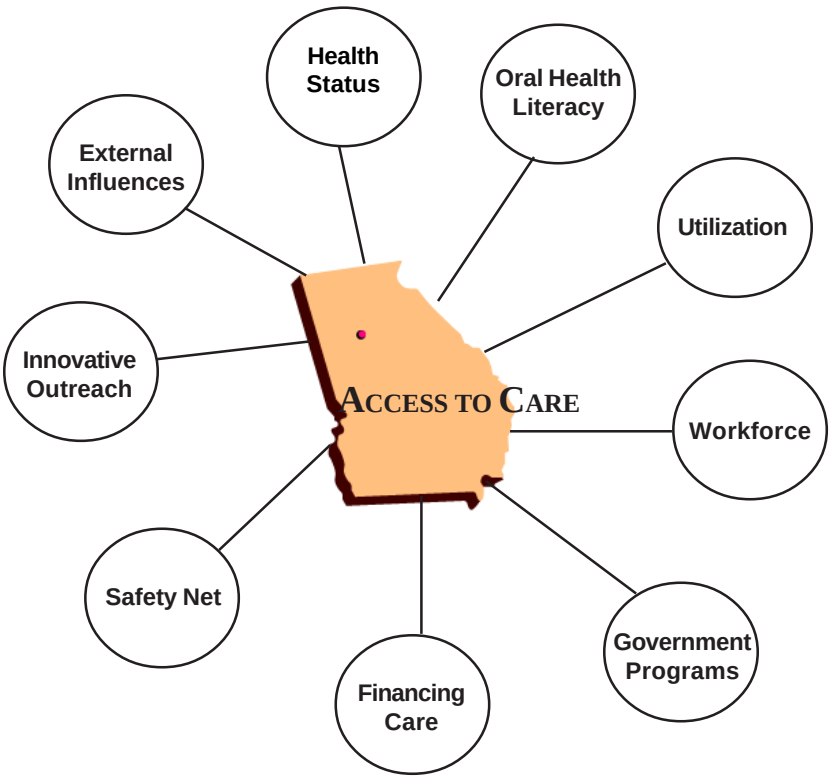
Georgia Dental Association

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



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Preface

The Georgia Dental Association's White Paper is dedicated to the memory of Mark S. Ritz, DDS, Past President of the Georgia Dental Association (2008-09).

If not for his untimely death, Mark would have been an integral member of the Patient Protection Task Force. We missed his knowledge and his untiring energy and dedication. It is appropriate that this White Paper, which speaks to the importance of patient service and dental professionalism, be offered as a memorial to the high ideals that Mark sought throughout his career as a dentist and as a member and leader of the Georgia Dental Association.

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

Position Statement and Recommendations

Experts now recognize that the health of the mouth is critical to the health of an individual. Numerous studies confirm 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 proven 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 schools days. Good oral health is essential to overall health and access to dental care is important for the health and well being of Georgians.

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 theAcademy 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 Georgians' 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 Georgia Dental Association's Dental Home Initiative 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. However, **Georgia's current workforce is adequate and a plan is in place to expand to meet the future workforce needs in Georgia through the expansion of the Medical College of Georgia's School of Dentistry.** A May 2010 report from the Georgia Board of Dentistry indicates 5,541 dentists hold an active license to practice in Georgia. Georgia averages licensing approximately 250 additional dentists each year. Georgia 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 Georgians.

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.**

Only two states' (Alaska and Minnesota) decision makers created a dental MLP as a solution to access to oral health care. These decision 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.** Georgia should not step backwards and expose patients to a lesser standard of care that has not worked in other countries.

Georgia has evidence that the creation of MLPs does not solve the problem of access to medical care. Despite the addition of physician extenders (MLPs), access to health care for many Georgians is limited or unavailable, especially in rural areas, and the cost of delivering health care continues to increase annually. Like most states Georgia is experiencing a shortage of primary care physicians, which may be exacerbated by the creation of MLPs.

Decision 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 Georgians 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 who 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 Georgia's solution to access.

Georgia's dental profession will stand firm on core principles. 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, has a minimum of two years of college and attains an associate degree before treating patients. 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 (CMOs) 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 Georgians 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 Georgians' oral health literacy.

In our quest to improve Georgians' 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 Georgians to have the same quality oral health care that each of us wants for our families.

