these challenges. You just really have to be in touch and feel enjoyment out of doing this type of practice."

From Infants to Nonagenarians, Dr. Emilee Bocker Provides Healthcare for Everyone

Emilee Bocker, MD is a family practice physician in Dixon and Amboy, Illinois, and a member of the RMED faculty at the University of Illinois College of Medicine. A 2014 graduate of the RMED program, Bocker grew up on a livestock farm just outside Lanark, Illinois. Before medical school, Bocker planned to be a pediatrician, but a six-week primary care preceptorship at KSB Hospital through the RMED program changed her mind.

It isn't uncommon for medical students to fall in love with whatever rotation they happen to be on, but Bocker's call to serve was more than a temporary infatuation. She quickly realized that seeing a mix of patients was rocket fuel for a long, sustainable career.

"I still love seeing pediatric patients, but I also love caring for people who are 90," she said. "I think I would be less excited on a daily basis if I had to pigeonhole myself into one area of medicine. I knew that practicing in a rural area was going to provide more opportunities to practice a full-scope of family medicine, and that's a lot of the reason I chose to go to medical school and be part of the [RMED] program."

The 16 weeks Bocker spent in a rural health practice under the guidance of a physician mentor prepared her for the wide range of services she now provides. She notes that many of her colleagues who practice family medicine in larger cities and healthcare systems grow bored with primary care practices that expect them to refer their patients to specialists. Not so for Bocker and many of her peers practicing in rural or underserved areas.

"We have limited resources, and that affects how soon we can get people into endocrinologists and dermatologists, but with our more diverse training, one of the things we can do is say, 'You don't have to go anywhere else for that. I can take care of that for you.' I think people in rural communities expect that rather than having to see a specialist for everything they may have going on," Bocker said.

A Rural Henry County, Illinois RMED Grad Speaks Up for COVID Vaccines

Andrew J. Peterson, MD, grew up on a hog farm in Havana, Illinois, an hour north of Springfield, Illinois, but even he was shocked by the needs he discovered in Kewanee and Galva, Illinois, where

he and his wife are both family medicine physicians, employed by OSF Healthcare since 2018.

"I'm a small-town kid, and had bounced around in bigger communities throughout my training, but felt like I wanted to raise a family and practice in a small-town setting, so I chose the RMED program because I felt it was the best available training to prepare me for that," said Peterson, a graduate of the University of Illinois College of Medicine RMED program, where he now serves on the faculty as an associate clinical professor.

Despite a handful of primary care physicians in the area, Peterson says the population he serves has many healthcare challenges, from lack of transportation to limited budgets for medication. The nearest specialty providers are often 45 minutes away, and there is no public transportation. OSF Healthcare recently acquired a van, which now offers free transportation to help patients get to local appointments.

"We don't even have a way currently to get a routine colonoscopy done in our small community, and that's something that everyone needs at age 50," Peterson says. Access to mental health services is also a problem. Getting an appointment with a psychiatrist can take months, and patients may have to travel a significant distance. "We still struggle with the stigma of mental health issues in rural communities," Peterson says. "For folks that struggle, I am able to handle some of it, but it would be nice to have a psychiatrist nearby."

A rural doctor is often the most educated in the community. That distinction makes physicians de facto community leaders, and the RMED program encourages trainees to leverage that influence. Peterson gives radio interviews and presentations at schools and community groups, and has appeared on a popular local podcast.

Because he lives where he works, local residents know that Peterson is from a small town and grew up on a farm. He surmises that his shared identity may boost the trust local patients are willing to give him.

Sensing local hesitation about the COVID vaccine, Peterson recently created an evidence-based presentation and shared it with various groups. "A handful of people told me that my presentation convinced them that the vaccine was what they wanted to do," he said. "I try to get my voice out there as much as possible to talk about healthcare and things people can do to optimize their health. I think hearing things from a local physician still goes a long way for a lot of people."

Screening for Mental Health and Learning to Treat Opioid Addiction are Folded into Clinical Experience at SIU School of Medicine

The Lincoln Scholars program attracts students like Maddie Nelson, a Jacksonville, Illinois native who attended a small Catholic high school before receiving her undergraduate degree at Purdue University. Now in her second year at SIU School of Medicine, Nelson says combining clinical experience with a heavy concentration of academic work during her first year was worth the stress.

"I like to think about how nervous I was when I saw my very first patient last year as a first-year student, and how much more comfortable I feel [this year] taking a good history, getting a physical exam and coming up with a diagnosis," she said.

Growing up in a community of 19,000 people gave Nelson a lens on the challenges she might expect by choosing to practice in a rural setting. "I've had a lot of family members who needed to seek medical care and had to travel long distances for appointments with specialists," she said. "[Access to healthcare] is something that I've always been passionate about. My family is important to me, so I'd like to stay reasonably close to Jacksonville."

Although Nelson is still years away from residency, she already sees the value of long-term relationships with patients who trust their primary care physicians to think like a specialist when a specialist isn't readily available.

"You're seeing these patients regularly, whether it's at their annual physical, or when they come in because they are sick," she said. "You're able to pick up on changes and sometimes counsel people who would not take the initiative to see a counselor."

Another member of the 2024 class of Lincoln Scholars, Owen Alford initially planned to become a physician/scientist, working in neurology. Alford had the benefit of shadowing Dr. J.D. Daniels, who had been his family physician when he was growing up in Quincy, Illinois. "He's the type of doctor who will sit down and talk to you for 30 minutes about your life and how you're doing in general, not just medically," Alford said.

After getting an undergraduate degree in neurobiology at the University of Iowa and completing research on hearing loss, Alford applied to several schools. Meanwhile, he realized that becoming a neurologist might be less satisfying than he thought.

Like his classmate, Maddie Nelson, Alford took note of the influence he could have as a primary care physician who helped people stay healthy through all phases of life. He pivoted from neurology to primary care, choosing SIU School of Medicine because of its holistic view of healthcare, which regards patients as whole human beings first.

Alford likes the fact that the Lincoln Scholars program put him to work in rural communities sooner than a traditional medical education program. "We're looking at things like opioid addiction, which isn't unique to the rural setting, but it has hit this region of southern Illinois pretty hard," he said. "[SIU] offers us MAP training, the program that helps people work on opioid dependence. As soon as we are licensed and get into residency, we'll be able to offer medication assistance programs."

Alford believes his early clinical experience is giving him better insight about healthcare needs in underserved communities, where patients drive an hour or more for wound care or common preventative procedures such as colonoscopies. After medical school, he hopes to reduce the burden on rural patients by providing a broad range of services wherever he chooses to practice. ●

Rural Health Care Crisis: Immersing Future Doctors in Rural Life with Hands-on Programs

LARRY BERESFORD

JOURNALIST

Larry Beresford is a freelance medical journalist based in Oakland, California. He specializes in covering hospice, palliative care, hospital medicine, and related topics.

He hails from the small town of Crookston, Minnesota, where his father was professor of horticulture at the local U of M campus.

You can reach him at @larryberesford.

As a third-year medical student in 2019, Allicen Waxlax, MD, undertook a nine-month, hands-on educational experience in small-town Aitkin, Minn., population 2,165. Following three months of intensive teaching through the University of Minnesota's main campus, she was primed to participate in many facets of the local health care system centered on Riverwood Healthcare Center, Aitkin's independent, 25-bed, critical access hospital.

