Treating Obesity in Rural Children: Are There Any Solutions?

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

In the years that I have been publisher of the Rural Health Quarterly, the editors each have had a unique philosophy regarding the way the publication portrays themes in each issue. Many look forward to the U.S. Rural Health Report Card issue which is in preparation for the upcoming winter, as it awaits the issuance of complete data for various parameters of our method. For each issue, the editor will tell me the theme and I usually write my column to reflect on that as uniquely as I can. Often, they have had to remind me of deadlines as I have a heavy workload from other duties at the University. Nevertheless, I enjoy writing this more than any other type of writing that I do. For this issue, we have covered many topics so it is hard to put a title to our theme for this one. My editor put it nicely, “you can write about whatever you like as long as it touches on rural!”

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

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

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

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

The simplest reason is theirs is a rural culture. What I have observed in over a dozen years working in West Texas and because I come from that culture, I know that liberty is much more ingrained among people who are accustomed to scarcity in nearly every aspect of life from internet bandwidth to health care access. When your days start and end with the rising and setting of the sun and what you do to make a living is produce food, fuel or fiber for others, then there’s a certain singularity to your life that produces a hardened self-reliance. One gets accustomed to deciding what to do in every kind of situation and for every kind of need and living with the consequences. A nyone or anything that poses a threat to that is likely to meet stiff resistance from people who are hardened, tough and strong.

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

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

A collateral matter is that the US rural culture is different and substantial. I worry that, like the Ukrainian enemy, that rural culture is being lost with urbanization. The point is that history turns on the hubris of such threats.

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

**ALABAMA //**

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

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

uah.edu | 02.22.22

**ARIZONA //**

Cochise County, Arizona was left reeling in Feb., as the county’s board of supervisors rejected $1.9 million in pandemic funds, citing pandemic fatigue.

Local doctors and residents protested the decision, as county health care continues to be swamped by COVID patients.

www.nytimes.com | 02.11.22

**ARKANSAS //**

The Delta Regional Authority has added 11 healthcare facilities to the DRCHSD, a program designed to enhance healthcare in the Delta Black Belt region.

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

www.ijpr.org | 02.19.22

**CALIFORNIA //**

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

www.usnews.com | 02.18.22

**FLORIDA //**

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

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

floridajobs.org | 02.21.22

**FRANCE //**

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

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

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

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

france24.com | 03.05.22

**UGANDA //**

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

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

techcrunch.com | 03.07.22

**AUSTRALIA //**

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

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

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

healthcarenews.com | 03.07.22

**SOUTH KOREA //**

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

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

businesswire.com | 03.08.22

**SCOTLAND //**

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

heraldscotland.com | 03.07.22

**HAWAII //**

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

dailyyonder.com | 02.17.22

**IDaho //**

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

The bill would affect students enrolling in WWAMI at the U of Idaho or U of Utah.

idahobusinesstoday.com | 03.07.22

**CANADA //**

The Canadian government has announced an investment of $2.2 million to three health organizations in the country, in order to increase access to healthy activities for older adults.

The Sinai Health System, McMaster University, and Cawthron Green Community Society will work towards expanding services for older adults to better maintain healthy habits.

newswire.ca | 03.08.22

**ALASKA //**

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

Dr. Buttrn has worked in rural Alaska since 1997, and received the award for organizing state-wide workshops on medical trauma.

alaskapublic.org | 12.08.21

**GEORGIA //**

The Georgia State Senate recently approved SB138, if passed it will extend Medicaid coverage for low-income post-partum women.

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

gorgiahealthnews.com | 02.07.22

**CONNECTICUT //**

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

usnews.com | 02.18.22

**RHQ //**

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

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

U.S. Mail: Rural Health Quarterly, F. M. airy Hall Institute for Rural & Community Health, 5307 West Loop 289, St. 301 Lubbock, Texas 79414

Voice: (806) 743-3614

FAX: (806) 743-7953

Web: Find more RHQ contacts at ruralhealthquarterly.com or follow us on Facebook at facebook.com/Rural-HealthQuarterly.
Missouri //
In rural Missouri, the definition of ‘rural’ has led to funding issues. Rural towns have struggled to apply for projects, but they don’t count as rural for some grant opportunities. The USDA is revising their definition, but could take years to conclude.
news.stltoday.com | 01.18.22

