

# The RURAL MONITOR

*A Publication of the Rural Assistance Center*

## Inside This Issue

Page 6

### Rethinking Human Services

*The Challenge of "Institutional Culture" in Human Services Integration*

by Tom Corbett, Ph.D.

Page 7

### Look What's Coming

*Plan B...*

by Wayne Myers, M.D.

Page 8

### Around the Country

*One-Stop Shop for Mind and Body; Special Series - Technical Assistance: Delta Rural Hospital Performance Improvement Project*

by Hope Hanson

Page 10

### Spotlight on Rural Research

*Rural Oral Health—All In The Family?*

by Hope Hanson

## Rural Dental Dilemmas Growing

By Hope Hanson

For Peter Johnson, finding a dentist was a life-and-death matter.

Johnson, of rural Gary, Minnesota, is suffering from kidney failure and receiving peritoneal dialysis, which are making the bones in his mouth susceptible to rapid deterioration.

"I had to find someone to take care of my teeth," Johnson said. "To get on the transplant list, all of your other health issues have to be taken care of first."

Johnson, 56, was having difficulty finding an affordable dentist near his home. Fortunately, he found Apple Tree Dental in Hawley, Minnesota. The nonprofit dental clinic—about 50 miles away—took him in for treatment.

"They understood my situation and were very compassionate," said Johnson, who is still awaiting a transplant.

Apple Tree is a program bringing dental care to people who otherwise would be without. But there aren't enough Apple Trees to go around. In Minnesota alone, more than 600,000 residents who are enrolled in Minnesota Health Care Programs (MHCP), the state's publicly funded health care program, have difficulty finding a dentist who will take them, mainly because most dentists limit the number of MHCP enrollees they will accept. In a 2001 survey, more than 80 percent of Minnesota dentists reported financial losses as a consequence of accepting MHCP patients and 41 percent said they do not accept new MHCP patients.

Even for patients in rural areas who are not on public assistance, finding a dentist can be difficult because of the



*Dr. Dan Boedigheimer, dental director of Apple Tree Dental clinic in Hawley, Minnesota, works on clinic patient Patricia Dahlin.*

low ratio of dentists to patients, compared to urban areas. This shortage of dentists in rural areas, coupled with a host of other problems unique to rural life, makes oral health an unreachable goal for many rural Americans.

"Dental treatment is very, very expensive. It's getting prohibitive to a lot of people," said Dr. Dan Boedigheimer, dental director at Apple Tree.

Boedigheimer, a dentist for 30 years, retired five years ago and was going to do volunteer dental work in a developing country. But, "there was no need to go abroad. There was a tremendous need right here in my back yard—I was bumping shoulders every day with people whose health was needlessly



The Rural Monitor is published by the **Rural Assistance Center**. For additional copies, or to subscribe:

**Phone:** 800-270-1898,

**Email:** info@raconline.org,

**Internet:**

<http://www.raconline.org>



## Rural Risks

Each year, the National Advisory Committee on Rural Health and Human Services produces a report to the U.S. Secretary of Health and Human Services. The committee, a group of 21 doctors, nurses, health care and human service professionals, educators and community leaders from across the country, identified several factors in 2004 contributing to oral health problems in the rural United States.

- **Geographic isolation.** Quite simply, remote rural residents have farther to travel to get to dentists.

- **Lack of adequate transportation.** In many parts of rural America, where public transit is nonexistent, private automobiles are the only source of transportation. While low-income families may have vehicles, they may not be reliable for traveling long distances.

- **Larger percentage of elderly population.** It's a fact of life that aging brings on more health problems, including oral health issues. The percentages of rural Americans who are older and sicker are greater than those of urban Americans, and Medicare does not provide dental benefits.

- **Lack of fluoridated community water supplies.** Community water fluoridation is considered one of the most effective means of preventing tooth decay. It is estimated that every \$1 spent on fluoridation saves \$38 in treatment costs. However, it is proportionally much more expensive to fluoridate small community water supplies than large ones. The Centers for Disease Control and Prevention (CDC) reports that it is six times more costly per person to fluoridate water supplies with fewer than 5,000 people than to fluoridate water supplies serving more than 20,000. In addition, many rural residents are on unfluoridated private wells. (For more information about fluoridation, visit <http://www.cdc.gov/OralHealth/waterfluoridation/>.)

[www.cdc.gov/OralHealth/waterfluoridation/](http://www.cdc.gov/OralHealth/waterfluoridation/).)

- **Less access to dental insurance.** Lower incomes in rural areas may not only prevent many people from seeking preventive oral health care, but may also make dental insurance cost-prohibitive. According to the AAPHD, only 40 percent of the rural population has private dental insurance, compared to 55 percent in large metropolitan areas. A study published in the December 2002 issue of the *Journal of the American Dental Association* indicated that “Adults living in rural areas typically are self-employed, work in small businesses, are employed in part-time work or seasonal enterprises, and lack private insurance coverage. It also has been

reported that nearly 23 percent of uninsured adults have unmet dental care needs.”

