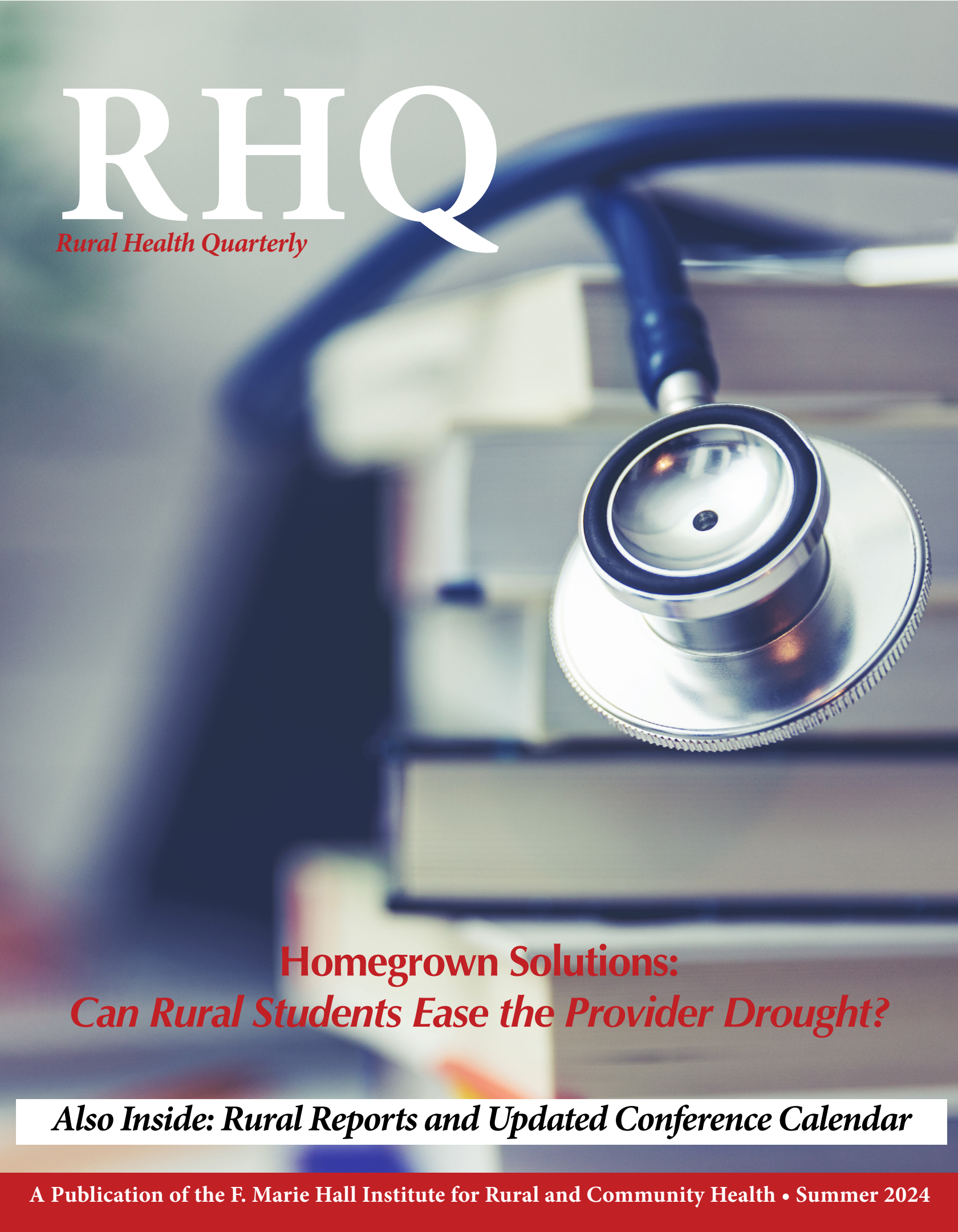

RHQ

Rural Health Quarterly

Homegrown Solutions:
Can Rural Students Ease the Provider Drought?

Also Inside: Rural Reports and Updated Conference Calendar

A Publication of the F. Marie Hall Institute for Rural and Community Health • Summer 2024

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Summer 2024

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RHQ
Rural Health Quarterly

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Can we help?

There have been many times in the 15 years that I have led the F. Marie Hall Institute for Rural and Community Health that my team has been asked to help with rural health issues. Indeed, we have a rich history of notable ways in which the Institute has provided help. When there were issues with emergency medical services, we developed a model to use telehealth equipment and training to expand access to those services. That program, the NextGen 911 Project, continues today with the support of the Commission of State Emergency Communications. When the need for mental health counseling was identified as a potential tool for Texas school children that might stem the tide of the mental health epidemic, we developed a school-based telehealth counseling model and proved it would work. That program is a statewide effort now, serving thousands and extending access to mental health care in rural and urban school systems alike. When health care providers in rural communities needed help with adopting new technologies like electronic medical records, wider-spread use of sonography, or telemedicine skills, we formed a learning lab and trained hundreds of practitioners. Recently, we have helped critical access hospitals with financial challenges to better understand the Rural Emergency Hospital designation, to make an informed choice as to whether to seek that change or not, and to transition accordingly. I could cite many other examples, but in each one, the F. Marie Hall Institute has led the way.

BILLY U. PHILIPS, JR., PhD

PUBLISHER
Executive Vice President, Division of Rural Affairs, and Director, F. Marie Hall Institute for Rural and Community Health

In September 2023, the Texas Tech University Health Sciences Center (TTUHSC) formed the Institute for Telehealth and Digital Innovations. It was soon recognized that this new entity within the TTUHSC would be much more effective if it were partnered with the Hall Institute under a new Division of Rural Affairs (DoRA). That way, we could better achieve our motto: Transforming Health Care Through Partnership and Innovation. DoRA has aegis to work with the schools that form the academic programs of TTUHSC, with community partners, and with those who need better access to healthcare in West Texas and beyond, as well as with providers who want to be part of the solution. DoRA was chartered in January 2024 and is rolling out innovative programs to meet community needs, such as K-12 school-based clinics; telepsychiatric services for rural hospitals, especially through their emergency departments; and the testing of a new early detection tool for breast cancer—Bexa, a scanning device—to determine whether it may augment mammograms. Other initiatives include the provision of easier digital access to Texas Tech Physicians services through a digital front door, as well as the pioneering widescale use of remote patient monitoring technologies that will bring better outcomes in the prevention and management of many chronic diseases.

