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PHYSICIAN

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Enigma Variations

Inside health care affordability

BY BETH BEAUDIN-SEILER, PhD

Health care in the United States costs more per person than in any other high-income country, without an equivalent gain in life expectancy or population health. Health care costs are rising faster than wages, and the gap is landing squarely on household budgets. In a recent national poll, roughly one in three Americans said they had cut spending on necessities to cover health care costs.

The Consumer Healthcare Experience State Survey (CHESS), developed in 2018 by Altarum, is a state-level survey designed to capture consumer perspectives on health care affordability and system navigation. Altarum is a nonprofit mission-driven organization, founded in 1946, partnering with government agencies and communities to advance their missions and improve health for all. On a state-specific basis, CHESS identifies both objective financial measures and subjective experiences of affordability, including the worry associated with health care costs.

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Gambling Disorder

A Hidden Public Health Challenge

BY BILL STEIN

The next public health crisis may not have anything to do with a contagious disease, natural disaster or environmental threat. It may have everything to do with the behaviors of sports fans, casino patrons, video-game players and others who increasingly have gambling opportunities at their fingertips.

Gambling — in its various forms — has become deeply embedded in American culture. In 2025, commercial gaming in the United States generated a record $78.7 billion in gross gaming revenue, according to the American Gaming Association. At the same time, a 2026 Gallup survey found that 45% of U.S. adults reported participating in some form of gambling during the previous year. And gambling is no longer confined to casinos, racetracks or lottery counters. Sports betting, casino games, poker, lottery games, prediction markets, online gaming and other forms of wagering can be accessed from a smartphone or computer, often at any hour of the day. For physicians, the important question is not simply how many people gamble. It is how many patients are experiencing harm — and how many of them are never asked about it.

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Inside health care affordability

By Beth Beaudin-Seiler, PhD

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Gambling Disorder
A Hidden Public Health Challenge

By Bill Stein

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A pilot study

By Lisa Lavin

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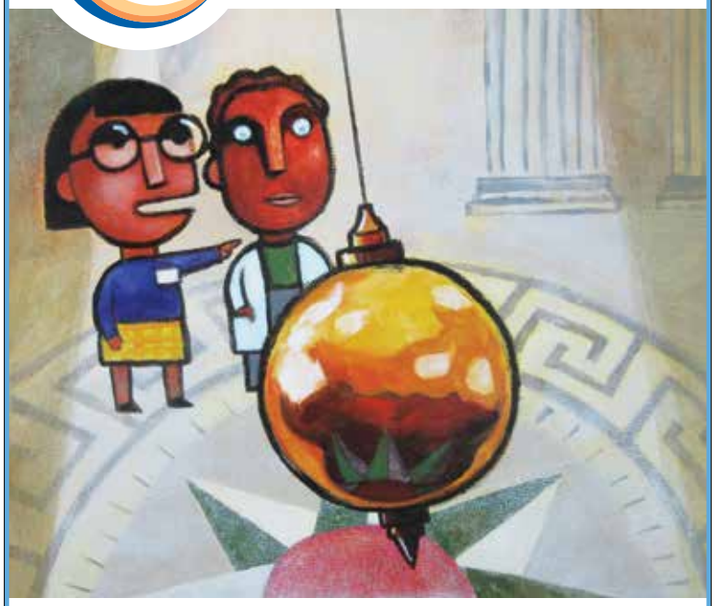
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Minnesota Health Care Roundtable 62ND SESSION

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BACKGROUND AND FOCUS:

At the heart of science is innovation. Global threats to public health, such as polio, AIDS and COVID, were successfully addressed through innovation. Advances in technology are improving outcomes across the entire spectrum of medical care with increasing speed. Unfortunately, misaligned financial drivers and shortsighted policies threaten innovation, creating health care affordability and workforce shortage crises. It is critical to make the problems these issues pose clear and work toward viable resolutions to them.

OBJECTIVES:

Our panel will cite examples of emerging innovations in medicine. They will discuss the need for improving policies that limit patient access and how this leads directly to higher costs and worse outcomes. We will define innovation in terms of how it applies to all elements of health care delivery and provide examples of how outside limitations can negatively affect the process. We will discuss what must be to ensure creating environments where innovation in medicine will thrive.

JOIN THE DISCUSSION

We invite you to participate in the conference development process. If you have questions you would like to pose to the panel or have topics you would like the panel discuss, we welcome your input.

Please email: Comments@mppub.com and put "Roundtable Question" in the subject line.

Health Partners and Essentia Announce Merger Plans

HealthPartners and Essentia Health have recently announced plans to combine their organizations. Together, the two Minnesota-based nonprofit health systems will expand access to high-quality care and coverage, strengthen specialty services, leverage technology to better serve patients and support clinicians to help make health care more affordable.

"This combination is about doing more for the people and communities who count on us," said HealthPartners president and CEO Andrea Walsh. "HealthPartners and Essentia Health share a belief that everyone deserves access to high-quality care and coverage, close to home and centered on their needs. Together, we can build on the strengths of both organizations to improve health, expand access and create a stronger future for the communities we serve."

"Our organizations share similar missions and values, deep roots in this region and a focus on improving health and well-being," said Essentia Health CEO David Herman, MD. "As a combined nonprofit health system, we will be able to better innovate and grow our workforce. That strong foundation will make us even better partners for our patients, working together to help people live their healthiest lives, wherever they call home."

Combining the strengths of each organization, the nonprofit health system will expand access to high-quality care across urban and rural communities. The new proposed organization will include 22 hospitals, more than 135 clinics and 6,000 clinicians, creating one of the region's largest nonprofit health systems and extending access to high-quality care across Minnesota and the upper Midwest.

The combined entity will strengthen local care while expanding specialty expertise. Patients will benefit from a greater depth of expertise and expanded access to specialists, advanced clinical programs, telehealth and coordinated care through strong local care teams and community relationships built over decades of partnership.

The new organization will be called HealthPartners. Andrea Walsh, will lead the new organization and David Herman will serve as president of combined clinical care group operations. No financial details of the merger were released. Pending regulatory approvals, the organizations anticipate the combination will be effective Jan. 1, 2027. Patients and members should not experience any changes or interruption to their care or coverage.

Mankato Clinic Victim of Potential Cyberattack

The Mankato Clinic recently announced that it is investigating unauthorized activity on its computer network after the Chaos ransomware group claimed to have stolen 610 gigabytes of data in mid-September. Stating that patient care remains unaffected and locations are open, the clinic has brought in legal counsel and cybersecurity experts to review the claims. The Chaos cybercriminal group listed the clinic on its dark web leak site, asserting it took data. Mankato Clinic has not verified the accuracy of the data theft claim and will notify individuals directly if personal data is confirmed to be compromised.

Chaos was first identified in 2025 and the ransomware criminal group has grown rapidly, launching double extortion attacks primarily in the U.S., with additional victims in the U.K., India and New Zealand. The group has been linked to former BlackSuit (Royal) operators based on overlapping tactics. It employs voice phishing for initial access, abuses remote management tools for persistence and uses a fast, selective encryption method to cripple networks.

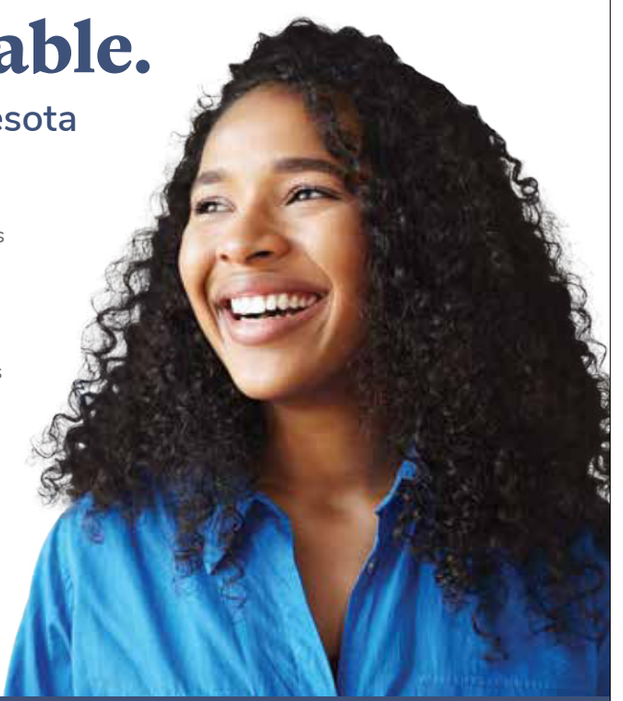
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It runs a data leak site to pressure non-paying victims, demanding ransoms up to $300,000. It relies heavily on social engineering, combining spam email floods, voice phishing (vishing) posing as IT support and tricking targets into using legitimate remote access tools like Microsoft Quick Assist.

