ORAL HEALTH ACCESS IN RURAL COLORADO

CoRHAC
Colorado Rural Health Advocacy Coalition

EXECUTIVE SUMMARY

Prepared by Colorado Health Institute for
The Colorado Rural Health Advocacy Coalition

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Colorado Rural Health Advocacy Coalition is a voice in health care policy that serves as a conduit to educate, listen and advocate on shared rural health issues.

The Colorado Rural Health Advocacy Coalition has brought together five organizations—**Action 22, Club 20, Colorado Rural Health Center, Progressive 15, and Rocky Mountain Farmers Union**—to develop a structure and voice for the rural health care needs for Colorado. CoRHAC has received funding from The Colorado Health Foundation.

For more information:
www.corhac.com

PARTNER ORGANIZATIONS:

ACTION 22: The membership, which includes individuals, cities, communities, counties, associations, businesses and organizations, bands together for a stronger voice at the State Legislature and in Washington, D.C. Action 22's mission is to serve as a leader for cohesive action to affect change and shape the future of Southern Colorado.

For more information contact:

Cathy Garcia
President/CEO
1.888.799.1799 or 719.560.9897
www.action22.org

CLUB 20 is an organization of counties, communities, tribes, businesses, individuals and associations in Western Colorado. Its activities include marketing and advertising, public education, promotion, meetings and events, and political action. CLUB 20 is the "Voice of the Western Slope".

For more information contact:

Reeves Brown
Executive Director,
970.242.3264
www.club20.org

The Colorado Rural Health Center (CRHC): The mission of CRHC is enhancing health care services in Colorado by providing information, education, linkages, tools and energy toward addressing rural health issues. CRHC has over 3,000 general members, 65% of which represent rural Colorado. The Colorado Rural Health Center works with people, organizations, and communities statewide.

For more information, contact:

Lou Ann Wilroy
Executive Director
303.832.7493
www.coruralhealth.org

PROGRESSIVE 15 advocates and affects legislation and policy for the economic vitality and quality of life for citizens. The mission of Progressive 15 is to speak with a single, unified voice on issues of mutual concern facing Northeastern Colorado. Its membership includes individuals, government agencies, non-profits, health care agencies, counties, municipalities, education, business, and agriculture.

For more information contact:

Cathy Shull
Executive Director
970.867.9167
www.progressive15.org

ROCKY MOUNTAIN FARMERS UNION is a progressive, grassroots organization dedicated to achieving profitability for family farmers and ranchers; promoting stewardship of land and water resources; delivering safe, healthy food to consumers; strengthening rural communities through education, legislation, and cooperation; and being the voice for family agriculture and rural communities. Since its beginnings in 1907, RMFU has led efforts to maintain and improve rural communities in Wyoming, Colorado and New Mexico through state and federal legislation, educational programs, and cooperatives.

For more information contact:

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Director RMFU Foundation
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www.RMFU.org/foundation

EXECUTIVE SUMMARY

ORAL HEALTH ACCESS IN RURAL COLORADO

There is growing awareness of the physical and oral health problems resulting from lack of access to primary oral health care services. Tooth decay is the number-one disease of childhood, more common than childhood asthma. As adults age, tooth loss and gum disease increasingly compromise general health due to their association with such chronic health problems as heart disease, stroke and diabetes. Tooth loss in working-age adults can compromise employment opportunities because, for many positions, physical appearance makes an important difference in employability.

Good oral health includes preventive self-care, including regular brushing and flossing of teeth, a diet that includes recommended quantities of fruits and vegetables, and regular dental checkups and hygiene visits for professional teeth cleaning.

One of the most challenging health care access issues in Colorado is access to preventive and primary oral health care services. This challenge is most acutely felt for low- and moderate-income families, older adults, and for Coloradans who live in rural areas of the state.

