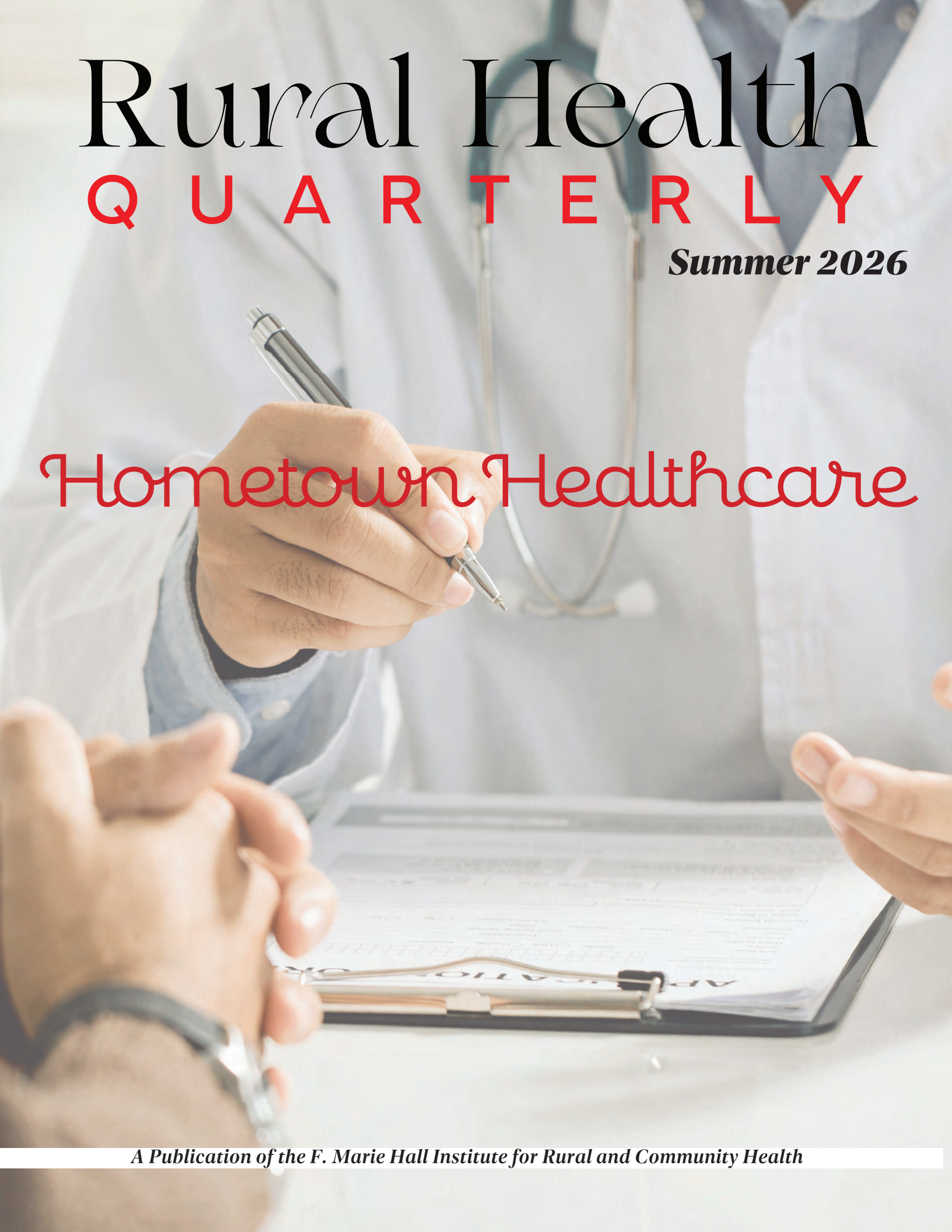
Rural Health QUARTERLY

Summer 2026



Hometown Healthcare

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In This Issue

Summer 2026

Welcome to the Rural Health Quarterly

For most Americans, going to see a doctor is simply dropping by a neighborhood clinic. That's not true for folks who live in the rural U.S. Access to healthcare is one of the biggest obstacles for them, whether it is because there are simply no medical facilities or doctors to operate them.

In this issue of the *Rural Health Quarterly*, we highlight efforts in rural West Texas to make quality healthcare available to everyone. We feature a new partnership between Texas Tech University Health Sciences Center's Division of Rural Affairs and Texas A&M Health, where they're turning shipping containers into medical clinics. You'll also hear from the nurse leading the first "container clinic," who shares her experience moving from Dallas-Fort Worth to far West Texas to support her new community.

You may be asking yourself about those people who live nowhere near these new clinics or simply can't travel to see a doctor. We look at a new program in the Permian Basin that's hitting the road to help people by bringing healthcare to schools and other community locations through a mobile unit. Also, learn about a program that's bringing back old-fashioned house calls for some seniors.

You can also learn how rural hospitals are working to keep their doors open by pursuing investments in areas like workforce development and technology through a program called Rural Health Transformation.

One issue that faces people in urban and rural areas is addiction. You can learn how one West Texas hospital is helping link people wanting to get clean to the help they seek.
Finally, we introduce you to a woman who's now helping women throughout West Texas get mammograms after dealing with her own battle of breast cancer.

As the government funding dries up for some programs, we know there's so much more work to do to increase rural access to care for people. This issue of the RHQ highlights a small amount of the work that's underway to try and improve the conditions.

How Shipping Containers & Telehealth are Bringing Health Care to Rural Texans

Smiley Garcia, MPA
Asst. VP , Institute of Telehealth and Digtal Innovation (ITDI)
Texas Tech University Health Sciences Center

Community-based telehealth provides access to high-quality healthcare in community settings through a community partner, offering online virtual primary care and remote monitoring to expand clinical care access and address community healthcare needs. The intended site for this model would be a rural county without direct patient-care physicians. Data from the Texas Department of State Health Services (DSHS) show 34 counties that currently meet that criteria.

Texas Tech University Health Sciences Center (TTUHSC) has successfully implemented this model on its clinical sites in Marathon, as well as in our partnership with Texas A&M Health in Fort Davis and our newest site in Burton. This initiative, led by the Institute of Telehealth and Digital Innovation (ITDI), which is a part of the TTUHSC Division of Rural Affairs, is currently working with the community of Burton to expand, with the overall goal of developing a scalable model providing an access to care option to rural communities throughout the state.

The Clinical Model

The centerpiece of the model is securing providers to deliver care through a partnership between TTUHSC's Family Medicine in Odessa and Texas A&M Health, which provides behavioral health counseling. This partnership is the foundation supported through ITDI that brings direct care to the frontier areas of the state. The successful operationalization and implementation of the clinic require investment from three primary components:

1. **TTUHSC Family Medicine Odessa and Texas A&M Health:** TTUHSC Family Medicine Odessa provides the primary care clinical components, including physicians/ medical residents, scheduling, and billing. Texas A&M provides a behavioral health professional to deliver specialty care. The provider is credentialed through TTUHSC.
2. **TTUHSC Institute of Telehealth and Digital Innovation (ITDI):** Provides telehealth equipment and technical assistance. During the implementation phase, ITDI also provides operational planning and leads the coordination of resource acquisition.
3. **Community Investment:** Fort Davis and Marathon have provided clinic space and clinical staffing for daily operations. Currently, both sites have hired a registered nurse to receive and enroll patients and manage daily clinical on-site functions.

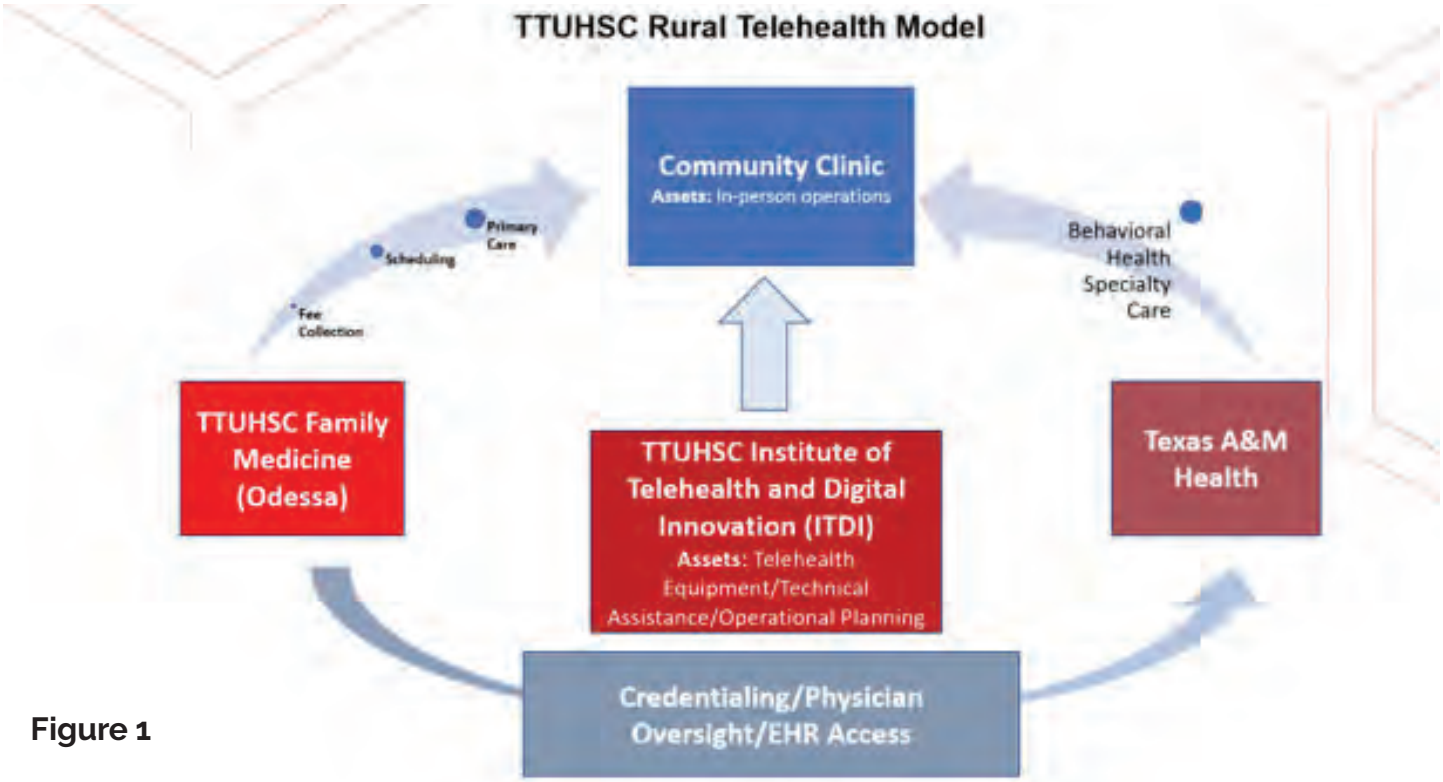


Figure 1

The TTUHSC Rural Telehealth Model (Figure 1) shows how these three parts connect in relation to clinical operations. For the community clinic, there are two variations of the model: Marathon set up its clinic in a community center, while Fort Davis uses a shipping container for its clinical space.

