We're in this *together* aren't we...?

A SPECIAL REPORT ON HEALTHCARE IN RURAL AMERICA BEFORE, DURING AND POST THE COVID-19 CRISIS

And how the Grange, America's rural fraternity, is responding in this time of need

The COVID-19 crisis is exposing the best and worst in humanity. For rural Americans, it's also a chilling wake-up call about the state of healthcare in our communities and a gap that must be closed as part of the rebuilding that will come when the virus is at bay.

‘Exploding in our hands as we speak’

A look at rural health before, during and after COVID-19

By Amanda Brozana Rios

National Grange Communications & Development Director

The COVID-19 crisis has ripped the mask from our eyes and put on full display many areas of concern for the U.S. economy, worker and family. One issue that has reemerged, as a major crisis point for Americans, is the healthcare system – especially concerns with rural care.

The flaws in the system are not new. Since long before the outbreak, the national conversation has focused on healthcare – the top issue for voters – with Medicare for All, Medicaid expansion, and the Affordable Care Act a consistent part of the national dialogue.

But this crisis has done something more – it has brought the stark realities of everyday rural health disparities and the nearly decade-long trend of rural hospital closures front of mind for many who were blissfully unaware or happy to overlook the issues.

This article is being written early in the battle against COVID-19, and by the time readers finish it, there will undoubtedly be new layers to the challenge we are facing. However, some of the underlying issues faced by rural Americans will persist, and may worsen. One thing is clear: as every part of the healthcare system sticks their hand in the pots of stimulus and recovery funds that will be made available, rural healthcare entities must come away with at least their fair share, or risk losing entirely the financial capacity to exist entirely.

Where we started

Access

Let’s first examine the rural health landscape in early 2020, prior to the COVID-19 pandemic.

The CDC has for many years acknowledged that “rural Americans face numerous health disparities compared with their urban counterparts.”

According to a 2017 Kaiser Family Foundation study, rural Americans face significant barriers to accessing care, including provider shortages, less early intervention and preventative care, recent closure of rural hospitals and long travel distances to providers. While about 20% of the U.S. lives in rural areas, only 11% of physicians practice in these areas. Rural Americans on average are older and sicker with higher rates of chronic disease, according to the National Rural Health Association.

Additionally, rural Americans tend to be less physically active, have higher risk of unemployment and more frequently partake in high-risk behaviors such as traveling without seat belts or long-term activities with negative health outcomes, such as smoking.

“We may never make rural America as healthy because of factors out of our control, such as the types of jobs done in rural communities that put people at higher risk for workplace injury, including farming, or the inability to provide competitive salaries and excellent research opportunities for specialists stationed in more remote healthcare facilities,” Dr. Erick Bourassa, professor of medicine at Mississippi College said. “We can see some improvement, though, if rural individuals limit their risks and be conscious to live a more healthy lifestyle.”

The overwhelming disparity between the number of providers per capita in rural areas (13.2 per 10,000 people) versus urban areas (31.2 per 10,000) is startling and shows just how unstable even the basic infrastructure of the rural health system is today.

According to research by Xcenda, a healthcare consultancy focused on health outcomes and reimbursement, this shortage forces rural providers “to prioritize cases and patients given limited resources and time in the day to treat patients.”

It feels as if a preventable death in a rural community would be the catalyst of a plot for a prime-time legal drama featuring attorneys seeking to right the wrongs of a broken system.

Bourassa said some specialists that rural individuals struggle to access are actually those in common areas – like OB/GYNs and mental health professionals.

“In the medical community, we know it’s not uncommon for some patients coming from rural areas to have to travel more than two hours to see doctors that the medical community recommends they see for annual or semi-annual preventive services or checkups.”

For those that follow the guidelines, seeing a primary care physician, dentist and gynecologist as best practice recommends, this could mean taking several days off of work each year and spending hundreds of dollars in travel cost by personal vehicle or other transportation.

“It definitely adds up in ways urban people – who often can leave their office building for a long lunch hour, walk a few blocks to a doctor and have a dental appointment or physical – would not see,” Bourassa said

This means many rural physicians provide a much wider scope of services to their patients” than their urban counterparts, Xcenda research shows, noting that “it is not uncommon for primary care physicians in rural areas to act as their patients’ rheumatologists, cardiologists, or obstetricians.”

For those facing sudden health crises like stroke or trauma, the reality is rural citizens will face greater than average medical response time and lengthy travel to sites of care.

Affordability & Insurance

In rural America, the struggle to afford healthcare is its own problem.

Despite a decade that saw the uninsured number dramatically decrease and a rising hope among many that the days of such

disparities among rural and urban Americans were coming to an end.

In an NPR report, Robert J. Blendon, co-Director of the survey and professor of health policy and political analysis at the Harvard T.H. Chan School of Public Health, said of the period after the Affordable Care Act was passed and many states expanded Medicaid eligibility, "At a time when we thought we had made major progress in reducing barriers to needed health care, the fact that one in four still face these barriers is an issue of national concern. Either it is still not affordable for them or the insurance they have doesn't work — or they can't get care from the health providers that are in their community."

A 2019 poll conducted as a joint venture between NPR, the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health, provides a stark picture: more than a quarter of rural respondents said they could not get health care at some point in the last few years when they needed it, citing the cost, distance, lack of appointments at times they could make work and inability to find a provider who would take their insurance.

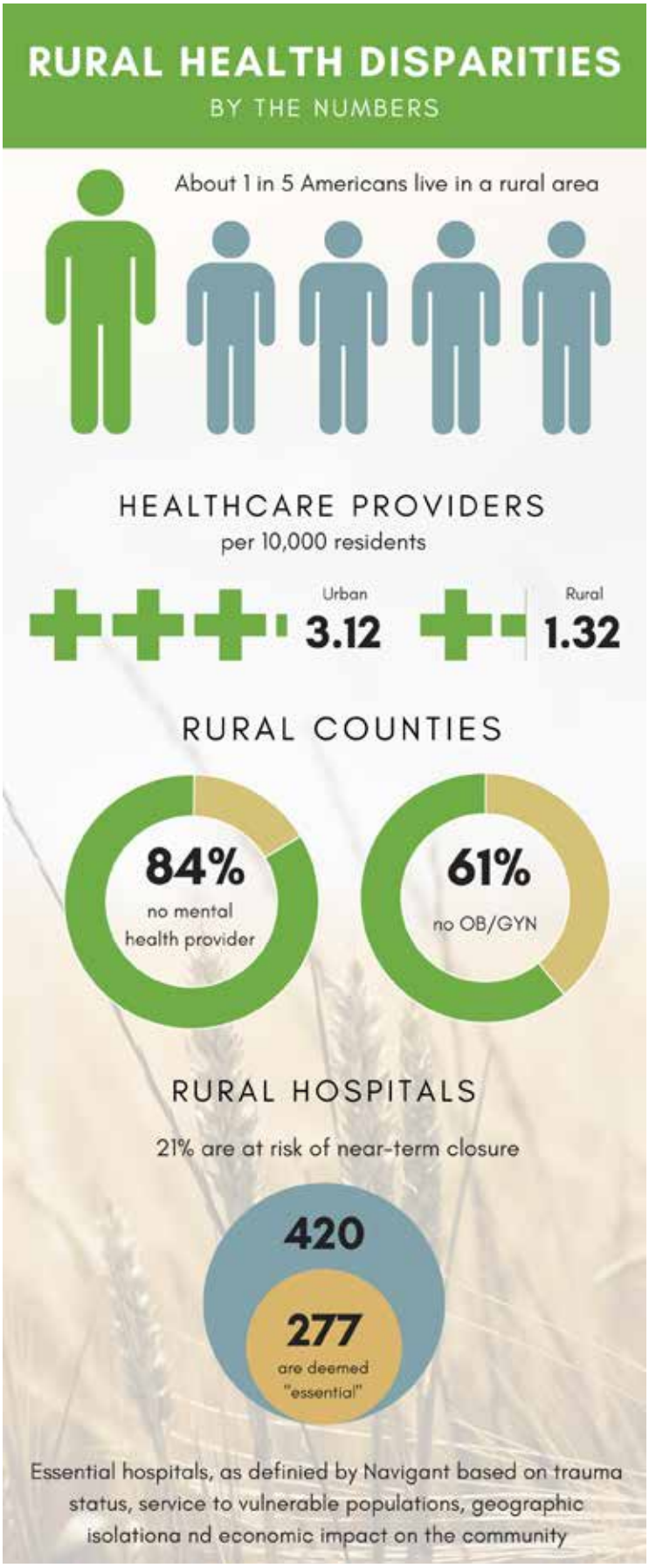
Rural Americans also tend to be less affluent than their urban and suburban counterparts and less likely to be employed – often because of higher retirement or disability rates and greater seasonal employment than found in urban areas. But job shortages and mechanization or outsourcing of jobs without replacement also have led to higher rates of unemployment, significant in relation to healthcare because most Americans get their insurance through their employer. Rural employers, often small businesses, are less likely to offer coverage, according to a 2018 study published by the Rural Policy Research Institute. The coverage that is made available to rural employees tends to offer minimal benefits and/or higher than average out-of-pocket costs.

As a result, more rural individuals have no or minimum health insurance coverage, a factor that makes them significantly less likely to seek preventative care and be seen only after health issues have become more severe.

An unplanned $1,000 medical bill, for example, could derail an individual or family in rural America, or so was the response by more than 40% of respondents to a 2019 NPR/RWJF/Harvard poll.

