

**ALABAMA DENTAL SUMMIT 2001**

**LET'S MAKE IT ADD UP!**

**CONFERENCE PROCEEDINGS**

*Montgomery, Alabama*

*December 6-7, 2001*

**Finding the**

**Solution**

**to the Problem:**

***Dental Access***

***For Alabama's Children***

**Finding the Solution**

**to the Problem:**

**Dental Access for Alabama's**

**Children**

**Conference Proceedings**

**ALABAMA DENTAL SUMMIT 2001**

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# LET'S MAKE IT ADD UP!

*Co-sponsored by:*

U.S. Department of Health and Human Services  
Health Resources and Services Administration  
Maternal and Child Health Bureau  
Association of State and Territorial Dental Directors  
21st Century Challenge Fund  
Robert Wood Johnson Foundation  
National Governors' Association Center for Best Practices  
Alabama Medicaid Agency  
Mike Lewis, Commissioner  
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## Siegelman Reaffirms Support for Programs To Increase Dental Access for Alabama Children

**MONTGOMERY** — Governor Don Siegelman today reaffirmed his support for state-based efforts to decrease the number of Alabama children suffering from poor oral health and its consequences as the Alabama Dental Summit opened a two day session here to explore new ideas to address the problem. “Good oral health is essential for every child to reach his full potential,” Gov. Siegelman said. “I am committed to ensuring the well-being of every child in Alabama and welcome this opportunity to continue the Smile Alabama! Initiative by looking further at ways to make dental care more available to children.” Increasing the number of Alabama children who get the dental care they need is the focus of the Alabama Dental Summit, a select, invitation-only group of 75 civic, health and government leaders meeting here this week to shape new initiatives to address dental access issues in the state. The Alabama Dental Summit will bring together some of the nation’s top experts in oral health policy and legislation with a diverse group of child health advocates to identify opportunities to increase the number of Alabama children who get the dental care they need. Participants will include public and private dental providers, physicians, and representatives of civic, faith-based, education, health and other organizations. Of the state’s 1.2 million children under age 21, nearly 400,000 children qualify for dental services through Medicaid but have limited access due to a shortage of dental providers enrolled in Medicaid. Other children who have no insurance or are underinsured for dental services also miss out on preventive or other basic dental care. As a result, an estimated 39 percent of all school-age children in Alabama have untreated cavities and account for more than 25,000 missed school days each year.

Recent studies have established poor oral health in children as a significant problem in the United States. Poor oral health is the most common disease of childhood, affecting five times as many children as asthma. Children with untreated caries often suffer from chronic pain, resulting in poor nutrition, inability to sleep, and missed school. Many of these children never experience a day without pain. The U.S. Surgeon General's Report on Oral Health revealed that 50 percent of children age five to nine have at least one cavity or filling and that 80 percent of low income children receive no preventive dental care. Sponsors of the Alabama Dental Summit include the Maternal and Child Health Bureau of the Health Resources and Services Administration, U.S. Department of Health and Human Services, the Association of State and Territorial Dental Directors, National Governors' Association, the Robert Wood Johnson Foundation's 21<sup>st</sup> Century Challenge Fund matching grants program, and the Alabama Medicaid Agency.

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### Preface

#### Let's Make It Add Up! *You are not healthy without good oral health.*

Four years have passed since state health leaders, provider associations and child health advocates collectively accepted the challenge of creating an oral health care system in Alabama that could meet the needs of all children in the state. During that time, many promising efforts have taken place and real progress has been made. For example, there were 100 more Medicaid dental providers in 2001 than in 2000, thanks to an aggressive outreach effort, a dental fee increase, grant support and a new spirit of collaboration among dental providers, Medicaid and others. Paperwork and Medicaid claims filing issues were addressed and a patient education plan was implemented through the *Smile Alabama!* Initiative. In Fiscal Year 2001, approximately 20,000 more children covered by Medicaid received at least one dental care service than in the previous year.

While these initial efforts have met with success, they also have underscored many of the gaps that continue to exist within Alabama's dental care system. For example, many counties – typically small, rural counties – do not have a dental provider or are significantly underserved. There are many pervasive social, economic and behavioral issues that create barriers to care as well. This was at the forefront as plans for Alabama's first Dental Summit were made. This included a realization that good oral health outcomes go beyond recruiting providers, and beyond producing education materials. Resolving this issue means that gaps in Alabama's dental care infrastructure and barriers to good oral health must be remedied with substantive change.

Approximately 75 Dental Summit participants joined together in December 2001 to hear presentations from nationally-recognized leaders in oral health, but also to work intensively to develop specific recommendations. These recommendations were received by the Alabama Oral Health Policy Team which subsequently incorporated many of them into the state's Oral Health Strategic Plan, creating a blueprint for realistic action.

Every day in Alabama, children suffer the painful consequences of untreated cavities or poor oral health. An estimated 39 percent of Alabama school children have untreated cavities, causing an estimated 25,650 missed school days each year. Approximately 80 percent of all children do not get the preventive care they need to head off dental problems. Add to this equation the fact that there are too few dental providers and too many children who need care, and it is easy to see that the numbers just don't add up – yet.

The challenge that lies ahead is to take the steps necessary to address the work force, education and other barriers identified during the Dental Summit that will ultimately result in all Alabama children getting the dental care they need. This will enable them to have good overall health, to be more available for learning and eventually, to become productive citizens.

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*C. Everett Koop, M.D.  
Former U.S. Surgeon General*

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Alabama Dental Summit Report Page

**James J. Crall, DDS, ScD**

## **Defining the Problem: A National View**

**James J. Crall , DDS, ScD**

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While the majority of children have excellent oral health, low income and minority children are significantly more likely to suffer illness, pain and difficulties due to tooth decay, according to Dr. James J. Crall, director of the HRSA/MCHB National Oral Health Policy Center at Columbia University.

As a result, policy makers and health officials must break this cycle with a multi-tiered response where expenditures for advanced restorative care and catastrophic care are reduced through a program of diagnosis, disease management and preventive care.

Dr. Crall, one of four national oral health experts participating in the Alabama Dental Summit, challenged the audience in his initial remarks to see problems associated with poor oral health as chronic, complex, but solvable problems. In the past, a more simplistic view of the problem first led to a response largely based on filling cavities, and later, a “one size fits all” prevention focus, he said. Now, a greater understanding of the problem and the need to target dental interventions to at-risk populations call for a different response, one that reaches children earlier and in an individualized and a more strategic manner.

Dr. Crall urged participants to look separately at the disease itself and the services children need.

“You can reduce dental disease by getting kids into services, but you can reduce disease in ways other than getting kids into services,” he said.

“You can do it through educational programs, oral health promotion, and a lot of public health kinds of things, such as water fluoridation. We need to disentangle those two things and to get more strategic in our approach,” he said, adding that states and communities that have adopted a more strategic approach are more likely to be making real progress.

To make progress, dental decay must be viewed not as a rare situation, but as one of the most common chronic childhood diseases, he said. Even in affluent preschoolers aged 2 - to 5-years old, 45 percent of tooth decay is untreated. However, by late adolescence, 35 percent of low income children have untreated dental disease while their more affluent counterparts have obtained needed dental care.

Dr. Crall further defined the problem by focusing on several key elements surrounding access to dental care. While funding for programs such as Medicaid, is a top issue, other oral health concerns include workforce issues, the prevalence, distribution and severity of dental disease, coverage issues, access and utilization, financial resources, program administration, cultural barriers and societal views about dental care generally.

Dr. Crall was appointed as director of Columbia University’s Oral Health Disparities and Policy Center in September 2000 and is the director of the HRSA/MCHB National Oral Health Policy Center. He has been the American Academy of Pediatric Dentistry’s Child Advocate since 1995. He received a doctor of dental surgery, master’s degree and certificate in pediatric dentistry from the University of Iowa, and is a Diplomate of the American Board of Pediatric Dentistry.

***Having Medicaid doesn’t  
always translate into access***

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***to care.***

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“We know that funding of these programs has been an issue, but it is not the only issue,” Dr. Crall emphasized. Funding, he explained, plays a pivotal role in provider acceptance of Medicaid patients and must be market-based or risk being a financial disincentive. He noted that expanding the pool of providers takes time and will follow a predictable process beginning with current providers increasing the number of procedures they do, followed by acceptance of more patients. Subsequently, additional providers will enroll and participate. To retain dentists, however, reimbursement levels must keep pace with the providers’ costs. Workforce issues are central to the modern-day dental dilemma, Dr. Crall explained, pointing to the proportional decline of dentists to the general population that has occurred since the early 1990s. Other factors have contributed to a shrinking dental workforce as well. Overall, he noted, dentists are older and as they age out, they are not being replaced. Another factor that is contributing to the problem is that 80 percent of all dental providers are general dentists who are typically more comfortable with older children. A related workforce issue that must be considered is that minority utilization is directly related to the density of providers as compared to the general population and that people are more likely to get care from those they associate with or consider to be part of their peer group. This is a problem, he explained, because minorities are underrepresented in dental schools, due to the expense of attending and other related issues. Another contributing factor is that no more than half of all community centers –

where poor children often get health care – have dental clinics.

Consequently, most dentists are busy and appointments are hard to get. And with most dentists working in small or solo practices, increasing patient workloads is not always possible.

To change this, Dr. Crall encouraged the group to work with local dental associations to help increase local capacity because dentists are most likely to be influenced by their peers.

From a policy standpoint, he emphasized that prevention is an important long-term strategy for reducing the need for restorative procedures.

However, the treatment of active, often severe disease for large numbers of children cannot be ignored.

“Prevention is a complement, not a substitute for treatment,” he emphasized.

On the epidemiological side, Dr.

Crall observed that approximately 20 to 25 percent of minority children experience 80 percent of all dental carries. In

addition, they are more likely to have decay, have more decayed teeth with more severe decay and have more untreated tooth decay than white kids at all income levels.

