

Access to Dental Care Snohomish County HPSA, 2007

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2007 HPSA Survey Results

In the spring of 2007, Snohomish Health District surveyed 330 Snohomish County dental practices to determine the amount of direct care provided by primary care dentists. The following summary highlights key findings about dental office capacity, population to provider ratios and availability of providers by payer.

Dental Care Capacity

- In 2007, there were 330 (unduplicated) primary care dentists that include pediatric dentists and FQHC staff. (303 in 2004)
- 280 surveys were received that met the HPSA provider criteria. (84.9% response rate)
 - The total FTE was 206.9 FTE including specialty care provided by the primary care dentists. Primary care FTE was 190.9 when specialty care was excluded. The reported FTE increased to 232.5 weighted by the number of auxiliary for the individual providers
 - For HPSA purposes, any specialty care (periodontics, oral surgery, endodontics, prosthodontics, orthodontics, etc.) is excluded)
- *Snohomish County does not meet criteria for a HPSA designation in 2007* for Snohomish county or for Snohomish County low income populations overall. The analysis was not of sufficient detail to determine sub populations or health planning areas.
 - There was one primary care dentist fte. for every 3581:1 (190.9 fte.)
 - After adjusting for availability of dental hygienists and dental assistants (HPSA adjustment), the ratio of population to providers improved to 2940:1
 - Ratios below 3000:1 are not considered a ‘shortage’ area for a general HPSA designation.
- *The gap in access to care for individuals with low incomes is improving in Snohomish County*
 - The ratio of low income individuals to a full-time dentist accepting low-income patients (<200% FPL) was 3768 : 1. In 2004, it was 4159:1
 - Ratios below 5000:1 are not considered a ‘shortage’ areas for a HPSA low income designations

Access to Care by Payer

- 21.4% of dentists accept new patient s with Medicaid coverage, mostly children
- *Only 3% of the dentists accept new adult Medicaid patients for routine care.*
- *FQHC’s see over half of all children (0-18 yrs) with Medicaid coverage.*

Children 0-18 years old with Medicaid coverage	2004	2007
Private Dentists	8661	7402
FQHC	8,066	9494

Access to Early Preventive Care

- 48.2% of dental providers recommend earlier preventive dental visits (54% in 2004)
 - 19.4% recommend age one or younger
 - *36.9% recommend starting at age 2 and younger (29.1% in 2004)*
 - 11.3 recommended under age 3

Wait Times

There is a slightly longer wait to get in for dental appointments

	2004	2007
Established patient	3 days	7.6 days
New patient	5 days	7 days

Background

The Office of Community and Rural Health, Washington State Department of Health works with local communities to survey primary care providers to assess eligibility for Health Professional Shortage Area (HPSA) status. While HPSA status is voluntary, it establishes eligibility for several federal assistance programs. These surveys are conducted on a three-year cycle. The survey includes questions such as:

- How much direct care is provided to patients?
- What are relative patient shares for privately insured, Medicaid¹ covered, and Sliding Fee Scale?
- Are specific primary care providers taking any new privately insured, Medicaid, or Sliding Fee Scale patients?

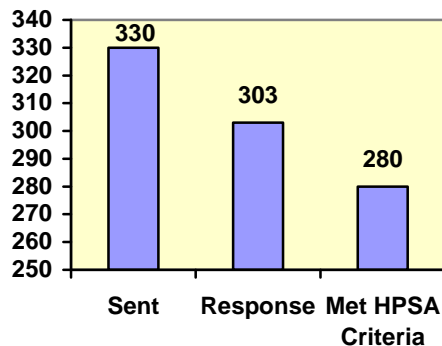
HPSA survey data offer a useful snapshot of access to dental care, but results should be interpreted with some care. Limitations of this survey data include:

- It covers only access to **primary care** dentists/pedodontists and their staff, dental hygienists and dentist assistants. Access to specialty care may be a concern if specialists are not accepting referral for Medicaid or Medicare patients. This in turn may be a factor influencing whether primary care dentists are willing to accept Medicaid patients.
- It is self-reported. Access may be lower than is reported here. The Office of Community and Rural Health compared self-reported Medicaid information from HPSA surveys to actual activity reported to the Medical Assistance Administration and found that some self-reports over-estimate Medicaid patient shares. When possible the survey is administered to the office manager who is often more aware of payment systems than are providers.
- Respondents were asked to provide an estimate of payer shares as 0%, under 5%, and then at 5% increments. This may introduce rounding bias. It is unclear which direction the bias may go.
- This study does not account for patients who travel into or outside the county for health care services. These border effects are likely to be particularly significant in southern Snohomish County areas bordering King County and Seattle. The magnitude of these effects is not yet known.

