



The Our American States podcast—produced by the National Conference of State Legislatures—is where you hear compelling conversations that tell the story of America’s state legislatures, the people in them, and the policies, process and politics that shape them.

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### **COVID-19: Health Care in Rural America | April 13, 2020 | OAS Episode 90**

Hello and welcome to “Our American States,” a podcast from the National Conference of State Legislatures. On this podcast, we’re all about legislatures: the people in them, the policies, process and politics that shape them. I’m your host, Ed Smith. Thanks for joining us.

Today we’re continuing with our series of podcasts focused on how states are responding to the corona virus pandemic. These podcasts are just one of many new resources NCSL has assembled to serve and support legislators and legislative staff during this unprecedented time.

NCSL also is presenting a webinar series looking at public health responses, workplace issues, education and childcare, the economy, elections, and continuity of government. You can find links for these webinars and view archive versions, along with links to a wide range of other resources, at [www.ncsl.org/coronavirus](http://www.ncsl.org/coronavirus).

We’re going to discuss healthcare in rural America today. Our first guest is Alana Knudson, co-director of the Walsh Center for Rural Health Analysis at the University of Chicago. She’ll give us a national overview of rural healthcare and its challenges.

Later in the show, we’ll talk with Dr. James Hotz, a physician who has been working in rural Georgia since the 1970s. He’ll fill us in on what frontline rural practitioners have seen during this pandemic.

Alana, welcome to “Our American States.”

Alana: Thank you for inviting me.

*Time Marker (TM): 01:37*

Ed: So, we know that rural health systems are particularly vulnerable to this pandemic for a number of reasons. Can you talk about how this pandemic is playing out and what you’re hearing from people in the field?

Alana: Absolutely. Like all citizens in our country, there is great concern about the safety and wellbeing of people in communities, and in rural America, just the same – there are some communities

that have already experienced a high number of Covid-positive tests, whereas in other parts of the country, they are just starting to gear up.

And as has been talked about in many other forums, we have been dealing with a number of rural hospital closures across the country. In fact, since 2010 there have been 128 hospital closures. And many rural hospitals are operating on very thin margins. In fact, about 48% of all rural hospitals had negative margins before this Covid crisis even started.

So, when you start looking at some of the challenges that these rural providers were facing before the crisis began, this type of a crisis adds all the more challenges as they are preparing and as they serve the health needs of their rural communities.

*TM: 03:05*

Ed: While there are glimmers of hope in New York, for example, some experts have raised a real concern that the worst of this pandemic has not even hit rural areas yet. You've been talking to people in the field. What's your view?

Alana: As I said, we hear a lot of different experiences from across the country. I spoke to one rural hospital administrator in Indiana this week who shared that his hospital has increased capacity from 25 beds... he's a critical access hospital administrator... from 25 beds to 68 beds. So, they have greatly increased their capacity.

In addition, they have added 16 ventilators to their medical equipment, so they're able to now care for 20 patients. This hospital has also been hit by some of the early Covid-positive patients in which they had some patients on ventilators for longer than they usually have patients on ventilators, which requires additional sedation medication, for example, and staff who are obviously trained and are providing that intensive care for those patients.

So, we hear a whole range of how different rural hospitals and rural health systems are responding.

On the flip side, then we also hear because people are adhering to social distancing, they are not using the local health system for primary care or outpatient care services, and that's particularly challenging for a lot of rural hospitals' financial bottom lines because in a lot of our rural hospitals, right now the majority of revenue that they receive, in fact, upwards of almost 80% of revenue, is generated by those outpatient services.

So, when they're not doing elective surgeries, they're not providing those outpatient services, and many patients are not seeking primary care as well, it also creates a situation where there are very limited revenues being generated. And for hospitals that are deep in the throes of caring for patients, they are exceedingly busy. For hospitals that are preparing to care for these patients, it is very quiet and there is great concern about how they are going to remain financially viable.

*TM: 05:46*

Ed: So, speaking about those healthcare professionals, my understanding is there is a shortage of healthcare professionals working in rural areas. How is that working out right now?

Alana: Well, it's so interesting you ask that question because on one hand, there is a shortage; we have a shortage of healthcare professionals; but on the other hand, there are also issues for some of our healthcare professionals not being able to serve patients.

