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The Voice of  
Dental Education

**Statement of the  
American Dental Education Association (ADEA)**

**Hearing on  
"Primary Health Care Access Reform: Community Health  
Centers and the National Health Service Corps"**

**The United States Senate Health, Education, Labor and  
Pensions Committee**

**April 30, 2009**

Good morning, Mr. Chairman and members of the Committee. I am Dr. Caswell Evans, Associate Dean for Prevention and Public Health Sciences, at the University of Illinois at Chicago College of Dentistry. I currently serve on the Legislative Advisory Committee of the American Dental Education Association (ADEA) on whose behalf I am honored to appear before you to offer recommendations with regard to primary health care access reform.

The American Dental Education Association represents all 58 dental schools in the United States, in addition to more than 700 dental residency training programs and nearly 600 allied dental programs, as well as more than 12,000 faculty who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge, where the majority of dental research is conducted, and where significant dental care is provided. ADEA member institutions serve as dental homes for a broad array of racially and ethnically diverse patients, many who are uninsured, underinsured, or reliant on public programs such as Medicaid and the Children's Health Insurance Program for their health care.

U.S. academic dental institutions (ADI) are the fundamental underpinning of the nation's oral health. As educational institutions, dental schools, allied dental education, and advanced dental education programs are the source of a qualified workforce, influencing both the number and type of oral health providers. Academic dental institutions play an essential role in conducting research, educating and training the future oral health workforce. All U.S. dental schools operate dental clinics and most have affiliated satellite clinics where preventative and comprehensive oral health care is provided as part of the educational mission. All dental residency training programs provide care to patients through dental school clinics or hospital-based clinics. Additionally, all dental hygiene programs operate on-campus dental clinics where classic preventive oral health care (cleaning, radiographs, fluoride, sealants, nutritional and oral health instruction) can be provided four to five days per week under the supervision of a dentist. All care provided is supervised by licensed dentists as is required by state practice acts. All dental hygiene programs have established relationships with practicing dentists in the community for referral of patients.

As safety net providers, academic dental institutions are the dental home to a broad array of vulnerable and underserved low-income patient populations including racially and ethnically diverse patients, elderly and homebound individuals; migrants; mentally, medically or physically disabled individuals; institutionalized individuals; HIV/AIDS patients; Medicaid and State Children's Health Insurance Program (SCHIP) children and uninsured individuals. These dental clinics serve as key referral resources for specialty dental services not generally accessible to Medicaid, SCHIP, and other low-income uninsured patients. ADIs provide care at reduced fees and millions of dollars of uncompensated care is provided each year.

### **Dental Access**

Access to oral health care is a growing challenge in the US. As many as 130 million American adults and children lack dental insurance, nearly three times as many as lack medical insurance. Now more than ever, academic dental institutions are a critical source of oral health services to those with the highest burden of disease and unmet

need. The disparities in oral health care are stark: 100 million Americans lack adequate fluoridated drinking water and only 10% of the highest risk children have dental sealants. Yet, fluoridation and sealants have been shown to prevent dental disease and reduce health care costs over time. Dental caries remains the single most common disease among children in America, with five times as many sufferers as asthma. Half of all children have untreated tooth decay by age 9 and 70% have at least one cavity by 18. Thirty percent of Americans over the age of 65 have no teeth. In the face of these alarming realities, academic dental institutions are working to reduce the burden of oral health disease.<sup>1</sup>

Many Americans do not have access to dental services given a lack of dental providers in their areas, or a lack of dentists who are willing to accept insurance. Over 2,000 counties or partial counties have been designated dental Health Professions Shortage Areas (D-HPSA), where individuals suffer from an absolute lack of dental providers. Less than half of these are served by safety net providers. Many dentists do not accept patients insured by public insurance, such as Medicaid.<sup>2</sup> This was the case of a 12 year old Maryland boy whose untreated infected tooth resulted in his death. His death could have been avoided by simply removing his tooth, a procedure costing about \$80. Though covered by Medicaid, the boy's family was unable to find a dentist willing to take new Medicaid patients. The implications of not having access to oral health care can be severe and even fatal.

