Reaching Rural Populations

Dan Porterfield: So welcome everybody. I'm excited to see a packed house for this important topic and I think most of you know this, but the Aspen Institute does a lot of things. In addition to putting on Austin convenings, it bring people together for change making conversations. We run programs on a wide range of topics in parts of the country, in the world where people have never been to aspen, Colorado, but they sure know what the Aspen Institute is and many of those communities are rural, rural us all around the world. We identify leaders, we work to frame issues in ways that can help lead to solutions. We've gathered people up for forms of convening that are locally organized about local issues and this is a chance for us to put a spotlight on three leaders who are really getting the job done on a critical questions of health in rural communities.

Dan Porterfield: I want to just frame the topic for a second and then we'll get right into the questions. So in thinly populated regions that stretch over vast territories, primary care is often a long journey from home, especially services are often completely out of reach, access to care in some more isolated communities. Maybe further complicated by cultural or language barriers, limited transportation networks and poverty. But advocates are working in the rural space. Take talking about solutions, not problems. Local empowerment, communication, technology hub and spoke models that link primary care providers to specialists and greater resource commitments are among the strategies bringing more care to historically underserved communities. And they're doing it in partnership with communities, not from the top alone but in a relationship. Um, and so on that note, we have three leaders working in diverse ways and Brad than getting them to come across and say too much about the organizations. I want to get us into the human side of these issues right away. So my first question, not a trick question, is tell your name, say and then tell a story that for you really helps you, um, convey the importance of the work you do and the people that you serve have. And so we'll start with Don Warren.

Donald Warne: Well. Thank you so much. My Name's uh, Dr. Donald Warren. I currently serve as the associate dean for diversity, equity and inclusion at the University of North Dakota School of Medicine and Health Sciences. And also director of what's called the Indians into medicine or INMED program and also director of the master of Public Health Program. And in terms of why I got into this work, it starts back when I was actually in college. I'm originally from a very small rural town called Kyle, South Dakota. And I was like to ask how many people had been to Kyle, South Dakota. One that's won more than usual extra, sorry, president as a very small community on the pine Indian reservation in South Dakota. But when I was in grade school, we moved to Arizona, is actually spent most of my childhood in the Phoenix area. And as I was going through college, my grandmother was getting older and she was a more frail and she decided to move to Phoenix to live with us.

Donald Warne: And unfortunately she had been a lifelong smoker and, uh, she was a full time mother full time grandmother had 10 children of her own. I don't even know exactly how many grandchildren she had at that time. But in the 1980s, she moved to Phoenix to live with us and she developed a cough that wouldn't go away. So we took her to Phoenix Indian medical center and they did a chest x ray and it was clear that she had lung cancer. But because of the rules within Indian Health Service, she was not eligible for a referral to an oncologist from Phoenix Indian medical center. She also had not done her 40 quarters of work to be eligible social for social security. She was not enrolled in Medicare. Uh, she could've qualified for Medicaid, but we couldn't prove how long she lived in Phoenix. We didn't put the light bill in her name when she moved to live with us.

Donald Warne: So the only way we could get her a referral as we had to take her back to South Dakota and in that process or is wait times even get her in to see a doctor wait times to get a referral. She wound up dying in an emergency room with lung cancer with never seen an oncologist and that could still happen today. So my interest in medicine started with wanting to be a primary care doctor, but it's evolved into recognizing that we have bad policy in this country in some populations are effected more adversely than others and it's not a happy story, but that's why I got into this work. Thank you so much for starting us off with that. Kind of a personal story a while, Sanjeev.

Sanjeev Arora: Yeah. My name is Sanjeev Aurora and I serve as the director of the echo project all over the world and this is a project to democratize knowledge, to get best practices to underserved people all over the world. Our goal is to help a billion people by 2025 but this story in 2001 in, I'm a gastroenterologist by profession. I'm a specialist in a disease called Hepatitis C, which affects 70 million people worldwide. Only 5% have received treatment. But in 2001 on a Friday afternoon, I walked into a patient in my clinic, my hepatitis C clinic, and there was a 43 year old woman sitting there. But what was different was there were two children in the room too. There was a 14 year old boys sitting with her nine year old girl. And I asked her, how can I help you? And she said that, you know, I have hepatitis C and I want treatment.

