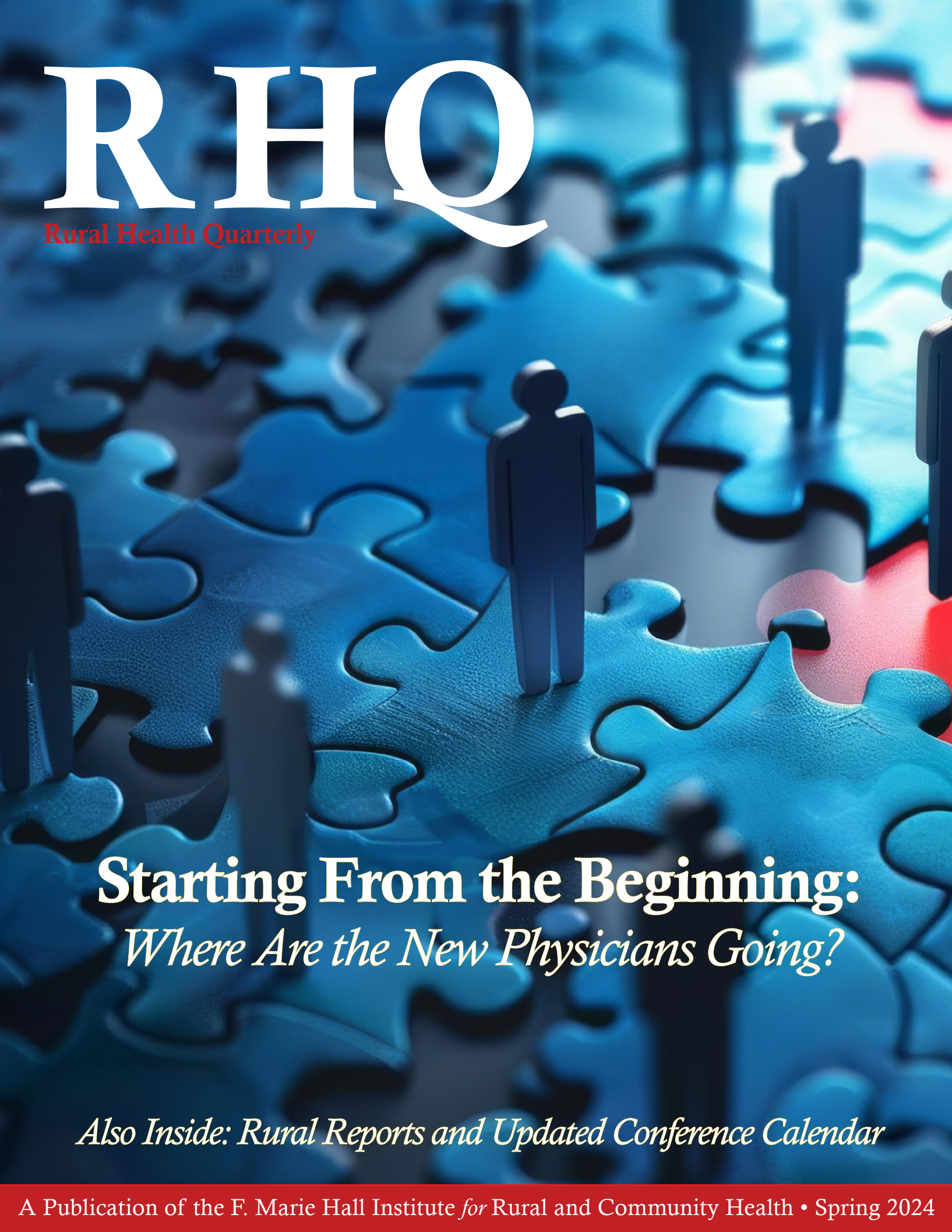

RHQ

Rural Health Quarterly

Starting From the Beginning:

Where Are the New Physicians Going?

Also Inside: Rural Reports and Updated Conference Calendar

A Publication of the F. Marie Hall Institute *for* Rural and Community Health • Spring 2024

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RHQ
Rural Health Quarterly

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Barking Up the Wrong Tree?

Texas has the largest rural population in the United States, according to the 2020 US Census, at about 4.7 million people. The 108 westernmost counties, what we call West Texas, are home to 3.2 million of that number—about 20% of Texas' total population. According to data from the American Association of Medical Colleges, medical students from rural areas account for only about 10% of current classes. Even before federal criteria changed regarding health professions shortage areas, most of West Texas was classified as such. A similar pattern can be observed among almost every other health profession.

BILLY U. PHILIPS, JR.

PUBLISHER
Executive Director, F. Marie Hall Institute for Rural and Community Health at the Texas Tech University Health Sciences Center

For most rural Texans, lack of workforce means less access to care. The COVID pandemic only made this situation worse—especially in nursing professions, due to the phenomenon of "travel nurses." Many rural regions of West Texas were forced to vastly alter, reduce, or discontinue services that are critical for the best health outcomes. In the Trans-Pecos region of Texas, pregnant women had to deliver in emergency rooms, lacked prenatal maternal and fetal care, and/or traveled long distances to access services that weren't available "at home." Examples of other key services follow a similar pattern of diversion, rationing, or closure of vital services due to workforce issues.

It is widely known that students who aspire to health careers who are born and educated in rural areas are much more likely to serve those areas once their education and training are complete. This is often in the face of less STEM education programs, yielding less competitive applicants, and fewer rurally located comprehensive academic health sciences centers that provide fewer rural training sites. There have been many attempts to solve the workforce shortages by offering loan repayment after years of service in rural areas; establishing Area Health Education Centers and supplementation programs through various US health service programs; creating specialized rural education centers in remote and underserved areas, and by a variety of other tweaks of the system.

It is generally accepted and a few studies have shown that students of various health professions (but mostly medicine) who grow up in rural areas are more likely to practice in rural locations. One of the most definitive studies of that proposition was a large meta-analysis of over 60 peer-reviewed publications spanning over a decade. However, rather than confirming a particular thesis, that study established more solid information on how to perform valid and reliable studies. Most of us who have worked on workforce issues and rural health know studies are not thesis-driven but are usually faulty because of things like methodological rigor, few multiple-site studies to ensure the spectrum of rurality as a study factor, longitudinal follow-up into employment, and incorporation of comparison or control-group designs that are prospective rather than retrospective in nature.

To be sure the science is not strong on workforce issues in health care. Too many studies use improper research designs and inappropriate statistical analytics, and studies must contend with the considerable confounding variables that plague the literature—employment for domestic partners and spouses, proximity to family, good schools, recreational opportunities, pay gradients, cost of living, and work/life balance. Operational definitions of these kinds of factors are not uniform and in fact, there is no agreement about a taxonomy of terms.

