Episode: Rural Health/Rural Communities
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Interviewer(s): Michael Donovan
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Donovan: IN THIS EPISODE OF SOCIAL SCIENCE SPOTLIGHT, I'LL BE TALKING WITH DR. ANN TICKAMYER, PROFESSOR OF RURAL SOCIOLOGY HERE AT PENN STATE AS WELL AS LISA DAVIS, THE DIRECTOR OF THE OFFICE OF THE PENNSYLVANIA OFFICE OF RURAL HEALTH AS WELL AS OUTREACH

I'LL BE SPEAKING WITH LISA DAVIS, DIRECTOR OF PENNSYLVANIA OFFICE OF RURAL HEALTH AS WELL AS HOLDING THE ROLE OF OUTREACH ASSOCIATE PROFESSOR OF HEALTH POLICY ADMINISTRATION HERE AT PENN STATE. WITH THAT, I COULD GIVE THE FLOOR TO BOTH OF YOU TO JUST GIVE ME A LITTLE BIT ABOUT YOUR BACKGROUNDS AND YOUR ROLES HERE AT PENN STATE, AND THEN WE CAN HAVE A SPIRITED DISCUSSION HERE.

Tickamyer: This is Ann Tickamyer. I came to Penn State nine years ago from Ohio University in Athens, Ohio, where I'd been a professor for almost 14 years. Before that, I was at the University of Kentucky for 18 years. In all of those places, I have done research on rural poverty, a very relevant topic for those places in Appalachia, of various parts of Appalachia where poverty, rural poverty especially, is particularly relevant.

Davis: Good morning. I'm Lisa Davis. I'm the director of the Pennsylvania Office of Rural Health. We're one of 50 state offices of rural health in the country, so there's one like us in every state in the nation, and we're one of 10 state offices of rural health that are university based. The state office of rural health program is federally funded through a federal-state partnership program to be the source of coordination, technical assistance, and networking between and among anyone within their individual state that is focused on increasing access to health care services in rural areas and increasing access to—increasing the health status of rural residents. We work at the community, state, and federal levels.

Donovan: WONDERFUL. THANK YOU BOTH. THANK YOU BOTH FOR BEING HERE. I THINK WE'D LIKE TO TALK A LITTLE BIT ABOUT THE UNIQUE DEMOGRAPHICS OF PENNSYLVANIA, THE RURALITY OF IT, HOW IT HAS REMARKABLE DIVERSITY ACROSS THE STATE GEOGRAPHICALLY AND DEMOGRAPHICALLY, PARTICULARLY WITH LARGE POPULATION CENTERS AND THEN VAST EXPANSES OF MUCH MORE DEPOPULATED AREAS.

Davis: Well, why don't I start off and then, Ann, I know, has a wealth of information that she can add. Pennsylvania is considered to be one of the most rural states in the nation and, actually, up until the 2000 census, we were considered to be the most rural state because we had the largest number of people who lived in areas that were federally designated as rural. When the 2000 census was launched, the US Census Bureau had put in sort of a mini-designation called micropolitan, so a number of the individuals who lived in what were considered to be non-

metropolitan areas were now in this micropolitan definition, and that is how we fell from being number 1 to either number 6 or number 10, depending upon who's counting.

Of course, in my office, we can still consider us to be number one, but Pennsylvania is, as you know, anchored by Pittsburgh in the southwestern part of the state and Philadelphia in the southeastern part of the state. If you look at the state overall, 48 of our 67 counties are considered to be rural, and those counties are predominantly in what is known as the rural "J," so along the northern border up against New York, down through the central part of the state, and then curling up underneath Allegheny County which is where Pittsburgh is located. Those counties tend to have a great deal in common in terms of their geographic isolation, the challenges that they have in terms of access to economic development, to broadband services, and other kinds of infrastructure to transportation issues, and access to health care services.

Although there is disparity between those counties, overall, those are some of the major characteristics. Those counties also tend to have a higher reliance on the public insurance programs of Medicare and Medicaid and fewer opportunities for educational advancement, especially above Interstate 80 where there are no community colleges and, also, challenges with being able to get from points A to points B because of the geography of those communities. Ann, I'm sure you have a great deal to add to that.

