Wendy Ellmo:

Last meeting. I said that these were gonna start coming out in September. We've pushed it back to November. We have created an infographic on brain injury, and each of the Comorbid areas that we've been discussing so far.

And that will include today for rural health. And these are available. There's a front and a back. And it goes through brain injury and the intersectionality with that system of support and some things that you can do and some resources, and these are available in English and Spanish. And again, we're just gonna. Do the full launch in November. So. I said earlier, please share these resources. The resource pages. They have been shared over 92,000 times. We know that that. That number is higher, but we don't know what it is, because we. Stumble upon where somebody has put it on a training page. Because we're we're really connected with a lot of you, and we're checking out your pages and referring people to all of you. So and we get your newsletters. So if we see something there, and you haven't told us about it.

We usually send back to you and say, Hey, how many people receive that newsletter? But please, if we've missed it. Then please let us know. And we want to be able to keep track. And that's in part for you, especially if you are a grant-based organization. We can share this information with you, and you can say, Hey, I'm part of this group. That. And we've made. This level of impact. So please let us know. Like, if you watch the video from the chronic pain one with your team, let us know how many people were there. So you can share it through email, blast and newsletters. You can have a mini conference and watch the video. Put your put a link to. Tennessee brighter futures or a specific resource pages on your website. Share via social media. Again, the goal is to be getting All of this out to our frontline providers. They're not all here on the call. They're out getting the job done, like many of us are. All of us are in different ways. And we want to get these resources to them, so that when they have someone. Who comes through their door. That. Has. Maybe another. Comorbidity and another issue that they're dealing with. They're alerted to be looking for it, and then they know what to do about it, how to screen. How to provide resources, how to get them to you. Maybe. Alright! Now on to. The main part of today. We're talking about rural health. And so this. Just to put this in context. We have been. So up until today. We've been. Talking about some of these. What I'm kind of calling a comorbidity. There's better words for that. But these main areas that tend to overlap with each other like mental health, substance, abuse. Brain injury. Domestic violence, chronic pain. And today is our first Step, into Some of the social determinants of health. How do those things impact. Our people in these other systems of support. So we're gonna be talking about that today. Next. The next meeting in November is on Racial and ethnic Minority, healthcare issues. That'll be another Social determinants of health Area.

So our presenters today are Dr. Tamara Chavez-Lindell from the lead epidemiologist, from the division of Health disparities, elimination. The Tennessee Department of Health. Alle Crampton safety net director. From the Tennessee Department of Health Office of Rural Health. Jacy Warrell, the Executive Director of the Rural Health Association of Tennessee. And then I'll come back at the end to give you an overview of the Tennessee charitable Care network. They're not able to be here today, because this is the last day of their annual conference. And you'll see the other. The groups that make up this rural health Group System of support. So without further ado, I'm going to. Just in, in. Oh, oh, yes! And a special shout out to Mindy Goff of the Office of rural health, who helped, who wasn't able to be here today, but Helped us to put this together today. So in one moment. This is our. I believe we're already recording. Okay, so I'm gonna hand it off to Dr. Tamara. Chavez Lindell, and you can take it from here.

Dr. Tamara Chavez-Lindell:

Great. Thank you, Wendy. So for future reference. Everybody just calls me Dr. T. That's a whole lot easier than going through the big, long, hyphenated double last name Have Hit people with that double barrel is quite a lot. Sometimes. So let me get my screen shared here.And we'll see if we can. If we can get this going. Alright! Come on! Does not one. There we go! Alright! So. Thank you everyone for joining us today. We really appreciate this opportunity to talk a little bit more about some of the programs that our State office of Rural Health. Administers and has available for. Practitioners, clinicians of all sorts, all across the State, and we wanted to sort of share some of those those resources, and that information with you. We do also have a whole lot of information that's available on our health disparities. Website. That has. You know, we have information about Rural health issues kind of more broadly, and health disparities very broadly across the State. We recently released our first. State, health Disparities, report. And that is available on the website as well. We didn't actually link that today to really focus on rural health issues. But so that's a talk. For another day. We can go even deeper into some of the health disparities that we see. And most of the what we most. What we see in the State really is Very dependent upon where people live. We know that geography plays a huge role. So that's definitely an area for a discussion. And we can, we can go into that a little bit more. So today I'm sitting in to kind of go over some of the issues that that Mindy Goff would have addressed. She is out on maternity leave right now, so we're excited for her. But so Alle and I are going to be picking up the pieces.