¹ See Appendix for definitions of Medicaid services, Basic Health, FQHC/Public Clinics

Methods

Response to Survey Snohomish County HPSA, 2007



The Snohomish County Health District compiled a list of all dental practices in Snohomish County and identified 330 primary care dentists that included 8 pediatric dental clinics. In the spring and summer of 2007, the business office of each dental practice was mailed or faxed a letter and survey with instructions. Non-responders were all contacted by telephone. 304 surveys were

The response rate for identified primary care dentists was 92.1% (304/330). After adjusting for inconsistencies, 280 of the returned surveys met the HPSA criteria for analysis, for an overall response rate of 84.9%

Methods to improve the response rate included;

- Faxing surveys to and from providers
- Abbreviated number of questions for late responders for HPSA specific questions
- Recording survey answers from phone interviews with office manager or front desk staff.

The Office of Rural and Community Health entered the data for the HPSA relevant information. The Snohomish Health District entered or collected secondary data for the county specific information

Snohomish County Profile

Snohomish County ranks 13th in size among Washington's 39 counties (2089 square miles) and is the 4th most densely populated. The county makes up the northern part of Seattle – Tacoma – Everett Metropolitan area. The county is a mix of older city areas and suburbs immediately north of Seattle, rapidly growing bedroom communities, and a few outlying areas such as Darrington that retain rural character. The population grew from 644,800 in 2004 and 683,655 in 2008. The county's largest industries are manufacturing (tied to Aerospace and the Everett Home Port), services, retail trade and local state and federal government¹. It is a largely urban/suburban county with 86% living within urbanized areas. Approximately two-thirds of the population is located in the Everett – Edmonds – Mill Creek area. The rest of population is located in the further suburbs of Monroe – Snohomish (10%), Marysville (12%), and Arlington-Stanwood (11%).

Language

The ability to obtain dental services depends upon the ability of a person to communicate with the dental office. The capacity of dental offices to provide services for those that speak a language other than English is one measure that can influence access to dental care. According to the US Census Bureau American Communities survey, the proportion of people that speak a language other than English is increasing in Snohomish County from 13.8% in 2004 to 15.7% in 2007.

Languages spoken in dental offices Snohomish County, 2007

Language	% County population	% Dentists by language spoken in office
English	84.3%	74.2% (66%-2004)
Other Language	15.7%	25.8% (34.0%-2004))

The most significant differences in oral health in Snohomish County are for those that speak a language other than English. (SMILE Survey, 2000, 2005).

Number of practices with linguistic capacity by HPA

The most common languages after English, in order, are Spanish, Russian/Eastern European, Asian and Arabic. Roughly 25.8% % of the 221 responding dentists reported that they, or a member of their staff, speak a language other than English. Since practices have multiple-language capacity; the number of languages spoken in practices may be greater than the number of dentists responding (duplicated). The number of dentists responding that they or their staff speaks a language other than English declined from 34% (2004) to 26.8% (2007)

Primary Care Dentists in Snohomish County, 2007



As of the summer of 2007, 280 primary care dentists provided 232.5 FTE of direct patient care. Direct patient care excludes specialty care and administrative time. It includes the number of auxiliary personnel that increases dentist productivity.

Adequate primary care dentist capacity is measured by the ratio of provider full-time equivalents to the population for HPSA shortage designations. This is a crude measure that is not adjusted for population treatment needs or provider productivity. While an ideal ratio/benchmark has not been determined for dental care in communities, there are three benchmarks used for federal designation as a shortage area:

HPSA Population to FTE Ratios

<3,000:1FTE	Not a federal shortage area
>3,000-5,000:1 FTE	Shortage area for federal designations
>5,000:1 FTE	Serious shortage area

Ratios of county population to dentist FTE by HPA

Snohomish County, 2007

HPSA	Population/ 1 FTE ²
Total Snohomish County	2940:1

Snohomish County did not meet the benchmark for the federal designation as a Health Professional Shortage Area (HPSA). The HPSA shortage designation ratio 2940:1 was less than 3,000 to 1.

This does not mean that there is or is not a shortage of dental services in Snohomish County. Information on dental treatment needs or dental provider productivity is not included in the HPSA survey analysis.

