Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Fall Meeting
Charlotte, North Carolina
September 10-12, 2018

Meeting Summary

The 84th meeting of the National Advisory Committee on Rural Health and Human Services was held September 10th-12th, at Duke Endowment and The AC Hotel in Charlotte, NC.

The committee members present at the meeting: Steve Barnett, DHA, CRNA, FACHE; Kathleen Belanger, PhD.; Ty Borders, Ph.D.; Kathleen Dalton, Ph.D.; Molly Dodge; Carolyn Emanuel-McClain, MPH; Barbara Fabre; Constance Greer, MPH; Joe Lupica, JD; Octavio Martinez, Jr., MD; Carolyn Montoya, PhD., CPNP; Maria Sallie Poepsel, MSN, PhD, CRNA; Chester Robinson, DPA; Mary Kate Rolf, MBA, FACHE; John Sheehan MBA,CPA; Benjamin Taylor, Ph.D., DFAAPA, PA-C; Robert L. Wergin, MD, FAAFP; Peggy Wheeler, MPH.

Present from the Federal Office of Rural Health Policy: Tom Morris, Associate Administrator; Steve Hirsch, Executive Secretary; Paul Moore, Senior Health Policy Advisor; Sahira Rafiullah, Senior Advisor.

Truman Fellows present from the Office of Rural Health Policy: Alfred Delena and Taylor Zabel.

THE DUKE ENDOWMENT – CHARLOTTE, NORTH CAROLINA

Monday, September 10, 2018

The meeting was convened by The Honorable Ronnie Musgrove, Chair.

WELCOME AND INTRODUCTIONS

Governor Ronnie Musgrove, Chair of the Committee, welcomed the committee members and stated that the topics of the meeting are Addressing Rural Chronic Obstructive Pulmonary Disease (COPD) and Improving Access to Rural Oral Health Care Services.

CAROLINAS ORIENTATION

Rhett N. Mabry, MHA

President
The Duke Endowment

Rhett Mabry welcomed the committee and thanked them for convening in North Carolina. The Duke Endowment opened four years ago, and Mabry wanted to have a role as a convener in order to bring people together from around the country to have conversations and find solutions to some of the many challenges of both society and rural health.

The Duke Endowment was established in 1924 in response to the glaring issues facing rural health in the Carolinas. In 1924, eighty percent of North and South Carolina lived in rural communities, compared to only twenty percent today. Despite this decrease in rural populations, rural communities are still a priority for the Duke Endowment, which continues to provide funding in rural areas in order to promote higher education, child welfare, increased/improved healthcare practices, as well as funding in the form of grants for rural Methodist Churches. Mr. Duke grew up on a small farm and turned a small family tobacco business into the largest tobacco company in the history of the world. Later, because of the antitrust legislation, he began investing in hydroelectric power to harness the flow of water to generate electricity and created Duke Energy. Mr. Duke understood rural communities because he was from a rural community. He also understood the opportunities and resources that rural communities possess.

Philanthropy and government need to find ways to work together more seamlessly. Philanthropy is based off of a model in which a project is funded after it proves that it can be successful. Many philanthropists have to then hope that the government will continue to see the benefits of their project and thus sustain it. It would be a far better approach to plan together and create a common vision. Government has a large capacity and reach while philanthropy has flexibility and the ability to take risks; Together these are the perfect combination. Funders and government need to innovate and sustain practices for rural communities and vulnerable populations.

Graham Adams
Chief Executive Officer
South Carolina Office of Rural Health

Graham Adams stated that Dr. Lilian Peake sends her regrets that she could not attend the meeting but she is involved in preparations for Hurricane Florence.

The Duke Endowment is the largest philanthropy in South Carolina and has made a huge difference in rural healthcare there. Mr. Adams stated that the first grant he submitted approximately twenty-four years ago was to Duke Endowment to increase access to Spanish speaking patients in rural areas.

South Carolina regions include the low country, midlands, the Pee Dee, and the upstate region. The population in South Carolina is currently 5 million people - and is seeing the fastest growth in the nation. The Hispanic population specifically is one of the fastest growing populations. About twenty-eight percent of the population is African American, eight percent other, and the rest of the population is Caucasian. About eighty percent of the land mass is rural and twenty-

seven of the population is rural. There is large growth around Columbia and areas around the coast and in the upstate region. The University of South Carolina is located in Columbia. Greenville/Spartanburg is the largest metro area with about 800,000 people. Columbia is around the 700,000 to 800,000 and Charleston's population is around 500,000. Myrtle Beach has a huge influx of vacationers during the summer months.

Rural areas are changing because people are moving out and not many are returning. Some rural areas around metro areas are seeing growth. Volvo, Chrysler and BMW have built plants in South Carolina, so many of their suppliers located in the area are creating jobs. Volvo is building in rural South Carolina and they want to train local people but they will also hire people from other areas. The state has to assure there is the infrastructure, housing and job creation in that rural community to support the new business. There is a balance between developing in these communities, while still maintaining the unique rural quality of the area.

About ten years ago, there were sixty-five independent hospitals in the state. However, that number is consolidating. The two largest health systems have merged and are going to cover sixty-five percent of the state. That will be a huge change in the care that is rendered and the location of the care. Many small hospitals have become part of hospital systems. The state had a rural hospital transformation fund program. It incentivized large health systems to own a small hospital, while the larger healthcare system received four million dollars for every project that was approved, in order to help assure the infrastructure of the rural facility for a ten-year period. There were eight such projects approved.

Many clinics in rural communities have also been purchased and physicians throughout the state have become employed by hospitals. There used to be one hundred and twenty-nine rural health clinics and now there are only about ninety. There are around nineteen Federally Qualified Health System entities in the state, with more than one hundred and fifty access points. They will be the only constant point of contact in rural locations for healthcare. Free clinics tend to be clustered around metropolitan areas. There is continued work with health systems to meet the needs of rural communities.

Elizabeth (Betsey) Tilson, MD, MPH
State Health Director and Chief Medical Officer
Office of the Secretary
North Carolina Department of Health and Human Services

Betsey Tilson thanked the committee for being invited to speak and thanked the committee for all of their efforts. She said that she would give an overview of North Carolina and speak about the North Carolina Department of Health and Human Services policy lens. The North Carolina Department of Health and Human Services is embracing holistic health. The Chief Medical Officer's role is to consider public health in a holistic manner and bring agencies together to partner and enhance public health.

North Carolina has a population of ten million people with a very diverse population and very diverse geography. There is high quality health care and universities that are concentrated in urban areas. North Carolina has a decentralized system so much of the work and program

administration happens at county level. There are one hundred counties that are governed by their county government so they draw from strength of the community, however, it can sometimes be challenging to work with a hundred different entities. There are very strong roots in collaborations in partnerships.

The Department of Health and Human Services Super-Agency includes human services, health services, behavioral health and IDD, medical assistance and business operations. The positive aspect of this is the ability to do cross sector work and organize internally.

In 1973, The North Carolina Office of Rural Health was the first state office of rural health in the nation, with a dedicated focus of enhancing the needs of rural communities by improving access, quality, and cost effectiveness of healthcare in rural communities. Eighty six percent of the budget goes directly to North Carolina communities.

The North Carolina Department of Health and Human Services' four priorities are (1) the opioid crisis, (2) early childhood, (3) Medicaid transformation and (4) opportunities for health. When considering a person's health issues, the family, community, jobs and transportation need to be considered. At the societal level, health equity (including historical racism) must be considered. The opioid crisis is not just about healthcare and the prescribing of opioids, but the cross-sector approach which includes law enforcement, health providers, community base organizations, treatment, housing and employment. The North Carolina early childhood action plan is being created with a focus on brain science, strengthening families and decreasing disparities in the population. Transitioning to Medicaid Managed Care is one of the biggest changes to the health system in forty years. It is not just about buying care, but about buying health. Medicaid transformation will build upon the existing infrastructure in North Carolina, in addition to attempting to learn from the best practices of other states, while keeping a focus on whole person health at the forefront. There is a commitment for all North Carolinians to have the opportunity for health. Eighty percent of health is outside of medical care, so non-medical drivers are vital to overall health.