The U of M's Rural Physician Associate Program (RPAP), one of a number of rural experiences for trainees offered by medical institutions around the country, has been giving selected students similar immersions into rural medicine and rural life for 50 years.

For Dr. Waxlax, who grew up in even smaller Barnum, Minn., population 613, this placement offered a longitudinal approach to encountering the medical curriculum that would not be possible for students at large urban medical centers, typically locked into tight monthly rotations.

"In Aitkin, I was able to do the full spectrum of medical care under the supervision of my preceptor, Dr. Donald Hughes," a local family practice doctor who has preceptored RPAP students for 27 years, Dr. Waxlax said. "I had a home base, and I could work with other providers to tailor my learning experience, developing relationships where they knew me by name and what I was capable of doing."

She participated in care in surgery and the emergency room when opportunities arose and followed her patients from hospital to outpatient clinic and even into hospice care. "We could do warm handoffs, and I could see my patients getting wonderful care in the clinic. I could help deliver babies and participate first hand," she said. "Then, while I was there, COVID hit. I know at other facilities medical students got completely shut out by the pandemic. But I was able to remain involved and continue seeing my patients virtually, doing wellness visits by Zoom or over the phone while actively learning."

Dr. Allicen Waxlax with her Aitkin, Minn., preceptor, Dr. Donald Hughes (Photo / University of Minnesota)

An Acute Physician Shortage

The ongoing crisis in rural medicine in America includes the challenge of recruiting enough doctors willing to locate in rural communities. Often-quoted statistics hold that while 20 percent of Americans live in rural areas, only nine percent of physicians do, even though the rural population, on average, is older, sicker and poorer. Yet in multiple surveys only three to five percent of recent medical graduates say they plan to practice in small towns or rural areas. Meanwhile, replacements are needed for rural primary care physicians who will soon be retiring or dying.

"Clearly there is a crisis in rural health care," says William Crump, MD, associate dean of the Trover rural regional campus of the University of Louisville's School of Medicine, located in Madisonville, Ky., population 20,000. "What's needed is to attract more doctors to rural settings. That means getting the right medical students in the first place."

For future doctors, one of the biggest determinants in whether they locate in a rural community is if they grew up in one.

Another factor is exposure to timely, intensive and positive immersion into medicine in a rural setting—although how long that immersion needs to be is subject to debate. Sarah Brill Thach, MPH, assistant director of the Master of Public Health Program at the University of North Carolina's Health Sciences at Mountain Area Health Education Center (MAHEC) in Asheville, says the gold standard for how to create a rural doctor has not yet been identified.

"This is an issue that needs more than one answer. Even though we haven't yet moved the needle that much, a lot of people are doing exciting, great work with rural-based programs," she said. MAHEC is an example of a rural health education center created with federal funding in the 1970s to support rural doctors with access to continuing education and medical libraries while offering multiple residency opportunities.

Lifestyle is an important consideration for providers, Thach said. Some might prefer the slower pace of life or access to nature. Others will want to know about educational opportunities for their children or job opportunities for their partner. "In Asheville, it's easy for us to show off the glamour of mountain living and after-hours quality of life. We can take job candidates white water rafting."

But rural training programs also need to emphasize preparation for rural life and teach a wide range of skills, including the leadership skills required to address a community's health needs, Thach says. "Good candidates are mavericks. They like adventure. In medical school you want to reinforce those tendencies."

Other programs nationwide include community-based, university-affiliated rural residencies, some of which use a "1+2" model, with one year of urban medical training followed by two years in a rural setting. Another option is a rural medicine accelerated track, offering motivated students an opportunity to complete medical school in three years, incurring one year less of tuition costs.

Dr. Waxlax said her experience in Aitkin further cemented a long-standing interest in pursuing rural medicine as a career—when she completes her family medicine residency in La Crosse, Wisc., in 2024. "I could really see myself practicing in a rural setting," she said, adding that she'd like to develop an emphasis on diabetes management and obesity education for an aging rural population.

Before answering the call to apply to medical school at Minnesota's Duluth campus, which has a rural focus, she worked as a registered nurse in Northern Minnesota for 17 years, often encountering RPAP students or mentors. "That further fostered my love for this work. I got to take care of the people who had taken care of me." But she also observed the problems posed by shortages of rural physicians.

Ensuring a Good Match

RPAP places 35 to 40 medical students per year in rural sites across Minnesota and western Wisconsin, with a cadre of about 60 local family practice doctors who work closely with the program, says Kirby Clark, MD, the program's director and Assistant Professor in the Department of Family Medicine and Community Health at the U of M.
One key to its success is ensuring a good match, he said. Applicants fill out a lengthy application asking them to reflect on where they see themselves in 10 years, their specialty, their scope of practice, other areas of interest. "We meet with each student who applies and we spend a lot of time on it." The program, in partnership with the University's regional Duluth campus, also offers a summer internship and shadowing experience between the first and second years of medical school.

Dr. Kirby Clark, Director of the University of Minnesota's Rural Physician Associate Program (Photo / University of Minnesota)

Participants do a community health assessment project to figure out local needs and identify local stakeholders. Such projects might explore, for example, access to mental health resources for adolescents or vaping in the schools. "We also want to make sure our folks don't feel isolated, so we encourage them to find hobby connections, perhaps take up youth coaching, or join a local church group," Dr. Clark said.

About 40 percent of RPAP participants end up pursuing a career in rural medicine, a number that has been borne out for other rural immersion programs. Many choose family medicine and primary care, but there's also a need for rural specialty practices such

as surgery or ob-gyn.

Howard Rabinowitz, MD, grew up in Pittsburgh, Penn., but spent two years during a break in his residency on a Native American reservation in rural Arizona, where he got a close look at medical practice in a rural setting. In 1976, when he returned to Pennsylvania to join the Family Medicine faculty at Philadelphia's Jefferson Medical College (now Sidney Kimmel Medical College), he was enlisted to direct its recently launched Physician Shortage Area Program (PSAP). "I was the only person on faculty with any rural experience. I ran the program for 42 years until I retired," he said.

"Our program is quite simple. The reason we have a reputation for rural placements is not necessarily because we have the best program, but because we've been tracking and publishing results from our graduates since the early 1980s." It has consistently shown similar rates as Minnesota's for participants opting to follow the path to a career in rural medicine.

PSAP provides preferential admissions and works to recruit future candidates from small towns and rural areas while they are still in college. Everyone who applies to the medical college is asked if they came from a rural area and plan to practice in such an area. If yes, they are invited to apply, with a small amount of financial support.

"We select about 10 students per year and provide them with strong mentorship, monthly meetings throughout medical school and a six-week rural rotation," Dr. Rabinowitz said.

Other Programs, Other Factors

Ashley Jessup as a second year medical student doing a free school physical in a town of 3000. She completed the 3-year accelerated medical school option and is now in FM practice in a town of 4000 near her hometown. (Photo/Pam Carter, University of Louisville School of Medicine)

Dr. Crump said his Kentucky rural immersion program's claim to fame is its complete pathway to rural practice, beginning with a High School Rural Scholar Program that annually recruits 12 to 18 participating rising high school seniors from five counties in Western Kentucky. They shadow health professionals in their county while living at home and taking daily virtual classes.

