SEAN COLLINS (00:04):
In the farmland near where I live. This has been a busy week. It was time to harvest feed corn. So the landscape here has been filled with combines sailing across the hills like on an ocean of dried cornstalks, leaving a field of stubble in their wake and filling huge wagons with dry yellow corn kernels, destined for commodity markets or silos of animal feed.

(00:35):
If you stand on the edge of this cornfield in Clinton County, Illinois, there's a field of corn behind us and behind that cornfield, there's another field planted with soybeans and across the road rape seed, soon to be bottles of canola oil, but in front of you, not 50 yards from the cornfield St. Joseph's Hospital. It's been here in the town of Breeze for 125 years, surrounded by farms and farmers and the people who make farming possible in an economy driven by agriculture, but not limited to agriculture, 50 million people in America live in a rural county, and those 50 million people might be an hour from a major medical center or three hours by car, maybe half an hour by helicopter. But here in town, there's a hospital like St. Joseph's licensed for 70 beds. It has an emergency department, a surgery center. There's a rural health medical practice that's based here, that's A Y M C A, attached to the hospital offering physical and occupational therapy. There's a home health program and hospice. But for more complicated care or for tests, you often have to drive an hour to St. Louis. And that pattern, that model, is repeated all over the country.

ALAN MORGAN (02:16):
If I'm at a meeting and the issues of transportation or housing don't come up in the context of rural healthcare, I'm at the wrong meeting

SEAN COLLINS (02:28):
On today's program, an exploration of medicine in the countryside.

ALAN MORGAN (02:32):
Well, there's two important stories to be told when it comes to rural healthcare. Number one, the story that's not being told, and that is the amazing quality of care that you can find in rural clinics and hospitals across the United States, number one. But number two, you have to overlay that with the workforce shortages and vulnerable populations and the fact that life expectancy is lower for Americans living in rural communities and just no rationale for why that should be occurring.

SEAN COLLINS (03:02):
And if a patient does need to be transferred from their rural home to a major medical center, what about their support network? Can families afford hotels to stay at their loved one's side? Oftentimes,

THERESA GLEASON (03:15):
You'll see babies in the NICU and the mother and father can stay at Hickel house, get some rest, and then go back over to be with the baby.

SEAN COLLINS (03:25):
Access to care today on the Hear Me Now podcast as we discuss rural medicine. I'm Sean Collins. Glad you're listening. Alan Morgan is the Chief Executive Officer of the National Rural Health Association, and he joins me now from Virginia. Mr. Morgan, welcome.

ALAN MORGAN (03:50):
Thank you so much for the opportunity to join with you today.

SEAN COLLINS (03:52):
There are a million issues that we could talk about today, and you know that better than I do. Tell me what you think the most important one is. What should we be thinking about when we think about healthcare in rural areas?

ALAN MORGAN (04:08):
Yeah. Well, there's two important stories to be told when it comes to rural healthcare. Number one, the story that's not being told, and that is the amazing quality of care that you can find in rural clinics and hospitals across the United States, number one. But number two, you have to overlay that with the workforce shortages and vulnerable populations and the fact that life expectancy is lower for Americans living in rural communities, and there's just no rationale for why that should be occurring.

SEAN COLLINS (04:39):
Let's talk about both of those first. All right, and let's start with the second one. The workforce issue is an acute one, I think. How do you begin to convince clinicians that they should consider practicing outside of big cities?

ALAN MORGAN (04:53):

Yeah, such a good question. It's a sad story because we're doing clinical recruitment and retention all wrong in the United States. What we're doing currently is we're attracting and we're the brightest, highest scoring kids into medical school, and they tend to be upper income urban kids. And then we have their medical school training in urban areas, and then we try to place 'em in rural communities across the US and we're dumbfounded that they don't want to stay there instead of actually attracting rural kids, training them in rural areas through rural residency training programs, and then seeing the success of them staying there. We're just doing it wrong.

SEAN COLLINS (05:38):
Where is it being done right. Can you tell me about one of those programs?

