HCAI
Department of Health Care Access and Information

National Rural Health Day

Celebrating the **Power of Rural!** ®

THURSDAY, NOVEMBER 21, 2024

Presented by the California State Office of Rural Health and HCAI Equity Office
November 19, 2024

Agenda

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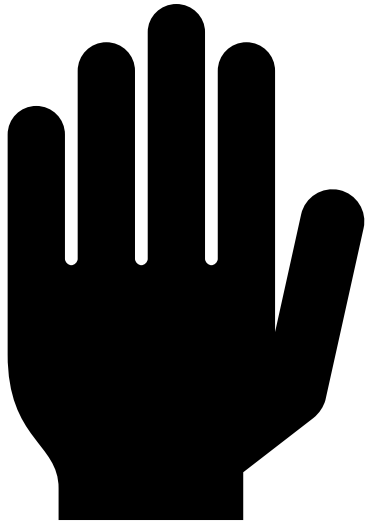
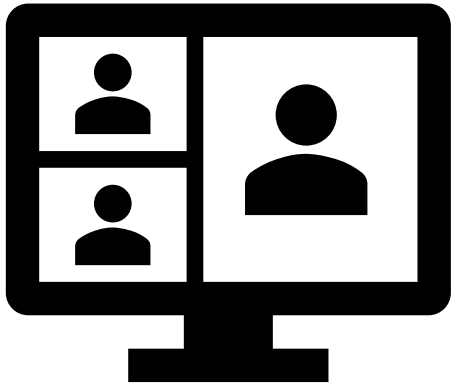
Welcome.

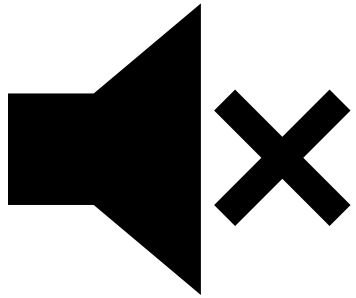
PLEASE Raise your hand IN MS TEAMS WHEN YOU HAVE A COMMENT AND/OR QUESTION.



IF POSSIBLE, ENABLE YOUR VIDEO



MUTE YOUR MICROPHONE UNTIL IT IS YOUR TURN TO SPEAK



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Purpose of National Rural Health Day

November 21, 2024

For 13 years the National Organization of State Offices of Rural Health (NOSORH) has dedicated the third Thursday of November to celebrate the “Power of Rural” on National Rural Health Day (NRHD). NRHD brings attention to and honors the incredible efforts of rural healthcare providers, communities, organizations, State Offices of Rural Health (SORH) and other stakeholders dedicated to addressing the unique healthcare needs that rural Americans face today and in the future.

NRHD celebrates the **Power of Rural.** This power is **rooted in the community.** On NRHD we recognize and seek to address **disparities in rural healthcare.**

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HCAI Equity Office

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Land Acknowledgement

The Department of Health Care Access and Information's (HCAI) Sacramento and Los

Angeles offices (acknowledge they sit on land stolen from the Miwok ("mee-waak"), Nisenan ("nish-n-non"), Chumash ("choo-mash") and Gabrielino-Tongva ("gab-ree-uh-lee-noh"- "to-VAA-ngar") People). We believe it is important to recall the historical truths regarding the structural, disease ridden, ethnic, and colonial genocide to the Miwok, Nisenan, Chumash and Gabrielino-Tongva people.

We acknowledge the resilience and fortitude of these and other native people who continue to survive as cultures and communities despite efforts at genocide. Despite the cross-generational trauma, systemic racism, and discrimination contributing to health disparities, lack of access to healthcare, and barriers to entering the healthcare workforce, we celebrate their perseverance. We will continue to evaluate our efforts in these areas to rectify injustice and ensure wrongs are not repeated.

In solidarity and allyship with native peoples, HCAI commits to being positive catalysts for change and advancing our understanding of the tribal health delivery system. In doing so, we will not standby as complicit witnesses of the injustices perpetuated throughout our history, acknowledging that inaction serves as the fuel for inequality.

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COMMUNITY AGREEMENTS

1. Humanity First!
2. Cultivate a safe and brave space.
3. Use "I" statements; I will speak from my own perspective.
4. All voices and lived experiences are equally valued.
5. Respectively listen with intent to understand.
6. Ask for clarity and leave assumptions at the door.
7. One mic, one speaker.
8. What is said here, stays here; what is learned here, is shared with the larger community.

