**“That’s Understandable” Season 2 - Episode 8**
**“Life in the Desert” Transcript**
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**Brendan (00:08)**
Hello everyone and welcome to That's Understandable. I'm your host, Brendan McEvoy, US head of external communications at AstraZeneca. If this podcast has been enjoyable and informative for you, take a moment to like and follow on your favorite streaming service. And if you know anyone else interested in today's topic, be sure to share because our goal is to help make everyone, because our goal is to help everyone to better understand what science can do when we all work together.

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I'd like to start today's episode off with a story that was shared by a listener. They said, I grew up in a small, rural Midwest community. At the age of seven, I was diagnosed with type one diabetes in a hospital that was a 30 minute drive from my parents' home. After that, my pediatrician advised us to see a pediatric endocrinologist. The nearest one was a hundred miles away. For the next 10 years, my parents packed my younger sister and me every three months and drove those 100 miles to the nearest Children's Hospital for my appointments. As kids, my sister and I loved it. We got to stay in a hotel with a pool and eat at neat restaurants in the big city, never realizing the immense stress these trips put on my parents. My mom and dad were farmers and like many other farm families at this time, were self -insured. For each appointment, my dad had to arrange for help to feed and care for our livestock. One time while we were gone, there was a large storm that scared the cattle and they ran through the fence. My dad had to rent a car and drive home while my mom, sister and I stayed at my appointment to help wrangle the animals that had run off, the animals that were our livelihood. Now that I'm a parent myself, I'm grateful to live in a large urban area with easy access to world -class medical care. But I still have friends back home who make the same trip my parents made all those years ago to take their children to get the specialized treatment they need. I can't help but wonder: What are we doing to help rural families have better access to healthcare?

I'd like to take a moment to thank the listener who shared their story with us. And it really, as they say, speaks to the lived experience of so many people throughout the country. With that, we're going to start to try and answer this listener's questions during today's conversation as we talk about healthcare deserts, sometimes called medical deserts. The World Health Organization defines a healthcare desert as a geographical area with limited access to qualified healthcare providers and quality healthcare services or areas where people lack adequate access to six key healthcare services, pharmacies, primary care providers, hospitals, hospital beds, trauma centers, and low -cost health centers. According to a study done by GoodRx in 2021, 80 % of the country lacks adequate access to healthcare. It also found that 30 million Americans live in healthcare deserts. That's more than the entire populations of New York, LA, Chicago, Houston, Philadelphia, Phoenix, Dallas, San Diego, San Antonio, and Washington, DC combined. But luckily, there are people working on solutions to address distance -related access barriers, and two of them are joining us today to discuss this topic. First is Dr. Cindy Juntunen, Associate Provost and Dean at California State University, Monterey Bay. Dr. Juntunen grew up on a North Dakota farm located in the healthcare desert and lived most of her life in the state. She has nearly 30 years of higher education experience

and is the chair of APA's Task Force on Developing Guidelines for Psychological Practices with Low Income and Economically Marginalized Clients. Welcome, Dr. Juntunen.

**Cindy Juntunen (03:41)**
Thanks so much, Brendan. Happy to be here. And please feel free to call me Cindy.

**Brendan (03:47)**
We'll do Cindy, thank you. And joining Dr. Juntunen, or Cindy, is Dr. Tripp Logan, Community Pharmacist and Vice President of SemoRx Pharmacies and Care Coordination in Charleston, Missouri. He is also the Chief Operating Officer of Choose My Pharmacy. Dr. Logan has been nationally recognized for his work on patient care, health equity, care coordination, social determinants of health, and positive health outcomes. Thanks for joining us, Dr. Logan.

**Tripp Logan, PharmD (04:15)**
Thanks, Brendan. Tripp here also.

**Brendan (04:17)**
All right, Cindy, with your background in education and research, I'd like to start by asking you, how did we get to this point where so many Americans live with limited access to adequate healthcare, notably access that depends on where they are physically located?

**Cindy Juntunen (04:34)**
Yeah, I mean, it's a pretty complicated picture, really, because there's a lot of factors that contribute to it. When we think about health care over time, in past centuries, people even in small towns, you know, there would be a healthcare provider that would sort of come from the population of that town, right? And then they would stay there. That's where everyone lived. People weren't as mobile. And as healthcare fields became more specialized, as more and more people had to get more extensive training and move away to hubs where there would be, you know, schools that could provide them with advanced training, whether it be in, you know, physical healthcare or mental healthcare or any of those, of things, more people had to leave the communities that they were living in, go away for training, and then once they had this sometimes very expensive, very time -consuming training, they were not surprisingly looking for ways to specialize and become more professionally mobile and they had more options in larger urban areas, right? So that's one of the big factors is our training demands increased over time.

We needed more complicated service providers, more complex and more sophisticated service providers as our scientific knowledge supported our medical advancements. And then people didn't return to sometimes, usually small towns. It's not just small towns that are deserts, of course, but often we can think about that rural communities really fit that picture that you're a listener described, right? And they gravitated toward larger areas where they had more opportunities. So that's one of the main things that contributed.