Some of this, he said, is because until recently, most children did not go to the dentist until they started school. Now, policies have changed. “The science is there that shows that early dental care is good for all kids,” he said. “But it is the at-risk kids who really need it early, to nip it (dental disease) in the bud.”

Unlike other chronic, childhood diseases that can be prevented with an immunization, dental disease in children is different, he explained.

“We know that dental disease is highly preventable. It is not uniformly preventable nor is it easily preventable,” Dr. Crall said, estimating that the 20 percent of Medicaid-eligible children who need advanced restorative care or who have

catastrophic dental needs use 75 percent of program resources. He added that this does not include children who require hospitalization, anesthesia or potent IV antibiotics to resolve their dental problems.

“If we can do something about these kids, if we

***For a lot of people in our society, it (oral health) is a nonissue... Their kids don't look like the kids covered in the program. It takes a while for them to get it, that these are American kids who live in your state that we're talking about, not children from a third world country.***

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***Things that are being done here and in other states are giving people a lot more optimism that this is a solvable problem and that strides can be made if people start to learn from one another, talk to each other, collaborate and work hard to make things happen.***

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can shift them out of these categories to something more manageable, there's a lot of savings there,” Dr. Crall said. “You will have much better access because you don't have to go to a pediatric specialist, and more (general) dentists will be able to take care of them. When access improves, kids’

health will be better.”

He pointed to numerous national studies that illustrate the significant oral health disparities that currently exist. For example, data from the Health Care Financing Administration (now Centers for Medicare and Medicaid Services) showed that only one in five Medicaid-eligible children received preventive services in 1993. Other national statistics indicate that while dental care expenditures account for more than 20 percent of pediatric health care expenditures only 2 percent of Medicaid pediatric health expenditures go for dental care.

“And we know that these kids have a lot of dental disease,” Dr. Crall emphasized.

Part of the access problem is rooted in the lack of dental coverage for poor and near-poor children.

Many of these children have health or medical insurance, but

no way to pay for dental care.

National studies show that for every child who lacks medical coverage, 2.6 children lack dental coverage.

Coverage, too, doesn't always result in care.

“Having Medicaid doesn't always translate into access to care,” he said.

Cultural barriers, too, may prevent many children from accessing the system. Growing numbers of Hispanic and other minority populations have given rise to parents who do not understand how to obtain care or why they should obtain dental care for their children. This is particularly the case when English is not the primary language in the home.

“It is not intuitively obvious how to get into the American health care system,” Dr. Crall observed.

“This is what is fueling a greater prevalence of disease in this population and what contributes to less treatment when there is disease.”

Societal barriers may affect many more children, he said. The issues of access and poor oral health are often hard for lawmakers and others to understand, especially as they relate to low-income children.

“For a lot of people in our society, it (oral health)

is a non-issue,” Dr. Crall said. “Their kids don’t look like the kids covered in the program. It takes a while for them to get it, that these are American kids who live in your state that we’re talking about, not children from a third world country.”

He urged state leaders and providers not to blame people for their circumstances, but instead work with programs such as Medicaid to educate and help them. For example, even though maternity programs may offer educational materials to new parents, those parents may not understand what steps to take to ensure that their young children have good oral health.

“We all pretty much know the science, what’s best for kids. But you can’t make that assumption that parents will know what to do and a lot of this has to be thought of as an education process,” he emphasized.

“Some folks are going to need more help in that regard.”

He emphasized

that

there are

things “in the

bag” now

that will

work, if they

are used and

applied properly, so that there is a closer match of providers’ expectations and patients’ understanding of how the whole process works.

While there is no “quick fix” to the country’s dental dilemma, Dr. Crall emphasized that steps taken recently in Alabama and elsewhere demonstrate that progress can be made in reducing oral health disparities in children.

“Things that are being done here and in other states are giving people a lot more optimism that this is a solvable problem and that strides can be made if people start to learn from one another, talk to each other, collaborate and work hard to make things happen,” he said.

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## **The Status of Oral Health in Alabama**

**Stuart A. Lockwood, DMD, MPH**

*Stuart A. Lockwood, DMD, MPH*

Alabama's state dental director at the Department of Public Health served with the Division of Oral Health at the Centers for Disease Control and Prevention for 12 years before returning home to Alabama. Dr. Lockwood is a graduate of Auburn University and the University of Alabama School of Dentistry. He received a master's degree from the University of Alabama at Birmingham with a double major in dental public health and epidemiology, and was a National Research Award fellow in oral epidemiology at the University of Michigan School of Public Health/Program in Dental Public Health before joining CDC in 1989.

Every day in Alabama, children experience severe pain, miss school or suffer infections, tooth loss or other health problems due to inadequate access to dental care in the state.

Eliminating these "avoidable failures" and improving children's oral health in Alabama will require that state leaders, the dental provider community, child health advocates and others to think creatively, to eliminate barriers and to forge new alliances, according to State Dental Director Dr. Stuart Lockwood.

According to Dr. Lockwood, dental disease in children continues to be a widespread problem in Alabama even though the rate of dental disease has been greatly reduced in the last 30 years. For example, in the state's 1990-91 dental survey, approximately 63 percent of all Alabama school children aged 5 to 17 years had experienced at least one cavity.

Other available data suggest that about 40 percent, or 312,000 Alabama children aged 5 to 17, have untreated dental caries or tooth decay, and about 20,000, or 7 percent, need urgent care. The problem is particularly acute for those children who live in rural areas or who are African-American. Thousands of Alabama children experience tooth decay that could have been easily prevented with good oral health habits, regular dental care and use of dental sealants, a protective plastic material placed on the biting part of the tooth. Dr. Lockwood noted that dental sealants are particularly effective in preventing tooth decay, and can provide up to 100 percent protection to treated tooth surfaces, if the sealant is maintained. However, only one in five Alabama children has received one or more dental sealants to prevent tooth decay, most from more affluent families.

"There is a ten-fold difference in the percent of children with at least one sealant by looking at income and level of education," he said.

While limited access to care is a major issue, the lack of early dental care by children at all income levels is also a major factor in the oral health of Alabama's children.

For example, Dr. Lockwood noted that many infants and toddlers have decay before age two, but the prevailing view of many general dentists is that dental care isn't needed until later.

"It appears that the older you get, the more treatment you get. The perception is that younger children don't need dental care," he said, also noting that many Alabama dentists are not comfortable working with younger children.

As he provided an overview of state-level issues, Dr. Lockwood pointed to recent news reports and a report card rating from Oral Health America that ranked Alabama and the United States poorly in terms of access to dental care.

While the access to care in Alabama, particularly for adults, is "dismal," Dr. Lockwood expressed optimism that improvements can be made that will make a difference for children, emphasizing that use of sealants, community water fluoridation and proper toothbrushing twice a day has the potential to change the long-term oral health outcomes for thousands of Alabama children.

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### **Mary G. McIntyre, MD, MPH**

As Alabama Medicaid Agency's Associate Medical Director, Dr. McIntyre is responsible for the Dental Program, Research and Development and Outreach and Education units. Prior to joining Medicaid, she worked as a biologist at the National Institute of Health, and as an emergency room physician, primary care physician and as medical director for the Alabama Department of Public Health's Montgomery Primary Health Care Center. She received her medical degree from Meharry Medical College in Nashville, Tenn., and a master's of public health in Health Care Organization and Policy from the University of Alabama at Birmingham.

## **Alabama's Response**

### **Mary G. McIntyre, MD, MPH**

***A lot of people think that teeth don't matter . . . This is the myth we have to overcome in this state if we expect to make a difference.***

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***One does not plan and then try to make circumstances fit those plans.***

***One tries to make the plans fit the circumstances.***

— General George Patton

Significant progress is being made in Alabama to increase access to dental care for children, but much work remains before all children are able to receive the prevention and treatment services they need to enjoy a healthy life.

Dr. Mary G. McIntyre, Associate Medical Director for the Alabama Medicaid Agency, credited the collective efforts of a diverse group of providers, government leaders, child health advocates and others who have worked together to improve children's access to dental care in the state. At the same time, targeted rate increases and an aggressive outreach effort have played a key role in recruiting dental providers.

Alabama's responses to the compelling oral health needs of children, including the *Smile Alabama!* Initiative, have been successful to date because of the involvement of providers, state health officials, child advocates and others, she emphasized. She also praised the financial and technical support of the National Governors' Association that has enabled state leaders to create the Alabama Oral Health Policy Team, an Oral Health Strategic Plan and the Oral Health Coalition of Alabama. Grant support from the 21<sup>st</sup> Century Challenge Fund program of the Robert Wood Johnson Foundation has also been instrumental through the funding two dental outreach workers, educational materials and provider support activities.

"Once we got all the groups to sit down together and put together a plan, we realized that we needed a way to pay for it. Their support helped make this possible," she said, emphasizing that the *Smile Alabama!* Initiative and the efforts of the policy team and task force are on behalf of all Alabama children, not just those on Medicaid.

During the past four years, the Alabama Medicaid Agency has worked to bring various groups together to build support for expanding the dental care system in the state. Beginning in 1998, Medicaid's Dental Task Force has explored changes and ideas to make Medicaid more "provider-friendly" while adhering to federal rules and guidelines.

***You have to make sure people understand it is not about a pretty smile. It is about healthy children and healthy people.”***

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By listening to providers and incorporating their suggestions into decisions on policy and procedures, the Agency has been able to make numerous improvements to the dental program. “For example,” she explained, “dentists told us that rates can go up, but it doesn’t make any difference if you can’t get your claims through the system to get paid.”

To address those issues identified by providers, Medicaid staff became actively involved by making personal visits to dentists’ offices, loading claim-filing software, working with Medicaid’s fiscal agent and taking any steps necessary to resolve outstanding problems.

