Specialty care in small-town America: health disparities, the impact of COVID-19, and some upsides of rural life for physicians.

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Rural communities experience significant health disparities along with the above-average prevalence of chronic conditions, and a lower-than-average ratio of providers to patients. The COVID-19 pandemic has introduced additional challenges, leading to a significantly changed environment. Orthopedic surgeons Dr. Tamara Huff (in Georgia) and Dr. Oluwasean Akimbo (in Kansas) join host Bill Finerfrock, Executive Director of the National Association of Rural Health Clinics, for a wide-ranging discussion about the state of rural health, and how living in the country has its upsides.

Bill Finerfrock: Welcome to the Movement Is Live Health Disparities Podcast. My name is Bill Finerfrock and I will be your moderator for today's discussion. We're going to be talking about small town, orthopedist and specialty care in small town America. We are familiar with shortages and access issues often as they relate to primary care, family physicians, general internal medicine and pediatrics, things of that nature but very often, it's very challenging to get specialty care and in particular, surgical specialties into smaller communities. And we are honored to have with us today, two individuals who are very, familiar with this topic. We have Dr. Tami Huff, who is an orthopedic surgeon and from Columbus, Georgia, and Dr. Oluwaseun Akinbo who is an orthopedic surgeon from Hays, Kansas, and we're going to be talking to them about some of these issues. And we're also going to be tying in health disparities and how this affects health disparities.

As I said, I'm Bill Finerfrock and I'm a member of the executive committee for Movement Is Life and I'm also the co-founder and executive director of the National Association of rural health clinics. And I'm honored to be a part of this project and our efforts to eliminate health disparities, particularly as it relates to musculoskeletal health. I want to just make a note that all the views and opinions expressed during today's conversation, are those of the participants and do not necessarily reflect those of the respective organizations or of Movement Is Life. We're recording this in early February and so, while there is a lot of good news coming out recently, about COVID, COVID vaccine and the availability of vaccines, it's clear that we have a very long way to go before we see the end of the pandemic. The number of deaths appear to be stabilizing a little bit and we've seen a dramatic drop in the number of new COVID cases since around January 10th. Some states like Alabama and Georgia have recorded the highest daily death rates since the pandemic began in recent days and in rural areas, we're seeing some impact there. It's significant, particularly due to some of the disparities that we're aware of that occur in rural communities. So, with all that, as a backdrop, I want to welcome Dr. Akinbo and Dr. Huff to our program today and talk first about some of the difficulties of trying to work in a COVID environment and some of the unique challenges that that presents to you in terms of your patients. Not only in terms of the actual surgical procedures, but preoperatively and

postoperatively and just getting patients in to see the doctor. We know that in the early spring, in the early days of the pandemic, we saw cancellation of a lot of surgical procedures. We saw as a reluctance on the part of patients to even come in to see their doctor, was that your experience throughout this pandemic? We'll start off with Dr. Huff.

Dr. Huff: Thank you so much Bill. I'm so happy to be here. I've had the distinct pleasure of serving in rural areas, both in Louisiana, Georgia, and Kansas, as well and especially with COVID, these communities are unique, each one's unique, but since COVID started we're seeing some challenges just on the most basic levels of bringing patients into the hospital because they can't have that family support. So, even, outside of COVID most patients like to come to the doctor with someone else. It's always good to have someone there as a second set of ears to understand what's going on and kind of be there to ask questions to follow up and things. That’s especially important in surgical subspecialties where we're planning for cases, there are questions and things we need to know and with COVID people can't bring their family members oftentimes into the hospital. It's even a bigger issue if it's an emergency situation and we can't have that family member there or after the surgery that family member can't be there. I think that's one of the understated complications we're seeing with COVID is just not having that family member there. Not to mention, I'm testing I know Dr. Akinbo will probably get into this too, every facility is different, but many

facilities such as my own, we have to have testing done for all elective cases. And whenever the numbers fluctuate, we cancel those elective cases which are positive for COVID.

Bill Finerfrock: Dr. Akinbo, you're in Hays, Kansas, and you've been there for a few years, can you tell us about what you saw in in Hayes with regard to your patients? They're coming into see with regard to your surgical issues, orthopedic issues, preoperatively, intraoperatively, and then postoperatively.