Initial state priorities are food security, housing stability, transportation, interpersonal violence, and employment. The state is creating a statewide infrastructure for healthy opportunities that includes: standardized screening for unmet resource needs, a "hotspot" map for social determinants of health, a statewide resource platform, community health workers, Medicaid managed care, and connecting existing resources.

Q&A

Octavio Martinez asked if, when doing contracts, are you building in needs for managed care companies to follow?

Elizabeth Tilson responded that they understood the importance of accountability and contract monitoring, and have people involved with that skillset so that there is an infrastructure of oversight. A positive of working with other states on creating the best practices is learning what worked and what didn't work.

Steve Barnett asked if the specialty services have improved since the small hospitals were acquired by the healthcare systems? Has the urban way of doing things been forced on rural?

Graham Adams responded that it is too soon to tell because it has only been about a year since the hospitals were purchased by the larger systems. There has not been an immediate influx of specialty care in those areas given that people are still going to the metropolitan areas for specialty care. The state has made a significant investment in telehealth and has built a lot of infrastructure, but it has not resulted in a large number of e-consults. Once there is parity around reimbursement, it is hopeful that the specialty care will be more available in rural locations.

WELCOMING REMARKS

Renee L. Ellmers, BSN, RN
Regional Director, Region IV
Office of the Secretary
US Department of Health and Human Services (Atlanta, GA)

Renee Ellmers thanked the committee and brings greetings from President Trump and Secretary Azar. She said she has the honor to work with Tom Morris, as well as with the North Carolina rural health group. Her home is in Dunn, North Carolina. During the week, she is in Atlanta and has the opportunity to work with the CDC. She was born in the upper peninsula of Michigan and her father, two brothers and mother moved to Detroit to become part of the auto industry. She is a registered nurse and her husband is a surgeon.

Dunn, North Carolina, has a population of 10,000 and is in Harnett County, which is fifty percent rural. People ask if she would rather live in Raleigh or Charlotte, but she would not move because she loves life in Dunn. She worked for her husband's practice and ultimately grew to love the community, which is why rural health is so important to her. After joining Health and Human Services, she enjoyed working with Tom Morris because they both have a love for rural. She was a member of Congress and learned that you really have to listen. It is not just about talking and sharing information, but listening as well.

President Mabry was talking about building public private partnerships, and that is what the administration is looking to do. It is important to find out what other states are doing and recreate the best practices. It is not about starting over, but about looking at what is already working and being able to broaden from that. The decisions that are made are not just made at the Hubert Humphrey building, but in the local communities. Every region has a Health and Human Services regional director who are part of the intergovernmental external affairs department; Their job is to listen to the region and bring the information back so that everyone at the federal government can know what is happening.

The resources that the committee is providing is appreciated. The administration is looking to harness innovation and technology like the discussion of telehealth in South Carolina. That is such an important component to bringing specialty care to rural communities. One of Secretary Azar's four priorities is the opioid crisis. It is necessary to make sure that federal money is available for research, innovation and state funding. The federal government also needs to make

sure that the funding is making its way to the local communities. Medicare and Medicaid transformation from fee-to-service, to a value-based quality care system is another priority. Prescription drug pricing is the third most important issue that Secretary Azar has put forward. All of the priorities are a wraparound for good quality healthcare. Another priority is addressing healthcare insurance and making sure it is affordable and accessible for everyone.

NATIONAL PERSPECTIVES ON RURAL COPD

Kurt J. Greenlund, PhD
Chief, Epidemiology and Surveillance Branch
Division of Population Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Kurt Greenlund stated that Centers for Disease Control and Prevention is based in providing evidence-based and science-based data. It is important for those at the federal level to hear from those at the local level, and the national committee meeting is a great opportunity to collect information. Chronic Obstructive Pulmonary Disease is a public health problem and is the fourth leading cause of death in the United States. The cost of COPD is estimated to be $32 billion per year and this number is estimated to rise to $49 billion in 2020. Fifteen percent of Americans have been diagnosed with COPD, and millions more have undiagnosed COPD symptoms. Rural populations are at greater risk for COPD.

There is geographic data on COPD available through death certificate data, Medicare data, data from COPD providers and data collected at the state level through the CDC Behavioral Risk Factor Surveillance System (BRFSS).

The National Center for Health Statistics groups counties in different categories which each have urban and rural classifications. Data using the mapping of counties demonstrates that COPD is higher in micropolitan and rural areas, as compared to urban. Hospital discharges, and death rates due to COPD are also higher in the rural areas.

Rural populations have greater COPD risk factors. Seventy-five to eighty percent of COPD is due to smoking. People in rural areas have a higher percentage of smoking history. Exposure to secondhand smoke is a risk factor. Additionally, there are less smoking cessation programs in rural areas. Environmental and occupation exposures is another major cause of COPD. Mold spores, organic toxic dust and nitrogen dioxide, gas, fumes and microbial agents can cause COPD. Other factors include genetics, respiratory infections and a history of asthma.

Rural counties in the Midwest and Great Plains have lower prevalence of diagnosed COPD. In some rural areas with lower rates of COPD, there are higher death rates due to COPD. There is not access to pulmonologists in rural communities, so it is more difficult to be diagnosed and treated for COPD. Pulmonologists are concentrated in the urban areas. There are higher rates of COPD in Appalachian states.

Ninety-two percent of adults in rural areas have access to primary care doctors. In 2016, statistics showed that only seventy-three percent of adults talked to their physician about their symptoms, and only forty percent were given a breathing test. Seventy-one percent of primary care providers evaluated COPD symptoms with a spirometry. Only sixty eight percent of primary care providers acknowledged pulmonary rehabilitation programs were available, and thirty-eight percent routinely prescribed pulmonary rehabilitation for patients diagnosed with COPD.

Opportunities for public health include CDC surveillance data, as well as working with healthcare to improve early recognition of COPD. Additionally, public awareness programs need to be available in order to improve recognition of COPD symptoms and promote discussions between physicians and patients. Rural prevention has to include access to smoking cessation programs and occupational prevention programs. Improved internet access, telemedicine, and telehealth are necessary for rural communities to have access to specialty care. Mobile pulmonary rehabilitation would expand access to care by reaching people in rural communities who do not have access to transportation.

Antonello (Tony) Punturieri, MD, PhD
Program Director, Division of Lung Disease
National Heart, Lung and Blood Institute
National Institutes of Health

Tony Punturieri shared that Chronic Obstructive Pulmonary Disease is a preventable and treatable disease that makes it difficult to empty air out of the lungs. It causes a person to become thirsty for air. The tissue gets destroyed so that oxygen cannot be delivered to the blood and/or tissue. It leads to shortness of breath or the feeling of being tired because the patient is working harder to breathe and maintain adequate oxygen levels. It is not uncommon for a patient with COPD to also have asthma.

The most common cause of COPD is cigarette smoke. Another cause is environmental factors such as exposure to certain dusts at work, chemicals, and indoor or outdoor pollution. Hereditary factors can also play a role in developing COPD. The single most important test to determine if a person has COPD is spirometry.

The most important treatment for smokers with COPD is to quit smoking. However, there are also medications available that are prescribed to widen the airways, reduce swelling and treat infection. Supplemental oxygen can be prescribed if the oxygen level in the blood is below normal. A person with COPD will feel breathlessness even with good oxygen levels. Daily medications are required to control COPD symptoms. Pulmonary rehabilitation programs offer supervised exercise and education for those with COPD, and this approach has had positive results.

COPD is the fourth leading cause of death in the United States following heart disease and cancer. In 2015, more than 155,000 people died from COPD including 81,000 women and 69,000 men. Molecular characterizations and imaging are leading to a better understanding of the various clinical COPD phenotypes and are paving the way for new precise therapies. However, there is still much work to be done. The complex multi-dimensional aspects of the disease need

to be evaluated, coordinated and implemented to result in effective treatment measures for patients, caregivers and society as a whole.

