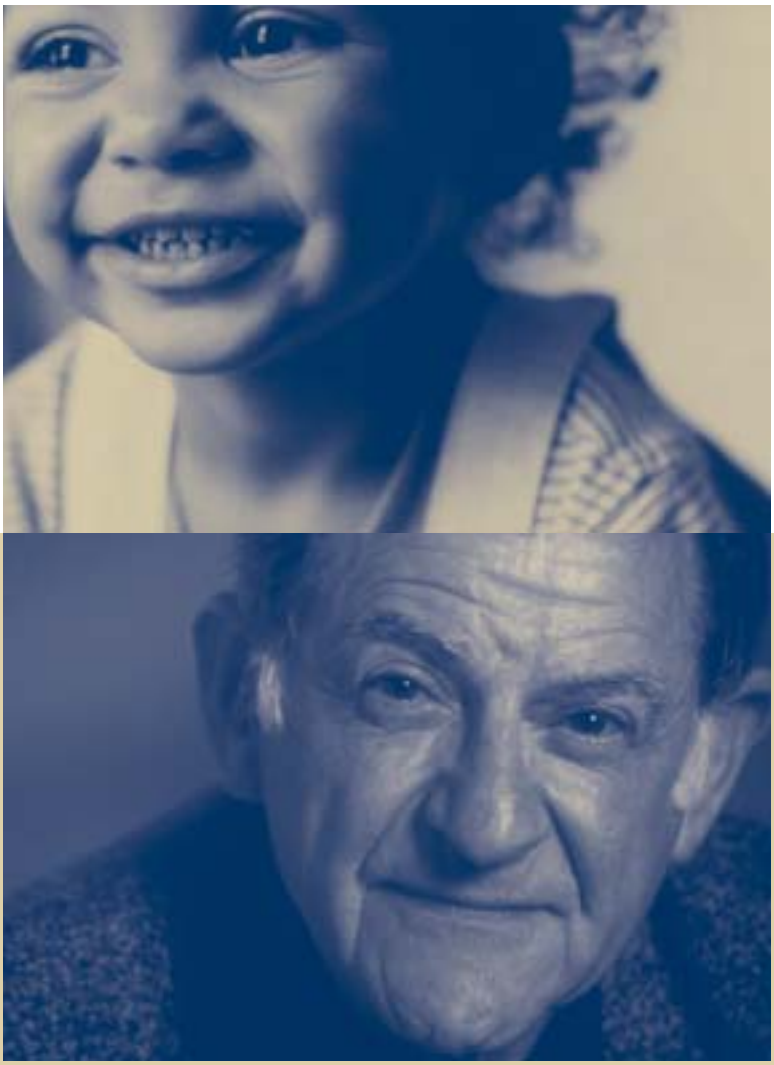
Keep America Smiling

ORAL HEALTH IN AMERICA



THE ORAL HEALTH AMERICA NATIONAL GRADING PROJECT 2003

NATIONAL GRADE: C

ORAL HEALTH AMERICA

Campaign for Oral Health Parity

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Keep America Smiling
2003 Oral Health Report Card

Overall Grade: C

Prevention: C

Access to Care: C-

Oral Health Infrastructure: C+

Health Status: C

State Policies: C-

I. Grader Comments

A. Oral Health Overview

The nation's oral health grade is a C for the second year in a row, reflecting stalled progress in advancing oral health and oral health care for all Americans. States with straight-A potential are struggling to advance. While our nation is gripped by world events, health needs, including oral health, are slipping through the cracks. America cannot afford to lose ground and let new opportunities pass by. The consequences of failing to act will result in poor oral health for many. For example:

- Poor oral health is a significant health problem for young people attempting to enlist in military service. The armed forces are spending a disproportionate share of medical resources to treat the dental problems of new recruits before they can be deployed.
- Diseases of the mouth remain as our number one chronic childhood disease.
- Fluoridation of public water supplies is the most cost-effective disease prevention strategy available, yet over one-third of the United States population (100 million people) is without this critical public health measure.[1]
- Medicare provides no benefit for routine dental care for older Americans.

Yet, signs of progress in some areas continue to show that improving disparities in oral health is one challenge the United States can overcome. Attention brought to oral health by the Surgeon General's 2000 **Report on Oral Health in America**[2] continues to build. Spurred by this report, Congress passed legislation sponsored by Senators Russell Feingold (D-Wis.) and Susan Collins (R-Me.) to expand the number of dental professionals and services available at the community level. That the Healthcare Safety Net Amendments Act is the only health care legislation signed into law since President Bush took office signifies a strong national will to improve oral health. If Congress acts to fund this legislation, and the commitment is sustained, states will see their grades increase. More importantly, more Americans will live in better health.

At the local level, signs of progress continue as well. Thousands of state and community-level programs are working hard to improve access to care through multiple strategies. The discovery and application of disease prevention measures over the past century have led to better oral health. Programs including Community Voices: HealthCare for the Underserved, and Apple Tree Dental are establishing models for improving oral health and showing that better, more cost-effective primary care and preventive health services can be provided by involving communities, integrating dental services into overall health care, and/or utilizing effective delivery systems.

Despite progress, large gaps remain. Many Americans continue to suffer disproportionately from oral pain and disease, including minority, low-income, and/or special care populations. A growing number of adults are also facing difficulties in accessing care, as states cut Medicaid dental benefits, and unemployment levels rise. Community health centers and public health facilities alone are not able to provide a sufficient safety net, and Medicare does not offer dental coverage. A majority of dentists do not participate in Medicaid. Millions of Americans are slipping through the cracks when it comes to oral health

[1] Centers for Disease Control and Prevention (CDC). Community Water Fluoridation: Surgeon General's Statement, 2001. (http://www.cdc.gov/OralHealth/factsheets/fl-surgeon2001.htm)

[2] U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

care, and state grades may deteriorate if commitment to oral health improvements at the national, state and local level wanes. There is no need to let this happen.

Strategies to Improve Oral Health Care

- Broaden insurance coverage for children, adults on Medicaid, older Americans, and special populations.
- Ensure dental services and education for vulnerable populations.
- Link oral health services to those who need them.
- Invest in the training of a more diverse dental workforce.
- Utilize effective disease prevention measures.

B. About this Report Card

This report card provides a snapshot of oral health in America using data available at the state level. The grading categories are intended to call greater policy attention to areas of need in prevention, access to care, infrastructure, health status and oral health related laws across the country. The report card is not intended to grade any one national, state, or local program, but instead look at the many factors that contribute to our nation's oral health and oral health care. It is our hope that opinion leaders, public advocates, policymakers, communities, health professionals, and the media will take note of oral health shortfalls, and will work to support successful policies and programs that will make oral health care an integral part of overall health care.

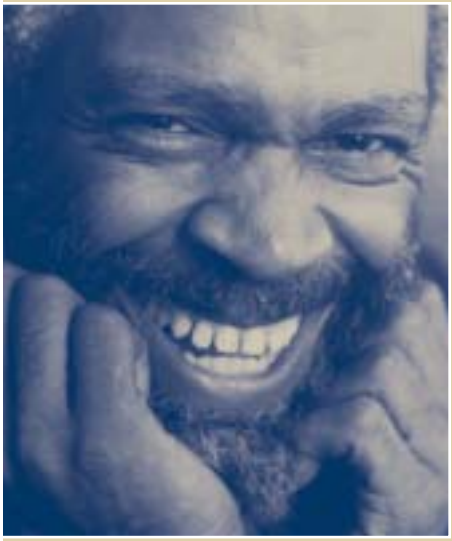
Methodology

Oral Health America gathered public health information from a variety of sources to create a state-by-state database. The most recent primary data sources possible were used. Sources for each category are listed with the grading scales. Additional data were collected through Oral Health America surveys of state dental health programs and state Medicaid programs.