Dr. Akinbo: Thanks Bill, thanks for having me. So, I'm going to piggyback on what Dr. Huff has said it certainly is a different environment now, so to speak, in terms of providing care to rural America. Before I go to Hayes, I actually walked in other rural areas include South Georgia as well as in Nevada but with COVID, it kind of changed things remarkably for us. Initially, we had to cancel clinic to sort of get our bearings in terms of what our policy was going to be and we had to cancel elective cases too. Once we figured that out, we're able to bring patients back to the office for consultations and also started offering telehealth. Before COVID, we didn't actually do that here in Hays, but since COVID it has become part of what we do, initially and actually, we still do that now. Everybody gets screened, every patient coming into the office gets screened, screening questions, temperature check, we didn't do that before our COVID. The physicians,

nurses, other workers at the hospital or the specialty clinics have to do the same thing, too. Self analism done before COVID. The masking that's done nationwide is also a big thing now and a refusal to mask, essentially, is a refusal to be seen. As regards how things have changed with preop-evaluations, initially, before COVID, everything was relatively seamless. You could see a patient a few days before surgery, get all of your blood work taken care of, get that your typing screen down for the joint replacement cases before surgery. With social distancing now and still needing to have every patient tested before surgery, we tend to have that done two to three days before the actual surgical day. But then the patients have to stay at home and not leave the house for two or three days before surgery, which prevents them from being able to get some tests done specifically for joint replacements with a type and screen test to have to be done before surgery. What that ultimately results in is we have some patients that might show up late on the day of surgery, those patients ultimately might be canceled or have their surgical staff delayed. Those who show up on time, if they have the type of cross done and it shows that they have antibodies to blood, it's the same process. They either get delayed to a later time of the day or they get rescheduled to another day. Those things were not issues before COVID, also, with COVID, our emergency care has been affected. When I say emergency care, I mean things that require implants being brought in for particular reasons, an example would be hip infections, knee infections. In the past,

when we had those issues, we could get rather quick access to implants being shipped over to our hospital, as needed. Problems with getting those implants transported over courier services, we've had delays, we've had some implants or instruments lost along the way, which, by itself, has a certain delay to when you can actually do these emergency cases, at least from an orthopedic perspective. And that's another thing that wasn't really there before COVID. Our reps have stepped in, so to speak, and before COVID, we generally have reps driving three to four hours to meet another rep halfway between two different states to pick up an instrument. I'm sure it probably happened but not with the kind of frequency that happened after COVID hit, which is another thing. And in terms of postop care, that wasn't really impacted as much by COVID other than there's a more concerted effort now to have patients actually go home after surgery. That certainly was the trend before COVID hit but that's become more important now because there's only so many patients nursing homes can have. And the other thing is, those patients have to have a negative COVID test before going to nursing homes. So, if you have a hip fracture patient come in, and hip fractures typically in my hands will go to some sort of a swing by the rehab facility. The discharge is not as seamless anymore, because they need a negative test before they can go. And typically, we get a negative test just right before we know they’re good to go. Unfortunately, it's not a rapid test, because there's a short supply of those rapid tests and you typically hold them for true emergencies, or you

variably and albeit reluctantly increasing the length of stay for certain patients. As regards visitations after elective surgery, we've come all the way down to just one family member in a 24-hour period and in the past pre COVID, we didn't have a limit. At some point during COVID we had no visitors, now we have one visitor on a 24-hour period and it can sub each other out. Dad can come in the morning and then leave so mom can come in the afternoon, if Dad shows up in the morning it's dad the entire 24 hours.

Bill Finerfrock: Wow, that's got to be hard, especially for your patients that are coming from long distance because I would imagine your coverage area for both you, Dr. Huff, in Columbus and you, Dr. Akinbo, in Hayes, you are seeing patients from a fairly, relatively long distance from where you're physically located. Dr. Huff, what would you estimate is your service area in terms of how far people are coming from to come to you for surgery?

Dr. Huff: Well, currently, I'm not practicing in Columbus, but in Kansas and some of the other places that I have practiced at, on average, people are traveling anywhere from 30, 45 miles if not longer. Again, many of these areas in many areas throughout the US have a very poor transportation infrastructure to start with so, there's just no public transportation, so it's very limited. Yes, there’s Medicaid and Medicare vans but many times, they can be on that for a very long time. And just as Dr. Akinbo kind of

alluded to, getting people back into the hospital to do preop testing, and perioperative testing is very, very, challenging. And for us, just circling back to one point in particular he made about the rapid test In preoperatively we're trying to get people tested. There's definitely a shortage rapid test and people have transportation issues, so they can't come back. We are having to cancel more people because we can't get that tests back in time and we end up canceling the day of surgery the day before surgery. Many people have very limited resources to start with and it's a big deal to ask a family member of friends to take off time for surgery and then have to reschedule it one to two weeks later. So, definitely, transportation is a huge issue not only for the patient, but also for the family members that are having to bring them back.