Tickamyer: The definition of what is rural varies a lot by the source. The US Department of Agriculture and the US Census both define what is rural. They don't necessarily correspond, so what we classify as rural varies a lot depending upon what source you're using. The primary method is to select non-metropolitan counties which often means that these are counties that are outside the metropolitan *[unintelligible 06:16]*. They're outside of convenient commuting distance for work and recreation in large urban centers.

That "J" that Lisa was talking about is primarily made up of non-metro counties, although some of the counties are metro even—because of the commuting patterns that people take to jobs, but they still, often, are primarily rural in terms of population density, in terms of the basic economy and, especially, in terms of the consequences of lack of services, lack of access to things like broadband, health care, other kinds of amenities that people basically depend upon in this day and age.

Davis: I think one thing that's important to note is that when you look at most of the federal definitions, which, there are about 40 different definitions at the federal level that define what is urban and what is non-urban. What is interesting about most of those is that they really focus on the urban or metropolitan areas, and anything that falls outside of that is considered to be either rural or non-metropolitan. There is one definition at the federal level called the Rural-Urban Commuting Areas, otherwise known as RUCAs, that is supposed to be the most accurate definition of rural, which looks at a scale of 1 to 10 with subgroups within there, but even that definition is inaccurate.

For instance, if you look at a county like Perry County that is right next to Dauphin County, which is where our county seat is, where the state capital is, and where we have Hershey Medical Center, because of the way that individuals within Perry County commute for work, that is used

as a proxy for commuting for other goods and services. Perry County, which just got its second stop light a couple of years ago and has a very small population, is actually considered to be urban and, therefore, is ineligible, in the world that I live in, for a lot of the federal grants that would alleviate health care disparities, so there is really no perfect definition.

Tickamyer: You can just look at Centre County, where we are right now, and it's considered metropolitan. It's one of the smallest metropolitan areas in the country but, nevertheless, it's metro. All you have to do is look at which direction traffic goes when people are coming into work or leaving work to see that it is the center of commuting for the surrounding areas. Nevertheless, you don't have to go very far outside of State College to see just how rural this area is. Many of the implications, political as well as service, follow suit.

Donovan: THAT'S INTERESTING AS WELL. I'D LIKE TO TALK A LITTLE BIT ABOUT THAT AND OUR PERCEPTIONS *VERSUS* WHAT A LOT OF THE ACTUAL WORK IS SHOWING OF COMMUNITIES THAT ARE LEFT BEHIND. WE'RE THINKING THROUGH WHAT'S THE DIFFERENCE BETWEEN RURAL POVERTY, INCIDENTS OF RURAL POVERTY *VERSUS* URBAN POVERTY, OR IS THIS GENERAL NARRATIVE THAT WE'RE PICKING UP ON THE NATIONAL SCALE, OF COMMUNITIES LEFT BEHIND, IS THAT REALLY BORN OUT?

Tickamyer: It's really an interesting question and one that's being debated pretty vigorously right now among poverty researchers and policymakers. There is good reason to think that rural poverty and urban poverty differ in some ways. Historically, the populations, the demography of rural poverty was very different from urban poverty. Being poor means economic deprivation, so everybody suffers in similar ways, but if you look at what the causes of rural poverty *versus* the causes of urban poverty over time, there was quite a bit of difference. Populations were different. Often, rural poverty, historically, meant working poverty, people who had jobs but didn't make enough to get them over official poverty lines.

Also, we know that the access to services, the consequences of being poor were quite different in rural areas and urban areas. If you look at areas of persistent poverty, places that have been poor a long time, if you go back 50 years or even further and fast-forward to the present, you still see the same pockets of rural poverty that have been persistently poor over time. Nevertheless, those have shrunk. There tend not to be quite as extensive across rural counties as they previously were, and the populations increasingly look more similar so that there is less—fewer rural poor are attached to the labor force than in the past. Fewer of the rural poor are in long-term stable marriages than in the past, so there's sort of a convergence between rural and urban poverty over time.

Donovan: THEN, OF COURSE, THERE'S THE VERY CRUCIAL LAYERING OF AN URBAN *VERSUS* RURAL POVERTY FRAMEWORK TO HEALTH CARE. I THINK THAT IN URBAN POPULATIONS, THERE'S OFTEN MORE RIGOROUS OR EXTENSIVE OPPORTUNITIES FOR HEALTH CARE TO SOME EXTENT. I THINK, MAYBE, LISA, IF YOU WANT TO TALK ANYTHING ABOUT THE ACCESS TO HEALTH CARE ISSUE AMONG RURAL COMMUNITIES NOW THAT'S REALLY LEAVING A LOT OF FOLKS BEHIND AS WELL.