It should be noted that for the third year in a row, gaps in oral health data pose a great challenge to any assessment of oral heath status on a state-by-state basis. For example, tooth decay is the most common chronic childhood disease, but data are not collected uniformly at the state level, leaving an unclear picture of areas of need or achievement throughout the country. Available oral health status data are often out of date or inadequate. It cannot be overstated how important health status data are to disease prevention and health promotion. A true commitment to ending oral health disparities throughout the country must include the ability to track the effects and progress of public health interventions for target populations.

Grades for each category are based, when possible, on desired levels of oral health status, and the availability and use of oral health services according to a variety of sources including the Healthy People 2010[3] goals, infrastructure recommendations from the Association of State and Territorial Dental Directors,[4] and conversations with numerous experts in a range of fields. In some categories, where desired levels have not been identified, Oral Health America developed grading scales based upon the national mean.

– Elizabeth L. Rogers
Director of Communications
Oral Health America



[3] U.S. Department of Health and Human Services (USD-HHS). Healthy People 2010 (Conference Edition, in two volumes). Washington; Jan. 2000.

[4] Association of State and Territorial Dental Directors (ASTDD). Building Infrastructure & Capacity in State and Territorial Oral Health Programs. April 2001. (http://www.astdd.org)

II. Report Card Categories and

Most oral health problems are preventable. Solutions to these problems are cost-effective.

Over one-third of the U.S. population has no access to community water fluoridation.

The following scale was used to assign point values for letter grades. An "I" represents "incomplete," where there were no data available. In several cases, states did not respond to our requests for information, indicated by a "DNR."

A	4.00
B+	3.33-3.99
B	3.00-3.32
B-	2.67-2.99
C+	2.33-2.66
C	2.00-2.32
C-	1.67-1.99
D+	1.33-1.66
D	1.00-1.32
D-	0.67-0.99
F	0.00-0.66
DNR	Did not respond—2 or more DNRs in any given category resulted in the lowering of the category grade by one point.
I	Data not available.
NG	No grade.

A. Prevention

A report[5] issued recently by the Task Force on Community Preventive Services underscores the importance of on-going preventive strategies that save long-term health costs and are proven to be effective in preventing disease, including the fluoridation of public water supplies and school-based sealant programs. These measures can prevent tooth decay, particularly among low-income families, those without private dental care, and those who are at highest risk for oral health problems.

1. Fluoridation

Community water fluoridation was introduced almost 60 years ago, but 100 million Americans still do not have adequate fluoride in their drinking water. Fluoride reduces the incidence of tooth decay and slows or reverses the progression of existing lesions (i.e., prevents cavities).[6] Older adults and children without regular access to oral health care benefit greatly from fluoridated water. Grades are based on the percentage of the population in each state served by public water supplies receiving fluoridated water.

A	88-100%
B	75-87%
C	62-74%
D	50-61%
F	0-49%

Source: State Synopsis 2002, Centers for Disease Control and Prevention (http://www.cdc.gov/nohss)

2. School-based or -linked Dental Sealant Programs

Dental sealants are among the most cost-effective and under-utilized means of protecting children's teeth from decay. Currently, only 23 percent of 8-year-olds in the U.S. have dental sealants, a plastic coating applied to the chewing surface of molar teeth. The prevalence is far lower for children who may have higher decay risk: less than 10 percent of low-income, minority children have received a dental sealant. Because sealant prevalence data collected by states are not standardized, Oral Health America surveyed state dental programs for the presence and reach of sealant programs. Grades are based on the information provided.

[5] Centers for Disease Control and Prevention (CDC). Promoting Oral Health: Interventions for Preventing Dental Caries, Oral and Pharyngeal Cancers, and Sports-Related Craniofacial Injuries: A Report on Recommendations of the Task Force on Community Preventive Services. Morbidity and Mortality Weekly Report. November 30, 2001. 50:1-13. (http:www.cdc.gov/mmwr/preview/mmwrhtml/rr5021a1.htm)

[6] Centers for Disease Control and Prevention (CDC). Recommendations for Using Fluoride to Prevent and Control Dental Caries in the United States. Morbidity and Mortality Weekly Report. 2001;50:1-42. (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5014a1.htm)

Data Sources, 2003

a. Sealant Program Data (25 percent of the sealant program grade)

A	The state regularly (every 1-5 years) collects statewide data on sealant prevalence and reports the data according to caries-risk (e.g., by race, income level, Medicaid eligibility, lunch program eligibility, and/or lack of insurance).
B	The state collects statewide data on sealant prevalence and reports the data according to caries-risk, but data are not collected every 1-5 years.
C	Statewide sealant prevalence data are collected every 1-5 years, but the state does not report the data according to caries-risk; or the state regularly (every 1-5 years) collects sealant prevalence data and reports according to caries-risk, but data are not statewide.
D	Sealant prevalence data are collected every 1-5 years, but it is not statewide and not reported according to caries-risk; or irregular data are either collected at a statewide level or the state reports the data according to caries-risk, but not both.
F	Data are not collected.

Source: Oral Health America survey of State Dental Directors 2002

b. State Sealant Program (75 percent of the sealant program grade)

A	A statewide sealant program is targeting and serving over 35% of a distinct population of caries-risk children (e.g., minority, low-income, Medicaid eligible, lunch program eligible and/or without insurance).
B	A statewide sealant program is targeting and serving 20-35% of a distinct caries-risk population.
C	The statewide sealant program is targeting and serving 5-19% of a distinct caries-risk population; or a substantial targeted regional program exists and is reaching over 30% of the caries-risk population.
D	The sealant program is serving less than 5% of the distinct caries-risk population.
F	No program exists.

Source: Oral Health America survey of State Dental Directors 2002

B. Access

Millions of Americans are unable to get the oral health care they need because they do not have dental insurance (public or private), cannot pay out-of-pocket, and/or cannot find a provider who will treat them. This is particularly the case for minorities, people with disabilities, and older Americans. Many regions of the country have a maldistribution of dentists, and most dentists do not participate in Medicaid. Medicare does not offer dental coverage, and Medicaid dental benefits are being cut by states with significant budget woes. There is not enough public funding for oral health services. Community health centers were able to provide preventive and basic dental care to less than 13 percent of the total clientele in 1998.[7] Failing to help those who are slipping through the cracks will result in high and long-term costs for systemic illness and invasive, emergency interventions.

Uninsured Americans with severe oral disease often end up in hospital emergency rooms, where the problem is addressed through painkillers and/or tooth extractions, both of which are only temporary fixes, wasting millions of taxpayer dollars annually.

[7] DHHS, Oral Health in America.

For every child that lacks medical coverage, 2.6 lack dental coverage. For every adult that lacks medical coverage, three are without dental coverage. Only two out of every ten older Americans are covered by private dental insurance.

Three times as many parents report that their child has an unmet need for dental care than for medical care.

1. Availability of Dentists

a. Availability of Dentists

An adequate supply of dentists is one factor in ensuring access to oral health care. Unfortunately, available data do not reflect the distribution of dentists throughout any given state (for example, in rural versus urban or suburban areas), nor do they address the extent that dentists are serving underserved populations or the number and types of services they provide. These factors have a direct impact on access to care, and the lack of such data prevents us from accurately determining and prioritizing areas of need. Grades are based on the number of professionally active, licensed dentists in each state compared to the state population.