This issue of the Rural Health Quarterly (RHQ) focuses on this larger question and some of the articles will explore best practices. Certainly, there is a pattern to the messages in this issue, and all the writers add something to the conversation. Simply stated, rural workforce shortages matter. They have been around for a long time. There have been valiant and creative approaches to change things for the better, and yet the problems persist. I will close by suggesting that our focus on workforce may not be the best approach to the bigger issue at hand, which is lack of access to health care. It's a technological era, AI is all the rage, and people very often these days use new means of doing the business of life—much of it thanks to smart technology delivered by phones and ever-faster and more affordable networks.

Maybe we're barking up the wrong tree with workforce woes. The transformation of health care will look like this: there will be shortages in rural areas because the economics don't support more. People who live in rural areas do so for a variety of reasons, and they understand that choice comes with pros and cons. Moreover, a telehealth and digital innovation age is dawning in health care. So maybe, just maybe, the solution lies in technologies that haven't even been invented or come to market yet. In the meantime, keep your smartphone handy and encourage the engineers and entrepreneurs to consider the power of rural. That just might be a better solution. We have a motto here at TTUHSC: "Transforming Health Care through Innovation and Collaboration." With that, the options are much richer!

RURAL REPORTS

RURAL HEALTH REPORTING
FROM ACROSS THE NATION
AND AROUND THE WORLD

ILLINOIS //

Gov. J.B. Pritzker announced the launch of "Beacon," the state's new mental health portal aimed at young people.

The result of a partnership with Google Public Sector, this service aims to improve access to youth mental health care in Illinois.

axios.com | 01.30.24

MARYLAND //

An effort to increase healthcare access for the state's undocumented population is afoot in the House of Delegates. The Access to Care Act aims to prompt the state's insurance marketplace to file a federal waiver allowing undocumented Marylanders to purchase individual healthcare plans.

marylandmatters.org | 01.29.24

MINNESOTA //

In rural Minnesota, where the typical drive time to access labor and delivery care is 30 minutes, only 55 percent of hospitals offer maternity care. While this number is better than the nationwide figure of 45 percent, the recent closure of Mayo Clinic's New Prague location adds to the growing problem.

axios.com | 01.30.24

MISSISSIPPI //

State Democratic representatives plan to file a bill that would offer an affordable private insurance option for Mississippi residents earning up to twice the federal poverty income level, as well as premium subsidies for those with employer-sponsored health insurance.

mississippitoday.org | 02.05.24

OHIO //

The EPA recently responded to allegations that the agency failed to share data collected in February 2023 in the wake of the East Palestine train derailment disaster.

The Government Accountability Project (GAP), a nonprofit group, claimed the EPA assured residents of their safety after finding elevated dioxin levels in soil and water samples. The EPA stated, however, that these findings were made at the derailment site immediately after the incident. Offsite testing, conducted in March 2023, did not indicate unsafe dioxin levels.

wkbn.com | 02.09.24

CANADA

An innovative initiative continues to address Alberta's rural doctor shortage by increasing the likelihood new physicians will practice in underserved areas after graduation. Each year, the University of Alberta's Rural Integrated Community Clerkship program sends up to 25 third-year medical students for intensive work experiences with a small number of rural teaching physicians.

medicalxpress.com | 02.01.24

ECUADOR

Recently, Ecuador became the first Latin American country to begin creating a National Surgical, Obstetric, Trauma, and Anesthesia Plan, commonly referred to as an "NSOAP." This is a program focused on strengthening a nation's surgical capacity and access.

Though this plan is the first of its kind in the region, neighboring countries are focusing on surgical outcomes in other ways. Via national databases, Brazil, Colombia, and Mexico are gathering and tracking data on surgical indicators.

globalhealthnow.org | 01.31.24

ENGLAND

The University of Lincoln has been awarded £10.9m to research health outcomes in rural and coastal communities. The money will be used to transform the Lincoln International Institute of Rural Health into the Lincoln Institute of Rural and Coastal Health, aimed at addressing healthcare inequalities.

"You should have the same outcomes...regardless of where you live," said Mark Gussy, a professor at the university. "Coastal and rural communities can be disproportionately impacted by economic problems."

bbc.com | 02.09.24

What's new in your neck of the woods? Let us know!

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OKLAHOMA //

The State Department of Health announced a new loan repayment program for healthcare professionals working in underserved areas. The OK Health Corps program will award clinicians up to $50,000 per person in exchange for two years of service.

kgou.org | 02.12.24

PENNSYLVANIA //

Under Gov. Josh Shapiro's new budget proosal, $400 million in medical debt held by Pennsylvanians could be erased, with efforts targeting the state's poorest residents. The pitch calls for $4 million in taxpayer dollars to help buy up the debt of residents who could not afford necessary care. Shapiro's proposal mirrors a bill introuced by Dr. Arvind Venkat, a state representative.

spotlightpa.org | 02.09.24

WASHINGTON //

New health kiosks, designed as part of a community testing initiative, will soon begin appearing around the state, offering free COVID-19 and flu tests. "These 24/7-accessible kiosks exemplify our commitment to health equity, especially for undeserved populations. Together with Tribes and local partners, we are making a meaningful difference in community health," said Dr. Umair Shah, Secretary of Health.

komonews.com | 02.10.24

WISCONSIN //

Gov. Tony Evers announced a new task force, aiming to address healthcare worker shortages. The state faces a potential deficit of 20,000 registered nurses by 2040, and Wisconsin is competing with nearby states to attract workers.

publicnewsservice.org | 01.31.24

WYOMING //

"Wyoming is deeply rooted in a culture of independence...that fosters a narrative of 'pull yourself up by your bootstraps,'" reads a new report from Gov. Mark Gordon's office. The report outlines Gordon's plan to address mental health issues statewide. Objectives include workforce development, criminal justicereform, and suicide prevention.

wyofile.com | 01.31.24

FRANCE

According to a recent report by the Association of French Rural Mayors (AMRF), rural residents consume 20% less medical care than their urban counterparts, and they have 31% less access to chemotherapy and dialysis services. This translates to a loss of about two years in life expectancy.

While the causes behind unequal distribution of medical care and personnel across France are said to be rooted in the country's economy, geography, and healthcare system, the effects are nevertheless apparent.

connexionfrance.com | 03.14.24

GEORGIA

A partnership between UNICEF Georgia and the Republic of Korea was announced earlier this year. The partnership's aims are to improve communication between patients and providers; enhance the collection of water, sanitation, and hygiene data; and enforce WHO infection prevention protocols.

unicef.org | 01.16.24

KENYA

Nairobi's Savannah Medical Hospital, in a push for rural maternal health, is promoting awareness of the Social Health Insurance Fund. "In 100,000 live births, we lose 414 women, which is a concerning statistic," said Dr. Wachira Murage.

capitalfm.co.ke | 03.10.24

COVER
STORY

Starting From the Beginning: Where Are the New Physicians Going?

