



**ASSURING ADEQUATE
ORAL HEALTH FOR
ALL PENNSYLVANIANS**

NUMBER 3 IN THE SERIES

Disparities in Access to Oral Health Care: Pennsylvania Children

November 2006

PA Dental Hygienists' Association

P.O. Box 606
Mechanicsburg, PA 17055
pdha@verizon.net
717.766.0334 (voice)
717.766.4452 (fax)

www.PDHAonline.org



Disparities in Access to Oral Health Care: Pennsylvania Children

The White Paper Series “Assuring Adequate Oral Health for All Pennsylvanians” has been produced by the Pennsylvania Dental Hygienists’ Association (PDHA) to:

- Raise awareness of the disparities in access to preventive dental hygiene services in Pennsylvania.
- Document the potentially severe negative impact on the health and well-being of those affected.
- State the PDHA’s recommendation to reduce or eliminate barriers to access by amending sections of the Pennsylvania Dental Practice Act and the Professional and Vocational Standards that prohibit independent dental hygiene practice in public and private institutions.

“Disparities in Access to Oral Health Care: Pennsylvania Children” is Number Three in this series.

The bright, sweet smile of a child is a universally familiar and heart-warming vision. To our shame, however, thousands of children living in Pennsylvania don’t fit that image. Their teeth are discolored, decayed or even missing. They feel pain from toothaches — and from low self esteem. Often stigmatized because of their appearance, these children typically place a hand over their mouths when they smile, or clamp their lips shut.

The physical and emotional distress of our children is difficult to think about. Even more troubling, however, is the fact that most of the youngsters described above have dental problems because they *don’t* have access to adequate preventive dental care. As stated in “Status of Oral Health in Pennsylvania”, produced by the Pennsylvania Department of Health in May 2002, these children are most likely to:

- be living in poverty
- have a physical or developmental disability
- lack private dental insurance
- live in one of the 67 Federally-designated Dental Health Provider Shortage Areas (DHPSA) in Pennsylvania

Disparities in access to adequate dental health prevention and education services affect children in all parts of the Commonwealth and interfere with the “. . . healthy growth and positive educational, economic and social outcomes. . .” the U.S. Department of Health and Human Services attributes to “good dental care.”¹

Scope of the Problem:

“Dental care is the most common unmet treatment need in children.”²

The prevalence and severity of tooth decay in U.S. children has declined over the past several decades. The consequences of tooth decay, however, have not. “. . . untreated dental disease can lead to pain, infection and destruction of teeth, and surrounding tissues, with associated dysfunction. Untreated tooth decay may lead to delayed overall development among young children affected with severe forms of the disease.”³

“. . . more children are affected by dental decay than asthma. . .”

- Despite the fact that it is highly preventable through early and sustained home care and regular professional services, more than 18% of U.S. children two to four years of age have visually evident tooth decay.⁴
- Beyond the early stages, the decay process generally tends to advance and become more difficult and costly to reverse, the longer it remains untreated.⁵
- Cavities in the permanent teeth of children, once nearly universal, now appear in only 25 percent of the pediatric population; and roughly 80 percent of *all cavities in the permanent teeth of children* are concentrated in that small group of children.⁶
- This high-risk, high-prevalence, high-severity group, currently nearly 20 million nationwide, is largely comprised of low-income children.⁷

To provide the effective prevention and early intervention needed to assure adequate dental health for all children, the American Academy of Pediatric Dentistry recommends that primary pediatric oral health care be delivered in a “dental home” where “competent oral health care practitioners provide continuous and comprehensive services”.⁸

For many of Pennsylvania’s children their “dental home” is a public or private institution; the only preventive dental care and education they receive is provided by their schools, Head Start programs, public health care agencies, Federally Qualified Health Centers, (FQHC) and group residences for adjudicated delinquent youth and for those with developmental disabilities.