But I think we'll. I think we'll do okay. But if there are things that you'd have questions about, feel free to ask, if we can't answer them, we will get To many, and we will get back to you. Alright! So one of the programs that the State Health Department runs. Is the let's see, I can't get that to hide. Can you guys see that. Is the State Loan repayment program. Now this is known by its very unfortunate acronym of T. Slur. You know it is what it is. I didn't make it up. I would change it in a heartbeat if I could. But I'm not in charge that so. The statement longer payment program. It's a very. It's a very important program that we that we run. t provides educational payment opportunities to practitioners throughout the State. There are some very specific requirements. It has an initial 2 year service obligation. People have to be in full time or part time practice. They need to be at either an ambulatory primary care site And that will. They have to be an ambulatory non primary care site, and it has to be either a public nonprofit or private nonprofit facility. And additionally. The facility needs to be located in one of the federally designated hips or health professional areas that are across the State. Those locations are available on the Hrsa website. And you can also see. The counties that are health resource shortage areas, which is a slightly different term that we use within our program on the Tennessee Department health website as well. So if Providers are eligible. They can receive up to $50,000 for that initial 2 year service obligation. This, of course, is dependent upon getting the funds appropriated from the legislature, but so far. Fingers crossed. It has gone well, and we've been able to provide relief Of debts for a number of Qualifying practitioners. Additionally If people are enjoying that, or want to continue having some of their loan or loans repaid.They can renew their service contract, and they will get up to $20,000 for additional year. So that is really exciting program. There are a number of different specialties. Who are eligible. So Primarily, what we're focused on is ensuring that we have, as you said, primary care access in these underserved areas. So we're looking for, we're looking for positions. That's the largest group that we're looking for. But additionally we can cover dentists and midwives, nurse practitioners pharmacists r ends and then a whole range of Behavior of mental health professionals as well. There are some specific requirements for this. People who want to participate must be either Us. Citizens or us. Nationals. They have to be licensed to practice in Tennessee, currently. And they need to be working at an eligible site already, or have already accepted a position. That will begin within 30 day or 60 days when they when they submit the application, so they have to be. Either already working, or just about to. These funds can only be used to repay qualifying educational loans, and, as we said before, they have to commit to a 2 year period of service, initially working either full or part time. Of course the reimbursement amount is contingent upon the number of hours they work.

So there are also some requirements for the sites that they would practice at. As you said, they need to be ambulatory sites, either public or private nonprofits, primary care, sites. But additionally, these sites have to sign and say that they will. Support a practitioner involved in the program. They have to confirm that they provide primary care services. They have to provide proof that they are within a federally designated hipaa area. And they need to provide services to Medicaid and Medicare patients. As well as accept. And provide a sliding fee scale for any uninsured patients. So they there are really. Some limitations on those sites, but we feel that these are very reasonable. To make sure that we are extending care as broadly as possible. If anyone is interested the application will be starting up this fall. The exact date is still hanging out there a little bit. We're waiting on a few more tweaks to the application process. But that is anticipated to happen in November. So you can keep checking back the website is available there. Either the shortened website or through the QR code. The Applications will be due in early in 2025. Probably in January. And then the selection process, the review making sure that all the documentation that's necessary has been submitted. Before those contracts can be processed, and then, once that goes through that people should be able to start receiving their repayments. Sometime in mid spring.