TTUHSC Clinical Practice Operations

In the Rural Telehealth Model, clinical practices are the centerpiece of providing primary and specialty care, as well as patient services.

Physicians from TTUHSC Odessa serve as primary care providers and as each clinic's medical director. This setup is essential for resolving credentialing requirements for both the on-site nurses in Fort Davis and Marathon and the behavioral health provider from Texas A&M Health. Medical students from TTUHSC also assist in delivering care.

Fort Davis, Marathon, and Texas A&M use TTUHSC Odessa's electronic health record (EHR) system to store patient data and charts. For patient services, TTUHSC Odessa manages scheduling and bill collection. The clinic charges a $30 flat fee for each patient visit, and TTUHSC provides the administrative resources to bill and collect payments.

At the Fort Davis clinic, Texas A&M Health's behavioral health specialist utilizes TTUHSC's EHR, scheduling, and billing systems for specialty care services.

Through its BUILD program, Texas A&M Health has provided a 40-foot-long shipping container retrofitted to clinic specifications, including lighting, fans, air conditioning, heating, and both 110-volt and 220-volt electrical outlets. Generators are included with each clinic, alongside upper and lower cabinets, three sinks, and ample shelving and countertop space (illustrated in Figure 2). This serves as a viable option for a community without an existing physical asset to host a clinic, though availability is subject to the supply and production capacity of the Texas A&M BUILD retrofitting team.

Clinic Support

ITDI, operating through TTUHSC's Division of Rural Affairs, provides the telehealth equipment and IT support for the clinics. This includes telehealth carts, necessary clinical peripherals, ongoing equipment replacement, and direct IT technical support.

As a clinic becomes operational, the Division of Rural Affairs through ITDI provides essential

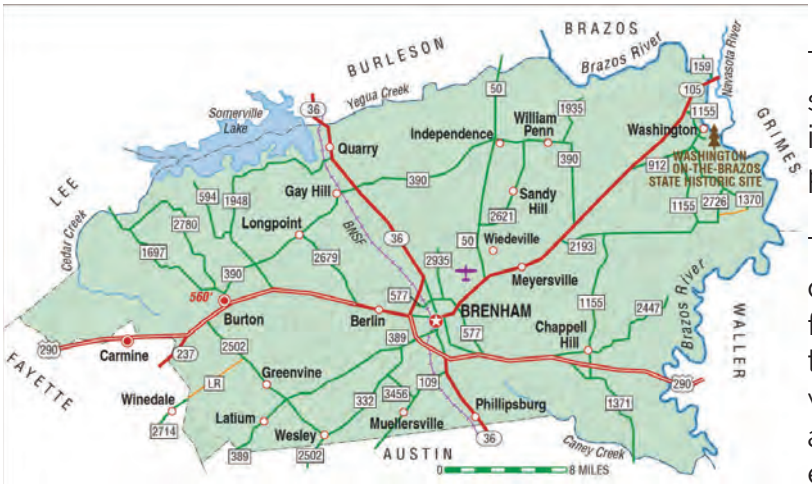
operations planning support while collaborating with community stakeholders to secure necessary assets. Additionally, Rural Affairs serves as a trusted advisor to help communities plan future expansions, such as integrating point-of-care testing, pharmacy services, and additional specialty lines.

Community Investment

While TTUHSC provides primary and specialty care services through telehealth, an in-person clinical facilitator is essential for successful operations. The on-site personnel enroll patients into the EHR, take vital signs and serve as facilitators for the telehealth visits. Both Fort Davis and Marathon have hired a registered nurse that manages the onsite operations and will incorporate the expanded services such as on-site testing and lab work. For facilities, Marathon has provided a community building to serve as its clinical space and Fort Davis allocated county-owned land for the shipping container.

Scalability & Tailoring to Community Needs

The key to expansion is developing a model that is not only scalable, but it is built around the community's resources. The first step to reaching this goal is the opening of the newest telehealth container clinic in Burton, Texas.



Washington County, Texas (Courtesy Texas Almanac)

Figure 2

Located 15 miles from Brenham in Washington County, community leaders approached TTUHSC and Texas A&M about bringing this clinic to this region of Texas as a bridge to rural access to care and to integrate the County's Emergency Medical Services (EMS) as the facilitators and clinical operators.

The Burton clinic allows patients to access primary care through telehealth courtesy of Texas Tech physicians. Texas A&M Health Telehealth Institute provides licensed professionals that offer tele-counseling services. Washington County EMS staff will create in-person touchpoints and patient visit care coordination.

The Burton Bridge Ministry, a local non-profit, provides a passenger van to transport patients to and from the clinic, overcoming a common rural healthcare barrier.

This is just one example of how telehealth support and care delivery components are integrated in the support and resources provided in Burton.

The Burton project highlights the evolution of the model by incorporating EMS as clinical facilitators. In May 2026, ITDI provided on-site training for EMS staff to familiarize themselves with telehealth equipment and how to conduct a telehealth visit. This site also highlights the evolution of how in-person clinical facilitation is implemented.

Prospective Expansion Service Area

As of 2025, the Texas Department of State Health Services (DSHS) data show there are 34 counties (Figure 3) that have no direct patient care physicians.

Based on the implementation of the Marathon and Fort Davis clinics, these counties are now priority sites for future expansion, providing immediate access to care for these communities and establishing primary and specialty care.

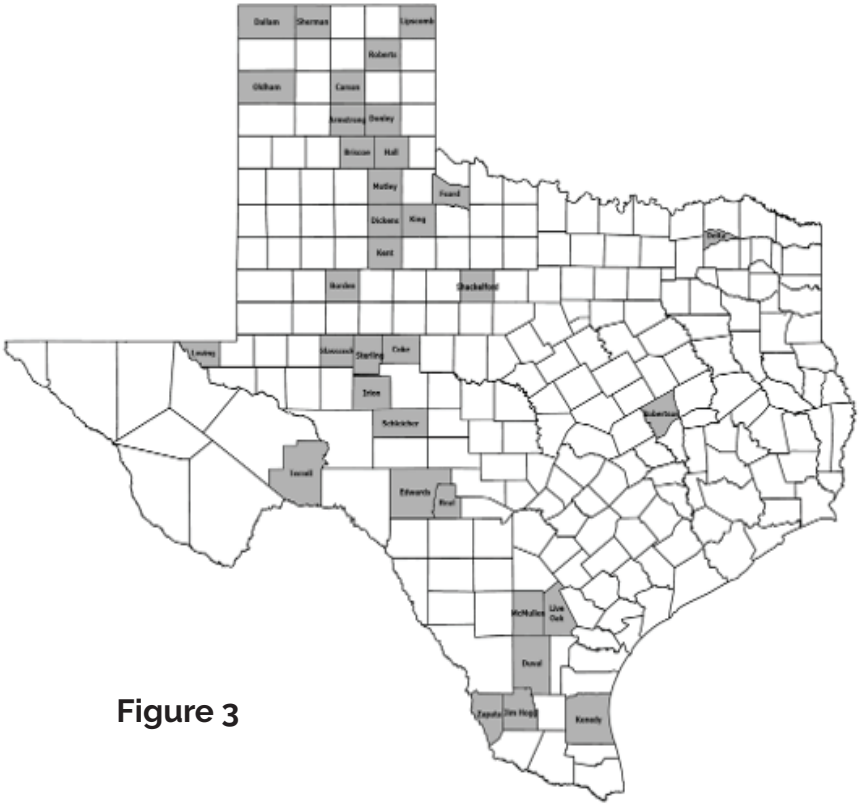


Figure 3

These 34 rural counties across West and South Texas—each home to less than 15,000 residents—face severe healthcare deserts. Similar to the conditions in Fort Davis and Marathon prior to launch, these communities lack practicing physicians, and residents must often travel 25 to 50 miles to reach the nearest hospital or clinic.

These counties include: Armstrong, Borden, Briscoe, Carson, Coke, Dallam, Delta, Dickens, Donley, Duval, Edwards, Foard, Glasscock, Hall, Irion, Jim Hogg, Kenedy, Kent, King, Lipscomb, Live Oak, Loving, McMullen, Motley, Oldham, Real, Roberts, Robertson, Schleicher, Shackelford, Sherman, Sterling, Terrell, and Zapata.

Best Practices and the Way Ahead

Fort Davis and Marathon have proven the successful implementation of the rural community telehealth clinical model. It has established TTUHSC as the provider of primary care and patient services. While this is provided through telemedicine, this model has shown that in person and on-site clinicians are required as well, with Fort Davis and Marathon investing in a registered nurse to receive patients and facilitate telehealth visits. This model has provided a primary baseline but is still plans to develop service lines and other services holistically based on the needs of the community. With our expansion in the Burton community, the model is evolving with the incorporation of the county EMS resources. In the long-term scalability of this model will be balanced with incorporation of community resources for long-term sustainable operations.

TTUHSC & TAMU Health teams in Burton, Texas

The Growing Pains of a Rural Clinic

Carol Brewer, RN BSN
Davis Mountain Clinic

As a Registered Nurse with more than 25 years of critical care and management experience in the largest hospital systems in the Dallas-Fort Worth metroplex, transitioning to rural healthcare provides me with a unique perspective. A perspective, quite frankly, this big city nurse is still trying to wrap her head around since opening the Davis Mountain Clinic nine months ago. This is an experience that has proven to be the most satisfying of my nursing career.

I was asked to write about the day in the life of a rural clinic, but I am still learning what that is. I was trained for and worked in the traditional healthcare system. The healthcare system designed to treat and manage thousands of patients during a single day, across hospitals and specialty practices. Where every process and procedure is documented. Where every answer is just a call or Tiger Text away. I might argue that based on this alone, rural practice provides more personal care than traditional healthcare provides.

