POLICY RECOMMENDATIONS FOR PREVENTION, EDUCATION AND ACCESS
ORAL HEALTH IN MISSOURI:

May 2002

MISSOURI COALITION FOR ORAL HEALTH ACCESS

Missouri Primary Care Association
Missouri Dental Association
Missouri Dental Hygienists' Association
Missouri Dental Assistants' Association
University of Missouri Kansas City
School of Dentistry
St. Louis University School of Medicine
Missouri Chapter
American Academy of Pediatrics
Missouri Children's Trust Fund
Missouri Head Start Association
Missouri Public Health Association
Missouri Area Health Education Centers
Missouri Association for Social Welfare
Missouri League of Women Voters
Missouri Association of Health Plans
Citizens for Missouri's Children
Boone County Council on Aging
Missouri Conference of the
United Methodist Church
Missouri Association for Community Action
Mineral Area Dental Study Club
ROWEL
Missouri Academy of Family Physicians
Alliance of the Missouri Dental Association

Boone County Group Homes
and Family Support
Miles for Smiles
Missouri Rural Health Association
Delta Dental
Boone County Group Homes and Family
Support

NATIONAL GOVERNOR'S ASSOCIATION POLICY ACADEMY ON IMPROVING ORAL HEALTH CARE FOR CHILDREN

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Missouri House of Representatives
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EXECUTIVE SUMMARY

The most critical oral health

problem facing Missourians is access, especially for the elderly, low income uninsured and Medicaid eligible adults and children, and people with special health care needs. Both medical and dental providers and health care policymakers have noted tremendous deficiencies in dental health status. The following data provides a snapshot of Missouri's Oral Health Status:

• 18% of 2-4 year olds have tooth decay
• 80% of untreated cavities in permanent teeth are found in roughly 25% of children who are aged 5-17.
• 78% of 17 year-olds have tooth decay
• For every adult 19 years or older without medical insurance, there are 3 without dental insurance.
• A little less than 2/3 of adults have visited a dentist within the last 12 months.
• In adults 35-44 years old, 69% have lost at least one tooth. 48% have gingivitis and 22% have destructive gum disease.

Oral health access is exacerbated by a workforce shortage among dental health professionals practicing in Missouri. The number of dentists has not increased since 1994 and the anticipated number of retiring dentists each year is 70, while the number of new dentists is half that number. The number of Health Professional Shortage Areas for dentists has increased dramatically over the past five years and the Missouri Department of Economic Development projects a 2% drop in the number of dentists practicing in Missouri by the year 2008.

If access to dental services in the general population is lacking, access to dental services for those people with Medicaid insurance or no insurance is critically deficient. Currently there are very few, or in some communities no dentists that accept Medicaid or provide a sliding fee scale. In addition, there is a statewide gap in dental insurance

even among the employed. This puts dental services largely in the self-pay arena and out of reach for many citizens.

Recently, oral health policy makers and other dental health advocates have come together to address some of the significant economic barriers in the Missouri Medicaid program which had precluded the provision of even the most basic of dental services. A responsive state legislature and the Division of Medical Services have also taken a series of steps to tear down barriers to oral health services, including the allocation of general revenue funds to open new dental programs at Federally Qualified Community Health Centers (FQHCs), and a Medicaid policy change allowing FQHCs to receive Medicaid reimbursement for contracted dental services with primary and specialty dentists. Missouri citizens have seen an increase in Medicaid appropriations for dental services from 1998 to 2001. Clinics, such as local health departments may now enroll as dental providers, Medicaid claim filing has been streamlined and nearly 95% of dental claims are processed within 15 days. Dentists may now report broken appointments to the Division of Medical Services.

Despite these activities, Missouri has yet to see significant oral health access improvement, or the elimination of the extensive dental neglect which has been so pervasive in our communities. In an effort to address the persistent dilemma of oral health access, key stakeholders created the Missouri Coalition for Oral Health Access. Organized in August 1999, the Coalition, administered by the Missouri Primary Care Association, sought to develop a statewide oral health initiative. Using a template developed by the National Governor’s Association Center for Best Practices, the Coalition set out to produce a relevant state oral

health plan for Missouri, based on Healthy People 2010 and the Surgeon General's Report on Oral Health.

The Coalition defined the following oral health issues and developed the recommendations proposed in this plan to focus on six key areas.