Many factors contribute to access problems, including the following:

- Low levels of coverage for private dental insurance;
- Inadequate reimbursement rates in the Medicaid program, resulting in an increasing number of Colorado's dentists refusing to serve Medicaid children;
- Lack of dental care coverage for adults enrolled in Medicaid; and
- No Medicare dental benefit for individuals with disabilities and senior beneficiaries.

Finally, there are large areas of the state that have been designated as Dental Health Professional Shortage Areas because the dentist-to-population ratio is so low. There are six counties in rural Colorado that do not have a single dentist in practice. Oral health access in Colorado is in need of policy attention.

PROMISING PRACTICES/POLICY OPTIONS FOR EXPANDING ACCESS TO ORAL HEALTH CARE

Oral health access in Colorado is in need of policy attention. There are policy solutions that hold significant promise to improve the situation, including:

1) Developing more aggressive "grow your own" programs in rural communities that partner middle and high schools with pre-health professions recruitment programs administered by partnerships between the state's Area Health Education Centers, the Colorado Rural Health Center, and dental hygiene programs and dental schools;

2) Increasing reimbursement rates paid by the Medicaid program, as has been done in Michigan, New York and New Jersey;

3) Developing local partnerships with advocacy organizations to educate parents about good oral health practices for their children and about how "no-shows" work against dental care access by discouraging dentists from seeing Medicaid patients;

4) Maximizing the use of dental hygienists in schools, Head Start programs and local public health agencies in applying dental sealants and fluoride varnishes to children's teeth, both of which have been found to significantly reduce the prevalence of dental caries among children. Colorado is one of a handful of states that allows dental hygienists to practice within their scope of practice independently;

5) Ensuring that dental hygienists are adequately reimbursed under Medicaid and CHP+ for services provided in independent practice settings;

6) Using promising community resources for the provision of primary dental care. Federally qualified health centers (FQHCs) provided an 85 percent increase in dental services between 2000 and 2005. Other safety-net clinics, such as the Marillac Clinic in Grand Junction and Inner City Health Center in Denver, provide promising models for expanding dental care access to uninsured patients through volunteer dentists in partnership with local dental societies; and

7) Promoting innovative programs such as "Cavity Free at Three." Several Colorado foundations joined together to fund "Cavity Free at Three" in communities around the state. The program is a train-the-trainer program that uses physician leaders to train local physicians in conducting oral health exams on infants under the age of three to identify potential oral health concerns that should be referred to a dentist.

IS THERE A PROBLEM WITH ACCESS TO ORAL HEALTH CARE IN RURAL COLORADO?

There are long-standing problems with access to oral health care in Colorado. Within the state, these problems are most acute among low-income children, the elderly, and those who live in Colorado's geographically isolated and small rural communities.

The 2000 "Oral Health in America: A Report of the Surgeon General" demonstrated that oral health disparities existed across all age groups as well as between people in differing socioeconomic situations. More importantly, the relationship between oral health and general health was established, and the fact that cavities and gum disease, the most common dental diseases, are fully preventable.

Since the release of the Surgeon General's report, there has been a growing awareness that poor oral health is a significant health care issue. Untreated oral disease has been linked to many physical health problems, including heart disease, stroke, and diabetes. When left untreated, tooth infections can spread to the brain, causing premature death or disability.

Expanding access to oral health care requires public and private policy interventions aimed at reducing or eliminating the disparities that currently exist based primarily on income and geography. Key barriers to oral health care access include lack of oral health coverage for low-income adults in the Medicaid program, no dental benefit for elders and people with disabilities under the Medicare program, and a growing unwillingness of dentists to serve low-income children covered by Medicaid because of low reimbursement rates.