Unfortunately, health insurance coverage is not the only barrier to care. Only 24% of rural residents with insurance, responded that they received necessary care – inhibited by distance to the provider, availability of appointments at certain times, transportation to specialists or doctors, money to cover co-pays and other fees related to service, including child-care, availability of provider who takes their insurance among other reasons.

More than 10% of rural individuals are veterans versus less than 8% of urban individuals, allowing them to access Veterans Affairs (VA) health benefits, in which about 57% are enrolled, according to the Department's website,



versus 37% of urban veterans. However, the distance many must travel for care is a barrier to access. According to a 2019 VA info sheet, veterans may travel up to 12 hours for procedures – even minimally invasive depending upon services offered at their Community-Based Outpatient Clinics (CBOCs) – that must be done at medical centers rather than clinics. Some of those procedures include laser removal of skin lesions, colonoscopies, some fairly common preventative gynecological procedures, even the removal of an ingrown toenails. Elderly veterans often use a combination of care strategies, seeking out VA medical services for some services and utilizing Medicare benefits at non-VA facilities for primary care and emergency care thanks to the VA MISSION Act signed in 2018.

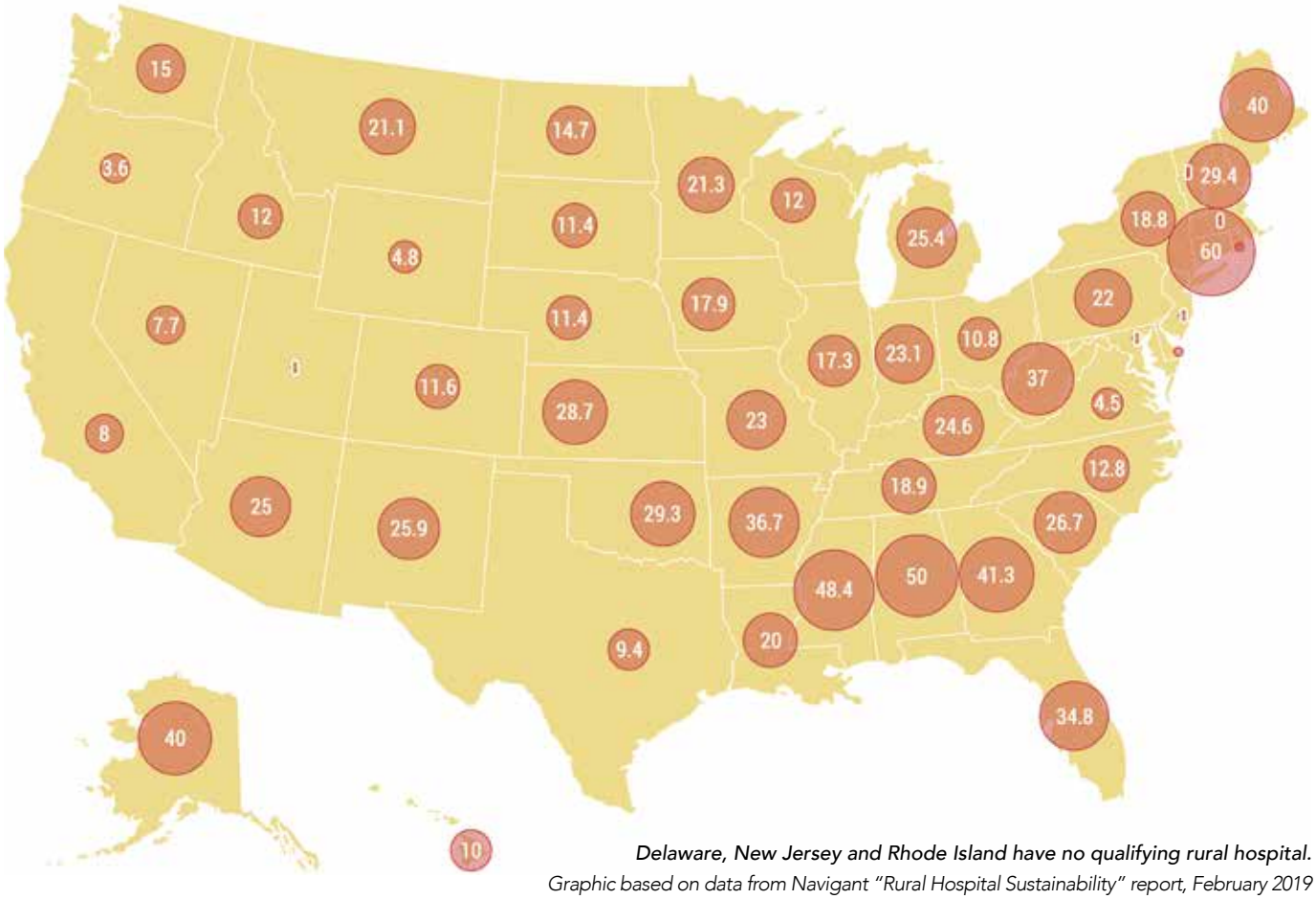
One in four non-elderly rural individuals have coverage through Medicaid. However, not all providers accept Medicaid due to low rates of reimbursement for services compared to private insurance. In a spot of bright news, Medicaid participation by doctors is highest in rural states, according to a study published in early 2019, which said about 90% of rural general practice or family doctors accept Medicaid versus 71% in urban settings.

When it comes to mental health, 65% of rural counties across America do not have a single licensed psychiatrist and 13% have no behavioral health provider – psychiatrist, psychologist, psychiatric nurse practitioner, social worker or mental health counselor.

This is of significant concern since a 2017 publication by the Rural Health Research Gateway suggests rural Americans are more likely than their urban counterparts to experience a major mental health issue in their lifetimes and the suicide rate in rural America is 17.32 per 100,000 rural residents versus 11.92 per 100,000 metropolitan area residents, according to a 2017 review of data by the CDC.

Higher substance abuse rates are also reported in rural communities, especially alcohol and prescription opioids – overdose deaths from which increased 325% in rural counties from 1999 to 2015 according to a study published in 2017 by the CDC. Limited treatment services and centers as well as greater distance, lack of insurance coverage and less communal resources needed, such as money for facility fees or to cover housing costs while in treatment, means the rate of individuals in rural areas taking part in voluntary in-patient services substance abuse treatment is low.

PERCENTAGE OF RURAL HOSPITALS IN DANGER OF NEAR-TERM CLOSURE BY STATE



Delaware, New Jersey and Rhode Island have no qualifying rural hospital.
Graphic based on data from Navigant "Rural Hospital Sustainability" report, February 2019

Photo by Annie Mapp

A few members of a group assembled to address their concern about the closure of the Pickens County Medical Center in Carrollton, Alabama, in March 2020, hold signs for passersby to see.

When one door closes, the next may be hours away

When you can't afford or find a primary care provider, a last resort is to go to a hospital emergency room. But that's become much harder in rural America over the past several decades.

It's unclear exactly when the balloon burst for rural hospitals. According to the Kaiser Family Foundation, many rural hospitals closed in the 1980s and 90s – 119 from 1980 to 1985 and another 208 from 1990 to 2000, 7.8% of the total rural hospitals shuttered in the 1990s according to a DHHS study.

In 2005, the Sheps Center for Health Research at the University of North Carolina began keeping track and reported that from the start of 2005 to April 1, 2020, 170 rural hospitals closed, eight in the first three months of 2020 alone.

That's a reported loss of more than 6,400 hospital beds in a decade and a half since data has been collected.

According to the Sheps Center research, there are six main reasons for hospital closures – declining local populations; bypass of local patients to farther afield hospitals with more resources; referral patterns that do not include rural hospitals; state and federal policies that impact a variety of regulatory and financial areas; technological advancements that reduce in-patient stays and other revenue streams; and mismanagement. Most cite financial problems.

However, over the past decade another factor is at play: states' decision regarding Medicaid expansion. "Hospitals located in states that have not adopted Medicaid expansion have lower median operating margin and have a higher percentage of rural hospitals operating with a negative operating margin," according to a study by the Chartis Center for Rural Health, released in February.

The difference is slight but critical – a median operating margin of 0.8% for rural hospitals located in so-called full Medicaid expansion states, and a -0.3% median margin for those in the 14 states who did not expand Medicaid eligibility under terms of the Affordable Care Act. The eight states with the highest rate of rural hospital closures have not expanded Medicaid, according to a 2018 article by the Georgetown University Health and Policy Institute.

Overall, 47% of rural hospitals began 2020 operating in the red, according to the Chartis Center study, and for states like Texas and Tennessee where more than 50% of their rural hospitals have been identified as vulnerable to closure based on current performance levels, a pandemic like COVID-19 may easily put a final nail in the coffin for much of their rural health system where "resources are stretched thinner than ever and moneymaking services like elective surgeries are curtailed during the outbreak," according to an April 1, 2020 report in the Associated Press.

As of January 2020, the American Hospital Association reported 1,821 rural community hospitals, but with one in four at risk of closing in the near future according to researchers.

This number is likely a conservative estimate, as oftentimes only the highest level of management understand the full financial balance sheet of the facility.

That seemed to be the case with Sumner County Hospital, a small facility in Wellington, Kansas, which closed on March 12 with no prior notice to the employees or community. With of staff of only 75 it was still one of the small town's largest employers and offered victims of serious and urgent medical crises the closest facility for some 35 miles.

