

Operator: Welcome and thank you for standing by. All participants are in a listen only mode until the question and answer session of today's conference. At that time if you'd like to ask a question, please press star then one. Also today's conference is being recorded. If you have any objections, you may disconnect at this time. I'd now like to turn the call over to your host Ms. Shawnda Schroeder. Thank you. You may begin.

Shawnda Schroeder: Thank you and good morning to everybody that is joining us. My name is Shawnda Schroeder, and I am the principle investigator of the Rural Health Research Gateway, also just referred to as Gateway. Today Gateway is hosting a webinar entitled Recent Trends in Children's Healthcare: Coverage and Oral Health Outcomes.

For those of you who aren't familiar with Gateway, we are a Web site that provides easy and timely access to research and findings of the Federal Office of Rural Health Policy-funded Rural Health Research Centers. This dates back to 1997. Our goal really is to help move the new research findings of those research centers to various end users as quickly and efficiently as possible. And one of the ways that we do this is through our webinar series.

Our website can be used to find abstracts of current and completed research projects, publications that came from those projects, and really any information about the research centers themselves, including contact information for the individual researchers.

Following today's presentation, this webinar will be posted to our website, and you can find Gateway at ruralhealthresearch.org. There is also a link to Gateway on the left hand side of your screen today. You can join our Gateway alerts and receive periodic emails whenever there's a new publication

available and new research findings as well as the recording of today's webinar will be sent out through those alert systems.

You can follow us on Twitter, like us on Facebook, and then you can receive daily notifications about all of our rural health research. We have muted all of your lines today, but I encourage you to use the chat box at the bottom of your screen if you should have any questions for Dr. Bennett. I will be interjecting as those questions appear and asking them of Dr. Bennett, and we will also open the line for question and answer at the end of the webinar.

Thank you again for joining us, and I'm now going to introduce our presenter Dr. Kevin Bennett. Dr. Bennett is an associate professor and director of research in the Department of Family and Preventive Medicine at the University of South Carolina School of Medicine in Columbia, South Carolina.

He's also a senior research associate at the South Carolina Rural Health Research Center and director of research for the South Carolina Center for Rural and Primary Care. His research agenda focuses upon care delivery for vulnerable populations such as non-whites, rural residents, and those with chronic diseases. His publications cover topics such as transitions of care across communities, facility availability and service provision, and finance of healthcare services.

He has also worked extensively with community organizations, rural health networks, and state agencies to evaluate rural healthcare programs and initiatives. He also serves as the chair of the editorial board for the *Journal of Rural Health*. Thank you so much for joining us today Dr. Bennett, and I will turn the presentation over to you.

Kevin Bennett: Okay. Thank you. I apologize in advance if there's any loudness going on. There's construction upstairs and occasionally it shakes the building. So bear with me. Hopefully you won't hear any of that. So I'm going to go ahead and get started. We're going to talk today - let's see if I can get this moving right. Okay, great.

So we're going to talk about a couple of things today. First, I want to kind of go over what the current policy context is that leads into some of the findings we're going to talk about. So we'll talk about a lot about Medicaid and CHIP, mostly because that's a huge payer for children in this country and especially when it comes to oral health as well.

So we'll talk about some of the policy issues that have gone on around that. I actually updated the slides yesterday and today based on things that have happened even in the next 24 or 48 hours. So we'll discuss some of that. If you have questions about that, that would be the time to chime in as well. And then we'll go into some more recent findings that we've done here and with other places around oral health and children's health.

And I say recent in quotation marks simply because the data is not that up to date. I think most of it's from 2012 or 2013. And we'll talk about that a little bit more when we get into it. And then we'll have some discussion toward the end. And I do want to reiterate, please chime in if you have questions during the presentation. I'd rather it be interactive in that way. And so don't be afraid to chime in and ask questions as we go, and I'll get to them the best that I can.

So diving right in here, first I want to go over some of the good stuff that's going on. Right now the uninsured rate among children is about 5%, which is an all-time low, and that's directly attributable to the Affordable Care Act and

largely to the Medicaid expansion that has happened in most of the U.S. without - with some exceptions obviously.

Medicaid and CHIP accounts for about 39% of that coverage for children and that varies state to state as far as how many children with insurance are covered by Medicaid and CHIP. In certain areas like here in South Carolina, that rate is a little bit higher especially when you're talking pregnancies and births. But in other words, Medicaid and CHIP is a huge player in this arena for coverage for children.