Oral health and access to care for children

National data of a representative sample of children for the period 1999-2002[1] show that 49 percent of kids between the ages of 6 and 11 had dental caries in their primary teeth and 50 percent between the ages of 12 and 15 had cavities in their permanent teeth. Numerous disparities in the prevalence of dental disease among children were noted, including the following:

- **Caucasian children had lower rates and severity of untreated tooth decay than Mexican-American and African-American children;**
- **Caucasian children were significantly more likely to receive dental sealants than other racial and ethnic groups; and**
- **Children living in households at or above 200 percent of the federal poverty level (FPL) [2] had lower rates and severity of dental caries and a higher presence of sealants than children in lower income households.** [3]

In the period 1999-2002, 55 percent of children between 2 and 19 years of age in families with incomes less than 100 percent of FPL had dental caries, compared to 38 percent of children in families with incomes in excess of 200 percent of FPL.

Colorado data collected on children in both rural and urban schools during 2003-04 reveal similar findings—36 percent of third graders in schools with half or more students eligible for free or reduced lunch programs had untreated tooth decay, compared to 18 percent in schools where less than a quarter of students were eligible. The findings were equally dramatic among kindergartners, where 37 percent of children in the lower-wealth schools had evidence of caries, as opposed to 20 percent of children in higher-wealth schools. It is clear that income matters in both the prevalence of dental disease experienced by children and the rates of untreated tooth decay.

In July of 2008, the Colorado Health Institute (CHI) conducted a survey of all licensed dentists in Colorado who live or practice in a rural area of the state, using the U.S. Department of Agriculture's classification system known as RUCA. Examples of rural communities used in the CHI survey include isolated rural towns such as Ouray, Pagosa Springs and Telluride; small rural towns such as Aspen, Trinidad and Rifle; and large rural towns such as Dillon, Sterling and Montrose (see "RUCA" map in Appendix A).[4]

Three hundred fifty-seven dentists met the definition of "rural" and were practicing in Colorado; of these, 251 returned the survey, for a 70 percent response rate. Only 21 percent of the rural dentists accept Medicaid payment, and of these, only 16 percent accepted new Medicaid patients into their practices. Given the high rates of childhood poverty in many rural areas of Colorado, this speaks to a potentially major access issue for those low income children who qualify for Medicaid coverage but have very limited access to a dentist in their home community (see "Poverty by County by Insurance" map in Appendix A).

1. National Health and Nutrition Examination Survey (NHANES), Centers for Disease Control and Prevention.
2. Two hundred percent of the federal poverty level (FPL) in 2002 for a family of two was $23,880 and for a family of four was $36,200.
3. Oral Health Environmental Scan, Colorado Health Institute. 2005, p. 9.
4. The CHI Rural Dentist Survey data file and findings can be accessed at Oral Health Environmental Scan", CHI. p. 25. 2005; Oral Health Environmental Scan", CHI. 2005; or www.coloradohealthinstitute.org/resourceHotissues/workforce_RuralDentist.htm.

Oral health and access to care for adults

According to the "Behavioral Risk Factor Surveillance Survey" administered by the Colorado Department of Public Health and Environment, the number of adults (age 18 and older) who report permanent tooth loss due to tooth decay or gum disease steadily declined between 1997 and 2006, with the least amount of change occurring between 2002 and 2006. The rates held steady at around 36 percent during this period, although it is also true that the older one gets, the more likely tooth loss is to occur. Seventy-two percent of older Coloradans (65+) in 2004 experienced some level of permanent tooth loss.

As with children, there were significant differences observed in tooth loss associated with income level. Slightly less than half (45 percent) of individuals with annual incomes under $15,000 in 2004 had all their natural teeth, compared to three-quarters of those with annual incomes in excess of $50,000. Also of significance was the observed relationship between self assessed health status and tooth loss. Thirty-one percent of adults reported to be in "fair" or "poor" health had five or more teeth removed due to gum disease or tooth decay, compared to only 9 percent of those adults reporting good health.

