NATIONAL RURAL HEALTH ASSOCIATION

Rural Horizons

The landscape of rural health

Building a rural integrated network for specialty care

Recruiting specialists is difficult for any hospital, and it's even more challenging for small, independent hospitals in rural areas. Most critical access hospitals (CAHs) don't have enough volume for full-time specialists in cardiology, pulmonology, orthopedics, urology, ear, nose and throat, and other specialties.

Smaller hospitals often rely on larger systems and bigger cities to provide specialty care. Patients may have to travel to receive care, or those systems may send specialists out to a rural hospital. "The challenge is that sometimes specialists coming from a larger system get pulled back for a greater need somewhere else in the system, so the coverage can be inconsistent," says Rob Schmitt, CEO of Gibson Area Hospital and Health Services in Gibson City, Ill.

"It's difficult to attract a specialist when there's not enough volume and the payer mix isn't good enough to make it worthwhile," adds Paul Skowron, CEO of Warner Hospital and Health Services in nearby Clinton, Ill. Warner Hospital had struggled for years to retain an orthopedic specialist at their location, and Gibson Area Hospital was equipped with a large surgical suite but didn't have enough volume to keep an orthopedic surgeon busy.

A win-win solution

Working together, the two CEOs found a mutually beneficial solution that helped both of their hospitals provide access to orthopedic care locally. "As one of the larger CAHs in the state, we thought Gibson Area Hospital could be a resource hospital for other CAHs, and we started recruiting specialists with this model in mind," Schmitt explains. For the past two years, Gibson Area Hospital has sponsored an orthopedic specialist who sees patients in Gibson City and Clinton. Outpatient services and labs are done in both locations, with complex surgeries performed at Gibson Area Hospital.

Success with this orthopedic model inspired additional plans to share an ear, nose, and throat specialist and urologist among three rural hospitals in the area. Starting in November, these specialists will split their time between Gibson Area Hospital (three days/week), Warner Hospital (one day/week), and Iroquois Memorial Hospital (one day/week).

"As hospital leaders, it's our responsibility to identify ways to meet the changing needs within our communities," says Don Williams, Iroquois Memorial Hospital CEO.

Rob Schmitt, Gibson Area Hospital and Health Services CEO

Paul Skowron, Warner Hospital and Health Services CEO

Pat Schou, ICAHN executive director and 2020 NRHA president

Don Williams, Iroquois Memorial Hospital CEO

"By working together to share specialists and keep those services local, we're addressing a significant medical need in the community in a way that makes sense for us financially."

Controlling costs in an ACO

All three hospitals are also in the Illinois Critical Access Hospital Network (ICAHN) accountable care organization (ACO), which helps reduce referrals out of network, builds local market share, and saves overall individual health care dollars. "It's a triple win,

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because patients are seen in the local community, the bulk of care is provided in the local community, and together we can maximize the value of a specialist from a cost standpoint," Schmitt says.

"There's value with a rural ACO because it encourages people to get their care locally with better care coordination, which helps control costs in the ACO. This helps hospitals to build market share and stay viable, while also helping to reduce individual health care costs," says Pat Schou, ICAHN executive director and 2020 NRHA president.