Davis: I'd be glad to. When we talk about access to health care, we talk about three components to that. It's access to the providers. It's access to the payment mechanisms, and it's access to transportation. In Pennsylvania, we have 10 medical schools, and all of those medical schools are located in urban areas. We have one that is located in a smaller community, but it is still considered to be an urban area. What we find is that health care very much is still centered around the primary care physician, and they play an enormous role in being—in access to care. When we look at the medical school graduates, we find that they are doing one of two things.

They are either moving out of the state because our state has been challenged with our medical malpractice rates over the last 20 years or so, or they are staying in urban areas where they've trained, where they may have a spouse who's also a physician and is interested in staying in a more urban area. They also have access to all of the bells and whistles, and all of the tools that they've grown up with, and all of the electronic support services. We look at a very special kind of person who wants to come out of an urban area and go to a rural community to practice. We find, actually, that after all of the studies have been done, and all of the research has been conducted, and all of the training programs have been put in place, that the biggest predictor of whether a physician will practice in a rural or medically-underserved area is whether or not they came from a community like that. That is the biggest predictor.

When we look at practices all over the state, two-thirds of all primary care physicians practice in the four most-populated counties in the state, three of which are located in Philadelphia or around that area, and the other is by Allegheny County or, actually, in Allegheny County. We're looking at a broad expanse of the state that lacks access to primary care providers. Many of those positions are, fortunately, filled with very talented advance practice nurse practitioners and with physician assistants, but we also see challenges with access to specialty services like oral health and, now, with the issues around the opioid issue in Pennsylvania, we're finding that it's very challenging to attract psychiatrists or behavioral health providers.

Then we need to look at the hospitals that are serving these communities. Across Pennsylvania, we have 197 general acute care hospitals, and out of those, depending upon who's counting, it's either 48 to 60 small rural hospitals. We're seeing an enormous affiliation happening across the state where these small independent hospitals are now affiliating with the larger health systems like UPMC or Geisinger or Penn Medicine or Pinnacle or Penn Highlands Health Care because they really need that large infrastructure in order to be able to support what they need in terms of access to the providers, access to a good infrastructure like a facility and to, let's say, for instance, telestroke care or other kinds of services where you need a strong broadband. Then, there is transportation, and I'm sure Ann has looked at this as well with poverty is that being able to get across the state can be very challenging.

Tickamyer: I'm curious to know if these small rural hospitals are remaining open. In many places across rural America, health care facilities are closing.

Davis: We're lucky here in Pennsylvania. We have had very few rural hospital closures. We have a couple of hospitals that are really on the edge financially, but they have not yet closed. That's a great question.

Donovan: IS THAT PARTICULARLY ATTRIBUTABLE TO STATE POLICIES OR FEDERAL SUPPORT SYSTEMS THAT HAVE KEPT SOME OF THESE RURAL HOSPITALS AFLOAT?

Davis: Yes. I would say that that's the case. One of the real benefits to the small rural hospitals was the passage of Medicaid expansion under the current administration because what that meant was that the hospitals were seeing fewer cases of uncompensated care, and they were also getting compensated for their Medicaid expenses at the state level.

Donovan: I WONDER, ANN, IF THERE'S ANY PERSPECTIVE ON WHAT YOUR TYPICAL DATA SOURCES HAVE BEEN IN YOUR RESEARCH AND IF THERE'S ANY INTERESTING ANGLES ON THAT FRONT?

Tickamyer: A lot of the data on rural poverty and poverty, in general, comes from federal sources. There are many of them, but the current population surveys and the census, the American Community Survey, all of those are important sources of information. Then there are a zillion other statistics available as well as household surveys that are conducted usually with public support but, nevertheless, done by university faculty across the country. However, there are also huge data needs, especially for rural poverty.

I was looking at the draft of a report by RUPRI, the Rural Policy Research Institute, that held a big conference a year ago last spring—on a rural poverty research agenda. One of the things that were identified and that we're starting to put together in a report is what are the data needs that—and what kind of research, what kinds of policy research is necessary in order to address these issues, how to be more systematic, how to get people to actually do this research? right now, rural is a little bit hot because of the current politics, because of the last election, so there's a lot more interest in rural everything, including rural poverty, but for most of the last, I don't know, 50 years or so, rural tends to get set aside. It tends to get ignored; it's flyover country.
Tickamyer: A lot of people will talk about the so-called hollowing out of rural America, which has been basically ignored by policy-makers, researchers, lots of people.