CHI analyzed tooth loss by where one lived in 2002-04 (broken out by 14 planning and management regions [PMRs] of the state) and found significant variation. For example, the statewide average for tooth loss was 36 percent, while in PMR1 (Logan, Morgan, Phillips, Sedgwick, Washington and Yuma), the rate was highest at 51 percent. It was lowest in PMR2 (Larimer and Weld counties) at 31 percent.[5]

CHI analyzed the percent of adults who visited a dentist for any reason by income level in 2004 and found that individuals with higher income levels were significantly more likely to have visited a dentist in the past year than those with lower incomes. Only 53 percent of adults with annual incomes below $15,000 had visited a dentist in 2004, compared to 82 percent with annual incomes in excess of $50,000.[6]

Public and private dental insurance

Low-income parents are eligible for Medicaid if their family income does not exceed 60 percent of FPL in 2008. In a two-person family, the parent could receive no more than $8,400 in annual income to qualify; for a family of four, annual income could not exceed $12,720. Yet, with $12,720 the parents do not receive a dental benefit. The same is true for low-income people with disabilities and seniors under Colorado's Medicaid program. If a tooth becomes abscessed, causing an acute medical problem, then the extraction would be covered by Medicaid. Acute oral health problems are one of the most common reasons that people use hospital emergency rooms in Colorado.

As noted above, parents of low-income children who are eligible for Medicaid benefits, including dental care, often have great difficulty finding a dentist who will accept Medicaid payment in Colorado, particularly among rural practicing dentists.

Colorado does not have recent state-level data on who has dental insurance coverage. Data from the 2001 "Colorado Household Survey" found that 70 percent of individuals under the age of 65 who reported having health insurance also reported having dental coverage; conversely, 96 percent of the health uninsured had no dental coverage, either. When examining dental insurance coverage by age among Colorado adults, individuals 65 years and older were least likely to have coverage—32 percent, compared to the statewide average for adults of 60 percent. The likelihood of having dental insurance increases with income. According to a survey of Colorado households conducted by the Colorado Department of Public Health and Environment, only 28 percent of individuals in households with annual incomes below $15,000 had dental insurance, compared to 70 percent in households with incomes in excess of $35,000.

Dental health care workforce in rural Colorado

The 2008 "Rural Dentist Workforce Survey" described previously analyzed data collected for isolated, small and large rural communities (RUCA designations can be found on the map in Appendix A) and most often found no differences based on level of "ruralness," but in those cases where differences did occur they are noted below.

Summary findings about Colorado's rural dentist workforce include the following:

- The average age of dentists practicing in rural Colorado is 50 years; the smaller the community, the older the dentist (55 years old in isolated communities, 50 years old in small communities and 49 years old in large rural communities);
- Ninety percent of rural dentists are Caucasian; among Hispanic dentists, who account for 4 percent of all rural dentists, the largest percentage are found in isolated rural communities (8 percent);
- Only 75 percent of rural dentists are actively seeing patients full-time; another 12 percent see patients part-time; and 8 percent are retired and not seeing patients;
- The vast majority of rural dentists report practicing in a rural area for quality-of-life reasons (94 percent), followed by those who practice in such areas to pursue recreational/leisure activities (85 percent), those seeking a slower pace of life (84 percent) and those looking for a good place to raise children (80 percent);
- Dentists practicing in isolated rural areas practice the fewest number of hours per week: 34 percent work 0-24 hours/week (compared to 34 percent of dentists in small and large rural communities who practice 33-40 hours/week);
- For all levels of "ruralness," dentists spend the majority of their practice time with adult patients aged 20-64 years (54 percent), followed by older adults aged 65+ (19 percent). In total, they report spending only 11 percent of their time with children up to 12 years and 14 percent with adolescents;
- Eighty percent of dentists practicing in a rural Colorado community went to dental school in a state other than Colorado; although 54 percent of those practicing in rural Colorado grew up in a rural area; and
- Eight percent of rural dentists reported they plan to leave their practice in the next 12 months (25/315); 52 percent of those planning to leave are from a solo practice, and the primary reason given for leaving is retirement.

5. Rates for all 14 PMRs for 2002-04 can be found on p. 25 of the 2005 CHI Oral Health Environmental Scan.
6. CHI Oral Health Environmental Scan, 2002-05, pg. 25. Rates for all 14 PMRS are listed.