**Brendan (06:16)**
Thank you. And Tripp, from your perspective, sort of in the same vein, has this sort of always been an underlying issue that maybe is just becoming more prominent now, or is it more of an emerging problem that has maybe sort of become more relevant or prevalent in recent years?

**Tripp Logan, PharmD (06:35)**

I think it's probably closer to the ladder of an emerging, but like the emergence has been, you know, we've got a long runway on the emergence. You know, this has been happening. I took my first steps in one of my dad's drug stores. I've been in this small community in the Mississippi Delta area of Missouri, living in of the poorest counties in the, in the state, which is also one of the poorest counties in the country. Grew up here, went to pharmacy school. I've been out for 20 something years. I've been watching this happen my whole career. There were five pharmacies in this little town. my dad got out of pharmacy school, I'm second generation. He got out in 1975, I think. And as of January 1st, now there's one pharmacy in the town, no federally qualified health center. We used to have multiple physicians in town. Now we have a family nurse practitioner, possibly a few days a week. So we're seeing what cause did.

Like Cindy was saying a lot of different reasons one of the things that we've seen is just the provider squeeze from a reimbursement in a regulatory standpoint pharmacy providers are you know, the the revenue is not there as it was 15 years ago for pharmacy providers and the burden of only regulatory but liability and there's just there's a lot to it You don't just show up in practice like you used to same thing with primary care.

And so it's just been a gradual, and I think the COVID pandemic through gasoline on this fire also, because then you had a high level of burnout and workforce is more expensive now than it was pre-pandemic. So it's all these things happening at the same time that's creating a problem. And I know in the pharmacy industry, my colleagues are struggling and pharmacies are closing regularly. And we could talk about, you know, there are more pharmacies or less pharmacies where they are, zip codes and so on. But I think it's just so multifaceted. The reality is it's here.

**Brendan (08:34)**
Yeah, that's interesting Tripp. you're actually, you know, you have the perspective of sort of being in the same community for a long period of time and kind of seeing the transition, right, of less and less, whether it's pharmacies or, you know, physicians. So does the example I shared, the listener story, does that sort of then resonate with you in terms of how you've seen into the community that you live over the years.

**Tripp Logan, PharmD (09:05)**
It does. So our service area is six, seven counties right now. I'm also a very involved in a national network of independent pharmacies, over 3,500 of them all in similar situations as this. the organization is called the Community Pharmacy Enhanced Services Network or CPSN. So I'm seeing it across, you know, it's not just here locally, but the story is very similar in most places where we are.

You know, like in my community, if you need an endocrinologist, you have to go at least one county over, maybe three counties away. That's really challenging if you've got issues, if you've got some transportation struggles. Transit isn't real dependable around here. know, the access points to care are hard to get to, including mail delivery, UPS, FedEx, like those are all challenges in areas like this, things that a lot of us take for granted, particularly those in urban areas, it's just hard to get to a post office, right? It's hard to get to endocrinologists. It's tough. So there are lot of solutions that are being experimented, that are being deployed right now, but I don't know that anybody's got it completely figured out

**Brendan (10:24)**

So, you know, in introducing both of you and the work that you do, it's clear that you've, you know, both have dedicated a lot of your efforts to helping to address some of the issues that we're talking about here. And in essence, trying to improve access to healthcare in communities where there's, where it's not readily available or accessible. So maybe starting with you, Cindy, what progress have you seen throughout your career as you sort

you know, focus your efforts and time in this area.

**Cindy Juntunen (10:55)**
Yeah, well there's a couple of big things that I think have really changed over time. I, know, most of my career has been spent training psychologists and counselors, right, to work on mental health issues and behavioral health and substance use, those kinds of things. And so one of the huge transitions, of course, in that area is increased access to services through telepsychology or telemedicine. You know, the idea, you know, even 15 years ago, 20 years ago, talking about doing be online felt like a really…. abnormal response to a situation and now it's, you know, it's really, it's almost commonplace, right? We started training, we started training students in 2010 to provide services via video and that was at the time one of only two or three places that were doing that. But we did it because we knew how hard it was for our rural clients to get into the hubs where their psychologists and counselors are located. So that's, you know, that's certainly one big shift.

The other thing that I think doesn't get as much attention but should is that helping providers see the benefits of working in isolated and rural areas. And I tend to focus on rural, there again, as I mentioned, it's not the only thing, but helping people see that this is a social justice issue, right? Like a lot of young professionals or young providers really care about that. They care about the idea of making sure that they're working with marginalized communities. And if we really help people understand that, yeah, when you're talking about geographic isolation, you're talking about engaging in social justice work, right?

And so, you know, we developed a program at the University of North Dakota that focused on rural psychology with the idea of helping people understand that rural culture is different. And you have to understand those differences in order to be an effective provider. And that really helped change the conversation in a really positive way as well. So that's, think, another important change that in the mental health field, there's a lot more attention being paid to the fact that rural communities have unique needs. It's not just that they're located somewhere. It's that there's a whole thing that goes along with rural life that's important for providers to understand. So I think that's a positive change.