- According to the 2000 U.S. Census, children under the age of 19 make up approximately one-fourth of Pennsylvania’s population.⁹
- Thirty-six (36) percent of all children under age 19 living in Pennsylvania at the beginning of the 21st century lived in households where the income was at or below two hundred (200) percent of the federal poverty level.¹⁰
- According to former Pennsylvania Physician General, Dr. Robert Muscalus, more children are affected by dental decay than asthma.¹¹

- School nurses in Pennsylvania reported that they deal on average with one or two dental emergencies per week; but in certain schools, dental emergencies are a very serious problem, occurring at a rate of at least one per day.¹²
- Between 2002 and 2003 the number of Pennsylvania children eligible for dental care via Medicaid's Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) increased by 5.4 percent (from 116,473 to 122,833).¹³
- During 2003 the number of 3-5 year olds eligible for EPSDT in Pennsylvania was 122,833; 68.4 percent of those children (84,210) did not receive preventive dental services; during that same period 60.7 percent (nearly 75,000) did not receive dental services of any type.¹⁴

Children with Disabilities:

During 2003 nearly 75,000 of the 3-5 year olds eligible for EPSDT did not receive dental services of any type.

The National Maternal and Child Oral Health Resource Centers describes children with disabilities as “. . . those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type and amount beyond that required by children generally”.¹⁵

This inclusive definition is critical to an understanding of the broad application of the term, which includes but is not limited to children who are blind or visually impaired; deaf or hearing impaired; have mental retardation or related developmental disabilities; have cerebral palsy, spina bifida, cancer, heart disease or muscular dystrophy.

Oral health problems are among some of the more significant secondary health conditions that contribute to the compounding difficulties faced by children with mental retardation and other disabilities. When the dental health care needs of these children are overlooked or neglected, the results can be devastating:

- Of the 37 million people with disabilities nationally, 35 million are ambulatory, and oral health is among their most neglected needs.¹⁶
- Extremely high incidence rates of periodontal disease is reported in individuals with Down Syndrome, the result of a compromised immune system with a corresponding decrease in the number of T cells characteristic of most individuals with Down Syndrome.¹⁷
- Genetic disorders or very high fevers can cause weakened enamel, which makes the enamel prone to cavity development in children with disabilities.¹⁸
- Increased dental decay is commonplace. . . because many medications have a high sucrose content. . . and. . . some children with disabilities are also restricted to soft diets and do not have the abrasive particles to help remove food and plaque.¹⁹

Children in Rural Communities:

According to The Center for Rural Pennsylvania (CRP), a legislative agency of the Pennsylvania General Assembly, “Dental access for low-income populations in rural Pennsylvania can be described in one word: insufficient”.²⁰ Research sponsored by the CRC found a number of barriers confronting access to dental care for children living in rural communities:

- The need for dental services far exceeds supply in many rural areas of the Commonwealth.²¹
- Rural residents who cannot afford dental care just do without it; this is then “interpreted as insufficient demand”.²²
- Dentists who are practicing in rural areas are generating sufficient case-loads from paying and privately insured patients and do not enroll as Medicaid Providers.²³
- Since dentist participation rates in the fee-for-service MA programs are low, dental service rates among the indigent population are much lower than those of the general population.²⁴
- Public school and Head Start screening programs may be the only contact many students have with oral health care providers.²⁵

Large numbers of Pennsylvania’s children have “little or no useful dental care access.”

When rural residents can find dental services, they often also find *other* barriers to access such as limited appointment schedules, inconvenient and unreliable transportation, and excessive wait times.

Children who are Uninsured or Underinsured:

Large numbers of Pennsylvania’s children have “little or no useful dental care access” as the direct result of financial barriers: the cost of dental insurance premiums are simply beyond the means of their families.²⁶ Many low-wage earners, often referred to as “the working poor,” earn too much to qualify for Medicaid but too little to afford dental care or even the most modest insurance premiums available for dental care. Vast numbers of other Pennsylvanians work for employers who provide health benefits that do not include dental coverage (perpetuating the myth that dental care is a luxury and not essential to good health).