Sanjeev Arora: So I said, terrific. That's what we do in this clinic. And how long have you had it? And she said, you know, I probably had it a long time. When I was 18, I experimented augmented with drugs with my friends, but I didn't like them. But, um, now eight years ago I was, I had hepatitis C and m. So I said, why is it that you, you're coming today as opposed to when they told you eight years ago. And she said, you know, I live four and a half, five hours away. I live in Albuquerque and she lived in a rural part of New Mexico and I had called your clinic because my primary doctor asked me to come and see you. And they said that first of all, I would have to wait eight months. There was an eight month wait to see me and I would have to make 12 trips to see you five hours each way by car.

Sanjeev Arora: And you know, I don't make that much money and I would have to pull my kids out of school. I'm a single mother and my car is unreliable and there's no way I could do that. I was feeling very tired, but I, I thought, you know, I'm just going to crank it out. So she kept working. She didn't come. So I asked her, why did you come today? And she said, now I'm having been here in my abdomen and when I work it hurts a lot more. So I, I do an ultrasound typically even at a patient like this, and I did an ultrasound and she had a cancer in the liver this big. So Hepatitis C people die from this disease, from liver cancer and cirrhosis and now she was willing to come as many times as I wanted her to, but it was too late.

Sanjeev Arora: It was too big to get a liver transplant. She already had cirrhosis. We couldn't cut it out because there wasn't enough residue. Good liver there and she passed away leaving these two children. I asked myself, look, I'm living in the richest country in the world, in the rural area. The treatment was available, the diagnostic tests were available. What happened here? What really happened was that the right knowledge didn't exist in the right place at the right time. Yeah, you can have unlimited resources, but if the right knowledge doesn't exist there, it will lead to massive inequity. And that's what happened here. And then I designed project echo in 2003 to solve this problem in every underserved part of the world.

Dan Porterfield: Thank you. Thank you. So dude, no, Michelle, you work in Guatemala. Yeah. Um, and I'm in a moment, I'm going to have that you'd share with the audience, your association with the Aspen Institute. It's so wonderful to be able to meet you and interview you. Um, but can you tell a story that motivates your work?

Michelle E: So I'm the medical director of wings. Um, it's an NGO in Guatemala and we provide contraception to half of the country. We traveled throughout the country with mobile units. So I want to say two short stories. The first of all, uh, when I entered the in wings, um, I told everybody we have to start, uh, doing vasectomies. And everybody told me I was crazy because men in Guatemala will not accept [inaudible]. Let's try. Uh, I told him let's dry. Uh, um, uh, one week of the Wiz thought doing a promotion for the vasectomy clinics. We had 80 men in our list. So we cut it to do a lot of clinics to, to serve this 80 men. And we went to a very difficult area. [inaudible] it's maybe 10 hours from the city. Um, and I told him, Nah, we're not going to have any men there because, uh, they separate indigenous population.

Michelle E: Um, and they're very, uh, based on myths of they're not going to accept us. And we had eight men. One of them told me, I've been waiting for this for years cause my, my, my wife has already eight children and she suffered enough. It's my time to software. So was I, because I'm a woman, I have to tell you a story of a woman. Uh, uh, I did that surgery, Tubal ligation, uh, and she, uh, after the surgery she stopped crying and crying a lot. So I thought, oh my God, I did something wrong. Maybe she didn't want it to, to have a surgery. And she told me, I am bipolar and I don't want kids because I know my kids can have the

same disease. And I went to eight places to have a surgery and nobody wanted to do it because I don't have kids. So thank you very much. And she started crying and that was a story we really focus on, surf on sir. Population people that nobody wants to treat. People who are, doesn't have any other possibilities. Yeah.

Dan Porterfield: So, so just, just amazing these, these stories. A grandmother, a mother, um, women and men in Guatemala who others thought wouldn't want the services you could offer. Um, there's so much eminence in the need of all of the individuals you've spoken about. Um, let's talk for a moment and quickly, but about the kinds of issues that we should be thinking about when we think about this question of rural or remote populations. So one is that government programs often are designed in a way that keep people out of access to service in one may be that there are cultural myths, expectations that aren't actually accurate about what people want. Yes. Okay. So what else?