Louisiana //
In the wake of Hurricane Ida, a program called Louisiana Just Recovery Network has helped hundreds of people in the southeast part of the state recover from the storm. Working as volunteers, the group has tarped roofs and cleaned out homes for free, assisting rural residents waiting on relief funds from FEMA and the state.
southerlymag.org | 02.22.22

Maryland //
The University of Maryland Extension has partnered with three mental clinics to help struggling farmers on the Eastern Shore. The clinics will offer more access to mental health treatment and resources, where 46% of farmers say it’s hard to access treatment.
delmarvanow.com | 02.10.22

Minnesota //
The University of Minnesota, Minneapolis, has opened a new Center for Rural Behavioral Health, to address mental health shortage areas in rural parts of the state. The Center will focus on workforce development and research.
ktry.com | 03.04.22

Nebraska //
The University of Nebraska at Kearney has received a $100,000 gift from Healthy Blue Nebraska to support a project bringing broadband to rural parts of the state. The Rural Measures project provides resources to keep patients connected to health care. They also address health disparities. unknews.unk.edu | 03.07.22

Pensylvania //
The AgriStress HelpLine, a new pilot project for mental health, has launched in Pennsylvania. Created for rural farmers and workers in the state’s agriculture industry, the pilot is funded by the USDA. The HelpLine is available 24/7, and can be reached at 833-897-AGRI (2474).
newsfromthestates.com | 02.11.22

South Dakota //
The Great Plains Epidemiology Center, located in Rapid City, is one of 12 tribal centers focused on epidemiology and tribal public health needs. The center serves 18 communities in four states, providing public health programs in schools and beyond.
newscenter1.tv | 02.09.22

Texas //
No Kid Hungry Texas and the Texas Rural Education Association have awarded $150,000 to five rural schools to assist their nutrition programs, a step towards reducing child hunger in rural Texas. The school districts used the funds to improve their food distribution and run curbside and delivery services.
keranews.org | 03.05.22

Utah //
In southwest Utah, National Guard members are being deployed to hospitals struggling with patient overflow and tapped out ICUs. With COVID-19 still an issue for rural hospitals in the state, St. George Regional Hospital will get 11 National Guard members to help out in non-clinical duties. Most rural facilities are operating at capacity.
sitrib.com | 02.11.22

Virginia //
Eastern Shore Rural Health, Inc. is expanding their services to the community by opening a new urgent care center in Onley, and adding a pharmacy at the Onley Community Health Center. The projects are in the planning phase.
shoaredailynews.com | 03.08.22

Washington //
The Washington Senate has passed a new bill that will increase access to affordable health care for the state’s residents. HB1616 will expand the state’s charity care law, requiring hospital systems to provide greater financial assistance to patients.
atg.wa.gov | 03.08.22

Wyoming //
The Wyoming Senate has approved five more appropriations from the American Rescue Plan Act funds, giving $33 million to state health initiatives. The funds will go towards suicide prevention, community health centers, and broadband projects.
wyomingnews.com | 02.20.22

Illinois //
U.S. Sen. Dick Durbin (D-Ill) has introduced a bipartisan bill called the Rural America Health Corps Act. The bill would build a National Health Service Corps, to improve retention of rural healthcare workers in medical shortage areas.
annanews.com | 03.05.22

Indiana //
In Seymour, Indiana, Schneck Medical Center admin reached out to the community to get locals vaccinated. Creating a task force, the town and employed interpreters to reach residents new and old to get the shot. As a result, 400 more people were vaccinated against COVID. wfyi.org | 03.05.22

Kansas //
In rural counties across the state, patients are dying waiting to receive care. According to state data 80 patients have died, exposing the consequences of rural hospital staffing shortages in the state.
kwch.com | 01.23.22

Kentucky //
In Lawrenceburg, Kentucky, the local police have teamed up with an ex-addict in a new effort to help those struggling with drug addiction. Andrew Hager has helped the police in treating addicts instead of jailing them, lowering incarceration rates.
dailyyonder.com | 01.18.22

Kirkland, Illinois //
In rural Kirkland, Illinois, the Kirkland Public Library has received a $25,000 grant from the Illinois State Library to improve the library’s Wi-Fi network.
kirklandilibrary.org | 03.07.22

