Rural Healthcare and Telehealth: The Importance of Social Work Departments at HBCUs in Developing a Competent Workforce in the Rural South

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Rural Healthcare and Telehealth: The Importance of Social Work Departments at HBCUs in Developing a Competent Workforce in the Rural South

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Abstract

Telehealth is an emerging area of practice within social work that can potentially have great impacts on the way care is provided to rural communities. Rural communities are racially diverse, older, and tend to have lower incomes resulting in unique barriers to already scarce rural healthcare options. In addition to understanding the logistic differences that may influence healthcare receipt in rural areas, such as transportation and cost, there are additional competencies that are required to effectively implement culturally competent telehealth to rural communities, such as understanding digital inequities. Thus, there is a need for a culturally competent social work workforce to engage with rural communities in order to implement effective telehealth practices. HBCUs are primed to create this workforce as evidenced by their historical contributions to the field and current proximity to marginalized communities. This article will explore rurality and healthcare in the Southern United States, provide a general overview of telehealth use by social workers, and discuss the importance of HBCUs in the role of developing a culturally competent workforce to engage diverse communities and enhance telehealth delivery in rural areas.

Rural residents face unique dilemmas related to access and barriers to healthcare. Community level access issues are also commonly conflated by cultural factors related to race/ethnicity and socioeconomic status. Telehealth as a medium for healthcare delivery, particularly in rural areas, has had a major impact on increasing access and reducing barriers to healthcare for traditionally underserved populations in marginalized communities, including those residing in rural areas with limited access to providers (Lambert, Gale, Hansen, Croll, & Hartley, 2013). Similarly, social workers employed as members of multidisciplinary teams in rural settings address a range of environmental and psychosocial barriers to care (Ginsberg, 2011). Yet, social workers' use of telehealth has been generally neglected in formal training and thus underutilized and examined infrequently (Reamer, 2013). Consideration must be made on how to effectively implement telehealth into education and practice in ways that reach clinicians who primarily service communities that would benefit from telehealth modalities.

Historically Black colleges and universities (HBCUs) are uniquely positioned to provide access to training opportunities for clinicians who service the aforementioned areas thus socializing professionals who can better engage these marginalized communities. HBCUs have been major contributors to culturally appropriate theory and practice targeted at addressing the unique needs of traditionally underserved populations. Historical events such as The Great Migration (see https://www.history.com/topics/black-history/great-migration) charged schools of social work at HBCUs to train and develop social workers who were prepared to address the needs of the era. Similarly, current societal changes such as the evolution of technology and changes in demographic trends will impact social work practice in both current and future generations of professionals (Ginsberg, 2014). Technological advances will have major implications on social workers' methods of practice, and cultural considerations will need to be addressed in the design and usefulness of these services in order to efficiently engage diverse communities. HBCUs, in alignment with their historical positions, have the potential to uniquely understand, identify, and tailor practice to address cultural considerations in telehealth practice. This article posits that social work programs at HBCUs in the Southern United States are uniquely positioned to contribute to the education and development of telehealth-trained social workers operating as members of multidisciplinary teams and engaging communities to implement competent practice in rural areas.

Rural areas face unique individual and community level barriers to treatment that require effective, culturally appropriate solutions. Telehealth has proven to be an effective solution to the difficulty accessing scarce services in rural areas as well as overcoming barriers and prioritizing receipt of healthcare. Rural residents

are less likely to have adequate transportation and are disproportionately poorer than those residing in urban areas (Dize, 2019; Meit, Knudson. Gilbert, Tzy-Chyi Yu, Tanenbaum, Ormson, TenBroeck, Bayne, S., Bayne, A., & Popat, 2014). Buzza, Ono, Turvey, Wittrock, Noble, Reddy, Kaboli, and Reisinger (2011) point out that distance and access to care is relative to not only the patients' logistic barriers but also their literal and perceived needs for care. Consequently, patients may prioritize immediate needs such as work and child-rearing responsibilities above healthcare, particularly services that may be considered "non-critical" such as psychoeducation, ongoing therapies, or general follow-up care. This reluctance to allocate already scarce personal resources is conflated with the trend that patients residing in rural areas are more likely to rely on Medicaid as their source of healthcare in areas with known shortage of Medicaid-accepting providers. Even when controlling for poverty and access issues, rural areas continue to show lower healthcare utilization, e.g., screenings (Caldwell, Ford, Wallace, Wang, & Takahashi, 2016). Thus, not surprisingly, there are higher rates of co-morbidity and mortality in these rural areas (Alabama Department of Public Health, 2016).