ALAN MORGAN (05:41):
Yeah. Fortunately, the federal government has recognized that this is a problem with a solution. And starting about five years ago, the creation of the Rural Residency Training program, grants from the federal governments were purse laid out. In fact, it's happening all across the US right now. A good example is Colorado, where the Rural residency program there is just really succeeding in an effort of getting rural kids, training 'em in rural areas and placing them back in the rural communities.

SEAN COLLINS (06:16):
I think about healthcare now compared to what it was even 20, 30 years ago, and it has become increasingly complex, I think is probably the word. It's also become more expensive, and a lot of that capability probably isn't available in rural areas in the same way that it's available in larger urban metropolitan areas with larger medical centers. If medicine is moving in that more technologically mediated mode of treatment, how is it possible that that level of care is available in rural areas?

ALAN MORGAN (06:58):
Yeah. Well, I think you have to start with what rural healthcare is and what it does extraordinarily well. And rural healthcare is primary care, general surgery, and looking at centers for Medicare and Medicaid services data, they do it exceptionally well. And probably not surprisingly, because clinicians know their community. They see you at the ballgame drinking that supersized Coke. They know your family history, they know you. There's a different level of care, and that's the reason why we see such high quality metrics. But to your point, what they don't do is specialized care. There just isn't both the patient population nor

the infrastructure to support that. So as a result, many times we'll see visiting specialists come into the community, more notably the rise of telehealth and telehealth applications, being able to bring some of the state's best specialist into that rural community. And that's so very important. You have to have both. You have to have that local access for primary care when you need it and emergency services, and then you need to have those network connections with health systems or universities to be able to bring in those specialists as needed.

SEAN COLLINS (08:16):
Right. This program has focused a lot over the last couple of years on the idea of whole person care, that we're not just a list of symptoms. We're human beings with connections in our communities. That often gets interrupted for rural patients. If they're transferred to an urban area for treatment, they may be in a hospital 200 miles away from their home for several weeks or a month or more. And you're starting to see larger medical centers build out sort of hospitality in a way or a way to provide subsidized or low cost housing for patients' families. I think we first saw it in the Ronald McDonald House model for families of pediatric patients, but I think other places are doing it now too. And I want you to say something about that, that need for making accommodations for rural patients when they do have to be transferred and making sure that their family can go with them.

ALAN MORGAN (09:25):
Yeah. The last 30 years of clinical data clearly shows the importance and the relevance of having a support network, having those that love you and trust you be with you during the healthcare engagement. So it's a paramount importance. And I got to tell you, if I'm at a meeting and the issues of transportation or housing don't come up in the context of rural healthcare, I'm at the wrong meeting. They're both so very important to this. And for all the reasons that you just articulated,

SEAN COLLINS (09:58):
Who's doing, where are you seeing progress being made? Are there any novel ideas out there that you're seeing, oh, this hospital center is trying this approach or this one's trying another approach?

ALAN MORGAN (10:12):
Yeah, I don't think, I know the data shows clearly that there is a transition within our healthcare system, and we focus so much on the rising cost of it and the bad outcomes from a life expectancy, but we don't always focus in on the success stories. And that approach of

involving the community and keeping the community engaged is a path that more and more institutions are following. And I want to point out also, one thing you didn't touch on in that question is engaging the community in the front end of healthcare as well, too. Engaging community health workers. Trust the people within the community that may not be clinicians, but help make sure that the family knows how to seek care. When do you get your medications filled? And they address hopefully the transportation and housing issues as well too. And it's not just one particular case of this, I just think it's a trend that we're seeing across America and most notably in rural communities today. Right.

SEAN COLLINS (11:22):
And in a lot of ways, I think rural people are used to having maybe non-credentialed health workers who are looking out for the good of others and their neighbors. And it's not a far stretch to see those rural health workers who have training take on a role that sort of has naturally been part of rural life in America.