Coupled with an across the board rate increase, all of the efforts have paid off, with more than 100 new providers enrolling with Medicaid in the first year of the *Smile Alabama!* Initiative, she said. As a result there are now 11 Alabama counties that have either one Medicaid dental provider or no providers who participate in Medicaid.

To help families of Medicaid-eligible children who are at risk of having severe tooth decay or poor access to care, the Agency now covers targeted case management services. Case managers are typically social workers who seek to help children and families overcome barriers to care, ranging from transportation issues to understanding

how a dental office operates.

“It doesn’t matter if you have providers out there if the families don’t know where they are or how to get to them. That has to be an important piece of it,” she said.

In addition, patient education is a core component of the *Smile Alabama!* Initiative, according to Dr. McIntyre. A year-long cooperative venture with the state Broadcasters’

Association

is providing

guaranteed airtime

on television

and radio for three

public service

announcements

that emphasize the

need for dental

health care and the

importance of

good oral health

habits. Promotional

and educational

materials have been developed for providers

to use as well. Posters, appointment reminder

cards and easy-to-read educational materials are

free to Medicaid-enrolled providers.

However, funding and administrative issues

are only part of the oral health problem in the state,

she observed. Attitudes and perceptions regarding

oral health are often part of the problem as well.

“A lot of people think that teeth don’t matter,”

she said. “ This is the myth we have to overcome in

this state if we expect to make a difference. You

have to make sure people understand it is not

about a pretty smile. It is about healthy children

and healthy people.”

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## **Alabama’s Oral Health Strategic Plan**

**Mary Lynne Hartselle Capilouto, DMD, SM**

***To ensure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized promoting the total well-being of the child.***

**Vision Statement**

## **Mary Lynne Hartselle Capilouto, DMD, SM**

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Implementation of Alabama's Oral Health Strategic Plan will play a key role in expanding access to dental care in the state, according to Dr. Mary Lynne Capilouto, dean of the University of Alabama Dental School and a member of the Alabama Oral Health Policy Team. To be successful, however, all efforts must focus on achieving the vision as developed by the policy team, a "true team" of 13 representatives from a broad range of public and private organizations.

Dr. Capilouto expressed the team's appreciation to Alabama Gov. Don Siegelman, state health leaders and others for their support as the state took several important first steps to address some of the most compelling issues as they relate to improving oral health care for children.

As a prelude to her discussion of the state Oral Health Strategic Plan, Dr. Capilouto presented the group's vision statement: "To ensure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized promoting the total well-being of the child."

Roadblocks to achieving this vision, she explained, include too few dentists, a poorly informed and apathetic public and a lack of state policy to protect and promote oral health.

Therefore, she explained that the group had performed a reality assessment of the strengths, weaknesses, opportunities and threats to success. (See chart next page) Identified strengths include state government support, increased Medicaid rates and increased outreach efforts while too few dental providers, lack of community education and reimbursement issues are weaknesses to be addressed.

She posed the following questions:

- Where do we want to be in the future?
- What does the preferred future for children with respect to oral health look like?
- What are the outcomes for children we hope to achieve?
- What will be the government's role in achieving this vision?
- What role will others play?
- How will we know we are making progress?

In terms of opportunities, Dr. Capilouto noted the willingness of the Alabama Dental Association to become involved, new funding sources for

dental resident education and for multi-agency participation as positive trends. Threats to progress are seen in workforce shortages, apathy toward

Dr. Capilouto holds the rank of professor and is dean of the University of Alabama School of Dentistry. She received her DMD from the University of Alabama School of Dentistry and a master's in epidemiology from the Harvard School of Public Health. Dr. Capilouto has 24 years of teaching experience at the University of Alabama at Birmingham and as a lecturer at the Harvard School of Dental Medicine. For nine years, she served as program director of the Advanced Educational Program in General Dentistry at the UA dental school.

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## **Strengths**

- Support from State government
- Multi-agency work group
- New dental clinics
- Grant support
- Increased Medicaid rates
- Increased outreach efforts
- Links to data collection systems
- State water fluoridation-state and federal funding
- School-based programs
- Majority of dental graduates stay in Alabama

## **Weaknesses**

- Reimbursement issues
  - Lack of dental providers
  - Lack of community education
  - Decreased state funding for dental
  - Insufficient database
  - Limitation on dental auxiliaries
  - Insufficient state personnel
  - Lack of policy to protect and promote oral health
  - Limited partnerships
  - Reluctance of dental community to accept third-party reimbursement
- oral health issues and the lack of knowledge regarding dental care in the general population. "A child is not well if he has poor oral health," she emphasized, noting that most people are aware of the need for overall good health, but often do not understand the role of dental health in achieving optimal health.

In crafting the state's oral health strategic plan, the policy team identified three priorities and developed action steps to accomplish each priority.

These are:

- 1) To increase the number of dentists in the state providing care to the underserved and address poor distribution in rural areas;
- 2) To increase educational and outreach efforts in communities and collaborative efforts among public/private entities and governmental

agencies; and

3) To develop and implement a surveillance and monitoring process to accurately assess and track the oral health status of Alabama citizens.

In terms of increasing the number of dentists available to Alabama children, some of the ideas in the plan call for exploring use of alternative providers to provide preventive and educational services to pregnant women and children under age 3, expansion of the Resident Placement program and efforts to increase capacity at the University of Alabama Dental School.

Dr. Capilouto commended the efforts of the *Smile Alabama!* Initiative for the progress made in terms of outreach and education, particularly in raising awareness about the need to obtain care. Other educational and outreach ideas contained in the plan include educational outreach to legislators and closer involvement with the state's Children's Policy Councils.

To help identify future needs, the state will need to conduct an assessment and identify areas of need while developing a database to monitor changes.

"To achieve our vision," Dr. Capilouto said, "we must identify the reality of where we are now . . . to close the gap."

## **Opportunities**

- Multi-agency partnerships
- State government aware of crisis
- Federal loan repayment program now available for dental graduates
- GME funding of dental residents
- Assessment of entire state as a health professional shortage area
- Federal government promoting dental science and technology
- Alabama Dental Association willing to assist in dental initiatives

## **Threats**

- State population increasing
- Worsening workforce shortages
- Inadequate state funding infrastructure
- Poor provider relationships with third-party payors
- Apathy regarding dental needs
- Failure to accept third party reimbursement
- General population lack of knowledge of the importance of dental care

# Elements of Success

**James J. Crall , DDS, ScD**

*The similarity of voice and message coming to policy makers really does make a difference. When they don't hear the message the same way, it gets confusing and when they are confused, rather than do something wrong, the tendency is to do nothing.*

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*In the long term, coalitions are extremely important in carrying the message to policy makers. They are an important element in making positive and sustained change.*

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While oral health successes in the past were typically measured by the number of cavities that were filled, future successes will be contingent on the ability of states and organizations to develop targeted interventions that address oral health issues within the context of overall health, according to Dr. James J. Crall, director of the Maternal

and Child Health Bureau's National Oral Health Policy Center at Columbia University.

To that end, the dental community, state leaders and interested organizations must seek to connect and cooperate, to be creative and to develop strong advocacy efforts to convince policy makers and others about the importance of oral health to overall health.

"The modern-day concept of disease management and awareness of environmental and cultural influences leads us to new levels and targets of oral health promotion," said Dr. Crall. He noted that dental decay is now regarded as a dynamic disease process where interventions can be used to prevent or delay the presence of decay through development of individual prevention and/or disease management strategies.

Outreach concepts in the past that focused only on treatment and then later, prevention, are no longer appropriate in view of the dynamics of the current situation, he explained. For example, "one size fits all" prevention efforts now must be more targeted to address issues of those most at risk of dental disease.

"This is much more than about teeth. It is a lot about environment as well as what people are doing every day to augment their health," he said. "We have got to be sure that the behaviors are there."

"I think the real opportunity here comes from engaging a broad range of individuals so we get a better understanding of why these populations have the dental diseases they do. Then we can design more effective interventions that are tailored to community differences," he said.

Dr. Crall stressed that state-based groups must work together to bring about legislative and policy initiatives that address oral health disparities.

Some of the more encouraging efforts now underway include the *Smile Alabama!* Initiative, the ABCD program in Washington state, a fluoride varnish demonstration project in North Carolina and the Delta Demonstration effort in Michigan known as the MI-CHILD program.

Several states also have taken the initiative to improve access by improving reimbursement

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## **Dr. Crall's Guiding Principles**

***This is about is getting everyone connected and working together.***

”

*We must connect people who can make a difference.*

“

- ***Try to get as close to the mainstream as you can. Most dentists are in solo or small practices and can't be Medicaid specialists.***
- ***Think in terms of prevention and treatment, not instead of. Both have to happen.***
- ***Integration, not fragmentation***
- ***Work on prevention in the long-term, but remember that there are kids with disease right now who have problems and that we need to get services to them.***
- ***Recognize that some children are hard to treat and not everyone will be able to treat them.***

rates, offering tax credits and loan forgiveness. Other states have established surveillance and demonstration programs to determine which programs and interventions are effective. Another idea suggested by Dr. Crall calls for creating a “dental home” for children before age 1, much like the medical homes created by many health insurance programs. This would be particularly important for those children at moderate-to-high risk for dental disease.

One of the most important things that states can do is to work with a broad base of individuals and groups to call attention to the oral health needs of children and the potential solutions. One way to do this, Dr. Crall said, is to work with community-based coalitions, such as the Children's Policy Councils in each Alabama county.

“In the long term, coalitions are extremely important in carrying the message to policy makers,” he said. “They are an important element in making positive and sustained change.”

Additionally, he observed that coalitions and groups aid in the change process through their ability to communicate a unified message to a wide audience.

“Sometimes it (change) takes years,” he said.

“In places where that (progress) is happening, the similarity of voice and message coming to policy makers really does make a difference. When they don’t hear the message the same way, it gets confusing and when they are confused, rather than do something wrong, the tendency is to do nothing. That’s why our issue has been on the back burner. You have to narrow it down and find the things they agree on.”