- **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 State Children's Health Insurance Program (SCHIP) patients—many of which are in rural America due to the higher proportion of people there living in poverty.

- **Acute provider shortages.** The ratio of dentists per 100,000 people in nonmetropolitan counties is less than half of what it is in metropolitan counties. Not surprisingly then, three-quarters of the nation's Dental

### FACTS ON ORAL HEALTH IN AMERICA

- 22 percent of adults report some form of oral-facial pain in the past six months.
- Oral and pharyngeal cancers, which are primarily diagnosed in the elderly, are diagnosed in about 30,000 Americans annually and 8,000 die from this disease each year.
- Only 58 percent of the rural population had visited a dentist in the previous year, while 67 percent of urban residents had done so, according to a study utilizing 1999 National Health Interview Survey data.
- Large metropolitan areas have about 62 dentists per 100,000 population; most rural counties have only about 29 dentists per 100,000 population.
- Rural adults ages 18 to 64 are nearly twice as likely as urban residents to have lost all their teeth.
- Rural adults (33 percent) are more likely than non-rural adults (26 percent) to have untreated dental decay.
- 58 percent of the rural elderly (over age 65) had not seen a dentist in the previous year compared to 47 percent of the urban elderly.
- 38 percent of rural elderly and 27 percent of urban elderly had not seen a dentist in the previous three years.
- 72 percent of rural and 66 percent of urban elderly lack dental insurance.
- 37 percent of rural and 27 percent of urban elderly are edentulous (have no remaining teeth).

Sources: American Association of Public Health Dentistry, <http://www.aaphd.org>; Rural Assistance Center, <http://www.raconline.org>; National Advisory Committee on Rural Health and Human Services, *2004 Report to the Secretary*, <ftp://ftp.hrsa.gov/ruralhealth/NAC04web.pdf>; National Rural Health Association, <http://www.nrharural.org>.

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. Additionally, many dentists are nearing retirement age—especially in rural areas.

## Oral Health Solutions

Given the increasing discovery of connections between dental and overall physical health, the government is awakening to the importance of oral health.

U.S. Surgeon General Richard Carmona issued **A National Call to Action to Promote Oral Health** in 2003 in an ongoing effort to address the country's oral health needs. This Call to Action builds on *Oral Health in America: A Report of the Surgeon*

*General* (May 2000) and the *Healthy People 2010* oral health objectives.

The new plan seeks to enlist the expertise of individuals, health care providers, communities and policymakers at all levels of society. The plan includes changing perceptions, increasing collaborations and replicating effective programs.

In the meantime, the government offers comprehensive dental services to needy children through Medicaid, but actual benefits vary by state. There's also **SCHIP**, which was created when the Balanced Budget Act of 1997 added a new Title XXI to the Social Security Act. The program helps states cover more uninsured children with money that must be matched with state dollars.

**Insure Kids Now!** is a U.S. Department of Health and Human Services program to link uninsured children to free and low-cost health

insurance, with some states providing dental care. States have different eligibility rules but generally cover uninsured children ages 18 and younger.

Underserved populations can also visit a **Federally Qualified Health Center** (FQHC) for dental care. FQHCs are funded through Section 330 of the Public Health Service Act, and are intended to help the medically underserved and vulnerable populations. There are about 900 FQHCs in the United States.

To combat severe dentist shortages, states are getting creative. Alaska has started the **Dental Health Aide Program** (<http://www.phs-dental.org/depac/newfile50.html>), which is authorized by federal law for operation in Alaska only.

The program focuses on prevention, pain and infection relief, and

## Starting a Successful Dental Program for the Underserved

There are many ways of approaching the rural dental dilemma. For instance, some communities have created mobile dental programs to answer the transportation problem for their rural residents. The following web sites offer information on mobile dental programs, as well as ideas and information for other kinds of community solutions.

- The Centers for Disease Control and Prevention web site contains a database rich in oral health data and program lists at <http://www.cdc.gov/oralhealth/>. The CDC also helps health departments collect, interpret and share oral health data specific to their areas.
- The Rural Assistance Center (RAC) has a Dental Health information guide at [http://www.raconline.org/info\\_guides/dental/](http://www.raconline.org/info_guides/dental/) and a list of success stories within the guide at [http://www.raconline.org/info\\_guides/dental/#success](http://www.raconline.org/info_guides/dental/#success). RAC also cites the Safety Net Dental Clinic Manual at <http://www.dentalclinicmanual.com> as one of the best references discussing start-up costs, choosing a location, construction, rules and regulations, mobile dental units, staffing and more. Also, RAC mentions Volunteers in Health Care (<http://www.volunteersinhealthcare.org>) for helpful guides, reports and tips on starting dental programs.
- The National Maternal and Child Oral Health Resource Center has a searchable Oral Health Programs Database and other program descriptions at <http://www.mchoralhealth.org/Programs/>.
- The American Public Health Association has a searchable Health Disparities Projects and Interventions database containing summaries of projects and interventions provided by members of the public health community. Visit <http://www.apha.org/nphw/solutions/>.
- The Healthy People 2010 Oral Health Toolkit provides “guidance, technical tools and resources to help states, territories, tribes and communities develop and implement successful oral health components of Healthy People 2010 plans as well as other oral health plans.” The toolkit can be found at <http://www.nidcr.nih.gov>.
- The Children's Dental Health Project (<http://www.cdhp.org>) has a variety of resources, publications and program ideas specific to child oral health issues.