- A safety net infrastructure to address primary and specialty oral healthcare needs
- A Medicaid reimbursement rate at the 75th percentile of usual and customary rate (UCR)
- A workforce plan that increases the number of dentists and oral health professionals and addresses the disparity of dentists providing care to rural and underserved populations
- A comprehensive prevention and education system
- An adequate and appropriate data system developed for effective policy decisions
- Ensure the Missouri Coalition for Oral Health Access is representative of all stakeholders improving oral health.

Using the Plan as a roadmap, the Coalition, in conjunction with Missouri policy makers, will implement strategies that improve access to oral health (including prevention, and wellness) with a special focus on the underserved and uninsured, address disparities in oral health access across Missouri, serve as the unified voice for the majority of the stakeholders in this issue, and promote progress, hope and change for the future.

The two most commonly mentioned barriers to receiving dental care for adults and children are cost and access. This is particularly true among the Medicaid eligible and the lower income families. Individual dental insurance policies are virtually non-existent and less than 40% of the employees of this state are covered by some level of dental insurance through their place of employment. The dental insurance available to state employees is rarely used because of the lack of providers enrolled in the existing plan.

Access for the Medicaid eligible population is a grave concern for state legislators, state agencies, the

provider community, and recipients. Medicaid enrolled adults and children have a difficult time finding a dentist who will accept Medicaid, and when they do, they are faced with waiting times of up to 6 months. Less than 25% of dentists accept Medicaid either through a managed care program or through fee for service.

CURRENT ENVIRONMENT:

Until recently, there were issues other than reimbursement that caused dentists across the state to discontinue as Medicaid providers. Those issues included the use of claim forms and reporting codes that were different from that which was standard in the insurance industry; a very high rate of claim rejections for various reasons and long delays in payment for services rendered. Another prominent factor was the "no-show rate" of participants for treatment appointments. These have all been addressed by the Division of Medical Services. The standard ADA Claim form and reporting codes are accepted, most predetermination requirements have been eliminated, rejection policies have been revised and the number of claim rejections has been dramatically decreased, recipients that miss dental appointments are counseled about the necessity of keeping the appointment. Providers are now able to file claims electronically.

The one remaining barrier is still the reimbursement level. For almost twenty (20) years Missouri Medicaid reimbursement levels for dental providers remained relatively unchanged. The first real increase in appropriations for reimbursements occurred in 1998, and each year since there has been some level of increase. In spite of four consecutive years of increases, the reimbursement levels are barely over 50% of fees normally charged by the dentists in this state.

Dental practices are small businesses with fixed and variable overheads. Most practices have an average of sixty-five percent (65%) fixed overhead. Reimbursement levels for Medicaid average 50% of the usual charge for those services, so many dentists

MEDICAID & OTHER INSURANCE BARRIERS

GOAL:

Reduce Financial Barriers to oral health access

make the business decision to refrain from accepting patients with Medicaid insurance. Currently in the MC+ dental areas, the state

contracts with medical HMOs who subcontract with vendors experienced in dental claims. A three layered administrative expense is the result, draining valuable resources from potential patient services. The MC+ dental vendors do not have an adequate provider network, again, due to the low reimbursement level for the provider. Fee-for service Medicaid also has only about 15% of the licensed dentists in their provider pool.

The State of Missouri has exercised the option to partially cover adult dental services under Medicaid. A decade ago an unsuccessful attempt was made to eliminate these services from Medicaid coverage. In 2002, Adult Dental Medicaid benefits were removed from the state budget, placing a greater strain on the other safety net proggrams already providing dental services for low income and uninsured at greatly reduced fees or at no charge. Eligible city and county health clinics can now apply for a Medicaid provider number which will allow the clinic to bill Medicaid for services voluntarily performed by licensed dentists and hygienists. This will allow more dentists to provide services without having to apply for a provider number or being "on the list".

RECOMMENDATIONS

• Reinstate Adult Dental Medicaid benefits and increase the dental Medicaid reimbursement to reflect the 75th percentile of fees charged using the most recent American Dental Association (ADA) fee survey for the West North Central Region.

• Consider a "carve out" of the dental Medicaid program from the other health care provider programs and have it administered by a private dental insurance carrier with a large provider network similar to a program developed in Michigan with Delta Dental.

• Improve the state employee dental

insurance coverage.
Conversations must commence with the current agency contracting with insurers for health coverage to determine the cost of a dental program with a wider provider network statewide.

