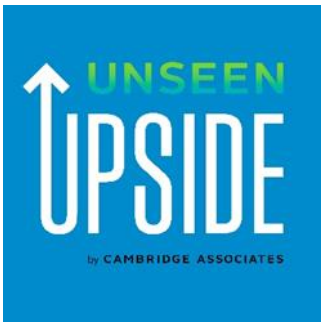

Season Five: Episode Three
From Barriers to Bridges: Rural Health Access
Launch Date: November 5, 2024

[MUSIC]

Hillary Ribaudo: Imagine having to drive—or even fly—for hours just to see a doctor or waiting months for an appointment that could save your life. For many in rural America, that's an everyday reality.

According to the CDC, about 1 in 5 Americans live in rural areas. Yet, only about 12% of doctors practice in these communities.

[MUSIC]

Alyssa Jaffee: And healthcare is not just the care you receive from a physician. Healthcare is the food that you have access to, how you pay for that food, the housing that you have, the transportation that you have, the job, the benefits, the insurance or none, your socioeconomic status. All of that goes into your overall health.

Hillary: Limited resources, long distance travel, and fewer healthcare providers make accessing care a constant struggle in many rural areas. This not only leads to delayed treatments or missed care altogether but also deepens health inequities, impacting millions of people in underserved communities.

[MUSIC]

Alyssa: There are people in this country who are born rounding home plate, and there are people who are born just trying to get to be a batter. And so, that creates such a seismic inequity, and we have so much work to do as it relates to not just social determinants but also the education required to help close the gap.

Hillary: In this episode, we're taking a look at how healthcare is reaching some of the most remote parts of the country. And we'll dive into the challenges these communities face and the innovative solutions that are making a difference.

Susan Rawlings Molina: We need people who believe in it, who want to put some money behind it. Investments in these areas can bear deep fruit and create some connections across diverse, not only populations, but resources in a way that actually bring everybody along.

Hillary: This is Unseen Upside by Cambridge Associates, where we explore investments beyond their returns. I'm Hillary Ribuado.

[MUSIC]

Hillary: To talk about rural health, we need to understand what "rural" really means. Interestingly, there's no single, universally accepted definition. The Washington Post reported that the U.S. government has at least 15 different definitions, with 11 coming from the U.S. Department of Agriculture.

A 2020 report by the Rural Policy Research Institute breaks it down to two very obvious points: rural areas are places that aren't urban, and they're defined by population size and how far they are from urban centers.

Lucas Trout: Depending on how you define rural, somewhere between 45 and 60 million Americans live rural or remote.

Hillary: Lucas Trout is a lecturer on Global Health and Social Medicine at Harvard Medical School.

They need healthcare as much as anyone else.

[MUSIC]

Hillary: Perhaps one of the most remote areas in the United States is the Northwest Arctic, in Alaska where access to health care has been a challenge for generations.

> **Esther Norton Video:** How we gonna take care of our sick people? No nurse, no doctors.

Hillary: Esther Norton was born in Noatak, a small village in Northwest Alaska. In the 1930s, when she was a young woman, the closest hospital was hundreds of

miles away. Transportation options were limited and dependent on weather. So, in times of crisis, the people of Noatak had to be resourceful.

> **Esther Norton Video:** When somebody is real sick, we write a letter to the hospital

Hillary: In this recording, Esther recalls a time during the early days of World War II when several people in her village were very sick. With no way to get them to a hospital, the community came together to create a solution. First,write a letter detailing the condition of sick residents. Then, a small group would travel across the tundra to deliver that letter in person to the hospital. And those back in Noatak would wait, not for a written reply but for a response from an entirely different source.

> **Esther Norton Video:** They blind message to us through the radio, and we write them down and we know what to do with this patient and what's the problem.

Hillary: Amazingly, the people of Noatak treated their sick by radio. The hospital would send instructions over the airwaves, and Noatak residents would tune in to learn how to care for their neighbors.

> **Esther Norton Video:** That's the way we managed to survive those years.