"We focus on diamonds in the rough, not the very top students but those who have an innate capacity but no one has ever raised their aspirations or helped them envision the possibility of becoming a doctor," Dr. Crump said. Local school counselors advise the program and help identify candidates.

A college rural scholars program continues to build the connection, along with a three-to-four-week pre-matriculation program before medical school starts and rural electives during medical school years one and two. "Home for the Holidays" immerses pre-clinical, rural-focused medical students in brief practice experiences close to their homes during winter break. Then, participating third-and-fourth-year medical students at Louisville relocate to Madisonville, where they complete all of their rotations in rural settings.

Choosing family medicine as a specialty is another factor in the likelihood of pursuing a rural medical career, Dr. Crump said. "Family medicine doctors who are attracted to rural practice want to do the gamut of medicine. You have to be comfortable with blood and guts and doing a lot of procedures."

The University of Alabama at Birmingham (UAB) has several rural-focused programs, including an assured admission program for rural students who take a post-graduate year of science and premed coursework at Auburn or UA-Tuscaloosa. This supplements the education they received at their rural high schools, said David Bramm, MD, UAB's director of rural medicine. "I go around to two-and-four-year community colleges with a slideshow and I talk to people. We encourage them to consider our rural programs, which have some special benefits while they take the same courses and tests as other medical students." The program targets rural students of all races, Dr. Bramm said. "The barriers rural students typically face are poor-quality high school preparation, modest financial means, and poor college prep from community college beginnings. Regardless of your race, if you come from a rural area and you're the first from your family to ever graduate from college, it's extremely tempting to look for bigger opportunities in bigger cities."

One promising candidate, from Fort Payne Ala., population 14,000, is Alicia Williams, MD, currently a first-year resident in pediatrics at UAB. She was a basketball player for Mercer University, Macon, Ga., and she and Dr. Bramm talked about basketball during her application process. He recognized that her poise and determination on the basketball court were ideal traits for a rural doctor. Once she was in medical school, he nominated her for an Underwood Scholarship for African-American students.

"Coming from a small town definitely makes you more likely to choose that setting for your career," Dr. Williams said. But she's not ready to commit. "Honestly, I'm just trying to get through my intern year. I haven't made any final decisions. When you train at a large academic institution, you start to see some of the opportunities for research, for doing teaching, which might draw you to a larger setting, instead," she explains. "But my whole family is from Fort Payne."

Don't Get in their Way

Most counties in Western Kentucky are health professional shortage areas, but many are just one full-time family practice doctor short of getting out of HPSA designation, Dr. Crump notes. "It would only take about 30 doctors to turn that around in this area and we have 150 in the pipeline—although the pipeline is very long."

The biggest current barrier to recruiting more rural doctors, he added, is that family medicine is still not adequately compensated or supported by national health policy despite 20 years of promised payment reform. Dr. Crump fears that the established model of small-town family practice is in danger of dying, undoing the good work of programs like his.
"Payment is not adequate for the office visits that are the heart of primary care. It's a broken system," he said. "Many of our graduates, who are family medicine specialists from a small town and should go back to such towns, become hospitalists instead, because family doctors aren't compensated enough to pay off their student loans."

"We have to do a better job of identifying those people who would be amenable to careers in rural medicine, preselecting them and giving them more encouragement," said Dr. Rabinowitz. If every medical school in the country dedicated at least 10 slots to rural programs and five of those graduates went into rural practice, it could double the placement of new physicians in rural settings, he added.

But not enough medical schools are doing these kinds of things, Dr. Clark said. More should incorporate rural programs, and they should try harder not to discourage future doctors' interest in primary care, family medicine and rural practice. Too many have an unwritten curriculum that says these are not proper paths for a high-performing medical trainee. "These students come in eager to learn. Their passion is palpable," he says. "They are bright, motivated, kind young people. They are ready to care for rural America. Our job is to give them the opportunity to do that and, in particular, to not stand in their way." ●

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RURAL

CANADA

Water Crisis: First Nations Community Marks 27 Years of Drinking Water Advisory

L.OUISE GAGNON

WRITER/EDITOR

Louise Gagnon is a Medical Writer/Editor based in Ottawa, Ontario, Canada

The face of Canada's long-term drinking water advisories is no better illustrated than by the sight of empty water jugs and bottles in Neskantaga, a First Nations community in the northern reaches of the province of Ontario, which recently marked a bleak milestone — a 27-year drinking water advisory, making it the longest such advisory confronting any First Nation in Canada.

Thousands of full water jugs and bottles have been shipped to the Indigenous reserve over the years as a solution to its water crisis. Consequently, empty plastic bottles and water bottles have amassed on the reserve, and the community is asking the federal government in Canada to help it dispose of all these empty containers in an environmentally conscientious manner.

Short-term and long-term drinking water advisories are unfortunately a common aspect of life in Indigenous communities in Canada. The length and duration of short-term and long-term drinking water advisories are tracked by the federal government and other sources. The number of short-term advisories frequently changes. Short-term advisories become labelled long-term advisories if they exceed one year.

When the federal Liberal government was elected in 2015, Prime Minister Justin Trudeau promised to eliminate all drinking water advisories in First Nations communities across Canada by March 2021. That objective was clearly not met.

Despite not meeting this goal, the federal government contends it is committed to clean drinking water for First Nations on reserves, according to Jennifer Cooper, a spokesperson for Indigenous Services Canada, the federal department involved in ensuring on-reserve water systems are safe.

"As of February 7th, 2022, First Nations, with support from Indigenous Services Canada, have lifted 127 long-term drinking water advisories since November 2015," wrote Cooper in a statement to *Rural Health Quarterly*. "There are 36 long-term drinking water advisories in 29 communities remaining. Additionally, First Nations and the Department (Indigenous Services Canada) work collaboratively to resolve short-term drinking water advisories before they become long-term. Since 2015, 208 short-term drinking water advisories were prevented from becoming long-term," wrote Cooper.

The federal government has also invested more than $2 billion to support water and waste water-related infrastructure projects, added Cooper.

There are three different types of drinking water advisories: boil water advisories, meaning water needs to be boiled before it is consumed; do not consume advisories, meaning the water can be used for things like washing hands but not for drinking; and, do not use advisories, meaning the water cannot be consumed or used for bathing or washing dishes.

The absence of water security that many Indigenous Canadians live with is not a uniquely Canadian problem, according to Corinna Dally-Starna, a sustainability professional and a PhD candidate in the School of Environmental Studies at Queen's University in Kingston, Ontario, Canada, whose work focuses on the barriers and enablers to achieve long-term water supply system functionality in rural Canada.

The absence of potable drinking water available on demand can have many cascading effects in Indigenous populations such as adverse consequences on people's health, food security, and well-being, pointed out Dally-Starna.

"What is the impact on health (of not having safe tap water)?" asked Dally-Starna. "Water insecurity causes mental stress. And when water needs to be collected from standpipes or rivers, there is a risk of injury and contamination. When the cost of 12L of bottled water can be around 30 dollars, as is the case in northern communities, residents may turn to unhealthful alternatives."

Health conditions such as obesity and diabetes are grave concerns in First Nations communities: in Canada, age-standardized prevalence rates for diabetes are 17.2% among First Nations individuals living on-reserve vs. 5% in the general population. Moreover, data from the Canadian Community Health Survey indicate rates of obesity of between 30% to 51% for First Nations individuals living on reserve.