So if you have additional questions specifically about ties. Our contact is Denise, and he is more than happy to answer lots of questions. And we can put you in contact with her. As well. Alright. So let's see the next one that we have. Is the Conrad 30 or j. 1 visa waiver program. So this is a program that occurs all across the United States. It utilizes positions. Medical graduates who come to the Us. On exchange, visitor visas. And this allows them to then participate in either work or study, based exchange programs and stay here in the in the United States. It allows them to waive some of the home residence requirements that we normally. Require individuals who have come particular visa category to go back to their country of origin before being able to reapply. And this just cuts that that wait time out. And so this is designed to address the shortage of qualified doctors in underserved areas. Eligible practitioners for this one. Our foreign physicians, who completed primary care, Residency in the Us. So meaning that they have gone through all the steps to. Have their foreign. Training. Validated here in the United States, and additionally, they need to have a medical specialty. And so they have to require, or they have to provide medical care to all underserved. Again, like we discussed before they need to have a sponsoring employer. Most of them need to average a 40 h week service at one of the qualifying healthcare facilities. Additionally, this one is not 2, but a 3 year contract that they need to have in place with their facility. They have to be eligible for medical licensure here in the state. And they need to be board eligible in there. Particular specialty. The way, the structure, the program structured. All 50 States have a version of the j. 1 visa program. That is, that's allowed. But each state kind of develops its own rules and guidance that are a little bit specific. Each State gets 30 slots per year. Of the last number of years we have filled all 30 slots, which is great news that means 30 additionally highly trained, very competent positions. In areas that might otherwise be. Underserved for these particulars. So if you have other questions about that again, we're happy to respond to them with the information that we have, or we can put you directly in contact with Anne Cranford, who is the Director for the j. 1 visa program State. All right. So that covers my part, I'm gonna pass it over to Alle to talk. But I'm going to keep advancing slides, work.

Alle Crampton:

Hi, Dr. T. Thank you very much. I am Alec Crampton. I'm the new director of the Uninsured Adult Healthcare Safety Net Program. Next slide. Please, ma'am. So the adult. The same net program is basically, in response to a lack of insurance. Across the State. It kind of tries to fill in the gap of the other programs where Tenn care Medicare Medicaid, where those might be lacking. And, as you all know, with rural health, adequate health insurance to health care services, or lack of health insurance can lead to overall poor health, outcome For individuals. So for Specifically for safety net. Right now we are trying to do a Rfp. A request for proposals or grant applications For the next round of applicants to highlight the county that don't have any safety net providers and majority of those counties happen to be rural. So that's how we are trying to assist with that issue. There. Next slide, please. This is just a graphic from our Fy. 23. Safety net annual report. The unassured population proportion. Of the United States versus Tennessee, and I think we all know here that Tennessee runs above average compared to the national average. So. We? Yes, as stated before, I work for the Tennessee Department of Health. The State Office of Rural Health, specifically, is where the safety net program is administered out of it Helps. Provide funds to providers, to see patients who are uninsured adults in Ages 19 to 64 who live in Tennessee. And that just shows that they're like. Not even a proof of residency, but that they are at a location in Tennessee, or that they do live in Tennessee. A lot of our locations. Not a lot of them. Some of our locations treat homeless individuals, and for those individuals. Residents, or the location is actually that clinic. The services that are provided Are done by Fqhcs. The Federally qualified health centers and Cfps Our community and big based clinics.

We have dental organizations, nonprofits, rural health centers, and then our project, our 5 project entities, who provide a care, coordination services. In addition to those, we also have local health departments. That provide primary care, acute care and dental care services to the Tennessee uninsured. This is a more visual representation of the funding, so. The uninsured adult healthcare safety net funds. When. We? It's appropriated or given to us by the Legislature. Every year is divided into between the Department of Health and the Department of mental health and substance abuse, and that funding is separate from us, and that goes towards behavioral health services. That. To include, but are in addition and Extra. I guess. Two normal care behavioral services, and the services that we see for our primary care providers. They can do a few behavioral health. Things. But it's primarily just The goal is to have funding for these providers. Set up. A continuity of care, if you will, that they have somebody to see at least twice a year. About funding. Oh, yeah, sorry. Go ahead, I can. I don't need to focus. So for Fy. 23 safety net was allocated 21.9 million dollars, and that's divided again into this 2 service categories that. Primary care plus Makes up Primary, Care And dental services. And then behavioral health services. And then project access is the care coordination services. And between all of those there were over 190. 1,000 unduplicated patients for Fy. 23 and almost 337,000 visits. Across the State. The primary care access site.