Currently a number of dental schools are taking it upon themselves to address dental workforce issues around the lack of diversity and lack of providers for underserved communities. The Arizona School of Dentistry and Oral Health at A.T. Still University is a new school with a focus toward social responsibility. Students spend their fourth year in a residency at a health center, Indian Health Service site, or Veterans Affairs facility.<sup>3</sup> The school was founded to help meet the staggering need for dental care in Arizona and to avert a significant shortage of dentists - given that 2,000 more dentists are retiring each year than entering practice in the state.<sup>4</sup> Some 200 applicants vie for 62 spots each year. The dental school graduated its first class in 2007. Graduates are specifically trained to be culturally-competent, community-responsive general dentists who are able and willing to serve as a resource in their community for dental public health issues.

Additionally, other dental schools in California, Kentucky, Missouri, New Mexico, and Oklahoma are exposing students during their training to patients covered by Medicaid or the State Children's Health Insurance Program (SCHIP). The Illinois at Chicago College

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<sup>1</sup> Ruddy G "Health Centers' Role in Addressing the Oral Health Needs of the Medically Underserved. "Report" National Association of Community Health Centers, Washington, DC August 2007.

<sup>2</sup> Ruddy G "Health Centers' Role in Addressing the Oral Health Needs of the Medically Underserved. "Report" National Association of Community Health Centers, Washington, DC August 2007.

<sup>3</sup> Krause B. "State Efforts to Improve Children's Oral Health," Issue Brief, Center for Best Practices, National Governor's Association, Washington, DC. November 20, 2002.

<sup>4</sup> Ruddy G "Health Centers' Role in Addressing the Oral Health Needs of the Medically Underserved. "Report" National Association of Community Health Centers, Washington, DC August 2007.

of Dentistry, the University of Michigan School of Dentistry and the College of Dental Medicine Columbia University go further and link students to underserved communities in an effort to encourage subsequent work with low-income and other vulnerable populations.<sup>5</sup>

Pipeline, Profession and Practice is a three year old program funded by the Robert Wood Johnson Foundation that now involves 27% of U.S. dental schools. Each school is slated to establish a community-based clinical education program and develop recruitment and retention programs directed at underrepresented minorities and those from low-income backgrounds. Even before graduation, students are in a position to improve access to oral health care.

### **Dental Workforce**

The representation of minorities in the health care workforce has not increased in over a decade. Black, Hispanics and American Indians represent more than 25% of the U.S. population, yet comprise less than: 9% of nurses, 6% of physicians and 5% of dentists. The U.S. Bureau of Labor Statistics (BLS), which placed the number of practicing dentists at 161,000 in 2006,<sup>6</sup> projects a 9 percent growth in the number of dentists through 2016. This rate would bring the total number of practicing dentists to 176,000.

About 80 percent of dentists are solo practitioners in primary care general dentistry while the remaining dentists practice one of nine recognized specialty areas: 1) endodontics; 2) oral and maxillofacial surgery; 3) oral pathology; 4) oral and maxillofacial radiology; 5) orthodontics; 6) pediatric dentistry; 7) periodontics; 8) prosthodontics; and 9) public health dentistry.

