Strategies to Expand Access to Oral Health Services: Emerging Models and Workforce Innovations

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Today's Presentation

- What is the Oral Health Workforce Research Center?

- Why is oral health research so important?

- Strategies to improve access to oral health services

  - Broadening the settings where are provided

  - Expanding roles for the oral health dental workforce

  - Engaging primary care clinicians to conduct oral health assessments

- State and local initiatives that have increased access

- Using research findings to inform oral health programs and policies

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Health Workforce Research Centers Supported by the Health Resources and Services Administration

- <u>University of California at San Francisco</u>: Long-term Care

- <u>George Washington University, Washington, DC</u> & <u>University of North Carolina at Chapel Hill</u>: Flexible Use of Workers

- <u>University of Washington</u>: Allied Health

- <u>University at Albany, School of Public Health, Center for Health Workforce Studies</u> : Oral Health and Health Workforce Technical Assistance

- <u>University of Michigan:</u> Behavioral Health

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The Oral Health Workforce Research Center

- Based at the Center for Health Workforce Studies (CHWS) at the School of Public Health, University at Albany, State University of New York

- The OHWRC was formed as a partnership between CHWS and the University of California, San Francisco

- Funded under a Cooperative Agreement with HRSA

- Conducts health workforce research aimed at improving the oral health of the nation's population

  - An available, competent, and well distributed professional workforce is required to meet unmet need for oral health services

  - OHWRC conducts studies of the oral health workforce to assist in future health workforce planning

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OHWRC Year 1 Projects (2014-15)

- Update State-level Scope of Practice Index scores for Dental Hygienists

- Comparing Utilization of Medicaid Dental Services in Two States with Different Adult Dental Benefits

- A Study of the Dental Assistant Workforce in the U.S.

- Case Studies of Eight FQHCs that Have Integrated Oral Health and Primary Care Services

- Four State Case Studies of Delivery Models for Dental Care Services in Long-Term Care Settings

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OHWRC Year 2 Projects (2015-16)

- Underrepresented Minority Dentists' Contribution to Reducing Oral Health Disparities

- The Provision of Oral Health Assessment Services by Physician Assistants

- Updating the Scope of Practice Index Scale for Dental Hygienists

- Impact of Dental Residents and Student Externs on Service Capacity at FQHCs

- Teledentistry Case Studies

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Making the Case for Oral Health Workforce Research

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Increasing Evidence of Links Between Oral Health and Physical Health

- Dental caries and periodontal disease are associated with:

  o Coronary artery disease, including stroke and endocarditis
  o Diabetes
  o Pre-term birth and infant mortality
  o Inflammatory diseases, such as rheumatoid arthritis
  o Systemic infections in patients with implants and joint replacements
  o Substance abuse

- Dental caries are preventable and transmissible

- Periodontal disease is often preventable with proper care

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Medical and Dental Services Tend to be Siloed

- Different delivery systems

- Narrow communication between systems:

  o EMRs don't interface with EDRs

  o Referral networks between physicians and dentists are limited

- Different insurance systems

- FQHCs are an important exception

  o Safety net provider required to provide or refer patients needing oral health services

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Oral Health Disparities Are Challenging

- Population-specific:
  - The poor, minorities, including American Indians, children, people with special needs, and the elderly, among others

- Geographic:
  - Rural
  - Inner city urban

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Uneven Access to Oral Health Services is a Public Health Crisis

- Dental caries are the most common and preventable chronic disease of childhood

- Poor oral health affects well-being and productivity

- Lost time from school or work due to oral health problems can disrupt academic success or employment

- Increasing number of costly ED visits for oral health problems

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Key Access Barriers

- Oral health literacy

- Oral health provider availability
    - Shortage/maldistribution
    - Willingness to treat Medicaid patients
    - Scope of practice limitations

- Resources to pay for needed care
    - Even those with dental insurance may be subject to high co-pays or limited service coverage
    - No benefit for seniors under Medicare
    - Limitations on Medicaid dental coverage, particularly for adults