Missouri //
In rural Missouri, the definition of ‘rural’ has led to funding issues. Rural towns have struggled to apply for projects, but they don’t count as rural for some grant opportunities. The USDA is revising their definition, but could take years to conclude.
news.stltoday.com | 01.18.22

Montana //
Montana State University is now offering a new doctoral program in Indigenous and Rural Health. The program is designed to meet workforce needs across the state, as well as address health disparities. Students will be trained to develop health systems and new policies, as well as train new health professionals.
greatfallstribune.com | 02.10.22

New York //
Xochitl Torres Small, USDA undersecretary for rural development, met with students from the College of Agriculture and Life Sciences at Cornell University for a Q&A. Highlighting challenges still impacting rural areas of the U.S., Torres Small discussed the food supply chain, access to resources, and climate change with the students.
news.cornell.edu | 03.08.22

North Carolina //
The Resilient Leaders Initiative, started in rural North Carolina, helps local communities implement trauma-informed practices. The Initiative also provides resources for rural communities and schools.
publicnewservie.org | 03.07.22

Pennsylvania //
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wyomingnews.com | 02.20.22
Dr. Stanley Sack, MD, PEDIATRICIAN

Treating Obesity in Rural Children: Are There Any Solutions?

When ever we have a public health crisis, so much is revealed about the status of all aspects of health care. We’ve certainly seen this with the recent COVID-19 epidemic. While much of what’s good about medicine has come to the forefront—the speed with which we’ve moved the conversation, the dedication of those on the front lines, families and businesses coming together—are gained at a price. We have a lot of challenges that are still with us.

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

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

In recent years, a lot has been written regarding the prevalence of childhood obesity, and a few statistics are telling. According to the Centers for Disease Control and Prevention, obesity (body mass index, or BMI, in above the 95th percentile on standard growth charts) was present in 13.3 percent of children and adolescents in the United States in 2017-2018. A nd in the United States, the prevalence of obesity, particularly severe obesity, appears to be increased in children living in rural areas.

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

In order to answer that question, I’ve turned to some individuals with firsthand knowledge of the issue: pediatrics who see the effect of those affected kids (as a pediatrician, I myself have practiced in a rural area in recent years. But as a provider who feels he could use a little help in successfully managing the problem of childhood obesity, I wanted to hear from others.) Dr. Claudia Preuschoff, a pediatrician in Poplar Bluff, Missouri, offers some insight into how parents might inadvertently contribute to the problem: “People get into a routine of buying food, and they think they’re doing a good job because they are feeding their children. But they might be eating at a fast food place several times a week, they might be giving juice because they heard juice is healthy.” Dr. Elisa Rosier, who has worked in both urban Detroit and rural Kentucky, offers a similar perspective: “Any treatment options are not available because family resources are limited” these can include issues with transportation getting time off from work to attend regular clinic appointments.

Lacking specialty services for most affected children in the pediatric providers local treatment for the condition in their own offices. Yet the roadblocks to doing so go beyond having to navigate the lack of direct access to treatment. Obesity is labor intensive, requiring regular appointments; it is difficult to accomplish in a busy office. In addition, the rural health clinics often will not pay practices for a diagnosis of obesity unless a co-diagnosis such as diabetes is present. Dr. Hassink: “When a provider who’s well aware of these frustrations is Dr. Sandra H. Askins.

A past president of the American Academy of Pediatrics, Dr. Hassink is former director of the Obesity Clinic at Nemours Children’s Hospital in Orlando, which was started in 1988. “People didn’t understand what I was doing,” she recalled. “It was actually quite wonderful.” Dr. Hassink, who is now a medical director at Nemours’ National Center for Healthy Weight, which has often precluded its consideration as a serious medical issue. “Obesity needs to be seen more as the chronic illness that it is.”

What Small Offices Can Do

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

In addition to asking what’s happening, it’s worth knowing how the family feels about the child’s weight. There’s no question that different cultures bring different attitudes literally to the table. Dr. Hassink has a spin on this that makes it quite understandable: “Realize that when you come from a place where a child is malnourished with chronic diarrhea, the ability to have food and maintain weight takes on a different meaning. The problem is largely when it continues through subsequent generations who have access to the American diet which is high in fat, high in sugar for anyone.” Cultural considerations and values may come into play during weight management counseling: “The parent may think: ‘If I make these changes, my child will go hungry.’”