"In addition to being further from a hospital than urban residents," a 2020 report produced by the National Grange in partnership with Xcenda says, "the University of North Carolina's Cecil G. Sheps Center for Health Services Research documented how rural residents' closest hospitals offer fewer services. Fewer rural hospitals offer surgical care, obstetric services, intensive care units, outpatient surgery, chemotherapy, and dental services, to name a few. So, while the average drive may be 34 minutes to the closest hospital, the distance to a facility with the specialty care needed can be much further.

One thing is clear: rural hospitals and the proximity to patients for immediate care, do mean the difference between life and death.

In 1992, there were about 20% more rural hospitals in operation than in 2015, and a 2% difference in mortality between rural and urban patients. From 2000 to 2015, as local hospitals that could offer fast, critical care were closing, the gap between rural and urban mortality rates was widening. As of 2015, an 18% difference in the rate of mortality. That's

probably because there are areas like Tonopah, Nevada, where Central Nevada Grange is located, where it takes three hours by road to get to the nearest hospital after the local one closed in 2015.

Brock Slabach, a former rural hospital administrator who now serves as a Senior Vice President at the National Rural Health Association told NPR in 2019 that "delayed care can often lead to tragic consequences." Sometimes delay doesn't come because a whole facility has closed, but because cuts have been made to specific departments.

One such area that has come on the chopping block at a disproportionately higher rate than others is the obstetrics units of rural hospitals.

Over a ten year period from 2004 to 2014, 179 rural hospitals ended obstetrics care, leaving pregnant women and newborns facing health issues with a greater share of the burden of the collapsing rural health systems.

Medicaid reimbursement rates are again a leading factor cited in closures of these units, as well as declining birth rates in rural communities and a lack of physicians and specialists who want to start their careers or move their practice to facilities with often little funding, poor research opportunities and a lack of technology.

As a result, in many of these rural settings, family practitioners stand in for obstetricians, delivering babies and providing initial care to the new mother and baby. However anytime there is something other than a normal birth, having a care provider who is not a trained obstetrician can greatly increase rates of complication and even death for mother or baby or both. From 2000 to 2014, maternal mortality rates rose 26% overall, with rural women disproportionately affected.

It will get worse before it gets better

Nearly half of all physicians practicing in rural communities as of 2017 were 65 or older, according to HRSA. Only one third were under 55. For mental health professionals practicing in rural areas, about 60% are older than 55 according to a 2015 report in the Journal of the American Medical Association.

Some reports suggest of the primary reasons young doctors are not setting up practices in rural communities, student loan debt – up nearly 3,400% on average for four-year graduates of medical school from 1971 ($5,500) to 2018 ($192,000) – is at the top. However, while sometimes cumbersome to attain, various student loan forgiveness products for rural practitioners are available.

However a variety of studies have shown that rural practitioners earn more than their urban counterparts, especially after changes by Congress to increase Medicare payment rates for rural physicians. Add in the typical lower cost of living in rural communities as an economic incentive for practicing in rural, and you would assume the shortage would soon cease, but instead reality suggests that economics alone is not the cause.

Instead, some physicians report that the barriers previously discussed make their practice more difficult and less satisfying. Because of the load these physicians carry, burnout is a very real part of the practice of rural medicine. In studies, those

A majority of physicians serving rural areas are 55 or older, and recruiting new doctors to rural communities has proved challenging.

considering entering practice in rural areas also noted that lower quality schools and housing, less educated peers for outside or work association and their own concerns with quality medical care available in rural communities made the positions there less attractive, especially if they were starting a family.

The number of medical students hailing from rural communities has dropped 28% over a 15 year period, from 2002 to 2017, according to study in the publication Health Affairs. While we all know it can be a challenge to show the beauty of small-town living to those raised in more metropolitan environments, having students from rural environments enter health professions is key to meeting physician workforce needs, according to Scott Shipman, director of primary care initiatives and clinical innovations at the Association of American Medical Colleges.

If the inability to attract young talent were solely financial, the plan ahead would be simple, if not easy. But making rural communities attractive places to live, work, raise families and feel professional fulfillment is a multivariate task that will take years to address, if at all. Instead, we have a problem that cannot be easily solved being compounded by the reality of mortality – a workforce that will end their practice long before we may be able to find their replacements.

And those replacements, may just take into account the staggering swiftness with which rural hospitals are closing and make a choice that seemingly offers more long-term employment stability.

Telehealth and Air Medical Services: The White Knights?

Telehealth – receiving a diagnosis or treatment remotely from a doctor or other health professional by phone, email, text message, mobile app or live video – has been touted as a potential near-panacea to the rural health problem for many

years.

As the COVID crisis grows, more individuals are being asked to see doctors and get basic consultations remotely to limit exposure. However, a 2019 survey of rural Americans showed that only a quarter of rural residents already had some experience with telehealth. Nearly 7 in 10 of those said it was the most convenient method for their particular need at that time, while 3 in 10 said they used telehealth because they were unable to go to a doctor in person – almost all of them saying it was because travel to the doctor was too difficult.

For those who participated in the survey who had previous experience with telehealth, 53% had received at least one prescription from their provider using the service, 25% received a diagnosis or treatment for a chronic condition, 16% for an emergency and 9% for an infectious disease.

The crisis has brought to the table providers that had previously opted out of providing various care via telehealth programs, often because reimbursement is not sufficient to make this form of healthcare attractive to new providers or for providers to pick up new patients using the care model.

Other providers cited concerns with HIPAA requirements and a lack of privacy that may come if they provide telehealth services. However during the first few weeks of the COVID epidemic, many of the HIPAA requirements that are more onerous to telehealth participants were waived as the crisis began to unfold.

Another key piece of the critical and urgent care puzzle in rural America is air medical services.

The most severely injured and gravely ill patients require rapid transport to larger hospitals by "air ambulances" - helicopters or fixed wing planes staffed by specially trained nurses, medics and pilots - to get the care they need.

Today, 85 million Americans in rural areas rely on air ambulance services to get to a Level I or Level II trauma center within 60 minutes, the so called "golden hour" that is critical to optimize patient outcomes. When a first responder at an accident scene or a doctor at a local hospital determines a patient needs a rapid transport to survive, they are authorized to call for an air ambulance. Each year, air ambulances make hundreds of thousands of flights from more than a thousand bases strategically placed around the country.

According to the "Air Medical Services Cost Study Report", prepared for The Association of Air Medical Services and Members by Xcenda, three out of four air med flights originate from rural areas.

In some states with a Grange presence, the rates are far above average – for Nebraska, 100% of flights are classified as rural, and 99.5% in Montana.

But these air ambulance flights are expensive - not unexpected given the costs of effectively miniaturizing an intensive care unit and making it fit within a helicopter and then keeping teams of pilots, trauma nurses and trauma certified medics on standby 24 hours a day, 365 days a year. Added to that is the per mile cost that rural individuals inherently incur in greater amounts due to the likely much farther distance from home or place of accident to trauma center.

And the providers of the service are under-compensated for 72% of their transports because of low Medicare and Medicaid rates or because the patient had

Telehealth and air medical services have both been lauded as important pieces of the current and future puzzle that is rural healthcare. However, unstable or nonexistent broadband connections and the expense, and often lack of coverage, for air medical services put both out of reach for many patients.

no insurance.

Therefore, like with many other medical services, private and commercial insurance plans assume a greater percentage of the operating costs.

In recent years, insurers have begun refusing to pay for flights, sometimes leaving patients with unanticipated bills because federal law requires the patient be sent a bill covering the balance the insurer refused to pay.

To solve the problem of surprise insurance denials, Congress is debating legislation that will force insurers to pay their fair share, and the National Grange has added its voice to that conversation, attempting to show how this issue disproportionately impacts rural individuals.

But the legislation to rectify the problem is one of the most contested issues Congress is addressing, with air ambulance providers saying that if Congress sides with the insurance industry, air medical bases throughout the country, including those in the most rural areas, will have to close due to insolvency.

And then came the pandemic

With all the stresses on the rural healthcare system, the last thing needed was a pandemic. "Rural health was a ticking time bomb, and now it is exploding in our hands as we speak," Bourassa said in late March.

In the early days of that explosion, the unleashing of COVID-19 and its potential devastating affects was met with great skepticism.

"The regular flu kills more people a year," was a common quip.

But this was not the flu, yet something can be learned from it, says Roger Ray, a physician consulting director with The Chartis Group, a healthcare advisory and technology company.

Ray told reporters recently that if the spread of coronavirus follows the same path as a seasonal flu, rural communities will experience cases later, but those cases will have a greater impact than in urban areas.

Not only do the demographics line up for a greater challenge – COVID cases in older individuals and in individuals with chronic conditions, both of which are more prevalent in rural communities – but early intervention is harder because of the various issues we've already addressed in relation to rural health.

"The beds and workforce are not there to handle a pandemic. It's almost like the hospital is there but it's not conditioned to take care of these folks," said Daniel Fellenbaum, a rural healthcare expert who works for Xcenda.

That was evident when Dr. Gregory Byrd, an executive at rural Woodstock, Virginia's Shenandoah Memorial Hospital, told a reporter his staff was improvising as they went along, "all caught with our pants down."

Also, the early response, including decisions to limit gatherings and orders for people to shelter in place took longer – if they were ever issued, since as of this report at least a dozen states had not done so. This greatly increased the likelihood of transmission and flew in the face of warnings by the CDC.