Hillary: Esther shared this story in 1996 at the Communities of Memory event at the NANA Museum in Kotzebue, Alaska. Even though it's decades old, her story of community care, innovation, and resourcefulness is still relevant today. These same principles continue to shape healthcare in remote parts of Alaska, where creative solutions are the key to delivering care.

Lucas: You can look back 10,000 years and see how folks were taking care of each other here on this land.

Hillary: Harvard Medical School's Lucas Trout.

Lucas: Those traditions still inflect the expectations of patients and the roles of caregivers today, in a way that I think we could probably learn a lot from in the rest of the country.

Hillary: These days, Lucas splits his time between Boston and Northwest Alaska.

[MUSIC]

Lucas: It is truly one of just the most beautiful places you could ever hope to see. It is really varied from coastal villages to upriver villages, very ragged tundra to beautiful forest, to coastal land. Every village is different.

Hillary: Lucas is also the founding director of Siamit, a health equity action lab at Harvard's Center for Global Health Delivery. It operates in partnership with Maniilaq Association, the region's tribal non-profit healthcare organization.

And he joined us from Kotzebue for this conversation.

Lucas: By Alaska standards, we do call Kotzebue a city. It is the hub for health and human services infrastructure for this huge region for about 40,000 square miles of the Alaskan Arctic and subarctic on the northwest coast of the state.

Hillary: With a population around 3,000, the city of Kotzebue plays a vital role in Siamit's delivery of healthcare in the surrounding area

Lucas: Kotzebue itself is about 33 miles north of the Arctic Circle, and it's off the road system, as are all our villages in the Maniilaq service area.

Hillary: In Iñupiaq, one of over twenty indigenous languages spoken in Alaska, Kotzebue is called Qikiktagruk which translates to "almost an island." And it truly lives up to its name in the sense that as remote as it is, Kotzebue connects to 11 federally recognized neighboring tribes or villages.

Lucas: Think a region the size of the state of Indiana with no roads connecting any community to the outside world or the communities to each other. The way you get around is on a small airplane, like a little Cessna grand caravan, or seasonally on a snowmobile or a boat.

Hillary: About 8,400 people are serviced on and around Kotzebue by the Maniilaq Association. And the city is a hub in a bigger healthcare system.

Lucas: The model for most of the regions is a hub and spoke model, where community health aides and behavioral health aides and dental health aides staff village clinics. A number of village clinics will be connected to regional hub hospitals that house most physician services.

And then those hub hospitals are connected to one big tertiary care center in Anchorage.

Hillary: Meaning, a hospital with the advanced equipment and expertise needed for more specialized care.

And today, like in Esther's time, the closest major hospital is a long distance away.

Lucas: We're 550 air miles away from Anchorage, which is our nearest tertiary care center. So, when a patient needs to get to definitive tertiary care for a health emergency or another issue, that's how far they're traveling, and it's always on a plane.

Hillary: The impact of these distances is clear in the statistics.

Lucas: Alaska natives have higher than U. S. averages for all 10 leading causes of death.

Hillary: In the U.S., the leading causes of death include heart disease, cancer, and unintentional injuries. A 2019 CDC study found that American Indian and Alaska Native populations have higher death rates across all age groups and the lowest average life expectancy compared to white, Black, and Hispanic populations. These disparities stem from a much larger historical context.

Lucas: American Indians and Alaska Natives have a federally guaranteed right to healthcare. They're promised all proper care and protection to ensure the highest possible standard of health. And a big part of the story of this country is through trust and treaty with various tribes across the country: the promise of health care in exchange for land.

Hillary: And where the federal government failed to meet treaty agreements, Alaskans advocated for and won the right to run their own healthcare system.

Lucas: So basically, in the 70s, Alaska Natives sued for land back and won. And the way that that happened was different regions formed Native corporations and got certain rights for tribal self-determination.

Hillary: This resulted in passage of the Indian Self-Determination and Education Assistance Act in 1975.