**Brendan (13:12)**
Yeah, definitely. And I definitely want to come back to the telehealth or telemedicine piece too, because I think we can dig into that. before I do so, Tripp, from your perspective, what progress have you seen?

**Cindy Juntunen (13:17)**
Yep.

**Tripp Logan, PharmD (13:22)**
Pre -pandemic and post -pandemic are kind of like, it's almost like to me, we've got, there was a pivot during this time, at least in my industry, and you see it throughout the healthcare. I

would imagine Cindy would concur that the availability and the acceptability of a tele -visit pre -pandemic and post -pandemic are totally different, at least they are in my area. From the payment, from the reimbursement abilities to just the patients accepting that as a viable option.

So I've also seen that. What I'm excited about also is very concerning, but maybe the excitement is coming out of a lot of concern is that a lot of people in what I will consider like underserved, underrepresented areas, whether that's urban, rural, wherever it is, we're calling them deserts here and a lot of different, looking at research and depending on how you want to spend, pharmacy desert or healthcare desert is, you there's a lot of different definitions and I don't know that anybody's really landed on, but if a patient needs care and they can't get access to the care in their community, that's to me what's a healthcare desert. So when you have that, what's the solution? How does this person find the care that they need, even if it's health -related social needs, if it's social determinants of health, those are all things that...

positively or negatively impact health. So it could be clinical, it could be social, it could be a number of things. So what we've been focusing on, and this is we're in year five of a national initiative to cross train community pharmacy technicians as community health workers. And so like I said, like in my community, we don't have a physician that's here every day, we don't have an FQHC, we don't have a hospital, very little transit, but we've got nine community health workers on site in pharmacies that are open every day during business hours, right? Somebody can walk in and find access to care through a community health worker who's an expert in all the resources available in the community. So if you need transit, they know who it is. There's not anybody in the country that knows more about Mississippi County, Missouri and the services offered than the community health workers in my practice. So that allows us to help people navigate the healthcare system better.

We currently have, in the last, let's see, 16 months, have created a network of pharmacies that are doing the exact same thing in 30 states right now that have community health workers embedded in pharmacies used for care coordination, longitudinal care coordination. You know, it may be transportation tomorrow, it may be medications too high the next month, it may be food insecurity the following month, and it may be back to transportation the next or some combination of. But that's what these community health workers are doing.

And their jobs are really to take community members by the hand and help them get the care that they need, the support that they need to best take care of their personal health and their family's health. And funding for that has come through a lot of different avenues. could go down to talk through that as much, but the acceptance of this type of service and the rate at which it's not only spread, but being utilized right now in the country is to me one of the most exciting things because they're community pharmacies and primary care clinics and these really local public health departments that often offer, I mean they offer services but a lot of times they're not working together. They need somebody to help everybody work together and that's how these community health workers and pharmacies are leading an effort and it's been really exciting to watch. We've got tons of data and publications that are not only out but coming out about how this work helps. Not that this solves all the problems, but if there's a pharmacy in a community, they are oftentimes the front door to healthcare because it's easier to get in there than it is to get into primary care or the hospital or wherever. And so we're really excited about that. That's a positive change. What's not super positive, Pharmacies are closing at a rapid rate. our primary care clinics, know, this is, we've got a, what I would say almost like tragic situation with the closure of independent primary care clinics, the closure and acquisition

and closure of independent community pharmacies or small chain pharmacies. There's all kinds of publications coming out right now where chains are closing drug stores, independents are closing drug stores. So that ruins our model because that access point isn't there. And so that gives me a lot of concern about what we're going to do in the future.

**Brendan (18:20)**
**TRANSITION 1**

Tripp and Cindy's description of the situation facing rural communities when it comes to access to care was eye-opening. As I listened, I wondered how much pressure the shortage of health care providers was placing on these communities.

Tripp, both you and Cindy have already talked about sort of, you know, COVID -19 and, you know, sort of before COVID and after COVID. So maybe Cindy, starting with you, because up front we talked about, you talked about sort of some of the obstacles or challenges which are contributing to why there's a, you know, lack of, you know, physicians and other healthcare services within communities around, you know, going to larger cities for more education and opportunity and potentially not coming back. So I would imagine and, and, you know, correct me I'm wrong or help me or maybe there's even other components to it that, that I won't highlight here, but I would assume COVID -19 then made the situation worse because we were heard, you know, nationally or internationally really that there was a lot of people that were just leaving the healthcare field because of burnout and other things. So I guess it's fair to say that it exacerbated the issue. Is that fair?

