

**Health Resources and Services Administration  
Office of Rural Health Policy**

**National Advisory Committee on Rural Health and Human Services**

**Spring Meeting  
Atlanta, GA  
March 2<sup>nd</sup>-4<sup>th</sup>, 2020**

**Meeting Summary**

The 87<sup>th</sup> meeting of the National Advisory Committee on Rural Health and Human Services was held March 2<sup>nd</sup>-4<sup>th</sup>, at The Centers for Disease Control and Prevention in Atlanta, Georgia.

The committee members present at the meeting: Steve Barnett, DHA, CRNA, FACHE; Kathleen Belanger, PhD, MSW; Robert Blancato, MBA; Kari Bruffett; Wayne George Deschambeau, MBA; Molly Dodge; Carolyn Emanuel-McClain, MPH; Meggan Grant-Nierman, DO, MBA; Constance Greer, MPH; George Mark Holmes, PhD; Joe Lupica, JD; Brian Myers; Maria Sallie Poepsel, MSN, PhD, CRNA; Patricia Schou; Mary Sheridan, RN, MBA; Benjamin Taylor, Ph.D., DFAAPA, PA-C; Robert L. Wergin, MD, FAAFP; James Werth, Jr., PhD, ABPP; Loretta Wilson.

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: Lamar Greene and Anne Hall.

Ex-Officio Members: Scott Miller, MPA, Office of the Associate Director for Policy, Centers for Disease Control and Prevention; Benjamin Smith, MBA, MA, Indian Health Service; Lacey Boven, Administration for Community Living,; Aleta Myer, Office of Research and Evaluation, Office of the Administration of Children and Families; Darci Graves, MPP, MA, Office of Minority Health, Centers for Medicare and Medicaid Services, Diane Hall, PhD, MSED, Office of the Associate Director for Policy, Centers for Disease Control and Prevention.

**Monday, March 2<sup>nd</sup>, 2020**

The meeting was convened by Paul Moore, Senior Health Policy Advisor, Federal Office of Rural Health Policy.

**WELCOME AND INTRODUCTIONS**

Paul Moore welcomed the committee members and stated that Chairman Jeff Colyer, MD, was delayed due to a patient requiring emergency surgery but he would join the meeting later in the

day. The topics of the meeting are Maternal and Obstetric Care Challenges in Rural America and HIV Prevention and Treatment Challenges in Rural America. Paul thanked committee member Benjamin Taylor for hosting the visit.

**Jeff Colyer, MD**  
**Committee Chair**

**Chairman Jeff Colyer** apologized for being late to the meeting, but he had an emergency surgery to perform. He thanked the committee for allowing him to be a member of an organization that has served the country well for thirty years. There are unique opportunities for the committee moving forward. The committee members bring a tremendous amount energy and fantastic insight from across the country. He grew up in a small town called Hays, in Western Kansas. Growing up in Hays gave insight into the health needs for more than 60 million Americans who live in rural communities.

When first nominated for Chairman of the National Advisory Committee on Rural Health and Human Services, by the Rural Health Care Association, he met with the Secretary Azar and the Deputy Secretary, Eric Hargan. The Deputy Secretary was born in a rural hospital that does not exist anymore. The Secretary of Health and Human Services considers rural health as one of the great challenges of health care and has formed a task force looking at rural health care opportunities. The committee can work closely with the taskforce. The Secretary wants the committee to think broadly but also give specific recommendations that can be considered in a timely manner. This is a tremendous opportunity and the committee members will be asked to join conversations between meetings in order to discuss issues with the policy makers.

Chairman Colyer thanked the Office of Rural Health Policy and the National Advisory Committee on Rural Health and Human Services for building a great foundation.

**Benjamin Taylor, PA, PhD**  
**HIV Subcommittee Chair**  
**Committee Member**

**Benjamin Taylor** welcomed the committee to the State of Georgia. He stated that it is his last meeting as part of the Committee. Georgia is the number one producer of peaches, peanuts, and pecans. The sweetest onion in the world, Vidalia onion, is historically grown in Vidalia, Georgia. Georgia is the largest state east of the Mississippi. A fun fact is there are 71 streets in Atlanta with the name peach tree in them.

Atlanta is known as the birthplace of the Civil Rights Movement. Martin Luther King, Junior's birth home is on Auburn Avenue in Atlanta, Georgia.

The Masters Golf Tournament is held annually at the Augusta National Golf Club in Augusta, Georgia. The tournament was founded in 1931 and is on the site of a former indigo plantation and commercial nursery named Fruitlands.

The population in Georgia is around ten million. Georgia's leading cause of death in 2017 was heart disease. Cancer and chronic respiratory disease are also leading causes of death. Infant mortality is 7.2% versus the United States rate of 5.8%. Females are more likely to live in poverty than males in the State of Georgia.

## **GEORGIA/SOUTHEASTERN ORIENTATION**

### **José Montero, MD, MHCDS**

Director of the Center for State, Tribal, Local, and Territorial Support  
Centers for Disease Control and Prevention

**Dr. José Montero** stated that Dr. Redfield sends his regrets that he could not attend the meeting. He was looking forward to meeting with Ambassador Young, Governor Colyer, and the Committee. Rural health is incredibly important to the CDC. The CDC continues to identify new areas to improve the health outcomes. The CDC coin is being presented to Ambassador Young on behalf of Dr. Redfield, to thank him for all his amazing work.

### **Ambassador Andrew Young, Jr.**

#### **Former United States Ambassador to the United Nations**

**Ambassador Andrew Young, Jr.** said that it is a pleasure to speak to the Committee because he is a child of rural health. His father was a dentist in Louisiana during the depression. He was born in 1932 and around 1937 the governor of Louisiana hired all the doctors and dentists and gave them trailers as mobile offices. As a child, he traveled around the State of Louisiana. His father would pull in front of the parish courthouse and connect to the electricity and water. A county public health nurse would line up the children so they could get dental care. It was a great upbringing and has affected him to this day. There were no bridges across the Mississippi River, so they crossed in fairies.

In the 1930's President Roosevelt initiated the Civilian Conservation Corp where they built levees along the Mississippi River. Even today, that experience still shapes his life. It made him very sensitive to the Mississippi River and the flood damage that it causes. Most of the work on the river was done in the 1930's and it was designed to last for fifty years. He stated that he will be 88 next week, so it is at least 80 years old and is crumbling. When he visits Louisiana, Memphis, or St. Louis, he is aware of the flood potential and how easy it would be to prevent if someone would pay attention. Last year, the damage done by the river cost 364 billion dollars. The Army Corp of Engineers estimates that the levy needs 125 billion dollars of repairs. He has warned to prepare for the flood, but no one is paying attention in political circles. He grew up reading Tom Sawyer and Huckleberry Finn and said that he really cannot get away from the river, and his public health experience is grounded in that.

Ambassador Young became a pastor in South Georgia. His first child was born in 1955, in Thomasville, Georgia, at the Archibald Memorial Hospital. He was a country preacher making about \$90 a month. He saved fifty dollars for the deposit for his wife to give birth at the hospital. They were not sure if they would have enough money for her to give birth at the hospital, so they started doing natural childbirth exercises. She did have their baby in the hospital, and they paid

the fifty-dollar deposit. When he checked out the next day with his baby girl, he was concerned on how he would pay the rest of the bill. He was told that he was receiving a refund because his wife did not even take an aspirin. They received wonderful health care in a rural hospital for thirty-two dollars. One of his grandson's was born ten years ago in Alabama and the family was covered by Blue Cross-Blue Shield of Georgia. When his daughter-in-law checked out of the hospital after a caesarian birth, it was around nine thousand dollars.

Ambassador Young worked with Dr. Louis Sullivan to start Morehouse Medical School. They convinced Senator Herman Talmadge that the Federal Government should invest twenty-five million dollars to start Morehouse Medical School. He still works with Morehouse Medical School to develop physicians with training and dedication to service for inner city and rural America. Over two-thirds of positions at Morehouse Medical School are women and they often invite him to their clinics. It was beautiful to visit one of the young physicians celebrated her birthday by inviting all the babies that she had delivered in the three years that she had been working in the county. She is an African American physician and the babies that she delivered look like America. They are every ethnicity and their families were from a huge variety of socio-economic backgrounds. Ambassador Young felt like he was viewing a revolution which is almost completed. A huge concern is the number of rural clinics closing on rural America.

Jimmy Carter's mother was a public health nurse in Sumter County, Georgia, which was 80% black. She considered all the babies that she delivered her children, so Jimmy Carter grew up thinking that 80% of his family were black. That was very unusual for a Southerner in the 1930's. The public health orientation of his childhood, added with his Naval Academy training, created a good President. Ambassador Young's father wanted him to be a dentist to follow in his footsteps. When he was sworn in as Ambassador to the United Nations, Thurgood Marshall told his father he must be proud of him. His father replied that if he would have been a dentist, he would have been somebody.

