Improving Oral Health Care Services in Rural America from the NACRHHS – 05/21/19

Kristine Sande: Good afternoon, everyone. I'm Kristine Sande, the program director of the Rural Health Information Hub. I'd like to welcome you to today's webinar, Improving Oral Health Care Services in Rural America. We are delighted to be collaborating with the National Advisory Committee on Rural Health and Human Services on today's webinar. I'll quickly run through some housekeeping items before we begin. We do hope to have time for your questions at the end of the webinar. If you have questions for our presenters, we ask that you submit those at the end of the webinar using the Q&A section that will appear on the lower right-hand corner of the screen following the presentations. We have provided a PDF copy of the presentation on the RHI Hub website. That's accessible through the URL that's on your screen. We'll also send the link via the chat function. If you have technical issues during the webinar, we ask that you call Webex support at 866-229-3239.

Our first speaker today is Paul Moore. He currently serves as the executive secretary for the National Advisory Committee on Rural Health and Human Services. He is also a senior health policy advisor to the Federal Office of Rural Health Policy. Paul brings a lifetime of experience related to rural health care for both his family heritage and more than 30 years in community and hospital pharmacy. His experience reaches beyond pharmacy, as he has also been the CEO of a County Health Care Authority consisting of one of the nation's earliest critical access hospitals, the County EMS, a physician clinic and a home health agency. Paul is also a past president of the National Rural Health Association. With that, I'll turn it over to you, Paul.

Paul Moore: Thank you, Kristine for the introduction. I'd like to take this opportunity to welcome our audience to today's webinar topic, Improving Oral Health Care Services in Rural America by the National Advisory Committee on Rural Health and Human Services. In this webinar, we will provide an overview of the committee, provide some background on the current status of oral health in Rural America, discuss relevant programs within the United States Department of Health and Human Services, review the committee's recommendations on this issue and finally, conclude with one of our speakers providing their personal perspective on using federal policies to advance positive change at the local and state levels. Just a little background at first, I would like to provide some background on the committee. As a federally chartered independent citizen's panel, the committee is tasked with advising the secretary of the Department of Health and Human Services on issues related to how the department and its programs can better serve rural communities.

The committee is comprised of 21 members whose experience and expertise covers a wide variety of rural issues and fields such as public health, medicine, nursing, human services, hospital administration, childcare, research, guardian's law and business. The committee was formed in the late 1980s after a large number of rural hospitals closed. Since then, the committee meets twice a year to examine pertinent issues that affect the health and well-being of Rural Americans and to also hear directly from rural stakeholders and health care and human services. Following those meetings, the committee produces policy briefs to the HHS secretary along with recommendations on policy or regulatory matters under the secretary's purview. Recent topics, the committee provided recommendations were, for rural health insurance markets, suicide in Rural America and adverse childhood experiences. Those policy briefs along with others can be found on the committee's website provided at the link on this slide. A quick online search of NACRHHS will also bring you to the website. The most recent briefs will be located under the publications tab on the left of your screen.

With that background covered, I would like to introduce our speakers for the remainder of this webinar. First, we will hear from Dr. Amy Martin. Dr. Martin is an Associate Professor and Director from Division of Population Oral Health at the Medical University of South Carolina's College of Dental Medicine. She is also a Senior Investigator and Adjunct Associate Professor at the South Carolina Rural Health Research Center in the Arnold School of Public Health, University of South Carolina. Dr. Martin's health policy research focuses on safety net populations, access to care and oral health with an emphasis on rural health care and public health systems. She is active in National Health Policy through various rural serving organizations including the Appalachian Regional Commissions Health Policy Council and the White House Rural Council's public-private partnership for health equity coordinating committee. She teaches health policy courses as well as dental public health.

Dr. Martin will be followed by Dr. Ben Taylor. Ben is a member of the National Advisory Committee on Rural Health and Human Services who also served as the subcommittee chair on this topic during our September meeting in the Carolinas. He is a member of the clinical faculty team for the Physician Assistant Program at the Medical College of Georgia and has been an emergency room provider for over 20 years. Dr. Taylor started his medical career as a registered nurse in the military and returned to the military as a battalion medical officer in the army after completing P.A. school. He has since provided primary care services in a variety of settings and is involved in teaching the next generation of providers at the Medical College of Georgia. He is the past president of both the Georgia Association of Physician Assistants and the Association of Family Practice Physician Assistants. With that out of the way, I will now turn it over to Amy to provide some relevant background knowledge on this topic.

Amy B. Martin: Thank you, Paul. I've been asked to share some background information on oral health as it relates to Rural America. I can't help but reflect on the many conversations I have with policy makers and our colleagues on the medical and primary care side of our rural health care systems. I find it, oftentimes, necessary to contextualize the importance of oral health, not just for the sake of having a nice white smile, but to also describe oral health's impact on the many medical related challenges and inequities that we, as a holistic system, try to address. When I think about, really, in terms of Medicaid expenditures and priority patient groups, I think about pregnant women who are at heightened risk for preterm labor, our senior adults who are living with memory loss disorder such as dementia and Alzheimer's. I also think about those living with chronic diseases such as COPD, diabetes and cardiovascular disease.

