

Bob St. Peter: Hello, I'm Bob St. Peter. I'm a pediatrician and the former president of the Kansas Health Institute. I'm here today to interview Dr. Robert Moser. Dr. Moser has a very long and distinguished career of service in Kansas. He began his career in family practice in Tribune. He became involved with the University of Kansas in the School of Medicine. He served a stint as the secretary of the Department of Health and Environment. He became dean of the medical school campus in Salina and started the Kansas Center for Rural Health there and now is back at KU leading an interesting project that we'll hear more about. Dr. Moser, thank you very much for being here today.

Robert Moser: Thank you. Good to be here.

BSP: This interview is part of the Kansas Oral History Project series, exploring health issues in Kansas. The Kansas Oral History Project is a nonprofit corporation that collects and preserves histories of Kansans. The series is supported by donations from generous individuals and a grant in this case from the United Methodist Health Ministry Fund. Our videographer is former Kansas State Representative Dave Heinemann. Thanks again for being here, Bob.

RM: You're welcome.

BSP: Tell me a little bit about your background and the early part of your life and how you ended up in Kansas.

RM: Sure. I was actually born in Denver, Colorado. My parents had moved there from Tribune, where they grew up and where their extended family was at. I was the third of five children that came along to Bob and Maggie, and they decided after #3, it was time to get back to a small community. So, they moved back home. My dad bought a building and set up a body shop and garage, and my mother ran the books, and I had a great opportunity to grow up in the big city of Tribune, Kansas.

BSP: Awesome. I didn't realize both your parents were both from Tribune.

RM: Yes.

BSP: Your family goes back quite a long way there.

RM: Yes. Our great-grandparents homesteaded out in Kansas. They had a Swedish colony and a German colony. My grandparents were on both sides of those colonies.

BSP: That's great. I love those ethnic communities throughout western Kansas that were largely settled in that period of time. So, you were in the School of Pharmacy when you were in college and yet ended up in medicine. Tell me a little about that.

RM: That really came about mostly from friends that were two or three years older than I was. My freshman year at college, I started off actually in chemical engineering, even though I knew I eventually wanted to go into medicine. I loved the sciences and the math end of it. I guess you

could say I wasn't exactly sure which pathway I was going to take to get there. I ended up rooming with a friend from Tribune, Chris Dixon, who eventually operated the local pharmacy in Tribune. He was in pharmacy school my second semester at KU. When I saw what he was studying and what I hoped to eventually be doing, I thought, "Okay, this looks a little bit more interesting to me." Of course, you always are worried, "What happens if I don't get into medical school? What would I do for a living?"

So, I decided to apply to pharmacy school, got in. At that time, it was a five-year Bachelor of Science degree. I decided once they accepted me, even though I was going to apply to medical school, I would complete my degree. I thought I could also work part time as a registered pharmacist after I got into medical school. That's exactly what happened. I graduated pharmacy school in May and then turned around and started medical school in August and then found a job working for the Venture Pharmacy down in Overland Park. So, I'd work there Fridays, Saturdays, and Sundays while I was going to medical school.

BSP: So you started this busy life very early in your career, it sounds like.

RM: Yes. I was kind of selective in the pharmacy. They weren't a terribly busy pharmacy on the weekend. If you remember the old-style pharmacies where the pharmacist was up on his little platform with the barrier so you couldn't see everything they were doing back there, but I would have two or three of my textbooks and notebooks opened up and take care of clients as they came in. We filled maybe fifty prescriptions a day. It wasn't terribly busy. So, it worked out great.

BSP: Did you tell your classmates why you were acing the pharmacology class?

RM: Interesting, even though you had a degree in pharmacy and were registered pharmacists at the time, they didn't give you any credit. You couldn't test out of a subject. At that time, they had an old DOS program where you'd go in and basically have some instruction on it, and you would take practice exams. Then the actual test was held like every Friday, but you had three chances to pass like Test #1 and then go to Test #2. I was looking at our test schedule, and I said, "I really want to focus more on the pathology and physiology tests coming up. So, I'll just wait, and I'll take all three at one time."

The week that that test was coming up along with all those others, I went to my mailbox, and Dr. Thorkil Jensen was the dean of students back then. There was a note to come see him. I thought, "Well, that's interesting. Maybe I've got a scholarship or something." Actually it was I was being called on the carpet by the pharmacology head that I wasn't attending lectures, which they were voluntary. I hadn't taken any exams yet. I wasn't overdue. I was going to take them all Friday. So a short story, I had to go get his approval that it was okay that I was going to take the test, and he kind of said, "Well, our first test is neuropharmacology. It's the hardest test, and the pass rate's not very high." I said, "I'm a registered pharmacist."

We debated a little bit about how much he was going to teach me in one semester versus what I learned in three years at pharmacy school. Needless to say, I passed all three exams on Friday, and I was in good standing. It was great background. Even in clinical rotations as a med student,

I had a lot of friends that would come up to ask drug questions and what not. I kept my little pharmacy handbook on the inside of my white coat so when they'd come up, I could pull it out and give it to the so I could continue on my notes and my duties and what not.

BSP: That's great. Well, we're just outside the window. Next to us here is a statue of Samuel Crumbine who is another physician who practiced in rural western Kansas and was a pharmacist before he got his medical training and then became the leader of the Department of Health early when the department was first created. I can't help but think about the parallels there.

RM: I learned about Dr. Crumbine really fairly early in medical school just because of that connection with being a pharmacist as well as a rural doctor. As it turned out, the last physician in my family was actually Dr. Merrit Shaw who was a Confederate surgeon and settled in Oklahoma in the Indian territory. The old photos back then, he had a drugstore. He was a registered pharmacist back then but was also a general practitioner, if you would, back in the horse and buggy days.

BSP: After you finished medical school and passed your pharmacology class, you did some of your training in Salina, actually, which again is very consistent with the story that you've had through your career. Tell me how you ended up in Salina, and then after that, how you ended up back in Tribune.