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Poll Question

California Urban and Rural Demographics Comparison

- Higher concentration of older residents – 26.5% rural vs 15.4% urban
- Higher poverty rates – 15.5% in rural vs 12.3% in urban areas in 2021
- 53% of rural residents are in the labor workforce compared to 64% of urban residents
- Median household income for rural counties is $83,100 compared to $92,400 for urban counties.
- Rural residents are more likely to rate their physical health as poor compared to their urban counterparts.

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California Rural Health Overview

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Some Rural Challenges

- Workforce shortages exacerbated by growing populations of insured Californians
- It can take 2-3 months for an appointment with a specialist and 21 days for an appointment with a primary care provider.
- Rural communities don't always have access to telehealth services due to the lack of broadband connectivity
- Lack of financial stability for hospitals
  - Since 2019, 56% of rural hospitals are losing money every day they provide care for patients – California Hospital Association
- 2 in 5 rural hospitals are at risk for closure.

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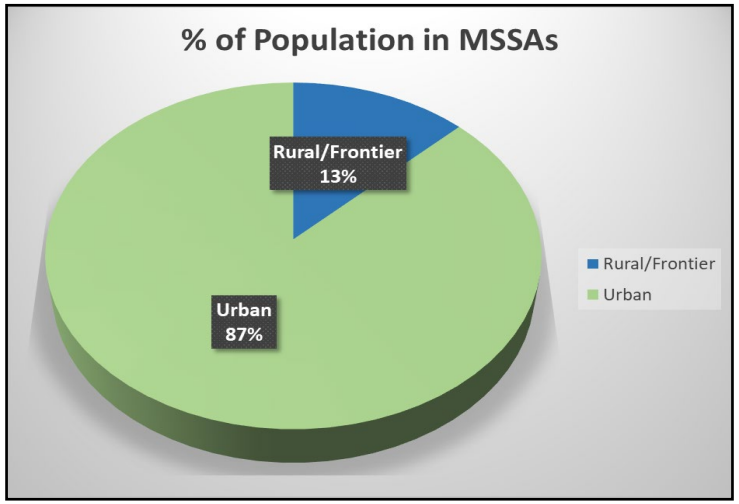
How Rural is California?

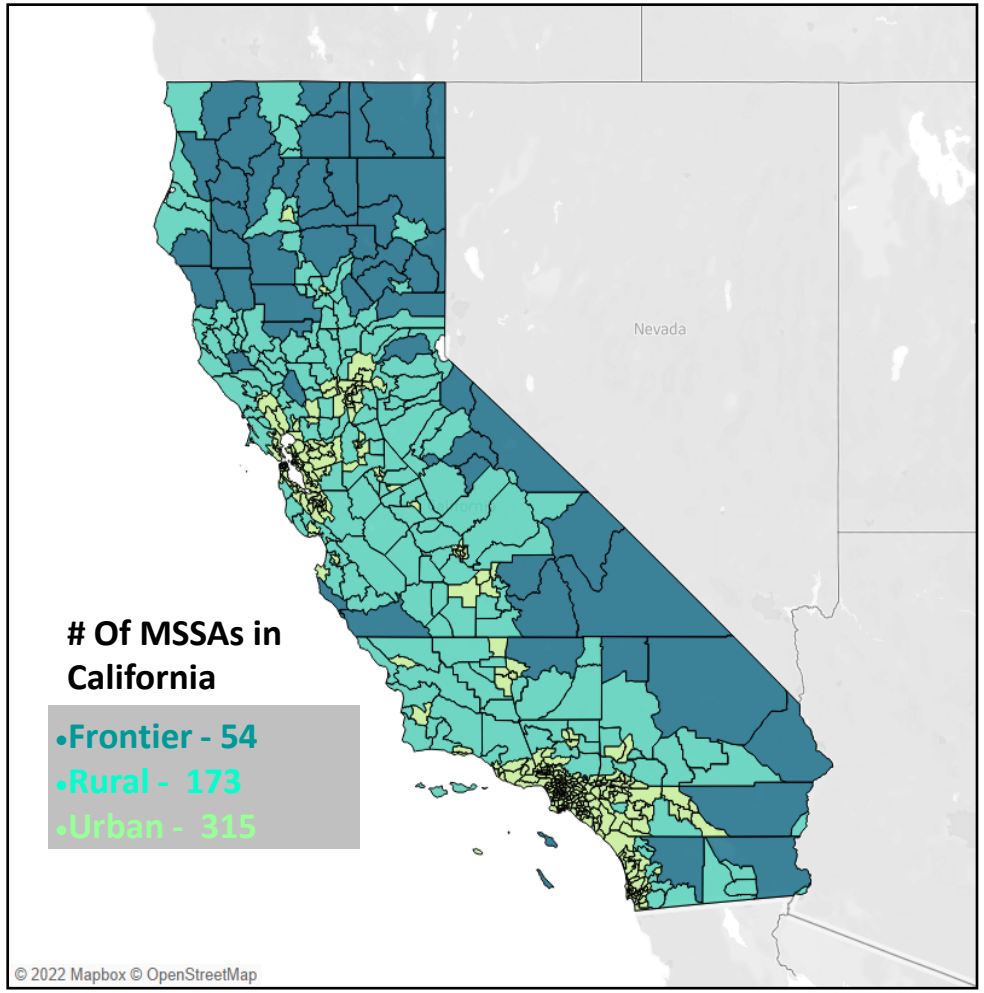
Rural - A non-metropolitan density population density less than 250 persons per square mile, and no population center exceeds 50,000.