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What We Are Learning From Our Work: Themes from OHWRC Research Studies

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There Are a Variety of Strategies That Can Increase Access to Oral Health Services

- Integrating oral health and primary care services
- Increasing the availability of oral health services in public health settings
- Using team based approaches to oral health service delivery
- Workforce innovations
  - Primary care workforce providing oral health assessments
  - Expanded function dental hygienists and dental assistants
  - New categories of oral health workers, e.g., dental therapists, community dental health coordinators
- Developing local solutions to oral health access issues

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Increasing Access to Service in Public Health Settings:

FQHCs &

Long Term Care

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Case Studies of 8 FQHCs in 9 States: Strategies for Integrating Oral Health & Primary Care

FQHCs:

- are uniquely positioned to provide integrated, patient-centered health and oral health services

- have great opportunities to innovate, especially in the use of novel workforce models to increase access to oral health services for underserved populations

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FQHCs Use Team Based Models for Delivering Oral Health Services

- The traditional dental team is the base:

  - Dentists, dental hygienists, dental assistants

- Primary care providers extend the team

- Oral health team innovations:

  - Public health dental hygienists

  - Community dental health coordinators

  - Dental therapists and dental hygiene therapists

  - Expanded function dental assistants

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Dental Residents and Students (Externs and Interns) Contribute to Oral Health Capacity

- FQHCs benefit from hosting student externs and dental residents:

  o Enhances capacity to meet demand for oral health services

  o Incentive programs, such as loan repayment, are an important tool for recruitment of new oral health professionals

- Students (dentists, dental hygienists, and dental assistants) and residents benefit from rotations in FQHCS:

  o Increases awareness of and experiences meeting the unique needs of the underserved

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Examples of FQHC Oral Health and Primary Care Integration Strategies

- Integrated or interoperable electronic health and dental records

- Oral health assessment at medical intake

- BP checks and health histories at dental visits

- Requiring patients in the dental practice to also be primary care patients

- Scheduling oral health assessments by dental hygienists as part of annual pediatric well visits up to three years of age

