

Review & Commentary on Health Policy Issues for a Rural Perspective – December 1st, 2005

Oral Health, Healthcare's Neglected Stepchild

From "Meeting Oral Health Care Needs in Rural America," a National Rural Health Association *Policy Brief*, 4/05 at <http://www.nrharural.org/>

"For too long, oral health and oral health care have enjoyed far less attention than other aspects of health and health care. As one prominent study put it, 'the perception that oral health is in some way less important than and separate from general health has been deeply ingrained in American consciousness.' **When they have focused on oral health, policymakers, health care providers, and the general public alike have focused primarily on teeth, rather than the person around the teeth.**"

"Fortunately, recognition of the importance of oral health and its interconnectedness to overall health is growing. In her introductory letter to *Oral Health in America: A Report of the Surgeon General*, then-Secretary of Health and Human Services Donna Shalala wrote, 'The terms oral health and general health should not be interpreted as separate entities. Oral health is integral to general health...oral health means more than healthy teeth...you can't be healthy without oral health.' "

"Recognition is also growing of the importance of oral health to self-esteem, employability, and overall well-being. For example, studies have shown that a healthy smile increases the chances that job applicants will receive an offer. Conversely, one study in West Virginia found that the number one obstacle in going from welfare to work is poor oral health."

"Out of this growing recognition have come calls for action to improve oral health the country. This policy brief is itself a call to action to improve oral health and

oral health care in a part of the country that often gets overlooked and underserved when it comes to health care: rural America."

Oral Health in Rural America—"With its mission to improve the health and healthcare of rural Americans and to provide leadership on rural issues through advocacy, communications, education and research, the National Rural Health Association (NRHA) has undertaken an effort to describe the status

of rural Americans with regard to oral health and to recommend ways to improve it. While data on rural oral health and health care are somewhat limited, sufficient evidence exists to suggest a distinct disparity in rural America:

- Even after controlling for population density and income, non-metropolitan counties have lower dentist-to-population ratios (62 dentists per

RWHC Eye On Health



"All I want is a dentist to fix my teeth and a dental association that puts kids before business."

"Everyone is entitled to their own opinion, but not their own facts." Daniel Patrick Moynihan, quoted at <http://www.factcheck.org/>

100,000 population in large metropolitan areas versus 29 dentists per 100,000 population in the most rural counties).

- Rural persons are more likely to have lost all their teeth than their non-rural counterparts; in fact, adults aged 18 to 64 are nearly twice as likely to be edentulous if they are rural residents.
- Rural adults are significantly more likely than non-rural adults to have untreated dental decay (32.6 percent versus 25.7 percent).
- In 2001, 67.1 percent of urban residents had visited a dentist in the previous year, while only 58.3 percent of rural Americans had done so.
- Rural residents are less likely than their urban counterparts to have dental insurance.
- Of the 2,235 Dental Health Professional Shortage Areas, 74 percent are in non-metropolitan areas.”

“According to the National Advisory Committee on Rural Health and Human Services, several factors contribute to the problems of rural oral health:

- *Geographic isolation.* People in remote rural areas have farther to travel to obtain care and access to fewer dentists, hygienists, and other professionals.
- *Lack of adequate transportation.* In many parts of rural America, private automobiles are the only source of transportation. Public transit is non-

existent, as is transportation for hire. Consequently, many rural residents—especially low-income residents—face great difficulty in going to the dentist or any other service provider.