RM: Sure. I decided when I got accepted to medical school—they had a program that the Kansas Farm Bureau was working with the School of Medicine back then. It was called MediServe. The idea was that you would have a group of rural doctors interview you, so you had some practice on the interview process before you actually went through that with the School of Medicine admissions. If they felt like you were a good candidate for the School of Medicine, they would write you a letter of recommendation.

It was kind of interesting because they wrote their letter of recommendation on hot pink paper. When you opened up the folder, that's the first thing that you saw. But I took the medical student loan program that they had at that time, and there were two options. One, if you were going to stay in Kansas, they would pay your tuition. If you selected to go back to a critically underserved community, they would pay your tuition plus a stipend. I pretty much knew even though my pharmacy background, it would have been for going on into anesthesiology, oncology, or something like that, I found that every rotation I went through, I really enjoyed. I pretty well knew that I made the right choice to look at going back rural and to do family medicine.

So, my next goal was to find a training program where you were kind of community based. Maybe you were the only residents in that health system, so you got to see everything in the front row and got to be the first assistant instead of #3. So I'd actually considered Salina, but they started that program in '78, and this was 1985. It had been there a while. It had some good success, but I still felt like it was kind of new, and I wanted to look at something more established. So, I convinced my wife, "Let's go out to Arizona and California and look at some of those community-based programs."

It was probably a good thing to do that. We decided we'd have to come back. We'd have to serve off the scholarship. Why not train in the community or in the area where you're going to be referring patients back to? So, I didn't really think I'd be going back to my hometown, but a lot of the physicians back in those days in Salina grew up rural or had practiced rural. We had a general surgeon, Dr. Ramon Schmidt who practiced in Garden City. He knew Tribune and what not. We had an OB-GYN, Dr. George Marshall, whose dad was a general practitioner out in Colby. It was great to have folks like that as mentors because when you told them you were going to go back to critically underserved locations, they were always like, "Then you need to see this. You need to do more of that." They really drove my training to make me better prepared I think to go back to a critically underserved environment.

When the time was approaching to look at what community am I going to select, we found out we were expecting our first child. It took a little bit of convincing to get my wife behind the idea of moving home. We joked she'd become citified. She was used to being a little bit more anonymous in a community like Salina than what you would be in Tribune. She wanted to use her degree, which was respiratory therapy, and so she liked the idea that we had two built-in sets of grandparents in the way of our parents.

So, we decided that, yes, let's look at moving back home. Really, truthfully at that time, I knew I was going to commit four or five years, but at some point, I always entertained that I really enjoyed the teaching side of things, and maybe going back and teaching in a residency would be in my future.

BSP: Did you have students or residents that would rotate through at all in Tribune when you were there?

RM: I sure did. It was kind of my opportunity to pay back. I had some great rotations up in Seneca, Kansas and Hays, Kansas when I was a medical student and enjoyed that and felt like to some degree, the way they operated that rotation, they didn't always necessarily select the best students. It was just any willing spot they would send a student out to.

It was interesting. I'd get kids out. I think they thought they were being punished. "Why did you choose Tribune?" "Well, I didn't. I was just assigned here" and then find out, "What do you want to do as far as your specialty?" Most of them were fourth year. They had already made a decision. A lot of them would, "I want to be a pediatric cardiologist." "I don't think you're going to see a lot of that out here, but you'll have a great broad experience" and what not. "I think you'll appreciate the challenges we face in caring for patients with complex problems." "We did get a couple of students that enjoyed it so much that they switched their specialty to family medicine.

BSP: That's awesome. I know they still rotate KU med students out to rural communities.

RM: Yes.

BSP: I have three nieces that all went through KU Med School and did that rotation and really enjoyed it.

RM: It's been going on since the fifties, Dr. Murphy's original plan, and I think it's important. No matter where you're going to end up practicing, if you're going to be a specialist, you're getting referrals in, and I think it's important you understand that these folks are practicing in limited resource environments. You need to recognize that. You can't tell them to order this or that test or do this procedure. They're probably not calling you because they just can't do that. They just don't have those resources. So, I think that exposure is good.

BSP: The clinic and health center in Tribune is infamous in Kansas for being very innovative and providing really great quality care at the community level. Tell me a little bit about how that was built up over time, your role in that. I know you were there at a very transformational time for that system.

RM: Yes. It was really kind of a generational shift. It used to be physicians would move to a community, and you'd be employed by the old docs, so to speak, almost like the apprenticeship programs back in the day, and then eventually buy them out. Well, I didn't go to pharmacy school with all of the business training there to work for anybody. My attitude was "We're independent. We'll operate that way and we can structure this to make it work."

At the time, the hospital was managed by a company the county had hired. The long-term care was managed by another company, and then you had the practices, which were independent, but in a community-owned clinic that we paid a dollar a year rent on. So, I thought it odd that we were all taking care of the same population, but we've got three different entities that are kind of making decisions. I found myself the only physician after about a year and a half of being there in Tribune, and then about nine months later, the old doc up in Wallace County retired, and they reached out to me. Their economic development office had done a survey. "Which community should we align with for health care?" Tribune got selected. I was like, "Well, that's fantastic, but I'm the only one."

So, I was busy trying to recruit nurse practitioners, PAs, and they're no different than physicians [as far as choosing rural practice]. It's kind of tough to move into that environment unless you grew up in it or had some exposure to it. So, for about two-and-a-half years, I was the only doctor covering those two counties. I found a nurse practitioner that I had for about six months. I was finally able to recruit another family physician out of the Smoky Hill program.

BSP: Just coming out of their training?