Medicaid, the nation’s major public health insurance program for low-income Americans, is a particularly important source of coverage for low-income children, covering over sixty (60) percent of all poor children.²⁷ Through a benefit known as **Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)**, Medicaid has proved critical to improving the health of our nation’s low-income children, including children with disabilities and other special needs.



In December, 1992, Pennsylvania enacted House Bill 20 (HB 20), which created the **Children’s Health Insurance Program (CHIP)**. It was, at that time, a one-of-a-kind program designed to provide insurance coverage to children whose families earn too much to qualify for Medical Assistance (Medicaid) — but who could not afford to purchase private insurance.

Pennsylvania’s CHIP program would later serve as the model for the Federal **State Children’s Health Insurance Program (SCHIP)** enacted in 1997 in an effort to build on Medicaid to provide insurance coverage to uninsured, low-income children above Medicaid income eligibility thresholds.²⁸

In Pennsylvania, about one-third of the state’s 3.3 million children are insured through public-insurance programs:

- For fiscal year 2005-2006, the Office of Medical Assistance Programs (OMAP) reports 962,727 children were enrolled in the Commonwealth’s Medical Assistance Program.²⁹
- As of June 2006, Pennsylvania had enrolled 143,501 in CHIP, the highest number ever, but about 133,500 children in the state are without coverage — though most are eligible.³⁰

But even for those children who are eligible, Medicaid and Pennsylvania’s CHIP have not been able to fill the gap in providing dental care. The Pennsylvania Department of Insurance estimates that for children under 19:

- 133,500 have no medical insurance
- 56,300 are Medicaid-eligible
- 34,700 are CHIP-eligible
- 25,500 are not eligible for public insurance ³¹

In addition, working parents in Pennsylvania cannot enroll their children in CHIP if the children are covered by employer-provided health insurance, no matter how limited or inadequate the coverage; and it is not possible to enroll or purchase CHIP insurance for dental care only.

“... about one-third of the state’s 3.3 million children are insured through public insurance programs.”

Access Issues:

- **Shortage of dentists** — Children form a significant proportion of the 1.5 million Pennsylvanians currently living in a Federally-designated DHPSA. The U.S. Department of Health and Human Services identifies an area as a DHPSA based on: (1) a population to general practice dentist ratio of 5,000:1; and (2) lack of access to dental care in surrounding areas because of distance, overutilization, or access barriers. Because of these shortages, schools, Head Start programs, and other public and private institutions often have difficulty complying with state and Federal mandates to meet the preventive dental hygiene needs of the children under their care.³²
- **Shortage of dental health Medicaid Providers** — Of Pennsylvania's 67 DHPSA's described above, eighty (80) percent are categorized as a "Special Population" DHPSA, meaning that the impact of the shortage is intensified by the shortage of dentists in the area who will treat low-income patients, especially those on Medicaid.³³

The Pennsylvania Department of Public Welfare (DPW), Office of Medical Assistance Programs reports only forty (40) percent of all licensed dentists in Pennsylvania are enrolled as Medicaid Providers; of those enrolled only fifty-four (54) percent actually participate in the program; and approximately fifty (50) percent of those enrolled and participating provide ninety-nine (99) percent of all dental services rendered to Medicaid recipients.³⁴
- **Pennsylvania dental hygienists are not recognized as Medicaid Providers** — While Pennsylvania's State Medicaid Plan does provide for dental services for children, the Office of Medical Assistance Programs (OMAP) does not include "dental hygienist" as an authorized Provider Type. Without this designation, dental hygienists providing services at any public or private institution cannot be directly compensated.³⁵
- **Requirements for supervision of dental hygienists providing services in public and private institutions in Pennsylvania** — The Pennsylvania Code section governing professional and vocational standards currently requires that dental hygienists engaged in professional practice in public and private institutions may do so only under the supervision or authorization of a dentist.³⁶

The U.S. Department of Health and Human Services identifies an area as a DHPSA based on . . .
" a population to general practice ratio of 5,000:1."



