Medical innovation in rural health care with Geisinger Health System & Sanford Health [Podcast]

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Featured topic and speakers

In today’s AMA Update, Jeremy Cauwels, MD, chief physician at Sanford Health, and Kenric Maynor, MD, MBA, chair of the Medicine Institute at Geisinger Health System, join us to discuss innovation in rural health care. AMA Chief Experience Officer Todd Unger hosts.

Learn how the AMA is #FightingForDocs and access resources from the AMA Recovery Plan for America’s Physicians.

Speakers

- Jeremy Cauwels, MD, chief physician, Sanford Health
- Kenric Maynor, MD, MBA, chair, Medicine Institute at Geisinger Health System

Transcript

Unger: Hello and welcome to the AMA Update, our video and podcast series. Today we’re discussing innovation in rural health care. I’m joined today by Dr. Jeremy Cauwels, chief physician at Sanford Health in Sioux Falls, South Dakota, and Dr. Kenric Maynor, chair of the Medicine Institute at Geisinger Health System in Danville, Pennsylvania. I’m Todd Unger, AMA’s chief experience officer in Chicago. Dr. Cauwels, Dr. Maynor. Thanks for joining us today.

Dr. Cauwels: Thanks very much for having us. Appreciate it.

Dr. Maynor: Good to be here today.
Unger: Well Dr. Cauwels, let's begin with you. You've said that simply living in a rural community is an adverse social determinant of health. Let's start by talking about why that is. We talk a lot about social determinants of health. I'm not sure that comes top of mind when people think about that.

Dr. Cauwels: Sure. Just in a recent report in the New England Journal of Medicine catalyst they revealed a lot of barriers to providing excellent health in rural areas. Recruitment and retention of physicians, distance and travel time to where you're going, are just a couple of them. I think where we live, three to four hours is not an unreasonable transit time to get to your nearest medical center. When you do that, putting off things like your mammogram or your next colonoscopy are absolutely things where they sometimes get lost in the hustle and bustle of daily life.

No matter where you are, I think diabetes is still diabetes, heart disease is still heart disease. And whether you live in South Dakota or New York, I think it's still easier to find a cheeseburger or a pack of cigarettes than it is to find access to health care. And I think as long as that stays out there, it's going to continue to be a problem. Right now, interestingly enough in the rural area, the other thing we see is that this is not the best time for farmers to be in and getting any sort of health care. This is the harvest. And I can tell you if you see a harvesting farmer come in right now, something is very seriously wrong, because they're not coming in with anything less than a severe illness until the harvest is completely brought in.

The other areas I would say is mental and behavioral health. 91% of the counties in North Dakota are designated as mental health shortage areas. We're committed to removing that barrier, particularly by bringing virtual care options, and bringing areas where people can still see their provider, even if they can't drive to see them.

Unger: Well, those kinds of access issues and what you talked about in terms of just ability to get there and travel times, that is a big challenge. Dr. Maynor, I know that Geisinger serves both rural and urban areas. So you have a unique perspective to see the differences between these two patient populations. Do you see the same kind of challenges that we just talked about in serving your rural patients, and how do you compare those to what you see as those experienced by their urban counterparts?

Dr. Maynor: Yeah, I would say there are similar categories of challenges for both rural and urban patients. The difference may be by a matter of degrees and scope effect. For example, access to care in our rural population is often predicated by distance to primary care and subspecialty services. Often it could be a matter of several miles or sometimes hours. Dr. Cauwels mentioned as well. Our mission has been to make health care easier and provide patient primary care where needed. Subspecialty access closer to home as well.

In urban areas access may not be predicated on the geographical distance but rather timely access to care. After all, if you're living only five minutes away from a primary care physician or subspecialist, but
you can't get that appointment for several months, then there's still an effective barrier to care. The issue is not the same, but related.

And geographical access to care, I think transportation or lack thereof is also a barrier to both the rural, particularly, and sometimes urban patient populations that we serve. And then finally, I think, broadband has been really noticed as a potential barrier to our rural health population. Maybe not so much in the urban areas as we're going along and continuing to offer telemedicine to many of our patients throughout the system.

And I would say finally, socioeconomic factors affect both rural and urban patient populations, as they still try to navigate this complex medical system that we have. And as much as possible, we aim to democratize health care, provide care in a manner that makes it accessible to all who need it, preferably in their communities.

**Unger:** Well, maybe it's because of the challenges that you're facing. But both of your systems are well known for being at the forefront of medicine. I think that might surprise people, because maybe there's an assumption that we think that urban hospitals are there, kind of driving the innovation. Dr. Maynor, why don't you start and talk a little bit about why does rural health care provide a great space for medical innovation?

**Dr. Maynor:** Yes, thank you for asking. Serving rural populations I think really means that you have to understand the community needs and tailor those services to fill care gaps that might exist. Rural communities provide a fertile ground for understanding those needs. And in many ways, those constellation of efforts mean that you have to be efficient in resource allocation. You have to be thoughtful in the way you're distributing and making programs.