Meanwhile, he emphasized that various groups involved in the issue need to try to work together to construct better policies to meet the oral health needs of all children by reducing the burden of oral diseases and increasing appropriate use of oral health services. And, there is a critical need to get funding levels where they need to be.

“Advocacy is a big piece of this. People have to be convinced that this is a broad issue.”

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## Surveillance Systems

**Kathy Phipps DrPH, MPH**

***Until we can measure baseline data to determine the impact of the programs we implement and show their effectiveness, we won’t have much impact on oral health.***

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”

States with an active oral health surveillance

program not only have good data for decision making, but also an effective advocacy tool to raise public awareness and build support for policy or funding initiatives to expand access to dental care, according to Dr. Kathy Phipps, a nationally recognized research consultant specializing in oral epidemiology.

Through discussion of oral health surveillance activities in other states, Dr. Phipps demonstrated for the Dental Summit participants how Alabama policy makers and state health leaders can use oral health surveillance data for advocacy, decision making and tracking.

Surveillance, she explained, means the ongoing collection, analysis and interpretation of health data essential to the planning, implementation and evaluation of public health practice. It also involves the timely dissemination of data to those who need to know. Surveillance programs can help public health officials monitor trends in oral disease, highlight at-risk populations, evaluate current programs, identify new program needs and justify program or actions in place. Dr. Phipps reminded the audience, however, that even the best data collection and analysis efforts are incomplete without dissemination of the data.

“We must use data for advocacy purposes so that we can base our policy decisions on good information that is available to us,” she emphasized.

On the national level, the National Institutes of Health (NIH) and the Centers for Disease Control perform this function.

While this information is helpful, it does not provide the level of detail needed to perform in-depth analysis at the state or local level. Another

national effort is the National Oral Health Surveillance System (NOHSS), a collaborative project between the CDC and the Association of State and Territorial Dental Directors (ASTDD) that serves as a clearinghouse for state level data on oral health. Some of the factors tracked by the NOHSS project include dental visits, teeth cleaned, complete tooth loss and fluoridation access for people of all ages. Additionally, caries (decay) experience, untreated dental decay, sealant use and incidence of oral cancer are collected on

***Kathy Phipps, DrPH, MPH***

As a consultant, Dr. Phipps has served for more than 13 years on a variety of national agencies and boards. She has written extensively on issues including oral health for all age groups, water fluoridation and bone density. She is a frequent presenter at seminars on dental health and the impact of osteoporosis on teeth. Dr. Phipps is an adjunct professor of Public Health Dentistry at Oregon Health & Science University in Portland. She received a master's of public health and a doctorate from the Department of Community Health Programs, School of Public Health at the University of Michigan, Ann Arbor.

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***We must use data for advocacy purposes so that we can base our policy decisions on good information that is available to us.***

“

”

children. National, standardized projects enable states to use the findings from oral health surveys to make state-to-state comparisons on socioeconomic groups, the impact of dental health coverage, race/ethnic issues, impact on individuals speaking English as a second language and the incidence of early childhood caries. This lays the groundwork to direct money to programs based on outcomes, she said. The benefits of an oral health survey in Alabama include documentation of problem

areas, raising awareness of oral health issues and potential for increased funding if used appropriately. She also explained that such a survey would not be expensive to implement.

In other states, data that has been effectively collected, analyzed and reported have been helpful in bringing oral health to the forefront through the news media and through publication of reports, in identifying populations in need and by increasing political awareness regarding oral health matters. Essential components of a statewide oral health survey include a basic, standardized screening tool, statewide problem sampling, trained examiners and diagnosis criteria.

Dr. Phipps also noted that better results are generally obtained from screening children who are at least in the third grade, although other age groups can be used.

She pointed to the experience of the State of Washington which conducted state surveys in 1993-94 and again in 2000. As a result of the first oral health survey, the state expanded its oral health program with the buy-in of the state legislature and the allocation of funds for a school sealant program. The project also stimulated public and private foundations to invest money in an oral health program.

Washington's 2000 survey built on earlier successes, using nursing employees already in the field and by fostering partnerships

with groups such as tribal organizations to collect data. In addition, the project worked to involve more groups and to use a random sampling of all children, not just those at high risk.

Other benefits of the Washington survey included encouragement to develop local

oral health coalitions and support and encouragement to the counties to develop data collection systems to collect data on a regular basis. Without good data, states will be limited in the progress they can make to improve oral health, Dr. Phipps observed.

“In my opinion, assessment must be made a priority to improve oral health,” she said. “Until we can measure baseline data to determine the impact of the programs we implement and show their effectiveness, we won’t have much impact on oral health.”

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## How to Have No Tooth Decay in 2008

### David Noel, DDS, MPH

*Is it possible to eliminate tooth decay?*



***Repairing teeth while***

***ignoring the underlying  
cause is the same as  
repairing a roof while  
the house is on fire.***

***David Noel, DDS, MPH***

Chief Consultant to California’s Department of Health Services Medicaid Dental Program, Dr. Noel also has served as an American Dental Association spokesperson and consultant to the ADA Council on Dental Practice. He received his DDS degree from Loyola University School of Dentistry in Chicago and a master’s of public health at the University of Michigan. He is a faculty member of the University of California, San Francisco, School of Dentistry, holds a lifetime appointment with California Community Colleges, and is an adjunct professor at San Diego State University.

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Dr. David Noel, chief dental program consultant for the California Department of Health Services, challenged Dental Summit participants to “let go of the past” and use current tools, methods and information to eliminate tooth decay in Alabama.

New science has transformed the way that we look at tooth decay, according to Dr. Noel. Now, it is generally known that tooth decay is the long-term result of a transmitted bacterial infection, often between mothers and young children. Of the

500 or so different types of environmental bacteria found in the mouth, about seven are associated with tooth decay. Consequently, states must develop systems to deliver and pay for the identification, control or elimination of tooth decay infection in a person's mouth, he said. This will require an active educational and awareness effort for providers and the general public and support from policy makers. Such efforts must of necessity be targeted to at-risk groups, Dr. Noel said, noting that low income and low educational levels are the most reliable indicators of people who are at the highest risk for tooth decay infection.

"We must inform these people that cavities occur long after tooth decay germs have invaded the mouth, that this infection can be prevented, controlled and/or eliminated and that there are tests that will show who is at risk," he said.

Dr. Noel advocates preventive care for mothers and infants, including saliva tests for pregnant mothers, training in proper oral hygiene techniques, diet counseling, fluoride applications and referrals to dentists for existing decay problems.

"Oral health programs are needed in day care centers, pre-schools, Head Start programs, schools, churches and in community groups," he said.

The present tendency, he observed, is for tooth decay to be repaired without addressing the environmental problems, which may have caused the problem. In California, this is seen in children who have repeated fillings to the same tooth.

He cited the work of nationally-recognized dental researcher Dr. John D.B. Featherstone, which established that filling cavities does not eliminate the bacteria that caused the decay, leading to dental disease progression. This is why new approaches must look at the root causes of the problem, Dr. Noel said.

"Repairing teeth while ignoring the underlying cause is the same as repairing a roof while the house is on fire." Dr. Noel emphasized. "Infection plus ignorance plus neglect equals tooth decay."



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**Diane Covington Brunson, RDH, MPH**  
**Thomas Vocino, PhD**

## **Workgroup Facilitators**

Diane Covington Brunson is the director for the Oral Health Program at Colorado Department of Public Health and Environment where her responsibilities include developing annual goals/objectives, establishing policies, procedures and activities for the Oral Health program, as well as overall management of budget resources. She also is a clinical assistant professor, Applied Dentistry/Dental Hygiene of the University of Colorado and is course director of Community Health Programs and Issues for senior dental hygiene students. A past fellow of the Regional Institute for Health and Environmental Leadership, Ms. Brunson currently maintains advisory councils, and serves as liaison with related coalitions, task forces, committees and groups concerned with oral health.

She received a bachelor's in dental hygiene from the University of Colorado and a master's of public health from the University of Northern Colorado. Her professional affiliations include serving as current president of the Association of State and Territorial Dental Directors, and memberships in the American Dental Association, American Association of Public Health Dentistry and numerous other professional organizations. A prolific author, Ms. Brunson has written extensively on issues addressing prevention, access to care and other critical matters relating to dental care for children of all ages.

Dr. Thomas Vocino, distinguished research professor and head of the Department of Political Science and Public Administration at Auburn University at Montgomery, is widely recognized for his expertise in public policy and public administration. He has served as a faculty member at AUM since 1974 and received the AUM Alumni Association's Faculty Service

Award for 1999.

Dr. Vocino is co-author and co-editor of five books, including Contemporary Public Administration, which has been used in over 100 universities, and currently serves as co-editor of the Public Administration Quarterly. He is also the author or co-author of over 50 articles, book chapters and technical reports and has been published in leading journals in his field including the Administrative Science Quarterly, the Public Administration Review and the American Review of Public Administration.

Dr. Vocino received his bachelor's and master's degrees from the University of Wisconsin at Milwaukee and his doctorate from Southern Illinois University.

He has served terms on the governing boards of the American Society for Public Administration, the National Association of Schools of Public Affairs and Administration, and the Southern Political Association. During 1996-97 he served as President of the Policy Studies Organization.

In 1991, he was the recipient of the Don Stone Service to ASPA Award of the American Society for Public Administration.