Specifically, the Georgia Dental Association's proposed solutions to improving the health status of Georgians 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.
2. Increase the number of high-risk children receiving dental screenings and referrals to dentists for care.
3. Increase the number of Georgians 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 Georgians, especially children.

• Oral Health Literacy:

1. Educate children and parents on the importance of good oral health, how to have good oral health, and the importance of seeing a dentist.
2. Educate Georgians on the importance of annual oral cancer examinations performed by a dentist and educate Georgians on the dangers of tobacco use as it pertains to oral cancer
3. Develop educational materials (written, visual, mixed media) that are at the appropriate education level and are culturally and linguistically appropriate for the target audience.
4. 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.
5. 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]
6. Form collaborations and partnerships with other interested groups to develop and disseminate oral health education materials. Possible groups include community-based health centers, public health clinics, area health education centers, K-12 school systems, and hospitals among others. Promote the Dental Home concept.
7. Improve patient education and counseling in the dental office environment to help increase dental knowledge in patients with low oral health literacy levels.
8. 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.
9. Engage populations and community organizations in the development of health promotion and health literacy action plans.
10. Encourage more interdisciplinary collaboration and care among health care providers to manage the health-oral health of each person.
11. 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*. (http://www.mdc.edu/medical/library/dentalbib.htm)

• Utilization:

1. Advocate that laws and/or regulations which prohibit children of state employees, who otherwise qualify, from being eligible for PeachCare for Kids be amended.
2. Initiate appropriate recruitment efforts to increase the numbers of under-represented minority anddisadvantaged students in dental schools.
3. Encourage providers to increase their cultural competency to create trust and comfort, thereby influencing utilization of oral health care.
4. Work with the federal and state governments to provide additional financial incentives for dentists to provide regular care in underserved areas.

• Workforce:

1. GDA Workforce Committee should continue to monitor Georgia DHPSA designations and report inaccuracies so that the need for additional dentists is reported accurately and not exaggerated.
2. 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.
3. 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.
4. Educate dentists in ways to maximize the use of the current workforce while maintaining dentist supervision.
5. Explore innovative ways to expand the capacity in current dental practices.
6. Encourage MCG School of Dentistry to collaborate with those states without a dental school to assist with meeting workforce needs.
7. Advocate for more loan forgiveness programs or monetary incentives that are tied to the dentist providing treatment in underserved areas.
8. Advocate for a state and federal tax deduction for dentists who provide well documented free care to the indigent population.
9. Establish a program with the Medical College of Georgia School of Dentistry to evaluate how the curriculum, recruitment and financial options could best be structured to provide for access needs in rural and underserved areas.
10. 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.
11. Advocate for DHPSA sites to become National Health Service Corps sites for loan forgiveness/repayment for new graduates.
12. Advocate for HRSA to evaluate and investigate DHPSA classifications so that funding of dental health care needs is based on accurate data.
13. Encourage the MCG School of Dentistry to structure General Practice Residency programs to encourage and target dental school residents for rural access slots of need.

• Government Programs:

1. Advocate for government programs to eliminate wasteful middlemen (administrators) from Medicaid and SCHIP programs.
2. Advocate for the government to provide adequate funding of public dental programs.
3. Advocate to prevent Care Management Organizations from closing panels and limiting access to government funded programs. Require CMOs 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.
4. Advocate for increased funding for Public Health that includes a plan on the most efficient use of the dollars.
5. Advocate for adult dental benefits in Medicaid.
6. 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 DCH through the Georgia Health Partnership (GHP) system which can be done online or mailed in for the application. However, there are also several additional required documents that can only be mailed in to complete the application. If the provider also wants to treat patients in one of the CMO plans, the provider must then be credentialed by DentaQuest. The entire process can take two to six months before the provider is given a Medicaid number to begin seeing patients. Providers should only have to go through the credentialing process one time.
7. Encourage the Department of Community Health to work in partnership to improve access to care for the Low Income and Aged, Blind and Disabled population covered under government programs.
8. Streamline the Medicaid and PeachCare paperwork and claims processes to more closely mirror private sector plans. Reduce the number of Medicaid/SCHIP procedures that require pre-authorizations.
9. Monitor the evolving health care reform legislation and advocate for appropriate dental benefits for children.