Sanjeev Arora: You know, you know, from my perspective, this is truly an issue of equity and inequity in health care can be driven by many, many considerations. True reality is one of them. We would call that the distance barrier, but there could be an economic barrier for inequity. There could be a linguistic barrier for inequity. You speak a certain language and knew they could be a cultural barrier for inequity because we are not taking care of the cultural needs of the native community and we want to apply our own. Uh, it could be racial barriers of iniquity. They could be gender barriers. One of the greatest gender, gender inequity occurs in a country like India for example, where the man will be able to travel 200 miles to get treatment. But a woman is not allowed to travel alone unless her husband takes time off of work. So therefore they can be gender inequity. There are so many reasons that we find for inequity, which can be overcome if the right knowledge and the right care is provided the right place where they live, rather than making them move into an area which they can be shocked by any one of these. They could be gay and people don't have a religious barrier and all kinds of things like that. So taking care to where they are is the, is is a way to overcome some of those problems

Dan Porterfield: and we'll get a chance to hear about the model of Echo, which, which addresses exactly that. Um, Don, any barriers that or factors that we should also have on the table in addition?

Donald Warne: Well, certainly coming from an American Indian perspective, we have our own unique health system that's largely not addressed and not discussed. So I appreciate being a part of this discussion because quite often we're not even at the table or on the stage, so to speak, when, when the issues arise regarding less access and certainly issues related to equity. But we have a lot of the issues that rural and frontier populations have just in terms of access. And it's not just access to medical care, specialty care, it's even access to local supermarkets. So, uh, it is a food desert where I am from Kyle, South Dakota. The closest supermarket is in rapid city, which is 90 miles away. So imagine doing 180 mile

round trip every time you wanted to go to the supermarket. And that's if you have good transportation and good weather, which we don't always have went in and rural impoverished reservation communities.

Donald Warne: So it is interesting and I appreciate your comments if we could have all of the knowledge in the world, but if we can't translate it into action, what good is it? So we could have diabetes educators, we could talk about nutrition, we could do nutrition counseling, but if people simply don't have access to healthy food, what good is that counseling? What good does that knowledge? We can't actually implement those types of things. So, um, certainly even in the medical side, not just specialty care in primary care, we also have problems with opioid addiction, like many rural populations have. And on, I'd say in my region, over 90% of the reservation communities have zero medication, assisted treatment providers mat, which is shown to be effective for opioid treatment. But we just simply don't have any providers that are certified. So, so the, the barriers are significant and it runs the whole gamut of primary prevention and social determines of health through primary care and specialty.

Dan Porterfield: Um, Michelle, something else.

Michelle E: In my experience, I've seen a lot of barriers festival, the myths because a lot of men in Guatemala thing that women is using contraception is because she's going to be with other men. Um, they don't have money to travel or them, uh, public sector has not been trained the personal, so they don't know how to insert an Iud, hormonal implants or those surgeries. So I have to say that the inmate experience then may barrier has been asked the providers because we have our own bias. Uh, no, not no lady. This is not good for you. You should continue using the Po for 50 years. So I think it's the most, uh, biggest challenge for us. Uh, other thing is that our roads, it's um, very, very hard to travel. Uh, there shorts, what am Elise Burberry tiny, but we have a very bad road system. So to travel to coven that is maybe nine miles away, it took me one day, 12 hours, 90 months. Yup. So, uh, how can you expect a woman to travel that distance, uh, to received something that she's hiding from, uh, her husband? So, Yup.

Dan Porterfield: So I want to pause in the editorial moment. Uh, the Aspen Institute has this super program that identifies around the world change makers, Michelle and many others who are making a difference. It's called the new voices fellowship. In fact, are there any other new voices

Dan Porterfield: fellows here right now? [inaudible]

Dan Porterfield: so everybody should be breathing in hope leadership, inspiration, determination, drive, resilience, courage. Uh, and I get it done mentality because it's in the air here. But we, you say a little bit about what this fellowship is.

Michelle E: Well, you can read more, but I want to say something from my heart. Um, it's a one year program that they train us. We are leaders in our countries, in Asia, Africa, America, and they train us to do this. Do you think it's easy for them to me for a Latin woman to be with three men, three exceptional man. So it's hard to, it's, it's not icy. So they are teaching us, they are giving us tools to raise our voices and improve, um, education and to uh, tell the world that there's more than only the United States or Canada or all in Europe. There's a lot more of them.