In this article, we 1) review rural healthcare, 2) provide an overview of the use of telehealth in rural primary care settings by social workers and allied health professionals, and 3) discuss how HBCUs can be at the center of developing qualified clinicians who are prepared to engage communities and enhance delivery to patients in rural areas.

Background
Challenges to Healthcare Delivery in Rural Communities

Healthcare delivery has consistently been a challenge in rural communities. People there are ordinarily not well served by health agencies and social services despite evidence of attempts to link services since the early 1970s (Bryant, Garnham, Tedmanson, & Diamandi, 2018; Kruse, Bouffard, Doughtery, & Parro, 2016). The problems these patients face come from a range of complex sociodemographic factors that lessen the likelihood needed services are available and may make it more difficult to access and use services when they are available. Rural patients and healthcare providers express numerous barriers linked to the delivery of decent and efficient healthcare services (Cyr, Etchin, Guthrie, & Benneyan, 2019). These barriers include rural resource confines, issues with confidentiality, intersecting roles for patients and

providers, travel, and remote difficulties, service entrance limitations, and boundaries in the delivery of adequate education (Brems, Johnson, Warner, & Roberts, 2006). Further, systemic barriers can be connected to patient demographics such as lack of insurance, jobs, chronic illness care, and prenatal care. Barriers can also be related to mezzo and macro level trends such as conflict between the backgrounds of rural healthcare providers and the experiences and cultural norms of rural residents (Sommers, Gunja, Finegold, & Musco, 2015).

Some rural areas still struggle with cultural barriers related to current and historical racism and long-standing discrimination, which has contributed to health disparities. The Black Belt region of Alabama has suffered from major racial and discriminatory barriers dating back to the early 1860s and has inherited the legacy of the plantation culture that left the region in a state of economic depression and underemployment with poor access to social services and mental healthcare.

Formerly sought after for its rich fertile soils, the Black Belt has become a region defined by its dire socioeconomic situation. As depicted in Figure 1, 17 of the poorest counties in Alabama are in the area designated as the Black Belt. In more recent decades, the highlighted areas became known for the emergence of the Civil Rights Movement started by the high population of African American

Figure 1. Alabama Black Belt (traditional)

Traditional Counties of the Alabama Black Belt

Source: Center for Business and Economic Research, The University of Alabama

residents in the region. From the plantations of slavery to sharecropping to displaced agricultural workers, economic opportunities have been systematically curtailed for African Americans in the area. This lack of opportunity exists in and contributes to other elements of the opportunity structure such as access to education and health services.

Medically uninsured residents in Alabama are higher than the national averages. According to a report examining uninsurability among low-income adults across the nation, Alabama has the second highest rate of uninsured low-income residents with 36% and 29% of people who reside in rural and urban communities being uninsured, respectively (Hoadley, Alker, & Holmes, 2018). Further, the average per capita income for urban Alabama residents in 2018 was $44,205 with rural per capita income at $35,765. The poverty rate was 20.6% compared to 15.7% in urban areas. In rural Alabama, 19.3% had not completed high school and unemployment was 4.3% compared to 3.8% in urban areas (United States Department of Agriculture, Economic Research Service, 2020).

Rural social service delivery and provisions to healthcare in rural health centers are limited in Alabama and its rural Southern counterparts. Social workers in Federally Qualified Health Centers struggle with resource distribution of care. The lack of social work services in rural areas and their declining accessibility over time is an issue that has been well documented (Bourke, Humphreys, Wakerman, & Taylor, 2012; Bourke, Taylor, Humphreys, & Wakerman, 2013; Dixon & Welch, 2000; Heflin & Miller, 2012; Pong, DesMeules, & Lagacé, 2009). It is currently an expectation that living in rural places is parallel with insufficient healthcare and service provision.