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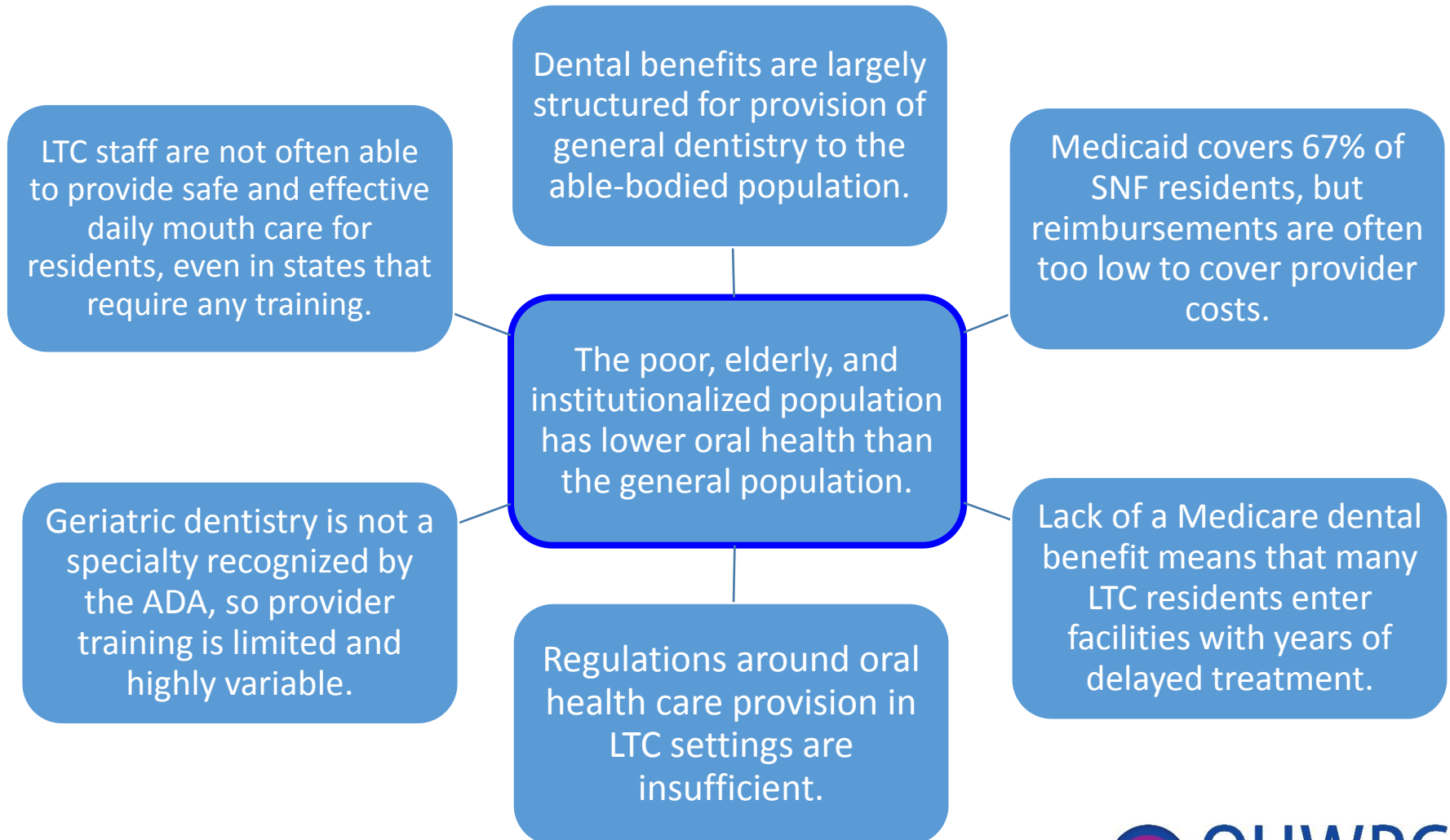# A Study of Delivery Models for Dental Care Services in LTC Settings

Mixed methods research was conducted on California, Minnesota, North Carolina, and Florida. These states currently have variable policy environments for allied provider scope, Medicaid expansion under the ACA, and adult Medicaid dental coverage.

- At some point in their lives, close to half of the 40 million people in the U.S. who are currently over age 65 will reside in long-term care (LTC) facilities

- Residents of LTC facilities or receiving in-home care (IHC) have higher risk of poor oral health status

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The Unique Challenges of Dental Care Delivery in LTC Settings

- Frail and cognitively impaired patients require more resources:

  - **Additional supplies and medications** are needed to help both providers and patients perform basic oral care tasks

  - **Additional staff and time** are needed to keep the patient safe and supported and to allow ergonomic practice for the provider

  - **Specialized equipment** is needed ranging from lift and movement assisting equipment to protection to decrease aspiration risk to patients

  - **Dental "clinics"** in LTCs are often set up in salons, chapels, or other makeshift spaces that add to the complexity of care provision

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Barriers to care for LTC residents

Dental benefits are largely structured for provision of general dentistry to the able-bodied population.

LTC staff are not often able to provide safe and effective daily mouth care for residents, even in states that require any training.

Medicaid covers 67% of SNF residents, but reimbursements are often too low to cover provider costs.

The poor, elderly, and institutionalized population has lower oral health than the general population.

Geriatric dentistry is not a specialty recognized by the ADA, so provider training is limited and highly variable.

Lack of a Medicare dental benefit means that many LTC residents enter facilities with years of delayed treatment.

Regulations around oral health care provision in LTC settings are insufficient.