As I reflect on the question of helping rural communities with their health care needs, I realize that the question is, "Can we help?" Many authors have written about finding your purpose as the first step to working in effective teams. Pastor Rick Warren of Saddleback Church wrote a book in 1995, entitled *The Purpose Driven Church*. In 2009, Simon Sinek, an inspirational business speaker, published *Find Your Why: A Practical Guide for Discovering Purpose for You and Your Team*. These books focus on "knowing your why in order to know your what." There are many rural health issues that do not have an easy fix, even though we might think they do. There are many rural communities that do not understand that paying for health care these days depends, in large measure, on having the volume necessary for financial viability.

Some years ago, I lived on a small farm in what was still a fairly rural area of the Houston metroplex. The distance from the farm to the closest hospital depended on the severity of the need—one way was a 30-minute drive to a community hospital, and the other way was a 45-minute drive to a comprehensive academic health sciences center. The primary care providers available for ongoing or routine care were a 15- and a 20-minute drive, respectively. Both required appointments and did limited walk-in business. What I understood then was that there is an expectation for the availability of health care—but is it practically achievable? Even in the county that houses the fourth most populous city in the United States, where the expectation was that health care access isn't on every corner, it's a barrier and a challenging problem to solve.

The same is true in rural areas and especially in West Texas. Even in the geographic areas where population is most sparse, and the dozen suburban hubs of West Texas, access to most care, including primary care, is about the same as in the Houston area. The insurance coverage and options are not as plentiful in urban areas, but insurance is only good if there are providers to take it. Still, rural areas are markets that offer good basic plans. Telehealth is a part of the solution, but while the distances are the barrier in rural areas, time is the

barrier in big metro areas. The sad reality is that most of Texas is experiencing workforce issues and the shortages that go with them. There are notable caveats, like the specialty care that is more plentiful in populous counties—one example is the MD Anderson Cancer Center—but even that particular facility is reaching out to areas like West Texas. This brings me to my next point: the expectation that access to health care should be available not just anywhere in Texas, but especially in the rural areas from which come the food, fuel, and fiber that are such major components of our economy. Every life matters and we must work together to make sure we do all we can for the people that we serve, whether in urban or rural areas.

I have often thought that the best way we might help those who need help is to develop communities to better know their *why* in order to know their *what*. Once there is agreement about purpose, people can build the capacity to imagine ways to form partnerships and plan with confidence to achieve their own needs. Having grown up in southwest Texas with a strong ranching heritage, I learned early the three most important things that I believe are keys to making this happen. First, make do with what you have until you can find or convince others to share the dream. What often happens, however, is that this "make-do attitude" is easier but not better. It leads to a downward spiral of the status quo, if for no other reason than that it leads to too much work or what some call the tyranny of the urgent. When it's just one, there is more to do than can be done and all can be urgent. Second, self-reliance sounds good in the imagination of rugged individualism and self-reliance, but rarely is it the best or most imaginative way to achieve. I have seen much more success when many such people learn to communicate and collaborate. Where there are many brains, lots of grit, and a shared commitment, something lasting can get done. Accomplishment is a team sport and all the reward that is necessary. Third, real progress is more likely if time and clear steps are articulated and those steps can be measured and/or are understood by all concerned. It's about managing expectations of how much time it might take to achieve a dream and failure that is most often due to not taking the time to write out the steps. Often doing that leads to more steps that the debunking of assumptions must then be articulated if we are to accomplish shared goals.

Finally, I think there are many ways that DoRA can help, but I am not sure we can do so unless communities that want our help know their why. Once that is known, then we can work together. If that is unclear, the question is, "Can we help?"

The Bexa scanning device, a pioneering early detection tool for breast cancer. *Photo courtesy Sure, Inc.*

RURAL REPORTS

RURAL HEALTH REPORTING
FROM ACROSS THE NATION
AND AROUND THE WORLD

ALABAMA //

The House Ways and Means Education Committee unanimously passed a bill proposing the creation of an advanced health sciences high school in Demopolis, first proposed by Gov. Kay Ivey in 2023. Bloomberg Philanthropies has pledged $26.4 million toward the residential high school.

aldailynews.com | 04.11.24

ALASKA //

A needle exchange in Homer is in the process of testing a mobile unit that would bring harm reduction programming to the central Kenai Peninsula. The volunteer-staffed exchange, started in 2016, offers free opioid overdose treatment and STI testing in addition to clean syringes.

alaskapublic.org | 05.31.24

ARKANSAS //

The Delta Regional Authority allocated $450,000 to help fund a new initiative, led by the Arkansas Rural Health Partnership, to train new medical workers in the state's most underserved areas. The funds will support a two-year program designed to offer both entry-level and advanced EMT training.

talkbusiness.net | 04.23.24

COLORADO //

Healthy School Meals for All, which provides all K-12 students with free breakfast and lunch, is facing a budget deficit that could prove disastrous. 9 out of 10 food-insecure counties are rural, and 1 in 3 Coloradans are food insecure, according to a 2023 Feeding America study.

dailyyonder.com | 06.05.24

GEORGIA //

The Mercer University School of Medicine and its Georgia Rural Health Innovation Center are expanding their rural pediatric health initiative to six additional rural hospitals across the state, bringing the total number of participating counties to 14.

This initiative, known as the Kids Alliance for Better Care (KidsABC) program, aims to support rural hospital emergency departments and provide rural pediatricians and behavioral health providers with training and resources.

savannahbusinessjournal.com | 06.05.24

HAITI

Amid widespread violence and gang control, Haiti's fragile health system is facing total ruin. Several medical centers, including the country's largest public hospital, have closed, and medications, fuel for generators, and other necessities are in short supply. "There are very, very few options right now," said Jacob Burns, a Doctors Without Borders project coordinator.

apnews.com | 04.23.24

INDIA

A cultural exchange program between Shrimad Rajchandra Hospital and Research Centre in India and Stanford Medicine in Palo Alto, California, is seeking to advance perinatal health in Gujarat, a rural area.