RM: Yes, indeed. He [Dr. Wendel Ellis] turned out to be a National Health Service Corps Loan recipient, and so he had to have a guaranteed contract. I said, "You should be employed by the hospital. You don't want to work for me. That's just not the right kind of arrangement." But as we ended up then using that same program to recruit a physician assistant, it was tough to set up a retirement plan and everything else that we needed. So, I finally said in that time frame about two years into me being the only provider, I convinced the county to put the nursing home under the Hospital Board and then said, "Okay, now it's time that we put the clinic, and we'll all work for this system."

That was a little tough. I was ten years into my practice. I was giving up a little bit of control, but it didn't take long to realize that really, it's a symbiotic relationship. If it's not working for the physicians, it's not working for the health system and vice versa. So, we kind of established where we were at the board meetings. We were hearing the financials, and we were part of whether that was succeeding or not. That was the mindset.

Then we went with convincing the Hospital Board that we needed to continue to recruit. I remember Melvin Cheney, one of our board members. He'd been there for a while, and he said, "Just how many physicians do you think the county can support?" I said, "It's not just really the county. It's the surrounding area, and I think four or five."

They were kind of flabbergasted that it was that big a number but interestingly, that was kind of our motto: Never stop recruiting. You just don't know when the opportunity is going to come up, or something happens, and you're suddenly shorthanded again.

But during that time, we'd also been blessed by bringing in folks typically that had married somebody in either Greeley or Wallace County. One of those that came back and joined our practice was Chrysanne Grund. Chrysanne was the first one that we said, "Hey, we've been doing these educational programs down at the Senior Center. It would be nice to have an LCD projector where we could show big enough"—they could see that. We said, "Why don't you write a request to the Kansas Health Foundation for an LCD projector?" She said, "How do I do that?" "Just write it up, say this is what we want, here's how we're going to use it and what not." She just took that, and we got not only the LCD projector but a laptop and a carrying case. We then sent her off to do grant writing.

Then we started looking at, "What are the needs that we have that we might be able to find seed money through grants and what not to start developing that?" Grant writing really became a strong suit of Chrysanne and the practice and the hospital system all behind that. When I left, we had over three million in grants for a variety of different projects, and all of that really did help with developing the system that we had there.

BSP: It seems like that perspective of understanding the needs of the community and organizing the services around that is something that stuck with you through your career in lots of the future roles that you played.

RM: Early on, before it became—required, where both public health, and the health nonprofits had to do community health assessments, we had one in 1992, so before I got a partner. We had the clinic in Wallace County and the hospital in Tribune along with the clinic. I was the medical director for the long-term care in Tribune, the long-term care in Wallace County. I suggested that maybe we ought to do this as two communities doing a community health assessment because we're kind of tied together. We had really great participation among both communities, and it was interesting because we had an opportunity to put a lot of ideas out there about things that maybe we ought to look at as a region, whether it improves our well-being or not, but maybe it's convenient.

So, one was the challenge in getting enough people willing to apply to run for office. So, these small towns have a county commission. They have the city council. We actually put a question in the 1992 community health assessment for Greeley County, "What would you think about just having a combined city/county kind of government?"

It was actually kind of 50/50. The one question that I thought would be fairly easy but raised the most controversy was I asked to consider why we don't all go under Central Time. We were one of four counties out there on Mountain. It was okay because obviously all of our practices were along Highway 27 north and south there, so they were all on Mountain Time, and it was kind of convenient. If I sent a patient to Garden City for hip, knee, general surgery, whatever, I tended to have them scheduled that so I could be there and do the surgery with them because I wanted to keep those skills up, but also to let those patients know I wasn't just sending you away and forgetting about you. But being on a different time zone meant I had to get up a lot earlier to get to Garden City for an 8:00 surgery. By the time surgery was done, I could run out and play nine holes of golf and be back in Tribune in time for afternoon clinic.

But it turned out that those in agreement for the time change was about 30 percent. Seventy percent said no. Of course, we had the opportunity for them to put the reason behind it. The reasoning was really fascinating. The majority of those didn't want to change because they banked in Colorado. I don't know what that has to do with the time on the clock. You just work around that time, but the most interesting one was on Mountain Time, you could watch the news and go to bed at 9:00. They had good reasons.

BSP: Remind people that Greeley County is right up against the Colorado border in western Kansas.

RM: Yes.

BSP: And is the least populated county in the state of Kansas with 1,200 and some residents.

RM: That's true.

BSP: So, all of these innovations that you're talking about were really ahead of their time, this multijurisdictional sort of approach to community health and organizing the system under a consolidated sort of structure is really very interesting. Tell me how being the only physician for that many years with call, tell me about the personal toll, the professional toll, the family toll of having that kind of responsibility in the community.

RM: That was tough. I mentioned we were expecting when we went out there. So, in January of '89, we had our oldest daughter, Lauren. In '92, we had our second daughter, Madison. This was all during the time when I was the only physician. It was tough because you're on call 24/7. When you heard a siren go off for the ambulance, "I might as well go to the hospital because they're going to be calling." Or you'd hear an ambulance siren approaching town, you just knew you were on.

So, yes, I was doing obstetrics and everything. That was tough because not having a partner, I couldn't do C-sections. You had to be a little bit more astute of what's going on. Is this progressing as we anticipate? And if it's not, being prepared to load up and go with the patient to Garden City. I had a couple of great OB-GYNs in Garden City that were very supportive of what we were doing. It made it easier. A good general surgeon, Dr. Arroyo, who came out of Garden City once a month to do outreach and cases in Tribune. There was support but not 24/7. I did have to recruit a couple of recently-retired old family doctors, one out of McPherson, one out of Scott City and pleaded with them, "Would you be interested"—

BSP: Give me a weekend off.

RM: Yes, give me a weekend off here and there. Neither one of them wanted to deliver babies. We kept our calendar, if you would, marked. Any time they were within three weeks of delivery, no vacations, no weekends off, but there occasionally you hit when you were delivering seventy to eighty babies a year, you hit a couple of weeks where you didn't have any anticipated.