SUMMARY

Data collected in other states reflects that when dentists are reimbursed 75% to 80% of the UCR, their participation in the Medicaid program increases dramatically. The federal government matches the state Medicaid funding at a rate of 60/40. It falls on the shoulders of State of Missouri to allocate enough funds to draw down the federal dollars at a level sufficient to reimburse the providers of oral health services to at least meet their fixed operating expenses.

Reducing financial barriers...

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Missouri’s oral health "safety net" is threatened by three primary factors: stability in the Medicaid program (reimbursement rates, and Medicaid eligibility), a dental provider workforce crisis, and a system that is not large enough to provide adequate access to dental services.
Private safety net providers who rely on Medicaid to reimburse them for the dental services are faced with the daunting challenge of keeping their operations viable when the Medicaid reimbursement rate is just about 50% of the UCR.
Access to dental services is made more difficult

because the number of general practice dentists in Missouri is declining rapidly. From 1994 to 2000, the number of full time general practice dentists in Missouri declined from 1913 to 1830. The shortage of dentists is evident especially in rural and underserved areas. Missouri is averaging a net decrease each year of 40-50 actively practicing dentists.

Missouri's fragile safety net system is anchored by the Federally Qualified Health Centers (FQHCs). All of Missouri's FQHCs either have or are developing dental programs, but expansion of new dental delivery sites must be a priority.

CURRENT ENVIRONMENT:

There are some volunteer clinics, where care is usually free or low cost. All of the Federally Qualified Community Health Centers across the state have or are developing dental programs to serve the underserved population.

Communities across the state are also developing their own solutions to the demand for emergency or urgent dental services, as well as routine care for populations typically underserved. Using support from the DHSS Oral Health Program, Marion County has a volunteer dental clinic at the County Health Department. DHSS Oral Health Program support also partially funded the purchase of dental equipment in Taney and Phelps Counties and the development of a dental program in Randolph County.

Miles for Smiles mobile dental unit travels in a service area consisting of seven counties in southwest Missouri. Jefferson City has two free clinics (Samaritan Center, and CEMO Cares) using volunteer dentists to provide services eight hours per week. The Heartland Health Systems in St. Joseph, MO has established a dental clinic to care for the Medicaid eligible and the uninsured under the 200% federal poverty level.

SYSTEMS & SAFETY NET INFRASTRUCTURE

GOAL:

A safety net infrastructure to address primary and specialty oral healthcare needs

A clinic has been established at the Springfield/Greene County Health Department, which is allowing

providers to serve Medicaid patients. The Missouri Primary Care Association has recently received an Integrated Service Development Initiative planning grant from the Bureau of Primary Health Care to build the foundation for expanding the federally qualified community health centers' ability to provide comprehensive dental services.
For almost 40 years, the public/private partnership between the DHSS Oral Health Program and the Elks Benevolent Trust of Missouri helps fund the Elks Dental Van which provides dental care for the developmentally disabled. More recently, DHSS received funding to facilitate the placement of 20-30 new dentists in identified high need areas.
The Missouri DHSS Primary Care Office and the Oral Health Program funded approximately 10 sites across the state in SFY 2000 to expand or initiate dental services at community health centers and/or local public health agencies.

RECOMMENDATIONS

• Secure federal and state funding to create a stable statewide oral health care delivery system:
o Create seven regional hubs for delivering services by integrating existing federally funded community health centers with local initiatives and private practice dentists.
o Introduce, for those regions without current access to such services, specialty care.
o Earmark state funds to serve the largest possible proportion of the uninsured and Medicaid enrolled patients.
• Identify other state and federal funding resources for establishing and supporting dental services.
• Expand the Dental Practice Act to ensure the greatest possible access for low-income, uninsured and Medicaid insured populations
• Expand the funding for the PRIMO program to increase opportunities for dental hygienist students to receive clinical education

experiences in rural and
underserved areas of the state.

A safety net infrastructure...