Response of the Pennsylvania Dental Hygienists' Association (PDHA)

The profession of dental hygiene was established in 1923 as a school-based profession emphasizing preventive services and education and has, over time, moved towards practice in the private sector, most often in a private dental office. There is clearly a need for high quality dental hygiene care in both settings. Increasing the opportunities for those dental hygienists who do wish to provide their professional services in an institutional setting, however, will go a long way in improving access to services for Pennsylvania children who are barred by their circumstances from receiving dental care in a private dental office.

“... an appropriate and truly functional ‘dental home’ can be located in a public or private institution. . .”

Here in Pennsylvania, the number and the proportion of the overall population of children eligible to receive preventive dental hygiene services in a public or private institution is projected to increase substantially within the next five to ten years. During this same period, the number of dentists licensed to practice is expected to decrease markedly. During 2001 there were 8,331 licensed dentists in Pennsylvania; in 2005 that number had dropped to 7,850 — a decline of nearly 6 percent.³⁷ This means that access to preventive dental care will become increasingly difficult as the number of children receiving dental care via public and private institutions increases at the same time as the number of dentists licensed to practice in the Commonwealth decreases.

Our legislation and regulations requiring direct or general supervision by a licensed dentist block professional dental hygienists from providing greater levels of preventive dental health care for children throughout Pennsylvania. They create unreasonable barriers for public and private institutions that can't provide preventive dental hygiene services because they have difficulty attracting dentists who are willing to authorize or supervise the work of professional dental hygienists.

By acknowledging the fact that an appropriate and truly functional “dental home” can be located in a public or private institution as well as a private dental practice, dental health care professionals and legislators in Pennsylvania can work together to assure that structured, consistent preventive treatment and education is the norm for all of Pennsylvania's children.

Current Requirement for Supervision:

“A dental hygienist is one who is legally licensed as such by the State Board of Dentistry to perform those educational, preventive and therapeutic services and procedures that licensed dental hygienists are educated to perform.

Such assignments shall be under the supervision of a licensed dentist.” Act 216, Section 2³⁸

“... ‘general supervision’... can even mean ‘a single authorization applying to one or more classes or categories of students or patients.’”

Pennsylvania’s requirement for “general” supervision of dental hygienists has actually evolved into a de facto form of independent practice for many dental hygienists who currently work in public and private institutions. Dentists providing general supervision, which may be off-site and “remote,” are not required to have any form of direct contact — phone, correspondence or person to person — with the dental hygienists they are supervising at any time before or after the dental hygiene procedures are completed. Common practice throughout the Commonwealth is for school districts, Head Start programs and other public and private institutions that are mandated to provide dental services to meet the letter of the law by arranging for “standing orders” and/or general supervision. When the term “general supervision” is broadly defined by the authorizing dentist and the institution, it can even mean “a single authorization applying to one or more classes or categories of students or patients”.³⁹

Current Scope of Practice:

A dental hygienist may offer to perform or perform services that involve:

- Periodontal probing, scaling, root planing, polishing or another procedure required to remove calculus deposits, accretions, excess or flash restorative materials and stains from the exposed surfaces of the teeth.
- Evaluation of the patient to collect data to identify dental hygiene care needs.
- Application of fluorides and other recognized topical agents for the prevention of oral diseases.
- Conditioning of the teeth for, and application of, sealants.
- Taking of impressions of the teeth.⁴⁰

Recommendations:

To address the growing need for preventive dental care for children and the disparities in access for those living in poverty, those with disabilities, those living in rural areas or an institutional setting, as well as those who are uninsured, PDHA recommends amending the Pennsylvania Dental Practice Act (Act 216) as follows:

1. Eliminate the requirement for supervision by a licensed dentist for dental hygienists practicing in a public setting.
2. Define facilities where dental hygienists may practice without supervision by a dentist as *public or private institutions*, such as schools, hospitals, birth centers, public health care agencies, Federally Qualified Health Centers, Head Start programs, long-term care facilities, assisted living facilities, personal care homes, hospices, nursing homes, nursing facilities, and group residences for juveniles, the elderly and those with developmental disabilities.
3. Eliminate the requirement that radiographs be performed only under the direct supervision of a licensed dentist.
4. Eliminate the requirement for employment by a licensed dentist in order for dental hygienists to perform the intra-oral procedures dental hygienists have been educated to perform and which require their professional competence and skill but which do not require the professional competence and skill of a dentist.
5. Add requirements for documentation of personal dental hygiene malpractice insurance and a minimum of 1800 hours of supervised experience before being able to practice independently in public and private institutions.