Ambassador Young shared that his son is involved in aquaponics farming which can grow enough food in a room to feed an entire community. Modern agriculture is going to be one of the methods used to heal the diseases of the future. While in the United Nations, he traveled all over the world and learned that people's diet and traditional methods of healing with herbs are vital.

The Atlanta Airport is the largest airport in the world and the busiest airport in the world. The airport did not cost the citizens of Atlanta or the United States anything. It was financed through Wall Street. This is called public purpose capitalism and there is no need to go to the government for money. There is more than enough money to solve the world's problems. Most of the money that came into Atlanta was from Holland. When Andrew Young was Mayor of Atlanta, the Dutch invested one billion dollars in the Atlanta Airport, and it was sold to Japan for around three to four billion dollars. Which is valuable evidence of the role public purpose capitalism serves in the community.

## **REMARKS FROM CENTERS FOR DISEASE CONTROL AND PREVENTION**

**Dr. Katherine Lyon Daniel, PhD**  
**Acting Deputy Director for Public Health Service and Implementation Science**  
**Centers for Disease Control and Prevention**

**Dr. Katherine Lyon Daniel** shared that the Director of CDC, Dr. Robert Redfield, wanted to speak to the committee but was called to Washington, DC, as part of the all agency activation response for Coronavirus. It took an event of this level to keep him from attending the meeting because he wanted to speak to the committee about the importance of public health in rural America.

Dr. Daniel said that she lives north of Atlanta in an area that used to be Norcross, Georgia, but is now called Peachtree Corners. It is gratifying to work at the CDC with people so dedicated to public health and their action-oriented approaches. Dr. Daniel led communications at the CDC for around eight years at the CDC before becoming the Acting Deputy Director for Public Health Service and Implementation Science in November of this year. It is a great opportunity to work more closely with those who are helping people on the front lines of public health. There has been an increasing recognition of the importance of rural health and different approaches, communication techniques, and types of tools for rural health audiences. The CDC looks forward to hearing the committee's recommendations and to many more collaborations moving forward.

## **NATIONAL PERSPECTIVE ON MATERNAL HEALTH CHALLENGES**

**Dr. Peiyin Hung, PhD, MSPH**  
**Assistant Professor**  
**Department of Health Services Policy and Management**  
**Arnold School of Public Health**  
**University of South Carolina**

**Dr. Peiyin Hung** thanked the committee for inviting her to speak about the important topic of maternal health challenges in rural America. She also thanked her colleagues from the University of Minnesota and the University of South Carolina.

The hospital obstetric unit closures have been a pressing concern in both rural and urban America. There are physical and mental health concerns for pregnant women and new mothers in rural areas due to travel burdens to hospital obstetric care. Childbirth is the most common and costly reason for hospitalization and there are half a million babies born each year. The total cost is twenty-seven billion dollars annually for hospital care and half of births are covered by Medicaid. The number of births covered by Medicaid in rural communities is even higher. There is a decline in access to obstetric services at rural hospitals and the potential effects include lack of prenatal care, long travel distances, higher costs, and higher risks of complications.

There was a decrease from 82% of micropolitan counties with hospital obstetric services in 2004 to 78% in 2014. In 2004, 40.4% of rural noncore counties had in-county hospital obstetric services available, but this decreased to 30.2% in 2014. In 2014, almost three-quarters of rural noncore counties did not have in-county hospital obstetric care.

Among the 19 hospitals that closed their obstetric units, the most common reason for closure was difficulty in staffing the unit, including retention, recruitment, and liability issues surrounding obstetricians. Other frequently cited reasons for closure included low birth volume, low reimbursement, and other financial issues, such as surgical and anesthesia coverage, the cost of operating the units, and budget cuts.

Counties that never had hospital obstetric services during 2004-2014 tended to have smaller area sizes. There are several clusters of counties across the country that had no obstetric services from 2004-2014. In some of these clusters, neighboring counties also experienced full obstetric services closure, potentially exacerbating access issues in these geographic areas. Black communities have the higher odds of closures. Compared to an average rural county, the odds were higher in counties with a higher percentage of non-Hispanic black women of reproductive age. Counties with one additional OBGYN per 1,000 reproductive age women had 14% lower odds of losing all hospital obstetric services. Counties with one additional family physician per 1,000 county residents had 12% lower odds.

A lower supply of family physicians in a county was associated with vulnerability to losing hospital obstetric services. Having one additional family physician per 1,000 residents could decrease a hospital's probability of closing its obstetric unit by 7.8%, and the probability of closing all hospital services by 4.7%. Family physicians are often the sole obstetric providers in rural areas, with over 39% and 75% of rural hospitals in Minnesota and Washington relying on them for cesarean deliveries, respectively. The study of rural hospitals in nine US states found that 55% of the hospitals had family physicians attending births, including 23% that relied solely on family physicians to provide obstetric services. In areas with physician shortages, a sufficient supply of family physicians providing obstetric care may allow hospital obstetric units to remain open despite financial stresses that may accompany serving low-income and low birth volume populations. However, from 2002 to 2010, there was a steady decline (20.7% vs. 9.7%) in the proportion of family physicians providing maternity care. This nationwide decrease in family physicians offering obstetric services may further exacerbate geographic barriers to obstetric care for pregnant women, particularly in rural areas. Counties with one additional OBGYN per 1,000 reproductive-age women had 14% lower odds of losing all hospital obstetric services. And those with one additional family physician per 1,000 county residents had 12% lower odds.

Rural America has the highest maternal and infant mortality rates. Black women are two to three times more likely to die from pregnancy-related causes than white women. Rurality residence exacerbates racial disparities in maternal and infant mortality rates. The continued loss of access to hospital obstetric services could exacerbate such racial disparities in maternal and infant outcomes.

Education is needed for women in rural communities during preconception and prenatal care to avoid the associated adverse maternal and birth outcomes. A continuity of care and perinatal care plan is vital for women in locations with hospital obstetric closures. Transportation options are essential between local hospitals and distant hospital obstetric services. Considerations of how to attract maternity care health professionals to health professional shortage areas in need of maternity care health services are important. Telemedicine could be very beneficial for mothers who do not have local hospital obstetric services.

## **MATERNAL HEALTH FEDERAL PROGRAMS**

**Dr. Michael Warren, MD, MPH, FAAP**  
**Associate Administrator**  
**Maternal and Child Health Bureau**  
**Health Resources and Services Administration**

**Dr. Michael Warren** said he appreciates the focus that the committee brings to rural health after spending the past fifteen years in rural Tennessee and growing up on a farm in rural Eastern North Carolina. He stated the Maternal and Child Health Bureau is viewing the maternal health challenge as Accelerate Upstream Together.

He has been at the bureau for fifteen months and is studying the previous work that has been done. A predecessor wrote, "Clearly maternal mortality is in great measure preventable. No available figures show a decrease in the United States in recent years, and certain other countries now exhibit more favorable rates". This was written in 1916, so 104 years ago there were the same conversations about maternal health. Colleagues who come after us in 104 years can't be having this same conversation. Women should not die as a result of becoming pregnant.

There are about 700 pregnancy related deaths a year. There are about 50,000 cases of severe maternal morbidity a year. Women's health across the life course must be considered if there is going to be improvement to maternal health. There is an optimal health trajectory that can be hampered by risk factors and, conversely, aided by health promotion factors. It isn't just about a personal health trajectory but intergenerational work.

Dr. Warren is a pediatrician by training and was an intern in the Neonatal Intensive Care Unit. On one occasion, an attending physician asked if he knew why a baby was premature. He knew the lab values and the physical exam of the baby for that day but not why it was premature. He was being challenged to think upstream and it was probably related to the mother's health long before she got pregnant. Young girls and adolescent female's health need to be considered before reaching childbearing age to improve birth outcomes. About 1/3 of 10-17-year-olds are overweight or obese. Almost half of young girls report one or more Adverse Childhood Experiences, and this is associated with chronic health conditions. Only 1/4 of women ages 18-44 have not had a wellness visit in the past year. There are many upstream factors, like these examples, influencing maternal health.

In public health, there must be a focus on prevention, and it is necessary to think upstream and consider primary prevention. Only 10-20% of health and wellbeing is from healthcare. There need to be places in communities to access healthy foods and ways to promote physical activity. The traditional clinical silos are necessary but not enough to support the health and wellbeing of people.