ALAN MORGAN (11:47):
Oh, absolutely. No less than the Institute of Medicine. And their landmark study equality through collaboration identified that in one sense, rural providers have an unfair competitive advantage against their urban providers because they're more inclined to network, to collaborate, and to engage directly with the community for better patient care. So in an urban context, there are a lot more social programs in place than you'll have in a small rural town. But in that rural town where you have that close community and you can rely again on the usage of community health workers to be that bridge between the family and the provider, it just makes all the difference in the world.

SEAN COLLINS (12:31):
Yeah. We're in the middle of an explosion of the population demographic of boomers. Being an octogenarian is going to be one of the hips things you can be pretty soon. I, I'm curious if you can tell me something about the age-friendly health initiative that you all are working on with the Hartford Foundation.

ALAN MORGAN (12:56):
Absolutely. I think as we move forward, everyone recognizes and sees it today that we need a more age-friendly healthcare system, one that recognizes and appreciates the unique concerns and issues of an aging population. And that's both in providing the support services on the front end and once they're inside the walls of a facility, providing with the dignity and respect

that's necessary. And this certainly is a movement that we're seeing in large urban health systems. And what we want to do is bring the best of that to rural communities as well, too, to make sure that when a senior presents in a rural facility, that they're respected and they're valued as a person and as a member of the community.

SEAN COLLINS (13:52):
I'm struck by the fact that you said when a senior presents in a rural community, is there also a role for seeking those people out and checking in on them and finding out, oh, you really do need to come in and see somebody rather than waiting for them to present

ALAN MORGAN (14:11):
Themselves? Yeah, and that's one of the things when we're bringing in our engagement, it requires perhaps non-traditional partners, most notably Meals on Wheels, the senior center, any other entity within that community that engages with the senior to be able to have a comprehensive approach to keeping track of them. And I will note this, one of the challenges we've had over the last 30 years is seniors needing to move out of their rural communities as they age. And what we're hopeful is to promote with new technologies, whether they be electronic monitoring and cell phones and video capabilities, that we're able to keep track of them and their health and allow them, empower them to take care of their own healthcare needs as well within their community.

SEAN COLLINS (15:05):
There certainly does seem to be a move towards making the home the point of care for a lot of medicine.

ALAN MORGAN (15:12):
Absolutely.

SEAN COLLINS (15:13):
And I think we're only going to see more and more of that in the years ahead. I noticed when I was preparing for the chance to talk to you, I noticed part of your biography and see that you come from Kansas. Did you come from a rural part of Kansas or an urban part of Kansas?

ALAN MORGAN (15:34):

I did. That's not a prerequisite to work the National Rural Health Association, but I will say coming from what was then a two stoplight town does allow you to appreciate both the strengths and the challenges of a rural community.

SEAN COLLINS (15:50):
And then you became a journalist. And I'm curious how you ended up at the Rural Health Association. What was your path there?

ALAN MORGAN (16:00):
So I wanted to be a newspaper reporter growing up. I worked for the college newspaper and covered the State House. And I think that daily, asking the tough and difficult questions of the governor at that time, they decided they wanted me on their side instead of on the side of asking the tough questions. So I gave up my dream of being a small town reporter and worked for the governor's office, transitioned to DC, worked for Congress, but there's a linkage between, at the heart of it, a journalist who wants to help communities and help move people forward to working in healthcare where you're directly trying to increase access to care and quality of care. So it's not that far of a stretch.

SEAN COLLINS (16:49):
Yeah. I'm just going down the list of programs that you all have a finger on, and it's impressive. I'm just going to run through it really quickly. There's a rural emergency preparedness and response effort, rural Health Fellows, rural health students, health Equity Council, rural medical education, border health initiative, rural community health community health workers, rural Oral Health initiative, and it goes on and on and on. When you all get together, I think you have several meetings that you sponsor over the course of a year, how many people are you helping to facilitate their work in rural communities?