So Dr. T. Did a fantastic job with our map here. That shows all the different locations for our. At clinics across the State. You can see that there are definitely counties that don't have access to that. And again, as I mentioned, we are focused and trying to allow other. Our new safety net providers, our existing safety net providers to open up services in those counties. But. And all. There's 56 Local Health Department that are in 16 of those are designated as Fqhcs. And then 118 fqhcs that are non. Local health departments, and then 44 community and faith based clinics across the State. For dental care access. This is similar to the slide before this just shows numbers across the State for access to dental care for the safety net or for uninsured adults across the State. And there's 45 local health departments to offer. Dental care services, 6 of Voyager Fqhcs. And then 20 other Fqhc's. That are not local health departments. And 20 community faith based clinics. So project access is our care, coordination, or specialty care providers. There's 5 of them. They are in Memphis, Nashville, Chattanooga, Knoxville, and Johnson City or Appalachian area. They do not provide clinical health Care services, but instead coordinate patients with Access to specialty care providers, laboratory services, diagnostic services, care management of social services. But To, and this is all done through Volunteer provider. They Sign up to say that they will do a certain number of hours or Want to make ours in return for continuing education credits, so they provide the specialty care that may be a normal primary care provider could not provide.

The network of volunteers, provide services to anywhere, to 3,500 to 5,200 uninsured adult Tennesseans per month So in addition to safety net, I over, I administer 2 other programs. Smile and 65 program with interfaith dental clinic of Nashville, and then smile 180 the safety net denture program Smile on 65 is for mobile. Adults over the age of 65 to be able to get Dentures if they need them, and for them to be paid for With interfaith of Nashville, who administers that program. We they have a Correct with us We give them the money to do that they fulfill those services within the Grant contract. And then smile, 1 80 Is through the smile 1, 80 foundation that is facilitated by delta dental. And the smile 180 For safety, net providers, dental providers. And they do. Yeah. Things like restorative services or Denture program dentures and implants for that program, too, or just the safety net patients. So ages 19 to 64. Did I? Oh, I flew through that sorry about that We can flip through the annual report. Or when you guys get this. We will. I think, send you guys the slides. You guys can look through our Fy. 23. Annual report. We are in the process of putting our Fy. 24. Annual report together now. So, as Ally said, you know, we have a wide range of services that are provided, as you kind of see, and I know we went through a lot of this really quickly. We are more than happy to answer questions about any of those programs or. You know, point you in the direction of. You know how to get hooked up with those resources, how to sign up. If you want to be Either. Participate in the Tiesler program for loan repayment or participate as a provider. Or simply point your, you know, figuring out where to point your clients. If they need some of these services. With that. I think I think that covers all of what we had today. But we're happy to stay on and discuss That link.

Wendy Ellmo, Brain Links:

Thank you. Thank you very much. And thank you. For that. That kind of diagram of the safety net. Because when we were planning all of this, I said, Oh, well, our folks will know about the safety net from. Our Talk on Substance Abuse and Dr. T. and Mindy were like, No, no, that's a little bit different. So it was nice to hear this other side of it. Yeah, it's. It's 1 pot of funding from the legislature distributed between the 2, the 2 State departments. But yes. 2 different safety nets for different reasons. Yes, ma'am. Thank you. That was helpful. Anybody have any questions at this point before we switch to Jacy. Alright, so now Jacy if you'd like to share.