Dr. Hasink finds it useful to consider affected children in a practice collectively. Often having a “weight management day” in the office is helpful to get perspective and provide a team approach to treatment; developing a list of children suffering from obesity to track treatment and connect to community resources is another tactic. As with any seemingly daunting task, getting a sense from the group of how they can be better assisted in tackling the problem. If an office group meeting is unfeasible, perhaps leading a meeting at a local church or Rotary Club would have a similar effect.

A with any seemingly daunting task, addressing childhood obesity is some times made easier by breaking the problem down. “Focus on one office initiative at a time,” notes Dr. Hassink. “An example, there can be a ‘no soda’ pledge among staff—at no one drinking soda at their desk in the office; ‘no soda’ posters, perhaps even a ‘no soda pledge that kids can sign’”

Finally, it’s important to realize that rural areas have their advantages when
The Case for Community: Exploring Solutions for Mental Health Care Inequity in Rural Georgia

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

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

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

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

Providing these types of services fills a desperate need in the state. Nuçi’s Space’s home county, Athens-Clarke, is one of the 85 of Georgia’s 159 counties designated Mental Health Professional Shortage Areas by the State Office of Rural Health in May of 2020. On average only 36.15% of rural counties reported a mental health professional shortage, indicating a majority of the population is not fully confident they are equipped with the tools to help someone in crisis.

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

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

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

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

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

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

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“AProposed Solution

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

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

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

The courses are entirely virtual but are designed to be completed without reliable broadband access, a necessity in regions with poor internet service. The trainees are certified through a combination of practical assessments, supervised casework and a roleplay-based exit qualification. They then receive continued support as they go out into the community.

So far these efforts have been well-received in India. Since then, Patel’s team has partnered with the Wellbeing Trust, a mental health advocacy organization, to bring their work to the United States.

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“It’s, in a sense, Global Health coming to the U.S.” Patel said.

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

The Case for Community

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

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

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

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

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

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

“If you're having a problem, you're going to probably benefit most by talking to someone who really understands your circumstance or where you're coming from,” Brightwell said. If a farmer comes to them with a direct need, Brightwell said the Office will seek out others who've had similar experiences and connect the two by way of a mentor-mentee relationship.

Typically potential mentors produce the same commodity as the mentee. For instance, if they raise cattle, the office will seek out another person who raises cattle. Once a mentor is selected, they will receive mental health first aid and QPR training, focusing on how to access different resources in the area.

“The nice thing about the farming community is that it is a very generous community,” Brightwell said, “Farmers are always looking to help other farmers. They may not want to help themselves, but they'll right away give you the shirt off their back.”

Changing the Culture

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

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

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

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

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

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

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

“It allows for communities to begin to address some of these issues that the state is not,” Miller said. “[Georgia] feels like a state that something wants to happen.”
Two Illinois Medical Schools Focus on Healthcare Access in Rural Communities

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

Attracting Medical Students with Cultural Understanding of Rural Communities

Dr. Hana Hinkle serves as the interim director and heads the National Center for Rural Health Professions at the University of Illinois College of Medicine in Rockford, Illinois, where the Rural Medical Education Program (RMED) is a core program. “Our goal, first and foremost, is to increase the quality and the types of physicians that are trained, and to improve the long-term distribution and supply of those physicians to rural communities,” Hinkle said.

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

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

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

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“We start very early on with students to make them aware of the possibilities, and then work to mentor them in their educational pathway throughout the recruitment process right up to when they apply to medical school,” she said.

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

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

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

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

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

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

Throughout medical school, Lincoln Scholars work with a mentoring family physician one day a week in southern Illinois clinics. They attend a weekly multidisciplinary collaborative session. “A really important point about our recruitment process right up to when they apply to medical school,” she said. "We start very early on with students to make them aware of the possibilities, and then work to mentor them in their educational pathway throughout the recruitment process right up to when they apply to medical school,” she said.