Bill Finerfrock: Dr. Huff and Dr. Akinbo and a colleague of ours from Movement Is Life, Dr. Mary O'Connor, recently authored an article that was published in the American Academy of Orthopedic Surgeons Journal, where you highlighted some of the unique challenges facing rural orthopedist and this issue of distance, I think, is one that obviously existed prior to COVID, as you were suggesting, and is now even exacerbated as a consequence. You mentioned vans that might be available, is that something that the hospitals are doing? Is there funding for that from outside sources? How are they able to sustain those programs do you know?

Dr. Huff: I can speak for us. It's more through Medicaid, if I'm not mistaken. The resources are very, very limited and it also depends on the funding from the state as well but it's very, very limited.

Bill Finerfrock: Okay. Dr. Akinbo in your community, as Dr. Huff alluded to, she said you know 35, 40, 50-mile radius has that been your experience there in your practice in terms of how far people are coming from and seeing similar experiences in terms of the ability of individuals to get to the hospital to the clinic for preoperative, postoperative or interoperative, those same kind of transportation challenges?

Dr. Akinbo: Yes, so, our hospital is relatively speaking the tertiary center for Northwest Kansas. So, our radius is like a 200-mile radius for our patients to come in. Getting the patients in is definitely an issue, when trying to get our patients in. A lot of times, though with patients that are coming to see us for surgical interventions, they usually have family members bring them over in town but in the city, the access vans, as provided by the insurance companies, definitely fill that void but for folks coming from much longer distances away, they usually rely on family friends, if they cannot drive themselves over. What we also do for those patients is if they're coming from that kind of distance, we typically will have them come in the day before surgery and there's a voucher that they use to get discounted stay at hotels around us. We have them stay in town the night before to kind of

help make them somewhat easier for them knowing how far they have to drive to get back to us.

Bill Finerfrock: So, in terms of the follow up aspect, we've seen a lot of talk and we saw a lot of policies changed with regard to telehealth. Do you find yourselves utilizing telehealth now, more so, than you did before, particularly for follow up with patients when they've gone home? In your case, Dr. Akinbo, that could be a couple 100 miles that you're able to do telehealth or is that something that has not yet really taken hold in your area and same thing for you Dr. Huff.

Dr. Akinbo: I can start on that. So, when COVID came into town, we had to sort of shore up our telehealth resources to try to address that. I will say though, that our community is not exactly technologically savvy, so, it makes it somewhat difficult for all of our patients to use telehealth. It makes it a little difficult and challenging for them to do and some of them actually prefer just coming in. There's also a partnership with the primary care providers in the local vicinity of those patients that apart from the elective joint replacement cases where we typically prefer to see those ones afterwards, the fracture case, folks that are much older and don’t want to do a telehealth or don't want to come in, the primary care providers typically will step in and sort of provide the postop care starting with the first visit in a week. The primary care providers typically will provide that

postop care if there any issues they will have come see us. So, our telehealth numbers certainly were a lot higher, say six months ago than they are now, we'll say in this year 2021, I haven't done a single telehealth visit. Last year, it was multiple telehealth visits a day. I think that's a combination of I was figuring out a way to work with a primary care physician to kind of provide this service for postop care in the local vicinity of the patients. But I think it also has to do with the decreased numbers of COVID cases in our area to making people feel perhaps more comfortable. And the vaccination certainly is helping in that regard to make people feel more comfortable with coming back out for the postop care.

Bill Finerfrock: And speaking of vaccines, can I assume that you both have had the opportunity to be vaccinated?

Dr. Huff: Yes.

Dr. Akinbo: Yes.

Bill Finerfrock: Dr. Huff, did you want to add anything where in terms of particularly as it relates to telehealth, the acceptance of telehealth, the availability, those things?