We are, really, what I think are on the precipice of the golden age of integrated medicine. Particularly, as it relates to oral health and its impact on these expensive ... what can be very expensive conditions. There are many complex bidirectional causalities as it relates to oral health in these many conditions, but the two fundamental underlying causes, really, is chronic inflammation and then the prescriptions that we often prescribe for these different diagnoses, which can lead to saliva depletion and dry mouth which exacerbates the bacteria that causes caries in the mouth and periodontitis. In some ways, it is really interesting bench in basic science research, but it's also not rocket science. We know that these expensive and life-threatening conditions to manage them and intervene early does begin in the mouth.

I would like to applaud the National Advisory Committee for taking on rural health and oral health. This is not the first time that they studied the issues of oral health as it relates to Rural America. There was a report done back in 2004 and you have to ask yourself, "In 15 years, what has changed Rural America's oral health well-being?" We have too few dentists. We have too few dentists now. We had too few dentists in 2004. Our many complex transportation challenges still plague our ability to access affordable, reasonable care. We have had some wins in the uninsured. Thanks to the Affordable Care Act poverty particularly for children, still plague Rural America. Medicaid participation continues to be a challenge. It was a greater challenge in

2004, but it does vary depending on which state expanded Medicaid verus didn't and then how states are managing, rather, their third-party Medicaid dental benefits.

Last but not least, accessibility to optimally fluoridated water. A state like mine does very well with ensuring our public water systems are optimally fluoridated, but we recognize that that is not the norm that these states still struggle with water fluoridation. Thankfully, since the last report in 2004, both the EPA and CDC came together to revise our fluoridation levels. Our hope is that that's manifesting in our rural children. I mentioned previously, we have too few dentists. This will be a special plug for the HRSA Data Warehouse. If you've not been on the HRSA Data Warehouse lately it has got all sorts of enhanced functionalities. This is a map that we were able to generate from their website. We have too few dentists.

I look at my State of South Carolina and my neighbors to the north in North Carolina, we have 46 counties in our state. All but he three have some type of dental HPSA designation, whether it'd be low income or geographic or whole county versus partial county, we still are inadequately staffed with our general FTE. This is an analysis that was done by HRSA's Bureau of Health Care Workforce, the Kaiser Family Foundation was kind enough to give us a nice visual of just how many practitioners we need to walk back our dental HPSA designation. As you can see, most every state in the union is going to be short on dentists in the next 10 years. This is something we need to make a national priority. Thankfully, the Act for Dental Health Improvement 2018 was bipartisan, sponsors and approved is going a long way to addressing this through a variety of mechanisms such as oral health workforce grants.

This is a complex table that I share with my third year dental students, so that they can be properly grounded in our challenges, nationally, around dental supply and demand. The original work was published by Howard Bailit who we lost a couple of years ago, just a premier scholar in understanding and predicting the dental safety net across the country. He and his colleagues, back in 2006, quantified the degree to which we were undermatched with supply and demand. The 2006 data showed an estimated 82 million underserved Americans. The good news, if you fast forward to 2018, we see a drop in uninsuredness from 17 to 10%. He passed away a couple years ago. We don't have new data, but I feel confident in saying, the degree of uninsuredness, at least as operationalized with access to insurance, has dropped. What we don't really know is how that impacts dental insurance.

When we look at who is seeing the dentist annually, back in 2006, it looked like around 27, 28% of Americans were seeing a dentist once a year. That's about 22.8 million lives. We do know that dental visits are down by about 7% for everybody. The American Dental Association has a great group, the Health Policy Institute, they spend most of their time finding really great reliable datasets of the US census and National Center for Health Statistics. What they have been able to demonstrate is a byproduct of the great recession shows that dental visits went down for everybody because people lost their benefits or they had to make decisions about how they spent their discretionary spending. I guess they figured out that if they went a year without going to the dentist, their teeth, in fact, would not fall out, that their health would not demonstrably change. Unfortunately, that holds true for a year, but it doesn't hold true for necessarily 10 years without going for care. We don't see where dental visits have rebounded in the same way that other types of health care seeking behaviors have.

Let's get to capacity, which is really the more sobering, impactful part of this formula. It's acutely felt in Rural America. Back in 2006, we looked at capacity. Howard Bailit and his team operationalized that the safety net back then had a capacity to see seven to eight million people. We've got, automatically, a bottleneck in a crisis. In '18, we really don't have new data other than, again, I will applaud HRSA from expanding their portfolio a funding, particularly, for FQHC. The FQHCs might grow their dental clinic footprints in the communities that they serve.

I'm very interested in seeing new numbers in what that distribution looks like relative to rural versus urban investments to our community health center colleagues. When you think about expansions and you estimate the number of new labs that we think they'll see is in the order of 2.5 million, but what Howard Bailit and his team ultimately walks away from in 2006 and I think hold true in 2019 is in Rural America, we're never going to have the capacity we need to address the need.

Many communities have to look to their private practitioners to meet that demand. A number of us are working with our rural private practitioners to modernize their practice management principles to equip them with patient management techniques that can ... I don't want to say safely but certainly, cautiously grow their capacity for seeing patients who have Medicaid or uninsured in ways that don't threaten their own financial viability. We're seeing that demonstrate real dividens and Paul will talk about that a little bit later as it was a part of the site visits that were conducted by the community here in the Carolinas. If you don't believe me, which is fine, you can believe the New York Times and the Washington Post and other important national medias that are drawing attention. Not just to the oral health crisis in our country but how it, uniquely, is impacting Rural America and folks who are in underserved community.