Jacy Warrell:

Okay, let me get my screen share here. Okay. Well, good afternoon, everyone so glad to be connected with you. I feel like I've been. Hearing about this work for a long time. We've got destiny, our membership coordinator on the call. She's been. But really glad to connect with you and share resources. Wendy. Thank you for sharing. That that slide about what members are wanting, because that's kind of how we structured. So it makes me feel a little bit more confident. Going into this. I'm Jacy. Warrell, Executive Director Rural Health Association of Tennessee. We are a nonprofit membership organization with more than 800 members across the State that includes school health coordinators. So fun. Fact, Tennessee is the only State that funds their own coordinated school health program. Other States. Are connected with Cdc. Funding and Rural Health Association was really instrumental in getting them up and running. So that's why they're a large part of our membership. Of course we've got hospitals and clinics. Minow and beret. Health providers, community based organizations. Anyone that cares about rural health can become a member of our organization.

Our mission is to lead the way to a healthy tomorrow. Throughout Tennessee we do this through partnerships, education, advocacy, and resources. Our policy priorities are member voted and inputted. So the last survey we did these are the things that rose to the top, increased provider rate reimbursement. And compensated care, reduction, Medicaid expanded, uninsured adult safety net eligibility. So really glad to hear some progress is being made there, rural health workforce development and then funding for rural communities address social drivers of health because we believe that rule leaders know best what's for their community and have really innovative ways. And ideas on how to do that. I'm just gonna really quickly run through some slides paying attention to time here. So I'll talk about some access to care in Tennessee really quickly. I've got some maps for you as well, and then cover a few of our programs. Our rural community opioid response, Tennessee community compass, which is a partnership with Tenncare, and find help, org, and some resources and events. So one of the questions I get asked a lot is, what is the definition of role, and that is pretty complicated. Tennessee has its own definition that focuses basically on if you're not in Shelby County, Davidson, Knox, and Washington. I'm guessing. That's Johnson City. Probably Rutherford as well. It's basically considered rule. We have to use a Hrsa definition. And so a lot of our statistics and data will be based on that.

But just an overview of kind of Who's where and what? In rural health, we've got actually 16 critical access now, more than 270 rural health clinics, 99 rural Fqhcs. Medicare dependent hospitals. And then we've got hospitals that are enrolled. They're just not critical access, and they use a different payment model. So. You will get copies of the slides, so you'll have access to this. But. Obviously all of Tennessee's rural communities are and health professional areas. Whether we're talking primary care or dental. This is a map of the community. Health centers across the State. So you see, the counties that are not shaded in do not have a federally qualified health center. That means that the only primary care services available in those communities are our health departments who do a great job. I've got another slide on them. And the services they provide. But we know that all of those services have different grants or different programs. So this. These communities here are when we're talking about uninsured adult safety net. These are the communities that are do not have primary care provider outside of the Health Department. Of course we do have our local and regional health departments. We've got the listing here. Some of the slides Dr. Alvarado had shared at our conference last fall, so that kind of gives you a visual of what they do across the State.

And then we've got other rural healthcare facilities that are lesser known, but just kind of wanted to show you the map for all that we talk about rural health and the challenges of access to care. We actually do have a lot of safety net providers across the State as far as the Federal Government is concerned, we do have federally designated rural health clinics. Probably less than 10 of those are nonprofit. Rural health clinics. You've got Vanderbilt and St. Thomas that are technically nonprofit. So they'll be able to apply for uninsured adult safety net funds. But we've got a lot of other providers that see medication medicare populations. They also see uninsured, but obviously their distance, and advised for doing so. But that kind of gives you in these areas the kind of base. Are your urban areas. Charitable clinics across the State. So we, our members, are charitable clinics to rural communities. Again. This slide shows the Tccn Member location, and then you'll see that again. That disparity in West Tennessee. It's no nobody's fault. It's just, there's a lot of resources in West Tennessee. So we do focus a lot of time on trying to bring Grant dollars to Tennessee and supporting providers there. And then, of course, in Middle Tennessee, I think we don't talk about it enough. Those counties down there, Wayne, Lawrence, Giles and Lincoln and Franklin are typically left off the map, no matter what we're discussing Moving into some of our resources. We do have a grant through Hrsa Federal Agency for rural community Opioid response. We've got a lot of great resources that are available and open to the public. First, st over here you can join our our core newsletter. This link, or you could go to our website, takes you to our rural health digest, which is sent twice. And then there's another option. If you're interested specifically in opioid substance, use response. There. We've also got some toolkits, a free, administering naloxone training and then be there campaign resources. So it is Recovery month. If you didn't know. Happy recovery, month. We've got a lot of free social graphics that are unbranded that you could use in your organization's social. We also Started through a contract with Tennessee Department of Health. And now it's kind of expanded. We've got a smaller contract with tent care, providing enrollment assistance across the State, so that hotline, that 8,006 number at the bottom is.