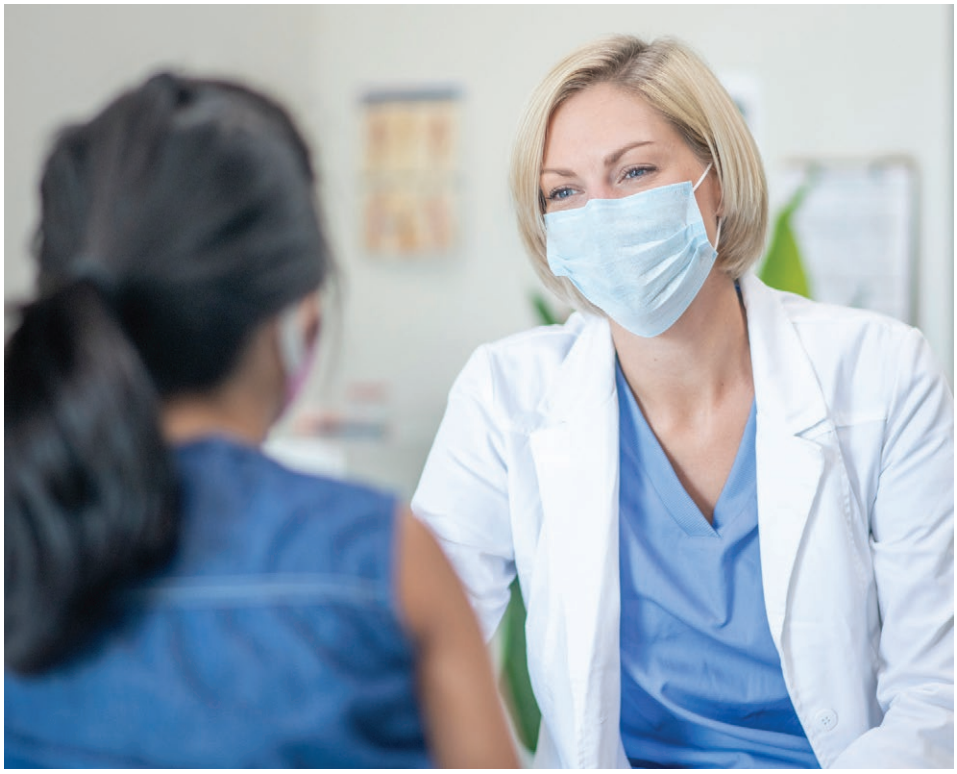
Benefits for patients and the community

Patients who live in rural areas may already be conditioned to travel long distances to larger hospital systems for their care. But when given the opportunity to stay local or travel a shorter distance, the benefits are clear. Patients can get their specialty care close to home from a specialist they know and trust in their community.

The benefits of working together to keep specialty care locally at CAHs include:

- Providing better access to specialists.
- Keeping patients local with better coordination of care.
- Reducing the cost and burden of patient travel.
- Remaining independent and reducing out-of-network referrals to larger systems.
- Retaining health care dollars in the local community.
- Sharing the costs of physician services and marketing.

One of the keys to success with an arrangement between independent hospitals is striking a balance that helps each hospital keep aspects



of specialty care local. "It's a good balance, especially for the types of specialty care that we're not able to offer here," Skowron says.

Trends in CAH collaboration

"In order to navigate the challenges currently facing rural hospitals, we need examples of what others are doing across the country, whether that means forming alliances or other creative solutions," Schou says. "I think we'll continue to see more relationship building among hospitals as a strategy going forward."

ICAHN provides opportunities for hospital leaders to partner with each other through the Trailblazer program. "Trailblazer roundtable meetings are designed to encourage outside-the-box thinking about new programs and services as well as opportunities for sharing resources and finding collaborative solutions," Schou says.

Trailblazer sessions helped launch the idea for sharing specialists among neighboring hospitals. "We started thinking about how to develop a better model that allows us to be independent and pick and choose specialists that provide the most benefit," Skowron says.

Being open to new solutions can help communities build a sustainable future in rural health care. "It's important to be honest about what you expect from the collaboration and willing to sit down and work things out," Schmitt says.

Williams emphasizes the importance of building a level of trust among stakeholders and setting the tone for effective collaboration. "As executives we can share the vision, but it's the teams in the hospitals who are working hard every day to carry out the plan logistically," Williams says.

"The hardest part is making a decision to try something and knowing that it might not work out," Skowron says. "Taking an informed risk and working through the challenges can help us better serve our communities in the long run."

‘It’s on us’: Health care’s unique position in the response to human trafficking

Adapted with permission from The Rural Monitor

By Jenn Lukes

Before joining the board of Transitions of Pennsylvania, a local women’s resource center, Kendra Aucker says human trafficking wasn’t exactly on her radar.

“I live in an idyllic part of the state, but I’ve learned that it happens right here. I mean, there are people right here who traffic their own children,” says Aucker, who also serves as CEO of Evangelical Community Hospital in Lewisburg.

“What really opened my eyes was learning that up to 88 percent of survivors indicated that they sought health care during the time they were trafficked,” recalls Aucker.

The reality of human trafficking

Human trafficking, as defined by the U.S. Department of Homeland Security, “involves force, fraud, or coercion to obtain some type of labor or commercial sex act.” Referred to as a form of “modern-day slavery,” human trafficking occurs in every state and is not limited by the size of a community. It has been identified as a public health concern by researchers, federal agents, and health care professionals.

“This is a social issue in our communities and, as human beings, we have the responsibility to treat human trafficking as the crisis it is and to do our part to tell the story and make a difference,” Aucker says.