The Clinic stated, "We understand that news of a cybersecurity incident can cause real concern, especially when it involves an organization people trust with their care and personal information. We take that responsibility seriously and are working to understand exactly what happened, what information may have been accessed and who may have been affected. We are aware that a cybercriminal group has publicly claimed it obtained data from Mankato Clinic. We have not confirmed the accuracy of that claim, including the amount or specific information the group claims to have obtained, nor have we confirmed how many people may be affected. We believe it is important to distinguish confirmed facts from unverified claims while the investigation continues. We want to reassure our patients that this incident has not impacted patient care. Our commitment to our patients remains unchanged, and our clinics continue to operate as usual while we work through this investigation."

Fairview Announces $100 Million New Central Laboratory Construction

Fairview recently announced that it was advancing plans for a new centralized laboratory facility designed to expand diagnostic capacity, support increasingly specialized testing and strengthen the laboratory infrastructure that clinicians and patients rely on throughout the care journey. A new 125,000-square-foot, $100 million laboratory is now under construction in Roseville, Minnesota, and it will unite lab services currently operating across multiple locations under one roof. The facility is expected to open in the first quarter of 2028.

The new laboratory will improve care for patients through faster, more effective diagnostics while increasing Fairview's testing capacity by nearly 2 million tests annually to meet growing clinical needs and support future diagnostic capabilities.

"Laboratory medicine touches nearly every part of health care, even though much of that work happens behind the scenes," said Jeoff Will, president and chief operating officer at Fairview. "This investment is about building the infrastructure our clinicians and communities will need as care becomes more specialized, more personalized and more connected."

The new laboratory is being designed to create more integrated workflows and reduce unnecessary movement and handoffs of specimens between locations. It will also provide space that can accommodate evolving laboratory technologies and support collaboration among Fairview's medical laboratory scientists, technicians, pathologists, operational teams, educators, cytologists, pathologist assistants, histology and other laboratory professionals.

"This gives us an opportunity to design laboratory operations around the way health care is evolving rather than around facilities and workflows built for another era," said Klint Kjeldahl, vice president of lab services at Fairview. "Bringing more of our expertise and technology together will help us support clinicians across Fairview while creating a stronger environment for the laboratory professionals who make that work possible."

Fairview is working with Hempel Real Estate on the new project. "For more than a year, our team has worked closely with Fairview to design a facility that will help their laboratory professionals work efficiently and adapt as technology and patient needs evolve," said Brandon Champeau, executive vice president of Hempel Real Estate. "We're proud to play a role in creating a space that will be a critical part of Fairview's operations for decades to come."





Mayo Launches Biomedical Database Project

The Mayo Clinic in Rochester and founding partner Thermo Fisher Scientific recently announced a new joint venture, Precure, LLC. Through one of the largest human multi-omics data-generation efforts to date, bringing together molecular data generated from one million biospecimens, the new company will create datasets integrating proteomic, genomic and longitudinal clinical data to help researchers identify early biological signals of disease and provide a foundation for new discoveries in disease biology, diagnostics and therapeutics. Advanced AI and large-scale data-analytics will be integral to identifying patterns within these complex datasets and translating them into actionable insights.

Many diseases begin developing biologically years before symptoms lead to a clinical diagnosis. By connecting molecular and clinical data over time, Precure, LLC has the potential to help researchers better understand these early changes, accelerate drug development and create new opportunities for earlier diagnosis, intervention and more personalized care across a wide range of diseases, such as cancer, cardiometabolic disease, neurological disorders and immune-mediated disease.

"At Mayo Clinic, we are committed to transforming patient care through innovation," says Gianrico Farrugia, MD, president and CEO, Mayo Clinic. "By harnessing the full potential of multi-omics data, Precure, LLC aims to help us better understand disease before symptoms appear, accelerating discoveries that can lead to earlier diagnoses, more targeted treatments and better outcomes for patients."

"Precure LLC has the potential to create a step change in how we generate and apply multi-omics data to improve human health," said Marc Casper, chairman and CEO, Thermo Fisher Scientific. "By combining Thermo Fisher's leadership in scientific technology with Mayo Clinic's leadership in clinical care, research and innovation, we can create new opportunities at unprecedented scale to detect disease earlier, accelerate drug development and enable more precise therapies."

Mayo Clinic's involvement in Precure, LLC is intended to advance its nonprofit mission. Any financial returns to Mayo Clinic will be reinvested in its mission of patient care.

St. Mary's Hospital Receives $14.5 million Expansion Funding

Essentia Health recently announced a $14.5 million investment in its St. Mary's Hospital-Superior, Wisconsin, facilities. Funding will expand access to specialty care, making it easier for patients across northwest Wisconsin to receive care closer to home. Expanded services will include clinician coverage, increased specialty outreach and surgical capacity as well as the addition of a Superior-based ambulance service. This builds on other recent expansions, including audiology, neurology, oncology, orthopedics and family medicine services. Additional near future plans will enhance pediatrics, cardiology, ophthalmology and gastroenterology services. The hospital will also increase surgical capacity by welcoming two new general surgeons aboard in October and adding advanced surgical technology, including robotic-assisted capabilities such as the da Vinci Surgical System.

"Our Wisconsin patients shouldn't have to delay their care due to travel-related barriers," said Kim Pearson, northwest Wisconsin administrator for Essentia Health. "By making more clinicians available, enhancing specialty outreach and strengthening emergency response, we can offer them more convenient options right here in Superior and across northwest Wisconsin."

The expansion coincides with the 2027 reconstruction closure of the Blatnik Bridge. "We know that the Blatnik Bridge closure will impact

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many residents in Superior, but the project shouldn't stand in the way of our community receiving timely, specialized and convenient care," said Superior, Wisconsin Mayor Jim Paine. "I'm grateful for Essentia's intentional planning and commitment to providing excellent care in Superior."

Each year, Essentia welcomes tens of thousands of patient visits from people living in Wisconsin, many of whom travel to its facilities in Duluth for services that may not be available locally. The upcoming bridge closure is expected to cause traffic disruptions, rerouting an estimated 33,000 vehicles daily. Essentia is working to bolster primary, specialty and surgical services, so Wisconsin patients can continue to receive timely care. The addition of the Superior-based ambulance service responds to this directly and will serve patients throughout northwest Wisconsin. The addition of two Essentia EMS trucks expands emergency response resources helping ensure the community has timely access to care.

Work Begins on Extensive North Dakota State Hospital Redesign

Construction of a new of North Dakota State Hospital (NDSH), just west of the existing state hospital, recently celebrated a beam signing, in which project workers, community members and future occupants write their names and well wishes on the final steel beam of a building before it is hoisted into place.

The 294,756-square-foot facility will replace the state's main 1980s building and several other aging structures that have served the state since 1885. The new facility will create a more sustainable and operationally efficient state hospital through the unity of multiple departments and specializations. Anticipating late 2027 completion, the NDSH will support more than 300 staff, with 140 beds in a future-ready, trauma-informed care environment.

The new state hospital will accommodate specialized therapeutic spaces, advanced security measures and expanded capacity to meet evolving needs. The facility also designates space for state-of-the-art psychiatric inpatient care, forensic evaluation and restoration, psychiatric rehabilitation, a geriatric psychiatric unit, and a sex offender treatment and evaluation program.

Beyond world-class care, the new state hospital will foster university partnerships and expand workforce opportunities through on-site education. The facility will include an education wing, medication room simulation, mock-patient room simulation areas, an adaptable classroom, telehealth and remote support technology and respite rooms for stress management. The overall concept gives providers and emerging health care professionals access to ongoing education, self-care and recovery — all key to staff retention and recruitment.

The NDSH project, which broke ground in August of 2025, is led by the North Dakota Department of Health & Human Services and North Dakota Office of Management & Budget, in collaboration with JLG Architects as the architect of record, architecture+ as associate architect, Mortenson as the construction manager, and Tegra Group as owner's representative.

"As both a health care architect and a mental health advocate, seeing the steel rise above the North Dakota prairie is an extraordinary moment. The new NDSH is more than a replacement for an existing hospital or a consolidation of fragmented departments. The project is a testament to the state's commitment to innovation and improved access to behavioral and mental health care," said Todd Medd, AIA, principal and health care practice studio leader with JLG Architects.