Dan Porterfield: [inaudible] okay.

Dan Porterfield: On that theme now of getting it done and solutions, can I ask each of you to reflect on the work you do? What's the difference that your work is making that can give us a sense of the proof of the possible?

Donald Warne: Yeah. Well I had mentioned that I'm director of what's called Indians into medicine or the INMED program. It's been around since 1973 and at University of North Dakota we've now graduated over 240 American Indian physicians from the university. So it's the most successful indigenous medical training program in history. Wow. Yeah.

Dan Porterfield: Thank you. [inaudible]

Donald Warne: our incoming class starting in August as a class of 2023 so that's the 50 year anniversary class of the Indians into medicine program. But we don't just look for rising stars that have already taken the MCAT at the medical college admissions test that are doing well in college. We recognize that we have to go much further upstream. So we actually have what's called our INMED summer institute and it's going on right now in grand forks, North Dakota. And we have American Indian students from all over the country from grades seven through 12. So middle school and high school. And they spend six weeks with us and they take courses in math, chemistry, physics, biology, communications and health. And they also get to meet other people, other people in their age group that are living on reservations and wanting to go into the health sciences. And I can speak from experience. It's not easy to be a nerd on the reservation. There's all kinds of pressures pulling us away from being successful in schools. We tried to create cohorts of people who, um, have common goals and ideas, uh, but recognize that we have to start very far upstream. Our big challenge has been our, our resources from Indian health service have not gone up in 12 years. So we've had flat funding and as Costco up, the numbers of students we engage actually goes down. So that's one of our big challenges. Trying to get adequate resources,

Dan Porterfield: programs like that are some of the most important ways to create the leaders of tomorrow. So incredibly valuable for those young people. Now we can't see them there, they're there. But if we have pretty closed their eyes and we

thought about them. Um, is there, what word or two do you think defines them?

Donald Warne: Resilient is one. You had mentioned the word resilience and a lot of our kids go through so many challenges with dealing with historical trauma, adverse childhood experiences, immersed in poverty and communities with lots of addiction, lots of violence. But they're still there. They're still doing well in school. They still want to become physicians and nurses and therapists there. They're both resilient and incredibly inspiring.

Dan Porterfield: So, you know, I asked, institute has a center for native American youth. It's run out of DC by Eric Segments is awesome program. It's, it's uh, it's uh, in brotherhood and sisterhood with your program. And I met this young man named Trenton who was out of school out of work through that program and Eric and his team that him and put him in a cohort just like you're doing. Um, although he may have had a winding path to get to that cohort and there was so much anger when he started. Um, and I was in a setting where Eric asked him about what changed and he said, well, I used to think that not voting was an act of rebellion. Now I know it's an act of surrender and they had awakened that political wow. Vitality that Hoe to act. That's incredible. So you're doing, um, okay. How about [inaudible] solutions?

Sanjeev Arora: Yeah, I think first of all, thank you for this invitation to come here and congratulations on this fellowship program. In fact, I want to also recognize, I think that a few people in this room, the Helmsley Trust, that's the success of echo in this world. The Helmsley trust has played a big role. The Robert Wood Johnson Foundation that both support you and there's a man in the audience, Stuart Portman, who is the health policy advisor for the Senate Finance Committee in the United States Senate, who I call the founder of the Echo Act of 2016 and Gotten 97 zero in the u s Senate because of his strategic leadership and the house unanimously. And then he got President Obama to sign it into law and now he's helping us with the Echo Act of 2019. So thank you all for this.

Dan Porterfield: [inaudible]

Sanjeev Arora: so going back to the solution, so you know, had seen this patient who passed away, but the problem was much bigger. They were 28,000 patients who had been diagnosed in New Mexico with Hepatitis C. This is a reportable disease. We knew their names, but only 1500 had been treated. They were trying to come to see me. They couldn't get there and uh, many people were dying. And I taught, okay, I have to figure out a way to bring access to treatment for everyone. And I then I'd have a model for complex disease in rural locations in developing countries. So in 2003 I launched echo based on four key ideas. One is to use technology to leverage expertise and the technology was one too many video conferencing and the expertise was a psychiatrist, a pharmacist, and the liver specialist. The second key principle was sharing best practices. So I had my protocol in my clinic that I used and what I did was I set up 21 new centers of

excellence for treating Hepatitis C in New Mexico, 16 and rural areas in five in prisons, each run by a primary care clinician.