Frontier - Population density of less than 11 persons per square mile



42%

of California MSSAs are identified as rural or frontier. There are a total of 542 MSSAs in California.



What are MSSAs?

Medical Service Study Areas are composed of one or more census tracts and generally align with “communities” in the sense of geographic, cultural, and sociodemographic similarities.

MSSAs will not cross county lines and are identified by Urban, Rural or Frontier classification, determined by population.

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Geographic Isolation

- 5% of rural residents are without vehicles for transportation
- 18% live in a car-deficit
    - Households with less than one vehicle per adult
- Both zero-car and car-deficit households tend to be located in the Central Valley—particularly in Fresno County, Tulare County, and Kern County—with significant shares of zero-car households in rural Northern California and significant shares of both in the Imperial Valley
- In California, many rural hospitals are the only source of care for miles around

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Travel Times for Services

When a rural hospital closes, those in poor health, seniors, and people experiencing poverty suffer the most (nationally, 13% of people living in an area affected by a closure are below the poverty line, compared to 9% overall). For Medicare beneficiaries, a closure means the median travel distance to access inpatient services increases by 20 miles; for specialized services, like treatment for substance use disorders, the median travel distance increases by almost 40 miles.

- California Hospital Association

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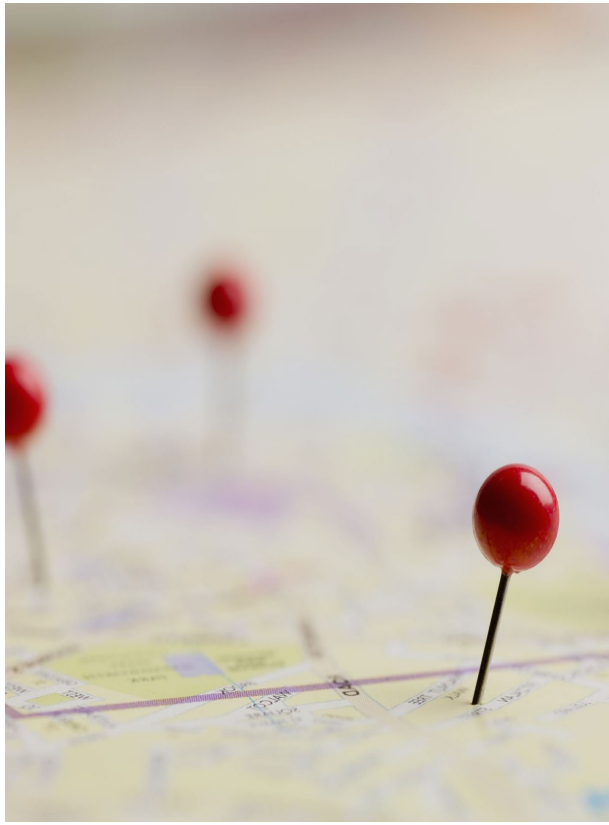
Poll Question

Travel Times for Services Stories

"A hospital in Ridgecrest has closed its emergency room to a standby section and eliminated their labor and delivery department and its 70 miles to the next hospital. Now don't think about driving down I5 70 miles you're going down a canyon road that has 60ft of rock on one side and 40ft of river on the other side. Tell a woman to hold her baby going down that trip." – Senator Shannon Grove, California State Senate

Seated in the northern end of the Sierra Nevada, Plumas District Hospital stopped delivering babies in 2022. The decision to do so was tumultuous, hospital CEO JoDee Read said. The next closest hospital with a maternity ward is roughly an hour and a half drive south on mountain roads to Truckee near Lake Tahoe.