Is a number you can call if someone needs help, either renewing their same care or looking for health insurance. We do events every month. I'll point you to our calendar page in a second, so you could see what that looks like. Rural health, equity, language, inclusion. This was also developed out of a grant with Tennessee Department of Health. It is not linked on our website. So you all are kind of getting the insider knowledge of this. We've got some recordings as part of a webinar series. And then we also put our traumatic brain injury that we worked with Wendy and team on as well. So that is linked there. This toolkit is a little bit different, and that it really focuses on language. The words we say, how we say them. So it's just a little bit different lens to topics that it sounds like you all have already been talking about. Also with Tenncare and Findout org that I mentioned earlier, we're working to help connect community based organizations and nonprofits with providers, hospital systems and each other across the State. It's called a closed loop referral system. So basically, whenever we make a referral, wouldn't it be nice if we know if that person that we referred was actually taking. Care of. And this is basically a system that Tenncare is hoping to implement, that will quote unquote close, that loop. So our job is to help connect all these different partners. And we've got some trainings coming up. If you're interested in learning more about that and this tool as a caretaker. We've got regular trainings, kind of intro trainings, and advanced trainings on how to claim your programs. If you're already listed in that, or if you're not. We can help you. Add that.PS. Community compass if it you're like. Oh, my gosh! I haven't heard of that. It has not officially launched. Our contract has started, and we are working diligently to help organizations get in the platform. So we are available to help. But don't feel bad if you haven't heard of this yet, because it is still not officially launched, you can go to our website for further. Learning and professional development opportunities. You've got the event, page there also, destiny does a really great job of keeping everything up to date in our newsletters coming up is our annual conference. We will be celebrating 30 years of rural health.

In Knoxville this November. This is through a contract with the State officer. Rural health and Really great opportunity to connect with all of those different member groups. We are really unique in that You know, a lot of associations will have like one specific kind of provider type. And we really do kind of crossover. So it's a really great opportunity. There you'll see. Some things Webinars and Lunch Series advertise on our website for rural health clinics. That's because of a specific grant targeting rural health clinics because they've kind of. Been left out of the conversation in Tennessee for so long. So that's how we've got the funding. But, as you'll see here. Sometimes there are topics that are relevant to other groups. And then, right now, as part of our recovery month celebrations, we've got some webinars. Recovery and rule. We just had one this week was excellent. We heard from some people that have been in recovery. And how, being enroll can both be a support and be a challenge because of those access issues that we talk about. And then next week we'll talk about more stigma. And then, lastly, here, this is a national resource, but really great for you. If you are writing grants, if you're looking for data, Rural health info Hub is funded again, Hrsa, the Federal office of Rule Health Policy. You can go to this website and you can search topics by State Or By topic. There are toolkits. I did a search for a brain injury. And you'll see some of the things that. Come up in there. So again, it kind of gives you really good relevant data. If rule, if you're looking at that intersectionality. That. Is it sorry I flew past, and hopefully I've left you all some time for some discussion. We definitely hope that you connect with us. Please join our newsletter, and then, of course, myself or Destiny, whose information is also in the chat are always willing to connect with you.