Dr. Huff: Well, I would love to say that we were able to do telehealth but actually, we did not participate in telehealth, at all, prior to this and have not participated in it during and it has been a significant challenge. Again, many hospitals in smaller areas have significant funding constraints and in actuality some of them are just now going into EMRs. Some still use paper charts so as electronic medical records. With that in mind, the technology bar is not only a bar that needs to be jumped or a hurdle that needs to be crossed by patients, it's a hurdle that needs to be crossed by the actual healthcare system. So, in my particular case, we did not see anyone be a traditional or common telehealth models, we actually did a lot of calls. And actually one of the things that was a side effect of that is we had several people that have fractures and developed COVID and we saw significant delays in presentation for fracture. I will also say some complications postoperatively, because they couldn't get the physical therapy they needed, because of COVID. And that was both the issue of the patient, getting COVID-19, and also people who had immunocompromised family members, and they were afraid to go out or afraid to have home health come in that's one of the blessings and the curses the particular area I work in. Well, up until the last three to four months, we did not have as big of an outbreak as the rest of the area around us so we continued elective cases. Unfortunately, those outbreaks started coming on, and those people were afraid and for good reason and their outcomes were

drastically affected by the fact that we couldn't get to them postoperatively or they couldn't get into us.

Bill Finerfrock: Your area, demographically, and where you are Dr. Huff and, demographically, where you are Dr. Akinbo, are you seeing the kind of disparities that we're seeing nationwide in terms of the impact of COVID on the patients in your community in that it's having a far greater impact within the minority community, particularly, African American and Hispanic, much higher case data reporting, those types of things? Is that typical of what you're seeing in either Georgia or Kansas? I'm not sure how diverse the population is in Kansas, relative to Georgia, but certainly Dr. Huff, what are you seeing and Dr. Akinbo, what are you seeing in your community?

Dr. Huff: I'm in a fairly diverse area. Definitely the socioeconomic side of things, we're seeing a large number of people that are in service industries where they can't take that time off. Actually, one that really struck me was one of my patients who had a tumor that we needed to take out, it was a benign tumor, had to be rescheduled for some COVID reasons. We actually had staffing issues and had to keep rescheduling her and in the process of this whole thing she lost her job, and coming up on the holiday, we had to find assistance for her to have food to eat for Thanksgiving until she could heal up and go back to work. So, anecdotally, while the area is a little bit more

diverse than some other areas in the country, we definitely are seeing black and brown people hurting as well as white people hurting, as well. It's definitely a socioeconomic issue where if you are someone that's working in service industry, we're seeing a lot with people that are in grocery stores and I actually had some public safety people, as well. It's just they can't stop working and then if they stop, they lose the job and then lose the health insurance, and that becomes a whole another issue.

Dr. Akinbo: So, we're not as diverse as Georgia is and I don't think the data here was actually broken down by race. We'll just piggyback on what she said and say I agree with the fact that I live in Kansas, it seems like a lot more people that had COVID were involved in the service industry. And health care workers also, in essence, people that didn't have or don't have the opportunity to work from home and have to be exposed by nature of their jobs. But as regards diversity I can't really speak to that because we don't really keep that data and Hayes is not particularly diverse.

Bill Finerfrock: I was pretty sure that that might be the case and to the point though, that you made Dr. Huff, I mean there is clearly a socioeconomic component into that, and in some areas, there's a high correlation between the socioeconomic and racial and ethnic disparities, but if you get to rural areas, and I think this has been one of the things that's been interesting for Movement Is Life, that as we have gone into some rural

communities, we see many of the same disparities and access issues there that you see in urban communities with communities of color, the difference being that in these rural communities, it's a disproportionately are very high, Caucasian population, but they have similar socioeconomic characteristics that seem to correlate to access to care.

Dr. Huff: Absolutely and actually you brought up a great point. So, with Movement Is Life class that we talked about the vicious cycle of having heart disease have a Type II diabetes, I'm having all of these issues that go along with obesity that stop you from moving and cause more and more problems. Well, that just basically created the perfect storm for these areas. The number of patients that have medical comorbidities, under diagnosed, poorly treated type two diabetes, undiagnosed, poorly managed hypertension, peripheral vascular disease, congestive heart failure, all these comorbidities, they're exacerbated by the fact there's very limited access to specialty care, even endocrinologist and things like that to help control those more fertile diabetics, we see it. And when you pair that along with, so you have a population that isn't necessarily the healthiest that has all these medical comorbidities. Then they're working jobs where they're facing the community every day, and then, on top of that, now you bring COVID on top of them. It's a mess. I mean, we had serious while our outbreaks took longer for it to happen, now they're happening. It's a major issue and many of the facilities, so once the patients unfortunately have

COVID and that comes into the hospital, that raises an entirely different issue of when staff start getting COVID. And that is a huge issue for a smaller hospital. Three staff could shut down the clinic.