Davis: I wanna talk a little bit, also, about the data. I think Ann mentioned some terrific sources. In the work that rural advocates do, we are looking very much at the census data, so any conversations about how the census process might change or be modified is really important. We want to make sure that everyone is counted regardless of your status here in the United States. What's important is that the correct data are collected so that those who are actually working in policy can make decisions based on very accurate data, not on who you hope will be included in the survey.

Davis: We also use a lot of what are called the BRFS data, the Behavioral Risk Factor Surveillance data, that come out because those are really important even though it's a small population because that has been such a consistent data source for several decades. It becomes really important to be able to look at trends. One thing that my office and rural advocates really need to do with all the data that are out there is that we're working with health care providers, so

it might a hospital CEO, or it might be someone working in a community-based community action center.

They don't really have the time nor the skill to be able to sift through all of the data, so we've developed a population health database, where we work with a group out in California to pull in all of the data and to do some very nice, very easy to understand presentations of the data so that the health care facilities and health care providers can make decisions based on those data but can also drill down to find, if they need, more information about where the data come from. Because data can be really confusing, and being able to tap into the appropriate data, I think, is really important, especially for those who are actually working in the communities.

Donovan: THAT'S GREAT. THAT'S A GREAT RESOURCE FOR ALL THOSE FOLKS ON THE FRONT LINE.

Davis: The other piece that I think is important is that, in the health care world, we're really moving from a volume-based system to a value-based system so that we're looking at quality *versus* quantity. There's something called the Triple Aim of health care, which is looking at cost, quality, and outcome as a way to move toward this new vision of health care which is focused on population health rather than individual health. I tend to think of population health as really being able to address the health of a population whether that's a community, or a group who've been diagnosed with diabetes, or a population group, but really looking at a population one person at a time. Data are absolutely critical to being able to assess population health and moving into this value-based system that we're now trending toward.

Tickamyer: That's really interesting, especially as we know that there has been a decline in life expectancy recently. A variety of health issues that are really critical for this country that—we should be embarrassed that our life expectancy values, our other kinds of indicators of health, have not kept up with a lot of the rest of the developed world.

Donovan: THAT'S RIGHT. CONSIDERING THE REMARKABLE INVESTMENTS AS WELL, THEY'RE REALLY A PRETTY LOW RETURN. MUCH OF THAT DECLINE IN THE LIFE EXPECTANCY CAN BE ATTRIBUTED TO WHAT'S REALLY RAVAGING THE STATE. AS YOU MENTIONED, THE OPIOID EPIDEMIC HAS REALLY DECIMATED A LOT OF RURAL COMMUNITIES AS WELL AS MEDIUM TO URBAN COMMUNITIES. IT'S INTERESTING ABOUT HOW THAT IS PERHAPS MOTIVATING A LOT OF THESE CONVERSATIONS BECAUSE OF THE EPIDEMIC LEVEL THAT'S GOING ON.

Tickamyer: I think it's really important to talk about the opioid epidemic, but it's not totally new. Before opioids, there was the meth issue. There was a variety of really serious health issues and drug use issues that certainly afflicted rural areas, that didn't get as much attention. I'm sure you know much more about this, Lisa, than I do. It's another one of those things where we suddenly wake up surprised that it exists when we should have seen it coming because there was so many background kinds of issues.

Donovan: THAT'S RIGHT. WELL, THAT'S ANOTHER REASON TO, UNFORTUNATELY, BE—OUR SYSTEM COULD BE ADMONISHED FOR MISSING THESE COMMUNITIES BEFORE, HOW SOMETHING WAS ABLE TO BE OVERLOOKED BEFORE IT GETS TO CATASTROPHIC LEVELS.

Davis: Kentucky is a really great example of that. Was that 10 or 12 years ago, Ann, that Hazard, Kentucky, was considered to be this nucleus for drug activity and for fatalities due to overdoses? But it didn't really catch on until we started seeing opioid deaths move out of what you would consider to be the traditional group of people who were experiencing that, which are, for the most part, low-income, isolated individuals, whether they're rural or urban. Suddenly, the opioid or addiction started to affect middle-class America, and that's when people stood up and started to take notice.