Big Springs Medical Association
Ellington
Cabot Westside Clinic
Kansas City
Central Ozarks Medical Center
Richland
Cross Trails Medical Center
Cape Girardeau
Douglas County Public Health Services Group, Inc.
Ava
Family Care Health Centers
St. Louis
Family Health Center
Columbia
Myrtle H. Davis Comprehensive Health Center
St. Louis
Northeast Missouri Health Council
Kirksville
Northwest Health Services, Inc.
St. Joseph
Ozark Tri-County Health Care Consortium, Inc.
Anderson
People's Health Centers
St. Louis
Samuel U. Rodgers Community Health Center
Kansas City
Southeast Missouri Health Network
New Madrid
Grace Hill Neighborhood Health Centers, Inc.
St. Louis
Swope Parkway Health Center
Kansas City

COMMUNITY HEALTH CENTERS

Community Health Center
Satellite Clinic

The Missouri Coalition for Oral Health Access was organized in 1999 by the Missouri Primary Care Association, the DHSS Oral Health Program and the Missouri Dental Association. The purpose of the Coalition is to develop a statewide oral health initiative, which would create a relevant oral health plan, based on Healthy People 2010 and the Surgeon General's Report on Oral Health. Twenty-one organizations make up the coalition, and to date, it has hosted two state-wide summits on Oral Health Access and has produced this Oral Health in Missouri Access Plan.

CURRENT ENVIRONMENT

The Missouri Coalition for Oral Health Access is a young organization made of members with varying perspectives on the strategies for improving oral health access. Expanding membership and building consensus among members on both the critical issues and the strategies for addressing access has been and will continue to be a challenge.

Communication, especially during the legislative season, is critical to the Coalition's education and advocacy mission. Creating a mechanism for consistent, effective and informed communication will be critical to the success of the Coalition. Creating a formal structure with at least 1 FTE staff will improve the Coalition's ability to effectively make recommendations to policy makers on the issue of oral health access.

RECOMMENDATIONS

• Ensure adequate resources to the coalition. The coalition is currently administered by the Missouri Primary Care Association. Coalition activities could be greatly maximized if the Coalition were staffed with at least 1 FTE.

• Secure funding to support Coalition. Explore both federal and state public funding opportunities, private grants, and coalition membership as possible avenues for creating financial stability.

• Expand coalition membership. Identify potential Coalition members and determine membership requirements, fees and participation.

COALITION BUILDING

GOAL:

Ensure the Missouri Coalition for Oral Health Access is representative

of all stakeholders
improving oral health.

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Our Photo Album...

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WORKFORCE GOAL:

Ensure an adequate, effective workforce for dental care, including dentists, dental hygienists, and dental assistants.

The number of active dentists, unlike most other health care professions, is not increasing in Missouri. Most of Missouri dentists, both general practice and in specialty practice, work in urban communities in private practice settings. Forty nine percent of the active dentists in 2000 were 50 years old or older. Replacing these essential health care providers is very problematic and involves increasing the number of graduating dentists practicing in Missouri, increasing the number of faculty at our one Missouri dental school.

CURRENT ENVIRONMENT

The number of retiring dentists each year is estimated at 70, while the number of new dentists is less than half that number. There are only 47 Pediatric Dentists (specialist) licensed in the state. The number of UMKC graduates practicing in Missouri has also declined to 20 graduates per year.
The University of Missouri, Kansas City School of Dentistry is the only active dental school in the state. They also contract with 4

states to provide slots for their students (Kansas, Arkansas, New Mexico and Hawaii). The School has moved to increase enrollment from 80 to 100 students in the fall of 2002. Of that number, the goal is to admit 70 qualified Missouri resident applications by the fall of 2004.

Outreach and community-based clinical training is a hallmark of UMKC School of Dentistry's curriculum. Currently students travel to Theodosia, Missouri for a 2 week elementary school-based clinical and outreach experience. They also travel to Nevada, Missouri for 2 week hospital based outreach and educational experience. A unique partnership between UMKC School of Dentistry and Heartland Health Systems in St. Joseph, Missouri has resulted in the creation of a community clinic dedicated to providing dental services to low-income and Medicaid populations.

Both state and federal incentive programs designed to recruit dentists and hygienist to practice in underserved communities have increased over the past two years. UMKC participates in the Federal National Health Service Corps Educational Partnership Agreement. The NHSC Scholarship Program recruits students with a desire and commitment to serve in underserved areas where the needs are the greatest.

The State's Primary Care Resource Initiative for Missouri (PRIMO) has expanded to include dental students, and beginning in July 2002 dentists and hygienists. PRIMO contractors identify promising students in high school and support them through a health professions pipeline. Support may take the form of academic enrichment, pre-admissions, financial aid, community-based clinical training, and culturally sensitive coursework, development of community-based systems of care and placement services.