The COPD National Action Plan is the first multi-faceted, unified fight against the disease. Congress requested for the National Institute of Health and Centers for Disease Control and Prevention to come up with a strategy. The plan provides a comprehensive framework for action by those affected by the disease and those who care about reducing its burden. Before the COPD National Action Plan was developed, one of the best COPD plans at the state level came from North Carolina.

The COPD National Action Plan has five goals: (1) Empower people with COPD, (2) Improve the prevention, diagnosis, treatment and management of COPD by improving the quality of care delivered across the health care continuum, (3) Collect, analyze, report, and disseminate public health data in order to drive change and track progress, (4) Increase and sustain research to better understand the prevention, pathogenesis, diagnosis, treatment and management of COPD, and (5) translate national policy education and program recommendations into research and public health care actions.

Grace Anne Dorney Koppel, MA, JD
Immediate Past President, The COPD Foundation
President, Dorney-Koppel Foundation

Grace Anne Dorney Koppel shared that she has severe COPD and said that something must be done. Since she was diagnosed in 2001, over two million people have died from COPD. The number of people in rural America with COPD is double that of Metropolitan America. Breathing is living, and if you do not breathe well you will not live a long life. Living with the disease is a twenty-four hour per day struggle for breath. Some patients refer to the struggle for breath as suffocation. Some medicines do relieve symptoms, but they do not stop the progress of the disease. There is treatment for COPD, but it is not largely available in rural America.

The Dorney-Koppel foundation partnered with other foundations to create eleven pulmonary rehabilitation clinics in rural America. They are located in West Virginia, North Carolina, Kentucky, Louisiana and Maryland. There are around a thousand graduates from the programs and the results are stunning. People learned how to take their medicines and how to recognize when they are getting an attack so they can see their family doctor instead of going to the hospital.

The COPD Foundation has a wonderful website which has 35,000 visitors. Patients post to the site, assist one another, and provide a greater support network. One patient wrote that they feel so anxious about being left alone in their house, so they choose to work from home. They feel like a tiny dot living on a tiny dot in a vast system of intense energy. Most people with COPD are housebound and reliant on their caregivers. One in four are clinically depressed. It is a very difficult life to be alone and tied to oxygen tubing.

When diagnosed with COPD, she had lost seventy percent of her lung function. She was also diagnosed with heart disease. The doctor wrote a prescription for pulmonary rehabilitation which

was only about a half an hour away. Two years after graduating from pulmonary rehabilitation, there was no evidence of heart disease. Four years later she was diagnosed with lung cancer and on oxygen for two and a half years. Exercise, nutrition and knowledge about the disease is empowering. It has been seventeen years and she now works fulltime and travels everywhere. If people are diagnosed early and have higher quality of care, an opportunity exists for them to feel better physically *and* feel better about themselves. Forty percent of women with asthma will be diagnosed with COPD. There is a lot of work to be done and the Office of Rural Health Policy National Advisory Committee work on COPD is very much appreciated. "The world breaks everyone and afterward many are strong in their broken places." - Hemingway.

Q&A

Carolyn Montoya asked if nurse practitioners are being included as primary care providers when talking about primary care provider access? In some rural areas there are no physicians but there are nurse practitioners that are seeing patients

Tony Punturieri said that the statistics only included primary care doctors but recognize others need to be considered such as nurse practitioners, physicians assistants and other health care professionals.

Robert Wergin said in rural areas COPD patients are probably cared for by local providers. Do you think that is true? Some people are being underdiagnosed so there needs to be a focus on educating the local providers because they are the first contact for these patients.

Tony Punturieri Yes. Primary care providers are usually the first to see the COPD patients in rural areas.

Robert Wergin said that the medications are very expensive for individuals with COPD. How can that be addressed?

Tony Punturieri said the cost of mediations is an issue but it is not something that Centers for Disease Control can address. People in rural areas have to make difficult choices between spending money on food or medications. Many are socially isolated and they have low incomes.

Kurt Greenlund said that the health and wellbeing of the caregivers needs to be considered as well. It goes beyond health care so community linkages need to also be considered. Some patients also have cognitive impairment so rehabilitation has to be considered.

Steve Barnett stated that there is a struggle with managing COPD in rural settings. What metrics can be tracked to see if there is improvement or if there is a quality of life that has been reached that can be maintained? It is difficult to find metrics on this topic. Are there any standard metrics?

Tony Punturieri replied that creating these metrics is something that needs to be worked on together. Hospitalizations could be tracked due to COPD.

Kathleen Dalton said that she is fascinated by county level data that is rural and regional. There are parts of rural where COPD is not higher. Why?

Tony Punturieri replied that historically Appalachia has mining and not as much healthcare available. There are higher smoking rates and an issue with affordability, availability and socio-cultural factors in that region. There could be mortality data where COPD is not being diagnosed or diagnosed as a heart disease. Education of the patient and provider is important.

Joe Lupica stated that COPD is a disease of isolation, depression and panic. If a person feels like they are dying and it is two in the morning, they are going to the emergency room. Diagnosis, rehabilitation, education, and building confidence in the patients is very important. How can providers be leveraged without pulmonologists?

Grace Anne Dorney Koppel responded that all of the eleven pulmonary rehabilitation clinics that were founded by the Dorney-Koppel Foundation are staffed by a family doctor. The most successful clinics are the ones that are staffed with family doctors. Family doctors can and must diagnose the patients or they will die in rural areas where there are no pulmonologists. Seventy percent of the cost of COPD is associated with hospitalizations.

There is a disincentive to establish pulmonary clinics. It is reimbursed at half the rate of cardiac rehabilitation. This has been an issue for many years and the programs are essentially the same. Pulmonary rehabilitation clinics are closing because the reimbursement is so low. With the right recommendations this can change.

Craig Thomas stated that early diagnosis and risk factors are vital. The increase in vaping devices and the effects are unknown. Is research being done on the effects of vaping?

Tony Punturieri said that research is being done and patients are being monitored for COPD symptoms. Monitoring lung health for all individuals would be helpful from a younger age for future knowledge. This can help people learn more about risks of exposures because the long-term vaping on lung health is unknown.

STATE PERSPECTIVES ON RURAL COPD

Betsey Tilson, MD, MPH
North Carolina Department of Health and Human Services

Betsey Tilson said that NC Department of Health and Human Services works in collaboration with the Duke Endowment and thus, she was asked to speak to the committee. North Carolina is a rural state but has urban locations with medical centers and academia. There are disparities in rural communities with health behaviors, clinical care, social and economic factors and physical environment and all are holistic factors to health. There are workforce shortages, high rural uninsured rates and high poverty rates in rural areas. In 87 counties there are more jobless workers than there are job opportunities.

There is a large prevalence of COPD in rural North Carolina. More people are dying of COPD in rural regions of North Carolina. There is a higher smoking rate in rural areas of the state. There are fewer physicians in rural regions and very few pulmonologists in rural regions. The Grace Anne Dorney Pulmonary Rehabilitation Center is located at Happy Valley Medical Center in Lenoir. The center is doing amazing work and the committee members will hear many success stories during their visit.

North Carolina was built on tobacco. That is important to remember, especially when talking about tobacco policy. Tobacco was an enormous burden to the state in terms of health. North Carolina is higher than the national average but the state is making progress. QuitlineNC is a cessation program with an evidence-based integrated telephone tobacco treatment program at 1-800-QUIT-NOW. There is also a web-based tobacco treatment program and texting, which can be combined with telephone coaching or stand alone. Free, confidential services are offered to all North Carolina tobacco users. Services are available seven days a week, twenty-four hours a day. Two-week starter kits of nicotine patches are provided to Medicaid and Medicare recipients and eight weeks of nicotine patches for uninsured residents who use tobacco are mailed directly to their home or work address.