Let's talk a little bit about how we might impact this through policy and practice. Again, citing the American Dental Association, we know, nationally, that 39% of dentists participate in Medicaid. That's ADA data. What is less clear is the rural urban breakdown. That's much harder to calculate. We recently attended a meeting sponsored by the National Rural Health Association and funded by the DentaQuest Institute. This became a space of information that we identified we just don't possess. I'm working with a wonderful person named Sean Boynes that, maybe, many of you knows at DentaQuest. We're trying to figure out how we might go about creating that measure at the state level and certainly, at the national level trying to get a sense of the degree to which rural dentists are enrolled and actively engaged in Medicaid care compared to urban. I know when I look at my own state's Medicaid claims data, it is obvious to me that you cannot be a successful private practitioner in rural South Carolina and not see our Medicaid brothers and sisters.

Related to that, we see some interesting things happening nationally. We see a decline in preventive services for rural children. That sobering statistic when you compare from 2007 to 2012, we also see parent reported oral health status remaining lower for rural than urban. I can attest to this, again, from South Carolina's perspective. I routinely monitor our Medicaid claims data and look at rural versus urban comparison so that I've got a good sense of what's going on. I'll tell you, from a broader EPSDT perspective, rural has always underperformed urban. Meaning, our rural children have much fewer well child visits than their urban peers. That slide happened around 2003. Some interesting things have happened. Thanks to both state and federal policies that had fluent well child service seeking behaviors. I'm pleased to report that for our urban kids in South Carolina. We see well child visits including preventive dental visits to start to rise and make the turn that we hope to see, but we don't see that for rural.

We continue to see an exacerbated inequity of dental service utilization for our rural children in our state. Where that's becoming more concerning is the first time in 10 years of data, we're seeing a rise in presentation of emergency rooms for unmet dental need for our state's children. That is exactly what you don't want to see kids. Our good friends and colleagues at the WWAMI Rural Health Research Center help contextualize this for us a few years ago. We've explained what we're seeing in utilization. It has a lot to do, again, with the availability of the dental workforce. I oftentimes like to go to the federal government's body of publications because it gives me guidance and justifications of actions I can take at the state level and certainly, at the region level. Several years ago, I believe it is 2008, the ION produced a compelling report titled, Improving Access to Oral Health Care for Vulnerable and Underserved Populations.

Unless I missed it, this was the first time that I observed as a rural health researcher, the ION really draw attention not just to oral health but the intersection of oral health and rural communities. This was an exciting publication for me. There's two recommendations I want to highlight for you. Again, this document is now 10 years old. It's interesting to me to see how far we've come and really what the next chapter from a policy perspective holds for us. The first is investments in dental education program. At my institution, is it a great fraternity or sorority, if you will, of other institutions of higher learning that that has successfully competed for predoctoral training grants in general pediatric and public health dentistry. If memory serves, there's about 12 of us who received this funding that comes directly from HRSA's Bureau of Health Care Workforce. There's many more than just the 12 of us that are benefiting from this funding, but this cohort of 12 that decided to really focus on strengthening the clinical, the business and the cultural acumen of our dental students for rural practice.

That aligns nicely and we hope was responsive to what the ION recommended that we do and that equip our students for that type of practice, but do so in the context of community-based and interprofessional teams. We've been very deliberate about that. The other piece to that though is, we can only confer competencies that our own faculty model and provide examples for, and I think that this is a space where, HRSA has certainly made investments around recruitment and retention of faculty. I think we can do better and work stronger to ensure that our faculty, if they do not come from rural areas, are entirely comfortable in understanding rural practice. Of course, recommendations for, calls for improved funding for Title VII initiatives, which is the funding pathway to achieving the recommendation three.

Thinking about that back here at my own institution, we took that in report. We married it with another important document to us, which is our first report that came out in February of 2014, The Integration of Oral Health and Primary Care Practice. What we discovered in our own survey of our dental students, our residents and our faculty is, while they may understand the community nuances of engaging at either private practice or FQHC-based dentistry, they did not necessarily understand the nuances and the unique attributes of rural health care system. They couldn't tell me the difference between an FQHC and an RHC. They didn't know what a critical access hospital was. They didn't understand the economic, the cultural and the policy drivers that in form and shape the way rural systems function and behave. We really were deliberate in restructuring our own curriculum. We're in the process, now, of sharing that curriculum with our colleagues and other university settings.

Another space that, I think, folks have been proactive and really comes from the Office of Rural Health Policy. I've been blessed to be a part of the public-private partnership initiative that actually began in the White House Rural Council in 2013. That group, along with leadership from the National Rural Health Association and the Office of Rural Health Policy, they came together to really build out an agenda of how private philanthropy could partner with public entities such as the federal government or even state governments to blend resources to address rural health priorities. Something really important happened in 2014. The Office of Rural Health Policy and NRHA facilitated a priority discussion. Of course, the laundry list of things to do in Rural America is lengthy, where do we even begin.

We engaged members from the great makers and health membership and those of us who care about rules to talk about what that blended funding might look like. What emerged was, the priority of health disparities, which was very broad and important but oral health came in second place. A very specific demonstration of an unmet need in a local health care system that we're inadequately prepared to address it. From there, that group went about a pilot demonstration that maybe many of you knew about, but in the world of oral health, my colleagues at the Duke Endowment walked away with me feeling inspired. The Duke Endowment is our region's largest philanthropy. They make health care and higher education

investments in both North and South Carolina. We walked away from this meeting with an 18-month very deliberate planning process where we reviewed lots and lots of the data.