A	1 dentist: 1-1,500 patients
B	1 dentist: 1,501-2,000 patients
C	1 dentist: 2,001-2,300 patients
D	1 dentist: 2,301-2,600 patients
F	1 dentist: 2,601+

Source: Distribution of Dentists in the United States by Region and State, American Dental Association (ADA) 2000; Population Division, April 1, 2000 Population Estimates, U.S. Census Bureau, 2002 (http://www.census.gov)

b. Availability of Pediatric Dentists

Only 2.4 percent of dentists are pediatric dentists, limiting access to care particularly for low-income children with poor oral health. As for general dentists, available data do not reflect the distribution of pediatric dentists throughout the state, nor do they address the extent to which dentists are serving underserved populations or the number and types of services they provide. Given that many children under one do not see a dentist, and that many children receive care from a general dentist, Oral Health America estimates that one third of the child population under age six may need access to a pediatric dentist.

A	1 dentist: 1-1,500 patients
B	1 dentist: 1,501-2,000 patients
C	1 dentist: 2,001-2,300 patients
D	1 dentist: 2,301-2,600 patients
F	1 dentist: 2,601+

Source: Distribution of Dentists in the United States by Region and State, ADA 2000; April 1, 2000 Population Estimates, Population Division, U.S. Census Bureau 2002 (http://www.census.gov)

c. Percentage of Counties Without a Dentist

In an effort to capture some measure of regional dental shortages, Oral Health America surveyed state dental programs on the percentage of counties in each state without a dentist. This category provides only a cursory glance at workforce gaps at the state level. It is our hope that restructuring of the Dental Health Professional Shortage Areas designation process will provide a better understanding of regional shortages in the future. Grades are based on the percentage of counties in each state that do not have a dentist.

A	0%
B	1-5%
C	6-10%
D	11-15%
F	16% or more

Source: Oral Health America survey of State Dental Directors 2002

2. Medicaid Providers

Efforts to increase dentist participation in Medicaid have had some success in a handful of states, especially when Medicaid program reforms include increases in reimbursement levels to market rates. For example, in North Dakota payments approximate the 50th percentile, and a substantial percentage of dentists are engaged in Medicaid.[8] Unfortunately, given the current economic environment and state budget shortfalls, we are unlikely to see additional states make this programmatic investment in the near future.

a. Medicaid Dental Providers

Grades for this category are based on the percentage of dentists who have billed Medicaid at least once in the prior year. It should be noted that this category does not tell us how active dentists are in the Medicaid program above and beyond one billing.

A	Over 70%
B	51-70%
C	36-50%
D	21-35%
F	20% or less

Source: Oral Health America survey of State Medicaid Dental Contacts 2002

b. "Significant" Medicaid Dental Providers

"Significant" Medicaid dental providers are those who have integrated Medicaid recipients into their practices at higher levels than other dentists. Grades are based on the percentage of dentists who are considered by the state to be "significant" providers of Medicaid services, meaning that they have billed Medicaid for at least $10,000, or have seen 50 or more unduplicated Medicaid patients.

A	Over 50%
B	37-49%
C	23-36%
D	13-22%
F	12% or less

Source: Oral Health America survey of State Medicaid Dental Contacts 2002

Millions of Americans, including our most vulnerable populations, are unable to access any care and suffer the most.

[8] Edelstein, BL. Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid. Connecticut Health Foundation, Farmington, CT. March 2003: 11.

At any given time, five percent of Americans 65 and older (about 1.65 million people) are living in long-term care facilities, where dental care is problematic. People with disabilities are at greater risk for oral diseases and are less likely to be treated.

c. Percentage of Counties without a Medicaid Dental Provider

Another way to provide a general picture of the distribution of Medicaid providers is to look at the number of counties in a state that lack Medicaid-enrolled dentists. Grades are based on the percentage of counties in each state that do not have a Medicaid dentist.

A	0%
B	1-5%
C	6-10%
D	11-15%
F	16% or more

Source: Oral Health America survey of State Dental Directors 2002

3. Access for Special Populations

Data on access for special populations are practically non-existent on a state-by-state basis. Oral Health America was able to identify one source of data on the insurance status of older adults, collected in 1995-97. It is included here to bring attention to need for better data collection and reporting, and also to raise awareness of the situation faced by many older Americans, who may have lost private insurance provided by work, and have no public insurance option, given that Medicare does not offer dental coverage.

a. Dental Insurance Status of Older Americans

Older adults often have special oral health needs. As there are no routine dental benefits under Medicare, older Americans without private dental insurance have no means of accessing care unless they are able to pay out-of-pocket. This is difficult or impossible for millions of older Americans who suffer from poor oral health. Grades are based on the percentage of adults in the state, 65 years and older, who reported having no dental insurance.

A	0-50 %
B	51-60%
C	61-70%
D	71-80%
F	81-100%

Source: Table 15. MMWR December 17, 1999, Surveillance for Use of Preventive Health-Care Services by Older Adults, 1995-1997, Centers for Disease Control and Prevention (http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/ss4808a4.htm)

C. Infrastructure

America's public health infrastructure plays a vital role in improving oral health for all Americans, but without state and national support, our public health system cannot address the needs of those who are not being reached by the traditional model of private dentistry. Oral Health America has identified the following categories to assess oral health infrastructure at the state level: leadership, oral health plan/input, budget, and data use. Each of the following categories are supported by the Healthy People 2010 Public Health Infrastructure Objectives.

1. Leadership

The presence of a state dental director is one indication of state commitment to addressing oral health problems. Grades are as follows:

A	The state dental director is full-time, and is an oral health professional with public health training.
B	The state dental director is full-time, and is either an oral health professional or has public health training, but not both.
C	The full-time state dental director is not an oral health professional and has no public health training; or the dental director is part-time and has dental or public health training.
D	The state dental director is part-time and has no oral health or public health training.
F	No dental director.

Sources: Centers for Disease Control and Prevention's National Oral Health Surveillance System (NOHSS) State Synopsis 2002 (http://www.cdc.gov/nohss); Association of State and Territorial Dental Directors web site (http://www.astdd.org); Oral Health America survey of State Dental Directors 2002

2. Plan/Input

a. Oral Health Plan

A key element in successful oral health policy is the development and maintenance of a state oral health improvement plan that, through a collaborative process, selects appropriate strategies for target populations, establishes integrated interventions, and sets priorities for the state. Grades are as follows:

A	The state has a long-term oral health improvement plan, developed through a collaborative process, with a broad range of constituents, and is reviewed regularly.
B	The state oral health plan was developed through a collaborative process, with a broad range of constituents, but is not reviewed regularly; or the plan is reviewed regularly, and was developed collaboratively, but not with a broad range of constituents.
C	The state oral health plan was either developed collaboratively, or was developed with a broad range of constituents, or is reviewed regularly.
D	The state oral health program was not developed collaboratively, with a broad range of constituents, and is not reviewed regularly.
F	The state has no oral health plan.

Source: Oral Health America survey of State Dental Directors 2002

There are significant structural problems in our oral health care system, and the problems are getting worse due to demographic trends, workforce trends, public health infrastructure inadequacies, and the increasing number of children, adults, elderly and special populations not covered by Medicare or Medicaid.

Twenty-five out of the fifty state oral health programs in the country are not adequately funded.