Interest in mental health care—a taboo topic in India, according to neonatologist Nilima Ragavan—was gauged at a recent symposium, as were attitudes toward the idea of self-care in new mothers. Infant mortality, particularly in babies born outside a hospital setting, was also discussed.

scopeblog.stanford.edu | 04.25.24

PAKISTAN

Researchers at Aga Khan University have been working to quantify the impact of the rotavirus vaccine since its initial inclusion in the routine battery of immunizations administered to Pakistani children. Recently, a 30 percent efficacy rate in reducing diarrhea-related hospitalizations was reported, thanks to a rotavirus vaccination rate of more than 80 percent.

Over six million cases of pediatric diarrhea are seen annually in the country, accounting for more than half of infant deaths.

gavi.org | 04.25.24

INDIANA //

$150 million in state funds will be given to county health departments as part of the Health First Indiana initiative. According to State Health Commissioner Dr. Lindsay Weaver, counties may make "data-driven decisions" as to how funds are used, from smoking cessation programs to expanded clinic hours.

indianacapitalchronicle.com | 06.05.24

IOWA //

A new law will amend the income eligibility threshold for infants and mothers to 215 percent of the federal poverty level for postpartum Medicaid coverage, reducing the number of patients who will qualify for coverage.

desmoinesregister.com | 06.07.24

KANSAS //

The physician assistant program at Kansas State University recently produced its inaugural graduating cohort of more than 30 students, many of whom hope to help close the the state's healthcare gaps. The program was conceived in 2018 out of a need, observed by university administrators, for more medical representation and access across Kansas.

kansasreflector.com | 05.21.24

KENTUCKY //

University of Louisville Health is expanding the reach of its Brown Cancer Center. A $25 million plan, centered on a new regional cancer center and a Center for Rural Cancer Education and Research, seeks to improve care access in south, central, and western Kentucky. Nearly 10,000 Kentuckians die of cancer each year, with this number projected to grow by 50 percent in the next 20 years.

spectrumnews1.com | 05.06.24

MONTANA //

The Veterans Affairs Montana Health Care System was recently granted approval to establish a research site in Montana. The site would be the first of its kind in the state, where veterans comprise 8.9 percent of the adult population.

dailymontanan.com | 05.17.24

OREGON //

The Confederated Tribes of Grand Ronde recently celebrated the expansion of their hospital system, marking a step toward independence from federally provided healthcare. The new public health clinic, offering vaccines, dental care, education, and more, aims to address healthcare gaps while advancing tribal sovereignty.

dailyyonder.com | 05.21.24

SCOTLAND

The Chief Scientist Office awarded £1 million to researchers from the University of Aberdeen conducting a five-year study of health inequities in the country's rural and island areas. Case study interviews will be conducted, with areas of particular interest including cancer and musculoskeletal conditions.

"Significant research gaps remain in our understanding of what care is available in different places [and] how this affects patients," said Professor Peter Murchie, co-Principal Investigator of the project.

abdn.ac.uk | 06.07.24

TANZANIA

A lack of affordable menstrual products leads man women to resort to unsanitary makeshift solutions, but an advancement in menstrual hygiene is on the horizon. Thanks to the Sustainable Rural Water Supply and Sanitation Program, cost-effective, antimicrobial pads will soon be available.

blogs.worldbank.org | 05.27.24

UKRAINE

WHO/Europe recently produced a policy brief, advocating for a free school meals program. "The idea of feeding children...in wartime becomes even more difficult to implement, yet even more important," said First Lady Olena Zelenska.

reliefweb.int | 04.18.24

COVER
STORY

Homegrown Solutions: Cultivating Rural Students to Address the Rural Healthcare Drought

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In rural areas of the United States, which comprise 20 percent of the nation's population, access to healthcare is a significant challenge. Contributing to the lack of rural access to more robust healthcare is the fact that only 10 percent of the United States physician workforce practices rurally. Furthermore, less than 1 percent of graduate medical education (residency) programs are located in rural areas (US Government Accountability Office, 2017). Additionally contributing to the lack of a more robust rural health workforce are the academic and social challenges that rural students must overcome in order to be accepted and then matriculate into primarily urban-located higher education institutions and healthcare training programs. Solving rural healthcare challenges has evaded the healthcare system, causing a chronic drought in rural healthcare access.

Rural health workforce development and cultivation are crucial to attend to both the shortages in rural healthcare services and the paucity of clinicians throughout rural areas of the United States. Rural students offer unique life experiences with connection to their rural areas, translating to a commitment to service in rural medicine, healthcare and community health. In this article, we propose that investment in rural students and increased rural medicine exposure to all healthcare training students through development of rural student mentoring programs, rural pathway programs for rural students into healthcare training programs, and rural training in place models for healthcare training (from higher education to graduate medical education programs) are the keys to improving access to healthcare in rural areas. Importantly, the two most significant factors that predict a future rural medical practice for a medical student are rural origins or significant rural life experience and rural medicine experience as a medical student (Parlier, 2018). Alarmingly, rural student application and matriculation into medical schools nationwide have been declining since 2002 (Shipman, 2019). In 2016 and 2017, incoming medical students with rural backgrounds in the United States accounted for only 4.3 percent of the medical student population.

The Rural Student Solution

With rural origins being a major determinant in a health professional's decision to practice in a rural community (Parlier, 2018), students in rural K-12 schools present fertile ground for meeting growing rural healthcare needs. Rural students enroll in colleges and universities at a lower rate than their urban and suburban peers (Wells, Manly, Kommers, & Kimball, 2019). One reason for this low matriculation rate can be the tension that rural students feel between their strong ties to their hometowns and a belief that they will need to leave their community to pursue certain careers (McHenry-Sorber & Swisher, 2020; Means et al., 2016; Nelson, 2019). Further, many rural communities have concerns about the "outmigration" of their youth, often those into which they have poured the most academic resources, who leave their communities to pursue higher education and never return (Carr & Kefalas, 2009).

Though it is important to acknowledge these challenges, there is also much room for hope. Rural students, on average, complete high school at a higher rate than their peers in any other geographic locale (NCES, 2022), and they are narrowing the gap in terms or enrolling in higher education (Wells et al., 2019). In addition, many rural students, particularly women, who enter higher education do so to pursue careers that they believe will be fulfilling, often in helping professions such as social work, education, and healthcare (Stone, 2018; Stone, Serrata, & Martinez, 2020).