- *Lack of fluoridated community water supplies.* This basic preventative treatment against tooth decay is unavailable in countless rural communities.
- *Higher rates of poverty.* Low-income status prevents many people from seeking and obtaining oral health care. It also prevents them from purchasing dental insurance. In addition, rural employers are less likely to purchase or offer dental insurance for their employees due to the smaller average size for most rural employers.
- *Larger percentage of elderly population.* With increasing age come increasing dental and oral health problems. The percentages of rural Americans who are older and sicker are greater than those of urban Americans, and Medicare does not provide dental benefits.
- *Lower dental insurance rates.* Insurance reimbursement rates—both public and private—for dental procedures are typically lower in rural areas than in urban. However, the actual costs of providing the services are often higher in rural areas.
- *Acute provider shortages.* As indicated above, the ratio of dentists per 100,000 population in non-metropolitan counties is less than half of what it is in metropolitan counties. Not surprisingly then, **three-quarters of the nation’s Dental Health Professional Shortage Areas are in rural America.** Worse still, the acute shortage of dentists nationwide is expected to worsen in coming years as dental schools graduate fewer students, despite the fact that dental school applications were up some 18 percent last year. Indeed, with the closing of seven dental schools since 1986, and subsequent opening of only three new ones, **more people want to become dentists than there are slots for.** It can be predicted that the combination of increasing levels of dental school indebtedness and fee disparities between urban and rural locations will lead to a reduced percentage of the dental school graduates locating in rural locations.

The **Rural Wisconsin Health Cooperative**, begun in 1979, is a catalyst for regional collaboration, an aggressive and creative force on behalf of rural health and communities. RWHC promotes the preservation and furthers the development of a coordinated system of health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

Eye On Health Editor: Tim Size, RWHC
880 Independence Lane, PO Box 490
Sauk City, WI 53583

<mailto:office@rwhc.com> <http://www.rwhc.com>

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- *Difficulty finding providers willing to treat Medicaid patients.* Because of low reimbursement rates, paperwork burdens, and a perception of a higher percentage of broken appointments, many dentists simply do not accept Medicaid or Children's Health Insurance Program (CHIP) patients—of which there are many in rural America due to the higher proportion of people living in poverty.”

“As a result of these factors, working individually and in tandem, rural residents in general have a harder time accessing, utilizing, and affording oral health care. That need not be the case. Corrective measures are available. Rural Americans can and should enjoy access to high-quality, affordable oral health care.”

Improving Oral Health in Rural America

“Improving rural Americans’ access to high-quality, affordable oral health care cannot be achieved over night, nor with the stroke of a pen. It will require in-depth analysis and careful crafting of legislation, regulations, policies, and programs to meet the needs and bridge the gaps. Most of all, it will require dedication and political will from policymakers at all levels of government, from faculty and administrators in oral health programs around the country, and from oral health providers themselves. If implemented, the recommendations presented here can help further that process and hasten the day when rural Americans have the oral health care they need and deserve.”

Recommendations

Access to oral health care in rural America

- “The National Health Service Corps should place more emphasis on loan repayment and scholarships for oral health providers.
- State loan repayment programs should cover dentists and other allied health professionals that provide oral health care.
- Dental schools should create a residency or externship requirement for dental students to increase their practical experience and their service to underserved communities, including those in rural America.

- Such a requirement would increase the number of residents providing care by some 3,000 per year, and increase the number of people getting care by several million. Delaware and New York have already instituted such a requirement.
- Congress should create and fund capital improvement programs that invest in rural oral health care by helping private practices remodel and update, purchase equipment, etc.
- Congress should provide dental schools and residency programs with financial incentives to rotate students and faculty through private practices and health centers in rural areas.
- Congress should increase support for public health infrastructure aimed at providing oral health care.
- Federal support should be increased to encourage community health centers to more fully integrate oral health care.”

Reimbursement for rural oral health services

- “Congress and the states should expand Medicaid coverage as a mandatory service for oral health services to eligible adults, including the elderly in long term care settings and the disabled. While Medicaid mandates some dental care for children, very few States mandate dental care for adults.
- Congress and the states should require that Medicaid cover preventive and basic restorative oral health care, not just emergency care and include transportation as a covered ancillary service.
- Congress and the states should require Medicaid reimbursement for oral health screening and treatment during pregnancy.
- Congress should add dental services as a rural health clinic reimbursable service as well as allowing rural health clinics to contract with local providers for these services.
- Congress and the Centers for Medicare and Medicaid Services should provide Medicare reimbursement for dental care.