Snohomish County Population Census 2008	Pop to Provider Ratio 2007	(2004)
683655	2940:1 (232.5 FTE)	1903:1

² Adjusted for full time equivalent

Low-income population (<200% FPL*) to dentist FTE ratio by HPA
 Snohomish County, 2007

Total Snohomish County	3768 : 1
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* Federal Poverty Level

Snohomish County is at the stress level for the total Snohomish County low income population. Although this stress appears to be reduced when compared to the 4159:1 ratio found in 2004.

(Populations with over 3,000:1 is the federal level at which signs of stress may be felt. (FTEs that report accepting Medicaid or sliding scale are the HPSA measures for low-income capacity.)

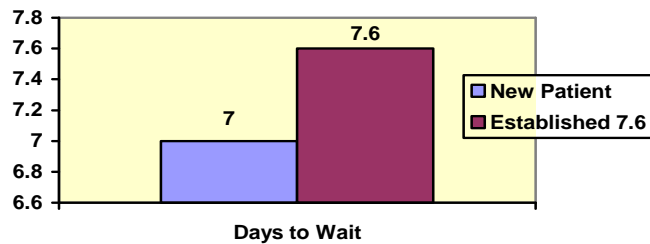
- Snohomish County low income populations meets the HPSA benchmark for a serious shortage area. (4,000:1)

ASAPS Pop 2004*	(HPSA reporting system)	Population to Provider Ratio 2007	2004
total pop 2004	649856	2795:1 (232.5 FTE)	
Res Civ 2004	644137	2770:1 (232.5 FTE)	
200%	117949 (18.3%)	3768:1 (31.3 FTE)	4159:1
100%	43991 (6.8%)		

*The Application Submission and Processing System (ASAPS) System Manager supports accurate data on the location of health care providers relative to the population. To this end, Office of Shortage Designation continually tries to obtain the latest data on health care providers and their practice location(s) at the lowest geographical level possible for use in the designation process, with the objective of minimizing the level of effort required on the part of States and communities seeking designations. The ASAPS 2004 data was the most comparable population data available for computing the HSPA designations.

Days until First Appointment for New Patients

Wait time (in days) for new patients to first appointment by clinic type
 Snohomish County, 2007



Wait times are an indication of access to dental care. Wait times have increased from 5 days to 7 days for a new patient and from 3 days to 7.6 days for an established patient when compared to 2004 .

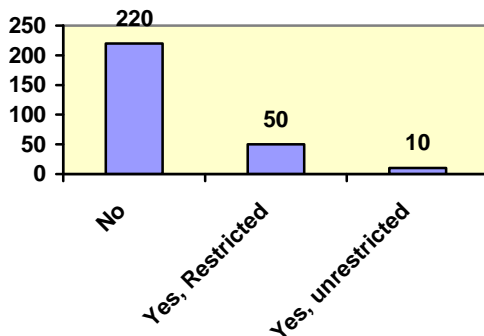
Capacity by Payer Source – Public, Private/Self-Pay

The Medical Assistance Administration pays dentists for select services for people that meet eligibility requirements that otherwise would be unable to afford dental care.³ Dental services covered by Medicaid programs are accepted in full without co-payments by the providers willing to accept Medicaid coverage. Typically, payment for services by the Medical Assistance Administration are less than payments by other insurance coverage or cash payments made directly from individuals. Private payers include third party payments and cash payments by patients. More dental services would be expected for those that are able to pay higher prices for dental care. Hence, it is not surprising that services are both less available and more restricted for those with Medicaid coverage.

Medicaid coverage is the safety net for those that find themselves unable to afford basic healthcare services. Medicaid coverage spans the gap between unemployment and employment, and therefore, access to employer-based dental benefits plans. One benefit of having a regular dental provider, as opposed to episodic dental care, is that dentists may be more likely to continue to provide dental care if life circumstances change.

New Patients

Dentists accepting new patients- those that accept Medicaid coverage Snohomish County, 2007

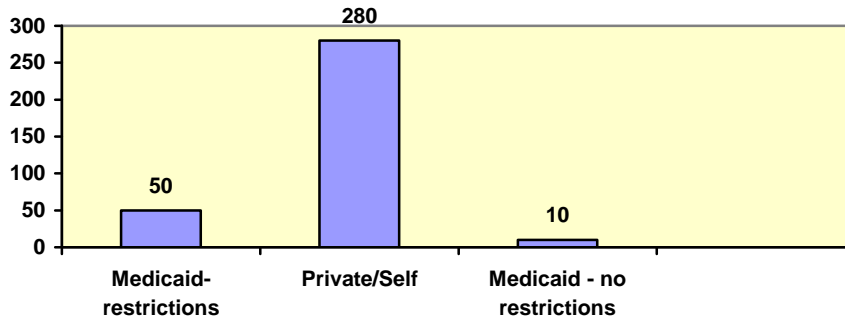


Medicaid coverage is accepted by few Snohomish County dentists (60/280). In contrast to privately insured patients, most providers are not accepting any new Medicaid patients.

