

## HCLQ Texas 2026 | Core Panel: Challenges Facing Rural Healthcare

As discussed, we are providing an outline from our recent discussion (Monday, May 11), in preparation for our panel at the HCLQ Texas on Thursday, June 11.

Please review and let us know if you have any follow-up questions or comments. We look forward to our next meeting.

### Reminder of Overarching Theme for the Day

Considering the forgotten or, too often, overlooked patient.

- Emergency Departments, EMTALA & Mandatory Care
- Challenges Facing Rural Healthcare
- Human Trafficking & Healthcare

Panels & Speakers: [HCLQ.org/topics](https://hclq.org/topics)

### Rural Health Crisis in America and Current Legislation

- Big Beautiful Bill Act pushes money to the states to attempt to meet the rural need.
- This looks like a money-grab setup to fail; funds aren't targeted to where they would be of their highest and most efficacious use.
- Money often goes to consultants rather than the local level problem-solvers.
- Grass-roots rural initiatives presented at the state level are often pushed aside.

### Problems Unique to Rural Hospitals

- Each community has different needs, unique from the needs in even neighboring counties. Ex.: one county has problems with patient transportation; another county needs an MRI; etc.
- Payor mixes among various counties can differ drastically; many patients receive their care at a FQHC.
- Patients in rural communities will often defer care due to access issues; many immigrants in rural communities won't seek out care for fear of deportation. Chronic conditions can really stretch a community.
- Resources need to be channeled in a way that makes sense to the needs of each community. How can care delivery be optimized unique to each county?
- Needs must be connected to the right resources/problem-solvers; this takes time to listen at the local level and won't be resolved by merely throwing money at the problems.
- Faith communities often help arrive at home-grown solutions.

## Current Models to Meet Care Delivery Needs

- **Texas A&M; 3–Pillar Program:** (1) Medical Provider Partnership; (2) Rural I.S.D. Program; (3) Community Stakeholders
  - A&M students are involved in rural communities to see what rural medicine looks like; involved in 68 counties currently
  - Dean requires rural rotation in 4 years; these communities will see 1000 students in the next four years
  - The I.S.D. program works to educate students on a career in healthcare
  - The attempt is to build a pipeline to addressing the rural hospital need
  - A&M Students attend community stakeholder events
  - Provides healthcare through container–clinic models (clinics built by the students out of actual storage containers)
- **Rural Healthcare Initiative (501(c)(6))**—Involves strategic background planning + communication + facilities resources to help solve the rural health crisis in America
  - Serves as a “Quarterback” to rural communities to help them with sustainability issues
  - Brings together experts from different disciplines to be brought to bear on answering difficult rural issues.
  - Conducts surveys to determine what the rural population needs and wants, and then reimagines continuity of care to reach acceptable sustainability score.
  - Provides a more appropriate assessment of where money should be spent toward better sustainability.
- **Hamilton HealthBox**
  - Multi–state endeavor to provide access to care through small–footprint, technology–enabled “microclinics” in rural settings
  - Integrates access to care networks and providers for patients in rural settings
  - Coordinates with hospitals and referral frameworks

## Draft Questions

1. We often talk about the ‘rural health crisis’ as though rural America is one uniform problem, but every county has different needs. How dangerous is it when policymakers attempt to solve rural healthcare with broad, one–size–fits–all funding strategies?
2. Recent federal and state initiatives are pushing large amounts of money toward rural healthcare. Are we actually investing in sustainable care delivery here?
3. Some rural communities don’t need a new hospital wing—they may need transportation, broadband, imaging access, or workforce pipelines. How do we better align resources with what communities actually need rather than what funding programs are designed to reimburse?

4. Payor mix is often the hidden story behind rural hospital instability. How much of the rural health crisis is fundamentally a reimbursement and sustainability problem rather than strictly a provider shortage (or population shortage) problem?
5. Many rural patients delay care because of transportation barriers, economic pressures, immigration fears, or simple lack of access. What happens to a community when healthcare becomes something people only seek in crisis?
6. We often hear that throwing money at rural healthcare is not enough. What does meaningful listening at the local level actually look like, and why is that process so difficult to replicate at scale?
7. Faith communities, schools, and local stakeholders often become essential partners in rural care delivery. Are some of the best rural healthcare solutions coming from outside the traditional healthcare system itself? How so?
8. Texas A&M's rural pipeline model exposes students early to rural medicine and embeds them in communities. How important is relationship-building and familiarity in convincing future providers to practice in rural America long term?
9. Programs like Hamilton HealthBox and container-clinic models challenge the traditional idea of what a healthcare facility must look like. Are we entering a future where rural healthcare is built around flexible, distributed access points rather than traditional hospital-centered systems? Does this have something to teach more urban healthcare models?
10. If the overarching challenge is sustainability, not merely survival, what should success look like for a rural community five or ten years from now—and how do we avoid imposing outside solutions that fail to reflect local realities?