Health Care Access in the Rio Grande Valley: The Specialty Care Challenge

October 2018

Rio Grande Valley Equal Voice Network Health Working Group:
By Salomon Torres[1]

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[1] The views expressed in this White Paper are presented as a summary of the collective views of the Members of the Equal Voice Health Working Group that conducted Results-Based Accountability (RBA) work sessions in the summer of 2018.

ABSTRACT

Low income and working families in the Rio Grande Valley do not have access to medical care for several reasons. The factors that impede access to medical care are multifaceted and systemic meaning they cannot be overcome through a single policy solution or a one-time legislative appropriation. Nonetheless, if we expect our regional leaders to adopt solutions, we need to inform them of the problem and we need to recommend potential resolutions. This White Paper offers to policymakers at the local, state, and federal level an inside look at how health care delivery can be improved through their leadership, particularly through the expansion of specialty care. It is the goal of this White Paper to provide policymakers, business leaders, The University of Texas Rio Grande Valley (UTRGV) School of Medicine, safety net clinics, and community advocates with constructive recommendations for action to reduce the serious gaps in health care in the Rio Grande Valley (RGV) through greater collaboration. The call of this White Paper is for more equitable access to quality health care. We should not strive for anything less for our hardworking population.

KEY HEALTH ACCESS DETERMINANTS

Lower Economic Capacity in the Rio Grande Valley

To anyone who was raised in the RGV, the economic and geographic transformation of this border region over the last 20 years has been extraordinary. The population of the RGV now totals 1.3 million, similar to the city population of San Antonio.[2] However, our economic growth has outpaced income growth and we lag in wage performance. For example, Texas' poverty rate is 14.7%, but the poverty rates in the RGV counties are double that figure.[3] In Hidalgo County, for example, median earnings are $20,574 per year; Texas median earnings are $30,692. Employees earning between $15,000-$25,000 top the categories of worker earnings in Hidalgo County.[4]

The type of jobs that predominate the RGV economy to a great extent contributes to the lower income levels. For example, the top three business sectors for jobs in Hidalgo County (our most populous county) are in Educational Services, Health Care, and Social Assistance (29.8%); Retail (13.9%); and Construction (8.5%).

[2] U.S. Census. The Valley's population in 1990 was 701,888 and in 2000 was 978,369.
[3] The poverty rates for Hidalgo, Cameron, Starr, and Willacy, respectively, are 31%, 29%, 40%, and 38%. U.S. Census QuickFacts.
[4] U.S. Census FactFinder.

For Texas, though, the sources of jobs are more broadly spread among other industries that can create greater salaries. Below are shown the sectors responsible for most of the jobs:

JOB SECTOR	TEXAS	HIDALGO C.
Educational Services, Health Care, & Social Assistance	21.6%	29.8%
Retail	11.5%	13.9%
Professional, Scientific, & Management & Admin.	11.2%	8.3%
Arts, entertainment, recreation, hotels, food services	9%	8.4%
Manufacturing	8.9%	4.2%
Construction	8%	8.5%

Source: American FactFinder, U.S. Census.

To a great extent because of these economic and income levels, we continue to face a disparity in access to health care for low-income individuals and families. For example, when looking at health care insurance coverage as an indicator of having access to health care, the RGV's uninsured rate continues to be higher than the statewide average or other areas of the state.

Below is a historic perspective showing we have made little progress with this determinant of access to health care. In 1999, 33% of RGV residents had no health insurance.[5] Nearly 20 years later, the current rates are not much better:

Table 1. No Insurance and Lack of Money as Barriers to Health Care

County	No Health Insurance	Unable to Afford Doctor
Hidalgo County	30%	32%
Cameron County	30%	25%
Starr County	28%	N/A
Willacy County	23%	N/A
Texas	**19%**	**18%**

Source: *Health Insurance Rates: U.S. Census QuickFacts.*
Source: *"Unable to Afford Doctor" Rates: Texas Behavioral Risk Factor Surveillance System (2015), UCD Health Connect (www.ucdrgv.org/healthconnect).*

[5]The Lower Rio Grande Valley Community Health Assessment, Jimmy L. Perkins, PhD et al, p. 46 (The University of Texas Health Science Center at Houston School of Public Health, October 2001).

As these rates show, the RGV continues to face formidable challenges to overcome if we are to aim for more health care access for our population.