The CDC has done a great job of supporting maternal mortality review committees in states. The committees look at cases of maternal death and morbidity and look at the underlying

determinants and if they are preventable. Community change at the local level creates state and regional change and national improvement.

HRSA is one of several operating divisions in Health and Human Services and the Maternal and Child Health Bureau's mission is to improve the health and wellbeing of America's mothers, children and families. Title V Maternal and Child Health Block Grant rural health activities include support for community health workers, doulas and midwives in rural areas; oral health programs; and telehealth projects that support workforce development and access to specialty consultation.

In Fiscal Year 2018, The Maternal, Infant, and Early Childhood Home Visiting Program funded services in 22 percent of all rural counties, and fifty percent of all counties served by the Program were rural. In these voluntary programs, trained professionals meet regularly with expectant parents or families with young children in their homes, reducing burden on families living in geographically isolated communities who may typically have to travel far distances or navigate limited transportation options to access services. Home visitors evaluate families' strengths and needs and provide tailored services that may be more difficult to access in some rural communities.

Key Maternal and Child Health Bureau support includes The Healthy Start Initiative, Eliminating Disparities in Perinatal Health and Healthy Start Funding for Clinical Providers. Focused investments for Maternal Health include: The Alliance for Innovation on Maternal Health, State Maternal Health Innovation Awards, Screening and Treatment for Maternal Depression and Related Behavioral Disorders, Women's Preventive Services Initiative & Bright Futures, The National Survey of Children's Health, Remote Pregnancy Monitoring Challenge, Opioid Use Disorder Challenge, Rural Maternal Obstetrical Management Strategies, Health Center Program, and Workforce Initiatives.

The Alliance for Innovation on Maternal Health creates bundled opportunities in a community setting where women are accessing services. The MCHB grant challenges choose a topic and ask for applicants to send proposals. There are about ten recipients for phase one and they get a little funding to develop their idea. They narrow down from there to about five winners. For each challenge, there is an awardee which receives about \$150,000. There are fascinating approaches that are developed through these challenges.

**Carlis Williams, MA**  
**Regional Administrator, Region 4**  
**Administration of Children and Families**

**Carlis Williams** stated that the Administration for Children and Families has more than 60 programs that are administered throughout the United States. One of the primary priorities of administration is assisting families with economic mobility. It is important to work with the whole family and across multiple generations in order to understand what services are effective for clients across the states. It is also important to look at prevention across all programs. Workforce is vital for economic mobility and it is important for states to look at their services to determine the most effective way to work with families. Focusing on social determinants of



health and the factors that hinder good health outcomes is vital in assisting families. If people can't get jobs, healthcare, education, and access healthy foods, then they will struggle to maintain their health.

Region 4 is a very rural area and there are not enough services to address many of the problems. Transportation is a huge problem and without transportation people can't get to the doctor. All the ACF programs are working together to serve families and connect families to services. There is a lack of services in rural communities, so several states are creating strategies to better address the need for rural support. In Georgia, there is network of experts working to support rural health professionals with Alzheimer's patients. Mental health issues and substance abuse are a huge problem in rural communities and there is a lack of services. Health agencies must work with Human Service agencies in rural communities to guide and redirect funding. Consider how to work across agencies in leveraging resources through creative ways. There is a program in North Carolina with a focus on Point of First Opportunity Referrals and closing the loop on referrals so there is continual communication. It is part of the NC Cares 360 program and it would be beneficial to study the program, how it has been structured, and learn about some of the outcomes.

**Dr. Michael King**  
**Regional Administrator, Region 4**  
**Substance Abuse and Mental Health Services Administration**

**Dr. Michael King** stated that there are ten SAMHSA employees located in different regions. He spent sixteen and a half years at the CDC as an epidemiologist. SAMHSA is mostly known for block grants to implement state priorities. People need resources to make change in their communities and the regional administrator's job is to help people connect to the resources.

SAMHSA.gov gives information on available grants and grantees in different states. The site also includes national and state specific data, an evidence-based practices resource center, suicide prevention resource center, and treatment locator. The SAMHSA treatment locator includes all the facilities that SAMHSA funds. It is robust but not very user friendly. Findtreatment.gov had the same substance abuse treatment centers and is more user friendly. The suicide prevention resource center is important for rural areas because they have higher rates than metro areas. There is information on how to get involved in each state regarding suicide prevention. Resources specific to mothers with substance abuse are available on the website.

As part of Substance Abuse and Mental Health Service Administration's behavioral health workforce, there is a National System of Technology Transfer Center with experts available to answer questions. Before 2018, it was not open to the public but now anyone can access the system and there is rural specific information. There are also Centers of Excellence that focus on mothers and children.

There is a National Network to Eliminate Disparities in Behavioral Health that anyone can join and which assists in connecting and sharing information. It is a national network that includes sharing training information with each other. It takes everyone working together because the mission is too immense.

## Q&A

**Steve Barnett** said that there are many resources available but when people are working it is difficult to have time to find the information. The concept of Accelerate Upstream together is a wonderful concept. Most of the issues discussed are connected to mental health issues. Women's health and their level of obesity is probably connected to elevated cortisol levels due to childhood trauma issues. Mental health must be more of a focus and get more attention in order to deal with the health issues that are a result from past trauma.

**Dr. Michael King** said that at the end of 2019, SAMHSA hosted a rural resource round table event. People sharing information and facilitating conversations is going to make change happen. This is a historic time and there is more known about the addicted brain and how to treat problems.

**Dr. Michael Warren** said that Early Child Home Visiting and other programs are equipping parents to support themselves and their children and that lowers Adverse Childhood Experiences. Home visiting does not seem like a mental health program, but it is because it prevents the trauma that would have to be dealt with later in life.

**Kathleen Belanger** said that there are human service deserts and would like to hear about the human service programs in rural areas.

**Carlis Williams** responded that States are looking more closely at the true need of the family to design the services and working with the family related to their goals and how agencies can partner to help support these goals. Federal agencies can partner and work together around the services and leveraging resources. ACF is partnering with the food and nutrition services and with employment and training programs and focusing on social determinants of health and human services. States are changing their services delivery model, so it impacts the rural areas as well.

**Mark Holmes** asked Dr. Warren if he could share rural focused promising practices that have been revealed through the grant challenges.

**Dr. Michael Warren** said they are in the middle of Phase 2 and two big things that have emerged are the technology challenges in rural and how to transfer information across systems. A hospital may have an electronic health record and other practices in the area have health records, but they are different sets of information and not connected to one another.

**Dr. Jean Sumner, MD**  
**Dean**  
**Mercer Medical School**

**Dr. Jean Sumner** shared that she spent 28 years practicing in one of the poorest counties in the state. She was invited to be the Dean at Mercer University and saw it as an opportunity to serve

her state further and hopefully change rural health. Rural communities are tough, and they want your respect. They don't want anything for free or for anyone to fix their problems, but they need leadership and guidance. They do not trust many people outside of the area and are not respected across the state. She shared a quote by columnist that wrote, "Rural Georgia is Atlanta's thankless burden". She stated that the food he eats, and the lumber used to build his house is from rural Georgia.

Mercer University is over 200 years old, but the school of Medicine started forty years ago for primary care and health care needs of medically and underserved Georgia. Mercer has campuses in Macon, Savannah, and Columbus. Georgia has 8 counties without doctors, 12 counties without family medicine, 37 counties without an internist, and 75 counties without an OBGYN. It is 80-100 miles to an OBGYN in many rural counties. There is also a severe maldistribution of doctors.

Mercer's foundation of quality is primary care. The students are given a broad range of skills and are expected to be community responsive physicians. The focus is on patient centered care. In 2016, 42 students were medical students from rural communities. When she first became Dean of Mercer Medical School, only 12% of Mercer's medical school students were from rural areas. They became the first medical school in the country to partner with 4H which is a leadership organization. Now they have one hundred and seventeen students with 70% from outside of the metropolitan area. The young people who work on a farm or the car dealership in the summer and do not get to study abroad, do as well on their national boards as those young people with a 4.0 and went to a private school in Atlanta.

The State of Georgia is number one in the country to do business but is number fifty in the country to have a baby. The state has put a lot of money into rural health, but their outcomes have not changed. Last year, Mercer was awarded the Georgia Rural Health Innovations Center and it is available to everyone in the state. This is a way for the state to look at best practices and they were assigned to develop criteria for training rural hospitals. The curriculum must include access to maternal services, follow-up at discharge, and taking care of the patient until they can see their doctor. There are two major vendors in the state and with the first wave of training, there were resignations from hospital authorities across the state. They resigned because they did not realize they could have conflict of interest. Mercer is a Center of Excellence in rural health. Healthy Start South Georgia are the only providers of obstetrical services in the county they serve.