**Cindy Juntunen (19:36)**
Yeah, think it definitely exacerbated the issue in a number of really important ways. I think the burnout by itself, and I know that there's still research being done on this, but I think when we actually can see the trends...

you know, if we get, you know, 10 years down the road and we can actually see my, I can't imagine that the data won't show that there's some kind of trend that was sort of triggered in COVID related to rates of burnout and departures from, from healthcare fields. Yep. There are also a lot of new students coming in because they were inspired by, you know, the heroic kind of, and that's important, but that still means that there's going to be this shift for communities that I think we're really barely at the beginning of understanding yet. And I also think, we really saw it in terms of like things like substance abuse treatment, you know, one of the things that COVID correlated with was an increase in the opioid crisis and an increase in overdose deaths, right? And we also saw that being accompanied by a decrease in providers, decrease in availability of providers. We have a large number of substance use counselors in the United States that are approaching retirement age and nowhere near enough students in the pipeline to replace that cadre of providers and that, you know, whether it's a coincidence that that happened at the same time as COVID or whether COVID exacerbated some of the retirement rates, you know, but those things were all happening at once.

I mean, that is an area that I think is an area of really extreme crisis that's become known and more discussed since COVID. So, and frankly, the rates of anxiety and depression went up during COVID as well, which has resulted in more need. And interestingly, COVID had the unexpected, think, potentially positive impact of people feeling more comfortable talking about their concerns, right? Like a lot of people said, hey, we're going through a crisis. It's okay to

feel like you're in a crisis, you know? And so it normalized the discussion, but normalizing the discussion about mental health things usually in an increase in services and there weren't an increase of service providers available to meet those needs. you know, so, so yeah, I mean, that all comes together in a pretty wicked little mix of factors.

**Brendan (21:58)**
Yeah, yeah. And Tripp, like other, you know, any builds from you in terms of, you know, how COVID -19 exacerbated or, you know, or, you know, positive or negative impacts in terms of, think, you know, Cindy, you had shared potentially some positive being people maybe being more comfortable in seeking mental health services. So Tripp, any thoughts from

**Tripp Logan, PharmD (22:25)**
I agree with Cindy on just generally how we've seen pre and post.

In pharmacy specifically, pharmacy prescription drug product reimbursement has been on the decline for a really long time. And during the pandemic, it kind of masked that because there was a lot of vaccination opportunity for pharmacies. Like I'm proud of my colleagues across the country that pharmacists and pharmacies did a great job vaccinating the public during the pandemic. And so that was a lifeline that a lot of my colleagues needed at the time. And it also opened the eyes of a lot of other segments of the healthcare industry and the public on access and services in a pharmacy, whether it's point of care testing, COVID testing, flu testing, strep testing, RSV testing, vaccinations, COVID and beyond. So those are definitely positives that have happened. But afterwards, once the pandemic started going away and moving into more like, normal life like we were seeing before. That's a lot of the financial challenges in community pharmacy practice have resurrected and reared their ugly head again. And so a lot of my colleagues are in a lot of trouble. And so if we're at risk of losing say 20, 30 % of pharmacies over the next five years in communities, that removes another access point and COVID.

I would say is not directly related to that, but it is, there is some correlation because after, during the pandemic, labor cost went up and there were a lot of things that, you're already, if your margin is already pretty tight and then labor costs are going up and reimbursements going down, it just expedites a problem that's already occurring.

**Brendan (24:18)**
Tripp, one thing as we're talking, and I'm going to sort of state the obvious for both of you, but it may not be as obvious to our listeners that when we're talking about pharmacies, think depending on where you live, the community you live, you might be thinking of pharmacies only as sort of these large chains, right? But I think it's important here, and I think the perspective that you're talking about is we're also talking about independent pharmacies, right?

I would assume have so much more overhead and burden than those that are supported by national networks or large corporations. So again, I'm stating the obvious, but I think just to help put in perspective, as we are seeing large national chains close down, I I can only imagine it's even more difficult for independent pharmacies in some of these communities where they don't have the lifeline of a larger corporation that maybe is helping them float during rough times.

**Tripp Logan, PharmD (25:20)**

Yeah, and thank you for saying that because that's at, so you look at like my little pharmacy, LNS Pharmacy in this town, it's just across the wall over here. You my purchasing power for drug product is a lot different than say a Walgreens, a CVS, a Rite Aid, Walmart, right? I mean, you can only imagine the difference in the purchase price, but the real tragedy is that I went to 14 semesters of college to get my PharmD. You know, pharmacists are very highly educated, very clinical minded experts in medication optimization. It's a healthcare professional that's located in a community that's very accessible. But the way that pharmacists have been historically paid is basically on a buy sell model. You buy a prescription drug and you sell the prescription drug and that margin is what pays a pharmacist. And there's a disincentive a lot of times. And so we're starting to see this across all pharmacies. So when I say community pharmacy, I'm saying a pharmacy with a front door. There's chain, there's independent. I've got a lot of great colleagues that are pharmacists working in chains, doing the best they can. A lot of times the mission is a little bit different and so is how they structure their budget. We're a lot more service oriented. A lot of pharmacies are essentially dispensaries. They're just dispensing drug product all day long and that's their business model.

