Alabama Dental Association

2012

White Paper on Alabama's Oral Health Status, Access and Barriers to and Utilization of Oral Health Care Services

EXECUTIVE ABSTRACT

The mission of the Alabama Dental Association is to encourage the improvement of the health of the public, to promote the art and science of dentistry, to promote fiscal responsibility throughout the profession, and to represent the interests of the dental profession and the public which it serves. The protection of the public, both for served and underserved populations, is a core principle of the Alabama Dental Association. When it comes to access to care issues, and equally or more importantly, barriers to care issues, we have a myriad of points and proposals to address these issues.

In the area of Health Status, we would like to see an increase in the proportion of eligible low-income elementary school children who receive sealants on the chewing surfaces of permanent molar teeth through appropriate school-based programs and through adequately funded government programs for these services. The ADPH indicates they would welcome this opportunity. They have equipment, supplies and staff to organize this endeavor; they only need volunteers and manpower to accomplish this recommendation. We would also like to see an increase in the number of high-risk children receiving dental screenings and referrals to dentists for care.

In the area of Oral Health Literacy, we need to educate children and parents on the importance of good oral health, how to have good oral health, and the importance of seeing a dentist. Children should be protected from television advertisement of products that present a threat to their oral health. We need to form collaborations and partnerships with other interested groups to develop and disseminate oral health education materials. Possible groups would include community-based health centers, public health clinics, FQHCs, area health education centers, K-12 school systems, and hospitals among others. We would recommend promoting the Dental Home concept. The Alabama Department of Public Health currently performs many of these tasks.

In the area of Utilization, we need to work with the federal and state governments to provide additional financial incentives for dentists to provide regular care in underserved areas.

In the area of Workforce we need to continue to monitor and support the Alabama Dental Rural Health Scholarship Program to evaluate how the curriculum, recruitment and financial options could best be structured to provide for access needs in rural and underserved areas.

In the area of Government Programs, we need to prevent Managed Care Plans (MCPs) from closing panels and limiting access to government funded programs. We must require MCPs to re-open the closed provider panels in the Medicaid/SCHIP program to allow more providers in the network to see the patients seeking care. BCBS of Alabama administers the All Kids program. Unless Alabama dentists

agree to become BCBS PPO providers, they are deemed ineligible to become an All Kids provider which creates a barrier to access to care for the underserved. Many Alabama dentists have indicated that they would participate with All Kids if they were not forced to become BCBS PPO providers to qualify. We also need to advocate for adult dental benefits in Medicaid. Alabama is one of only 8 states that do not cover adult dental benefits. This policy is decided at the state level rather than the federal level, and policy makers have chosen to target services for individuals less than 21 years of age based on limited funding

In the area of Financing Care, we need to seek grants to fund the building of one or more satellite School of Dentistry Clinics as well as modern mobile dental clinics for areas of greatest need as determined by Dental HPSAs where students and GPR residents would rotate through the clinic(s) just as they do with other externships. Dr. Zack Studstill, our ALDA Executive Director, has proposed the concept of the "West Alabama Initiative" to bring greater access to underserved areas in West Alabama. We also advocate that dental reimbursement fees for the Medicaid and SCHIP dental programs be evaluated on at least a biannual basis and that fees be established that are more competitive with market-based fees, using the BCBS PPO fee schedule as a minimum.

POSITION STATEMENT AND RECOMMENDATIONS

Experts now recognize that the health of the mouth is critical to the health of an individual. Numerous studies suggest that many systemic adverse health conditions have manifestations in the mouth. Adverse oral health conditions affect three aspects of daily living: 1) **Systemic health** – periodontal disease has been suggested to have a direct impact on heart disease, diabetes and low birth weight babies; 2) **quality of life** – edentulism (without teeth), soft tissue lesions, oral clefts and missing teeth affect the ability to eat and function; and 3) **economic productivity**–dental disease accounts for many lost work and school days. Good oral health is essential to overall health and access to dental care is important for the health and well-being of Alabamians.

Numerous components impact access to dental care: oral health literacy, financing care, health status, utilization, safety net, workforce, external influences, government programs, and innovative outreach. **Barriers may impact an individual's ability to access oral health care services and solutions to overcoming those barriers must be multifaceted. Any solution that compromises the welfare and safety of the patient should not be considered, even in the spirit of "any care is better than no care."** There is no health or financial gain in compromising oral health care. Our goal must be to open the doors of access to care while ensuring the health and safety of the public.

Accessing dental care is uniquely individual. According to the Academy of General Dentistry, solving the access problem requires that those who are interested in helping a person access care "recognize and address the unique barriers encountered by an individual seeking dental care, including the patient's perceived need for care, oral health literacy, dentist and dental team distribution, financial circumstances, special needs, transportation, location, language, cultural preferences and other factors influencing entry into the dental care system."[1] Access to oral healthcare is far more complicated than a one solution response.

The dental profession recognizes the importance of oral health and Alabamians' ability to access dental care. We took the lead in improving oral health literacy and advocating for government assistance programs for those who cannot afford care. The profession is the outspoken advocate for improving access to care for all population groups. The Alabama Dental Association and Alabama dentists work with the Alabama Medicaid Agency to ensure that Medicaid eligible children have a dental home. This effort is geared toward educating dentists and patients about the importance of establishing a dental home, and our many volunteer supported dental clinics provide care to those in need.

An adequate workforce is a key element in providing access to dental care. The determination of an adequate workforce is more than the number of dentists or dental auxiliaries within a state. From a workforce perspective adequate access is affected by the following: the geographic distribution of dentists and dental auxiliaries, the availability of specialty practitioners, and the number of dentists that participate in government-funded programs. A shortage of dentists may exist in a few states. A 2010 report from the Board of Dental Examiners of Alabama (BDEA) indicates 2,461 dentists hold an active license to practice in Alabama. Of that number, 351 dentists have an Alabama license but live or practice in another state. This leaves 2,110 licensed dentists in Alabama. The BDEA currently averages licensing approximately 60 to 70 additional dentists each year. Alabama also has an excellent and competent supply of dental assistants and dental hygienists who complete the dental team's ability to provide quality dental care to Alabamians.

Recently, groups outside the dental profession entered into the discussion of improving access to oral health care. Most of these groups are single focused in their solution to the multifaceted problem of accessing oral health care. Some entities propose a new category of dental provider called a Mid-Level Provider (MLP) as the solution to access. This approach may be the result of frustrations from losing government funding battles for Medicaid and SCHIP programs and believing that some care is better than no care. **While these groups may be well intentioned, their solution is not based on science or data that support adding MLPs to the dental workforce actually improves access or lowers the cost of care.**

A few states' policy makers created a dental MLP as a solution to access to oral health care. These policy makers looked to unproven solutions without considering quality of care, the potential ill-effect of the patient's health or the potential additional cost. In good conscience they believe this to be a quick and an adequate response to the access to care issue. However, creating a new category of provider will not solve the complex issue of access; it will only create a two-tiered delivery system.

New Zealand has employed MLPs since 1921. However, reports indicate that this strategy has not solved access to dental care or improved the oral health of its citizens. If this strategy had been successful, New Zealand would not be experiencing pockets of oral health disease at the level of regions traditionally characterized by poor oral health status. Indeed, in some areas the severity is at the level of developing or Eastern European countries.[2] **The recent data prompted New Zealand to reconstruct its dental delivery system. What this information underscores is that merely creating different types of providers to augment care from a dentist does not provide appropriate and accessible oral health care.** Alabama should not step backwards and expose patients to a lesser standard of care that has not worked in other countries.

Alabama has evidence that the creation of MLPs doesn't solve the problem of access to medical care. Despite the addition of physician extenders (MLPs), access to health care for many Alabamians is limited or unavailable, especially in rural areas, and the cost of delivering health care continues to increase annually. Like most states Alabama is experiencing a shortage of primary care physicians, which may be exacerbated by the creation of MLPs. It is important to note that primary care physician shortages are measured differently than dental shortages. Nurse Practitioners and Physician Assistants are not included in the measurement. (See Attachment A)

Policy makers and health care advocates who are interested in seeking a sustainable solution will recognize that lowering the standard of care will not solve the problem of improving oral health, will not increase access and will not lower costs. **The dental profession, decision makers and other interested parties must work together to examine what is broken, what works, and what we can do to meet the challenge to provide Alabamians with quality dental care while increasing access to care for all.** Many solutions are required, and the solution for one state is not likely to be the same for all states. However, we must be understanding of those states that employ extraordinary measures in an attempt to solve their health care delivery issues, but we must never let their compromise set the standard of care. Other states' solutions should not be adopted as the professional standard of care or accepted as Alabama's solution to access.