Some of the counties in rural Georgia have worse maternal mortality rates than third world countries. Women must travel 80-100 miles for care. There was a need to set up telehealth connections in some of these rural areas so the residents can go into the counties and the attending physicians at Memorial and Savannah could oversee the visits. There is a focus on maternal mental health. Dr. Jennifer Barkin is a nationally recognized researcher at Mercer University who created an assessment that measures how a new mother is functioning in her day-to-day post-baby life.

Hospitals across rural Georgia have closed and Mercer is committed to putting primary care clinics in rural areas. President Carter is a trustee and called the Mercer President to tell him that

they had lost their doctor in Plains, Georgia. A week later President Carter called back and said it had been a week and they did not have a doctor yet. There was a small clinic in Plains that was a concrete block building that was lime green. They refurbished the building and put in telehealth, hired a family medicine doctor and nurse practitioner. The clinic was booked for three months before it opened. It is drawing people for every surrounding county. They are committed to women services in every Mercer Clinic. They also make house calls for people who need them. A person who is one hundred years old should not have to sit in a waiting room and get the flu just for a check-up.

Mercer Medical School just went through strategic planning. The strategic plan is built around the grand challenges of rural health. Building trust is important in rural and it takes competence but most of all caring to build that trust. The system of care needs continuity, doctors that answer the phone and take care of their patients. The doctor – patient relationship is key and must be built around trust.

Dr. Sumner's grandfather went to Medical School at Emory and practiced in Sandersville, GA. Her father, Dr. William Rawlings, practiced in Sandersville for 42 years. Because she was William Rawling's daughter, she had the trust of the people in that community. A new, young physician who is not known in the community had to establish themselves and it is a lonely, hard job so it is important for them to have mentors to ask questions or get a second opinion.

There was a gentleman who was a brick mason who had never been out of the county. He had a serious heart condition and was going to die but refused to see other people. She told him that he needed to see a doctor at Emory in Atlanta. She convinced him to go to Emory to see Dr. King. She received a call from Dr. Hurst, who is one of the top cardiologists. Dr. Hurst told her that he had a problem because Dr. King went home sick so he had to work the clinic and that her patient would not let Dr. Hurst touch him unless she convinced him that he is a good doctor. She told him that Dr. Hurst was President Eisenhower and President Johnson's doctor. Her patient was quiet for a while and then replied, "Well, they're both dead". She did successfully convince him to allow Dr. Hurst to do the procedure. The important message is there must be trust and building of relationships with people in rural areas.

There are many ways to better support the health of rural communities. Health literacy and empowering patients is important. Patients cannot navigate a broken system. Social determinants of health are real and matter. There are food deserts in rural America. Hospital systems should be incentivized to support enhanced urgent care and continuity of care in rural counties. Health care transportation needs to be Uberized. Telehealth is important in rural Georgia and it needs to be integrated into the practices that are already in these areas. Health Departments need to be utilized and every resident needs to have a rotation in rural communities.

**Diane Durrence, APRN, MSN, MPH**  
**Women's Health Director**  
**Georgia Department of Public Health**

**Diane Durrence** thanked the committee for the opportunity to speak and share some of the maternal health programs that are underway at the Georgia Department of Public Health. To

move women's health forward in the state requires working deliberately and collaboratively. Many of the maternal health improvement initiatives are not happening in silos. Georgia Department of Public Health works as a central point of coordination for many of the initiatives in place.

The department is responsible for completing a review of maternal deaths in the state and responsible for the operations of the maternal mortality review committee that was established in 2013. The committee has completed reviews of maternal deaths that occurred from 2012-2015. There are about 25 disciplinary members of the committee. The 2016-year cases being reviewed currently, and the process has been revised to speed up the process including adding additional workforce and doubling the amount of review committee meetings. The 2016 and 2017 cases will be completed this calendar year. The goal is to complete 2018 and 2019 in 2021 and from then on, the deaths will be reviewed within a 2-year time frame. Key informant interviews are critical in order to speak to women who were close to the woman who died. This can give more context about these women's lives.

There were 349 maternal deaths between 2012 and 2015 that were reviewed. Of those, 145 were determined to be pregnancy-related deaths. About two-thirds of those deaths were deemed preventable. The leading causes of the pregnancy-related deaths were cardiomyopathy, cardiovascular and coronary conditions, hemorrhage, embolism, preeclampsia, and eclampsia.

The Georgia Perinatal Quality Collaborative was established seven years ago. The collaborative has about 35 subject matter experts from different organizations that lead the work. The work of the collaborative in the early years was small scale, but in late 2017 the department was awarded CDC state-based perinatal quality collaborative funding. In 2018, the first maternal initiative was relaunched, and the goal was to have ten hospitals participate and they exceeded the goal with sixty-three participating hospitals.

For the hemorrhage bundle, all the hospitals have a designated piece of equipment with instruments and medications for patients with maternal hemorrhage. Of all the hospitals that participated, 88% now have this in place. The hemorrhage and hypertension bundle are to establish a process for critical simulation drills.

Georgia's Perinatal Care System is established to ensure that mothers and babies in the state have access to risk appropriate care. There are six perinatal regions in the state with at least one regional perinatal center located in each region. They accept patients regardless of their income and are responsible for coordinating a process of maternal and neonatal transport to higher level facilities for all the hospitals in their birthing region. The Georgia Department of Health manages the contracts for the funding that is received by the regional perinatal centers. This allows the opportunity to coordinate the communication between the medical directors and the maternal and neonatal outreach educators. They are great partners and the success of the perinatal collaborative is due to the relationship with the perinatal centers.

Health departments and telehealth networks can be used to increase the availability of locally provided prenatal and postpartum care. This can provide remote OB supervision and remote maternal-fetal medicine consultations in rural communities.

## Q&A

**Joe Lupica** asked what the federal government can do to have more physicians in rural areas?

**Dr. Jean Sumner** said there needs to be better science education in public schools. Young people start out wanting to be doctors but by the time they finish high school they do not have hope. Five percent of admissions to medical schools are young people from rural communities. They need scholarships, especially those from rural communities who will return to rural to work. Quality family medicine with expansive training is important in rural because there are not specialists in rural America. Young people in medical school are hearing from their peers not to go to rural areas because they are too smart to practice in rural or there are only poor people in rural. These disparaging comments must stop. The federal government can increase funding for scholarships for young people who are from rural areas and want to practice in a rural community.

**Sallie Poepsel** said that there are many perinatal levels of maternal care. Of the rural hospitals that provide OB services, how many of them have Level 1, Level 2, or Level 3? Is there something that the committee can address regarding policy?

**Diane Durrence** replied that under the current process, hospitals are licensed through the Department of Community Health through the Certificate of Need Program. There is no verification process in place. A hospital may be licensed thirty years ago as a Level 3 Perinatal Care Providing Hospital, but there has been no verification in place since that time. This program assures that hospitals are practicing in accordance to current national guidelines. The incentive is that hospitals can only advertise they have been designated as that level if they go through the process. Most of the Level of Care Designation around Perinatal has been based on neonatal recommendations. Georgia is not the only state that is beginning to look at a more formal process. It is important for patients to understand that their hospital has been through a verification process and have the training and equipment necessary to treat them.

**Mark Holmes** asked Ms. Durrence if the program is in the field.

**Diane Durrence** responded that it is not in the field now but there is a draft plan and support from the Georgia OBGYN Society and there is legislative interest. It is much needed and there is optimism that it will come into fruition. The plan was developed with Georgia OBGYN membership, the regional perinatal center medical directors, and the faculty responsible for residents at Augusta University. There will be a pilot with Augusta University and two maternal fetal medical practices would like to partner with the Georgia Department of Public Health as the plan moves forward.

## NATIONAL PERSPECTIVES ON HIV PREVENTION AND TREATMENT CHALLENGES

**Dr. Ken Dominguez, MD, MPH, CAPT USPHS**  
**Medical Epidemiologist**

**Centers for Disease Control and Prevention  
National Center for HIV, Viral Hepatitis, STD, and TB Prevention**

**Dr. Ken Dominquez** said that the focus of the presentations will be on the rural HIV epidemic and share lessons learned from the HIV Epidemic Initiative in East Baton Rouge, Louisiana.

Comparing urban to rural, the rates for diagnosed HIV infection are much higher in urban due to the population density. The non-metropolitan areas have the highest rates among African Americans and Hispanic Latinos. Rates in rural areas are highest in the Southern United States for people living with diagnosed HIV infection. Between 1985 and 2017, there has been a decrease in the percentages of clients with AID's classifications among those diagnosed with HIV. In rural areas, there has been a gradual increase in the number of clients with the AID's classification. This is probably due to larger urban areas getting more funding for treatment.