When I was first interviewed for the clinic, it was very much in its infancy. There were a lot of things that were still being worked out. That is an understatement because I didn't even know what my salary was going to be. It sounds crazy that anyone would accept a job without knowing their salary, but I didn't move to Fort Davis to make money. I moved to Fort Davis to semi-retire, enjoy the scenic views and cool climate (for Texas). Working at a clinic that is a ten-minute walk from home seemed like the perfect fit. With a leap of faith, I accepted the position. In October 2025, a 40-foot retrofitted shipping container provided by the Texas A&M (TAMU) student organization BUILD that houses the Davis Mountain Clinic, was opened to patients with

Fort Davis Clinic

telemedicine services provided by Texas Tech University Health Sciences Center's Division of Rural Affairs and tele-counseling provided by the TAMU Telehealth Institute.

In the Mountains

The Davis Mountain Clinic is in Fort Davis, which is the county seat of Jeff Davis County. The county is 2,264 square miles and currently has a population of approximately 1,800 residents. That is less than one person per square mile, illustrating the remoteness of the mountainous community the Davis Mountain Clinic serves. This area is so remote that the U.S. Postal Service (USPS) does not deliver mail to physical addresses. County residents must retrieve their USPS mail from PO boxes. Jeff Davis County has an aging population with more than 45% of the residents being 65 years of age or older, among the highest percentage of seniors in all Texas counties.

The Team

The Davis Mountain Clinic is a 501c3 non-profit clinic that partners with Texas Tech and Texas A&M University to provide telemedicine and tele-counseling services, respectively. Beyond these services, both partners provide strategic guidance for expanding clinical capabilities and operational improvements.

The clinic's Board of Directors is comprised of county residents with varying backgrounds who relate to the unique needs of our underserved area. The Board plays an important role in guiding the establishment and future of the clinic.

The clinic has one staff member, a Registered Nurse who also serves as Executive Director of clinic operations.

Jeff Davis County officials were instrumental in bringing the clinic here and provided the county-owned property to house the clinic structure. The clinic's Executive Director provides a monthly report to Jeff Davis County Commissioners.

The Beginning

The first big question was how the community would respond. Let's face it, there will always be naysayers, and in Jeff Davis County there were quite a few. Some folks don't take well to something new they don't fully understand.

To break the ice, one month after opening, the clinic invited the community to an Open House. A ribbon-cutting ceremony with county officials, academic representatives, and local business leaders was held in July 2025. The community was also invited, but few attended. This later Open House in November 2025 was a low-key affair that provided the community with a non-ceremonious opportunity to see inside the clinic, ask questions, and meet their nurse. The event was advertised on community Facebook pages and with flyers posted throughout the county. More than 100 people attended the open house or dropped into the clinic on their own during the first month of operation.

Fort Davis Clinic Ribbon-Cutting Festivities, July 2025

Each Patient is a Learning Experience

The clinic opened on October 1, 2025, and had our first patient just six days later on October 7th. Our first patient required a pre-operative clearance. The patient did not bring orders from their surgeon, so we didn't know what the surgeon required. After a call was made to

the surgeon's office, we learned that the patient had all required testing completed recently enough that no additional examination or testing was required. That was our first lesson learned, and over the coming weeks it became clear that clarifying patient needs prior to scheduling a clinic appointment, whether for telehealth or tele-counseling, would be key to making efficient and effective use of everyone's time and affect patient satisfaction.

Eliminating Hurdles to Receiving Care

In rural areas, patients may delay care due to the travel distance or lack of transportation. To date, the most common example the clinic has seen is patients who have exhausted all refills on their medications, such as those to treat high blood pressure. The original prescribing physician will not refill until they see the patient. The good news is that our telehealth physicians will order labs, medications, and regular follow-up appointments to safely manage stable chronic conditions.

Patients have also visited the clinic for injuries and wound care. As previously mentioned, there is a high percentage of elderly patients in Jeff Davis County. We have seen many patients who have suffered wounds with delayed healing, making them at higher risk of infection. After seeing the telehealth doctor, it is convenient for the patient to return to the clinic for the prescribed wound care. In some cases, patients or a family member can be educated and perform wound care themselves. In other cases, when the patient is unable to complete the wound care or doesn't have anyone to help them, the clinic can perform the wound care. This allows for timely, easily accessible care – saving the patient the cost of time and travel.

There are instances where there is no choice but for the patient to be referred to a specialist two to three hours away. The clinic continues to support that patient if there is any care we can provide that has been ordered by their specialist. For example, a patient was referred to a vascular surgeon, who determined that the patient required a vein ablation. While the patient waited for the surgeon's office to get insurance approval, compression wraps were prescribed. Between the trusted relationship built with the clinic, and the convenience of being within two blocks of their home, the patient asked if the clinic could assist with compression wraps. The clinic was more than willing to assist, of course. In this instance, the patient did not have to obtain home health care for the two weeks it took to get their insurance approved and the procedure scheduled. Because of easy access to care, they were able to maintain their normal routine. The uninsured do not have to delay care because telehealth appointments are available for $30 per visit. In the event an uninsured patient does not have $30 to see a doctor, the clinic has established a fund to cover the cost. Cash-paying patients, if needed, can also take advantage of cash pricing for ancillary testing at the closest hospitals in the region.

Care Coordination

There is a significant amount of care coordination for our rural clinic patients, especially when

patients are referred to outside sources. The clinic assists the patients in organizing and navigating their care. I assist patients with connecting them with needed resources, coordinating appointments, requesting records and test results from outside organizations, helping them understand their care plan, and monitoring their progress.

I may be biased, but I believe the patients who visit a rural clinic will benefit the most from clinicians with broad clinical expertise and experience. Critical thinking and judgment are necessary to keep the patient's care as efficient as possible. With rural medicine, access becomes part of the plan of care for their diagnosis. In addition to what is the best treatment, the question is how we can ensure that the patient receives the very best treatment. For example, an established patient previously seen for liver-related health issues reports they were diagnosed with breast cancer over a year ago but has not been to a doctor since the original diagnosis. Obviously, the patient needs a mammogram. Because the patient has developed trust with the clinic and telehealth providers, rather than go to the nearest location for breast imaging, they requested to make the trek to Odessa, Texas for their mammogram.

To ensure the patient continues to receive the very best care, we ensure that an in-person clinic appointment and any additional testing is scheduled on the same day as the mammogram. This gives the patient the opportunity to take advantage of access to care during their 300-mile round trip visit.

Where We Are Going

The number one request the clinic receives is to participate in the Veterans Affairs Community Care Network to ensure our local veterans have access to timely, quality healthcare that does not require hours of time and travel to VA facilities. The Texas Tech HSC team, along with Texas A&M and the Davis Mountain Clinic, are supportive of the request and plan to include it in a future phase of the clinic's offerings.

In addition, the Board of Directors, together with current and new partners, are looking at and planning to grow clinic offerings to improve our community's health, including women's services, in-house lab results, medicine on the move, and chronic condition support groups.

Conclusion

Much to my surprise, my perception of rural healthcare has changed. Rural health is intellectually demanding and far from a simple practice. Every day, I rely on my years of clinical experience, critical thinking, judgment, and ability to adapt, all while juggling limited resources and the patients' unique obstacles.

While a rural medicine clinic affords a welcome work/life balance, which can be difficult to find in the traditional healthcare setting, it by no means should imply it is any less challenging than working in a large urban healthcare system. Rural medicine is not a lesser version of healthcare. It is care practiced at its broadest, most resourceful, and most personal level. Making it the most rewarding job in my career.

Checking Out Better Health at the Local Library

Madeline de Figueiredo
Writer, The Daily Yonder

For some rural Texans, the closest link to a doctor may now be the local library. Across the state, libraries are helping residents, particularly older adults, access telehealth appointments and digital health tools in communities where clinics, broadband, and transportation remain limited.

Telehealth has emerged as a key tool for improving health care access for older adults in rural communities, where long travel distances, physician shortages and higher rates of chronic illness are common.

However, broadband access, technology barriers, and shifting telehealth policies continue to limit how widely older people in rural areas can use these services.
"The most expensive part of any broadband development is the last mile. You can get broadband to a rural library, medical clinic, or hospital, but what about the person who lives a mile and a half out of town? That's the most expensive piece of broadband expansion, that last-mile access," said Brock Slabach, chief operations officer at the National Rural Health Association (NRHA). "So, you're going to have people, especially in rural areas, including elderly residents, who unfortunately won't be able to access broadband or telehealth because they don't have that connection right now."

Rural libraries in Texas are stepping in as digital access points for telehealth appointments and local health care support.

The Dublin Public Library, in Erath County, used grant funding to distribute internet-enabled devices to more than 50 residents through a Digital Navigator program, relying on partnerships with local organizations to identify community members most in need of technology and connectivity.

This effort was part of a broader state initiative aimed at helping libraries bridge the digital divide by providing devices, connectivity support, and digital skills assistance to underserved residents.

This story was originally published in the Daily Yonder. For more rural reporting and small-town stories visit dailyyonder.com.

"Access to reliable broadband remains a significant challenge in Erath County, particularly for residents in more rural areas. The library plays a critical role in helping bridge that digital divide by serving as a free, trusted access point for both technology and connectivity," said Adina Dunn, the library director at Dublin Public Library. "For many of our patrons—especially older adults—the digital world can feel overwhelming or even inaccessible at first…From expanding telehealth access to strengthening digital literacy programs, we are committed to making sure that no one is left behind as more essential services move online."

