

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

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

**Spring Meeting  
Sacramento, California  
April 3<sup>rd</sup>- 5<sup>th</sup>, 2019**

**Meeting Summary**

The 85<sup>th</sup> meeting of the National Advisory Committee on Rural Health and Human Services was held April 3<sup>rd</sup> – 5<sup>th</sup>, 2019, at Residence Inn by Marriott Sacramento Downtown at Capital Park.

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

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

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

Ex-Officio Members: Cara James, PhD, Office of Minority Health, Centers for Medicare and Medicaid Services; Scott Miller, MPA, Office of the Associate Director for Policy, Centers for Disease Control and Prevention; Benjamin Smith, MBA, MA, Indian Health Service; Shobha Srinivasan, PhD, Division of Cancer Control and Population Sciences, National Cancer Institute.

**Wednesday, April 3<sup>rd</sup>, 2019**

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

**WELCOME AND INTRODUCTIONS**

Governor Ronnie Musgrove, Chair of the Committee, welcomed the committee members and stated that the topics of the meeting are Examining Rural Cancer Prevention and Control and Supportive Services and Caregiving for Older Adults in Rural America. Governor Musgrove thanked Peggy Wheeler for hosting the meeting and stated that it is a pleasure to meet in Sacramento.

Paul Moore, The Office of Rural Health Policy Senior Health Policy Advisor, thanked Governor Musgrove for his service as Chair of The Rural Health and Human Service National Advisory Committee. He stated that Governor Musgrove has been the chair of the committee for ten years and this is his final meeting. He served five Secretaries of Health and Human Services, two Presidents of the United States, and worked with approximately sixty members of the Rural Health and Human Service National Advisory Committee. His leadership and service are greatly appreciated.

## **CALIFORNIA ORIENTATION**

**Moon S. Chen, Jr., MPH, PhD**  
**UC Davis School of Medicine**  
**UC Davis Comprehensive Cancer Center**

**Moon Chen** thanked Governor Musgrove and stated that he is from Southern China and that Sacramento is his ancestral home. His grandfather was from Southern China and the village where he lived was flooded. The whole village decided to move to a land where there was gold and that was California. The entire village moved to California and they thought they would mine gold, but Chinese were not allowed to mine for gold. The only jobs they were allowed to do is clean the miner's cabin or work on the railroad. His grandfather decided to work on the railroad and the railroad work took him to El Paso, Texas and then Columbus, Ohio. He then opened a Chinese laundry in downtown Columbus, Ohio and that is where his father was born. His father was orphaned at age eight and adopted by a couple who were teachers. He went to college as an aeronautical engineer but could not find a job after graduation. He joined the Air Force as a pilot and volunteered to go to China. Dr. Chen's father met his mother in China and that is where he was born. Dr. Chen had not heard of Sacramento when he got a job at UC Davis. It is a coincidence that he returned to the same place where his grandfather once lived.

Dr. Chen stated that he would relate his information about California to Mississippi since Governor Musgrove is from Mississippi. California is equal to three Mississippi's in terms of area and thirteen Mississippi's in terms of population. The county where there will be a site visit is Glenn County where Northern Valley Indian Health is located. Some of the top educational institutions are in California. California provides more fruits and vegetables to the nation than any other state.

**Peggy Wheeler, MPH**  
**Vice President – Rural Health & Governance**  
**California Hospital Association**

**Peggy Wheeler** welcomed the committee to Sacramento and stated that this is her last meeting on the National Advisory Council on Rural Health and Human Services. She appreciates that the last meeting is in her hometown and hopes that the members will enjoy their time in Sacramento.

There are thirty-nine million people living in California and it is one of the five largest economies in the world and the third largest state in the nation. California is a rural state that has large urban populations. The state has all the problems of rural communities because most of the state is a frontier and rural landmass. Looking at California through the lens of population density, there are few populated areas with a large population.

As Vice President of Rural Health & Governance of the California Hospital Association, Ms. Wheeler is the voice of rural hospitals inside the association and outside the association. Sacramento is in the middle of the legislative session and there are over 2,700 pieces of legislation being introduced and 1,000 are related to healthcare. The legislation must be reviewed from the point of view of the impact on hospitals in rural settings. There are four hundred hospitals in California and sixty-four are rural hospitals. Within the sixty-four rural hospitals, thirty-four are critical access hospitals. Twenty years ago, a piece of legislation was introduced that hospitals would be able to withstand an earthquake. This was an unfunded mandate for hospitals.

Recently a Rand Report was released that the estimated cost to bring hospitals into compliance with the 2030 seismic safety standards, would be one hundred and forty-three billion dollars at the highest level. There is a bill in the legislature this year regarding policy alternatives for hospitals to treat patients and get them out of trauma designated areas. Many rural hospitals will not be able to afford to meet the high cost of compliance and will be forced to close.

An issue in rural California is physician recruitment and retention. The geography of the rural areas is declining so the California Hospital Association is working closely with UC Davis on telemedicine to try and address some of the needs in rural California.

The California Hospital Association is working to bring back healthcare services after the recent fires in Paradise. The fire warning was at 8:05 and by 8:22 the hospital in Paradise was evacuated. Some patients were left on the helipad because they could not get them out. During the campfire, people were trying to take those injured to hospitals, but their tires were melting. Two ambulances burned. There was no loss of life at the hospital, but eighty-six people could not make it out of their homes and lost their lives. Wildfires in California are becoming more frequent and burn hotter and faster so there are preparedness protocols being implemented with the hospitals.

**Geni Cowan, PhD, MA**  
**Professor**  
**Educational Leadership & Policy Studies**  
**California State University, Sacramento**

**Geni Cowan** started by asking everyone to stand and take a moment to honor and give thanks to the traditional people on whose land we are meeting. This includes the Maidu, Miwok, Patwin, and Yahi. We are in Indian Country and it is important to recognize and acknowledge the traditional people.

Dr. Cowan shared that she is Choctaw and originally from Mississippi. Her mother was raised on the Choctaw Reservation. She stated that she would give the committee an idea of what it is like in California for Native people who live on reservations. They have a very different experience from the Native Americans living in urban areas. Recently, she drove from Sacramento to Willits, California. All along Highway 20 to Highway 101 you will go through reservation land. You will pass through a Rancheria on Highway 20 and there is a Native Casino, a small town called Clear Lake, and many lakeside towns. Highway 101 is about 10 miles north of Ukiah which is a city where people living in the surrounding areas drive once a month for at least an hour to three-hour drive to go shopping.

Willits is a gateway to north country. Dr. Cowan went to Willits to work at Round Valley Rancheria which is in Covelo, California. Covelo is very difficult to get to after dark and there is one motel that may have some rooms available depending on the weather. She had to stay in Willits and had another hour to drive to Covelo. She was working with the tribal TANF program and had three days of training. The two-lane highway from Willits to Covelo over the mountains and through the valley can be driven at about forty miles an hour. There is a country store, a recreation center and a couple of schools in Covelo. The sheriff's office shares space with the TANF program. The program director drove Dr. Cowan around the reservation. The houses on the reservation were in bad shape. Some of the land is native land and some is privately owned that had been taken by non-natives. The federal government returned some of the land but it is not contiguous so you may have to cross non-native property to get to native land.