We also examined the political will of our, let's say, dental associations, our hospital associations, our medical leaders, our state offices of rural health and their own board of trustees. What emerged was a pretty fantastic oral health portfolio that we're just now implementing. One is a school-based oral health program expansion. Both states have some models of comprehensive school-based oral health programs. The Endowment set aside a considerable amount of their own resources to fund these types of programs in the states. We have leveraged the examples of HRSA. Historically, HRSA has funded comprehensive school-based programs that gave us a blueprint for how we might evaluate the impact. Those investments have been deliberately made in rural underserved school-based settings, again, in both Carolinas. I want to skip to see and come back to the second one.

We also set aside some small resources to create a two-state research consortium that might advance evidence-based oral health policy. We pulled together friends from both the North and South Carolina rural health research centers to do a pretty extensive primary data collection where we identified many of the information needs that the states need to advance evidence-based oral health policy such as research that would help inform our state Medicaid programs to bring their adult dental benefits into alignment with evidence-base practice. Integrated care models served as the third leg of this oral health portfolio, again, that we are actively implementing. This is what it looks like as a proof of concept in a demonstration. The Endowment, along with our state Medicaid program felt convinced based on the meta analysis that we had done for our state Medicaid program that integrated care models, even in a rural underserved areas, could be self sustaining if we focused on population priorities where we know the evidence supports the integrated care approach.

We settled on diabetes. In the world of diabetes, we know, again, the underlying trigger is inflammation. Inflammation is bad for diabetes. It is bad for periodontitis. They have a bidirectional relationship that are inextricable. This might be the first time in my professional life where I've done intervention research where I didn't have to convince a policy maker. The policy maker was almost ahead of me and was directly involved in driving the design. When we were talking with Medicaid and the Duke Endowment about where we might launch an integrated care model pilot tested in a rural system where we could demonstrate the introduction of oral health as a part of comprehensive diabetes management, there was no question we would go to the McLeod Health, which is a large rural health care system in the middle of the Pee Dee region of our state.

McLeod also had the fortuitous benefit, although this was not a part of our original design, but it operates an independent rural family medicine residency. We have built what's called the Molar Program and Molar Sense for the McLeod Oral Health Leadership & Referral Program. There are four pillars to this work. Clearly, it's the integrated care delivery concept whereby this particular practice has constructed a three-chair dental operatory in their rural family medicine residency building. As the patient comes in for diabetic care and primary care has done everything you can to address the A1c elevation, they now have readily available to them dental care that can be attained on the same day. We have an integrated residency-training program now.

They have hired a rural dental medicine faculty member, Dr. Jamie Driggers. Her first day was just this month. Dr. Driggers will split her time between providing direct patient care for the patients I just mentioned, but also participating in the education of the family medicine residents. In that space, she will teach these residents what they can do within scope of practice to address unmet dental needs and tee up the patient to a place of readiness and empowerment to receive dental care. Of course, money and policy are, by far, the two most

significant drivers of the success of an integrated care model. I mentioned, we've got the Duke Endowment making that initial investment. We as a college of dental medicine, are there very regularly providing the technical assistance they need for successful launch and implementation. Again, we've got Medicaid who is very engaged working alongside those of us who are doing the evaluation and are reflecting on how they operationalize either their own policy levers as a Medicaid agency or constructing contracts with MCOs to institutionalize oral health as a component of comprehensive diabetes management.

What's compelling about this project is, it's being implemented in a portion of our state where it literally has half the dental workforce of the other regions of our state. There are places where patients live that are in the McLeod service area where dentists are not readily available. We try to always ground this work in the humanistic part of it all. Very quickly, just two patient stories out of McLeod that serve as motivators for this new rural demo medicine faculty member, the residents she trains and the physicians that she works professionally with. As we were getting ready to frame and build this model, the director of the Family Medicine Program who is a saint of a human being and just a real visionary for how integrated care can work in rural South Carolina, for sure, shared with us the story of a woman, a middle aged woman, who really had no demonstrable co-occurring morbidities walked into his practice with such fasciitis and sepsis that he had to admit her. Within six hours of admission, she died.

Well, there's so many illness that are compelling about her story is, her death certificate will never read the true cause of death, which is untreated abscess. The cause of death on that certificate is going to read fascitis and sepsis. We get sensitive here in rural South Carolina and certainly in other national forums that we find ourselves when we talk about the Deamonte driver who was the young man from Maryland who died from dental infection and an abscess that traveled to his brain. We get frustrated when we talk about the Deamonte driver as though there have been those subsequent deaths from unmet dental disease. Here is a woman in our own community who died from untreated disease. If the humanistic elements of her story doesn't get the attention of policy makers and clinicians, we've got another one that was even more recent.

They had a senior adult who lost a lot of weight rather in a short amount of time. The residents and supervising faculty did what good primary care clinicians do. They launched every diagnostic tool at their disposal to try to figure out what is going on with this older man because he was reaching a weight off limit where they were really worried about some other things going wrong. They were perplexed because none of their diagnostic tools really gave them the information they needed. Dr. Jebaily said, "Well, now, hang on, we got weight loss and we've got inconclusive imaging. Has anybody looked in the mouth?" Sure enough, a very simple and basic oral examination revealed that this man's dentures had stopped fitting properly. He had been wearing them. What resulted was infection, inflammation and such irritations that he could not even gum food. He stopped wearing his dentures. He stopped eating whole foods and began living on a diet of baby food.