Wendy Ellmo, Brain Links:

Thank you so much. Jacy, that was great. And I loved that. We were hearing some things for the 1st time here, so thank you for sharing. With us. Tennessee, brighter. You heard it here. Before I jump in and talk a little bit about TCCN. I had a question for all of you in rural so.In, pulling together like A picture of What are the rural healthcare issues that are out there? I heard lack of access to care. Whether that's lack of access to insurance, lack of access to like programs, maybe not even having programs around. I think probably we heard increased substance use in rural areas. That goes along. Jacy, with your grant.

Jacy:

Yeah, I would say, mental health and substance use to the top of issues our members say that they're concerned about. I think that's also reflective. In the Tennessee Department of Health Community Health Council Network. They do those community health assessments. And I'm pretty sure that that's always in their top 3 of needs as well. Great? And do we do we also see things like Increased diabetes? Or is obesity an issue in the population? Anything else like that.

Yeah, that's something I could have added in the presentation, basically, any health measure or health outcome that you're looking at. There's gonna be higher prevalence in rural communities. Because of all of the things. And so there's another presentation. I like to show that kind of shows demonstrates that our health is really impacted by our Zip code. Urban and rural communities. So education, poverty, transportation, all of those social supports can affect all of the things. Whatever statistic you're looking at, if it's the State, Tennessee is going to be higher than the rest of the States usually, and your rule communities are going to be higher than those metro communities.

Wendy Ellmo: We just had a question from Tina Fox in the chat. What about domestic Sexual violence. Would that also be

Jacy Warrell: Yeah. It is actually. And I really encourage you. If you don't mind, just drop that link to the health equity toolkit. In the chat. We did do a presentation on that as well, Tina. Unfortunately, our record didn't work. We were devastated. We do want to re-record it, but we've got some information about domestic and sexual violence as well.

Wendy: Okay. And so then, just related to all that I would say, health, education. Health, knowledge. Is going to be less and some of those areas.

Jacy Warrell:

Health literacy is typically, I mean, I think health literacy is a challenge everywhere and urban, just because our system is so complicated to navigate. I think probably even some of us on the call would, could attest to that. So yeah. But whenever you've got lack of providers, you also have lack of healthcare that can kind of talk about those preventative activities, those resources. Whenever you have less nonprofits. In a community. You're going to have less resources going out that do that. Education. And providing some tangible resources.

Wendy Ellmo:

Great. Thank you. Any anything that anybody else wants to add to that. Any issues that they see. Alright. In that case. Or just go ahead and Chime, in. I just want to share A little bit. It was already touched on about the Tennessee charitable care network like I said they weren't able to be here Today But I felt like they were important. We've we have connected with them in the past. So these I'm not gonna go into it a lot, because I Can't tell you a lot, but I want you to know that these slides are going to be available to you, that you can Look at I have in order In Who they are. Have these 2 slides with lots of information. And then what I pulled from the website that I really liked was They support, educate, and represent nonprofit organizations that provide charitable services to low income, uninsured and undeserved tendencies. And I felt like that was A good way to just pull together What it is that they do. And I think, believe, just showed this map, or one like it. That shows where they are. And it shows there's medical. There's dental, there's the combined. And there are also. Those project Access places as well. And I think the big takeaway from this for me is that their demand exceeded capacity, and I think we're hearing that all over. 80% of their patients were uninsured And for more information about TCCN. You can contact Darren Thomas. And that information will be right there. Any questions? Come, anybody.

Before I switch to the intersectionality with brain injury. Thank you for all of the links that. You all have been putting into The chat. That's really helpful. Okay. So I want to talk about the intersectionality. Just. For a couple of minutes with brain injury. So people in rural areas are actually more likely to sustain a TBI to have a traumatic brain injury. In the 1st place. They have more fatalities. After TBI, compared with urban areas. And they're more likely to have worse outcomes. They have lack less access to pre-hospital services to the high level. Trauma units that are often needed. To the neurosurgical interventions that are needed. Rapidly, very often. And less access to rehabilitation afterwards, which leads into the. The functional outcomes in rural areas are worse. They're not getting the treatment that they're needed. The rehabilitation. Additional Barriers or lack of transportation to be able to get to and from. And that's probably something that would be on that list. Overall, not just brain injury, difficulty paying for healthcare.