These proposed changes are related to supervision of dental hygienists practicing in public or private institutions only; they would not expand the scope of practice for dental hygienists or impact supervision requirements related to practice in any private setting, such as a dental office.

The recommendations of the PDHA would remove the impediments of access to, and availability of, preventive dental health care for *all Pennsylvanians* by permitting dental hygienists to independently perform activities within their scope of practice in a public setting; they would preserve the current structure for dental health care delivery, with dentists providing services requiring advanced skills and competencies. They would reduce the need for unnecessary referrals to dentists in an already overburdened system by providing for direct prevention and early intervention by licensed dental hygienists. They would provide an efficient, cost-effective triage system for dental patients, helping to assure the prudent use of an increasingly limited dental workforce (and public dollars), and prioritizing those in need of urgent care for immediate treatment and referral.



Potential Impact of Recommended Amendment:

In states where legislation has been adopted to permit dental hygienists to practice without supervision in public settings, preliminary studies indicate profound positive outcomes related to access and utilization of oral health care by those groups previously identified as un- or underserved. The American Dental Hygienists' Association (ADHA) has documented a significant increase in "the measured effect on access to care" for underserved populations in Connecticut, Maine, Missouri, New Mexico, Nevada and Washington, following a change from restrictive practice requirements in those states.⁴¹

In June 2002, ADHA Executive Director Stanley B. Peck offered written testimony to the U.S. Senate Committee on Health, Education, Labor and Pensions, documenting changes in California, Washington, Oregon, Colorado, Connecticut, Missouri and Maine which designated dental hygienists as Medicaid providers, with a resulting increase in "access to much needed Medicaid oral health services."⁴²

Proposed Legislation

New bipartisan legislation was introduced during the 2005-2006 session of the Pennsylvania legislature to improve access to dental hygiene in public and private institutions.

Senate Bill 1010 was introduced by Senators Pat Vance (R-Cumberland) and Lisa Boscola (D-Northumberland), who cite their concerns that schools, nursing homes and other public institutions cannot access essential dental hygiene services because of the difficulty in obtaining the necessary supervision — even when the law requires them to provide those services. SB 1010 was referred to the Senate Consumer Protection and Professional Licensure Committee.

In the House, Representatives Steve Nickol (R-Adams) and Louise Bishop (D-Philadelphia) introduced HB 2200 in order to allow dental hygienists to provide their services in public and private institutions — and to open the door to better access to preventive dental health care for *all Pennsylvanians*. HB 2200 was referred to the House Professional Licensure Committee.



Relevant Legislation and Regulations

Pennsylvania Act 216 — State Board of Dentistry
Section 2, Definitions.

Professional and Vocational Standards — Pennsylvania Code Title 49.
Chapter 33. State Board of Dentistry
Section 33.205. Practice as a Dental Hygienist; Section 33.211.
Unprofessional Conduct.

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) —
EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and provides for periodic screening, vision, dental and hearing services for children covered by Medicaid. The law as amended requires that dental services (including initial direct referral to a dentist) conform to the state periodicity schedule, which must be established after consultation with recognized dental organizations involved in child health care.

State Children's Health Insurance Program (SCHIP) — Social Security Act. Title XXI. 1997
Enacted as part of the Balanced Budget Act of 1997, SCHIP builds on Medicaid to provide insurance coverage to uninsured, low-income children above Medicaid income eligibility thresholds.