"It's not a surprise though. This is novel. It's not like anything we've seen, so there isn't a precedent to follow. And people in rural communities making decisions often aren't consulting the large national agencies, but listening to their neighbors or their own pocketbooks for guidance," Bourassa said. "They're following the lead of their county or state governments, which in many of our more rural states were days or more behind the federal agencies in telling people anything other than 'be cautious.' They weren't making it clear that this disease will be devastating to our nation, and even more so to our communities with already limited resources, especially healthcare options, if it gets out of hand."

The pandemic also brought about multiple changes in the way healthcare professionals could do their work, and where they could practice.

As the number of COVID cases began to jump daily in March, some traveling nurses and doctors were deployed specifically to rural communities, clinics and hospitals to help fill coverage gaps. This was made possible in part because, in many areas, licensing requirements were eased to allow healthcare providers to practice across state lines, something that impacted both in-person and telehealth services. The Federation of State Medical Boards supported state efforts to immediately verify the credentials and disciplinary history of healthcare professionals and CMS waived state-specific licensure requirements for

Rural communities, already susceptible to higher rates of loneliness and feelings of isolation, may have seen their first COVID infections later that major urban centers, but still felt the impact of the pandemic in health and social life.

Medicare and Medicaid providers who go to work in a different state to help during the crisis.

Fellenbaum called the moves an experiment in action.

"We're all definitely watching to see if they remove some of these barriers to expand the rural healthcare workforce after this, or if all the rules and regulations go right back into place."

A late start, a larger impact

Dr. Anthony Fauci, the nation's leading infectious disease expert who many have put great stock in as part of the daily press briefings by the White House, dropped a bombshell speculation just before the close of March – 100,000 to 200,000 Americans could die from the coronavirus. While he walked it back a bit, saying that the number is just a projection, a "moving target" because of so many independent factors that will play into the final outcome.

The fear that death will be a more common outcome for those who contract COVID-19 in rural communities comes because of all these other factors that have been at work for years in the rural healthcare space.

The information flow, health literacy rates and overall trust of the government and agencies is lower in rural communities, limiting the knowledge about the disease, its spread and prevention; there are heavily ingrained cultural gathering practices of extended families and friend groups for weekly means, church services and the like; all combined with the rebellious individualism that seems to run through many small communities undermines progress from the beginning. Add, too, the allure to city-dwellers of migrating to an isolated area to "ride out the storm."

There there's the lack of doctors and up-to-date facilities or clinics, which leads to less testing and early diagnoses, less monitoring of patients and greater distance patients have to move to see providers, meaning exponentially greater chances the virus spreads as they stop to fill up, get lunch or go to the bathroom during their travel.

If they become critically ill, these patients arrive to an overwhelmed system that lacks adequately staffed hospital beds, fewer and older pieces of equipment, no space to create specific containment wards and a lack of personal protective equipment for providers to use when moving from patient to patient.

"A LARGE FEAR IS THAT RURAL HOSPITALS WILL HAVE TO MAKE CHOICES AS TO WHO GETS CARE IF THEY CANNOT OFFLOAD PATIENTS TO LARGER FACILITIES – WHICH ARE ALSO EXPECTED TO BE OVERRUN BY PATIENTS."

- DAVID FELLENBAUM, RURAL HEALTHCARE EXPERT

The smaller, poorer, less connected providers also do not have the wherewithal to duke it out - financially or with influential political intervention - against larger more moneyed systems and win their fair share of adequate resources.

It's an earthquake followed by a tsunami. Insult to injury. Unnecessary but unavoidable risk at every turn.

For some states, the unimaginable is being discussed.

Alaska, one of the nation's most rural states, has only about 1,500 hospital beds in the entire state. Traditionally many severely injured or ill patients in places like Alaska get flown to the lower 48 states by air ambulances for care. If CDC estimates are correct that nearly 300,000 of its residents will contract the illness, and about 5% of those cases will require hospitalization, about 14,750 beds will be needed. While that flood will not come all at the same time, there certainly will be a shortage, stressing an already fragile system perilously thin.

And that's all without the single car accident, overdose, act of violence or heart attack.

"The world is not shutting down, everyday healthcare issues that the population faces do not stop," said Fellenbaum.

According to Fellenbaum, an epidemic where many people require medical devices becomes "tricky" and may crash a rural health system in which "rural hospitals are operating behind – their cash on hand is behind."

"A large fear is that rural hospitals will have to make choices as to who gets care if they cannot offload patients to larger facilities – which are also expected to be overrun by patients," Fellenbaum said. "How do you triage? What are the decisions that need to be made by hospital leadership? Do they have a policy? It's a scary world to be in for these facilities in these times."

And if hospitals have to make those choices, the consequences to them and the rural healthcare system could be dire, Bourassa said.

"Imagine if your mother was admitted to the local hospital, a small, rural one with its share of financial strain. And maybe the community around it already had its doubts about the abilities of its doctors, nurses, the technology at the facility, the equipment. If she goes and cannot receive adequate care or dies while there, it just promulgates the idea that the hospital system is not good."

"Even if the hospital makes it out of the COVID crisis," Bourassa said, "it may not make it out of the negative community rap it will get."

If that's the case, he said, "The next time someone is sick or has an emergency, they will actively avoid that small hospital in favor of one some distance away that is considered better and the problems the

small hospital had just multiply and then that small hospital won't be there as a choice at all."

Stimulus funds and their impact

The third, and as of this writing, most massive of the stimulus bills, provides as part of its $2.2 trillion increased funding "for community health centers; Medicare payments; telehealth and home service; and public health agencies such as the Center for Disease Control and Prevention," to the tune of $280 million, according to an early report by the Washington Post on the 880-page piece of legislation.

Additional provisions will also help healthcare facilities, like the part where they can defer payroll tax for up to two years and immediate write-offs by hospitals of any building improvements.

Rural hospitals and federally qualified health centers will be able to be reimbursed for any home health care and telehealth services they provide during this crisis, allowing additional revenue options as well as care flexibility for the facilities. They would also be able to request up to a six-month advance on Medicare payments from CMS to provide a steady cash flow in order to keep their doors open and staff paid.

According to the National Rural Health Association, small hospitals will also have access to the more than $500 billion in small business emergency relief funds that come in the form of loans with capped interest rates, no early pre-payment penalty and some forgiveness opportunities.

"We certainly are happy to see the availability of funding to address cash-flow needs right now for rural hospitals," said Alan Morgan, CEO of National Rural Health Association, which was named a National Grange Champion of Rural America in 2018. "Additional long-term funding is available, but we will need to see the details on when and how much will be targeted for rural providers."

One specific area of concern because of the much higher rate of service used by rural residents for air ambulances, are efforts by health insurers to insert provisions in legislation that will set an artificially low, median payment rate these services. Should this federally mandated price control pass, many air ambulance providers have expressed a deep concern about their ability to continue operating many of the rural bases.

So far, legislators have resisted the insurers' efforts, but with more COVID-19 legislation on the way, fights on this issue will continue and may be compounded.

The post-COVID world

While no one knows quite how long this crisis may last, one thing's for certain: after COVID-19 has been contained, vast health disparities between urban and rural individuals will remain.

The healthcare system will have to be evaluated and reinvented in some ways, so it's important that rural facilities and care are not ignored.

"We need to work towards building a sustainable rural health care system," said Morgan. "Not only a delivery model that works for rural communities, but a payment system that does as well. Specifically, we need to recognize that rural communities are generally older, and have more chronic health care needs. Medicare has to target these rural clinics and hospitals as essential, and develop a payment system that recognizes the concentration of high health needs in these small rural towns."

Morgan told a reporter for the Los Angeles Times "there is literally no room for error here. Rural America is a tinderbox of a healthcare crisis for those most in need."

The healthcare system will be evaluated and reinvented in some ways, so it's important that rural facilities and care is not ignored.

National Grange Legislative Director Burton Eller said it is one of the top priorities of the organization and something he and Grange leadership will be closely engaged with as we move through the period of crisis back to whatever the new normal looks like.

"As a nation, we cannot continue to create a health care system of haves and have-nots between urban and rural Americans," Eller said. "It's high time for political commitment, medical innovation and high speed broadband connectivity as we come out of this crisis."

And, he said, the influence of individuals contacting their local, state and national legislators will be paramount to the fight to improve access to rural health facilities and build an innovative care system for rural individuals after the virus is contained.

This pandemic created a whole new appreciation among the American public for medical and emergency personnel and for farmers, ranchers, food processors and the supply chains that deliver," Eller said. "No one can deny, both groups are essential to life itself."

"AS A NATION, WE CANNOT CONTINUE TO CREATE A HEALTH CARE SYSTEM OF HAVES AND HAVE-NOTS BETWEEN URBAN AND RURAL AMERICA. IT'S HIGH TIME FOR POLITICAL COMMITMENT, MEDICAL INNOVATION AND HIGH SPEED BROADBAND CONNECTIVITY AS WE COME OUT OF THIS CRISIS."

- BURTON ELLER, NATIONAL GRANGE LEGISLATIVE DIRECTOR

Barriers reported by rural members accessing telehealth

By Elizabeth Hiner
Colorado State Grange Lecturer & Senior Communication Fellow

Phones seemed the only reliable technology rural members could use when trying to access telehealth services, a clear indication that further deployment of broadband will have to play a role in the advancement and expanded adoption of this method of care for rural residents.

The COVID-19 crisis has pushed many people to use the internet for things never dreamed, including this area of healthcare access.