basic restorative services. It was developed as the result of a South-east Alaska Regional Health Consortium white paper describing the enormous magnitude of dental disease crises experienced by Alaska Natives. This 1999 paper documented experiences of the approximately 85,000 Alaska Natives living in the 200 villages that make up rural Alaska. Most of the villages are not connected to the rest of the state by roads. The only health care provider routinely available is a community health aide who provides services out of a small clinic, many of which lack running water or piped sewer.

Replication of this dental aide program is being considered in other states. The Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Center for Health Workforce Studies (CHWS) is looking into the feasibility of using the model elsewhere. (Visit <http://www.fammed.washington.edu/chws/> for more information.)

However, some groups don't agree that aides should be doing the work of dentists. The American Dental Association (ADA) and the Alaska Dental Society filed suit Jan. 31 in Superior Court, saying the Alaska Native Tribal Health Consortium is violating state dental licensing laws, the *Anchorage Daily News* reported. The report said the ADA supports a dental aide program that provides only preventive care but is concerned about dental therapists performing the more invasive procedures like extracting and drilling teeth. The lawsuit comes after a decision last year by the Alaska attorney general's office, which said that the work of the dental therapists, who receive two years of training, is legal.

## Dentist Recruitment

States like Alaska are also working on dentist recruitment through loan

repayment and scholarship programs offered by the Indian Health Service (IHS), the National Health Service Corps (NHSC), and the National Institutes of Health (NIH).

The IHS offers a scholarship program available to American Indians and Alaska Natives at various educational levels. The IHS loan repayment program (LRP) pays participants up to \$20,000 per year in addition to salary, in exchange for signing a two-year service contract with an eligible Indian health program. The LRP will also pay an additional 20 percent annually to the IRS to offset the increased tax liability incurred by the participant. (Visit <http://www.dentist.ihs.gov/loan.cfm> for more information.)

The NHSC also offers a scholarship program and an LRP. (More information is available at <http://nhsc.bhpr.hrsa.gov/>.)

The NIH sponsors four LRPs that help pay educational debts. In return, participants must sign a contract agreeing to conduct qualified research activities as NIH employees. (For further information, go to <http://lrp.info.nih.gov>.)

More information on LRPs is available at [http://www.raconline.org/info\\_guides/funding/hpeducation.php](http://www.raconline.org/info_guides/funding/hpeducation.php), in the Health Education Financial Aid information guide.

## Who is Responsible?

Some wonder why dentists themselves don't rise to the occasion and help those desperate for dental treatment. Yet dentists are often trapped between helping needy people and trying to make a living.

"I don't believe dentists are uncompassionate. The government puts us in a position forcing us to not only give away the care, but to pay for the care, too," said Boedigheimer. "Dental programs for

the underserved are inadequately funded."

Most dentists can't afford to accept uninsured patients, or even those on medical assistance, on an unrestricted basis because the reimbursements usually do not cover the cost of providing services. Boedigheimer said dentist reimbursement rates are now at about 50 percent, and dentists can't afford to deliver treatments to all poor people.

"Accepting everyone would put dentists out of business, and that's not good for anyone," he said.

Boedigheimer said he thinks dentists should not have to bear the burden of improving everyone's oral health. He says the solution to making all of America smile about having ideal oral health is preventive care, education and teamwork.

"A lot of savings can be found in prevention and education. That's where we have to go. But people have to take responsibility and educate themselves about the importance of dental health. They have to make an effort on their own," Boedigheimer said. "So do all sectors of America—health, dental, government and corporate. It's a group effort. Everyone has to cooperate."



**RAC**  
Rural Assistance Center

**The Rural Monitor Staff**  
Beth Blevins, Editor  
Hope Hanson, Writer  
Julie Arnold, Design & Layout

**Call for Input**  
Something newsworthy going on in your part of rural America? Send a one-paragraph summary to the editor at: [editor@raconline.org](mailto:editor@raconline.org)



## Rethinking Human Services

by Tom Corbett, Ph.D.

### The Challenge of “Institutional Culture” in Human Services Integration

In prior articles in the *Rural Monitor*, I have tackled several challenges to achieving service integration, including some that are particularly vexing. In this piece, I will explore further a particularly problematic challenge—that of incompatible “institutional cultures.” By way of reminder, institutional culture is a shorthand term for the underlying norms, values and behavioral patterns that shape the way an agency functions and makes decisions. This concept is so critical to doing service integration well, and so potentially damaging to the best intentions of policy entrepreneurs, that I will focus on it in considerable detail over several articles.