So in 2015, which is the most recent data and estimates I could find, Medicaid is covering about 36.8 million children and about 8.4 million through CHIP. So these are major players that are vitally important in a policy context and a healthcare access context.

So current policy, what's going on right now? And I say this without sarcasm, you literally need to check almost daily what's going on now. There's a couple great resources out there for those of you that are interested in policy issues like this. There's daily emails that different news organizations send out.

One is through Politico and the other one is through Vox Media. One comes in the morning and one comes in the afternoon and they're a perfect summary of everything that happens in between and the day before and those kinds of things. So those have been very helpful for me as far as keeping up with what's going on, as far as legislation and who's supporting what and who's not supporting what and those types of things.

So big issues that are going on right now, CHIP did expire and it's been more than a month, I think close to six weeks now where it has been expired

without appropriations from the legislature. And we'll talk about that more in a minute. Medicaid funding and expansion is an ongoing type of issue. If you followed the election from the other night, you'll see that Maine voters supported a ballot initiative to expand Medicaid, which the legislature in Maine has been working on for quite some time, with the governor there vetoing it every time it was passed.

So this was overwhelmingly supported and passed but and we'll - I think we'll talk about that more in a minute. But basically the governor is once again saying, no we're not going to do it unless you pass a bill to appropriate funds for it. So even with that ballot initiative things are still on hold there.

There's a lot going on with the ACA and marketplace stability and the cost share reduction payments. And if you've been reading anything about those, you know, the Trump Administration said in the past month or so that they would no longer make those payments to insurers, which most of the insurers had anticipated already. And they had already built in to the marketplace plans that increase and that is why most of those plans the premiums increased by 15% to 30%.

If those get restored, which there is some talk in Congress to make that happen, if they get restored then those premium costs would go down. And then actually some folks would actually get reimbursements, refunds. But that is not typically - not currently going anywhere. And of course, you know, current policy there's always talk about repeal and replace in some way, shape, or form. The big efforts to do that failed some time ago, but there's always what they call stealth efforts to do so. And we'll get into that a little bit more.

So let's talk about CHIP a little bit. Like I said, this is a major program to cover children in the U.S. covering close to 9 million kids, mostly low to middle income families. And this is an expansion that adds on to traditional Medicaid coverage and covers children who are and sometimes their parents that are higher income but still lower income. So, you know, between 100% and 400% poverty depending upon the state.

So these funds expired September 30, which means that the federal government is no longer sending funds to the states to pay for this expanded coverage. Now most states are okay right now because they had excess funds or they had contingency plans for this. And so most of them are able to continue their program at least through the end of the year as is the case for a couple states. But there are several states who will run out of money very soon.

Minnesota has already run out of money, and they got an emergency appropriation from the feds to keep going so they wouldn't have to drop coverage. Utah and California both would run out by the end of the year, which is for Utah about 19,000 kids and California about 1.3 million kids that could potentially lose coverage if funds are not restored. And then other states would start losing funds as we get into the new year just as their funds run out. They would have to make a choice on appropriating funds or cutting coverage.

So obviously that's not something we want. We don't want 9 million kids to lose coverage over the next year. So there are bills in Congress right now to try to fix this problem. The House recently passed a bill combined with an appropriation to cover and to pay for health center funds, which also expired. That is currently supposedly dead on arrival in the Senate. They don't like the

way it's being paid for and appropriated basically. So it seems unlikely that that bill in and of itself would get a vote in the Senate.

There was a prior bipartisan framework that was agreed upon that involved basically cutting funds down to pre-ACA levels. So over the course of about four years it would have been about a 25% cut in funds. But that seems to have been abandoned right now. And each House and Senate are working on their own bills, like I said. So keep an eye on that one. It seems unlikely that they won't pass something, but who knows what it will take shape with and what the funding levels will be. Those are things to look for.

And, you know, there is a possibility that it would take funds from other services to fund this, such as the Public Health Reinvestment Fund through the ACA. So these are not small issues. And unless they get moving on it very quickly, it is possible kids would lose coverage in the interim. So that's something we need to keep an eye on. That's obviously not good for rural kids, because a lot of those folks are in rural as well.