Sanjeev Arora: So I give them my protocol, but not a single one of them was willing to give this chemotherapy of weekly injections in the prison or rural area. So I, that brought us to the third principle. So I asked myself and I did my fellowship in Boston. How did I become an expert? So I would see a patient present to my professors, see another one to my professor. I kept doing it for two years and they started calling me a gastroenterologist. I said, Aha, I'm going to use this model to create new Hepatitis C ologist in New Mexico brand new ones. And we call this iterative guided practice, case based learning. And the fourth principle is tracking outcomes and do Internet. So I started this Deli Echo clinic in 2003 all 21 would join together one by one present de identified patients to each other and to our team.

Sanjeev Arora: And what we found was in a year they became great experts. The weight in my clinic in 18 months went down to two weeks and we started doing research showing that the joy of work increase their professional satisfaction, went up, efficacy, went up, isolation went down, and then we published in the New England Journal that they could produce the give chemo in a prison or rural area at the same effectiveness. Once we showed that, we then expanded it to 40 separate networks in New Mexico, but we want to help a billion people. So we started training other universities all over the world, get developed a digital infrastructure for it, which we give away to everyone for free. And every one of you is, is welcome to use it if you reach out to us. And now we operate in 35 countries with hubs and 50,000 or so clinicians and other people participate on our networks for 70 different networks in healthcare. We have about 20 networks in education. We have, um, and so on and so forth.

Dan Porterfield: So that, that, that is really a skill, a way of building scale by creating networks, leveraging technology, um, and information. It's incredible.

Sanjeev Arora: Yes. We all are days I spend finding innovators like you and you and we go to them and say, hey, you're doing something amazing. You figured out some amazing solutions can be give you echo so you can amplify your impact. 100 Ford, we call that force multiplication. Exactly. Exponential improvement. That capacity to deliver best practice solutions. That's our fundamental reason for existence.

Dan Porterfield: Okay. So on the theme of force multiplication, if we multiply, your force is going to be a big bang. You have so much force. So tell me about your work solutions, uh, that you're, that you've moved into development,

Michelle E: I think. Uh, is this working? Yes. Sorry, the upside, um, corruption has been a cancer for countries as mine. Um, and we are showing that with a $1 million budget for a year. We're saving lives and we are doing amazing things. So we traveled throughout half of the country, uh, with three trucks, our mobile units,

um, and we put everything in there so we can, uh, make a clinic and a school in a house, in a community center wherever we can. And we provide, um, uh, cervical cancer screen and the Iud and hormonal England's and with some, um, friends, hospitals with the Tubal ligations vasectomies. Uh, and we try to really respect the culture. So we have, um, for nurses, um, in specific places that work with a Baggie in their shoulders and they carry everything and they provide services with cultural respect. So for example, in the highlands, in Solando Tanika Pan, it's 99% of the population indigenous.

Michelle E: So we hired a beautiful [inaudible], our nurse, um, she's an amazing nurse that I supervise and, uh, I trained supervised medical audit, uh, because we really think that people should have the same quality care. Then in the Best Hospital of Guatemala. So he uses a, how indigenous close, uh, to provide services. And this allowed women to believe in her because if I'm this Weide girl come to the, uh, the, the, uh, the village and tell them I have to give you something. I want to talk to you about something. I'm not gonna listen to me. Uh, but they listen to the night. So we have discovered that I'm respecting the cultural specific situations is the clue and provided quality services. So we are only 40 members and, uh, we have three programs, uh, I youth educational program that we, um, and we show, uh, the youth about sexual and reproductive, um, uh, teams.

Michelle E: Uh, at the end, we don't want them to, they'll have a pregnancy pregnancy. Um, we have, uh, brought, uh, voluntary promoters in 50 places of, of the country, and they provide, um, a short acting methods and some of them don't even know how to write a book. Quarterly. We put them all together and we train them in specific help, um, themes. And we have the community services. So we do our UDS hormonal in blends, Tubal, ligations, vasectomies, um, and the cervical cancer screen at the end, one in one year, we can serve, um, 25,000 women and men with 1 million, uh, budget. Um, so we're showing that the, uh, our country president and everybody in the Congress, uh, there's not enough money if everybody is holes it Steelton. Thank you. Okay. Um, but if you're careful with your resources, we can do a lot of things with very little resources. Yup. Thanks.