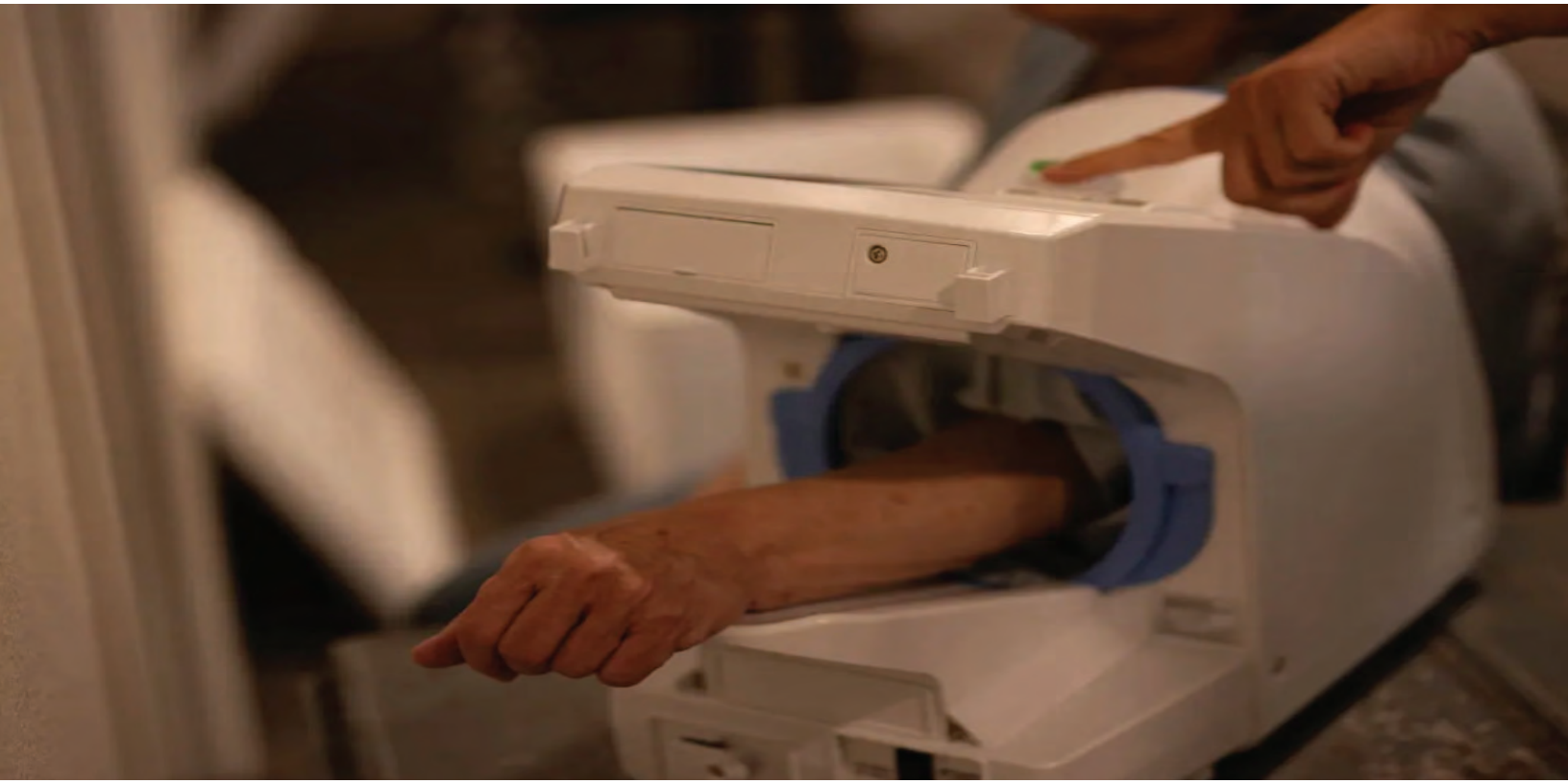
Dunn said the library plans to expand its role in supporting telehealth by participating in the Texas State Libraries and Archives Commission grant program to create a dedicated telehealth space with privacy and reliable internet access. "In the meantime, we already assist patrons with a wide range of healthcare-related technology needs. The most common requests include helping individuals set up and access email accounts, log into patient portals, complete online medical forms, and join video appointments," Dunn said. "For many, even small barriers—like remembering passwords or navigating unfamiliar websites—can prevent them from getting the care they need."

Some rural libraries have already developed and implemented telehealth hubs on-site.

In 2024, the American Heart Association partnered with rural West Texas libraries, beginning in Jeff Davis County (Jeff Davis County Public Library) and expanding to Reeves County (Reeves County Library) and Hockley County (Sundown Public Library), to launch virtual health hubs. These libraries were equipped with private telehealth rooms, blood pressure monitors, pulse oximeters, and weight scales for self-checks during virtual medical visits.

The initiative also made CPR training kits, tabletop blood pressure machines, and take-home monitoring cuffs available to library patrons, aiming to address local high hypertension rates—31% in Jeff Davis County, 33% in Reeves County, and 33% in Hockley County—as well as limited access to healthcare providers in these rural communities.

"We wanted to build a space that was somewhere that's quiet, it's comfortable, it's a

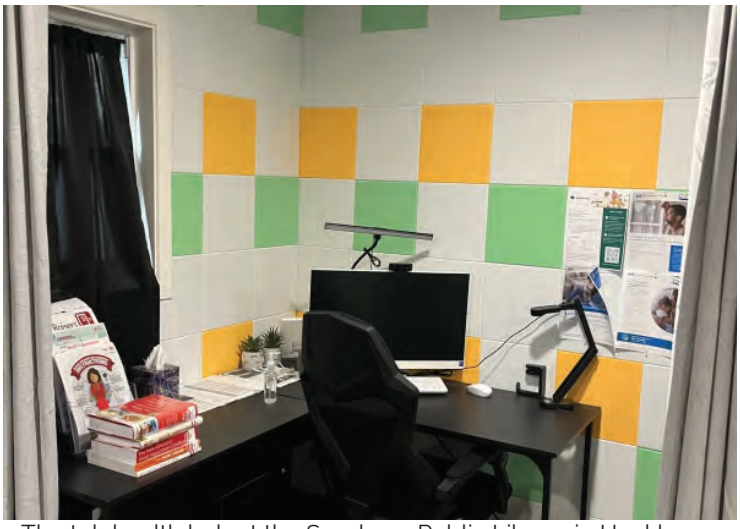


A community member uses a tabletop automated blood pressure monitor at Sundown Public Library in Hockley County, Texas. (Photo by Dakota Guevara/American Heart Association)

place that the community already trusts and is already utilizing, such as a county or city public library," said Kassandra Hunt, a registered nurse and the senior director of community impact at the American Heart Association. "We wanted to make it a comprehensive space where people could access health care by utilizing telehealth."

Hunt said this model specifically accounted for older populations in rural Texas.

"We know that older residents can't always travel easily, some people are homebound or rely on others for a ride. In some cases, they may still have to drive to the library, but that's often much more feasible than driving an hour or two to the nearest health care provider," Hunt said. "With library staff also able to help with the technology, we're trying to make it accessible for everyone, regardless of age."



The telehealth hub at the Sundown Public Library in Hockley County, Texas. (Photos courtesy of Sundown Library)

For the town of Sundown, in Hockley County, expanding health care resources has been top of mind for the past decade. In 2016, the town cut all EMS services due to budget issues, increasing wait times for first responders by about 15 minutes. The library has stepped in to help fill that gap.

"We've tried to be diligent about teaching hands-only CPR to community members, because it can potentially save lives," said A'ndrea McAdams, the library director at Sundown Library. She recalled a case where a man in his mid-40s suffered a cardiac arrest, and his wife—trained through her school—was able to perform CPR until EMS arrived.

Although internet access in Sundown is generally high, many older residents remain unfamiliar with digital technology, creating barriers to telehealth and other online services. Library staff have worked to bridge this gap, helping patrons understand how to connect with doctors via phone or computer, navigate patient portals, and access virtual medical appointments, which can save both time and travel costs.

"Especially in rural communities, you just look after each other. For healthcare, just taking the time to sit and have discussions with patrons and be available, even though it's a time commitment, can help them feel more comfortable using technology. That's our goal," McAdams said.

That approach is already showing results.

"Our telehealth usage has increased 60% from last year, so we're reaching more people, but it's really about moving beyond the idea that the library is just for books. We actually have a library of things," McAdams said.

The library's stationary tabletop blood pressure kiosk has been used more than 300 times over a 15-month period, and a trained community health worker has partnered with the library to further support patrons.

In Jeff Davis County, where the median age is 58, the Jeff Davis County Library's telehealth and partnership with the American Heart Association is helping residents age in place, staying at home and remaining independent as they grow older.

"We have a lot of people who are aging in place here, and so anything that can help them access doctors and specialists and not have to leave their home or not have to tax their limited income is really useful," said Erin Ray, the library director of the Jeff Davis County Public Library. "I've been so impressed with all of the various entities that have leaned into kind of provide

The telehealth hub at the Jeff Davis County Public Library. (Photo courtesy of Jeff Davis County Public Library)

that support and help bridge those gaps."

The library's telehealth services are part of a broader effort to address the challenges of rural health care, where long distances, limited transportation, and physician shortages make access difficult for older adults. Aside from the telehealth clinic at The Davis Mountain Clinic, the nearest hospitals and patient centers are in Alpine, a 30-minute drive away.

"There really is a huge sort of gap in services and in rural areas," Ray said. "For a lot of our residents, even driving to Alpine for medical care can be difficult—either because they're elderly and may not be able to drive, or because their socioeconomic status makes it hard to afford the trip. Because of that, the need for some kind of medical attention locally is pretty great. That's where the library stepped in."

By providing private telehealth rooms, medical monitoring equipment, and guidance from staff, libraries are stepping into a role once reserved for clinics, helping residents manage chronic conditions and stay connected to care without leaving their communities.

In the Rio Grande Valley, the Hector P. Garcia Public Library in Mercedes is taking a similar approach, but with an added focus on bilingual services. Spanish-language courses and digital literacy programs help older adults and Spanish-speaking residents navigate everything from online job applications to telehealth portals.

One of the library's digital navigators, Tristan Garza, said older patrons often struggle with technology and mistrust online information, making in-person guidance essential. "Patrons can call the library or visit in person to get a second opinion or verified information from reputable sources," Garza said, highlighting the library's role in bridging both language and digital literacy gaps.

For many rural libraries in Texas, evolving to meet health care needs is part of their mission.

"Many of our older patrons come to the library not just for internet access, but to stay connected—to their families, their community, and essential services," Dunn said. "Ultimately, the library is more than a place—it's a partner. We're here to help people stay connected, informed, and supported, no matter where they're starting from."

Reaching Patients on the Outskirts

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When it comes to rural communities, one word that comes to mind is inspiring. This is our experience in West Texas communities, where we see community after community learning to adapt to its many challenges despite the limited resources. Inspiration is one important attribute the Medicine on the Move (MOTM) program is trying to emulate.