So moving on to Medicaid in general, like I said there's a lot of children and sometimes their parents covered through Medicaid. And, you know, expansion status is still up in the air. Not a lot of states are looking to expand. Some states are still debating it. Kentucky and Ohio, for example, have expanded but they're looking at pulling that back with some changes in their administration.

Virginia is interesting now with the change in governorship. It will be interesting to see if they're able to expand Medicaid as many in that state wish to do. So that's a possibility as well. And of course there are waivers, and we'll talk about waivers here more in a second.

A couple of things to keep in mind, work requirements are becoming a lot more common. These four states listed here have some sort of work requirement built into their waiver for expansion status. And that has the possibility to reduce enrollment as well as folks are unable to either find work or able to - or just are unable to work in some way would drop off the rolls.

Of course this would be impacted greatly if there is an ability to repeal and replace Obamacare or ACA in some way. As we saw during that debate the Graham-Cassidy Act was proposing to use block grants to fund Medicaid. And if any of you are familiar with block grants, you'd know that would be a tremendous change for the program and quite possibly lead in reduced services or enrollment as well. So there's a lot of issues still involved here with Medicaid that need further monitoring and understanding so that expansion coverage and coverage for kids is not affected negatively.

So waivers, waivers are interesting in they were initially within the ACA to provide a flexibility and design and coverage and that type of thing for the states. There are right now around 41 waivers across 33 states for different types of things. Some of them are carved out for mental health. West Virginia just got an approved waiver for substance abuse, mostly opioid treatment waiver to carve that out and do it - and provide that in a different way.

There are 19 states with 20 waivers pending right now. Iowa hasn't, you know, I think it's been denied. The news report said it was denied, but there's still some debate about that. Oregon's was recently approved, and it involves a reinsurance pool. Oklahoma recently withdrew theirs because they didn't get a response from the federal government in time based on the deadlines.

So, you know, these are issues that you need to continue to keep an eye on. There are going to be some states that will provide or propose new waivers.

Recently the Medicaid director for the federal government gave a speech to the Medicaid directors indicating that they had an emphasis on work requirements, like I discussed earlier. So it seems like they would be very amenable to that, where the Obama Administration was not previously.

So basically if you build into a waiver some sort of work requirement for those enrolled, the current administration has signaled they would be approving those. So that might be something to keep an eye on in the future. Some states might expand via a waiver with those kinds of requirements, which will provide some coverage but not as much as without. So that's just something to keep an eye on as these waivers that are pending continue to get approved or not approved to see what's going on there.

And then, you know, briefly ACA policy, you know, it still is the law of the land. We are in an open enrollment period right now. And that enrollment period has been shortened with some of the outreach being cut back. But current reports are that the rate of uptake and enrollment is higher than in previous years. So it may not be all doom and gloom. There may be folks who are still able to access the plans, enroll in the plans, and get the coverage that they need through this part of the program.

Zombie repeal and replace will always be there as long as these administrations I think are in power. So, you know, there's a lot of talk about synthetic repeal, which is basically how can they repeal all the bits and pieces of it without actually passing a legislation to repeal the whole thing. There have been some talk about executive orders. One currently being rumored about is an executive order that would eliminate the mandate, the insurance mandate. Whether or not that would actually happen remains to be seen.

Funding cuts are currently being discussed. The tax cut bills that are being proposed and written up right now there's some talk that there are some significant tax - not tax but funding cuts that could occur within that that would affect the ACA. So that's something to look out for as well. And there's other administrative actions that are agency-level actions, like I said when they reduce the enrollment period, for example. Those are things like that that they can do to effectively cut or repeal the ACA without actually legislatively doing so.

Other things to keep an eye on is like I said earlier about the marketplace. If we can get those CSR payments, there is some movement to replace those, but it may not happen as well. A big issue, especially for rural areas, is the number of options available in the marketplace in a specific county. There's a lot of areas across the country that only have one insurer, one option within the marketplace, which is not ideal. You want - you would want several options for competitive, for pricing and for those kinds of things.

And, you know, the Alexander-Murray Bill seems to have died. But the basic framework within that was to basically do a number of things to fix the marketplace. So this is a bipartisan type of framework as well. There has been other talk about Medicare X, which I think would be really interesting to keep an eye on. It's basically a public option. Let's do a light version of Medicare and offer it on the marketplace as well. The likelihood of many of these things passing seems low at this point, but you literally never know anymore. So I'm constantly surprised by what is and is not viable at this point.