Another consideration among many is respiratory health with respect to the potential impacts of frequent boiling of water in households, which can lead to the development of mould, pointed out Dally-Starna.

And while the support for infrastructure is one element in ending drinking water advisories, it is one piece of the puzzle, said Dally-Starna. "Just because a community has a working (water) treatment plant does not mean all community members are water secure," she said.

Indeed, qualified personnel to staff water treatment plants is necessary to minimize the length of short-term drinking water advisories and avoid them from becoming long-term drinking water advisories. Organizations like Water First, a Canadian non-profit with a mandate to train and educate the next generation of water treatment plant operators, is providing training and education to young operators so that a given Indigenous community does not have one sole operator of its water plant. Water First works with its Indigenous Advisory Council to identify training needs. The Council provides feedback to Water First on the delivery of services.

"There may be only one operator who is responsible for the whole community," said Jen Atkinson, Director of Operations at Water First. "That makes it very difficult for that person to take a day off and be sick. This is also about planning and succession. Having a community that has multiple operators or skilled people who can step up is part of the longer-term solution."

Short-term water advisories may occur because something has broken down at the water treatment plant or flooding, which can threaten the source water, has occurred, explained Atkinson, adding run off erosion from industry can also threaten the source water to a community.

Another hurdle to overcome is equity in pay for Indigenous staff at water treatment plants, according to Kerry Black, PhD, Peng, Assistant Professor, Department of Civil Engineering, Canada Research Chair, Integrated Knowledge, Engineering & Sustainable Communities, Centre for Environmental Engineering Research and Education at the University of Calgary in Alberta, Canada.

"First Nations operators are paid less than non-Indigenous operators," said Dr. Black, explaining the funding for services on First Nations communities comes from the federal government and is not plentiful. "You have to choose where you can allocate the funding for operation and maintenance. It's really difficult to find enough money to adequately pay operators who work on a reserve. There are a lot of well-trained operators and technicians who can do it, but there is limited funding to be able to pay them adequately for the work that they need to do. We do need to put a ton of money and effort into training and capacity."

The pandemic and the familiar refrain about frequent hand washing has underlined the critical nature of having water on demand available, according to Dally-Starna. "The water that comes out of the tap is also essential for personal hygiene," she noted.

"I think Covid-19 has made it clearer that there are disparities in the population and these disparities have widened," said Dally-Starna. "Unless the media reports cover the breadth of issues surrounding Indigenous communities' water security, it is easy for other Canadians to forget how some of these communities are struggling."

Another factor is the need to establish or re-establish trust with Indigenous communities, making the case that their water is free of contaminants and not harmful to drink, according to Dr. Black.

"Another part of this conversation is once you do repair infrastructure, how do you rebuild trust?" asked Dr. Black. "If you had spent the better part of your life not being able to trust the quality of the water that came out of the tap, how can you just flip a switch and think the water is safe? We need to think about this in terms of rebuilding trust around something that the rest of us take for granted, which is having water that is safe to drink."

While there are Canadian Drinking Water Quality Guidelines for the country's 13 jurisdictions (provinces and territories), the uptake of and adherence to these guidelines is voluntary. Moreover, safeguarding the quality of drinking water in First Nations communities does not fall under provincial jurisdiction. Instead, it is the requirement of the federal government to work with First Nations to ensure acceptable drinking water quality on reserves.

It has been viewed that with the lack of provincial or territorial involvement and investment with respect to achieving satisfactory drinking water, many reserves have fallen or are at increased risk of falling between the cracks.

Dawn Martin-Hill, an Indigenous Canadian living on Six Nations of the Grand River in Ohsweken, Ontario, and an Associate Professor in Indigenous Studies and Anthropology at McMaster University in Hamilton, Ontario, Canada, noted that water in Indigenous communities is often held in concrete cisterns, putting the water at risk of contamination because of possible damage to the structure of the cisterns or events like overland flooding. In addition, wells that had been built decades ago also have allowed for contamination of the water they hold. "Many of the wells that were built were not built to standard," noted Martin-Hill.

Private industries have operated near First Nations reserves and created waste, which threatens the cleanliness of the source water. In addition to water treatment plants, waste treatment plants are also in need in Indigenous communities, stressed Martin-Hill.

Martin-Hill criticized federal efforts to date aimed at ending drinking water advisories. She said the plans have lacked an organized approach. She contrasted these efforts to those directed at responding to the Covid-19 pandemic — a cohesive plan came together to respond to the urgency of the pandemic with respect to the availability of masks, sanitizer, public messaging about social distancing, infection, and isolation. Moreover, research got off the ground quickly which translated to the emergence of vaccines and jabs in arms less than a year after the World Health Organization declared the pandemic.

"They should make a strategic national plan (to respond to the lack of water security)," said Martin-Hill. "Universities and engineers travel all over the world to bring clean water to economically-depressed communities. If we pull the greatest resources we have and really tackle this issue with the proper government authorities, using that kind of multi-partner model, we could address this issue. We need leadership." ●

RURAL
REPORT

LGBTQ+ Older Adults Needing Long-Term Care in Rural Settings: Invisible No More

L. MICHAEL POSEY

WRITER/EDITOR

A pharmacist-editor-journalist since 1980, L. Michael Posey is a regular writer and editor for The Gerontological Society of America, Postgraduate Healthcare Education's PowerPak.com website, and other clients. He is the author of many news and journal articles and author or editor of several books, including the landmark pharmacy textbook *Pharmacotherapy: A Pathophysiologic Approach.*

A transgender woman in "Sunrise County," Maine, the easternmost point of the contiguous United States. A lesbian couple in Sunset Hills, Missouri, a suburb of south St. Louis. A widowed lesbian in the northwest Chicago village of Niles. A transgender woman in the sparsely populated mountains of northwestern Colorado.

Each of these LGBTQ+ individuals sought a place to live in community and safety in older adulthood. Instead, facilities denied them admission, permitted and contributed to harassment, or complicated the process until the person sought care elsewhere.

"People have this dream to retire and move to whatever that dream destination is," said Sherrill Wayland, director of special initiatives at SAGE and the National Resource Center on LGBT Aging. "But there's probably a larger majority of people that they want to remain where they're connected to community, to family, to social interactions. If you're an LGBTQ individual living in a more rural community, you have to ask yourself, 'do I want to stay here?'"

When LGBTQ+ —lesbian, gay, bisexual, transgender, queer, and other communities — people seek long-term-care in rural, frontier, and territorial areas, open and welcoming assisted-living and long-term care options are a rarity. The good news for LGBTQ+ older adults is that several initiatives are casting light on this dilemma and offering tips and tools for identifying long-term care homes that can meet their needs. Advocates for elder health and the LGBTQ+ community are also active in the legal, regulatory, and policy arenas. This article details these challenges and identifies emerging trends.

LONG-TERM CARE IN RURAL AREAS: THE INVISIBLE LGBTQ+ RESIDENTS

Case in Point

Wetzel v. Glen St. Andrew Living Community, LLC: Marsha Wetzel moved into this Niles, Illinois, residential community after her partner of 30 years died. "Within months of her arrival, [she] faced a torrent of physical and verbal abuse from other residents because she is openly lesbian," according to a Seventh Circuit U.S. Court of Appeals decision. "Time and again, she implored St. Andrew's staff to help her. The staff's response was to limit her use of facilities and build a case for her eviction." In a landmark decision, the Court held that the home was in violation of the federal Fair Housing Act (42 U.S.C. §§ 3601–3619), prohibiting discriminatory harassment that "unreasonably interferes with the use and enjoyment of a home."