There is a clinic, a recovery program, and an extensive effort to find ways to provide support. It is over an hour to drive to Willits which makes it impossible to get there if there is an emergency, so it is very difficult to be elderly and live in Covelo. The tribe is aging and will stay on their traditional homeland. The TANF program is considering ways to train people to be caregivers of the elderly and register them with the State of California. This will give people in the area a means of making money and assist with the issues of caring for the elderly. Half of the community is elderly and there is no reliable transportation and family in the area. There are also natural disasters that are difficult to overcome. This is the reality for native people living in California on traditional lands. Casino tribes make up about 25% of tribes in California and the other tribes do not have those resources. The challenge is to gain an experiential understanding of their situation and to get creative about ways to address the issues facing Native Americans living on reservations and rancherias in rural California.

Dr. Cowan's father was a teacher at the Bureau of Indian Affairs Boarding School in Nevada and that is where she grew up. She knows what it is like to live in frontier America but did not know any different as a child. As an adult she realizes the challenges and her mission is to support the people who live outside of the reach of urban advancements.

## **Q&A**

**Octavio Martinez** asked what is a rancheria.

**Geni Cowan** replied that historically when Native Americans were being removed and put on spaces of land that no one else wanted that they were reservations. In California, the land was

chosen and designated as a ranheria and then the Native Americans were placed on the land. There are very few ranherias in California that belong solely to a single tribe because of the way California performed Indian removal. Reservation land was owned by the federal government and ranheria land was given to the tribes.

**Octavio Martinez** asked how many programs in higher institutions are dedicated to the rural workforce?

**Peggy Wheeler** replied that there is only one program that is targeted for rural and it is the Rural Prime Program and it takes applicants interested in working in rural and gives them residencies in rural areas. There are several programs in the state that give state money to award scholarships to students that indicate they want to work in rural California, and one is The Steven Thompson Physician Corps Loan Repayment Program.

**Sally Poepsel** said information technology is challenging and not having infrastructure and bandwidth in rural areas. Has anyone considered being the template of a medical mission? People volunteer and go on a regular basis to rural areas where people are not able to get to doctors or dentists? Taking the infrastructure to the rural or frontier areas.

**Steve Barnett** said that he worked with the Hoopa Valley Tribe which is in Humble County which is 280 miles from Sacramento. They originally communicated via telemedicine and they asked questions about medical cases. They contacted UC Davis and one of the problems were the low mammography rates among the women. The previous solution was to travel to a hospital that took the entire day. Through funding from the California Breast Cancer Program, they were able to take a mobile mammography van to the tribal community. The results were a 20% increase in mammography rates. Centers for Disease Control funding to the California Rural Indian Health Board will continue the use of the mammography van.

## **WELCOMING REMARKS**

**Edward Heidig, JD**  
**Regional Director, Region IX**  
**Office of the Secretary**  
**US Department of Health and Human Services**

**Edward Heidig** shared when he was in his twenties, he served on an advisory commission and values the role that the committee serves to assist in solving the issues of delivering quality healthcare to rural areas. He said that it is an honor as a regional director to serve in the Secretaries office and is appreciative of Secretary Azar's leadership in bringing down health costs and outlining the health costs strategy in bringing down the cost of prescription drugs. The cost of prescription drugs is a problem in Region IX and rural America.

It is 8,000 miles from one end of the region to the other so there are vast territories of rural. California is a has a large population and the infrastructure needs are overwhelming which is visible on his daily commute from Sacramento to San Francisco. When he moved to California

in 1970 and there were 18 million people and now there are 38 million people. There is a need for upgraded freeways, water systems and much more of the infrastructure needs to be expanded to meet the needs of the growing population.

Mr. Heidig thanked the committee for their visit to California and for the work they are doing.

## **NATIONAL PERSPECTIVES ON RURAL CANCER PREVENTION AND CONTROL**

**Nikki Hayes, MPH**

**Branch Chief**

**Comprehensive Cancer Control Branch – Division of Cancer Prevention Control**

**National Center for Chronic Disease Prevention and Health Promotion**

**Centers for Disease Control and Prevention**

**Nikki Hayes** thanked the committee for inviting her to the advisory committee meeting and appreciates talking about the work that they are doing and finding ways to work together to increase the efforts in rural communities. People in rural communities get cancer less often but they die of cancer at higher rates.

The Division of Cancer Prevention and Control are one of nine centers in the Agency's National Center for Chronic Disease Prevention and Health Promotion. There is a focus around data, translation, and evaluation to prevent and control cancer. There is a focus on getting people to the right cancer screenings at the right time and do all they can to enhance the quality of life for cancer survivors.

There is a focus on the HPV vaccination to prevent HPV associated cancers and the Hepatitis B vaccination and encouraging Hepatitis C screening due to trending rates of increases in liver cancer. DCPC is making their data as accessible as possible and are creating sets of data that can be used as cases are completed.

There are four flagship programs that include National Breast and Cervical Cancer Early Detection Program, Colorectal Cancer Control Program, National Comprehensive Cancer Control Program, and the National Program of Cancer Registries. All the programs are funded through state health departments. The National Breast and Cervical Cancer Early Detection Program is nearly thirty years old and serves underinsured and underserved woman to provide access to mammography and cervical cancer screening, patient navigation that helps women get into treatment. The Colorectal Cancer Control Program has thirty awardees with a focus on working in health systems to help improve and enhance systems, so they make more referrals for screening and do adequate follow-up. National Comprehensive Cancer Control Program is about twenty-five years old. All programs use the data to guide and inform the decisions of prioritizing the work they are doing in their communities. The National Program of Cancer Registries is the least funded program that is twenty years old to help states, tribes and territories pull together the stakeholders in their communities and leverage their resources.

The National Comprehensive Cancer Control Program supports all fifty states, the District of Columbia, seven U.S. territories, and eight tribes and tribal organizations. Since 1998, more than 98,000 people have been involved in cancer coalitions and sixty-nine cancer plans have been

created and updated. The program supports robust state, tribal, and territorial-wide coalitions that address public health needs of cancer survivors in order to plan and implement policy, systems, and environmental changes. The program emphasizes primary prevention of cancer and supports early detection and treatment activities.

Networking2Save is a consortium that has funded eight organizations across the country around tobacco control and cancer control in communities that are geographically isolated and have low socio-economical status. The Geographic Health Equity Alliance is a network with a focus on communities that are geographically isolated and bring people together through planned activities. The Geographic Health Equity Alliance placed smoking cessation messages on barns in rural communities to reach rural residents about quitting smoking. The Project ECHO platform was used to create a mobile app to help navigators track activities and their patients and stay connected and assist one another. There were issues with internet connectivity and getting people to share information and gave a better understanding of challenges that occur in rural communities.

The National Program for Cancer Registry collects data on 1.7 million cancer patients a year. There is an effort to make the data available to everyone in a user-friendly way. The data can be used to drive program activities. The Kentucky Breast and Cervical Cancer Screening Program registry data allowed identification of counties with low breast and cervical cancer incidence and high mortality rates and determine costs for clinical services in these areas. There is a data visualization tool that could benefit the committee that shares information about cancer mortality and incidence at the state, county and congressional district level. Additional data will be added for HPV cancer and the tool will continue to be upgraded.

Geography alone can't predict cancer risk, but it can impact prevention, diagnosis, and treatment opportunities. Targeted public health efforts and interventions can close the growing gap between rural and urban Americans.