Polaris is a federally funded nonprofit that maintains one of the most extensive data sets on the issue of human trafficking in the United States. Informing the data are thousands of calls, texts, and messages that are fielded by its National Human Trafficking Hotline. Polaris’ latest statistics indicate that human trafficking has continued to rise, from 7,748 confirmed cases reported to the hotline in 2016 to 10,949 in 2018. Polaris’ demographic breakdown shows that nearly half of survivors are minors, there are five times more females trafficked than males, and minorities are more likely to be trafficked.

The federal Trafficking Victims Protection Act of 2000 differentiates between sex and labor trafficking but pegs the former as the most common by nearly 8:1. Both have been identified as problems in rural America, but definitive statistics are lacking. What is known is that the characteristics of many rural locations make them attractive to traffickers passing through or looking to set up shop. A secluded location, away from heavy legal forces and home to vulnerable populations, can be the perfect haven for traffickers.

Lisa Davis

Lisa Davis is the director for the Pennsylvania Office of Rural Health and is a driving force in the effort to educate rural health care facilities on the reality of human trafficking.

“The stories I’ve heard are gut-wrenching, but they are all over the map,” says Davis, who went on to describe desperate situations that become advantageous for human traffickers: a young girl who has run away from home, a migrant worker with a dream of a better life, someone with a substance use disorder looking for relief, a desperate mother who can’t pay rent.

The Pennsylvania office’s efforts have served as a model for other state offices of rural health, with the

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Types of human trafficking

The two most common forms of human trafficking, as defined by the Trafficking Victims Protection Act of 2000:

Sex trafficking: A commercial sex act induced by force, fraud or coercion, or in which the person induced to perform such an act has not attained 18 years of age.

Labor trafficking: The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

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first Pennsylvania Rural Human Trafficking Summit in 2019 to raise awareness and train health care providers.

Preying on the vulnerable

Individuals who are trafficked in rural areas have vulnerabilities, such as recent migration or relocation, single motherhood, recent contact with the child welfare system, a substance dependency, homelessness, or mental health conditions. Often, the victim already has a relationship with the perpetrator who has taken advantage of their trust and targeted their vulnerabilities to create dependency.

Anne Boatright

The Nebraska Hospital Association (NHA) created a human trafficking toolkit to be a practical guide for health care systems to help identify human trafficking and develop a standard policy to address it. At the start, NHA sought out professionals with varying expertise to give input, including Anne Boatright, a practicing sexual assault nurse examiner (SANE).

Boatright has trained more than 3,000 Nebraska medical providers, the majority of whom practice in rural areas, on human trafficking identification. She commends the toolkit, which has helped her quickly disseminate the information.

"Many think of human trafficking happening only in urban areas to people who are abducted and held against their will," Boatright explains. "But we aren't seeing that a lot. We see those with a vulnerability and someone exploiting the vulnerable because they have the ability to do so."

Lisa Lohnes has lived and worked among vulnerable populations in rural Minnesota. She is currently one of eight Safe Harbor Regional Navigators, part of a program funded by the state of Minnesota. Lohnes serves as the main point of contact for connecting sexually exploited youth and adults to human services.

Lohnes grew up in Minnesota's Cass Lake, home of Leech Lake Indian Reservation, and is a member of the Spirit Lake, Mni Wakan Oyate tribe. She has seen sexual exploitation firsthand. "They're desperate, so they trade sex for drugs, products, and even food that they need. And sex traffickers are master manipulators, so they tend to target the vulnerable," she says.

She went on to explain what researchers and public health professionals agree is often at the root of exploitation: "Historical trauma and intergenerational trauma create a loss of hope. They don't see a way out. That's where survival sex comes in — something that happens a lot with these communities. Not everybody is provided opportunities, so we try to make a way out for them." Homelessness is a big factor that contributes to sexual exploitation in northwest Minnesota, so Lohnes and her team coordinate with transportation services, homeless shelters, transitional housing, and mental health providers.

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Like many human service organizations, Support Within Reach offers trainings to communities and professionals such as law enforcement and health care providers. Right now, the pandemic has moved their trainings online, allowing them to reach more groups of people at a faster rate.

Rural providers uniquely positioned

Health care providers have a valuable role to play in the identification of human trafficking victims and the provision of their physical and psychological care. Survivor records from 2018 indicate that health services were one of the most common points of access to a lifeline for those actively being trafficked, along with family, friends, and law enforcement.