The vast majority of the 176,634 professionally active dentists in the U.S. are White non-Hispanic. At the present time the U.S. population is 303,375,763.<sup>7</sup> At the time of the last census, when there were 22 million fewer people, the largest segment of the U.S. population was White (75 percent), but an increasing percentage was minority with 35.3 million (13 percent) Latino, and 34.6 million (12 percent) Black or African Americans

The allied dental workforce, comprised of dental hygienists, dental assistants and dental laboratory technologists, is central to meeting increasing needs and demands for dental care. About 167,000<sup>8</sup> dental hygienists, 280,000<sup>9</sup> dental assistants and 53,000<sup>10</sup> dental laboratory technologists were in the U.S. workforce in 2006. Both dental hygiene and dental assisting are among the fastest growing occupations in the country with expected growth of 30 percent and 29 percent respectively through 2016, bringing the total

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<sup>5</sup> Ryan J. *Improving Oral Health: Promises and Prospects*. National Health Policy Forum Background Paper. Washington, DC, June 2003.

<sup>6</sup> U.S. Bureau of Labor Statistics, <http://www.bls.gov/oco/content/ocos072.stm>, accessed February 5, 2008.

<sup>7</sup> U.S. Bureau of the Census, <http://www.census.gov/population/www/popclockus.html>, accessed February 5, 2008.

<sup>8</sup> U.S. Bureau of Labor Statistics, <http://www.bls.gov/oco/pdf/ocos097.pdf>, accessed February 5, 2008.

<sup>9</sup> U.S. Bureau of Labor Statistics, <http://www.bls.gov/oco/ocos163.htm>, accessed February 5, 2008.

<sup>10</sup> U.S. Bureau of Labor Statistics, <http://www.bls.gov/oco/ocos238.htm>, accessed February 5, 2008.

numbers of dental hygienists to about 217,000 and dental assistants to 361,000. Only about 2,000 dental laboratory technologists will be added to the workforce by 2016. The ability to increase the number is limited. At the present time there are only 21 accredited training programs.

We must acknowledge that the current dental workforce is unable to meet present day demand and need for dental care. If every man, woman and child were to have a dental home and were covered by dental insurance, the nation would clearly have an insufficient number of dentists to care for the population. We are not close to being at this point but we aspire to get there as quickly as possible so everyone who needs and wants dental care is able to achieve optimal oral health.

The need and demand for dental services continues to increase; in large measure this is due to the population explosion. Also, Baby Boomers as well as the geriatric population, are retaining more teeth and there is a growing focus on increasing access and preventative dental care.

Each year academic dental institutions (dental schools, allied dental programs and postdoctoral/advanced dental education programs) graduate thousands of new practitioners to join the dental workforce. About 4,500 predoctoral dental students graduate annually. About half of these new graduates immediately sit for a state licensure exam before beginning private practice as general dentists, or they join the military, the U.S. Public Health Service, or advance their education in a dental specialty. Approximately 2,800 graduates along with hundreds of practicing dentists apply to residency training programs. Nearly 23,000 allied dental health professionals graduate from ADIs each year and join the dental workforce. Approximately 14,000 dental hygiene students, 8,000 dental assistants, and 800 dental laboratory technologists graduate annually.

According to the U.S. Surgeon General, the ratio of dentists to the total population has been steadily declining for the past 20 years, and at that rate, by 2021, there will not be enough active dentists to care for the population. The number of Dental Health Professions Shortage Areas (D-HPSAs) designated by the U.S. Health Resources and Services Administration (HRSA) has grown from 792 in 1993 to 4,048 in 2008. In 1993, HRSA estimated 1,400 dentists were needed in these areas; by 2008, the number grew to 9,432. Nearly 48 million people live in D-HPSAs across the country. Although it is unknown how many of these areas can financially support a dentist or attract a dentist by virtue of their infrastructure or location, it is clear that more dentists are needed in these areas.

### **Oral Health and Community Health Centers**

Over 2000 counties or partial counties have been designated dental Health Professions Shortage Areas where individuals suffer from an absolute lack of providers in addition to all of the other barriers facing the uninsured and publicly insured. Less than half (875) of these dental HPSAs are served by federally qualified health centers (837), FQHC look-alikes (6), or rural health clinics (32). Many counties eligible for dental HPSA status have not applied for the designation, whether because of the administrative burden or for other reasons.