Seven states do not have a dental director.

b. Oral Health Coalition

A working state oral health coalition can provide linkages with partners to increase public awareness of oral diseases, leverage resources, broaden approaches to programming, enhance advocacy and resource development, improve duplication and gaps in services, and add time, energy and resources of their own. For example, coalitions have played an essential role in educating the public about the benefits of water fluoridation. Broad-based citizen coalitions have led successful campaigns to fluoridate a number of large U.S. jurisdictions in the past decade, including Los Angeles, Sacramento and San Diego, CA; Manchester, NH; Las Vegas, NV; San Antonio, TX, and Salt Lake City, UT.[9]

A	The state oral health coalition meets regularly and represents government agencies, health departments, private organizations, providers, communities and consumers.
B	The state oral health coalition meets regularly, and represents government agencies, health departments, private organizations, providers, and either communities or consumers.
C	The state oral health coalition meets regularly, and represents government agencies, health departments, private organizations, and providers, but does not represent communities or consumers.
F	There is no oral health coalition.

Source: Oral Health America survey of State Dental Directors 2002

3. Budget

Grades are based on whether or not the state oral health budget adequately funds the infrastructure and capacity to plan, develop, and implement oral health programs at the state and community levels. Oral Health America looked at three measures: budget size, past year budget changes, and state support for the oral health program budget in an attempt to gauge budget strengths and weaknesses. Given the importance of an adequate budget in ensuring the success of an oral health program, this category is weighted twice in the Infrastructure Grade calculation.

a. State Oral Health Program Budget Size

Grades for this category are based on the averages of upper and lower budget estimates detailed for four model state oral health programs representing varying levels of resources and environments as identified by the Association of State and Territorial Dental Directors (ASTDD).[10] The numbers provided are estimates of adequate funding levels, but are not intended to serve as target funding ranges.

A	$.44 or more per person
B	$.31-.43 per person
C	$.21-.30 per person
D	$.11-.20 per person
F	$.10 or less per person

Source: Oral Health America survey of State Dental Directors 2002

[9] Centers for Disease Control and Prevention (CDC), Preventing Dental Caries Fact Sheet. (http://www.cdc.gov/nccdphp/pe_oh.htm)

[10] ASTDD, Building Infrastructure & Capacity in State and Territorial Oral Health Programs.

b. State Oral Health Program Budget Changes

A	The state oral health program budget increased significantly in the past year.
B	The state oral health program budget increased with inflation in the past year.
C	The state oral health program budget stayed the same in the past year.
F	The state oral health program budget decreased in the past year.

Source: Oral Health America survey of State Dental Directors 2002

c. State Support for the Oral Health Program

Most programs are funded by federal block grant dollars, state dollars, or a combination of both. The presence of state funding indicates a greater level of commitment to oral health of state residents.

A	The state oral health program is supported within the state budget.
F	The state oral health program is unsupported by the state budget.

Source: Oral Health America survey of State Dental Directors 2002

4. Assessment/Data Use

Grades are based on the presence of a state oral health surveillance system for ongoing monitoring, timely communication of findings, and the use of data to initiate and evaluate interventions, especially for the following core measures: sealant prevalence, untreated caries, caries experience, recency of dental visits, and fluoridation. For each measure, a point system was used to grade the state on whether or not data were collected regularly (every 1-5 years), the level (state or county) data reflects, whether or not the data can estimate oral health program impact on target populations, how the program uses data, and how the program disseminates data.

A	19 or 20 points
B	14-18
C	9-13
D	1-8
F	0 points

Source: Oral Health America survey of State Dental Directors 2002

D. Health Status

In developing a picture of America's oral health status on a state-by-state level, one thing is clear: more uniform state specific data are needed to track progress and identify areas of need. At a national level, disparities exist among certain populations, but in looking at oral disease prevalence within states, the picture becomes foggy at best. Following are health status data sets available for every state, and it should be noted that the most recent available information is primarily from 1999.

80 percent of tooth decay is found in 25 percent of children—concentrated in minority populations. Less than 10 percent of low-income, minority children aged 8 are protected by dental sealants. Poor adults and elderly have a higher percentage of untreated decayed teeth. Members of racial and ethnic groups experience a higher level of oral health problems.

Oral health ailments—cavities, cancer, gum disease, tooth loss, oral-craniofacial injuries and birth defects—afflict more Americans than any other cluster of health problems.

Poor oral health causes suffering.

Oral health problems cause pain, impact our ability to eat, sleep, work or get a job, and concentrate in school. Evidence suggests that poor oral health can complicate or is linked to diabetes; heart disease; pneumonia; stroke; and pre-term, low birth weight babies.

Nearly one-third of persons 65 years and older have untreated tooth decay.

One-in-four parents of a child with special healthcare needs report that their child is in need of dental care.

1. Dental Status of Adults

Measuring the percentage of self-reported adults with six or more teeth removed due to decay or disease.

A	Less than 10% of adults have had 6 or more teeth removed due to decay or disease.
B	10-18% of adults have had 6 or more teeth removed due to decay or disease.
C	19-27% of adults have had 6 or more teeth removed due to decay or disease.
D	28-35% of adults have had 6 or more teeth removed due to decay or disease.
F	36% or more of adults have had 6 or more teeth removed due to decay or disease.

Source: Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) 1999 (http:www.cdc.gov/nohss)

2. Edentulous (having no natural teeth) Older Americans

Grades are based on the percentage of self-reported people 65 and older, with no natural teeth.

A	Less than 17% of adults aged 65 years and older have no natural teeth.
B	17-24% of adults aged 65 years and older have no natural teeth.
C	25-32% of adults aged 65 years and older have no natural teeth.
D	33-41% of adults aged 65 years and older have no natural teeth.
F	42% or more of adults, 65 and older, have no permanent teeth.

Source: Center for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS) 1999 (http://www.cdc.gov/nohss)

3. Youth Tobacco Use

The use of tobacco products has been strongly linked to the development of numerous oral diseases, including oral and pharyngeal cancers, as well as periodontal disease, gum recession, tooth decay, and oral lesions. Smokeless or "spit" tobacco use is also strongly linked to oral soft tissue lesions in both young people and adults.

a. High School Cigarette Use

Grades are based on the percentage of high school students reporting cigarette use in the past 30 days.

A	0%
B	1-16%
C	17-25%
D	26-35%
F	36% or more

Source: Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System (YRBSS) 2001 (http://www.cdc.gov/nccdphp/dash/yrbs/2001/index.htm)

b. High School Male Smokeless Tobacco Use

Grades are based on the percentage of high school males reporting smokeless or "spit" tobacco use in the past 30 days.

A	0%
B	1-7%
C	8-14%
D	15-20%
F	21% or more

Source: Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System (YRBSS) 2001 (http://www.cdc.gov/nccdphp/dash/yrbs/2001/index.htm)

4. Change in Oral and Pharyngeal Cancer Mortality Rates

About 30,000 Americans are diagnosed with oral and pharyngeal cancers each year, and each year more than 8,000 die from these diseases. Prognosis for oral and pharyngeal cancers, which are primarily diagnosed in older adults, is poor. The five-year survival rate for white patients is 56 percent, for blacks, it is only 34 percent.[11] Grades are based on the change in oral cancer mortality rates over the past 26 years from the 1973-77 reporting period to the most recent 1995-1999 reporting period. Rates are based on the number of mortalities per 100,000 people.