Lucas: One of the outgrowths of that was the Alaska Tribal Health Compact, where tribes assumed ownership of their own health services. So instead of relying on the federal government to directly administer services, tribal health organizations, as they're called, enter into these compact agreements, where they receive funding from the Indian Health Service among other funders, but they run their own health services.

Hillary: The Indian Health Service, or HIS, provides federal health services to 2.8 million American Indians and Alaska Natives across 37 states.

Maniilaq Association is an example of a tribal health organization that serves Kotzebue and the surrounding villages. It's overseen by a 12-member board that's made up of local tribe representatives, who manage their own health system.

Lucas: There's a ton of latitude to design a health system that best suits your patient population, that meets the need of your own specific local or regional context.

[MUSIC]

Hillary: In Northwest Alaska, controlling healthcare means focusing on prevention and community health, not just clinics. This approach, which is called "social medicine", looks at how things like poverty, education, and living conditions impact health. It aims to make healthcare more fair and accessible for everyone.

Lucas: I think of social medicine as consisting of two parts. One is a sort of field of inquiry charged with understanding the social forces that shape health, and the second piece, equally or really far more important, is delivering care that attends to those forces.

Hillary: Social medicine is at the core of Siamit's mission. But before we dive into their work, it's important to understand what it really means to deliver care here.

Lucas: Care, for the most part, is delivered as close to home as humanly possible, which is something I really appreciate about this system.

Hillary: Instead of making patients travel to the doctor every time they need care, providers go directly to them. These providers are highly adaptable; they're equipped with a broad set of skills to handle a variety of healthcare needs.

Lucas: A doctor here is also a nurse and a social worker and a community health worker and a patient advocate by necessity, and their patients expect that, and it is really on them to occupy all of those roles to the best of their ability.

Hillary: But one of the biggest challenges is that there simply aren't enough providers. And this shortage is not just an issue in Alaska—it's a problem affecting rural areas across the country.

Lucas: Across the Indian health service the physician vacancy rate can be just stunningly high. I think it's pretty much always north of 25 or 30 percent with big discrepancies from place to place throughout the United States.

Hillary: So here is where Siamit comes in.

[MUSIC]

Lucas: Siamit is an Iñupiaq word that means to spread or scatter.

Hillary: Siamit's mission is to deliver world-class care to rural communities in Northwest Alaska, while also training future tribal health leaders. They partner with the Maniilaq Association and bring best practices from top hospitals, like Mass General, and then integrate them into the local health system, while adapting those approaches to fit the needs of the communities.

They also offer internships and fellowships for Harvard Medical School students, giving them hands-on experience in rural Alaska. This not only helps the students learn about tribal health but also addresses the shortage of healthcare providers in the region. And Siamit's faculty also support programs in the Indian Health Service.

Lucas: The name was recommended by the regional elders council a long time ago, as we were looking for a word that would sort of encompass this vision of seeding this next generation of tribal health leaders both here in our region and around the country that we would be able to offer something to help that next generation train and take root across the Indian health service.

Hillary: Long before founding Siamit, Lucas was already committed to public service and healthcare.

Lucas: All throughout college, I worked as a firefighter and later EMT and search and rescue team member in the Mountain West.

Hillary: Eventually, he made his way to Northwest Alaska, where he'd spend the next decade working with the Maniilaq Association.

Lucas: My first years here in the region, I spent a lot of time in the village clinics and had the chance to watch a lot of community health aides work day in and day out.

Hillary: The Maniilaq Association provides health, tribal, and social services across the Northwest Arctic, with an 80,000-square-foot hospital and various

clinics across the villages. For Lucas, the experience of learning from these local health aides in these village clinics left a lasting and profound impression.

Lucas: I had sort of the surprising chance to observe a group of people who were exceedingly good at this very under-recognized thing. And I had the chance to internalize a lot, like I did with the fire department, to see a group of people you don't traditionally think of as the country's leading example of how to deliver really good care.