There are over 7,000 community health centers (CHC); 52.8% are in rural communities<sup>11</sup>. In calendar year 2007 16 million patients were served. The CHC dental workforce includes 6,899 oral health professionals: 2,107 dentists, 806 hygienists and 3,986 assistants<sup>12</sup>.

Currently, community health centers are providing dental services to over 2.3 million patients, a growth of 77% since 2000. Most new dental care patients are likely to be those who lacked access to care prior to seeking it at a health center, therefore more likely to suffer from caries and periodontal disease and require more intensive services than simple preventive care. The people who make up the largest proportion of community health center patients, namely low-income families, members of racial and ethnic minority groups, the uninsured and rural residents, experience more unmet oral health care needs than other groups, and suffer greater losses to their overall health and quality of life as a result. Research shows that the provision of preventive dental care is cost effective.<sup>13</sup>

Of existing community health centers 73% provide oral health services and all new community health centers are now required to provide comprehensive oral health care. But challenges persist as these centers continue to expand their capacity to better meet the oral health needs of their patients. Community health centers cannot bridge the gap between the supply and demand for oral health care alone. They will continue to depend on the important contributions of the large, private dentistry workforce as they work to provide dental care for the medically underserved.

### **CHC State by State Analysis**

Appendices A, B, and C provide state-by-state data on the proportion of community health centers providing oral health services, community health center dental staff, and related patients and visits in 2005. As Appendix A demonstrates, 100% of community health centers in **Vermont** and **Nevada** provide all four major dental service categories – preventive, restorative, emergency, and rehabilitative, and 100% of the community health centers in three other states (**Delaware, Missouri, and New Mexico**) provide three out of the four services (preventive, restorative, and emergency).

Appendix B provides for each state information on patients who rely on community health center dental services. Not surprisingly, these centers in eight large states (**California, Florida, Massachusetts, Michigan, New York, Pennsylvania, Texas, and Washington**) account for half of all community health center dental patients. While nationally 17% of all health center patients use health center dental services, more than 25% of health center patients in six states (**Connecticut, Michigan, Missouri, Nebraska, Vermont, and Washington**) receive health center dental services.

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<sup>11</sup> Health Resource Service Administration. Accessed May 2007

<sup>12</sup> Uniform Data System, 2007 Data

<sup>13</sup> Ruddy G “Health Centers’ Role in Addressing the Oral Health Needs of the Medically Underserved. “Report” National Association of Community Health Centers, Washington, DC August 2007.

Lastly, Appendix C provides a close look at community health center dental services staffing and visits per dentist and dental hygienist by state. Although nationally the average dentist provided 2,719.5 visits last year, health centers in three states (**California, Florida, and Wyoming**) provided over 3,000. In addition, the average dental hygienist in four states (**Connecticut, Maryland, Michigan, and Oregon,**) and Puerto Rico provided over 1,600 visits, compared to the national average of 1,279.8.

### **Oral Health and the National Health Service Corps**

The National Health Service Corps (NHSC) has been important to the oral health of the underserved for more than 26 years as it positively addresses two public health concerns: (1) enabling underserved populations to access qualified, high-skilled health care practitioners; and (2) facilitating continued interest in serving these special populations after participants have left NHSC. It is more important than ever that the NHSC embrace a bold proactive health agenda. Due to the increased focus on children's oral health, the findings reported in the *U.S. Surgeon General's Report on Oral Health*, and increasing research data linking oral health to systemic health, the NHSC is of paramount importance.