A	Significant (20% or more) reduction in oral and pharyngeal cancer mortality rates; moderate (0-19%) reduction to lower rates (2.8 or less).
B	Moderate (0-19%) reduction in average (2.9-3.9) oral and pharyngeal cancer mortality rates; no change to lower (2.8 or less) rates.
C	Moderate (0-19%) reduction in higher (over 4) rates; no change to average (2.9-3.9) rates.
D	Moderate (0-19%) increase in lower (2.8 or less) or average (2.9-3.9) rates.
F	Significant (20% or more) increase in oral and pharyngeal cancer mortality rates; or no change to higher (over 4) rates.

Sources: North American Association of Central Cancer Registries-SEER Cancer Statistics Review (http://www.seer.cancer.gov)

E. Policies

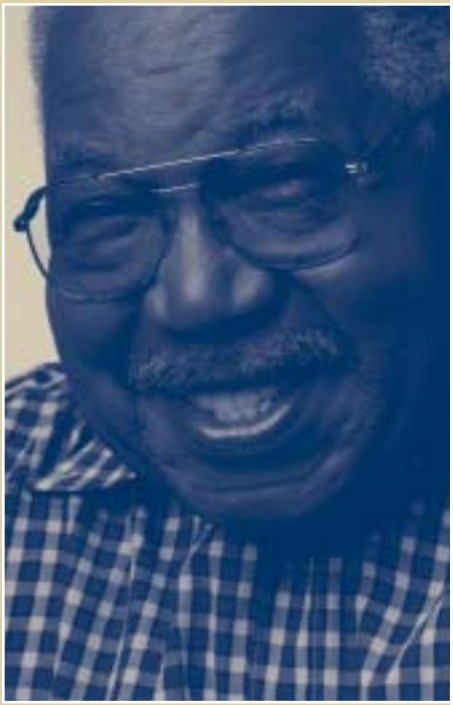
1. Fluoridation Laws

State fluoridation laws are a good indication of state commitment to the fluoridation of community water supplies. States with strong laws are in a better position to support the maintenance and upkeep of aging water systems and encourage communities to adopt fluoridation as a preventive oral health measure that will benefit all residents, regardless of income or race.

A	A state law exists that intends to provide statewide fluoridation. The state mandates fluoridation for all communities except where natural fluoridation occurs.
B	A state law exists that intends to provide statewide fluoridation, and a significant percentage of the population on community water supplies receives fluoridated water. Limited exclusions exist within the law.
C	The state has a fluoridation law, but there are attached conditions that provide barriers to the state's ability to fluoridate.
D	There is no law intending to provide statewide fluoridation.
F	Laws exist that impede community water fluoridation.

Source: Personal communication, Tom Reeves, Water Engineer, Centers for Disease Control and Prevention

[11] DHHS, Oral Health in America.



2. Competitive Food Policies

Healthy food choices and good oral health go hand in hand. Given that by their senior year in high school 80 percent of adolescents in the U.S. have experienced tooth decay, Oral Health America believes that it is imperative for schools to enable children to learn good nutrition habits through healthy meal programs. The U. S. Department of Agriculture has established policies, which all states follow, to control the sale of foods sold in competition with school meal programs. However, these policies provide few restrictions, and states and school food authorities that have not chosen to place additional restrictions on the sale of competitive foods are failing to promote an environment that enables children to learn about healthy food choices. With schools facing budget cuts into the foreseeable future, now is the time for states to establish clear guidelines on the sale of foods of little nutritional value in schools, including soda and sugary, high-carbohydrate foods. Grades are based on state competitive foods policies above and beyond USDA regulations.

A	Comprehensive nutrition standards for all foods sold outside the USDA meal programs, anywhere on campus, throughout the school day. (No state has such standards)
B	Minimal nutritional standards set for foods sold outside the USDA meal programs, anywhere on campus, throughout the school day.
C	Limit sales of foods of minimum nutritional value anywhere on campus up until the last lunch period is over.
D	USDA Regulations only; additional regulations only relate to who makes the money (such as Louisiana's regulations).

Source: United States Department of Agriculture (USDA) State Competitive Foods Policies 2001 (http://fns.usda.gov/cnd/HealthyEating/CF_State.htm)

3. State Tobacco Excise Taxes

Numerous studies show that increasing tobacco excise taxes is one of the most effective ways to reduce tobacco use among youth and adults. Higher taxes make tobacco products more expensive, keeping young people from using products. For this category, Oral Health America reviewed existing excise taxes for cigarettes and smokeless tobacco products, as an indication of the state's commitment to enacting and enforcing laws that can reduce the number of young people who use tobacco products.

a. Cigarette Excise Taxes

Oral Health America salutes the many states that have implemented or passed new cigarette tax increases since 2002. Grades for this category are based on a scale developed for the American Lung Association's *State of Tobacco Control: 2002.*[12]

A	$1.25 or more per pack
B	$.93-1.24 per pack
C	$.64-.92 per pack
D	$.36-.63 per pack
F	$.35 or less per pack

Source: Campaign for Tobacco Free Kids, State Cigarette Excise Tax Rates, March 28, 2003 (http://tobaccofreekids.org/research/factsheets/pdf/0097.pdf)

[12] American Lung Association. State of Tobacco Control: 2002. (http://lungaction.org/reports/tobacco-control.html)

b. Smokeless Tobacco Excise Taxes

While states have implemented or passed new cigarette taxes in the past several years, smokeless or "spit" tobacco is often overlooked. Studies have shown that when cigarette taxes are raised without a significant corresponding increase in smokeless tobacco taxes, users, especially young people, may switch to smokeless tobacco rather than giving up nicotine entirely. In addition to increasing smokeless tobacco taxes to correspond with cigarette taxes, Oral Health America encourages states to impose smokeless tobacco taxes based on wholesale price rather than weight. Taxes based on wholesale prices increase with inflation, while taxes based on weight reduce state tax on premium brands favored by youth.[13] Alabama, Arizona, Connecticut, and North Dakota are the only states that impose smokeless tobacco taxes by weight. These states did not receive a grade as the grading scale below is based on percent of wholesale price. Grades are based on moist snuff taxes in each state.

A	90% or more of wholesale or manufacturers price
B	65-89% of wholesale or manufacturers price
C	40-64% of wholesale or manufacturers price
D	20-39% of wholesale or manufacturers price
F	Less than 20% of wholesale or manufacturers price

Source: Campaign for Tobacco Free Kids, State Excise Tax Rates for Non-Cigarette Tobacco Products, March 12, 2002 (http://tobaccofreekids.org/research/factsheets/pdf/0169.pdf)

4. Adult Medicaid Dental Policies

Current Medicaid law allows for states, at their own discretion, to provide dental services for adults. These services are being threatened with painful cuts as a result of growing state budget deficits. Only eleven states currently provide full adult dental benefits. By cutting back on services allowed, or eliminating them entirely, states will only increase health care expenses, and uninsured Americans will be forced to seek costly emergency room interventions for systemic dental infections. Grades are based on the level of oral health services provided through Medicaid.

A	The state Medicaid program has full adult dental benefits, including preventive services.
B	Medicaid adult dental benefits are fairly comprehensive, with the exception of some services.
C	The Medicaid program provides partial adult dental services.
D	The state Medicaid program covers tooth extractions and emergency adult dental services only.
F	The state Medicaid program covers no adult dental benefits.

Source: Oral Health America survey of State Dental Directors 2002

Medicaid dental coverage for adults is not mandatory and state budget shortfalls are leading to a spike in benefit cuts. Twenty-four states have emergency-only adult coverage or no adult coverage at all; further cuts are likely.