In January 2023, El Centro Regional Medical Center in Imperial County closed its maternity wing after 67 years of service. The closure of El Centro's maternity wing left only a single hospital Pioneers Memorial, providing maternity care in the entire county, which stretches some 4,000 square miles and has a population of 175,000 people, not including an influx migrant workers during parts of the year. Pregnant people who were patients at El Centro were told that outside of Pioneers Memorial Hospital, their other options were a 62-mile drive out of state to Arizona, or a 108-mile drive to Palm Springs.



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California State Office of Rural Health

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Overview of SORH

The State Office of Rural Health (SORH) program is a federal-state partnership through the Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy (FORHP).

All 50 states have a state office of rural health. Most are organized within the state health departments, but some are in universities or not-for-profit organizations.

The general purpose of a SORH is to help rural communities build healthcare delivery systems.

A SORH is expected to:

- Collect and disseminate information
- Coordinate rural healthcare activities in states to avoid duplication
- Provide technical assistance to public and non-profit private entities

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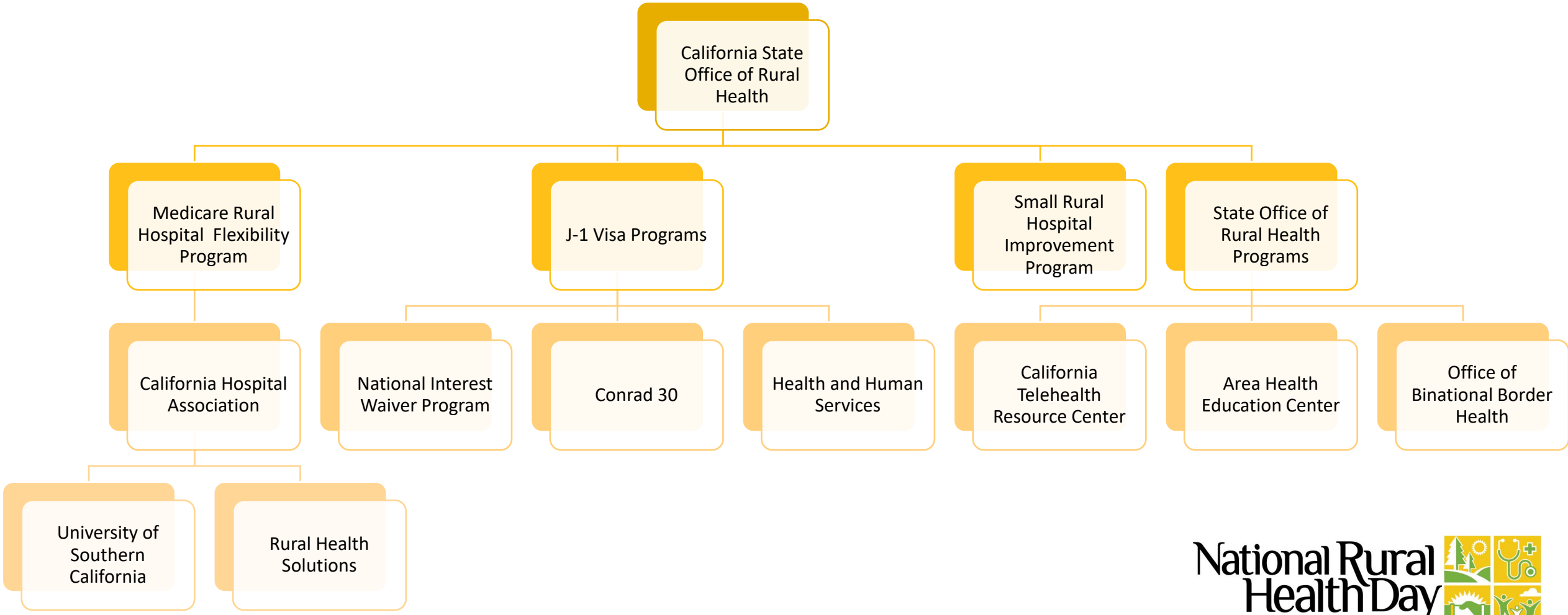
Poll Question

