

CHAPTER 6 SUMMARY FINDINGS AND RECOMMENDATIONS

6.1 CONCLUSIONS AND FINDINGS

Oral health in the Appalachian Region is closely tied to the region's economic status. Following national trends, Appalachian communities with low economic status are more likely to have shortages of dental health providers. This affects everyone in the community. Dentists in these areas are at risk of higher case loads and a higher proportion of low-income or non-paying patients.

Nationwide, the number of dentists in general practice is inadequate to meet the population's need for care. The Appalachian Region has 36 percent fewer dentists per 100,000 population than the United States average. Retention of dentists in underserved areas is made difficult by low pay and high workloads. Recent state licensure board movements to increase scope of practice for non-dentist assistants and licensed dental hygienists offer hope for increased care access, but even an increase in work force cannot overcome the financial barriers associated with high dental care costs and low insurance coverage.

Medicaid and government employee programs are the only predictable sources of dental insurance benefits. Private insurers offer dental as an optional, additional policy but the coverage is often excluded from employer-provided benefits.

Oral health remains the primary health issue for children, and a major issue for adults. Oral health and physical health are directly associated with one another, and dental pain has been associated with poor school performance and low workplace productivity. Use of services nationally is directly associated with insurance coverage. Fluoridation of public water supplies can help strengthen community teeth, but not all of the population is served by public water sources. More rural populations are less likely to have community water.

Data on dental health services and dental health insurance coverage are limited to national interview surveys. Sampling frames are too small to support county or sub-regional analyses. Behavioral Risk Factor Surveillance System (BRFSS) samples are too small and too inconsistent for even an Appalachian Region-wide analysis.

Most of the data on oral health status is collected by probability sampled telephone interviews. Appalachian households without telephones have plagued research efforts for decades. The new phenomenon of eliminating land lines in favor of cell phones, many of which have temporary numbers, will present even more challenges to inferences drawn from these surveys.

6.2 IMPLICATIONS

Poor oral health will likely remain a problem throughout the United States, particularly in low income and rural areas. Consequently, the best public investments will be those aimed at coupling public awareness of good oral hygiene practices with well-being. Because oral health problems surface early in children, oral hygiene practices that begin in infancy and are reinforced at the family and community level are important. Investments in fluoridation can offset some but not all failures of oral hygiene.

Health reform resulting from the Patient Protection and Affordable Care Act of 2010 will expand state Medicaid program enrollment and increase state costs for the basic benefit packages (Lane, 2011). In this environment, there is little likelihood that states will be able to consider expanding benefits to increase dental coverage in the absence of other cost saving initiatives. Most of the new enrollees will be adults with low incomes, who are likely to have many years of accumulated dental care needs.

6.3 RECOMMENDATIONS

In order to monitor success of any initiatives, the Appalachian Regional Commission needs baseline information. ARC should issue a formal request to CDC to modify the BRFSS sampling procedure to develop a sample frame and consistent questions to provide year to year information about the Appalachian Region, and its sub-regions. A larger sample and consistent questions would provide independent feedback on the impact of state, federal and private initiatives to address oral health disparities in the Appalachian Region. This may take significant time to negotiate, because CDC relies on states to share funding for BRFSS surveys and permits each state to select or change the questions asked.

A systematic study of the economic costs of poor oral health might be helpful to policy makers who are considering ways to stabilize this important component of good community health. In the interim shared studies and anecdotes will be the primary sources of information for oral health improvement.

Similarly, collaboration among the ARC, Appalachian states, the Appalachian charitable foundations and the National Academy of State Health Policy to regularly support and convene the groups working on this important issue will help all of the investors to focus their limited resources on oral health investments, in the Appalachian Region, that are most likely to improve school performance and improve worker productivity. Particularly in the areas of non-dentist workforce deployment and engagement of the dental workforce that has committed to work and invest in the Appalachian Region, such collaborative effort may surface new ways to engage total communities in good oral hygiene. The task is too large for investments that focus on limited sectors.

ARC should work with Health Resource Services Administration and the National Health Service Corps to set specific goals for placing loan forgiveness and subsidized professionals with dental professionals who are committed to the Appalachian Region. These initiatives should occur with careful consideration to their impact on sustainability of these existing practices. ARC should build on the communications started at the Healthy Families, Healthy Future conference to provide a support network to the individuals and groups who are working with expanded practice for non-dentists.

Local initiatives focused on preventive interventions have made significant contributions. However, most require grant subsidies to be sustained. The grant program grantees should be supported in continued dialogue, to identify their common threads of sustainable initiatives.

6.4 AREAS FOR FURTHER STUDY

An Appalachian Region-wide study of oral health hygiene literacy and cultural practices that support or challenge it would help move from anecdotal information to evidence-based guidance for health investments. Similar benefits could accrue from careful study and documentation of the impact of communications campaigns similar to Kentucky's Healthy Smiles and Mississippi's community wide oral health programs. To assist with outcome measurement, CDC should be asked to tailor BRFSS sampling frames to produce annual survey information that can be attributed to the five Appalachian sub-regions: North, South, North Central, Central and South Central, and to the five rural-urban county types.