There are threats to continued progress. Ninety percent of smoking starts before the age of eighteen. There had been great success in decreasing youth tobacco use, but recently the numbers have gone up again. Much of the upward trend is due to the rise in popularity of e-cigarettes – how this will translate in COPD will be realized in the coming future. This is a huge issue due to the high nicotine and high amount of chemicals found in cigarettes and e-cigarettes alike that can be very damaging.

Adverse Childhood Experiences (ACEs) are traumatic or stressful life events experienced before the age of eighteen. This can include child abuse or different types of household disfunctions. The association between experiencing these events in childhood and the development of later adulthood diseases is high. The more ACEs a person experiences, the more susceptible they are to chronic diseases as an adult. This is due to toxic stress, stress hormones, immune system and inflammation responses to ACEs. ACEs can have lasting effects on health, behaviors and life potential. The more ACEs a person has experienced, the more probability they will smoke, and thus the higher likelihood that they will develop COPD.

It is important that rural communities receive financial support for rural clinics and hospitals. There is a need for more pulmonary rehabilitation programs in rural and workforce initiatives and incentives. Provider and patient education are important for diagnosing and treating people in rural communities with COPD. Telehealth and broadband are necessary in rural areas where there is no access to specialty care.

Other opportunities for addressing COPD in rural areas are investing in tobacco prevention and cessation, addressing non-medical drivers of health, controlling environmental exposures and promoting family resiliency.

Graham Adams
Chief Executive Officer

South Carolina Office of Rural Health

Graham Adams stated that he would speak to the committee about COPD. Dr. Ray Lala is the Director of the Oral Health Division at the South Carolina State Health Department and will speak about that topic. The Pee Dee region has the poorest health statistics and are where much of the efforts need to be focused. Most of the state of South Carolina is a HIPSA in mental health, dental and primary care. The state has done a good job of placing physicians in the right areas, but there is the issue of payment and transportation. There is a physician within a 15-mile radius in every part of the state. South Carolina is below the national mean in household income. South Carolina is a non-expansion state, so many of the people do not have a source of care. South Carolina rural communities have a higher incidence of chronic disease, including hypertension and diabetes. Rural residents are more likely to be obese, smoke and have a sedentary lifestyle.

South Carolina has a higher number of adults with COPD than the national average. People with lower income have a higher rate of COPD. Hospitalization due to COPD is higher in rural areas as well as for African Americans. Risk factors for COPD include smoking, low income, occupation related exposure, secondhand smoke, air pollutants, genetic factors, asthma and respiratory factors. Smoking is the number one cause of COPD. People in rural areas smoke more than in urban areas. The use of e-cigarettes is increasing among high school students, while conventional smoking is decreasing. It is disturbing because there is not enough research about e-cigarettes and all of the dangers associated with them.

COPD prevention includes tobacco prevention and control. Early treatment and control of asthma is important in preventing COPD. Reducing occupational exposure to dust and chemicals is also important. More workplace programs need to be in place. States went through the tobacco settlement process in the late 1990's and early 2000's. While North Carolina did a good job of putting systems in place and using the money for long term tobacco prevention efforts, in South Carolina, some funds went to a bridge in Charleston. There was a need for the bridge, but it may not have been the best use of the funds. There is an opportunity to do a better job of investing resources for long-term use. South Carolina has one of the lowest tobacco taxes in the nation along with most of the Southeast.

South Carolina has done a great job of making school systems tobacco free. Small communities have been more reluctant to institute smoke-free workplace policies. Hospitals have been smoke-free since around 2005. People who suffer mental illness are more prone to smoke. In South Carolina, there is the Quit for Keeps South Carolina Tobacco Hotline. All seven FDA approved medications are available with no prior authorization or copays. Additionally, individual and group counseling is also available for people with the desire to quit smoking.

Raymond Lala, DDS
Director of the Division of Oral Health
Department of Health and Environmental Control

Raymond Lala stated that the number of adults in South Carolina seen by a dentist for a routine check-up in the past year is below the national average. Children in South Carolina with urgent oral health needs were higher in rural than in urban areas between 2008 to 2018. During that time period, there was a larger percentage of children in rural than urban South Carolina with caries and untreated caries. In schools where there is a mobile provider or a local dentist, a larger percentage of children have restored decay.

South Carolina has five goals for advancing oral health including, (1) integrating oral health into primary care, (2) oral health promotion and disease prevention, (3) improving access to care, (4) improvements in oral health literacy, and (5) advancements in oral health related public policy and research. The first goal of integrating oral health into primary care will begin with a statewide oral health primary care integration program that targets diabetes. The process was started by Dr. Francis Rushton, a pediatrician from Beaufort, South Carolina. He received funding from Centers for Medicaid and Medicare Services for a Quality through Innovation and Pediatrics Grant. One of the components that the eighteen practices were asked to address was oral health integration, and Dr. Rushton trained every office in the state himself. The Medicaid agency has decided to maintain the activities from the grant and there are now thirty-one pediatric practices doing dental screenings, education and fluoride varnish. Eau Claire Cooperative Health Centers received a HRSA Grant to establish a learning laboratory as part of a Perinatal and Infant Oral Health Quality Improvement Expansion Grant. This integrates oral health in the pediatric environment and is offering dental screenings and education for pregnant women and children. There is a screening and fluoride varnish program in nursing home environments. Dentists are also integrating diabetes screening into practices.

About ninety percent of the South Carolina population on community water systems have access to fluoridated water. There will be an assessment of community water systems to identify and meet priority needs. A couple of communities lost fluoridation because of the inability of the community to replace worn out equipment. Thus, there are clearly further infrastructure problems that will have to be solved before adding the fluoridation.

In 2002, there was an agreement between the Department of Education, the Department of Health and Environmental Control, the Dental Association and Dental Hygienist Association to provide preventative services in schools under general supervision. It has been tremendously impactful on the state. Last year, dental services were provided to 21,000 children in 450 schools and 35 counties.

Graham Adams
Chief Executive Officer
South Carolina Office of Rural Health

Graham Adams spoke about the Live Healthy South Carolina State Improvement Plan. It is a state health improvement plan and assessment. The state health department is going through the process of being accredited and using the opportunity to create a meaningful plan. They are engaging the community and building upon resources that are already in place and creating a framework for a variety of input.

Historically, people in the healthcare field have not studied access to food, housing, job creation and the ability to support families. The plan is examining a multitude of issues including the lack of access to food and the lack of ability to find employment in rural communities. Health should be discussed when making broader policy decisions (for example, policy decisions regarding land use, economic development, transportation, education, employment, housing and public safety). The South Carolina Health Alliance is about sixty entities throughout the state that has been meeting for about five years. A collective impact model can create common goals for the state and hold each other accountable. The state improvement priorities are: chronic conditions, behavioral health, child resiliency, healthcare transformation and social determinants of health. The South Carolina Office of Rural Health will study livable and viable communities outside of traditional health care - this will be specifically through a rural lens.

Access to comprehensive services will be researched as part of the plan. Duke Endowment has done great work with the Access Health Program and has made a strong investment in North Carolina and South Carolina. The plan involves examining people making multiple hospital visits to the emergency room as well as people who do not have a medical home, and then building systems of care based on this information. South Carolina will build on these successes and the work that the telehealth alliance is doing in the state to promote greater coordination.

Q&A

Carolyn Montoya asked who can apply dental varnishes and what is the reimbursement for varnishes?

Raymond Lala replied that it depends on the state. In South Carolina it has to be a licensed healthcare provider applying varnishes. Not all of the WIC clinics has an RN or LPN. It is a low reimbursement because

Betsey Tilson replied that in North Carolina the program is state wide. Counseling, screening and varnish is done and there is a high reimbursement.

Barb Fabre stated that she is involved with Adverse Childhood Experiences in Indian Country. Adverse Childhood Experiences are part of the issues that Indian country has experienced. White Earth Tribe has children on medical assistance and it is difficult to find a dentist that will take them. They worked with Indian Health Services and Head start fluoride treatments. Are you having a problem with dentists accepting medical assistance? Have you seen an increase in access due to the Affordable Care Act?