CalSORH Umbrella



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SORH Projects

- California Needs Assessment Evaluation
- Site Visits
- Rural Health Clinic Listserv
- Rural Listening Sessions
- Rural Report
- Annual Rural Health Workshop

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SORH Resources

State Office of Rural Health

CALSORH@hcai.ca.gov

National Partners:

Rural Health Information Hub (RHIhub)

National Rural Health Association

National Rural Recruitment and Retention Network (3RNet)

Federal Office of Rural Health Policy

State Partners:

Area Health Education Centers (AHEC)

California Primary Care Office

California State Office of Rural Health

California Primary Care Association

California Health Professions Consortium

California Telehealth Resource Center

Office of Binational Border Health

Resiliency:

Crucial Learning

Hennepin Healthcare Institute for Professional Worklife (IPW)

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Medicare Rural Hospital Flexibility Program

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Overview of FLEX

Established through the Balanced Budget Act of 1997, The Flex Program provides Quality Improvement, Financial, and Population Health technical assistance specifically to Critical Access Hospitals (CAH) throughout the state of California.

The California State Office of Rural Health (CalSORH), in partnership with the Federal Health Resources and Services Administration (HRSA), participates in the Flex Program.

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Poll Question

What is a Critical Access Hospital?

California currently has 38 small rural hospitals designated as CAHs.

Hospitals designated as CAHs:

- Have 25 or fewer acute care inpatient beds
- Be located 35 miles from another hospital
- Maintain an annual average length of stay of 96 hours or less for acute care patients
- Provide 24/7 emergency care services

CAHs receive increased revenues through the cost-based reimbursement Medicare Program and are certified under a different set of eligibility rules called Medicare Conditions of Participation.

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FLEX Activities and Projects

- HRSA Grant Application
- Flex Monitoring and Reporting
- Technical Assistance and Site Visits
- CAH Assistance for Rural Healthcare Enrichment (CARE) Grants
- Annual Critical Access Hospital Workshop
- CAH Data Collection Project – How can we leverage HCAI's current data collection to include the data collection needs of the Flex program

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FLEX Resources

National Partners:

National Rural Health Resource Center

Flex Monitoring Team

Rural Health Value Team

Rural Health Redesign Center

Rural Health Information Hub (RHIhub)

Federal Office of Rural Health Policy

State Partners:

California Hospital Association

Rural Health Solutions

University of Southern California

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California Rural Health Stories

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Mark Twain Site Visit

The California State Office of Rural Health conducted a site visit in partnership with HRSA Federal Office of Rural Health Policy and California Hospital Association where we learned about the needs for mental health services and transportation for their community. They shared information about their rural rotation program they are participating in.

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Lake County Site Visits

This year the California State Office of Rural Health and Primary Care Office joined site visits conducted by HRSA and CMS where we learned about the great work two critical access hospitals are doing to support their communities. Adventist Health Clear Lake, provides services such as transitional housing and behavioral health internship programs. Sutter Lakeside Hospital is working on collaborative efforts with community partners to invest in their communities.

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A Team of Angels at Sutter Lakeside Hospital

Our story starts with a young woman who is 22 weeks pregnant with her first baby. She had been experiencing three days of abdominal pain that had been evaluated at her hometown by her normal physician. While visiting beautiful Lake County, she fainted, and lost consciousness briefly surrounded by loved ones on a boat. They rushed her to our ED on August 31st, 2024.

The emergency room team initially thought that it may have been related to heat and dehydration, however initial treatment efforts and further evaluation by Dr. Teismann revealed continued unstable blood pressure. Further tests then revealed the culprit, a ruptured splenic aneurysm.

The general surgeon on call, and the OR team activated in the middle of the night with “all hands-on deck”. Massive Transfusion Protocol was implemented as she was prepped for surgery. Meanwhile, transfer to HLOC was also initiated with accepting ICU bed at SSRRH.

In the OR, the anesthesiologist was ready for the anticipated critical moments around the initiation of anesthetic and the incision that released the tamponading pressure which was keeping her stable. Fortunately, the excellence in teamwork kept her alive through some very unstable moments, giving our surgeon enough time to stop the bleeding, in less than 10 minutes from time of incision and just past midnight on September 1st.