**Shobha Srinivasan, PhD**  
**Health Disparities Research Coordinator**  
**Office of the Director – Division of Cancer Control and Population Sciences**  
**National Cancer Institute**  
**National Institutes of Health**

**Shobha Srinivasan** thanked the Office of Rural Health Policy for their support when she contacted them about rural health issues. The National Institute of Health is a research entity that aims to get to the truth and switch the science to reality, which is a huge challenge. There are two programs and one is on rural issues and the other is focused on American Indian, Alaskan Native and Native Hawaiian issues. These three groups have land agreements with the federal government and that is why they were in a group.

Only three percent of the portfolio is on rural cancer control and even less in American Indian, Alaskan Native, and Native Hawaiian populations. The National Institutes of Health has a vetting process so there must be a gap in science and a way the science can address to fill the gap. The National Institutes of Health wrote an article on making an investment in rural cancer control and began a rural agenda.

Colorectal cancer is highly preventable, easily detectable, and highly treatable. The rates are coming down which is great news but if you look at the statistics by race it is not good. If you compare by rural and urban, there is an uptick in rural. There needs to be more focus on prevention and screening in rural. Geography is a big issue and it is difficult to work with small populations. There is a challenge of how to estimate the population and some people in rural don't want people to know they have cancer.

Many rural residents are low-income and rural communities are underserved and lack access to hospitals and services. A program National Institutes of Health is collaborating with the FCC is a lunch program in Kentucky. They are trying to increase broadband to see if telehealth and telemedicine will work in the area. There is a program in collaboration with HRSA in South Carolina based on coordination of care. People are getting treatment in urban areas but sent back to rural and don't know what to do when they return home. The local doctor needs information to assist them so coordination of care is vital.

The National Cancer Institute has seventy cancer centers across country but none in rural areas because to be a cancer center it must be a research-intensive cancer center. In the past five years there was the development of catchment area agenda because there was the need for a wider net in rural to get funding. A rural supplement program was developed and about twenty-one entities were funded across the country so they could work with clinics and community organizations to build a coordination of care agenda. This is all still research looking at how best to deliver care. Interventions in urban areas cannot be developed in rural. An example is that New York cannot create a telehealth system in North Dakota without knowing about North Dakota. There is another program that is focusing on rural clinics. There must be an understanding of the federal regulations before building a clinic in rural because it can affect other services and local hospitals. There must be partnerships built with existing clinics. Population data must be examined at a local level. There must be a granular level of data to serve these populations.

National Community Oncology Research Program can refer people to clinics and do research on providing the best standard of care in remote areas. A national NCI supported network brings cancer prevention clinical trials and cancer care delivery research studies to local communities. The program designs and conducts cancer prevention, control, screening and post-treatment surveillance clinical trials, designs and conducts cancer care delivery research studies, and participates in treatment and imaging clinical trials conducted by the NCI National Clinical Trials Network. The Partnership to Advance Cancer Health Equity is a partnership with research intensive cancer centers with a minority serving institute. This is for creating integrated partnerships and applying for funding together.

The National Institute of Health is building a network with researchers and communities to move the agenda forward. The context of talking about cancer must be considered when that is not the first thing on people's minds. They are thinking about keeping food on the table and paying rent. It is important to hear their stories before talking about cancer. Medical mistrust is an issue in rural so there must be ways to create trust.

There are multiple levels of disparities for example rural and access to care that must be addressed when considering cancer prevention and treatment. There needs to be an

interdisciplinary approach and better partnerships must be created and some solutions have to be regional.

## Q&A

**Kathleen Belanger** asked if the data that is collected for cancer patients is from their place of residence or treatment

**Shobha Srinivasan** responded that it depends. According to the law, it is from the place where the person got the treatment, but the person's residence is considered.

**Connie Greer** stated that Ms. Hayes talked about the funding for eight tribes and there are five hundred seventy-three federally recognized tribes. Is there an issue getting to tribal participation?

**Nikki Hayes** said that they fund eight for a comprehensive cancer control. There is a good health and wellness in Indian Country grant that focuses more on prevention and is a larger pool of money. They fund many more tribes with this grant and work collaboratively on this. The funding is limited, and everything is population health based and they must find the best way to look at the general populations and focus on special populations with unique needs.

**Robert Wergin** stated that people must go to urban areas to get treatment, so it seems that people with cancer live in those urban areas. People are coming from rural though and that is not being considered. Additionally, there is reluctance for parents to get their children the HPV vaccine and that affects numbers which is a barrier.

**Carolyn Emanuel-McClain** shared that she is a cancer survivor and is a CEO of an FQHC. They strive every day to provide cancer services and they are installing a mammogram in their center this year. A challenge is that rural communities that are closer to metropolitan areas have difficulties because they are too close to metro when they are competing for rural grants. There are a lot of people who need the services.

**Shobha Srinivasan** said that IHS in North Dakota, South Dakota and Alaska, colonoscopies are done by primary care physicians and nurse practitioners. From a prevention agenda, it is brilliant to let other people perform these services. How to make this type of change in primary care clinics is going to be a challenge.

## STATE PERSPECTIVES ON RURAL CANCER PREVENTION AND CONTROL

**Rosemary Cress, MPH, DrPH**  
**Research Program Director II, SEER Principal Investigator**  
**Public Health Institute, Cancer Registry of Greater California**  
**Professor – Department of Public Health Sciences**  
**UC Davis School of Medicine**

**Rosemary Cress** stated that she would share information about disparities of early diagnosis and cancer treatment in urban versus rural areas of California. The registry collects information on every cancer that is diagnosed in California and has been recorded since 1988. The study focused on breast, cervix, colon, endometrium, gastric, lung and ovarian cancers.

California has fifty-eight counties that cover the whole length of the state and some are very large and diverse. Riverside County includes suburbs of Los Angeles and the mountains and desert of eastern California. County level indicators do not work in California. The rural-urban commuting area is census tract based and uses various indicators to show whether someone is extremely rural or if they are in a rural area that is near a larger town. There are gradations or rurality.

The stage of diagnosis and quality of care measures were researched and compared between rural versus urban. There were nearly 500,000 cancer patients that were considered living in urban areas and 16,000 living in rural areas. The rural cancer patients tended to be older, there were more males and a much larger number of Caucasians and were poorer. The rural cancer patients were slightly more likely to be diagnosed at a later stage and slightly less likely to get radiation and chemotherapy.

Rural residents are slightly less likely to have breast cancer and slightly more likely to have lung cancer. This is related to socioeconomic status and smoking. Women in rural areas were slightly more likely to be diagnosed at later stages with breast cancer but significantly less likely to get radiation therapy after breast conserving surgery but more likely to get radiation after a mastectomy.

There is no difference in the stage of diagnosis of urban versus rural related to cervical cancer. Rural women are more likely to get brachytherapy for those treated with primary radiation with curative intent in any stage of cervical cancer, and chemotherapy for women who received radiation for stages IB2-IV cancer or to women with positive pelvic nodes, positive surgical margin, and/or positive parametrium.

Colon cancer has no significant difference in stage of diagnosis between urban and rural. Rural has a slightly larger number of people with adjuvant chemotherapy administered or considered for patients with AJCC stage III. There is a significantly lower percentage of rural cancer patients with at least twelve regional lymph nodes removed and pathologically examined for resected colon cancer.