• Financing Care:

1. Encourage a higher maximum dental benefit and the elimination of waiting periods and pre-existing clauses in all private dental insurance plans.
2. Encourage employers to consider a direct reimbursement model to allow the employer and the employee to be more actively involved in dental health decisions.
3. Encourage the increased use of flexible spending accounts for dental care.
4. Encourage offices to be flexible with payment plans in-house or utilizing the services of companies that provide financing services (with interest) for patient treatment to open treatment for more individuals.
5. Advocate that dental reimbursement fees for the Medicaid and SCHIP dental program be evaluated on a regular basis and that fees be established that are more competitive with market fees.
6. Adequately fund the Medicaid and PeachCare programs through state and federal funding.
7. Offer incentives to dentists to establish practices 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.

• Safety Net:

1. 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 Georgia's children.
2. Increase starting and mid-point salaries for public health dentists and dental hygienists to the current maximum salaries.
3. Provide funding to expand dental clinics in all Federally Qualified Health Centers; encourage competitive salaries for dentists and dental hygienists to attract providers.
4. Continue to collaborate with stakeholders to maintain and to establish additional programs that are community-based solutions to access to care.

• Innovative Outreach:

1. Consider legislation that would provide state tax credits for donated dental services provided in volunteer clinics
2. In communities where the population cannot support a dental practice, mobile dental vans could be an alternative for care.
3. Teledentistry is an emerging technology. Therefore, the GDA believes that appropriate oversight and regulations should be in place to assure patient safety .

Introduction

Oral health is not only important for a healthy mouth, it is also important for overall health. 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 Georgians 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, cultural issues, to cite a few. 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 9.8 million people living in Georgia in 2009 an estimated 4,512,941 were enrolled in a private dental plan and 1,162,900 were enrolled in a public plan, such as Medicaid/SCHIP.[6] Almost half of Georgia'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 Georgians. 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.

Georgians who utilize dental care enjoy the highest quality of care in the world. It is the goal of the Georgia Dental Association for all Georgians to have access to dental care. The GDA is a leading proponent of educating Georgians on the need to seek dental care. We established a program to promote the "Dental Home" concept to dentists and patients. In addition, according to a GDA April 2010 survey, Georgia dentists provide approximately $4.3 million annually in donated dental care through private offices and volunteer-staffed dental clinics.

While the profession has enjoyed great successes in increasing access to dental care for Georgians, 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 Georgians 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 Georgian. We encourage those who are interested to work with the Georgia Dental Association to make Georgians 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]

Care Management Organizations (CMOs) – A private organization that has entered into a risk-based contractual arrangement with the Georgia Department of Community Health (DCH) to obtain and finance care for enrolled Medicaid or PeachCare for Kids members. CMOs receive a per capital or capitation claim payment from DCH for each enrolled member.[9]

Dental Health Professional Shortage Area (DHPSA) –The U.S. Health Resources and ServicesAdministration 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.

Utilization of Oral Health Care Services – "The percentage of the population receiving oral health care services through attendance to oral health care providers, while taking into consideration factors including, but not limited to, health-related behaviors, 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."[10]

Executive Summary

Numerous components impact Georgians 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 Georgia-specific data and information.

Health Status:

Data collection on oral health issues is somewhat limited in Georgia. Ongoing budgetary constraints have limited annual surveillance data and research must rely on periodic assessment of oral health status. The most recent information is from the report, "Status of Oral Health in Georgia -2007."[11] 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.[12]

Georgians' 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 Georgians does not meet the standards set in Healthy People 2010 objectives by the U.S. Department of Health and Human Services.

Dental caries (cavities), both untreated and treated, have a major impact on young children. According to Georgia Head Start,[13] low income children are affected more than affluent children. Hispanic children are affected more than Black children, and Black children are affected more than White children. Over one-quarter (27%) of third graders in Georgia have untreated dental caries, although over three-quarters of children have been seen by a dentist in the past year. [14] The oral health of adults in the state of Georgia is also a concern. According to a 2006 report issued by the Georgia Behavioral Risk Factor Surveillance System[157], 69% of adults visited a dentist or a dental clinic in the past year. 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 70% of adults*who had ever visited a dentist* had their teeth cleaned in the past year. Adults aged 65-74 with an annual household income of less than $15,000 are most likely to have lost all of their natural teeth.