Telehealth has been in use for years and is defined by the CDC as the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Not to be confused with telemedicine, which has been in use for many years to monitors congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD) and hypertension through machines based in the patient's home.

Jennifer Oliver of Tacoma, Washington, a member of Collins Grange #893, and LPN for more than 20 years said she has been part of that system that doesn't go without its challenges but is much more automated and in some cases requires far less access to high-speed broadband.

For urban and suburban patients, this may not be new, but to many in rural communities this practice had previously been far from embraced by the typically older, less connected and more wired for face-to-face small-town style interactions that build rapport between doctor and patient. Additionally, there are concerns about privacy and the ability to properly diagnose and treat a patient that cannot be examined in the traditional hands-on way.

"Most clinicians have historically shunned the idea of telehealth/telemedicine, as most clinicians feel (rightfully so) that it is just one more thing that is disrupting the doctor-patient relationship," Dr. Erick Bourassa, a professor of Medicine at Mississippi College wrote in a recent e-mail interview. "Another major hurdle to implementing telemedicine is the fact that most parts of a physical exam can't be done - how do I check even basic vital signs (temperature, blood pressure, heart rate) let alone do an abdominal exam or check someone's tonsils?"

Bourassa acknowledged that those most staunchly opposed were having to make the choice – serve virtually or do not serve patients at all at this time.

With the saturation of coverage of COVID-19 on the news, many telehealth visits, he said, have been from patients concerned because they were "feeling feverish and having a cough and/or sore throat."

Without the physical exam, and in communities where connectivity issues limit the ability for the doctor to see the patient in a real-time video setting, Bourassa said clinicians were often responding to these symptoms, never knowing if it would have been the same care they would have provided if the patient had been present for an in-office visit.

The options, Bourassa said, for providers were to tell the patient to be tested for COVID-19 if sites were even available; to "prescribe possibly unnecessary medication to cover my bases...."

Unfortunately, he said, a lot of "over-prescribing to cover all possibilities," has been happening as providers were struggling to "rule out or in diseases without a physical exam."

Grangers share common barrier in telehealth experiences

Since the early 2000s, the National Grange has been working hard on the issue of broadband expansion to rural communities so rural residents enjoy the same services and opportunities as their urban and suburban counterparts, often

citing telehealth as one major service that would be made available for rural residents far flung from providers if a better broadband infrastructure was in place.

Several Grange members from around the country had their first telehealth visit or a telehealth visit different from those they have had in the past, and each reported issues around connectivity and technology, but most were still happy to have the option for certain types of care.

Suzy Ramm of Newberg, Oregon, a member of Springwater Grange #263, used telehealth for an annual follow-up appointment and said she has also used phone appointments for follow-ups on quarterly tests in the past.

For this appointment, however, she expected to connect via computer, but was unable to and had to attend instead by phone. While not ideal, it was still better than the alternative of waiting, Ramm said, so while she will need to have some further tests in a facility or with a provider when the crisis is over, for now the basic check-in via telemedicine allowed her more time and gave her peace of mind.

Ann Keaton of South Coffeyville, Oklahoma, a member of Thompson Grange #352, had her first telehealth experience in mid-March as isolation measures were moving from voluntary to mandatory,

While she said the experience was a good one overall, call-back time for appointments ranged from 5 minutes to never as systems were overloaded and some calls were lost in the sheer volume of requests coming in for appointments and providers learning new systems.

I, too, tested the process, using telehealth for an appointment for the first time during the crisis to address anxiety I was feeling.

I saved myself potential exposure and a 40-minute round trip and used FaceTime to visit with my doctor by phone because connecting by computer was impossible. Even via phone data, there was a lag in service that was frustrating.

Had it been a more critical matter or if I were an impatient person with a different type of condition, there is a possibility the technical issues may have led me to abandon the appointment and not get the service I sought out.

Karen Cline of Rising Sun, Maryland, and a member of Calvert Grange #424, had a completely different experience.

Cline – who on a scale of rurality if there is such a thing may be on the lowest end of the scale, living about 20 miles from Newark, Delaware and within 50 miles of Baltimore and Philadelphia – said while her insurance has opened a host of telehealth options for patients at this time, she stuck with her existing physician with whom she scheduled a telehealth visit.

"For my needs, it was helpful to speak to doctors familiar with my health history. However, there were serious limitations," said Cline. "To my physicians, telehealth is utilizing a phone call as the primary means of communication. I recently have been in contact with three doctor's offices via phone. None were able to receive photos via email or text and they were unable to utilize video technology. This was very limiting because I was experiencing something that they needed to see. Without the ability to see photos via email or text or even on video, they were really not able to help me."

"I WANT THE ABILITY FOR DOCTORS TO BE ABLE TO CHAT WITH ME ON VIDEO AND TO RECEIVE PHOTOS AND VIDEOS. I DO SEE THIS AS AN AREA THAT WILL EXPAND. I HOPE IT EXPANDS QUICKLY."

- KAREN CLINE, CALVERT GRANGE #424, MARYLAND

Cline said the experience was eye-opening and she hopes healthcare providers reflect and find ways to expand their telehealth services in the future.

"I want the ability for doctors to be able to chat with me on video and to receive photos and videos. I do see this as an area that will expand. I hope it expands quickly. I sent one doctor a link to a video conferencing solution that I have access to, but he said he was unable to use external communication methods that were not secure and authorized by his hospital system."

Bourassa agreed that there are many times telehealth – even some of the more low-tech methods – could make a large difference for people, especially those who live many miles from a provider or do not have access to transportation.

He said people who had recently been seen in-office, were provided treatment and either weren't feeling better or the doctor wished to do a follow up, would find telehealth useful.

"Instead of having them come back into the office, I think telehealth would be a great way to check in with those patients. Also, a lot of older patients have someone at home (child, spouse) providing significant amounts of care, and they get concerned and feel the need to bring that patient to the office; in many cases, a quick conversation via telehealth (with the option of showing me the bruise, the rash, the ulcer, etc.) would allow a clinician to provide recommendations and prescriptions without the need for an office visit, which means keeping the elderly patient safe at home."

While the stories collected are a small sampling, they show there are major barriers that will have to be addressed in order to truly make viable this method of care for rural individuals.

Across nation, Granges, members pitch in

By Heather Simon
National Grange Intern

In an unprecedented time of viral spread and crisis, Granges and individual Grange members stepped up as could only be expected to assist their neighbors in need during the pandemic. From high-tech interventions for those on the front lines to some of the simplest, but necessary outreach gestures, members are responding in a variety of ways.

National Grange President Betsy Huber said the action taken by Granges and individuals is both amazing and expected.

"Grangers are by nature some of the most giving and selfless people. In any time of crisis, you can see Grangers working to make sure others are safe and have what they need. Of course, many of the tried-and-true methods of giving to those in need or bringing the community together like having community dinners weren't options, but still we saw amazing stories of Grangers and Granges at work for the good of their neighbors," Huber said.

"I would like to thank all of our members who assisted others to help stem the spread of the disease."

Build, donate, organize all part of Grange's response

The virus first began emerging on the West Coast, and Goldendale Grange #49 in Goldendale, Washington, was there.

Member Richard Lefever reported the group took on three initiatives to help the residents of the area and have been working on other small donations as needs arise and they are able to fill them.

First, they created simple hand sanitizing stations that can be used long after the threat of COVID has passed and be easily replicated as a service project by other Granges, Lefever said. These were distributed to local high-traffic facilities.

Then the Grange made a donation of $500 to Klickitat Valley Health Hospital Foundation to help the facility purchase two microwaves for COVID patient isolations rooms it was creating.

Along with a small group of dedicated volunteers, and under the direction of Aimee Nelsen-Waddell, who owns a local estate sale business and second-hand store in the area called Aimee's Attic, the Grange created a combination donation and distribution center, stocked with essential items, including paper goods, especially toilet paper and paper towels, along with non-perishable food items and diapers. The center volunteers chose to caters their efforts primarily to young mothers with small children and confined elderly individuals living at home, filling a needed niche. They also provided delivery service.

The efforts drew other local businesses leaders, such as the owner of a café and lounge who donated her entire stock of perishable items; and the state legislator serving the area, who spent a full day volunteering at the resource center.

At the other end of the country, Jen Beamon of Hamburg Grange

Build sanitizing stations

Richard Lefever, Goldendale Grange #49, Washington

Creating portable hand sanitizing stations is an easy community service that will positively impact your neighbors and add to the visibility of your Grange. Offer them to fairs, schools, hospitals or clinics, government or administrative buildings and other appropriate places in your area.

The estimated cost of materials for constructing the unit is $35 to $40, not including sanitizer, and all materials can be purchased at a local hardware store.

Materials:

8 foot white PVC 5" fence post, cut in half (use other half for second unit!)

White PVC post topper

5 gallon plastic bucket with lid

Bolts

Sanitizer unit

Construction:

Install onto halved fence post the sanitizer unit (and add a Grange logo sticker or vinyl to the post). Fill bucket two-thirds with sand and push fence post all the way down in center. Top off with about 3" concrete that will keep unit from blowing over or being easily stolen. Add post topper and give away.

#2107, Pennsylvania, made the decision to stay at home as much as possible, but offered to provided personal service to neighbors in need, posting to Facebook her offer.

She said it was important to spend time with her young family, making sure her kids felt safe during the crisis, but to also not forget about those who may be in need and at high risk of infection.

Relief Committee Revived

Meanwhile, an emergency team was being formed by Mary's River Grange #685 in Philomath, Oregon, with member Sonny Hays-Eberts taking lead.