Dan Porterfield: [inaudible].

Dan Porterfield: So I have a question, but I'm going to hold it because I want to let you get some questions in and I'll come back maybe with one more. Um, so on the right. Yes. Thank you so much. Thank you so much for being here. Just quick question. Uh, some of the other panelists have talked today about telemedicine being a big answer for rural situations to happen. I'd be curious, I didn't hear that, uh, in your answers yet. Do you think that's hype or you think that something real? Could you ask the question again? What was it? Tell telemedicine. Telemedicine. Thank you. Yeah, telemedicine.

Sanjeev Arora: I can take that. I think that telemedicine is an extraordinarily useful modality to overcome what we call a geographic divide. The patient is fight away. The patient doesn't have to travel. You can put a specialist on one side,

Sanjeev Arora: but the other person on the camera and take care of him.

Sanjeev Arora: What telemedicine does not do is capacity expansion. When I look at the world that are 6 billion people in the world who don't get the right knowledge at the right place at the right time, there's an absolute shortage of specialist. That means if I take myself as a specialist in Albuquerque and put myself into it on a camera to see a patient in rural New Mexico, I'm going to see one less patient in Albuquerque and I have a long way to see me in Albuquerque so that the net total number of patients seen in the world does not increase where isn't a Tele Echo clinic, which is different from telemedicine up purpose is different. In telemedicine. We give them fish and Deli Echo. We teach them how to fish so that we fundamentally increased capacity to deliver best practice 10 times. First and then a hundred times. And that's, that's the primary difference. Both can be very effective and complimentary as long as you have enough specialists to deploy on a telemedicine framework.

Michelle E: Uh, just, uh,

Michelle E: an example, um, we have 13 nurses, uh, basic, uh, the, their educational is very basic, so I've trained them to do via cervical cancer screening and I do medical supervision and I do medical audit, but sometimes they're on the field alone and they don't know what they are looking. So, uh, they send me a whatsapp shell. Can you please help me? They take a pictures in it and I, I can say, oh, she needs a cryo or you can refer for a colposcopy.

Dan Porterfield: That's, that's, that's technology too. I've telemedicine to.

Donald Warne: Yeah. And just very briefly, I'm a current issue that I'm hoping is not a longstanding issue is opioid addiction. Um, so ideally we would be preventing, but telemedicine is incredibly useful and valuable for medication assisted treatment when you do not have local mat certified

Dan Porterfield: providers. Yes. There's a quick thank you. Exactly the question right here.

Audience Member: Thank you so much for to this excellent panel. I'm a daisy array, one of the new voices fellows, and I'm from Nigeria. So Nigeria, our population is like 200 million. We have roughly 10,000 primary health care centers that are mostly due to corruption and do too many other factors for location of staffing. Paul resourcing in terms of medic medication and equipment personnel. So you can see where there's a large population that doesn't have access to basic healthcare in effect. So my question would be what would you think about the possibilities and the prospects of public private partnerships in delivering care to mostly rural populations through basic primary health care? Nope. Thank you.

Donald Warne: Well, and I can take the first stab at that next year. That's something that we need vital. Even so from my perspective with a working in tribal populations in Indian health service, that is more of a public sector arena, but we certainly don't have all the providers and specialists and types of services we need within the IHS. So we have to have partnerships with the private sector. So for example, back to telemedicine, we do have a relationship with what's called Avera health. Out of Sioux Falls, South Dakota, and they provide telemedicine to the entire great plains region. So it's a four state region but 17 tribes. So that's just one example where we do need to have public, private partnerships and recognize it quite often in rural impoverished communities. We don't have the resources to meet all the needs.