Let us start with the simple assertion that each program or agency possesses a culture that touches on everything important to what it is and does. What kinds of people are recruited? How are they trained? What responsibilities are they given? How much latitude are they given to do their job, and to help shape the way things are done? How do they communicate with each other, and with management? What signals are sent to actual and potential customers about what the program is all about and what to expect? And so much more.

So, what is the problem for service or systems integration? The problem lies in blending together service programs that draw on radically different traditions and ways of operating. Earlier in this series, I introduced the problem of culture clash rather abstractly. Here, let’s take a more practical tack and look at what some term “institu-

tional friction,” through the lens of agency workers.

Think about Worker A located in Program (or Agency) Y. Let’s call him Jim. His basic responsibility, what I have called the institution’s core technology in earlier articles, is to issue benefits and to make sure that only eligible people get what they are allowed by law. Typically, Jim is told what to do and when. He operates according to detailed rules, and is penalized most often for making mistakes or operating outside his prescribed role.

Now, think about Worker B in Agency Z. Let’s call her Jennifer. She is responsible for dealing with family or individual crises that threaten children and families, or which prevent individuals from fulfilling adult roles such as work and raising children appropriately. Her basic tasks might differ significantly from client to client. Therefore, Jennifer needs more latitude in doing her job and exercises professional judgment rather than referring to given rules all the time. She might be rewarded for thinking creatively and acting “outside the box.”

Jim, you will quickly recognize if you read my earlier work, is operating in what we might term a fully-routinized organization; Jennifer in what we might term a non-routinized organization. And, of course, we might well envision partially-routinized agencies or programs where rule-bound help is temporized with some worker-level discretion.

Now, think ahead to what might happen if we bring together such workers from fully-routinized and non-routinized cultures and ask them to work together on solving complex family problems. Jim and Jennifer might quickly conclude that his or her counterpart is clueless about what needs to be done and

how. Their different operating styles could well generate suspicion, envy, mistrust and other challenges to efficiently and successfully helping challenged families.

To Jennifer, Jim will look rigid and highly bureaucratic, never taking risks and always afraid of making a mistake. To Jim, Jennifer will appear to be undisciplined, at best, and a rebel, at worst, with little regard for legitimate agency or program rules and regulations.

Moreover, Jim may well be threatened, even disoriented, if suddenly given discretion or asked to participate in designing new ways of helping families. On the other hand, Jennifer might find the manuals and inflexible rules associated with most routinized systems to be overly constraining and limiting to her exercise of professional judgment.

Beyond that, Jim may feel more comfortable working alone, focusing on numbers and forms. He might try to avoid dealing directly with clients, or subtly subvert efforts to work in teams with workers from other service agencies. Jennifer, on the other hand, should respond positively to human interactions and team approaches to solving complex family problems.

While this scenario is highly stylized and simplistic, it is more than mere speculation. My colleagues and I have visited a number of sites where service integration models have been introduced. Virtually all of the policy entrepreneurs in charge have described in detail the cross-systems frictions they have confronted and tried to resolve. In extreme cases, staff turnover has been high or many workers have been reallocated to new jobs until the dust settles.

Though we have discussed culture conflict primarily from the worker

*(continued on page 12)*



## Look What's Coming

by Wayne Myers, M.D.

### Plan B.....

In this series I've focused on long-term growth of our health care spending and the problems it poses for the country. According to the Centers for Medicare and Medicaid Services (CMS), health care spending had a growth rate of 8 percent in 2004 and accounted for 16 percent of the economy that year. Now, over a year later, it seems fair to estimate current health care spending at one-sixth of the economy. The growth rate of health spending in 2004 was twice that of the economy in general. Health has been doubling its share of the economy about every 35 years since the Great Depression. It seems unlikely to stop spontaneously.

Medicaid costs are outgrowing state revenues. We're seeing a flurry of state legislation aimed at slowing the growth of Medicaid spending. Most of these bills only look at Medicaid, ignoring the underlying driver, i.e., that health care is outgrowing the rest of the economy. There are a few state efforts across the country to reduce the number of people without health insurance. The Dirigo Health Plan, here in Maine, is unusual in its modest efforts to control the increase in health costs as well as helping pay insurance bills. It is facing lots of opposition and is becoming a major political issue.

In recent months, in addition to the states' problems with Medicaid and families' problems paying medical bills, we've heard Ford and General Motors point to health costs as factors in their difficulties. But we're not hearing national proposals to get our health spending growth to sustainable levels. Why? I'll try to outline the tough issues that have to be addressed. I won't presume to

know the right answers, at least this month.

First, what are some of the things about American society that make it hard for us to come to grips with health spending? (1) We mistrust authority. We want to make our own decisions about health care even if we don't have the information to make good decisions. (2) We believe in medical miracles. The cure for an incurable condition is just a little farther away in either distance or time. Any symptom is a market. (3) Routing money through an insurer is expensive. The insurer keeps at least 15 percent of the premium, and providers spend a lot trying to get paid. Though patients and doctors make most of the spending decisions, neither feels responsible for the costs. (4) The health treatment industries are uniquely powerful, with about one-sixth of the U.S. workforce on payroll. The consumer advocacy group Public Citizen estimates that 952 lobbyists spent \$141 million helping Congress with the 2003 Medicare bill. Any significant structural change will be tough.