Mimicking the RMED program at the University of Illinois College of Medicine, the Lincoln Scholars Program targets students with ties to rural communities and/ or an innate passion for practicing in a rural area. Their strategy accommodates what’s worked particularly well in the long haul: underserved communities sometimes attempt to draw new physicians...
by offering generous pay and contracts. M. one
draw new providers, but it doesn’t always keep
them, especially if healthcare isn’t a passion or
there is no real connection between recruit-
ed physicians and the communities they serve.
(“The Lincoln Scholars Program”) is more
a big-picture solution of training physicians
and providers in a way that they feel confident
in providing service in underserved areas and
recognizing their value to those communities,”
Rose said. “We’re choosing
people who aspire to
to that early on in their
careers and helping them
bloom into the provid-
ers those rural commu-
nities need.”

The first two classes of
Lincoln Scholars to ma-
triculate through the pro-
gram share some com-
mon traits. “From what I
have seen of these students
are really committed to
their decisions,” she said. “They’re brave, and
they have a kind of a pion-
ering spirit. Because this
is a new venture for the
SIU School of Medicine.
They recognize that this
is a new opportunity,
a new adventure and
they’ve said, ‘Yes, this
is what I want to do and
how I want to be.’

High Test Scores Aren’t
Everything
The Lincoln Scholars
Program and the RMED
program are different solutions to a problem that has perpet-
uated physician short-
ages in rural and remote
communities. Students
typically attend medical school in urban areas
because they see a high volume of patients and a
wider range of conditions.
If they are from a rural
area, they often develop
taste for urban lifestyles
and amenities.

Facing increasing student
pressure after gradu-
ation, future physicians
are forced to think about
where they can make the
cost of living and enjoy the
taste of living. “A thesis
evaluation progress, more
of our students became
less interested in primary
care and more interested
in specialty care in urban
areas,” said J. D. Daniels,
M. D., M. PH, former assis-
tant dean of students at
SIU School of Medicine.

The advent of electronic
medical records may have
evacuated the physician
shortage by shifting a dis-
proportionate amount of
work to primary care phy-
sicians who see a high vol-
um of diverse patients.
Daniels says that unequal
burden diminished job sat-
isfaction among primary
care physicians and made
primary care less attrac-
tive to students drawn to
healthcare for altruistic
reasons.

“We try to select people
who are organized, thought-
ful and good on docu-
mentation, but it’s not like
we’re hiring a bunch of
accountants.
We want them to focus on
clinical medicine to
diagnose this person? Not
‘what’s the best way to
do this?’

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

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

Lincoln Scholars get involved in community projects where
they interact with high school
students in rural parts of south-
ern Illinois. “That’s the most
powerful tool we have to
introduce healthcare care-
ers.” Daniels said. “The stu-
dents see our medical students
and say, ‘I can do this.’

Atracting healthcare providers
to underserved areas also
call to our attention.
SIU has revised its thinking
about who gets accepted into
medical school. “Once you
hit a certain level on your
MCAT score, any higher than
that doesn’t necessarily make
you a better doctor,” Daniels
said.

Since interpersonal skills
are the heart of this school,
SIU School of Medicine focuses
less on attracting students with the
highest test scores, and
more on how applicants handle
themselves in interviews.

A Private Practice in
Greenville, Illinois
Based on Trust
Practicing as a primary care
physician in a rural or un-
derserved community can be
mentally and physically
extremely challenging, which
is why many healthcare systems
and medical schools em-
phasize work-life balance
among physicians. For
many graduates of medical schools with rural educa-
tion tracks, the opportunity
to make a difference in an
underserved community
offsets the drawback of a
heavy workload.

“The entire background of
what it’s going to take to
be successful, to be a leader,
to train that care, to become
very and be a resource—that’s
the kind of information
the RME program starts to
provide. When you’re not part of a system
or a pharmacy puts a big X and
the nearest neighbor was a
hog farm in Havana, Illinois, an hour
north of Springfield, Illinois, but even he
say he sleeps well at night because
his job is to use the system for
people who practice family medicine in larger
cities and healthcare systems grow bored
with primary care practices that expect
they have to do things but not
necessarily do it for the
promised outcomes.
Not so for Bocker and many of her
peers practicing in rural or underserved
areas.

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

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

A ndrew J. Peterson, M. D., grew up on a hog
farm in Havana, Illinois, an hour
north of Springfield, Illinois, but even he
he was shocked by the news he discovered in
Kewanee and Galva, Illinois, where

A 2014 graduate of the RME program,
Bocker grew up on a livestock farm just
outside Leland, Illinois. Before medical
school, she was going to be a nurs-
ian, but a six-week primary care pre-
ceptorship at KSB Hospital through the
RMED program changed her mind.