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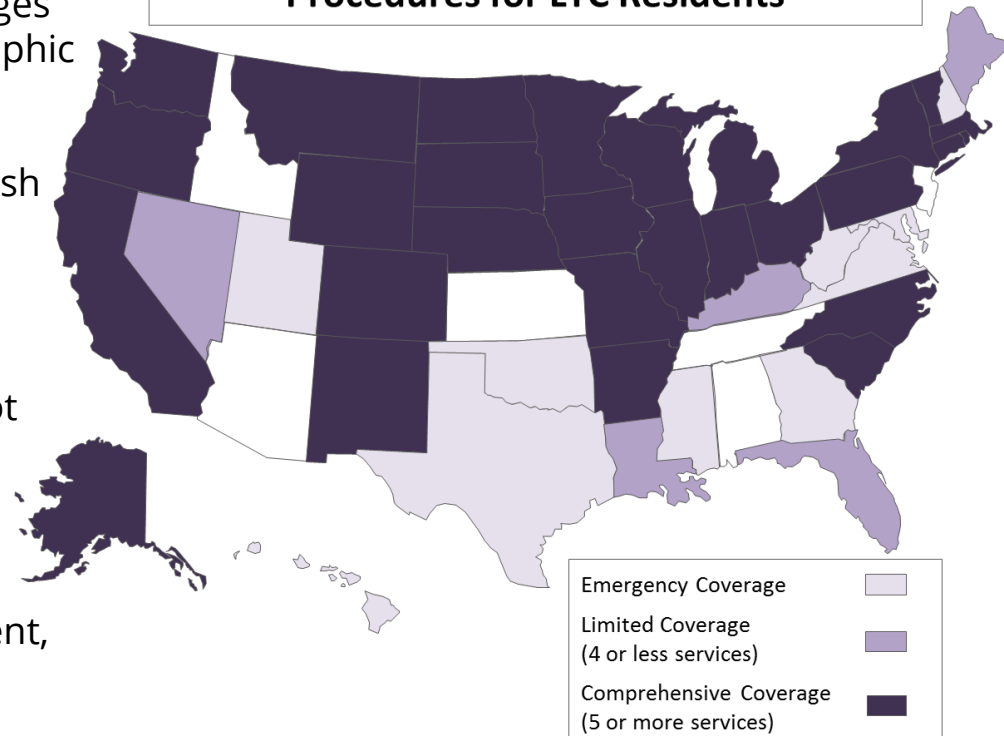Oral Health Workforce Research Center

Medicaid Coverage in the U.S.

Common Procedures in LTC settings:

- **D0120** - Periodic oral evaluation, established pt
- **D0150** - Comprehensive oral evaluation, new or established patient
- **D0210** - Intraoral series of radiographic images
- **D0220/D0230** – Intraoral periapical radiographic image, first/each additional
- **D0110** - Preventative prophylaxis adult
- **D1206/D1208** – Application of fluoride varnish
- **D2330/D2331** – Resin restoration – one/two surface anterior
- **D2391/D2392** – Resin restoration – one/two surface posterior
- **D4341/D4342** – Periodontal Scaling and Root planning, 1-3teeth/>4teeth
- **D4910** – Periodontal maintenance
- **D5110/D5120** - Complete denture maxillary/mandibular
- **D5410/5411/5421/5422** - Denture Adjustment, complete/partial, maxilla/mandible
- **D5650** - Add tooth to existing denture
- **D7140** - Extraction
- **D7210** - Sectioning of tooth and including elevation of muco-periosteal flap if indicated

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Medicaid Coverage of Common Dental Procedures for LTC Residents

Emergency Coverage

Limited Coverage
(4 or less services)

Comprehensive Coverage
(5 or more services)

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Medicaid Coverage by Care Configuration