[13] Campaign for Tobacco Free Kids. Benefits from Increasing Smokeless Tobacco Tax Rates. April 4, 2002. (http://tobaccofreekids.org/research/factsheets/pdf/0180.pdf)

5. Dental Board Policies

State dental boards have the power to restrict and control access to care within states. Oral Health America recommends that dental boards eliminate restrictions that are creating barriers to care, particularly in areas proven to have no detrimental effect on quality of care and patient safety.

a. Dentist and Dental Hygienist Licensure by Credentials

Under licensure by credentials, state dental boards grant licenses to dentists and dental hygienists who are currently licensed and in active, continuous practice for a specified period of time (typically five years) in another jurisdiction, without further theoretical and clinical examination.

A	Licensure by credentials accepted by the state.
F	Licensure by credentials not accepted by the state.

Source: American Dental Association Department of Governmental Affairs 2002; American Dental Hygienists Association, 2002

b. Dental Hygienist Practice Acts

There are disparities in practice acts governing dental hygienists between and within states. While many low-income patients need restorative care that can only be performed by a dentist, hygienists are trained to provide various preventive and "triage" services but are often prevented from doing so under state practice acts. By freeing hygienists to provide preventive care without the presence or authorization of a dentist, states take steps towards solving access disparities and regional workforce shortages. To illustrate state differences, Oral Health America looked at state dental hygienist practice acts for prophylaxis (routine cleaning and polishing of teeth) and pit or fissure sealant placement. Grades are assigned separately for each procedure.

A	U
B	N/U
C	N or P/U
D	P/N
F	P

P = Physical presence of a dentist is required.

N = Physical presence of a dentist is not required.

U = Physical presence of a dentist is not required. No prior authorization by a dentist is required but there may be requirements for a type of cooperative arrangement with a dentist. Some states require special dental hygienist education.

/ = Where two letters are present, the first indicates the supervision level in the private dental office. The second indicates the supervision level in other settings such as independent dental practices, long-term care facilities, hospitals, etc. on non-ambulatory patients.

Source: ADHA Practice Act: Permitted Functions and Supervision Levels by State (ADHA, 2002)

Grades

State	PREVENTION					ACCESS			
		SEALANT PROGRAM				DENTIST AVAILABILITY			
	Fluoridation	Sealant Program Data (.25)	Sealant Program (.75)	Sealant Program	Prevention	Dentist Availability	Pediatric Dentist Availability	% Counties w/o Dentist	Dentist Availability
ALABAMA	B	C	D	D	**C**	D	B	B	**C**
ALASKA	D	F	F	F	**F**	A	A	NG	**A**
ARIZONA	D	A	B	B	**C**	C	F	A	**C**
ARKANSAS	C	A	D	C	**C**	F	D	B	**D**
CALIFORNIA	F	B	D	D	**D-**	A	B	B	**B**
COLORADO	B	A	C	C	**B-**	B	A	D	**C**
CONNECTICUT	A	D	D	D	**C+**	A	A	A	**A**
DELAWARE	B	A	B	B	**B**	C	D	A	**C**
DIST. OF COLUMBIA	A	D	F	F	**C**	A	A	I	**A**
FLORIDA	C	F	D	D	**D+**	B	B	B	**B**
GEORGIA	A	F	C	D	**B-**	C	C	C	**C**
HAWAII	F	A	F	D	**F**	A	A	A	**A**
IDAHO	F	A	D	C	**D**	B	F	D	**D**
ILLINOIS	A	C	B	B	**B+**	B	C	B	**C**
INDIANA	A	A	B	B	**B+**	C	B	B	**C**
IOWA	A	A	D	C	**B**	B	B	A	**B**
KANSAS	C	C	F	F	**D**	C	F	D	**D**
KENTUCKY	A	A	C	C	**B**	B	A	B	**B**
LOUISIANA	F	C	F	F	**F**	C	C	A	**C**
MAINE	B	C	B	B	**B**	C	F	A	**C**
MARYLAND	A	A	B	B	**B+**	A	B	I	**B**
MASSACHUSETTS	C	B	B	B	**C+**	A	A	I	**A**
MICHIGAN	A	DNR	DNR	DNR	**B**	B	D	DNR	**C**
MINNESOTA	A	D	D	D	**C+**	B	D	A	**C**
MISSISSIPPI	F	A	C	C	**D**	D	F	A	**C**
MISSOURI	B	C	C	C	**C+**	C	F	B	**D**
MONTANA	F	D	F	F	**F**	B	C	F	**D**
NEBRASKA	B	F	D	D	**C**	B	A	F	**C**
NEVADA	C	A	B	B	**C+**	F	F	F	**F**
NEW HAMPSHIRE	F	A	C	C	**D**	B	B	A	**B**
NEW JERSEY	F	C	D	D	**F**	A	A	A	**A**
NEW MEXICO	B	A	A	A	**B+**	C	D	C	**D**
NEW YORK	C	A	A	A	**B**	A	A	A	**A**
NORTH CAROLINA	B	C	C	C	**C+**	D	D	B	**D**
NORTH DAKOTA	A	C	F	F	**C**	C	F	F	**D**
OHIO	A	A	A	A	**A**	B	B	A	**B**
OKLAHOMA	B	A	B	B	**B**	C	D	A	**C**
OREGON	F	A	D	C	**D**	B	A	D	**C**
PENNSYLVANIA	D	F	F	F	**F**	B	B	A	**B**
RHODE ISLAND	A	F	C	D	**B-**	B	B	A	**B**
SOUTH CAROLINA	A	A	C	C	**B**	C	C	A	**C**
SOUTH DAKOTA	B	B	F	D	**C-**	C	F	F	**D**
TENNESSEE	A	DNR	DNR	DNR	**B**	B	A	DNR	**B**
TEXAS	C	A	B	B	**C+**	C	B	F	**D**
UTAH	F	A	F	D	**F**	B	D	C	**C**
VERMONT	D	A	A	A	**C+**	B	B	A	**B**
VIRGINIA	A	A	B	B	**B+**	B	B	B	**B**
WASHINGTON	D	D	F	F	**F**	B	B	A	**B**
WEST VIRGINIA	B	D	D	D	**C**	C	D	B	**C**
WISCONSIN	A	A	B	B	**B+**	B	B	A	**B**
WYOMING	F	A	F	D	**F**	B	C	A	**B**
UNITED STATES	**C**	**B**	**C**	**C**	**C**	**B**	**C**	**B**	**C**