Hillary: And Lucas also saw first-hand the challenges of delivering care in this region, which sparked an idea…

Lucas: Like a lot of tribal health organizations and much of the Indian health service, we were going through a pretty significant staffing crunch, and something that I proposed to the board of directors at the time and our leadership team was the possibility of pursuing this academic tribal health partnership model, where we would develop relationships with big academic medical centers who are already churning out clinically excellent and extremely abundant providers, like cities like Boston are not short on doctors by any stretch of the imagination.

Hillary: On a trip to Boston, Lucas floated the idea to someone he'd met in his days as a firefighter, Stuart Harris, the chief of the Mass General Hospital Division of Wilderness Medicine.

Lucas: I said, “Would you be interested in sending fellows to Alaska to help us with our staffing needs? And in exchange, we can offer this training in social and community medicine, and a chance to practice someplace where you're really needed.” And to my great surprise, he took me up on the offer, sent the first fellows up, I believe that following year.

Hillary: So in 2016, Siamit was born. The program is funded by a number of different sources.

Lucas: It's a pretty unwieldy thing because it brings together these different institutions, so the Harvard Medical School Center for Global Health Delivery and the Department of Global Health and Social Medicine, under which that center operates, and Massachusetts General Hospital and Brigham and Women's Hospital and Maniilaq Association. We have distinct components that operate in different ways, but the top-level picture is it's a mix of support from all of those institutions. From grants, from fundraising, we've really sort of pieced it together piece by piece.

Hillary: Lucas says the program has steadily grown over the years, integrating seamlessly with the region's existing health system. Through health pathways, fellowships, and staffing, Siamit is making ground in Northwest Alaska.

But the shortage of healthcare providers is just one of many challenges rural areas face.

Across the country, communities are stepping up to tackle these issues, with investment dollars fueling innovative solutions.

[MUSIC]

Susan: The challenge in the rural space is that there's just miles between people.

Hillary: Susan Rawlings Molina is the CEO of Ground Game Health, a social impact company that helps connect hard-to-reach populations with healthcare and resources.

Susan: You're 20 miles from your physician. You're 10 miles from your neighbor. You're maybe another 10 miles the other direction from a grocery store. And although you might be on a farm and can grow some of your food, potentially, you also might not be. You might be in rural Louisiana, surrounded by a bayou. And those individuals are just as much in need as somebody in an urban area, and they're much harder to reach.

Hillary: Susan says that in rural America, lack of resources isn't necessarily the main block.

Susan: Many times, there are resources available for these folks that they're not connected to. They don't know that they exist. Or even if they know they exist, they don't know how to access them.

Hillary: The Rural Health Information Hub reports that many people in rural areas struggle to access healthcare simply because they aren't aware of available services or how to use them. Barriers like low health literacy, complex systems, and poor communication can make things even harder. For example, a patient might not know they qualify for telehealth services, or they may have trouble understanding how to use them. On top of that, language barriers or a lack of culturally relevant materials can prevent people from getting the care they need.

Susan: When someone is out in a rural part of the United States, in rural Montana, for example, and their primary care physician is 30 miles away in Helena, and they have an

emergency issue… Many times folks are overwhelmed, they don't know how to do it, and they don't do anything. And then everything gets worse. And it happens quickly.

Hillary: And the list of potential barriers is long…

Susan: There's lesser internet connectivity. Depending on the part of the country we're talking about, there may be greater poverty, so a greater unconnectedness in those rural markets.

Hillary: Another significant challenge Susan and her team have run into is transportation. In rural America, unreliable transportation can have a serious impact, making it harder for people to access the care and resources they need.

Susan: Folks in rural areas can access SNAP benefits, which are food stamps essentially, right? They go further ‘cause it's a little cheaper to live rurally. That's one vantage point. But many of the folks who would need to access those food stamp benefits, the SNAP benefits, also have issues with transportation. So, when you actually factor the transportation issue in, it actually costs more. It's a situation that gets magnified.

Hillary: Access to nutritious food is a major factor in people's health, and it’s a challenge that affects communities nationwide. A 2024 study from the non-profit Feeding America shows that rural areas are especially impacted.

Lucas: In Alaska specifically, something to flag is just the incredible cost of everyday necessities.