THE CHALLENGES TO EXPANDING ACCESS TO ORAL HEALTH CARE IN RURAL AREAS

- The percentage of Colorado children with untreated tooth decay is unevenly distributed geographically, with the greatest unmet need in geographic areas with a high percentage of low-income families;
- Rural households in Colorado tend to have higher rates of the population at or below 100 percent of the federal poverty level. The statewide average in 2000 was 7 percent, while the rural counties of Alamosa, Baca, Conejos, Costilla, Huerfano, Las Animas, Otero, Rio Grande and Saguache all had poverty rates in excess of 16 percent of the population;
- Few dentists practicing in rural Colorado report that they accept Medicaid payment and the most frequent reason given for not accepting Medicaid payment is low reimbursement rates;
- In 2005-06, only 30 percent of Colorado's children eligible for Medicaid received any dental care;
- Only 30 percent of adults over the age of 65 have any type of dental insurance;
- Nearly half of all Colorado counties are currently designated as a geographic or low-income Dental Health Professional Shortage Area (see HPSA map in Appendix A); and
- A significant number of dentists practicing in rural areas are planning to retire in the next 12 months.

PROMISING PRACTICES/POLICY OPTIONS FOR EXPANDING ACCESS TO ORAL HEALTH CARE

Oral health access in Colorado is in need of policy attention. There are policy solutions that hold significant promise to improve the situation, including:

1) Developing more aggressive "grow your own" programs in rural communities that partner middle and high schools with pre-health professions recruitment programs administered by partnerships between the state's Area Health Education Centers, the Colorado Rural Health Center, and dental hygiene programs and dental schools;

2) Increasing reimbursement rates paid by the Medicaid program, as has been done in Michigan, New York and New Jersey;

3) Developing local partnerships with advocacy organizations to educate parents about good oral health practices for their children and about how no-shows work against dental care access by discouraging dentists from seeing Medicaid patients;

4) Maximizing the use of dental hygienists in schools, Head Start programs and local public health agencies in applying dental sealants and fluoride varnishes to children's teeth, both of which have been found to significantly reduce the prevalence of dental caries among children. Colorado is one of a handful of states that allow dental hygienists to practice within their scope of practice independently;