³ See Appendix for definitions of Medicaid and Medicaid programs

Restrictions on Acceptance of New Patients

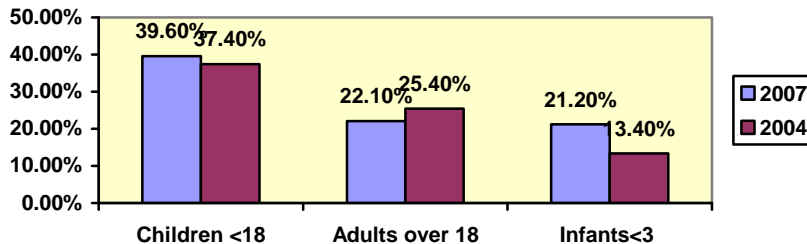
Dentist acceptance of new dental patients with no restrictions by payment type
Snohomish County HPSA, 2007



Only 60 dentists accepted Medicaid coverage (21.4%). The majority 50 (83.3%) were accepting some new patients, mostly children 0-18 years of age. When compared to 2004 (26.7%) there was a decrease in the proportion of dentists accepting Medicaid coverage. However, there was an increase from 3 providers (2004) to 10 providers identified that accept new patients with Medicaid coverage, without restriction.

Capacity

MAA dental utilization in Snohomish County for infants, children or adults
Medical Assistance Administration
FY 2007

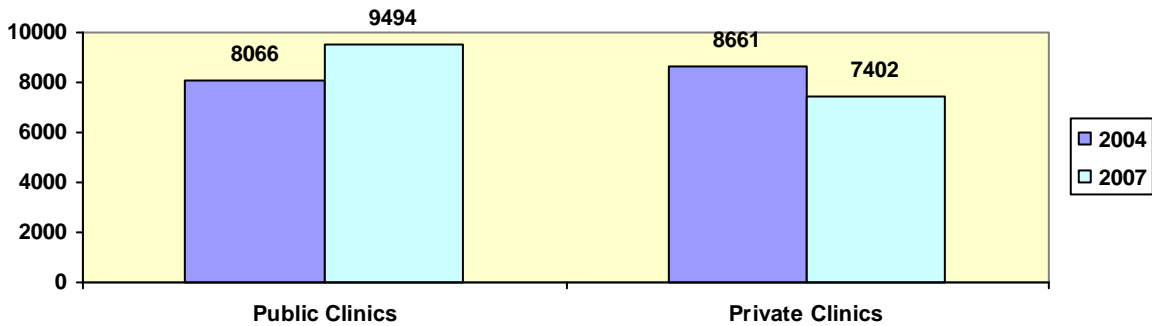


Capacity for adults with Medicaid coverage continues to decline as compared to children since 2004 in addition to the more stringent requirements for adults to be eligible for coverage. (from 25.4% to 22.1%) Less than one quarter of adults with Medicaid coverage received at least one dental visit in the last year while nearly 40% of children had a dental visit. Infant and toddler visits increased nearly 40% from 13.40% to 21.2%

Capacity for payment plans for uninsured/underinsured

People that do not have insurance or have limited/restricted dental coverage must pay for dental services out-of-pocket. Payment plans and sliding fee services increase opportunities for individuals to obtain dental treatment in a timely manner by extending payments over time. People with low incomes often do not qualify for bank loans or credit card services.

Children receiving at least one Medicaid dental service 0-18 years of age Medical Assistance Administration Fiscal Year 2007



Public clinics contributed 56.1% of Medicaid capacity (9494/16,896) for children 0-18 years old in 2007. This was a 14.3% increase from 2004.

In 2007, 39.6% of all Medicaid eligible children 18 years or younger received one or more dental visits.

More information is needed to determine if there is a difference in treatment needs between patients seen in public clinics and private dental offices

Pediatric Dentists in Snohomish County

There has been an increase from 5 to 8 pediatric dentists in Snohomish County. Three of the eight pediatric dentists accept new patients with Medicaid coverage, with two having restriction for children under age 6. Pediatric dentists are the primary dentist referral source for children with extensive or complex dental needs. The lack of pediatric dental resources for referral, for older children, children with behavioral issues, and children with special health care needs, may be an extenuating circumstance that prevents some dentists from participating in the Medicaid program.