So these are just some big things, big picture policy things to keep an eye on in the coming months that will affect broad insurance coverage, Medicaid, CHIP, those kinds of things. And as, you know, we'll get to in these findings that we're going to go through here shortly, you know, this has a big impact

upon kids' health. You know, if you don't have coverage, especially Medicaid-type coverage, a lot of kids will be affected in a negative way.

So, moving on to current evidence. And I say current evidence, you know, again with some quotation marks. Most of this data is from 2012 or 2013. There's a lot of issues with getting good data, especially when you want to boil it down to rural areas, for example. So part - I'm going to start with some work that we've done with some Medicaid data. And 2012 is the most recent data we have. Now when we got it, there were 35 states included in it. Right now, if you were to buy it today, it would have 47 states and then 2014 there's only 17 states.

So not only is there a time lag with getting a national representative sample of states, it may not actually be fully representative even if you go back to 2012, for example. The most recent data they have I think is 2016, but there's only five or six states available for that right now. So that's not ideal, and, you know, we'd rather use, you know, it is 2017. You know, we'd rather have more recent data, especially as the ACA gains steam from between 2010 and where we are now. But this is basically the best that we can do.

So what we were able to get was a summary file from the Research Data Assistance Center that told us a lot of information about each Medicaid enrollee across these 35 states. And I will make sure you understand this caveat that it kind of undercounts the West. There's not a lot of - there's only I think three or four western states included in this 35-state sample.

And this file told us a lot about eligibility, how they enrolled in Medicaid, their demographics, and summaries of their utilization in a broad sense. So we were able to pull this data together. It represented about 53 million enrollees.

And we were able to just do a snapshot of who they are and what they look like broken down by rurality. Okay?

And there's some really interesting findings here that we wanted to highlight. So, rural Medicaid enrollees tended to be somewhat older. There's a lower proportion in the under 18, about one percentage point lower, and about a one percentage point higher in the greater than 65. This represents rural populations pretty well in general, which tend to be older - skewed older and not as young. So that's not a huge surprise, but it is something to take note.

The male/female breakdown was pretty similar across rural/urban, but there were some important regional differences where there's some overrepresentation in the South versus the Northeast, for example. So there is some regional, you know, what this is basically saying is 55.8% of Medicaid enrollees in this sample were in the South. And again, we're under counting the West. So that doesn't surprise us, but there's still a higher concentration there even if we were to control for the West.

This one is something that really stuck out to us that I think really could change a lot of the narratives that we use around Medicaid. So within rural, our sample was 67% white, compared to urban it was only 38% white. And this is still, it's not that surprising given that rural tends to be whiter, not as high of a concentration of non-whites. But it's still, I think when you talk about Medicaid, I think this is an important difference to point out because it is a very different population rural versus urban.

There's a significant 2.4% American Indian, Alaskan Native representation as well. Surprisingly the Hispanic distribution is not as high within rural as you might anticipate. It's a lot higher among urban. Now there's still a significant portion covered as you can see in this chart over here. It looks like 8.7%, but

that's still all, you know, about 1/3 of the proportion that you would see in urban areas.

So I think that also might be a misconception that some folks might have about Medicaid enrollment, especially when you're talking about just rural areas. So, you know, that's something to keep in mind. This has important delivery service type of component as well. Okay?

There's further differences when you - when we break it down by region. And again, you know, keep in mind the West is a little bit underrepresented here. But the West, and this is just among rural, the West has a much, much younger type distribution than you'll see like in the Northeast, for example. And again the rural South tends to be older as well as the Midwest.

So even when you're talking, okay let's look at, you know, Medicaid in the South, rural South is going to be very different than in the rural West. It's going to be, you know, different race. It's going to be different age groups, so therefore different services might be involved as well.

When you look at these differences here by race, you know, in the rural South we're talking 25% that are black versus 4.4% is the highest than any others. So the other way to look at this—I've got to find my notes here—89% of all rural blacks on Medicaid in our sample were located in the South, which is really something to think about. So there's really a maldistribution, a maldistribution of by race across these populations.

So, you know, we all know that Medicaid is a state-by-state type program. But I think it's very important to understand this when we're doing planning for services and providers and those kinds of things to really look at who these enrollees are and what that might mean for service delivery. If it's non-white,

if it's older, if it's younger, where they're located would have a huge impact on what's provided.