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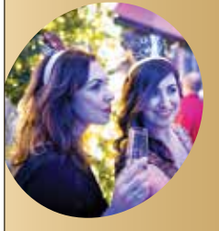
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Making Sure Geography Doesn't Determine Health Outcomes

Alan Morgan, MPA is the CEO for the National Rural Health Association

Please tell us about the mission and history of the National Rural Health Association (NRHA).

The National Rural Health Association has been advocating on behalf of rural America for nearly five decades. Our mission is simple — to improve the health and well-being of the 60 million Americans who call rural America home.

We represent rural hospitals, clinics, providers, public health professionals, researchers, educators and community leaders from across the country. If you care about rural health, there is a home for you in the NRHA.

Throughout our history, we've worked to ensure that people living in rural areas have access to high-quality, affordable health care close to home. Whether it's shaping federal policy, providing education and training or helping rural communities share innovative solutions, our goal is to make sure geography doesn't determine health outcomes.

What are some of the most important issues affecting the provision of health care in rural communities?

Among the biggest challenges facing rural health care today are workforce shortages, financial pressures on rural providers, aging infrastructure, transportation barriers and limited access to specialty care including behavioral health.

Many rural communities struggle to recruit primary care physicians, nurses, behavioral health professionals, dentists and pharmacists. At the same time, rural hospitals often operate on extremely thin margins while serving older populations with higher rates of chronic disease.

Broadband access is another significant issue, because so much of modern health care depends on digital connectivity. When a community lacks reliable internet service, it limits telehealth, remote monitoring and access to specialists.

What are some of the most creative responses to these challenges you have seen?

One of the most encouraging trends is that rural communities are creating partnerships and solutions that fit their local needs. We've seen hospitals partner with local schools to build health career pipelines beginning in high school. When maintaining a local hospital or clinic is not feasible, we've seen mobile clinics bring primary care, dental care and behavioral health services directly to underserved areas. Telehealth has expanded access to specialists who may be hundreds of miles away. Recently of course, we've seen artificial intelligence assist with clinical documentation, freeing up staff time to focus on clinical care itself.



> "America is aging, and rural America is aging even faster."

We've also seen a rise in multisector and community partnerships. Communities share resources regionally instead of each facility trying to do everything independently. That collaborative approach can be incredibly effective.

The integration of community health workers (CHWs) into primary care, remote patient monitoring (RPM), and emergency medical services (EMS) innovations have also emerged as effective strategies for extending care beyond traditional clinical settings while addressing social determinants of health. NRHA through its National Rural Age-Friendly Initiative (NRAFI) recently developed a policy brief on how integrating CHWs into primary care can advance rural age-friendly care for older adults living in rural communities.

Please tell us about the findings from the report on your recent work with the Rural Policy Research Institute (RUPRI).

Rural health care must move beyond simply preserving existing systems and instead focus on transformation. This report emphasized the importance of strengthening the workforce, modernizing facilities, expanding broadband access, integrating behavioral health services and addressing social factors that affect health such as housing, transportation and food security.

Another key takeaway from the summit is that innovation is already happening in rural communities. The challenge is scaling successful models and providing the financial and policy support needed to sustain them over the long term.

Health care workforce shortages present significant concerns to rural health. What are the best ways to solve these problems?

There certainly isn't a single solution to address rural workforce shortages. However, several approaches have proven effective in addressing the issue.

First, with more than 95% of incoming medical students coming from urban areas, we absolutely must do a better job growing our own workforce by encouraging rural students to pursue health careers and creating pathways that help them return home to practice.

Second, we need stronger loan repayment and scholarship programs that encourage providers to serve rural communities.

Third, we should expand training opportunities in rural settings because providers often choose to practice where they train.

Fourth, workforce retention programs and incentives are equally important. Greater investment is needed in retention initiatives, such as professional development opportunities and educational benefits, along with competitive incentives, including bonuses, career advancement opportunities, comprehensive health benefits, retirement plans

such as 401(k) accounts, paid time off, bonuses and other employee benefits. These efforts will be critical to recruiting, retaining and sustaining a strong rural health workforce over the long term.

Finally, technology can help extend the reach of existing providers through telehealth, virtual consultations and team-based care models. This is a great opportunity to highlight the incredible innovation that is happening in rural America today. Because of the tremendous challenges facing rural health care, we see that rural communities are serving as innovation hubs — many times on the cutting edge of innovation. Advances in artificial intelligence, combined with telehealth, are expanding the workforce and serving as models for future care.

A recent nationwide survey of rural hospitals and facilities found that 92% were in the planning process of addressing outdated facilities, however access to funding was a universal concern. What advice can you offer to help locate and coordinate funding opportunities?

The most successful organization approach typically combines multiple funding sources rather than relying on a single grant or loan program.

Federal agencies such as the Health Resources and Services Administration and the U.S. Department of Agriculture offer programs that can support facility improvements and infrastructure investments.

State offices of rural health can also be excellent partners. I would encourage rural facilities to develop a long-term capital plan, build partnerships with local governments, community organizations private organizations and non-profits and seek technical assistance early in the process. Often the biggest challenge isn't finding funding opportunities, it's coordinating them effectively.

Another significant challenge is the limited availability of experienced grant writers and the capacity to sustain funding over time. Rural organizations can address this by investing in grant-writing training for existing staff, collaborating with experienced grant writers through local and regional partnerships or consultants and, when feasible, sharing grant-development resources and grant opportunities across organizations. Building internal grant-writing capacity and developing a long-term sustainability plan from the onset can improve competitiveness for funding and help ensure that successful projects continue beyond the initial grant period.

What are your thoughts on the state of the federal government's Rural Health Transformation Program?

This is a once in a lifetime historic opportunity to develop an innovative, sustainable future for rural health care. The program represents an important recognition that rural health care requires solutions tailored to rural realities. That only occurs, however, if the program is implemented correctly, with the funds going to rural providers and communities.

What excites me most is the emphasis on innovation and flexibility. Rural communities differ tremendously from one another, so allowing local leaders to design solutions that meet their unique needs is critical. At the same time, strengthening multi-state collaborations, community partnerships and dissemination of successful state models are also key to success and sustainability. The lessons and best practices emerging from these

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Enigma Variations from cover

CHESS employs a web-based panel methodology, surveying approximately 1,500 adults (aged 18 and older) in each participating state. The survey has approximately 100 questions that deal with health insurance coverage and adequacy, health literacy, experiences with surprise medical bills and medical debt, system navigation, burden and worry related to affording care and support for policy actions. Responses are weighted using post-stratification methods to align with state demographic profiles based on U.S. Census data.

Since its launch, CHESS has been implemented in 37 states plus the District of Columbia, with 64 survey waves completed. Applications span legislative action, government reports, legal proceedings, academic research, media coverage, policy implementation and public campaigns such as prescription affordability awareness across multiple states. The survey's consistent methodology, large sample sizes, rigorous quality controls and weighting support its use as a reliable source of consumer perspectives on state-level health care affordability. In 2026, Altarum developed the CHESS National dataset by merging 64 survey waves to include nearly 20,000 respondents. The dataset documents how deeply and widely shared these burdens are across the United States while allowing findings to be compared at the individual state level.

CHESS has been deployed in Minnesota in 2019, 2021 and 2024. Altarum's 2024 CHESS of more than 1,400 Minnesota adults found that affordability burdens are widespread, care is being skipped and medications rationed, worry about the future is high across all income levels and support for government action to address costs is strong and remarkably bipartisan.

> Concern about affording health care is nearly universal in Minnesota.

Minnesota Isn't an Exception

In the CHESS National dataset, 71.2% of respondents reported at least one affordability burden in the past year — skipping or rationing care, financial strain from medical bills or going without insurance because of cost.

Skipping needed care because of cost is nearly as common, 68.8% of respondents said they had done so. The CDC attributes chronic-disease treatment failures to poor medication adherence, much of it cost-driven, and links nonadherence to worse outcomes in hypertension, diabetes and cardiovascular disease. Nearly one in five adults nationally say their health worsened because they delayed or skipped needed care. Among people with diabetes, roughly one in six reported rationing or abandoning medication to save money. Among respondents in the CHESS National dataset, 27.4% reported rationing medication in the past year because of cost.