Grades

State	Access: Medicaid Providers: % Counties w/o Medicaid Provider	Medicaid Dental Providers	Significant Medicaid Dental Providers	Medicaid Providers	Dental Insurance Status of Elderly	Access	Infrastructure: Plan/Input: Dental Director	Oral Health Plan (.5)	Oral Health Coalition (.5)	Plan/Input	Budget: Budget Size (.50)	Budget Change (.25)	State Support for Oral Health Budget (.25)
ALABAMA	C	D	C	C	D	C-	A	B	B	B	D	B	A
ALASKA	NG	A	A	A	B	B+	A	D	F	D	B	A	A
ARIZONA	A	D	I	C	B	C+	A	B	A	A	C	I	I
ARKANSAS	B	C	D	C	F	D	A	A	A	A	D	A	A
CALIFORNIA	B	C	C	C	A	B	F	F	B	C	D	C	A
COLORADO	F	C	F	D	C	C-	A	B	B	B	C	A	A
CONNECTICUT	A	F	F	D	D	C	A	A	A	A	F	A	A
DELAWARE	A	D	D	C	I	C	A	B	A	A	A	C	A
DIST. OF COLUMBIA	I	F	F	F	I	C	F	F	F	F	A	I	I
FLORIDA	C	F	F	D	C	C-	A	F	C	D	F	B	A
GEORGIA	D	D	D	D	C	C-	A	A	A	A	B	B	A
HAWAII	I	D	B	C	A	B+	A	A	A	A	A	C	A
IDAHO	F	A	B	C	F	D	B	A	A	A	C	C	F
ILLINOIS	D	F	F	F	D	D	A	A	A	A	D	A	A
INDIANA	B	C	C	C	D	C	A	B	A	B	D	C	A
IOWA	A	A	B	A	F	C+	F	A	C	B	C	C	A
KANSAS	F	D	F	F	C	D	F	F	C	D	F	A	F
KENTUCKY	A	C	F	C	F	C-	A	F	A	C	B	A	A
LOUISIANA	B	C	D	C	F	D+	A	B	A	A	F	C	A
MAINE	A	C	I	B	F	C-	B	F	A	C	A	A	A
MARYLAND	I	I	I	I	B	B	C	A	A	A	C	A	A
MASSACHUSETTS	I	F	F	F	F	D+	A	A	A	A	D	B	I
MICHIGAN	DNR	D	F	F	B	C-	F	DNR	DNR	NG	DNR	DNR	DNR
MINNESOTA	A	A	C	B	I	B	A	B	A	A	F	C	A
MISSISSIPPI	B	C	F	C	F	D	B	F	A	C	D	A	A
MISSOURI	F	D	F	F	D	D	A	A	A	A	F	D	A
MONTANA	F	A	C	C	F	D	B	F	A	C	F	C	F
NEBRASKA	I	A	B	B	F	C-	B	F	F	F	D	C	F
NEVADA	F	I	F	F	B	D	F	A	A	A	D	C	F
NEW HAMPSHIRE	A	B	D	B	D	C+	B	B	A	A	A	C	A
NEW JERSEY	A	F	I	C	C	B-	B	B	A	A	F	A	A
NEW MEXICO	D	D	C	D	C	C-	A	A	A	A	A	B	A
NEW YORK	B	D	F	D	C	C+	A	C	A	B	F	B	F
NORTH CAROLINA	F	B	D	D	I	D+	A	A	C	B	A	F	A
NORTH DAKOTA	I	A	A	A	F	D+	B	F	F	F	C	B	F
OHIO	B	D	F	D	D	C-	A	A	B	A	B	A	A
OKLAHOMA	F	F	F	F	F	D-	A	A	A	A	C	B	A
OREGON	I	A	A	A	D	C+	F	A	F	C	F	A	F
PENNSYLVANIA	B	D	F	D	D	C-	A	B	B	B	D	A	F
RHODE ISLAND	A	B	F	C	D	C	A	A	A	A	C	A	F
SOUTH CAROLINA	A	B	C	B	I	B-	B	A	C	B	F	A	A
SOUTH DAKOTA	D	A	A	B	F	D	B	F	A	C	F	D	F
TENNESSEE	DNR	DNR	DNR	DNR	F	D	B	DNR	DNR	NG	DNR	DNR	DNR
TEXAS	F	F	F	F	D	D-	A	A	A	A	D	F	A
UTAH	D	C	D	D	D	D+	B	F	A	C	D	F	F
VERMONT	A	A	A	A	D	B-	A	A	A	A	A	B	A
VIRGINIA	F	F	I	F	D	D+	A	A	A	A	A	C	A
WASHINGTON	A	C	D	C	D	C	C	F	A	C	D	C	A
WEST VIRGINIA	B	B	B	B	F	C-	C	B	A	A	B	C	A
WISCONSIN	A	C	C	B	F	C	A	A	A	A	D	A	A
WYOMING	I	B	C	C	D	C	B	A	A	A	A	B	A
UNITED STATES	C	C	D	C	D	C-	B	B	B	B	C	B	B

		Data Use							Health Status						
											Youth Tobacco Use				
	Budget	Data Use: Sealants	Data Use: Untreated Caries	Data Use: Caries Experience	Data Use: Recency of Dental Visits	Data Use: Fluoridation	Data Use	Infra-structure	Adults w/ 6 or more removed teeth due to decay/ disease	Edentulous Elderly	High School Cigarette Use	High School Male Smokeless Tobacco Use	Youth Tobacco Use	Change in Oral Cancer Mortality Rates	Health Status
	C	C	C	C	F	B	C	**B-**	C	D	C	D	D	D	**D+**
	B	D	D	D	C	C	D	**C+**	B	B	D	F	F	D	**C-**
	C	C	D	D	D	F	D	**C+**	B	B	C	B	C	B	**B-**
	C	B	C	B	D	A	B	**B**	C	C	D	F	F	D	**D+**
	C	C	D	C	D	F	D	**D+**	B	B	C	C	C	B	**B-**
	B	B	B	B	C	B	B	**B**	B	B	D	F	F	A	**C+**
	C	C	C	C	B	C	C	**B-**	B	B	D	B	C	A	**B**
	B	A	A	A	A	A	A	**B+**	C	C	C	C	C	A	**C+**
	A	D	D	D	C	C	D	**C-**	C	C	B	B	B	A	**B-**
	C	C	C	C	B	B	C	**C**	C	B	C	C	C	C	**C**
	B	B	D	F	D	A	C	**B**	C	C	C	D	D	B	**C**
	B	A	A	A	A	B	A	**B+**	B	A	C	B	C	A	**B+**
	D	B	B	B	C	C	B	**C+**	B	C	C	C	C	B	**C+**
	C	C	C	C	C	B	C	**B**	C	B	D	C	D	B	**C+**
	C	B	A	A	A	A	B	**B**	C	D	D	C	D	B	**C-**
	C	B	B	B	B	B	B	**C**	C	B	D	D	D	A	**C+**
	D	D	C	D	C	B	C	**D-**	B	B	D	D	D	B	**C+**
	B	B	B	B	B	C	B	**B**	D	F	F	I	F	B	**D**
	D	C	C	C	F	B	C	**C+**	C	D	D	D	D	C	**D+**
	A	A	B	C	B	B	B	**B**	C	D	C	C	C	A	**C**
	B	C	C	C	C	C	C	**B-**	C	C	C	B	C	C	**C**
	C	C	C	F	D	B	C	**C+**	C	C	D	B	C	A	**C+**
	NG	DNR	DNR	DNR	DNR	DNR	NG	**F**	C	B	D	C	D	B	**C+**
	D	D	C	C	B	B	C	**C+**	B	B	D	D	D	A	**B-**
	C	B	B	B	D	C	C	**C+**	C	D	C	D	D	F	**D**
	D	D	F	C	D	C	D	**C+**	C	D	D	D	D	A	**C**
	F	C	C	B	C	C	C	**C-**	C	C	D	F	F	D	**D+**
	D	F	F	F	C	B	D	**D**	B	C	D	F	F	A	**C+**
	D	B	B	B	B	B	B	**C-**	C	B	D	C	D	A	**C+**
	B	A	B	B	B	B	B	**B+**	C	C	C	C	C	C	**C**
	C	C	F	F	D	F	D	**C**	B	B	C	C	C	A	**B**
	A	A	A	A	A	B	B	**B+**	B	C	F	D	F	F	**D+**
	D	B	C	C	C	C	C	**C**	C	B	D	C	D	A	**C+**
	B	B	B	B	F	D	C	**B**	C	C	D	C	D	B	**C**
	C	C	C	F	D	F	D	**D+**	C	D	F	F	F	A	**C-**
	B	A	A	A	A	B	A	**B+**	C	C	D	D	D	A	**C**
	B	A	A	A	A	A	A	**B+**	C	D	D	F	F	A	**C-**
	D	C	C	C	D	F	D	**D**	B	B	C	D	D	B	**C+**
	D	B	B	B	B	B	B	**C+**	C	C	D	D	D	A	**C**
	C	F	F	B	B	B	C	**B-**	C	C	C	B	C	A	**C+**
	C	D	D	D	C	C	D	**C**	C	C	F	C	D	F	**D**
	F	D	D	D	D	D	D	**D**	C	C	D	F	F	F	**D**
	NG	DNR	DNR	DNR	DNR	DNR	NG	**C**	C	C	D	F	F	C	**D+**
	D	C	D	D	D	C	D	**C+**	B	B	D	D	D	B	**C+**
	F	B	B	B	B	B	B	**C-**	B	B	B	B	B	A	**B**
	A	B	B	B	B	B	B	**B+**	C	C	C	C	C	A	**C+**
	B	B	C	B	B	C	B	**B+**	B	C	I	I	I	B	**B-**
	C	I	I	I	F	B	D	**C-**	B	B	D	D	D	B	**C+**
	B	C	C	B	B	B	B	**B-**	F	F	F	F	F	B	**D-**
	C	B	C	B	C	B	B	**B**	B	B	D	C	D	B	**C+**
	A	C	C	C	F	D	D	**B**	B	B	D	D	D	F	**C-**
	C	**C**	**C**	**C**	**C**	**C**	**C**	**C+**	**C**	**C**	**D**	**D**	**D**	**B**	**C**