ALAN MORGAN (17:33):
So the easy answer is we have more than 20,000 members directly. To your question, more than 90% of the nation's rural hospitals, rural health clinics and rural community health centers are our members. But honestly, if you care about rural health, there's a home for you in the National Rural Health Association. And what we do through all of those programs are we identify best practices, we share those best practices at our conferences for the hope of replication. And in that process, we occasionally find policies or legislative measures that prohibit those best practices or a barrier to the best practices. And when that happens, then we engage policymakers in advocacy to try to remove those barriers.

SEAN COLLINS (18:30):
The one that jumps off that list for me is the Rural Health Fellows. Tell me about those fellowships and what goes on.

ALAN MORGAN (18:38):
Oh, thank you so much. Over the past decade, we've had 154 rural hospitals close across the US and there are 154 different reasons why they close. One unifying theme always, and it is leadership matters. The defining factor between a clinic or a hospital, closures is leadership, and it doesn't have to come from the C-suite, it just within that organization. As such, we put a priority on growing rural leaders. We identify across the country leaders within their communities, and we bring 'em together in a program to hopefully provide 'em the tools and resources to become leaders at the federal level to help us, as I said earlier, to remove those policy and legislative barriers that are prohibiting the best practices from being replicated.

SEAN COLLINS (19:33):
So the pool of people who are fellows, what are they doing now before they start their fellowship? What sort of work are they involved in?

ALAN MORGAN (19:42):
Yeah, so we are the National Rural Health Association, so we have roughly 75 to a hundred applicants every year. We only choose 15 to 20, and we try to build a class that is diverse, both in geographic sense from racial sense as well too, but also from provider type. So we'll build a class with a couple of hospital CEOs, a couple of rural clinicians, maybe a state individual that works at the State office of Rural Health that oversees that. And certainly public health. We always try to put public health. We try to put e M s. We try to put, well, you get the picture here, and again, it goes back to something you had brought up earlier, and that is the collaboration that you find in a rural community. And that's really what we're moving towards. How do you build systems of care in these small towns?

SEAN COLLINS (20:35):
That's Alan Morgan. He's the Chief Executive Officer of the National Rural Health Association. Mr. Morgan, I'm really grateful for you taking the time to talk with us. Thank you.

ALAN MORGAN (20:45):
Oh, I appreciate the opportunity. And GO RURAL!

SEAN COLLINS (20:46):
Go rural. Indeed. We're headed now to Anchorage, Alaska and to the Providence Hickel House on the campus of the Alaska Medical Center in Anchorage. That's where Theresa Gleason and Erica Manor work, and they join me now. Thanks to you both for taking the time to talk with me today. Welcome.

BOTH GUESTS (21:06):
Thank you for having us. Thank you so much.

SEAN COLLINS (21:08):
Theresa Gleason, what is Hickel House? Tell me about it.

THERESA GLEASON (21:11):
So Hickel House is a guest housing facility, looks like a hotel, but it's a guest housing facility with 43 units for patients and their families who are from outside of the Anchorage area and are here for medical treatment.

SEAN COLLINS (21:31):
So you're providing a place for families to be while they have someone who's getting inpatient care in the hospital?

THERESA GLEASON (21:39):
That's correct.

SEAN COLLINS (21:40):
Theresa, you are the senior manager there, Erica, you're a customer service rep. Erica, tell me what that means.

ERICA MANOR (21:47):
I work at the front desk. I check guests in when they arrive. When I answer the phones, I put them on what we call the waiting list for whatever date they're requesting a room for. So I just do a lot of the administrative work in the office.

SEAN COLLINS (22:05):
I suspect you're the first person they see when they walk in the door.

ERICA MANOR (22:09):
Yep, that's correct. That's usually one of us.

SEAN COLLINS (22:13):
You look as medicine changes in the lower 48 and everywhere places like Hickel House are going to become more and more needed as rural people have to travel to large medical centers for subspecialty care. And I really hope the two of you can talk to me a little bit about why a place like Hickel House is important.