The National Health Service Corps dispatches clinicians to urban and rural communities with severe shortages of health care providers. Currently, more than 4,000 NHSC clinicians, including dentists, physicians, nurse practitioners, physician assistants, nurse midwives, and behavioral health professionals, provide health care services to nearly five million Americans. About half of all NHSC providers are at community health center sites. In order to meet the medical staffing needs of underserved communities, including hundreds of vacancies at community health centers, the NHSC must be expanded. Scholarship and loan repayment programs ease provider shortages with approximately 20% of loan repayment awards currently going to dentists.<sup>14</sup>

There are several straightforward steps that Congress can take to immediately address the challenges we face. The answer lies in prioritizing resources both in terms of manpower and funding to tackle these challenges. Some are fairly simple and pragmatic while others, admittedly, will require coordination among multiple interested parties and compromise. The American Dental Education Association stands ready to work with Congress and our colleagues in the dental community to ameliorate the access to dental care problems the nation faces and to meet the needs of the future dental workforce. Specifically, we recommend:

- Evolution in dental education to involve a more diverse, representative student body, greater attention to public health, and collaboration with dental hygienists as well as primary care providers will help improve access to oral health care in the long term;
- Financial, administrative and clinical support incentives will increase the likelihood that dentists at both ends of their careers will choose to care for the underserved. Reimbursement and remuneration may also need to more

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<sup>14</sup> Ruddy G "Health Centers' Role in Addressing the Oral Health Needs of the Medically Underserved." "Report" National Association of Community Health Centers, Washington, DC August 2007.

closely reflect those in the private sector if more dentists are to choose to care for the underserved;

- Innovative programs involving public-private partnerships in several states have improved dentist participation in Medicaid and increased take-up by eligible persons. These programs provide templates for other states to devise solutions to challenges around use;
- Maintain Support and restore adequate funding for Title VII General and Pediatric Dentistry Residency Training programs;
- Strengthen and Improve Medicaid;
- Prioritize Dental Access in Rural Health Clinics;
- Bolster Prevention to Eradicate Dental Caries; and
- Establish Dental Homes for Everyone.

### **Conclusion**

In conclusion, the American Dental Education Association thanks the Committee for considering our recommendations with regard to addressing access and dental workforce issues. A sustained federal commitment is needed to meet the challenges oral disease poses to our nation's citizens including children, the vulnerable and disadvantaged. Congress must address the growing needs in educating and training the oral health care and health professions workforce to meet the growing and diverse needs of the future. ADEA stands ready to partner with you to develop and implement a national oral health plan that guarantees access to dental care for everyone, eliminates oral health disparities, bolsters the nation's oral health infrastructure, eliminates academic and dental workforce shortages, and ensures continued dental health research.

## Appendix A

### Percent of Community Health Center Grantees Providing Dental Services Onsite\* by State, 2005

State	# Health Center Grantees	% Dental Preventive Onsite	% Dental Restorative Onsite	% Dental Emergency Onsite	% Dental Rehabilitative Onsite
Alabama	15	73.3%	73.3%	66.7%	40.0%
Alaska	24	66.7%	58.3%	58.3%	25.0%
Arizona	14	92.9%	85.7%	100.0%	64.3%
Arkansas	12	75.0%	75.0%	75.0%	50.0%
California	97	74.2%	72.2%	72.2%	44.3%
Colorado	15	80.0%	80.0%	80.0%	73.3%
Connecticut	10	90.0%	90.0%	90.0%	70.0%
Delaware	3	100.0%	100.0%	100.0%	33.3%
District of Columbia	3	66.7%	33.3%	33.3%	33.3%
Florida	36	69.4%	66.7%	69.4%	47.2%
Georgia	23	65.2%	52.2%	52.2%	34.8%
Hawaii	11	54.5%	54.5%	54.5%	27.3%
Idaho	10	70.0%	70.0%	70.0%	60.0%
Illinois	33	75.8%	66.7%	69.7%	45.5%
Indiana	13	61.5%	61.5%	53.8%	53.8%
Iowa	9	77.8%	77.8%	77.8%	66.7%
Kansas	9	55.6%	33.3%	44.4%	33.3%
Kentucky	14	64.3%	64.3%	57.1%	28.6%
Louisiana	18	66.7%	66.7%	55.6%	44.4%
Maine	16	75.0%	62.5%	62.5%	50.0%
Maryland	13	76.9%	69.2%	69.2%	46.2%
Massachusetts	33	72.7%	69.7%	66.7%	51.5%
Michigan	26	76.9%	73.1%	73.1%	61.5%
Minnesota	12	66.7%	66.7%	66.7%	33.3%
Mississippi	19	84.2%	78.9%	84.2%	36.8%
Missouri	17	100.0%	100.0%	100.0%	82.4%
Montana	12	75.0%	66.7%	58.3%	41.7%
Nebraska	5	80.0%	80.0%	80.0%	20.0%
Nevada	2	100.0%	100.0%	100.0%	100.0%
New Hampshire	8	62.5%	62.5%	50.0%	50.0%
New Jersey	17	76.5%	70.6%	70.6%	64.7%
New Mexico	14	100.0%	100.0%	100.0%	78.6%
New York	47	91.5%	89.4%	85.1%	63.8%
North Carolina	24	75.0%	75.0%	75.0%	37.5%