Shortage of Primary Care Professionals

Access to primary care physicians is another way that the quality and quantity of health care can be improved. The following table illustrates that despite substantial efforts by the State of Texas, elected officials, the medical community, and community advocates, we lag the state in access to primary care physicians.[6]

Table 2. Primary Care Physicians (PCP) Ratios (Ratio of Population to Total PCPs) for the Rio Grande Valley and Selected Texas Counties

County	No. of PCPs	PCP Ratio
Hidalgo County	378	2,230:1
Cameron County	192	2,200:1
Starr County	12	5,320:1
Willacy County	8	2,740:1
Webb County	87	3,100:1
El Paso County	398	2,100:1
Lubbock County	234	1,280:1
Nueces County	281	1,280:1
Bexar County	1,385	1,370:1
Texas	**---**	**1,670:1**

Source: County Health Rankings & Roadmaps (2015 Data), Robert Wood Johnson Foundation (www.countyhealthrankings.org).

[6] Primary Care Physicians include nonfederal, practicing physicians (M.D.s and D.O.s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. County Health Rankings & Roadmaps (Robert Wood Johnson Foundation) (www.countyhealthrankings.org).

It is outside of the scope of this White Paper to address potential solutions to the shortage of primary care physicians because the establishment of The UTRGV School of Medicine should help to improve these ratios over time as more local residents are recruited to pursue a medical degree and their graduates opt to practice locally. The substantial investment by the state and by local hospitals, through the creation of accredited residency programs, in the region will pay off because of the expectation that physicians tend to stay where they receive their specialty training. That was the plan and that is the hope for our region.

A more urgent concern is the dearth of resources for our medically underserved population to access secondary care recommended by primary care.

LACK OF ACCESS TO SECONDARY OR SPECIALTY CARE

Federally Qualified Health Centers (FQHCs) and other safety net clinics[7] that participated in the Equal Voice Health Working Group Results Based Accountability (RBA) sessions have provided valuable insights and data to explain this challenge that they face every day.[8] This White Paper recognizes that these longstanding community clinics preceded the establishment of some RGV hospitals and The UTRGV School of Medicine and that their expertise and experience is valuable in developing any new strategies for greater access to health care.

Below is a listing of the clinics and the years they were founded and their patient volume per year as provided by the clinics:

Table 3. Rio Grande Valley Safety Net Clinics

[7] Unless otherwise specified, the White Paper will refer to all of these clinics as "safety net clinics."
[8] Both Cameron County and Hidalgo County operate Indigent Health Programs that allocate funding for primary and secondary care services if income eligibility requirements are met. Neither Starr nor Willacy County operate such programs.

Clinic	Annual Patient Volume	Year Founded	Number of Clinics	Location of Clinics
Nuestra Clinica del Valle	25,813	1971	11	Hidalgo & Starr Counties
El Milagro Clinic	3,800	1996	1	McAllen
HOPE Clinic	4,200	1996	1	McAllen
Su Clinica Familiar	32,605	1971	4	Cameron & Willacy Counties
Brownsville CHC	20,000	1972	4	Brownsville
Totals	**86,418**	---	**21**	---

The following highlights were collected through a survey distributed to the participating clinics:

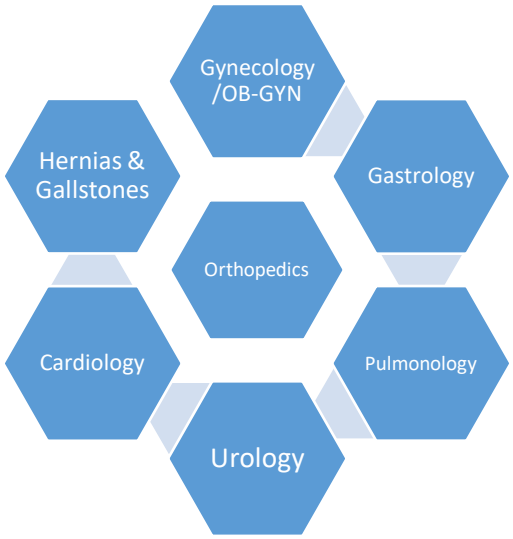
- ✓ There was general agreement that a lack of secondary care presented a significant challenge to patients.
- ✓ One respondent reported that 25-30% of the patients were estimated to stop medical care due to the patient ceasing to pursue secondary care. Another clinic reported 60-70% of their patients making the same choice.
- ✓ One respondent reported that out of 15,000 referrals in the first quarter of 2018, an estimated 80-90% of those appointments were cancelled kept due to the patients' lack of funds or inability to access funds to begin the specialty care procedure or care.
- ✓ Another respondent found that 45% of its patients were unable to access secondary care in 2017. The lack of coordinated partnership or collaboration between the safety net clinics and the hospitals, specialists, and medical school was referenced by respondents as a cause of lack of access

Why did patients not pursue secondary care?