And so I think one unique initiative that we've been into a program is our fresh food pharmacy program. And it specifically tailors around quality control diabetics with food insecurity in our communities that we serve. It provides fresh fruits and vegetables along with lean meats to diabetic patients. In addition, they receive nutrition classes and cooking advice. And being a value based organization any time we can shift care upstream within primary care and get to some of those basics, to address those insecurities, the downstream consequence has led to a significant improvement of overall health care results.

What we've seen is approximately a 40% reduction in their hemoglobin A1C. So from a numerical standpoint, that's a decrease of two to three points. Quality measure care gaps have closed, and we've seen them increase overall from 50% to 70%. We've had a reduction in inpatient and ED utilization among this group and 30% increase use in primary care and overall engagement. So what that speaks to is when in these environments, when you can address some of these basic needs and have programs around them, you can really improve health to the community. So we're looking to expand this to other vulnerable patient populations like chronic renal disease, as well.
Unger: Those are some incredible statistics. And probably things people aren't thinking about when they think about innovation. Dr. Cauwels, when you think about the same thing, and again, driving innovation in a rural setting, what do you think about that?

Dr. Cauwels: Well, I think for us it's about the steadfast commitment of ensuring that our patients have access to the right care at the right time, in the right place. And that has to be no matter where you live. I think Dr. Eric Topol was the one that said previously we have to change it to the patient will see me now. It's not I'll set something up and the patient has to conform to my rules. But rather for us, it's a 1 million patients over 250,000 square miles. We need to be able to bring things to our patients where they need them.

For us a couple of those examples include OB video visits. As anybody who's ever had a baby knows, coming in for a 10 or 15 minute appointment on a routine basis is fine if you live across town. It's not fine if you live 200 or 300 miles away from your obstetrician. And so decreasing those visits by up to one third helps tremendously.

In behavioral health, we've shown clearly across our organization that the net promoter scores of our patients who get virtual behavioral health options actually improve over our average outpatient behavioral health scores. They like it better if they can see the doctors where they need to. Right now, one in five of our behavioral health appointments are scheduled virtually. We provided 600,000 virtual consults over the last decade and 20 million miles saved by our patients driving back and forth to places where we have clinics, whether it be on country roads or through the harsh winter weather we're gearing up for now.

Unger: That's a lot of miles. And what an advantage that's coming through in this course that you talk about. Let's stick with this idea about, again, innovation in this space. Dr. Cauwels, Sanford Health is literally doing groundbreaking innovation in August. You broke ground on what will become the Sanford Virtual Care Center. Let's talk about what the vision is for that center and the gaps that it's looking to fill.

Dr. Cauwels: Sure. So we were blessed with the opportunity of having $350 million to help understand what virtual care really looks like. For us, it's really about six key pillars. Number one is innovation. We've got to make sure we're bringing new and existing clinical trial opportunities to people who otherwise wouldn't have access to them.

It's also about care delivery. We want our patients to save on time, travel and expense. We want a streamlined experience that gets them to the doctor in the doctor's office when they need it. But if they don't need to be there, how can we make sure they can stay closer to home? Closer to work? Closer to their kids?
In education. One of the things we want to do is start training physicians, residents, medical students and nurses to provide this kind of care. We have to do a good job of making sure they understand the differences between somebody in your office and somebody on your screen.

We have to continue to improve access. The goal eventually is that the patient will see me when they’re ready and that ready can be at a moment’s notice. Now we’re not there today but that’s absolutely part of the dream. And it’s about dedicating a virtual team. We have to be able to have a team of people who do this for a living, who truly are experts in the field. And community learning on how our communities need to deal with this and how they can get involved.

So as you said, we broke ground on a 60,000 square foot facility here recently. And we’re building that out so we can build things like satellite clinics. What if your small town of less than 2,500 people had a clinic on Main Street? What if you knew the nurse that was working there and you could get to any doctor you wanted without ever leaving that clinic? Because we would bring them virtually to you.

One of our goals is also to make sure that we’re improving on waiting time. Making virtual visits possible within 24 hours rather than waiting weeks or months to see a specialist. And then the other thing we hope to do is transition more than 350,000 outpatient visits a year to care from home. And continue to extend that over more than 275 clinics across the Midwest.

Unger: So interesting to think about, the kind of real life infrastructure that it takes to pull off great virtual care. One of the things that kind of just keying on what you talked about before, is this idea of not needing the patient to come in because you’re monitoring them remotely. Dr. Maynor, Geisinger has had a lot of success in remote patient monitoring. Will you tell us more about that kind of success? And what do you what are you doing going forward from here?

Dr. Maynor: Absolutely. Clearly we learned through the pandemic that utilizing telemedicine with a component of patient monitoring was absolutely essential and fortunately possible. At the height of COVID, our Geisinger At Home team was able to provide a essential monitoring of key vital signs and in-person and telemedicine visits for care at home. It provided the ability to expand the care of patients without admitting them to the hospital, which were full at capacity or beyond, and it ended up being a very cost effective, patient centric model with high levels of patient satisfaction.