For example, physical therapy – a lot of patients are not coming in to get their physical therapy. They're adhering, as I said, to the social distancing. And hospitals and healthcare systems are so dependent on being able to find often just a very few people who are serving in those ancillary roles that they're very reluctant to furlough or lay off any of their healthcare workforce that they have because recruiting future workforce to be able to fill those roles when people start coming back, for example, for their physical therapy, is going to be very difficult.

So, on one hand, there's a great deal of concern for the healthcare workers that are providing care for those patients that are Covid-positive, and there is concern about them also becoming Covid-positive. Then on the other hand, there are some healthcare workers, because of the reduction in outpatient and elective services, that are not generating revenue and are not able to work as many hours or at all because of the current situation.

*TM: 07:30*

Ed: Later in the show I'm speaking with Dr. James Hotz in the Albany, Georgia area, and he expressed some hope that the Cares Act would provide them with a financial lifeline because of exactly the kinds of problems you're talking about.

What are your thoughts about the state and federal response to the pandemic, particularly how that's going to affect people in rural areas?

Alana: Well, one thing about rural communities, they're very resourceful and rural communities really come together to support one another. And I think what we have seen so far in this response is that our rural communities are really coming to the table, trying to find different ways, in whatever capacity they have, to support their healthcare system.

For example, we have a number of quilting groups that are making masks and gowns. We have a number of, for example, restaurants that are donating food. We have a whole lot of folks at the local level that are very supportive, and likewise across the country, I also hear that our state and local responses through public health and other agencies have also been incredibly responsive.

And I think too, as we see these different opportunities, for example, to expand telehealth so care can be provided directly to patients through telehealth, those types of changes in federal rules and regulations and reimbursements have really been supportive to be able to ensure as much continuity as possible for care to be delivered.

I know we have a lot of vulnerable older adults in our rural communities. In fact, rural communities have approximately 20% of the population over the age of 65 as compared to the nation as a whole at 15%. So, when we're looking at ensuring that there is access to care, being

able to provide telehealth is one means of being able to accomplish that while being able to ensure social distancing.

*TM: 09:48*

Ed: So, as this pandemic continues to unfold, is there anything you're going to be paying attention to particularly as you watch what happens in rural America? Are there any troubling signs or things that would trigger you to be more concerned maybe than you already are?

Alana: Well, rural America is still addressing the opioid crisis. That has not gone away with Covid. And so, I think we are still very interested in keeping a pulse on ensuring that there are substance use disorder treatments available so that we can continue to support people as they go through treatment, as well as supporting their families.

We also have a great concern regarding the different social determinants of health. There are many vulnerable people out there who have shared with their healthcare providers the need for food, the need for transportation, help in being able to complete unemployment applications, ensuring that they have access to other types of services that they need as they are facing, for example, layoffs.

So, I think in rural America, we're very concerned to be sure that social determinants of health are met, recognizing that many times those healthcare providers on the front line are the first ones to be able to help identify what those needs are. And through our different primary care providers and public health professionals, being able to make those connections and link people with services is very important during this time.

*TM: 11:34*

Ed: Well, it's an excellent point that people's other challenges in life don't disappear simply because we have a pandemic.

Is there anything else you'd like to share?

Alana: I think one thing I'd like to share is that people in rural communities are very generous, and I think there is a great opportunity to also look at how rural communities have been able to come together.

We often talk about rural as really being an incubator for innovation, and we've seen a lot of unique ways that different health systems, for example, have come together in looking at cross-training staff, especially those that have a little bit of lag time between where they are today and where they expect to start seeing Covid-positive patients.

So, we see a lot of different ways that communities and healthcare providers are pulling together their resources and really looking at being able to shore up the strengths and assets that they have in their communities to best respond to the crisis.

Ed: Well, Alana, thank you so much for talking with me today. It's really given me and I'm sure our listeners a lot to think about. I wish you the best and stay safe.

Alana: Thank you so much.

Ed: We'll be right back with our conversation with Dr. James Hotz, a physician in rural Georgia.

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Ed: Welcome back. Now we're going to speak with Dr. James Hotz, who practices medicine in rural Georgia. Dr. Hotz, thank you for your service and welcome to "Our American States."

Dr. H: Glad to be here.

*TM: 13:27*

Ed: Can you update us on the corona virus situation where you practice in the Albany, Georgia area, and how you and other healthcare providers are coping?