Scheduled for implementation in July 2002, the Healthy Communities Incentive Program (HCIP) provides payments to

primary care physicians and dentists in exchange for practicing four years in an underserved area. The practitioners must agree to accept Medicaid recipients and provide a sliding fee scale to adjust fees charged to the uninsured, under 200% of poverty. Eligible practitioners include general and pediatric dentists and primary care physicians.

Dental hygienists and dental assistants are not experiencing the critical shortages reflected in the Missouri dentist workforce. It is estimated that by the year 2008, that the number of dental hygienist will increase by 30% and the number of dental assistants will increase by 32%. However the same disparities exist in the distribution of dental hygienists and assistants as exists for dentists. The vast majority of assistants and hygienists work in urban or private practice settings.

WORKFORCE RECOMMENDATIONS

• Increase the number of dentists and hygienists who are accepted to dental education programs. Increase the number of dental graduates who practice in Missouri from 20 graduates to 50 graduates.

• Training these additional students will require that we address the shortage of dental school faculty. The American Dental Education Association (ADEA) survey of dental schools projects that the number of unfilled budgeted faculty positions in U.S. dental schools now approaches 400. Retirement was identified as the leading reason for full-time faculty separation, while separation to enter private practice was the second most frequent reason for leaving the institution. Offering salaries that compete with the salaries of private practice was identified as the most critical factor in recruiting future faculty.

• To increase the number of dental hygienists practicing in underserved areas, dental hygiene students should be qualified to participate in the National Health Service Corps Scholarship (NHSC) and PRIMO programs. These programs assist students with the increasing costs of their professional education while promoting access to care in underserved areas.
• Collaborate with key organizations (MAHEC) to develop community based training or dental providers in PRIMO supported practice sites.

Adequate, effective workforce…

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GENERAL DENTISTS BY ZIP

Each dot represents a zip code with at least one General Dentist.
Total number of General Dentists=2202
Male=1865
Female=282
Average Age=48.2

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According to the Surgeon General's Report on Oral Health in America, safe and effective disease prevention measures exist that everyone can adopt to improve oral health and prevent disease. Appropriate daily oral hygiene, regular dental visits, water fluoridation, good nutrition and some behavior changes have a direct impact on oral health. Tooth decay, however, is still the most common chronic disease of childhood. Untreated tooth decay in preschoolers can lead to severe pain,

decreased school performance, absenteeism, impaired speech development, poor eating habits and low selfesteem. With eighty percent of preventable tooth decay occurring in only 25 per cent of the population we need to concentrate our efforts on those families. We must educate not only the primary caregivers but also all of the people who touch their lives.

Since lack of dental care in children is not seen as life threatening, the cost of health care is rising, and state budgets are in crisis, prevention and care is viewed as optional. For every dollar spent on prevention in oral health care, $8 to $50 is saved in restorative and emergency treatment. Hence, the state initially saves money by cutting oral health care but in the long run spends more state dollars on restorative work as well as other health related issues.

Recently passed legislation allows dental hygienists who have been in practice at least three years and who are practicing in a public health setting to provide preventive services to children who are eligible for medical assistance without the supervision of a dentist. However, due to budget constraints, there are still barriers in place which prevent this program from being fully implemented. Hence, the access to prevention and care continues to hit roadblocks especially for Missouri's lowincome families.

Education—of families, pediatricians, teachers, childcare providers, social service agencies and all organizations that touch the lives of children—goes hand in hand with prevention. As discussed in the Surgeon General's report, oral health means much more than just healthy teeth; it is integral to general health. If we are to be successful in our mission to prevent oral disease, it is essential to distribute oral health information widely and to promote oral hygiene.

CURRENT ENVIRONMENT:

The Missouri DHSS Oral Health Program has provided dental outreach and education since its inception. In addition, there are several initiatives across the state working on prevention and education. The Missouri Coalition for Oral Health

EDUCATION & PREVENTION

GOAL:

Develop a comprehensive oral health prevention and education system

Preventing disease is imperative...

Access has targeted pregnant women and young children for their prevention campaign. Simple and informative brochures, to be distributed to families, were produced through a grant from the American Dental Association Health Foundation. With additional funding from the Missouri Head Start State Collaboration Office Show Me Your Smile! flipcharts are also available for use by child care providers, health professionals, social service staff and WIC agencies for one on one discussion with families.