Bill Finerfrock: Yeah, I want to kind of get into some of this workforce issue that you both have alluded to it. So, Dr. Akinbo you now find yourself in Hays, Kansas, can you tell our audience a little bit about your journey? What got you to Hays, Kansas? And is there anything there that's instructive on how to get orthopedic surgeons or other specialties to some of the smaller communities where we are having shortages of physicians, not only orthopedic surgeons, but other types of specialty physicians as well.

Dr. Akinbo: When I actually finished fellowship, I practiced in New Haven. I was in New Haven for about two and a half years.

Bill Finerfrock: New Haven, Connecticut?

Dr. Akinbo: New Haven, Connecticut. After living in New Haven, Connecticut, I did locums for about a year. And I just wanted to see the country and I chose the places I went to, based on places I knew I was never going to live or practice in. So, I chose a tiny town in Nevada, Ely, Nevada. I was in Waycross, Georgia. I think I was in Salina, Kansas also and then I did Hayes too, and I liked it. I like Hays. I like the people. I like both staff. I like

the hospital. I like administration. I did it for almost a year before formally joining the staff. In terms of what's instructive there, I will say it was the relationship between the staff and the physicians that made it a facility I wanted to be at. For me, the practice I ended up in is going to affect my happiness and that's to be something that kind of gels with like the way I kind of want to live my life a little bit stress free and Hays, certainly is stress free. Everything is within a 10-minute distance and have the basic, necessities that you need. But yeah, well kind of did it for me was the relationship between admin and other physician workforce. And it's not unusual in certain places to have that relationship, not be seen less but here, we could run into our CEO in the lounge almost every day, some members of our admin staff and just kind of layout what our issues are and it definitely gets heard and a good number of times it gets acted upon and that made it an easy transition from a big city, big hospital, to a small town, a much smaller hospital.

Bill Finerfrock: But then the flipside, and I hear this, and Dr. Huff, I'd like to get your perspective but one of the things that I also hear from healthcare providers in the smaller environments is how much healthcare or advice you get asked for standing in the line at the grocery store? That, you know, for the same reasons that you're seeing the CEO, your community, your patients are seeing you out in the community while you're maybe having a cup of coffee in the morning or you're in the grocery store and some don't

particularly like that. They prefer the anonymity that can come with practicing in a larger community where they can completely divest themselves from that practice situation.

Dr. Akinbo: Yeah, I definitely prefer that anonymity initially coming from a bigger city, but it can have that at Hays. I've done a post op check in the grocery store [inaudible 31:27] come for his post op visits, and I examined his knee at the grocery store while he was pushing his grocery cart. So, you kind of get used to it and I haven't had an unpleasant encounter so far. So, it makes it seem not that bad compared to what impression I might have had of it before. I think almost every day that I go to the grocery store, I probably will run into a patient or someone I know.

Bill Finerfrock: Right, right. So, Dr. Huff, what got you to where you are in kind of your pathway? And you have similar experiences to what Dr. Akinbo was discussing.

Dr. Huff: Well, I love small towns, mostly because of the people, the patients are amazing. Like Dr. Akinbo, I've had a couple of interesting checkups in the YMCA, checking out knees, trying to workout, along the street corners and that things like that. I enjoy it because there is a need, and the people are just, amazing. You just meet some of the neatest, most amazing patients. And honestly, I love food. And my patients, typically, no matter where I

am, whether I'm practicing down at home in Louisiana and getting the best bread pudding, white chocolate, blueberry bread puddings, and all kinds of fried turkey and jerky and everything else. Down in Georgia and up in Junction City, Kansas, I have had some of the most amazing patients ever, in those areas, because they know that you don't have to be there. And they're just happy to have you, their happy to have someone that's interested in them that's interested in their town that they can run into at the grocery store or the YMCA or at your church and things like that. It's a great group of people.

Bill Finerfrock: So, you would you would encourage your colleagues to follow your path and take a look at practicing in smaller towns?