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## **Dental Summit Recommendations**

Alabama Dental Summit participants met in small workgroups where they were tasked with the responsibility of identifying system, provider and patient education strategies that would ultimately result in increased access to dental care for all Alabama children. Facilitated by experts in oral health care, policy and system development, epidemiology and government policy, the workgroups met twice during the two-day meeting to focus on four key issues:

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Workgroup experts included Kathy Phipps, DrPH; Diane Brunson, RDH, MPH; James J. Crall, DDS, ScD; and Thomas Vocino, PhD. As a result of the two sessions, each workgroup developed a set of recommendations to be submitted to the Alabama Oral Health Policy Team for possible inclusion in the state's Oral

Health Strategic Plan (See Appendix Page 36)

- Building Public Awareness
- Obtaining Legislative and Regulatory Changes
- Surveillance/Monitoring System Development
- Identification of Funding Resources

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## **Obtaining Legislative and Regulatory Changes Workgroup**

### ***Recommendation 1:***

Define how oral health team communicates with legislature

Responsible Parties

Public Health, State Dental Director, Medicaid, Head Start

*Action Step(s)*

- Talk with individuals involved with children's affairs at the Cabinet level
- Understand how policy councils function and how they can be used for oral health issues
- Create a legislative advisory council

*Timeframe for Implementation / (Due Dates)*

These measures should be implemented as soon as possible

### ***Recommendation 2:***

Provide incentives to increase the dental work force to underserved areas. These could be in the form of loan repayments, tax credits for serving Medicaid patients, and community matching programs (state or federal funds)

Responsible Parties

Public Health, State Dental Director, primary care offices, schools, dental associations

*Timeframe for Implementation / (Due Dates)*

Recommendations to the legislature by June 2003 with implementation by January 2004

### ***Recommendation 3:***

Remove barriers to oral health workforce expansion by exploring licensing options and practice acts (e.g. increase licensing options to increase the number of providers in underserved areas, such as out-of-state dentists who volunteer in underserved areas)

Responsible Parties

ALDA, ADA, Public Health, Board of Nursing, Board of Dental Examiners, Schools

*Action Step(s)*

- Carry proposals to the Board of Dental Examiners
- Modify practice acts to expand duties to auxiliary personnel and redefine those identified to perform dental health services
- Explore the Nurse Practice Act to identify how nurses can assist

#### **Recommendation 4:**

Increase funding to UAB School of Dentistry to increase capacity to serve underserved populations

Responsible Parties

Public Health, Schools, UAB, Head Start

*Action Step(s)*

- Initiate a qualified workforce study
- Develop a packet (fact sheet with focused message) to deliver to legislature
- Rally support of UAB administrators to forward recommendations to the legislature

*Timeframe for Implementation / (Due Dates)*

Complete study by October 2002 and deliver information to legislature by December 2002

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## **Identification of Funding Resources Workgroup**

#### **Recommendation 1:**

Investigate partnering with churches or other public or private entities to provide dental care in alternate settings

A. Investigate partnering with churches or other public or private entities to provide alternate dental treatment facilities. (Other possible entities to work with might be UAB or county health departments)

B. Partner with public/private entities to create volunteer networks of dentists using donated space from facilities as alternate dental treatment facilities

Responsible Parties

Local Children's Policy Councils

*Action Step(s)*

- Research applicable laws; tort liability (Good Samaritan laws)
- Identify needed supplies (both equipment and treatment)
- Locate suitable facilities (e.g. church, health department) outside providers' own facilities

#### **Recommendation 2:**

Use alternate methods of contacting and educating parents (and children) on dental preventative care. This might include requiring dental education for Medicaid-funded prenatal visits, using the WIC program as a contact opportunity, day care, school-based services screenings

*Action Step(s)*

- Look for a grant from Robert Wood Johnson Foundation
- Create educational materials and disseminate to family practice/pediatricians for “age appropriate education” for EPSDT screening

**Recommendation 3:**

Pursue funding for production and distribution of educational materials

*Action Step(s)*

- Explore grants available through CDC, NIDCR, private foundations, corporations
- Expand distribution channels (WIC, pediatricians, augment training, provide toothbrushes to providers to give to parents of 9-12 month olds)

**Recommendation 4:**

Establish a mechanism to identify available sources of funding (and maximize them) for oral health services (e.g. identify services and/or funding eligible for federal match, etc.)

**Recommendation 5:**

Explore the feasibility of developing a program similar to the Washington State Access to Babies and Children Dentistry (ABCD) Program

*Action Step(s)*

- Check with Washington State for their curriculum
- Determine if Alabama dentists are interested (survey to determine level of interest)
- Availability of continuing education

**Recommendation 6:**

Survey other Medicaid and Public Health agencies to identify innovative, unusual means to fund dental access, e.g. Auburn-Opelika area school systems, BC/BS Program in Bibb County

## **Building Public Awareness Workgroup**

### **Recommendation 1:**

Educate policymakers who make decisions regarding oral health

*Action Step(s)*

- Compile fact sheets with statistics for legislators

### **Recommendation 2:**

Continue educational programs, such as those in conjunction with Medicaid's Patient 1<sup>st</sup>, *Smile Alabama!* Initiative

*Action Step(s)*

- Continue/expand on materials and continuing education programs for pediatricians, medical organizations, primary care MDs, dentists, dental organizations, RNs, children's hospitals (consistency is key)

### **Recommendation 3:**

Educate the public on sealants and optimal fluoride usage

### **Recommendation 4:**

Approach diverse groups to disseminate information in different ways to make an impact regarding oral care and education

### **Recommendation 5:**

Establish a public awareness work group to develop a broad based, consistent oral health message/communication tool for 0-5 population

Responsible Parties

Alabama Oral Health Policy Team

*Action Step(s)*

- AL Oral Health Policy Team to pull participants together
- Conduct a comprehensive needs assessment, including identification of all available resources as well as developing an evaluation component
- Identify partnerships in spreading the message (WIC, Head Start)
- Develop continuing education components, not only for dental services for others as well
- Seek support from the business community (funding and marketing expertise)
- Develop training tools for Head Start and day care educators

## **Surveillance and Monitoring Workgroup**

### **Recommendation 1:**

Collect oral health data as early as possible in each child's life (e.g. 6 months – 5 years by county).

### **Recommendation 2:**

Implement a statewide oral health survey of 3<sup>rd</sup> graders.

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MOBILE  
BALDWIN  
ESCAMBIA  
WASHINGTON  
CLARKE  
CHOCTAW  
MONROE  
CONECUH  
MARENGO  
SUMTER  
DALLAS  
BUTLER  
COVINGTON  
COFFEE  
DALE HENRY  
BARBOUR  
PIKE  
HOUSTON  
GENEVA  
RUSSELL  
LEE  
CHAMBERS  
BULLOCK  
MACON  
MONTGOMERY  
ELMORE  
AUTAUGA  
LOWNDES  
TALLAPOOSA COOSA  
CHILTON  
BIBB  
PERRY  
HALE  
PICKENS TUSCALOOSA  
JEFFERSON  
SHELBY  
LAMAR  
MARION  
FAYETTE  
WALKER  
WINSTON  
FRANKLIN  
COLBERT  
LAUDERDALE  
LAWRENCE  
LIMESTONE  
MADISON  
MORGAN  
JACKSON  
DEKALB  
MARSHALL  
CHEROKEE  
ETOWAH  
ST. CLAIR CALHOUN  
CLEBURNE  
RANDOLPH  
CLAY  
TALLADEGA  
CULLMAN  
BLOUNT  
CRENSHAW  
WILCOX  
GREENE

1,335,954 children in the state<sup>1</sup>

386,223 children eligible for Medicaid<sup>2</sup>

1,560 licensed general dentists<sup>3</sup>

71 licensed pediatric dentists<sup>4</sup>

565 Medicaid dental providers<sup>5</sup>

# **Alabama Dental Statistics**

<sup>1</sup> U.S. Census Bureau, 2000 population information,  
<sup>2</sup> Alabama Title XIX EPSDT Participation Annual Report to HCFA (now CMS),  
March 2001, FY 2000 data  
<sup>3</sup> Alabama Department of Public Health, Office of Primary Care and Rural Health.  
(Data from Board of Dental Examiners reflects licensed dentists in year 2000.)  
<sup>4</sup> Alabama Department of Public Health, Office of Primary Care and Rural Health.  
(Data from Board of Dental Examiners reflects licensed dentists in year 2000.)  
<sup>5</sup> Alabama Medicaid Agency, EDS enrolled provider records, November 20, 2001.  
(Number reflects part-time providers, out-of-state providers, inactive Medicaid dental  
providers and providers who serve more than one county).

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39,232 children in the county

7,843 children eligible for Medicaid

55 licensed general dentists

0 licensed pediatric dentists

9 Medicaid dental providers

### **Baldwin County**

27,314 children in the county

3,118 children eligible for Medicaid

12 licensed general dentists

0 licensed pediatric dentists

2 Medicaid dental providers

### **Autauga County**

6,124 children in the county

1,902 children eligible for Medicaid

6 licensed general dentists

0 licensed pediatric dentists

4 Medicaid dental providers

### **Bibb County**

### **Barbour County**

3,558 children in the county

2,055 children eligible for Medicaid

2 licensed general dentists

0 licensed pediatric dentists

2 Medicaid dental providers

### **Bullock County**

14,826 children in the county

3,504 children eligible for Medicaid

7 licensed general dentists

0 licensed pediatric dentists

6 Medicaid dental providers

### **Blount County**

8,554 children in the county

2,509 children eligible for Medicaid

9 licensed general dentists

0 licensed pediatric dentists

5 Medicaid dental providers

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31,713 children in the county

10,812 children eligible for Medicaid

37 licensed general dentists  
1 licensed pediatric dentists  
17 Medicaid dental providers

### **Calhoun County**

6,677 children in the county  
3,113 children eligible for Medicaid  
5 licensed general dentists  
0 licensed pediatric dentists  
5 Medicaid dental providers

### **Butler County**

10,469 children in the county  
3,371 children eligible for Medicaid  
8 licensed general dentists  
0 licensed pediatric dentists  
5 Medicaid dental providers

### **Chambers County**

6,141 children in the county  
2,094 children eligible for Medicaid  
4 licensed general dentists  
0 licensed pediatric dentists  
2 Medicaid dental providers