I had a Smoky Hill graduate who was down in Syracuse [Dr. Doug Parks], and he delivered. From time to time, we said, "Hey, if somebody comes in, I'm going to have back-up for covering the ER and everything, but if it's a baby, can we send them to you, or will you come up here?" We had it worked out, but our vacations—I think our daughters grew up, thinking that a vacation was a hotel with a swimming pool. If we had that, that's all they cared about, but they knew Dad would be gone most of the day at educational webinars and maybe they'd have a big supper and that would be that.

Yes, we did miss out. I think there were several Christmases where I didn't get to wake up with the kids and the excitement because I was over delivering a baby. We missed out. It was amazing when I got my first partner, and he said, "Look, I'll be on call for a week, and you'll take the next week." I'm like, "Okay, that sounds great." And all of a sudden, it's like, "What am I going to do with all of this extra time?" It's just amazing. It's the old frog in the boiling water. You don't realize just how hot it is until you step out of it.

BSP: You mentioned a couple of programs—loan repayment, National Health Service Corps that back in the day were very important in getting physicians to practice in small rural communities. It continues to be a challenge to this day to get practitioners to practice there, physicians, nurses, advanced practice nurses, all those sorts of things. What's your view of how it was working back then and how it's working now?

RM: It's only changed a little bit in they reduced the number of slots. I think there needs to be some flexibility because things change. We're all economic creatures and every time there's some proposal in health care policy where primary care is going to be elevated to a more important role and you get reimbursed better, then you kind of see students start selecting family medicine in larger numbers. But for the most part, that program remains very successful. The students that take that tend to go back out to rural practice. I haven't looked at the data in the last eight years or so, but what I see anecdotally is that we're probably getting more students where it used to be like myself, when you took that loan, and you kind of assume, "It's a four-year commitment." You're probably ingrained in the community by that time, be least likely to leave.

Now I think you're seeing a little bit more where they do their four years, and next thing you know, they've moved on a little closer to maybe not urban, but closer to an urban center. But in general, it's still the best way to at least get an opportunity for them to get out there and establish a practice and support the community.

BSP: Talk about the medical school campus in Salina and its role in helping to address this provider issue and how it's unique from other campuses at the med school.

RM: I've been involved a lot over the years of how do we get more doctors to rural and looked at all of the national studies Rabinovitch and folks back East [did that showed] the more you trained rural, the more exposure you have to rural, the more likely you'll do primary care and practice rural. So, when Governor Sebelius formed a GME task force to kind of look at how we pay for residency programs, particularly in the Wichita program which is part of the—the Salina program is part of that. Then shortly after that, KU with Dr. Mike Kennedy had a physician work force. He and Allen Greiner looked at, "What is the current work force? What do we need? Where are the gaps?" I got to serve on that and then eventually be named the chair of the Primary Care Collaborative Committee, which was really to take all of the recommendations that came out of that and to work with the school, Dr. Barbara Atkinson, and try to implement that.

One of those was we looked at the fact that the more we can train them in rural, the more we'll get primary care, more likely rural practice. We were already expanding third- and fourth-year clerkships into Salina.

BSP: What years was this?

RM: This would have been about 2005 to 2008. We put forward the recommendation that KU should look at expanding to full four years in Salina, a full four-year medical school in Wichita. That way, they were spending more time. Wichita, to most people, that's one of the largest urban centers in Kansas, but it's a very strong primary care system. A lot of the family medicine providers were doing OB and hospital rounds and what not. Over time, that's obviously changed. They've had a fairly high success rate, a percent of students choosing primary care and ending up practicing rural. It made sense. The more time we could have them train in those environments, the more likely.

When they approached the Salina community about expanding to a four-year medical school, I think they were kind of concerned. What's the impact going to be on the family medicine residency program? The other is, would there be enough community physicians' interest in helping with teaching and clinical exposure for the students? But Dr. Cathcart-Rake [KUMC-Salina founding Dean] got behind that and got community physicians behind it and got that up and rolling. Of course, they had it in what was an old nursing school building behind Salina Regional. I was secretary at KDHE at the time and got to go down and tour the school and what not. These students are making a commitment to come here with the physical layout compared to what they have in Kansas City or Wichita. This is a group of students that are going to be tough and really committed. They've done well with the number of students that are choosing primary care.

Salina, as we see with a lot of educational programs, if you build it, they will come in the sense that now you've got medical students who are training there four years going off and doing residencies, but Salina has benefited by having more orthopedic surgeons come back, pediatricians, etc. That only strengthens that training program further for the school.

When Dr. Cathcart-Rake announced he'd gotten the school going, he was ready to step back, and they reached out and asked if I might be interested in that role. Having been part of that physician workforce committee, I thought that would be really a unique experience. I was doing some teaching in the Department of Pop Health, mostly leadership and public health practices.

BSP: Population health.

RM: Yes, population health. I'd been involved with the new curriculum that KU had developed and felt like this would be fun. Little did I know when I took that role in June of 2019, that we'd shortly be in the COVID pandemic. That made it a little bit challenging transition.

BSP: I'll come back to that. We skipped a little bit. You spent twenty-two years in Tribune.

RM: Yes.

BSP: And began your work with KU in different capacities. Then you got a call from somebody we were talking about earlier, Kenny Wilk, talking about health care and health policy in Kansas. Tell me about what that conversation led to.

RM: Yes. When the youngest daughter graduated high school, I was one of five family physicians in Tribune. So, we'd really built up the medical community. Four of us were delivering babies. So, my older partner and I decided since I was the old guy, I could step out and no longer deliver babies, which was actually one of the things I really enjoyed, but that was okay. I wanted the younger ones to get the experience.