Most of my colleagues in my network, you know, they're service first, which means deep prescribing to some like somebody comes into our place. They've got 12 drugs. My clinical team's like, you know, like really do we need all 12 of these or can we possibly get you off of a couple when the by cell model that, you know, that doesn't make sense. Right. So, so as we're shifting to pharmacist as providers and open up scope, the pharmacist scope of practice in states and in federally.

Yeah, that we're seeing more and more. just not moving quickly enough, and that's that's one of the unfortunate realities. Medication mismanagement, medication misuse like that's a major driver of hospitalization, and so if we can help minimize that in the community, then that's what we really should be doing. Not contributing to the problem by having to sell more drugs. You know that's not what any of us went to school for, and so there you know we're in this in the middle of this transition period with pharmacies.

And I've seen press releases from major chains that they're shifting to more service oriented post pandemic because they saw the value of COVID testing and vaccines and so on. so their independence have been doing that for a long time, but it's my hope that really we shift from this, know, buy sell product driver of how the business model works for pharmacy to really where our job is for medication optimization and do the best by the patient and it's based on service -based delivery, not necessarily product.

**Brendan (28:10)**
Yeah, thank you. It's helpful to sort of get more of an inside scoop on the impact and the model that currently is in place. And I do, it resonates with me having, you know, live in a more, an area where there's access to more services that, you know, a viewpoint I think that would be common in a pharmacy in the town that I live is that you would essentially go there to drop off or fill a prescription. It would probably be less likely ask the pharmacist there for sort of advice or questions about your healthcare conditions or whatnot. So it's an interesting perspective. And I like early on where I was thinking in my head, through the work that you're doing in the pharmacy there, you're actually kind of like rebranding in a sense, like what the role of a pharmacist is, which is great. I do have one more question specifically related to something you said, and I'd love to shift gears a bit to talk about some of the ways from a policy or broader industry perspective of how companies can help to help sort of remediate the

issue. So Tripp, one of the things that you mentioned upfront, think you briefly mentioned sort of mail order pharmacies, online pharmacies, and you put a point upfront that you said something around sort of even that mail services might be sort of limited depending on town.

Is mail order pharmacies, is that sort of addressing some of the gaps in communities where we are seeing less, know, pharmacies either disappear or is that maybe creating an inaccurate sense of comfort that pharmacies, know, mail order pharmacies are kind of plugging the hole.

**Tripp Logan, PharmD (30:01)**
I like, thank you for this question. I like this question a lot. So I like to always frame this in what does the patient need? Do they need a pharmacy or a pharmacist? Okay, and so 90, like if I'm getting my oral contraceptive or I'm getting my allergy medicine, you can get that from the mail or your pharmacy from a kiosk, right? You don't really need a pharmacist. You need a prescription. You need a pharmacy, right? But a lot of people need a pharmacist and it is really challenging in underserved, underrepresented areas, when there's a need for a pharmacy, you've got a major drug interaction, you've got out -of -pocket cost issues, you've got an access barrier, you don't know how to use your inhaler, administer insulin, you've got a question, my insulin was out of the fridge for a while, and I don't have minutes on my cell phone, right? That's what we deal with. So these people need a pharmacist, and it's typically the most complex, most at -risk, with the worst outcomes and the highest cost to healthcare system. Those are the ones that need a pharmacist.

So when you remove the pharmacist from that region and all that's left is service for somebody that needs a pharmacy or just a prescription, we created a healthcare vacuum. And so that's what I'm afraid of and that's what we're seeing now. So you're not gonna see a lot of colleagues of mine saying mail order pharmacy is the enemy. What we're saying removing the pharmacist from the community where there's not an access point to healthcare, that's the enemy. And so we need to make sure that we stabilize those and that's what we're working every day trying to ensure that we're doing.

**Brendan (31:36)**
Okay, that's great, thank you. So Cindy, I'll point this one to you first as we get into certain considerations that could help expand access to services or sort of eliminate the barriers. So the first is, are there sort of policy considerations that we should consider that might help support expanded access in rural or areas where healthcare services are limited?

**Cindy Juntunen (32:07)**
Well, certainly there's still policy considerations related to like telemedicine that's that haven't been resolved consistently across jurisdictions, right? You know, in terms of reimbursement rates, as Tripp kind of mentioned, and those kinds of things that that needs some additional work. The other thing that sometimes gets overlooked in all of this, too, is the way in which we do licensing is usually jurisdiction, you know, in most of the health care professions is by state. It's really hard. Portable licensing is a policy thing that could really help. You know, you've got somebody who lives at the border of North and South Dakota and you know they can't see the rural neighborhood next door because of the you know as one example right like of course some states have worked have worked out those things but there's but the inconsistency across the country is is substantial and so from a policy perspective looking at the way licenses can be more mobile and information could be shared more easily across state lines would really help providers and and the patients that they work with across many of the health

disciplines it definitely would be a really huge factor for a lot of mental health areas that I'm more familiar with. So I think those are important things.

