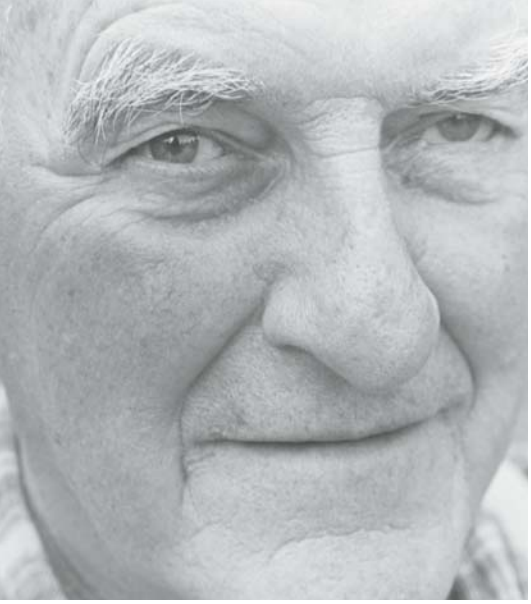
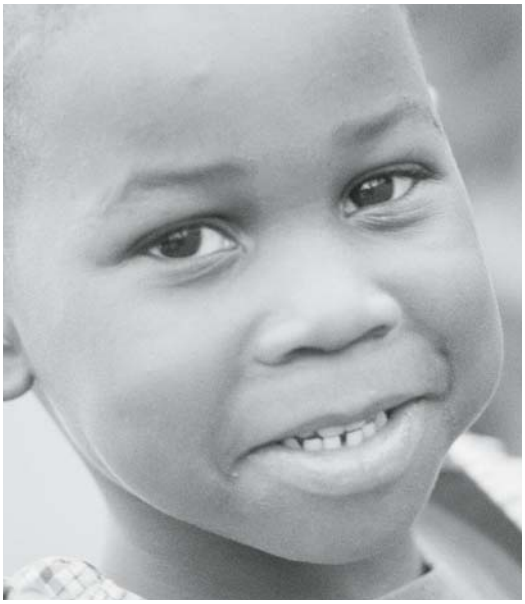


Kids and Dental Providers in Georgia: The Gap between Demand and Supply

prepared by

The Child Policy Initiative
of The Georgia Health Policy Center
Andrew Young School of Policy Studies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May 2001

Georgia Health Policy Center

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The Gap Between Demand and Supply

This report provides a snapshot of dental access for low-income children in Georgia. Our goal in presenting this information is threefold:

- Characterize the extent to which dental access issues differ in different parts of the state;
- Inform the development of strategies for improving access; and
- Provide a baseline to measure future progress.

We begin with a comparison of Georgia data for 1999 with the benchmarks and goals for oral health contained in Healthy People 2010. Following this introductory section we provide a detailed look at the demand for, and supply of, dental care for low-income children throughout Georgia and for each dental health district.

Demand As our measure of demand we report the number of low-income children, defined as children living in households with a family income below 200% of the Federal Poverty Level (FPL). This allows us to compare Georgia to the benchmarks and targets in Healthy People 2010, which also uses 200% FPL to define which children are "low-income". In 1999, 200% FPL was also the cut-off for PeachCare for Kids, Georgia's Children's Health Insurance Program (CHIP).

Next, we take a current measure of access to dental care among low-income children. We present data on the utilization of dental services by Medicaid- and PeachCare-enrolled children as a proxy for access to dental services by all low-income children. Children below 200% FPL and not enrolled in either Medicaid or PeachCare, may have private insurance, but are more likely uninsured and have limited, if any, access to dental care.[1]

Utilization of dental services is presented as the number (and percent) of children who received any dental service, preventive dental services, and restorative dental services. The percentage of children receiving preventive dental services can be thought of as a measure of the breadth of access to dental care, while the percentage of children receiving restorative dental care can be viewed as a measure of the depth of access.
Children may be receiving preventive services in settings such as schools, but not receiving the indicated follow-up care. Restorative services are not often provided in school settings because of the types of facilities required to provide those services. While it is important to offer screening and preventive services, ensuring access to restorative care for problems identified in the screening visit involves additional challenges. The parents must be involved to schedule and keep appointments, provide or arrange transportation to a fixed clinic or private dental provider, and arrange for time off from work, if necessary.

Because children often cycle on and off Medicaid rolls, we also show these data for children enrolled at least 6 months during the course of the year. Presumably, when a family is first

[1] No data are available for either uninsured or privately insured children.

enrolled in Medicaid, dental care is not their first priority. We chose to use six months enrollment for additional data points since 6 months is the recommended interval for preventive dental visits.