This mobile health initiative started in 2022 at the Texas Tech University Health Sciences Center (TTUHSC) - Permian Basin with the goal of bringing healthcare to outlying communities without any real access to healthcare. The program aims to accompany surrounding communities, learn their needs, and look for opportunities to collaborate, support, and empower its underserved populations.

Thanks to funds from the Permian Strategic Partnership and the Blue Cross Blue Shield Caring Foundation, special vans help student (medical, nursing, physician assistant, and social work) volunteers get out into the area to provide community and rural medicine experiences, community engagement visits, health promotion outreaches, rural telemedicine clinics, vaccination programs, a rural summer camp for high school students interested in healthcare careers, and several workforce development and wellness initiatives.

In its early stages, the MOTM program worked primarily with the communities surrounding Odessa. One of the main activities in the first two years was a vaccination program with the school district and rural communities of Marathon and Coyanosa.

MEDICINE ON THE MOVE

The program also participates regularly in the Hope for the Homeless at the American Legion Odessa, with added support from the Nursing School and the Department of Family Medicine and Community Medicine at TTUHSC Odessa. The advocacy with the homeless coalition resulted in the identification and securing of the Health Resources and Services Administration Street Medicine grant to the TTUHSC-PB Department of Family and Community Medicine under the leadership of Dr. Vani Selvan. This grant will provide primary care training for TTUHSC-PB resident physicians in providing care for people experiencing homelessness in settings outside of clinics.

Recently, Medicine on the Move expanded into several rural communities in the Permian Basin with the priority of finding and serving those communities without access to local healthcare options. MOTM has regularly scheduled visits in St. Lawrence, Coyanosa, Balmorhea, and Barstow. The outreach in Balmorhea has been so successful that we have established a permanent access point at Balmorhea Independent School District. The program also continues to support TTUHSC's fixed telemedicine sites in Marathon and Fort Davis.

In a typical MOTM telehealth visit, a rural community navigator brings a patient to a community location, and a trained presenter helps with getting information from them, including their chief complaint, the history of present illness, and past medical history. Afterward, the patient is then linked up through Zoom (which is HIPAA-compliant) with a resident and faculty physician at the TTUHSC PB Family Medicine Clinic back in Odessa. The medical team has the necessary equipment, such as a stethoscope, otoscope, ophthalmoscope, and dermatoscope, to expand the capabilities of the physical exam.

Appointments accomplished are for common chronic diseases such as hypertension and diabetes, but some urgent care appointments are also possible. The program is looking to add point-of-care testing equipment to boost its diagnostic capability and provide in-person healthcare at some frequency, using a rural medicine physician assistant fellow and pharmacy services.

In the past four years, MOTM had TTUHSC medical students, nursing students, and family medicine resident physicians as regular participants, with additional involvement from the physician assistant program, physical therapy, and pre-medical students from the University of Texas Permian Basin and Midland College.

Just this year, the program started integration into the TTUHSC Institute of Telehealth and Digital Innovation, paving the way for adding a new set of health screening programs ranging from children, women, and elderly community members. As the only mobile health program of this kind with the TTUHSC-PB, Medicine on the Move stands as a beacon of inspiration for emerging programs in the confluence of mobile, community, rural, and telehealth.

Beyond the Grant:
How Collaboration Strengthens Healthcare in Rural Texas

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For many rural Texans, access to healthcare is about more than just distance. It is about whether a neighbor can receive care close to home, whether a family can avoid traveling hours for services, and whether a community can sustain the healthcare resources its residents depend on.

Across the state and the nation, rural communities continue to face significant healthcare challenges. Since 2010, more than 20 rural hospitals in just Texas alone have closed, creating lasting impacts for patients, families, and local economies. When a rural hospital or clinic closes, communities lose more than a healthcare facility. They lose a trusted resource that supports the health and well-being of the people who call that community home.

Strengthening rural healthcare requires more than one organization or one solution. It requires collaboration among healthcare providers, community leaders, researchers, regional organizations, and residents who share a commitment to improving access to care.

Creating Opportunities Through Collaboration

The Rural Health Transformation (RHT) Program created an opportunity for rural hospitals across Texas to pursue investments in areas such as technology, workforce development, prevention, and long-term sustainability.

As these funding opportunities became available, another challenge quickly became clear. While the resources created new possibilities for rural communities, many small hospitals faced barriers to submitting competitive applications. Complex funding opportunities often require extensive planning, data collection, budgeting, and grant writing expertise. For rural hospitals with limited administrative capacity, responding to a detailed funding opportunity within a short timeframe can be difficult.

The first round of Rural Health Transformation funding required eligible hospitals to respond within just a matter of weeks. While many rural hospitals had innovative ideas and a strong commitment to serving their communities, they lacked additional support to translate those ideas into competitive applications.

This challenge highlighted the importance of collaboration.

Across the Texas Panhandle, healthcare organizations and community partners have built a strong foundation of trust and shared purpose. These relationships allow communities to come together quickly, identify opportunities, and support one another in addressing challenges that no single organization can solve alone.

Building Relationships Before Building Proposals

Successful collaboration begins long before a grant application is written.

Throughout the Texas Panhandle, rural healthcare leaders have developed longstanding relationships through organizations such as the Coalition of Health Services. The coalition brings together hospital leaders from across the region to discuss challenges, share ideas, and identify opportunities to strengthen healthcare delivery.

These partnerships are built on trust. They grow through years of communication, shared experiences, and a willingness to support each other. When new opportunities emerge, these existing relationships create a foundation for action.

Regional organizations such as The RANGE have also helped connect healthcare leaders, researchers, and community partners to support rural innovation and economic development throughout the region.

The most important part of this work is understanding that every community has its own history, strengths, and needs.

That requires listening first.

Farwell, Texas is in Parmer County in the Texas Panhandle, and sits on the Texas-New Mexico state line. (Courtesy Google Maps)

It requires showing up.

It requires building relationships before discussing solutions.

From Relationships to Action: The Farwell Story

Farwell Hospital District had a clear goal:

Farwell Clinic, Currently Closed

to expand access to care for residents of Farwell, Texas, by pursuing funding through the Rural Health Transformation Initiative 6: Infrastructure and Capital Investment for Rural Texans.

The opportunity represented more than a funding application. It represented a chance to bring healthcare services closer to residents of a rural community in Parmer County.

Before any application could be developed, relationships had to be established.

When I traveled from Amarillo to meet with the Farwell Hospital District and The RANGE team supporting the effort, one lesson became clear: trust is the foundation of successful collaboration.

Rural communities are often approached by individuals and organizations offering solutions without first understanding the community's needs, history, or priorities. Building meaningful partnerships requires more than presenting an idea. It requires taking the time to listen, learn, and demonstrate a genuine commitment to the community.

"We were so incredibly blessed to have a resident in our community who informed us of a grant that would enable us to make much needed repairs and improvements to a medical building that had been vacant for a few years. None of the board members had any experience applying for and securing a grant. We met with the members of The RANGE team and informed them of our needs," says Jack Kirkland, President of the Farwell Hospital District Board. "Within a matter of a couple of weeks, we were able to work through all the requirements of the application process and submit. Without the help of The RANGE and their amazing staff, this application process could not have been completed."

The visit to Farwell was not simply a conversation about a grant opportunity. It was also an opportunity to understand the community's goals, connect with local leaders, and work alongside partners who were committed to improving healthcare access.

Through an ongoing and collaborative process, the Farwell Hospital District was able to apply for the Rural Health Transformation Initiative 6 funding opportunity. More importantly, the process demonstrated what can happen when communities have trusted partners who are willing to support their vision.

Why Collaboration Matters for Hometown Healthcare

The story of Farwell is not just about one application or one funding opportunity. It represents a broader lesson for communities, funding agencies, and hospitals across Texas: strong hometown healthcare is built through relationships.

Funding opportunities can provide important resources, but partnerships create the foundation needed to make those opportunities successful. When rural communities have trusted networks of support, they are better positioned to identify challenges, pursue solutions, and create strategies that reflect the needs of their residents.

"The Panhandle faces unique healthcare challenges, but it also has tremendous strength, said Amanda Mathias, PhD, PI of Healthcare at The RANGE. "I believe true progress occurs when organizations work together, rely on good data, and respond and tailor collaboration and service development based on the unique needs of the people they are serving."

Rural healthcare does not exist in isolation. It is supported by physicians and nurses providing care, hospital leaders making difficult decisions, community members advocating for their neighbors, researchers helping identify solutions, and regional partners connecting communities with resources.

The future of rural healthcare depends on continuing to build these connections.

When organizations take the time to listen, collaborate, and invest in relationships, they help create stronger communities where residents have the opportunity to receive care close to home.

That is the true meaning of hometown healthcare.

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Primary Care for Rural Homebound Seniors

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Older adults in the U.S. today make up approximately 19.2% of the total population, which is demographically defined as individuals aged 65 and older. That accounts for almost one-fifth of the entire country's population. Furthermore, data from the U.S. Census Bureau indicate that the 65+ demographic is growing significantly faster than working-age adults and children. This reality necessitates a shift in national social, economic, and health priorities. Moreover, within this demographic group itself, there are differing characteristics shaped by social determinants of health.

One defining characteristic is whether an older adult is bound by circumstances to his or her living space. On average, homebound older adults are older (average age 83), more likely to be women, more likely to be members of racial and ethnic minorities, and more likely to have lower incomes and educational attainment. They are also more prone to multiple chronic illnesses and more likely to have been hospitalized during the previous year (Ornstein et al., 2015).

What is the extent of the homebound older adult population in our country? An article by Ornstein et al. in JAMA Internal Medicine provides a clear picture of the proportions of older Americans in this category. Analyzing data from the 2011 National Health and Aging Trends Study (NHATS), which surveyed 7,603 community-dwelling Medicare beneficiaries aged 65 and older, the researchers found that approximately 5.6% of community-dwelling Medicare beneficiaries (about 2 million people) were either completely or mostly homebound. About 395,000 were completely homebound, while roughly 1.58 million were mostly homebound. An additional 15% of older

adults were considered semi-homebound, meaning they could leave home only with assistance or experienced significant difficulty doing so.

One of the most vital preferences of this population is the desire to age—and ultimately die—in place. Facing multiple chronic illnesses, limitations in activities of daily living, and significant challenges in obtaining care from traditional community-based settings, homebound elders need dedicated resources to access primary care that supports their ability to self-manage chronic conditions. Yet, despite having substantial medical needs, only 11.9% of completely homebound individuals reported receiving primary care at home (Ornstein et al., 2015).