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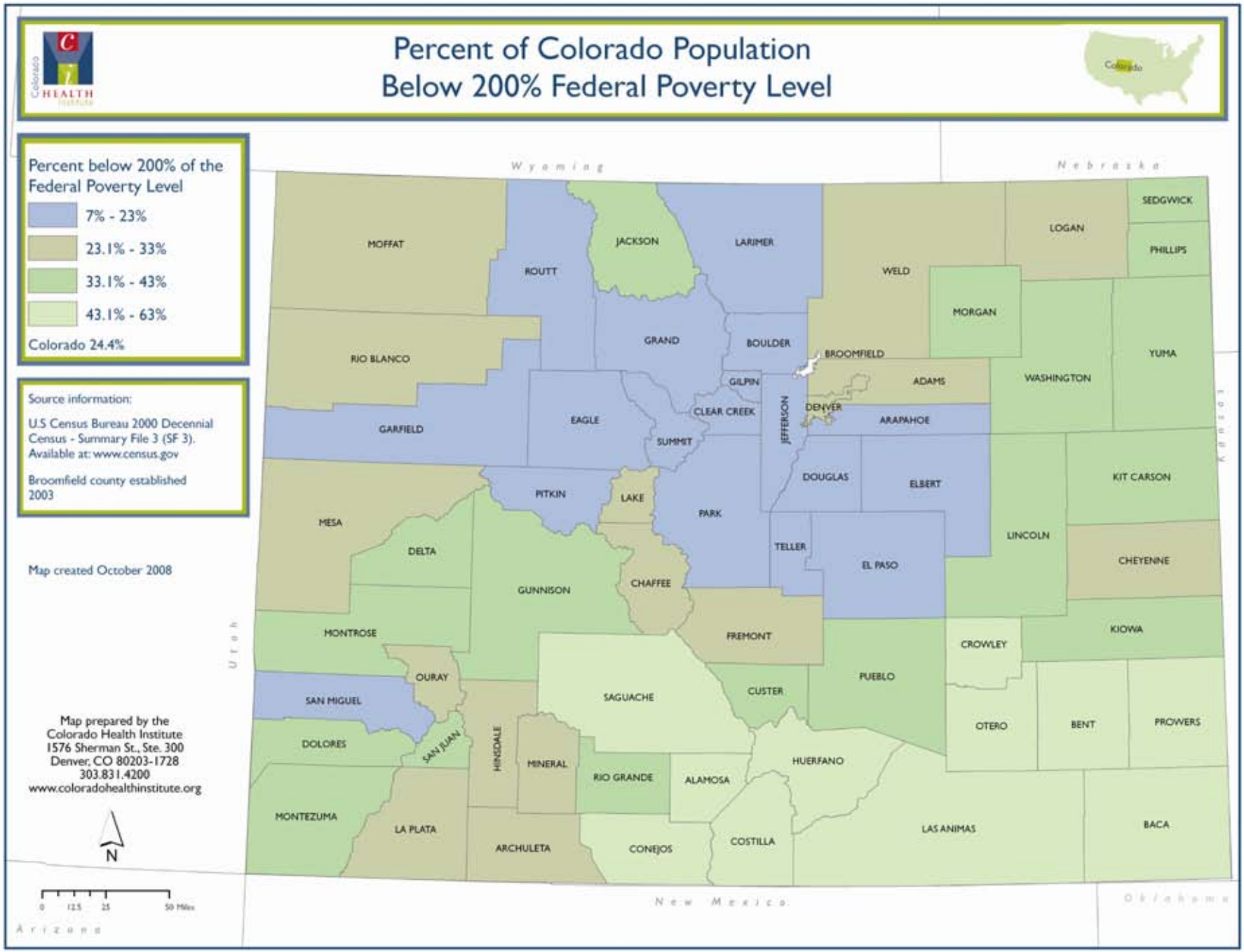
7) Promoting innovative programs, such as "Cavity Free at Three." Several Colorado foundations joined together to fund "Cavity Free at Three" in several communities around the state. The program is a train-the trainer program that uses physician leaders to train local physicians in conducting oral health exams on infants under the age of three to identify potential oral health concerns that should be referred to a dentist.