Most adults and adolescents with HIV diagnosed in 2018 resided in metropolitan areas with populations of 500,000 or more in the United States. The rate (per 100,000 population) of diagnosis of HIV infection was highest (16.1) among adults and adolescents residing in metropolitan areas compared with adults and adolescents residing in areas with smaller populations at the time of diagnosis.

In each population category, approximately 32–36% of diagnoses of HIV infection were among adults aged 25–34 years at diagnosis, 20–23% were among persons aged 13–24 years, 18–21% were among adults aged 35–44 years, and 14–15% were among adults aged 45–54 years. Approximately 10–12% of diagnoses in each population category were among adults aged 55 years and older at diagnosis.

Most adults and adolescents with HIV infection diagnosed in 2018 resided in metropolitan areas with populations of 500,000 or more in the United States. Blacks/African Americans accounted for the largest percentage of diagnoses of HIV infection regardless of the population of area of residence at diagnosis. Whites accounted for a smaller percentage (23%) of diagnoses of HIV infection in metropolitan areas with populations 500,000 or more than in areas with smaller populations. Hispanics/Latinos accounted for a larger percentage (28%) of diagnoses of HIV infection in metropolitan areas with populations of 500,000 or more than in areas with smaller populations.

In 2018, in the South region of the United States, the highest rates (per 100,000 population) of diagnoses of HIV infection in each population size category were among blacks/African Americans. The rates of HIV diagnoses among blacks/African Americans, Hispanics/Latinos, and whites decreased as the population size decreased. The rate of HIV diagnoses among persons of multiple races was highest in the MSA of 500,000 or more. The rates in American Indian/Alaska Natives, Asians, and Native Hawaiians/other Pacific Islanders, and persons of multiple races should be interpreted with caution, because both the population sizes and numbers of HIV diagnoses in these groups were small.

In each of the population size categories in the United States, 77–83% of diagnoses of HIV infection among males during 2018 were among those with infections attributed to male-to-male sexual contact. Approximately 9–10% of males in each population size category had diagnosed HIV infections attributed to heterosexual contact.

In each of the population size categories in the United States, 83–85% of diagnoses of HIV infection among females during 2018 were among those with infections attributed to heterosexual contact. Approximately 14–17% of females in each population size category had diagnosed HIV infections attributed to injection drug use. The overall pattern of the distribution of transmission category did not differ by the population of area of residence at the time of diagnosis.

In 2018, most Stage 3 AIDS classifications among adults and adolescents with diagnosed HIV infection were in metropolitan areas with a population of 500,000 or more; the South had the largest numbers of Stage 3 (AIDS) classifications. The distribution of stage 3 (AIDS) classifications in the South shows larger percentages in smaller metropolitan (50,000–499,999) and nonmetropolitan areas compared to other regions of the United States.

In July, Louisiana received federal funds for East Baton Rouge to begin the pilot project, Ending the HIV Epidemic Initiative. They expanded the opt out testing in three large hospitals. One of the challenges was getting the providers and clients on board. Facilitators have done a great job training staff and take on the role of opt out testing. The screening criteria is to offer testing in a routine fashion to anyone between the ages of 18-65. Everyone in this age group was offered testing so it helped reduce the stigma. They have experienced a drop in new AIDs diagnosis rates. There has also been increased HIV and Hepatitis C testing in the state and local prisons. A challenge has been loss of follow-up because clients are released. There is a facilitator at the state health department that coordinates with the Department of Corrections and that has assisted to reduce barriers.

There are TelePrEP services provided on the Louisiana Health Hub website. It provides virtual connection with a provider by phone or video chat. A person can self-enroll over the phone and they are assigned a lab in their area to get tested and complete a medical evaluation and they receive their medications through the mail. Challenges have included client concerns about affordability, so they have worked through social marketing to share information about the pharmacy assistance programs.

Another prevention pillar is syringe services programs. One challenge was lack of funding for outreach to clients in rural areas. There was pilot funding to provide facilitators and to hire phlebotomist to do testing. There were also collaborations to work with groups to get access to vans in order to go to the rural areas. Fear of arrests was a challenge so facilitators worked with police so that clients could access services.



Rapid Start Navigators were hired to link people who were recently diagnosed with HIV to services within 7 days of diagnosis. A challenge is that it is difficult to reach people in mental health facilities and those with non-permanent housing. Facilitator work with leadership of agencies to facilitate access and use emergency contact information to locate homeless clients.

The CDC National HIV surveillance data provides useful information to inform future HIV prevention efforts. Ending the HIV Epidemic Pilot Project in East Baton Rouge provides important lessons learned for other rural communities in relation to HIV diagnosis, prevention, and treatment.

**Dr. Mahyar Mofidi, DMD, PhD, CAPT USPHS**  
**Director**  
**Division of Community HIV/AIDS Programs, HIV/AIDS Bureau**  
**Health Resources and Services Administration**

**Dr. Mahyar Mofidi** stated that it is an exciting time in terms of working to end the HIV epidemic. The President's plan is to reduce infections by 90% in the next ten years and it is the 30<sup>th</sup> year of the Ryan White Act legislation. The policy recommendations from this meeting will reinforce and bolster the efforts of local communities, Federal Government, CDC and HRSA. The Ryan White Program funding is \$2.4 Billion in fiscal year 2020.

Ambassador Young mentioned partnerships and HRSA is all about partnerships. Through partnerships new innovative approaches will be learned and interventions to increase access to care. Since 1991, the Ryan White Program has been providing comprehensive services and medical care including oral health, mental health, behavioral services, medical case management, and medication services. The program works with cities, states and community-based organizations. HRSA HIV/AIDS Bureau administers the Ryan White Program, and this is the guiding vision to provide HIV/AIDS care and treatment for all people with HIV. The mission is to provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people with HIV and their families.

The Ryan White Program provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. More than half of people with diagnosed HIV in the United States receive care through the Ryan White HIV/AIDS Program. Funding includes grants to states, cities/counties, and local community-based organizations. Recipients determine service delivery and funding priorities based on local needs and a planning process.

Parts A, B, C, and D (community-based organizations for women, infants, children, and youth) services include medical care, medications, and laboratory services, Clinical quality management and improvement, Support services including case management, medical transportation, and other services. Part F Services include clinician training, dental services, and dental provider training, development of innovative models of care to improve health outcomes and reduce HIV transmission among hard to reach populations. In 2018, 87.1% of Ryan White HIV/AIDS Program clients were virally suppressed, exceeding national average of 62.7%

The Ryan White Program served 533,758 clients in 2018. 73.7% of clients were racial/ethnic minorities. 61.3% served were living at or below 100% of the federal poverty level. 46.1% of the clients were 50 years or older.

Nationally, 6.2% of Ryan White Program providers are in rural areas. Approximately 90% of rural providers received Public Health Service Act 330 funding. Ryan White providers in rural areas were funded to deliver a greater number of service categories per site than in urban areas. Clients who visited rural providers tended to be older, white, non-Hispanic, living at or below the federal poverty level, and uninsured. Once a rural client goes to a clinic funded by the Ryan White Program, their retention rate and viral suppression rate goes up.

Through HRSA's Ryan White Program and the Health Center Program, the agency is playing a leading role in the four pillars of diagnose, treat, prevent and respond. Challenges ahead include improving the viral suppression rates and decreasing disparities for people with HIV who are receiving care and enhancing linkage to care and engagement in care for people newly diagnosed with HIV.

HRSA will hold Ending the HIV Epidemic listening sessions addressing mental health, substance abuse, incarceration, transportation, and homelessness. It is important to include community-based organizations, community health centers, and people with HIV. There will be training for clinical staff to insure culturally responsive and supportive experiences for clients. The listening sessions will also address stigma, health education, and criminalization laws.

Rural communities face barriers to providing HIV treatment and prevention. Some of those barriers to care include stigma, lack of clinicians with specialized experience to treat HIV, transportation to services, mental health and substance health issues, staffing, lack of HIV education and awareness, limited Syringe Services Programs, and non-Medicaid expansion.

HIV related stigma in rural communities is being addressed by the Centers for Disease Control and Prevention Campaign: Let's Stop HIV Together. The campaign is educating the community, including health care providers, on HIV and giving a voice to people with HIV. The campaign provides resources to stop stigma including a Stigma Language Guide that uses specific words to openly talk about HIV and stigma in a way that can help empower those living with HIV. Some examples of how providers can challenge their perceived stigmas are by seeing the person as an individual rather than a stereotype (e.g., learning about their personal history and the context that brought them to the doctor's office or health center). "Putting yourself in the other person's shoes" and reframing the interaction with the patient as one between collaborating equals, rather than between a high-status person and a low-status person.