How Has Snohomish County Medicaid Participation Changed?

Snohomish County Medicaid providers and patients under age 19 ⁴
MAA Fiscal Year, 2007

	Children seen per private provider	Children seen by public clinics	Dentists that saw at least one child
2000	60.8	5591	124
2001	59.7	6462	122
2002	69.3	7148	115
2003	72.7	7994	122
2004	75.3	8066	115
2007	72	9494	103
Change from 2004-2007	(4.4% decrease)	(15.0% increase)	(10% decrease)

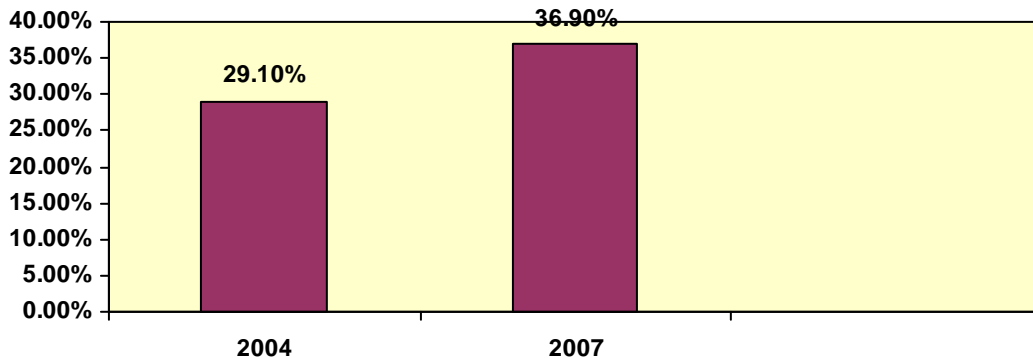
Similar to Washington State, Snohomish County dentists participating as Medicaid providers has been declining annually. The private dentists and public clinics that accept Medicaid coverage are treating more patients each year. Typically communities have seen slow erosion of provider capacity, not a massive flight.

⁴ Washington State Medicaid Dental Utilization, 0-18 year olds, fiscal years, Medical Assistance Administration, December 21st, 2007.

Early Dental Visits

Early identification of high risk children and referral for preventive oral health care by a dentist by age one is recommended by the American Academy of Pediatric Dentists, the American Dental Association and the American Academy of Pediatrics. For the April 2007 survey, we again asked the question, “What age do you recommend for a child’s first dental visit?”

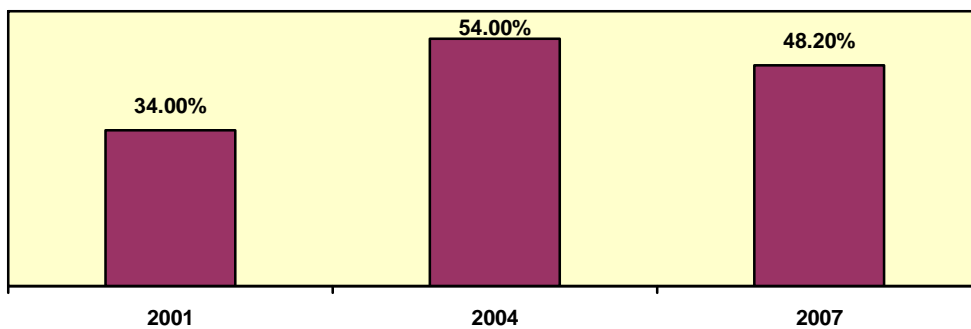
Age that first dental visits are recommended by dentists Snohomish County HPSA, 2007



The number of Snohomish County dental providers that advocate for early dental visits is increasing.

- 36.9% recommended less than age 2 for a first dental visit.
- 19.4% recommend age one or younger
- 11.3 recommended under age 3

Age three or under, for first dental visits as recommended by dentists Snohomish County HPSA, 2007



Standard dental practice has recommended that children begin dental visits at age three. New guidelines from the American Dental Association and the American Academy of Pediatric Dentistry indicate that age 3 is too late to prevent early childhood dental caries and recommend dental visits beginning at age one. The number of dental practices recommending dental visits beginning at age 1 is increasing. (29.1% to 36.9%)

Conclusions

Snohomish County as a whole does not have a serious access problem. Population growth, provider retirement and shrinking numbers of private Medicaid dental providers indicate that access will become more serious in the next 5-10 years, especially for those with lower incomes.