It’s uncommon for medical students
to fall in love with whatever rotation they
have to happen, but Bocker’s call to
serve her community as a primary care
physician was part of a family tradition.

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

The 16 weeks Bocker spent in a rural
health practice under the guidance of
a physician mentor prepared her
for the wide range of services she
provides. “It’s a reminder of how
not so for Bocker and many of her peers
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they may have going on. Bocker says.
he and his wife are both family medicine physicians, employed by OSF Healthcare since 2018. “I’m a small-town kid, and had bounced around in bigger communities throughout my training, but felt like I wanted to raise a family and practice in a small-town setting, so I chose the RMED program because I felt it was the best available training to prepare me for that,” said Peterson, a graduate of the University of Illinois College of Medicine’s RMED program, where he now serves on the faculty as an associate clinical professor.

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

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

A rural doctor is often the most trusted community member, and that influence, Peterson gives radio interviews and presentations at schools and community groups, and has appeared on a popular local podcast.

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

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

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

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

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

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

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

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

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

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

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

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

LARRY BERESFORD

JOURNALIST

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

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

You can reach him at larryberesford@icloud.com.

An Acute Physician Shortage

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

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

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

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

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

“This is an issue that needs more than one answer. Even though we haven’t yet moved the needle that much, a lot of people are doing exciting, great work with rural-based programs,” she said. MAHEC is an example of a rural health education center created with federal funding in the ’70s to support rural doctors with access to continuing education and medical libraries while offering multiple residency opportunities.

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

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

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

Ensuring a Good Match

RAP places 35 to 40 medical students per year in rural sites across Minnesota and western Wisconsin, with a cadre of about 60 local family practice doctors who work closely with the program, says Kirby Clark, M.D., the program’s director and A ssistant Professor in the Department of Family Medicine and Community Health at the University of Minnesota.

One key to its success is ensuring a good match, he says. Applicants fill out a lengthy application asking them to reflect on where they see themselves in 10 years, their specialty, their scope of practice, other areas of interest. “We meet with each student who applies and we spend a lot of time on it.” The program, in partnership with the University’s regional Duluth campus, also offers a summer internship and shadowing experience between the first and second years of medical school.

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

A bout 40 percent of RAP participants end up pursuing a career in rural medicine, a number that has been borne out for other rural immersion programs. M any choose family medicine and primary care, but there’s also a need for rural specialty practices such as psychiatry, surgery, and pediatrics, as well as a demand for generalists who can provide comprehensive care to a diverse patient population.

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

Other programs nationwide include community-based, university-affiliated rural residencies, some of which use a “1+2” model, with one year of urban medical training followed by two years in a rural setting. A other program is a rural medicine accelerated track, offering motivated students an opportunity to complete medical school in three years, incurring one year less of tuition costs.
Howard Rabinowitz, M.D., grew up in Pittsburgh, Penn., but spent two years during a break in his residency on a Native American reservation in rural Arizona, where he got a close look at medical practice in a rural setting. In 1976, when he returned to Pennsylvania to join the Family Medicine faculty at Philadelphia’s Jefferson Medical College (now Sidney Kimmel Medical College), he was enlisted to direct its recently launched Physician Shortage Area Program (PSA P). “I was the only person on faculty with any rural experience. I ran the program for 42 years until I retired,” he said.

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

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

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

Other Programs, Other Factors

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

Once she was in medical school, he nominated her for an Underwood Scholarship for African-American students. Dr. Rabinowitz said he recognized that her poise and determination on the basketball court were ideal traits for a rural doctor.

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

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

Don’t Get in their Way

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

The biggest current barrier to recruiting more rural doctors, he added, is that family medicine is still not adequately compensated or supported by national health policy despite 20 years of promised payment reform. Dr. Crump fears that the established model of small-town family practice is in danger of dying, undoing the good work of programs like his.

“Payment is not adequate for the office visits that are the heart of primary care. It’s a broken system,” he said. “If any of our graduates, who are family medicine specialists from a small town and should go back to such towns, become hospitalists instead, because family doctors aren’t compensated enough to pay off their student loans.”