What was needed was either new dentures or a fitting adjustment that would've caused anywhere from two to $700. What ended up happening, and for this case, is the patient or I should say the system whoever was paying the bill, incurred $25,000 in diagnostic cost, which, really, were unnecessary because all that was needed was a basic oral examination. I guess what I'm trying to say is, there are humanistic imperatives. There are cost imperatives. There are patient safety imperatives for rural health to really support integrated care models. I have long contended, it is the rural health care system that is most nimble, better equipped to engage in this type of care transformation because in most places, it is the rural health care system that is triaging and managing comprehensive health in uniquely different ways from even academic

institutions like mine. I'll stop sermonizing, Paul. I will transition back over to you or to Ben. I think I'm cue to send it over to Paul.

Paul Moore: Acknowledging that the breadth of programs related to oral health at the federal level deserves a full seminar in its own right, I will briefly cover only the federal programs that relate to the committee's recommendations to the secretary on rural health. Now, please note that this is, by no means, an exhaustive list of all federal programs related to oral health. The two programs with a notable emphasis on oral health within the administration for children and families are the dental health requirements within the headstart program and the health professions opportunity grants within the temporary assistance for needy families or the TANF program. Head Start grantees are required to meet the following performance standards related to oral health to determine a child's oral health status within 90 days of enrollment, to get early and periodic screenings and treatment from a dentist to establish a partnership with the child's dentist for care coordination and to ensure the development of a treatment plan for dental care.

In the TANF health professions opportunity grants, they provide funding to train TANF recipients and health professions including oral health fields such as dental hygiene. Another agency, the Center for Disease Control and Prevention promotes proven interventions to reduce disparities in the right of cavities including providing support for states to maintain basic infrastructure. Coordinating a dental sealant program targeted toward youth at high risk for cavities and promoting water fluoridation and collecting surveillance data on oral disease burden. CDC also works to integrate dental public health into a national dialogue focused on broad health system transformation, which includes pursuing better integration with other chronic disease programs and with medical care. Additional core CDC functions include tracking the right of cavities and other oral diseases, developing and promoting adherence to infection prevention and control guidelines and supporting a dental public health residency program.

Over to Center for Medicare and Medicaid services, CMS, they play an important role in serving Rural Americans. High rates of poverty and an aging population are persistent concerns for most rural communities and many rely on CMS programs that provide health care coverage. For example, Medicare, child health insurance program and Medicaid. They are constantly refining the collection and analysis of data and quality measures related to the delivery of oral health services provided through these plans. Most notably are the quality measures and the pediatric dental program, P Dent, which measures each state's progress on the right of enrollees ages one through 20 who have received a preventive dental service. Second one being SEAL, which tracks the right of enrollees age six through nine years old who got a sealant on a permanent molar.

CMS supports the inclusion of sealants and continuity of care in electronic health records. They provide technical assistant support for states that are testing value-based payment approaches for the inclusion of oral health services through Medicaid. They sponsor the oral health initiative, which seeks a 10% increase in the proportion of Medicaid children receiving preventive dental services of 2018. The health resources and services administration, the reason I stumble on that as we just call it HRSA, is one of the largest agencies in the federal government dedicated to addressing issues related to the access of oral health services. HRSA's Bureau of Health Workforce, Ryan White HIV/AIDS Program, Maternal and Child Health Services Bureau along with several other offices and bureaus have programs and grants that focus on the many barriers to quality oral health.

Most relevant to the upcoming recommendations are the rural health research centers that are funded to HRSA's Federal Office of Rural Health Policy. These are the entities who provide the much needed research to advance evidence-based policy decisions and all levels of government. Finally, I'll mention the United States Public Health Service Oral Health Coordinating Committee

that's housed within the Office of the Assistant Secretary for Health. This committee is tasked with coordinating and directing at broad range of oral health policy, research and programs within the United States Public Health Service, across federal agencies and between the public and private sectors. One of the most recent actions of this committee was their 2014 through 2017 oral health strategic framework for the Department of Health and Human Services.

Now that I've introduced you to these programs, I want to introduce, Ben, then to present on behalf of the committee, committee's recommendations to the secretary of health and human services on this subject.

Ben Taylor: Thank you, Paul and Amy for setting the state for the committee of recommendation on this topic. During our meeting in September, the subcommittee on rural oral health traveled to Winnsboro, South Carolina with the Winnsboro family dentistry graciously hosting our meeting. Winnsboro is a city of approximately 3,500 people relying in the wetlands region of Fairfield County, South Carolina between Charlotte, North Carolina and Columbia, South Carolina. As I alluded to previously, the committee cited the oral health and was hosted by the Winnsboro Smile Family Dentistry which has operated downtown Winnsboro for nearly 35 years, but other community and state organization were present as well and the representative of oral health and primary care practitioners, they've helped employees and helped administrators.

During the discussions at Winnsboro, the oral health practitioners appear to show a consensus on the importance of Medicaid programs coverage for endodontic treatment such as root canals. We all know, a lack of coverage for these services leaves dentists to recommend tooth extraction instead, a cheaper but potentially, unnecessary alternative. Dentists from Winnsboro Smiles all family dentistry and Fairfield Family Dentistry know that their initial lack of experience providing dental care to rural pediatric patients. These practitioners felt that dental school curriculum, which emphasize community-based training would have been beneficial during that all matriculation. They attributed that current confidence working with this patient population to be a more experienced mentors who have established practices in rural communities.