Grades

State	POLICIES												FINAL GRADE
			TOBACCO TAXES				DENTAL BOARD POLICIES						
	Fluoridation Laws	Competitive Food Policies	Cigarette Excise Taxes	Smokeless Tobacco Excise Taxes	Tobacco Taxes	Medicaid Adult Dental Policies	Dentist Licensure by Credentials	Hygienist Licensure by Credentials	Hygienist Practice Acts: Teeth Cleaning	Hygienist Practice Acts: Sealants	Dental Board Policies	Policies	STATE GRADE
ALABAMA	D	D	F	NG	F	F	A	F	F	F	D	D-	C-
ALASKA	D	D	B	B	B	D	A	A	C	C	B	C-	C
ARIZONA	D	D	B	NG	B	D	A	A	C	C	B	C-	C+
ARKANSAS	D	D	D	D	D	D	A	A	D	F	C	D	C-
CALIFORNIA	C	B	C	C	C	A	A	A	B	B	B	B-	C
COLORADO	D	C	F	D	D	F	A	A	B	B	B	D+	C+
CONNECTICUT	B	C	A	NG	A	A	A	A	B	B	B	B	B-
DELAWARE	B	D	F	F	F	F	F	A	C	C	C	D	C+
DIST. OF COLUMBIA	A	C	B	F	C	F	A	A	C	F	C	C-	C
FLORIDA	D	C	F	D	D	D	F	F	C	F	D	D	C-
GEORGIA	B	C	F	F	F	C	F	F	F	F	F	D+	C
HAWAII	D	B	A	C	B	D	F	F	D	D	D	C-	C+
IDAHO	D	C	F	C	D	D	A	A	B	B	B	C-	C-
ILLINOIS	A	C	B	F	C	B	A	A	D	D	C	C+	C+
INDIANA	D	D	D	F	D	B	A	A	C	F	C	D+	C+
IOWA	D	D	D	D	D	C	A	A	C	C	B	D+	C
KANSAS	D	D	C	F	D	D	A	A	C	C	B	D+	D+
KENTUCKY	B	C	F	F	F	B	A	A	C	C	B	C	C
LOUISIANA	D	D	D	D	D	C	A	A	D	D	C	D+	D+
MAINE	F	B	B	C	B	D	A	A	C	C	B	C-	C+
MARYLAND	D	C	B	F	C	C	A	A	D	D	C	C-	C+
MASSACHUSETTS	D	D	A	A	A	F	A	A	C	C	B	C-	C
MICHIGAN	C	D	A	D	B	C	A	A	B	C	B	C	C-
MINNESOTA	A	D	D	D	D	B	A	A	C	C	B	C+	C+
MISSISSIPPI	D	C	F	F	F	D	A	A	D	F	C	D	D+
MISSOURI	D	D	F	F	F	B	A	A	B	B	B	C-	C-
MONTANA	D	D	F	F	F	D	A	A	C	C	B	D	D
NEBRASKA	B	C	C	D	C	A	A	A	C	C	B	C+	C
NEVADA	B	D	F	D	D	D	A	C	B	B	B	C-	C-
NEW HAMPSHIRE	F	D	D	D	D	D	A	A	C	C	B	D	C
NEW JERSEY	D	C	A	D	B	A	A	A	D	F	C	C	C
NEW MEXICO	D	D	C	D	C	A	A	A	A	A	B	C	C+
NEW YORK	D	C	A	D	B	A	A	A	C	C	B	C+	C+
NORTH CAROLINA	D	B	F	F	F	A	A	A	F	F	D	C-	C
NORTH DAKOTA	D	D	D	NG	D	I	A	A	C	C	B	D+	C-
OHIO	B	D	D	F	D	B	A	A	C	D	C	C-	B-
OKLAHOMA	D	D	F	D	D	D	A	A	C	C	B	D	C
OREGON	D	D	A	B	A	C	A	A	B	C	B	C	C-
PENNSYLVANIA	D	D	B	F	C	B	A	A	D	D	C	C-	C-
RHODE ISLAND	D	D	A	D	B	A	A	A	C	C	B	C	C+
SOUTH CAROLINA	D	D	F	F	F	D	F	A	D	D	D	D-	C
SOUTH DAKOTA	B	D	D	F	D	A	A	A	C	C	B	C	D+
TENNESSEE	D	D	F	F	F	DNR	A	A	C	F	C	D	C-
TEXAS	D	D	D	D	D	F	A	A	C	C	B	D	C-
UTAH	D	D	C	D	C	D	A	A	C	C	B	D+	C-
VERMONT	D	D	B	C	B	A	A	A	C	C	B	C	B-
VIRGINIA	D	C	F	F	F	F	F	A	C	C	C	D	C+
WASHINGTON	D	D	A	A	A	A	A	A	B	B	B	B-	C-
WEST VIRGINIA	D	B	D	F	D	D	A	A	F	F	D	D+	C-
WISCONSIN	D	D	C	D	C	A	A	A	B	C	B	C	B-
WYOMING	D	D	D	D	D	D	F	F	C	F	D	D-	C-
UNITED STATES	D	D	C	D	D	C	B	A	C	C	C	C-	C

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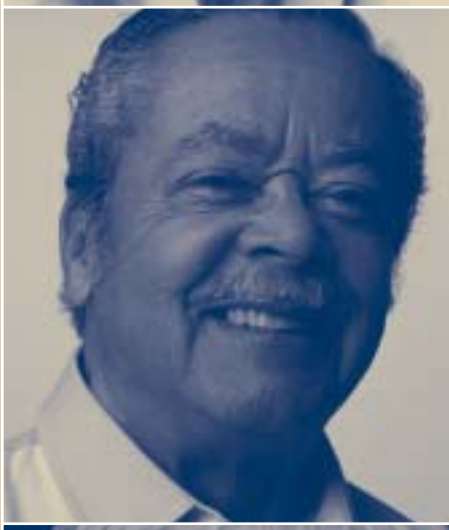

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