Public Performance Standards for Operating Head Start Programs — Title 45. Public Welfare. Chapter XIII. Part 1304(a)(ii), Office of Human Development Services of the U.S. Department of Health and Human Services
Requires all Head Start programs to obtain within 90 days of a child's first entry into the program a determination as to whether each child is up to date on a schedule of appropriate preventive and primary health care — including dental health; and to determine each child's current dental health status.

Children's Health Insurance Act — HB 20. 1992
Established Pennsylvania's Children's Health Insurance Program (CHIP), separate from Medicaid, with a more limited health insurance role. Pennsylvania's CHIP program is funded by the Federal government, the state's General Fund, and by a tax on cigarettes sold in Pennsylvania. Dental benefits are provided through a DPW contract with a private insurer, United Concordia, and must be provided by a participating United Concordia dentist.

Schools Public — Pennsylvania Code. Chapter 23. School Health. Section 23.3
Requires dental examinations on original entry into school and in grades three and seven.



Group Homes — Pennsylvania Code. Chapter 6400. Community Homes for Individuals with Mental Retardation. Section 6400.142. Dental Care

States that an individual 17 years of age or younger shall have a dental examination performed by a licensed dentist semi-annually; an individual 18 years of age or older shall have a dental examination performed by a licensed dentist annually; and that an individual shall have a written plan for dental hygiene, unless the interdisciplinary team has documented in writing that the individual has achieved dental hygiene independence.

Youth Development Centers (YDC) and Youth Forestry Camps (YFC) — Pennsylvania Code. Chapter 3680. Administration and Operation of a Children and Youth Social Service Agency. Section 3680.51. Health, Medical and Dental Care.

Requires each YDC and YFC to have written policies and procedures governing the provision of health, medical and dental care. The full range of health care that must be provided to all youth includes vision, hearing and dental screens.



End Notes

- 1 U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: National Institute of Dental and Craniofacial Research, National Institute of Health, 2000.
- 2 Newachek PW, Hughes, DC, Hung YY, Wong S, Stoddard JJ. "The Unmet Health Needs of America's Children." *Pediatrics* 2000; 105: 989-99.
- 3 U.S. Department of Health and Human Services. *Guide to Children's Dental Care in Medicaid*. Rockville, MD: Centers for Medicare and Medicaid Services, October 2004. 2 -3.
- 4 Vargas C, Crall J, Schneider D. "Sociodemographic Distribution of Dental Caries: National Health and Nutrition Examination Survey III (NHNES), 1988-1994." *J Am Dent Assoc.* 1998; 129: 1229-1238.
- 5 U.S. Department of Health and Human Services. *Guide to Children's Dental Care in Medicaid*. Rockville, MD: Centers for Medicare and Medicaid Services, October 2004. 1-3.
- 6 Kaste LM, Selwitz RH, Oldakowski RJ, Brunelle JA, Winn DM, Brown LT. "Coronal Cavities in the Primary and Permanent Dentition of Children and Adolescents 1-17 Years of Age: United States, 1988-1991." *J Dent Res.* February 1996; 75 Spec No: 631-41.
- 7 Vargas C, Crall J, Schneider D. "Sociodemographic Distribution of Dental Caries: National Health and Nutrition Examination Survey III (NHNES), 1988-1994." *J Am Dent Assoc.* 1998; 129: 1229-1238.
- 8 U.S. Department of Health and Human Services. *Guide to Children's Dental Care in Medicaid*. Rockville, MD: Centers for Medicare and Medicaid Services, October 2004. 4-5.
- 9 Pennsylvania Department of Health (May 2002). *Oral Health Strategic Plan for Pennsylvania.* 2-3.
- 10 Ibid.
- 11 Pennsylvania Department of Public Welfare. "Dental Information for Stakeholders and Advocates." www.dpw.state.pa.us/Business/003674869.html.
- 12 Pennsylvania Department of Health (May 2002). *Oral Health Strategic Plan for Pennsylvania.* 23-24.
- 13 U.S. Department of Health and Human Services. Centers for Medicare and Medicaid Services. *Pennsylvania Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Annual Report.* 2002. 76.