Alabama's dental profession will stand firm on core principles and the performance of education appropriate procedures must be a minimum requirement. Education is the foundation of science. Dentists are doctors with an undergraduate degree and a minimum of four additional years of dental school. Many continue for advanced studies in a General Practice Residency or in one of the nine specialty programs. Contrast these requirements with a dental assistant who generally receives one year of training and works under the direct supervision of a dentist or a dental hygienist who works under the supervision of a dentist. In many states a dental hygienist has a minimum of two years of college and attains an associate degree before treating patients. Alabama is very fortunate to have the Alabama Dental Hygiene Program (ADHP). The ADHP is a shining example of the Alabama dental community's commitment to access to care. The ADHP has allowed many smaller or rural communities to have access to dental hygiene services. Dental hygienists are highly trained and educated but a two or four year undergraduate program does not prepare them to diagnose or perform irreversible procedures. **Proposals for a two year training program for a Dental Health Aid Therapist (a type of MLP) would allow under-educated individuals to diagnose disease and perform irreversible procedures. Taking a step back in education is not a solution; it is a problem that will adversely impact the oral health of future generations.**

Areas of the current dental delivery system could be improved, but lowering the education standards by creating a dental MLP is not one of them. The dental delivery system could work more effectively if not faced with the limitations of underfunded government programs or Managed Care Plans (MCPs) that close panels and deliberately ration care to avoid utilization. These constraints hamper dental care from being delivered to the population that needs government assistance. Employer plans have some of the same problems. The dental benefit for most employees is capped at $1,000 annually and has not changed since the late 1960s. This is not consistent with medical benefits and can be a barrier for employees who seek care. Many Alabamians with dental coverage do not go to a dentist because they do not understand

the importance of oral health. We must put education programs in place to increase Alabamians' oral health literacy.

In our quest to improve Alabamians' access to oral health care we must never compromise patient health or safety. We must look for ways to bridge the gaps between the "haves" and the "have-nots" by collaborating with those who truly want to work toward solutions that allow all Alabamians to have the same quality oral health care that each of us wants for our families.

Specifically, the Alabama Dental Association's proposed solutions to improving the health status of Alabamians by improving the access to and the utilization of oral healthcare include, but are not limited to, the following:

Recommendations

Health Status:

1. Increase the proportion of eligible low-income elementary school children who receive sealants on the chewing surfaces of permanent molar teeth through appropriate school-based programs and through adequately funded government programs for these services. The ADPH indicates they would welcome this opportunity. They have equipment, supplies and staff to organize this endeavor; they only need volunteers and manpower to accomplish this recommendation.
2. Increase the number of high-risk children receiving dental screenings and referrals to dentists for care.
3. Increase the number of Alabamians on public water supply served by fluoridated community water systems with optimal levels of fluoride.
4. Advocate for more data collection and surveillance by the appropriate state agencies to determine the oral health status of Alabamians, especially children.

Oral Health Literacy:

5. Educate children and parents on the importance of good oral health, how to have good oral health, and the importance of seeing a dentist.
6. Educate Alabamians on the importance of annual oral cancer examinations performed by a dentist and educate Alabamians on the dangers of tobacco use as it pertains to oral cancer.
7. Develop educational materials (written, visual, mixed media) that are at the appropriate education level and are culturally and linguistically appropriate for the target audience.
8. Increase the proportion of school-based health centers with an oral health component. Schools can be an effective way to improve access to health knowledge and skills through the health centers, nurse's offices, or general health education classes.
9. Pursue development of a comprehensive oral health education component for public schools' health curricula in addition to providing editorial and consultative services to primary and secondary school textbook publishers.[3] Target the at-risk groups first – poor children, racial and ethnic minorities, the elderly, rural residents, and individuals with disabilities or other special needs.

10. Provide information to dentists and their staffs on cultural diversity issues which will help them to reduce or eliminate barriers to clear communication and enhance understanding of treatment and treatment options.[4]
11. Form collaborations and partnerships with other interested groups to develop and disseminate oral health education materials. Possible groups would include community-based health centers, public health clinics, FQHCs, area health education centers, K-12 school systems, and hospitals among others. Promote the Dental Home concept. The Alabama Department of Public Health currently performs many of these tasks.
12. Improve patient education and counseling in the dental office environment to help increase dental knowledge in patients with low oral health literacy levels.
13. Change perceptions of oral health by explaining in the simplest terms why oral health is important and what simple steps individuals can take to preserve their own oral health and that of their children, as well as recognize possible signs of trouble and when to seek out care.
14. Engage populations and community organizations in the development of health promotion and health literacy action plans.
15. Encourage more interdisciplinary collaboration and care among health care providers to manage the health-oral health of each person.
16. Encourage greater utilization of currently available resources for oral health, such as the *Oral Health Literacy: An Annotated Bibliography of Materials for People with Limited Literacy Skills*.

Utilization:

17. Advocate that laws and/or regulations for children of state employees, who otherwise qualify, as being eligible for Alabama All Kids for Kids continue to be eligible for the program. This was achieved, effective April, 2011.
18. Initiate appropriate recruitment efforts to increase the numbers of under-represented minority and disadvantaged students in dental schools.
19. Encourage providers to increase their cultural competency to create trust and comfort, thereby influencing utilization of oral health care.
20. Work with the federal and state governments to provide additional financial incentives for dentists to provide regular care in underserved areas.

Workforce:

21. The Alabama Dental Association should collaborate with the Office of Primary Care and Rural Health (OPCRH), ADPH, to assure that the Health Resources and Services Administration (HRSA) criteria for establishing Dental HPSAs is accurate, utilized and reported correctly, and ALDA should encourage Alabama dentists statewide to participate in the Dental HPSA designation survey. * (See Attachment A)
22. Advocate for solutions for access to care based on correct data and assumptions utilizing the experience of dental practitioners rather than the medical model or under trained providers. The OPCRH, which implements the Dental HPSA survey, reports that inaccuracies often result from dentists or office staff refusing to participate in the survey. (See Attachment A)

Alabama does participate in the "First Look" program using pediatricians (MDs) trained in performing oral health screenings on infants and young children.

23. Continue to monitor business trends that can impact the dental delivery system and educate dentists about opportunities to streamline and obtain economies of scale without compromising the quality of patient care.
24. Advocate for standardization of the licensure process to facilitate dentists to move into states with access issues. The BDEA currently has a fairly liberal licensure by credentials policy.
25. Educate dentists in ways to maximize the use of the current workforce while maintaining dentist supervision.
26. Explore innovative ways to expand the capacity in current dental practices such as joining with other dentists to provide hours outside of the traditional 8am to 5pm five days a week.
27. Increase dental class sizes to maximum capacity to provide dentists for states without a dental school.
28. Advocate for more loan forgiveness programs or monetary incentives that are tied to the dentist providing treatment in underserved areas.
29. Advocate for a state and federal tax deduction for dentists who provide well documented free care to the indigent population.
30. Continue to monitor and support the Alabama Dental Rural Health Scholarship Program to evaluate how the curriculum, recruitment and financial options could best be structured to provide for access needs in rural and underserved areas.
31. Advocate for resource grants and gifts to supplement the cost of dental education for those students willing to practice for four years in a designated area of need. This is already available in Alabama through National Health Service Corps
32. Advocate for Dental HPSA sites to become National Health Service Corps site for loan forgiveness/repayment for new graduates. Most every Dental HPSA site qualifies as a NHSC repayment site.
33. Advocate for HRSA to change the criteria for Dental HPSA classifications so that funding of dental health care needs is based on accurate data. Also, providers need to understand that the data provided to HRSA comes from surveys done with the general and pediatric dental offices. Some dentists refuse to participate or provide inaccurate data – all of that impacts the accuracy of the Dental HPSA numbers. (See Attachment A)
34. Encourage the University of Alabama School of Dentistry to structure GPR programs to encourage and target dental school residents for rural access slots of need.

<u>Government Programs:</u>

35. Advocate for government programs to eliminate wasteful middlemen (administrators) from Medicaid and SCHIP programs. Blue Cross Blue Shield of Alabama (BCBS) serves as the administrator for the All Kids programs. EDS is the intermediary for Medicaid in Alabama.
36. Advocate for the government to provide adequate funding of public dental programs.
37. Advocate to prevent Managed Care Plans (MCPs) from closing panels and limiting access to government funded programs. Require MCPs to re-open the closed provider panels in the Medicaid/SCHIP program to allow more providers in the network to see the patients seeking care. BCBS of Alabama administers the All Kids program. Unless Alabama dentists agree to become **<u>BCBS PPO providers,</u>** they are deemed ineligible to become an All Kids provider. **<u>With this</u>**

policy, BCBS of Alabama is greatly contributing to the prevention of access to care to the most vulnerable segment of Alabama society, the underserved. Alabama dentists have indicated that they would participate with All Kids if they were not forced to become BCBS PPO providers to qualify.

38. Advocate for increased funding for Public Health that includes a plan on the most efficient use of the dollars.
39. Advocate for adult dental benefits in Medicaid. Alabama is one of only 8 states that do not have adult dental benefits. This is policy is decided at the state level rather than federal level, and policy makers have chosen to target services for those less than 21 years of age based on limited funding.
40. To encourage Medicaid provider participation, simplify the credentialing process for dental providers by allowing applications to be completed online in their entirety. Currently providers must be credentialed by the Alabama Medicaid Agency. Applications are not able to be done online at present, but the application can be downloaded from the Medicaid website. Once the application is received at Provider Enrollment at HP, it takes 5-10 working days for approval. Providers should only have to go through the credentialing process one time.
41. Encourage the Alabama Department of Public Health to work in partnership to improve access to care for the Low Income and Aged, Blind and Disabled population covered under government programs.
42. Streamline the Medicaid paperwork claims processes to more closely mirror private sector plans. Reduce the number of Medicaid/SCHIP procedures that require pre-authorizations. Alabama All Kids paperwork claims process does mirror private sector plans for PPO dentists for BCBS.
43. Monitor the evolving health care reform legislation and advocate for appropriate dental benefits for children.