A stakeholder from how mental health summarize the biggest challenge in bringing dentist to the rural community by stating, "The cost of education is getting out of hand, opening a dental office is an expensive endeavor and Medicaid reimbursement is not enough to justify the cost of running the practice." Input from South Carolina State Office of Rural Health also attributed the separation of medical care, mental health care and oral health care as an important consideration in tracking dentists to the rural areas. We have five recommendations as our committee put together. Recommendation one, one of the most notable challenges mentioned during a meeting in Charlotte and Winnsboro was a difficult starting a dental practice in rural regions. Primarily, due to educational debt, high start of cost, small economies of scale. Therefore, in addition to the educational loan support provider from programs such as the National Health Service Corps, the committee believe that dedicated capital grant program for dental practitioners starting or expanding practices that needed to ensure accessible health care for this population.

An example of PATH funding through HRSA, which could be used as a model to expand and go was the HRSA Oral Health Workforce grant received by Winnsboro Smile Dentistry from 2015 to 2018 through South Carolina's Rural Oral Health Enhancement and Delivery Systems Program. Winnsboro Smiles previously did not accept Medicaid patients until receiving this grant or they were to pay crucial funding to accommodate them into their practice. A 2012 study for approximately 1,000 Medicaid eligible rural children who participated in Head Start led by none other than our own Amy Martin, found a higher percentage meeting their oral health care needs compared to nine Head Start children. In addition, in fiscal year 2017 at the enrollment in the Head Start program, 89% of children had access to a dental home and 90% were enrolled in

either Medicaid, the Children Health Insurance Program or better known as CHIP or a state funded health insurance program.

The committee recognized that rural Head Start programs are achieved in success and their students getting access to the assessment and treatment. However, the proceedings of the site visit in Winnsboro indicate that there are still barriers to care particularly in the most remote community. We recommend the best practice to assessing quality and reliable oral health care in this study be disseminated to rural health start grantees and also implemented in their Peer-to-Peer Technical Assistance Training Program. A significant body of research has shown there is less access to dental coverage treatment and insurance in a rural community compared to urban and suburban communities. As a result, patients may delay dental care and have higher likelihood in going to the emergency department for treatment of acute dental pain depending on the geographic location. As I work in emergency department, I can totally attest that we see them everyday.

During a stakeholder meeting in the Winnsboro, South Carolina, local dentist and medical practitioners also mentioned dental pain as a common avenue for misuse in prescriptive opioid. A 2015 study found that 50.3% of patients who present with non-traumatic dental pain in an emergency department received an opioid prescription compared to only 14.8 of other emergency department patients. Thus, the committee suggest further investigate in its difference in the use, misuse and prescribing opioids for dental purposes in rural regions as this may be an important contributor to the ongoing opioid epidemic. Limited research exist on the availability and scope of dental benefits offered through Medicare Advantage Plan. The use of private supplemental dental coverage, utilization of services, access to providers and the cost of care in rural versus urban areas.

HRSA should pursue research studies using available federal data sources such as Medicare current beneficiary survey, Medicare advantage enrollment and benefit files to better understand the provision of dental care among rural Medicare beneficiaries. The most recent publication from the Oral Health Coordinating Committee was the 2014 through 2017 oral health strategic framework for HHS. Although the third goal within this framework was to improve quality and access to oral health care a few specific references were made to rural communities except there are difficulties to accessing transportation, AHEC efforts to facilitate rural health initiatives. The committee believe as an interagency effort initiated by the OHSCC is necessary to address the unique challenges in improving oral health in rural and tribal areas of the country. For example, fluoridation initiatives for individuals who use well water or even non-communal water systems. This action plan will coincide with the surgeon general's upcoming report on oral health and the Indian health service soon to be released oral health strategic framework for 2018 to 2027. I think I'm turning it to back over to Amy. I'll give it right back to you.

Amy B. Martin: Thank you, Ben. In the limited amount of time we have, I have more slides that I'm going to address. I just would like the opportunity to demonstrate how my state has responded to the many federal frameworks and policies that both Ben and Paul have described in hopes that folks of you who either work for state offices of rural health or rural advocates can think about your next steps as the different grant and policy opportunities reveal themselves. We did not have success overnight. This has definitely been a journey with extensive partnerships that include our Public Health Agency, our Medicaid Agency, our Dental Association, our Hygiene Association and others, but because of CDC funding in 2012 and '13 that was awarded to our Public Health's Division of Oral Health, we did an oral health needs assessment. We had the benefit of comparison and we found that we were closing a lot of gaps that are notorious in oral health disparities such as race and income.

We were really doing a great job of closing that gap, but the rural inequities appeared to persist. We became deliberate about addressing that gap. Some important body of works came out of HRSA and HHS in 2014. As Paul mentioned, the framework for oral health was released. It just expired in 2017. I know HRSA particularly, God bless the Chief Dental Officer doctor and they were weary of me asking, "Where's the next framework? Where's the next framework?" We need that because we take it very seriously. We do set the frame and ground state policy, community priorities and leverage for bringing to their partnerships on the public and private side. These are not just documents that sit on shelves. Those of us from the trenches do use them to advance science practice and policy. In the same year, the integration report came out. I mentioned that previously.