This means that with high percentages of rural students

graduating from high school and an increasing percentage pursuing higher education, these students could be guided into health professions. Making clear to young rural students that there are opportunities to pursue careers in healthcare and serve their own communities could help ease the academic and career aspiration tensions that often prevent these students from enrolling in higher education. Providing viable pathways to pursue these careers in or near their hometowns could be an additional way to resolve these tensions and address rural healthcare needs.

The Paucity of Current Rural Medicine Training Offers Rural Student Education Opportunities for Rural Medicine Growth and Investment

Rural natural cause mortality (NCM) has recently been shown to be staggeringly worse than urban NCM, with analysts pointing to the differences in rural healthcare delivery as one of the key drivers (Thomas, 2024). This lack in healthcare delivery is mirrored by the paucity of rural medical training. There has been an additionally concerning decline in medical students choosing to practice in rural-first locales, even in programs with excellent track records of recruiting and training these clinicians (Prunuske, 2017). Detailed analysis of existing rural training programs has proven challenging due to a variety of factors, though student outcomes in terms of rural practice do vary widely (Deutchman, 2013). Moreover, despite recent efforts to expand the number of graduate medical education positions in rural areas, the projected need of these patient populations continues to outstrip supply (Carmody, 2020).

A central misunderstanding of rural life and rural medical training continues to plague efforts to ameliorate this problem; that is, a rural student in one region is not necessarily interested in practicing in a different rural area. For example, an aspiring family medicine physician in Duluth, Minnesota may not want (or be well prepared for) training in frontier Presidio, Texas. Rural life, just as living in an urban center or suburban region, is rich in its diversity of experiences and cultures.

Furthermore, the practice of rural medicine is robust in its opportunities for clinician and trainee alike. Clinicians may see a wide range of pathologies long before subspecialty care is involved, often with different resources than would be available at large academic centers. Students, in turn, may be more likely to have more robust clinical opportunities; they are often the only learner present and may have more one-on-one time with experienced physicians. Finally, in some situations, learners may have more freedom to train alongside other health professionals in this setting. As an example, there is little reason not to train a medical student and an ultrasound technician student together when there are fewer students between which to split patient volumes. To capitalize on this richness and ensure that the right prospective students are being guided to the training programs that will provide them with the tools and environments to help them thrive, strategic decentralization of some academic programs may be necessary.

This strategic decentralization may be more appropriately called rural training in place (RTP), as has previously been proposed (Weber, 2024). RTP is most appropriately implemented during preclinical training with modern technology, can provide students with the opportunity to train in conditions that mirror their desired practice environment, and can allow for robust identity formation and team building with fellow rural students, which has been shown to improve student outcomes (Downey, 2010). This training concept allows for students to become or continue to be embedded in rural communities, which opens the door for multilevel mentorship between rural physicians, medical trainees, members of the interprofessional team (including advanced practice providers, nurses, and technicians) and middle/high school level students. These relationships can be fostered by partnerships with academic institutions, who may choose to recruit these learners via rural summer camps, shadowing, and volunteer opportunities. Such efforts may provide robust pathways to build a diverse healthcare workforce across the spectrum of practice levels.

As previously noted, rural life and the practice of rural medicine are not monolithic. An expansion in the number of rural academic centers, championing RTP, may be the best solution to serve both patients and the learners who will care for them. These new centers, networked within and across large academic institutions, will better be able to utilize local resources and address the specific needs, including the diversity of social determinants of health, of the communities they are training clinicians to serve. Without a change in the who, the where and the how we train healthcare training students, we can only expect the rural healthcare drought to continue. Our rural residents depend upon our academic institutions to be socially accountable to rural students, providing these students the opportunity to serve their communities in healthcare.

Executive Summary

Considering this discussion and the current state of rural healthcare training and delivery, we propose the following priorities:

1. Increase mentoring of rural high school students by healthcare training students and faculty in regional healthcare training programs.

2. Increase availability of healthcare training programs (i.e., CNA, LVN, EMT) in rural high schools, including those that lead to associate degrees.

3. Increase rural healthcare shadowing opportunities

for high school and pre-health college students.

4. Increase RTP opportunities for rural students in postsecondary education (associate to terminal degrees) with establishment of more rural academic health centers on rural college campuses.

5. Improve access to rural training exposure via mandatory and elective opportunities for healthcare training students, including longitudinal rural clerkships for third-year medical students.

6. Expand rural graduate medical education programs.

7. Create more pathway programs for rural high school students into healthcare training programs in higher education institutions.

8. Establish rural-focused admissions medical programs to mentor and support rural healthcare training students prior to matriculation into healthcare training programs with ongoing support while admitted to healthcare training programs. ●

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NEXT GENERATION 911

TRANSFORMING HEALTHCARE THROUGH INNOVATION AND COLLABORATION

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CARE

ACCESS

Hospital Care at Home: What Does the Future Hold?

AMBER C. PARKER

Amber C. Parker is Lead Writer at the F. Marie Hall Institute for Rural and Community Health.

Efforts are now underway on Capitol Hill to get the Centers for Medicare & Medicaid Services (CMS) to extend the funding for an innovative program that's gained popularity at the nation's hospitals since the COVID-19 pandemic. It's called "Acute Hospital Care at Home" and it's set to expire at the end of 2024 unless Congress extends it. In early May 2024, the House Ways and Means Committee passed legislation that would extend the program for five years. Hospital leaders from across the county are urging lawmakers to pass the extension to help more people.

CMS launched the program to help ease ER overcrowding at the height of the pandemic when hundreds of patients waited in the ER for days or even weeks for a hospital room, but the idea for such a program has been around for years. In 2019, Ariadne Labs, a collaboration between Brigham and Women's Hospital in Boston and the Harvard T.H. Chan School of Public Health, developed the Rural Home Hospital Model.

These programs generally work like this: after arriving at the ER, a patient is screened to see if they would be a good candidate for the program. If the patient agrees to participate, they're transported back home, where a member of the Hospital at Home team meets them. The team member will set up all the equipment the patient may need for treatment, including a tablet for virtual visits with the care team, a phone that immediately connects to the team, a wearable device that helps keep tabs on vitals, and an emergency alert device. Before the patient even arrives home, the patient's primary caregiver, usually a family member, is assessed to make sure they are competent to provide care, including medication management. The case manager also checks out the home to make sure it is a safe environment.