Financing Care:

44. Encourage a higher maximum dental benefit and the elimination of waiting periods and pre-existing clauses in all private dental insurance plans.
45. Encourage employers to consider a direct reimbursement model to allow the employer and the employee to be more actively involved in dental health choices.
46. Seek grants to fund the building of one or more satellite School of Dentistry Clinics as well as modern mobile dental clinics for areas of greatest need as determined by Dental HPSAs. Require students and GPR residents to rotate through the clinic(s) just as they do with other externships.
47. Encourage the increased use of flexible spending accounts for dental care.
48. Encourage offices to be flexible with payment plans in-house or utilizing the services for companies such as Care Credit to open treatment for more individuals.
49. Advocate that dental reimbursement fees for the Medicaid and SCHIP dental program be evaluated on at least a biannual basis and that fees be established that are more competitive with market fees, using the BCBS PPO fee schedule as a minimum.
50. Advocate funding the Medicaid and Alabama All Kids programs through state and federal funding at a minimum of the prevailing BC/BS reimbursement level.
51. Offer incentives to dentists to set up practice in rural, underserved areas of the state by providing sales tax breaks for the purchase of equipment necessary to set up a dental practice and/or to build a practice. The OPCRH, ADPH, offers federal scholarships and loan reimbursement up to

$30,000.00 per year for an initial two years if the student goes into an area of designated dental need. State loan repayment opportunities are not currently available.

Safety Net:

52. Recognize the importance of oral health to overall health by providing adequate funding to maintain the public health safety net that provides much-need prevention services to Alabama's children.
53. Increase starting and mid-point salaries for public health dentists and dental hygienists to the current maximum salaries.
54. Approximately half of the Community Health Centers offer dental services. Encourage increased funding to initiate more dental clinics in the FQHCs which would provide additional venues for adult dental services.
55. Provide funding to expand dental clinics in all Federally Qualified Health Centers; encourage competitive salaries for dentists and dental hygienists to attract providers.
56. Continue to collaborate with stakeholders to maintain and to establish additional programs that are community-based solutions to access to care.

Innovative Outreach:

57. Teledentistry: Because Teledentistry is unregulated and fairly new to dentistry, the ALDA advocates for definitive Teledentistry regulations that require direct supervision by dentists.
58. Advocate for strict regulation of mobile vans to allow access to communities that cannot sustain a dental practice.
59. Consider legislation that would provide state tax credits for donated dental services provided in volunteer clinics as well as other types of donated dental programs.

INTRODUCTION

Oral health is critical for overall health and well-being. The ability to access dental care is an essential element of a healthy population. Dentistry is a prevention-based profession and most dental disease can be eliminated or dramatically improved by seeing a dentist regularly. For every dollar spent on prevention there is a four dollar savings in treatment costs.[5] However, many Alabamians do not understand the importance of seeking dental care. Some individuals have difficulty accessing the system because fewer dentists can participate in government programs because the program is inadequately funded and will not pay for the cost of providing the services. Others can experience barriers such as transportation, literacy, or cultural issues. Numerous people purchase dental care with discretionary dollars and do not always see the importance of making oral health a priority in their personal budgets. Employer dental benefit plans have not kept up with the cost of care and many plans fail to pay first dollar coverage for preventive services.

Of the 4.7 million people living in Alabama in 2010 an estimated 2.05 million were enrolled in a private dental plan and 661,830 were enrolled in a public plan, such as Medicaid/SCHIP. (Medicaid was 572,620 and All Kids was 143,302).[6] From a 2009 report 45% of Alabama's population has no dental benefit and

self-pays for dental services.[7] Most dental insurance is purchased through employers and very few stand alone dental plans exist. The plans that do exist are generally not competitively priced based on the benefits they provide. Requiring insurance companies to offer a stand-alone competitively priced dental plan that covers preventive services could increase access to care and improve the oral health status of Alabamians. Increased access to dental care could potentially save unnecessary costs incurred by patients seeking care from hospital emergency rooms and physicians who can only treat the symptoms of dental disease, not the underlying cause.

Alabamians who utilize dental care enjoy the highest quality of care in the world. It is the goal of the Alabama Dental Association for all Alabamians to have access to dental care. The Alabama Dental Association is a leading proponent of educating Alabamians on the need to seek dental care and has established a program to promote the "Dental Home" concept to dentists and patients. In addition, by very conservative estimates for the Birmingham District Dental Society's web site survey, Alabama dentists provide approximately **$119 million** annually in donated dental care through private offices and volunteer-staffed dental clinics. Alabama's "Donated Dental Services" (DDS) program, from their 2010 letter to participants, donated $339,595 in services to 159 patients in 2010 and has provided **$2,958,149** in donated service to 1,411 patients since the DDS program's inception in 1998.

While the profession has enjoyed great successes in increasing access to dental care for Alabamians, there is still much that needs to be done. The dental profession is eager to work with private groups, government entities, community organizations, teaching facilities and public health entities to help Alabamians understand the need for regular dental care and to have access to that care. The following document outlines some of the current delivery system strengths and the challenges we need to address to reach optimal oral health for every Alabamian. We encourage those who are interested to work with the Alabama Dental Association to make Alabamians number one in optimal oral health.

DEFINITIONS

Access to care - "The ability of an individual to obtain dental care, recognizing and addressing the unique barriers encountered by an individual seeking dental care, including the patient's perceived need for care, oral health literacy, dentist and dental team distribution, financial circumstances, special needs, transportation, location, language, cultural preferences and other factors influencing entry into the dental care system."[8]

Dental Health Professional Shortage Area (Dental HPSA) –The U.S. Health Resources and Services Administration Shortage Designation Branch develops dental shortage designation criteria and uses them to decide whether or not a geographic area, population group or facility is a Dental Health Professional Shortage Area. Many federal programs depend on this designation to determine eligibility for funding (i.e., National Health Service Corps scholarship and loan repayment program, Area Health Education Centers, cost-based reimbursement for Federal Qualified Health Centers).

Federally Qualified Health Centers (FQHCs) –A community-based organization that provides comprehensive primary care and preventive care, including oral health care, to persons of all ages, regardless of their ability to pay. Services utilize a sliding fee scale with discounts based on family size and income.

Mid-level Dental Provider (MLP) –An oral health care provider whose training and responsibilities would fall between those of a dental assistant and those of a licensed dentist who are under-educated and may be allowed to diagnose and perform irreversible procedures with less education than a dentist.

Numerous components impact Alabamians ability to access **dental care: health status, oral health literacy, utilization, workforce, financing care, government programs, safety net, innovative outreach, and external influences**. Where possible, the following discussion portrays Alabama-specific data and information.

Health Status:

Data collection on oral health issues is somewhat limited in Alabama. Ongoing budgetary constraints have limited annual surveillance data and research must rely on periodic assessment of oral health status. ADHP's most recent data collection report is "Alabama Statewide Dental Screening of Third Graders 2006-2007." Alabama survey data is found in the National Oral Health Surveillance System (NOHSS) at: www.cdc.gov/nohss/alabama. The statewide data is also available at: www.adph.org/oralhealth/dentalscreeningprogram.. Oral health is critical to overall health and must receive the same attention and resources as medicine. According to the 2000 Surgeon General's Report, dental caries is identified as the most common chronic disease of childhood, five times more common than asthma.[9]

Alabamians' oral health has improved tremendously in the last 50 years, yet there is still more improvement that needs to take place. The oral health of Alabamians does not meet the standards set in Healthy People 2010 objectives by the U.S. Department of Health and Human Services. (Data source: www.cdc.gov/oralhealth/healthypeople2010/oralhealthobjectives.)

Dental caries (cavities), both untreated and treated, have a major impact on young children. According to the 2000 Surgeon General's Report on Oral Health, low income children are affected more than affluent children. Over one-quarter (27.6%) of third graders in Alabama have untreated dental caries (according to State Oral Health Survey data reported to CDC). Sixty percent of 3rd grade children have caries experience which indicates either treated or untreated caries. (State Oral Health Survey – as above)

The oral health of adults in the state of Alabama is also a concern. According to a 2008 report issued by the Alabama Behavioral Risk Factor Surveillance System, 63.4% of the population visited a dentist or a dental clinic in the past year (AL BRFSS 2008). White adults are significantly more likely to have visited a dentist than black adults. The percentage of adults who visited a dentist or dental clinic during the past year increased with increasing income levels. Overall 64% of the population who had ever visited a dentist had their teeth cleaned in the past year

Cancer of the oral cavity or pharynx is the fourth most common cancer in black males and the seventh most common cancer in white males in the U.S.[10] Alabama's oral cancer rate is higher in both race and gender when compared to national averages. According to statistics from the LifeExpectancy.com, males have a higher incidence of oral cancer than females and the incidence of oral cancer among males in Alabama is higher than the incidence of oral cancer among males in the U.S. In fact, Alabama is second in all of the United States in oral cancer incidence and eighth in the United States in deaths resulting from

oral cancer. The use of alcohol and tobacco is a contributing factor to oral cancer. (Alabama data can be found at: www.adph.org/cancer_registry.)