Rural America disproportionately needs more long-term care services but lacks facilities. One fourth of homebound older adults live in rural areas, where they more frequently "age in place" in their homes and rely on scarce resources (Williams & Mattos, 2021). An estimated 1.2 million to 2.2 million LGBTQ+ individuals live in rural America (Harootyan et al., 2021).

Pamela Teaster, PhD, has seen the challenges faced by LGBTQ+ people firsthand in her work as an ombudsman for long-term care facilities and researcher in eastern Kentucky and the Blacksburg area of Virginia. "One day, I just popped this question during interviews on elder abuse in general in rural Appalachia, 'what about people who are LGBTQ?'" said Teaster, professor and director of the Center for Gerontology at Virginia Tech. "The woman answered, 'They should never say they are.' That statement never left my mind as it was such an important question to explore."

Published data backs that perception. A 2009–2010 Justice in Aging survey reached 284 LGBTQ+ older adults in long-term care settings and 485 family members or friends, service providers, and others. Of the 289 service providers, 247 believed that LGBTQ+ people would not be safe disclosing their sexual orientation or gender identity or that they should not do so. A 49-year-old social worker from Ashland, Virginia, said she had never known anyone in a facility who stated any alternative sexual orientation, "which says a lot in itself." A 51-year-old provider who was a transgender man in a very rural, very conservative state said, "I have done training for long-term care staff and administrators in this state, but most feel that there are no LGBT residents in their facilities."

"what about people who are LGBTQ?"

"They should never say they are."

Yet in many ways, the LGBTQ+ community is one with greater need for long-term care than the rest of the population. Statistically, fewer LGBTQ+ individuals and couples have children who could provide informal care in their homes, and families and relatives are more often unavailable when they have rejected LGBTQ+ individuals. An estimated 29% of LGBTQ+ adults age 25 years or older have children, compared with historical figures of 47.5% of the U.S. general population (Williams Institute at the University of California at Los Angeles School of Law, 2019; U.S. Census Bureau, 2016).

LGBTQ+ ABUSE, DISCRIMINATION REAL PROBLEMS IN LONG-TERM CARE

Case in Point

Mary Walsh and Bev Nance, as reported in in *McKnight's Senior Living*: This same-sex married couple in 2018 sued the faith-based, nonprofit senior living community Friendship Village Sunset Hills on the outskirts of St. Louis after they were denied a unit. After accepting a $2000 deposit from the couple, the home in 2016 blocked their move-in because they did not meet the "Biblical definition" of marriage being between a man and a woman. The suit was settled out of court.

Many of the millions of LGBTQ+ American living in rural areas have been comfortable in recent decades to stop hiding their gender orientation and sexual identity. Yet, when they need long-term care, they sometimes feel that they must play a game of "don't ask, don't tell" with facilities and other residents. When residents remain "out" in long-term care facilities, abuse can be physical, verbal, or sexual but is frequently more systemic, reports the Nursing Home Abuse Center. This can include denial of visits from friends without staff approval, refusal to allow same-sex partners to live together, and refusal to allow non-biological families to take part in medical decision-making. As a result, many LGBTQ+ individuals dread needing long-term care, a setting where "fear runs deep" among LGBTQ+ older adults when they anticipate needing long-term care services (Putney et al., 2018).

"A lot of times, folks in rural communities may have to make a decision about disclosure," said Wayland. "Do I come out? Do I not come out? LGBTQ+ people 'second closet' or 'recloset' for their own protection, their own safety and wellbeing. It's often necessary to not be open about their sexual orientation or gender identity. It's a real fear that people have — and one that I can understand."

WORSENING SHORTAGE OF RURAL FACILITIES, BEDS

Case in Point

Lisa Oakley, as reported by Colorado Public Radio: A 68-year-old transgender woman in the small Colorado mountain town of Craig, Ms. Oakley said she was denied admission by about 60 facilities because of her gender identity. Despite the help of a hospital care coordinator, facilities were nonresponsive and evasive; eventually, the coordinator realized discrimination must be in play. One home said Ms. Oakley could not share a room with a cisgender woman, and would have to pay for a private room since she refused to share a room with a man and "still had her boy parts." Ms. Oakley wanted to stay in Craig, but eventually had to move 150 miles away to Grand Junction, Colorado.

While the federal Nursing Home Reform Act prohibits discrimination and requires that residents have certain rights, facilities have found many ways of denying care to LGBTQ+ individuals or trying to get them to move out once they are there. Given the chronic lack of an adequate number of long-term care beds and assisted-living units in rural areas, many people have trouble locating (and paying for) a bed in their community or near friends and relatives in the social support system.

Their concerns about safety and care lead LGBTQ+ individuals to seek facilities that cater to the LGBTQ+ community and trained in the special needs of LGBTQ+ older adults (Caceres et al., 2019; Jihanian, 2013; Smith et al., 2018), but in rural areas, those choices are few and far between.

Lack of expansion of Medicaid under the Affordable Care Act has exacerbated this deficit (Rhubart et al., 2021). According to a Leading Age report, 555 facilities closed nationwide in 2015 through 2019, and 37% of those homes were in rural areas. Three of the states that have not expanded their Medicaid programs as funded in the Affordable Care Act (Texas, Wisconsin, and Kansas) were among the nine states accounting for most of the closures. States where more than half of closed homes were in rural areas were Nebraska, Kansas, Montana, Minnesota, Oklahoma, Iowa, Washington, Kentucky, and New York.

HOPE ON THE HORIZON: THE LONG-TERM CARE EQUALITY INDEX

Case in Point

Doe v. Sunrise Assisted Living, LLC: This case of a 78-year-old woman is currently pending before the Maine Human Rights Commission. After an acute medical emergency, Ms. Doe required placement in an assisted-living facility in the rural community of Jonesport, Maine. After initially telling a hospital social worker that rooms were available, the facility administrator denied admission after learning Ms. Doe was a transgender woman and might want to be placed in a room with another woman.

How then are LGBTQ+ people able to find a facility that is not just acceptable but is openly affirmative and welcoming to this community? What rights do residents have once they are in a facility?

"Consumers are better off if they locate a long-term care facility that takes a more proactive stance and communicates, 'we are open and affirmatively welcoming to LGBT folks,'" said Eric Carlson, directing attorney at Justice in Aging. "We see them, we recognize them. That is certainly a positive thing for individuals who are looking for a place to stay, for a place to live."

The Long-Term Care Equality Index, developed by SAGE and the Human Rights Campaign, is designed to make Carlson's idea a reality. As spelled out in a 2020 report that presented the "case for inclusive long-term care communities," LEI is "an important process that all [long-term care communities] should engage in—especially if they pride themselves on being rooted in person-centered care; if they are intent on continually enhancing their diversity, equity, and inclusion; and/or if they wish to grow their market of potential residents."

The first LEI self-assessment survey was released in 2021. "We are seeing communities that want to be a part of this work," SAGE's Wayland said. "That's promising. It's similar to the experience of the Human Rights Campaign. When the Healthcare Equality Index was launched 13 years ago, they began with numbers very similar to ours. Now they have more than 1,600 LGBTQ friendly healthcare facilities participating in the program. We envision that same momentum for long-term care communities across the country."