### **Cherokee County**

4,722 children in the county  
1,838 children eligible for Medicaid  
5 licensed general dentists  
0 licensed pediatric dentists  
4 Medicaid dental providers  
11,700 children in the county  
2,941 children eligible for Medicaid  
9 licensed general dentists  
0 licensed pediatric dentists  
3 Medicaid dental providers

### **Chilton County**

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### **Choctaw County**

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4,194 children in the county  
2,157 children eligible for Medicaid  
2 licensed general dentists  
0 licensed pediatric dentists  
0 Medicaid dental providers

### **Conecuh County**

15,122 children in the county  
4,838 children eligible for Medicaid  
17 licensed general dentists  
0 licensed pediatric dentists  
10 Medicaid dental providers

## **Colbert County**

12,462 children in the county  
3,961 children eligible for Medicaid  
16 licensed general dentists  
0 licensed pediatric dentists  
3 Medicaid dental providers

## **Coffee County**

3,918 children in the county  
1,352 children eligible for Medicaid  
2 licensed general dentists  
0 licensed pediatric dentists  
3 Medicaid dental providers

## **Clay County**

8,960 children in the county  
3,799 children eligible for Medicaid  
9 licensed general dentists  
0 licensed pediatric dentists  
7 Medicaid dental providers

## **Clarke County**

3,973 children in the county  
1,306 children eligible for Medicaid  
0 licensed general dentists  
0 licensed pediatric dentists  
1 Medicaid dental providers

## **Cleburne County**

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10,335 children in the county  
3,982 children eligible for Medicaid  
11 licensed general dentists  
0 licensed pediatric dentists  
6 Medicaid dental providers

## **Covington County**

3,386 children in the county  
1,047 children eligible for Medicaid  
1 licensed general dentists  
0 licensed pediatric dentists  
1 Medicaid dental providers

## **Coosa County**

21,925 children in the county  
6,001 children eligible for Medicaid  
19 licensed general dentists  
0 licensed pediatric dentists  
8 Medicaid dental providers

## **Cullman County**

3,862 children in the county  
1,565 children eligible for Medicaid

3 licensed general dentists  
0 licensed pediatric dentists  
0 Medicaid dental providers

### **Crenshaw County**

15,187 children in the county  
4,704 children eligible for Medicaid  
11 licensed general dentists  
0 licensed pediatric dentists  
5 Medicaid dental providers

### **Dale County**

15,426 children in the county  
8,710 children eligible for Medicaid  
11 licensed general dentists  
1 licensed pediatric dentists  
7 Medicaid dental providers

### **Dallas County**

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19,424 children in the county  
4,488 children eligible for Medicaid  
9 licensed general dentists  
0 licensed pediatric dentists  
4 Medicaid dental providers

### **Elmore County**

10,922 children in the county  
4,086 children eligible for Medicaid  
11 licensed general dentists  
0 licensed pediatric dentists  
10 Medicaid dental providers

### **Escambia County**

5,139 children in the county  
1,632 children eligible for Medicaid  
4 licensed general dentists  
0 licensed pediatric dentists  
0 Medicaid dental providers

### **Fayette County**

28,742 children in the county  
8,537 children eligible for Medicaid  
36 licensed general dentists  
1 licensed pediatric dentists  
13 Medicaid dental providers

### **Etowah County**

### **Franklin County**

18,556 children in the county  
5,908 children eligible for Medicaid  
16 licensed general dentists  
0 licensed pediatric dentists

7 Medicaid dental providers

## **DeKalb County**

8,906 children in the county

3,198 children eligible for Medicaid

8 licensed general dentists

0 licensed pediatric dentists

3 Medicaid dental providers

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5,865 children in the county

2,642 children eligible for Medicaid

1 licensed general dentists

0 licensed pediatric dentists

3 Medicaid dental providers

## **Hale County**

3,367 children in the county

1,648 children eligible for Medicaid

6 licensed general dentists

0 licensed pediatric dentists

0 Medicaid dental providers

## **Greene County**

## **Geneva County**

15,041 children in the county

4,094 children eligible for Medicaid

14 licensed general dentists

0 licensed pediatric dentists

10 Medicaid dental providers

## **Jackson County**

26,236 children in the county

9,032 children eligible for Medicaid

35 licensed general dentists

4 licensed pediatric dentists

18 Medicaid dental providers

## **Houston County**

4,587 children in the county

1,683 children eligible for Medicaid

5 licensed general dentists

0 licensed pediatric dentists

4 Medicaid dental providers

## **Henry County**

7,095 children in the county

2,630 children eligible for Medicaid

4 licensed general dentists

0 licensed pediatric dentists

1 Medicaid dental providers

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4,400 children in the county

1,401 children eligible for Medicaid  
3 licensed general dentists  
0 licensed pediatric dentists  
3 Medicaid dental providers

### **Lamar County**

191,320 children in the county  
50,492 children eligible for Medicaid  
380 licensed general dentists  
33 licensed pediatric dentists  
86 Medicaid dental providers

### **Jefferson County**

### **Lawrence County**

### **Lauderdale County**

10,269 children in the county  
2,369 children eligible for Medicaid  
39 licensed general dentists  
1 licensed pediatric dentists  
1 Medicaid dental providers

18,742 children in the county  
3,932 children eligible for Medicaid  
14 licensed general dentists  
0 licensed pediatric dentists  
2 Medicaid dental providers

### **Limestone County**

39,037 children in the county  
7,535 children eligible for Medicaid  
26 licensed general dentists  
3 licensed pediatric dentists  
17 Medicaid dental providers

### **Lee County**

30  
24,357 children in the county  
5,932 children eligible for Medicaid  
39 licensed general dentists  
1 licensed pediatric dentists  
9 Medicaid dental providers

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8,233 children in the county  
3,404 children eligible for Medicaid  
4 licensed general dentists  
0 licensed pediatric dentists  
7 Medicaid dental providers

### **Macon County**

82,973 children in the county  
14,943 children eligible for Medicaid  
121 licensed general dentists  
9 licensed pediatric dentists  
45 Medicaid dental providers

## **Madison County**

4,693 children in the county  
2,414 children eligible for Medicaid  
1 licensed general dentists  
0 licensed pediatric dentists  
7 Medicaid dental providers

## **Lowndes County**

7,297 children in the county  
3,115 children eligible for Medicaid  
4 licensed general dentists  
0 licensed pediatric dentists  
0 Medicaid dental providers

## **Marengo County**

## **Marshall County**

8,230 children in the county  
2,417 children eligible for Medicaid  
8 licensed general dentists  
0 licensed pediatric dentists  
3 Medicaid dental providers

## **Marion County**

23,594 children in the county  
7,599 children eligible for Medicaid  
29 licensed general dentists  
0 licensed pediatric dentists  
7 Medicaid dental providers  
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7,916 children in the county  
2,889 children eligible for Medicaid  
7 licensed general dentists  
0 licensed pediatric dentists  
1 Medicaid dental providers

## **Monroe County**

127,655 children in the county  
40,117 children eligible for Medicaid  
164 licensed general dentists  
6 licensed pediatric dentists  
46 Medicaid dental providers

## **Mobile County**

32,269 children in the county  
7,218 children eligible for Medicaid  
36 licensed general dentists  
2 licensed pediatric dentists  
15 Medicaid dental providers

## **Morgan County**

69,654 children in the county  
24,685 children eligible for Medicaid

89 licensed general dentists  
4 licensed pediatric dentists  
31 Medicaid dental providers

## **Montgomery County**

### **Pickens County**

4,236 children in the county  
2,510 children eligible for Medicaid  
4 licensed general dentists  
0 licensed pediatric dentists  
4 Medicaid dental providers

### **Perry County**

6,605 children in the county  
2,672 children eligible for Medicaid  
2 licensed general dentists  
0 licensed pediatric dentists  
2 Medicaid dental providers

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### **Sumter County**

18,649 children in the county  
4,706 children eligible for Medicaid  
13 licensed general dentists  
0 licensed pediatric dentists  
17 Medicaid dental providers

### **St. Clair County**

42,708 children in the county  
3,597 children eligible for Medicaid  
27 licensed general dentists  
1 licensed pediatric dentists  
6 Medicaid dental providers

### **Shelby County**

6,567 children in the county  
2,358 children eligible for Medicaid  
5 licensed general dentists  
0 licensed pediatric dentists  
3 Medicaid dental providers

### **Randolph County**

15,168 children in the county  
5,519 children eligible for Medicaid  
5 licensed general dentists  
0 licensed pediatric dentists  
2 Medicaid dental providers

### **Russell County**

9,477 children in the county  
4,021 children eligible for Medicaid  
8 licensed general dentists  
2 licensed pediatric dentists

3 Medicaid dental providers

### **Pike County**

5,118 children in the county

2,896 children eligible for Medicaid

4 licensed general dentists

0 licensed pediatric dentists

5 Medicaid dental providers

33

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23,390 children in the county

7,780 children eligible for Medicaid

16 licensed general dentists

0 licensed pediatric dentists

6 Medicaid dental providers

### **Talladega County**

51,424 children in the county

13,686 children eligible for Medicaid

59 licensed general dentists

2 licensed pediatric dentists

31 Medicaid dental providers

### **Tuscaloosa County**

11,516 children in the county

39,51 children eligible for Medicaid

13 licensed general dentists

0 licensed pediatric dentists

5 Medicaid dental providers

### **Tallapoosa County**

4,661 children in the county

2,989 children eligible for Medicaid

3 licensed general dentists

0 licensed pediatric dentists

3 Medicaid dental providers

### **Wilcox County**

5,956 children in the county

1,993 children eligible for Medicaid

3 licensed general dentists

0 licensed pediatric dentists

3 Medicaid dental providers

### **Washington County**

19,387 children in the county

6,800 children eligible for Medicaid

21 licensed general dentists

0 licensed pediatric dentists

7 Medicaid dental providers

### **Walker County**

### **Winston County**

6,793 children in the county

2,183 children eligible for Medicaid  
3 licensed general dentists  
0 licensed pediatric dentists  
0 Medicaid dental providers