DR. STANLEY SACK

Stanley Sack, MD, practiced pediatrics for 33 years in Massachusetts and Florida. He currently works as freelance writer and editor, specializing in health topics.

It's hard to fathom that not that long ago, there was concern about a pending glut of doctors. This talk of a physician surfeit, which peaked around the early '90s, now seems like ancient history. Noted even back then, however, was the uneven distribution of providers, with a disproportionate number setting up shop in metro areas.

It's likely that none of this is really news (except, perhaps, to those of you who weren't around in the "physician surplus talk" era). What we'd really like to know is how to alleviate this shortage, particularly in physician deserts, and get people the care they need.

While the dearth may be in some small part due to decisions providers make after starting their careers—early retirement, for example, or a switch to part-time work—I thought it would be useful to look at what's happening in the early-career and even pre-career stages. Regarding the latter, medicine does still appear to be a popular field of study. In 2013, there were 690,281 applications and 20,055 matriculants. Fast forward to 2023, and those numbers become 966,947 and 22,981. Given that medicine still seems a sought-after career—and that new schools are opening, and spots are being created--what is the issue in terms of supply?

To examine these questions, I decided to focus on pediatrics, the field with which I'm most familiar. Even narrowing the field of study down to one specialty creates a workforce equation with several parts to solve. First off, we need to address the problem of maintaining an overall supply of pediatricians. Secondly, it's important to ensure adequate numbers of both primary care doctors and subspecialists. Finally, there's the issue of getting

these providers to where they're needed most—which by most calculations, unsurprisingly, ends up being rural areas.

Fortunately, the need for both generalists and subspecialists in relation to current workforce projections is being actively studied by pediatric researchers. One such researcher is Robert Vinci, M.D., former Chair of Pediatrics at Boston University School of Medicine. Dr. Vinci has done extensive work gathering and presenting data regarding the pediatric workforce—perhaps most notably in the journal Pediatrics, which in June of 2021 published his article, "The Pediatric Workforce: Recent Data Trends, Questions, and Challenges for the Future."

Dr. Vinci's findings do project some good news. More pediatric residency positions are being created, and over 98% of the available slots are still being filled. However, the number of vacancies has also increased. Dr. Vinci shared with me that a prestigious pediatric residency program in the Northeast had 10 unfilled positions. "(That) was catastrophic and incredibly shocking to all of us who know that program so well," he notes.

In addition, a lower percentage of American medical school graduates with an MD degree are choosing pediatrics as a specialty. The same is true of new holders of a degree of Doctor of Osteopathic medicine (DO). Fortunately, DO graduates do fill an increasing number of residency vacancies in pediatrics, as do international medical graduates. This is particularly beneficial for the programs in Texas: Although 214 of 218 pediatric positions were filled in 2023, only 122 were filled by new graduates of an MD program. It remains to be seen, however, how much of an effect this will have on the overall shortage of providers.

As concerning as those numbers are for the care of children and adolescents, the numbers appear even worse where pediatric subspecialty care is concerned. It's not unusual to have up to 40% fewer applicants than positions in the subspecialty fellowship programs. This is leading to severe shortages of trained clinicians in many disciplines. One field, developmental/behavioral pediatrics, has a vacancy rate of close to 50%.

We know we have work to do in filling those slots. That said, we are still minting new primary care pediatricians as well as pediatric subspecialists. What happens then? Where are they going?

I asked Dr. Vinci if the rural/urban maldistribution of pediatricians is worsening. "Probably yes," he says. This is confirmed by a Journal of the American Medical Association article from 2023, which did indeed find a decrease in general pediatricians per population in rural counties. The situation is similar for subspecialists: "If you look at some of the rural states, the distribution of subspecialists is so much lower than it is, say, in Boston. There's definitely a divide between the urban and rural areas."

This unfortunate but not totally unexpected take on where things stand for rural kid care begs another set of questions: Why not rural practice? And what can be done?

In order to address these questions, it's desirable to look at the priorities of these young physicians. We do know from a 2009 study that students consider location of paramount importance when considering residency—more than program prestige or even lifestyle issues (such as call schedule or family policies).

Regarding post-residency plans, two important factors found by the study are lifestyle and access to specialists. On these counts, a rural practice might present challenges for some. One might end up being the only primary care provider on call for a long stretch, or on every-other-night call, whereas an urban practice may have more night and weekend support. And many remote areas can't support a specialist or equipment for certain tests or treatment. In the area I practiced, for example, it was difficult to recruit a neurologist due to the absence of a neurosurgeon.

The lack of a pediatric subspecialists in rural areas may be even more concerning. One issue, according to a study published in the journal Pediatrics just last month, is that most trainees in a pediatric subspecialty stay near the location where they trained.

This leaves patients traveling greater distances—and primary care providers doing their best to take on some tasks that would normally be relegated to a specialist.

Clearly, training more pediatricians and distributing them to rural areas is going to require more work. Initially it was thought that family practitioners and mid-level providers would fill the gaps in care. But family practitioners, although making up a large percentage of providers in rural areas, often don't see children. Similarly, many nurse practitioners don't have specialized training in pediatrics. In any case, primary care pediatricians are often the referral provider of choice for complex children and for hospital inpatients. In the area where I practiced, night and weekend hospital call for children was provided exclusively by four pediatricians for a few dozen area providers that saw children along a 110-mile stretch. Thus, it appears there will always be a need specifically for pediatricians. Dr. Vinci agrees: "The number of children with complex medical disease has increased. For that reason, I think that there's more of a need for pediatricians and pediatric subspecialists."

More work needs to be done over the lifestyle/location situation. Are they driven by provider family issues—jobs, schools, activities? Could we be working more closely with spouses' companies to allow more work-from-home situations, allowing pediatricians to live in a rural area? How about partnering with transportation companies so that families who really do need to visit a metro area, say for a family visit, can do so more easily?

We'll need to continue to examine the professional challenges in more detail. Are there conditions that are technically within the scope of a pediatric practice but often referred to a specialist? Can we get general pediatricians comfortable with diagnosing and treating these? And can we get patients and families comfortable with our treatment? Are there solutions to alleviate what might be constant night call?

Finally, the issue of diversity must be addressed. The American Academy of Pediatrics is committed to embracing and increasing diversity among its members. Is this something we should be looking at more in rural medicine, in other to attract providers who hail from other states and countries? And is the distribution of providers reflective of the diversity of the population they serve?

One thing that I haven't mentioned is something that hits home for many: finances. Although only 3% of residents cited financial concerns as a means of choosing a program, things can be quite different when setting up a practice career. With the ever-increasing tuition of medical schools—and the burgeoning overall cost of living in many places—financial help may be a significant incentive.