Designing a plan to slow health cost growth will require answering some hard questions. (1) Should the distribution of resources like doctors and hospital beds be guided by competition or needs-based planning? Competition requires surplus capacity. Does this surplus capacity increase or decrease costs? (2) Should the insurance mechanism cover routine preventive measures, as espoused by public health advocates, or be limited to payment of extraordinarily large bills, arguably fostering individual fiscal responsibility? (3) Should the proposed plan(s) be operated by government or by private firms? (4) Who will decide what interventions are covered? (5) How do we move

funding streams from their present courses to some new pattern?

In 1993 politicians of both parties, most notably the Clintons, floated proposals for major health system change. The size and complexity of the proposed changes frightened a lot of people. Opponents of change sponsored television commercials featuring Harry and Louise, an ordinary American couple. Sponsors of the various bills sustained significant political damage. Health system change seems to have become politically untouchable since then.

As I write this, the January 28<sup>th</sup> issue of *The Economist* is reporting that President Bush's State of the Union message will announce new efforts to control health costs. Strategies will reportedly center on tax incentives for individuals to buy high deductible health insurance, "catastrophic coverage" and legislation to reduce liability suits.

If you feel you have the answers to medical costs please pass them along. But on second thought, it might be in your personal interest to keep them to yourself. Harry and Louise may be watching.

*Wayne Myers, a pediatrician, founded the University of Kentucky Center for Rural Health and served as its director. He also served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration. He is a past president of the National Rural Health Association and currently serves on its Board of Trustees.*

# Around the Country

by Hope Hanson

## Michigan

### One-Stop Shop for Mind and Body

A one-stop shop for the mind and body will soon open its doors to Grant's rural residents.

Baldwin Family Health Care (BFHC), a federally qualified rural health center, is combining health care and human services into a new 21,000-square-foot building designed to simplify access to care in this Newaygo County community. It is scheduled to open March 6.

"This is a comprehensive facility that will help us manage many of the most significant health care problems that we face in rural America—access to pharmacy, access to dental, and access to routine primary health care," said BFHC physician's assistant Ron Nelson.

As the community's needs outgrew its current 3,100-square-foot health center in Grant, the BFHC board of directors moved to improve the situation by applying for a low-interest, \$4 million loan through the U.S. Department of Agriculture's Rural Development Community Facilities Direct Loan Program. The terms of the loan are 4.25 percent for 30 years.

"The loan was an absolutely vital step in helping us provide more efficient and better health care services here," said Linda Shively, executive director.

Staffing in Grant will grow from 16 to 42, which will include additional medical providers, dentists, a pharmacist and support staff. The new facility has many amenities that the old one did not, including a private mental health counseling area, a diagnostic laboratory, a complete X-ray facility, a dental center with nine exam rooms, a full-service pharmacy with prescription discount programs for low-income and elderly patients who do not have prescription drug coverage, and space for individual and group health education sessions. Programs will include Alzheimer's education and referral, teen parent services, immunizations, well-child care, behavioral health and comprehensive diabetes education.



Members of Baldwin Family Health Care's staff look forward to the opening of the new health care facility at Grant. Shown (from left) are Kellie Vincent, receptionist; Anita Acosta, medical assistant; and Kelly Watson, physician's assistant.

The Grant center is one of three primary care rural health centers operated by BFHC in Lake and Newaygo counties.

To learn more about this project, visit <http://www.familyhealthcare.org>. For more information on the USDA's Rural Development Housing & Community Facilities loan and grant programs, visit <http://www.rurdev.usda.gov/rhs/cf/cp.htm>.

## Special Series: Technical Assistance Centers

*Editor's note: This is the second in a series of articles on rural health technical assistance resources around the country funded by the federal Office of Rural Health Policy (ORHP). The first article (see *The Rural Monitor*, Fall 2005) gave an overview of what is meant by technical assistance and highlighted the Rural Assistance Center. In this issue, the Delta region technical assistance entities are featured. For a complete list of technical assistance resources available through ORHP, see <http://ruralhealth.hrsa.gov/links/TACenters.asp>.*

### Delta Rural Hospital Performance Improvement Project

Rural hospitals that want to perform better and more efficiently often find that making improvements demands time and energy—commodities that can be in short supply for those working in rural health care. Fortunately, help is out there. More than 70 small rural hospitals in the Delta Region have accepted this help and made a step toward securing their

futures through the Delta Rural Hospital Performance Improvement Project (RHPI).

"The project can provide the technical expertise, information and business tools small rural hospitals need in order to survive and thrive," said Christy Crosser, the project's associate director.

RHPI offers consultations to rural hospitals in the Delta region of the United States, which covers portions of Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi,

Missouri and Tennessee. To be eligible for RHPI, those hospitals must have 50 or fewer beds. The demonstration project, which began in September 2001, helps hospitals improve their financial, clinical and operational performance.