Dr. H: Well, it is a real challenge. We've been very hard hit and in our area we have now 507 cases and have had 38 deaths. We have a case index about the same prevalence as New York State. And it's been very taxing. Our group manages 48,000 people in eight counties in one of the poorest health districts in the country, and it's been particularly devastating.

We've had to change the way we do our work. Our hospital has been slammed. We now have the National Guard coming in helping us, but we have a large regional hospital system and have five intensive care units full of corona virus patients. It's been a very great challenge.

It's something that I'm very proud of my group. We've got 82 people who provide services in my group and have over 340 people working for us. Fourteen have come down with the virus. But we're still out seeing patients, trying to maintain that frontline of defense in this very poor rural area.

So, it's been a major challenge. We're having to change the way we see patients from trying to prevent them from hitting our emergency room, which is overwhelmed right now, and seeing them as outpatients and virtually seeing them on telephones and Facetime visits. So, it's really changed within two weeks the whole way we practice medicine.

*TM: 15:04*

Ed: Now, I want to tell our listeners that we're recording this on April 3<sup>rd</sup>. Sadly, these figures are changing so rapidly that events usually outstrip us before we get these podcasts posted.

Now, you've been practicing medicine I know since the 1970s and I'm sure you've experienced many previous disease outbreaks and health crises. But what's different about this one?

Dr. H: Well, it's interesting because our group is community health centers, so 30 million people seen in health centers throughout the country. And we're kind of the first line in the areas where the usual medical economics doesn't distribute people.

So, in the early 80s we saw the HIV epidemic hit, and we now manage the largest rural HIV program in the country. It took us several years to adjust to a practice of care where we turned HIV from get sick, go to the emergency room and hit our intensive care unit to maintaining people as outpatient. Now about 95% of our patients have no viral load.

It took us a long time to adjust, but it wasn't a large population: 1.5 people get HIV in our area per 100,000. This thing... We also had a couple of natural disasters. We had a flood occur in '94 where we literally flew helicopters; they had to fly across the river to five of our offices that were isolated, and we saw folks.

But you could see the end in sight. It was two weeks, wait for the water to go down; it was a 1,000-year flood. It was a real challenge going to 24-hour care.

This is different. We've not faced a pandemic. We've not faced something where not only are you taking care of challenging patients and a lot of them who can become critically ill... just lost a neighbor yesterday... but you're also at risk yourself. HIV initially when we saw patients and we didn't know it was a virus... we had case #420... we really weren't certain how it was transmitted. But once the facts got out, we felt more comfortable in managing it. It didn't feel like that kind of personal risk if you used standard blood precautions.

This thing is a little different because it's highly infectious. I've got four kids who are doctors. Just got a call from my son who is on the faculty at Indiana University and found out he had just come down, he's very sick, and he's got a Covid virus. So, he's got three kids at home, a wife, and nobody can help him now.

So, the difference is the amount of courage it takes for people to wade in there and see these patients, the uncertain nature of this epidemic. We've not seen anything quite like this before as far as the amount of responsibility it takes for our patients to kind of stay at home and not get at risk.

I converted my practice over. Last week and this week I've seen 120 people via virtual visits on the telephone. Being around for a while, my patients are also older. My average patient is 75 and has 5.6 chronic conditions. I don't want them getting exposed. So, I'm personally calling each one of them, going through their same medications, maintaining the refills of the medicines.

They're dealing with a lot of fear and concern. A lot of them can be taken advantage of. So, what we're having to do within the span of a couple of weeks is change the whole way in which we interface with our patients.

*TM: 18:42*

Ed: Well, I knew your children were in medicine as well, but I'm so sorry to hear about your son. I hope he has a full recovery.

On a topic of risk to frontline health workers, what are some of the precautions you and your colleagues are taking to protect yourselves and those most vulnerable?

Dr. H: Well, you do your standard precautions, wear the N95 mask, wearing gloves, gown if you're going to be around spray. We've had to shut down our dental practices right now and we're repositioning them over.

By the way, the other big issue is the financial stress on the practice. We were going to run out of money next month. We lost 200,000 hours in March alone. The President's small business package is going to mean 4.5 million dollars to our organization over the next couple of months. Now, we're a pretty large organization, but it's going to allow us to keep all our employees.