Women in rural areas are slightly more likely to be diagnosed with later stages of endometrial cancer but women in urban areas have a significantly higher number who receive chemotherapy and/or radiation to patients with stage IIIC or IV. Patients in rural areas are slightly more likely to be diagnosed with late stages of gastric cancer. A significantly lower percentage of rural patients have at least fifteen regional lymph nodes removed and pathologically examined for resected gastric cancer. Patients in rural areas are slightly more likely to be diagnosed with lung cancer and slightly less likely to have at least 10 regional lymph nodes removed and pathologically examined for AJCC stage IA, IB, IIA, and IIB resected non-small cell lung cancer. Women in rural areas are more likely to be diagnosed with late stages of ovarian cancer and less

likely to have salpingo-oophorectomy with omentectomy, debulking/cytoreductive surgery, or pelvic exenteration in Stages I-IIIc ovarian cancer.

Patients from rural areas make up 3% of cancer population in California. They are significantly older, non-Hispanic white, and of lower socioeconomic status and less likely to have surgery, chemotherapy, or radiation than urban residents. Rural patients are generally more likely to be diagnosed at later stages with cancer. Living in rural areas is associated with lower odds of meeting certain quality of care measures, though there are no significant differences by urban/rural residence for several measures. Some of the limitations with the research was the small sample size of the rural patient population, variables used to define the Commission on Cancer eligibility criteria were not a perfect match to registry variables, and limited treatment information in the California Cancer Registry.

Not everybody has the resources to leave their rural community and get the care they need in an urban area. Patients who don't have family or financial resources don't have the same opportunities.

**John Rochat, MD**  
**Oncologist**  
**Hematology, Oncology & Anticoagulation Clinics**  
**Mendocino Coast District Hospital**

**John Rochat** said he would share about cancer and the rural California coastal perspective. He is a hematologist and oncologist in Mendocino County which is a large county that is very diverse.

Dr. Rochat said that his family is from a rural town in western Switzerland and his grandfather immigrated to Tennessee, then his father moved to Texas, and then they moved to Mississippi when he was in junior high school. He joined the Navy after Ol' Miss medical school and went to San Diego to do his residency and fellowship and USC for his second fellowship. He went to Guam because a typhoon destroyed the hospital and clinic and was the only oncologist for 250,000 people on various islands. Next, he went to the hospital in Mendocino County. Mendocino County has a population of 80,000 and is over 3,878 square miles. The US Census considers the county mostly urban because most people live in a town.

Mendocino Coast District Hospital is in Fort Bragg, California and is a critical access hospital. It is three hours north of San Francisco, four hours north of Palo Alto, and four hours west of Sacramento. It is two hours and twenty minutes to the nearest level II trauma center and blood bank, and one hour to the nearest level IV trauma center.

The hospital payer mix is mostly Medicare at around 55%. Other payers include Managed Medi-Cal (20%), commercial (13%), traditional Medi-Cal (7%), and managed Medicare (3%). Most of the Native American patients served are Pomo, Miwoks and Wiyots. The nearest Indian Health Center is in Santa Rosa which is a county away. Dr. Rochat is a Veteran's Association Choice Provider because it is over 40 miles away to a VA center. The nearest VA oncology facility is in San Francisco. Many of the patients own their own homes which is an asset so that affects their ability to get financial assistance for expensive medications. The patient population is older, and many patients have lower education levels.

Three percent of oncologists take care nearly twenty percent of oncology patients. The cancer incidence in rural areas are lower but the mortality rates are greater. Nearly 20% of Americans are considered rural by some standards. There is a lack of internet availability in rural areas which makes it more difficult for people to access information.

Unger, Et al., Geographic Distribution and Survival Outcomes for Rural Patients with Cancer Treated in Clinical Trials found that rural clinical trial patients were more likely to be 65 or older, Caucasian, male and had prognostic factors that were similar. The trial also determined that equal applications of standards of care has the greatest impact on outcomes. The National Comprehensive Cancer Network is a great tool that can be used and is free. Different networks are doing clinical trials and sharing guidelines that are sharing standards of care and can make a huge impact. Patients can be shown that the therapy in a rural setting like Fort Bragg is the same therapy that they would receive in an urban setting. Most cancer care is outpatient so does not need to be achieved through a hospital. Patients who are outpatient must follow the regimen and have appropriate supportive care. “It takes a village” to deliver standards of care including a medical oncologist, oncology nurse, pharmacist, radiation oncologist, surgeon, pathologist, radiologist, and primary care providers.

Assessing for distress is very important with cancer patients. Traveling a distance for treatment is disruptive to sleep and diet. There is nearly no public transportation. Patients who travel for treatment must pay for transportation, food and lodging. Patients must work to have health insurance and they have families and other commitments. There is a lack of mental health support.

Rural areas are at risk at poor community self-esteem. They don't feel they have the ability or talent to do what is necessary. The electronic health systems are incompatible so that is a problem with continuity. The perception of HIPAA is a destructive force. It has good origins but has kept people from knowing that they can communicate about a patient's care.

Improving primary care access in rural is vital. Other suggestions are encouraging National Comprehensive Cancer Network use, educate all providers about performance status versus ageism, make “HIPAA” user friendly, encourage academic support/collaboration and medical student and allied health student rural training, grant library/journal access for rural providers, and improve rural reimbursement rates for cancer care.

**Moon S. Chen, Jr., MPH, PhD**  
**UC Davis School of Medicine**  
**UC Davis Comprehensive Cancer Center**

**Moon Chen** said that UC Davis is working to create a rural approach to cancer prevention and control. UC Davis is not located in rural so there is a distance factor. The catchment area is the size of West Virginia and that is a challenge. UC Davis collaborated with Northern Valley Indian Health which is a very sophisticated primary care serving institution that serves rural and Native American populations, so it was a perfect collaboration.

The focus of the research was on HPV vaccination because it is known to prevent cancer. There has been an HPV needs assessment, clinic wide staff training, and parent workshops and focus groups. The community needs assessment findings are that there is limited knowledge of HPV, most parents would allow the vaccine for their children if recommended by provider and would get it if the school required it. The clinical training preliminary results reflected that all staff need to be on the same page about vaccination and that using scripts were helpful to address parent concerns. The use of cancer statistics and clinic rates was helpful in educating parents.

The conclusion of the parent workshops was there is not enough information from the medical provider to make an informed decision. Parents need easy to read informative and educational materials to take home for review. Most parents would get the vaccine if the provider recommended it and it was administered outside of a clinic setting. Parents were shocked by the cancer statistics. They appreciated the information that was shared about how a vaccine is approved and added to Advisory Committee on Immunization Practice recommendations.

## Q&A

**Molly Dodge** stated that there is a theme that equal access of standard of care has best outcomes, but rural people lack confidence in their abilities. The best practices in growing trust and confidence is critical because rural communities rely on trust.

**John Rochat** replied that patients go to an academic center in a city and are told that the rural providers don't do things well and that is a huge problem. The larger institutions need educating on what rural providers and medical centers are trying to accomplish.

**Steve Barrett** stated that patients think that urban areas have more sophisticated equipment than rural but that is not always the case. Providers need to have evidence-based data to explain that to patients they are receiving as high-quality treatment as everyone else in the country.

**Carolyn Montoya** said the committee has addressed scope of practice and made recommendations on a regular basis. There are twenty states have full scope practice. Physicians need to band together, at an organized level, as a group at an American Medical Association or state conference to say that it is time to have a full scope practice.

**John Rochat** replied that physicians are historically not part of associations. Research institutions need to show proof that there should be a full scope of practice.

## Committee Discussion or Rural Cancer Prevention and Control

### Tom Morris – Topics Discussed by Committee

#### Possible Recommendation/Consideration Areas

- Research study into the safety and effectiveness of having other primary care providers or Rx offer vaccines.