THERESA GLEASON (22:46):
I can talk to why it is so important. Many of the communities in Alaska are only accessible by airplane or by boat. So when somebody leaves their community and come to Anchorage for treatment, Providence is the largest healthcare facility in the Alaska region. So many patients are coming from these outlying communities to providence for treatment. Many of them don't know anybody in Anchorage whom they could stay with while they're getting medical treatment or while their loved one is. So having a place like Hickel House meets that need for them either for themselves or for their loved ones. So oftentimes you'll see babies in the nicu, pediatrics, things like that, and the mother and father can stay at Hickel house, get some rest, and then go back over to the hospital and be with the baby. So it really does address that need. It's close to the hospital so they can literally walk across the sky bridge and get over to the hospital. So yeah,

SEAN COLLINS (24:19):
That's great. Tell me, how is this paid for? Are patients and families paying for their stay or is this being subsidized in some way?

THERESA GLEASON (24:30):
So I would say the majority of our guests at Hickel House have a Medicaid voucher. So Medicaid does pay for housing at Hickel house. We also receive funding from the foundation. We have sometimes guests who can't afford the full daily rate. So the foundation will usually offer up to 13 nights of coverage that they'll pay for. That's the Providence Alaska Foundation. And then we do have guests who pay privately, so with credit card or

SEAN COLLINS (25:11):
Cash. Yeah. Erica, what's your take on this? Why is this place important?

ERICA MANOR (25:19):
I think it's important because as Theresa mentioned, a lot of the rural areas don't have facilities to assist people with the type of care that they need. So they have to be here. And so the NICU moms, they can stay in the nicu, however, they have families at home, like other kids. And in order for them to have somewhere to stay, when the mom comes over here and she wants to see her other kids, her baby might be in the NICU for a while, she doesn't know. So when her family comes into town, they get to stay with her over at Hickel house. She gets to visit with them, get that support that she needs since they're still out there. And I always tell them like, Hey, you have the best babysitters over there at the nicu, so just get some rest over here while the baby's there. Or a lot of the cancer patients that are here getting treatment, they are away from their families as well. So it's just really difficult on a lot of people being away from home, and a lot of people here build a community with each other. And so it's really great. And I definitely think it's necessary.

SEAN COLLINS (26:25):
It absolutely is necessary. And you mentioned building community. Tell me something about that. What is the vibe like? I am assuming you have common areas where people are rubbing elbows with other families. Tell me about that interaction.

ERICA MANOR (26:42):
Yeah, yeah. Have a full kitchen in the lobby. We do have long-term guests sometimes who want to get tighter or fast food and want to make their own. So we have some cabinets that they can check out with us. We have refrigerators, larger refrigerators in the kitchen, so they have a mini refrige and a room, but for the kitchen, they have more rooms so they can put their stuff and make food. And sometimes guests will make food for other guests. The smells wafting through the building, and a lot of the guests are really friendly. They'll make additional food for some of the other guests. They talk about each other's situations, and they make friends. Even today, this woman left and she came back and brought a gift for the woman who was in the room right next to her. She left her some flowers and a little gift for her. And I mean, they've only been here for three days together, but they're already friends now.

SEAN COLLINS (27:39):
Yeah, I know that experience firsthand. I spent three months in the waiting room outside an intensive care unit in Boston, and you really do get to know everyone else who's sitting in that waiting room with you and to the point that you overhear phone calls, you overhear arguments

among families, and it becomes in some way a very raw experience. And at the same time a very loving experience because people are being vulnerable in front of one another. And it does help build community.

ERICA MANOR (28:19):
It does. It does. I like the way they do it here. The guests here, how they lean on each other and they're there for each other and sometimes they don't even know their names. So come in the office and ask us who was the person I was just speaking with? So that's great. But they know the whole situation about the person. They just don't necessarily know the name. They know the whole story though.