Medicaid Coverage for Care Configuration Related Policies

Legend:
- Teledentistry ★
- Mobile Dentistry (light blue)
- Behavioral Management (pink/red)
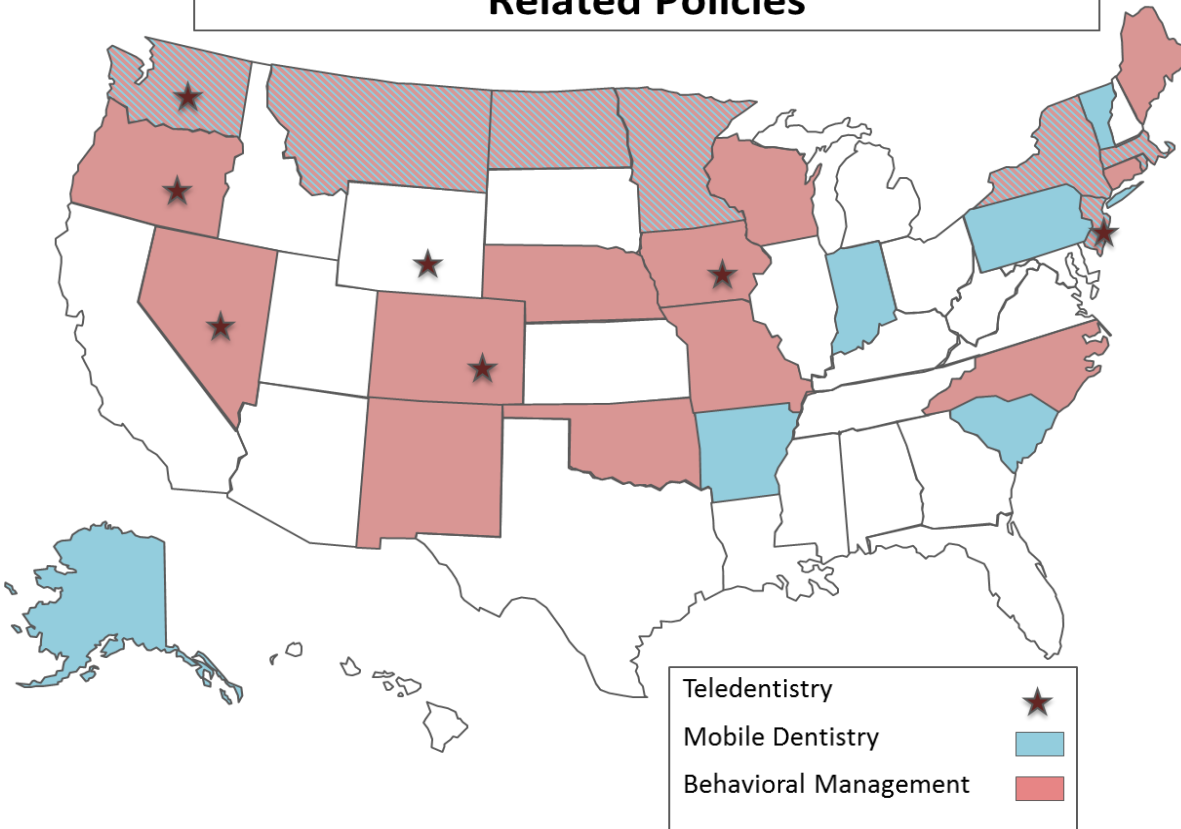
Policy-enabling codes (optional for states):

- **D9410** - Mobile Dentistry Facility Fee

- **D9920** - Behavioral Management

- **D0190/D0101/ D0601 -** Teledentistry / Screening

- **D9221/D9241/ D9248 -** Sedation

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Policies and Practices Enabling Oral Health Care in LTCs

- **Workforce policies** that enable service for LTC residents include expanded training in geriatric dentistry, as well as hygienist autonomy, billing abilities, and expanded practice

- **Care configuration policies** shown to support LTC dentistry include interprofessional practice, mobile services, and teledentistry

- **Payment policies** to improve LTC dental care include a Medicare dental benefit, Medicaid adult dental benefits, and a reimbursement structure that encourages safe, effective, and evidence-based dental care

- **Best practices** for LTC residents require complex interprofessional teams – domains that have not traditionally overlapped need to consider structural changes to improve coordination

- **The will of policymakers and public payers** must be mobilized to make needed changes on behalf of vulnerable and underserved LTC patients

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Workforce Innovations to Increase Access to Oral Health Services

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Updating the State-Specific Dental Hygiene Professional Practice Index (DHPPI) Scores