Percent of Colorado Population
Below 200% Federal Poverty Level
Colorado
Percent below 200% of the Federal Poverty Level
7% - 23%
23.1% - 33%
33.1% - 43%
43.1% - 63%
Colorado 24.4%
Source information:
U.S Census Bureau 2000 Decennial Census - Summary File 3 (SF 3). Available at: www.census.gov
Broomfield county established 2003
Map created October 2008
Map prepared by the Colorado Health Institute
1576 Sherman St., Ste. 300
Denver, CO 80203-1728
303.831.4200
www.coloradohealthinstitute.org
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Wyoming
Nebraska
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ADAMS
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GARFIELD
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CLEAR CREEK
JEFFERSON
DENVER
ARAPAHOE
SUMMIT
DOUGLAS
ELBERT
KIT CARSON
PITKIN
LAKE
PARK
MESA
DELTA
TELLER
EL PASO
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CHEYENNE
GUNNISON
CHAFFEE
MONTROSE
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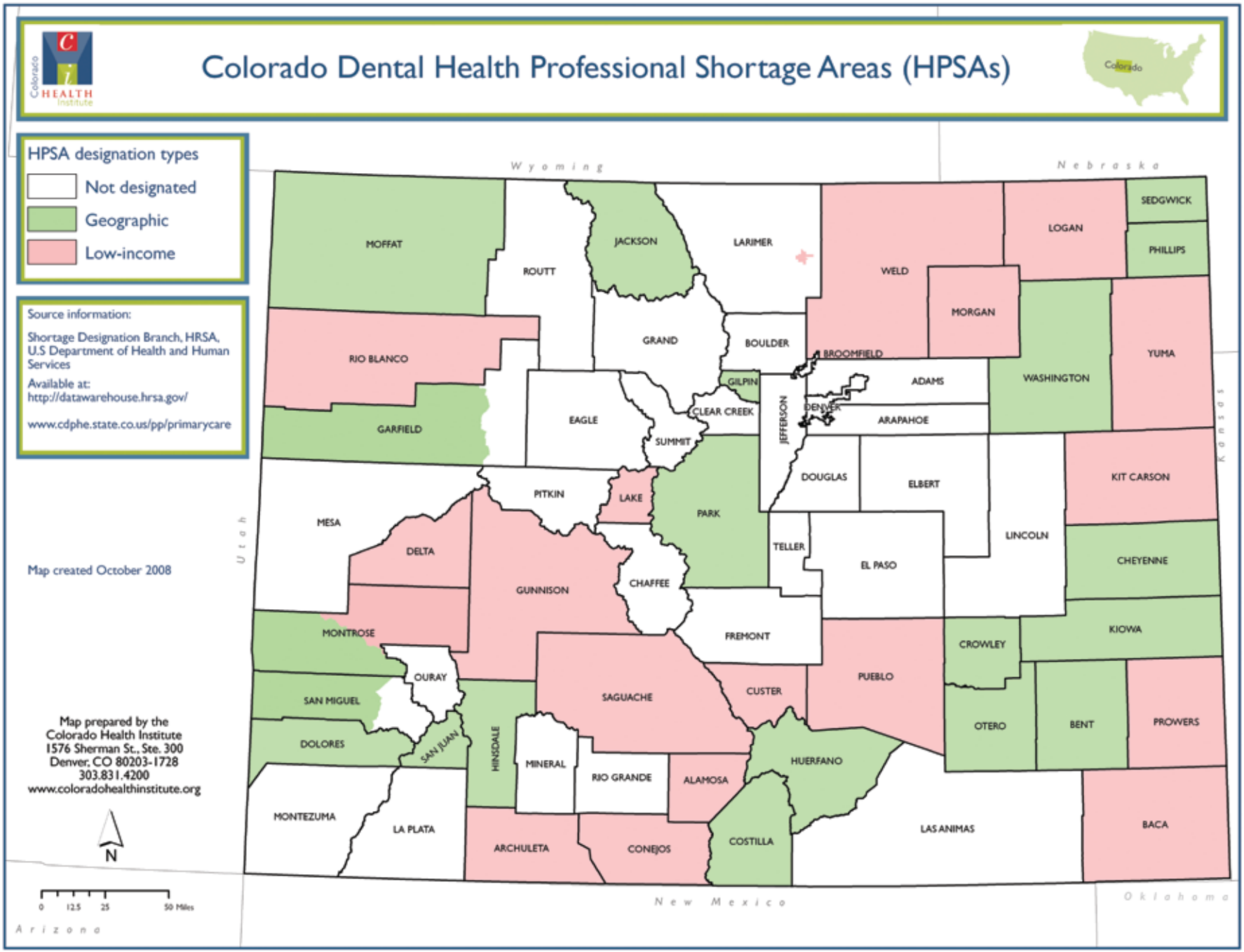
Colorado Dental Health Professional Shortage Areas (HPSAs)
Colorado
HEALTH Institute
HPSA designation types
Not designated
Geographic
Low-income
Source information:
Shortage Designation Branch, HRSA, U.S Department of Health and Human Services
Available at:
http://datawarehouse.hrsa.gov/
www.cdphe.state.co.us/pp/primarycare
Map created October 2008
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Colorado Rural-Urban Commuting Areas (RUCA)