And then They also see denial about the seriousness. Of the injury when it comes to brain injury. So Not a big deal, so I think the education would play A role there. So some common challenges that we see after brain injury are going to be present as well. Memory, attention, speed of processing headaches. Dizzying ballot, dizziness and balance issues. Problem, solving impulse control issues, irritability, frustration, agitation. These are all very, very common. Brain injury outcomes And so it could make It harder to do things like budget, or apply for housing, pay for your rent, hold a job, maintain a property Remember your appointments. Remember to take medications. Be able to communicate your needs. What Your issues are. Be aware Even that they need services. That's a big issue with brain injury is lack of awareness. So Not even knowing that there's something needed. So best best practice is to screen for a prior history Of brain injury. If that can be happening. It sounds like these clinics are already inundated But being able to screen for a prior history of brain injury. Screen for deficits. If there is a prior history. Teach people to use accommodations. And follow up with people with brain injury need follow up More often and longer in order to get what their brain injury needs met, but then also get other needs met, because they'll forget about Taking their diabetes, medication, and taking Their blood pressure, medication and getting it renewed. And all of those things. But any before I go on actually any other, Oh, and then and then telehealth is one possibility as An option in in rural areas. I think we've talked about not always, First, but best Approach, but Might be able to so fill in some holes.

Any other thoughts about Intersectionality with Your area of support. So how, for all of the rest of you out there who work in Another area, maybe domestic violence or Have you had any issues with people from rural communities having Have you seen these issues? Have you faced them? Client per day. And Some of you may work only in urban areas. I appreciate you being here because I really feel like it's important. It was helpful for me To understand the State as a whole. To really understand all of the issues that we're all facing. And to keep in mind. You know, when we are maybe dealing with something at a state level Was everybody dealing with.

Jacy Warrell:

Wendy, I'll just add, for the sake of conversation. I don't think I said this already, but we never want to pit rule against Urban, you know, and when we're talking about. Lack of access. We know that urban communities have really challenging access issues as well when it comes to like urban providers. I know you just said. You know, there may be a lot of urban providers here. I just wanna stress the importance of our urban providers to our rural communities, since we don't have those access to resources, you know. Rule, people will be seeking care. In urban centers. We know that, especially for specialty. But I think that knowing these things that you just said about, you know the hesitancy and the education are an important cultural competence piece to be able to serve people in rural communities.

Wendy: That's a very good point. About yeah. Everybody has their own issues, right? Sometimes they're they're the same. Sometimes they're different. Then we can probably learn from each other a whole lot. Alright, so please any. At this point. Anybody. Chime, in. I just want to show you the The rural health. Resource pages. They are not necessarily done. If sometimes we'll take things that come up. From today. Things that were put in the chat. Things that were mentioned were mentioned that we hadn't found. Or hadn't been suggested to us, and we'll Them in there. So these rural health ones are 5 pages. These are, they always begin with an overview of that. Area. And then of that topic area of that day, and then the intersectionality with brain injury. And then they go into. Different screenings, Jen, do you want to go through these, or should we. Should we keep on going. We have the time. If you want to.

Jennifer Rayman:

I think it would be ideal if we had the opportunity for everybody to. Have a discussion after we finish the training part of this and I'll be, and I have them on standby if we wanna pull those up at the end.

Wendy Ellmo:

Okay, I believe We are complete. So I'll just keep on going to let you know So the resource pages are there. These are just the first 3. And okay, so we can end after this. So if You are watching this, so not anybody who's live here with me right this moment. But anybody who is watching this at a later time please take this Survey. It takes 1 min. We're gonna show this to everybody who is here in person again at the end. After our discussion will stop recording, so that people can feel free to not have the Or to be struggling with something Our next meeting Is another social determinant of health area which is racial and ethnic minority. Health. On November 7.th From one to 2:30, central, 2 to 3:30. Eastern. And we can go ahead and stop recording there.