- The Dental Hygiene Professional Practice Index (DHPPI) is a numerical scale that quantifies scope of practice (SOP), i.e. the legal practice environment for dental hygienists (DHs), in each state

- The DHPPI was developed in 2001

- Higher scores on the DHPPI are generally associated with broader sets of tasks, more autonomy (i.e. less direct oversight), and greater opportunities for direct reimbursement for DHs

- This project updated the state-specific DHPPI scores to reflect SOP in 2014

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Scope of Practice (SOP) for DHs Has Broadened in Many States

- High scoring states in 2001 remained high scoring in 2014

- Some states noticeably advanced DH SOP:
  - Montana moved from a satisfactory ranking in 2001 to excellent in 2014

- Some states lost ground in comparison to their previous rankings

- More states recognize public health practice for dental hygienists permitting provision of preventive services under general supervision or unsupervised and without prior examination by a dentist

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Does SOP Matter?

- Conditions for practice affect patients' access to and cost of services

- In 2001, the DHPPI was significantly correlated with a number of indicators of oral health service utilization and oral health outcomes

- In 2014, multi-level modeling found a significant relationship between a broad scope of practice for DHs and positive oral health outcomes in state population

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Existing Scale May Not Reflect Ideal Practice for DHs Currently

- Variables in the index were developed in 2001

- Some states have achieved near perfect scores in 2014 using the 2001 index

- Need to update and account for expanded tasks and allowable restorative services

- Critical elements a new scale might include:

  o The ability to supervise dental assistants (some services require two-handed dentistry)

  o Provision of basic restorative services that includes dental oversight, supervision, and consultation

  o Provision of local anesthesia without direct supervision for certain periodontal procedures

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Dental Assisting Workforce Study: Key Findings

- Limited data sources on dental assistants (DAs)

- DAs characterized by variability:

  - Multiple educational pathways into dental assisting, from on-the-job training to formal dental assisting programs

  - Variation in state requirements for DA training, titles, and allowable tasks; over 40 titles identified based on tasks, training, and qualifications

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Expanded Function Dental Assistants (EFDAs)

- An emerging dental assistant classification

- Permitted to perform more complex tasks:

  - Preventive functions - coronal polishing, fluoride varnish, and sealant application

  - Restorative functions - placing and finishing dental restorations, and creating temporary crowns

- Signs of increasing state-level standardization for EFDAs, including requirements for education/training, competency testing, and certifications

- Using EFDAs on oral health teams is believed to contribute to greater capacity and efficiency for dental providers

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Survey of Physician Assistant Education Programs: Integrating Oral Health Assessment into Curricula

- Survey found that 78% of PA education programs include specific curriculum on oral health and oral disease

- 93% provide didactic instruction, and 60% also provide clinical training in conducting an oral examination and identifying oral disease

- 25% of respondents reported using interprofessional training opportunities with their students

- A current study of active PAs on both barriers to and best practices for integrating oral health evaluation and examination into clinical practice

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State and Local Strategies to Expand Access to Oral Health Services

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Workforce Innovations in Maine

- Several types of dental hygiene practice enabled, including traditional dental hygiene, public health dental hygiene, independent practice dental hygiene, and dental hygiene therapy

- The dental hygiene therapist is permitted to perform some restorative functions

- Expanded function dental assisting is allowed

- Dental hygienists in expanded roles can bill Medicaid directly

- *Into the Mouths of Babes*, a Maine medical initiative, trains primary care providers to screen and place fluoride in the mouths of young children

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Strategies to Expand Oral Health Access in Michigan

- Michigan has enabled a robust public health dental hygiene program

  - Approximately 200 dental hygienists work in 50 public health programs, providing services in clinics, nontraditional locations, mobile dental vans, and to migrant farm worker programs

  - DHs in this program treat tens of thousands of safety-net patients annually

- Michigan has contracted with Delta Dental to manage all dental services for Medicaid-eligible children through the *Healthy Kids* dental program

  - The program has received national attention because of the sustained increase in utilization of dental services by children