A key challenge for social work is the delivery of appropriate social services and healthcare to rural and remote areas in order to reduce healthcare inequalities (Liaw & Humphreys, 2006). Getting needed services to rural communities means looking at innovative methods of care and delivery of services. Thus, there is a growing body of literature that claims the use of the service renders increased access to care to individuals in these rural locations, which in turn could minimize existing healthcare disparities.

Telehealth

In rural communities telehealth is a useful tool in the delivery of health services through primary care organizations such as Federally Qualified Health Centers. Telehealth is a broad word that describes multiple forms of technology-based interaction between a patient and clinician including live interactive video conferencing, email communication, self-guided web-based interventions, mobile applications, text messages, and many other forms of communication (Reamer, 2013). The ability to access healthcare remotely expands access to care for patients who would have to travel long distances in rural or remote locations in the Black Belt to receive the same care (National Advisory Committee on Rural Health and Human Services, 2015). Options for receiving care via this modality brings increased access to those patients with multiple barriers. Therefore, patients who would otherwise forego utilizing services because of inconvenient and difficult travel circumstance would gain access to care (National Advisory Committee on Rural Health and Human Services, 2015). Additionally, utilizing technologies for appointments that do not require in-person visits can save money for patients and, in some settings, for Medicaid and Medicare when travel is reduced or eliminated (National Advisory Committee on Rural Health and Human Services, 2015).

The vastness of existing telehealth research completed with physicians and allied health professionals supports and describes the effectiveness of the practice in different domains of healthcare (Iacono, Stagg, Pearce, & Hulme Chambers, 2016). Studies show that telehealth can be just as or even more effective than traditional face-to-face behavioral interventions with patients with chronic disease. In a study examining the effectiveness of various treatment modalities for psychotherapy with individuals diagnosed with both depression and Type 2 diabetes, participants using telehealth showed more benefits (i.e., lower symptoms of depression and higher indicators of stability on their diabetic management) compared to the face-to-face sample (Egede, Walker, Payne, Knapp, Acierno, & Frueh, 2018). Comparably, a study evaluating a behavioral intervention for depressed elderly homebound people found that participants receiving the telehealth intervention showed prolonged reductions in their depressive symptoms over the duration of the study period as compared to face-to-face participants (Choi, Marti, Bruce, Hegel, Wilson, & Kunik, 2014). While there is ample research that sufficiently supports the use of telehealth as beneficial, equally important is the acceptability and usefulness of telehealth.

Telehealth has been actively researched to determine both its acceptability and usefulness

in rural settings. Primary care physicians and allied health professionals have measured the use of telehealth on patient outcomes in multiple ways including patient knowledge, preference, and satisfaction with services. Kruse et al. (2016) explored the association between telehealth and patient satisfaction in a rural location. The authors generated two primary factors related to patient satisfaction; effectiveness, described as improved outcomes and communication, and efficiency relating to decreased travel time, ease of use, and low cost. Studies exploring these factors found that patients receiving care via telehealth in primary care settings identified telehealth as convenient and equitable to quality of care as compared to care as usual, and that it is a preferable method for receiving potentially distressing information (Polinski et al., 2016; Powell, Henstenburg, Cooper, Hollander, & Rising, 2017).

Special Considerations in the Delivery of Telehealth

Significant barriers exist at the intersections of rurality and culture, implying barriers to care experienced by rural dwelling patients may vary by the patient's individual demographics. Thus, cultural considerations are an important factor in telehealth implementation. In a 2015 survey examining psychiatrists' interest in using telehealth, over one-third of symposium participants expressed a concern that some cultures would be less accepting of the treatment modality (Hilty, Sunderji, Suo, Chan, & McCarron, 2018). Similarly, patients' age and race may affect how they view the acceptability of using telehealth to address their care needs.