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.[16] Georgia's oral cancer rate is higher in both race and gender when compared to national averages.[17] According to statistics from the Georgia Comprehensive Cancer Registry 2000-2004,[18] males have a higher incidence of oral cancer than females and the incidence of oral cancer among males in Georgia is higher than the incidence of oral cancer among males in the U.S. The use of alcohol and tobacco is a contributing factor to oral cancer

Water fluoridation helps to reduce the caries rate in children and adults. People are faced with more and more amounts of refined carbohydrates (sugars) in their diet. Optimally fluoridated water helps combat these increases of sugar in our diet and has been praised by the Centers for Disease Control and Prevention as one of the greatest public health measures of the 20th century. In Georgia 95.8 % of Georgians using public water systems are receiving optimally fluoridated water (around 9 million people).[19]

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."[20] 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.[21] 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 or education level.[22] Limited health literacy has been estimated to cost the U.S. between $100 and $200 billion each year.[23]

Increasing oral health literacy will take a concentrated efort. A good start at raising the dental IQ of our nation could be accomplished by targeting the two most significant circles of influence of 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.

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 9.8 million people living in Georgia in 2009 an estimated 4,512,941 were enrolled in a private dental plan and 1,162,900 were enrolled in a public plan, Medicaid/SCHIP.[24] Georgia provides comprehensive dental benefits to eligible children under 18 but only provides emergency coverage for eligible adults.[25] Federal regulations make a child ineligible for Medicaid if the child's parent is a state employee.[26] Some people speculate that as many as half the state employees in Georgia would be eligible for Medicaid based on income. State employees may be unable to afford dental insurance for their children yet the children of state employees are also denied access to PeachCare for Kids (SCHIP) coverage.

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% of families whose income was 100% or less of the federal poverty level had at least one dental visit**.[27] Children from high-income families were twice as likely to have a dental visit as poor children.[28]

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 school having a dental visit.[29]

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 resides, residential or nursing homes, often do not provide regular dental care for residents and may not provide transportation for off-site dental care.[30] **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.**[31]

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.[32] A survey of Latino parents revealed that language issues were cited as the single greatest barrier to health care access for their children.[33]

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.[34] 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.[35] 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.[36] Efforts to increase access to care must be diverse to address the many barriers to care that 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 and the plan is in place to expand to meet the workforce needs in Georgia as the population increases.**

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, Georgia is experiencing a significant shortage of primary care physicians.**

According to the American Dental Association, 4,167 dentists are *actively practicing* in Georgia or 4.30 dentists per 10,000[37]. Therefore, it appears that Georgia 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.

A May 2010 report from the Georgia Board of Dentistry indicates 5,541 **dentists** hold an active license to practice in Georgia. Of that number 973 dentists have a Georgia license but live or practice in another state. These practitioners come from all 50 states and Puerto Rico.[38] Georgia's dental school graduates about 60 dentists annually and since 1973, 85% of the graduates remained in Georgia. Georgia averages licensing approximately 250 additional dentists each year The 2011 freshman class will have 80 students and class size is projected to be 100 by 2016. Advanced dental education residency slots for specialty areas and general dentists will go from the current 44 to 72 once the new dental school is in place.

Georgia's **age demographics** are much more favorable for a stable and growing workforce than many other states. Thirty-five (35%) percent of Georgia's actively practicing dentists are 55 or older. Of that number 11.89% are over the age of 65. Sixty-five percent (65%) of practicing dentists are under the age of 55 and the mean age is 49.5 years.[39] These demographics suggest a vibrant work force for the next 20 years.

Over the last four years the **workforce for government funded programs** decreased dramatically. Some of this is due to dentists voluntarily leaving the Medicaid and PeachCare programs after 2006 when the Care Management Organizations (CMOs) were awarded the contract to administer the plans. The CMOs implemented excessive administrative changes, limitations on treatment procedures and draconian cuts in Medicaid and PeachCare reimbursements forcing about half the dentists out of the program. A previously robust program of over 1,800 participating dentists became a program with fewer than 900 dentists. Of the 900 dentists in the program, fewer than 300 dentists would be classified as "significant providers" treating approximately 80% of all the patients who receive care. The CMOs closed their dental panels within six months of their state contract and began to systematically weed out dentists who were high producers. In four years, 65% of these patients went from receiving at least one dental visit annually to about 30% accessing care.[40] Data substantiate that a large segment of the dental community was willing to provide care to this patient population prior to the entry of the CMOs. When inadequate funding and difficulties in administration evolve, inadequate numbers of providers result thereby compromising access to care.