The other, know, there is a pretty successful set of programs, mostly funded by the federal government, but some by state governments, of doing student loan repayments to encourage people to relocate to areas that are food deserts, or sorry, since food deserts, so sorry, medical deserts. And that those have been pretty successful, but they are cumbersome. A lot of people don't apply for them because of the hassle connected to them. So there could be some streamlining there. And I think it's also probably worth considering whether upfront scholarships that are then contingent on service might actually help more people get into the training required for health care professions. So if you reduce the financial barrier at the front end and give people tuition waivers or scholarships contingent on them then working in underserved areas for some period of time, I think that's a policy work that could really make a difference and actually encourage more people from the beginning of their training to be considering working in these desert areas. And then that would allow them to get the training experience they need in underserved settings to be more successful and to hopefully minimize and increase retention and minimize some of the burnout that we see with people who go to more isolated areas. So those are three things that come to mind that I think could have a real powerful impact.

**Brendan (34:37)**
Just a follow up question from as so I understand and correct me if I'm wrong. So from a physical physical standpoint, if you're, you know, licensed professional in one state, you might not be able to, know, or you can't, guess, policy sort of restrictions and to your example, like if you were on the border of North and South Dakota, being able to sort of help the next community over, does the same apply for from a telehealth perspective? Are there different, you know, if you are licensed in North Dakota, does that mean you could only sort of provide services to telehealth services to patients in the same state, or do they have sort of workarounds from a telehealth perspective?

**Cindy Juntunen (35:20)**
So there are emerging workarounds, but again, they're really inconsistent across jurisdictions. So generally, the issue is that you have to be licensed wherever the patient lives. And so you will see people who are, you know,

So I live in California, I have a license still in North Dakota. If I got a license in California, I could see patients in both North Dakota and California, that would be fine. But I couldn't see patients other places in the country based on most, and that even, that's not 100%, that's based on the jurisdiction of, that's based on the rules of the state or province where the patient lives. So, yeah, so it also is really confusing. It's confusing for the provider as well as the potential patient, right?

You know, you'll have people who say, well, you know, I'm moving over here. I can still see you and I like seeing you and you're you can do it online. Well, I can't see you anymore, unfortunately, because I mean, it's very baffling for everyone. So consistency is the kind of issue here, right? Is there a way for for for these these licensure laws to be a little bit more transparent and a little bit more malleable, given the reality of how mobile we've become like we have become way more mobile than our licensing boards sort of recognize right now. Yeah.

**Brendan (36:50)**
Yeah, yeah, it is quite complex there. Tripp, from your standpoint, any other considerations from a policy lens that could help support?

**Tripp Logan, PharmD (37:03)**
A lot of times when I'm thinking through this or we're working through this, whether that's in a state or with this federal, I like to look at what's going on in other sectors of healthcare. So if you look in, so we're in the middle of what will soon become the worst financial crisis in the history of community pharmacy, Pharmacies are closed, like we're seeing this and there's a,

There's a little pushback in some sectors of the industry saying, well, that may or not be true. It's absolutely true. what has happened in other places? There are a lot of other programs like critical access hospitals. The reason that those exist is they're subsidized in order to be there in that community because that community has a high default rate on payment. Right? And so if they close then there's a healthcare vacuum that costs the system more money, that costs the state government, the federal government more money. So there's a critical access hospital there. So that could be applied in pharmacy, but very little are talking about solutions such as that. There are other subsidy programs, farm subsidies. I'm in an agriculture area, there are farm subsidies. And typically those subsidies come about because there is some market access change that is implemented by the government or out of the control of the farmer.

There's another mechanism there where an area could be subsidized because market pressures in the area, they're out of the control of the providers. But again, that's gonna require some rethinking of how we view healthcare regions, healthcare ecosystems, and how these healthcare system, how they're all interoperable. Because if I'm just one pharmacy sitting out here and I don't talk to anybody else, nobody's thinking about me.

But if the health system, the health plan, the public health department, the state department of health, if they see me as valuable to the community, and all of a sudden this changes. So that's what we're trying to really speed up is the value expression of the pharmacies and hey, patients' outcomes are better if they go to this pharmacy versus this pharmacy or this pharmacy versus no pharmacy. So those are the things that we're currently studying and researching and publishing as fast as possible to in an effort to not only show the value of these pharmacies in the communities, but ensure that they're sustainable and they're there for another 20, 30, 40.

**Brendan (39:39)**
**Transition 2**
As Cindy and Tripp discussed possible solutions and steps that could be taken to help alleviate some of the burden placed on rural communities and remove some of the barriers to access, I had a thought: How could other players in the health care system collaborate with providers to help increase access?

You know, I think we touched on, you know, in addition from a policy standpoint, some other potential, you know, ways in which to alleviate the, you know, the issue or, you know, lack of access to healthcare services. I actually had, an episode recently where we talking about sort of the importance collaboration, right, within the healthcare ecosystem, but outside as well. with that in mind, do either of you feel that there are actions that other players in the healthcare

ecosystem, including large corporations, Pharma, Biotech, other providers, or even outside the healthcare ecosystem, are there actions that those players could take to help remediate these shortages?