Water fluoridation helps to reduce the caries rate in children and adults. Alabamians consume significant amounts of refined carbohydrates (sugars) in their diets. Optimally fluoridated water helps combat these increases of sugar and has been recognized by the Centers for Disease Control and Prevention as one of the 10 great public health achievements of the 20th century. In Alabama, 82.2% of the citizens served by public water systems are receiving optimally fluoridated water (around 3.8 million people). (www.cdc.gov/fluoridation/mywatersfluoride/alabama.) The number of fluoridated water systems in Alabama has declined in the past decade due to funding issues, old equipment, temporary chemical shortages and other similar rationale. However, the primary reason that local water systems have chosen to discontinue fluoridating is due to a lack of state legislation requiring Alabama public water systems to provide optimally fluoridated water.

Oral Health Literacy:

Oral health literacy as defined by the U. S. Department of Health and Human Services in Healthy People 2010 is "the degree to which individuals have the capacity to obtain, process and understand basic oral and craniofacial health information and services needed to make appropriate health decisions."[11] Low oral health literacy can affect any population group and can have a significant impact on a person's ability to understand instructions being given by the dentist or hygienist. Difficulty understanding instructions on prescription bottles, appointment slips, or educational brochures affect their ability to seek out needed health information, as well as their ability to make appropriate health care decisions.

The average American reads at an **eighth or ninth grade level. However, most health information is written at a higher reading level.**[12] **Limited literacy skills have been found to be a stronger predictor of an individual's health status more so than other common factors, such as race, ethnicity, age, income, and education level.**[13] Limited health literacy has been estimated to cost the U.S. between $100 billion and $200 billion each year.[14]

Increasing oral health literacy will take a concentrated effort. A good start at raising the dental IQ of our nation could be accomplished by targeting the two most significant circles of influence for our young people – schools and parents. It is critical to place accurate information about oral health into the school curriculum and reinforce this with information to help parents understand and support oral health education in the home. Educating parents on the dangers of carbonated beverages, sports drinks and processed sugars as well as how to properly teach a child to brush and floss is critical. Helping parents and educators to raise a generation that has good oral health is beneficial to our society and future generations of children. We support legislation banning advertisements of high-sugar content breakfast cereals, snacks, power bars, power drinks and soft drinks to the children of Alabama.

Utilization:

Utilization of dental care is affected by potential barriers that are unique to each patient. Barriers can include insurance, financial resources, education and transportation, geographic limitations, a patient's age, cultural background and fear of dental procedures.

Of the 4.7 million people living in Alabama in 2010 an estimated 2.02 million were enrolled in a private dental plan and for public plans 89,210 children were enrolled in Alabama's SCHIP, All Kids, and an additional 572,620 are eligible for Medicaid. Alabama provides comprehensive dental benefits to SCHIP/ALL Kids eligible children under19 and Medicaid-eligible children/young adults under 21, but provides no coverage for adults including pregnant women.[15] State employees' children can now qualify for ALL Kids if they meet the income guidelines and other criteria. Federal regulations make a child ineligible for Medicaid if the parent is a state employee.[16] Alabama does have policies designed to increase access for developmentally disabled adults.

A patient's income plays a large role in whether he or she seeks dental care. **When family income was 200% to 400% of the federal poverty level, 41.9% of families had at least one dental visit whereas only 26.5% families whose income was 100% or less of the federal poverty level had at least one dental visit**.[17] Children from high-income families were twice as likely to have a dental visit as poor children.[18]

Low oral health literacy can have a significant impact on a person's ability to seek needed health information and to make appropriate health care decisions. The higher the individual's education level, the more likely they are to have at least one dental visit. In fact, 54.5% of college graduates went to a dentist at least once as compared to only 21.9% of individuals with some or no higher education having a dental visit.[19]

While the older demographic has one of the greatest needs for dental care, they often have the fewest resources to obtain treatment. The elderly currently have little or no safety net for dental care. Government assistance is virtually non-existent and the facilities in which much of the older population reside, residential or nursing homes often do not provide regular dental care for residents and may not provide transportation for off-site dental care.[20] **National statistics show that 49% of adults (age 45-64) and 43% of older adults (age 65 and older) had a least one dental visit during 2004.**[21]

Cultural barriers can be a significant obstacle to care. While the Hispanic population is quickly growing to be 30% of the U.S. population, they comprise only 4.1% of actively practicing dentists.[22] A survey of Latino parents revealed that language issues were cited as the single greatest barrier to health care access for their children.[23]

Many organizations have proposed to solve the access to care issue by creating new types of non-dentist, mid-level providers to treat patients or by expanding the services an existing dental auxiliary can provide with reduced or no supervision from a dentist. Neither of these approaches has been successful.

Colorado sought to increase access by allowing dental hygienists to have independent practice. Stand alone dental hygiene offices had the same expenses for equipment, supplies and office space as dental offices and thus relatively comparable fees for preventive dental services. As a result, most of these independent hygiene practices were located in affluent or middle-income areas where their potential effect on access to care for the underserved was inconsequential.[24] It is possible that the independent

practice of dental hygiene increased the overall cost of dental care and created a convenience issue when the patient could not access dental hygiene services and dental restorative services at the same time.

In New Zealand and Canada a new type of dental provider, called the dental health aid therapist (DHAT) was created. New Zealand attempted to utilize the DHAT to provide free care to all children. This proved to be financially unsustainable. According to New Zealand's Ministry of Health, there continues to be pockets of children with oral disease at the level of developing or Eastern European countries.[25] Canada also had little success with the DHAT. With only two years of dental training, the salaries for these mid-level dental providers were inadequate to entice them to practice in the remote areas where access is a problem.[26] Efforts to increase access to care must be diverse to address the many barriers to care which exist. Merely creating different types of lesser educated mid-level providers has proven to be ineffective.

Workforce:

An adequate workforce is a key element in providing access to dental care. The determination of an adequate workforce is more than the number of dentists or dental auxiliaries within a state. From a workforce perspective, adequate access is affected by the following: the geographic distribution of dentists and dental auxiliaries; the availability of specialty practitioners; and the number of dentists that participate in government programs**. The current workforce is adequate but there are geographic distribution problems which could be overcome with the use of mobile dental clinics and satellite clinics for underserved areas.**

Other factors that influence the ability to maintain and recruit an adequate workforce can be directly related to having a dental school within the state, the number of dental hygiene and dental assisting training programs, the ability of a community to provide economic viability for a dental practice as well as the quality of life that can be offered to the practitioner. **Any new category of provider will be faced with the same influences that create dentist shortages in certain areas and communities**. It is impossible to alleviate distribution shortages by adding a new category of dental provider, such as the mid-level provider.

Following the **medical model** is not the solution to access. The medical community struggles with access to medical care despite having created a plethora of physician extenders, which has not alleviated the mal-distribution or shortage in certain areas and has not lowered the overall cost of medical care. In fact, the use of physician extenders may have had a negative impact on the ability to recruit and train more physicians and may be a factor in increasing costs. Like most other states, Alabama is experiencing a significant shortage of primary care physicians. (see graphic, page 17)

According to Census Bureau and BDEA statistics, 2,110 dentists are actively licensed in Alabama or 4.48 dentists per 10,000.[27] Therefore, it appears that Alabama has an adequate number of dentists based on the dentist to population ratio. However, there may be rural areas where the economic viability of maintaining a dental practice precludes dentists from locating in these communities.[28] A December 2010 report from the BDEA indicates 2,461 dentists hold an active license to practice in Alabama. Of that number 351 dentists have an Alabama license but live or practice in another state. This leaves 2110 licensed dentists in Alabama. However, as the Board has no status for retirees, some of these 2110 dentists may not be engaged in active, full-time practice. Alabama's dental school graduates 54 to 56 dentists annually.[29]