Fortunately, such help does exist. The National Health Service Corps has provided loan repayment in return for practice in a physician shortage area. The decades-old (save for a short period in the late '80s and '90s, coincidentally when I would have been eligible for it) program has managed to provide rural areas a health care provider for a few years at a time. This was for primary care, however. Dr. Vinci did tell me that a similar program, the National Pediatric Subspecialty Loan Repayment Program, has been recently rolled out.

The bottom line is that there is still a lot of work to do, both in terms of interesting people in pediatrics overall and, more specially, rural practice. It's heartening that resources are being put in to carefully examining physician workforce projections and the myriad issues surrounding affected providers and their patients. One can only hope that just as we examine "root causes" when talking about hospital quality issues, we keep in mind the "roots" of the practitioner—and expose them to the possibilities of pediatrics and rural practice early on. ●

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CARE

ACCESS

By the Numbers: Healthcare Access in Texas Counties

AMBER C. PARKER

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Texas ranks at the very bottom when it comes to access to care for the three million people who live in the state's rural counties. That's according to the most recent U.S. Rural Health Report Card. People who live in West Texas in four counties, Comanche, Crockett, Montague, and Moore, know all too well about the struggle to find health care. Data from the Texas Department of State Health Services (DSHS) illustrates just how bad the problem is in these four counties and throughout rural Texas.

Primary Care Physicians (PCPs)

Getting in to see your primary care physician when you're sick, just need a medication refill, or need a referral to see a specialist isn't as easy as it sounds. It's even tougher when there simply aren't enough PCPs for the population. For example, in 2017, Comanche County had only 52.5 PCPs for every 100,000 residents, while Crockett County had only 25.3 PCPs for the same number of residents. Montague County's ratio was 41.3 PCPs, and Moore County's ratio was 59.9 PCPs for every 100,000 residents.

Things slightly improved by 2021 when Comanche County had 92.4 PCPs, Montague County had 47.0 PCPs, and Moore County had 55.7 PCPs for every 100,000 residents. But things got worse in the four years for Crockett County, where the ratio of PCPs to residents dropped to 24.6.

The state's ratio of PCPs to 100,000 residents slightly increased between 2017 and 2021, going from 74.7 in 2017 to 76.2 in 2021.

Types of PCPs in County

The term "primary care physician" covers many types of health care providers. Family practitioners, internal medicine specialists, OB-GYNs, pediatricians, and physician's assistants are all under the PCP umbrella. The majority of the PCPs in the four spotlighted counties were family practitioners per capita. Comanche County had an aver-

age of 14.8 family practitioners in 2018 compared to 7.4 internal medicine providers. In 2018, Montague County had 15.3 family medicine specialists compared to 5.1 internal medicine doctors. Moore County had an average of 27.9 family medicine practitioners in 2018 and an average of 4.7 internal medicine and general medicine providers.

The Texas DSHS did not have data on the breakdown of PCPs in Crockett County; none of the counties studied had a pediatrician, and only Moore County had an OB-GYN specialist available, with 14.0 per capita in 2018.

Direct Patient Care Physicians and Physician Assistants

The Texas DSHS defines direct patient care physicians as any provider who sees patients face-to-face, including primary care physicians. It also looks at the ratio of direct patient care physicians and physicians' assistants to 100,000 residents.

In Comanche County, the ratio of direct patient care physicians steadily climbed from 67.4 in 2017 to 106.3 in 2019 before ticking up in 2020 to 107.1. The ratio rebounded in 2021 to 107.9. In Crockett County, though, the ratio of direct patient care physicians held steady at 24.8 in 2020 after holding around 25 in the years before the pandemic. The ratio ticked down to 24.6 in 2021. Montague County's ratio of direct patient care physicians steadily climbed just before the pandemic dramatically declining in 2021. The ratio went from 67.4 in 2018 and 72.7 in 2019 down to 62.5 in 2020 before dropping to 57.4 in 2021. The ratio of direct patient care physicians in Moore County barely fluctuated between 2018 and 2021, going from 83.1 in 2018 to 78.7 in 2019, 92.7 in 2020, and down to 74.3 in 2021.

The ratio of physicians' assistants in each of the four counties followed a similar pattern in the same years. Comanche County's ratio for PAs spiked in 2021 to 38.5 after staying relatively steady in the years leading up to the pandemic. Crockett County's ratio held stable before and after COVID-19, going from 24.9 in 2019 to 24.8 in 2020 and 24.6 in 2021. The ratio of PAs in Montague County and Moore County changed very little before or after the pandemic.

The state's ratio of direct patient-care physicians barely increased over the same period, going from 185.3 in 2017 to 190.4 in 2020 and 192.2 in 2021. The pandemic had little effect on the state's ratio of physicians' assistants, which went from 28.2 in 2017 to 31.8 in 2020 and 33.1 in 2021.

Nurses Per Capita

The Texas DSHS also collects data on the ratio of nurses to 100,000 residents throughout the state. The data is broken down into each type of nurse, including APRN (Advanced Practice Registered Nurse), CRNA (Certified Registered Nurse Anesthetist), Licensed Vocational Nurse (LVN), NP (Nurse Practitioner), and RN (Registered Nurse).

LVNs and RNs had the highest ratio in Comanche, Crockett, Montague, and Moore Counties in the two years before the pandemic. In 2018, Comanche County had a ratio of 688 LVNs for every 100,000 residents, and it rose to 736.4 LVNs in 2019. The county had 381.5 RNs for every 100,000 residents in 2018 and 440.3 in 2019. Crockett County had a ratio of 373.2 RNs and 248.8 LVNs in 2018. In 2019, the ratio of RNs increased to 374.1, while the ratio of LVNs inched up to 324.2. In Montague County, the ratio of LVNs and RNs each increased in the same period. The county had 553.7 LVNs for every 100,000 residents in 2018 and 602.7 in 2019. The ratio of RNs went from in 2018 to 336.0 in 2018 to 368.9 in 2019. Moore County averaged 411.5 RNs in 2018 and 490.5 RNs in 2019, while the ratio of LVNs went from 259.7 in 2018 to 323.9 in 2019.

The ratio of the other types of nursing professionals varied, depending on the county. For example, the ratio of APRNs in Comanche County went from 34.1 in 2018 to 53.1 in 2019. The county's ratio of NPs also increased from 27.3 in 2018 to 38.0 in 2019. The ratio of CRNAs in Comanche County followed a

similar pattern, going from 6.8 in 2018 to 15.2 in 2019.

Crockett County had no CRNAs in 2018 or 2019. It also didn't have any NPs or APRNs in 2018. The ratio of NPs and APRNs in 2019 were both 24.9.

The ratio of other nursing professionals in Montague County barely changed in 2018 and 2019. For APRNs, the ratio went from 28.4 in 2018 to 31.2 in 2019. The ratio of NPs in the county dipped from 23.7 in 2018 to 20.8 in 2019. The ratio for CRNAs more than doubled, going from 4.7 in 2018 to 10.4 in 2019.