Supply As a measure of the supply of dental care resources, we report all known dental resources, and note those known to serve low-income children. For community health centers and county health departments we report the number that have dental clinics out of the total number in that district (or statewide). The only dental school in the state is included in the Augusta district and the 13 dental hygiene schools are shown in the districts in which they are located. These dental professions schools have teaching clinics that serve low-income children. We include the number of K-12 schools with dental programs, as well as the total number of these schools. Finally, the number of private practice dentists participating (nominally and actively[2]) in Medicaid is shown, along with the total number of licensed dentists. This last number overstates the number of private practice dentists potentially available for treating low-income children because it includes dentists who are not actively practicing.

We compiled the above data on a county basis, then grouped it by dental health district, and for the state as a whole. A map of the dental public health districts is shown in Appendix A.

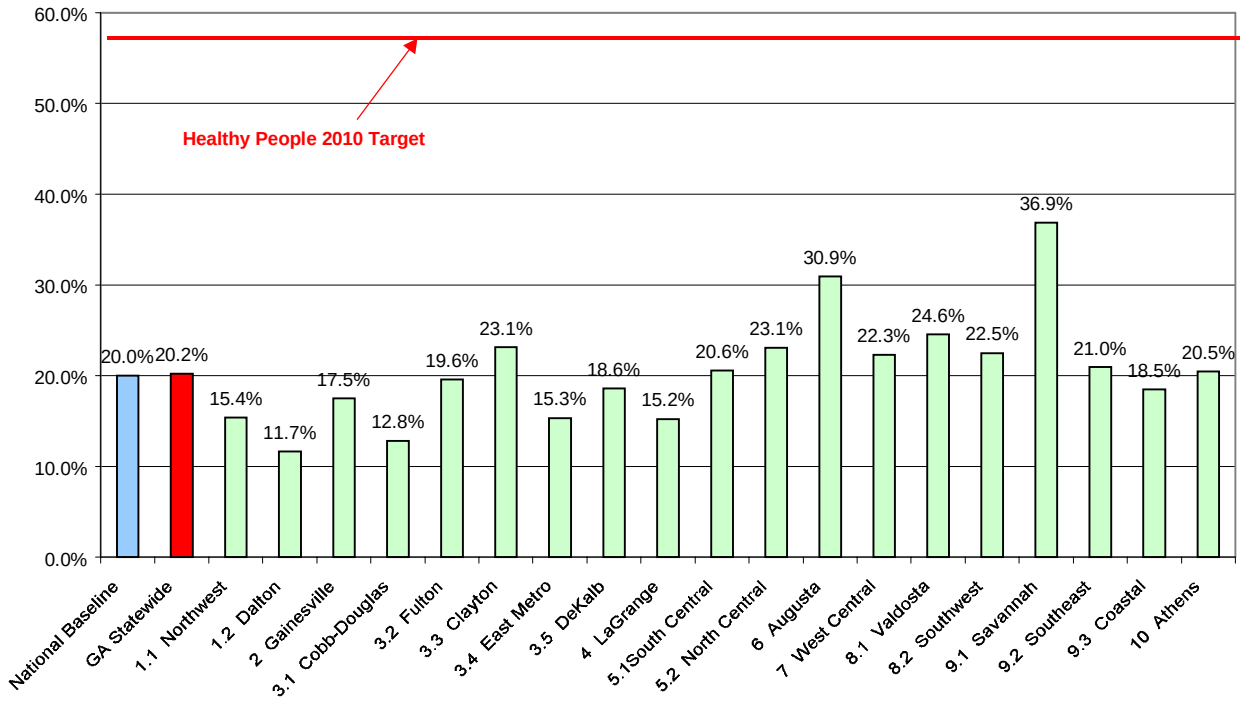
[2] Dentists participating nominally are those that have filed at least one claim during the calendar year. Those participating actively are those that average at least one Medicaid patient per week, or 52 or more claims during the year.

The Current Picture

To assess the current status of dental access for children throughout Georgia, we compared our state data with the national baselines and targets identified in Healthy People 2010.

Nationally, 20% of children under the age of 19 at or below 200% of the federal poverty level had a preventive dental visit in 1996. The Healthy People 2010 target for this population is 57%. Ten of Georgia's 19 dental public health districts exceeded the national baseline using data for children enrolled in Medicaid and PeachCare, but none approach the target. The statewide average was 20.2%. See Figure 1. These numbers overstate the accessibility of dental care for low-income children because uninsured children, who presumably have fewer dental visits than children enrolled in public insurance programs, were not included in either the numerator or denominator.