Oregon	21	61.9%	52.4%	57.1%	28.6%
Pennsylvania	29	86.2%	79.3%	82.8%	62.1%
Rhode Island	7	100.0%	100.0%	85.7%	42.9%
South Carolina	21	33.3%	28.6%	33.3%	28.6%
South Dakota	7	57.1%	42.9%	42.9%	28.6%
Tennessee	22	50.0%	45.5%	50.0%	27.3%
Texas	43	88.4%	86.0%	88.4%	48.8%
Utah	11	90.9%	72.7%	72.7%	63.6%
Vermont	3	100.0%	100.0%	100.0%	100.0%
Virginia	21	57.1%	47.6%	57.1%	28.6%
Washington	23	95.7%	95.7%	87.0%	52.2%
West Virginia	27	44.4%	37.0%	37.0%	22.2%
Wisconsin	15	80.0%	73.3%	73.3%	73.3%
Wyoming	5	80.0%	20.0%	20.0%	0.0%
United States**	952	73.4%	68.7%	68.8%	46.4%

North Dakota	4	25.0%	25.0%	25.0%	0.0%
Ohio	23	73.9%	69.6%	73.9%	56.5%
Oklahoma	9	44.4%	44.4%	44.4%	22.2%

\* "Onsite" includes services rendered by salaried employees, contracted providers, National Health Service Corp Staff, volunteers, and others such as out-stationed eligibility workers who render services in the health center's name. Grantees may also provide these services through formal referral arrangements.

\*\* US totals include American Samoa, Fed. States of Micronesia, Guam, Marshall Islands, Virgin Islands, and Palau.

Note: Includes only federally-funded health centers, and therefore may underreport the volume of health care delivered by health centers.

Source: Bureau of Primary Health Care, HRSA, DHHS, 2005 Uniform Data System.

## Appendix B

### Community Health Center Dental Services Patients, Visits per Patient, and Percent of Total Patients by State, 2005

State	Total Dental Services Patients	Average Dental Visits per Dental Patient	Percent of Total Patients Using Dental Services
Alabama	42,057	1.6	15%
Alaska	16,243	1.9	21%
Arizona	40,353	2.2	14%
Arkansas	18,565	1.7	15%
California	285,460	2.8	14%
Colorado	65,018	1.9	16%
Connecticut	58,046	1.7	29%
Delaware	3,874	2.1	18%
District of Columbia	13,851	1.9	18%
Florida	102,464	1.9	16%
Georgia	24,137	1.4	10%
Hawaii	13,480	2.1	16%
Idaho	13,599	2.0	15%
Illinois	66,582	1.9	9%
Indiana	22,089	1.8	14%
Iowa	16,715	2.0	18%
Kansas	4,689	1.5	8%
Kentucky	21,424	1.7	11%
Louisiana	27,780	1.7	22%
Maine	20,604	1.5	16%
Maryland	27,574	1.6	16%
Massachusetts	86,305	2.4	20%
Michigan	113,385	1.5	27%
Minnesota	29,804	1.9	24%
Mississippi	41,031	1.7	15%
Missouri	71,510	2.1	24%
Montana	18,287	1.5	24%
Nebraska	5,989	2.2	17%
Nevada	Data Unavailable	Data Unavailable	Data Unavailable
New Hampshire	4,550	1.1	8%