Once the home care starts, patients usually get two daily in-person exams from someone on the medical team. As part of the Hospital-at-Home program at one St. Louis, Missouri hospital, an interdisciplinary team of acute-level doctors, advanced practice providers, nurses, pharmacists, and therapists oversee patient care through in-person and online visits. The average length of "stay" is four days.

While the Hospital at Home program isn't the same as home health care, participants are sick enough to be in the hospital but are still well enough to do basic activities, such as walking safely to the bathroom. The program allows patients to receive care in the comfort of their own homes, with round-the-clock remote monitoring and twice-daily visits from medical personnel.

Hospital-at-home interventions may be particularly fitting for patients with chronic diseases, as these patients tend to use health services more frequently. As many as 60 different acute conditions can be treated at the patient's home, from asthma, COPD, and pneumonia to congestive heart failure. So far, CMS has authorized variations of hospital-at-home programs at more than 300 hospitals in 37 states, and how each facility's program works differs, based on state laws and other regulations.

As with any program, there are benefits and challenges. The biggest benefit of hospital-at-home-type programs is the cost. The Texas Hospital Association says the total cost of care for each patient is 25 percent lower for at-home patients compared to those who are treated in a hospital. The THA also says patient satisfaction rates are higher, the length of stays is about 35 percent shorter, and readmission rates are three times lower. One study found these types of programs also help lower the anxiety some patients have when they're in the hospital. According to the National Council on Aging, it takes one week to recover for each day an older adult spends in the hospital. Many supporters of the Hospital at Home program say patients who are treated at home tend to sleep better and even get more exercise.

Experts say one of the most pressing issues facing these hospital-at-home programs is having a strong enough internet connection for telehealth services. While work is underway to improve conditions in rural America, people living in rural areas are nearly twice as likely to lack broadband access.

Another issue is getting more hospitals to invest resources into the program. While some private insurers have signed on, some of the nation's biggest commercial payers are waiting to see if the federal government continues the funding.

While it's anyone's guess if Congress will act in time to extend the Hospital at Home program, healthcare organizations are working to urge quick action. In March 2024, more than 65 organizations, including the American Medical Association and the American Telemedicine Association, signed a letter urging lawmakers to extend the Acute Hospital Care at Home waiver program for at least another five years. The group noted that if the program is extended, one in six hospitals will have hospital-at-home programs by 2030. ●

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Medicaid Unwinding Deals Blow to Tenuous System of Care for Native Americans

JAZMIN OROZCO RODRIGUEZ, TFF HEALTH NEWS

Jazmin Orozco Rodriguez, correspondent, works for the KFF Health News rural health desk and is based in Elko, Nevada.

About a year into the process of redetermining Medicaid eligibility after the Covid-19 public health emergency, more than 20 million people have been kicked off the joint federal-state program for low-income families.

A chorus of stories recount the ways the unwinding has upended people's lives, but Native Americans are proving particularly vulnerable to losing coverage and face greater obstacles to reenrolling in Medicaid or finding other coverage.

"From my perspective, it did not work how it should," said Kristin Melli, a pediatric nurse practitioner in rural Kalispell, Montana, who also provides telehealth services to tribal members on the Fort Peck Reservation.

The redetermination process has compounded long-existing problems people on the reservation face when seeking care, she said. She saw several patients who were still eligible for benefits disenrolled. And a rise in uninsured tribal members undercuts their health systems, threatening the already tenuous access to care in Native communities.

One teenager, Melli recalled, lost coverage while seeking lifesaving care. Routine lab work raised flags, and in follow-ups Melli discovered the girl had a condition that could have killed her if untreated. Melli did not disclose details, to protect the patient's privacy.

Melli said she spent weeks working with tribal nurses to coordinate lab monitoring and consultations with specialists for her patient. It wasn't until the teen went to a specialist that Melli received a call saying she had been dropped from Medicaid coverage.

The girl's parents told Melli they had reapplied to Medicaid a month earlier but hadn't heard back. Melli's patient eventually got the medication she needed with help from a pharmacist. The unwinding presented an unnecessary and burdensome obstacle to care.

Pat Flowers, Montana Democratic Senate minority leader, said during a political event in early April that 13,000 tribal members had been disenrolled in the state.

Native American and Alaska Native adults are enrolled in Medicaid at higher rates than their white counterparts, yet some tribal leaders still didn't know exactly how many of their members had been disenrolled as of a survey conducted in February and March. The Tribal Self-Governance Advisory Committee of the Indian Health Service conducted and published the survey. Respondents included tribal leaders from Alaska, Arizona, Idaho, Montana, and New Mexico, among other states.

Tribal leaders reported many challenges related to the redetermination, including a lack of timely information provided to tribal members, patients unaware of the process or their disenrollment, long processing times, lack of staffing at the tribal level, lack of communication from their states, concerns with obtaining accurate tribal data, and in cases in which states have shared data, difficulties interpreting it.

Research and policy experts initially feared that vulnerable populations, including rural Indigenous communities and families of color, would experience greater and unique obstacles to renewing their health coverage and would be disproportionately harmed.

"They have a lot at stake and a lot to lose in this process," said Joan Alker, executive director of the Georgetown University Center for Children and Families and a research professor at the McCourt School of Public Policy. "I fear that that prediction is coming true."

Cammie DuPuis-Pablo, tribal health communications director for the Confederated Salish and Kootenai Tribes in Montana, said the tribes don't have an exact number of their members disenrolled since the redetermination began, but know some who lost coverage as far back as July still haven't been reenrolled.

The tribes hosted their first outreach event in late April as part of their effort to help members through the process. The health care resource division is meeting people at home, making calls, and planning more events.

The tribes receive a list of members' Medicaid status each month, DuPuis-Pablo said, but a list of those no longer insured by Medicaid would be more helpful.

Because of those data deficits, it's unclear how many tribal members have been disenrolled.

"We are at the mercy of state Medicaid agencies on what they're willing to share," said Yvonne Myers, consultant on the Affordable Care Act and Medicaid for Citizen Potawatomi Nation Health Services in Oklahoma.

In Alaska, tribal health leaders struck a data-sharing agreement with the state in July but didn't begin receiving information about their members' coverage for about a month — at which point more than 9,500 Alaskans had already been disenrolled for procedural reasons.