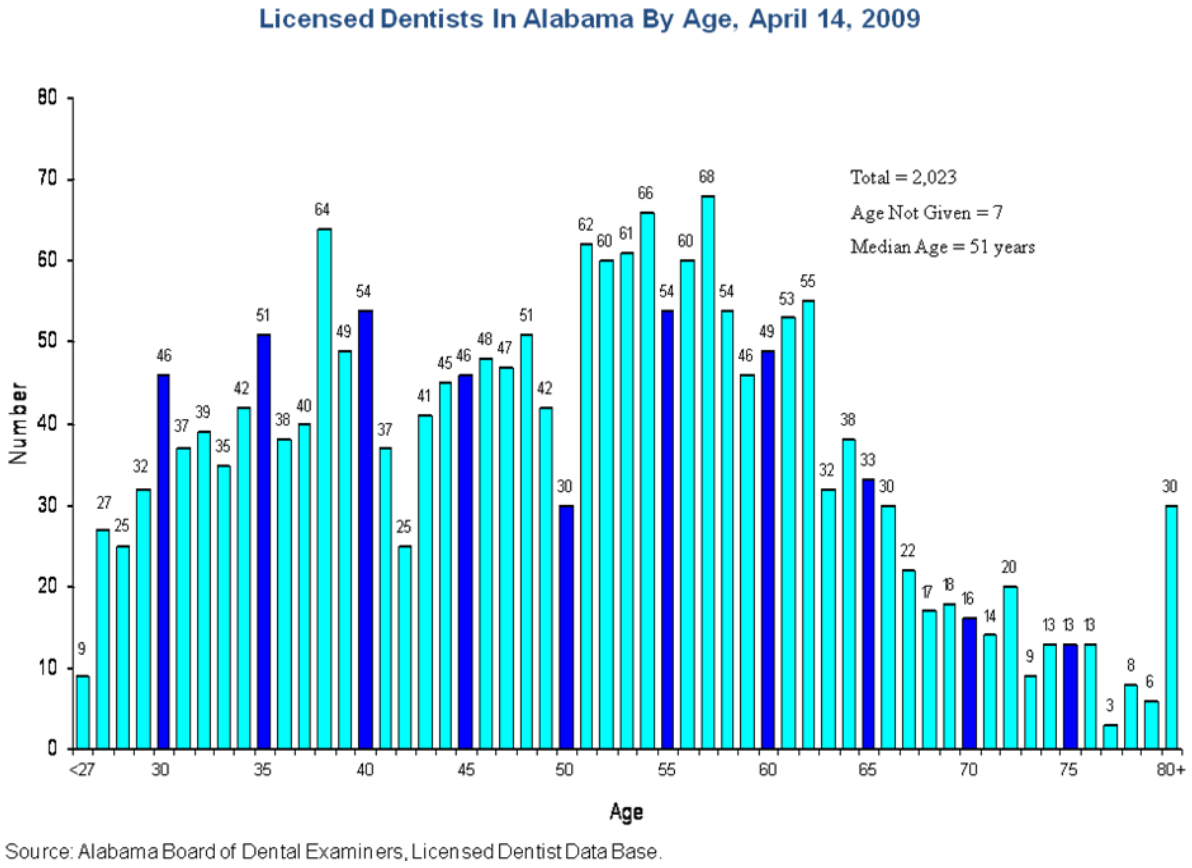
ADA data suggests a failure to retain UASOD dental graduates in Alabama after graduation is a concern, e.g. in the 1970s about 83% of dental graduates stayed in state; in the 1980s it was 75%; in the 1990s there was a dramatic decrease to 66%. (These findings were very similar to findings from the 2003 Dental Examiners database.) These statistics came from Dr. Stuart Lockwood's compilation of the Alabama Dentist Workforce Survey, 2005. If this trend continues, it will decrease the supply of dentists to Alabama, unless more out-of-state dental graduates are licensed. For the 2000s data are available for 2000-2006. For the seven graduating classes from 2000 to 2006 71% of the 389 graduates showed a license addresses in Alabama address as of January 1, 2007.[30]

There are many thoughts as to why we are seeing a decrease in the number of dental school graduates that choose to stay in Alabama. One thought is that we are accepting more out of state students to the dental school. However, this is not the case. Data received from the School of Dentistry on May 27, 2011 show that over the last seven years, 2004-2010, the average number of out of state students is 14.54% with some year to year variation. There is no definite trend in this area. This number of out of state students is on par with the 14% out of state students at the School of Medicine, and much better than the 50% out of state students at the School of Optometry. Three year data for the classes of 2004-2006 show that 36% of these out of state students continue to live and practice in Alabama. These out of state students are mostly very highly academically competitive, represent under-represented minorities, or have an Alabama connection by being related to SOD alumni or having attended an in state school for their undergraduate degrees. The **triple (3x)** out-of-state tuition is helpful to the very strained budget of the School of Dentistry. At one time, out-of-state students paid the increased out of state tuition for one year and then established Alabama residency to have in-state tuition for their remaining three years. The Alabama Legislature changed the law where **out-of-state students pay the triple out of state tuition for their entire four years of dental training**. It has been offered that the biggest reason that students are opting to go to other states is due to an almost monopolistic situation with the State of Alabama's largest dental third party payer. This one company has an extreme advantage in market share and students see other states as more of a free market where they are able to practice freely, without the threat of a monopolistic third party payer setting fees that are extremely low and have not been significantly raised in many, many years.

Alabama averages licensing approximately 60 to 70 dentists each year. The 2011 freshman class will have 55 students and class size is not projected to increase. There are physical limitations as to the size of the dental school, the decrease in state funding, and the limited number of faculty members that currently preclude any increase in class size. At Alabama's School of Dentistry, advanced dental education residency slots for specialty areas and general dentists are currently at 104 for all classes and graduate 43 postdoctoral dental students per year. This number can vary slightly from time to time.

Alabama's **age demographics** are much more favorable for a stable workforce than many other states. Thirty-eight (38.26%) percent of Alabama's actively practicing dentists are 55 or older. Of that number 13.05% are over the age of 65. Sixty-two (61.74%) percent of Alabama's practicing dentists are under the age of 55 and the median age is 51 years. These demographics suggest an adequate work force for the next 20 years. This report did not take into account AL licensed dentists not working or those only working part time. It was based entirely on the BDEA's database using dentists with an AL address and

date of birth.



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According to a 2009 report compiled by the National Center for Chronic Disease Prevention and Health Promotion Oral Health Resources, no Alabama counties are without a dentist providing full time care within the county.[31] However, there were 6 counties in state without a Medicaid billing dentist who saw 50+ beneficiaries under age 19.

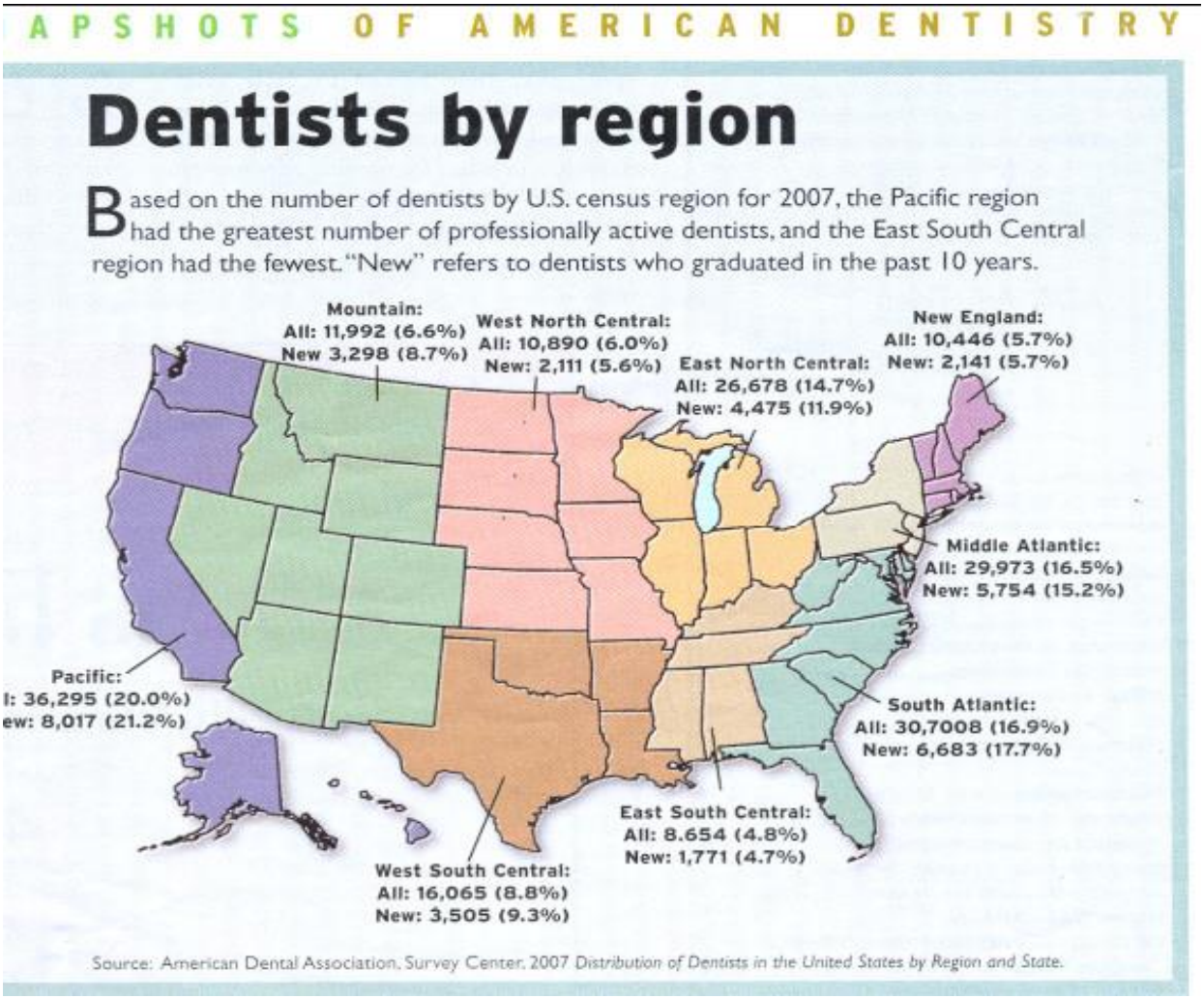
Although the Alabama Department of Public Health in general has taken huge budget hits, the dental program continues to provide preventive services for children. Unfortunately, there is no present funding for a **dentist** to serve as the **dental director** of the Oral Health Branch of the ADPH. A dental hygienist has served as Interim Director of the Oral Health Branch for 5 of the past 11 years as two dental directors have resigned or retired. Identifying qualified dentists with Public Health experience has been a challenge for the ADPH dental director search committee. Several well-qualified candidates were identified in 2010, and a director was about to be hired. However, budget cuts were imposed on state agencies in January, 2011 before the position could be filled. As funding issues improve, a dentist will be hired as Alabama's state dental director. The mission of the Oral Health Branch: The Oral Health Branch is dedicated to preventing dental disease for Alabama's citizens by promoting and developing quality, cost–effective community and school-based preventive, educational and early treatment programs which emphasize elimination of oral health disparities. Alabama has approximately thirty-seven (37) community-based dental clinics or sites such as CHCs, county health departments, school-based clinics and other charity-type clinics where dental services are provided free or at a reduced fee, regardless of funding source.