In 2015, we were able to use these documents and oral health needs assessment data to successfully compete for the oral health workforce grant call that both Ben and Paul mentioned, the Winnsboro practice is a part of the ROHADS initiative. Again, that stands for Rural Oral Health Advancement Delivery System and then Road Trip is the derivative training component for our predoctoral training program. I've already described the public-private partnership in the Duke Endowment portfolio. This is all of these documents laid out, so you can see the lifecycle of this type of work with the documents of '14. Then in '15, Qualis gives us a blueprint for oral health integration into primary care, which we found to be interesting and the subsequent implementation got to be theoretically relevant, but what was missing from those Qualis documents was the translation for the rural health clinic or the FQHC. It, really, was geared towards large group practices that we found a lot of opportunities to improve for rural practitioners.

Fast forward to 2017, DentaQuest and the NRHA gets serious about that and publish best practices on how to integrate or facilitate oral health interprofessional practice in rural settings. Of course, now, we've got our document that's come from the National Advisory Committee on Rural Health and Human Services to bring this all home for practical implications. Again, I've mentioned these reports, but I just want to emphasize, again, the importance of policy alignment and when the federal government publishes these works, we take them seriously, so seriously that in our state, the body of work that has resulted from these important federal documents are real-time manifestations. In 2017, we were able to expand the oral health screening and examination requirement that's a part of a well-child visit from 13 to 21 because we know that as children in their adolescence, the defiance manifest in many ways. One of which is going to the dentist. We need rural health clinics and rural primary care providers to continue that messaging in the adolescence and to the valued importance of good oral health and hygiene.

We also were successful in restructuring how we reimburse for risk assessments and fluoride varnishing so that it's easier and more convenient for both the primary care provider and the patient. Finally, through our McLeod experiment, we're demonstrating the intersection of perio care and diabetes management and how that might manifest into important and significant cost savings to the MCO or to Medicaid. We're living this in real-time. This work matters, but it does take a well-choreographed, well-coordinated effort amongst all the partners that I mentioned at a state level with leadership and technical assistance and frameworks from the federal government. We're just so grateful in our state that we have enjoyed the success that we've had, but it doesn't happen overnight, for sure. On that note, Paul, I'm going to pass the globe back to you to bring it all home.

Paul Moore: Thank you, Amy for highlighting the best practices in your own home state in South Carolina. We appreciate the work you and others are doing to expand the research and policy for the benefit of our rural communities. Ben, thank you for your presentation of the recommendations on behalf of the committee and for your work as the subcommittee chair for this topic. Before we

move into the Q&A session, please remember to visit the committee's website on this upcoming slide. There you go. To learn more about the committee and to read up on the committee's previous work. At this point, I'll turn it back over to Kristine for some Q&A. Kristine.

Kristine Sande: If our presenters are able to stay with us for a few minutes past the hour, we can open it up for questions. Anyone not able to do that? All right. Then we will open it up for questions. A Q&A box should have appeared on the lower right-hand corner of your screen. You can use that to enter your questions. We do have one question that came in over the chat while we were doing presentations. Amy, this relates to one of the examples you gave with the dentures and the need for denture fitting. The question is, "Does Medicare cover dentures and the procedures needed for the dental fitting?"

Amy B. Martin: Oh, that's a great question. I just want to make sure that I heard Medicare.

Kristine Sande: Right. Medicare.

Amy B. Martin: There's no dental benefit in Medicare. There's no real opportunity to address that need. Now, depending on what state you're in, your state Medicaid Program might pay for dentures if you are eligible for Medicaid enrollment. What's important to know about Medicaid benefits is, generally speaking, the federal guidelines around pediatric dental benefits are pretty consistent across all 50 states. Everybody has to abide by the same rules. The Affordable Care Act codified a lot of that, but it really is the wild west on the adult side because it's an optional benefit. Adult dental programs in Medicaid are not mandatory benefit structures. A state like mine is very limited and I'll tell you we absolutely do not pay for dentures, but if you went to another state that may be expanded Medicaid or just has a different pay structure, there may be a denture benefit, but it really varies by state. Medicare does not pay for that.

Kristine Sande: All right. Thank you. Just to remind the speakers to mute their lines while we're hearing from other speakers. It helps with some of the audio issues we're experiencing, I think. The next question is, "How have dental hygienist contributed to your integrated health model and rural oral health goals in South Carolina?"

Amy B. Martin: That is a great question. I can answer it two way. At the McLeod example, again, this was not part of the original design but we fortuitously fell into it. There is a fantastic hygiene training program in town at the local technical college. We're in the process, now, of working out an enhanced learning opportunity for those hygienists who will surely strengthen their competency skillsets in chronic disease management. Whereby, as an elective, those hygienists in training, if they wish to come over to McLeod and train alongside those family medicine residents and I think, interprofessional screening, cleaning, et cetera, then they're going to be invited to do that. The new faculty that I mentioned is working to coordinate that right now.