Betsey Tilson responded that there has been a broad number of dentists who accept Health Choice or Medicaid in North Carolina. The state increased reimbursement for dental services for children on Medicaid so that has helped. There was broad participation especially with younger children. North Carolina is not a Medicaid Expansion state. Health Choice is the state chip program. There has not been a huge service from ACA with the pediatric access probably because NC is not a Medicaid Expansion state.

Raymond Lala said that in South Carolina, there is a continued reduction in the amount of oral disease and there has not been a lot of impact of disparity between urban and rural areas. In 2000, there was a Medicaid rate increase up to the 79th percentile. That increased had a huge impact on the number of dentists accepting Medicaid, but there are still areas with challenges and gaps in care.

Robert Wergin stated that patients are not taking medications because they can't afford them. Another issue is that Primary care physicians need to be engaged and educating the patients on going to the doctor and telling the doctors their symptoms. Many times, the patient has waited until the problem has progressed.

NATIONAL PERSPECTIVES ON RURAL ORAL HEALTH CARE ACCESS

Amy B. Martin, DrPH, MSPH
Assistant Professor and Director- Division of Population Oral Health
James B. Edwards College of Dental Medicine
Medical University of South Carolina

Amy Martin said she has been on faculty at the Medical University of South Carolina for four years. Prior to that she worked at the South Carolina Research Center for ten years. She also worked in a small rural hospital and rural health has always been one of her priorities. Health inequities that rural systems face are something she has tried to understand for years. Oral health has an impact on many of the inequities. Some rural populations have medical and dental systems that are not just clinically grounded, but where there are also policy pathways to addressing inequities between them. Medical and dental linkages have two pathways which are: (1) inflammation and (2) oral flora. Preterm birth, memory loss, unmet oral health problems, and cardiovascular disease all have inflammation in common. There are also linkages between asthma and unmet oral health needs. Kids who have asthma are more likely to be mouth breathers or to take medications that cause them to have dry mouth. This means that they don't have as much saliva present in their mouths, which then leads to higher levels of bacteria. Children with asthma need dental care much earlier than children without. Severe and moderate periodontitis is linked to Pregnancy tuberculosis for pregnant women with other risk factors such as age, obesity, HIV, and pre-eclampsia. Systemic inflammation likely worsens neuroinflammation for people with Dementia and Alzheimer's. People with chronic diseases such as diabetes and cardiovascular disease are also more prone to oral health issues.

Policies for reimbursement rewards to medical professionals who recognize the linkages between medical and dental health in a value-based way need to be in place. A Rural Health and Human Services National Advisory Committee report from 2004 noted that there were not enough dentists, transportation challenges, uninsuredness, poverty, Medicaid participation, and access to optimally fluoridated water.

Dental Health Professional Shortage Areas across the country have a deficiency of dentists. In South Carolina one half of the HPSAs experience geographical shortages, while the other half are low income. North Carolina has more HPSAs in low income instead of geographic areas.

There are dentists needed to remove HPSAs. In the next 20 years there is expected to be a surplus of dentists. Last year the James B. Edwards College of Dental Medicine received 1,200 applications for seventy-five spots. As the workforce surplus is created, there is anticipation that dentists will locate in rural areas. The national estimate of underserved in 2006 was eighty million people - much of this is due to poverty and uninsured individuals. The Affordable Care Act caused the uninsured rate dropped from seventeen percent; This drop in uninsured from seventeen to ten percent may have been due to Medicaid enrollment. Between 2016 and 2018, Community Health Centers expanded their dental footprint. There was a fifty percent response rate from CHC's to start up and/or expand their dental services.

Dental schools are currently changing their process – this will have a generational impact on the dental workforce. The DAT is the entrance exam for dental school, and it is like the SAT with multiple choice questions. After graduation, they take the dental board exam that is also multiple choice. The profession is changing and becoming integrated and has clinical value in a system-based world. The board exam too is changing to an integrated board exam, in that it will present a patient case and ask more questions about treatment planning based on integrated care models. In the next four years, the dental profession will be an integrated profession that is more system based. South Carolina is including private practice partners to fill the gap in dental care necessities. The state has included rural private practitioners to participate in the safety net system. A big issue is that only four in ten dentists across the country participate in Medicaid. There is a decline in utilization for children and a dip in preventative services, while at the same time, there is a rise in emergency room visits for children due to dental issues.

The Community Rural Health Research Centers did a report titled, "Improving Access to Oral Health Care for Vulnerable and Underserved Populations". The report recommendations include: increasing the enrollment and support for students who are underrepresented minority, low-income and in rural communities. The report also recommends requiring students to participate in community-based education rotations with opportunities to work with interprofessional teams. A third recommendation is to recruit and retain faculty with expertise and experience in caring for underserved and vulnerable populations. The IOHPCP initiative is to improve access for early detection and preventive interventions

The Federal Office of Rural Health Policy Public Private Partnership Initiative began under the White House Rural Council in 2013. The funding priority discussion in 2014 was that oral health came in second place to health disparities. Within an eighteen-month planning period, The Duke Endowment created a new oral health portfolio. The oral health portfolio includes school-based oral health program expansions, an integrated care model and a two-state research consortium to advance evidence-based oral health policy.

The Family Medicine and Pediatric Residency Program works within their own competency space. It identifies areas to add oral health messages. In the pharmacy program there is a requirement for students to get a certificate in diabetes management. The family medicine and pediatric students' system of policy courses are connected to the dental program so that they are given the risk assessment tools to be practically applied when they do their rotations. The Safety Net Dental Practice Certificate Program includes courses in practice management, leadership policy and poverty and health that is teaching empathy as a clinical skill. Many dental students

come from communities of privilege and may not have had first world experiences in rural South Carolina, so the school creates the experiences for them. One student went into the National Service Corp, one in the armed services, and one is going into practice in the rural Pee Dee region of the state.

There are two examples that reflect who the National Advisory Committee's work is so important for. An elderly man in a rural area who had not received proper oral healthcare had lost eighteen pounds in six weeks. The family medicine resident and supervising faculty could not determine the origin of the weight loss. He was given an expensive imaging MRI and it revealed no information on why he was losing weight. The residency director suggested examining his mouth, and as a result, they found that his poorly fitted dentures had caused extensive irritations, inflammation, and infection. Another example is a middle-aged woman in the Pee Dee region of South Carolina who presented with fasciitis and sepsis due to an untreated abscess. She was admitted to an impatient bed in September 2016 and died due to the sepsis six days later.

Marcia Brand, PhD
Senior Advisor for National Policy and Programs
DentaQuest Foundation

Marcia Brand stated that she began her career as a dental hygienist. She was the Director of the Office or Rural Health Policy and is now the Senior Advisor for National Health Policy and Programs for the DentaQuest Foundation. She told the committee she would provide information about Health and Human Services, HHS agencies, and their oral health activities. She also would speak about dental coverage in Medicare, Medicaid and the Children's Health Insurance Program and give suggestions on how the Committee can engage Health and Human Services around polices.

The Department of Health and Human Services Secretary is a member of the president's cabinet. The Surgeon General is the leading spokesperson on matters related to public health and has an important role to play in oral health. The Surgeon General is producing a new report on oral health that should have a reflection on rural health. The last report was produced back in 2000, so this is a major opportunity for the National Advisory Committee. The National Advisory Committee could also recommend to the Secretary that a new oral health strategic plan should be developed, including information on rural oral health. Another recommendation is to separate rural and urban entirely when doing assessments for policy and regulation.

Health and Human Services activities that impact oral health include: developing strategic plans that include oral health goals, targets and strategies. HHS develops policies and regulations that impact oral health programs, conduct public health assessments, and implement programs authorized by congress that support oral health. The Office of Management and Budget has submitted budgets that include support for programs that impact oral health.