**Cindy Juntunen (40:51)**
Well, just one quick thought that I have is I think, this kind of tags a little bit onto what Tripp was saying earlier about the community health worker. I think one of the things that, I think it's really critically informed that we have an informed public, a public that has enough health literacy that they understand that there are services that they can ask for and that they can advocate for themselves to access. You know, I think about one of the things about being in a medical desert area is things sometimes don't get diagnosed until so late into their expression that you end up with more severe cases. I'm thinking about a situation I worked with with a student one time where we had somebody who came in for treatment thinking that their issue was substance use. And they actually had a bipolar disorder that had been undiagnosed for years. And the complications of the lack of information and the lack of health literacy complicates these issues. And I think lots of agencies could be involved in helping to ensure that we have an educated population that understands some of these things, that understands how to advocate for themselves and how to get access to them.

And then I also think a key piece of that working more effectively is, you know, integrated care models whenever possible where you've got professionals from different aspects. You know, if you have a pharmacist and a psychologist and a physician working as a team, then even the kind of really hardest to serve folks with the most complicated set of things are getting better wraparound care, right? And if a team is working together, even though at first, you know, making the team work takes some initial upfront investment and time, you know, you have to think and you have to learn about other professions, but in the long run, it ends up being a workload. Most people suggest that once they get into those kinds of systems, they have more support. So even in isolated areas, they have colleagues they can turn to and trust. Those are things that I think lots of entities, including employers and companies, could be involved in supporting.

**Brendan (43:03)**
Mm -hmm. That's great. Tripp, any additional thoughts from you on that question?

**Tripp Logan, PharmD (43:08)**
Yeah, I love Cindy's answer. if I could like, if this was a text message, I would hit that double exclamation or whatever. Because I'll tell you a quick story. in Missouri, CPS in Missouri is our network. We had three pilots with the National Kidney Foundation. And the pilot last year was to see if community health workers within community pharmacies can identify chronic kidney disease before it becomes, know, progressed like, you know, late progression, right? Prevent dialysis, prevent end stage renal disease. And what we have discovered is that community pharmacists who recognize people with blood pressure and diabetes and their community health workers who have relationships can actually get these people screened. We used a local public health department in my community, collaboration, and we detailed the local providers in the three county region and then we referred into them. And guess what? Now we've got great working relationships.

And we've got data to show that we're effective in preventing chronic kidney disease, is in - stage renal disease, which leads to dialysis, terrible outcomes, transportation issues, dialysis.

mean, just terrible things for people. So that's why I'm doing this podcast because messaging, we have to get the message out there that collaboration is important, that these communities have complex patients that tell it doesn't work for some people. Like my people don't have broadband and they don't have cell phone minutes.

We do tele visits, right? And we do phone -based visits and we facilitate them, but it's not good for everybody. And so in a technology age where an app or a cell phone is the answer a lot of times, for those with low health literacy, low technology literacy, it's not the answer. And so I feel like sometimes we as Americans get too far into digital, digital, digital and forget healthcare is local, healthcare is very personal. And sometimes you don't want to do it over a device. And the more we can get this message out there that local collaboration is still needed to drive positive outcomes in healthcare, that some can be done digitally, and we do all the time. And I'm a proponent of Mayo, if that's the best, if that gets you your medicine best, that's great. But the people that we take care of, they need a whole lot more and we got to be

**Cindy Juntunen (45:28)**
And what I love about what you just said, Tripp, too, I think is so focusing on prevention and early intervention. Sometimes, know, different health care fields have been worried about that because like that it will somehow interrupt their own workflow. We're always going to have plenty of people who have full blown disease structures, whatever they might be, right? That being able to get policy makers to pay attention to the value of prevention and early intervention would have benefits for the entire population because you can prevent a lot of costs and a lot of heartache and a lot of personal loss and pain through those kinds of programs. I think that's a fantastic example.

**Brendan (46:15)**
That's great. And, Tripp, one of the things that you said, which I'm glad you said it because, and we've had other, I've had other conversations around digital and whether or not that is something that is, obviously we talk about it sort of revolutionizing the world in so many ways, but the point that the previous guest made that I think you made as well, which is an important one, is that there is still an equity component there as well, right? Because there's not equal access to digital. So it's as great as a resource telemedicine or telehealth is, there's still barriers even with that. So there's not one quick solve to a lot of the issues that we're talking about.

So we're coming up on our time here. So I do have one more question that I'm going to ask you. But first, I wanted to give you both an opportunity, if there's anything sort of burning on your mind that you want to make sure that you share with your listeners on today's topic before I get to that last question.