But when the youngest daughter graduated, I thought, "You know, I don't think I can leave Tribune, Greeley County, Wallace County in any better hands than now. If I step out now, they're not going to be terribly shorthanded." This would be my opportunity to get back into the academic side of things. I had Dr. Rick Kellerman who was the chair of the Department of Family and Community Medicine, he'd taken over the Smoky Hill residency the summer that I graduated and started my practice. We'd known each other over those twenty-two years. He was always bending my ear about, "You ought to come back and teach and get involved in the program."

When I reached out to him, actually it was at the National American Academy of Family Physicians meeting, sitting there with my wife, and said, "I'm going to ask Rick about whether he's got any spots for teaching." I leaned over and he kind of reared back. He said, "I've been asking you for twenty years. Yes, I've got a spot for you."

We started making the plans on how that would work, what would it look like. We decided we'd make that move. So, I stepped out of my practice in Tribune in August and started with the department down there in September 2010. Lo and behold, in October—

BSP: That was short-lived.

RM: Very short-lived. I was actually helping supervise Wesley Family Medicine residents, and a family medicine resident who grew up in Tribune, was doing family medicine there. She was on her OB rotation, and I was faculty covering. I got to go in and watch her handle her first delivery as a resident. I got back to the house. It was about 8:00, and the phone rang. I was fairly new to Wichita. I assumed it was the residency or the school. Lo and behold, it was Kenny Wilk. I'd known Kenny from the Kansas Leadership Center. We had a few great conversations. He was on Governor Brownback's transition team, and he called. He just wanted to ask, "It's being tossed around that maybe we ought to go back to the old days and hire a physician to be the director, the secretary of the Department of Health and Environment. They can also be the state health officer." I said, "Yeah, that would be a great idea." I gave him a good five-minute lecture on why I could see the benefits of that on both sides. I said, "You'd probably save a little bit of money, too." I didn't know that was probably one of the driving forces.

Anyway, he wanted to know why I hadn't thrown my hat into the ring to be the secretary of the Department of Health and Environment. I kind of laughed at him. I said, "I'm just an old country doc. I don't think I'm qualified. He said, "Wait a minute. You told me you're the county health officer and all these things. I think you ought to at least come up and have a conversation."

So, I said, "Well, it can't hurt, I guess." That's one of the things, I'm willing to at least have the conversation. The next thing I knew, I was being promoted into that, appointed as the secretary of Health and Environment, serving as the state health officer. Within the year, I was the CLIA [Clinical Laboratory Improvement Amendments] medical director for the Public Health Lab because we could reduce the contract cost for that.

BSP: I was here working at the Institute when that happened. It was a great opportunity for public health in the state. I think people really did appreciate that background that you brought to that position. Tell me a little bit, what experiences do you think were particularly helpful to you in your role as secretary of KDHE?

RM: It was the area when you look at how broad and complex that agency is with health and environment, and then we made it more complex by bringing in health care finance, the Medicaid program. I probably had more interaction with the environmental side of KDHE as the county health officer.

BSP: Back in Greeley.

RM: In Greeley County, serving on our economic development board, the Bureau of Waste Management. Even when my father decided he was ready to retire and sell his garage because it was a garage in a body shop, they came out and wanted to drill wells to test for oil leaking through the soil. We both thought that humorous in the fact that it's all clay soil, and it's 300-

plus feet to get to water. There's no way in the world that clay soil is going to let oil or gas leak down there. But he had to go through that expense and what not.

I'd gotten to know a couple of state health officers going to some of the public health meetings. I was the medical director for the County Health Departments, both in Greeley and Wallace for a while, and then turned over some of that work to one of my partners so we could split up the duties. I had some good interactions. They were all great folks to work with, the staff. I probably gave more nasty letters to the hospital survey and long-term survey teams because they'd come out and pick on things that really had nothing to do with patient care. It was just, "This tile's loose." Okay. How's that an immediate jeopardy kind of a thing?

But anyway, I've been known to write a few letters to the secretary about we really need to pull in and make this less adversarial. It should be nobody goes into health care to do harm. Why can't you come out and help them do a better job? They don't have the resources out here that they do in some of the larger communities.

Then finding out that that's really a contracted work that we do for CMS. So, they made that sound like you can't—

BSP: CMS is the federal government that runs Medicare and Medicaid.

RM: Yes. So, CMS contracts for Kansas to do the surveys. It's like, "Well, they tell us what to do." I'm like, "You should have a little bit of a backbone because that's a federal bureaucracy. They absolutely have no understanding of how these things operate."

BSP: Yes.

RM: And the rules were probably written by people that probably had never worked in a hospital or a long-term care facility. So, I got an opportunity to get involved in that once I became part of KDHE. It was an eye-opening experience.

BSP: The list of roles that you held in Greeley County covers a lot of bases at KDHE. I think maybe one you left off the list was county coroner.

RM: Yes, that was one of those things that they don't teach you about in medical school. You're going to be out and all of a sudden, you're called to the scene to pronounce and play coroner. That was tough. I hadn't even been in—I think I opened up my practice on August 1st, and in three days, I was on my first coroner call for a suicide, which was someone I'd gone to high school with. That was kind of eye-opening. It was like, "Why am I going?" Well, the older doc was the coroner, but he had appointed me as deputy of the deputy. I had to do that. It was kind of like, "Okay, I need to know more about what are those duties, and how do I need to conduct myself" and what not.

BSP: The public health, the regulatory oversight of facilities, the environmental side, the lab side, all of that. As you were saying, you had touched on that throughout your career. I think Kenny maybe saw that more clearly than you did.

RM: He may have. As I had gone through the initial kind of interview process, most of it was interest in health care policy, and I'd been in AAFP and KMS and AMA and all the conversation is around health care for all for about three years, hearing all kinds of national debate around that before the Affordable Care Act. He was more interested in that but did recognize that—we'd had a conversation about—he was fascinated that I got involved in building a golf course in Tribune. He was like, "How in the world did that happen?" I said, "Well, we had three sewer lagoons, and when the last gets full, they used to just let it kind of overflow into the old creek bed because water doesn't run anymore," and KDHE said, "You can't do that anymore." So, they were looking at the expense of building another large lagoon, and we just said, "You help us cover the expense of routing a pipe to take water, we'll chlorinate the water, and we'll use this to irrigate the greens on a grass golf course." The county said, "Okay, that's better than building a new lagoon."