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

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

References

3. https://mahed.net/
Despite not meeting this goal, the federal Liberal government was asked to help it dispose of all these empty containers. In an environmentally conscientious manner.

Thousands of full water jugs and bottles have been shipped to the Indigenous reserve over the past two decades due to potable water crisis. Consequently, empty plastic bottles and water jugs have amassed on the reserve, and the community is asking the federal government in Canada to help it dispose of these empty containers in an environmentally conscientious manner.

The face of Canada’s long-term drinking water advisories is no longer as common a feature in the northern reaches of the country as it was in the past due to the water crisis. Consequently, empty plastic bottles and water jugs have amassed on the reserve, and the community is asking the federal government in Canada to help it dispose of all these empty containers in an environmentally conscientious manner.

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

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LOUISE GAGNON
WRITER/EDITOR
Louise Gagnon is a Writer/Editor based in Ottawa, Ontario, Canada

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

The absence of water security that many Indigenous Canadians live with is not a uniquely Canadian problem, according to Black, who is a registered public health nurse and is the lead for the engineering research and education initiative. The concentration of Indigenous communities' water security, it is very difficult for that person to take a day off and be sick. This is also about planning and succession. Having a community that has multiple operators or skilled people who can step up is part of the longer-term solution.

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

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

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

It has been viewed that with the lack of provincial or territorial involvement and investment in First Nations, it would be difficult to achieve satisfactory drinking water, many reserves have fallen or are at increased risk of falling between the cracks.

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

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

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

“Should they make a strategic national plan (to respond to the lack of water security),” asked M artin-Hill.”Universities and engineers travel all over the world to bring clean water to economically-depressed communities. If we pull the greatest resources we have and bring in the best brains and make the provincial government authorities, using that kind of multi-partner model, we could address this issue. We need leadership.”
LGBTQ+ Older Adults Needing Long-Term Care in Rural Settings: Invisible No More

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

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

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

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

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

Case in Point

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

Published data backs that perception. A 2009–2010 Justice in Aging survey reached 284 LGBTQ+ older adults in long-term care settings and 485 family members or friends, service providers, and others. Of the 289 service providers, 247 believed that LGBTQ+ people would not be safe disclosing their sexual orientation or gender identity or that they should not do so. A 49-year-old social worker from Ashland, Virginia, said she had never known anyone in a facility who stated any alternative sexual orientation, “which says a lot in itself.”

A 51-year-old provider who was a transgender man in a very rural, very conservative state said, “I have done training for long-term care staff and administrators in this state, but most feel that there are no LGBT residents in their facilities.”

“People have this dream to retire and move to whatever that dream destination is.”

Yet in many ways, the LGBTQ+ community is one with greater need for long-term care than the rest of the population. Statistically, fewer LGBTQ+ individuals and couples have children who could provide informal care in their homes, and families and relatives are more often unavailable when they have rejected LGBTQ+ individuals. An estimated 29% of LGBTQ+ adults age 25 years or older have children, compared with historical figures of 47.3% of the U.S. general population (Williams & Mattos, 2021). An estimated 1.2 million to 2.2 million LGBTQ+ individuals live in rural areas, where they more frequently “age in place” in their homes and rely on scarce resources (Williams & Mattos, 2021). An estimated 2.2 million LGBTQ+ individuals live in rural America (Hacrotyan et al., 2021).

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

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

Case in Point

Mary Walsh and Bev Nance, as reported in in McKnight’s Senior Living: This same-sex married couple in 2018 sued the faith-based, nonprofit senior living community Friendship Village Sunset Hills on the outskirts of St. Louis after they were denied a unit. A tenant agreed to pay a $2000 deposit from the couple, the home in 2016 blocked their move-in because they did not meet the “Biblical definition” of marriage being between a man and a woman.

The suit was settled out of court.

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

Worsening shortage of rural facilities, beds

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

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

Their concerns about safety and care lead LGBTQ+ individuals to seek facilities that cater to the LGBTQ+ community and trained in the special needs of LGBTQ+ people. They desire facilities that are sensitive to their concerns about their sexual orientation or gender identity. It’s a real fear that people have — and one that I can understand.

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

Because of the work my aunt and uncle do in their small community, they know just about everyone, but I walked away with the sinking feeling that society was not real a threat as bed sores can be, but it was, and if I would go get her a calendar at home, I wasn't prepared for my witty, sardonic grandma to look so vulnerable and lost.