Now within this data, we were able to identify, theoretically identify at least, who was enrolled in CHIP. And so we talked about this a good bit earlier. So I don't need to go into that a whole lot. But within our sample, we wanted to know okay how - what's the proportion enrolled in CHIP and what does that distribution look at. So within this one is about 5% of the whole Medicaid group that we had was enrolled in CHIP either for part or all of the year. And of course you can be enrolled depending on circumstances and if you meet requirements and those kinds of things.

This was a higher proportion in rural than urban, okay. In our sample, 10% of the kids in Medicaid were via CHIP, compared to 4.3% of the urban. So this I think is very vital to keep in mind especially with this debate on how or when are they going to reappropriate and pass CHIP legislation. So it has the potential to negatively impact rural children more than urban because it's a greater proportion. Okay?

Again mostly white when you're talking rural CHIP and a lower proportion of black than other rural or urban enrollment proportions. So it tends to favor white as opposed to non-white, and there's a sizeable proportion. You know, 13.9% of those enrolled in rural are actually adults. And, you know, you might say well how does that make sense? That can't be right. But there are waivers out there for CHIP to cover parents of kids who are also eligible for CHIP. So it's not just kids. It impacts their parents as well if this does not get reapproved. Okay?

So that's our Medicaid data that we have. We are waiting on approval for some policy briefs that we wrote based on this data. So if you keep an eye on,

excuse me, the Gateway, they should let you know when those are published. You can also sign up for alerts from our research center as well that we will send out alerts when these things are approved and distributed as well.

Now I wanted to kind of step back and try to give you a little bit more up to date national data from the National Health Interview Survey. And for those of you who are not familiar with the NHIS, it's conducted by the CDC. It's non-institutionalized, and it's nationally representative of the U.S. So it's a cluster sample survey type of thing.

These are not rural estimates for many complicated reasons. Basically you have to go through this lengthy approval process, go to a data center, and do the analysis there in order to get any kind of rural estimate. So it's rather difficult. You can see the data. The most recent data for this is 2015. So we're still a couple years behind. In order for us to do actual national rural estimates for the NHIS, it would take us another year and cost quite a bit of money actually. So it's very difficult to do a lot of national rural data on some of these types of things.

But I wanted to give you this kind of overview and then we'll dive into some of the oral health stuff as well because it does relate. So, you know, when we're talking about unmet need of healthcare in some general way, you can see there is racial differences here. Except for Asian, if you're non-white you have a higher unmet need proportion.

Income - unmet need by income, this should not surprise anyone, but lower income has a much higher unmet need. And you can just see the stair step goes straight down there. And this is the gap that, you know, Medicaid coverage theoretically should try to meet that need. But as you can see, if you're less than \$35,000 there's still a high unmet need there.

So you could still have Medicaid coverage potentially if you're in that group but not have met needs because access is still not realized. As we all know, providers don't always take Medicaid patients. They might take a few, but the payment on them at most states is at such a level that they can't afford to have a huge Medicaid patient population. So even with coverage, this is still a problem.

As you can see here, this further elucidates that. You know, if you have private insurance, your unmet need is very low. It's twice as high if you are covered through Medicaid or other public. And in uninsured it's much, much higher, which again is not surprising but again it does point to the fact that coverage in and of itself will not meet a need. You still have to be able to realize it through access, transportation, those kinds of things.

This was the one breakdown we could do in this national data and this is by MSA, metropolitan statistical area, which most of us are, you know, we don't really like a whole lot because it's too broad of a stroke. But you can see unmet need actually goes down a little bit by MSA. But this is not controlled for insurance status, income, any of those factors that really make an impact on that. And these differences are not huge but still something that would be interesting to look at if we could actually get into the data more broadly.

So all of that to say and that kind of sets a picture for what this final part we're going to talk about with this National Survey of Children's Health where we're going to dive into some oral health outcomes that we have worked on. So this NC - NSCH, the National Survey of Children's Health, is run by the Maternal and Child Health Bureau through HRSA. This is a telephone survey, and they've actually added cell phones to try to capture those folks because

we all know that that's a big issue right now. Most people may not even have land lines anymore.

The 2016 survey actually combined the special needs survey, if those of you are familiar with that data. And there is a - the 20 - starting in 2017 iterations, this data should be coming out almost annually, which will be great for analytics if we can actually get access to some of the rural issues. So there's a good, robust survey, about 90,000 observations, and with some work again going to a data center, you're able to do some defined rural analysis. In this case we used RUCAs. And if you're not familiar with RUCAs, then you can look it up or I can't talk more about that at the end here, so.