BSP: So, reusing all that water.

RM: Yes, reusing that. We had to go through a lot of permitting approval process for that. I definitely had a lot more exposure, but I sure relied on my Department of Environment folks. They were great at their job and great at educating me on their roles and responsibilities.

BSP: Talk a little bit about, you said you had a love for science, and you're a physician and a pharmacist and have a lot of scientific training background. Tell me how that blends and interacts with the unavoidable politics, the political arena in a role such as secretary of KDHE.

RM: Yes. Boy, a great question. We've seen of a lot of challenge to that post-COVID where you're training to the expectation of your knowledge base was good enough to warrant an opinion and respected, and now it's kind of gone the other way. It's suspect. Science tries to be as accurate as possible, recognizing that there are variables that you can and some you can't control. But in general, it's being a little bit more astute and using that observation skills and maybe even being a little bit pragmatic at times in how you approach things and always worrying about the unintended consequences. You know, it sounds good, but if you don't stop and think about, "How does that apply here or there?"

So, with policy, I guess I sometimes went into it with the attitude, things were a little bit more cut and dried than they are. They don't have as much nuance. That was a little challenging. Probably the most frustrating thing was feeling like you had an idea of where their ideology was at. Some of that, you could certainly align that you don't like others telling you exactly how to do your work or if you don't like the federal government telling the state what to do. It makes sense. You should have some self-determination and what not.

But to be involved at the state level and then see the legislature literally do that to the communities is like, "Wait a minute. Where's the hypocrisy here?" That was a little bit frustrating. Being involved with the idea that the Health Policy Authority was going to be blended in and the Medicaid was going to come under KDHE, that was intriguing in that we had to find a way to incorporate that and find some efficiencies in that. But with Medicaid reform being on Governor Brownback and Lieutenant Governor Colyer's desires, I liked the idea that it

was going to be directed a little bit more towards outcomes, not just throwing money at problems, but really trying to figure a way to make it better.

And early on, I obviously came in at the time that to everybody, ACA was a dirty word and all that, but there were some things out of that as a provider, particularly a rural provider where I took care of everybody who came through my door. We didn't do a wallet biopsy first to see could they afford it or what was their insurance. It was they're part of the neighborhood. They're part of our population. Knowing that our rural population had a higher uninsured rate, we didn't have a lot of major industry out there. You worked, and you had your insurance through that company. If not, You had private insurance. So, I saw the benefit of that in that we could reduce some of the cost burdens to rural health services by making everybody a little bit more available for insurance.

BSP: You led that agency in a very consequential time.

RM: Yes.

BSP: It was a great tenure from the perspective of a lot of people. Tell me a little bit about how you transitioned out of that role and sort of worked your way to what you're doing now.

RM: All of the transitions I've had to make in my career have been tough and not without a lot of debate. What are the pros and cons? If I leave, is there anything I can do to make this succession more successful? KDHE, it was pretty obvious into my third year that I guess I'd always been kind of led to believe that there was an opportunity to look at expansion, but Kansas kind of wanted to look at a way to do it that might make more sense and be palatable, but when it was clear that that wasn't going to happen, I could never see myself being able to stand in front of a committee and say, "What a great idea it is to not give access and care to people that need it."

So, knowing I couldn't do that, it was time to look at what was out there. Of course, the old practice was, "You can come back any time." Dr. Kellerman let me know that, yes, they'd converted my office to storage, but they could clear that out. "You can come back down here."

But in October of 2014, I was asked by the KU Health system to go out and talk to a group of folks around thirteen counties about this Kansas Heart Stroke Collaborative. As I learned more that, hey, this was a CMS innovation award to look at addressing the disparities in the outcomes for heart attack and stroke in rural Kansas, and they wanted me to talk about population health. KDHE had put out a report in 2012 about heart disease and stroke and disparity between outcomes and mortality rates, and higher readmission rates.

So, I knew there was an opportunity. I kind of knew part of the problem was as we brought on new partners in our practice, what we really benefited from was learning how they were managing things. So, they had elevated our knowledge to more current guidelines. A lot of times, you just do things the way you were trained, and you never change. That's why it takes seventeen years for new evidence to become standard of care.

After talking to that group and seeing the excitement of what they were looking at, it was about a month later the election was over. It was a done deal. It was kind of time. About that time, guess who shows up again? Kenny Wilk who's working for the University of Kansas Health System and the director of our division of cardiovascular health over there, Barbara MacArthur at the time. They just said, "You know, we really just wanted to make an appointment to see if you had any idea who might be a good candidate for an executive director for this work."

BSP: I'm seeing a theme.

RM: I'm like, "Can I put my name in the ring?" Kenny acted kind of surprised. "I'm serious. I don't think that I'm going to be able to stay in this role even though I love working with the folks at KDHE and the challenges that they're facing. I can't serve in the role I'm at now. I'd really like to get back working more directly with rural practices."

So, they said yes. By December 2014, I'd stepped out of KDHE and started with the KU health system with the Heart Stroke Collaborative. Dr. Doug Girod said, "If you're coming to KU Health System, we want part of your time. We'll let you have him 75 percent, but we want 25 percent with the School of Medicine. So, I got those appointments with Pop[ulation] Health and the Department of Family Medicine."

BSP: I had the opportunity to participate in some of the meetings early around the Heart and Stroke Collaborative, a very interesting, innovative idea where KU would coordinate, making resources available through training, through telemedicine, through lots of resources to help them deal with heart and stroke emergencies that they were dealing with.

RM: Yes.