- Encourage CDC in identifying community clinical partners like FQHCs could also note RHCs, CAHs and other small rural hospitals (<50 beds) since heavily focused on primary care.
- The need for more specific targeted focus on prevention for tribal populations. NCI has some work underway in this area and it may be worth recommending they do more.
- Recommendation on rural data collection specificity given travel to treatment and if the data is collected at the site you undercount rural.
- The NCI work as a broader HHS best practice for the Rural Task Force to consider.
- The cost of the HPV vaccine.
- Vaccination rates in value-based care.
- Promote the National Comprehensive Care Network guidelines.

## **NATIONAL PERSPECTIVES ON SUPPORTIVE SERVICES FOR OLDER ADULTS**

**Craig Thomas, PhD, MS**

**Director – Division of Population Health**

**National Center for Chronic Disease Prevention and Health Promotion**

**Centers for Disease Control and Prevention**

**Craig Thomas** said that he would share data on cognitive decline, dementia, and Alzheimer's disease. He is also going to share the CDC public health response to the epidemic. The topic of caregivers in rural areas and information about the work that the CDC is doing in Indian country will be discussed. Most of the data that will be shared is from the Behavioral Risk Factor Surveillance System.

There are higher rates of arthritis in rural areas for those 45 and older. Mental distress and diagnosed depressed disorder are significantly higher in rural counties. Cognitive decline is also more prevalent in rural settings.

Nearly six million Americans are living with Alzheimer's disease. The annual cost of Alzheimer's is 2.17 billion dollars. By 2050 the annual cost is estimated to be 1.1 trillion of healthcare costs.

Thirty-five percent of people diagnosed with dementias, or their caregivers, are aware of the diagnosis. Twenty five percent of hospitalizations are preventable among older adults diagnosed with dementia. Forty five percent of people with Subjective Cognitive Decline discussed memory concerns with health care provider. Seventy percent of people with dementia live in community settings and ninety five percent of Medicare beneficiaries with dementia have one or more chronic conditions. Dr. Thomas shared that he has been a caregiver for a parent with Alzheimer's Disease, so he is aware of the challenges and day to day stress that it creates for families. One in three caregivers for people with Alzheimer's report worsening health. In comparison from 1999 – 2014, the rural areas have the most significant increase in deaths due to Alzheimer's.

The Healthy Brain Initiative is a national public health roadmap to maintaining cognitive health, focusing on education and empowerment of communities and working with national partners. There are specific topics that are part of the Healthy Brain Initiative Roadmap such as caregivers, accelerating risk reduction and promoting brain health and advancing early detection.

In rural settings, financial barriers are often the biggest challenge for caregivers. The informal network in rural areas and the ability for caregivers to be more adaptive is higher in rural than metropolitan areas. It is based on being resilient from facing numerous challenges in rural communities.

The Division of Population Health funds tribes directly through the Good Health and Wellness in Indian Country Initiative. Heart disease is the leading cause of death among American Indians and Alaskan Native people and a major risk factor for dementia. One in ten people in the U.S. over the age of 65 have Alzheimer's. One in three American Indians and Alaskan Native people over 65 develop dementia, including Alzheimer's. *Spring 2019 – Roadmap for Indian Country.*

Elders play an essential role of ensuring that knowledge of tribal practices are passed from one generation to another. With the increasing numbers of dementia, it is very concerning for tribal practice. The Tribal Practices Program looks at addressing the importance of culture in Indian Country and supporting the culture. Looking at ways at the grassroots level to increasing activity and what diet is best for helping with hypertension.

**Emily Allen**  
**Senior Vice President**  
**AARP Foundation**

**Emily Allen** stated most people are familiar with AARP, but fewer are familiar with the AARP foundation. AARP Foundation works to end senior poverty by helping vulnerable older adults build economic opportunity and social connectedness.

Everyone knows an elderly person who is in social isolation, but we just don't take it into account. She said that there was an elderly woman in her neighborhood that she saw going to the bus stop to work but didn't know her. One day she saw her walking in the rain and felt that she should stop and offer her a ride, but she didn't. Something stops us from connecting with our neighbors, friends, and even family in this day and time. AARP is one of the largest organizations that focuses on the needs of residents in small towns through programs and advocacy. AARP Foundation is the charitable organization that focuses on eradicating senior poverty with the goal of building economic opportunity and social connection. There can't be economic opportunity without social connections. A challenge is that systems and services are siloed.

The difference between isolation and loneliness is that isolation has quantifiable measures, but loneliness is a subjective feeling. If there is a focus on isolation it is more likely to address

loneliness. People who are socially isolated don't have anyone to call if there is an emergency. Isolation is a health issue and is as bad for health as smoking fifteen cigarettes a day and results in things like high blood pressure and greater risk of disease and an early onset of dementia.

Older adults who describe themselves as lonely have a 59% greater risk of functional decline and a 45% greater risk of death. Forty six percent of women seventy-five and older live alone. Social isolation among older adults is associated with an estimated \$6.7 billion in additional Medicare spending annually. Each month, Medicare spent an estimated \$134 more for socially isolated older adults.

Isolation is the result of being disconnected from support groups of family, friends and community. Risk factors and causes of isolation include limited transportation, unsafe or inaccessible neighborhood, and societal barriers. Being low-income increases the chances of isolation for older adults and there are 37 million low income adults in the United States. One quarter of all Americans 65 and older live in a rural environment. The positive aspect of being in a rural area is that there are more connections with community members. The negative aspect of being an older adult in a rural community is that the life expectancy has not kept the pace of urban communities and neither have services. Social isolation is more prevalent in rural areas where physical distances, lack of public transportation, and fewer community resources pose barriers to social engagement. Only 33 percent of residents of small towns and 11 percent of those in rural areas have access to public transit options such as buses or van pools.

There are many ways to improve the problem of social isolation. Clinical visits can include screening and detection for social isolation. Programs within the Administration of Community Living can be leveraged. Expanding broadband and increased access to transportation will broaden avenues of communication for older adults. Support for the Corporation for National and Community Service volunteer programs. Funding additional research with a focus on rural Americans will assist in solving the issues of isolation in rural America.

**Terry Fulmer, PhD, RN, FAAN**  
**President**  
**The John A. Hartford Foundation**

**Terry Fulmer** thanked the committee for being invited to speak and for their leadership. She served for 10 years on The Geriatrics and Gerontology Advisory Committee for The Department of Veterans Affairs that reports to the Secretary. These types of committees have an extraordinary opportunity to make an impact at the Secretarial level.

Dr. Fulmer grew up in a town with a population of 300 in upstate New York. One of the most meaningful websites that she views was created by a high schoolmate in her rural hometown. Daily he posts a picture from the community. When she joined the page there were 300 followers and now there are 3,000. This is an example of the importance of connectiveness.

Dr. Fulmer is the Chairman of the Board of Bassett Medical Center in upstate New York. The medical center covers 6,000 square miles of rural poverty. The area faces financial and access challenges. When there are snow storms it is very difficult.

The John A. Hartford Foundation was founded in 1929 by A&P grocery store money and is dedicated to improving the care of older adults. Priorities include creating age-friendly health systems, supporting family caregivers, and improving serious illness and end of life care. Age-friendly health systems focus on what matters to older adults receiving care, improving health outcomes, reducing harm, and achieving lower costs and better value. Serious illness and end of life care priorities include making palliative care more widely available, supporting clinician training, and promoting advance care planning. Family caregiving priorities include helping health systems assess and address needs of family caregivers and advancing family-centered care. More than 18 million people are family caregivers.