According to data received from the BDEA, there are 3,641 **dental hygienists** who hold an active dental hygiene license. There is no definitive information on how many of these licensed hygienists are actually working. Anecdotally, the ALDA staff is hearing from the hygiene educators that a significant number of graduates are having difficulty finding jobs. Alabama programs graduate approximately 145 hygienists annually, 125 from the ADHP and an additional 20 or more per year from one of the state's community college dental hygiene programs, Wallace State in Hanceville, AL or Tri-State Institute, Birmingham, AL (first class will graduate in 2013). Of that number as well as hygienists moving in from other states, the Board averages licensing 165 new hygienists per year. With the vast majority of these licensees being graduates of the ADHP (Alabama Dental Hygiene Program) there is almost 100% guarantee of employment for the ADHP graduates in their existing practices. Dental hygienists render a valuable service and are an integral part of the dental team. Their skills are meant to be applied in concert with the broad skills and knowledge of the dentist. As part of the umbrella of care, dental hygienists improve access to care. Alabama is very blessed with the ADHP. The ADHP is in fact one of the most innovative avenues in improving access to care. An experienced dental assistant can pursue his/her hygiene license under the tutelage of her sponsoring doctor and in one year be trained through a rigorous program at the UASOD and subsequently be licensed and enter the pool of dental health care providers in underserved areas. Education, proper oral hygiene and preventative intervention are the keys to decreasing the higher rate of oral neglect in the lower socio-economic population of the limited access population. The ADHP trained hygienists are key elements in filling this need. The ADHP graduate is truly an example of the Alabama dental profession's expanded duty auxiliary with over **sixty** years of **proven success**!

There has been no report of a shortage of **dental assistants** in Alabama. Dental assistants are not licensed and their training can be accomplished on the job or through any of the more than seven dental assisting programs in the state. In addition, Alabama allows for "on-the-job" training for any citizen that wants to become a dental assistant with any dentist that is willing to train them in-office. The Alabama Board of Dental Examiners as well as the Alabama Dental Association are currently investigating and researching concepts for expanding the duties that can be performed by dental assistants. Some proposals calling for a dental assistant to perform any of these expanded duties, require that he/she must take an Expanded Duty Dental Assistant course given by the schools. Dental hygienists who are trained in the expanded duty functions would also be able to perform these duties.

The process of designating **Dental Health Professional Shortage Areas (HPSAs)** has implications for access to care and proposed solutions to addressing access to care. Originally Dental HPSA designations were based on a goal of encouraging dentists to practice in remote locations, which are true shortage areas. Over time they have evolved into designations that are based on need, but the nomenclature has not been modified to reflect this change. Consequently, the nomenclature is now illogical and implies that simple solutions (more dentists and/or expanded scopes of service) can solve highly complex issues. The nomenclature does not address the intricate issues related to the demand for dental care (economics, oral health literacy, cultural barriers, transportation, etc.). The number of Dental HPSAs has increased dramatically to the point that the designation may now exaggerate the need for additional dentists and the benefits associated with the designation may no longer predictably target the areas of greatest dental under-service. (Please see Attachment A at the conclusion of this paper that defines how dental HPSAs are designated, what criteria are used, and additional descriptive information about the designation process.)

While ALDA strongly disagrees with HSRA's statistical methodology, ALDA is committed to being completely transparent on this difficult and complicated issue. To that end, graphics and maps, including HSRA's designation status for specific Alabama counties can be found at www.hpsafind.hrsa.gov.



There are distinct **differences between the delivery of dental and medical treatment**. Dental care delivery and financing systems emphasize prevention, primary care, cost containment and administrative efficiency. Approximately 80% of all dentists are generalists, compared to 40% in medicine.[32] Dentistry does not compete for the health care dollar; it usually vies for the discretionary dollar. Because of these differences, medical model solutions should not be artificially imposed onto the dental model.

The following excerpt is taken from the Academy of General Dentistry's White Paper on Access to Care:[33] "One might contend that independent mid-level providers in medicine, such as advanced nurse practitioners, have benefited the health care system. However, independent mid-level providers in dentistry and advanced nurse practitioners differ fundamentally in the models by which they practice, or intend to practice… The medical model is driven by a first diagnosis at the patient's 'point of entry,' and often a second or third diagnosis based upon the direction of referral. On the other hand, dentistry has

served its patients quite well through the prevention-based 'dental team concept' rather than a 'point of entry' concept. The dental team concept serves the function of dentistry and patients' access to care with its focus not merely on diagnosis of dental diseases, but rather on prevention and continuity of care through treatment. That is, in dentistry, the 'point of entry' is the point of prevention and treatment—it is not just a segue to further diagnosis and possible intervention—thereby saving both time and cost."

Financing Care:

A patient's decision to seek dental care often depends on who pays for the care. An individual's inability to access care is generally related to financial barriers. Dental care financing options include Government Health Insurance Programs for those that qualify, such as Medicare, Medicaid and SCHIP; Private Insurance/Private Coverage including employer sponsored dental insurance (HMO, PPO), indemnity plans, discount dental plans, and direct reimbursement plans; and private pay.

Government Programs include Medicare, Medicaid and SCHIP plans. Medicare does not pay for dental services, except for those that are an integral part of a covered medical procedure. Medicaid is available to people with limited incomes. In Alabama benefits are primarily available for individuals under age 19 for ALL Kids and under age 21 for Medicaid, with no exception for pregnant women and those whose family has an income of 100 – 200% of the federal poverty level (FPL) or less depending on the category the individual falls within. Medicaid covers most standard preventive and basic restorative services.

SCHIP, known as Alabama All Kids for Kids in Alabama, provides comprehensive health care, including dental benefits, to eligible children. Eligibility requirements include that the child be a U.S. citizen and Alabama resident, age 18 and under and have a family income that is more than 200% of the FPL but less than or equal to 300% of the FPL. A sliding scale monthly premium is charged for children ages five to 19 based on family income.

Multiple options are available for private dental insurance. Health Maintenance Organizations (HMOs) offer dental plans that require the individual to choose a dentist from a limited list of providers. These plans contract with dentists to be paid at a capitated rate and the patient pays a copayment at the time of service. The premium for these plans is generally lower than Preferred Provider Plans (PPOs). PPO dental plans allow the individual to choose from a larger list of providers and allow for more freedom in their treatment; providers contract to be paid at discounted rates by service code. Indemnity plans provide the freedom of choice of dentist but has higher out-of-pocket expenses. Discount dental plans have a minimal annual fee whereby dentists in the "network" have agreed to discount standard fees for those on the plan. Indemnity and PPO plans generally have annual maximum benefits (standard is around $1000 per person per year). Most HMO plans do not have maximums but may limit services in other ways. Direct reimbursement is a fee-for-service, freedom of choice dental plan that is self-funded by the employer. Employees/patients pay for services and submit a receipt for reimbursement, which is based on dollars spent on dental treatment. According to the National Association of Dental Plans, in 2009 an estimated 2.02 million Alabamians were enrolled in a private dental plan and most were in a dental PPO plan (1.86 million).[34]

Out of-pocket is the final option to pay for dental services. There are dental financing companies available that offer payment plans with interest for patients who need to pay over time. Dental school clinics and dental hygiene schools use students supervised by licensed faculty to provide services, which are generally 20-60% less than at a private dental office. However, there are often long waiting lists for

care, longer overall appointment times, and there is only one dental school in Alabama (Birmingham). Dentists may also offer fee reductions for payment in advance or offer their own payment plan within the office. For those who truly cannot afford care, there are also several low cost and free dental clinics in Alabama. There is also the **National Foundation of Dentistry for the Handicapped's** Donated Dental Services program which is very active in Alabama.

Government Programs:

In Alabama government programs provide most of the funding needed to make basic oral health care available for low-income children and the SCHIP Alabama All Kids Program for children under 19 whose family incomes are less than 300% of the FPL.

Enrollment in government plans tends to increase during times of economic down turns generally due to higher unemployment. State budgets are stretched to provide necessary services. Hence, many strategies are employed to reduce the financial burden to the state and yet attempt to meet federal requirements for matching funds.

The ADPH offers limited dental services through four county health department dental clinics. Federally Qualified Health Centers (FQHCs) also provide dental care. Better collaboration between public and private health delivery systems should be a high priority to obtain maximum efficiency in delivery of services. Appropriate federal funding must accompany federal mandates.

According to some estimates, more than 50% of our population will be at least sixty five years old by the year 2012. Many will remain in the workforce longer. However, they will present greater health care demands, including demand for dental care. Efforts to improve dental care delivery must prepare for these demands.