BSP: Tell us a little bit about how that worked and the impact at the community level in the rural parts of the state.

RM: We looked at the age-adjusted mortality rate in rural Kansas, particularly around those conditions and then that higher readmission rate. It was kind of curious as to "Why is that higher in rural?" So, we knew we need to collect a little more data. We went out and collected all of the heart attacks, all of the strokes for six months at each of these participating sites and started looking at "How were they doing based on the national benchmarks for these time-critical diagnoses?"

BSP: What happens in the first hour after a patient presents in the ER?

RM: Yes. Actually the first thirty minutes. The golden hour for trauma, the thirty minutes for a heart attack, particularly. It was really fascinating information, but the data showed for hospitals that were more than an hour away from a cath lab, it was taking about 74 minutes to get the clot-busting drug on board, and the goal is 30. For those that are within an hour, getting them in the door to the ER, stabilized and addressed and on their way to the cath lab was taking about 140 minutes, and goal there is still 30 minutes.

When we were looking at the why behind all that, some of it was just, “Yes, we know there’s guidelines, but we haven’t quite adopted them yet for a variety of reasons.” Turnover of staff, turnover of administrators, turning over nursing. So, we basically worked with the subject matter experts. What would be a good order set off of evidence-based guidelines? My job was, “We don’t have this. We don’t have that. We make it adaptable to rural Kansas” and then gave it to the rural practices and said, “Take a look at this, and let’s adapt it to your local realities.” Ideally, if you had advanced ambulance services with paramedics, you could go out on the scene, and somebody would get an EKG in the field and they could call and say, “Hey, it is an ST-segment elevated MI.”

BSP: The sign of a heart attack.

RM: Yes. Then you could get your team activated. These were mostly volunteer EMTs. As a matter of fact, our data showed that over 75 percent of patients with chest pain in rural Kansas arrived by private vehicle. They don’t call 911. So, as we did focus groups, “I live twenty miles out in the country, but by the time I call 911 and they get here, I could be at the hospital.” Stroke was a little bit better. It was around 60 percent. They showed up by private vehicle. We decided after doing some focus studies it was just harder if you were the only person there with someone when they had that stroke, if they couldn’t move one side, you couldn’t get them in the pickup or the car. So, you would more likely call the ambulance.

Within the first three months of starting this, after they looked at their order sets and they adjusted them and made them local orders, we went back and started collecting, “How were you doing on your time measures?” We went from seventy-four minutes to get the lytic down to fifty. Door in, door out dropped to about seventy. Over time, it kept getting better to where the door to lytic was almost at the goal of thirty minutes. The door to transfer kind of still varied around a lot, mostly because you had to call whatever the system wanted. You called the ER, and you talked to the ER doc and then say, “I’ve got a heart attack patient.” Then they might ask a few more questions and said, “Yes, send them to us” or “No, you need to talk to the cardiologist.” You talked to the cardiologist. So, you spent thirty minutes on the phone—some built-in things with larger regional medical centers that actually impacts our ability to deliver quality care in a rural setting.

But we saw great results. These folks enjoyed the fact that instead of telling them, “I know you’re distributed out here in northwest Kansas. Come to Hays for a meeting, and we’ll talk about the evidence-based guidelines, and why your order sets are designed the way they were.” Having been there, done that, I knew that you might get one, and they’d go back and nobody else would understand why they’d want to make these changes so the likelihood of success would be low.

We decided that the way we were going to do the training was to go in person and we do training for EMS nursing, physicians, you name it, all the providers in the morning and then do another one in the afternoon so everybody could hear the evidence behind the orders.

BSP: I would describe that as a very experienced, informed approach to helping rural practitioners and has been a really innovative program that’s still ongoing in different shapes and

forms. Just from a time perspective, after you did some of that work is actually when you went back and worked in government. But let's continue this thread about innovations addressing rural health. Tell me about the project that you're involved in now and sort of where that is headed.

RM: Sure. We continued to add other conditions and ended up changing our name from the Kansas Heart Stroke Collaborative to just the Care Collaborative. We went from thirteen counties to thirty-six, forty-eight, and now we're in sixty-nine counties and to have over ninety different entities that are members of the Care Collaborative. We don't charge to be part of it. We just ask that you put in the sweat equity that you know that we're going to focus on quality. We'll start with STEMI, the heart attacks, the stroke. We added sepsis in 2015, which turned out to be kind of timely for COVID.

BSP: Sepsis being an overwhelming body infection.

RM: And that was really what COVID was, was a viral sepsis. As we expanded training programs and expanded sites and what not, we had turnover of staff. We'd have sites that would want to have refresher training. Then we took on a few other grants just based on what the needs were that were identified. So, behavioral health was really something that everyone reached out to say, "What can you do to help us with that?" "So, we were able to establish a tele behavioral health program with ten sites in 2018. That is still operating, mostly because every time, we'd take a grant or an opportunity, we'd look at, "How can we make a business model for this to make it sustainable?"

So, Jody Schmidt who's our executive director now for the Care Collaborative, we kind of joke that we look at grants as venture capital. It just gives us a chance to implement the program, and in that, we find a way to make it sustainable. So, we've established chronic care management that we do for some rural practices, which is a billable service. They just don't have an extra body to spend the time on the phone working with patients, remote patient monitoring is something else that we've ventured into for rural sites.

So, because of all that involvement with rural, I was fortunate, a good relationship with Governor Kelly. She just reached out in August and wanted to see if I had time to come in and talk about rural health, particularly this rural health transformation program that was coming out after the bill passed in July around the HR-1, the budget bill. They were going to try to make up for this 78 billion dollars that's going to disappear for Medicare and Medicaid reimbursement with the 50 billion dollars distributed to try to transform and maybe stabilize rural health care.