The foundation is working on an age-friendly social movement with a vision of using the work of AARP on Age Friendly Communities, the World Health Organization's work on Age Friendly Cities, the John A. Hartford work on Age Friendly Health Centers, and the Trust for America's Health work on Age Friendly Public Health Systems. The vision is that all systems will be measured the same and the same names will be used for an equal power base and continuity of care. There is a grant for age-friendly public health systems in Florida. There are 40 of the 60 counties in Florida where the ageing networks and public health networks are coming together to look at redundancies, synergies and where they can work smarter.

John Beard, a physician from Australia, coined the term age-friendly and the John A. Hartford Foundation is advancing the idea further. The American Hospital Association and The Catholic Health Association is helping to develop the age-friendly health system. The aim is to get 20% of health systems and hospitals to be age-friendly by 2020 so people get the best care possible in every setting. There is a 4M framework for an age-friendly system which is mobility, medication, what matters, and mentation. These are interactive and if someone is on medications that aren't appropriate it will affect what matters, mentation, and mobility.

Age-friendly care results in concordant care, improving health, cost effective services, and attaining joy in work. There is a critical workforce shortage in rural areas. The Geriatric Workforce Enhancement Program Grant from HRSA embedded age-friendly health systems and the 4Ms into their latest call for proposals. On an annual basis it is 35 million dollars per year for five years so people will begin talking about age-friendly health systems and the 4Ms.

## Q&A

**Octavio Martinez** said that he appreciates the work that is being done on dementia. There are some individuals being classified as having dementia, but it is delirium. Sometimes it can be an infection like a UTI and once it is treated for the infections the delirium clears. Are you including delirium in the context of healthy aging?

**Craig Thomas** responded that delirium is not included because they are the only group at the Centers for Disease Control that are looking at healthy aging. There is a targeted focus on Alzheimer's. This is an important issue because delirium is related to healthcare. Thank you for sharing and it can be considered going forward.

**Terry Fulmer** said that Hartford Hospital has data that demonstrates if people are screened and delirium is prevented it can cut down the number of days that people spend in the hospital. The National Advisory Committee on Aging for National Institute on Aging is focusing efforts on dementia and delirium.

**Carolyn Montoya** said that the RN workforce is not working at the full scope of their practice. What has happened to public health nursing?

**Terry Fulmer** the public health system around public health nursing has been decimated due to cost cutting and shifting priorities. Through a grant that is working with public health systems there is a goal to consider public health nursing. She said that two of her aunts were public health nurses and they saved lives because they got to the person before they were so sick that they had to go to the emergency room.

**Steve Barnett** said that the impact of oral health on the elderly population is important to consider. Chronic disease such as periodontal disease is often prevalent with older adults and is linked to the inflammatory aspect of disease. Oral cancer and carries are an issue with older adults and some oral health issues are due to the medications they are taking. Medicare doesn't cover dental treatment so there is a financial burden and lower quality of care.

**Terry Fulmer** responded that she has done work on oral health. The American Dental Professionals opted out of Medicare in 1965 and now it is understood that it was not a good idea. This is a serious caregiver issue because oral health is difficult to do for caregivers.

**Kathleen Belanger** asked if the speaker could express how human services can be utilized and reduce the burden and caregiving?

**Craig Thomas** said there is an action plan in the road map he spoke about and there are policy related actions that could be addressed by state and local representatives.

**Emily Allen** stated that human services and social services are linked to the funding streams they receive and that creates siloes. Money needs to be distributed into communities that will treat the whole person. Philanthropy needs to be considered in an innovative way.

**Steve Barnett** asked if there is anything positive or negative with small rural facilities that are part of accountable care organizations?

**Terry Fulmer** stated that many small facilities haven't had the funds to become accountable care organizations. It is important to do follow-up after a person is discharged so a telehealth home visit would be very useful. The government could decide that ACOs won't be paid for anymore, so the work must be done now.

**Chester Robinson** asked how the committee can give direction to policy makers, looking at all the information that has been covered, that would be the most useful to them. Has there been an analysis on trends, or will that be a topic for the committee consider? There is great work being done in different areas but how is the best way to bring it together?

**Emily Allen** said the isolation issue or the social determinant issue and the bridge between human services and health care are important focuses. There is evidence that screening and intervening around social determinants, particularly food insecurity, is working. From an education policy and practice standpoint, this could bring focus to these issues.

## **STATE PERSPECTIVES ON SUPPORTIVE SERVICES FOR OLDER ADULTS**

**Sarah S. Steenhausen, MS**  
**Senior Policy Advisor**  
**The SCAN Foundation**

**Sarah Steenhausen** said it is wonderful to have the opportunity to speak to the committee. The SCAN foundation focuses solely on the needs and issues impacting older adults. Three main focuses are transforming care and delivery into more person-centered models of care, driving the financial policies across both the healthcare and long-term health care systems, and developing resiliency in older adults and their families by responding to the needs of the aging population.

The policy sector of the SCAN Foundation is part a broad policy team that provides technical assistance and education at the state and federal level. The policy team supports different initiatives, educates the broader public, and work on the program level.

Long-term services and supports include non-medical functional support and help with activities of daily living. These supports can be in a home, community, or institutional setting and provided by paid or unpaid caregivers. Most people would like to remain in their home but some older individuals may have cognitive impairment and not have family in the area so they may move into an assisted living facility. In the traditional institutional setting such as nursing homes people can receive long-term support. The impact in rural parts of California are significant regarding LTSS when people don't have family who live in the area and it is difficult for older individuals to live at home. They may not know about programs that can provide paid supports. There are infrastructure and workforce issues so there is not capacity in rural areas to provide services. Unpaid family caregivers are the backbone of the system. Two thirds of people over the age of 65 who live at home receive all their LTSS from an unpaid family member or friend. There are 4.5 million family caregivers in California that provide 58 billion dollars' worth of services. In the institutional and home settings the paid caregivers are personal care assistants and home health aides. In institutional settings and assisted living centers there are certified nursing assistants.

Through Medicare, people in California over the age of 65 can get acute care, prescription drugs, and post-acute care. Long-term services and supports are not covered by Medicare and most people are not aware of this and don't prepare in advance. Medi-Cal is the Medicaid program in

California and is for low-income individuals and people who are aged, blind, and disabled can qualify for LTSS through Medi-Cal. In California there are approximately 1.4 million dual-eligible individuals and they are the sickest and most vulnerable in the population. There is an intersection between healthcare and social service delivery needs. There should be a perfect wrap-around system, but it is currently a very fragmented service delivery system.

The LTSS financing system is broken in California and the nation. Out-of-pocket expenditures account for 53% of services and support expenditures. This includes people who are hiring home health care aids or moving a loved one into a nursing home or an assisted living facility. Unfortunately, many people are impoverishing themselves paying for their long-term care needs and must receive Medicaid. When Medicaid was established in 1965, it was not intended to be a primary source to pay for long-term care. It is very expensive for the state and federal governments and is not an ideal system. Private long-term care insurance that started expanding in the 1990's has challenges with the policies. It is very expensive, and people are being excluded with preexisting conditions.

The California system of home and community-based services are funded through Medi-Cal or other sources such as Area Agencies on Aging, caregiver resource centers and independent living centers. Medi-Cal program runs the nation's largest personal care service program. It is an entitlement in the state so if a person qualifies for Medi-Cal and needs long-term care you can hire someone to provide personal care services at home. This is the backbone of the service delivery system but IHHS and home supportive services alone can't meet the needs of the long-term care system. If a person doesn't qualify for Medi-Cal they don't have access to the program. There are small Medicaid waiver programs that provide services in the home and community but have not been scaled to meet all the needs.