Digital inequality in rural areas may also result in limitations regarding the use of telehealth to provide direct clinical care to patients residing in rural areas (Robinson et al., 2015). Rural areas often lack in reliable, consistent Internet service and patients may be less likely to have access to capable equipment (i.e., camera-enabled computers or laptops). Even though Internet accessibility has improved, access to smartphones, limited data plans and cellphone tower coverage has impeded the ability to effectively implement telehealth with a rural patient (Wodarski & Green, 2015).

Social Work and Telehealth

It has long been acknowledged that the complete integration of social workers into rural healthcare as members of the multidisciplinary team can improve care provided to rural-dwelling patients (Badger, Ackerson, Buttell, & Rand, 1997;

McGregor, Mercer, & Harris, 2018). In particular, social workers possess a special skill set useful in identifying psychosocial issues that could impact care compliance and thus impact the progression and trajectory of disease. Unfortunately, similar to barriers experienced by other allied healthcare professionals, social workers employed in county and regional health clinics are often limited to the types and intensity of face-to-face interventions they can use to address the areas contributing to these health disparities on a group and/or individual level. Telehealth services may be an effective means for increasing access, reducing overall costs of healthcare delivery including management of disease in non-acute settings, and increasing the quality of care delivered. However, special considerations must be made when considering how social workers effectively implement and assess telehealth in order to ensure it is in alignment with the professional standards of care and ethical guidelines (Reamer, 2019).

In 2017, the four major governing social work bodies worked together to create a guiding document for the use of technology in social work practice. Yet, there continues to be a shortage of formal research and training to prepare clinicians for the use of telehealth in social work direct practice. The document outlines standards relating to the design and delivery of services; gathering, managing, and storing information; and using technology to provide supervision and continued education to social workers. Social work ethical standards of practice as well as the document guiding the use of technology in practice require that the profession continue to advocate for the use of, and simultaneously examine the appropriateness and efficacy of, telehealth on patient satisfaction and outcomes as technology continues to evolve. In general, there is a paucity of research examining client attitudes and opinions, outcomes, and implementation processes for allied health professionals use of telehealth (Iacono et al., 2016).

It is important for social workers to be producers of knowledge relating to the use of telehealth in practice in order to contribute to service delivery, efficacy, and policy development to improve the lives of patients residing in rural areas. Baker, Warburton, Hodgkin, and Pascal (2014) argue that social work has historically had difficulty incorporating technological advances and posit that "social work professionals need to begin a dialogue with IT developers, social service managers, and funding bodies (pg. 467)" to enhance the use of technology and adapt clinical

practice in an efficacious manner.

HBCUs' Role in Social Work and Telehealth

There is a long-standing history with HBCUs creating and molding a diverse staff of social workers. This history dates back to the great migration of African Americans from areas in the South to urban Northern cities (Martin & Martin, 1995). As the demographic make-up and physical residency of the U.S. population evolves, HBCUs continue to create a culturally competent professional healthcare workforce that contributes to diverse communities, both urban and rural (Noonan, Lindong, & Jaitley, 2013). Accordingly, a 2004 study found a relationship between rural African American communities' proximity to an HBCU, educational attainment among African American rural residents, and economic growth in the community (Mykerezi & Mills, 2004). Thus, is it beyond likely the social workers created at HBCUs are overwhelmingly uniquely positioned to engage diverse, rural areas in which these schools and their student body originated and continue to dwell.

Historically HBCUs were significant in, amongst other things, contributing a workforce prepared to manage the overwhelming task of providing interventions to a new class of African American urbanites at the height of African American migration to Northern cities. The early social workers created at HBCU institutions contributed to new ways of understanding diversity and strengths in the social work profession. Dominated by deficit-based models, early social work programs at HBCU institutions were infused with theory and models of practice that had been developed and normed to serve white welfare recipients (Martin & Martin, 1995). However, given the opportunity, HBCUs forged the capacity to produce and direct knowledge acquisition to contribute to evidence-based practice for enhanced services in a culturally sensitive time, including a changing technological and political landscape. Bowles et al. (2016) point out that HBCUs have historically been "bridges to…social reform in American society." They continue by describing how initial contributors to the social work field such as Dubois and Frazier stressed the importance of scholars using their knowledge to act as activists. With the recent changes in the political climate relating to the insurability of many rural residents (e.g., the Affordable Care Act of 2014), HBCUs sit in a unique position to contribute to the discussion and solutions relating to increased access to care in areas that continue to have a shortage of services.