The Department of Health and Human Services agencies are: Administration for Children and Families, Administration for Community Living, Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Food and Drug Administration, Health Resources

and Services Administration, Indian Health Services, National Institutes of Health, Substance Abuse and Mental Health Administration.

The Administration for Children and Families promotes the economic and social wellbeing of families, children, individuals and communities. The programs with an oral health impact are Temporary Assistance for Needy Families and Head Start. The Administration for Community Living includes programs for older adults and people with disabilities. The ACL encourages the Ageing Services Network to engage in oral health promotion and disease prevention intervention with older adults and people with disabilities. The Agency for Healthcare Research and Quality invests in research to make healthcare safer and improve quality and generates data used by providers and policy makers. Centers for Disease Control and Prevention Division of Oral Health works to improve the oral health of the nation and reduce inequalities in oral health by developing oral health plans, working with state oral health coalitions, training and resource development. Center for Medicare and Medicaid Services oral health efforts include the collection and analysis of data and quality measures. CMS also sponsors the oral health initiative and annually reports state progress on oral health quality measures. Health Resources and Services Administration's health center program increases access to quality primary health care services, including oral health services for medically underserved populations. HRSA designates dental Health Professional Service Areas and supports Dental Workforce Development Grants. Indian Health Service provides direct care to American Indian/Alaska Native patients or contracts with tribal organizations to provide oral health assessment and fluoride varnish application training to primary care providers and other staff. Indian Health Services also supports an Early Childhood Carries Collaborative and promotes childhood oral health and application of dental sealants. National Institutes of Health conducts oral health research through the National Institute of Dental and Craniofacial Research.

Very few states offer comprehensive dental coverage to Medicaid adults. Sixteen states offer extensive care, twenty states offer a limited mix, twelve states offer emergency care for relief of pain and infection. Three states offer no dental benefits. Typically, Medicare does not include coverage for routine oral health. Some people get coverage through Medicare-Advantage, employer-sponsored retiree health plans and/or individual purchased dental plans. About one in five older Americans have untreated decay and seventy percent have periodontal disease. This impacts their nutrition, self-image, mental and physical health.

Some rural oral health policy levers and opportunities include supporting transportation to dental care facilities, revising dental care models, working with the Veteran's Association to improve access to dental services, promoting dental disease prevention and creating programs that reduce emergency room visits due to dental problems.

The DentaQuest Foundation is the largest oral health philanthropy since 2000. There are more than 1,000 members of a cross-sector network of national, state and community-based resources. The shared goal is to eradicate dental disease, incorporate oral health into the primary education system, include an adult dental benefit in publicly funded health coverage, integrate oral health into person-centered health care, and build a comprehensive national oral health measurement system.

Q&A

Carolyn Montoya stated that she is in academia and does not feel like she could fit anything more into her curriculum. How are you fitting in the four courses for the graduate level certificate?

Amy Martin said that it is four courses but they are all online. The students can build in when they want to do the courses. The program has deadlines so that students do not have difficulties because of struggles with time management. The students are allowed to have three electives so it is recommended when they begin that they need to plan for the electives to be used for the courses to receive the graduate level certificate**.**

Barb Fabre asked if they were working with childcare to address the oral health issues?

Amy Martin said that the Head Start data was linked to the Medicaid clients and the children had far better utilization and preventative diagnostics than children who were not participating in Head Start. The public health agency in South Carolina has a great childcare training curriculum. The information that would be great to analyze would be regarding what happens when children graduate from Head Start (i.e. do the utilization patterns change?). Rural private practice dentists are partnering with public health organizations, but much of the work is localized and not a statewide strategy.

Ben Smith asked if there is more information that can be shared about alternative workforce models. He said that he is with Indian Health Services, and they have had experience with alternative workforce models. The Dental Health Therapist Program has been very successful in Alaska and is soon going to expand outside of Alaska due to this success. Dental assistants are able to perform basic supportive dental procedures, and it has been very beneficial to the oral health of the community. Needs have to be meet at the community level. Have you found other successful models?

Marcia Brand replied that she was at The Office of Rural Health Policy when The Dental Health Aid Therapist Program was created. The model trained people from the communities to go back and provide oral healthcare. The providers who were part of the program have been studied extensively to measure the quality of service and it was found to be exceptional and culturally appropriate. As a result, other states have looked at alternative models. There are around sixty countries that have used alternative dental providers for a number of years. Tele-dentistry can give assistance to those providers in rural communities when needed.

STATE PERSPECTIVES ON RURAL ORAL HEALTH CARE ACCESS

Graham Adams, PhD, MPH
Chief Executive Officer
South Carolina Office of Rural Health

Graham Adams shared that the South Carolina Office of Rural Health's mission is to improve the health status of rural and underserved people through advocacy, education, and assistance to providers, communities, and policymakers. The SCORH is a non-profit organization with forty-four employees. There is a location in Lexington and Orangeburg. The annual budget for this organization is around six million dollars.

The South Carolina Rural Health Action Plan was modeled after North Carolina's action plan, and insures that every community member has adequate and appropriate access locally or via telehealth to primary care, preventative services, emergency care, oral health services, behavioral health services, robust care coordination, appropriate diagnostic and outpatient therapy, and long-term care. The plan talks about oral care more broadly as well as implementing other things into healthcare that do not traditionally fall under the primary care category.

South Carolina's Office of Rural Health supports rural health centers and rural primary providers on patient-centered medical home development, quality measurement or practice improvement. They have contracts with the state Medicaid and Public Health agencies, as well as quality improvement organizations. SCORH is currently working with over fifty Rural Health Centers and rural primary care providers on patient-centered medical home development.

Promoting oral health is important because there will not be an influx of dentists into rural areas. This means that other healthcare professionals are expected to meet the oral health needs in rural communities. The MORE Care Collaborative is a project funded by DentaQuest to implement the best oral health practices into the primary care practice setting. MORE Care was developed in close concert with DQI and the MUSC College of Dental Medicine. MORE Care Practices is a twelve-month collaborative program, with six participating rural practices. It began in June of 2015 with pre-work and practice recruitment.

MORE Care targeted Patient Centered Medical Home recognized practices. All of the six practices incorporated some oral health services into their primary care systems of care. The focus was primarily on pediatric oral services. Two of the six practices were able to integrate both pediatric and diabetes-focused changes, while five out of six practices included oral health risk assessments of pediatric patients, an oral health exam, fluoride varnish, and incorporated oral health patient education into the visit. Seventy-five percent of eligible patients received an oral health risk assessment and oral health exam within eight months. Six out of six practices initiated referrals to a dental partner and established a referral relationship with community dental providers. South Carolina was the initial pilot state to implement oral health integration within the rural primary care setting. After the pilot, MORE Care was expanded to four other states.

Lessons learned from MORE Care include: (1) It is important to pair oral health risk assessments with oral exams, (2) Patients may initially be skeptical of oral health services being delivered within primary care practices, (3) Comprehensive must be reframed for patients and the care team, (4) Practices on how to order, bill and train for varnish applications need to be supported, and (5) Rural practices have an advantage over large practices in that, because the approval process is less complicated in rural practices, they are able to make changes more quickly.

Margaret (Maggie) Sauer, MHA, MS
Director – North Carolina Office of Rural Health
North Carolina Department of Health and Human Services

Maggie Sauer thanked the Federal Office of Rural Health Policy and the Duke Endowment for inviting her to speak about oral health in North Carolina. It is important to view things regionally and it is also important that organizations work together in order to solve issues. The North Carolina Department of Rural Health has an opportunity to work across different areas of healthcare. The North Carolina Office of Rural Health works to place dentists and hygienists in Health Professional Shortage Areas and explore loan repayment. There are fourteen state designated rural health centers in North Carolina. This gives an opportunity to be innovated with what services these hospitals can provide. There can be telehealth and oral health in these centers. There are North Carolina community health grants to support access to care at public health departments, rural health centers, school-based systems, and community health centers. There is an opportunity for providers to expand their dental coverage for their patients. There was a seven and a half million-dollar grant that doubled to fifteen million. This has given an opportunity to think outside the box and support some of the rural health centers and other safety net organizations to do some of the work.