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Alabama Dental Summit Report Page

- Dental Task Force established January 1998
- Rates increased for targeted dental codes January 1999
- Legislative proclamation issued April 2000
- Governor's letter of support issued to state dentists October 2000
- Dentists surveyed in coordination with Alabama Dental Association 1999 and 2000
- Interdisciplinary Workgroup established to evaluate state March 2000 needs and develop strategic plan for Medicaid dental program
- Simplified enrollment material with user friendly billing manual Fall 1999 developed for dentists
- Claims payment process streamlined with free software, October 1999 ADA-approved claim forms and scanning technology
- Provider outreach program initiated Summer 1999  
Fiscal agent visits all dental providers Spring 2000  
Participation in state and regional meetings  
Annual presentations to dental students
- Grant applications  
Robert Wood Johnson Foundation November 2000  
National Governors' Association October 2000
- Targeted Case Management program for dental initiated March 2000
- Global Dental Rate Fees increased October 2000
- *Smile Alabama!* Initiative launched October 2000
- Robert Wood Johnson grant awarded February 2001
- Easy-to-read patient education materials developed including May 2001 posters, brochures, reminder cards and rights and responsibilities
- Dental Workshops statewide draw 750 dental providers and staff June 2001
- Workgroup renamed Oral Health Coalition of Alabama to reflect July 2001 broader mission of improving oral health in state
- Patient education video created for October 2001

Medicaid providers and outreach locations

- New Medicaid dental providers yield 33% increase September 2001
- Number of counties with 1 or no Medicaid dental November 2001 providers reduced from 19 to 11

## Measuring Our Progress

35

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# Alabama Oral Health Strategic Plan

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## PRIORITY ONE

Increase the availability and accessibility of dental care to children by expanding the scope and supply of the oral health work force in the state of Alabama and address the lack of distribution in rural areas.

### 1.1.1. Assess feasibility of utilizing GuardCare for dental services

#### Action Steps - Completed

1. Dr. Thornton to contact Ltc Pal Given about utilization of GuardCare to address areas of state with need for immediate access to oral health care
- 2 Meet with Governor to establish need to mobilize dental unit for GuardCare
3. Meet with Guard, ADPH, Medicaid, and community dentists to establish partners, dates and referral sites
4. GuardCare scheduled for April 30-May 4, 2001. Met goal to screen at least 500 adults and children, referring those requiring care

#### Action Steps - Current

Explore expansion of this initiative to other areas of the state

### 1.1.2. Explore expansion of Resident Placement Program and other alternative care settings through partnership with churches or other public or private entities to provide dental care

#### Action Steps - Completed

1. Meet and discuss with UAB Dental School (Dr. Capilouto and Dr. Thornton) feasibility of utilizing residents in health department clinic sites and community health care centers
2. Review Medicaid policy on reimbursement of residents

#### Action Steps - Current

1. Determine if additional payment sources exist for set-up of clinics- Meet with Children's Commissioner, Pam Baker
2. Meet with Alabama Primary Health Care Association and ADPH to determine if existing space can be utilized, determine potential sites
3. Look for funding, grants, volunteer dentists, etc. for start-up new dental clinics in counties with limited to no dental care access

4. Investigate partnering with churches or other public or private entities to provide alternate dental treatment facilities as well as partnering with public/private entities to create volunteer networks of dentists using donated space from facilities as alternate dental treatment facilities

Strategies

A. Research applicable laws; tort liability (Good Samaritan laws)

B. Identify needed supplies (both equipment and treatment)

C. Locate suitable facilities (e.g. church, health department), providers' own facilities

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**1.1.3. Develop program that increases utilization of auxiliary assistance with a linkage back to dentists to ensure continuity of care**

**Action Steps - Completed**

1. Investigate feasibility of amending practice statute to allow hygienists to practice in limited

settings under general supervision

**Action Steps - Current**

1. Draft suggested language for changes/amendments to Dental Practice Act

2. Develop screening/referral program utilizing auxiliaries with linkage back to community

dentists - June 2003

**1.1.4. Explore the use of alternative providers (OB/Gyn's, FP's and Pediatricians) to provide preventative and educational services to pregnant women and children under the age of 3**

**Action Steps - Completed**

1. Review Physician and Dental Practice Acts to determine need for amendments

2. Develop educational materials for use by providers identified above

**Action Steps - Current**

1. Pursue development of program utilizing alternative providers for patient education and

oral health screening services, evaluate funding for implementation-December 2002

2. Working with dental school to increase capacity

**1.1.5 Work with Dental School, Legislature and communities to increase dental workforce with**

**emphasis on under-served areas in the state**

**Action Steps - Current**

1. Identify costs to add positions to dental school. (How much does a single additional slot cost?)

2. Work to increase funding to the UAB School of Dentistry to increase capacity to serve under-served populations of Alabama

Strategies

A. Initiate a qualified workforce study

B. Distribute a packet (including legislative fact sheet) with a focused message

(See 1.2.5)

C. Rally support of UAB administrators to forward recommendations to the legislature

3. Pursue investments – State/Private funding

4. Pursue establishment of scholarship/loan repayment program, tax credits for serving

Medicaid patients, and community matching programs (state or federal)  
Recommendations to Legislature by 2003.

*Responsible parties-ADPH, state dental director, primary care offices, schools, dental associations*

5. Diversity enhancement – Start middle school level career path. Offer dependent on meeting requirements, return to community for guidance.

Career fairs (*Market dentistry*)

6. Contact Office of Rural Health Utilization to see what assistance is available

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## **PRIORITY TWO**

Increase educational efforts in communities regarding the importance of oral health.

### **2.1.1. Statewide *Smile Alabama!* Public awareness campaign emphasizing prevention and the need to obtain care**

#### **Action Steps - Completed**

1. Develop materials and obtain approval from Governor, Dental Task Force and Medicaid Commissioner
2. Obtain contracts for development of videos/PSA's
3. Obtain contract(s) for radio/television oral health awareness campaign
4. Start running of PSA's by December 2001

#### **Action Steps - Current**

1. Refinement of the message for consistency and wider distribution
2. Pursue additional funding for production and distribution of educational materials  
Strategies  
A. Explore grants available through CDC, NIDCR, private foundations, corporations  
B. Expand distribution channels (WIC, pediatricians, augment training, provide toothbrushes to give to parents of 9-12 month olds)

### **2.1.2. Provision of information on oral health in non-traditional dental settings through case managers**

#### **Action Steps - Current**

1. Review information for inclusion in prenatal packets on oral health-In progress, due by May 2002. *Responsible Parties-Medicaid & ADPH*
2. Work with ADPH and Medicaid in distribution of materials, development of programs January 2003. *Responsible party-Medicaid*
3. Determine key message(s) and communication strategies by April 2002. *Responsible Parties-Medicaid & ADPH*
4. Provide training to case managers in order to integrate dental education into prenatal and post-partum care coordination visits by June 2002. *Responsible Parties-Medicaid & ADPH*

Strategies

- A. Pursue additional grant funding
- B. Disseminate materials developed to family practitioners/pediatricians for "age appropriate education" for anticipatory guidance requirements under EPSDT

### **2.1.3. Coordination with Policy Councils (67 County Level Councils)**

#### **Action Steps - Completed**

1. Meet with Children's Affairs Office and Commissioner Pam Baker

#### **Action Steps - Current**

1. Distribute materials developed, providing packets and originals for copying at the

county level by June 2002. *Responsible Parties-Children's Affairs & Medicaid*  
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#### 2.1.4. Use partners (Coalition) for op-ed opportunities and to assist in implementation of strategic plan strategies

##### **Action Steps - Completed**

1. Schedule meeting of Oral Health Coalition of Alabama (OHCA) to request assistance in distribution of materials and to obtain input on additional steps to accomplish identified goals - Meeting held July 10, 2001

##### **Action Steps - Current**

1. Redefine function of dental workgroup to act as advisory group to state oral health team
2. Establish quarterly schedule of meetings for the Oral Health Coalition of Alabama with the formation of subgroups or committees for finalization and implementation of recommended action steps and development of strategies-by February 2002.  
*Responsible Party-Medicaid & OHCA*
3. Identify diverse groups for the expansion of materials and educational programs on oral health
4. Seek and identify supporters from the business community for marketing expertise and possible funding assistance

#### 2.1.5. Develop Oral Health Fact sheet for Legislators and other policy makers

##### **Action Steps - Current**

1. Work with Alabama Oral Health Policy Team to develop fact sheets for distribution to key policy makers at the start of the legislative session-February 2002 and Yearly.  
*Responsible Parties-Medicaid, ADPH*  
Strategies
  - A. Compile fact sheets with statistics for legislators
  - B. Talk with individuals involved with Children's Affairs and the Governor's office
  - C. Understand how the Policy Councils function and how they can be utilized to further an understanding of oral health issues
2. Define how the Oral Health Coalition communicates with the legislature-by May 2002.  
*Responsible Party-Oral Health Coalition of Alabama, subgroup on Education & Awareness*
3. Obtain approval from Governor's office prior to distribution
4. Identify specific counties to target and get information on specific counties into the hands of appropriate legislators in the form of a letter from the coalition- *Counties identified*

#### 2.1.6. Conduct State Dental Summit to obtain buy-in of additional stakeholders and assistance in implementation of plan

##### **Action Steps - Completed**

1. Submit proposal for funding to CMS Regional office/HRSA
2. Seek assistance from NGA in finalizing agenda with requests for assistance with speakers

##### **Action Steps - Current**

1. Determine need for follow-up Summit in one year.

## **PRIORITY THREE**

Develop and implement surveillance/monitoring process to accurately assess oral health status in the State of Alabama

### **3.1.1. Conduct needs assessment of resources and identify areas of need**

#### **Action Steps - Completed**

1. Develop questions to be used by Policy Councils in assessing oral needs in each county
2. Determine counties within the state with no or only one participating Medicaid provider

#### **Action Steps - Current**

1. Provide feedback to coalition members on findings
2. Obtain status report from Policy Councils on finding of county needs assessments done through Councils
3. Collect oral health data as early as possible in each child's life (e.g. 6 months-5 years by county)
4. Implement a statewide oral health survey of 3<sup>rd</sup> grader - By 2003.