Financial strain follows the same pattern, 38.4% reported financial burdens from health care costs, including depleted savings, difficulty covering food, housing or utilities because of medical bills and being contacted by a collection agency about medical debt. Nationally, medical debt is estimated in the tens of billions of dollars and affects tens of millions of Americans. Roughly half of U.S. adults say they could not cover an unexpected medical bill of over $500 without going into debt or being unable to pay it at all.

Worry compounds the financial reality — 77.9% of respondents reported at least one health care worry, most commonly losing coverage, health care coverage becoming unaffordable or being unable to afford care in the event of a serious illness.

Comparably, from the 2024 Minnesota CHESS, nearly two in three Minnesota adults (64%) experienced at least one health care affordability burden in the prior year. Financial fallout from that burden is common, 41% of Minnesota respondents reported at least one financial strain tied to medical bills in the past year. Examples of this include:

- 20% used up all or most of their savings
- 16% were contacted by a collection agency
- 16% could not afford basic necessities like food, heat or housing because of a medical bill
- 14% incurred large amounts of credit card debt
- 11% borrowed money or took out a loan or mortgage
- 10% were placed on a long-term payment plan

These burdens are not evenly distributed. Households that include a person with a disability were nearly twice as likely to report medical debt, depleted savings or sacrificed basic needs (60%) as households without a person with a disability (35%). Black, Indigenous and other Minnesotans of color reported this financial strain at notably higher rates (52%) than white, non-Hispanic respondents (38%). Medicaid enrollees, people already covered by a public program designed to protect against cost, reported the highest rate of financial



burden from medical bills of any insurance type (51%), essentially matching the 47% reported by people with employer or self-purchased private coverage.

Skipping or Foregoing Care and Rationing Medication

Over half of Minnesota adults delayed or went without needed health care in the past year because of cost. The most common forms include:

- 34% skipped needed dental care
- 34% delayed going to the doctor or having a procedure done
- 29% avoided going to the doctor or having a procedure altogether
- 27% cut pills in half, skipped doses or did not fill a prescription
- 27% skipped a recommended medical test or treatment
- 22% skipped needed vision services
- 20% had problems getting mental health care or addiction treatment
- 13% skipped needed hearing services or a medical assistive device

> Over half of Minnesota adults delayed or went without needed health care.

This burden concentrates sharply where cost pressure is highest. Nearly three-fourths of respondents earning less than $50,000 a year (72%) reported an affordability burden, and 65% in that income group went without care altogether, compared with roughly half of higher earners. Younger adults went without care at far higher rates than older adults — 66% of 18- to 24-year-olds and 64% of 25- to 34-year-olds, compared with 43% of 55- to 64-year-olds and just 31% of those 65 and older. Medication rationing follows the same age pattern — 36-37% of adults under 35 rationed medication due to cost, versus 9% of those 65 and older.

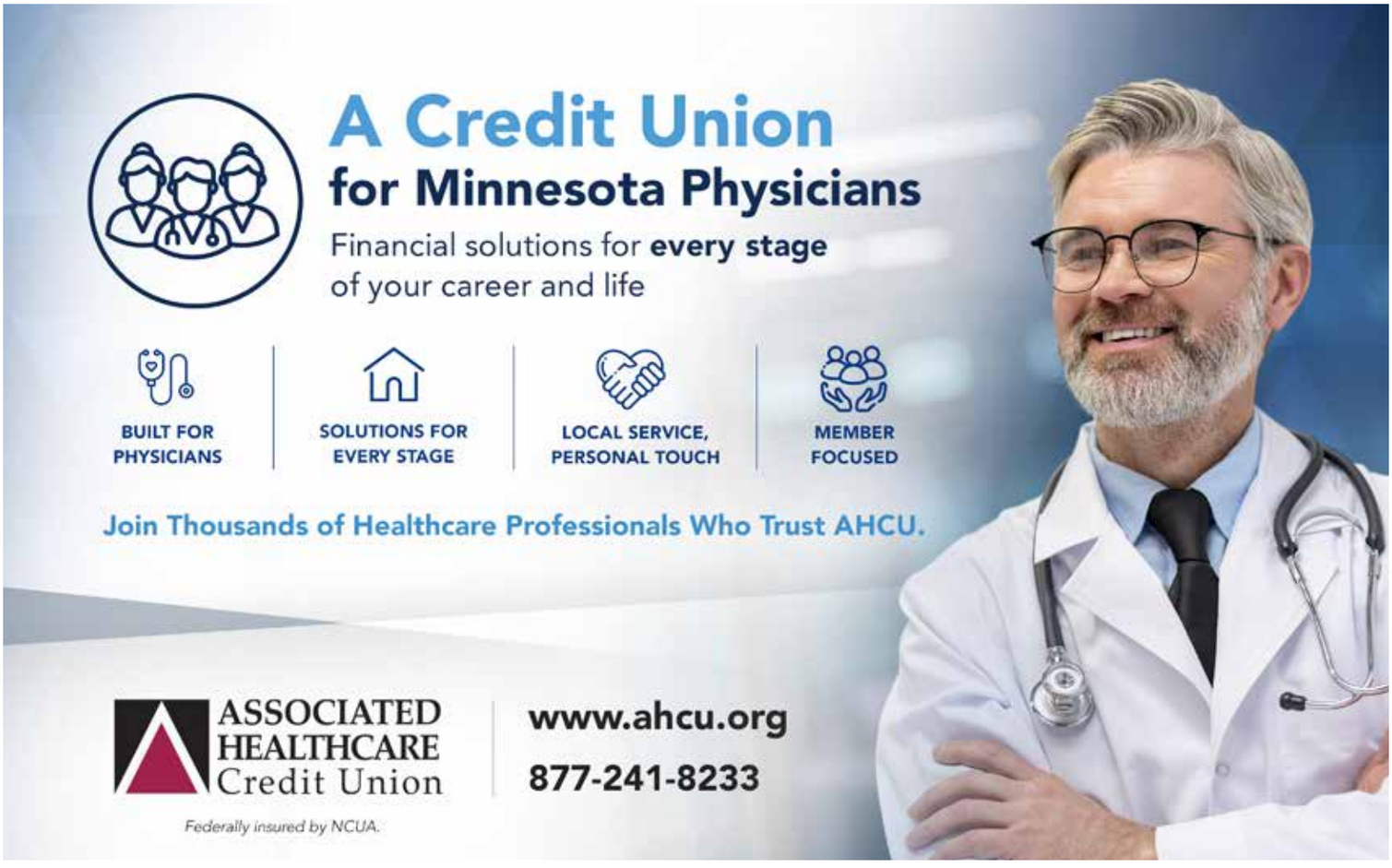
Disability status produces the widest gap anywhere in the Minnesota dataset — 74% of respondents living in a household with a person with a disability went without care due to cost, compared with 50% of those in households without a person with a disability. Similarly, 45% rationed medication, compared with 21% who did not.

Respondents with a disabled household member also reported delaying a medical assistive device such as a wheelchair, hearing aid or prosthetic limb due to cost at higher rates than households without a disabled member (31% vs. 7%).

By insurance type, Minnesota Medicaid enrollees reported the highest rate of going without care of any group (71%) and the highest rate of skipping or rationing medication (46%), despite having active coverage. Medicare, the only insurance option for most seniors and people with serious disabilities, does not fully insulate enrollees — 39% went without care due to cost in the prior year.

In their own words, Minnesota respondents described skipped surgeries, abandoned prescriptions and dental problems left untreated for years. These

Enigma Variations to page 12



◂ **Enigma Variations** from page 11

patterns recur across people with Medicaid, Medicare, employer coverage and no coverage at all.

Affordability Concerns

Concern about affording health care is nearly universal in Minnesota — 83% of respondents said they worry about affording some aspect of health care in the future, most commonly the cost of nursing home or home care (67%), medical costs in old age (65%), health insurance becoming unaffordable (65%) and the cost of care from a serious illness or accident (63%).

Worry does not track income the way skipped care does. It is not highest among the lowest earners but among middle- and upper-middle-income households — 88% of respondents earning $75,000–$100,000 and 84% of those earning more than $100,000 reported worry, compared with 79% of those earning under $50,000. Respondents ages 35 to 54 most frequently cited worry about long-term or elder care costs, suggesting many are weighing the cost of caring for aging parents alongside their own future needs.

Worry also varies sharply by insurance type and disability status. It was highest among people who buy insurance on their own (87%) and those with employer coverage (87%), somewhat lower among Medicaid enrollees (83%) and lowest among Medicare enrollees (71%), though even that "lowest" figure represents more than two in three seniors. Households with a person with a disability reported the highest worry of any subgroup (89%).