So we have a history of using these, and these are three of our reports, a couple of them from 2003 and then we have another one that just came out recently based on oral healthcare and that's what we're going to talk about here, some of those findings here. So if you go to our website, you can pull down these reports, one of which I actually worked on as a grad student. So that's kind of a nice throwback actually. I remember getting some of those photos as a grad student and getting permissions and all that kind of thing. So that's a nice throwback.

But all that being said, you know, there's a history of using this data, and we're hoping to do more of it when more of the most recent data comes out but that will be some time before we're able to do that. The Maternal and Child Health Bureau actually report - produced reports as well. There's nothing out on the 2016 data yet.

And these just focused a little bit more on health and wellbeing, and they took more of a, you know, rural-versus-urban type approach without boiling it down to small rural, large rural, those types of things as well, which is where

we kind of stepped in to fill that gap. But you're - you can look those up as well. Just wanted to make sure you know that those are out there as well.

So, some of the findings from this work that we've done. So this is the median out-of-pocket spending based on size of rural. So we - you see we have urban, we have large rural, and we have small rural. And you can see there's some changes over time from 2007 to the most recent '11/'12 data, where surprisingly the out of pocket has actually gotten lower for everybody except for small rural, where it actually went up a little bit.

And we're really not sure why but, you know, I think it is interesting to note that, especially with small rural it could possibly be to reduce provider availability. If there's fewer providers then there's less competition, those kinds of things. But it's something that's worthwhile for further study. And I think to keep in mind that, you know, there may be a larger out-of-pocket burden for small rural residents, which may reduce their use and getting the care that they need as far as oral health is concerned.

What's interesting, though, is when you break this out by non-Hispanic white, non-Hispanic black. You can see, you know, for whites the same trends held. Everything is lower except for small rural. But if you look at black, you'll notice that overall those numbers are higher, especially for small rural. We're talking \$12 median higher, which \$12 doesn't sound like a lot, but, you know, when you look - start looking at the tails, that could be \$50, \$100 more for blacks living in small rural areas compared to urban areas. So that's a disproportional type of burden as well. And, you know, we have Hispanic in there as well, but those results were not actually any different. So that's interesting to know.

Moving on to oral health, this is basically those who reported having excellent or very good teeth. And you can see we have actually went back to 2003 for this data, and there was some market improvements, especially among whites that kind of evened out except for large and small rural where it started to dip down a little bit for whites. I'm not sure why, but that is something to keep an eye on as well to see, you know, if we - once we're able to get into the '16/'17 data, will that downward trend continue or not.

For blacks, however, you can see market improvements for urban and large rural but very, very minute, small differences within small rural, basically flat. And again, you know, if you look back at that out-of-pocket spending, there seems to be something going on there. Is it an access issue? Is it, you know, since the out of pocket is higher do they get less and therefore there's no improvement? It's really something to keep an eye on there.

And then when you look at Hispanics, you can see urban, which is that grey line there, a fairly steady improvement going from 47 to about 54%. And then you look at the rurals. For some reason in 2007 there was a significant dip, but in 2011 and '12 there was an increase such that they were actually better off than urban. Really no idea what's going on there. I don't know if that was a result of targeted interventions or just the sampling frame, but that's something to keep in mind when we look at future data as well to try to figure out what's going on there.

And then this is just I wanted to split this out just to look at it a different way broken down by race across the rurals. And this is just for '11 and '12. And you can see for everybody except Hispanics, rural is less than urban, but Hispanic is slightly higher. So good news for Hispanics and rural, you know. But I think if you were to look at the Hispanic, you would see it's still only 56, 57% that have excellent or good teeth, which is a lot lower than we want it

to be. You know, it's still a lot lower than the 75% you see among whites. So still a disparity there.

Excuse me. So oral health percent with a dental visit. So this is something that, you know, just what percentage went to see a dentist at some point during the year. You can see for whites, stayed steady in urban actually went down among rural over the years, again something to keep an eye on. It's not a huge dip, but it's a dip nonetheless.