Rural Populations of Older Adults and the Need for Homebound Care

More than 60 million Americans live in rural areas across the United States, and approximately 43 million people live in rural Primary Care Health Professional Shortage Areas (HPSAs). About 9.7 million of these residents are older adults, constituting approximately 20% of the total rural population. Older adults living in rural areas face significantly greater barriers than urban seniors, often confronting multiple obstacles simultaneously:

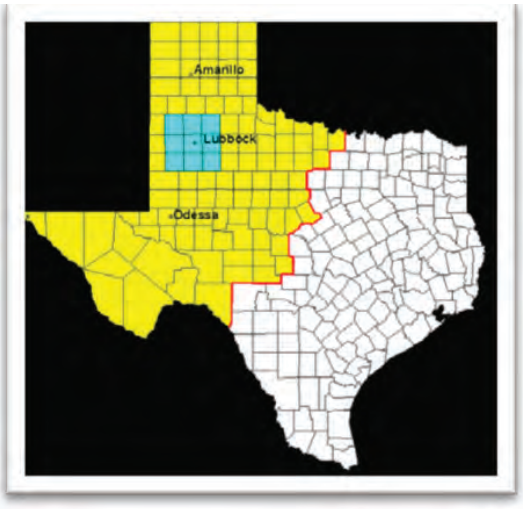
- Longer travel distances to primary care clinics combined with limited public transportation options
- Higher rates of disability and mobility impairment alongside greater chronic disease burdens
- Fewer specialists and geriatric providers
- Higher rates of dependence on Medicare

Faced with the compound challenges of advanced age, chronic illness, transportation deficits, and provider shortages, the need for home-based primary care (HBPC) for rural older adults is critical. The overlap between "rural populations" and "homebound older adults" highlights one of the fastest-growing healthcare priorities in the U.S.

A Solution: The Senior House Calls Program

The aging population will profoundly impact the organization and delivery of healthcare nationwide. A growing demographic imbalance—characterized by the rapid growth of older adult populations alongside a declining proportion of individuals aged 16 to 34—threatens society's capacity to manage the care burden of old age. With projected increases in the number of people aged 65 and older (particularly those 85 and older), community-based primary care is becoming an urgent priority. HBPC offers an effective solution to this challenge.

One community's approach to addressing this issue is the Larry Combest Community Health and Wellness Center's (LCCHWC) Senior House Calls (SHC) program. The LCCHWC was originally established by the Texas Tech University Health Sciences Center School of Nursing (TTUHSC SON) to provide primary care to medically underserved populations in the city and county of Lubbock. It has since evolved into a nurse-led Federally Qualified Health Center (FQHC) offering a broad range of clinical and programmatic services across the region.



The Center's service area encompasses nine West Texas counties: Lubbock, Lamb, Lynn, Hale, Floyd, Hockley, Crosby, Terry, and Garza. The combined population of this area is approximately 414,421, based on U.S. Census Bureau American Community Survey 2019–2023 5-year estimates. The region features a mix of urban and rural communities, with Lubbock County serving as the primary

urban hub and the remaining eight counties representing predominantly rural areas. Except for Lubbock County, all counties in the service area are designated as rural under U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) criteria. The service area also contains multiple medically vulnerable communities designated as Medically Underserved Areas and Health Professional Shortage Areas (U.S. Census Bureau, 2023). Although most patients reside in Lubbock County and surrounding rural areas, the Center serves patients throughout its entire West Texas catchment area.

This service area demonstrates persistent socioeconomic and healthcare access barriers:

- **Demographics:** Hispanic or Latino residents comprise approximately 40.5% of the total service area population. In the eight counties outside Lubbock, Hispanic or Latino representation ranges from 41.6% to 60.8%, exceeding the Texas statewide average of 39.5%.
- **Poverty:** The overall poverty rate across the service area is approximately 17% (exceeding the Texas rate of 13.8%), with county-level rates ranging from 12.6% to 22.1%.
- **Income:** The population-weighted per capita income is approximately $33,400, well below the Texas statewide average of $39,446.
- **Insurance Coverage**: While the population-weighted uninsured rate across the service area is 15.6%, county-level rates range from 13.7% to 25.5%, with several rural counties exceeding 25%.

These coverage gaps—compounded by rural geography, long travel distances, provider shortages, and limited specialty services—severely restrict timely access to primary care, behavioral health, preventive care, and chronic disease management (U.S. Census Bureau, 2023).

History of the SHC Program

With initial start-up funding from the CH Foundation, a local philanthropic organization, the LCCHWC established the SHC program in 2003 to serve senior citizens in Lubbock and surrounding areas. The program was created in direct response to community-identified barriers, including immobility, lack of transportation, and a shortage of physicians accepting Medicare.

The primary goal of the SHC program is to provide a continuum of community-based

services for the elderly as a viable alternative to institutional care. Given the stressors reported by the target population, the program emphasizes prevention, education, and mental health/social work services. Advanced Practice Registered Nurses (APRNs) deliver the majority of direct care, with backup services provided by physicians from the TTUHSC Department of Family and Community Medicine. Additionally, a Licensed Clinical Social Worker (LCSW) provides mental health support services.

At its inception, the program's key objectives were to:

1. Build program infrastructure;
2. Provide individualized health, social, and supportive services to elderly clients in their homes and communities;
3. Establish a network of community resources supporting home-based care;
4. Create fiscal arrangements to ensure sustainability beyond initial grant funding by optimizing billing; and
5. Implement an ongoing quality improvement process.

These founding objectives continue to guide the program today. Current goals focus on expanding provider expertise in pain management, wound care, and dementia care, as well as strengthening community partnerships to enhance primary care and health education for target populations (Esperat et al., 2015).

Services Provided

Family Nurse Practitioners (FNPs) deliver in-home primary care services to older adults within the catchment area. Services include addressing social needs, providing counseling for depression and anxiety, managing prescription medications, and coordinating referrals through a network of community providers.

Home and personal safety evaluations are conducted during initial assessments and updated as needed. Referrals are coordinated with Adult Protective Services (APS) for issues such as suspected abuse, neglect, or financial exploitation—making APS one of the program's most vital community partners.

Program sustainability is maintained through several key practices:

- Completing billing in a timely manner
- Controlling costs through prudent clinical decision-making
- Pursuing aggressive claims follow-up
- Ensuring accurate clinical coding
- Implementing population-targeted marketing
- Building strategic organizational partnerships

To date, the program has served approximately 5,000 unique patients who rely on the SHC program as their primary medical home.

Basic services begin with a health and behavioral needs assessment by the LCSW to evaluate emotional, social, and financial requirements. When appropriate, patients are connected to LCCHWC's Prescription Assistance Program (PAP), which coordinates with pharmaceutical companies to provide medications at no cost. Psychotherapy for

depression, anxiety, and grief is offered as needed, along with dedicated family and caregiver support for patients living with dementia.

Routine clinical services for seniors include age-appropriate immunizations and laboratory testing, functional assessments, home safety and osteoporosis counseling, and comprehensive case management designed to keep patients safe and healthy at home.

Challenges and Issues

Recruitment and Retention of NP Providers

Recruiting and retaining qualified Nurse Practitioners (NPs) represents one of the program's most pressing challenges. As the population ages and the prevalence of chronic conditions rises, the demand for HBPC will continue to grow. However, the supply of clinicians willing to practice in home-based settings has failed to keep pace, creating significant operational and financial strains.

These shortages are felt acutely in rural and underserved communities. Geographic isolation, long travel distances, and limited professional support resources make recruiting experienced advanced practice nurses particularly difficult. The resulting competition for a limited pool of providers leads to prolonged staff vacancies and increased workloads for existing clinicians.

Establishing and Maintaining Program Sustainability

Securing ongoing financial sustainability remains a continuous effort. Because 99% of the program's patient population is covered by Medicare, maintaining a strong, viable Medicare volume is essential to operational success. Key strategies to ensure sustainability include:

- **Increasing Patient Volume:** Ongoing marketing initiatives seek to expand referrals from family practice and geriatric teams, internal medicine clinics, home health and durable medical equipment agencies, the Department of Aging and Disability Services, Adult Protective Services, the South Plains Association of Governments, local churches, pharmacies, and health fairs.
- **Optimizing Patient Visits per NP:** Increasing daily visits per NP from the current break-even threshold of five visits to six or seven visits (by optimizing scheduling and accounting for patient acuity) provides a crucial financial buffer.
- **Enhancing Operational Efficiencies:** Operational sustainability is maintained by maximizing billing efficiency, enforcing timely submissions, controlling costs, managing claims, maintaining coding accuracy, and leveraging collaborative partnerships.
- **Improving Electronic Health Record (EHR) Productivity:** The health system's transition from Cerner to Epic aims to streamline documentation and operational workflows. While system transitions temporarily disrupt clinical workflows, the SHC program is establishing an efficient "new normal" under the updated platform.

- **Developing Contingency and Revenue Plans:** LCCHWC leadership actively pursues targeted grant opportunities and seeks strategic partnerships to diversify and enhance revenue streams.

Client Responses

Twice a year, the SHC program evaluates patient satisfaction. Qualitative feedback reflects the meaningful impact of the program on patients and their families:

- "Senior House Calls has been a blessing to us. My mother and father have not been able to leave their home for several years. Without Senior House Calls available to us, both of them would be in nursing homes."

- "Senior House Calls has been a blessing. My mother only needs to pick up the phone and call. The responses are timely and caring."

- "The Senior House Calls Nurse Practitioner is really interested in me and listens to me."

- "When my father's health was deteriorating, the staff at Senior House Calls provided everything we needed."
- "Senior House Calls staff always go the extra mile. When no one else could help us find insurance, medical equipment, or visits when we needed help, Senior House Calls was always there for us. We feel safe in their care."

- "Senior House Calls knows how to care for all of us. We can phone them and get results. They come to see us and we get results. They care!"

Conclusion

Senior House Calls programs exemplify the principle of delivering compassionate, comprehensive primary care directly into the homes of vulnerable older adults. Healthcare is at its most effective when it reaches those who face the greatest barriers to access.

Evidence consistently demonstrates that home-based primary care improves access, enhances health outcomes, and empowers older adults to age in place safely. By investing healthcare resources into home-based models today, we help build a more equitable, patient-centered healthcare system for tomorrow.