Grandma rebounded from the injury quickly despite her demographics and co-morbid conditions. She had a dementia diagnosis in 2016 and was dependent upon a wheelchair or support staff. She couldn't find them. She did not know how to get her medication on time.

I watched her come back to life with each catch and toss, and I wondered if our laughter was disturbing other residents. I quickly decided noise and youthful energy might be contributing to her recovery.

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

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

A colleague’s mention of the “silver tsunami” a few years earlier came to mind, and I made a mental note of the safety concerns I observed despite her good outcome:

1. Staff hard to locate;
2. There was open access to a vulnerable patient; and
3. She couldn’t hear, and her hearing aid was not working properly when we did locate them.

At the time, it turns out she was one of the healthier, more mobile patients nation-wide.

Rural Care Facilities

Communities where care options are limited, and the costs are not shared equitably, are often %at risk, especially in rural areas. While some of the best conversations I had with my grandparents occurred around their kitchen table playing cards. They stayed fit, alert, and not overly-sentimentally, if you count the fried eggs and bacon my slight, athletic grandfather ate daily. They maintained their own home, and had their youngest daughter and her husband nearby to do the heavy lifting when needed and who regularly looked in on them. It took some convincing for my grandma to leave her home, but once she landed at M Alpine Ridge, she found a group of friends and settled in.

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

She kept a jar of change in the lower kitchen cabinets for nickel and dime pocket that we played regularly throughout the years. Some of the best conversations I had with my

grandparents occurred around their kitchen table playing cards. They stayed fit, alert, and not overly-sentimentally, if you count the fried eggs and bacon my slight, athletic grandfather ate daily. They maintained their own home, and had their youngest daughter and her husband nearby to do the heavy lifting when needed and who regularly looked in on them. It took some convincing for my grandma to leave her home, but once she landed at M Alpine Ridge, she found a group of friends and settled in.

Tracy Granzyk

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

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

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

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

“One investigative reports should remain public and should factor into the scoring,” M. Eryweather said. “We should not be seeing a 5 star rating for a nursing home that is fined over $600K. The star rating program needs to be updated so consumers can have some trust in the results.”

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

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

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

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

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

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

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

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

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

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

This started a guarded conversation about how well the staff was treated, and I told her that I’d love to hear her story some time. I thanked Grandma in and out of bed when it was clear that just walking up and down the hallway was an effort for her. I asked her if she was able to take maternity leave and she said it was unpaid leave and that she really couldn’t afford to take time off.

I had a D N R in place, and staff along with my mom, aunt, and I contemplated whether or not we should take her across the street to the hospital for further evaluation. There was a general lack of urgency, and the logical part of my brain told me we couldn’t just sit and wait for her blood pressure to bottom out and let her die.

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

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

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

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

Frances Zabrauskas with her husband, Stanley. (Photo/Tracy Granzyk)
Looking forward to what God had in store for her next even though recently asking me, “Tracy, do you think there really is a heaven?" She was loved and had tremendous social support up until her last day with my aunt by her side when she left us.

Not all residents in nursing homes and long term care are fortunate. Family and community are a large part of the solution to force lasting change for every patient. It goes without saying that we lost too many dedicated providers in long term care facilities due to COVID, along with their patients because they lacked resources and leadership.

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

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

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

I listened to ER staff contemplate an emergency room after all with limited staff and little time to be constantly cleaning up after incontinent patients. They ultimately decided to insert the catheter making her odds greater. Patients and families suffer, too.


Frances Zabrauskas at Harborview. (Photo/Tracy Granzyk)
Check out our list of rural health conferences, and let us know if you’re hosting one so we can help spread the word. Email us at RHQ@ttuhsc.edu.

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

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

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

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

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

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

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

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

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

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

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

International Conference on Rural Community and Public Health Systems Management
Sept. 27 - 28, San Francisco, CA
2023

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

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

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

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

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

21st Rural Health Clinic Conference
Sept. 27 - 28, San Francisco, CA
Sheraton Kansas City Hotel at Crown Center

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

21st Rural Health Clinic Conference
Sept. 27 - 28, San Francisco, CA
Sheraton Kansas City Hotel at Crown Center

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

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

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