When you're looking at black populations, urban and large rural saw a market increase there. Not a huge increase but still an increase while small rural saw a decrease. So again the same kind of trend of you see rural blacks with higher out of pocket, teeth not doing as well, fewer percentage with a dental visit. But I think there are some definite trends that are emerging from this type of data that warrant further study and further research.

Shawnda Schroeder: Dr. Bennett I want to interject quickly, there is a question.

Kevin Bennett: Oh sure.

Shawnda Schroeder: They're wondering if you have any policy recommendations to better target services and reduce the cost for non-Hispanic black populations.

Kevin Bennett: Me personally? No. Oral health policy is a little bit out of my wheelhouse. I do know there are a lot of folks working on these types of things. If you look at Dr. Martin and the work she's doing at the Medical University of South Carolina, I know that they are doing some basically access for rural populations. And here in South Carolina, that's a larger black population.

But ultimately it's - and the big question is and again this is '11/'12 data so we're already five years out from it. Is it still the case or is it getting worse? I don't know yet, but, you know, I think awareness of it going to your states and their policymakers and saying, hey there's this issue. What can we do to make changes here? So it might be a question of provider placement or, you know, we're trying to do some work here in the schools where the kids get sealants in the school setting, those types of things I think would be effective.

But yes it's not a - how do you reduce the cost is a big issue. You know, Medicaid coverage would be beneficial for that as well I think. But that's going to be difficult with our current political state as, you know, we kind of discussed earlier, so. Yes, so that was a good question but, you know, I'm not 100% sure on that one, so.

And then, you know, I wanted to point this out, Hispanics separately, percent with a dental visit. For some reason, you know, large rural took a big dip among Hispanics, whereas urban and small rural trucked right along and saw good improvements. And again I'm not really sure what's going on here, because it's kind of counterintuitive to some of the data we saw earlier about Hispanics actually doing a little bit better. So that's an interesting one that I think, you know, this might be a statistical survey type blip or it might be an ongoing trend and where future data would be helpful for that.

Doing more of this, so not just having a dental visit but going and having a specific preventive dental visit, you can see over the years some improvement up through 2007 and then a dip back down among large and small rural, a small dip among urban but a larger dip among large and small rural among whites. See the same thing among blacks, but there's a dip across all three populations. So it's a four-point drop among our small rural folks and even,

you know, 3 to - 3% drop among our urban folks, where the large rural held steady.

But again, you know, broader, bigger picture, there's something going on with among rural blacks with this type of thing. You know, only 75% with a preventive visit. Not that different than whites, which is a good finding. Not a huge disparity there but a difference nonetheless. And then again Hispanic populations, there's something going on between the small and large rural that makes a difference. And, you know, what that is it's really unclear. And again, I think it's worth noting here, you know, this is, you know, the small and urban they're around 73, 74, 75%, which is again not that different from the black and even the white populations we just saw earlier.

So there's some good news hidden in here if you just kind of ignore that large rural problem there, which we don't want to ignore, but, you know, we really don't really know what's going on there. So that might be something worthwhile to investigate in the future as well. And again this is just - I wanted to split it out a different way to visually see it where you can see those racial differences across the different populations. And you can see there's kind of baseline around that 75, 74% except for, you know, the urban whites and Hispanic large rural that are kind of the outliers there.

Percent with delayed care, now I, you know, there are some differences here, but I do want to point out these are relatively low. This is less than 5%. And it seems to be dropping across the populations. If you look at whites, the small rural went down, which is great. Large rural went up, which is not so great, and then urban stayed basically the same. So this is something to look at. You know, this might be indicative of a provider issue. There may be fewer spots, fewer providers so they have to delay care and wait six months for employment, for example.

If you look at blacks, you see a huge increase there among urban, well huge, almost a percentage point, where you see significant declines among rural, which again is kind of counterintuitive based on everything we've seen before with higher costs, lack of preventative visits, those kinds of things. So this might be a health behavioral issue where they don't seek care and so they just don't get the care. So there's not a delay, but they're just not seeking it even if they need it. That, you know, is - that's an assumption based on the data, but I think it might be something to look into as well.

And again Hispanic populations, that large rural with that huge drop in percent with delayed care, is really interesting. That's a - one of the few good findings that Hispanics have seen in this data set. Not really sure what's going on there because other indicators among the large rural indicated poorer care or poorer outcomes. So yes, so I don't know what else to say about Hispanics because they're all kind of all over the place.