According to a 2007 report compiled by the Georgia Division of Health Planning, 20 counties have no dentist providing full time care within the county.[41] However**, many counties have population numbers (10,000 or less) that make it difficult to sustain a dental practice. Access to a dentist is within a reasonable drive time for residents of these rural counties.** Commercial mobile vans provide access to care for many of the counties listed as not having a dentist. Although the state department of **public health** in general has taken huge budget hits, the dental program continues to provide preventive services for children. There are 44 county dental clinics and 14 public health mobile vans. The mission of the Oral Health Unit is to prevent oral disease among Georgia's children through education and early treatment.

According to data received May 2010 from the Georgia Board of Dentistry, there are 6,686 **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 GDA staff is hearing from the hygiene educators that a significant number of graduates are having difficulty finding jobs. Georgia programs graduate approximately 220 hygienists annually and with the current economy it is likely that hygienists who want to practice in certain locations may find it difficult to get a job. 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.

There has been no report of a shortage of **dental assistants** in Georgia. Dental assistants are not licensed and their training can be accomplished on the job or through any of the more than 17 dental assisting programs in the state. The Georgia Board of Dentistry expanded the duties that can be performed by dental assistants. For a dental assistant to perform any of these expanded duties, he/she must take an Expanded Duty Dental Assistant course given by the schools or the Georgia Dental Association. Dental hygienists who are trained in the expanded duty functions can also perform these duties.

The process of designating **Dental Health Professional Shortage Areas (DHPSAs)** has implications for access to care and proposed solutions to addressing access to care. Originally DHPSA designations were based on a goal of encouraging dentists to practice in remote locations, 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 a highly complex issue. The nomenclature does not address the intricate issues related to the demand for dental care (economics, oral health literacycultural barriers, transportation, etc.). The number of DHPSAs 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.

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.[42] 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 theAcademy of General Dentistry's White Paper on Access to Care:[43] "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. 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.

According to a publication by the Georgia Department of Community Health (DCH) in January 2009, 38% of Georgians are enrolled in a tax-payer funded government health program and approximately 17% of Georgians are uninsured.[44] DCH also reported that health insurance premiums in Georgia increased 65%, and employer sponsored health insurance declined by 7% from 2000 to 2006.[45]

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 Georgia benefits are primarily available for individuals under age 21, with the exception of 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 PeachCare for Kids in Georgia, provides comprehensive health care, including dental benefits, to eligible children. Eligibility requirements include that the child be a U.S. citizen and Georgia resident, age 18 and under and have a family income that is more than 200% of the FPL but less than or equal to 235% of the FPL. A sliding scale monthly premium is charged for kids ages five to 19 based on family income.

Dental Medicaid and PeachCare for Kids represent a very small percentage of the annual state budget. In 2009 Georgia's budget was $19,203,246,010 and the amount spent on dentistry in that same year was $217,339,391, making **dentistry only 1.13% of the state budget**. In that same year the budget for the Department of Community Health, which covers health care services for the Medicaid and PeachCare population, was $2,350,221,089 and dentistry was less than 10% of that budget.

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 4.5 million Georgians were enrolled in a private dental plan and most were in a dental PPO plan (3.4 million). [46]

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 Georgia (Augusta). 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 Georgia.

Government Programs:

In Georgia government programs provide most of the funding needed to make basic oral health care available to low-income children and pregnant women as well as for those with certain disabilities through the Aged, Blind and Disabled Medicaid Program, the Low Income Medicaid Program and the SCHIP PeachCare Program for children under 18 whose family incomes are less than 235% of the FPL.

In FY2006, the Georgia Medicaid program served 1.5 million members with **federal and state expenditures of $5.9 billion.**[47] The Georgia Medicaid program receives $1.63 in federal funds for every $1 in state funds.[48] Funding for PeachCare is provided by the State of Georgia, the federal government (Title XXI funds), and premiums collected for children ages six through 18. Federal funds are available to subsidize nearly 73% of the benefit cost, less premiums, with the remaining 27% coming from the State of Georgia. The percentage of federal matching is adjusted annually.