The LEI process starts with a signed commitment by facility leadership to create an inclusive, welcoming, and culturally competent environment free from discrimination and willing to complete LEI's online assessment within three months. The assessment is repeated each fall to assess progress in foundational policies, employee benefits and policies, resident services and support, and resident and community engagement.

This process produces an online interactive map older adults can use to identify LEI communities in 32 states. LEI Pioneering Participants are listed in the 2021 LEI report, including 78 long-term care organizations and 184 communities, some of them in rural areas. But inspection of the online map quickly shows large swaths of land with no LEI facilities, including the expanse between Puget Sound and Minnesota's western border, and rural areas such as West Texas, Northeastern California, and South Georgia.

Using a question-and-answer format, a consumer guide provides useful advice about what community policies LGBTQ+ people should ask about. Sample language is provided for inclusive nondiscrimination, visitation, and rooming policies.

California, long a bellwether state, has a bill of rights for LBGTQ+ residents' in long-term care facilities. The 2017 law — a model for other states — covers admission, assignment of rooms and sharing of rooms, clothing and cosmetics, visitation, consensual sexual relations, and medical and nonmedical care.

"If communities in metropolitan and urban areas are recognizing the need for creating open, inclusive communities that are welcoming to LGBTQ+ people, then the same need exists in rural areas."

FINDING COMMUNITY

Establishing and ensuring rights of residents — including those already in place at the federal and state levels —requires sustained effort over a long time period. As facilities recognize the advantages of affirming the rights of LGBTQ+ individuals in long-term care, such progress can be accelerated and baked into the system.

"If communities in metropolitan and urban areas are recognizing the need for creating open, inclusive communities that are welcoming to LGBTQ+ people, then the same need exists in rural areas," Wayland said. "Many LGBTQ+ people call rural areas home and want to continue to age in the communities where they have created community and a sense of belonging. Long-term care communities in rural areas that embrace LGBTQ+ inclusion can extend that sense of community and belonging and provide an opportunity for LGBTQ+ people to age in the communities they call home." ●

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RURAL

COMMENTARY

Grandma: My Canary in the Coal Mine of Long Term Care

TRACY GRANZYK

WRITER/CONSULTANT

Tracy Granzyk, MS, MFA is a healthcare consultant and freelance writer who currently serves as the founding Senior Director, Center for Healthcare Narrative at the MedStar Institute for Quality and Safety; is founding Editor-in-Chief of *Please See Me*, an online magazine that elevates the health-related stories of vulnerable populations and those who care for them, and is on faculty at the Academy for Emerging Leaders in Patient Safety (AELPS). Tracy has written, directed, and produced award-winning healthcare films and published numerous articles on health-related topics. She earned her MFA in Creative Writing at the University of California-Riverside Palm Desert Low Residency program, and is currently at work on a TV pilot along with several long-form creative nonfiction projects. Her portfolio can be found at: www.tracygranzyk.com

When Frances Zabrauskas moved a few miles from her home in Dyersburg, TN population 16,500 to Maple Ridge, a newly-built assisted living community with graduated care, she was 96 years old. It was the spring of 2016, and the thought of a pandemic was the furthest thing from any of our minds. She had been living independently in the modest but nicely appointed ranch home she took great pride in decorating since Stanley, her husband of sixty-five years, passed away in October of 2007.

Fran and Stan were my grandparents, first generation Lithuanians who were part of our greatest generation. Born during the Spanish Flu, they grew up during the Great Depression first in southern Illinois, then in Marquette Park, a south side Chicago neighborhood. Church was their place of worship and where they socialized, and the place they met. Each had five siblings and one of grandma's sisters married one of grandpa's brothers. They were stubborn, independent, regimented, flawed and fabulous.

When Grandma came to stay with us in 1978 to give my parents a much needed weekend escape, she immediately put us to work doing chores. We still joke that she made my younger brother, eight-years-old at the time, wash the tires of our car. "But Grandma, they're tires. They're supposed to get dirty," he said, a salesman even then. "It will be good for them, and you," she said, handing him a rag and bucket.

She kept a jar of change in the lower kitchen cabinets for nickel and dime poker that we played regularly throughout the years. Some of the best conversations I had with my grandparents occurred around their kitchen table playing cards. They stayed fit, ate right, not necessarily well, if you count the fried eggs and bacon my slight, athletic grandfather ate daily. They maintained their own home, and had their youngest daughter and her husband nearby to do the heavy lifting when needed and who regularly looked in on them. It took some convincing for my grandma to leave her home, but once she landed at Maple Ridge, she found a group of friends and settled in.

Because of the work my aunt and uncle do in their small community, they know just about everyone, making Grandma somewhat of a VIP wherever she received care. She had my aunt by her side for every doctors' appointment, and when she broke the ball of her femur shortly after moving into Maple Ridge, the risks related to hip surgery at her age were discussed in detail with my aunt.

Every precaution went into her successful surgery, and she was up walking the following day without any pain. A nurse friend and physical therapist checked in on her daily during her short hospital stay, and she was moved to Dyersburg Manor, now American Health Communities, a skilled nursing and rehabilitation center nearby. This is where my exposure to long term care facilities first became personal.

I had been working in patient safety and quality at MedStar Health, helping to build a culture of safety, transparency and high reliability going on five years when I drove south from Chicago to visit her in rehab. She was praying her rosary when I walked into her room, and she looked right through me. When she finished her prayers, she focused in on me and told me her hearing aids weren't in and that she couldn't find them. She asked me repeatedly what day it was, and if I would go get her calendar at home. I wasn't prepared for my witty, sardonic grandma to look so vulnerable and lost.

Once I found an aide and we located her hearing aids she returned to herself. Three of her eight grandchildren came by to visit that same weekend with their four children, and three of four generations sat in the lobby of the nursing home, tossing a football in a circle which included her. I watched her come back to life with each catch and toss, and I wondered if our laughter was disturbing other residents. I quickly decided noise and youthful voices were exactly what was needed throughout the halls of the facility.

In that short visit, I observed why breaking a hip is the beginning of the end for the elderly. Immobility and being shut in without the stimulation and creature comforts of home; loneliness and isolation as real a threat as bed sores and infections.

Grandma rebounded from the injury quickly despite her age, but I walked away with the sinking feeling that society had been kicking a very important can down the road too long.

A colleague's mention of the "silver tsunami" a few years earlier came to mind, and I made a mental note of the safety concerns I observed despite her good outcome: 1) Staff was hard to locate; 2) There was open access to a vulnerable patient; 3) She couldn't hear, and her hearing aids weren't working properly when we did locate them. At the time, it turns out she was one of the healthier, more mobile patients nationwide.

A Kaiser Family Foundation report looking at nursing facility data from 2009-2016 showed that 65% were dependent upon a wheelchair or support from others. Many required management of bladder and bowel incontinence, and almost half of all residents had a dementia diagnosis in 2016 and almost two-thirds were on anti-depressants, anti-anxiety medications, sedatives, hypnotics and anti-psychotics.

Aside from the occasional story driven by a singular bad experience, scrutiny of care experienced by residents in these facilities had only just begun.