The National Governor's Association Oral Health Policy Academy Team and the Missouri Department of Elementary and Secondary Education have joined forces to develop a stronger, broader oral health education component for all public schools in Missouri. Through their partnership they hope to provide a more uniform approach to oral health education by producing a well-planned, sequential oral health curriculum appropriate for all public schools.

Missouri Head Start hosted a Missouri oral health training conference in February 2002. In attendance were over 100 representatives from the various early childhood education agencies, county health departments, dentists, dental hygienists, and state agencies. There were numerous presentations

concerning oral health ranging from fluoride and nutrition to tooth decay and prevention. This is a great beginning, but we need to develop a system to insure that all of Missouri's early childhood agencies, health providers, and social service agencies get the necessary information and training.

Using partial funding from the DHSS Chart program, Dallas County created a "Bright Smiles" program to promote community wide oral health education. The Dental Health Educator visits the schools regularly presenting lessons on tooth brushing and oral hygiene. Children are encouraged to continue brushing at home but at-school brushing is viewed as a learning opportunity. Newsletters are sent home monthly with information on relevant topics such as fluoride levels throughout Dallas County.

Since Head Start Programs are mandated by their Federal Performance Standards to provide dental screenings, exams, prevention activities and restorative work, there are many creative programs providing the education and prevention strategies necessary to impact the oral health of their children. However, due to the barriers described elsewhere in this report, these programs have to work extremely hard to get the needed services.

RECOMMENDATIONS

• Secure state, federal or private funding for the following pilot projects:

o A state-wide public awareness campaign to distribute educational materials already developed.

o Continuing education programs for pediatricians and primary care providers (especially those providers working in current safety net settings) with information and training about oral health disease and prevention and improve oral health screening during primary care office visits.

o Secure funding to implement a

pilot that is modeled on the Access to Baby and Child Dentistry (ABCD) program in Spokane, Washington designed to identify and erase barriers to early preventative treatment for Medicaid eligible infants, toddlers, and preschoolers.

• Improve community water fluoridation. Even though the percentage (80.5%) of Missouri's fluoridated water supply is higher than the national average, there are still communities with unflouridated water.

SUMMARY

Tooth decay, the most common chronic disease of childhood is preventable. Today in America we have safe and effective disease prevention measures that everyone, regardless of age or income, can adopt to improve oral health and prevent disease. It is imperative that we employ these measures. However, until Missouri's legislators and citizens understand the impact good oral health care has on them individually and collectively; oral health dollars will continue to be cut. The solutions are simple—education, daily oral hygiene, regular dental visits, water fluoridation, good nutrition and a few behavior changes. Education is the most important initial step in initiating change. We must continue initiatives already in place and redouble our efforts to enlist the assistance of local, state and federal agencies to expand and support educational endeavors.

The Surgeon General's report on Oral Health notes that we must accelerate the building of the science and evidence base and apply science effectively to improve oral health. Vital to progress in this area is a better understanding of the etiology and distribution of disease. Epidemiologic and surveillance databases documenting oral health and disease, health services, utilization of care, and expenditures are limited or lacking at the national, state, and local level. Such data are essential in conducting health services

research, generating research hypotheses, planning and evaluation of programs, and identifying emerging public health problems. Further, in order to address the issue of primary oral health concern in our state, lack of access to care for Medicaid enrollees and the uninsured, data on issues having an impact on access and utilization, and financing, will be critically important.

The nation's health information system is under going transition to meet the current and future needs. Consequently, many factors influence how and what data are collected and analyzed. These factors include emerging technologies, legislation about how data are to be collected and confidentiality and privacy concerns. The need for epidemiologic and surveillance data change as the understanding of specific diseases and conditions evolves and as societies goals and priorities change. The increasing focus on the long-term benefits of disease prevention and health promotion and the need to close the gap on disparities also affects how and what data are collected.