We were curious obviously with all the work we do with rural, what was going on, what kind of conversations have been happening because we hadn't heard much about it. So, in our conversation with Governor Kelly, there was a great question from her as always, "What are you hearing? What do you see as the biggest challenge?" I said, "It's easy. Every time I go talk to a group, they'll talk about their work force. What are you doing to grow your own? What are some of your biggest challenges around meeting these quality measures?"

So, work force was always #1. Transportation, EMS by statute was set up as a 911. They've got in their mind that the only time they really have to go out is when the dispatch calls them for a

911 call. They kind of lose sight that they're actually part of the health system. That means that that local hospital has somebody who actually needs to be transferred for a higher level of care. Maybe they're not emergent, but it's certainly urgent. Why wouldn't that qualify? You get paid for that. A lot of communities have met a lot of ebb and flow resistance on using ambulance services to move patients between rural hospitals and larger. So transition of patient care, it's just terribly common out there.

And then the third thing I kept hearing and observed are regional hospital systems as they've struggled to maintain nursing staff. They've lost some capacity for patients to be referred into. So, you get denied. You can't send your patient here. You've got to send them further. Then they've lost some specialties. When they lose that specialty care, then our patients have further to travel.

So, we had the conversation and said, "Where's the state at on the application? We're sure interested to help in any way we can." Before the day was done, we basically said, "Look, we'll stand up and help write this grant with the interagency work group and what not. We'll do that at no charge. We've got some commitments from funders to help with costs." So, a grant writer and Martie Ross who's been with Pershing Yoakley Associates, PYA, and was the one who wrote the grant that created the Kansas Heart Stroke Collaborative. She's been involved in that.

So, we've been engaged with the Kansas Rural Health Transformation program and working with Secretary [Janet] Stanek and her team and Matt Lara, her chief of staff who's the program director for that and KDADS [Kansas Department for Aging and Disability Services] and what not. So, it's been really fun to be kind of be involved back at that level and in developing a program and a plan we hope will give our rural communities, our regional hospitals an opportunity to look at "How can we become a little bit more financially stable? How can we develop some of the services, the needs that are within that area and truly do a little bit of transformative and innovative models of care?"

BSP: It's a critical time for the health care in rural parts of the country and in Kansas. This 50 billion dollars to partially offset the cut in some of the reimbursements, how much will actually come to Kansas out of that?

RM: We were fortunate. They told us on the application process to assume that you would get 200 million, which was tough. How do you develop a plan with the idea that if you don't get 200 million, you're going to be reducing some funding for certain activities, and maybe that will impact that activity from being successful. We went into it with great input from a large number of stakeholders. The governor created the Kansas Rural Health Innovation Alliance of rural stakeholders. We had over 250 submissions of ideas and projects and what not that people submitted that we were able to break down into the five themes that became our five initiatives which really do align with the five strategic pillars of the Federal Rural Health Transformation Program. Out of that, we've got twenty-four different programs and fifty-five different projects. It's a very complex plan. I'm sure there are a number of things you can look at and say, "Why wasn't this included?" or "Why wasn't that?" I think in the fact that even though this plan's approved, and it's basically what the plan will be for the next five years, there's still opportunities to address a number of other areas that folks feel might have been left out. But

we're sticking around and helping the state with the implementation on this. What we knew was in order to maximize the possibility of grant funding coming in was to have a lot of shovel-ready programs and projects together. Obviously, the Care Collaborative has been involved in a lot of that. We could expand on some of that work. So, yes, we figure prominently in the application planning and in the implementation, but mostly because we've been doing this for eleven years, and we've been successful at it.

BSP: It's a great opportunity for the state to use those funds well and make some improvements. Great.

RM: Thank you.

BSP: Thinking back on your career, I love the consistency of your passion and focus on rural issues. What would your advice be to a young person, a medical student, a resident thinking about that as possibly a career choice?

RM: I would strongly encourage them. I know you're hearing all the time, on every rotation you're going through as soon as you tell them you want to do family medicine, they're going to tell you you're wasting your skills and knowledge, that you're going to be replaced. I've been hearing that for forty years, and it's not true. I think the other is that when you think of where you're at now as a student or resident, sure, you don't have the skill set. You don't have the experience. You haven't been exposed to a lot of things. That will happen as you go through your training, particularly if you make yourself available to be on call with the ob gyns. When they've got a case, you'll be called. That's kind of what I did. The general surgeons in Salina were great to work with. You just say, "Hey, give me a call any time after 6:00 because I won't be on call this week for this rotation. I'll come up and be your first assistant."

So, if you make an effort, you can get that experience and exposure. That will help with that fear everyone has about practicing rural, which is what I lived through and I survived, but you don't want to find yourself in solo practice. You're the only doctor in a rural community. That's what I think drives most to be fearful of making that commitment. But I think there's ways you can set that up so that you're not. We've seen that where we've recruited in southwest Kansas kids that are interested in missionary medicine. There may not be a spot for you all to move to one town. Benjamin Anderson in Lakin kind of helped initiate that. But if you are in Lakin and Garden [Garden City] and Tribune and you all decide you want six weeks to go do a medical mission, then you can do that.

BSP: Cover for each other.

RM: Exactly. Instead of all three of you being in one community and now you're all gone, that would really leave the community behind. So, there are ways around it. I think I'd just encourage most students, if you really have a passion for rural—I'd even say if you want to go back and serve your own community, it's doable. There are some built-in challenges, but one thing I noticed is I knew everybody's social history and family history pretty good. I didn't have to ask a lot of questions. But it's exciting, and you get to practice at the extreme limits of where you've been trained and your opportunities. I think a lot of them see my career and get excited about

being involved in policy and things like that. I always tell them, “Temper that excitement. Gain the experience. Participate when you get the opportunity on committees and learn.” You’ll have a chance. It doesn’t just happen overnight. You’ve got to kind of build on that exposure.

BSP: I think that’s a great place to wrap this conversation up. Thank you very much for joining us today.

RM: You’re welcome. I enjoyed it. Thank you.

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