Before every meeting begins at MedStar, we take a time out for a Safety Moment. When I returned home from visiting Grandma in July of 2018 after she experienced a transient ischemic attack and a year before she died, I couldn't wait to share with my team of global patient safety leaders that the real work for patient and provider safety needed to move into the long term care facilities, especially in rural communities where care options are limited, and stat! "With the number of baby boomers approaching the age where care like this will be needed, we should have started to measure, monitor and improve these systems years ago," I said in earnest. No one disagreed.

Researcher and healthcare leader, Pat Merryweather, is the current Executive Director of Project Patient Care, and a longtime hospital quality administrator, patient advocate, and policymaker, who has been focused on improving care for seniors for over a decade. The news reports throughout 2020 and 2021 gave a thirty thousand foot view of how COVID had its way with patients and staff in long term care facilities from the start. But healthcare leaders like Merryweather knew it was only the tip of a very large, well-hidden iceberg.

"The pandemic spotlighted the lack of infection prevention in nursing homes," Merryweather said. "In November of 2019, the ACA mandated that nursing homes had an infection preventionist onsite which the Trump administration pulled back. In Illinois, three or four residents lived in rooms meant for one person in some places. They were short staffed without the personal protective equipment (PPE) they needed to stay safe."

Merryweather points out that delivering safe, high quality, and equitable care in our nursing homes is a complex problem with many social, fiscal, and policy levers.

A lack of transparency around ownership making it difficult to track facilities that are unsafe, multiple stakeholders reporting to different agencies which lack a universal database to aggregate survey reports and complaints to track progress and outcomes, adequate pay for geriatricians and certified nursing assistants (CNAs), and a way to keep a spotlight on the failures and progress for public awareness are all areas ripe for improvement.

The social change, however, is something every one of us can participate in.

"There needs to be a cultural shift on ageism, and oversight by the community. This can be a community council that operates in all communities with nursing homes," Merryweather advised. This means making a concerted effort to not only re-value the elders in our communities, but also the stories of their lives and all they've done to get us to today.

One the biggest challenges is that caring for nursing home residents is a costly business, and comes with great fiscal responsibility. In 2020, overall spending for services at freestanding nursing care facilities and continuing care retirement communities was $196.9B, up 3.9 percent over 2019 attributed to increased federal funding for COVID.

Overall Medicare spending in 2020 was $829.5B with Medicaid spending not far behind at $671.2B . Medicaid was the primary payor for most certified nursing facility residents particularly in the southeastern states as of 2016, covering 6-in-10 residents for a total of 832,000 Americans.

Understandably then, the Center for Medicare and Medicaid Services (CMS) would have a vested interest in receiving quality outcomes for dollars spent. CMS is tasked with certification and oversight of the approximately 15,600 nursing homes across the United States.

In 2016, CMS updated and standardized nursing regulations for the first time since 1991. New requirements for staffing, antibiotic stewardship, and protection from abuse and neglect were included, and regular surveys every fifteen months evaluate compliance in caring for Medicare and Medicaid participants.

The new surveys were rolled out in November of 2017, well before the pandemic began taking lives in drastically disproportionate numbers within long term care facilities, but too late for some of the lives affected by existing poor quality of care across the country.

It would only make sense that policymakers would begin to pay greater attention to the cost and quality of care given the quickly aging baby boomer generation soon to need long term care options en masse.

In June of 2019, U.S. Senators Bob Casey (D-PA) and Pat Toomey (R-PA) released a report exposing the poor care in America's nursing homes. In a bipartisan effort, the senators wrote a letter to CMS in March of 2019 on behalf of their constituents in Pennsylvania who lived in nursing facilities.

It had come to their attention that CMS had a list of poor performing facilities across the country that, because of budget cuts, were not included into their Special Focus Facility (SFF) initiative to

help poor performing facilities improve, yet they were still operating. By May of 2019, CMS produced a list identifying both SFF and SFF-eligible facilities.

Because of the lag time in survey reports and identification of poor performing facilities, delay in star rating updates, additional fines or enforcements and related probation periods, and concerns about access if care was terminated in some communities, many poorly run facilities continued caring for patients.

Transparency in quality status is yet another challenge for families when making the hard decision to place a family member in long term care with a rating system in need of improvement. Thanks to *The New York Times* investigative reporting in March 2021, the government's 'star rating' system for nursing homes was shown to be based on severely inaccurate, and at times deceptive, data in need of improvement too.

"Investigative reports should remain public and should factor into the scoring," Merryweather said. "We should not be seeing a 5 star rating for a nursing home that had so many COVID deaths and fined over $600K. The star rating program needs to be updated so consumers can have some trust in the results."

In 2019, CMS announced a plan to further improve quality of care which included: 1) strengthening oversight of State survey agencies; 2) enhancing CMS enforcement practices to hold nursing homes accountable for their care; 3) increased transparency to empower consumers and families with information to aid care decisions; 4) development of quality measures based on patient outcomes and investment in programs focused on care; and 5) making patients the priority over paperwork to ease burden on providers.

The idea of how care is delivered versus the reality of care delivered is a saying in healthcare for a reason.

When it comes down to it, agencies can make all the regulations they want, but if nobody is there to enforce them, or facilities lack qualified staff to deliver high quality care, especially in rural communities where options are limited, how do improvements happen and how can family members protect their loved ones?

Julie Apold, vice president of quality and performance excellence at LeadingAge Minnesota, is part of an association that supports long term care facility and nursing home leaders with tools, advocacy, educational resources and networking opportunities to lead transformation in the space and instill public trust and confidence in the care being delivered.

Julie was a longtime patient safety and quality professional in hospitals before she came to LeadingAge Minnesota to improve care for our seniors. She believes it's not a bigger stick and increased regulation that will improve the care, but rather a commitment to transparency and a greater investment in the people delivering the care.

"Some believe the way to improve safety in long term care is to provide more oversite, more fines, more regulation and that's the opposite of what we need to do," Apold said. "We learned from the 1999 Institute of Medicine report "To Err Is Human" you need to create a safe environment where people are willing to speak up, and say 'I've made a mistake, something is wrong.' Instead, we've created a culture of fear in many ways. We need to be able to look at what's going on, uncover the root-cause and work together to solve those problems and then invest in the changes that need to be made. Instead we're fining nursing homes, taking money away from them instead of working together to understand and build a better system that has continuous learning and improvement."

Safe Care for Seniors is one quality and safety improvement program designed by LeadingAge Minnesota to prevent harm while caring for older adults. The program provides tools that help to "create safe, trusted and inclusive environments that elders are proud to call home and give families confidence and peace of mind."

One aspect of the program is a commitment by staff to get to know their residents so that they might understand the stories of their lives and become more than 'congestive heart failure in room 1010' or 'Alzheimer's patient in room 2020.' The power of stories is a tool we have used at MedStar since 2012, and it has helped us shape a culture of safety.

When I visited Grandma in June of 2019, I knew it would likely be the last time I would see her. She had been admitted to Harborview, a skilled nursing facility, to manage a recalcitrant urinary tract infection.

One of the nursing aides caring for her was so pregnant I thought maybe she would give birth any minute. She was lifting Grandma in and out of bed when it was clear that just walking up and down the hallway was an effort for her. I asked her if she was able to take maternity leave, and she said it was unpaid leave and that she really couldn't afford to take time off.