The Department of Health and Human Services Healthy People 2010 has provided a framework for data collection and analysis tied to specific objectives and have helped identify needs for new health data systems. HP 2010 contains 17 specific objectives on oral health, one of which calls for an oral health surveillance system. It states the following: State and local dental programs have been

DATA & SURVEILLANCE GOAL:

Ensure adequate and appropriate information is available for effective policy decisions.

hampered severely in carrying out their programmatic activities to improve health because of a lack of Statespecific oral health data. The existence of surveillance systems within States to assess oral health needs is essential

for determining trends in oral diseases, implementing and evaluating interventions, and identifying where resources are required to improve oral health status. Surveillance systems are not just data collection systems, but involve at least (1) a timely communication of findings to responsible parties and to the public and (2) the use of data to initiate and evaluate public health measures to prevent and control diseases and conditions. An oral health surveillance system for a State should contain, at a minimum, a core set of measures that describe the status of important oral health conditions to serve as benchmarks for assessing progress in achieving good oral health.

For Missouri to move towards attaining the Healthy People 2010 objectives on oral health, and to address the issues noted in the Surgeon General's report, it must have a sustainable, effective, data driven system. We need this system in order to define priorities, enhance accountability, and continuously improve oral health programs. The rationale for developing an effective system to monitor and improve the performance is straightforward. Policy makers, program officials, and others need to know the magnitude and scope of oral health problems through out our state and over time in order to establish program priorities and effectively allocate resources. Information on progress or lack of progress is necessary to judge whether or not public expenditures are being used effectively. Finally, we need a strong data and surveillance system to determine our strategies to improve program performance, and most importantly to protect and improve the oral health of all Missourians.

RECOMMENDATIONS:

• Enhance the current oral health surveillance activities to provide county level oral health status data using the indicators for the ASTDD/CDC National Oral Health Surveillance System. Other enhancements should include data on sub groups of vulnerable populations such as Children with Special Health Care Needs, Seniors, and Medicaid enrollees.
• The HRSA GIS mapping project should be incorporated in the Oral Health Program web page and expanded and enhanced to include appropriate data items. Other data collected by state agencies such as but not limited to Oral and Pharyngeal cancer, the Youth Risk Factor Behavioral data, PRAMS, and hospital discharge data should be linked to or included in the Oral Health program web page.
• Serious attention should be given to strengthening and enhancing collaborative data collection and analysis between the DHSS Oral Health Program, and the Medicaid program specifically, and other providers, such as community and migrant health centers, schools, and other public service clinics. Although there have been various initiatives between DHSS and DMS, and data indicators have been in place for several years from the Quality Assurance and Improvement committee for the managed care area, to date, even the most rudimentary indicator; i.e. an unduplicated utilization rate is not available, nor is data on the other agreed upon indictors. This data is also not available for the fee-for-service areas of the state. Despite the fact that the lack of access to oral health care for Medicaid enrollees is well documented, and has been repeatedly high lighted as the most important oral health problem in our state, we still cannot accurately quantify and qualify the problem. In the

absence of this data, we cannot expect to implement effective solutions, and measure their impact on the problem.
• Develop a pilot program which assesses oral health screening in primary care settings (especially in the FQHC setting)

Effective policy decisions...

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PHOTOS

Used with permission from the West Central Missouri Community Action Agency and the University of Missouri Kansas City School of Dentistry.

Missouri is fortunate to have strong

commitment from among many concerned patients, organizations and agencies to support expanded access to dental care in the state. Volunteer programs, Federally Qualified Community Health Centers, dental providers, the UMKC School of Dentistry, the Missouri Department of Health and Senior Services, Head Start Programs, and local community members only scratch the surface of oral health access. The Oral Health safety net system provides the vast majority of dental care to low income and uninsured patients in Missouri. Expansion of the 1) safety net system, 2) the oral health workforce needed to staff the system, 3) the oral health education and outreach initiatives to educate communities, individuals, and providers on preventing oral diseases is necessary to improve access. Support for existing dental providers including an increase of the Medicaid reimbursement, and comprehensive oral health data surveillance is also required to improve access.

The Missouri Coalition for Oral Health Access intends to build upon current efforts to address the oral health access issues addressed in this plan. Continued leadership from Coalition members, State policy makers and dental providers and additional State, federal and private funding will be necessary to carry our efforts forward and to oversee the implementation of this long term plan.

Conclusion...

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ADMINISTERED BY THE
Missouri Primary Care Association
SUPPORTED BY THE
Missouri Department of Health and Senior Services
Office of Oral Health
Missouri Dental Association
University of Missouri, Kansas City, School of Dentistry
Missouri Head Start Collaboration
FUNDED BY THE
Missouri Primary Care Association
Department of Health and Human Services
Health Resources and Services Administration
Bureau of Primary Health Care