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Local Solutions in Michigan

- *Points of Light* – links pediatricians to community dentists through a web-based application that permits real-time referrals for children

- *Altarum Project* – uses the state's immunization surveillance system to build a referral network for oral health services

- *Calhoun County Dental Access Initiative* – pay-it-forward oral health initiative that engages social service providers, dentists, and patients through a points system for oral health treatment services

- *Michigan Community Dental Clinics* – the largest group dental practice in the state; created through the cooperation of approximately two dozen county and regional departments of health

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Local Solutions in California

- Virtual Dental Home (VDH) model allows:

  - DAs, DHs, and other allied dental providers to store and forward digital oral health images to a dentist for analysis and diagnosis, and

  - Hygienists to treat patients to the extent of their scope under the direction of a dentist and without direct supervision, so the patient does not have to physically see a dentist, thus increasing access, reducing cost, and improving efficiency.

- Registered Dental Hygienists in Alternative Practice (RDHAP) work independently of dentists (in collaborative practice) in underserved areas or with underserved populations, including LTC facilities.

- Both VDH and RDHAPs came into existence in California thanks to the Health Workforce Pilot Project (HWPP), which allows new concepts in health care delivery to be piloted before a legislative change is made.

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Using Oral Health Workforce Research to Inform Programs and Policies

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Who are the stakeholders?

- o Federal government

- o State planners and policy makers

- o Health and oral health professionals

- o Health care providers and their associations

- o Consumer advocates

- o Oral health coalitions

- o Educators

- o Patients

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Future Research

- A study of the configuration of dental service organizations in the U.S. with emphasis on their capacity to increase access.

- A study of mobile and portable dentistry programs to understand their impact on underserved populations.

- A study of Hispanic dentists to better understand their practice patterns.

- A study of FQHC efforts to expand their capacity to provide oral health services.

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Resources

The following reports are posted to the Oral Health Workforce Research Center website at http://www.oralhealthworkforce.org/resources/ohwrc-reports-briefs/

- Baker B, Langelier M, Moore J, Daman S. *The Dental Assistant Workforce in the United States, 2015*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; October 2015.

- Langelier M, Moore J, Baker BK, Mertz E. *Case Studies of 8 Federally Qualified Health Centers: Strategies to Integrate Oral Health with Primary Care*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; September 2015.

- Mertz E, Wides C. *Evolving Delivery Models for Dental Care Services in Long-Term Care Settings: 4 State Case Studies*. Rensselaer, NY: Oral Health Workforce Research Center, Center for Health Workforce Studies, School of Public Health, SUNY Albany; January 2016.

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Resources

The following reports are posted to Center for Health Workforce Studies website at http://chws.albany.edu/reports/

- Langelier MH, Glicken AD, Surdu S. *Adoption of Oral Health Curriculum by Physician Assistant Education Programs in 2014*. *J Physician Assist Educ*. 2015;26(2):60-69.

- *The Professional Practice Environment of Dental Hygienists in the 50 States and the District of Columbia, 2001*.

Maine

- Langelier M and Continelli T. *Report of the Survey of Dental Safety Net Providers in Maine*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. December 2012.

- Langelier M, Moore J, and Continelli T. *The Oral Health Workforce in Maine*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. December 2012.

- Langelier M and Moore J. *Executive Summary of the Report of Interviews of Oral Health Stakeholders in Maine*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. November 2012.

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Resources

- Langelier M and Surdu S. *Assessment of Oral Health Delivery in Maine: An Analysis of Insurance Claims and Eligibility Data for Dental Services, 2006-2010*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. September 2012.

- Langelier M, Moore J, Surdu S, and Armstrong D. *Oral Health in Maine, A Background Report*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. January 2012.

Michigan

- Langelier M, Surdu S. *Oral Health in Michigan*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; June 2015.

New Hampshire

- Langelier M, Armstrong D, and Continelli T. *Oral Health in New Hampshire: A Chartbook for the New Hampshire Oral Health Access Strategy Workgroup*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. July 2011.

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Questions?

For more information,

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