New Jersey	57,914	2.0	22%
New Mexico	53,839	2.1	24%
New York	196,811	2.1	18%
North Carolina	52,196	1.9	17%
North Dakota	3,726	1.8	17%
Ohio	53,171	1.9	17%
Oklahoma	10,184	1.9	12%
Oregon	41,620	1.8	21%
Pennsylvania	72,543	2.1	16%
Puerto Rico	27,699	1.7	7%
Rhode Island	19,724	1.7	21%
South Carolina	11,319	1.6	4%
South Dakota	7,353	2.0	15%
Tennessee	29,648	1.7	12%
Texas	117,025	1.9	18%
Utah	13,169	1.8	16%
Vermont	10,526	1.6	30%
Virginia	21,803	1.8	11%
Washington	174,972	2.2	30%
West Virginia	23,653	1.5	8%
Wisconsin	37,513	1.9	24%
Wyoming	4,779	1.6	25%
United States*	2,340,710	2.4	17%

\* U.S. totals include American Samoa, States of Micronesia, Guam, Marshall Islands, Virgin Islands, and Palau.

Note: Includes only federally-funded health centers, and therefore may underreport the volume of health care delivered by health centers.

Source: Bureau of Primary Health Care, HRSA, DHHS, 2005 Uniform Data System.

## Appendix C

### Community Health Center Dental Services Staffing and Visits by State, 2005

State	Dentist Visits	Visits per FTE Dentist	Dental Hyg Visits	Visits Per FTE Hygienist	Dental Support Staff* FTE	Total Dental Services FTE	Total Dental Services Visits
Alabama	67,204	2,941.1	19,945	1,360.5	36.8	74.3	87,149.0
Alaska	31,210	2,100.3	3,429	546.0	29.2	50.3	34,639.0
Arizona	88,994	2,604.4	21,737	1,232.3	96.5	148.3	110,731.0
Arkansas	31,030	2,800.5	5,486	1,284.8	24.3	39.7	36,516.0
California	808,672	3,239.2	28,780	1,100.6	497.6	773.4	837,452.0
Colorado	122,860	2,642.7	22,624	1,147.3	102.9	169.1	145,484.0
Connecticut	100,335	2,837.5	45,555	1,867.0	58.6	118.4	145,890.0
Delaware	8,278	1,851.9	1,646	1,266.2	5.7	11.5	9,924.0
District of Columbia	25,756	2,846.0	0	0.0	11.8	20.8	25,756.0
Florida	195,566	3,177.9	34,402	1,284.1	126.2	214.5	229,968.0
Georgia	34,186	2,387.3	8,682	1,205.8	22.2	43.7	42,868.0
Hawaii	28,702	1,807.4	2,122	742.0	28.0	46.8	30,824.0
Idaho	26,655	469.2	5,342	1,077.0	19.2	35.4	31,997.0
Illinois	128,316	3,050.1	12,073	1,223.2	73.0	124.9	140,389.0
Indiana	39,730	2,579.9	11,668	1,511.4	29.0	52.1	51,398.0
Iowa	34,056	2,742.0	5,985	1,031.9	31.5	46.7	40,041.0
Kansas	7,177	2,648.3	1,866	790.7	6.0	11.1	9,043.0
Kentucky	37,280	2,782.1	9,184	1,111.9	24.6	46.2	46,464.0
Louisiana	48,409	2,384.7	2,746	888.7	30.4	53.8	51,155.0
Maine	31,140	2,077.4	25,309	1,202.3	30.4	66.4	56,449.0
Maryland	45,259	2,935.1	5,994	1,927.3	24.3	42.9	51,253.0
Massachusetts	205,754	2,870.1	37,419	1,514.3	94.8	191.2	243,173.0
Michigan	174,784	2,703.5	79,163	1,663.1	114.1	226.4	253,947.0
Minnesota	56,932	2,564.5	14,316	944.3	28.6	66.0	71,248.0
Mississippi	68,943	2,496.1	7,991	1,225.6	40.9	75.1	76,934.0
Missouri	148,374	2,582.2	20,709	1,320.7	108.0	181.1	169,083.0
Montana	27,351	2,811.0	7,146	1,791.0	16.5	30.2	34,497.0
Nebraska	13,359	2,515.8	1,332	672.7	11.7	19.0	14,691.0
Nevada	Data Unavailable	Data Unavailable	Data Unavailable	Data Unavailable	Data Unavailable	Data Unavailable	Data Unavailable
New Hampshire	5,145	2,198.7	3,969	1,160.5	2.5	8.3	9,114.0
New Jersey	116,724	2,824.2	6,497	1,486.7	65.6	111.3	123,221.0
New Mexico	110,404	2,455.1	28,684	1,221.6	92.2	160.7	139,088.0
New York	408,533	2,468.0	78,776	1,558.1	251.2	467.3	487,309.0