Sexually transmitted diseases, urinary tract infections, pregnancy, and physical injuries are just a few reasons for appointments or emergency room admissions. But the signs aren't always recognized. "One former trafficked person was in a hospital 17 times before someone noticed there was something else wrong," Davis says.

Boatright says some of the indications are more obvious than others, such as an unusual tattoo, malnourishment, and evidence of injury. Others may be related to the guardian, such as large age gap, insistence on being present during an exam, or controlling the patient's identification card. A hotel key or large amounts of cash may also warrant suspicion.

"It's ultimately about power and control for these traffickers," Boatright explains. "But it's not unusual for nurses or physicians to miss these signs. When I was regularly identifying trafficked persons, there would be times where I knew something was wrong, but I didn't know quite what it was or how to name it. It's common for medical personnel to have similar feelings. I try to teach people to follow their gut and know where to go with it."

One challenge is that trafficked persons may not recognize that their situation qualifies as trafficking. For instance, they may say that they can't afford to leave their boyfriend or that an uncle is making them sleep with a drug dealer for cheaper drugs. Providers can help their patients self-identify by asking the right questions. At the same time, Boatright reminds health care providers that their job is not to act as investigators but to provide trauma-informed health care to build trust so that the victim feels comfortable opening up about their reality.


Kendra Aucker

Leading a systemwide response

After learning about the reality of human trafficking in Pennsylvania, Aucker immediately started implementing systemwide changes throughout Evangelical Community Hospital in 2018. She started with a mandatory training for her staff, followed by voluntary trainings from a third-party expert.

"It was probably one of the most profound trainings that we have ever done. People were texting their family members calling for family meetings. People got emotional. I think when you talk about what human trafficking is, people think about their wives, their daughters, and their neighbors because it's modern slavery — force, fraud, or coercion — people were appalled by it. And so, it lit my workforce."

Aucker and her team recruited champions within the facility to lead the charge. An on-call system with SANE nurses and a screening assessment were created to help clinic and hospital staff accurately identify a trafficked person.

Now, they're working with larger health care systems to adopt the training throughout those systems.

"What Kendra has done can be replicated in any hospital, regardless of geography," Davis says.

Since launching the plan, Evangelical Community Hospital has successfully identified ten trafficked persons, contributing to 621 victims identified in Pennsylvania.

An intentional approach

These trauma-informed steps, outlined in the Nebraska Hospital Association's Human Trafficking Toolkit, can be the first steps to help a victim out of a harmful situation.

- Provide a quiet, safe place for the patient
- Separate any companions from the patient
- Attend to the physical needs
- Adopt an open, non-threatening body position
- Engage the patient

Aucker gives the credit to her staff: "It's one of the benefits of being a community hospital. I now have nearly 2,000 individuals who have this on their radar and who are speaking out about this."

Where do we go from here?

One of the first steps to address human trafficking on the local level, Aucker suggests, is for people in leadership positions to get educated: "An administrator of a hospital is a leader who can give a voice to this. That's your responsibility. The rest is already out there to aid you in developing a program for your organization."

Once identified, trafficked persons will need a line of support services if they are to successfully break away from their perpetrators. "If we fail to get them the help they need, they may end up back in this situation," warns Boatright. Psychological trauma such as post-traumatic stress disorder commonly follows survivors of human trafficking. If in-house therapy is not offered, immediate referrals to a tertiary care center is important for healing.

Connecting to community groups that can provide multidisciplinary efforts to address human trafficking can also pay off. Child protective services, human services organizations like law enforcement, and state patrol all have a vital role to play.

On the state level, Davis advocates that rural health organizations have a responsibility to train their health care facilities and staff. "I think state offices of rural health are in a unique position because they know their rural communities and their rural health care leaders and are a respected source of information," Davis says. "They also have forums in which they can speak collectively and stress that human trafficking is a rural concern, and it is a responsibility of a health care delivery system to raise awareness and serve as a point of intervention."

Experiencing COVID-19 as a doctor and patient

Matthew R. Shahan, West River Health Services CEO

Karl Viddal, M.D., West River Health Services hospitalist and family medicine doctor

As a rural doctor on the front lines of the COVID-19 pandemic, Karl Viddal, MD, recognizes the overwhelming stress health care workers are under. He also understands what it's like to be a patient with COVID-19 fighting for his life. Viddal survived his own battle with COVID-19 last spring. The 46-year-old spent 55 days in the hospital, including 28 days in a medically induced coma and 34 days on a ventilator.