Some ways that federal resources can address the needs of people with HIV in rural communities, are developing innovative approaches, educate communities and reduce HIV-related stigma, greater access to telemedicine, and syringe service programs. Ryan White Program providers are a crucial component of HIV care delivery in rural communities. Increasing the number of mental health and substance abuse specialists, mid-level providers, and community health workers in rural communities is vital in order to meet the needs of people with HIV in rural America.

**Dr. Fayth Parks, PhD, MS**  
**Associate Professor**  
**Leadership, Technology, and Human Development**  
**Georgia Southern University**

**Dr. Fayth Parks** stated she would talk about the challenges and opportunities providing HIV/AIDS behavioral health care in rural settings and discuss the current climate and the features that describe rural communities in the United States. She will also identify the major barriers to providing HIV/AIDS primary care, behavioral healthcare and prevention services to individuals living in rural communities and discuss preliminary findings from the Rural HIV Health Provider Perspectives Survey.

Behind every statistic there is a story. When the rural community of Austin, Indiana had a large outbreak of HIV/AIDS community and state officials stated that is not only possible but probable it will happen somewhere else. It can get out of control very quickly. The question is where is the next HIV outbreak looming?

There are several definitions for rural. The US Census Bureau states that rural includes all populations, housing, and territories not included within an urban area. The Management and Budget Office uses metropolitan, micropolitan or neither. The Federal Office of Rural Health uses the nonmetro counties rural, urban commuting area codes.

The 2010 Census states that a little over 59 million people live in rural areas. Of those, 65.4% live in the state of their birth. There are fewer people in rural areas with a bachelor's degree or higher. There is a lack of internet access in rural communities.

The Robert Wood Johnson's Foundation and Harvard School of Public Health conducted a survey about the most important reasons people chose to live in rural communities. The most important reason is because their family lives there and they grew up in the community.

Some of the strengths in rural America include the closeness of the community, living in a small town, and the feeling of being surrounded by good people. People in rural communities' share produce with one another and look out for each other.

African Americans and Latinx people are more likely than Whites to believe their community does not receive its fair share of the state government resources. Rural adults belonging to minority groups see much higher rates of discrimination against members of their group than others.

When asked the biggest problem facing rural communities it is drug addiction and economic concerns. People are leaving rural communities because they of a lack of jobs. There are significant problems when the younger generations are leaving the rural communities. Four in ten rural Appalachians (41%) say drug addiction is the biggest problem facing their local community. More than half of rural Americans living in Appalachia (58%) say they personally know someone who has struggled with opioid addiction. African Americans remain the largest single minority group in the Appalachian region. Largest proportions of African Americans are in southern Appalachia (Mississippi, South Carolina, North Carolina, Alabama, Georgia). Seven states with substantial rural HIV burden are Alabama, Arkansas, Kentucky, Mississippi, Missouri, Oklahoma, and South Carolina.

There are differences in rural and urban HIV/AIDS testing. While, 20.0% of rural residents have been tested for HIV in the past year, 24.5% of urban residents have been tested. In their lifetime, 21.5% of rural residents have been tested for HIV and 26.9% of urban residents have been tested. The places that people are getting testing is in emergency rooms. The “Opt Out” system is where people in rural communities are being diagnosed.

HIV risk factors in rural communities are due to injection drug use, high risk sexual behaviors, and lower perceived negative consequences of opioid use than associated with use of heroin. Health Equity means that everyone deserves to live lives with access and support to live a quality of life regarding health and wellbeing. Policy needs to consider health equity. Rural communities lack syringe exchange programs and some policies may be blocking the use of evidence proven strategies. Some rural providers are uncomfortable with screening and treating Hepatitis C due to fear and lack of knowledge.

Challenges to HIV primary care, behavioral healthcare and prevention services in rural settings includes provider and workforce shortages, limited transportation, poverty, culturally competent care, care accessibility, confidentiality, healthcare insurance, isolation, and lack of social services supports. Stigma, implicit bias, distrust of the mental health system, culture and self-reliance, and discrimination are other challenges regarding HIV primary care, behavioral health care, and prevention services in rural America. People do not want to drive up to an HIV clinic so there have to be creative avenues for testing and services.

Implicit bias can also be a challenge regarding HIV health care. It is stereotype-confirming thoughts and unconscious bias that suddenly pass through our minds. Overgeneralization that sometimes leads to discrimination even if people do not think of themselves as prejudice or unfair. There is also a bias towards people who live in rural communities so that is something that needs to be considered as well.

Research shows HIV infection overlaps with major mental disorders such as major depressive disorder. Depression remains a common comorbidity among HIV-infected persons. The prevalence of depression among persons with HIV is more than three times that of the general population.

One of the HIV associated comorbidities is depression. If there is not behavioral health available in these rural areas, people may have suicide risks and risky behaviors. It is important for people in rural areas to have HIV comprehensive care. Screening for depression, anxiety and substance use is vital. Expanding telehealth, texting services, and web-based initiative are needed as alternative methods of support.

Decreasing health disparities is important and there must be trust and transparency regarding health care providers. One historical example where providers failed their patients was the Tuskegee Experiment when public health discriminated against Alabama sharecroppers by only giving them placebos for syphilis instead of penicillin so that they could track the diseases progression.

Ways to reduce the incidence of HIV include expanding strategies for improving engagement, re-engagement and retention in care in rural communities. Expanding initiatives through

community partnerships to educate at-risk groups to reduce HIV and Hepatitis C diagnoses attributed to injection drug use. Support harm reduction and Syringe Services Programs and remove legal barriers to implementing syringe services programs and to facilitate access to treatment for substance use disorders.

The Rural HIV Health Provider Perspectives Survey asked what needs to be addressed to end the HIV epidemic in rural areas. The responses included ending hate and stigma and increasing resources. Science is not enough if we're not addressing the day-to-day challenges of our communities. Providers also said that the money to address HIV is being sent to the urban areas and not rural areas. Adherence, retention, linkage, and education need to be focuses. There are issues with transportation in rural communities that hinder people's ability to get services. There is a lack of community and faith-based involvement.

In summary, factors affecting rural health disparities vary. HIV/AIDS initiatives should be tailored for the rural health context. HIV and HCV risk factors primarily associated with IDU and opioid crisis, and race/ethnicity, social, and cultural factors influence HIV/AIDS. It is vital to support place-based solutions and rural community partnerships and build on strengths of rural American communities. County fairs would be a great place for testing and a variety of events in rural communities.

## Q&A

**Steve Barnett** asked if there is less HIV education than there used to be.

**Dr. Fayth Parks** said that there needs to be more HIV education because many people think that HIV is gone. Awareness needs to be addressed.

**Patricia Schou** asked if medical professionals have less fear than they did in the past regarding HIV. In the 1980's, there was a lot of fear by health care providers.

**Dr. Fayth Parks** said that the people who are HIV positive have trauma. Medical professionals must consider that trauma as well. Stigma is an issue with the health care workers.

**James Werth** asked what links, overlaps or lessons are there from other infectious diseases like Hepatitis C?

Cognitive impairment is also an issue for people with HIV. What can be done with prevention and treatment?

**Dr. Ken Dominguez** said that there could be incentives to motivate people to adhere to the treatment and taking their medications. Testing everyone within a certain age group, like they are doing in Eastern Baton Rouge, helps with the stigma because everyone is being tested instead of just testing people who may be at higher risk.

**Dr. Mahyar Mofidi** said that changing the perceptions of HIV and addressing the stigma with providers, organizations, and systems of care is important.

There is a large group of people with HIV who are getting older. Their system is being fatigued so there is a wide variety of core morbidities that also affect psychological distress. There is not data on the impact of aging on cognitive impairment.

## **STATE PERSPECTIVE ON HIV PREVENTION AND TREATMENT CHALLENGES**

**Michael Murphree, LCSW**

**CEO**

**Medical Advocacy and Outreach**

**Michael Murphree** said that he is the only person from Pine Level, Alabama, to ever speak at the Center for Disease Control. He stated that he is representing the country folks of central and south Alabama and is proud to represent rural. He is the grandson of farmers and sharecroppers and the son of farmers who had to move into town to work and farm at the same time. He still lives on the family farm.