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Authors' Note: We used GenAI tool (ChatGPT) for the purpose of organizing content and synthesis of selected data. All AI-generated material was critically reviewed, revised, and appropriately integrated professional judgment, disciplinary knowledge, and dissemination goals.

Inspired to Help Rural Women Fight Breast Cancer

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I received the call on January 3, 2022, on my first day back at work from the holidays. The incoming call was from my local hospital system, and I knew this was either going to be good news or news that would change my life moving forward. When the man on the other line asked if I was at home or at work, I instantly knew the news was not good. The conversation quickly turned into the words "it is cancer".

In December of 2021, I had my annual mammogram. Every year I was diligent in my health care screenings and had periodically been called back for further testing due to 'dense breast tissue'. So, when I had to return in December for further imaging, I was not surprised. A 3D mammogram turned into a waiting game in the dressing room, followed by more images and waiting, before being called into the ultrasound room. As I laid there in imaging room, the technologist began clicking and sending all sorts of images "upstairs". Before I knew it, a radiologist was in the room watching the images on the screen in real time. I knew that whatever they saw was concerning.

A biopsy was scheduled for the following week. Surely, I thought, this is nothing and a biopsy was really going over the top. During that uncomfortable process, a small cut was made, and a needle was inserted into my breast to take core tissue samples to be sent off for testing. Also, a small, coiled metal clip was inserted into my breast to mark the area so it would be easily located in any future scans or surgery. Whether the spot was cancer or not, it needed to be tagged. I felt like I had been chipped!

Honestly, getting the cancer diagnosis wasn't too much of a surprise. It ran in my family. I lost my mother to cancer in 2011, and her father (my grandfather) had died of cancer when I was in my teens. What was surprising was that it was breast cancer. January 3rd was a Monday. My first day back at work. Stunned I sat in my cubicle trying to soak in what had just been explained to me. The whole conversation after the word "cancer" was a blur. I didn't mention it to anyone and continued through the workday in autopilot. That evening I told my husband, which was one of the hardest things I've ever had to do. Telling our teenage children proved to be harder. Our 17-year-old son just hung his head. He feared the worst.

Two days later, my husband and I met with a local surgeon and developed a plan.

I wanted to nip this whole cancer thing in the bud and elected to have a double mastectomy. This was no easy decision, but I didn't want to wonder when and where the cancer would strike next. I was encouraged by the surgeon to participate in a genetic test to see if I carried the BRCA gene mutation. I eagerly wanted to know my genetic issues, if any, and base any further decisions on the results of the test.

Two days after this appointment, I tested positive for COVID-19. "Cancer" on Monday… "COVID" on Friday. Not a good week and not a good way to start 2022! The COVID diagnosis delayed my surgery a few weeks, unfortunately. During the delay all I could think about was getting the cancer out of my body.

A month later, I had my 5-hour surgery. Thankfully, no cancer was detected in my sentinel lymph node in my armpit, meaning the cancer had not spread to my lymph node system. This allowed me to receive breast implants during the same surgery. As my surgeon removed one breast at a time, a local plastic surgeon followed his progression and was able to insert implants. Coming out of anesthesia, I remember asking three burning questions:
"Did you get it all?" "Yes."
"Did it spread to my lymph nodes?" "No."
"Was I able to receive the implants?" "Yes."

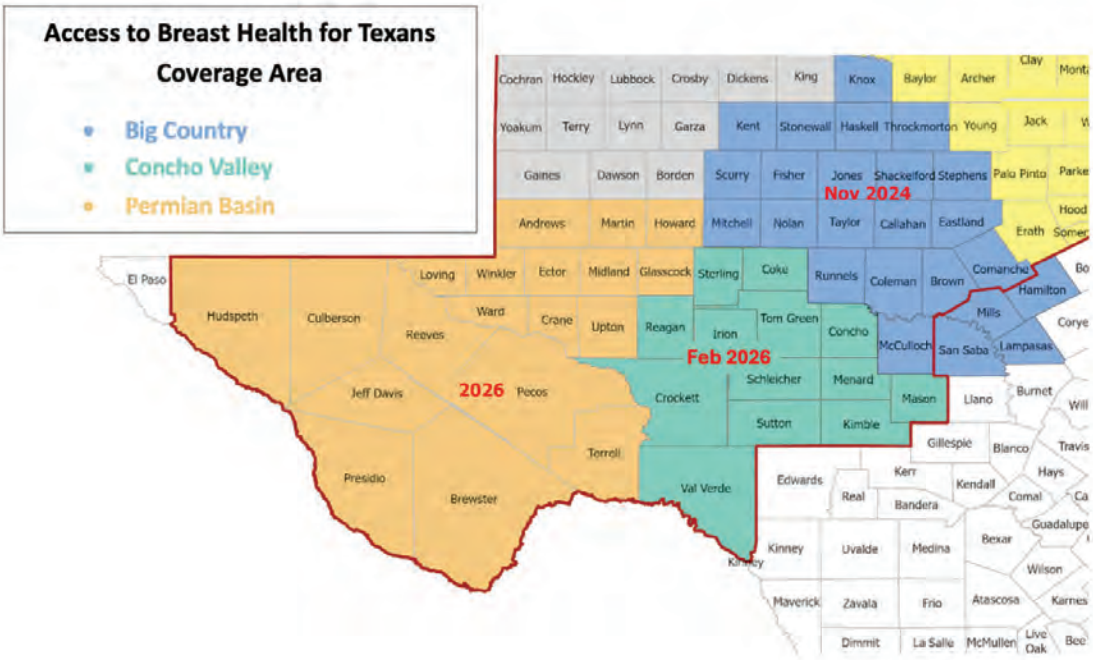
Tamara with (L to R) her husband, Justin; son, Jaden; daughter, Jaci; and son-in-law, JT

Since the cancer was caught so early, was stage 1, had not spread, and I had elected to have a double mastectomy, I did not have to endure chemotherapy or radiation. Early detection matters! I do take a daily aromatase inhibitor pill to keep estrogen and progesterone from forming in my body even though I had a full hysterectomy three months after the double mastectomy. These two hormones were "feeding and fertilizing" the cancer.

Based on the genetic testing I had participated in at my initial surgeon's appointment, I discovered that I did not carry the BRCA gene mutation, which is so highly related to breast cancer. That was good news. I do, however, carry a gene mutation on the MSH6 chromosome known as Lynch Syndrome. That was not so good news. Lynch Syndrome aka "faulty DNA repair gene" can mismatch when cells repair. This repair error can lead to genetic damage and heighten the risk of cancers in the stomach, colon, pancreas, urinary tract, ovaries, and uterus. Hence the reason I pushed for a complete hysterectomy. I wanted to remove anything that was not needed which I felt was a ticking time bomb in my body.

Two years after my surgeries, in 2024, I was informed about a new rural health care initiative through Texas Tech University Health Sciences Center that the Laura W. Bush Institute (LWBI) for Women's Health was hiring for. The new initiative, Access to Breast Health for Texans (ABHT), was to serve rural populations with free breast screenings using a new technology called Bexa. I knew I had to pursue the position and help rural residents be proactive in their breast health journey. So, I applied for the job, was hired, and it has been such a rewarding career change.

Currently, the ABHT is led through the Institute of Telehealth and Digital Innovation at TTUHSC in collaboration with the LWBI. To date over 4,000 individuals have had a free, Bexa exam through the ABHT program. Currently there



are two teams that travel weekly to rural locations to offer exams to individuals. The teams consist of two community liaisons employed by TTUHSC who schedule and coordinate each exam site as well as a trained ultrasound technologist that is employed by Sure Inc./Bexa. One team covers 24 counties in the Big Country, and the other team covers 13 counties in the Concho Valley. An additional third team is being developed that will cover the vast area of the Permian Basin.

The Bexa exam is not a competitor to mammography. The goal is to reach those that are under 40, do not have insurance, cannot travel to imaging centers, and/or are simply not choosing to have a mammogram. The process is highly comfortable, offers no radiation or squeezing, accurate even for dense tissue, safe for pregnant/breastfeeding women, quick with immediate results, safe for men or women, and completely free! The Bexa device uses elastography, sound waves, to detect any tissue that is harder or stiffer in the breast.

If there is no Bexa finding, the examinee receives a printed report before leaving the exam location. If there is a finding, the trained technologist can perform an ultrasound with a handheld transducer immediately on the spot detected by the Bexa device. Examinees are then contacted within 24-48 hours by a radiologist who reads the images with their recommendations moving forward. Some cases of cancer have been found which otherwise may have gone undetected. The program is saving lives one community and one individual at a time. It is worth noting that a Bexa finding does not always lead to cancer. The stiffer or harder masses in breast tissue could be identified by the radiologist as a cyst, clogged milk duct, or scar tissue.

I believe that God allows us to experience trials in life to ready us for future events. Looking back, I feel that my cancer journey paved the way for me to assist and connect with individuals who are seeking innovative ways to be proactive in their healthcare journey. No matter which route works for you, I encourage anyone reading this to receive an annual breast exam. Early detection saved my life, and it could save yours as well.

NEXT GENERATION 911

TRANSFORMING HEALTHCARE THROUGH INNOVATION AND COLLABORATION

The **Next Gen 911 Project** is a partnership between the **Texas Commission for State Emergency Communications (CSEC)** and the **Texas Tech University Health Sciences Center (TTUHSC)** in Conjunction with **EMS Providers** that serve Texans.

WE CAN BE HELPFUL TO YOU.

Next Gen 911 seeks to work with EMS Providers as a trust advisor on telemedicine and digital equipment. We are vendor agnostic, but have a breadth of understanding of the newest resources available to EMS Providers.

TTU HSC
RURAL AFFAIRS

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
F. Marie Hall Institute *for* Rural *and* Community Health

To request information:

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Rural Road to Recovery

Norman Wheeler, JD
CEO, Covenant Hospital Levelland

Rural health care continues to evolve as the needs of our communities change, and one change needed in small towns across the U.S. is more help to fight substance abuse. At Covenant Hospital Levelland, we have seen firsthand how listening to the community can reveal urgent needs and open the door to meaningful solutions.

About Our Community

I am Newman Wheeler, the CEO of Covenant Hospital Levelland. Our community recently celebrated its 100th anniversary, and our hospital remains the only hospital in Hockley County, Texas, which is home to about 14,000 people.