- 14 Ibid.
- 15 Pennsylvania Department of Health (May 2002). *Oral Health Strategic Plan for Pennsylvania*. 46-47.
- 16 Academy of General Dentistry. "Special Dental Patients Require Special Care." www.agd.org/consumer/topics/decay/disabilities.asp
- 17 Shapira J et al. "Caries Level, Streptococcus Mutans Counts, Salivary pH and Periodontal Treatment Needs of Adult Down Syndrome Patients." *Special Care Dentist*. 1991. 11: 248-51.
- 18 Margolis, Fred DDS. President, Illinois Foundation of Dentistry for the Handicapped. "Special Dental Patients Require Special Care." Academy of General Dentistry. www.agd.org/consumer/topics/decay/disabilities.asp
- 19 Ibid.
- 20 The Center for Rural Pennsylvania. *CRP Newsletter May/June 2004*. www.ruralpa.org.news0504.html.
- 21 Miller, Rep. Sheila. Chairman's Message. The Center for Rural Pennsylvania. *CRP Newsletter May/June 2004*. www.ruralpa.org.news0504.html.
- 22 Ibid.
- 23 Davis L, Schwartz M, Cardelle A, Whitmire K. "Dental Service Supply and Demand for Indigent Populations in Rural Pennsylvania." The Center for Rural Pennsylvania. *CRP Newsletter May/June 2004*. www.ruralpa.org.news0504.html.
- 24 Ibid.
- 25 Ibid.
- 26 Pennsylvania Department of Health (November 2002). *Oral Health Strategic Plan for Pennsylvania*. 23.
- 27 The Kaiser Commission on Medicaid and the Uninsured. "Early and Periodic Screening, Diagnostic, and Treatment Services." October 2005. Publication No. 7397.
- 28 Pennsylvania Insurance Department. "Pennsylvania's Children's Health Insurance Program. CHIP: A Brief History. Partner Facts." <http://chipcoverspakids.com>
- 29 Pennsylvania Department of Public Welfare. "MA Children Tables - August 2006." *Medical Assistance, Food Stamps and Cash Statistical Reports 2006*. www.dpw.state.pa.us/General/AboutDPW/Organization.



- 30 Pennsylvania Insurance Department. "Testimony of William Shaffer on Cover All Kids Initiative." Joint Meeting of the Pennsylvania Senate and House Policy Committees. June 21, 2006.
- 31 Ibid.
- 32 University of California, San Francisco. The Center for the Health Professions. "Dental Health Professional Shortage Areas: Methods and Policy". National Oral Health Conference. April 2003.
- 33 Pennsylvania Department of Health (November 2002). "Executive Summary." *Oral Health Strategic Plan for Pennsylvania*.
- 34 Pennsylvania Department of Public Welfare. Office of Medical Assistance Programs (OMAP). *Provider Type Specialties Crosswalk*. Last Modified 8/13/04.
- 35 Pennsylvania Code. Title 49. Professional and Vocational Standards. Chapter 33. State Board of Dentistry. Section 33.205. Practice as a Dental Hygienist; Section 33.211. Unprofessional Conduct.
- 36 Pennsylvania State Licensing Board. Dentists with Pennsylvania Addresses: 2001, 2005.
- 37 Pennsylvania Act 216. Section 2. State Board of Dentistry. Definitions.
- 38 Pennsylvania Code. Title 49. Professional and Vocational Standards. Chapter 33. State Board of Dentistry. Section 33.205. Practice as a Dental Hygienist.
- 39 Ibid.
- 40 American Dental Hygienists' Association. "Response to The Economic Impact of Unsupervised Dental Hygiene Practice and its Impact on Access to Care in the State of Colorado." 2005.
- 41 American Dental Hygienists' Association. "Testimony of Stanley B. Peck, Executive Director on The Crisis in Children's Dental Health: A Silent Epidemic." Subcommittee on Public Health. U.S. Senate Committee on Health, Education, Labor and Pensions. June 2002.
- 42 Ibid.