- Congress and the states should require Medicaid reimbursement for medical practitioners for doing oral health exams.
- Congress should encourage oral health care within school-based clinics and within programs such as Head Start aimed at low-income children.”

Oral health training programs

“Dental and dental hygiene education institutions should:

- Orient the admissions process to encourage applications from students with rural backgrounds and those with demonstrated service to the underprivileged and minority populations.
- Ensure that adequate dental student and dental faculty slots are filled so to lessen the expected shortage of providers due to retirement.
- Emphasize serving as a safety net provider in the training of oral health care providers.
- Increase dental student rotations through rural settings; create a rural residency or externship program.
- Mandate that family practitioners and pediatricians as well as mid-level providers have training in oral health assessment.
- Make scholarships available for practicing dentists, dental hygienists and students to do fellowships in geriatric oral health care.”

Rural oral health research

“The NRHA calls for a national rural oral health initiative including all stakeholders to look at a comprehensive way of improving rural oral health. In addition, rural health research centers should:

- Synthesize rural-specific data from existing public and private sources.

- Comprehensively study of the functions and utilization of allied health professionals, differences among state practice acts and the supply of personnel in these fields, to explore the expanded use of so-called mid-level or allied health providers such as dental assistants, hygienists, and others.
- Study, catalogue, and promote the adoption of best practices among state practice acts that enhance the rural oral health care workforce.
- Study the issue of the lack of licensure reciprocity and how it acts as a barrier to recruitment.”

Rural Wisconsin Hospital Wins Top Honor

The following is from a press release by Joint Commission on Accreditation of Healthcare Organizations:

“The Joint Commission on Accreditation of Healthcare Organizations named Memorial Health Center, Medford, Wisconsin, a 2005 winner of the ninth annual Ernest Amory Codman Award to recognize excellence in the use of outcomes measurement by health care organizations to achieve improvements in the quality and safety of health care.”

“Memorial Health Center is one of two recipients of the award in the hospital category and is being recognized for improving the care and outcomes for diabetes patients. As a result of Memorial Health Center’s initiative, the majority of their 500-plus patients with diabetes are successfully controlling their blood-sugar levels within nationally recommended goal ranges.”

“Named for the physician regarded in health care as the ‘father of outcomes measurement,’ the Ernest Amory Codman Award showcases the effective use of performance measurement by health care organizations to improve the quality and safety of health care. A panel of national experts in quality measurement and improvement selected the recipients of the 2005 Awards.”

“ ‘Achieving this award and this level of acknowledgment for our diabetes care is momentous for our organization,’ says Greg Roraff, CEO, Memorial Health Center. ‘Great things can come from a small place where you have the dedication and the desire to really make a difference in the lives of patients. I’m pleased and proud to work with professionals who have the drive to provide the best patient care possible and who are willing to go the extra mile to achieve their goal to do so. Receiving this award will provide the impetus to take our quality initiatives to another level. I also offer my own gratitude for the project team’s efforts and congratulate all our staff for their success in working together to improve the diabetes care processes for our patients.’ ”

“Memorial Health Center’s new diabetes program resulted in better control of blood glucose levels for patients with type 2 diabetes. Average hemoglobin A1c levels, which indicate a patient’s blood sugar control during a two to three-month period, are now under 6.8 percent for over 500 patients. In 2003, the organization also became a state leader for adhering to guidelines for the frequency of checking A1c levels, achieving a 95 percent compliance rate compared to the statewide rate of 89 percent. At the same time improvements in care and outcomes were being achieved, Memorial Health Center experienced a dramatic rise in the number of type 2 diabetes patients who received diabetes self-management education, including medical nutrition therapy by registered dietitians. Additionally, the number of registry patients increased from a pilot sample to over 500 members.”