The ratios of the other nursing professionals in Moore County each doubled between 2018 and 2019. For APRNs, the ratio went from 24.0 in 2018 to 50.9 in 2019, while the ratio for NPs increased from 20.0 in 2018 to 41.6 in 2019. The ratio of CRNAs went from 4.0 in 2018 to 9.3 the following year.

For the rest of Texas, RNs had the largest ratio among the other types of nursing providers, going from 828.4 in 2018 to 860.7 in 2019. The state's ratio of LVN was also high, going from 287.8 in 2018 to 292.3 in 2019.

The ratio of NPs and APRNs was similar in Texas during the same years. For NPs, the ratio climbed from 63.2 in 2018 to 72.9 in 2019. As for APRNs, the ratio also increased each year, going from 79.9 in 2018 to 90.3 in 2019. The ratio for CRNAs in Texas also increased from 12.7 in 2018 to 13.1 in 2019.

Mental Health Professionals

Data from the Texas Department of State Health Services (DSHS) show the state is seriously lacking when it comes to enough mental health professionals to serve people in rural areas. The DSHS numbers keep tabs on how many Licensed Chemical Dependency Counselors (LCDC), Licensed Clinical Social Workers (LCSW), Licensed Master Social Workers (LMSW), Licensed Professional Counselors (LPCs), and even Licensed School Psychologists each county has to serve the population.

Many Texas counties have very few, if any, addiction counselors. In Comanche County, the data shows the county had 37.5 LCDCs for every 100,000 residents in 2017, but the ratio declined the following year to 30.2 and 22.8 in 2019. In 2020, the ratio was up to 30.6. People in Crockett County seeking help for an addiction had to look outside the county in 2017 and 2018 since the county had none. In 2019, the ratio was 4.6, and 5.2 in 2020. Montague County was served by 5.2 LCDCs in 2018, but the county didn't have any the following year. In 2020, the ratio bounced back to 4.6. Moore County didn't fare any better. It had a ratio of 4.6 addiction counselors in 2017, but the county had none between 2018 and 2020. The data shows a shortage of addiction counselors across the state. In 2017, the state had 19.6 counselors to 100,000 residents. The ratio increased in 2018 to 19.9 but slightly increased in 2019 to 20.2. The ratio dipped slightly to 20.1 in 2020.

Texas counties also need social workers, both licensed clinical social workers (LCSW) and licensed master social workers (LMSW). Comanche County saw a decline in the number of LCSWs, going from 15.0 in 2017 to just 7.5 in 2018. The ratio held steady at 7.6 in 2019 and 2020. The county's ratio for LMSWs held at 7.5 in 2017 and 2018 before edging up to 7.6 in 2019. In 2020, the ratio jumped to 13.9 LMSWs. Crockett County did not have any LCSWs in 2017, and the ratio was just 5.2 between 2018 and 2020. Also, the county did not have any LMSWs between 2017 and 2019, and the ratio in 2020 was 10.4. Montague County had a ratio of 5.2 LCSWs in 2017, but the county had none between 2018 and 2020. The county fared better with LMSWs in the same period. In 2017, the county had a ratio of 10.3 LMSWs for every 100,000 residents, 15.5 in 2018, 10.4 in 2019, and 7.6 n 2020. No LCSWs served Moore County between 2017 and 2020, while the county had an average of 9.2 LMSWs in 2017 and 2018 and 9.3 in 2019 and none in 2020.

Across the state, the ratio of LCSWs for 100,000 Texans barely changed in the same period. It went from 27.3 in 2017 to 28.2 in 2018, 29.1 in 2019, and 29.6

in 2020. The LMSW ratio showed even less change, going from 37.0 in 2017 to 37.4 in 2018, 38.2 in 2019, and 38.5 in 2020.

People in many counties across the state have only licensed professional counselors (LPCs) to turn to in times of crisis. The number of LPCs in Comanche County stayed steady between 2017 and 2019 before dramatically declining in 2020. The county had 52.5 LPCs for 100,000 residents in 2017, and that ratio edged up to 52.8 the following year and up to 53.1 in 2019. In 2020, the ratio dropped to 38.2. In Crockett County, the ratio dropped each year in the same period, going from 25.3 LPCs in 2017, 25.1 in 2018, 24.9 in 2019, and 24.8 in 2020. The number of LPCs in Montague County stayed relatively steady between 2017 and 2020. In 2017, the county had 20.7 LPCs for 100,000 residents, 25.9 in 2018, and 26.0 in 2019 and 2020. The number of LPCs in Moore County varied between 2017 and 2020 going from 13.8 LPCs for 100,000 residents in 2017, 9.2 in 2018, 9.3 in 2019, and 13.9 in 2020. The ratio for LPCs across the state has increased over the same period, going from 68.6 in 2017 to 73.2 in 2018, 75.9 in 2019, and 82.5 in 2020.

No area of mental health illustrates the desperate need in Texas than how many school districts across the state are without a licensed school psychologist (LSP). The four counties in our spotlight are prime examples of this need as Comanche County is the only one that had a school psychologist on staff. Between 2017 and 2018, Comanche County schools had a ratio of 7.5 LSPs and 7.6 in 2019 and 2020. Of the other three counties, Montague County is the only county that had LSPs available for at least one year. Montague County schools had a ratio of 5.2 LSPs in 2017 only. It did not have any LSPs on staff in the other years, while Crockett County and Moore County schools did not have any LSPs in the same period. The ratio of school psychologists in the rest of Texas was also low in the same years, going from 11.7 in 2017 to 11.9 in 2018. It stayed stable at 12.1 in 2019 and 2020.

The Commercial Alternative to Traditional Medicare Is Putting Financial Strain on Rural Hospitals