"We already lost those people," said Gennifer Moreau-Johnson, senior policy adviser in the Department of Intergovernmental Affairs at the Alaska Native Tribal Health Consortium, a nonprofit organization. "That's a real impact."

Because federal regulations don't require states to track or report race and ethnicity data for people they disenroll, fewer than 10 states collect such information. While the data from these states does not show a higher rate of loss of coverage by race, a KFF report states that the data is limited and that a more accurate picture would require more demographic reporting from more states.

Tribal health leaders are concerned that a high number of disenrollments among their members is financially undercutting their health systems and ability to provide care.

"Just because they've fallen off Medicaid doesn't mean we stop serving them," said Jim Roberts, senior executive liaison in the Department of Intergovernmental Affairs of the Alaska Native Tribal Health Consortium. "It means we're more reliant on other sources of funding to provide that care that are already underresourced."

Three in 10 Native American and Alaska Native people younger than 65 rely on Medicaid, compared with 15% of their white counterparts. The Indian Health Service is responsible for providing care to approximately 2.6 million of the 9.7 million Native Americans and Alaska Natives in the U.S., but services vary across regions, clinics, and health centers. The agency itself has been chronically underfunded and unable to meet the needs of the population. For fiscal year 2024, Congress approved $6.96 billion for IHS, far less than the $51.4 billion tribal leaders called for.

Because of that historical deficit, tribal health systems lean on Medicaid reimbursement and other third-party payers, like Medicare, the Department of Veterans Affairs, and private insurance, to help fill the gap. Medicaid accounted for two-thirds of third-party IHS revenues as of 2021.

Some tribal health systems receive more federal funding through Medicaid than from IHS, Roberts said.

Tribal health leaders fear diminishing Medicaid dollars will exacerbate the long-standing health disparities — such as lower life expectancy, higher rates of chronic disease, and inferior access to care — that plague Native Americans.

The unwinding has become "all-consuming," said Monique Martin, vice president of intergovernmental affairs for the Alaska Native Tribal Health Consortium.

"The state's really having that focus be right into the minutiae of administrative tasks, like: How do we send text messages to 7,000 people?" Martin said. "We would much rather be talking about: How do we address social determinants of health?"

Melli said she has stopped hearing of tribal members on the Fort Peck Reservation losing their Medicaid coverage, but she wonders if that means disenrolled people didn't seek help.

"Those are the ones that we really worry about," she said, "all of these silent cases. … We only know about the ones we actually see." ●

KFF Health News is a national newsroom that produces in-depth journalism about health issues and is one of the core operating programs at KFF — the independent source for health policy research, polling, and journalism.

An East Texas County Fights a Bitter Battle Over a Reborn Hospital

KATHRYN JONES, *TEXAS OBSERVER*

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This article was originally published by the Texas Observer, *a nonprofit investigative news outlet. Sign up for their weekly newsletter, or follow them on Facebook and X.*

The dueling election signs beckoning voters to choose their next hospital district board have popped up in yards, on street corners, and in the windows of businesses across the small East Texas town of Crockett.

"Keep Our Hospital Open," reads a large sign with four hospital board candidates' names emblazoned in red in front of the Moosehead Café on the Houston County courthouse square. Next door, a smaller blue sign imploring people to "Keep a Strong Hospital" lists four other names—the opposing slate.

Elsewhere in Texas, voters are heading to the May 4 polls to choose everything from city council members to school board members. But in this town of about 6,300 residents, the hot local race is over who will govern the future of the only hospital in the county: Mid Coast Medical Center-Crockett.

In the last decade, the hospital—which has had different names—has closed, reopened, and changed operators several times. Now it's facing financial pressures, including wrestling with costs from treating patients who cannot or will not pay their bills.

Houston County's struggle to keep its hospital open reflects similar challenges faced by rural hospitals across the state. Texas not only has the highest rate of uninsured residents in the nation, it also has the highest number of rural hospital closures—26 as of 2023, according to an analysis by Chartis, a healthcare advisory firm. In the 10 states that haven't expanded Medicaid coverage, including Texas, more than half of the rural hospitals are operating in the red, the study found.

Many rural hospitals like Crockett's encounter resistance to raising local property taxes to keep up with rising costs. They don't have as much leverage as larger facilities in bigger communities when negotiating reimbursement rates with insurers. Their demographics often make supporting a local hospital more difficult.

"You're talking about a population that's older, poorer, sicker, and less insured," said John Henderson, president and CEO of the Texas Organization of Rural & Community Hospitals.

Crockett, Houston County's largest town, and the county as a whole have seen their populations decline since 2000. Almost a fifth of the population in Crockett, and 23 percent of the county, is 65 and older, compared with 13 percent for Texas. More than a fifth of Crockett residents under age 65 are uninsured, compared with

18.9 percent statewide for 2022. The poverty rate of 27.3 percent is almost double the 14 percent rate for Texas. Only 14.8 percent of county residents age 25 and over hold a bachelor's degree or higher, less than half the statewide rate of 32.3 percent.

Barbara Crowson, the current hospital district board president, who is not up for reelection, points to another challenge in supporting the 25-bed hospital in Crockett: geography.

"We're a very large county and if you live at the southern end, they're closer to Huntsville than they are to Crockett," Crowson said. "On the other [eastern] end of the county, they're closer to Lufkin. They're not going to drive to Crockett" to go to the hospital when cities closer to them have medical centers.

Most of the hospital's patients come from the Crockett area or the Houston County Lake area to the north, she said.

The hospital's fate resonates with many people in this town, named for Davy Crockett, the frontiersman and congressman who died defending the Alamo. Houston County is the oldest county in Texas, established when the state won its independence from Mexico and named after the Republic of Texas' president, Sam Houston.

In recent years, residents have packed some hospital board meetings. Critics have disrupted meetings, refusing to sit down. The meetings became so contentious that the board proposed and clashed over a "code of conduct" for its own members and the public.

As property values have risen, some people have demanded that the district lower their tax rates, which the board did in a divided vote in 2023, from 13 cents to 10.7 cents per $100 of valuation. The hospital board itself is split between those who want to support the hospital by raising property taxes if necessary to cover costs and expand services and those who say it's not needed. Tax opponents say the hospital's operator, Mid Coast Health System, a nonprofit chain based in El Campo, southwest of Houston, receives enough public funds.