Hillary: Siamit's Lucas Trout.

Lucas: A gallon of milk is right around $15. Buying meat at the native store or here in Kotzebue at AC, our grocery store, is almost cost prohibitively expensive.

Hillary: Issues like access, awareness, and education are central to Ground Game Health’s mission. Susan says GGH focuses on "connecting the unconnected," or helping people break down social barriers that prevent them from getting healthcare nationwide. She believes that closing the health equity gap begins with addressing the needs at the individual level.

Susan: We sometimes lose track that the experience of the healthcare system is a really individual one.

Many times, people just don't understand how the system works. And those of us who maybe are in the business of healthcare forget that we have to make sure we get granular enough to help that one person. Because that, in mass, becomes the healthcare system.

Hillary: Susan has nearly 40 years of experience, primarily in the health insurance industry, helping Medicare and Medicaid beneficiaries. And her experience has helped shape what in 2016, became Ground Game Health.

Susan: We work with individuals, help them prioritize, let's call it, their constellation of issues. And then we work locally on the ground with community partners to help those issues that have been identified get taken care of, whether that's a meal on the table, access to government benefits, for example, or even maybe finding a primary care physician. We focus on that N of one.

Hillary: To explain how Ground Game Health works, Susan likes to compare it to an hourglass.

Susan: At the upper of that hourglass are organizations that are interested in impacting their employees, their insured members, or someone on the social side of the scale and they're willing to pay for it.

Hillary: Think insurance companies, or employers...

Susan: The bottom end of that hourglass is what's on the ground. That's community-based organizations. That's where people live. It's the people we're helping. And Ground Game Health is in the middle of that hourglass. We essentially modulate between those organizations.

Hillary: Up until the 1960s, it was the norm for doctors to make house calls in cities, but in rural areas, this isn’t outdated—it’s often the most practical approach. This model works well in places like Northwest Alaska or rural Louisiana, where GGH partners with local agencies to bring care directly to those who need it through home visits, which ensures access in remote communities.

Susan: We have a program we call “Door Knocks”, when we can't reach someone over the phone, or we can't get an appointment set, we'll send someone to knock on the door.

Hillary: And sometimes breaking these access barriers takes more than knocking on doors.

Susan: One of the individuals we were assigned to work with needed home healthcare, but the home healthcare folks would not go in the person's home because the person had a hoarding issue, and they felt it was too risky to go in or unsafe.

And so, the local agency, very much on the ground, found a local community service organization, where they had kids that were doing service requirements and sent those kids in and helped clean that woman's home. Cleared it out and helped her get stable in enough of a way that the home care person come in and assist her with her diabetes. This woman would have not been helped without the partnership between us and the community, the health plan, and the state of Louisiana.

It definitely takes a collaborative partnership, particularly in the rural areas to get to these folks who need help.

Hillary: Susan says GGH works with long-established organizations at a community level.

Susan: It could be a Meals on Wheels. It could be an area agency on aging. It could be a YMCA somewhere, for example, they're social workers by their nature. So, they're supported by their local markets and local communities to do this for a living.

Hillary: GGH developed and operates an online platform that tracks workflows in real-time, automates questionnaires, and uses AI to address social gaps. It also handles billing and payments, making things much easier for community health workers.

But it's important to acknowledge technology is not a cure-all, and it really cannot replace human to human interaction and relationships, when it comes to providing quality healthcare in rural communities.

[MUSIC]

Lucas: One of the most remarkable stories of innovation and infectious disease treatment and control in the history of the United States is from the tuberculosis epidemic.

TB Video: Tuberculosis is caused by a germ.

Hillary: You're listening to a 1937 National Tuberculosis Association video.

TB Video: No one, artist or statesman, rich or poor, young or old, is immune to it.

Hillary: One of the oldest human diseases, Tuberculosis was a leading cause of death among Alaskan communities during the first half of the 20th century.

When the disease took on epidemic proportions in Alaska, the first response at the time was simple: Evacuate affected patients to sanitariums in the south of the state and Seattle. The idea was to isolate them to prevent the spread of the infection.