Dr. Huff: Yes, I think it's really key to broaden your horizons. So, like Dr. Akinbo I actually currently doing locum tenens. So, prior to this, I worked full time in Waycross, Georgia, in practice there for several years, and then into Columbus, Georgia, my hometown, and currently I'm traveling, but you get an opportunity to see other cultures. It's so easy to make these assumptions. I am born and raised in the South, lived in every state in every corner of the South and there are assumptions that people make of the Southeast, there are assumptions that people make of the Midwest, of up North, and any opportunity you have to break out of that mold. You'll be surprised, there are some amazing people. I know that Dr. Akinbo

wouldn’t have thought he would have fallen in love with Hays, Kansas but there are some amazing people in this country of ours and as physicians, we do need to sometimes put our assumptions to the side and see what's out there and broaden our horizons.

Bill Finerfrock: Yeah, I had similar experience. When we were talking earlier, I was mentioning my background, and I worked for about six years for a senator from Iowa. I grew up outside of Philadelphia and before I went to work for him, I had never been further west in Pittsburgh. And so, I had this image of what Iowa must be like and the first time I went there, and certainly some things prove true, obviously a lot of corn, a lot of soy beans, some of the smells were interesting because of hog confinement in a slaughterhouse but much like you were talking about the people there were just so genuine and so friendly and accepting and the word you use was appreciative. And when I talked to rural providers, you know, whether it's stocks or PAs or NPs or nurses or whoever it is, that's a common theme that you hear is that one of the things that they enjoy is they have patients who appreciate what you're doing for them in terms of trying to help them. Dr. Akinbo, I found it interesting when you were relating your locum’s experience, and I think I heard you say you chose places that you didn't think you'd want to practice in.

Dr. Akinbo: Yep.

Bill Finerfrock: And yet, you ended up in Hays and you stayed there. And so, like Dr. Huff, maybe you or you went, and it was like, hey, this wasn't at all what I expected, and you found someplace that you really liked. One of the things that we've continued to hear is supply. You guys have alluded to shortages of the quick COVID tests. Are there other things like PPE, are you still experiencing shortages of PPE or other equipment and other supplies that are impeding your ability to provide the care your patients need or have we kind of turned the corner and we were kind of at a stasis in terms of supply and demand as far as supplies are concerned?

Dr. Akinbo: So, my hospital is relatively bigger than the typical rural hospital.

Bill Finerfrock: How big is your hospital? How many beds?

Dr. Akinbo: I think it's almost 200 beds.

Bill Finerfrock: Just 200, okay.

Dr. Akinbo: Initially, we had a shortage of PPE, and we had to ration things out, but even then it wasn't as bad as it was in the northeast. I think at this point of Rich Nastasis, we don't really have the crisis or crisis level events going on anymore. Certainly, if another surge were to happen, we might be back

where we were a few months ago but I think, at this point, we're doing okay, as regards the PPEs. Certainly, the rapid test is still an issue with us here. We don't have enough to do a rapid test on every patient because if we did, we'd probably do have then patients just show up the day of surgery, as opposed to having the test done two to three days before surgery and not being able to provide them some compensation for the lost productivity that some of them will have to endure for the two to three days they have to quarantine and just sit at home until the day of their surgery.

Dr. Huff: So, Morose Risa hospital is considerably smaller, only 50 beds and, again, during the height of the pandemic in the fall, when it spiked, again, we definitely had some shortages. The larger problem for us was that we were such a small hospital, we don't have that leverage that some of the larger places have to find other vendors. If you're short on a certain type of surgical glove that you want, there's only one place that we have that contract with. We can't necessarily leverage our sides to get resources from other places. So, that was something that we ran into, but we were never anywhere to the point that they were of the shortage they were seeing in the Northeast.

Bill Finerfrock: I wanted to go back a little bit on some of the workforce issues. We talked about, from a physician perspective, I'm not sure, but I think with Dr.

Akinbo, you alluded to, or one of you about you had to cancel surgeries, not because the patient wasn't there and the surgeon, but you didn't have the other staff that would be necessary. And we tend to often, when we talk about these things, think about it in the context of physician or even PA or NP availability but we ignore the nursing staff availability, the other staff availability, whether it's maybe a medical assistant or a surgical technologist or, you know, whoever is helping you do your work. How are we doing in terms of the meeting the needs or the demand for those personnel? Do we need to focus from a public policy perspective, not just on provider, the doctor, PA, NP workforce, but the other types of health professionals, as well. What are you seeing in those areas?