The Farmworker Health Program has contracts with ECU School of Dental Health and a number of rural health centers to provide dental services. The Rural Health Information Technology Program is making sure that rural practices can connect to the state, as well as exchange health information with the state. A report was written to the legislature around telemedicine and they are currently working on a broadband effort. This is important in creating more access points for dental health. The Rural Hospital Program and Medication Assistance Program are state funded. There is a telepsychiatry program through East Carolina University that provides psychiatry support for emergency departments.

Opportunities regarding oral health lay in developing cross team cultivation by creating three service areas to provide support. There is the potential of taking each program and assigning a team to the service areas, so that there can be a local focus and everyone has an opportunity to know their team member for a program.

The North Carolina Health Action Plan was published in 2014. While dental health was discussed, it did not make it into the official recommendations. However, it continues to be recognized as a need. The importance of the health care workforce, economics in a community, nutrition, substance abuse, jobs and education were all discussed in the plan. The North Carolina Leadership Alliance was created and the North Carolina Rural Center created a plan that included health in relation to economic development and jobs. The University of North Carolina Sheps Center partners with the NCORH and does incredible work providing data for response to legislative reports.

There have been over fifty-five people served by The Missions of Mercy Portable Dental Clinics since 2003. In the past two years the dental society has charged local communities to do the

Mission of Mercy activities. These services are appreciated, but unfortunately, communities are now being charged.

The NCORH is working on providing loan repayment for those who agree to work in rural areas, but there has to be people who want to/are willing to work in rural areas in the first place. The office is working with the dental school about creating incentives earlier in their education. The NCORH is preparing a report in graduate medical education, and they are considering using rural hospitals as training sites. The NCORH is finding ways to assure that people are interested in going to rural areas, as well as attempting to increase this desire.

The Foundation for Health Leadership and Innovation is doing work with The Duke Endowment and other partners around the oral health collaborative. NCDHHS will work with The Duke Endowment and the Oral Health Collaborative, while continuing to advocate for whole-person care. There are great partnerships with ECU and UNC to create opportunities for people to be trained and retained in rural areas. NCDHHS will also be working with North Carolina Area Health Education Centers, who are developing new innovative models to include behavioral and oral health as standard measures of care.

Stacy E. Warren
Program Officer – Healthcare
The Duke Endowment

Stacy Warren thanked the Committee for visiting the Carolinas, and said that, during her four years with the Duke Endowment, one of her main focuses is rural health. For years, the Endowment has heard from communities and health systems that behavioral health and oral health are two major issues in rural communities. In the past four years, national and local experts have defined a three-part strategy to address oral health in the Carolinas. The focus of the strategic plan is promoting prevention, oral health integration, system reform and policy change.

The School Based Oral Health Initiative is a very exciting program. Dental disease *is* preventable because prevention techniques like sealants and varnishing works! School based programs are some of the best places to provide access to children. Eight school based oral health programs that were already in place were examined to find out what areas were working, as well as what areas were not. The programs struggled with business planning, as well as an efficient operations model. There was also difficulty with collecting, reporting and using data in meaningful ways. The initiative was designed to help the school-based programs with these issues. The programs can apply for a six-month planning and readiness phase. During that time, they will receive funds to work with Amy Martin, Safety Net Solutions and a technical assistance team at the Medical University of South Carolina. If they complete the requirements, they can apply for two-year implementation grants through the Endowment. Every year, ten programs will be added in the hopes that in five years time, there should be fifty strong, sustainable school-based programs in the Carolinas.

Oral health integration is medical and dental integration for chronic disease management. The Duke Endowment is working with McCloud Health Systems in Florence, South Carolina. This

program is to get physicians and nurses to also provide dental care. The primary patients will be diabetic the clinic opens in October.

System Reform and Policy Change Initiative has two primary investments and they are the two-state oral health research and policy consortium. The Duke Endowment co-funds with BlueCross Blue Shield, while DentaQuest co-funds with the North Carolina Oral Health Collaborative. North Carolina has no services that hygienists can do independently, and this is needed in order to increase access to oral health care. The collaborative added the president of the Dental Society and the Director of Dental Benefits for Medicaid and other state leaders to go to Colorado to visit programs and see how they were using hygienists to improve access. Some of the policy changes that the collaborative has recommended are: Eliminating the prior exam rule in community settings, allowing dental hygienists to supervise a dental assistant II, and allowing public health dentists to supervise more than two hygienists. Eliminating of the prior exam will allow hygienists to be able to go to a school and put on a sealant without a dentist having to do an exam first.

Another policy accomplishment is the “Brushing is Fun” project. This project promotes using fluoride toothpaste with young children, both for parents at home, as well as in daycare centers. The Special Adult Network of Dentists project is building a network of dentists who provide services for special needs parents. They will provide resources to parents to find dentists.

PUBLIC COMMENT
There was no public comment.

Tuesday, September 11th, 2018

Tuesday morning the subcommittees depart for site visits as follows:

SITE VISIT
ADDRESSING RURAL CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

HAPPY VALLEY MEDICAL CENTER
Lenoir, North Carolina

Subcommittee members: Kathleen Dalton (Subcommittee Chair), Steve Barnett, Ty Borders, Connie Greer, Joe Lupica, Octavio Martinez, Jr., Sallie Poepsel, John Sheehan, Robert Wergin and Peggy Wheeler.

Staff Members and Guests: Robert Coble, Alfred Delena, Kurt Greenlund, Steve Hirsch, Jay Kennedy, Grace Anne Dorney Koppel, Scott Miller, Allison Owen, Paul Moore, Tony Punturieri, Craig Thomas, and Shannon Wolfe.

COMMUNITY PANELISTS AND ATTENDEES

Amanda Barnes, RN- West Caldwell Health Council, Inc
Bryan Belcher - High Country Community Health
Steve Benfield- COPD Patient
Peter Charvat, MD -Johnston Health
Mary Creed – COPD Patient
Dan Doyle, MD – Appalachian Pulmonary Health Project
Michael (Brad) Drummond, MD, MHS – University of North Carolina at Chapel Hill
Chuck Elliott, FACHE – Johnston Health
Lisa Emery – New River Health
Hector Estepan – West Caldwell Health Council
John Francis – Helping Hands Clinic
Eddie Gragg – COPD Patient
Nancy Hannah -COPD Patient
Jerry Harrell – COPD Patient
Jeff Heck, MD – Mountain Area Health Education Center (MAHEC)
Curt Hiller, BS, RRT - Happy Valley Medical Center and Caldwell County Senior Center (Retired)
Maria Hiller – Appalachian Regional Healthcare System
Thomas McRary, MBA - West Caldwell Health Council, Inc.
Valerie McRary - West Caldwell Health Council, Inc.
Patricia Miller – COPD Patient
Allison Owen, MPA - North Carolina Office of Rural Health
Hayley Penley, RN, BSN – Happy Valley Medical Center

Gaither Rich – COPD Patient
Alice Salthouse – High Country Community Health
Margaret Small – Gardner Webb University
Deborah Stallings – West Caldwell Health Council, Inc.
Joshua Swift, MPH – Caldwell County Health Department
Michelle Waters – Caldwell UNC Healthcare
April Winkler, RRT, RCP - CVMC

SITE VISIT
APPROVING ACCESS TO RURAL ORAL HEALTHCARE SERVICES

WINNSBORO SMILES DENTAL CLINIC AND BETHEL ARP CHURCH
Winnsboro, South Carolina

Subcommittee members: Ben Taylor (Subcommittee Chair), Kathleen Belanger, Molly Dodge, Carolyn Emanuel-McClain, Barb Fabre, Carolyn Montoya, Chester Robinson, Kate Rolf, and Mary Sheridan.

Staff Members and Guests: Tom Morris, Sahi Rafiullah, Taylor Zabel, Jocelyn Richgels, Jennifer Holtzman, and Ben Smith.