Lucas: It was often seen as just taking folks away from home to never be heard from again.

Hillary: The effectiveness of sanitariums is up for debate, but one thing was clear: the isolation had a profound emotional and mental impact on patients, their families, and the surrounding communities.

So, the people of Alaska decided to try a different approach, and sometimes innovative solutions have nothing to do with technology.

Lucas: The solution that evolved was recruiting community volunteers to partner with traveling public health nurses to do what essentially amounted to the precursor to the gold standard for tuberculosis treatment today: directly observed therapy, where these community volunteers, that eventually became community health aides, would go door to door and basically administer an ambulatory tuberculosis chemotherapy program on behalf of their friends and family and neighbors.

And this whole system was really much more about like relationship-based care on the local level.

Hillary: That idea became the foundation of the Community Health Aide Program, which started in the 1960s. Today, it continues to be a vital part of healthcare, providing frontline services in many villages.

Lucas: I think the Community Health Aid Program is one of the strongest community health worker programs in the world. That program today serves 180 villages, provides somewhere around a quarter million annual clinical encounters, and community health aides now have counterparts in dentistry and behavioral health as well.

Hillary: And Lucas thinks this model could be adapted to other places in the world.

Lucas: I would be very excited to see that take root, in global health or in other communities in the United States.

Hillary: It's easy to see how effective community-based care models are, but the reality is, these programs are still underfunded.

Susan: It takes a village, right? And this by the way, is not an issue just in the United States. It's an issue around the world.

Hillary: Ground Game Health's CEO, Susan Rawlings Molina.

Susan: So, I think investments in these areas can bear deep fruit and create some connections across very diverse, not only populations, but resources in a way that actually brings everybody along.

Hillary: And where funding goes really matters.

Lucas: One of my concerns about the future is that a bunch of people in cities will get together and decide the technology is going to fill every single gap in rural health systems and that we can just convert the entire enterprise to telemedicine and that everything will just be fine if we go down that route.

And of course, there is a big role for technology as we normally think of it in rural health systems and care delivery. Like Alaska has been a leader in telemedicine and folks have really benefited from that, but it can't come at the cost of investing in local health systems and health workers and the infrastructure you need on the ground.

Hillary: Technology cannot replace on the ground resources and services, but they can work in tandem. And one investment firm sees technology as a way to facilitate human-centered and preventative healthcare, not overtake it.

Alyssa: You don't go to see your doctor until something happens to you. It's a bit of a whack a mole game. Something happens, you show up, they treat that symptom, you leave. Something happens again, you show up, and it becomes sort of a vicious cycle.

Hillary: Alyssa Jaffe is a partner at Seven Wire Ventures.

Alyssa: We are an investment firm focused on investing in digital health companies that help empower what we call "informed connected health consumers". Patients are people that have things done to them. Consumers of health are active stewards. So, everything that we do is all about helping people to become better stewards of their own health.

Hillary: And they put care and prevention first.

Alyssa: People often only think about healthcare as sick care, right? They don't think about it as health and care, about the ways that this system should be designed to keep us healthy, that we should be empowered with our own information where we connect into the system, the system connects back to us, so we can prove our own health outcomes.

Hillary: The company's name illustrates how they see technology as a tool for connection.

Alyssa: The reason the business is called “Seven Wire” is because the first connection between Europe and the United States was seven copper wires that created transatlantic communication, and those seven wires are what allowed for the digital connectivity that now, we take for granted today. And so, as we thought about building Our firm, what was so important, is how do we create that type of connection where we take something that's archaic, and we take something that's disparate, and we take something that lives in silos, and we use technology to connect people and resources and institutions in order to better the collective.

Hillary: Alyssa and her team believe tech plays an important part in improving health care access in rural communities. And they invest in companies aligned with this idea.