Medical Advocacy Outreach is a non-profit organization and a HRSA Ryan White Part C grantee. They are also a Part B provider for the state of Alabama and do Part D work in the southern part of the State. African Americans make up 76% of people served and the next largest group are Caucasian at 21%. There are 66% of men and 30% females served. Recently, there are more women coming to the outreach and there is predominantly heterosexual transmission in the area. They are a one-stop-shop with a variety of programs. They are a pre-exposure provider and are using their telemedicine program and face-to-face visits to educate people. The Non-Occupational Post Exposure Prophylaxis Program is for victims of sexual assault. There is also a dental clinic and pharmacy. The AIDs Education Training Center for the State of Alabama is operated in collaboration with Vanderbilt University. There is an in-house pharmacy and it is important because there are some people in their 50s who have not had dental care since they were five years old. Twenty-eight counties in the southern part of Alabama are served but people from forty-one counties come to Medical Advocacy and Outreach. There is a network of telemedicine sites and the satellite sites are at county health departments, federally qualified health centers, and the University of Alabama at Birmingham.

The people living with HIV in Alabama, South Carolina, and Mississippi live in rural areas, but historically the funding has gone to urban areas. Those living with HIV in Alabama are in the same areas that had a plantation culture in the early 1800's. There was a financial boom during that time, culminating into a post-civil war economic disaster with the impact is still visible. There not a middle class in those areas and those are the areas with the highest poverty rates.

The health professional shortage areas in the south are real. Only five counties in the state have enough health care professionals and at least sixty-two with no health care professionals. Transportation is always an issue in these areas. Hospitals are closing in Alabama and they did not have Medicaid expansion. There are higher rates of uninsured people in rural areas. Rural culture and stigma are still an issue. People in rural areas do not go to the doctor early, they are crisis driven and not preventative driven. There must be health education and literacy in rural communities.

There is a van of health care professionals that go to satellite areas, but it was getting too expensive to travel such a distance. Medical Advocacy and Outreach partnered with Thrive Alabama in Huntsville and Whatley Health Services, Inc. in Tuscaloosa to bring telemedicine services to 50 of Alabama's 67 counties. Telemedicine links rural satellite HIV specific primary care medical clinics to providers in their permanent clinics and delivers improved access through expanded reach by providers and health facilities to patients in rural and distant locations. Telemedicine allows a video chat between a doctor outside of the rural area and a patient. This enables patients to have access to medical care, psychotherapy, addiction counseling pharmacologic management, social work services, and follow-up inpatient telehealth consultations. There were approximately 912 patients who received some part of their care through our telehealth network.

**Eric Paulk, JD**  
**Deputy Director**  
**Georgia Equality**

**Eric Paulk** shared that Georgia Equality is a statewide policy and advocacy organization focusing on issues impacting LGBTQ communities and people living with HIV. The Ending the Epidemic Plan is a great biomedical plan but does not address the structural social determinants of health that have to be addressed in order to end the epidemic. The HIV epidemic cannot end without ending the epidemic in black communities and with black, gay or bi-sexual men. The main topics that will be discussed are HIV criminalization, harm reduction, and Medicaid Expansion/Waiver.

An HIV clinic in Oklahoma City hired a case manager in Woodward County, over two hours away, to serve rural residents and spare them the long drive to urban clinic services. The clinic had to eliminate the position because people did not want to be seen walking into the HIV case manager's office. Stigma causes people to go from the rural communities to the urban areas to be tested and that leaves a gap in treatment and services.

HIV criminalization is the use of criminal law to penalize perceived or potential HIV exposure. This also includes acts that have no risk of transmission. People can be sentenced to decades in prison or require a sex offender registration, often in instances where no HIV transmission occurred or was even likely or possible. These laws were from the 1990's and have not been updated. There have been advancements in HIV science since that time. The HIV Criminalization in Georgia: Williams Institute Report provides data and the impact of the laws in the state. Much of the data showed that many of the people criminalized in Georgia, are living in rural communities. The report was based on arrests and convictions under Georgia's HIV-related criminal exposure statute, which contains seven separate offenses. There may be disparities in enforcement of HIV criminalization laws related to geography, race/Ethnicity, sex at birth, or sex worker. These laws deter people from getting treatment or tested.

There is more work being done around harm reduction and increasing access to syringe service programs. Additional services need to be available for people in rural areas. There is an increase in rates of injections and infectious diseases in rural areas. There has been an increase in

Hepatitis C since 2010 and other bacterial infections. Syringe programs are underfunded, and they are the most effective way to prevent infectious disease. They do not increase drug use, are cost effective, and are typically the only place for people to get naloxone. When considering LGBTQ communities and people taking hormones, there is discrimination in health care settings. People are sharing unclean needles, and this causes issues for people who are already stigmatized and marginalized.

Medicaid is the largest source of coverage for people living with HIV. In 2014, half of all Americans living with HIV were on Medicaid or Medicare. Meanwhile, 14 percent, or about one in seven HIV positive people, had no insurance at all, according to Kaiser. Medicaid expansion did not happen in many southern states. Medicaid waivers provide an opportunity to consider experimental goals to further the goals of Medicaid. Eight out of ten new infections come from people who are not in HIV care. Barriers need to be removed so that people can be tested and receive care.

**Gregory Felzien, MD, AAHIVS**  
**Medical Advisor**  
**Division of Health Protection**  
**Georgia Department of Public Health**

**Gregory Felzien** shared that he grew up on a farm between Kanorado and Goodland, Kansas. He is happy to now live in rural Georgia. Georgia has been number one in HIV rates per 100,000 for the past three years but only received funding from End the Epidemic for four counties in the State.

People from rural areas go to urban centers on the weekends and become exposed to diseases. In rural clinics, he can talk to his clients about their health and talk to them about what they may be doing that is unsafe behavior.

There are still other diseases like syphilis, that doctors must be cognizant of other than just HIV. The CDC recently reported that there are the highest rates of STD's ever. There are fifty-nine thousand people living in Georgia with HIV, and sixteen thousand people live in Fulton County where Atlanta is located. There are people with HIV living in every county of the State of Georgia and many are in rural areas. There are still babies being born with HIV and a majority are outside of metropolitan areas. In January 2019, Dr. Felzien visited an OB clinic in southern Georgia. There was a baby born with HIV and the doctor said they did not screen for it because it doesn't happen in rural areas. Treatment is important but prevention is also very important. We must make people aware of risk factors. Pre-Exposure Prophylaxis Clinics should include sexual health and wellness.

Eighty-four percent of individuals are virally suppressed when they are retained in care. This can be a challenge when people do not want to disclose their status so they will drive to another district to avoid being seen. Prevention, treatment, adherence, all so many more factors must be considered when discussing challenges in rural communities. The way people are perceived and stigmatized in rural communities is also a huge hurdle.



The lack of a health care workforce in rural communities is a real problem. Education debt is a consideration when people are choosing careers. It is important to keep people in the state where they are trained, but they are going to the urban areas instead of rural communities. Loan repayment programs are vital, and the Cherokee Nation in Oklahoma helped pay for Dr. Felzien's college debt. He took every opportunity to work in rural areas and then spent six years at Indian Health Services.

Dr. Felzien's specialty is infectious diseases and public health. Men are getting paid more than women. Men and women come out of college with the same debt but if a woman gets paid less than her counterparts, she may not go to a rural area. There are 242 infectious disease providers in Georgia and 159 counties. There is around a 50% burnout rate for healthcare providers in rural areas. There is an aging population of physicians in rural communities, so this adds to the lack of health care workforce in the future.

Governor Kemp has an initiative to increase access to the internet in rural areas. Georgia's Telehealth network will be expanding and providing expertise statewide through video. The network is recognized as one of the most robust and comprehensive public health networks in the nation and a best-practices model of care. It connects all 159 county health departments and specialty clinics and allows connection to partners and providers in patient's homes, hospitals, universities, and private practice offices.

Project ECHO is a lifelong learning and guided practice model that revolutionizes medical education & exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities. The heart of the ECHO model is shared networks, led by expert teams who use multi-point videoconferencing to conduct virtual education with community providers. In this way, healthcare providers enhance their knowledge in caring for patients in their own communities. The goal of ending the HIV epidemic is to reduce infections in 5 years by 75%, and a 90% reduction in 10 years.

**Lamar Greene**  
**Truman Fellow**  
**Rural Health and Human Services**  
**Office of Rural Health Policy**

Hi Everyone. I wanted to ask that you all consider the racial health disparities present in the maternal health crisis as you all think about and conceptualize your policy recommendations. California has been a guiding light for the country working to increase access and improve quality to maternal healthcare in both urban and rural areas. Although they have been able to reduce pregnancy-related deaths by up to 50% for all women, the racial gap remains the same with Black women 3 to 4 times more likely to die from childbirth. How can policy be leveraged to address this, specifically policy beyond implicit bias training because research shows this must be repeated at least every 3 months to be effective.