- ✓ Unaffordable costs, often ranging from $200-$300 for initial payments, required by specialists or secondary care providers.
- ✓ Even the cost of a diagnosis may be often out of reach for patients, resulting in the patient foregoing further and indefinite assessment of their condition.
- ✓ Limited or lack of insurance coverage.

- ✓ Secondary care providers not accepting marketplace insurance plans.
- ✓ Denial by secondary care providers due to low reimbursement rates.
- ✓ Refusal of secondary care providers to accept referrals from the county indigent programs.
- ✓ The safety net clinics have no funds to pay for the specialty care.
- ✓ Lack of providers willing to treat an uninsured patient.

The safety net clinics responded the following as the most common medical areas where treatment and surgery is out of reach for local residents:



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CALL TO ACTION – A MENU FOR POLICYMAKERS, SAFETY NET CLINICS, AND STAKEHOLDERS

Below are presented the recommendations that were created by the Equal Voice Health Working Group through the Results-Based Accountability (RBA) sessions conducted in the summer of 2018. It is noteworthy that the recommended actions underscore the need and value of greater collaboration among all parties engaged in prevention and the delivery of health care services in the RGV.

PROPOSAL 1: New Strategy for a Health Services District/Public Hospital

PURPOSE: Greater Public Awareness of the Need for More Public Investment in Health Care

The Equal Voice Health Working Group concluded that the formation of an RGV health care district and/or public hospital needs to be revisited. Either mechanism would create new financial resources to enable medical providers, including safety net clinics, to provide more specialty care regardless of the ability of patients to pay. A public awareness campaign about the benefits of a health care district and/or public hospital is needed to produce community interest and motivation for more stakeholders to be involved. The discussion needs to be framed early on in the process before another proposal is presented to the public for discussion. This action requires that the parties supporting this public investment convene to discuss the new strategy and the new explanation for the need.

Recommendation 1: Advocates of a Health Services District will convene with private medical providers to discuss the formation of a public awareness campaign prior to any additional voter referendum. All health care partners, including the hospitals, safety net clinics, medical school, elected officials, and community health advocates would be organized to discuss a new strategy.

PROPOSAL 2: Public Hospital for the Rio Grande Valley

PURPOSE: Expansion of Care to the Residents in Greatest Need and with the Least Resources

The Equal Voice Health Working Group believes that a public hospital would greatly enhance access to care in the RGV because it would attract new physicians seeking to practice in a publicly funded facility catering to the needs of the underserved. The feasibility study and projected operation of a hospital to address health care disparities in the RGV would provide a careful analysis of projected need and services that would be rendered, establishing a clearer framework to assess the viability of a public hospital

Recommendation 2: Safety net clinics will present a funding request to private and philanthropic funders to fund a study on the feasibility of a public hospital for the Rio Grande Valley.

PROPOSAL 3: Greater Collaboration among the RGV Safety Net Clinics

PURPOSE: Alignment of Services among RGV Safety Net Clinics

Where resources are lacking, coordination of services by existing providers can be the key to have greater impact. Below are examples of potential coordination to align services.

Safety Net Clinics in Hidalgo & Starr County	Safety Net Clinics in Cameron & Willacy County

Safety Net clinics (both FQHCs and non-FQHCs) in Hidalgo and Starr Counties meet frequently to share best practices and discuss issues that are of common interest, allowing open communication for the clinics to speak with the same voice when issues arise that affect their operations or affect the ability of their target population. The Equal Voice Health Working Group has provided the opportunity of open communication through a subcommittee that is comprised of the CEOs of the safety net clinics in Hidalgo and Starr counties. However, the clinics in Cameron County do not participate in the Equal Voice Health Working Group subcommittee, resulting in fragmented voices of the RGV safety net clinics and weakens the message of the RGV safety net clinics when communicating with policymakers or state or federal agencies.

PROPOSAL 4: Greater Collaboration between the RGV Safety Net Clinics, Community-Based Organizations and UTRGV School of Medicine

Recommendation 3: UTRGV School of Medicine will convene the Safety Net Clinics operating in Hidalgo and Starr County with the Safety Net Clinics operating in Cameron and Willacy County to discuss the gaps in primary and specialty care in the Rio Grande Valley to develop options for collaboration and leveraging of resources to expand services.