Fear of losing coverage entirely follows a different pattern than fear of unaffordability — Medicaid enrollees were most worried about losing coverage outright (48%), while people who purchase insurance on their own were most worried that it would become unaffordable even if they kept it (73%). Across every income group, insurance type and geographic region, concern about affordability exceeded concern about losing coverage. Minnesotans are less worried about coverage disappearing than about coverage becoming something they can no longer use.

Crossing Party Lines

Minnesota's dissatisfaction with the status quo is broad and bipartisan — just 35% agree "we have a great health care system in the U.S.," while 74% agree "the system needs to change," including 67% of Republicans, 78% of Democrats, and 73% of Independents.

That shared dissatisfaction translates into shared support for government action. Minnesota respondents supported several policy options that were tested by wide, cross-partisan margins. These included:

- 94% support requiring drug companies to give advance notice and justification for price increases (92% R / 96% D)
- 93% support requiring insurers to give upfront cost estimates (91% R / 95% D)
- 92% support capping out-of-pocket costs for life-saving medications like insulin (88% R / 96% D)
- 92% support expanding health insurance options so more people can afford coverage (87% R / 95% D)
- 90% support funding home and community-based services for people with disabilities (85% R / 95% D)

Even the policies with the widest partisan gap in the survey — 8 to 10 points — still command support from roughly 85% or more of Republican respondents. On health care affordability, Minnesota's political divide is far narrower than national rhetoric would suggest.

Trusting Data-driven Solutions

The data that CHESS collects does not examine its causes or speculate around potential solutions to the problems it clearly defines. It is, however, fair to say that there is no underlying single problem and that the data presents the results of a complex and imbalanced network of systems interactions that can not be solved with a single simple solution.

Minnesota's data does more than describe one state's experience, it demonstrates the reason CHESS exists. Only a state-level survey can tell Minnesota policymakers whether their residents are the ones facing the affordability burden, the skipped care, the worry and the resulting bipartisan support for state-level solutions documented above.

The Minnesota CHESS data gives state policymakers and agencies the evidence base needed to accurately assess the scope of the problem, target interventions where they are needed most and track whether policy changes are actually moving the numbers over time. As federal changes to Medicaid and ACA Marketplace coverage unfold in the coming years, that kind of direct, state-level measurement will be indispensable for understanding what is actually happening to Minnesotans and residents of every state rather than relying on national projections alone.

Beth Beaudin-Seiler, PhD, is the senior manager of the Health Economics and Policy team in the Health Research and Insights program at Altarum Institute.



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◂ **Gambling Disorder** from the cover

Gambling Disorder is a Medical Condition

Gambling disorder is a behavioral addiction recognized in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, within the category of addictive disorders. The World Health Organization (WHO) also recognizes gambling disorder in the International Classification of Diseases, 11th revision.

WHO defines the disorder in terms of three core characteristics — impaired control over gambling, increasing priority given to gambling over other activities and continuation of gambling despite negative consequences. Importantly, gambling-related harm can occur even when a person does not meet the full criteria for a clinical diagnosis.

That distinction matters in a medical setting. A patient does not have to be gambling away a retirement account or facing bankruptcy before the behavior becomes clinically relevant. Gambling disorder is sometimes called the "hidden addiction." Unlike alcohol or substance-use disorders, there may be no obvious physical signs. A person can maintain a job, appear financially secure and interact normally with family and friends while gambling privately for hours each day. With smartphones and online platforms, gambling can take place without anyone else knowing it is happening.

That secrecy is often reinforced by shame, embarrassment and denial. Patients may minimize how much they gamble or how much money they are losing. They may describe gambling as entertainment even when it has begun to interfere with sleep, relationships, work or financial stability.



Some warning signs that physicians might spot in their patients include:

- Frequently talking about gambling or thinking about the next opportunity to gamble
- Increasing the amount of money or time spent gambling
- Trying unsuccessfully to cut back or stop
- Chasing losses by returning to gamble in an attempt to win money back
- Borrowing money, selling possessions or using savings to fund gambling
- Hiding or lying about gambling activity or losses
- Experiencing irritability, anxiety or restlessness when attempting to stop
- Gambling despite problems with work, school, finances or relationships
- Using gambling as a way to escape stress, depression or other emotional problems

These signs may not appear in a traditional medical history unless someone asks.

Health vs. Financial Consequences

The financial consequences of gambling disorder can be devastating, but they are only part of the picture.

Gambling-related harm is associated with anxiety, depression, stress, sleep problems and other mental health concerns. WHO identifies financial distress, relationship breakdown, family violence, mental illness and suicide among the potential harms associated with gambling.

The consequences can ripple outward. A patient may begin missing work, school or family obligations. A spouse may discover hidden debt or depleted savings. Parents may be unable to pay household expenses. Patients may experience escalating credit-card debt, loan defaults, bankruptcy or even illegal activity to obtain money for gambling.

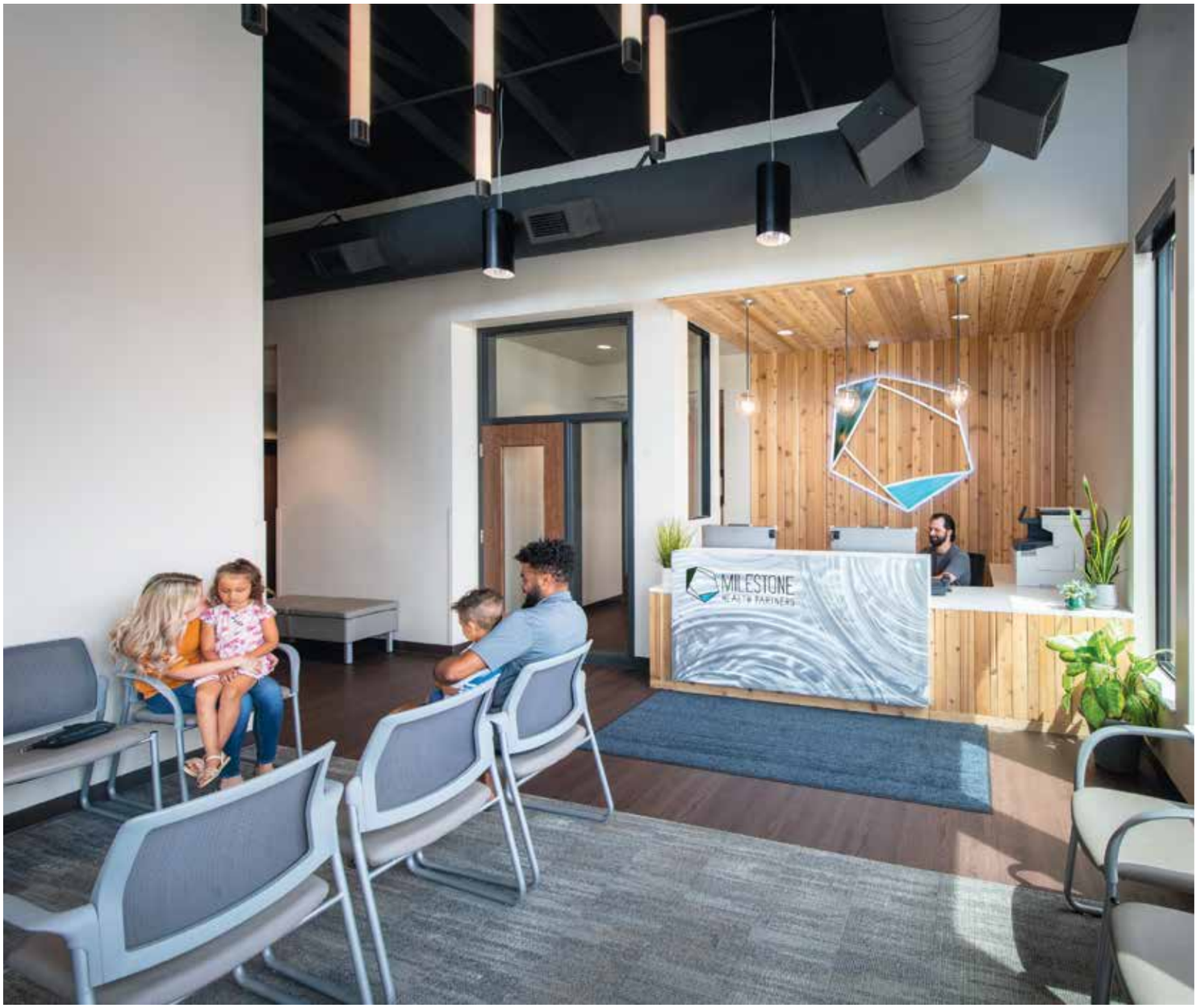
The affected population is considerably larger than the person who is gambling. WHO cites research suggesting that approximately six other people may be affected by the gambling of one person experiencing high-risk gambling. Those affected others can include spouses, children, parents, friends, coworkers and other family members. The economic cost is substantial as well. The National Council on Problem Gambling estimates the annual social cost of problem gambling in the United States at approximately $14 billion, including health care and criminal justice costs, job loss, bankruptcy and other consequences.