The system is very fragmented and there are many different funding streams and programs so individuals can't navigate the system on their own. The funding streams aren't driven to be person-centered, so people don't often get the services they need. In general, it is important to note that the service delivery system has been based on fee-for-service. Nationally and at the state level there is a movement toward more organized service delivery. The Medi-Cal managed care service delivery system is playing a greater role in service delivery across healthcare and long-term services and supports. There is a move towards a person-centered system with individuals having a needs assessment in order to have access to all the services necessary. Every county now has a Medi-Cal managed care infrastructure. There are six main models of care including two plan models with a commercial plan and local initiatives. There are counties that run one health plan for all the Medi-Cal population and most rural areas operate out of the county organized health system. Traditionally the Medi-Cal managed care plans served the younger population but five or six years ago the state mandated that all people on Medi-Cal including people with disabilities have Medi-Cal managed care plans. There are implications for the broader infrastructure including rural areas because they must meet the needs of a broader population.

California's Coordinated Care Initiative, Cal MediConnect and Managed LTSS, works to integrate and coordinate service delivery. The coordinated care is in urban areas so rural areas haven't been part of the expansion and the state is looking at how to expand this successfully in

the coming years. There are other integrated service delivery models including The Program for All-Inclusive Care for the Elderly, Medicare Advantage, and dual-eligible special needs plans, and accountable care organizations.

Integrated care and rural considerations should include the availability of integrated care choices for Medicare. Medi-Cal beneficiaries significantly vary depending on where they live in California. The My Care My Choice online resource assists dual eligibles understand options. California's population is aging, and the state has limited resources. It is anticipated that within the next ten years the population will nearly double. There are already capacity issues, particularly in the rural areas. The 60 plus population is growing and some counties are seeing a 200 percent increase in their older population and will face significant issues in the future.

The SCAN foundation worked with West Health Foundation on polling work. Overwhelmingly, voters felt that the state is not prepared on these issues and want to see a comprehensive plan to address the issues. The candidates committed to doing a plan and Governor Newsom announced that it is time for California to plan for the needs of the growing demographic and do a master plan on aging in California.

The SCAN foundation vision is a society where older adults can access health and supportive services of their choosing to meet their needs. The mission is to advance a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence.

**Jedd Hampton, MPA**  
**Director of Public Policy**  
**LeadingAge California**

**Jedd Hampton** stated that LeadingAge California is a trade association that represents over six hundred nonprofit providers including senior affordable housing, skilled nursing, assisted living, home and community-based services, home care, and PACE providers. The LeadingAge vision is to be the champion for aging services in California and the mission is to advance housing, care, and services for older adults. The LeadingAge California values are a commitment to security of older adults, to be mission driven, support socioeconomic and cultural diversity, advocate for not-for-profit status, support dignity and equality for older adults, and be community based. The goals are to strengthen membership value, lead policy, cultivate leadership, and provide leading education. Some of the issues facing long term services and supports include workforce issues, lack of financing, senior specific affordable housing, and transportation challenges. Workforce challenges include access to qualified workforce, increasing competition, and lack of personal support systems. One of the biggest issues is the lack of training opportunities available at the clinical level. There has been work with community colleges on frontline staff. A lack of certified nursing assistants is the biggest challenge for long-term service providers. A law was passed in 1987 that disqualifies a skilled nursing facility from hosting their own training program for two years if they are sited with a violation of around ten thousand dollars. There are about twelve hundred and fifty skilled nursing facilities and only forty-eight have training sites. There are immigration challenges with

certified nursing assistants and there is an increase in the immigration workforce to meet the needs of the state.

Approximately six million Californians have no workplace pension or retirement savings program. Sixty four percent of workers without access to a workplace retirement plan are people of color, with Latinos being the highest percentage. Nearly half of California workers are projected to retire with incomes below 200% of the federal poverty level. For those with retirement savings there are tax penalties for withdrawing savings before the age of 59, and withdrawals at any age is taxed as ordinary income, even if it is used for long term services and supports.

The long-term insurance market currently has premium hikes on both prospective and retrospective businesses and tightened underwriting practices. Ninety percent of insurance companies that once offered long term care insurance on a national basis no longer do so and there is a trend towards high-end niche products and few or no insurance options for those with a middle-income.

Seniors are among the most rent burdened in the state. Homelessness among seniors is on the rise and there is a lack of funding for senior affordable funding. Nearly 1.5 million elderly households with incomes below fifty percent of area median income paid more than half of their income toward rent. There are fifty million people living in rural America and fifteen percent are older adults and ten percent live in poverty. Section 202 funding is chronically underfunded. There is a lack of transportation funding in rural communities. There need to be incentives for developers to build more rural senior affordable housing.

## Q&A

**Molly Dodge** said that Jedd Hampton had mentioned barriers to education through community colleges for certified nursing assistants. Have your members looked for programs through adult education, integrated training programs, or partnering with K12 and allowing high school students to start a career as a CNA? Have the members considered tuition reimbursement programs for CNAs to upgrade their skills? Have your members looked at social impact funds to fund tuition?

**Jedd Hampton** stated that he would answer the question about the social impact funds first and he is not sure, but it is a wonderful question and he will talk to the members. Cali mortgage program is specific for not for profit health care providers or public entities that allows them to build and upgrade facilities with very low interest rates. It is intended to encourage non-profit providers to take out the loans and upgrade their infrastructure. The K12 education has been considered but the challenge is the high minimum wage and the physical and mental demands of the CNA job. A sixteen-year-old can work at a restaurant and then work as a CNA and it is too difficult for the pay level. A person can work in fast food and make the same amount of money. A person must have a special perspective to want to do the job. The members are active and involved with the community college and works with the K12 system. They are hosting a career fair in San Francisco that has been promoted all over the state.

**Octavio Martinez** asked Sarah Steenhausen if they are working with the state on the California Supportive Care Initiative and working on contract language that you can include with a continuum of care approach?

**Sarah Steenhausen** responded that the legislature was really involved because it was driven as a budget initiative in 2012. It became controversial because the governor was hoping it would save upwards of 800 million dollars through the coordinated care initiative. Many people agreed with the goals but didn't think that running it as a budget initiative gave it the attention needed. The legislature has put specific parameters around the movement towards integrated service delivery, so the state doesn't have the flexibility to pursue it with the federal government. The Department of Health Care Services has a bandwidth issues, so this is not its highest priority at the time. There is a lot of potential for significant movement but there is more work to do to set the vision and follow with the managed care contracts.

## **PUBLIC COMMENT**

**Chester J. Austin, MD**  
**Medical Director**  
**Northern Valley Indian Health, Inc.**

I support having Advanced Practice Clinicians working to the full level of their scope, whether independently or in collaboration with a supervising physician. Even with a supervising physician, they are not currently working to their full scope, as Medicare requires a physician to sign documents for incontinence supplies and other durable medical equipment and some referrals and even requires a physician to see a patient for diabetic shoes. APCs are fully capable of assessing whether a patient needs diabetic shoes or incontinence supplies. These ridiculous requirements put an unnecessary burden on physicians and adds to the challenges of recruiting and retaining adequate physician coverage in rural settings.