Yeah. I am unaware, at least, of any place else where, in a rural system, hygienist and family medicine students are learning side by side under the chronic disease management model. That is going to be fantastic. We're very, very excited about that. On the existing practitioner level, we couldn't do integrated care without the demonstrable contributions of hygienist. We've mentioned ROHADS now a few times, Winnsboro being one of three of those ROHADS initiatives. We walked into that work thinking that it would be the primary care providers who would demonstrate the leadership in integrating care model. It would be the dental playing catch up. What we found was not expected. RHCs and I know preaching to the choir are operating at such a thin margin to ask them to take on additional duties is very difficult. What the partners figured out is, if we let our hygienist really run blocks, so to speak, and work closely with those RHCs, then they were more successful in transitioning patients from primary care

into dental settings, and it became that hygienist to really with the oral health educator in chief on the team.

What we're doing now is exploring the second generation of that hygienist role in the integrated care model and what a virtual handoff might look like. I have to give credit, again, to DentaQuest who's really studying this and what is the best way to handoff a patient from primary care to dentistry and what they are learning. It is a warm handoff, but a warm handoff is not always practical in rural. At least one of our ROHADS practices, we're equipping them with the telehealth conference line so that as the RHCs identifying a patient who needs dental care, she can dial up the hygienist over in the dental practice and have a personal introduction to the patient to the hygienist who can then go ahead and collect some basic patient information to give that referral process. While that's important from a calls and practice efficiency perspective, man, there's just no substitute for being introduced to the hygienist who's going to take care of you at your next appointment. That's been very exciting for us to observe.

Kristine Sande: Thank you. The grad level certification in safety net practice, do you have any numbers on integration and are those MDs or DMDs? Can you tell us a little more about that?

Amy B. Martin: Sure. With our predoc training grant, we created an online certificate program for our dental students. When I came to the College in Dental Medicine in 2014, we really didn't have anybody going into the National Health Service Corps. In fact, the class of 2014, out of 75 dental students, 22 were going into the military for loan repayment. While that is a prestigious career decision, if loan repayment was the primary motivator for enlisting, well, we felt like we had a different opportunity that we needed to make available to our students in the four sets that's a National Service Corps. We created this curriculum. There's four courses in safety net and rural dental practice management, dental leadership in the safety net, oral health policy, and then last but not least is a great interprofessional course titled, Poverty and Health Care Consumerism. It's in that class that we teach empathy as a clinical skill. That is the only of the four courses that's open to all health profession students here on our campus. The other three are exclusively designed for our dental students. I don't have the numbers off the top of my head.

We launched it in 2015 with our first cohort. We've just graduated two classes. Each of those two classes, we have had one student to go into the National Service Corps. We're now two for two with applicant getting accepted into the corps, which pleases our soul and both are practicing in rural South Carolina.

Kristine Sande: All right. The next question is, "Are you aware of work being done to implement extensive oral health education in the education of primary care providers such as in medical school or during family medicine residency programs?"

Amy B. Martin: Yes. I actually just had a conference call with that team a couple of weeks ago on the heels of the National Oral Health Conference. I spoke with a wonderful person named Kristine Reedy. I think what they are doing is offering technical assistance both in terms of curriculum design as well as evaluation services for residency programs and other institutions of higher learning who wish to take on integrated care curriculum. We had not been aware of them, HRSA helps connect those dots. We have reached out to them and have offered to share our lessons learned with what we're doing at McLeod. I'm not sure what they're really is in the rural. We might contribute something a little different to the products that they're working on. I'm excited about the reciprocity of that investment that I think HRSA has funded and support with what we're doing with Duke Endowment Dollars.

Kristine Sande: The program you were talking about, that's the Center for Integration of Primary Care in Oral Health. Is that correct?

Amy B. Martin: Yes. Yes.

Kristine Sande: Okay. All right. Can you speak to any successes in implementing school-based oral health programs apart from Head Start or having health clinics and sites at schools that include dental care in their scope in rural areas?

Amy B. Martin: Oh, sure. Sorry, I don't have the publication on my computer activated, but there is a great publication that HRSA's contractor had published. Goodness. I think it was last year. I'm pretty sure it's a 2018 publication. It's in the Maternal and Child Health Journal that evaluates comprehensive school-based oral health programs as it is integrated into primary care based programs. That's a great document that gives a good blueprint for services, scope of services, availability of services and what are some reasonable expectations of outcomes. In fact, I had a slide dedicated to the school-based model that we're implementing and referenced that document. If you have access to my slides, I think I've got that publication cited on that slide, but it was helpful in tampering expectations that the Duke Endowment and some of our other partners that really were motivated to say, "Hey, we need to incentivize prevention services and not treatment services and that certainly is the world we all envision," but when you're walking into rural and underserved schools, you're walking in based on this data that was published in this MCHJ article. You're not walking into a world where you can start cleaning teeth. You have a high degree of unmet need that has to start with treatment in order to move them into prevention.

If memory serves, I want to say over the course of 40 years, this cadre of grantees that were supported by HRSA were able to move 55% of patients who were ready for prevention to 88%. That, literally, half the kids when they walked into these nine different programs across the country, half the kids had unmet treatment needs. Tampering expectations becomes really, really important.

Kristine Sande: All right. I think I do not see any other questions at this time. I think we will bring the webinar to a close. On behalf of the Rural Health Information Hub, I'd like to thank our speakers for the great information that you've shared with us today. I'd also like to thank our participants for being with us today. The slides used in today's webinar are currently available at the link listed on the slide. In addition, a recording and a transcript of today's webinar will be sent to you by email in the near future. You can listen again and share the presentation with your colleagues. A survey will also be included in that email. Thank you for joining us today and have a great day.