"Houston County definitely is not completely unique, but it has a historically torn district on really understanding what all it takes for a small rural hospital to stay viable," said Brett Kirkham, Mid Coast Health System's chief executive.

Part of the dissension may stem from Crockett's rocky history with previous operators that leased the county-owned hospital. East Texas Medical Center, based in Tyler, operated it for about 15 years, then cut back on satellite hospitals and ended its lease in 2015. The county hospital district and the Community Hospital Corporation took over managing the facility temporarily.

The county thought it found a partner when Timberlands Healthcare, a subsidiary of Little River Healthcare based in Rockdale, entered into a lease agreement in early 2016. But Timberlands ran into financial problems and told the board that it had to stop delivering babies. In June 2017, Timberlands closed abruptly, putting almost 200 employees out of work. Patients arriving at the hospital found a sign taped to the front door that read, "Hospital Closed," with no explanation. Patients had to call 911 in the event of an emergency or travel 35 miles to the nearest hospital in Palestine.

A year later, Little River filed for Chapter 11 bankruptcy, then sought to liquidate its holdings, which included medical facilities in Cameron, Rockdale, and elsewhere in Central Texas. Little River was the target of a U.S. Justice Department investigation that contended it funneled payments to Texas doctors in exchange for referrals for laboratory tests from Little River and two other companies. In June 2022, the department said 15 Texas doctors agreed to pay $2.8 million to settle the kickback allegations.

After Timberlands' closure, hospital district board members worked to bring in new operators to take over the empty space and lease the facility. A pair of Austin-area doctors reopened the hospital in July 2018 as Crockett Medical Center LLC. It operated on a smaller scale than Timberlands, with an emergency department and 25 inpatient beds.

Crockett attracted attention as one of only a handful of communities in Texas that had a local hospital close and reopen.

"That's about unprecedented," said Henderson, of the rural community hospitals group.

Indeed, it was such a rare occurrence that KFF Health News did a long story about it. TV stations and other media also covered the reopening.

Crockett Medical Center seemed to be going strong. Then one of the partner doctors left. The remaining partner decided to return to Austin for personal and professional reasons and informed Crowson that he wouldn't renew the lease.

"It was a huge shock," Crowson said.

In 2023, Mid Coast Health System took over the lease. The nonprofit also operates hospitals in El Campo, Palacios, Llano, Bellville, and, most recently, Trinity, about 30 miles from Crockett in adjacent Trinity County. That facility, which had closed seven years earlier, also joined the short list of shuttered hospitals that reopened. Mid Coast held a ribbon-cutting ceremony at the Trinity hospital earlier this month.

Kirkham, the CEO at Mid Coast, said the corporation has tried to find the right formula to keep rural hospitals afloat, sharing costs as much as possible among its six hospitals.

It's worked well, he said. "But still you have to have the community support. Most of our facilities have a hospital district with some tax support for indigent uncompensated care. But none of that even covers the full burden. … That's where us being able to pull out cost, to get better contracts, helps give these hospitals a fighting chance."

One of Mid Coast-Crockett hospital's advantages is that it's designated as a "critical access" facility by the federal Centers for Medicare & Medicaid Services. That means the hospital provides 24/7 emergency care and receives cost-based reimbursements for Medicare patients, among other benefits.

Kirkham envisions synergies between Crockett's and Trinity's hospitals.

"We can further our mission of keeping expenses down, sharing leadership, flexing staff between both facilities," Kirkham said. "But it still relies on district support and our communities supporting and wanting and using the hospital locally."

Kent Waters, the Crockett hospital's administrator, said he sees that support after one year in the community. The hospital averages about 800 emergency room visits a month and has begun a "swing bed" program that's paying off. Patients who go to larger hospitals in Lufkin and Palestine for surgery, for example, can come back and receive rehab and nursing in Crockett's hospital instead of in a skilled nursing facility.

Medicare Advantage plans, which are offered by private insurers, are cutting into that, though, because they tend to reimburse less than traditional Medicare, according to the Chartis study. Kirkham said Advantage plans dilute a key benefit of critical-access programs by increasing rural hospitals' financial risks with lower reimbursement rates and, at times, slow repayment. "We're seeing about 55 days to get a claim paid" under Medicare Advantage programs, Kirkham said. He cited an "egregious" case where it took seven months to get the payment.

Insurance trade groups, like AHIP, say Advantage plans provide better services and access to care at a lower cost.

As far as Medicaid expansion goes, "We know that's a very touchy topic in Texas, but for most hospitals it definitely would mean a lot" by increasing the number of paying patients, Kirkham said. A Texas A&M University study released in 2020 found that nearly a million newly eligible Texans would sign up for Medicaid if the program were expanded.

On the other hand, hospitals like Mid Coast-Crocket might still have to deal with Texas's low Medicaid reimbursements, which don't cover all the costs, Kirkham said.

Currently, the hospital district board provides $225,000 to the hospital each month; $100,000 is returned to the district for the hospital lease payment. That means a net of $125,000 is used for indigent care costs, Waters said. But actual costs vary and have run as high as $400,000, he said.

During the last cold and flu season, the ER experienced one of its busiest weeks, Waters said. Some people visited for problems better treated by their doctor or by themselves.

"The other day someone came in and it was like they had touched a pan that was a little bit too hot," Waters said. "A Band-Aid at home probably could have sufficed."

With all the forms of unpaid care, "That's why most hospitals still rely on a healthy tax base," Kirkham said.

Inside the Moosehead Café on a recent Monday morning, diners sat in booths with checkered tablecloths and sipped coffee. The café attracts many locals and visitors from all over Texas and the nation, thanks to its collection of animal heads—including, yes, moose heads—vintage souvenirs, political signs, and its funky, laid-back Texas feel.

Hospital board candidate Buddy Conts, the café's co-owner, sat at a table with board incumbents Rhonda Brown and Dina Pipes, who are seeking reelection. They want to keep the hospital open but push for more transparency and oversight.

"We aren't negative," Brown said. "We want to see this hospital open, prosper, and serve this community." The candidates said they know the hospital must provide indigent care, but they want more information about

Image courtesy of Kathryn Jones

where non-paying patients are coming from and how tax dollars are being spent.

"I grew up poor. I know what it's like to struggle," Brown said. "I am not against helping people by any means." But Mid Coast is required by contract to give more financial information—how every dime is being spent, she said. "That's our job."