"I am so very proud so many volunteered so quickly and willingly to help those in need," Hays-Eberts said of the 17 who stepped up within the first week.

The team, based off the idea of a Grange Relief Committee that was popular at one time, is helping people with shopping, laundry, picking up over the counter drugs, animal care and other services.

They have also offered the use of the Grange hall for emergency needs, and other members even outside the emergency team are forming small telephone groups that will call each other regularly to provide a small level of comfort for those who are isolated.

In addition, they donated plants they started, which would have been sold at their annual plant sale, to a local food garden and are working with a local farm to distribute seed potatoes to the community and food garden as well.

They have an eye on helping small farm members with deliveries to help keep them in business in this difficult time, lessen the workload of these producers and reduce their exposure.

Hays-Eberts said it's an act that helps keep their local food system intact and secure.

Submitted Photo

Lori Alsup, pictured, and other members of Central Nevada Grange's quilters' club got to work on masks for healthcare workers as a way to do good during the pandemic.

Submitted Photo

Sasha Garcia, provides supplies to a resident of Goldendale, Washington, as part of the Grange's food and supply bank started in response to the pandemic.

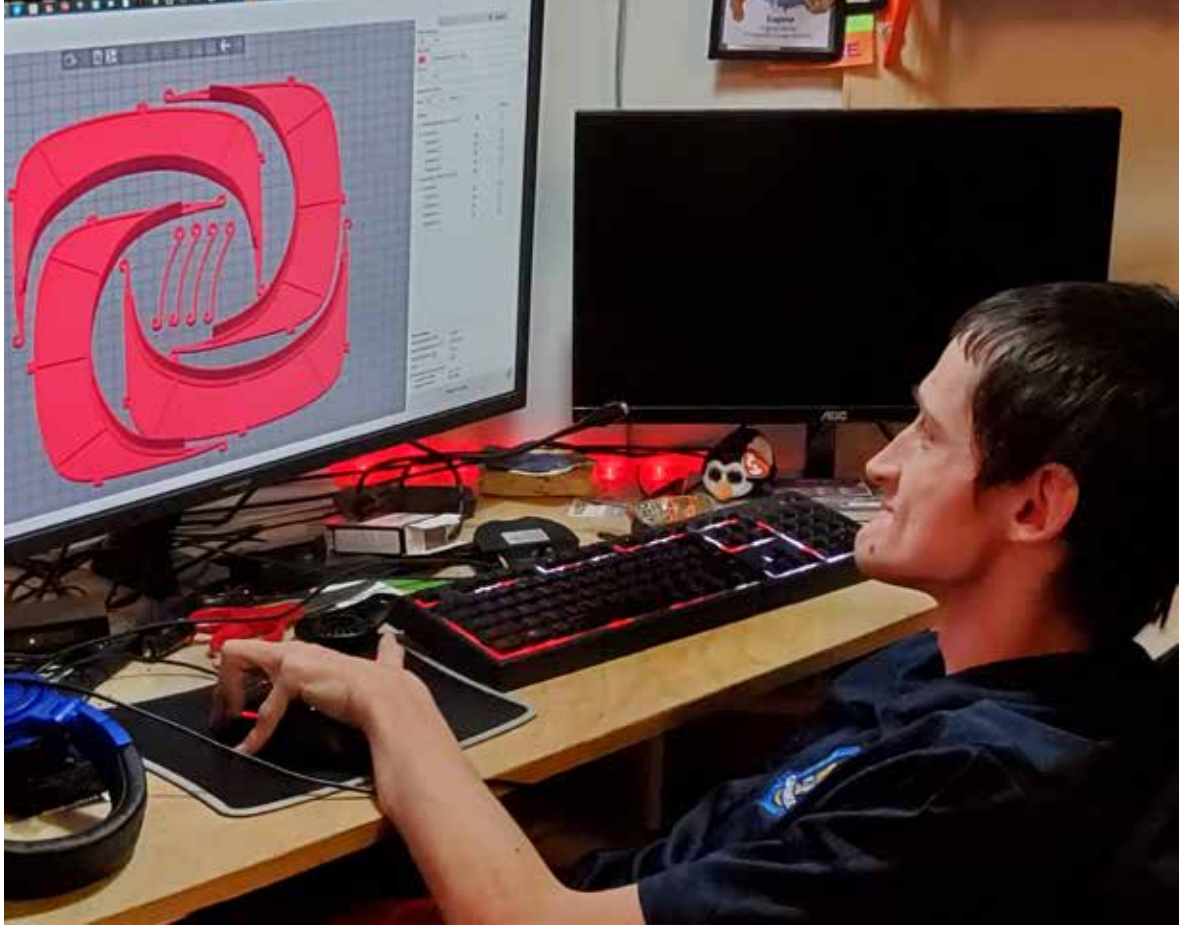
Supplying the Front Lines

With reported shortages of personal protective equipment (PPE) emerging very early in the crisis, many members with sewing machines or Grange quilters groups joined the millions of others around the nation creating cloth masks and covers for professional respirator masks to be donated to healthcare facilities, first responders, essential workers and more.

From California to Kansas, New Jersey to North Carolina, it seemed every Granger with a sewing machine found a way to push through the panic by helping others with homemade masks. Some members even bought their first machine to take part in the effort, such as Annie Montes, a former Maryland State Grange member who moved to Albuquerque, New Mexico, a few years ago and has stayed engaged as an e-member.

Montes' mother works as a registered nurse in the nearby hospital and was one of the first in the area to test positive to COVID, something Montes said is because of the lack of PPE healthcare workers at the facility and around the country were experiencing. In just days, Montes gathered supplies, learned the ins and outs of the new machine and made dozens of masks to give to the hospital, all while learning her mother's boyfriend, a nurse's aide at the same hospital, had also contracted COVID.

In nearby Nevada, Central Nevada Grange #23 in Tonopah, has a six-person quilt group that was activated to make masks,



Submitted Photo

Eugene Fletcher, a member of Orangevale Grange #354, California, who lives in Michigan, used his 3D printer to create frames that hold face shields in place and donated them to a local hospital.

churning out more than 100 quickly based on a pattern sent to them by the daughter of member Deb Mullen Cobb.

Cobb's daughter, Ciara Sallee, works as a pediatric nurse at a clinic in Chehalis, Washington State. She had lived in and been part of the Grange in Tonopah, but with few job opportunities in the medical field because there are no nearby facilities - the nearest hospital a three hour drive away - Sallee had taken a position in Washington, but looked home for help when the crisis hit.

Central Nevada Grange sewers also made masks for the local grocery store and the EMTs in their area.

Eugene Fletcher, a member of Orangevale Grange #354, California, found a more high tech solution to the PPE crisis.

Fletcher put to work his 3D printing machine that he uses for his business, 3D Gene Designs, creating frames that hold face shields for healthcare workers dealing with the infectious disease. He worked as part of a team of various individuals with 3D printers doing assembly work on the PPE.

Currently residing in the Upper Peninsula of Michigan, Fletcher was able to use a design approved by a nearby hospital and made 100 in just a few days that he took to the facility to donate.

Fletcher and his group were also contacted by the Community Action Agency, an organization that collaborates with Meals on Wheels, who asked if the 3D print artists could provide their kitchen staff with face shields that can be used by volunteers preparing and delivering meals.

Fletcher and his group will be working on an easier model

for the volunteers that will require less assembly and not require elastic or foam cushions.

With their success, the group was contacted by MatterHackers, one of the largest distributors of desktop digital manufacturing equipment and materials in the United States, and invited to participate in making their face shields to help distribute throughout the country, which they plan to do.

Granges support continued learning, worship

In the central part of the country, Alamo Grange #1446 in San Antonio, Texas, State Grange President and Alamo

member Karen Overstreet, is a retired teacher who felt called to help, ensuring that children in the area continued to learn and feel a sense of normalcy during the crisis.

She, along with other member of the Grange, planned lessons, combined materials, textbooks and supplies so parents could drive by and pick up their child's packet to take home.

To engage the creative and physical needs of children, member Irene Nieto created daily online activities that she shares on Facebook. Her daughter, Mari Nieto is offering virtual Zumba classes, something she encouraged children, parents and grandparents all to take part in to stay active during the isolation period.

Back in Nevada, other members of the Central Nevada Grange who were not engaged in sewing masks worked to provide children with kits that include paper, scissors, pencils and crayons delivered to their homes to keep them busy while they were home from school because of closings.

The children of the area, Mullen Cobb said, struggle to access learning tools online because of little or no broadband availability.

Several member of Alamo Grange also attend the same local church, and while visiting her parents in the area at the start of closings forced by the pandemic, Samantha Wilkins, National Grange Operations Coordinator and Junior Director, worked with others to get the church online for streaming services.

Submitted Photo

Alamo Grange #1446, Texas, created learning packets for children enrolled at a local school

She said it helped bring a sense of calm and normalcy back to the lives of many of the Grange members and community members and helped to reconnect her and her family, who had moved the previous year to Pennsylvania, with the church they had been missing.

Junior Ambassador leads project to comfort member battling COVID

Word gets around the Grange family quickly when there is someone sick or in distress. So was the case when 50-plus-year member and veteran Gary Prichard of Oregon was diagnosed with COVID-19.

Lane County Pomona President Martin McClure reached out - with Prichard's permission - with information about Prichard's illness. He noted Prichard's joy when receiving cards, especially from other Grangers.