**Thursday, April 4<sup>th</sup>, 2019**

Thursday morning the subcommittees depart for site visits as follows:

**SITE VISIT**  
**Supportive Services and Caregiving for Older Adults in Rural America**  
**SIERRA NEVADA MEMORIAL HOSPITAL**  
**Grass Valley, California**

**The subcommittee members present at the meeting:** Octavio Martinez, Jr., MD (Subcommittee Chair), Steve Barnett, DHA, CRNA, FACHE; Kathleen Belanger, PhD.; Kathleen Dalton, Ph.D.; Molly Dodge; Constance Greer, MPH; Chester Robinson, DPA; Mary Kate Rolf, MBA, FACHE; Mary Sheridan, RN, MBA.

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

**Guests:** Ellen Allen, AARP; Eliza Heppner, AARP; Cara James, CMS; Scott Miller, CDC; Craig Thomas, CDC; Shannon Wolfe, Committee Staff.

## COMMUNITY PANELISTS AND ATTENDEES

### Morning Session

**Collen Bond, RN**- Helping Hands Adult Day Program

**Brian Evans, MD, MBA** - Dignity Health Sierra Nevada Memorial Hospital

**Margaret Borowiak** - California Agency on Aging;

**Janeth Marroletti, MPH, CHES** - Gold Country Community Services

**Aimee Sagan** - Chapa-De Indian Health

**Lauren Swinney, RN** - Dignity Health Sierra Nevada Memorial Hospital

**Fred Skeen, RN, PHN** - Hospitality House

**Kimberly Parker** - Dignity Health Sierra Nevada Memorial Hospital

### Afternoon Session

**Ana Acton** - FREED Center for Independent Living

**Debra Dworaczyk**- Hospice of the Foothills

**Barbara Larsen** - Elder-Care Providers' Coalition of Nevada County

**Michelle Cowen**- Disability Consultant

**Brian Snyder** – FREED Center for Independent Living

**Valerie Sharp**- FREED Center for Independent Living

**Karen Marinovich**- Falls Prevention Coalition of Nevada County

**Peter Stack**- Partners in Care

## SITE VISIT

### Examining Rural Cancer Prevention and Control

#### NORTHERN VALLEY INDIAN HEALTH

#### Willows, California

**Subcommittee members:** Peggy Wheeler, MPH (Subcommittee Chair); Carolyn Emanuel-McClain, MPH; Kelley Evans; Joe Lupica, JD; Barb Fabre; Carolyn Montoya, PhD, CPNP; Sallie Poepsel, MSN, PhD, CRNA; Benjamin Taylor, PhD, DFAAPA, PA-C and Robert Wergin, MD, FAAFP.

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

**Guests:** Shobha Srinivasan, PhD, National Cancer Institute; Benjamin Smith, MBA, MA, Indian Health Service; John Rochat, MD, Mendocino Coast District Hospital.

The subcommittee met with Chester Austin, MD, at Northern Valley Indian Health.

The subcommittees' returned to The Residence Inn, Sacramento, CA, to discuss site visits.

## **PUBLIC COMMENT**

There was no public comment.

**Friday, April 5<sup>th</sup>, 2019**

## **DRAFTING OUTLINE OF POLICY BRIEF**

### **SUPPORTIVE SERVICES AND CAREGIVING FOR OLDER ADULTS IN RURAL AMERICA**

Subcommittee findings and possible recommendations include:

- The importance of data sharing across the continuum of care.
- The current fragmentation of acute, post-acute, and long-term services and supports services with poor coordination/collaboration among most parties.
  - Challenges incentivizing providers to improve this as CMS shifts focus to value-based/managed care.
- Challenges navigating the system as a consumer of supportive service programs.
- Rural isolation and homelessness.
- Stigma associated with accessing aging resources.
- Loss of public health infrastructure as a key partner in data collection and accessing supportive services.
- Workforce issues: provider shortages, training of unpaid caregivers (or lack thereof), the need for respite options, and burnout.
- A lack of adequate housing and transportation.
- The constraints of Medicare/Medicaid billing regulations regarding telehealth and accessing primary care, specialists, and home and community-based services.
- Age friendly systems.
- Cases of cognitive decline have a higher prevalence in rural.

Recommendations:

1. Non-Emergency Medical Transportation (NEMT) through Medicaid should remain as a required service for all states to provide.
2. Expand telehealth/Medicare billing beyond traditional brick and mortar in rural areas.
3. Similarly, in rural communities, allow for the billing of multiple services over one visit due to the geographic distance most rural patients must travel for care.
4. Including Age-Friendly concepts within RHOP (rural health outreach program) and other rural health grants.

5. Explore Medicare Advantage Dual-Eligible Special Needs Plans ability to reach rural enrollees.
6. Peer navigators for those who need assistance finding local programs.
7. Rural communities develop a comprehensive plan.

Considerations:

- Supporting the reauthorization of the Older Americans Act in 2020
- The need for public education on the dangers of social isolation (equivalent to smoking 15 cigarettes per day)
- Including social isolation within the Healthy People 2030 framework
- Expand the Family Caregiver Support Program:  
<https://acl.gov/programs/support-caregivers/national-family-caregiver-support-program>
- The need for an expansion and promotion of ADRC services and Intergenerational/collaborative care programs
  - Incorporation of ACEs, Social Determinants of Health, and Age-Friendly Systems into their program framework
- The need to fund community health workers through Medicaid managed care
  - No HRSA-funded paraprofessional program for community health workers (other than for the opioid response program) despite their importance improving health outcomes.
- Conducting a meta-analysis of what is working and why among long-term services and supports and aging programs.
- Emergency preparedness and response for seniors and those with disabilities.
- Training for family caregivers to understand what is happening and to assist with their grieving. Training for paid caregivers.
- Use public information campaigns on how residents prepare for old age in their rural community.

## **RURAL CANCER PREVENTION AND CONTROL IN RURAL AMERICA**

Subcommittee findings and possible recommendations include:

What makes cancer control unique in rural is a key theme and access to primary care is the key to rural cancer control.

- Health and Human Services should use provider mechanisms to train primary care doctors so they can be in communications with specialists and work more with prevention and screening.
- HHS should have a focus on rural cancer care and what works better in rural.
- Define the responsibilities of patient navigators.
- More education for rural providers to use existing codes.

- National Cancer Institute recommendation to increase funding for rural cancer control program.
- Focus on states with higher cancer rates.
- Money needs to come together from different sources for better models of care coordination.
- Having culturally competent materials.
- There are lower cancer rates but higher death rates in rural. Facilitate studies to research possible explanations.

## **DISCUSSION OF FUTURE TOPICS AND RURAL HEALTH RESOURCES**

### **SEPTEMBER MEETING**

**September 9<sup>th</sup> – 11<sup>th</sup>, 2019**

The Health and Human Services Secretary may join the meeting with focus on a Rural Task Force. Centers for Medicare & Medicaid Services and Health Resources and Services Administration are convening listening sessions on supporting rural stakeholders. The taskforce is focused on transformation and redesign in rural communities and looking at essential services that are needed.

#### **Topics may include:**

- Transformation and redesign in rural - crosscutting health and human services
  - How to change financial structures and redesigning services.
- Access to maternity care-obstetrics / early childhood development.
  - If families don't have access to obstetrics care people are leaving rural areas.
  - This can also be connected to the opioid epidemic and neonatal abstinence syndrome.

Possible locations include Michigan, Missouri, Montana, Arizona, Indiana, and Texas.

#### **PUBLIC COMMENT**

There was no public comment.