After two rounds of massive transfusion packed cells and FFP (platelets are not immediately available at Lakeside), the patient successfully survived the emergency splenectomy. And was prepared to transfer to SSRRH to continue the treatment for both her and her baby.

When the team heard the news about the survival of the baby from SSRRH and the accolades from the parent calling everyone here a “team of angels”, tears were shed. That is why we are all in for Lake County and Sutter Health here at Lakeside Hospital.

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The Gritty Sutter Lakeside Hospital

The power of ONE Sutter and the power of living our Sutter values is exemplified by the events of this fateful Tuesday that started as a normal day.

In the morning, a young woman who was 39 weeks pregnant presented to the family birth center at Lakeside. Nothing out of the ordinary was apparent to the team. Both the OB/GYN and the mid-wife were present. Her pre-labor was proceeding normally until she had a sudden seizure. A “rapid response” was called overhead, and the team sprang to action. The baby monitoring indicated a decelerating heartbeat. “Stat C-sec” was called overhead at 1030hr. Mother became very obtunded and was rushed to the OR.

The Family Medicine-OB physician was called out of clinic and directed to the OR to assist. While in the OR, the C-section commenced. With baby out, both the mother’s life and the baby’s life were in jeopardy. “Code Blue” called overheard at 1058hr. The ED physician responded to the OR with a 2nd anesthesiologist. ICU/ED nurses, and surgical NP responded to the OR. One team worked on the mother and one team worked on the baby.

Meanwhile, the family gathered outside the OR. The mother of the patient cried out in prayer, “Take my life Lord, not my daughter”.

A pink baby girl emerged from the OR and was rushed pass the family to the nursery where our team of nurses and the hospital-based pediatrician awaited. The baby was prepared to transfer to the NICU at CPMC.

The mother of the newborn was still crashing with a highly skilled team diligently working to stabilize her. Finally, the OB/GYN emerged from the OR to speak with the family stating that the mother was critical and needed to go the ICU. She informed the hospitalist physician who was going to assume care in the ICU about the situation. Her belief was that mother experienced an amniotic fluid embolus and was going into DIC (disseminated intravascular coagulation), a leading cause of maternal mortality. “Massive Transfusion Protocol” was called overhead as the patient was rushed to the ICU with her mother clinging to her hand.

The lab manager helped to orchestrate the MTP with our lab/pathologist medical director on the phone. With platelets being dispatched from Santa Rosa, our team worked with the eICU and pharmacy through the protocol expertly. Our recent experience of saving a life with MTP served us well in being prepared for this scenario.

After several hours of heroic effort, the bleeding slowed, and the team could breathe. It was time for the mother to see her daughter. It was 1800hr. She took my hand as we walked down the hall to the ICU. She immediately started singing a lullaby to her daughter who lied still, machines keeping her alive.

At 1030hr, the patient was transferred to Sutter Sacramento Medical Center. The day began with routines, and the same day ended with the knowledge that teamwork, excellence and compassion had saved two lives.

There is lesser-known story of sweet significance on this day. During the height of the emergency in the family birth center on this November 5th morning, another baby decided it was time to enter the world, and the mother began to push. Thankfully, our midwife was ready and waiting to help usher this infant into the world at 1058hr, the exact time when two heartbeats stopped momentarily.

These stories not only exemplify the power of ONE Sutter. These stories also exemplify the importance of maternal care access in rural places, the importance of having the right resources at the ready, and the grit that it takes for miracles to happen. We are Sutter Lakeside, and we are gritty.

Need More Info?

Below are links to the resources used for the presentation

California Hospital Association

Center for Healthcare Quality and Payment Reform

Transportation Barriers – National Center for Sustainable Transportation

Cal Matters

Daily Journal - Maternity Unit Closures

Public Policy Institute of California – Spotlight on Rural California and Rural California Fact Sheet

USDA Economic Research Service

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Final Thoughts

What is one insight you gained about rural health that surprised you, and how might it impact your work or perspective on healthcare access?

How might different departments or community organizations work together to address rural health challenges? Can you think of any partnerships that could be particularly impactful?

What's one small step you can commit to taking—personally or professionally—to support rural health equity in California?

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Thank You!

To contact the California State Office of Rural Health send us an email at CalSORH@hcai.ca.gov

To contact HCAI's Equity Office send us an email at equity@hcai.ca.gov

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