Donovan: I'D LOVE TO TALK MORE ABOUT HOW WE CAN BRAINSTORM INTERSECTIONS BETWEEN POLICY SPACE AND ACADEMICS TO REALLY MOVE FORWARD THESE ISSUE AREAS THAT ARE IMPORTANT TO US.

Davis: Well, a couple things I wanted to say. One is, and I'm sure Ann's experienced this a great deal, we never think about rural as just its own space. Rural and urban and suburban, although no one talks about suburban, but rural and urban are very much interconnected, very much so. It's not one against the other, or one is better than the other. That, I think, has been really important for us in being able to work across the state with organizations, institutions across the entire state, whether it's rural or urban.

What is impacting poverty and what is impacting rural Pennsylvania is, essentially, everything, so you're talking about economic development, education, health care, infrastructure. There are so many ways in which the worlds in which we live intersect each other in just about everything. Whether you're talking about access to health care, access to affordable and healthy foods, access to sustainable living situations, it's everything. Would you agree?

Tickamyer: Absolutely. It's interesting that you mentioned suburban areas, too, because one of the things that has recently been realized is that there's an increase in poverty in suburban locations. We don't know exactly why. We think part of it may be just reclassification of boundaries, so places that previously had been—

Donovan: MOVED THE GOALPOST.

Tickamyer: - rural now are the exurbs and suburbs of urban areas. We also think that there has been population movement in and out and, of course, the great recession impacted every place, and many places haven't recovered yet. But, yeah, it's all interconnected. It's a mistake to see these as separate issues.

Davis: We work a lot with those who are in Ann's department and at Ann's college. Actually, we used to be in Ann's department many, many years ago, and see that connection to that academic community as absolutely vital to the work that we do in terms of being able to talk about best practices, being able to know who we can call on if we need data or information. We

also do a lot of work with the agricultural, safety, and health programs that are in the College of Ag-Sciences and work very closely with them on trying to do a lot of outreach and education to ag producers on, not only safe farming practices but, also, helping them access the health care system, seeing who might be eligible to enroll in health care, health insurance programs. It's very broad.

Tickamyer: And it works the other way around. Researchers need the people who have the on-the-ground connections and know how outreach works in order to conduct the research, so it's always a two-way street.

Donovan: THAT'S RIGHT.

Davis: One great example of that is that we do some work with the College of Engineering in the Industrial Engineering department, and they have what they call a learning factory, where they take students who are in their senior year and students pick—a team of students will pick a project that's been proposed. We've had two of those projects done with our critical access hospitals in the state, which are the smallest, most rural, and most financially vulnerable hospitals. They have been able to develop programs for these hospitals to help them increase their staffing efficiency or increase physician order entry—or, I'm sorry, prescription order entry for physicians. These are benefits to the hospitals where if they paid for this outside of—a regular consulting company—

Davis: - $60,000 to $80,000, it's been estimated.

Donovan: THAT COULD DECIMATE THEIR BUDGETS.

Davis: Right. These are terrific opportunities that we have here. We also do a lot of work with the College of Medicine and, especially, in their training programs that they have and, also, in the Area Health Education Center program, which works with academic medical centers and communities to connect physicians and trainees.

Donovan: THAT'S GREAT. I AM INTERESTED IN HOW WE CAN FURTHER REALLY LEVERAGE DATA—ADMINISTRATIVE DATA, A VARIETY OF DIFFERENT SOURCES ACROSS THE GOVERNMENT, BOTH STATE COMMONWEALTH AND FEDERAL SOURCES—FOR REALLY FINE TUNING OUR APPROACH GOING FORWARD.

Tickamyer: Well, unfortunately, for rural areas, especially, the American Community Survey for census data, in general, has substituted, for the old long form, individual detailed census questionnaires. They're on a five-year cycle, so the smallest places have to wait five years before the data is available. In this day and age, that kind of lag is not really very realistic in terms of understanding what's happening.

Tickamyer: Now, you do have other sources of data, so the current population surveys are much more common.

Tickamyer: Of course, one thing that's coming up quickly is the so-called big data sources. I have a colleague, for example, who is very much involved in analyzing Twitter data and, at this point, it's limited by your imagination in how to use it. Now, it may not be as representative for rural areas because of broadband issues. Nevertheless, most of that is accessed by cell data, so it's a little more. It's not quite as bad as not having really good broadband access. People are just really starting to make use of those sources, and I like to plug what I call little data because I think, increasingly, we respect smaller-scale qualitative studies.