SEAN COLLINS (28:44):
I got to tell you, I looked at some of the photographs that I have available to me of what the place looks like. And you said it looked like a hotel, Theresa, which is true. I thought it looked also like a small dorm on a college campus. I mean, it's got a very sort of vaguely institutional look, but also trying very hard to be homey. And what sealed the deal for me was the fact that you obviously have a playground outside of the building. And that really touched my heart. It speaks to the fact that you've got families with all sorts of aged members who are hanging out with you for could be weeks, and the fact that you've got a playground there really says something.

THERESA GLEASON (29:34):
Yes, there's a playground outside. And then inside we actually do have a kid's room that has a lot of toys and just an open space for the kids to play inside. And then right next to that is a exercise room for the grownups that are there so they can walk on the treadmill, get some exercise that way with our long winters. That's important.

SEAN COLLINS (30:04):
Yeah, absolutely. I'm just cognizant of the fact that this is a really stressful time for these families, right? And they're working through potential loss. They're scared, they're uncertain what's happening, and you all are providing a place for them to try to take a deep breath and try to relax as much as that's possible. When you're that stressed out and they're surrounded by people who are sharing a lot of those feelings, how important is that place that you provide? How necessary is it for people to heal?

ERICA MANOR (30:42):

Very necessary. The great thing about Providence is that they provide so many things. I mean, you can request a chaplain to come over. We Sister Angela works over there at Horizon House. She comes over periodically to tell us about things people meet. God forbid they have to have funeral arrangements or something like that, but we can help them have a place somewhere here where they can talk about that. If they don't want to discuss it in their room, they want to be outside their room. I just like that we try to be whatever we can be that they need that helps them. Once they're here, you pretty much just pay for the room. And if you have laundry to do, you'll have to pay for that as well. But other than that, we don't charge any additional fees or anything. There's donations, there's just all sorts of things. We just try to make sure we can accommodate people through these difficult times as much as possible.

SEAN COLLINS (31:40):
Erica Manor works at the front desk at the Providence Hickel house on the campus of the Alaska Medical Center. We also heard from Theresa Gleason who directs the guest housing facility in Anchorage.

(31:55):
A year ago, Geraldine Picha stayed at Hickel house. She and her husband needed to be at the side of their youngest son who had a medical emergency while working on a commercial fishing vessel out of Kodiak. I reached Geraldine by phone.

GERALDINE PICHA (32:12):
A load was just lifted off of us. We had a place to stay. We didn't have to have an end date, and it was close to our son. We could walk back and forth throughout the day to see him, and it was just a wonderful, clean place to stay. Where you met other people that were on some type of journey. I did have the opportunity to visit with the staff quite often because we spent so much time in the hospital at our son's bedside. We used it to shower and sleep, and that's about it.

SEAN COLLINS (32:52):
That's what you needed.

GERALDINE PICHA (32:54):
That's what we needed. Not knowing that I had to reserve a room for the next week or the next couple days. They let us know ahead of time that our room would not be given up, that we would have it as long as we needed it, and that was so wonderful.

SEAN COLLINS (33:15):
How's your son doing now?

GERALDINE PICHA (33:17):
He is home. He is recuperating getting his strength back. Thank goodness. It was a happy ending. It could have gone the other way, but he's doing fine.

SEAN COLLINS (33:35):
Geraldine Picha and her husband stayed at the Providence Hickel house on the campus of the Alaska Medical Center in Anchorage last year, while her youngest son was being treated there. Earlier we heard from Erica Manor and Theresa Gleason both at Hickel House, and we began with a conversation with Alan Morgan, Chief Executive Officer of the National Rural Health Association.

(34:03):
The Hear Me Now Podcast is a production of the Providence Health System and its family of organizations. Find us online and subscribe at HearMeNowPodcast.org

(34:16):
The program is produced by Scott Acord and Melody Fawcett. We have research help from medical library staff, Carrie Grinstead, Basia Delawska--Elliot, Sarah Viscusso, and Heather Martin. Our theme music was written by Roger Neil. The executive producer is Michael Drummond. I'm Sean Collins. Thanks for listening today. Be well.