Safety Net:

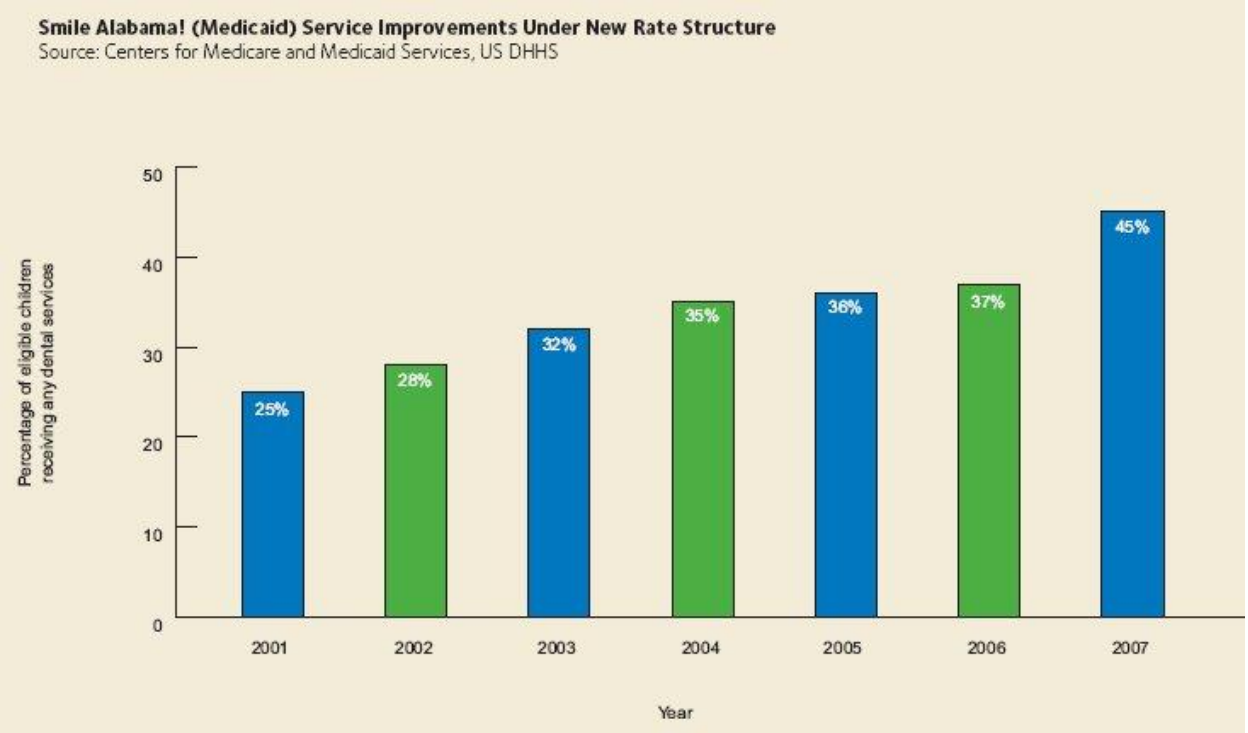
Access to a dental care safety net for certain populations in Alabama are fragile. Dental care for the indigent, the working poor, developmentally and mentally disabled, and the elderly can be challenging to obtain. Even though Alabama's Medicaid and ALL Kids programs have helped mitigate children receiving care, some children are still experiencing difficulty in accessing care. Safety-net dental care for some adult populations is an even larger problem in Alabama. With no exceptions for emergency care for extractions of teeth, there are no Medicaid benefits for adults in Alabama, including the elderly in nursing homes. Therefore, Alabama's safety net for care is even more critical for these populations.

Dentistry in Alabama recently had the honor of being highlighted in a 2011 paper from the American Dental Association entitled: *Breaking Down Barriers to Oral Health for All Americans: The Role of Workforce*. The text is as follows:

"Alabama reformed its state-administered dental Medicaid program in 2000 to reimburse dentists at rates equivalent to those paid by commercial insurers. (The program still reimburses dentists at year 2000 rates). The changes included creation of the Smile Alabama! initiative, which encompassed administrative reforms, a case management program, and increased outreach to both patients and dentists. As a result of the Smile Alabama! Initiative, there has been a 216% increase (from 151 to 477) in the number of dentists who see more than 100 Medicaid patients a year, while the number of counties with

one or no Medicaid dental provider had declined from 19 to three by September 2009. The effort resulted in an 84.3 percent increase in dental utilization, from 25 percent (103,630) of eligible children in FY2001 to 45 percent (190,968) of eligible children in FY2007."

The ADA report had the following graph attached:



Alabama's limited safety net is vastly smaller than in previous years. Government funded programs have continued to experience extensive budget cuts, especially in the past few years. State funding to the local health departments through the grant in aid program has had ongoing reductions for the past several years. In 2009 the ADPH Oral Health Branch provided the following: Fluoride Mouth rinse 5,000 children served, Oral Health Education/Promotion 35,000 people served, Oral Health Surveys 10,735 people served, Pregnancy Risk Survey 1,231 women surveyed. There are four local health departments that have a dental program for preventive & restorative services. Many of Alabama's 67 counties have no public health dental services.

In Alabama, Community Health Centers have been providing services for many years and assists thousands of individuals each year. There are currently 101 Federally Qualified Health Centers/Community Health Centers and Satellites statewide. Of these FQHC sites, 22 facilities have full-time, part-time or satellite dental clinics. (Data source: Alabama Primary Health Care Association, Community Health Centers and Satellites By Category, May 2011.)

DENTAL CLINICS IN ALABAMA FOR UNDERSERVED POPULATIONS
May 2011

Community Health Centers				**Days of**
County	**City**	**Facility**	**Phone**	**Operation**
Baldwin	Loxley	Loxley Family Dental Center	(251) 964-4011	M – F
Blount	Oneonta	Blount Co. Quality Health Care	(205) 274-9799	Opens 11/2011
Calhoun	Anniston	Anniston Quality Health Care	(256) 221-0230	M – F
Choctaw	Gilbertown	Gilbertown Medical Center	(251) 843-5537	M – Th
Cullman	Cullman	Cullman Quality Health Care	(256) 775-0230	M – F
Escambia	Brewton	Brewton Dental Clinic	(251) 809-3925	M – F
Etowah	Gadsden	Quality of Life Health Complex	(256) 492-0131	M – F
Etowah	Gadsden	Gadsden Family & Student Health	(256) 439-6384	Opens fall/2011
Hale	Greensboro	Hale County Dental	(334) 624-7270	M – F
Jefferson	Birmingham	Northside Dental Clinic	(205) 322-8288	M – F
Lamar	Vernon	Vernon health Center	(205) 758-6647	M – F
Macon	Tuskegee	Central AL Comp. Health	(334) 727-6880/Ex. 7050	Tue – F
Madison	Huntsville	Central Health Care Services	(256) 536-6311	Resumes 07/2011
Mobile	Eight Mile	Eight Mile Clinic	(251) 456-1399	Pt time as needed
Mobile	Mobile	Mobile County Health Dept.	(251) 690-8832	M – F
Mobile	Mobile	Medical Mall	(251) 432-4117	M – F
Mobile	Mt. Vernon	North Mobile Health Care	(251) 829-9884	Pt time as needed
Mobile	Plateau	Mobile Co. Training School-based	(251) 456-2276	M – F
Mobile	Semmes	Semmes Clinic	(251) 445-0582	Pt time as needed
Montgomery	Montgomery	Montgomery Primary Health Care	(334) 293-6653	M – F
Perry	Uniontown	Uniontown Health Services	(334) 628-2651	MTTF only
Talladega	Talladega	Talladega Quality Health Care	(256) 315-1697/Ex.5185	Wednesdays only
Tuscaloosa	Tuscaloosa	Theodore Hendrix Dental Center	(205) 748-6647	M – Sat.
Tuscaloosa	Tuscaloosa	Whatley Health Services*	(205) 758-6647	M – F
County Health Departments				
Coffee	Enterprise	Coffee Co. Health Department	(334) 347-5550	M – F
Jefferson	Birmingham	Jefferson County Health Dept.*	(205) 930-1435	M – F
Jefferson	Bessemer	Bessemer Health Center**	(205 497-9308	M – F
Jefferson	Birmingham	Central Health Center**	(205) 930-1015	M – F
Jefferson	Ensley	Western Health Center**	(205) 241-5277	M – F
Jefferson	Woodlawn	Eastern Health Center**	(205) 510-3405	M – F
Talladega	Talladega	Talladega Co. Health Department	(256) 315-4940	M – F
Tuscaloosa	Tuscaloosa	Tuscaloosa County Health Dept.	(205) 562-6913	M – F
School-Based Dental Clinics				
Lee	Auburn	Auburn City Schools Dental	(334) 887-1948	August - May
Lee	Opelika	Opelika City Schools Dental	(334) 741-5609	August - May
Madison	Huntsville	HEALS Dental Clinic	(256) 428-7276	August - May

* Program also provides mobile dental van services in qualifying communities.
** Satellite dental clinic for Jefferson County Department of Health
*** Clinic provides dental care for patients with special needs only.

Currently in Alabama there are two Community College based schools: Wallace State, Hanceville and Tri-State Institute, Birmingham as well as the Alabama Dental Hygiene Program that educate and train students to become dental hygienists. The ADHP students have clinical training and provide basic preventive services for education purposes to patients in a private practice setting, but do not provide restorative care.

The Alabama School of Dentistry has a clinical program administered by faculty for the education and training of dental students and residents. The clinic provides an additional resource for restorative services for underserved populations in the Birmingham area and for those patients willing and able to travel.