It used to be that those were seen as problematic, certainly not as representative and, therefore, in the social sciences and in my discipline, sociology, sometimes, not as highly respected. I think it's increasingly recognized that you need both qualitative data, small-scale studies that go into great depth, as well as large-scale quantitative studies to really understand the process and meaning of different kinds of situations. We wanna understand what poverty means to people, how they experience it, how they cope with it. Some of those small-scale qualitative studies are really important.

Donovan: THAT'S GREAT.

Davis: In the world that I live in, we think a lot about paired data, primarily, Medicare and Medicaid paired data. Being able to get access to those data pretty quickly are very important because policies change so quickly, or a state may move in and out of Medicaid expansion, so being able to have access to those data are really important for us. We find that a lot of the data that come out for some of the big national programs that we work in, because they lag by 24 months, it's interesting but not necessarily always useful, that we need to look much more at state data rather than federal data.

Tickamyer: I think we increasingly have the means to report it and make—and give access to data as it's happening. I know there's now something called a nowcast for economic data. It's not a forecast, it's ongoing, and I don't see any reason why we couldn't have similar kinds of data availability for health issues, for poverty issues, for whatever. We just need the will, the economic resources to make this happen.

Donovan: THAT, I FIND, IS A CRUCIAL POINT AND, LISA, YOU MADE NOTE OF IT IN REFERENCING THE TIME LAG THAT'S OFTEN PROBLEMATIC. I THINK ONE THING THAT REALLY CAN SUPPORT THE INTERSECTION OF ACADEMIC WORK AND POLICY WORK IS MAKING THOSE RUNWAYS AS SHORT AS POSSIBLE FOR ACADEMIC WORK. OFTEN, THE TIMELINES ARE JUST A LITTLE DIFFERENT. THE POLICY COMMUNITY IS IN NEED OF SOMETHING IMMEDIATELY, LIKE YESTERDAY. OFTEN, THE TIMELINE IN ACADEMIC CIRCLES IS A LITTLE LONGER, ESPECIALLY FOR SOMETHING THAT GOES THROUGH PEER REVIEW AND IS PUBLISHABLE AND HAS AN EXTENSIVE REVIEW PROCESS. WORKING ON RESPONSIVENESS, I THINK, IS AN IMPORTANT ANGLE.

Donovan: WE JUST COVERED QUITE A NUMBER OF TOPICS. WE'VE DISCUSSED SPACIAL INEQUALITY, THE RURALITY OF PENNSYLVANIA, CHANGING DEMOGRAPHICS AND POPULATION MOVEMENTS. WE DISCUSSED MAJOR RURAL

HEALTH ISSUES THAT ARE AFFECTING PEOPLE DAILY AND TRYING TO PREPARE OURSELVES FOR THE NEXT EPIDEMIC. I WANT TO GIVE MY WONDERFUL GUESTS HERE AN OPPORTUNITY FOR ANY CLOSING STATEMENTS

Tickamyer: I'd like to say that rural poverty has been a serious issue for this country for many, many years, for decades. The current interest is wonderful, but we shouldn't let it be something that disappears again. Rural poverty, as well as poverty in general, are issues that we need to address in a serious way without regard to what's currently popular or interesting or in vogue.

Davis: I would say that rural America is absolutely critical to all of America. While 20 percent of the population lives in rural areas, 90 percent of the United States' land mass is outside of urbanized areas. All the food that's grown is grown in rural communities, and they tend to be the backbone and the anchor of the United States, so it's important to think about rural communities as places that deserve respect and attention.

Donovan: I THINK WITH THAT WE CAN BRING THIS EPISODE TO A CLOSE. I WANT TO THANK MY LOVELY GUESTS HERE, LISA DAVIS, THE DIRECTOR OF PENNSYLVANIA OFFICE OF RURAL HEALTH AS WELL AS THE OUTREACH ASSOCIATE PROFESSOR OF HEALTH POLICY AND ADMINISTRATION HERE AT PENN STATE AND, ALSO, DR. ANN TICKAMYER, PROFESSOR OF RURAL SOCIOLOGY HERE AT PENN STATE.

Davis: Thank you.

Tickamyer: Thank you, Michael.

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