



Oral Health Care in Rural America

BY ERIK SKINNER

In addition to their large, sparsely populated geographic areas, [rural communities](#) often confront unique social, demographic and regional differences that contribute to the challenge of achieving a robust and responsive oral health system. Rural areas have higher rates of poverty and a larger elderly population than non-rural areas, for example, and transportation to and from the dentist can be difficult for some rural residents. Rural communities also have higher rates of people covered by Medicaid and Medicare, according to the Centers for Medicare and Medicaid Services (CMS), making the limited number of [dentists who accept Medicaid](#) especially challenging.

Because fewer dentists practice in [rural communities](#), people living in them go to the dentist less and have higher rates of cavities than in urban

populations. This [lack of access to care](#) complicates efforts to address higher rates of tooth loss and dental decay in rural communities. The federal [Health Resources and Services Administration](#) (HRSA) quantifies provider-to-population imbalances by designating certain areas as health professional shortage areas (HPSAs).

Oral health is an indicator of overall health. Accordingly, some state and federal policymakers seeking to improve the health of their rural residents are considering a range of policy options to help address provider shortages.

State Action

State strategies to improve access to oral health care in rural areas include creating or supporting student recruitment and loan repayment programs, recognizing and regulating non-dentist oral health providers, and integrating oral health services with primary care and teledentistry.

Did You Know?

- Rural Americans are twice as likely to lose their adult teeth as their urban counterparts.
- Seventy-two percent of the country is classified as rural, but is home to only 15 percent of the population (46.2 million people).
- According to the [Pew Center on the States](#), rural residents are more likely to use emergency departments for their oral health needs because of a lack of dental insurance and a shortage of dental providers.

North Carolina uses loan repayment and targeted recruitment to encourage oral health providers to practice in rural areas. In June 2017, North Carolina adopted [Senate Bill 257](#), which requires the Office of Rural Health to use funds for loan repayment for medical, dental and psychiatric providers who practice in state hospitals, medically underserved communities or rural areas. [East Carolina University School of Dental Medicine](#) incorporates unique criteria in its recruitment strategy. The university accepts only in-state students, actively recruits from regions where access to health care is limited and favors candidates with a strong record of community involvement. It is also building Community Service Learning Centers that will immerse four-year students in the rural communities where they may work.

Some states have expanded their oral health workforce by permitting mid-level oral health providers to perform certain oral health services such as applying fluoride varnish in schools or oral health screenings in nursing homes. For example, some dentists have hired dental therapists—who might be compared to physician assistants—to expand their practice, accommodate additional patients and expand the dental workforce. At least [five state legislatures have authorized licensure for dental therapists](#). Maine, Minnesota and Vermont enacted legislation to recognize dental therapists, Washington’s tribal authority employs dental therapists on reservations and Oregon authorized dental therapists under a pilot program for its tribal communities. In June 2016, Vermont [Senate Bill 20](#) established the dental therapist profession, defined their scope of practice and authorized dentists to hire them.

Many states have explored supervision requirements for dental hygienists. [Georgia](#) recently became the 40th state to authorize dental hygienists under “direct access.” Direct access allows hygienists to initiate treatment and perform basic functions such as teeth cleanings in community settings such as schools and nursing homes without the supervision of a dentist. This often increases access to care for underserved populations.

At least [19 states](#) have adopted policies related to teledentistry—offering oral health services remotely. Such policies have established teledentistry by including it in overall telehealth legislation, authorized pilot programs to explore teledentistry or linked teledentistry to scope-of-practice legislation. The [policies](#) are wide-ranging and can cover services such as face-to-face consultation via video conference, sharing images and records among

providers and monitoring patients remotely. Teledentistry can also act as an educational tool for dental professionals.

Montana adopted teledentistry legislation ([SB129](#)), signed in March 2017, that requires insurers to cover teledentistry services if that same service would be covered in person. The language ensures that teledentistry services are subject to the same deductible, coinsurance and copayment provisions as the corresponding in-person service. The law also includes data privacy requirements and technology considerations.

Oregon adopted another strategy aimed at improving access and quality by integrating oral health into the traditional medical system. Oregon’s [House Bill 3650](#) in 2011 created a new payment and delivery structure called a coordinated care organization (CCO). [This approach differs](#) from most accountable care organizations (ACOs) by recognizing dental services, along with physical and behavioral health, as covered services and part of its vision for “whole-person care.” As this model evolves, evaluators will pursue [pilot programs](#) to reduce the cost of dental services in CCOs by integrating dental hygienists into primary care settings, providing enhanced dental services to people with diabetes, and increasing the development and use of teledentistry. Oregon continued its work to increase the presence of oral health in the CCO’s decision-making process in 2017 by passing [House Bill 2882](#). It requires a representative from one of the state’s dental care organizations to serve on the governing body of each CCO within the state. According to the [Oregon Health Authority](#), the act is part of an effort to increase the cross-agency awareness of oral health.

Federal Action

The federal government assists rural oral health programs in states through its [support of loan repayment or forgiveness programs](#) in underserved areas. Such programs support dentists and other oral health providers in all 50 states, the District of Columbia and Puerto Rico. Federal efforts to develop an adequate workforce include offering funding to providers and states, tracking loan forgiveness programs and providing application resources for interested providers. These activities allow policymakers and clinicians to identify the areas of greatest need and other geographic and demographic trends that can either improve or restrict access to oral health care in their state. [HRSA’s Oral Health Strategic Framework](#) provides a guide for states and includes a comprehensive list of strategies and federal partners.

Additional Resources

[NCSL, “Oral Health Care and Coverage During Pregnancy”](#)

[NCSL report, “Improving Lifetime Oral Health: Policy Options and Innovations”](#)

[NCSL report, “Oral Health: State Policy Options”](#)

[NCSL webpage, Children’s Oral Health](#)

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