As part of our biennial community town halls, we heard a concern that had become impossible to ignore -- substance use disorders were affecting more individuals and families throughout our community. Those conversations became the catalyst for creating the 180 for Life program.

Developing a Response: 180 for Life

As we explored ways to help, our hospitalist, Dr. Mu Chen, and I developed a comprehensive program to ensure patients receive the necessary immediate care and appropriate follow-up as they start on their recovery. The 180 for Life program provides an on-site service coordinator for substance abuse intervention at the point of stabilization through a withdrawal-management model.

180 for Life is an inpatient, hospital-based medical stabilization model designed to provide structured withdrawal management and case-management-driven transitions of care. The program brings together medical monitoring, evidence-informed withdrawal protocols, recovery support, coordinated discharge planning, and continued case management after discharge to strengthen engagement in ongoing care.

We recognized that traditional pathways often rely on fragmented referrals, short inpatient stays without coordinated follow-up, and inconsistent connections to ongoing treatment.

How 180 for Life Works

Individuals who voluntarily seek help are admitted for approximately three days of inpatient medical stabilization, where they receive treatment for withdrawal symptoms under close medical supervision.

Before discharge, the 180 for Life care team develops a personalized follow-up plan that may include residential rehabilitation, outpatient treatment, counseling, medication-assisted treatment when

appropriate, and connections to community support services.

The program accepts Medicare, Medicaid, most commercial insurance plans, and private-pay patients, making care accessible to a broad range of individuals.

Expanding Access to Care

The level of need for coordinated care quickly exceeded our expectations.

Last year alone, 180 for Life served 101 patients. While the program was created to serve Hockley County, referrals soon started arriving from surrounding communities throughout West Texas and Eastern New Mexico.

Not every patient seeking help with substance abuse qualifies for inpatient medical stabilization, so we had to consider how best to support those individuals as well. To address that gap, one of our local primary care physicians, Dr. Allan Camacho, worked with Dr. Mu Chen and our 180 for Life coordinators to develop an outpatient withdrawal service line through our clinic.

Transforming Lives

The most meaningful measure of the program's success has been the people whose lives have changed because someone was willing to walk alongside them.

Former patients have contacted us months after completing the program to share stories of recovery, restored relationships, renewed employment, and a future they once believed was out of reach.

Implementing this program has required significant staff education and training, but it has also become one of the most rewarding initiatives our team has undertaken. Our nurses consistently demonstrate extraordinary compassion, and patients frequently tell us they felt genuinely cared for throughout their stay.

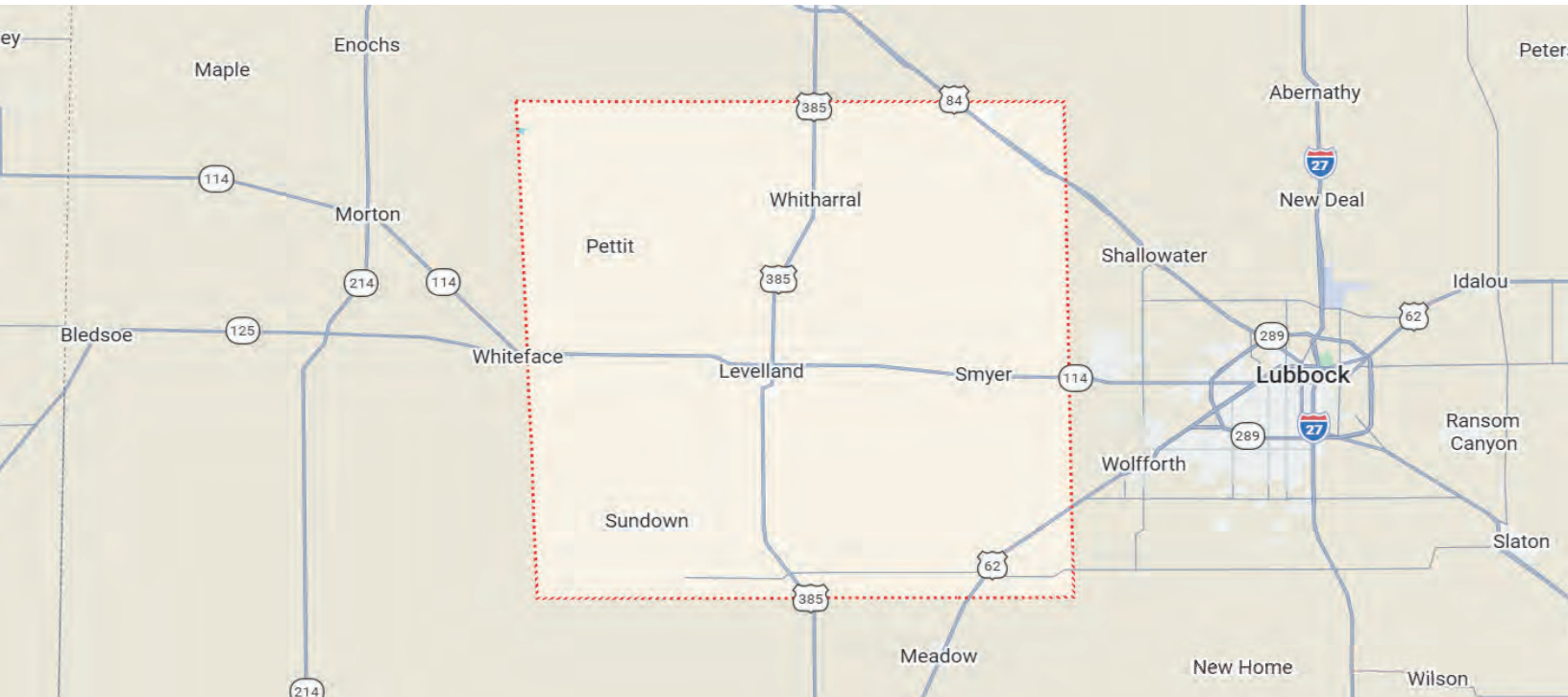
Perhaps the most powerful feedback we receive is from individuals who say that, during some of the darkest moments of their lives, this was the first place where they felt treated with dignity, respect, and humanity.

Looking Ahead

This year, we are on track to nearly double the number of people the program has helped. Our growth has uncovered the dire need and social barriers that affect addicts and their recovery, proving that our work is not only necessary but far from complete.

Being able to meet needs in our community, provide excellent care, support positive outcomes, and walk alongside patients on their journey toward better health and wellness has been one of the most meaningful experiences of our role in the community.

Rural hospitals are more than places for medical treatment; they reflect the communities they serve and offer a place where people seek better health, life, and hope. Hospitals like ours are cornerstones for communities across rural Texas and the rural U.S.



Summer 2026 Conference Calendar

2026 Mid-South Critical Access & Rural Hospital Conference
August 5-7
Sheraton New Orleans Hotel
New Orleans, Louisiana

2026 Eastern North Carolina Rural Health Symposium
August 6-7, 2026
Education Center at Eastern AHEC
Greenville, North Carolina

2026 Ohio Rural Health Conference
August 6-7
Ohio State University - Wooster Campus
Wooster, Ohio

2026 MATRC Telehealth Summit
August 10-12
Crowne Plaza Dulles Airport
Herndon, Virginia

2026 Kentucky Rural Health Clinic Summit
August 13
The Campbell House
Lexington, Kentucky

2026 Annual NACHC Community Health Conference & Expo
August 16-18
Aria Resort
Las Vegas, Nevada

National Tribal Health Conference
August 16-21
Sheraton Grand at Wild Horse Pass
Chandler, Arizona

TORCH/TARHC Fall Conference
August 24-27
Kalahari Resort & Convention Center
Round Rock, Texas

2026 Missouri Rural Health Assn Conference
September 9-10
Camden on the Lake
Lake Ozark, Missouri

Rural Oncology Care Symposium
September 11
Texas Tech University Health Sciences Center
Lubbock, Texas

2026 4th Annual West Texas Health Disparities Research Symposium
September 11
C.J. Davidson Conference Center
San Angelo, Texas

2026 24th Annual Rural Health Clinic Conference
September 15-16
Sheraton Kansas City Hotel at Crown Center
Kansas City, Missouri

2026 Rural Women's Health Symposium
September 15
Desert Willow Conference Center
Phoenix, Arizona

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.

2026 Georgia Rural Health Assn Annual Conference
September 16-18
The King and Prince Beach & Golf Resort
St. Simons Island, Georgia

2026 Rural Nevada EMS Conference
September 16-19
Elko Convention Center
Elko, Nevada

2026 New York Rural Health Symposium
September 17-18
Thousand Island Harbor Hotel
Clayton, New York

2026 54th Annual AAIP Meeting & Health Conference
September 17-20
OKANA Resort & Waterpark
Oklahoma City, Oklahoma

2026 53rd Annual NARMH Conference
September 27-29
Eldorado Hotel & Spa
Santa Fe, New Mexico

2026 Annual Oklahoma Rural Health Conference
September 30-October 2
Stoney Creek Hotel & Conference Center
Broken Arrow, Oklahoma

2026 Investing in Rural America Conference
September 30-October 2
Omni Grove Park Inn
Asheville, North Carolina

Alaska Native Diabetes Conference
October 5-8
Sheraton Anchorage Hotel & Spa
Anchorage, Alaska

2026 43rd Annual Oregon Rural Health Conference
October 7-9
Riverhouse Lodge
Bend, Oregon

2026 American Heart Assn Eastern States Rural Health Summit
October 9
CAMC Center for Learning & Research
Charleston, West Virginia

2026 Transforming Community & Rural Healthcare Symposium
October 12-13
Mayo Civic Center
Rochester, Minnesota

2026 Annual Iowa Community Health Conference
October 13-15
Iowa Events Center
Des Moines, Iowa

2026 Annual Grantmakers in Aging Conference
October 20-23
The Westin Denver Downtown
Denver, Colorado

2026 Louisiana Rural Health Summit
November 12-13
Le Pavillion at Parc Lafayette
Lafayette, Louisiana

2026 Annual New England Rural Health Conference
November 17-18
Grappone Conference Center
Concord, New Hampshire

2026 Annual Tennessee Rural Health Association Conference
November 18-20
Marriott Knoxville Downtown
Knoxville, Tennessee

2026 Idaho Rural Health Assn Annual Meeting & Awards Reception
November 19
Riverside Hotel
Garden City, Idaho

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