“RHPI can help strengthen rural hospitals as centers of health care access,” Crosser said. “A financially stable hospital is critical when it comes to residents’ health and a community’s economic vitality—especially in rural areas.”

RHPI offers three types of services:

- **Performance Improvement Assessment** - This detailed analysis of the hospital’s market and organization results in recommendations for clinical service line, operational and financial performance opportunities.

- **Targeted Consultation** - This addresses a single issue, such as strategic planning, customer service, length-of-stay issues or provider recruitment strategy.

- **Balanced Scorecard** - This management system enables organizations to clarify their vision and strategy then translate them into action. It is available to hospitals that already have a strategic plan in place. Crosser said Balanced Scorecard tracks performance in several areas and presents a “balanced” picture of organizational performance.

“We look at not only the bottom line but many factors contributing to a hospital’s overall success as an organization,” she said. The balanced scorecard system was developed at Harvard University by Dr. Robert Kaplan and Boston consultant David Norton.

## Consultants? Oh no!

Although many working in health care dread the idea of a consultant coming into their workplace,

feedback on the RHPI has been positive. Last year, a client feedback report indicated that 100 percent agreed that RHPI consultants “had the appropriate skills, knowledge and experience to assist them with performance improvement efforts,” and all said they would recommend the program to others.

“I would highly recommend this service to other rural hospitals because it helps small, rural facilities focus their efforts, which is needed with today’s limited financial resources,” said Bob Moore, chief executive officer of the Red Bud Regional Hospital in Red Bud, Illinois.

Red Bud, which opened in 1900, is a Critical Access Hospital operating 25 beds.

“We got involved with RHPI last spring as a result of looking to improve our operations and connection to the community served. RHPI helped us fund the development of a Balanced Scorecard,” Moore said. “The process has been extremely helpful and has given us a tool to track our successes and opportunities to improve.”

Another hospital that received a RHPI consultation, Lawrence Memorial Hospital in Arkansas, improved its profit margin significantly and reduced staff turnover by more than 20 percent. As a result, it received an award in 2004 from HealthLeaders as the Top Leadership Team in the small hospital category (see the Fall 2004 *Rural Monitor* for more details).



*Christy Crosser, associate director of RHPI, discusses the program at the ORHP Annual Meeting in August 2005 in Washington, D.C.*

Crosser said that because RHPI is a federally funded program, eligible hospitals need only ask for the help and don’t need to come up with loads of cash for the consultants’ services.

“Our services are free to eligible hospitals, but we do accept voluntary contributions,” Crosser said. She added that if the hospitals were to go out and hire other private consultants for the same services, the bill could run easily over \$30,000.

RHPI is managed by Mountain States Group of Boise, Idaho, and partners with the Rural Health Resource Center of Duluth, Minnesota. State offices of rural health and hospital associations are also involved in the project. For more information, contact Christy Crosser, Associate Director, Delta Rural Hospital Performance Improvement (RHPI) Project, PO Box 1959, Lyons CO 80540-1959; phone (303) 823-5991; fax (303) 823-6634; e-mail [ccrosser@MtnStatesGroup.org](mailto:ccrosser@MtnStatesGroup.org); or visit <http://deltarhpi.ruralhealth.hrsa.gov>.

## Delta Resource Project

To complement the work of RHPI, another federally funded project has been developed to help health care providers, as well as entire communities, improve access to health care in the Delta region.

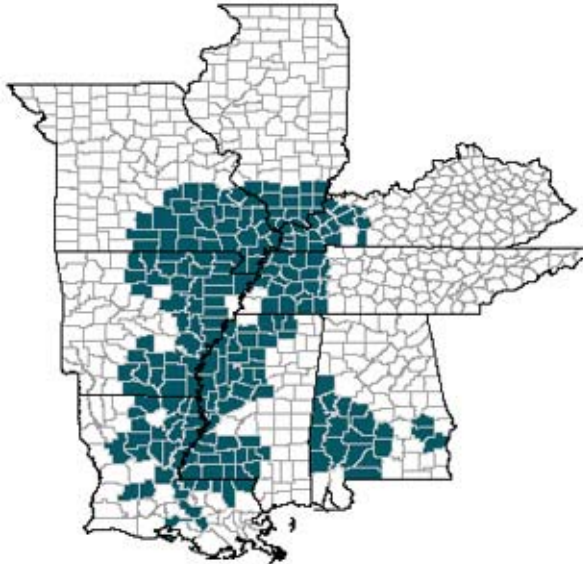
The Delta Resource Project is designed to provide quick and easy access for communities to obtain the resources they need for program planning and fund-raising activities.

“Through our web site, we disseminate information that can assist rural Delta communities in achieving a variety of community goals related to health and social services,” said Kristine Sande, project director. “For example, individuals interested in improving transportation in their area can go to the Topic Page on transportation and find publications, success stories, tools and organizations, as well as funding opportunities, that can help them to successfully approach the issue.”

Established in 2005 as a special project of the Rural Assistance Center, the Delta Resource Project web site focuses on the 209 rural counties in the eight-state Mississippi Delta region.