PURPOSE: Alignment of Services by Providers of Primary Care

RGV Safety Net Clinics	UTRGV Medical School

A 2004 survey of FQHCs found that safety net clinics affiliated with a medical school or hospital reported greater access to special medical services. The study recommended that "[p]olicymakers should encourage these affiliations and expansion of on-site services while supporting future research to explore other aspects of CHCs associated with referral success."[9]

[9] "Access to Specialty Care and Medical Services in Community Health Centers," Health Affairs, p. 1466 (September/October 2007, Vol. 26, No. 5).

In 2017, the U.S. Department of Health and Human Services (through the Health Resources & Services Administration) awarded The UTRGV School of Medicine with a 5-year $3.75 Million award to create three Area Health Education Centers (AHECs) in the RGV. The centers are intended to serve multiple purposes: (1) increase access to primary care for rural and underserved areas, (2) provide medical students with medical practice training environments, and (3) teach medical students about health disparities and the social determinants of health by getting off campus to have a learning experience in communities in great need of primary care.[10]

As noted at the outset of this White Paper, the shortage of physicians in the RGV continues to be pronounced. Thus, The UTRGV School of Medicine's effort to address this professional labor shortage is commendable. However, an opportunity was lost in the development of this new AHEC network by the lack of consultation with the existing network of FQHCs, safety net clinics, and local community organizations that work with medically underserved populations.

The safety net network of primary care providers could have offered additional training sites at their clinics for the medical students. Second, the RGV-wide safety net clinic network would have likely advised that a new AHEC system should be designed with access to specialty care as well. In fact, other AHECs around the country have expanded their primary care focus to specialty care.

For example, the Southern Regional AHEC serving south-central North Carolina established the Specialty Medical Center within the AHEC. This is structured as a partnership with local specialists and doctors from the Duke University Medical Center and UNC-Chapel Hill School of Medicine providing underserved child patients with such specialties as pediatric cardiology, hematology and sickle cell treatment.[11] The Michigan Area Health Education Center, in affiliation with Wayne State University, partnered with a FQHC in northern Michigan to "provide both primary and specialty care for all."[12]

A 2004 survey of FQHCs found that safety net clinics affiliated with a medical school or hospital reported greater access to special medical services. The study recommended that

[10] "UTRGV School of Medicine Awarded $3.75 Million to Provide Healthcare to Underserved Areas," Jennifer L. Berghom, UTRGV Press Release September 13, 2017 (www.utrgv.edu).
[11] southernregionalahec.org.
[12] miahec.wayne.edu/north.

"[p]olicymakers should encourage these affiliations and expansion of on-site services while supporting future research to explore other aspects of CHCs associated with referral success."[13]

Recommendation 4: The Rio Grande Valley safety net clinics and UTRGV School of Medicine will convene to discuss potential ways to collaborate to establish specialty care services in the Rio Grande Valley.

PROPOSAL 5: Pilot Program: Mobile Specialty Care Delivery

PURPOSE: Offer Specialty Services Directly to Residents in Greatest Need

To build on the success of mobile units that deliver primary and preventative care, the Equal Voice Health Working Group proposes that specialty services be brought to colonias, small cities, and other underserved areas. To do so, a new partnership with a nongovernmental or private sector funder would have to be formed to develop a funding strategy and scope of specialized services to be delivered. To evaluate this strategy, an appropriately equipped mobile unit(s) could be leased on a pilot basis to measure the effectiveness of this approach.

Recommendation 5: RGV safety net clinics will convene with UTRGV and UTHealth to develop a funding proposal to funders for a pilot initiative to fund 1-2 units offering specialized care in the Rio Grande Valley.

PROPOSAL 6: Fund Incentivized Specialty Care Partnerships

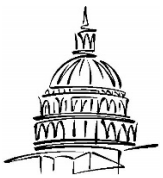
PURPOSE: To Maximize the Value of Health Care Taxpayer Dollars through Greater Collaboration

The Equal Voice Health Working Group believes that to maximize existing resources, reduce costs, and expand the scope of medical services, a collaborative partnership culture needs to be

[13] "Access to Specialty Care and Medical Services in Community Health Centers," Health Affairs, p. 1466 (September/October 2007, Vol. 26, No. 5).

established. The RGV legislators – both at the state and federal level – need to create funding incentives contingent on the degree of collaboration practiced by the clinics, medical school, and health care providers. RGV legislators should focus on creating funding partnership opportunities revolved around the specialty areas in greatest need of being offered to our low income families and uninsured (e.g., orthopedics, surgery, urology, oncology, and gastroenterology).