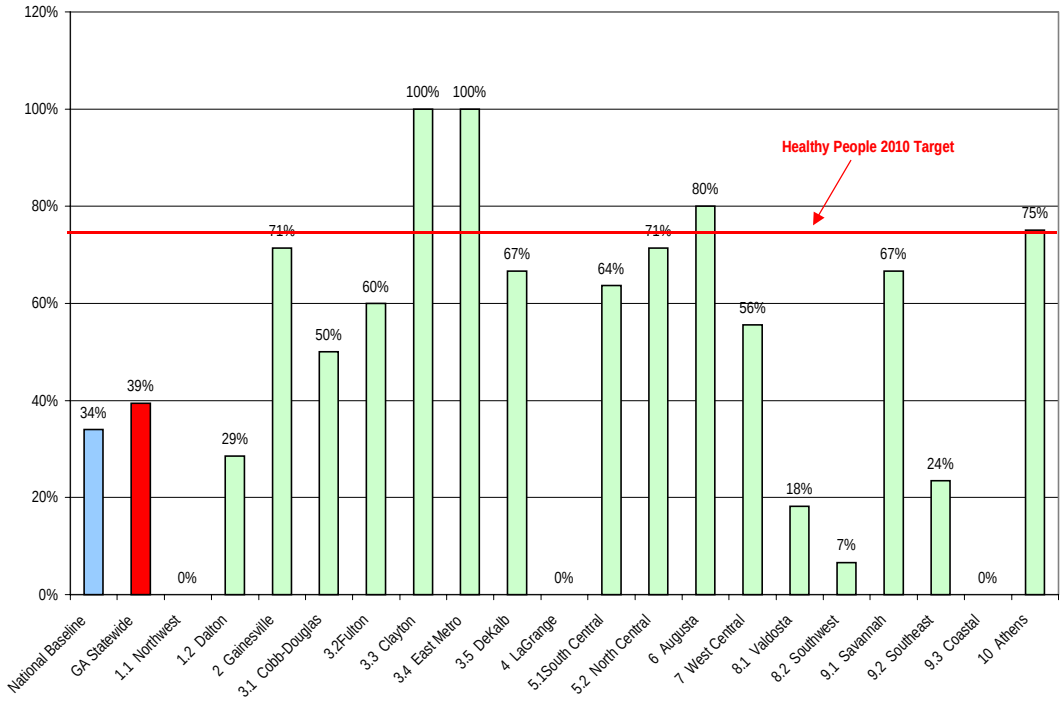
Figure 1
Percent of Children below 200% of the Federal Poverty Level
With At Least One Dental Visit*



Most of the state's low-income children are travelling out of their home county for dental care. The map below shows that in 84 of Georgia's counties, more than half of the Medicaid and PeachCare dental visits by children are with a provider in a different county. In 51 counties, over 75% of the visits are out of county. With the location of cities with a population over 10,000 added to the map it is clear, that in counties with a city, it is less likely that children will need to cross county lines to get dental care. However, in Ware, Colquitt, Whitfield, and Newton counties, more than 75% of the dental visits were made out of county, despite the location of a city within the county's borders.

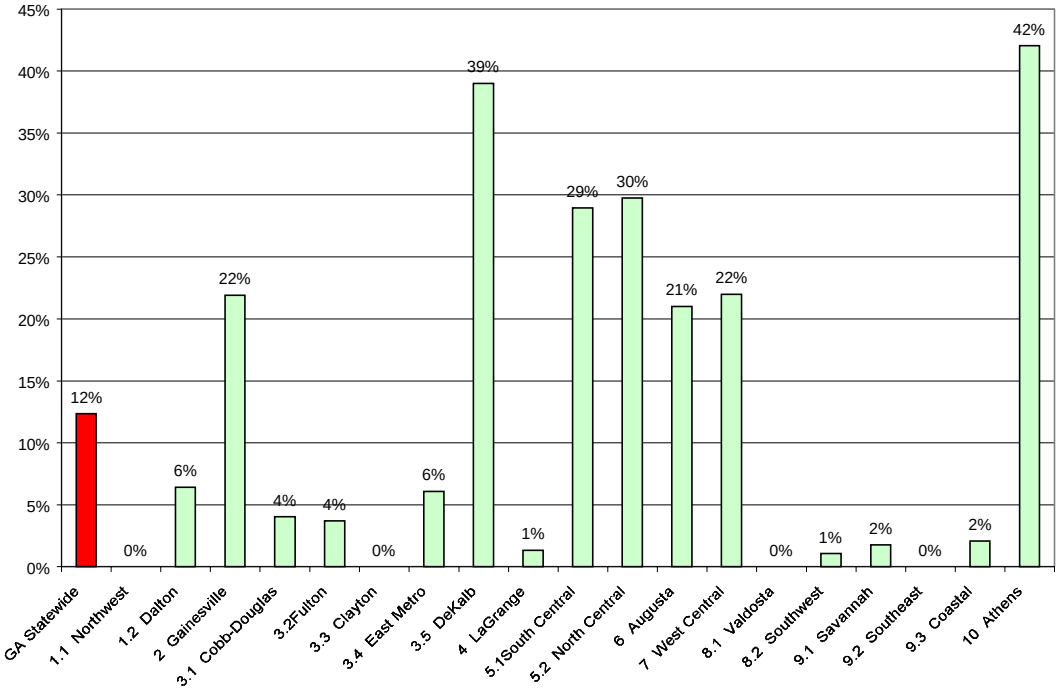
Thirty-nine percent of Georgia's county health departments and community health centers have dental services. In 1997, the national baseline was 34%. The Healthy People 2010 target is 75%. See Figure 2 for a breakdown by dental public health district.