This started a guarded conversation about how well the staff was treated, and I told her that I'd love to hear her story some time. I thanked her profusely for the attention she paid to Grandma, and bought the staff lunch one day and brought in breakfast snacks another day. The need to better care for staff, to understand their stories, became another red flag I collected during my visit with Grandma in Dyersburg, which was not a surprise to Apold.

"Turnover is a concern, and we are advocating to address our workforce challenges with public policy solutions. We need help from our partners in state and federal government so we can pay professional caregivers the wages they deserve." Apold added. "Offering a family-sustaining wage will help us to recruit and retain quality caregivers. I talk to so many people who share with me that caregiving is their calling. They need to be able to afford to stay in the aging services sector. This is a profession, and we need people who can come to do this work and make it a career."

The pictures that accompany this piece include one taken on my last visit with Grandma. She had just finished physical therapy, and we had taken a walk/roll out to the enclosed outdoor space for her to let the sun shine on her face.

She's wearing my sunglasses and looks pretty hip for a ninety-nine year old, still self-consciously trying to avoid the center of attention and the focus of the camera lens like many of her non-selfie generation.

Shortly after we wheeled her back into her room, her blood pressure dropped and she greyed out while in the bathroom. I had to lift her before she fell and injured herself on the porcelain toilet. I was surprised how light and easy to lift she was, her weight now down below 100 pounds. I helped the aide get her back into bed, and heard bones creak. I worried that I had hurt her, but she denied any pain. I wasn't prepared for was how fragile her skin was or how brittle her bones sounded, and in that moment I knew what skilled nursing meant.

Once safe in bed the bigger problem was that her blood pressure remained low, and she was dropping in and out of conscious. She had a DNR in place, and staff along with my mom, aunt, and I contemplated whether or not we should we take her across the street to the hospital for further evaluation. There was a general lack of urgency, and the logical part of my brain told me we couldn't just sit and wait for her blood pressure to bottom out and let her die.

Frances Zabrauskas with family. (Photo/Tracy Granzyk)

Frances Zabrauskas with her husband, Stanley. (Photo/Tracy Granzyk)

She had been laughing and talking only minutes earlier, and she certainly didn't deserve to die from indecision or delay in care.

Treating a UTI is by no means extreme measures. But this cycle of infection, of trying to keep a facility full of adults of varying weights with varying degrees of incontinence clean and toileted is just one big logistical challenge staff deals with on behalf of families. I wondered how many people died this way without anyone there to advocate for them.

In the end, the ambulance arrived to take her across the street, and we sat in the emergency room with her. "Are you going to check for sepsis?" I asked her nurses in the treatment room. I had been trained that sepsis is a stealth killer, often missed by healthcare professionals. I worried that her UTI and fall in blood pressure might be an indication of urosepsis.

Cursory research showed sepsis to be the leading cause of transfer from nursing homes to the hospital so it wasn't an unreasonable request. I didn't know how expensive the testing for sepsis was, or how many tubes of blood needed to be drawn.

I listened to ER staff contemplate placing a catheter in. They were an emergency room after all with limited staff and little time to be constantly cleaning up after incontinent patients. They ultimately decided to insert the catheter making her odds of infection even greater.

She was admitted, given a course of antibiotics and after a few days returned to Harborview where she would die peacefully almost two months later on July 23, 2019. She was my canary in the coal mine of long term care.

Her story covered just short of a century. She had three daughters, eight grandchildren, and four great grandchildren that knew her as GGMa. She lived a full life built upon her Catholic faith and was looking forward to what God had in store for her next even though recently asking me, "Tracy, do you think there really is a heaven?" She was loved and had tremendous social support up until her last day with my aunt by her side when she left us.

Not all residents in nursing homes and long term care are that fortunate. Family and community are a large part of the solution to force lasting change for every patient.

It goes without saying that we lost too many dedicated providers in long term care facilities due to COVID, along with their patients because they lacked resources and leadership.

Admittedly, there is much room for innovation and improvement in these environments. It is likely that some degree of oversight, monitoring, transparency, policy and culture change are where the tactical answers lie.

The disparities in care provided in nursing homes serving Black and Hispanic populations is shameful, and needed to be addressed years ago. Most of all we need more compassion for those who care for our elders, and for every person in a nursing home or assisted living facility regardless of their age or the part of the country they live in.

Rural communities are especially at risk because there are fewer options and they are harder to reach. It could be argued, however, that long term care no matter the location is a collection of disconnected islands scrambling for whatever resources they can find.

Sufficient funding for pay that shows respect for the skilled nurses and geriatricians who care for our family members when we cannot is imperative, as is funding to keep everyone safe with the equipment and resources needed to deliver high quality care. Similar to acute care, when providers aren't valued, patients and families suffer, too. ●

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Frances Zabrauskas at Harborview. (Photo / Tracy Granzyk)

Frances Zabrauskas at work. (Photo / Tracy Granzyk)

RHQ CONFERENCE CALENDAR

Check out our list of rural health conferences, and let us know if you're hosting one so we can help spread the word. Email us at RHQ@ttuhsc.edu.

2022 Annual Rural Training Track Collaborative Annual Meeting
Apr 27 - 29, Stevenson, WA
Skamaniah Lodge

2022 Appalachian Health Leadership Forum
May 6 - 7, Daniels, WV
The Resort at Glade Springs

27th Health Equity Conference
May 10, Albuquerque, NM
Albuquerque Convention Center

Rural Medical Education Conference
May 10, Albuquerque, NM
Albuquerque Convention Center

45th Annual Rural Health Conference
May 10 - 13, Albuquerque, NM
Albuquerque Convention Center

7th Rural Hospital Innovation Summit
May 10 - 13, Albuquerque, NM
Albuquerque Convention Center

2022 Annual Dakota Conference on Rural and Public Health
June 8 - 10, Grand Forks, ND
Alerus Center

2022 24th Annual Indiana Rural Health Conference
Jun 14 - 15, French Lick, IN

2022 Annual South Dakota Rural Health Leaders Conference
Jul 12 - 13, Pierre, SD

20th Rural Health Clinic Conference
Sept. 20 - 21, Kansas City, MO
Sheraton Kansas City Hotel at Crown Center

21st Critical Access Hospital Conference
Sept. 21 - 23, Kansas City, MO
Sheraton Kansas City Hotel at Crown Center

International Conference on Rural Community and Public Health Systems Management
Sept. 27 - 28, San Francisco, CA

2023

34th Rural Health Policy Institute
Feb. 7 - 9, 2023, Washington, D.C.
Hilton Washington D.C. National Mall

28th Health Equity Conference
May 16, 2023, San Diego, CA
Sheraton San Diego Hotel & Marina

Rural Medical Education Conference
May 16, 2023, San Diego, CA
Sheraton San Diego Hotel & Marina

46th Annual Rural Health Conference
May 16 - 19, 2023, San Diego, CA
Sheraton San Diego Hotel & Marina

8th Rural Hospital Innovation Summit
May 16 - 19, 2023, San Diego, CA
Sheraton San Diego Hotel & Marina

21st Rural Health Clinic Conference
Sept. 26 - 27, 2023, Kansas City, MO
Sheraton Kansas City Hotel at Crown Center

22nd Critical Access Hospital Conference
Sept. 27 - 29, 2023, Kansas City, MO
Sheraton Kansas City Hotel at Crown Center

Did we miss one? Let us know at RHQ@ttuhsc.edu

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