Collaboration helps to avoid duplication and competition which can waste taxpayer dollars and can lead to greater accountability of how regional needs are met through a public university. It also ensures that the institution is truly serving and engaging the community before executing new initiatives and programs intended to meet local needs.



Recommendation 6: Request that the Rio Grande Valley state and federal legislators secure funds for the UTRGV Medical School to establish specialty services at the RGV safety net clinics through incentivized partnerships.

PROPOSAL 7: Fund a Rio Grande Valley Safety Net Clinic Residency Program in Conjunction with the UTRGV Medical School

PURPOSE: To Strengthen the Capacity of Safety Net Clinics and Enrichen the UTRGV School of Medicine Experience

Medical school residency programs can be instrumental in accomplishing key goals, including more health care access and the fulfillment of medical school training requirements. The residency programs that have been established by the UTRGV School of Medicine at various hospitals are a testament to the value of this model.

The Equal Voice Health Working Group believes that the medical school education training can be improved by offering a Safety Net Clinic Residency Program where residents would be offered the opportunity to conduct diagnoses and participate in the delivery of secondary care treatment at one or more of the clinics in the four RGV counties. Our FQHCs currently deliver internal medicine services, dental care, women's services, and pediatric care and will have the capacity to expand on these and other services through a new Residency Program.

The UTRGV School of Medicine, in consultation with the safety net clinics, would develop specialty care areas of training and potentially create specialty niches at the clinics. The training locations outside of the hospital setting would broaden the exposure of medical students to the landscape of medical need and potentially motivate them to establish their future medical practice in underserved areas of the RGV.

Recommendation 7: Request that Rio Grande Valley state and federal legislators secure funds for a new Safety Net Clinic Residency Program to be operated by the UTRGV School of Medicine.

PROPOSAL 8: Expand Dental Care Services through Operation Lone Star

PURPOSE: To Maximize the Effectiveness of a Proven Source of Dental Care

Since 1999, The Texas Department of State Health Services and Texas Military Department, through Operation Lone Star, has coordinated the delivery of free preventive medical services in the RGV annually in coordination with local health departments. Operation Lone Star is highly anticipated every year by thousands of residents lacking health insurance or the economic means to pay for preventative care such as child immunizations, hearing and vision screenings, diabetes and blood pressure screenings, and sports physicals.[14] This year, preventive dental services for children were provided at one site (Rio Grande City) and dental services for adults and children were provided at two sites (Brownsville and San Juan).

The Equal Voice Health Working Group believes that to serve greater numbers of RGV residents, an additional version of Operation Lone Star needs to be offered that focuses on dental care.

Source: themonitor.com

The UTRGV School of Medicine offers an excellent mobile unit to bring preventive medical services to rural and underserved areas. However, its dental unit remains to this date unused for dental services due to the lack of RGV dentists willing to provide services.This is an example of a UTRGV resource being under utilized in the community. If the mobile unit were to be

[14] Texas Department of State Health Services (www.dshs.texas.gov).

added to a project like Operation Lone Star, the regional cooperation would greatly benefit the community and broaden the reach of the UTRGV School of Medicine,

Source: uthealthrgv.org

Source: cityofedinburg.com

Recommendation 8: Direct Rio Grande Valley lawmakers and The Texas Department of State Health Services to request that the Texas Department of State Health Services execute separate Operation Lone Star services at additional dates in multiple locations to deliver dental services for children and adults.

PROPOSAL 9: Provide Financial Assistance to Access Specialty Health Care

PURPOSE: Underwriting Continuation of Care through Secondary Health Care

Safety net clinics reported that patients continuously denied recommended secondary care due to the unaffordability of the upfront costs for exams and treatment. A mammogram/sonogram can cost $100-$200 and a needle biopsy for diagnosis can range from $1,500 to $2,000 in the RGV. Even with insurance, the applicable deductibles are too expensive for an individuals in the community. Individuals may be able to access indigent care assistance for cancer treatment through their county program, but these individuals are not able to pay for an initial screening appointment that is not covered by the Indigent Care Program.