**Tripp Logan, PharmD (47:18)**
I've got something. So healthcare deserts is the theme. And there was like a hearing on Capitol Hill. This comes up a lot, particularly around pharmacy. And what I'm seeing in practice right now with pharmacies, patients being able to access pharmacies is, and I hope your listeners understand this because I think it's foundational to knowing if we're having, if we have an emerging pharmacy, healthcare desert problem or not, is there are a lot of pharmacies closing and there are other pharmacies opening. And so when you look at numbers, sometimes it looks like, well, we had a thousand close and we had 999 open. So really that's a loss of one. But if you look at the zip code of where the pharmacies are closing, so if you have five

pharmacies in five counties, two of them close, but two of them open combo shops like they do long -term care and those are two additional license, but there's still two communities without pharmacies. We're also seeing hospitals open up outpatient pharmacies that didn't have them before. And if you can access the hospital, you can access healthcare. Chances are the pharmacy that closed on the other end of the county, that community is without a pharmacy. And so there are these market dynamics that are happening right now in pharmacy. And so it may be a net loss of small. But the loss to the community and to the patients is huge. And we'll see this in research coming out soon, but this is in the last 18 months, the trends that we're seeing. I just wanted to share with the audience that be aware that this is a true, an emerging problem and the numbers may not always tell the right story.

**Brendan (48:59)**
That's great. No, I appreciate you sharing that. Something we'll definitely have to keep an eye on. So we're at our last question, but before, know, and I want to make sure that it's kind of a tall ask here because we've covered a lot of ground during this conversation. But in thinking about everything that you said today to each of you, what is the single most pressing thing that needs to be done to help address barriers in accessing health care for patients living in these health care deserts?

Cindy, can I start with you first?

**Cindy Juntunen (49:32)**
Yeah, think, I think, so this is, so it's a big ask, and this is going to be a broad answer to a big ask. I think that it is critically important that we figure out ways to make what are now deserts both equitably reimbursed and supported for professionals and enticing in important enough ways that people will choose to live there so that we get professionals to those areas and don't continually ask the people who live in desert areas to make massive compensations in order to get to services. I agree with what was just said that, know, tele devices help. They are not a panacea. They've never, and they won't, I don't see any way that they'll become a panacea.

So how do we change this equation so that we don't put all the work for equitable distribution of healthcare services on the consumer? Because that's what we're doing right now, asking people to give up a day of work to get to the services and instead systematically shift providers into a more equitable distribution across communities. I don't think we can do that by mandating that people live in certain areas.

But I think we can figure out ways to systematically build in incentives so that that work is viewed as equally prestigious, equally important, and equally rewarding as work in more clustered areas.

**Brendan (51:14)**
Thanks Cindy. And Tripp, same question to you.

**Tripp Logan, PharmD (51:17)**
So, Brendan.  And I had no idea how I was gonna answer this until Cindy, and so I love what she said. So, I'm gonna take this right down the pharmacy lane too. So, in order for that to happen in pharmacy, pharmacies have to be viewed as not the same. So, right now when you go get a prescription, it's like, which pharmacy do you want? They're all the same. Well, they're

not. All health systems are different. They're all graded and rated. Every nursing home, long - term care facility is rated. Every health plan's rated.

Pharmacies do not have standardized ratings, which means that the value expression of one pharmacy to the other is equal. It's can you fill a prescription? So until we measure that, and so that's where Choose My Pharmacy and how we've spent in my network, we spent a lot of time segmenting out value, like value expression from one pharmacy to another based on standardized measures. How does one pharmacy stand up to the other? Because once you can show that, well, all of a sudden, using one pharmacy is less expensive because when you get insurance, underwriting is lower in the premium because you're using a safer pharmacy. Or when payers and employers are building their pharmacy networks, they know that pharmacies have better outcomes. So my employees need to go to that pharmacy, that's preferred pharmacy. But in today's world, that's not how networks are built and pharmacies are viewed the same. So I totally agree with Cindy. Until we differentiate and really try to focus on how we get the resources in the right areas.

In pharmacy, we have to define the right area and that could be based on social vulnerability index, that could be based on zip code, but it probably needs to be based also on the providers that are providing care in the area and include pharmacy in the equation, which pharmacy has typically been excluded from that equation.

**Brendan (53:01)**
Well, you've definitely given us a lot to think about. So I just want to thank you both again for joining me today on today's discussion. But more importantly, thank you so much for the work that you're both doing to both bring awareness to the realities of patients living within these healthcare deserts, as well as the work you're doing to help bridge those gaps for those patients. So thank you so much for joining.

**Cindy Juntunen (53:22)**
Yeah, thank you.

**Tripp Logan, PharmD (53:23)**
It's great meeting you, Brendan, and you too, Cindy. Great meeting you.

**Brendan (53:27)**
With all the amazing advances we've made in healthcare over the years, sometimes it's important to step back and take a hard, realistic look at the issues that are still in front of us. Access to quality healthcare is critical in ensuring both people and society stay healthy. Thanks again for joining us on That's Understandable. For more information about today's episode, be sure to check the show notes. Until next time, be well, be healthy, be understanding.

**END OF SHOW**