So, it's the personal risk that you have having to wear the equipment. We're used to having to wear that equipment, but it does tire you to have to do it all the time. But then on the back line, we're a large nonprofit organization with a very narrow bottom line. We were doing pretty well until this hit, and we are facing becoming insolvent within a month to two months' time.

That package that was passed yesterday was great. So, I think the personal protection side is important. The other thing is that a lot of patients also fear risk and hearing their doctor's voice on the phone reassuring them that the six-foot distance, the washing of hands, the mask, and also telling them that this virus doesn't kick your door down and come in. It attacks you because of proximity and because of droplet particles. And if we're smart and we hunker down, we can make a difference.

One of the real challenges we have is a lot of my patients, and of those 120 patients I saw, only 28% are web-enabled or have smartphones. So, if I talk to somebody like my neighbor and did a virtual visit on a smartphone yesterday, was able to see him and that, I get my full Medicare reimbursement. I talk to somebody on the phone who has got a flip phone or who has got a landline, who has poor transportation, and it's like \$13 for the visit.

That's one of the issues that are probably out today if legislators look at it. For a short time, that contact on the telephone for these poor rural people, a lot of whom don't have broadband, and trying to bring up the reimbursement of that so that we have just as much incentive to contact them, keep them home, keep them safe, keep them out of harm's way, have as much incentive to do that as we would to see somebody maybe who is affluent, who has an iPad, they're communicating with.

*TM: 21:57*

Ed: Doctor, one of our primary audiences is state legislators. What would you ask them to do to support you and other frontline medical workers?

Dr. H: Well, number one, look at reimbursing a telephone visit the same way as you would... it's a virtual visit of telephone and voice only; it's a telehealth visit if you get some type of visual. Most of my patients get the same impact by both. So, incentivize people to continue contact with their patients and looking at a way to reimburse people the same for your poor people with flip phones and landlines as you would for people with iPads. Okay? That would be an important thing.

Number two: this command and control structure – the fact that the Governor was able to send folks down, get National Guard in, give relief to people that are really impacted through this.

We've got a great hospital group here; it's a big hospital system we're dealing with because it covers a region. Being able to send replacement troops in, to get relief; they sent in a medical unit down, so we've got nurses coming in, pharmacists, physicians to help man some of the critical care units and offload that support.

We've been able to have good communication so that we have protective devices. But we've done a real scramble. Our administrator, Scott Steiner, was actually on CNN describing about how they were repurposing masks and sewing them, and they actually showed how to do it. So, having communication with those hospitals, that chain of command, and getting equipment out.

Right now, we have ventilators. We expect to surge over the next one to two weeks and there will be concern about whether or not we have enough ventilators. But the idea, that connection to the Governor, making sure the Governor... and the other thing that I think all legislators need to do is follow the advice of Dr. Fauci and Berks (??): shut down states, minimize people's impact.

We had a funeral here that was described in the New York Times. We had a lot of people coming together a couple of weeks ago before we knew the virus was here. So, we ended up getting a couple of cases where we had a tremendous influx; we got a (??sounds like people??) disease. And so, we got hit extremely hard, and it just shows that if you don't follow this isolation protocol, that you can get this incredible bump.

*TM: 24:44*

Ed: Well, before we wrap up, is there anything else you'd like to share with listeners?

Dr. H: This is a real disease. It's something that people have to be concerned about. Right now, we have 1,173 tests that are pending. We have 1,223 that are negative, and we have 751 positive ones that have been tested through our hospital system.

The disease is out there. Their communities can get hit just like ours. The better you protect yourself, the more you follow instructions, the less we're going to have. And if you think your community can't get hit hard, a month ago I didn't think ours was going to get hit hard.

So, listen to the precautions, pay attention to the social distancing. The President's plan is a very important one. And for the physicians and clinical folks out there, stay in contact with your state folks. For our state legislators, that public health infrastructure is important in communicating with people on the front lines.

We're going to get through this thing. We've seen a lot of disasters in the past. And I do see this country coming together. But I think controlling this disease is everybody's personal responsibility. Treat everybody like they're infected, treat yourself like you're infected, and let's minimize the amount of spread we get out there.

Ed: Thanks so much, Doctor. I really appreciate you taking the time to talk with us.

And that concludes this edition of our podcast. We encourage you to review and rate our episodes on iTunes, Google Play or Spotify. You may also go to Google Play, iTunes or Spotify to

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