*Responsible Party-ADPH*

### **3.1.2. Develop database**

#### **Action Steps - Current**

1. Develop survey for statewide assessment on oral health status-In progress
2. Conduct statewide survey to obtain baseline data -- Planned for 2002,
3. Establish benchmarks and develop ongoing monitoring process.

*Responsible Party-ADPH*

Revised February 17, 2002  
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## ***Indigent Care Dental Clinics***

***May 2001***

MOBILE  
BALDWIN  
ESCAMBIA  
WASHINGTON  
CLARKE  
CHOCTAW  
MONROE  
CONECUH  
WILCOX  
MARENGO  
SUMTER  
DALLAS  
BUTLER  
COVINGTON  
COFFEE  
DALE  
HENRY  
BARBOUR  
PIKE  
HOUSTON GENEVA  
CRENSHAW  
RUSSELL  
LEE  
CHAMBERS  
BULLOCK  
MONTGOMERY  
ELMORE  
AUTAUGA  
LOWNDES  
TALLAPOOSA  
COOSA  
CHILTON  
BIBB  
PERRY  
HALE  
GREENE  
PICKENS  
TUSCALOOSA  
JEFFERSON  
SHELBY  
LAMAR  
MARION  
FAYETTE  
WALKER  
WINSTON  
FRANKLIN  
COLBERT  
LAUDERDALE  
LAWRENCE  
LIMESTONE  
MADISON  
MORGAN  
JACKSON  
DEKALB  
MARSHALL  
CHEROKEE  
BLOUNT  
ETOWAH  
ST. CLAIR  
CALHOUN  
CLEBURNE  
RANDOLPH CLAY  
TALLADEGA  
MACON  
CULLMAN

**Health Department Clinic**

**FQHC Clinic**

**Other**

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## ***Dental Shortages By County***

***May 2001***

4.2  
3.4  
7.7  
3.7  
10.9  
3.8  
3.0

3.0  
0.8  
4.5  
0.8  
0.3  
2.5  
1.1  
1.1  
45.4

**DESIGNATION TYPES**

Health Professional Shortage Areas

Prepared by: Alabama Department of Public Health, Office of Primary Care and Rural Health.

Source: Bureau of Health Care Delivery Assistance Network, Health Professional Shortage Area Listing.

Numbers represent additional dentists needed to eliminate the shortage designation.

Call 1(800) 255-1992 for additional shortage area information.

**No Designation**

**Whole County Population**

**Low-income Population**

1.7

MOBILE  
BALDWIN  
ESCAMBIA  
WASHINGTON  
CLARKE  
CHOCTAW  
MONROE  
CONECUH  
WILCOX  
MARENGO  
SUMTER  
DALLAS  
BUTLER  
COVINGTON  
COFFEE  
DALE  
HENRY  
BARBOUR  
PIKE  
HOUSTON GENEVA  
CRENSHAW  
RUSSELL  
LEE  
CHAMBERS  
BULLOCK  
MACON  
MONTGOMERY  
ELMORE  
AUTAUGA  
LOWNDES  
TALLAPOOSA  
COOSA  
CHILTON  
BIBB  
PERRY HALE  
GREENE  
PICKENS  
TUSCALOOSA  
JEFFERSON  
SHELBY  
LAMAR  
MARION  
FAYETTE  
WALKER  
WINSTON CULLMAN  
FRANKLIN  
COLBERT  
LAUDERDALE  
LAWRENCE  
LIMESTONE  
MADISON  
MORGAN  
JACKSON  
DEKALB  
MARSHALL  
CHEROKEE  
BLOUNT  
ETOWAH  
ST. CLAIR CALHOUN  
CLEBURNE  
RANDOLPH  
CLAY  
TALLADEGA

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# ***Dental Shortages By County***

## ***August 3, 2001***

14.8

3.4

7.9

**LOW INCOME POPULATIONS**

**Health Professional Shortage Areas**

Prepared by: Alabama Department of Public Health, Office of Primary Care and Rural Health.

Source: Bureau of Health Care Delivery Assistance Network, Health Professional Shortage Area Listing.

Numbers represent additional dentists needed to eliminate the shortage designation. Multi-county designations are indicated by the numbers enclosed in white frames astride county lines.

Call 1 (800) 255-1992 for additional shortage area information.

**Single County Designations**

**Multi-County Designations**

MOBILE  
BALDWIN  
ESCAMBIA  
WASHINGTON  
CLARKE  
CHOCTAW  
MONROE  
CONECUH  
WILCOX  
MARENGO  
SUMTER  
DALLAS  
BUTLER  
COVINGTON  
COFFEE  
DALE  
HENRY  
BARBOUR PIKE  
HOUSTON GENEVA  
CRENSHAW  
RUSSELL  
LEE  
CHAMBERS  
BULLOCK  
MACON  
MONTGOMERY  
ELMORE  
AUTAUGA  
LOWNDES  
TALLAPOOSA COOSA  
CHILTON  
BIBB  
PERRY  
HALE  
GREENE  
PICKENS  
TUSCALOOSA  
JEFFERSON  
SHELBY  
LAMAR  
MARION  
FAYETTE  
WALKER  
WINSTON  
CULLMAN  
FRANKLIN  
COLBERT  
LAUDERDALE  
LAWRENCE  
LIMESTONE  
MADISON  
MORGAN  
JACKSON  
DEKALB MARSHALL  
CHEROKEE  
BLOUNT  
ETOWAH  
ST. CLAIR CALHOUN  
CLEBURNE  
RANDOLPH  
CLAY  
TALLADEGA

8.1

5

2.3

1.4

5.2

4.9

5.8

6.6

45.4

12.8

7.7

13.9

3.9

15.4

4.5

3.9

22.6

4.9

4.7

5.1

1.7

2.7  
50  
9.1  
3.3  
5.2  
10.7  
2.3  
1.3  
1.2  
3.5  
7.9  
9.1  
5.3  
1.4  
3.3 2.8  
6.9  
6.9  
2.2

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## ***General Dentists By County*** ***May 2001***

The number in the county represents the number of licensed general dentists in the county.

State Total 1,478

121  
36  
26  
59  
27  
380  
35  
8  
89  
11  
164  
37

MOBILE  
BALDWIN  
ESCAMBIA  
WASHINGTON  
CLARKE  
CHOCTAW  
MONROE  
CONECUH  
WILCOX  
MARENGO  
SUMTER  
DALLAS  
BUTLER  
COVINGTON  
COFFEE  
DALE  
HENRY  
BARBOUR  
PIKE  
HOUSTON  
GENEVA  
CRENSHAW  
RUSSELL  
LEE  
CHAMBERS  
BULLOCK  
MONTGOMERY  
ELMORE  
AUTAUGA  
LOWNDES  
TALLAPOOSA  
COOSA  
CHILTON  
BIBB  
PERRY  
HALE  
GREENE  
PICKENS  
TUSCALOOSA  
JEFFERSON  
SHELBY  
LAMAR  
MARION  
FAYETTE  
WALKER

WINSTON  
FRANKLIN  
COLBERT  
LAUDERDALE  
LAWRENCE  
LIMESTONE  
MADISON  
MORGAN  
JACKSON  
DEKALB  
MARSHALL  
CHEROKEE  
BLOUNT  
ETOWAH  
ST. CLAIR  
CALHOUN  
CLEBURNE  
RANDOLPH CLAY  
TALLADEGA

39

36

MACON  
CULLMAN

2

4

5

0

13 8

13

16

2 5

3

21

14

3

0

19

7

29

14

4

16

12

2

9

4

1

6

2

3

8

17

8

4

11

2

7

9 3

0

5

3

4

5

1

3

55

11

16

9

5 11

4

9

46

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## ***Pediatric Dentists By County***

# November 2000

9

1

3

2

1

33

3.0

2

4

1

6

## **PEDIATRIC DENTAL SERVICES BY COUNTY**

The number above the county name represents the number of licensed pediatric dentists in the county.

Private Practice/PHC 66

Dental School Professors 4

Retirees 3

Total 73

## **Pediatric Dental Services**

### **No Pediatric Services**

1

MOBILE

BALDWIN

ESCAMBIA

WASHINGTON

CLARKE

CHOCTAW

MONROE

CONECUH

WILCOX

MARENGO

SUMTER

DALLAS

BUTLER

COVINGTON

COFFEE

DALE

HENRY

BARBOUR

PIKE

HOUSTON GENEVA

CRENSHAW

RUSSELL

LEE

CHAMBERS

BULLOCK

MACON

MONTGOMERY

ELMORE

AUTAUGA

LOWNDES

TALLAPOOSA

COOSA

CHILTON

BIBB

PERRY

HALE

GREENE

PICKENS

TUSCALOOSA

JEFFERSON

SHELBY

LAMAR

MARION

FAYETTE

WALKER

WINSTON

FRANKLIN

COLBERT

LAUDERDALE

LAWRENCE

LIMESTONE

MADISON

MORGAN

JACKSON

DEKALB

MARSHALL

CHEROKEE

ETOWAH

ST. CLAIR

CALHOUN

CLEBURNE

RANDOLPH

CLAY

TALLADEGA

1

2

CULLMAN

BLOUNT

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NGA Center for

BEST PRACTICES

**ALABAMA DENTAL SUMMIT**

**2001**

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