“Memorial Health Center includes a 25-bed, not-for-profit critical access community hospital with four primary care physician clinics. Memorial Health Center also owns and operates a 101-bed skilled nursing facility, a 28-unit residential care apartment complex, a low-income housing complex for senior citizens, and a retail pharmacy.”

Rural Health Disparities Don’t Always Count

Yesterday a friend quoted her eight year old grandson asking one of life’s timeless questions, “How do we know there is a God if we can’t see him.” Probably because I had spent time that day in a “discussion” on what we should and should not call “health disparities,” I had to resist the temptation of responding with an echo, “Does a health disparity exist if we don’t call it ‘social injustice’?” The importance of the question is that much of the public and private foundation funding that is available to improve a community’s health appropriately takes into account a judgment about what health disparities are present or not present in that community.

Some only consider a difference in health to be a “disparity” if the differences are connected to a claim that the difference is caused by a recognized social injustice. Not enough people grapple with the problem that “social injustice” is a “social construct,” very dependent on the ebb and flow of political sentiment.

I am not arguing against social injustice as a critical element in defining health disparities, only that we need to recognize its limitations, particularly the bias against rural communities as the language or frame of social justice is not typically part of the culture of most rural communities. Poor rural health outcomes are real to the people effected, regardless of definitions; these disparities are effected by public and private policies, policies that can and should be addressed.

Wisconsin Hospitals and Clinics Needed for the Rural Wisconsin Childhood Asthma Study—Please consider requesting, as appropriate, your patients to participate in the Children’s Hospital of WI/Medical College of WI “Rural Childhood Asthma Study.” We don’t have that many rural specific studies in Wisconsin so when we have one come along we need to support it. The study is composed of an anonymous survey that is being distributed to rural families across the state of Wisconsin. The survey asks questions regarding the child’s asthma symptoms, affect on daily life and asthma medication use. They are trying to reach as many rural providers that we can to have them distribute these surveys to the appropriate patients. For more information about their study, you can visit their website at <http://www.mcw.edu/asthmastudy> To participate contact: Alan Adler, MD, Principle Investigator, or Katie Larson, Clinical Research Coordinator, Toll Free: 1-877-659-5183 or <mailto:asthmastudy@mcw.edu>

One reason rural specific research is so important, is that it informs and frames the definition of “disparity” and subsequent allocations of scarce dollars. In the meantime, this definition remains too often a matter of political judgment more than science.

In Wisconsin, there is substantial variability in health outcomes between metro

and non-metro counties. As previously noted in an earlier issue of this newsletter, the *Wisconsin County Health Rankings 2004*, a report by the Wisconsin Public Health & Health Policy Institute at the University of Wisconsin-Madison, shows that 56% of the state's metro counties are in the top (best) quartile for health outcomes compared to only 9% of non-metro counties; 32% of non-metro counties are in the bottom (worst) quartile compared to 12% of metro counties. The national rural research literature has much to support this position:

Here are three summaries of excellent articles in the *American Journal of Public Health* special edition on Rural Health, October, 2004.

Rural health as a disparity (From Eberhardt M, Pamuk E. The Importance of Place of Residence, Examining Health in Rural and Non-rural Areas. *American Journal of Public Health*. 2004;94(10):1682.) "On some key measures of health, residents of rural areas fare worse than residents of more urbanized areas. Many factors are related to rural health disparities, including demographic and socioeconomic characteristics, health risk factors, and health care access. Differences in health status often do not exhibit a monotonic pattern between rural and urban areas, and the greatest differences usually occur between rural and suburban areas. Therefore, accurately characterizing health disparities across the rural-urban continuum will require measures of urbanization that include a suburban category. Continued rural health research will document progress toward eliminating the health disadvantage of rural areas and will provide information to policymakers who seek more efficient targeting of limited public health resources."