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. **Georgia has sought to cap their risk by transferring the risk to private for-profit entities, such as Care Management Organizations (CMOs).** Because the CMOs are risk bearers, they look for ways to minimize their risk and make a profit. These types of plans tend to limit the number of participating dentists, reduce reimbursement to providers, and/or eliminate certain treatment codes. The result is that fewer providers can afford to participate in the government program and access for this patient population can be challenging.

Georgia's Public Health Department offers limited dental services and some 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.

People 65+ represented 12.4% of the population in the year 2000 but are expected to grow to be 19% of the population by 2030. [49] 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 Georgia is fragile. Dental care for the indigent, the working poor, developmentally and mentally disabled, and the elderly can be challenging to obtain. Even though Georgia's Medicaid and PeachCare for 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 Georgia. With the exception of emergency care for extractions of teeth, there are no Medicaid benefits for adults in Georgia, including the elderly in nursing homes. Therefore, Georgia's safety net for care is even more critical for these populations.

Georgia'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 FY2008, a total 190,839 children received services from Georgia's Dental Public Health Programs (prevention, education, and treatment services). [50] The State Oral Health Unit operates 44 county dental clinics and 14 public health mobile vans. Many of Georgia's 159 counties have no public health dental services.

In Georgia Community Health Centers have been providing services for 29 years and assist approximately 238,000 individuals each year. There are 27 Federally Qualified Health Centers (or Community Health Centers) at 115 sites. Of the 27 FQHCs 13 provide dental services.

Currently in Georgia there are 14 schools, with one more coming on line in the near future, that educate and train students to become dental hygienists. The dental hygiene students have clinical training and provide basic preventive services for education purposes to patients in the school setting, but do not provide restorative care.

The Medical College of Georgia 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 Augusta area and for those patients willing and able to travel. **GDA member dentists give of their time and expertise to help those in need to obtain care. According to a GDA April 2010 survey, approximately $4.3 million is given away each year in Georgia in pro bono dental care through various programs and in-office treatment.** However, while donated care is helpful in providing dental care to the less fortunate, it does not constitute a health care system.

Innovative Outreach:

Georgia 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 Georgia dentists are mentioned below.

Cobb Assistance Program (CAP) This program matches low-income Cobb County public school students who have urgent dental needs with volunteer dentists. The dentist provides immediate care at no charge.

Care for Survivors of Domestic Violence Many Georgia dentists voluntarily provide no- or low-cost care to survivors of domestic violence. The Partnership Against Domestic Violence (PADV) and The American Academy of Cosmetic Dentistry Charitable Foundation (AACDCF) Give Back a Smile are examples of these types of programs.

Dentistry from the Heart (DFTH) DFTH volunteer dentists provide free dental care to those in need in their communities. DFTH has 250 events scheduled for 2010, including four in Georgia, and estimates volunteer dentists will help 30,000 patients.

Free School Entry Oral Evaluation Program Approximately 450 GDA dentists annually participate in the GDA School Entry Free Oral Evaluation Program. This is a statewide service for children entering Georgia public schools for the first time.

Give Kids A Smile (GKAS) GKAS occurs in February and GDA member dentists provide free preventive and restorative care to needy children. In 2010, the GDA sponsored GKAS programs in every GDA district (8 programs). **Volunteers cared for 704 children and provided dental services valued at approximately $139,000**.[51]

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. **Georgia dentists donated care for 12 DDS patients with care valued at $41,038.**[52]

Smile for a Lifetime Foundation. Foundation dentist volunteers provide free orthodontic treatment for low-income patients.

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

Volunteer–Driven Dental Clinics. A recent GDA membership survey revealed that 79.1% of responding dentists provided free or reduced fee services to indigent persons, and almost half stated that they provide between $1,000-$10,000 in donated services annually.[53] One way that Georgia dentists donate their time is by volunteering at the 23 clinics statewide that provide no- or low-cost dental care to the needy. Many dentists not only volunteer personally, they also bring along paid staff members. GDA dentists also support the clinics financially.

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.

Large corporate and retail dental clinics have sought to bring innovations to the dental delivery system through economies of scale, multiple locations and expanded hours. In the future, traditional private practitioners in dentistry may explore some of these modalities as ways to offer the patient a more flexible dental delivery system.

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. Georgia'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 GDA 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 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.

Conclusion
The Georgia 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 Georgians. 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 Georgians.

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For additional information or documentation on the topics discussed in the White Paper, contact the Georgia Dental Association's Executive Office.

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