COMMUNITY PANELISTS AND ATTENDEES

Suzanne Doscher—Fairfield Memorial Hospital
Sandy Kammermann—John A. Martin Primary Health Care Center
Arnold Hamilton—?
Reid Warren—Winnsboro Smiles
Lauren Gregory—Winnsboro Smiles
Charles McElmurray—John A. Martin Primary Health Care Center
Kathryn Davis—Palmetto Health Foundation
Jim Curtis—Palmetto Health-USC Medical Group
Trell Belk—Eau Claire Family Dentistry
Neil Wrenn—Fairfield Family Dentistry
Therese Elloitt—Fairfield Family Dentistry
Philip Wilkins—Winnsboro Smiles
Elizabeth Crouch—South Carolina Rural Health Research Center
Graham Adams—South Carolina Office of Rural Health
Maggie Sauer—North Carolina Office of Rural Health

The subcommittees' returned to Saratoga Hilton in Saratoga Springs, New York, to discuss site visits.

PUBLIC COMMENT

Grace Anne Dorney Koppel, MA, JD

Immediate Past President – COPD Foundation
President – Dorney- Koppel Foundation

There are at least three Centers for Medicare and Medicaid Services payment modalities for reimbursement for Pulmonary Rehabilitation:

Outpatient Hospital Reimbursement for Pulmonary Rehabilitation which is about $58/session. This is approximately half of the reimbursement for outpatient cardiac rehabilitation and does not permit reimbursement for the cost of the program.

FQHC Pulmonary Rehabilitation is reimbursed at Physician Provider rates (considered to be Physician's Office Service) at $38/session. This is totally inadequate to cover the costs of the pulmonary rehabilitation program.

Critical Access Hospital Pulmonary Rehabilitation— under contracts with CAH's, costs are covered under year-end reconciliation.

Under present licensure, Respiratory Therapists are only permitted to work with patients under the direct supervision of a physician or nurse practitioner.

Wednesday, September 12th, 2018

DRAFTING OUTLINE OF POLICY BRIEF

ADDRESSING RURAL CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)
Subcommittee findings and possible recommendations include:

- **Early Diagnosis**
- **Provider (Non-Specialist) Education**
    - Primary Care Providers are on the frontline for treating COPD. Therefore, these providers need to be trained on how to diagnose COPD.
    - Spirometry testing is under-utilized in non-pulmonary clinics
        - **Policy Areas/Potential Recommendations**
            - Programs to support mobile spirometry testing in rural areas
            - Increase incentives to conduct spirometry should be supported
            - Decentralization of COPD expertise to the community level
- **Rural Access to Care and Treatment**
- **Support for Rural Pulmonary Rehabilitation Programs**
    - PR addresses the psychosocial aspects of the disease which may be elevated in rural areas given their distance from urban centers.
    - Benefits of PR include reduced hospitalizations, reduced unscheduled healthcare visits, reduced symptoms of dyspnea and leg discomfort, improved exercise compacity, improved limb muscle strength and endurance and improved health related quality of life.
- **Other Innovative Access-to-Care Supports**
    - **Policy Area/Potential Recommendations**
        - Focus on supporting novel and innovative methods to increase patient access to healthcare - such as ride sharing programs for clinic and PR visits; funding for the development of paramedicine programs-paramedics are trained to do home assessments/spirometry with e-consultation and non-urgent basis.
- **Financing/Payment Issues**
    - Primary Challenge: Despite pulmonary rehab and cardiac rehab sharing similar principles and goals.
    - Payment models- three different models for PR based on facility type: Outpatient hospital-based PR
    - Challenge: Respiratory therapists can only practice under the direct supervision of a physician – need to expand ability of RTs to see patients.
    - **Potential Recommendations:** Payment for PR be equal to CR.
- **Barrier: affordable medications**
    - Currently, 17 FDA approved maintenance inhalers for COPD – only one is available in a generic form.
        - Without insurance – cost for standard inhaler regime: $800/month

        - Even with insurance: copays are still high, especially for low income patients
    - Out-of-pocket costs, particularly for those with multiple chronic diseases, resulting in reduced adherence and increased overall health care costs.
    - **Policy Area/Consideration:** The Secretary and HHS encourage Congress to include PR and CR with other conditions for copayment waiver.

IMPROVING ACCESS TO RURAL ORAL HEALTH CARE SERVICES
Subcommittee findings and possible recommendations include:

Financing of Oral Health Providers

- Increase funding for Dental Education Loan Repayment and Practice Startup Costs
- Expand funding for oral health primary care GMEs
- Expand the interpretation of "medically necessary" dental care for Medicaid populations in rural areas
- Replicate Title III Model for South Carolina which focused on expanding access to oral health treatment for rural residents

Oral Health: Eliminating Barriers to Care, Relevant HHS Programs, and Other Placeholders

- Support transportation to oral health care
- The Committee supports the goals of the IHS strategic plan
- Get the oral health coordinating committee's action plans on rural oral health
- What is the role of Rural Health Clinics in providing oral health care?
- Why has preventative dental care declined across races in rural areas?

OFFICE OF RURAL HEALTH POLICY
FEDERAL UPDATE

Tom Morris
Associate Administrator, Federal Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services

Secretary Azar's Priorities include: The Opioid Crisis, Prescription Drug Pricing, Health Insurance Affordability, Mental Health, and Value in Health Care.

The Office of Rural Health Policy will get $100 million in the budget this year to focus on the Opioid Crisis. There is less infrastructure in rural communities to combat the opioid epidemic, so it is an important issue for The Office of Rural Health Policy. Health Insurance Affordability has been a focus of the committee in the past. Value in Health Care may have challenges for rural areas because it is moving towards a risk-based model. Additionally, mental health has many challenges in rural communities.

Scott Miller, MHA, MS
Senior Policy Advisor – Policy Research, Analysis and Development Office
Centers for Disease Control and Prevention

The *Call to Action* (CTA) will be a part of the Office of the Surgeon General's (OSG) "Community Health and Economic Prosperity" initiative. It is slated for publishing in the spring of 2020.

The CTA will compile the available evidence and best practices to:

- Illustrate the connection between private sector investment in the health of their employees and communities and collective prosperity,
- Inspire future research, and
- Provide tools and examples for effective, efficient community health investments that produce results.

CDC is assisting the OSG with the development of the CTA.
CDC published a Request for Information in the Federal Register on September 6 (https://www.federalregister.gov/documents/2018/09/06/2018-19313/surgeon-generals-call-to-action-community-health-and-prosperity). The RFI invited public comment on the CTA topic and examples of the connections between community health and prosperity.

P. Benjamin Smith, M.B.A., M.A.
Deputy Director for Intergovernmental Affairs – Indian Health Service
Department of Health and Human Service

A consideration for the next topics includes the exploration of innovative models of care organization and delivery offer opportunities in rural health. This links to the HHS Priority of Transforming the health care system to one that is value-based. For example, a number of hospitals have either closed or transitioned to Critical Access Hospitals or other facility types. The Advisory Committee may benefit from exploring opportunities and recommendations for a system of care that is capable of better performance in rural America. The rural health care system encounters challenges of limited access to services, low utilization of inpatient services with very low average daily census, intermittent presentation of high acuity ED events (e.g. trauma, medical, and obstetric emergencies), need for better training of clinical staff, and recruitment and retention difficulties for both clinical and administrative staff.

FALL MEETING - POSSIBLE TOPICS AND LOCATIONS

FUTURE TOPIC IDEAS
Potential Topics

- Access to Obstetrics and Maternity Care
- Rural Cancer Control
- Elderly Services
- Agriculture Health
- Transportation

- Home Health Services

POTENTIAL MEETING LOCATION FOR NEXT MEETING-SEPTEMBER

- Nacogdoches, Texas (consider for fall meeting)
- Georgia
- Indiana (consider for fall meeting)
- California (Spring)

PUBLIC COMMENT
There was no public comment.