Dr. Akinbo: So, we didn't really have that issue because, again, a bigger facility than most of the rural care officer. I certainly know of hospitals where a few nurses go down and that's it for the OR, knowing how the practices where an MA or a couple of MAs go out with COVID and that's the orthopedic clinic gone for the week. We were able to weather that because we have a bigger workforce, we have more staff members than most of the rural hospitals in Kansas. So, it wasn't as much an issue for us. The way it became an issue was having to sub people in like say in the OR, the typical person that does knee replacements and helps out with knee replacement is out with COVID, you have to bring somebody else to fill-in that spot. Well, the somebody else you bring in might have no experience

with doing the case you're having them sub in to do. So, that definitely happened. That was definitely an issue. And same thing applies or will apply in the office, like the MA you typically work with has COVID and so you have somebody else take a position and cover for her and the person might have never worked with you before. That's the case that results in loss of or slows down your efficiency. And so we had those problems.

Dr. Huff: My most recent hospital definitely was a smaller type of a hospital where we saw all of those problems. In a small hospital, there may only be two or three people staffing your entire clinic or one or two surgical assistants or surgical technologists there are comfortable doing a total knee, or a total hip or any of those specialty cases. So, just like Dr. Akinbo said, if one of those people goes down it shuts everything down. So, that was already a problem that we were seeing. COVID has drastically exacerbated that. We've had instances where an entire staff got COVID, and shut down the Orthopedic Clinic for two weeks. And that's an issue for patients, that's an issue for us being able to even answer the telephone. So, if you're working in a facility that's smaller, and you already have limited resources, having five employees out for COVID could definitely shut whole departments of your hospital or down. It can shut OR down. Also, too, in that same vein, a lot of these smaller facilities, contract workers when it comes to surgeons, but also ancillary staff such as respiratory anesthetists are really important parts of the team, however, those are contractors coming in. So, with

COVID, and the shortages of having people with ICU experience or ventilator experience, we have had significant problems, being able to secure anesthesia groups to cover just, basic surgical cases. So, I believe that COVID has just exacerbate the strains that are already present on these rules systems. And when you talk about policies, or how we can make things better, implementing training programs, implementing resources, so you can increase the number of people with those skills that are in the community, of course, the communities need those jobs, but we also need people with that skillset. So, having places where they can train would be an amazing asset because, again, I've worked in two hospitals recently, and it was staffing issues. We've had the beds to take care of more people, but we either didn't have the nurses, or we couldn't do the cases because we didn't have the anesthesia staff, or we didn't have a scrub techs to do it.

Bill Finerfrock: So, it's a little known, fact that I have been empowered by the authorities to designate you, each for a day as king and queen of health policy. So, I'm using my power to grant to you the opportunity to fix two things in our healthcare delivery system and you now get the opportunity to tell us, what are the two things that you would fix as the queen of healthcare or the king of healthcare? So, ladies first, Dr. Huff, as the Queen of Healthcare, what will you wave your wand and decree to get fixed?

Dr. Huff: If I could change anything, I would increase the number of healthcare providers that are involved in policy. To me, the biggest challenges that we're seeing in how we address the pandemic, or just how we relate to patients is because many people that have that power that could change things do not have any clinical experience. So, empowering, whether its physicians, whether it's other practitioners, such as nurse practitioners or physician assistant to have the business background and have the administrative background to offer solutions from the ground up. So, in design theory, in business, I'm going to steal ideas from them in my perfect world as a queen. In those other industries, many times your best ideas come from people that are doing the day to day activity. So, when they go in, IDO goes in to solve the problem of how to fix a buggy, they don't go to the CEO of the grocery store on how to fix the problem, no, they go to the poor people that are pushing these buggies around the store and having all the problems. The same things with healthcare. If I had my magical wand, the first thing I would do is make sure that people in administrative positions and public policy, spend a day in the hospital. Just spend time to see and trace patients through that whole process because I think it will open-up people's eyes and break down those silos. Because it's not because your patients being non-compliant because they can't get transportation. So, I would say opening up that opportunity to see the world from every different state and kind of reimagine how we look at

medicine in a more of a holistic terms. Secondly, I would make sure that internet access and broadband access was much more prevalent in our rural areas because the idea of telehealth is spectacular but if you have a dial-up connection, if you have 3G access, it's just the grainy bits of information. It's like watching a black and white television. So, if I could get those two things done, I would be a very happy Queen of the Universe.