And again this is just flipping it around by race within the most recent data. You can see the differences there that Hispanic - large rural Hispanic really kind of even - and especially among blacks too it's a real difference there. It's a good thing, great to see, but really not a whole lot of explanation behind it that we can discern. Okay?

So overall, just to kind of summarize what we've talked about today and then kind of to lead us into any questions that we may have, you know, Medicaid is a huge coverer for kids and it's a big payer for medical and oral health coverage. There are still unmet needs if we looked at that NHIS data that was by NSA, but there's unmet needs among oral health as well. Financing may be a big driver. We saw that unmet need among the uninsured.

And then there's some indications of higher out-of-pocket costs among non-white populations but yet some indication that they're not really delaying care because of that. But they don't have preventive care that they theoretically should have. So there's, you know, it's not really clear data on a lot of these types of things, but I think they are indicative of some problem areas that would require some further examination.

And I do want to point out the *Journal of Rural Health*, putting on my board chair hat here, just in their Autumn 2017 issue, if you look that up, they had a special section on oral health that talked a lot about some of these issues about the role of primary care, referrals across disciplines, access, and usual source of care. There's some really good articles in there that talk about a lot of these issues and provide some more up-to-date kind of research on interventions and programs that have been effective, especially with oral health. So, with all that being said, I would be happy to take any questions or comments or the like that anyone may have.

Shawnda Schroeder: Thank you so much, Kevin, for sharing all of that information. I will encourage all of you if you would like to ask questions to do so now through the HRSA operator. While we wait for a couple of questions to come in, I do want to just mention briefly that we are celebrating National Rural Health Day next week on November 16. And I'm going to share some information regarding National Rural Health Day.

So there are many ways to participate. You can attend several free rural health webinars that are being hosted by various rural organizations. You can participate in rural health Twitter chats, which Gateway will be doing as well as other rural advocates. We'll be working with rural communities, and there are a lot of different ways to engage your rural communities.

And so if you'd like to learn more visit powerofrural.org. This is also a day that we're able to promote and celebrate all of the efforts of our individual state offices of rural health and the National Organization of State Offices of Rural Health. So if you'd like more information, please do visit powerofrural.org and celebrate on November 16. Do we have any questions on the line?

Operator: If you would like to ask a question, please press star then one, unmute your phone, and record your name when prompted.

Shawnda Schroeder: I do see a couple questions being typed and coming in. So if they come in, I will read those as well.

Operator: And we are showing no questions from the phone lines at this time.

Shawnda Schroeder: Okay. I'll wait just a moment because I do see a little bit of typing in the chat box. So I'll wait and see if we have any questions. While we wait, I will remind you that if you would like the slides from today's presentation or if you would like to share the webinar, the slide presentation or the recording, you can do that from our alert that we will send out following today's webinar or you can visit our Web site ruralhealthresearch.org and you can access our webinar archive there as well.

Kevin Bennett: Yes, and I will add too that on the last slide there there's a bunch of contact info for myself and for the Center. Feel free to email me if you need any other info or anything like that. We're happy to help any way we can.

Shawnda Schroeder: Great and I will move to that slide quickly and if people would like to, you know, take down your contact information. That one. There we go. It looks

like most of the comments coming in are feedback about a great presentation. And I don't see any other questions. So if any other questions...

Kevin Bennett: Yes. It looks like we have one person typing it looks like.

Shawnda Schroeder: True, one left.

Kevin Bennett: Hold out for the...

Shawnda Schroeder: Final type right?

Kevin Bennett: Absolutely. Ah, okay. Thank you, Jan. We will make sure we collect - correct that.

Shawnda Schroeder: Okay. I'm not showing any other questions at this time. And much like Kevin said, if you have other questions specifically about his research or the work of the research centers, please do contact Kevin directly on the information in the contact here. Otherwise, I do want to thank all of you...

Kevin Bennett: Absolutely.

Shawnda Schroeder: ...for joining us today. Do you have anything else you'd like to mention Dr. Bennett?

Kevin Bennett: No. I think I'm good.

Shawnda Schroeder: All right. Well thank you everyone for joining us today, and if you have questions about the presentation, please do contact Dr. Bennett or anything else about the webinar or how to share the information, you may contact Gateway. Thank you everyone for joining us.

Kevin Bennett: All right. Thanks everybody.

Operator: And that concludes today's call. Thank you for participating. You may disconnect at this time.

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