The Equal Voice Health Working Group recommends a separate source of funding needs to be created to provide financing for secondary care and procedures. The funds would be considered loans, which would be paid back in reasonable installments without jeopardizing their family livelihood. Funds could be initiated through a revolving loan model for small

businesses. Under this model, interest payments are generated through loan payments and generate additional funds for additional loans to other community members. This loan model would provide long-term sustainability and eliminate a costly barrier to access to secondary health care for our lower income, uninsured or underinsured residents.

Recommendation 9: Request that the Rio Grande Valley state and federal lawmakers secure initial funding for the creation of a collaborative and independent Secondary Health Care Community Fund to finance medical payments to be made to medical providers for secondary health care.

PROPOSAL 10: **Establish a Diabetes Prevention and Treatment Fund for the State of Texas**

PURPOSE: **Statewide Resources to Address Diabetes as CPRIT did for Cancer**

In 2007, Texas voters overwhelmingly approved a constitutional amendment establishing the Cancer Prevention and Research Institute of Texas (CPRIT) that authorized the state to issue $3 billion in bonds to fund cancer research and prevention programs and services in Texas, enabling individuals to access cancer screening and diagnosis services.[15] The Equal Voice Health Working Group advocates that state legislators make a similar investment towards diabetes prevent. Texas has a similar Caucasian (41.9%) and Hispanic (40%) population, but the rate of diabetes is higher for Hispanics (12.2%) than Caucasians (10.2%).[16] The racial discrepancy is more apparent when looking at mortality rates because Hispanic adults are twice as likely to die from diabetes than Caucasian adults. [17] In addition, a diabetic is 2-4 times more likely to die from heart disease than an individual without diabetes.[18] Heart disease is the leading cause of death in the Lone Star State – 43,722 Texans died from this chronic disease that could be prevented through diabetes education.[19]

The Equal Voice Health Working Group believes that there has been extensive diabetes research and funds should be allocated towards prevention and education and to screen patients for diabetes and help diabetics to manage their conditions. Screening and education

[15]www.cprit.state.tx.us
[16] 2017 Diabetes Fact Sheet—Texas, Texas Department of State Health Services.
[17] Ibid. The mortality rate for Hispanics was 30.9% versus 17% for Whites. Blacks' mortality rate was the highest at 33.7%.
[18] American Heart Association.
[19] Stats of the State of Texas 2016, Centers for Disease Control and Prevention (CDC).

activities are critical to help individuals make lifestyle changes immediately and prevent or manage a deadly disease

Recommendation 10: Request that Rio Grande Valley state legislators propose a statewide funding initiative to fund diabetes prevention and medical care services in local communities.

CONCLUSION

Policymakers who make health care less of a priority than the economy, the business environment, and the educational system may do so believing that progress in those areas somehow trickles down to improve our families' health. That is a common mistake that leads to delay in taking aggressive and specific actions to improve health access. It is strategically more beneficial to seek public policy that raises the prospects of all. A *healthy* community can make a community more prosperous by attracting new investments and new residents.

In his 1962 landmark book The Other America, Michael Harrington described the vicious cycle of poverty that families and entire communities can be subject to when health care is not provided, pointing to multiple ways that health is intertwined with other social indicators.

> *The poor get sick more than anyone else in the society. That is because they live in slums, jammed together under unhygienic conditions; they have inadequate diets, and cannot get decent medical care. When they become sick, they are sick longer than any other group in the society. Because they are sick more often and longer than anyone else they lose wages and work, and find it difficult to hold a steady job. And because of this, they cannot pay for good housing, for a nutritious diet, for doctors. At any given point in the circle, particularly when there is a major illness, their prospect is to move to an even lower level and to begin the cycle, round and round, toward even more suffering.*[20]

A sick community with no or limited access to primary care and secondary treatment will eventually lead to social and financial repercussions that affects Texas. On the contrary, a *healthy* community can make a community more prosperous by attracting new investments and new residents.

[20] Michael Harrington, The Other America: Poverty in the United States, p. 16 (Penguin Books, Baltimore, rev. edition 1973)

The Rio Grande Valley is fortunate to be represented by eight (8) State Representatives, three State Senators, three U.S. Congressmen, and two U.S. Senators who have enough firepower to work towards a healthier community. In addition, the support of local elected officials at the municipal, county, and school board levels will help the legislators should feel empowered with local support to pursue these recommended actions. With a coordinated strategy in Austin or Washington, D.C., the RGV could have a healthier workforce and more prosperous future.

We appreciate the work of the RGV Equal Voice Network Health Working Group members and the Rio for all their hard work and efforts.