Biological Components

Gambling disorder should not be viewed simply as a failure of willpower. Research indicates that genetic and environmental factors both contribute to vulnerability. A large twin-study analysis found substantial genetic contributions to gambling disorder liability, with one analysis estimating genetic factors accounted for about 60% of variation in liability. A broader meta-analysis of twin studies found moderate genetic influence on gambling behavior and somewhat higher estimates for disordered gambling.

There is no single "gambling gene." Rather, researchers have identified overlap between genetic vulnerabilities associated with gambling disorder and other psychiatric and addictive conditions. Neurobiology is also relevant, with research showing involvement with the brain's reward and reinforcement

Gambling Disorder to page 16 ▸



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◂ **Gambling Disorder** from page 14

circuitry, including the mesocorticolimbic dopamine system. Dopamine appears to be involved in reward anticipation, reinforcement and sensitivity to uncertainty. Serotonergic and noradrenergic systems also appear to contribute to impulse control, arousal and other aspects of gambling behavior.

Additionally, emerging research suggests that fluctuations in ovarian hormones may influence impulsivity and compulsive behaviors during certain life stages or transitions. These changes may represent another factor that increases vulnerability to developing gambling disorder in some individuals.

Physicians should also be mindful of medications that may increase impulsive or compulsive behaviors. Recognizing these potential effects when prescribing and monitoring patients can be an important part of identifying and addressing gambling-related concerns.

> Gambling disorder is sometimes called the "hidden addiction."

The science is still evolving, but the overall message for physicians is clear: gambling disorder has biological, psychological and environmental dimensions. Treating it as merely irresponsible behavior can obscure the clinical problem and reinforce the stigma that keeps patients from seeking help.

Start by Asking Questions

Despite the prevalence of gambling, routine screening during medical exams remains uncommon. A 2026 national survey conducted by The Harris Poll for the National Council on Problem Gambling found that 65% of U.S. adults age 21 and older reported participating in at least one form of gambling before age 21. Yet only 15% of adults said they had ever been asked about their gambling behavior by a primary care provider. This represents an important, missed opportunity.

Physicians shouldn't be expected to conduct an extensive gambling assessment during every visit, but a few straightforward, nonjudgmental questions can open the door. These can include:

- During the past year, have you tried to cut down, control or stop gambling and found that you couldn't?
- Do you spend a lot of time thinking about gambling, planning future bets or figuring out how to get money to gamble?
- Do you often return after losing money to try to win it back?
- Have you hidden your gambling or lied to family members, friends or health care professionals about how much you gamble or spend?"

The way the questions are asked matters. A neutral question such as, "I ask all of my patients about behaviors that can affect health, including alcohol, tobacco, drugs and gambling. How often do you gamble?" is less likely to communicate judgment.

If a patient answers yes to one or more questions, the physician does not have to make a definitive diagnosis on the spot. The next step is to explore the behavior further, assess for associated mental health or substance-use concerns and determine whether gambling is affecting the patient's health, finances,

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- Regions Hospital (St. Paul)
- Glencoe Regional Health Services (Glencoe)
- Glenfields Living with Care (Glencoe)
- Sanford Medical Center (Thief River Falls)
- St. Luke's Hospital of Duluth (Duluth)
- Madelia Health Hospital (Madelia)
- Windom Area Health (Windom, MN)

relationships or daily functioning. This can be accomplished through a referral to a counselor or certified gambling treatment provider.

Treatment and Recovery

One of the most important messages physicians can convey is that gambling disorder is treatable. Evidence supports approaches including cognitive behavioral therapy and motivational interviewing as the most effective. Treatment should be provided by professionals with appropriate gambling-specific training. Depending on the provider's credentials and scope of practice, treatment may be delivered by certified gambling treatment counselors, licensed mental health professionals and other appropriately trained addiction professionals.

In Minnesota, state-approved gambling treatment providers offer free or low-cost services to eligible residents, and assistance is also available to family members and other people affected by someone's gambling. The Minnesota Department of Human Services supports both outpatient and inpatient treatment.

Minnesota also has a statewide, confidential Problem Gambling Helpline at 1-800-333-HOPE (4673). Treatment information and referrals are available through the helpline, and telehealth services are available through participating providers.

For people with severe gambling disorder, or those who have not been successful in less intensive settings, residential treatment is another option. Minnesota is home to one of the country's few specialized residential gambling treatment programs, Project Turnabout's Vanguard program in Granite Falls.

For physicians, a referral does not have to be complicated. Providing a patient with the helpline number or connecting the patient with a state-approved treatment provider may be an important first step.

Young People are Particularly Vulnerable

The changing gambling environment also creates a prevention challenge for physicians who care for children, adolescents and young adults. Gambling has moved from casinos and betting parlors into smartphones, social media and video games. Loot boxes, skin betting and other game mechanics can expose young people to chance-based purchasing and gambling-like experiences well before they are legally permitted to gamble.

Research has found an association between loot-box purchasing and problem gambling among adolescents. In one study of Australian adolescents, recent loot-box purchasing remained significantly associated with at-risk and problem gambling even after accounting for conventional gambling participation, age and gender. The researchers cautioned, however, that the study could not establish a causal relationship.

Young people are also developing in an environment of near-constant digital access. Gambling-related content can appear alongside sports, entertainment and social-media feeds, helping normalize wagering as another form of recreation. That makes prevention important. Parents, educators, pediatricians, family physicians and other health professionals can help young people understand that gambling is not an investment strategy and that the ability to make a bet does not mean the bet is financially safe.

A Public Health Response

Treatment is essential, but treatment alone will not address the broader problem. Gambling has become increasingly normalized through its association

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◂ **Gambling Disorder** from page 17

with professional and collegiate sports, digital entertainment and other mainstream activities. WHO has called for population-level approaches that address gambling availability, marketing, product design, stigma and regulation in addition to treatment.

There is also an important policy dimension. In 2018, the U.S. Supreme Court struck down the federal Professional and Amateur Sports Protection Act, concluding that its prohibition on state authorization of sports gambling violated the Constitution's anti-commandeering principle. The decision left states with substantial authority to determine whether and how to regulate sports betting.

Minnesota remains an unusual case. As of 2026, the state has not established a statewide commercial sports-betting market, although legislation to authorize sports betting has repeatedly been introduced. At the same time, gambling opportunities accessible to Minnesotans extend beyond state-regulated casinos and lotteries, including online and (illegal) offshore platforms.

The policy debate is ultimately a matter for legislators and regulators. From a health perspective, however, physicians have a legitimate role in ensuring that gambling-related harms are part of that conversation.

A Role Beyond the Exam Room

The most immediate opportunity for physicians may be the simplest one —ask questions. Gambling disorder is often hidden, and patients may never volunteer the information. A physician who asks a few routine, nonjudgmental questions can identify a problem that otherwise might remain invisible until it becomes a financial, psychiatric or family crisis.

Physicians can also help reduce stigma by describing gambling disorder as a health condition rather than a moral failing. They can recognize and treat co-occurring depression, anxiety, substance-use disorders and suicidal thinking, while referring patients to professionals with gambling-specific expertise.

Beyond individual patient care, physicians can contribute to prevention and public health efforts by educating colleagues, medical students, patients and families about gambling-related harm. They can participate in community partnerships and help ensure that policymakers understand the health consequences that may not be visible in economic measures of gambling activity.

Gambling itself is not inherently a disorder, and millions of people gamble without developing significant problems. But as gambling becomes more accessible, more heavily promoted and increasingly integrated into everyday life, physicians will encounter its consequences with greater frequency.