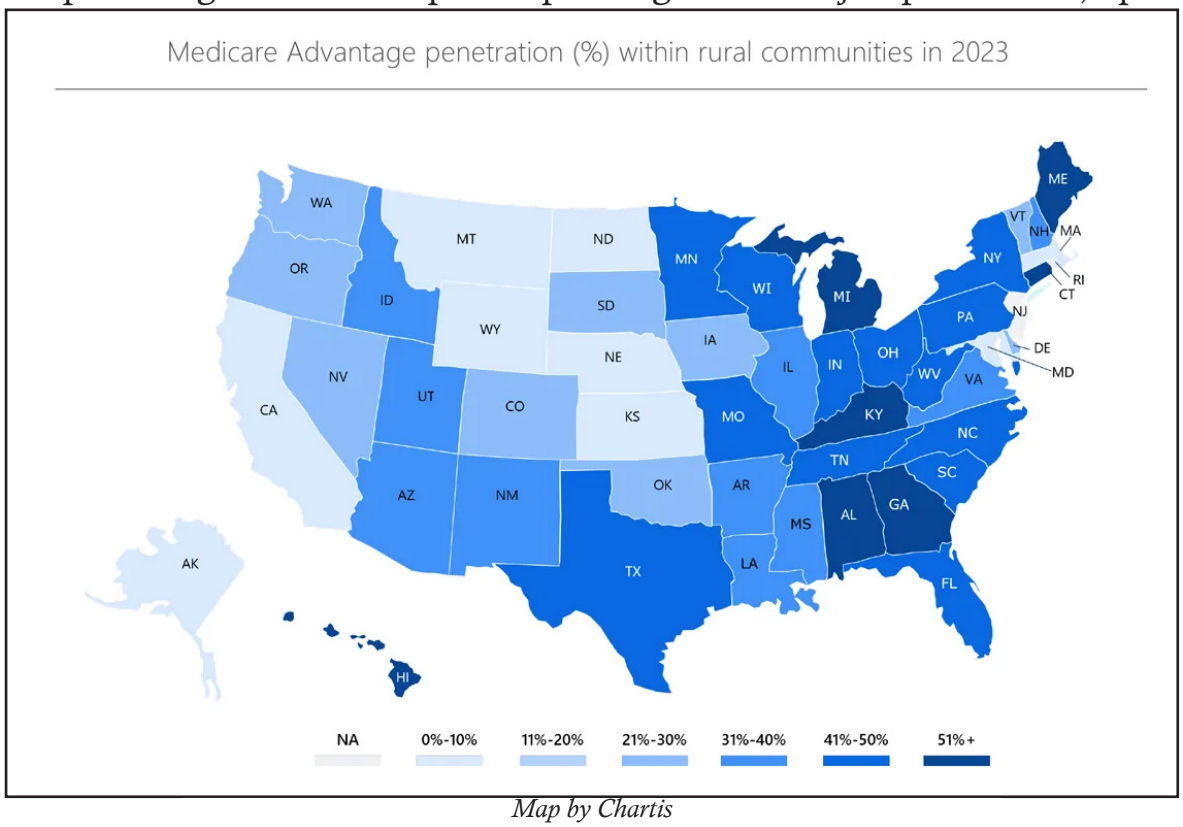
LIZ CAREY,
The Daily Yonder

Liz Carey is a veteran journalist with more than 20 years of experience in the field. Working in Ohio, Kentucky and South Carolina, Carey has covered government, education, business and agriculture in the past, receiving more than 30 awards for her writing and reporting. A graduate of Miami University, Carey currently works as a freelance reporter focusing on rural issues, healthcare and workers' compensation issues.

For more than a dozen years, leaders in the rural health care field have issued strong warnings: Rural hospitals are struggling financially.

Despite public attention and some changes in federal policies, difficulties continue. A new report from a private healthcare consulting company has found that nearly 20% of all rural hospitals are at risk of closing.

The report, issued annually by the Chartis Center for Rural Health, said the percentage of rural hospitals operating in the red jumped to 50%, up



Map by Chartis

from 43% last year. Of the independent rural hospitals across the country, 55% were operating in the red. More than 60% of rural hospitals are affiliated with larger health-systems. Of those, 42% were operating in the red.

All told, Chartis identified 418 of the 2,115 of the rural hospitals as "vulnerable to closure." Since 2020, 35 rural hospitals have closed, including nine last year. Nearly 200 rural hospitals have closed since 2005.

"I think we're in a much, much worse situation," Michael Topchik, national leader for the Chartis Center for Rural Health said in an interview with the Daily Yonder. "I mean, more than 15 years ago, I remember sharing some of these statistics… and there was a little bit of 'Chicken Little' in the air with a third of rural hospitals operating in the red… Now, to see half of rural hospitals operating in the red… in the absence of something being done, things have just gotten more challenging."

Those increased challenges include changes to Medicare and Medicaid reimbursement rates, changes to how hospitals are categorized, and what services hospitals are able to provide, among other things.

One federal program, the Rural Emergency Hospital (REH), provides rural hospitals with larger payments from Medicare and Medicaid, as well as a $3.2 million annual stipend, but eliminates a hospital's ability to offer in-patient services.

Passed as a way to prevent the loss of emergency services in communities at risk of losing their hospitals, the new designation for hospitals within the Center for Medicare and Medicaid Services went into effect in 2023. Eighteen hospitals chose to become an REH, Topchik said. While the program is new, he anticipates more rural hospitals will make the change.

"For many hospitals on the edge, Congress certainly saw it as a solution to maintain those vital services," he said. "The verdict is still out though… I think we'll easily see 300 to 400 rural hospitals who take up REH."

Still more is needed, he said. One issue to be addressed is how Medicare Advantage programs affect rural hospitals' bottom line, he said.

Medicare Advantage plans offer privatized versions of Medicare that are often less expensive for consumers and provide more benefits than the government-run program. Enrollment in these plans has more than doubled over the last 10 years. Enrollment in rural communities has increased over the last four or five years, he said.

And that's a problem for rural hospitals, he said. Medicare Advantage takes longer to pay than traditional Medicare and is more likely to deny claims or prior authorizations. That change has up-ended rural hospitals' bottom line, he said.

"Traditional Medicare is very predictable about what's allowed and what's not allowed, and they pay promptly on a monthly basis," Topchik said. "If your biggest payer is Medicare, which for most rural hospitals it is, and now more than a third and in many states it's more than 50% of your patients are on Medicare Advantage, well, then, all of a sudden, your entire financial foundation has just shifted, like an earthquake, and it's just really hard to make up for that."

Harold Miller with the Center for Healthcare Quality and Payment Reform (CHQPR) said his organization's look into the situation found worse results than Chartis. CHQPR estimates the number of hospitals vulnerable is closer to 600, with 300 at immediate risk of closing.

He said the federal government needs to further regulate Medicare Advantage plans.

"Even if they didn't deny the claim, the amount that they would pay for the claim might not be adequate to cover the cost," he said. "What is the federal government doing to ensure that Medicare managed care plans in particular, are paying the hospitals an adequate amount?"

Additionally, he said, the federal government should require insurance companies to negotiate with smaller rural hospitals.

"Many of the hospitals tell me they can't even get the plans on the phone," he said. "These are all things that the federal government could be doing to try to solve the problem and they're not."

Existing programs that were designed to help keep rural hospitals in better financial condition are in danger of being eliminated, officials said.

According to the American Hospital Association (AHA), two programs that currently benefit rural hospitals could expire this year. The Medicare-dependent Hospitals (MDH) program that provides higher payments small rural hospitals where Medicare patients are at least 60% of their admissions, and the Low-volume Adjustment (LVA) program that helps rural hospitals with low patient volumes to cover the cost of providing services, are both in danger of expiring on September 30, the AHA said. The programs are necessary to keep the hospitals open, it said.