For more information or to access the Delta Resource Project web site, visit <http://delta.raconline.org>. A printable resource manual comprising the web site’s information is available at [http://delta.raconline.org/pdf/resource\\_manual.pdf](http://delta.raconline.org/pdf/resource_manual.pdf). The project contacts are Holly Gabriel and Kristine Sande, Rural Assistance Center, PO Box 9037, Grand Forks

ND 58202; phone (800) 270-1898; fax (800) 270-1913; or e-mail [delta@raconline.org](mailto:delta@raconline.org).



*These counties in the Delta states are eligible for the Delta RHPI project and the DSRDN grant program.*

## Rural Health Policy Center at Penn State College of Medicine

Also providing guidance and assistance to the Delta states is the Rural Health Policy Center at the Penn State College of Medicine.

“Our role is to provide technical assistance to the **Delta States Rural Development Network** program grantees,” said Michael Beachler, project director. “While many technical assistance centers may have narrower focuses, we are broad in scope of services because of the nature of the Delta States program.”

Beachler and Deputy Director Curtis Holloman do a variety of tasks to provide technical assistance to the federally funded Delta States Rural Development Network (DSRDN) grantees.

“We conduct site visits to the eight Delta states, conduct quarterly conference calls and provide grantees

with advice regarding both program ideas and additional funding resources. We assist in organizing annual conferences that bring together the grantees to learn from national experts and from each other,” Beachler said. “And, we also occasionally provide advice to the federal Office of Rural Health Policy staff regarding the program.”

The DSRDN program is designed to stimulate collaborative efforts through planning and implementation grants.

“The program has evolved over the past few years with most Delta States grantees moving toward multi-county coalitions. This has allowed the multi-county networks to pool together the \$17,000 per county available per year. By pooling resources together with other counties, grantees can make a more substantial impact,” Beachler said. The networking has resulted in such successes as helping medically indigent individuals obtain free or low-cost pharmaceuticals, developing innovative obesity reduction projects and coordinating disease management efforts to aid the chronically ill.

Beachler says the programs funded by DSRDN grants have been well received by the public and generated even more funding opportunities.

“As each of these programs has matured, the number of people reached continues to increase,” he said. “And, it has mobilized efforts to secure state and private funding to have an even greater impact.”

The Rural Health Policy Center also administers the **Southern Rural Access Program**. The goal of the program is to help improve access to basic health care in several of the Delta states. The program benefits residents in the Delta states of Alabama, Arkansas, Louisiana and Mississippi, and also helps rural

*(continued on page 12)*

## Spotlight on Rural Research

by Hope Hanson

### Rural Oral Health— All In The Family?

Studies show that rural residents suffer from more oral health problems than urban or suburban residents. Researchers at the University of Pittsburgh, who are working with West Virginia University's School of Dentistry, think the problem goes beyond lack of access to dentists. Their study, "Genetic Factors to Oral Health Disparities in Appalachia" is taking a relatively rare research approach by examining the underlying genetic and environmental risk factors for oral disease.

"We're measuring a large number of genetic risk factors, including behavioral and host response issues—such as immune function—that tend to aggregate within families," said Dr. Robert Weyant, the study's co-principal investigator. "One of the strengths of this study is it's looking at oral health issues comprehensively. We're trying to find the risks, whether they're genetic, economic, behavioral or environmental."

Since 2002, Weyant and his team have been looking closely at the oral health of people who live in rural northern Appalachia, including West Virginia and Pennsylvania. Families in rural Appalachia are known to have many challenges in maintaining their oral health. Lack of access to dentists, low incomes and poor diet are known to contribute to compromised oral health in the region.

"It's been documented that people in Appalachia suffer some of the highest burden of oral disease of any definable group in the country," Weyant said. "Ultimately, we want to develop interventions that reduce the amount of disease, and prevent the next generation from suffering from these problems."

Weyant said they're working with 500 families whose health habits,

attitudes and genetics are being loosely assessed through on-site questionnaires, clinical examinations, interviews and gene analysis. The researchers have found participants using various means of advertising, including schools, radio, newspapers and church fliers. Family members in the study get a free dental exam and a referral for care, if needed.

"We believe families are the most important behavioral and biological influences in oral health. If mom doesn't brush, neither will the kids," Weyant said.

Weyant, an epidemiologist, is taking on the part of the study involving socioeconomic and environmental factors. His co-investigator, geneticist Mary Marazita, is responsible for the genetic side of the research. Funded by the National Institute of Dental and Craniofacial Research (NIDCR), the study will continue into 2009.

Contact Weyant at (412) 648-3052 or [rjw1@pitt.edu](mailto:rjw1@pitt.edu), or Marazita at [marazita@sdmgenetics.pitt.edu](mailto:marazita@sdmgenetics.pitt.edu) for more information.

Other recent research in rural oral health includes closer looks at elderly adults and nutrition, dentist recruitment and children.