Recognizing gambling disorder as a legitimate health issue is an important first step. Asking about gambling, understanding its potential health consequences and knowing where to refer patients can make it easier to identify problems before they become crises. For physicians, addressing gambling disorder does not require becoming an expert in gambling. It requires recognizing that, like alcohol, drugs, tobacco and other behaviors that affect health, gambling belongs in the conversation between patients and their health care providers.

You can learn more about problem gambling by visiting mnapg.org.

Bill Stein, is a contract writer for The Minnesota Alliance on Problem Gambling.



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Improving Rural Health Access

A pilot study

BY LISA LAVIN

For many older adults in rural Minnesota, taking medication correctly is harder than it should be. About three in four adults 65 and older take five or more medications, and roughly half do not take them as prescribed. In small towns, the challenge is compounded by distance. Nearly 80% of rural America is designated medically underserved, and 46% of U.S. counties have at least one pharmacy desert, affecting about 15.8 million people.

When a pharmacy closes or the nearest clinic is 30 miles away, the effects add up quickly. Patients skip refills, stretch doses or delay care until a problem becomes an emergency. Emergency departments are the most expensive place to receive care, so the cost falls on patients, families, rural hospitals and payers alike. Rural residents are older on average and have higher rates of diabetes, hypertension and obesity, which means those who need consistent care the most often have the least access to it.

Managing medication is hard work. Sorting pills, remembering what to take when and tracking changes after a hospital visit can challenge even sharp, independent seniors, and vision changes, arthritis or mild memory loss make a schedule harder to follow. Caregivers are stretched, too. The ratio of caregivers to seniors is falling from about seven to one toward four to one, and rural families often live far from the people they help. Doing more of the same will not close the gap. There are not enough caregivers, and pharmacies and clinics keep closing in rural communities, so care has to be delivered differently. Technology can help bridge the gap.

A Six-month Pilot Study

The Rural Health Innovation Initiative is a six-month pilot designed to test a simple idea — bring the pharmacy and care management into the home allowing rural residents to stay healthier where they live. The study is collaboration among local leaders, researchers, a national pharmacy and a home health technology company.

The University of Minnesota Center for Healthy Aging and Innovation leads the research and will track and measure the results. Ōmcare provides in-home services through its pharmacy-integrated Ōmcare Home Health hub®. ExactCare Pharmacy, a national pharmacy partner, delivers pharmacy services through the hub. Two mayors have lent their support as community champions — Wade LeBlanc of Silver Bay and Alicia Pearson of Lanesboro.

The study is observational and retrospective. Participants are Medicare members who are 65 or older and take five or more medications a day. They live in or near Lanesboro and Silver Bay, and the initial group is about 25 people.



During the six months, each participant transfers prescriptions to ExactCare, uses the hub at home and completes four surveys. Researchers will track medication adherence, health care use, emergency department visits and hospitalizations, patient-reported health and wellness and patient satisfaction.

Making Care Easier to Reach

The goal is to show that a virtual-first care model, built on pharmacy home delivery and medication support, works in a rural setting and can be repeated in other communities. If it does, rural residents get the benefit of a nearby pharmacist and a connected caregiver without having to drive for either.

> Managing medication is hard work.

The Ōmcare Home Health Hub® is the last mile of the pharmacy in the home, meaning the final step between the pharmacy and the moment the patient actually takes a dose. Each month, ExactCare sends the participant a roll of medication pouches, pre-sorted and labeled by day and time. The roll goes into the hub, which follows a schedule synchronized with the pharmacy and dispenses the right pouch at the right time. Three cameras verify that the dose was taken, and the information flows to a caregiver dashboard so family members or care staff can see adherence at a glance and respond to missed doses.

One touch connects the participant to pharmacy staff at any hour. Another connects them by video to family, friends or caregivers. A daily check-in feature invites conversation instead of surveillance. If a participant needs more help, a caregiver can assist remotely and watch the dose taken on camera. The same audiovisual platform is also the foundation for a longer-term goal —adding telehealth services, so a patient could see a clinician or pharmacist through the hub without leaving home.

Assessing Outcomes

The university will compare adherence, emergency visits, hospitalizations and patient-reported measures over the six months. Participants will also report how satisfied they are with the service. The aim is also to learn whether the model is practical enough to expand. For patients, the benefit is less work and more confidence — no pill sorting, no trips to the pharmacy and a way to see a familiar face on screen. For caregivers, it is reach, because one person can keep an eye on more households without adding drive time. For clinics and payers, it is earlier warning when a patient falls behind, which can mean fewer avoidable emergency visits. In other settings, the same approach has produced dose-level adherence of about 98%.

Potential Obsticles

A pilot is also a way to find the problems. Several barriers to participation are already clear.

The first is trust and timing. Older adults are understandably cautious about a new device in the home and about switching pharmacies. Moving prescriptions is a real decision, and it has to be explained by someone they know, so recruitment is happening in person and through familiar community channels.

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Improving Rural Health Access from page 21

The second is insurance. Participants need Medicare with coverage for their medication, and the fall open enrollment period is a stressful time for many beneficiaries. Some are losing coverage they had counted on, and joining a study while sorting out a new plan is a lot to ask. The teams have to be clear about what the study requires, and the hub is provided at no charge, with no added fees for the pharmacy services.

The third is connectivity. The hub is designed to run on little bandwidth, but some rural homes have no home internet at all. Cellular hotspots can fill that gap, and the study is planning for the cost. National data suggests about 22% of Medicare beneficiaries also qualify for Medicaid lack internet access, so this is not a small issue.

Three in four adults 65 and older take five or more medications.

Beyond participation, the larger challenge is building a model that works at scale. A pilot of about 25 people can succeed because the team knows every participant. A model for thousands of rural residents has to work without that level of attention. That means a pharmacy partner that can serve patients across many states, a technology platform that integrates with the pharmacy's systems, recruitment methods that can be repeated and a payment approach that makes the service sustainable.

Early Findings

The study is still young, and the results are not in. The first weeks, however, have already shown what matters to participants and communities. The video screen is where the hub is most visibly different from a conventional pill organizer. One touch connects a participant to a family member, a friend or a caregiver, and the large, bright display makes faces easy to see. The same screen shows the schedule, so the participant can see at a glance what to take and when.

The study would not be moving without local people. The mayors of Silver Bay and Lanesboro have championed the project. Home-delivered meal volunteers have carried study fliers to older neighbors. A local pharmacy and a veterans home have posted information. A community radio interview is scheduled for after the election.

Community members have also made clear where the work is hardest. Recruiting is slower than expected where insurance changes are underway, and it takes repeat visits to explain the study to some residents. The research team has responded with home visits, plain-language materials and a willingness to talk through insurance questions before anyone signs up.

From Pilot to Practice

If the pilot shows that a pharmacy-connected device in the home improves adherence and reduces avoidable emergency visits, the model could extend well beyond Silver Bay and Lanesboro. Rural residents everywhere face the same pharmacy deserts, the same stretched caregivers and the same difficulty

Improving Rural Health Access to page 24





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following a medication schedule. Our vision goes a step further. Because the hub already connects patients by video, we plan to add telehealth services through that audiovisual platform, so the device that delivers medication can also bring a visit with a clinician into the home.

Health and Cost

Better adherence is the first benefit, and better health follows. When people take the right medication at the right time, chronic conditions are easier to control and complications are less likely. Fewer emergency visits and hospitalizations mean fewer disruptions for patients and families, and lower costs for the system. In value-based care programs, estimates suggest that every dollar spent on adherence can save $3 to $10 in avoidable care. Whether that holds in rural Minnesota is exactly what the study will help answer.

> "The mayors of Silver Bay and Lanesboro have championed the project."

There are also gains that are harder to measure. Older adults who stay in their own homes longer keep their independence and their connections to the community. Caregivers can use their limited time more effectively.

Defining Success

Success will depend on several groups. Health systems and clinics must be willing to refer patients and use adherence data in care planning, and as telehealth is added, to see patients through the hub. Someone has to pay for the technology and the services that go with it, including the hub, the pharmacy services, the remote monitoring and eventually telehealth. Payers, health systems and employers need to see the results and decide whether to fund the service, whether as a covered benefit or a value-based arrangement that shares the savings from fewer emergency visits and hospitalizations. Pharmacy partners must be able to deliver pouch-packaged medication to rural homes reliably. Local governments, senior services and community organizations need to help residents learn about the option and trust it. Researchers will need to keep asking hard questions about what works and for whom.