National Junior Grange Ambassador Bryce Danko, of Pennsylvania, who hopes to serve in the military when he comes of age and was especially touched. He created a call to action video, posted on Facebook, in which he challenges all Junior members and

any other Granger who wished to send cards or letters to Prichard.

You can see the video by Danko at bit.ly/brothergary

More than 60 cards poured in over the course of the first 10 days since Danko posted the video with more coming each day from Grange members all over the country.

McClure said Prichard was so thankful and cheerful because of the outpouring of support and has reported that he is no longer infected, but remains under care of doctors in order to rebuild strength and stave off any post-COVID complications.

Cards, letters, and prayers are still welcome and may be sent to:

Lebanon Veterans Home
Resident Mail
Gary Prichard
Bravo #214
600 North 5th St.
Lebanon, OR 97335

Submitted Photo

Junior Granger Gretchen Reich, a 1+ member with Valley Grange #1360, Pennsylvania, delivered toilet paper to a local crisis service center.

Food banks and toilet paper in demand

For a few years, Ekonk Community Grange #89 in Sterling, Connecticut, has had its own food bank. The town sends needy individuals to the Grange who provides them with monthly food baskets that includes a variety of items, including meats, fruits, seasonal items.

The cost of the baskets are covered through a variety of ways, including the collection of "F bills" – the dollar bills with an F on them – from Grange members, public donations of nonperishable food items brought to dinners form members of the community who receive a raffle ticket for their donation, some generous Grange members and additional funds when needed from the Grange.

Vice President Jamie Cameron posted on Facebook information about the food bank and welcomed people who were looking for a way to give back to send donations as they group expected more people may be in need of the service due to the economic fallout from the crisis.

Stanford Grange #808 in New York also has a little food pantry located on the porch of their hall. Started just weeks before the pandemic broke out, President Katie Fallon reports it came at just the right time for their upstate, rural community.

Juniors were part of many efforts around the country as well, some learning new handicraft skills or getting in on service projects in various ways.

In central Pennsylvania, 9-year-old Gretchen Reich deliver rolls of toilet paper to New Life for Girls, a women's shelter that is a frequent beneficiary of donations and service efforts by members of Valley Grange #1360 throughout the year, after she learned that the facility was running low. With the support of her mom, Tina, and approval from Grange President Michael Martin, the Reichs went to the Grange Hall, which is closed until safe again to meet, and gathered the 19-roll supply from the hall's closet to deliver.

It may not be much, Tina Reich said, but "it wasn't helping anyone by just sitting on our shelf."

Pandemic leads shut-ins to rediscover Victory Gardens

By Burton Eller

National Grange Legislative Director

During World War II, Americans in urban centers and suburban towns planted victory gardens to assure they and their neighbors would have food.

As the economy faltered and food worries grew, school and community gardeners produced close to 40% of the country's fresh fruits and vegetables from 20 million garden plots.

This outbreak seems to have rekindled a desire among many people to grow their own food.

And it's not just toilet tissue and meat that's flying off store shelves; it's seeds!

Community gardening is booming. Seed suppliers report they're scrambling to restock inventory in early April.

Southern Exposure Seed Exchange in Mineral, VA, just down the road from the home of a National Grange staffer, reports having to rework its website because it couldn't keep up with the demand.

High Mowing Organic Seeds in Vermont says they're having way more conversations with folks who have never gardened before and want to get into it.

Amid some really tough times for all Americans, it's heartwarming to see our neighbors rediscover where their food comes from.

Victory Garden poster produced by the USDA War Food Administration during World War II.

Submitted Photo

Parade 'best birthday present' for future Junior

When members of East Sangerville Grange #177, Maine, heard future Junior Granger Owen Cookson's birthday party was another victim of the COVID pandemic, they sprung to action.

Cookson, who has been attending Grange meetings since he was a newborn, was turning 3 and knew it – having looked forward to his party for months.

Instead, he got a parade.

Members jumped in vehicles and rode passed Cookson's home, with drivers honking and waiving along with passengers showing off handmade signs with birthday wishes – a way for the adults to feel helpful and hopeful as the unprecedented continued to unfold each day.

The act of kindness was covered on the local news and included a video clip Cookson's dad, Benjamin, had posted to Facebook, one of the earliest parade celebrations seen on social media during this time. You can see the video at bit.ly/owen3parade

He said to media who covered the parade, he believed it was "the best birthday present [his] son could have received."

Photo by Bob Trombi

Jane Trombi, a member of Walpole Grange, New Hampshire, pulled out materials and her sewing machine to create masks for healthcare workers in the early days of the pandemic.

National Grange produces video with details on sewing masks

In mid-March, the National Grange released a video on social media and through our website detailing what crafty individuals could do to create masks that could be used by healthcare professionals and those with N-95 respirator masks, as well as a simple mask anyone could wear to reduce their risk of infection.

The 2 minute and 15 second video includes links to patterns and provides tips like calling ahead to healthcare facilities to make sure they are accepting masks and if they have specific requirements. It also notes that masks worn by the general public should be thoroughly changed and washed often, so grocery clerks and others wearing them for a shift should consider taking multiple and changing them every few hours.

In early April, information about making headbands healthcare professionals can use to attach the elastic sides to, rather than using their ears, was added to the video.

The video can be found at: **bit.ly/covid19-mask**

Grange's porch pantry came right on time for town

By Katie Fallon

President, Stanford Grange #808

In July 2019, I was invited while serving as National Grange Outstanding Young Patron, to a meeting at Marcellus Grange, near Syracuse New York. I brought my mom, a State Grange Junior Deputy, and Ryan Orton, New York Grange Camp Co-Counselor.

I figured the more people to spread the word the better.

What we did not expect upon going on this trip was the discovery of the concept "little food pantry."

The concept was so appealing: not only would it be stocked with canned foods and other non-perishables, but hygiene, cleaning products, baby items and pet food.

After our roadtrip, we talked about it nonstop, and knew we had to bring this to our Grange.

Our town's closest food pantry is about 20 minutes away, but opens once a month if they have enough volunteers; the next is a 45-minute drive. Our closest grocery store is 30 minutes away. For those without reliable, personal transportation, this is a huge burden.

Add to that the demographics of our town: many are low and lower-middle class families and individuals, and a lot are farming families. Food and other necessary items are sometimes just out of reach and we understood sometimes our neighbors just need something to help them get through.

Our Grange had recently elected a lot of new members into offices and they wanted to step up and get to work. We all wanted to take our involvement in the community a step further than ever before.

The summer is really busy with camp, New England Youth Conference and fair, so we waited to bring the idea to the group until September to give us time to do more research.

When we did finally get to talk about it, I brought pictures I found of examples. The vote was unanimous to move forward.

It seemed like that was all we needed, but we were wrong.

We spent the next few months trying to find a cabinet to store everything. Immediately we realized anything that worked cost decent money!

Our Grange is always invited to our town board meeting since our new council took office, and we take advantage of that opportunity. We get time, as well as others in town, to talk about what's going on. We brought a flyer and showed off our concept and explained how this would help the town. After the meeting several people approached us and gave us donations. Community organizations like the Fire Hose and Lions Club said we got your back, let us know what you need.

Two cabinets, a small refrigerator and a few short months later, we had a food pantry on our hall's back porch and were open for business - err, giving - by February 15.

The community continued to pitch in. Local farmers donate products, people drop off goods and Grange members and our Grange itself donates money.

Photo by Katie Fallon

The little food pantry on the porch of Stanford Grange Hall has been well-used since the start of the COVID crisis and donations to keep it stocked have been coming in from Grangers and individuals, businesses and organizations.

At first it was pretty easy. Every few weeks we anticipated shopping for supplies, but then only a few weeks into our food pantry's existence, the COVID crisis came about and everything changed.

Now, we go shopping for at least $750 products every two weeks. We are making deliveries to families who are quarantined or laid off. There's even people who cannot find the essential things at the grocery stores who check with us to see if we have things like milk.

We find people need things like flour, sugar, oil, ketchup, cleaning supplies, wipes, baby diapers, pet food and paper products the most. But now that kids are home from school, the need for food has picked up ten-fold, especially cereal, mac and cheese and snack foods. Some unique things are food supplement drinks. hair spray, light bulbs, foil, and toilet bowl cleaner.

Never was there such a need in our community but it has honestly brought so many together. The struggle is praying for donations to buy more goods.

Normally we would have held our fundraisers and been fine, but we are not allowed to host events currently. I think because the Grange has always been there for people, they are making donations, but eventually that could stop.

But Grangers always find a way to help those in need.

Grange uses 'Cultivating Connections' theme as guide to forge new paths during COVID crisis

By Amanda Brozana Rios
National Grange Communications & Development Director

Grange Month is upon us and the theme could not be more apt: Cultivating Connections.

Yet, the idea of making those connections for many includes human contact or proximity at meetings, open houses, events and through general fellowship with Grangers, neighbors and friends – all of which the coronavirus has made impossible in most cases.

Still, National Grange President Betsy Huber has urged Grange members to remain connected – holding meetings virtually, creating or activating phone trees to check in on one another, sending cards or notes to reduce the feeling of isolation and employing any other safe method to remain connected though apart in this time of crisis.

"The greatest part of Grange is that we are all truly connected like a family, and in a crisis the people you worry about most and turn to, to get through is family," Huber said. "That's why it's so important to make sure we are doing what we can to remain together, even if we're not permitted to meet."