North Carolina	96,581	2,530.3	18,872	1,217.5	71.2	124.8	115,453.0
North Dakota	6,777	2,823.8	1,337	568.9	5.6	10.3	8,114.0
Ohio	103,027	2,762.9	15,728	1,012.7	72.4	125.3	118,755.0
Oklahoma	19,325	2,049.3	3,233	829.0	15.9	29.2	22,558.0
Oregon	73,311	2,260.6	24,353	1,742.0	63.4	109.8	97,664.0
Pennsylvania	154,850	2,517.5	33,388	1,239.8	97.1	185.5	188,238.0
Rhode Island	32,567	2,649.9	19,375	1,490.4	31.4	56.7	51,942.0
South Carolina	18,227	2,112.1	4,494	1,129.1	13.6	26.2	22,721.0
South Dakota	14,358	2,033.7	3,845	1,248.4	14.7	24.8	18,203.0
Tennessee	49,224	2,507.6	4,359	736.3	26.4	51.9	53,583.0
Texas	224,858	2,543.6	46,622	1,185.4	186.1	313.8	271,480.0
Utah	23,232	2,242.5	3,176	1,549.3	17.8	30.2	26,408.0
Vermont	16,881	2,718.4	10,030	1,297.5	12.1	26.1	26,911.0
Virginia	40,317	2,599.4	2,660	537.4	33.4	53.9	42,977.0
Washington	391,782	2,893.3	30,543	1,000.4	333.3	499.2	422,325.0
West Virginia	36,623	2,886.0	10,689	1,138.3	26.9	49.0	47,312.0
Wisconsin	72,454	2,575.7	17,672	979.1	57.3	103.5	90,126.0
Wyoming	7,779	3,758.0	4,065	2,032.5	4.1	8.2	11,844.0
Puerto Rico	45,797	2,346.2	5,382	2,152.8	28.3	50.3	51,179.0
United States*	4,728,590	2,719.5	834,042	1,297.8	3,268.2	5,649.6	5,562,632.0

FTE = Full-time employed

\* Includes Dental Assistants, Aids, and Technicians.

\*\* U.S. totals include American Samoa, States of Micronesia, Guam, Marshall Islands, Virgin Islands, and Palau.

Note: Includes only federally-federally funded health centers, and therefore may underreport the volume of health care delivered by health centers.

Source: Bureau of Primary Health Care, HRSA, DHHS, 2005 Uniform Data System.