How You Can Help

Physicians have a particular role. If you care for older adults in rural Minnesota who take five or more medications, tell them about the study and encourage them to call the University of Minnesota at 612-626-4816, email HealthStudy@umn.edu or visit redcap.link/ruralhealth. If you lead a clinic, health system or plan and want to understand how this model could fit your patients, we would welcome a conversation. One pilot will not fix rural health, but a well-studied one can show others the way.

Lisa Lavin is the founder & CEO, Ōmcare.

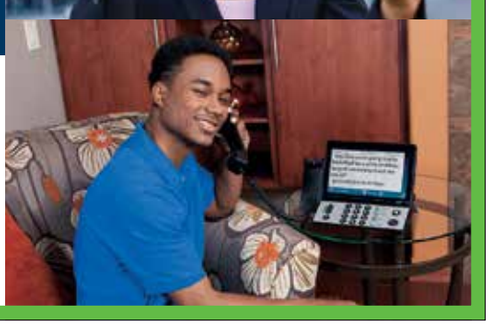
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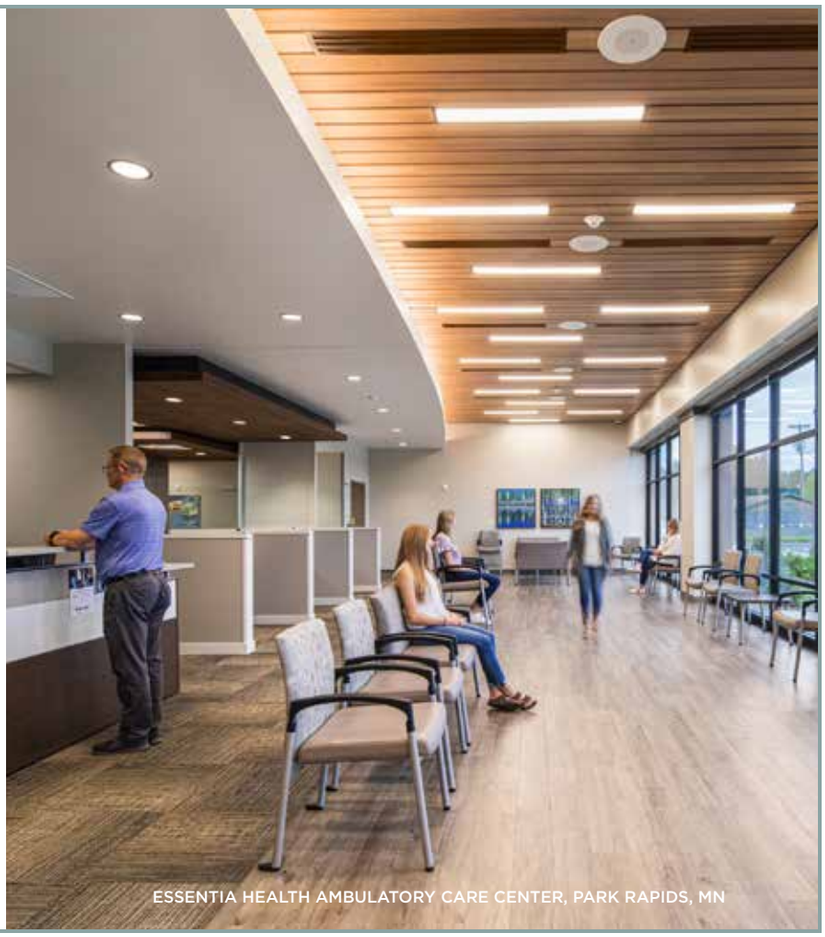
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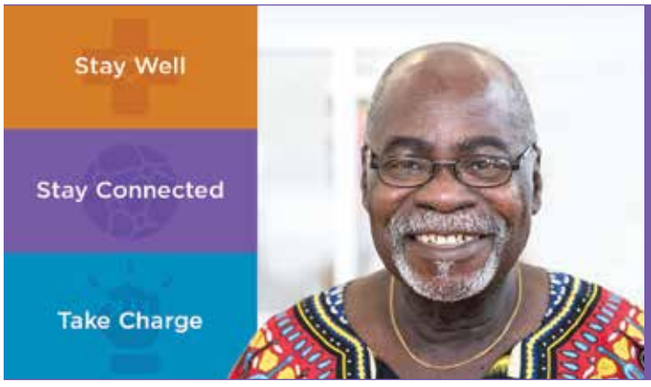
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Making Sure Geography Doesn't Determine Health Outcomes from page 9

efforts can help inform and strengthen rural health policy nationally.

Moving forward, success will depend on sustained investment, strong accountability measures, clearly defined performance measures and ensuring that communities of all sizes have the capacity to participate.

What are some innovative programs that individual states and legislatures have enacted to address the challenges facing rural health?

States have become laboratories for innovation. Many states have expanded loan repayment programs for rural providers. Others have supported rural residency programs to train physicians locally. Some have invested heavily in broadband expansion to support telehealth.

We've also seen innovative approaches to behavioral health integration, community paramedicine programs and regional partnerships that allow multiple rural facilities to share resources and expertise. There has also been significant growth in rural age-friendly initiatives including, remote patient monitoring, telehealth, dementia and memory care, direct care workforce development, PACE site expansion and Area Agency on Aging (AAA) partnerships to extend care coordination reach into rural communities.

> "Rural health care isn't just about treating illness — it's about sustaining communities."

The common thread is that successful programs recognize that rural communities often need flexibility rather than one-size-fits-all solutions.

Can you project the affects slated changes to Medicaid redetermination in 2027 will have on rural access to care?

While it will vary across states, this is going to have a substantial adverse impact to rural health nationally. Rural populations simply have a higher percentage of individuals with high health needs, and the inability to pay for that care. Any significant changes to Medicaid eligibility or enrollment processes can have major consequences for rural communities because Medicaid is such an important source of coverage in many rural areas.

If eligible individuals lose coverage due to administrative barriers or confusion about the renewal process, we could see increases in uncompensated care, delays in treatment and additional financial strain on rural hospitals and clinics. At the end of the day, rural facilities will close as a result of Medicaid funding reductions.

One of your recent projects is the National Rural Age-Friendly Initiative. What can you share with us about this?

America is aging, and rural America is aging even faster.

Our National Rural Age-Friendly Initiative focuses on helping rural communities become better places to grow older. That means looking

Making Sure Geography Doesn't Determine Health Outcomes to page 30

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Making Sure Geography Doesn't Determine Health Outcomes from page 28

beyond health care alone and considering transportation, housing, social connections, caregiver support and community services.

The goal of our initiative is to help rural communities create environments where older adults can remain healthy, engaged and independent for as long as possible.

The initiative, supported by the John A. Hartford Foundation, is helping integrate Age-Friendly Health Systems' (AFHS) 4Ms Framework (What Matters, Medication, Mentation and Mobility) into rural health care to improve the quality of care for rural older adults. Through this AFHS work, the initiative is strengthening the rural workforce by training CHWs to deliver rural age-friendly care and connect older adults with essential community resources.

The initiative extends its activities beyond the AFHS work by partnering with organizations across the age-friendly ecosystem to advance multisector collaboration and coordinated systems-level programs/initiatives/approaches to healthy rural aging.

This work benefits everyone because age-friendly communities tend to be stronger communities overall.

Another project is your Rural Oral Health Initiative. What is the impetus behind that collaboration?

Oral health is often overlooked, but it is a critical part of overall health. While I understand oral health impacts both urban and rural residents, the impact is most acutely felt in rural communities.

Many rural communities face shortages of dental professionals and limited access to preventive dental care. Poor oral health can contribute to other health problems, including heart disease, diabetes complications and adverse pregnancy outcomes.

The Rural Oral Health Initiative brings together partners from across the health care system to identify practical solutions that improve access, expand workforce capacity and integrate oral health more effectively into primary care.

What advice do you have for all of those who are working in rural health care?

First and foremost, I am greatly appreciative of all who work in rural health. Rural health professionals are some of the most dedicated people you'll ever meet. They wear many hats, solve problems creatively and often serve communities where everyone knows them by name.

My advice is to continue building partnerships, embrace innovation while keeping patients at the center of every decision and remember that your work matters. Rural health care isn't just about treating illness — it's about sustaining communities.

The challenges are real, but so is the resilience of rural America. Every day, I see people finding new ways to improve care and strengthen the communities they serve. That gives me tremendous optimism about the future of rural health.

Alan Morgan, MPA is the CEO for the National Rural Health Association.



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DEPARTMENT OF HEALTH

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