He was one of the most severely ill patients early in the pandemic to recover with the help of a last-resort, lifesaving intervention. When he was at risk for organ failure, he was placed on extracorporeal membrane oxygenation, a life-support machine that sustains the heart and lungs during recovery from respiratory distress. "The doctors and nurses risked exposure to this virus on a daily basis," Viddal says. "They literally navigated through uncharted waters to treat the virus. I'm so grateful to the medical team that cared for me. If it wasn't for this team of incredible physicians — their early interventions and their heroic efforts — I would not be here today. They gave me a second chance to be a father and a husband."

Having dealt with the heart-wrenching decisions that arise with critically ill COVID-19 patients and their families, Viddal is grateful for the compassionate care he received as a patient at Dignity Health hospital system in Gilbert, Ariz.

"In retrospect, it is still hard to believe this happened to me, how drastically this virus can affect different individuals. Prior to COVID, I was healthy and without any past medical issues, and this virus nearly ended my life," Viddal says.

After recovering from his illness and going through rehabilitation in Arizona, Viddal decided to return to the setting where he could continue to help others. He now works as a hospitalist caring for some of the sickest patients at West River Health Services (WRHS), a 25-bed critical access hospital in Hettinger, N.D.

Viddal completed his residency through the rural training track at WRHS in 2019 and has since returned to work part-time to help with COVID surges.

Fighting COVID-19 in North Dakota

WRHS has six physicians based out of Hettinger who staff the hospital and five rural health clinics ranging from 26 to 60 miles outside of town. "The closest tertiary facility is two to two and a half hours away, and we try to do as much as we can locally, but our providers are stretched thin," says Matthew Shahan, West River Health Services CEO. "Bringing in Dr. Viddal as a hospitalist allowed us to relieve the burden on primary physicians who are covering the hospital and driving out to clinics serving five local communities."

"It was definitely interesting being on the other side of medicine," says Viddal, who has been able to lean on his personal experience as a patient with the coronavirus, as well as his relationships with physicians in Arizona.

"Viddal did his residency training at WRHS, so we're all familiar with him, and many patients know him too. We're fortunate enough to have that relationship and bring someone in to help during our greatest time of need," Shahan says.

A critical shortage of health care workers

Rural hospitals needed strategic plans for managing staffing levels in the wake of COVID-19 surges. Critical shortages of health care workers pushed hospitals to their limits, with burnout and exhaustion taking a devastating toll on doctors, nurses, and staff.

"Rural hospitals across America were already in a staffing shortage before COVID, and now we're deep into a staffing crisis," Shahan says. With COVID-19 cases rising quickly in North Dakota last fall, WRHS had to focus additional resources on caring for extremely sick COVID-19 patients.

"When COVID cases started surging in our state, it became clear that the tertiary centers don't have the capacity to take on transfers from surrounding areas. We've been able to quickly adapt to meet the needs of our community, but the surge in COVID cases was a strain on our facility and staff," Shahan explains.

> "In retrospect, it is still hard to believe this happened to me, how drastically this virus can affect different individuals. Prior to COVID, I was healthy and without any past medical issues, and this virus nearly ended my life."

Having a hospitalist on staff is a new strategy for WRHS, and it helps alleviate the additional workload for on-call primary physicians. "We are acutely aware that our doctors, nurses, and staff on the front lines are facing risks to their own health every day, and we're doing everything we can to keep them safe," Shahan says.

Stronger together

"We're finding solutions through collaboration with other hospitals. Working with other CAHs and tertiary facilities has led to discussions that help our community and our neighbors. We've been in constant contact with hospital administrators across the state on meeting the challenges of COVID-19, how to handle COVID-positive staff, and providing moral support. Through collaboration, we're building efficiencies and learning from each other," Shahan says.

In many cases, WRHS staff members are caring for people in their community who they've known throughout their lives, which Shahan says makes the losses even harder on health care workers who are already overwhelmed.

"I'm in awe of what our teams are able to accomplish under such stressful and dire circumstances," Shahan adds. "The care they provide for patients is amazing. I couldn't be more proud of what our front line health care workers are doing."

Viddal echoes that sentiment and offers a sobering message on the severe unpredictability of the virus: "Some people are lucky and only develop cold- or flu-like symptoms at worst. However, if this virus has your number, it will hospitalize you and potentially cause multi-organ system failure or death regardless of your age or health status. To date we can only speculate who will be adversely affected. Being infected by and treating this virus has been a humbling experience."

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