Waters responded that the company gives the board monthly reports on the hospital's operating condition, as well as a monthly uncompensated-care report. "[We have] done all that we can to get them the information they want without violating any HIPPA concerns" regarding medical privacy, he said.

The opposing slate of candidates aligned with Crowson—the current board president—includes Robert Grier, who has a doctorate in human genetics and biochemistry and was a past board president, and Jarvis McElhany, a 26-year-old paramedic at Houston County EMS. McElhany said he's seen firsthand the need for the local hospital.

"We have quite a lot of cardiac arrests," he said. "It's very hard to do CPR in a helicopter, so we're going to take them (by ambulance) to the closest facility, which nine out of 10 times is Crockett.

"Right now we need a hospital more than ever."

McElhany said he's concerned that "a lot of bickering and needless fighting" will drive the hospital's operator away.

Crowson, Grier, and McElhany said they favor raising the tax rate to 12 cents per $100 of valuation. The new funds could be used to start a diabetic clinic and attract at least one new doctor to town, they said.

Brown, the current board member who is seeking reelection on the opposing slate, said raising the hospital tax rate is not necessary "because we are meeting all our obligations with sufficient funds."

Whether enough taxes and other revenue can be squeezed out of a poverty-stricken, underinsured county to keep a hospital afloat is the question many rural hospitals and taxing districts are grappling with these days. Kirkham said it all boils down to community support.

"We're appreciative of the support we get, but if we're not wanted here, we can spend our time and efforts in other communities," he said. "It's a sad thing, but that's the reality." ●

SUMMER 2024 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.

2024 Kentucky Harm Reduction Summit
June 20
Marriott Louisville East
Louisville, KY

2024 Virginia Rural Health Clinic Summit
June 20-21
The Inn at Virginia Tech
Blacksburg, VA

Building Dementia Awareness in Tribal Communities Through Interactive Programming: Implementing the Virtual Dementia Tour
June 25
Virtual

2024 Annual South Dakota Rural Health Leaders Conference
June 25-26
Drifter's Event Center
Fort Pierre, SD

2024 Journeying Toward Wellness Opioid Conference
June 25-28
Kewadin Casino and Convention Center
Sault Ste. Marie, MI

Advisory Committee on Infant and Maternal Mortality Meeting
June 26-27
Virtual

2024 Illinois Health and Hospital Association Small & Rural Hospitals Annual Meeting
June 27
Crowne Plaza Springfield
Springfield, IL

Building a Behavioral Health Continuum of Care: The Role of Rural Leaders and Behavioral Health Directors
June 27
Virtual

Exploring the Impact of Sleep in Rural and Agricultural Communities
June 27
Virtual

49th Annual National Institute for Social Work and Human Services in Rural Areas Conference
June 27-28
Fort Hays State University Memorial Union
Hays, KS

Improving Retention and Reengagement in HIV Care: Expert Insight and Patient Experience for Addressing Barriers in Rural and Underserved Communities
June 28
Virtual

49th Annual USAging Conference & Tradeshow
July 8-11
JW Marriott Tampa Water Street and Tampa Marriott Water Street Hotels
Tampa, FL

Medicare Advantage and Its Impact on Rural Health Care
July 9
Virtual

Agricultural Health and Safety Course for Medical and Safety Professionals
July 9-10
Harold M. and Beverly Maurer Center for Public Health
Omaha, NE

2024 Kentucky Rural Health Clinic Summit
July 11-12
WKU Knicely Conference Center
Bowling Green, KY

2024 Annual NRHA State Rural Health Association Leadership Conference
July 16-17
Hilton Portland Downtown
Portland, OR

Rural Health Open Door Forum
July 18
Virtual

2024 Annual Rural Community Health Worker Network Making Connections Conference
July 18-19
The Lit Grand Rapids
Grand Rapids, MI

2024 Annual National Rural ITS Conference & ITE Annual Meeting and Exhibition
July 21-24
Philadelphia Marriott
Philadelphia, PA

2024 California Rural Health Conference
July 22-24
Lake Natoma Inn
Folsom, CA

2024 Ohio Rural Health Conference
July 29-30
Raabe College of Pharmacy at Ohio Northern University
Ada, OH

2024 Annual Minnesota Alliance of Rural Addiction Treatment Programs Conference
July 30-31
Willmar Conference Center
Willmar, MN

35th Annual Illinois Rural Health Association Educational Conference
July 30-August 1
I Hotel and Illinois Conference Center
Champaign, IL

2024 National Rural Assembly
Everywhere
August 1
Virtual

2024 Annual Association of Clinicians for the Underserved
Conference
August 4-7
Westin Downtown
Washington, D.C.

2024 Annual Arizona Rural Policy Forum
August 7-9
Clark Memorial Clubhouse
Clarkdale, AZ

2024 Rocky Mountain Tribal Leaders Council Public Health Conference
August 14-15
DoubleTree by Hilton Hotel
Billings, MT

Barriers to Care: Solutions for Mental Health and Substance Use Treatment Provision in Rural Communities
August 21
Virtual

51st Annual National Association for Rural Mental Health Conference
August 26-27
Bryant Conference Center
Tuscaloosa, AL

Appalachian Regional Commission 2024 Annual Conference
September 4-5
Chattanooga Convention Center
Chattanooga, TN

2024 New England Rural Health Student Summit
September 7
Dartmouth-Hitchcock Medical Center
Lebanon, NH

2024 Annual State Health Policy Conference
September 9-11
Renaissance Nashville Hotel
Nashville, TN

2024 Annual National Organization of State Offices of Rural Health Meeting
September 10-12
Sheraton Niagara Falls
Niagara Falls, NY

2024 Georgia Rural Health Association Annual Conference
September 10-12
Jekyll Island Club Resort
Jekyll Island, GA

2024 Indiana Rural Health Association Fall Forum
September 11
Ivy Tech Community College
Culinary and Conference Center
Indianapolis, IN

2024 Annual Rocky Mountain Rural Trauma Symposium
September 12-13
Hilton Garden Inn
Missoula, MT

2024 Midwest Rural Opioid and Stimulant Conference
September 17
Marriott Kansas City Overland Park
Kansas City, KS

2024 Annual Rural Nevada EMS Conference
September 18-21
Elko Convention Center
Elko, NV

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