The National Grange has also taken steps to keep members connected and cultivate connections with those who may wish to be part of our Order.

In the first days of the crisis, several Granges were able to hold meetings using the National Grange Zoom platform, including the Oregon State Grange executive committee and at least one Subordinate Grange.

"We had important business we had to get through, but we couldn't put our members at risk," said Susan Noah, President of the Oregon State Grange and a National Grange Executive Committee member.

While that remote meeting forum has been used for many years by the National Executive Committee and some State Granges, for many local Granges the COVID-19 pandemic provides a reason to try the new technology.

Screenshot by Amanda Brozana Rios

Pennsylvania State Grange Public Relations and Membership Director Lizzie Bailey was one guest on the daily "Cultivating Connections in the time of COVID" web-series that aired live and is available for playback on the National Grange Facebook page, starting in late March. Those who tuned in live could leave comments and questions that were included in the episode. The series is set to run for as long as most areas are under stay-at-home orders.

A 2016 Master's Ruling issued by Huber, in which she made clear Grange meetings could be held virtually and those attending were enfranchised to vote, made it possible for Granges to embrace this change and have business as usual – kind of.

"Virtual meetings are no replacement for real, face-to face, organized Grange meetings, but any meeting is better than no meeting at all," Noah said.

She and Huber said they hope Granges are still using the opening and closing ceremony, though with some alteration based on limitations to traditional floorwork done in presenting and retiring the flag and opening and closing the Bible.

Huber said someone should still make sure those items are available and recognized in the meeting, by pledge or anthem for the flag and recognition that the Bible is opened.

Huber highly recommended Grange leaders look to youth in their Granges to assist with the set-up of virtual meetings and use it as a way to empower and engage them that they will remember fondly after the crisis is over.

"They're natives to all this technology," Huber said of the Junior-age and Youth that may be isolated with parents and grandparents who are Grangers. "Even if they aren't members yet, ask them to help set you up on your phone or a computer to attend meetings. They may be interested in what you're doing and stay to listen, or they may just allow you to continue your attendance and participation."

Speaking of new uses of technology, as part of the effort to keep Granges united and provide a sense of community, Communications Director Amanda Brozana Rios launched a daily live web series

appearing on the National Grange Facebook page and related groups depending on the topic. The series included a variety of presenters who provided a look at serious topics, fun discussions and tutorials. On the first Saturday of April, a virtual talent show was held to show off the musical gifts a few members from around the country have.

National Lecturer Chris Hamp assisted with rounding up additional State Lecturers and other members to provide skills-based sessions, humorous presentations and more.

More events were also in planning stages at the time of this writing that would become Facebook live videos as well as three different Youth Department sponsored teleconferences – one for parents, one for teachers and one for young professionals – to swap tales about being thrust into homeschooling, learning to teach on the fly from afar and suddenly being a teleworker, respectively.

During several of the first events in the series, presenters and Rios, who served as anchor/host for the series, talked about the "itch" many may feel when coming out of this period of isolation to reconnect with others in their community in meaningful ways and how that could mean a renewal of interest in fraternal organizations.

"By cultivating those connections with people in our community during this difficult time, " Huber said, "we are reminding them that they are welcome in our fraternity now or in the future."

During a Facebook Live event as part of the "Cultivating Connections in the time of COVID" series, Huber suggested members embrace technology in ways beyond the meeting. She encouraged members to take ownership of the free website they are provided by National Grange and update it or to create Facebook Page for their Grange. On these platforms, displaying contact, event and meeting information is essential, but so too is telling the community what your Grange does of importance – including what you are doing in response to the crisis for those in your community.

National Grange Community Service Director Pete Pompper said some of the outreach by Granges right now are powerful and meaningful elements of that cultivation.

"People are looking for ways to give back and ways to feel as if they belong," Pompper said. "When we show them what Granges CAN do and how Grange members never felt alone during this time of isolation; oh that's gonna hit the spot for many of these people."

Pompper and Huber encouraged Granges to be ready to welcome the community back together and find ways to let them enjoy coming together again-- simple ways to make them feel comfortable around Grangers, in the Hall and at Grange events that may turn into a membership boom.

When Hamp was the featured guest on the web series, she had a "soapbox moment" in which she told viewers that it is not too much to desire a Grange in every community across the country.

"Granges are powerful and what we can do is so meaningful," Hamp said. She referred to the autonomy Granges enjoy to meet the needs specific to their community as one of the biggest reasons why a Grange is so valuable.

Members display talents to combat loneliness in 'Date Night In'

A virtual Grange talent show was not only a special edition of the daily live webseries "Cultivating Connections in the time of COVID," offered by the National Grange it was also a kind of social community service for members and their friends feeling the effects of social isolation.

The show aired live on Saturday, April 4 starting at 8:30 p.m. Eastern, and was dubbed "Date Night In."

The program, hosted by National Lecturer Chris Hamp and National Communications and Development Director Amanda Brozana Rios featured six performers, including two duo acts, playing live for the audience of members and friends gathered around their individual devices from across the country.

"The talent show was an excellent opportunity for us to use other resources to keep our Grange family connected outside of our halls and provide us programming that was relevant and unique, not just what's on the networks or Netflix," said Scott Nicholson, Montana State Grange Lecturer, who tuned in with his wife, Marie.

He said this and the other daily episode of the web series shows the way the organization is "working to improve the lives of Grange members every day during this most stressful time."

Performers included Victoria and Ron Kushnir, New Jersey, Callie and Bodie Ballinger, Kansas; Addison Eyler, Maryland; and Ethan Edwards, Illinois.

Brozana said she expects there will be at least two more of the shows with different performers before the crisis and period of isolation ends.

Submitted Photo

Above, Victoria and Rob Kushnir of Bards Grange, New Jersey, kicked off the show with bluegrass music, and below, Ethan Edwards, Lecturer of Illinois State Grange, played cello to end the performances.

11 REASONS RURAL AREAS STRUGGLE MORE WITH HEALTH CRISES LIKE COVID

When it comes to the spread of viruses, rural America is anything but immune. Experts offer many reasons why our most remote and smallest communities often are harder hit than their urban counterparts

1 "OLDER AND SICKER" POPULATION

With a greater percent of the population age 65 or older and more residents suffering from chronic conditions, disabled or having poor general health, rural Americans are more vulnerable to infectious diseases like COVID-19

2 POOR RURAL HEALTH INFRASTRUCTURE

Fewer doctors, fewer specialists, fewer facilities, less and older equipment all plague the rural health system everyday, but during a crisis, the conditions deteriorate more quickly because of these factors. The rural healthcare facilities are also unable to compete with larger, richer and more connected hospitals for resources.

3 INSUFFICIENT HEALTH LITERACY

Defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions," studies have shown that rural individuals score considerably lower in health literacy than urban and suburban individuals. Lower levels of education, reading comprehension and reduced care options are all part of the problem.

4 SLOW RESPONSE FROM AUTHORITIES

When it came to the COVID crisis, many of the most rural states in the nation failed to issue orders restricting travel or socialization, to close nonessential businesses and to work with healthcare entities to get tests, establish containment protocols and more. This is not uncommon to this pandemic or other crises as many of these governments rely more on self-determination and work from a small-government perspective.

5 PERSONAL ECONOMIES

Rural residents tend to be more economically challenged, with less in savings for a rainy day. Many work jobs that are low-skill but deemed essential, such as fast food, grocery clerks, truck drivers, etc., putting these workers at higher risk for contracting COVID-19.

6 DIGITAL DIVIDE

While urban and suburban individuals were overwhelmed by the amount of information coming at them about all aspects of the virus, including symptoms, spread and containment measures, rural individuals with challenged connectivity were missing a key component. Additionally, if offered the opportunity to work from home and reduce the risk of contracting the virus, lack of broadband access made the move to telework impossible

7 CULTURE OF CONNECTEDNESS

Rural communties are known for being tight-knit and residents place high value on personal interactions and social gatherings, like dinners with extended family, church services and other face-to-face encounters. Reluctance to change their way of life or the concept that they are safe from the virus in houses of worship or at gatherings in family homes reduces compliance with stay-at-home orders.

8 DISTRUST OF (FEDERAL) AUTHORITIES

Ask any rural American and they will like tell you the federal government is completely out of touch with the people - their people. Utilitarian policies of long-gone administrations that stripped land from individuals and states especially in the west and the lingering issues of tribal people - who disproportionately live in rural communities - are just two examples in a large list of why directives from federal authorities are often ignored.

9 MISGIVINGS ABOUT MEDIA

Trust in the media has fallen over the past several years, especially among those in rural communities, not just because of perceived bias, but also because of a great sense of disconnect rural residents feel from what they see of the world versus what is being reported by many media outlets.

10 REBELLIOUS & RUGGED INDIVIDUALISM

Even if there is trust in government officials and entities, there are distinct streaks of self-reliance and self-determination in rural America and a sense that residents know what is best for themselves and their communities. The habitat of the off-gridder and individuals who claim themselves as soveriegn citizens, rural Americans tend to be self-guided, something that can mean making poor choices that risk their health (see lower seat belt use among rural Americans as an example).

11 OUTSIDERS SEEKING REFUGE IN RURAL COMMUNITIES

City residents often have an idyllic view of rural America and in times of crisis often see it as an enchanted place immune to a variety of urban issues. As an epidemic like COVID-19 explodes across urban terrain, many flee to rural areas, sometimes bringing with them the very thing they're running from and stressing already limited health resources if and when they do become ill.

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