Disparities in the availability of care between those with higher and lower incomes appear to be easing with the establishment of the Federally Qualified Health Centers that contributed 56.1% of the capacity for children 0-18 years of age.

Medicaid coverage is not acceptable to a majority of Snohomish County dentists as payment for services.

Adult dental services have decreased as access to dental care for children has increased.

County and state discussion on improvements in dental coverage and expansion of dental coverage may improve access to dental care for all Snohomish County residents.

Dental disease is preventable. New research indicates that early detection and intervention, especially before age three, may have significant impacts on children's oral health. Dental sealants, another preventive strategy, reduce decay experience in the permanent teeth up to 75%.^{5 6}

⁵ Anderson M. Risk assessment and epidemiology of dental caries: review of the literature. *Pediatr Dent*. 2002 Sep-Oct;24(5):377-85.

⁶ Bader JD, Shugars DA The evidence supporting alternative management strategies for early occlusal caries and suspected occlusal dental caries *J Evid Based Dent Pract*. 2006 Mar; 6(1):91-100

Appendix: Overview of Medicaid, Basic Health and Federally Qualified Health Centers

This overview is extracted from the Introduction to Health Care Services section of the Health of Washington State, 2002 and updated in 2004ⁱⁱ and from the Federally Qualified Health Center Fact Sheet published by the Department of Health and Human Services

Medicaid This state-federal health insurance program for low-income people covered 950,000 Washington residents in Fiscal Year 2003. Medicaid primarily covers people currently and formerly on public assistance with family incomes within 200% of the federal poverty line, including Temporary Assistance to Needy Families (TANF), and people with disabilities. Children who are not eligible for TANF but have family incomes within 250% of the federal poverty line can enroll in Medicaid through the State Children's Health Insurance Program (SCHIP). About 29% of Medicaid payments are processed through Healthy Options; Washington's Medicaid managed care option. Welfare reform, which moved thousands of Washington families off public assistance, caused a 2.4% drop in Medicaid participation from 1997 to 1999. More recently, enrollment has been increasing as a result of the state's faltering economy, an increase in households unable to cover extraordinary health costs, and implementation of SCHIP. This increase has occurred despite difficult decisions to tighten eligibility criteria and shift non-residents from Medicaid to Basic Health. For a more detailed overview of Washington's Medicaid program see the Department of Social and Health Services 2003 report Facing the Future.

Basic Health (BH). The BH program is administered by the Washington State Health Care Authority to provide subsidized health insurance to low-income individuals who do not qualify for Medicaid. [I can't remember...Basic Health is either 200 FPL or 250 FPL] In 2000, more than 217,000 state residents received coverage through the BH program or Basic Health Plus (BHP), for Medicaid children enrolled in BH. Basic Health Plus includes dental coverage for children only. During the 1990s, the program offered Washington residents a chance to purchase unsubsidized insurance coverage through the BHP. This unsubsidized option is no longer offered, and fewer than 1,000 people remain under this coverage. Subsidized BH coverage was capped at 131,250 in 2000, and the cap was lowered to 125,000 in 2001.ⁱⁱⁱ An additional 56,000 children were enrolled in BHP in December 2001. With passage of Initiative 773 in 2001, funding was made available for an additional 20,000 to 30,000 BH enrollees. Subsequent legislation allowed this additional funding to be used to cover the costs of existing Basic Health members. Basic Health enrollment declined to 118,000 in 2003 and is still dropping.

Federally Qualified Health Centers (FQHC/Public Clinic/CHC) The FQHC benefit under Medicare was added effective October 1, 1991 when Section 1861(aa) of the Social Security Act was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are "safety net" providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. Medicare pays FQHCs an all-inclusive per visit amount based on reasonable costs. Payments are calculated, in general, by dividing the Center's total allowable cost by the total number of total visits for FQHC services.

ⁱ Full-Time and Part-Time Employment by Major Industry. Regional Economic Information System. Washington State University Cooperative Extension. May 2003.

ⁱⁱ Schueler V. Health care services. In *The Health of Washington State*. Olympia(WA): Washington Department of Health, forthcoming. Available June 2002 from: URL <http://www.doh.wa.gov/>

ⁱⁱⁱ The Urban Institute. *State responses to Budget Crisis in 2004: An Overview of Ten States - Overview and Case Studies*. State and local initiatives to enhance health coverage for the working uninsured. New York: Kaiser Family Foundation January 2004 Available from: URL: <http://www.kff.org/medicaid/7002.cfm>