Bill Finerfrock: There you go. Alright, Dr. Akinbo, you're up. You're the king now and you get to fix two things during your tenure as King of Healthcare, what would you fix or what would you do?

Dr. Akinbo: I think the overarching thing is resources. A lot of rural hospitals or rural facilities don't have the resources to say, hire more people so you can cluster them to do multiple jobs, so to speak. You won't have the resources to recruit more physicians to particular areas, or more nurses or Pas. You will have the resources to build out your OR facility or like, from an orthopedic perspective, have enough space to stock whatever your implant company might want to have stocked over there. So, I think the overarching thing is resources and if I had like the magic wand to wave, it would be unlimited resources to rural facilities, and I think that will change a lot of things. And rural facilities or rural hospitals will also end up providing a lot of jobs to those in the community. I think Hays medical centers, in terms of employees in the area, would probably have one of

the highest numbers. And if we had more resources, perhaps we could even employ more people in the community and that could bridge the socioeconomic gap with we alluded to earlier. So, with resources being overarching, my other thing will be telehealth/telemedicine, but I think you can't really have that without having increase in resources. I think its one thing to say there's sort of like a technological blind that prevents my ADL patients from being able to show up for a Zoom appointment. Well, she probably doesn't have a laptop. It might be a lot of a lot easier to like jump that technological divide and one of the ways that can be improved is with resources. You can allocate more money to developing like broadband for folks that might need providing of free broadband access for folks that my need it and that might improve the ability to provide telehealth or telemedicine services.

Dr. Huff: I have to steal in one last thing. So, my third wish, if possible, would also be investment in I would guess social services, so basically, navigators. We talk about navigators all the time, in joint replacement, things like that, but service navigators for rural areas, because all those things we're talking about with resources, with transportation, making sure you have food services, making sure that coordination appear, people are trying their best, but everything's so spread out having a central area of resource of having all these resources, but having somebody that understands

those resources and could be a guide for people to go through would be an amazing addition. So, I'll pull away my wand, now.

Bill Finerfrock: That's fine. That's fine. You know, it was interesting, Dr. Huff, you made reference to kind of getting the management kind of down at that floor level so they could see what was going on. And years ago, I had the opportunity to do some work with surgeon generals. Most people see the Public Health Service Surgeon General, but actually each of the military branches has a surgeon general as well. And this was the surgeon general of the Air Force and he was a physician and he worked two half days a week at one of the Air Force clinics in the DC area. And he wanted to keep his skills up but, more importantly, he wanted to see what was actually occurring at that clinic level. So, he would get reports from his subordinates, oh, supplies are great, communication is great, all this stuff is great, but then once he was down on the floor, it's like, “Oh, I need this.” “Oh, well, we don't have that, our supplies didn't come in.” So, he was able to see the disconnect between what he was getting in the way of reports in the aggregate, versus what was the reality at that floor level. I think that's what you're getting at, is don't rely on the reports that you're getting, but actually get down to that floor level and see for yourself, what's happening and where the gaps are and where the problems are.

Well, I just want to say thank you. On behalf of Movement Is Life, Dr. Akinbo, it's been an honor and a pleasure to get to meet you and talk with you today and for all of us to get benefit of your insight and perspective, and what it's like to be an orthopedic surgeon in a place like Hays, Kansas, and learn a little bit about your journey. Dr. Huff, you and I have known each other for a few years, but I always love the opportunity to chat and I always learn something from you, through our interactions. And you're an amazing member of the Movement Is Life steering committee, your contributions, your work on Operation Change. Thank you for what you're doing. And for both of you, on my computer here, I have the Latin phrase “anxietas de aegris,” which translated means, “worry about the patient.” And although neither of you, perhaps said that, what came through in your comments today is that everything you're doing is because you share that perspective. You worry about the patient, and I want to commend you both for that and for the work that you're doing.

Dr. Huff: Thank you so much, Bill. It's been a pleasure.

Dr. Akinbo: Thank you, Bill. It was nice for you to have us. I enjoyed the experience. Thank you.

Bill Finerfrock: Thank you, again. This is Bill Finerfrock with Movement Is Life. Thank you very much.

(End of recording)