The changing demographics of the Southern U.S. population warrant a shift in how we conceptualize and integrate cultural competence into standards of practice. In the early 1900s, nearly 90% of African Americans resided in the South. Though the Great Migration saw a shift in the concentration of African Americans, they have consistently had a higher concentration in the South, with 55% of the population currently living in the Southern region. In recent decades, the African Americans in the South grew more than in other geographic areas, with an 18% increase across the population (Rastogi, Johnson, Hoeffel, & Drewery, 2011). Similarly, the aging population, those most likely to have significant medical needs in rural primary care settings, has also shown to be disproportionately concentrated in rural areas in the Southern region with nearly half (46.9%) of America's rural older adults living in the Southern region between 2012 and 2016 (Smith & Trevelyan, 2018). These minority populations, combined with the aforementioned sociodemographic factors known to impact access and barriers to care, would benefit from a diverse workforce adequately trained in both social justice issues and advancements in practice (i.e., telehealth).

HBCUs have consistently been at the forefront of tackling social justice issues in American culture (Gasman & Bowman, 2011; Shorette & Palmer, 2015). From their active participation in the fights for their organization and rights as students at the institutions, to participation in the civil rights movement, the institutions continue to nurture students who challenge various forms of systemic oppression including access to resources, for example, Internet accessibility (John & Stage, 2014). HBCUs as an entity are additionally uniquely positioned to advocate for policy that enhances the strengths of existing community resources when implementing telehealth (Gasman, Lundy-Wagner, Ransomis, T., & Bowman, 2010).

Additionally, the graduates produced at HBCUs show more social mobility, especially when accounting for factors related to precollege success, indicating that socially disadvantaged communities including rural areas with lack of economic, health, and education opportunity gain collectively from HBCU graduates. First, research identifies that HBCUs have higher retention and graduation rates among students who originate from lower socioeconomic status families (Nichols & Evans-Bell, 2017). The authors point out that though historic research identified low graduation and retention rates at HBCUs as

compared to primarily white institutions, prior research often neglected to consider how variance in pre-college preparation and educational programs differ in communities that are primarily lower socioeconomic status. When considering the household income of incoming freshmen, HBCUs produce a higher graduation rate for students with low-income backgrounds (Nichols & Evans-Bell, 2017). HBCUs foster growth of a complex workforce, inclusive of students who may come from difficult environments and enter with educational deficits. Thus, it is likely that students coming from the rural Black Belt counties of Alabama are more likely to successfully complete degrees at an HBCU.

Conclusion and Implications for Future Research and Curriculum Development

Though social workers' use of technology to enhance patient-provider interactions and patient outcomes has evolved immensely in the last 20 years, it remains underdeveloped and is infrequently implemented. Further, social work is only beginning to explore theory, policy, and practices as they relate to telehealth delivery. Social workers' use of telehealth to decrease known health disparities and improve healthcare outcomes among rural-dwelling patients is a special consideration in this exploration. Smyth (in Robbins, Coe Regan, Williams, Smyth, & Bogo, 2016) notes that digital literacy in itself is a form of cultural competence and that neglecting to incorporate technology in social work education precludes an instance where social workers are willingly culturally incompetent. As such, it is of paramount importance that African American social workers, along with other groups of color, receive the necessary training so that a sufficient pool of culturally aware and knowledgeable social workers are available to engage diverse communities. In this regard, HBCUs have a unique and important role to ensure that African American social workers are trained and equipped to practice in a culturally competent manner. In conclusion, it is essential that social workers are trained to expand the delivery of services to marginalized communities. In turn marginalized communities benefit from professionals versed in culturally competent engagement strategies.

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