Like other health care institutions, the pivot to telemedicine occurred from marginal to a significant percentage of our clinical visits. And we use that experience really to understand what we can do, now and into the future. Today within the Medicine Institute, approximately 12% to 15% of all clinical visits occur through telemedicine and where possible for those individuals that have geographical difficulties getting to our clinic areas or broadband difficulties, we have a primary care clinic where they can go near their home that’s set up for telemedicine to be able to have that subspecialty care and visit associated with it. A health concept, if you will.
So all of that to say that we’re going to continue to explore opportunities to care for patients at home. The telemedicine and remote monitoring capabilities to bring that within the home setting is absolutely, I think, the vision of the future. And patients will continue to thrive, I think, with additional support. Patient populations that have CHF and COPD I think are other examples of chronic care populations that we can continue to help avoid unnecessary ED and inpatient admissions.

Unger: Well, let’s spend a little time before we close here thinking about the future. And how do you take the learning and the innovation that both of your systems are doing right now and kind lay out a vision for the future? Obviously we think about telemedicine and requires a lot more than technology infrastructure. It requires a lot of collaboration. Why don’t we start Dr. Cauwels with talking about what Sanford’s doing and bringing together the kind of folks that are—it’s going to take to really have models like this take hold. You had a summit in August that brought leaders together. Talk about what you learned there, why do you do this and how are you’re going to influence folks at the forefront of rural health care innovation.

Dr. Cauwels: Thanks Todd. In August we did indeed get together with what we call the Summit on the Future of Rural Health Care. We brought together U.S. senators, John Thune and Tina Smith, leaders from Salesforce, Microsoft Health, Medtronic, the AMA, the Advisory Board, Care Journey and CMS’s Office of Minority Health. And I think it was really about bringing together what you might consider the whole team.

How do you bring together a group of people who are all focused on the same thing? And so making sure that access becomes affordable, accessible, equitable and quite honestly sustainable for generations to come is making sure that we put the physician voice at the forefront. But that all of the pieces we need to provide good care all come in and lend themselves to more high quality seamless care. And I really think that’s sort of the driving force of bringing together a group like that.

Unger: And obviously one of those key players that we think a lot about and how we terms we’ve approached virtual care, telemedicine over the past few years, obviously the government. And it’s really important that physicians, health systems are talking to legislators, policy makers, to make sure that they have a very strong sense of what’s needed, especially as we try to serve rural residents better. Dr. Maynor, talk about Geisinger’s Rural Health Policy Institute and how you’re leveraging that to achieve objectives there on the legislative side.

Dr. Maynor: Yes, thank you. The Institute brings together a diverse multidisciplinary groups of professionals really to conduct research focused on finding workable solutions to rural health care policy issues. As an organization we want to use the platform that we have to advocate for our patients and their needs. And one recent example is Karen Murphy. Geisinger EVP. And her colleagues had an article in JAMA which proposed a strategy to preserve rural hospitals. The vision which subsequently developed into the Pennsylvania Rural Health Model was really to continue to provide support and opportunities to transition from a fee-for-service reimbursement system, based on

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volume, to a multi-payer global budget payment method based upon value.

And intended to improve outcomes and quality of care while lowering costs. This is currently an initiative being done within the state of Pennsylvania. It's got a six year run limit, and we'll reevaluate and see what the results are in the next year or two. We should be able to continue to get data on this. But at the end of the day, we want to continue to forgo hospital closures, as we know that given the financial difficulties that were present before COVID, it contributed significantly to rural hospital closures, and that trend is only continued now in our current health care environment.

We realize that rural hospitals provide not only essential care but also bring economic stability to the region. And we believe that highlighting research and the effects of policy implications on rural communities is a core function of caring for our communities that we serve.

**Unger:** Well, last question, and Dr. Maynor, let's start with you. What do you see as the most exciting thing in this space about rural health care innovation.

**Dr. Maynor:** I believe that we are getting and gaining significant traction on understanding that the mores of telemedicine and those patient populations not being amenable to them or the intersection of now community technology policy decisions, we really can make a difference. That there are real programs and real efforts where we all stack hands and put resources behind it to improve the health, the welfare and the lives of our rural community residents. And, again Dr. Cauwels has already mentioned, so much of that really brings to bringing the resources back to the community, having health care be local and being able to educate and give the communities they need in order to also be more engaged in the process of improving their own lives.

**Unger:** Dr. Cauwels, what excites you about the future?

**Dr. Cauwels:** I think the privilege of caring for and supporting our patients and residents, the other people in our communities, is a responsibility we don't take for granted. And I think the advent of virtual care gives us tremendous possibilities to improve the health and well-being of all those folks we serve. I think being able to develop a doctor's webside manner, not just their bedside manner, is going to be absolutely key to making sure that as we shape the future for health care, generations to come we'll still be able to connect with their doctor in a way that they feel is real and in a way that they feel brings them the best health care they can have no matter where they live.

**Unger:** I get to talk to a lot of physicians but it's the first time I've heard the term webside manner. So I learned just yet another thing of many that we got to talk about today. Dr. Cauwels and Dr. Maynard, thank you and to your system Sanford and Geisinger for all the work that they're doing to take care of this patient population and for the innovation in this space.
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