Sanjeev Arora: So we definitely have a very strong partnership with the Knight. Did your government and uh, we run many projects in Nigeria and we have brought our technology platform to your government, the zoom platform and I project Echo Resource Library in the cloud where we share our intellectual property from all 35 countries and all the major universities with the government of Nigeria. And third, the primary use that your government has chosen of echo in Nigeria is for HIV and TB control. And you may be aware of some of these programs. I see you nodding. And so that's an example of a private partnership. But my dream is, uh, that uh, the Nigerian government will partner with us for a lot more than just HIV and TB cause this was funded mostly by USAID and pepfar. But I think we want to ontrack how to treat hypertension, diabetes, and especially prevention of kidney disease, which as you know, is a very major problem in your country. So I think that we are ready for expansion of this private partnership with you.

Dan Porterfield: Thank you. It does. It does wings. Everybody. Private partners.

Michelle E: Yeah. Uh, actually were very tiny and we have to be strategic. So we tried to find these partnerships, uh, to the promotion because it's not worth it to come into a village and not having any woman. Uh, so we have to work with other organizations and the government, the public sector, uh, on all the surgeries would do it in, in hospitals or health centers. So we have to have partnerships.

Dan Porterfield: Yup. Thank you.

Dan Porterfield: Oh yeah. Straight ahead. Mr Secretary Glickman. Yes. Full disclosure, former agricultural sector secretary, uh, and longtime member of Congress and we'd ever within the dangler. Uh, well first of all,

Audience Member: Michelle, thanks for your work. I've been to Guatemala. I visited some of the areas and what you're doing is just spectacular. But I would say two things. There's two recent incidents that really hit me. One is, is that this John Stewart incident when he went before Congress and really be rated them for not providing the funding for the nine 11 uh, problems that people are having. And then in the last year, the Va, the veterans administration at all these problems and people came by the hundreds if not thousands to tell the congress that the

system was really a big failure. I guess my point is I'm really impressed by your stories. Stories are more important than statistics to be honest with you. But the stories need to be told, especially in the United States, to policy makers. So you build champions, a lot of people talk about rural health care. When push comes to shove, I don't know how many champions that you've got. And it really means that you both and people like you have to be out there advocating like crazy for what you believe. You've got to make it a little bit uncomfortable for these public officials. Our system allows for that. And I think what you're doing really can encourage that. So you mentioned

Dan Porterfield: [inaudible]

Dan Porterfield: clear help following that up, but by asking Michelle, uh, because there, there must be some pretty strong opposition to what you're doing because just in my words, it's fundamentally challenging the power of the patriarchy. Yeah. Um,

Michelle E: but we have some regions.

Dan Porterfield: Yeah.

Michelle E: But, uh, women are getting more powered, you know, uh, and they say, okay, does her husband, the husband leaves and they're very, very powerful and taking decisions. Yeah. Especially in non indigenous regions, you can see where my family is from. [inaudible] women are like strong. Yeah. Um, in indigenous populations we have a lot of, um, uh, relationship with, um, lses our church, Catholic church, angelical church. So it's a lot of, um, more than the husband is the church or the leader of the community that decides for them? No. Yeah. Thank you. More than the husband.

Donald Warne: Yeah. And I would just say regarding advocacy, um, we do have national Indian health board, which is a, an important organization based in Washington DC. But for, uh, tribes in the u s one of our biggest challenges is that we have federally recognized tribes in 35 states. So therefore 15 states and 30% of the Senate has no tribes in their constituency. So what do they care about our issues? It's not going to help them get reelected if they advocate for us. So the truth is we need partners in advocacy and that's something that we have been working on. Trying to have other entities and even being here is meaningful because we're not always the table in these discussions, but I agree 100% and I was at Senate committee on Indian affairs just several weeks ago, but there's, there's not enough, um, advocacy and support for indigenous health in the United States. It's remarkable. I, I work with a public health academics all over the country and I always like to remind them that you do not have to cross an ocean to find third world health conditions. It's right here on our reservations.

Dan Porterfield: Great.

Speaker 7: Yup.

Audience Member: Hi Pam Grogan. I'm family medicine and lifestyle medicine actually working in a rural health clinic about 60 miles away from here. And so I have a little comment and a question. So we're projected to have a shortage of primary care physicians in America of about 30,000 in the next 10 years. And family medicine physicians are kind of the front line in our rural health communities. So two part question, how do we incentivize new medical students to actually choose primary care and to go into these rural health settings? And the second part is to how do we transform our healthcare system from a sick care system into something where we actually incentivize prevention and wellness care. So we don't have our patients who are dying of liver cancer because of Hepatitis C, so thank you. Yeah, thank you.