Figure 2
Percent of County Health Departments and Community Health Centers with Dental Services



Healthy People 2010 discusses the potential of schools for improving health services access to vulnerable children. Increasing the proportion of school-based health centers with an oral health component is a developmental objective, meaning specific targets have not been set. Georgia has few school-based health centers, but school-based dental services are provided through the Oral Health Prevention Program of the Oral Health Section of the Department of Human Resources. Some county health departments in the metro area also provide school-based dental services. Twelve percent of Georgia's schools have a dental program of this type. See Figure 3 for the percentage of schools with dental programs in each dental public health district.

Figure 3
Percent of K-12 Schools with Dental Programs



Key to Terminology and Sources of Data:

The Shortage Area Designation section identifies those counties or populations that have been designated as having a shortage of dental health professionals by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The Shortage Area Type is whole (the whole county), low income (the low income population within the county) or area (a municipality, or part of a municipality).

The **total child population** county estimates are based on the U.S. Census Bureau's "Population Estimates for Counties By Age Group: July 1, 1999". The child population is defined as anyone under age 18.

The **Percentage of Children Below the Federal Poverty Level** county estimates are based on the U.S. Census Bureau's "County Estimates for People Under Age 18 in Poverty for Georgia: 1997".

Our source for **Enrolled Children** in PeachCare and Medicaid in 1999 is Electronic Data Systems, the Department of Community Health's contractor for compiling eligibility and claims records. An individual is considered "enrolled" if they were enrolled for any length of time during 1999. "Children" are all individuals under age 19 on January 1, 1999.

Children Enrolled at Least 6 Months come from the same source as **Enrolled Children**. This group was required to have at least 6 months of enrollment, rather than just any duration of enrollment.

The number of **Enrolled Children Who Received Dental Services** was calculated by examining the 1999 dental claims for PeachCare and Medicaid enrollees. Claims data came from Medstat. A dental claim is defined as a medical claim stored in the "Dental" portion of Medstat's claims database.

Preventive dental services are defined as dental claims with one of the following Georgia Specific Procedure Codes: D1120, D1110, D1203, D1351, D1510, D1515, D1525, D5550.

Restorative dental services are defined as dental claims with one of the following Georgia Specific Procedure Codes: D2110, D2120, D2130, D2131, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2380, D2381, D2382, D2385, D2386, D2387, D2751, D2920, D2930, D2931, D2932, D2940, D2950, D2951, D2970.

Community Health Centers are counted in the dental public health district in which they are located as well as in other districts, if their service area includes counties in other districts.

County health departments have either preventive dental services based in the schools, or a fixed clinic where preventive and restorative procedures may be performed. County health departments are included in the count if they provide either type of dental program.

Schools of dental hygiene are listed in the district in which they reside. No effort was made to identify the area from which the school draws students. For purposes of this directory, the relevant information is where they have physical facilities that may be used to treat low-income children.

The **K-12 schools** with dental programs were identified by the Oral Health Section.

The numbers of **Licensed Dentists** and **Licensed Dental Hygienists** in each district were determined using licensure and address information from the Georgia Board of Dentistry. Dental practitioners were located in a county based on the address listed on their license. It is important to note that dentists may or may not practice in the county or district where their license address is located. Additionally, some dentists may practice in more than one county or district.

The number of **Participating Dentists** is the number of dentists who participate in PeachCare and Medicaid and who also saw at least one PeachCare or Medicaid child in 1999. This excludes some dentists who participate in public programs but who did not see any enrolled children during that year. We chose this definition of participating dentists because some dentists who no longer practice in Georgia are likely still listed in Medicaid's dental provider database. Therefore, including everyone in their database would overestimate the available supply of dentists.

Dental Visits are defined as dental claims with a unique Internal Control Number (ICN).