"Rural Older Adults: Oral Health, Diet and Quality of Life" is another study being supported by the NIDCR. Sara Quandt, professor of epidemiology at the Wake Forest University School of Medicine, is leading the investigation into how the oral health of rural adults 60 years and older affects their nutritional status, their social interaction and their overall quality of life. This project builds on eight years of community-based research on nutritional self-management and nutritional status in two rural, multiethnic North Carolina counties. The researchers are collecting data from more than 700 people, includ-



*"If mom doesn't brush, neither will the kids." — Dr. Robert Weyant, University of Pittsburgh*

ing African-American, Native American and white older adults. Work will continue on the study through 2009.

For more information, contact Quandt at (336) 716-6015 or [squandt@wfubmc.edu](mailto:squandt@wfubmc.edu).

- California has examined ways to recruit dentists to their rural areas. The California State Rural Health Association and the University of California San Francisco Center for Health Workforce Studies completed a study titled *Evaluation of Strategies to Recruit Oral Health Care Providers To Underserved Areas of California* in 2004. This report cites itself as "the first to evaluate the impact of the multitude of programs in California to recruit and retain oral health care providers in underserved areas ... and seeks to answer several questions about these efforts."

The study evaluated the impact of the many recruiting programs for underserved areas already in place. It also proposed several ideas, including developing new degrees combined with training incentives, and also creating "integrated dental education and service centers to pilot the creation of a cadre of new oral health professionals (with expanded function and independent practice) trained not only in dental care but in public health."

*The project was funded by The California Program on Access to Care. The full report can be viewed at [http://www.futurehealth.ucsf.edu/pdf\\_files/Dental\\_Strategies\\_Full\\_Final\\_Report.pdf](http://www.futurehealth.ucsf.edu/pdf_files/Dental_Strategies_Full_Final_Report.pdf).*

---

• The National Conference of State Legislatures (NCSL) also wanted to identify state strategies for increasing the supply of dentists in rural areas. With help from the federal Office of Rural Health Policy, the group prepared a report titled *State Experience with Dental Loan Repayment Programs*. Researchers evaluated current dental loan repayment programs in all 50 states. They established baseline information about these programs and pinpointed successful programs for use in other states. The study is available at <http://www.ncsl.org/programs/health/forum/dentalloan.htm>.

*For more information, contact Donna Folkemer, Group Director for Health, NCSL, at (202) 624-8171 or [donna.folkemer@ncsl.org](mailto:donna.folkemer@ncsl.org).*

• Although it's an older study (2003), "Oral Health Status of Children and Adolescents by Rural Residence, United States" holds much information used today in making the case for improvements needed to hasten better oral health in rural dwellers. The study, conducted by faculty at the University of Maryland Dental School, documents the oral health status and dental care utilization of U.S. children by place of residence.

Published in the Summer 2003 issue of the *Journal of Rural Health* (<http://www.nrharural.org>), the report concludes that children residing in rural areas have less access to and utilization of dental care compared to children residing in urban areas. Moreover, poor rural children display less utilization of dental services than poor urban children. The study also contends that studying the oral health status of the rural population furthers the understanding of oral health disparities associated with sociodemographic characteristics in the United States.

---

### *Continued from Rethinking Human Services, page 6*

perspective, systems and management differences also exist. Let us take a couple of examples. Agency Y above is most likely bureaucratic in orientation, more hierarchical, with top-down communications, low worker participation in decision making, and with performance outcomes that focus on process measures as opposed to client change. Agency Z is likely to be

professional in character, driven by missions grounded in outcomes focused on customer and community change, emphasizing discretion, team work, worker participation in decision making and acceptance of risk taking.

So, how does one deal with these vexing challenges associated with institutional culture clashes? I will take up that challenge, and the

continuing saga of Jim and Jennifer, in the next article in this series.

*Tom Corbett has emeritus status at the University of Wisconsin-Madison and is an active affiliate with the Institute for Research on Poverty where he served as Associate Director. He has worked on welfare reform issues at all levels of government and continues to work with a number of states on issues of program and systems integration.*

---

### *Continued from Delta Rural Hospital Performance Improvement Project, page 10*

communities in Georgia, South Carolina, East Texas and West Virginia. Many of the residents are living in counties with significant disparities in health status and access to care.

"The health needs in these counties are immense. These are some of the poorest counties in the country and are extremely underserved," Beachler said. "The Southern Rural Access Program was set up to address some of these incredible health needs."

He said some of the program's successes include health workforce recruitment of primary care providers, setting up rural health networks, and helping providers access loans to build or renovate health care facilities.

For more information, contact Michael Beachler, director, Rural Health Policy Center, Penn State College of Medicine, 600 Centerview Drive, Suite 5301, PO Box 855, MC A530, Hershey PA 17033-0855; phone (717) 531-

2090; fax (717) 531-2089; e-mail [mbeachler@psu.edu](mailto:mbeachler@psu.edu); or e-mail Curtis Holloman, deputy director, at [cholloman@psu.edu](mailto:cholloman@psu.edu). For more information on the federal Delta States Rural Development Network Grant Program, see <http://ruralhealth.hrsa.gov/funding/Delta.htm>. For more information on the SRAP program, see <http://www.srap.org/>.