ALDA member dentists give of their time and expertise to help those in need to obtain care. Using very conservative estimates from the Birmingham District Dental Society's web site survey, Alabama dentists provide approximately **$119 Million** annually in donated dental care through private offices and volunteer-staffed dental clinics. Alabama's "Donated Dental Services" (DDS) program, from their 2010 letter to participants, donated $339,595 in services to 159 patients in 2010 and has provided **$2,958,149** in donated service to 1,411 patients since the DDS program inception in 1998. However, while donated care is helpful in providing dental care to the less fortunate, it does not constitute a health care system.

Innovative Outreach:

Alabama dentists have always been leaders in seeking innovative ways to provide care to disadvantaged patients. A few of the many innovative dental outreach programs supported by Alabama dentists are mentioned below. Refer to the complete document for more information.

Care for Survivors of Domestic Violence Many Alabama dentists voluntarily provide no- or low-cost care to survivors of domestic violence. The American Academy of Cosmetic Dentistry Charitable Foundation (AACDCF) "Give Back a Smile" program is an example of this type of program.

Give Kids A Smile (GKAS) GKAS occurs in February and ALDA member dentists provide free preventive and restorative care to needy children.

MOM (Missions of Mercy) Alabama's first Missions of Mercy (MOMs) Project - a dental access day for underserved Alabamians – is scheduled for 2011-2012. The Alabama MOMs Project will be in partnership with the North Carolina Dental Association. Dentists, dental hygienists, dental assistants, and other dental office personnel are encouraged to participate.

National Foundation of Dentistry for the Handicapped (NFDH) NFDH, a charitable affiliate of the American Dental Association, helps needy disabled, elderly, or medically compromised individuals arrange for dental care through a network of 15,000 volunteer dentists; Alabama's "Donated Dental Services" (DDS) program donated $339,595 in services to 159 patients in 2010 and has provided **$2,958,149** in donated service to 1,411 patients since the DDS program inception in 1998.

Smile for a Lifetime Foundation. This is a Foundation where dentist volunteers provide free orthodontic treatment for low-income patients. This program exists in Georgia and many other states, but

unfortunately does not operate in Alabama on an official basis. However, contact with many orthodontic specialists in Alabama about this program revealed that most all Alabama orthodontists do pro-bono cases every year.

Special Smiles Dentist and other volunteers provide free dental screenings during Special Olympics events in the Special Olympics' Special Smiles® program.

External Influences:

Access to dental care is being influenced by factors that are extraneous to the dental delivery system. External forces are gathering stakeholders and others to reorganize the dental delivery system. Entities, such as the Institute of Medicine (IOM), the Health Resources and Services Administration (HRSA), numerous foundations and policy institutes are initiating oral health policy and advocacy discussions without involving organized dentistry as part of their planning and implementation. The current economic climate is also playing a role in these discussions since financing care is a large part of the ongoing discussion on access to dental care.

Dentistry is a small part of health care spending and the newly enacted **federal health care reform** legislation is unclear on what it will do to provide more care for children. It appears that it may actually offer less care in an effort to contain costs.

Innovative approaches to providing medical care are being embraced by many patients looking for basic care and treatment for uncomplicated illnesses. **Retail practices and large corporate dental practices** are taking advantage of new market conditions. With the economies of scale, multiple locations and expanded hours they are better positioned to be successful with the new insurance offerings and government subsidized programs. Private practice dentists can learn from these entities and be in a position to expand the coverage they are able to offer.

Over the past several years more foundations are trumpeting the message that organized dentistry has been proclaiming for decades: oral health care is important, especially for children. Alabama's dentists are pleased that many organizations are recognizing the need for individuals and families to find a 'dental home' and that oral health affects overall health. Our concern is not with the increased interest in oral health, but with the approaches that many foundations are taking in affecting change in public policy.

Rather than focusing on the issue of underfunding of government based programs or focusing on programs to boost the dental IQ of the populace, some foundations are proposing programs to dismantle the current dental delivery model and promote the institution of lesser trained individuals (MLPs) providing dental services. The use of MLPs is not a solution. It is another problem and one that can compromise the health and safety of the patient.

The ALDA has grave concerns about the vast reach and implications of numerous organizations and foundations that are making decisions on dental care delivery and access to care based on faulty assumptions, inadequate data, and comparisons to the medical model. The profession believes that the health and safety of the patient is paramount. We believe that the some of the proposed solutions being put forward by outside entities, in the name of access, do not place the health and safety of the patient first.

Executive Summary:

The Alabama Dental Association is dentistry's voice in our state and seeks to work with any and all groups willing to help promote and provide access to quality dental care for Alabamians. We invite interested individuals to help the profession strive to find solutions to well documented problems that we know can be addressed by better funding, implementing oral health literacy programs, establishing more safety-net programs for those who fall through the cracks and simplifying third-party insurance plans, which allow dentists to be more productive. Time and valuable resources should not be wasted in pursuit of proposals that lower the standard of care by creating a two-tiered delivery system utilizing lesser educated individuals that has been proven not to work.

Working together we can improve the oral health of all Alabamians.

Attachment A

Direction from the HPSA Coordinator

Dental Health Professional Shortage Areas are a reflection of the supply of general and pediatric dentists within a rational service area. The designations are updated every five years and an application is created and submitted by the Office of Primary Care and Rural Health (ADPH) to the Office of Shortage Designation (HRSA). The application data is obtained at the state level through four venues: first, a database of licensed dentists is provided by the Board of Dental Examiners of Alabama and assists the HPSA Coordinator in determining a base line for where providers are practicing. Second, the HPSA Coordinator can request Medicaid claims data from Alabama Medicaid Agency. In addition, the National Health Service Corps Program Coordinator is consulted in obtaining an accurate list of NHSC scholars and loan repayors currently serving in Alabama (these physicians are not surveyed). The fourth set of data is the most important – surveys are conducted using the contact information for dentists from the provider list. During the survey the dental practice representative (typically the office manager) is asked to verify (1) the physical address of the practice (2) the name of the dentist(s) at the practice, and (3) the age of the dentist(s). New information is requested that can only be accurately provided by the dental practice representative: (1) How many hygienists are working with each provider, (2) what percentage of each dentist's patient base utilizes Medicaid services, and (3) what percentage of each dentist's patient base utilizes sliding fee scale services, if one is available. This data results in two FTE values: one general that represents the dentist's service to the service area and one low-income FTE value is calculated to represent the percentage of the practice devoted to the low-income population within the service area. If a dentist does not offer Medicaid of Sliding Fee Scale services, his or her low-income FTE value is zero.

The primary issue that arises in "accuracy" of the Dental designations is a direct result of the information provided by dental clinics. The Dental HPSA surveys are often met with resistance and even refusal to participate. Of course dentists have the right to refuse participation, but when this occurs the HPSA Coordinator averages all of the responses from participants to obtain survey results for the non-participants. This also creates inaccuracies. The best way to address this issue is to increase participation from the Dentists and the accuracy of the information they provide. If there truly is not a shortage of low-

income dentists, the HPSA score will reflect that when accurate survey data can be collected. Any assistance in collecting more accurate survey data would be greatly appreciated.

Each rational service area is measured by the number of low-income FTEs compared to the low-income population. The ratio of population to provider that a rational service area must meet for a Geographic designation is ≥5,000:1; a Geographic designation with high needs is ≥4,000:1 with additional parameters; a Low-Income Population group designation must meet a ≥4,000:1 with >30% of the population at or below 200% of the Federal Poverty Level. Low-Income Population designation is the only type that is currently in use for Alabama. In addition, it is notable that the Low-Income designations only account for the low-come population and the low-income full time equivalents (FTEs).

HPSA designations also involve the elimination, at the state level, of contiguous areas (areas within a 40 minute travel distance) that are accessible strictly based on transportation time. In addition, accommodations are made for travel by public transportation and variations in travel time based on the types of roads. Once the travel radius has been identified and determined accessible, the HPSA Coordinator can also inform the HRSA representative that the area is particularly impacted by socioeconomic differences or overutilization. In addition, we can cite cultural barriers to care for a given population based on the population of providers accessible.

The scores created for Alabama, and any data directly linked to Dental HPSA designations, is only reflecting the low-come sector. When HRSA releases information to the public and it says that Jefferson County has a low-income designation with 18 FTEs, and the "#short" is 34, they actually mean that Jefferson County has a Dental HPSA designation based on the Low Income needs of the Rational Service Area. Jefferson County has 18 Low-Income FTEs and is short by 34 Low-Income FTEs. Data can be found at http://hpsafind.hrsa.gov/ .

Our office has updated the map of Low-Income FTEs short each dental catchment area is based on current designation information. Please note that some designations are in the process of being reviewed by HRSA and will be updated over the next several months. The numbers on the map represent the shortage of low income Full Time Equivalents (FTEs) for each dental catchment area. This is calculated using geographical distribution of practices, specialties (general and pediatric only), hours worked, number of auxiliaries, age of dentist, and percentage of Medicaid and sliding fee scale of the patients served. Those dentists participating in the Federal Loan Repayment program are not included.

Alabama Health Provider Shortages (May 2011)

- 135 Primary Care Full-Time Equivalents
- 35 Psychiatry Full-Time Equivalents
- 245 Dental Full-Time Equivalents
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All data and designation information comes from materials provided by Health Resources and Services Administration and 42CFR5.1. Primary care designations are collected via a similar model, but very different information is used for decision making. Designation status for specific counties can be found at www.hpsafind.hrsa.gov.

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