In February, the organization urged Congress to support the Rural Hospital Support Act S. 1110) and the Assistance for Rural Community Hospitals (ARCH) Act (H.R. 6430) that would extend those programs.

"The network of providers that serves rural Americans is financially fragile and more dependent on Medicare revenue due to the high percentage of Medicare beneficiaries who live in rural areas," the AHA said in a statement. "Rural residents also on average tend to be older, have lower incomes and higher rates of chronic illness than urban counterparts. This greater dependence on Medicare may make certain hospitals more financially vulnerable." ●

This story was originally published in the Daily Yonder. *For more rural reporting and small-town stories visit dailyyonder.com.*

RURAL

COMMENTARY

Uninsured Country: Affordable Health Care Eludes Many Family Farmers and Ranchers

JORDAN GASS-POORÉ, *Texas Observer*

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This article was originally published in the Texas Observer*, a nonprofit investigative news outlet. Sign up for their weekly newsletter, or follow them on Facebook and Twitter.*

Super glue and animal antibiotics are in the medicine cabinets of many farmers and ranchers in Texas — tools of the trade they sometimes use on themselves to avoid a trip to the doctor. It's not that they have anything against physicians. It's because they either lack health insurance or their coverage is so limited that a doctor visit could saddle them with a hefty bill.

I know this because I've seen the glue (used to seal wounds) and animal meds in first-aid kits of some of my family members who are uninsured farmers and ranchers in South Texas. And they're not alone. Nationwide,10.7% of farm household members had no health insurance, higher than the 9.1% for the U.S. population, according to a U.S. Department of Agriculture report using 2015 data, the most recent available.

Finding adequate, affordable health insurance can be a huge challenge for people who run small, family farms or ranches, said Alana Knudson, director of the NORC Walsh Center for Rural Health Analysis. That's because many farmers and ranchers are self-employed, with no access to affordable group plans, and have low incomes. Even other private plans with limited coverage are often inadequate and pricey.

"It's very cost-prohibitive for farmers and ranchers to be able to get and maintain health insurance," Knudson said.

The problem is widespread but not often tracked closely by many states, including Texas. There are about 3.4 million farmers and ranchers in the country, according to the USDA's 2022 Census of Agriculture. Because many are self-employed, they're at a high risk of being uninsured or underinsured, endangering their health, Knudson said.

To gain health insurance, some farmers and ranchers take a second job off the land with an employer that offers group coverage. Or, their spouses work full time to get health insurance for the family, such as at a local school district or municipality.

Others in middle age, like my Uncle Todd, who lives near New Braunfels, Texas, decide they'll wait until they're 65 and can go on Medicare, even though it means risking physical injury from their work every day. Todd has about three years to go and

lives alone in a cabin on my family's property in Comal County, about 36 miles north of San Antonio.

Texas leads the nation in the number of farms and ranches, with 248,416, and has the highest rate of uninsured residents, at about 18%. The state has refused to expand Medicaid to cover more low-income adults, so it's likely many farmers and ranchers have little or no health insurance. The rural areas they live in suffer from shortages of doctors and hospitals. From 2005 to 2023, a total of 24 hospitals closed or reduced services across Texas, according to the University of North Carolina's Cecil G. Sheps Center for Health Services Research.

Even if Texas expanded Medicaid, barriers to health care would remain, said Dr. Rick W. Snyder, a Dallas-based cardiologist and president of the Texas Medical Association. Many doctors in the state won't accept Medicaid patients because the reimbursements are so much lower and slower than private health insurance. "Coverage is not the same thing as access, and access to waiting lists is not the same thing as access to health care," Snyder said. "So just because you have a card that says you are covered by Medicaid does not mean you're going to find a hospital or a physician who actually accepts that."

Dr. Doug Curran, a physician in Athens, Texas, said the low reimbursement rates are stark compared with private plans.

"Medicaid will pay you about 28 bucks for seeing a kid with an earache," he said. "You know, you can't even pay the electric bill, hardly, for that."

In 2021, the Texas legislature began allowing the Texas Farm Bureau, an agricultural nonprofit, to sell its members health plans that do not have to comply with the Affordable Care Act's consumer protections, such as rules that prohibit insurers from discriminating against people with pre-existing conditions.

Texas Farm Bureau plans aren't considered health insurance and operate without oversight by state insurance regulators. Monthly premiums are often lower, but the lack of ACA rules could mean higher costs for farmers and ranchers when they seek care.

Most people who sign up for these and other alternative plans tend to be self-employed, concluded a 2023 Government Accountability Office report.

Some farmers and ranchers I spoke with don't bother with a doctor anymore, not even for medication. Instead, they use antibiotics made for livestock they buy from a veterinarian or feed store. This workaround became more difficult in June 2023, when the Food and Drug Administration tightened access to antibiotics in an effort to combat bacterial resistance; some of these drugs had long been available over the counter. A veterinarian's prescription is now required.

Kenneth McAlister, a fourth-generation farmer in Electra, Texas, takes another tack. "I go to Mexico about twice a year and I'll buy a lot of Mexican antibiotics."

Before the ACA, McAlister said he and his family had private insurance through his wife's job as a teacher's aide. But after their children grew up and left home, it didn't

make financial sense for her to keep working.

Now, McAlister has coverage through a national insurer, but said the plan wouldn't cover the full cost of the knee replacement he needs. So he's waiting for five years until he can go on Medicare.

"I can't afford to have my knee done. If I hit the lottery and win millions of dollars, I might consider going to get it done before then," he said.

McAlister pays cash on the rare occasions he goes to the doctor — like on the Sunday he went to the emergency room to get a fish hook removed from his finger.

"I have no idea what the best thing to do is," he said. "I'm hoping that I can find something along the way that maybe is better than what I got."

Risks of a Rural Life

Farming and ranching have given my family financial independence – and caused some members to suffer injuries to body and spirit.

The Centers for Disease Control and Prevention ranks farming and ranching as some of the nation's most dangerous occupations. Since I was a kid, my mom has told me stories about family friends who were injured or killed when their tractors overturned — a leading cause of injury or death for farmers.

Family members share that risk.

My 89-year-old Aunt Corinne told me recently that when she was a child, she was her dad's – my great-grandfather's – "right-hand man" on their 1,500-acre ranch in the Texas Hill Country. She helped him work the land, riding a horse named Booger Red.

The work and risks didn't end when she got home. At age 6 or 7, she got her arm stuck in the washing machine. Back then, people put their clothes through an electric-powered wringer. She suffered nerve damage and still can't feel part of that arm.

"Mama finally got it stopped when it got up out of here," she said, pointing to the scars on her upper arm. She wasn't rushed to the hospital. "You didn't do that. You just took your meat and pushed it down."