Different lenses add value (From Phillips, CD, McLeroy KR. Health in Rural America, Remembering the Importance of Place. *American Journal of*

Public Health. 2004;94(10):1661.) "Historically, public health has been viewed through a variety of lenses. One lens focuses on the contrast between the science and the practice of public health. Another focuses on individual versus social responsibility for health. A third lens visualizes the contrast between an emphasis on disease categories and an emphasis on functional communities. A fourth focuses attention on the distinction between market forces and social justice. Of particular importance for public health professionals interested in rural health is that lens through which one sees an important part of the history of public health's development as oscillation between a focus on health issues facing populations defined by their demographic characteristics and health issues in populations defined by their geographic location."

Framing rural health issues as health disparities is relatively new (From Hartley D. Rural Health Disparities, Population Health, and Rural Culture. *American Journal of Public Health*. 2004;94(10):1675.) "In this commentary, I place the maturing field of rural health research and policy in the context of the rural health disparities documented in *Health United States, 2001, Urban and Rural Health Chartbook*.

Because of recent advances in our understanding of the determinants of health, the field must branch out from its traditional focus on access to health care services toward initiatives that are based on models of population health. In addition to presenting distinct regional differences, the chart book shows a pattern of risky health behaviors among rural populations that suggest a 'rural culture'

health determinant. This pattern suggests that there may be environmental and cultural factors unique to towns, regions, or United States Department of Agriculture (USDA) economic types that affect health behavior and health."

RWHC Eye On Health



Lies, Damned Lies, and Statistics

Offered as a warning regarding the still evolving science of public reporting on health care quality; from “Statistically False, The more we believe the twisted numbers, the dumber we get” by Michael Crowley in *Reader’s Digest*, 11/05:

“Mark Twain famously said that there are three kinds of lies: ‘lies, damned lies, and statistics’. Over 100 years later, things haven’t changed.”

“Maybe you’ve heard that 100,000 Iraqis have been killed during the war. Or that before long, Social Security will be \$11 trillion in the red.”

“In recent months, these stats have turned up repeatedly in heated political debates. And they are either misleading or just flat wrong. Pick them apart and you’ll see that solid-sounding numbers can be as slippery as a greased pig. Who’s feeding us these phony figures? Hardcore partisans who twist numbers to score a point. Call it twististics.”

“You could be forgiven for believing politicians when they throw out specific stats. ‘There’s a tendency to assume that a number is a little nugget of truth, that it’s real in the sense that a rock is real,’ says Joel Best, a University of Delaware professor and author of *Damned Lies and Statistics*.”

“The politicians and special-interest partisans sure know this. Okay, they might not always realize they’re using funny numbers, but the people whom they hire to provide the research sure do.”

“Look at how the Bush Administration has spun the training of Iraqi security forces—a critical barometer of our success in that country. Back in March the Pentagon said that more than 140,000