Donald Warne: And, and so being at a medical school, and we deal with this all the time, and I am a family physician myself. Um, so we do have incentive programs that some of the rural communities helped to support a medical students. Certainly through Hersa the health resources services administration. There are a loan repayment programs and other types of funding mechanisms to support that. But even with all of that effort, we're still going to have this tremendous shortage. And I do agree that we also had more of a focus on preventive medicine. So one of our other projects is we're in process of trying to develop a rural and tribal focused preventive medicine residency. There's preventive medicine residencies all over the country, but none with the rural and tribal focus. And when I think about what we could do with that, we could have preventive medicine physicians who are licensed physicians, but they could be providing mat, they could also oversee home and community based services. I think the, the Promatores model, the community health worker model is under utilized, particularly in rural populations. I could envision preventive medicine doctors as the, the medical directors of home and community based services and then the policy side that needs to be billable under Medicaid.

Dan Porterfield: Yes. Yup. So each of you is a leader, um, and each of you was trained as a physician and there's a kind of a relationship. I think it's sacred between a physician and the person who gives you her or his trust for care. And once you've given that care, you've received that trust, something is different. You could have done that your whole careers, but each of you chose to build on that, to work at the level of structure, system, organization. In some cases, politics. Does your training and that relationship that you learned to value as a physician inform what you do now

Sanjeev Arora: do enough for me? You know, fundamentally what I learned in my practice of medicine, which I did for a couple of decades before I started echo, was empathy. And at the end of the day, the root off echo is not the model. It's empathy. It's not a technique, it's not technology. It's fundamentally understanding how much suffering there is in the world, even when the medicine is lying in the next room and it's not a financial problem and it's free. Let me give you an example. In India, 1100 people die every single day of tuberculosis when the medicine is free. And in every village, every place you

have a gene expert machine to do the TB diagnosis, but you don't know how to use it. So I think the issue for me was can we use the technology platform to democratize empathy, to give primary care the support they need? Because when we talk to primary care clinicians and say, what happens, why do you leave and then start working for industry, you know what they tell us?

Sanjeev Arora: It wasn't just a lack of money. They were isolated. They felt unsupported. They were not able to create teams. They, they just felt that the mission for [inaudible] went into primary care. They're having a hard time fulfilling because the knowledge was exploding at an exponential pace. They couldn't keep up with it. So they left, they surrendered to it. And, and that's the problem we are trying to solve. But at the heart of equity is empathy. And that empathy being saying that there are people in this, all human beings have the same aspirations. They have the same hopes and dreams and can be used what we've been given to help him. Yeah. For me. Yeah, sorry. Finding

Michelle E: uh, a meaningful life was, uh, that decision point. Uh, I used to have my clinic, my private clinic, and I did very well, a lot of money. Uh, but at the end of the day I went to my house. So empty and stress. Um, just to put an example, uh, with wings, we go to very poor places and after the the clinic day, they always have soup, prepared soup and maybe it's the only chicken. Then they that they raised them, the little chickens, that's the, that doesn't have a belly. So we use the word a trust. We're really trying to, to build trust with our donors, with, uh, between the team, uh, with the patients. So I think trust is like the, the word that we have to base our actions in this time. Very few

Dan Porterfield: [inaudible]

Donald Warne: for me working in advocacy, I did not learn that in medical school. Um, but I, I was fortunate to do a fellowship in minority health policy where I did get a master of public health as well, and did acquire some skills there. But in truth, much of it is just learning how to operate in two worlds as, as an indigenous person and deeply connected to culture. We have to learn not only a new language and, and the modern healthcare system, but even a, a completely different set of values and, and not losing track of who we are from a cultural perspective while still trying to thrive in a system that is in many ways foreign to us is a challenge. But I would say that was not learned in medical school, that for me, that was learned in other settings with public health, but then also just working with communities and maintaining that connection culturally.

Dan Porterfield: Yeah. Thank you don. So the aspens to takes pride in building networks of values driven leaders who want to make positive change. Um, not only are you the embodiment of that, but I'm so proud that you're part of this network. Uh, thank you all for being here. Thank you to our audience.