The increasing cost of health care has limited the ability of some U.S. farmers and ranchers to increase their operations because they're unable to work the land full-time. They have to work outside jobs to get health insurance; when they come home, they must feed the animals, repair the fences, help a cow give birth and plow the fields.

"It's a big responsibility, you know, it's not an eight-to-five job. It's round the clock," said Robin, a family friend and farmer from the Hill Country. She asked that only her first name be used. "Farmers and ranchers just don't have any idle time, really. There's always something to do."

Robin went to school with one of my aunts and attended the same Lutheran church as many of my relatives. Her small farm, like ours, has been in her family for more than a hundred years.

She and her husband both work outside the farm to help cover expenses and pay for health insurance. Her husband sometimes jokes that they should move into a

condo. But they were both raised on a farm and that's how they raised their children, who enjoyed wide-open spaces and learned how food is made.

"It's bred in you," Robin said. "It's just something that gives me pleasure that I can keep dad's livelihood going. The cost is big — a lot of times you don't break even, but, you know, it is what it is."

Sometimes families barter for health care using what they produce.

"You can trade out some stuff — doesn't have to be exactly equal value — and you can just figure out what's fair and give them some help," said Dr. Robert L. Hogue, who lives in Brownwood.

Even when farmers and ranchers have health insurance, few are completely satisfied with the coverage — and it doesn't fix the problems inherent in rural living.

The quality of rural care can be low. Derisive nicknames, like the Quack Shack and Death Valley, abound. There is limited or no coverage for mental health and substance use disorders, and sometimes there are no mental health care providers nearby. It can be a long drive to a doctor's office or hospital. In my family's case, and others', the roads aren't paved and are prone to flooding by creeks, which delays or blocks ambulances.

Aunt Carrie told me about the times she went into town with Hilda Mary Acker, her grandmother — my great-grandmother — and because it had rained so much, they couldn't cross the creek. So they had to stay in the car until the water went down, sometimes all night.

The ambulance may not arrive.The majority of rural Texans live in so-called ambulance deserts, where they have to wait more than 25 minutes for an emergency medical team to arrive, according to a 2023 national study by the Maine Rural Health Research Center.

In many parts of Texas, the ambulance service is staffed, at least in part, by unpaid volunteers, Knudson said. So response times depend on the availability of those volunteers, and funding is limited.

"It is supported by bake sales, spaghetti suppers, pancake breakfasts, you name it," she said.

Despite filling a critical need, EMS workers in Texas — and well over half the country — are not recognized by the state as an essential service. If they were, as is the case in 13 states and the District of Columbia, the state and local governments would have to fund and provide emergency medical services that meet a minimum standard of care.

A Quiet Distress

I'm a seventh-generation Texan and one of the few members of my family who isn't a self-employed farmer or rancher. Instead, I'm a self-employed journalist who now lives in New York City. But that doesn't mean my family's land in the Hill Country isn't part of who I am.
I often think about my

ancestors who lived – and died – there. I have a framed photo collage of two generations of my farming and ranching family in my bedroom. I often think about how, even though I'm not in Texas, I still want my loved ones and the 261,666 other self-employed farmers and ranchers in the state to have a healthier life than their ancestors, with access to quality, affordable health care.

One of the women in that photo is Hilda. She was, and remains, the tallest woman in my family, at 5'7". Even though I'm 5'3", I've been compared to her for most of my life. I, too, have scrawny arms, enjoy writing and smoke cigarettes. But Hilda, who was known as Omie, was a farmer who may have had lung cancer (relatives said she coughed up blood) and died by suicide only a few feet away from my childhood swingset. She was 60.

The story goes that instead of seeing a doctor, Hilda went to a psychic in New Braunfels who told her she was sick. In 1975, not wanting to burden the family, Hilda placed a shotgun between a y-shaped branch of a tree and pulled the trigger. Her son found her body.

But the health care system doesn't benefit them enough. The difficult work of farming and ranching often brings isolation, tensions with urban America, culture and political wars, blame for rising food prices, and gaps in the health care safety net that shorten lives.

A lack of health insurance for the self-employed drove me out of Texas. Perhaps it drove my great-grandmother to an early grave. And it may be the reason my family eventually sells the land. But there's still a chance that won't happen. Maybe, in the future, health insurance will be widely accessible and there will be one less problem farmers and ranchers have to worry about. •

This story was produced with support from the Center for Rural Strategies and Grist.

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RHQ CONFERENCE CALENDAR

Check out our list of rural health conferences, and let us know if you're hosting one so we can help spread the word. Email us at RHQ@ttuhsc.edu.

Rural Training Track Collaborative 2024 Annual Meeting
April 10-12
Asheville, NC
DoubleTree Asheville

2024 JEMS Innovation Summit
April 16-17
Indianapolis, IN
JW Marriott

2024 Conference for Agricultural Worker Health
April 23-25
Atlanta, GA
Hyatt Regency Atlanta

2024 Appalachian Health Leadership Forum
April 26-27
Roanoke, WV
Stonewall Resort & Conference Center

2024 New York State Annual Public Health Partnership Conference
May 1-3
Saratoga Springs, NY
Hilton & Saratoga Springs City Center

ATA Nexus 2024
May 5-7
Phoenix, AZ
Phoenix Convention Center

NRHA Health Equity Conference
May 6-7
New Orleans, LA

Rural Medical Education Conference
May 7
New Orleans, LA
Sheraton New Orleans

2024 Accelerating Health Equity Conference
May 7-9
Kansas City, MO
Sheraton Kansas City

NRHA Annual Rural Health Conference
May 7-10
New Orleans, LA

NRHA Rural Hospital Innovation Summit
May 7-10
New Orleans, LA

2024 Annual NASEMSO Meeting
May 12-16
Pittsburgh, PA
Omni William Penn Hotel

2024 Annual gpTRAC Regional Telehealth Conference
May 21-22
Bloomington, MN

2024 National Network of Public Health Institutes Annual Conference
May 21-23
New Orleans, LA

Dakota Conference on Rural and Public Health
June 4-6
Grand Forks, ND
Alerus Center

2024 National PACE Association Summer Conference
June 7-9
Grand Rapids, MI
JW Marriott

Indiana Rural Health Conference
June 11-12
French Lick, IN
French Lick Springs Hotel

2024 Forum on Rural Population Health & Health Equity
June 12-13
Virtual

2023 Annual Council for Affordable and Rural Housing Meeting & Legislative Conference
June 24-26
Arlington, VA
Ritz-Carlton, Pentagon City

49th Annual USAging Conference & Tradeshow
July 8-11
Tampa, FL
JW Marriott / Marriott Water Street

2024 Annual NACo Conference
July 12-15
Tampa, FL

2024 AHA Leadership Summit
July 21-23
San Diego, CA

2024 NTCA Summer Symposium
July 21-24
Savannah, GA
Hyatt Regency Savannah

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