**Tuesday, March 3<sup>rd</sup>, 2020**

Tuesday morning the subcommittees depart for site visits as follows:

## **SITE VISIT**

### **HIV Prevention and Treatment Challenges in Rural America**

#### **Health Services Center**

#### **Hobson City, Alabama**

**The subcommittee members present at the meeting:** Benjamin Taylor, PhD, DFAAPA, PA-C; (Subcommittee Chair), Steve Barnett, DHA, CRNA, FACHE; Bob Blancato, MPA; Kari Bruffett; Wayne Deschambeau, MBA; Joseph Lupica, JD; Patricia Schou, James Werth, Jr., PhD, ABPP; and Loretta Wilson.

**Present from the Federal Office of Rural Health Policy:** Steve Hirsch, Executive Secretary; Sahira Rafiullah, Senior Advisor, Lamar Greene, Truman Fellow.

**Additional Attendees:** Mahyar Mofidi, HIV/AIDS Bureau Health Resources and Services Administration.

## **Community Panelists and Attendees**

- Dr. Barbara J. Hanna – Executive Physician, Health Services Centers
- Quinton Hearn – Permanent Housing Coordinator
- Kathie Hiers – CEO, AIDS Alabama
- Christina Humphrey – Alabama Department of Public Health
- Lanita Khalil – Executive Director, AIDS Alabama South
- Billy Kirkpatrick – CEO, Five Horizons
- Mary Elizabeth Marr – CEO, Thrive Alabama
- Melissa Parker – Prevention Director, Health Services Center
- Mesha Parker – Director of Substance Abuse Services, Health Services Center
- Jitesh Parmar – COO, Thrive Alabama and the Alabama Regional Quality Management Group
- Daniel Pawlus – Major Gifts Specialist
- Marvellus Prater – Alabama Department of Public Health
- Sonia Preston – Clinical Director, Health Services Center
- Lawanda Richardson – Rural Outreach Specialist
- Ashley Tarrant – COO, Medical Advocacy and Outreach and the Alabama Regional Quality Management Group

## **SITE VISIT**

### **Maternal and Obstetric Care Challenges in Rural America**

#### **Mercer School of Medicine**

#### **Macon, Georgia**

**Subcommittee members:** Kathleen Belanger, PhD, MSW; Molly Dodge, Meggan Grant-Nierman, DO, MBA; Constance Greer; Carolyn Emanuel-McClain, MPH; Brian Myers, Mark Holmes, PhD; Sallie Poepsel, MSN, PhD, CRNA; Mary Sheridan, RN, MBA and Robert Wergin, MD, FAAFP.

**Present from the Federal Office of Rural Health Policy:** Tom Morris, Director, and Anne Hall, Truman Fellow.

### **Community Panelists and Attendees**

- Donna Brown - Senior Case Manager, South Georgia Healthy Start
- Tiffany Crowell, RN, MSN, MBA - Valdosta Healthy Start Program Manager
- Melanie Dallas, LPC - CEO, Highland Rivers Health
- Clifford Hunter - Fatherhood Coordinator, Heart of Georgia Healthy Start
- Rose Morris - Field Program Specialist, DFCS Region 9
- Berinda Nwakamma - Director, Georgia Home Visiting Program of Lowndes County
- Damien Scott, PT - CEO, Emanuel Medical Center
- Phyllis Solomon, NP - Former women's health nurse practitioner in public health department
- R.B. Tucker - CEO, South Central Primary Care Center
- Jacob C. Warren, PhD, MBA, CRA - Director, Center for Rural Health and Health Disparities

The subcommittees' returned to The Centers for Disease Control and Prevention, to discuss site visits.

### **PUBLIC COMMENT**

There was no public comment.

### **Wednesday, March 4<sup>th</sup>, 2020**

**Diane Hall, PhD, MSED**  
**Senior Scientist for Policy and Strategy**  
**Office of the Associate Director for Policy**  
**Centers for Disease Control and Prevention**

**Diane Hall** thanked Scott Miller, with the Centers for Disease Control and Prevention, for all the work he did to organize the meeting. Dr. Redfield wanted to attend the meeting but was called to Washington regarding the Coronavirus. CDC is committed to the health and wellbeing of rural communities and is honored to have hosted the Rural Health and Human Services National Advisory Committee Meeting.

**Jeff Colyer, MD**  
**Committee Chair**

**Chairman Colyer** stated that the committee members have been given a brief synopsis of information collected from stakeholders during the site visits regarding *Maternal and Obstetric Care Challenges in Rural America* and *HIV Prevention and Treatment Challenges in Rural America*. The committee will discuss the information collected and decide on specific recommendations to present to the Secretary of Health and Human Services.

The Secretary of Health and Human Services, Alex Azar, and Deputy Secretary, Eric Hargan, have rural healthcare as a priority and realize there are significant health disparities that need to be addressed. It is a personal issue for both, and they have shared their experiences with rural healthcare in different areas of the United States. They welcome the committee's recommendations so it is important to share information that can guide policy.

**Amit Sachdev**

**White House Fellow**

**United States Department of Health and Human Services**

**Amit Sachdev** spoke to the Committee about the challenge of closing the disparity gap between rural and urban America by figuring out ways for target approaches using data analytics. Examining data at the national, state, local, and county level and find ways to target federal resources to close the disparity gap is essential. The federal resources should focus on the five leading causes of death which are cancer, cardio-vascular disease, stroke, COPD, and unintentional injury.

**Tom Morris, MPA**

**Associate Administrator for Rural Health Policy**

**Health Resources and Services Administration**

**U.S. Department of Health and Human Services**

**Tom Morris** stated that there are counties in Georgia that are rural but not eligible for rural funding and felt that the definition of rural should be reexamined. The Committee agreed that it could be considered as a recommendation. There can be unintended consequences of redefining the definition that can also be discussed.

The Office of Rural Health Policy funds two Centers for Excellence for Telehealth. Their job is to try out new areas for telehealth and develop protocol. One Center for Excellence for Telehealth is in South Carolina and the other is in Mississippi. They could be directed to better define how to use telehealth for HIV services or high-risk obstetrics care.

Grants can be given priority points so there could be an option to recommend the use of priority point to emphasize family medicine training to include obstetrics.

## **DRAFTING OUTLINE OF POLICY BRIEF**

### **HIV PREVENTION AND TREATMENT CHALLENGES IN RURAL AMERICA**

Subcommittee findings and possible recommendations include:

### Funding

- Expansion and modernization of the Ryan White Care Act
- Funding going directly to rural health groups at the grass roots level
- Ensure that community-based organizations know about grants and funding available
- Simplifying the process of applying and receiving grants
- Reconsider grant funding with population specific stipulations

### Stigma

- Health and Human Services education campaign to combat community, provider, and internalized stigma surrounding HIV
- Centers for Medicare and Medicaid Services work with state governments to improve reimbursement procedures and billing for “Opt-Out” STI testing
- Increase the availability of Harm Reduction Programs and educate communities about the benefits
- Increase public awareness about HIV criminalization laws and their impacts
- Increase telehealth programming that works with urgent care, hospitals, health departments, and various other provider facilities
- Integrating STI testing and HIV care
- Pilot programs with storefronts in rural communities with computers for HIV telehealth services
- Distributing funding for HIV health education and promotion programs that work in rural areas
- Centers for Medicare and Medicaid Services provide reimbursement to expand telehealth and community health workers
- Strengthen broadband in rural areas
- Host grant writing workshops for community-based organizations
- Community-based organizations receiving eligibility for National Health Corps Service Groups
- Multi-agency task force to review gaps and overlap in rural funding

## **MATERNAL AND OBSETRICS CARE CHALLENGES IN RURAL AMERICA**

Subcommittee findings and possible recommendations include:

### Topics of Discussion:

- Issues related to transportation, housing, jobs, broadband, and self sufficiency
- Integrated case management
- Malpractice
- Loss of hospital-based obstetrics in rural areas
- Linking health care to human services
- Underlying disparities and disease burdens unique to rural communities

- Research demonstrating if Medicaid coverage post-delivery for more than 60 days improves outcomes
- Highlight more flexible options for residencies

**Possible Recommendations:**

- More utilization of Certified Nurse Midwives
- Issues with inconsistencies of rural definitions
- HRSA funded Telehealth Centers for Excellence
- Emphasis on family medicine with obstetrics
- AIM bundles and integrating with The Medicare Rural Hospital Flexibility Program and community access hospitals
- Tele-mentoring for rural providers for obstetrics and maternal health using models like ECHO
- More flexibility in allocating regular Head Start slots to Early Head Start
- Additional grant mobile health challenges
- Added use of community health workers

**PUBLIC COMMENT**

There was no public comment.