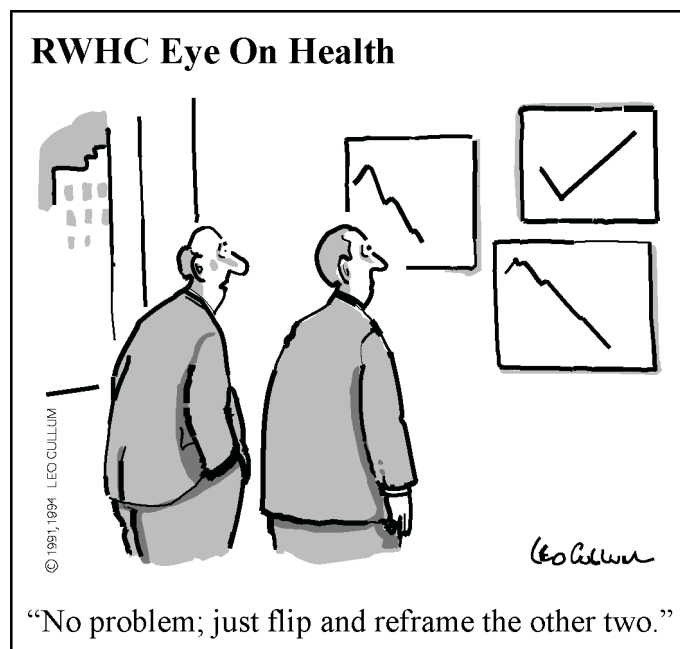
Iraqi police and soldiers had been trained. That sounded impressive. But a nonpartisan government study pointed out that the figure included possibly thousands of Iraqi policemen who had gone AWOL, and thousands more with just a few weeks of basic training. The chairman of the Joint Chiefs of Staff told the Senate that the number of Iraqis who ‘can go anywhere in the country and take on almost any threat’ was around 40,000 as of last January. Seven months later, Sen. Joe Biden was insisting we had ‘fully trained’ fewer than 3,000 Iraqis. Whatever the right figure, we’re not dealing with rounding errors.”

“Of course, critics of the Iraq war haven’t played it straight either. A team of scholars made a splash with a 2004 study published in a British medical journal claiming the war had killed 100,000 Iraqis. That number caused an uproar, especially among antiwar liberals. But a closer look showed that the number of deaths was wildly uncertain. The same study indicated it might range from 8,000 to 194,000. When does uncertainty become a meaningless guess—or political math?”

“Likewise, both sides have dirt on their hands in the debate on Social Security reform. At a public forum back in January, President Bush made much of an Administration estimate that the Social Security system faces a future shortfall of \$11 trillion. That sounds terrifying—until you realize that this megafigure projects the future of Social Security not over a generation or so, but into infinity. The nonpartisan

American Academy of Actuaries has called such projections worse than useless, and ‘likely to mislead anyone lacking technical expertise’ into thinking the system is in worse shape than it is.”

“But liberals have some statistical explaining to do too. Last winter, the activist group Moveon.org ran an ad implying that Bush would cut Social Security benefits by 46 percent. The ad ignored Bush’s repeated assurance that he would



not cut benefits for anyone at or near retirement—and, indeed, the 46 percent figure referred to the projected growth of benefits for retirees some 75 years down the road. It also ignored estimates that, if we do nothing to fix Social Security, by mid-century benefits will have to be cut by around a quarter anyway.”

“Then there was the Social Security benefit calculator posted at several Democratic Senators’ websites. The calculator showed deep benefit cuts under Bush’s plan, but only if you assume that the stock market—where Bush wants to allow some Social Security funds to be invested—will grow at just 3 percent over inflation. What the calculator fails to calculate is that, over the past century, the stock market has averaged more than twice that level of growth.”

“I could go on and on: misleading divorce rates, exaggerated counts of homeless veterans, inflated numbers of illegal immigrants. There’s enough baloney out there to start a deli.”

“So what’s a person to do who just wants to get the straight facts? First, assume that the numbers you’re

given have been through the spin cycle. If it’s a hot-button political issue, they probably have. Double-check suspicious statistics by looking for multiple, nonpartisan sources. A good place to start is the web site sponsored by the Annenberg Public Policy Center: <http://www.factcheck.org/>”

“My own assumption, as a reporter, is that at least 50 percent of the stats I see don’t tell the whole story. But you’d be smart to check that number out.”

**RWHC RURAL HEALTH PRIZE
14th ANNUAL \$1,000 COMPETITION
April 15 Deadline**

The Hermes Monato Prize of \$1,000 is awarded annually for the best rural health paper. It is open to all students of the University of Wisconsin. Students are encouraged to write on a rural health topic for a regular class and then to submit a copy to RWHC as an entry by April 15th. Previous award winners as well as judging criteria and submission information are available at:

<http://www.rwhc.com/Awards/MonatoPrize.aspx>

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