Alyssa: Technology is the great equalizer. If you have psoriasis, typically get diagnosed a topical steroid. About 50, 60 percent of people fail that treatment. And the next step is to be getting UVB light therapy. Historically, it was basically like a giant tanning bed inside a provider's office, and it only really exists in big cities. And oh, by the way, you have to go three to four times a week for three months. And so now you're asking people to drive 20, 30, 40 miles plus to go stand in this giant tanning bed, four times a week for months at a time.

And you best believe people don't do that. And so what do they do? They go on a biologic. They go on Humira, Cosentix, and those are immunosuppressants. They're extremely dangerous and expensive. They cost the average payer maybe 30,000 to 50,000 per member per year.

And so enter a business like Sarigo, which is the full platform, which they have a handheld UVB light therapy application, where you can sit in the comfort of your own home and watch TV and deliver your therapy, that you can talk to your care team for support, that you can get real time updates and analytics on the progress of your condition, and you actually can move towards a healthier life.

Hillary: I can't believe you brought up that example because I grew up in rural Vermont. My brother has horrible psoriasis. He failed the first treatment that you mentioned. He's now been prescribed this light therapy. It's an hour away. You have to go multiple times a week. He owns his own excavation company and has a young toddler at home. He cannot go. He's like, I would rather just have the psoriasis, but his insurance denied the Humira until he goes through the light therapy. So, he's like, who can drive an hour three times a week when I'm trying to put food on the table for my family?

Alyssa: Exactly.

Hillary: Seven Wire also partners with companies like Ground Game Health that use technology to strengthen, not replace, community-level care.

Alyssa: This is just an incredible company that really is a provider of a population health platform that connects community-based organizations. With health plans and providers to meet those social determinants of health needs of the most difficult to engage healthcare populations.

And so, it creates a closed loop platform and a network of community care workers to enable that efficient flow of resources. From a managed care organization to a CBO, a community-based organization, and address a lot of those unmet social needs on the ground. Health plans, many of them are national plans, and this creates the bridge to provide a hyper local perspective.

And make it possible for those health plans to then reduce the cost of care to enter new markets and improve their members health at scale.

Hillary: From an investment standpoint, Alyssa points out that Ground Game Health navigates one of the biggest challenges in the healthcare space.

Alyssa: And the challenge is it's hard. It's very hard. Selling it to manage Medicaid is one of the most challenging ways to sell into healthcare. And so, thinking about those channels, it will take longer. It will be more convoluted. And so, you have to have stamina.

Hillary: Seven Wire, Ground Game Health, and Siamit embrace the potential to make a real difference in rural healthcare.

Alyssa: The biggest opportunity is that you really can make an impact, and it's a huge population, so the market size is massive. So if you can do this and do it right, you will build a great business and you will do extremely well for the people that need you.

Lucas: I think if we look back in a decade and say we were really successful, it'll be because we kept asking the question “what do you need and how can we do better?” Something I'm really excited about personally is a renewed interest in primary care and in rural and indigenous health at Harvard and its affiliated hospitals. There's a really strong ethos of “nothing about us without us” across a lot of Native America, certainly in Alaska.

I would just be on cloud nine to see Harvard and MGB become leaders in training this next generation of rural and indigenous health leaders.

You ought to be directing true health resources in those directions. And I really do think that the next couple of decades could be a really exciting and generative time for solving some of those challenges.

[MUSIC]

Hillary: If you want to learn more, please visit us at cambridgeassociates.com/unseenupside or check out the show notes. If you like what you’re hearing, leave us a review and tell your friends and colleagues.

At Cambridge Associates, our podcast team includes Michelle Phan, Megan Morrissey, and me, Hillary Ribaudo. And a special thank you to Robert Scherzer, Krista Matthews, Song Han, and Christian Rolleau.

We are especially grateful to the University of Alaska Fairbanks Oral History Program and Kotzebue Communities of Memories Project Jukebox for allowing us to share Esther Norton’s story.

From PRX Productions, Isabel Hibbard and Sandra Lopez-Monsalve are our producers, with support from Emmanuel Desarme. Genevieve Sponsler is our editor.

This episode was mixed by Samantha Gattsek. The executive producer of PRX Productions is Jocelyn Gonzales.