Policy Options for Expanding the Oral Health Workforce

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Agenda

- Overview of the Pew Children's Dental Campaign
- Describe the need to expand the dental workforce
- Clarify the term “expanding the dental workforce”
- Address the economics of a new provider
- Provide a national perspective of states that have adopted or are considering expanding the dental workforce
- Discuss examples of new providers: Minnesota and Alaska
The Pew Children’s Dental Campaign

Our Mission:
The Pew Children’s Dental Campaign strives for cost-effective policies that will mean millions more children get the basic dental care they need to grow, learn and lead healthy lives.
Focusing on Three Policy Areas

**Prevention**
- Community water fluoridation campaigns (CA, MS, KS, OR)
- National messaging & strategy development

**Funding for care**
- Advocating for federal appropriations for oral health programs
- Medicaid reimbursement for fluoride varnish by MDs and RNs

**Dental Workforce**
- Ensuring adequate workforce to care for children (MN, CA, ME, NH)
- Research on economics of new models

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How We Work: Facts Matter

**Evidence Based Assessment**

+ **Evidence Based Discussions**

= **Evidence Based Policy Solutions**
The Pew Children’s Dental Campaign

Our Motivation:

• Dental disease is the most common chronic disease among children in the U.S.—five times more prevalent than asthma.
• More than 16 million children in America go without dental care each year.
• In California alone, 504,000 children ages five to 17 were absent at least one school day in 2007 due to a toothache or other dental problem.
• A 2010 survey of hospitals in Washington State found that dental problems were the leading reason why uninsured patients visited ERs.

The Access Problem Makes Headlines

State Lags in Dental Health Care for Kids

Early in the morning on April 2, Dominique Allen’s family rushed her to the emergency room because of jaw pain and inflammation.

An infection from four rotting or decayed molars had spread into the jaw and neck of Dominique, 16, causing so much swelling that she could hardly open her mouth or breathe. Her condition was “life-threatening,” according to a case history provided by a spokesman with the Petaluma Valley Hospital.

Low reimbursements to dentists from Medicaid make getting dental care difficult for children and adolescents covered by the government health plan, a study finds.

Sandra L. Decker, senior service fellow in the division of health care statistics at the U.S. Centers for Disease Control and Prevention, found that in states with the highest Medicaid payments, children were more likely to get dental care, although they received care less often than children with private insurance.

Six states received an “A” grade from the non-profit policy analysis group for their dental health policies. But even children in those states have problems accessing care, the report says.

Millions of people each year are skipping out on their annual trip to the dentist. And it’s not because they’re afraid of the drill.

Many people just can’t find a dentist or can’t pay for an exam: 33.3 million Americans live in areas that have severe shortages of dentists.

Study: 1 in 5 kids don’t see dentist each year

At least one in five U.S. children go without dental care, according to a study released Tuesday by the Pew Center on the States.

Key policies treatments, according to the Pew Center on the States.

Young Medicaid recipients have a harder time getting emergency dental appointments than privately insured youngsters, according to a revealing study in which graduate students posed as mothers seeking care for a 10-year-old son who fractured a front tooth in a bicycle accident.

Emergency dental care out of reach for most kids
The Needs are Great

Total Population
281 Million

Institutionalized
4 Million

Live in Community
277 Million

Severe Medical Co-morbidities
25 Million

Generally Healthy
253 Million

Economically Disadvantaged
43 Million

Able to Pay
210 Million

Remote
11 Million

Non-Remote
199 Million

Remote
3 Million

Non-Remote
40 Million

83 Million Americans lack access
--according to the ADA

Americans lack access

Economically
Disadvantaged


6,600+ Dentists are Needed:
Shortages AND Maldistribution

Additional Resources Articulating the Need

**Institute of Medicine Report:** Improving Access to Oral Health Care for Vulnerable and Underserved Populations:


**July 2011 Issue of the California Dental Association Journal:** Barriers to Care: [http://www.cda.org/library/cda_member/pubs/journal/journal_0711.pdf](http://www.cda.org/library/cda_member/pubs/journal/journal_0711.pdf)

Current Oral Health Workforce

- Dentists
- Dental Hygienists (DHs)
- Dental Assistants (DAs)
- Dental Laboratory Technicians

What are we talking about when we say “expanding the workforce” or “creating a new provider?”
### Community Dental Health Coordinator (CDHC)

<table>
<thead>
<tr>
<th>Education</th>
<th>12 mo. didactic, 6 mo. Internship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation</td>
<td>Certification</td>
</tr>
<tr>
<td>Scope</td>
<td>Patient navigation, health literacy, some preventive services</td>
</tr>
<tr>
<td>Pros</td>
<td>May facilitate dentist participation in Medicaid</td>
</tr>
<tr>
<td>Cons</td>
<td>Few reimbursable services; solves wrong problem</td>
</tr>
</tbody>
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### Dental Therapist (DT, DHAT model)

<table>
<thead>
<tr>
<th>Education</th>
<th>2-year degree, through University of Washington DENTEX program</th>
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</thead>
<tbody>
<tr>
<td>Regulation</td>
<td>Certified by ANTHC in AK</td>
</tr>
<tr>
<td>Supervision</td>
<td>Remote (general) supervision by dentists</td>
</tr>
<tr>
<td>Pros</td>
<td>Proven model: many studies supporting safety, quality, effectiveness</td>
</tr>
<tr>
<td>Cons</td>
<td>ADA, many dental associations, oppose restorative capacity and diagnosis</td>
</tr>
</tbody>
</table>
### Advanced Dental Hygiene Practitioner (ADHP)

<table>
<thead>
<tr>
<th>Education</th>
<th>2-year Masters program for bachelor’s level hygienists (6 yr total)</th>
</tr>
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<tbody>
<tr>
<td>Regulation</td>
<td>Licensure</td>
</tr>
<tr>
<td>Scope</td>
<td>Similar to DT</td>
</tr>
<tr>
<td>Pros</td>
<td>Pool of RDHs ready to train; could be supported by reimbursable services</td>
</tr>
<tr>
<td>Cons</td>
<td>Very high level of education for few added services, not cost effective; evokes long-standing turf battles between dentists and hygienists</td>
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### Dental Hygienist / Dental Therapist

<table>
<thead>
<tr>
<th>Education</th>
<th>Three-year modular approach: 1 yr basic sciences, 1 yr hygiene, 1 yr dental therapy</th>
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</thead>
<tbody>
<tr>
<td>Regulation</td>
<td>Licensure?</td>
</tr>
<tr>
<td>Scope</td>
<td>Primary and restorative services</td>
</tr>
<tr>
<td>Pros</td>
<td>Pool of 2-year RDHs ready to train; could be supported by reimbursable services</td>
</tr>
<tr>
<td>Cons</td>
<td>Evokes long-standing turf battles between dentists and hygienists; may trigger same objections as dental therapists</td>
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The Good News!

Adding a new provider to the dental team makes sense economically for both dentists and states.

Pew’s It Takes a Team Report

What prompted our report:

- Health care reform will spur demand for children’s dental services
  - 5.3 million more children will have dental insurance by 2014
- Dental services are mostly delivered by private practitioners
- What are the productivity and profit implications of deploying new allied providers in private practice?
- Can dentists see more Medicaid/CHIP kids without suffering financially?
What We Learned

Key findings:

• New types of allied providers can strengthen both the productivity and financial stability of private dental practices.

• These new providers can make it financially viable for most dental practices to serve Medicaid patients.

• Medicaid rates play a key role in making it financially viable for practices to serve more low-income patients.
Solo General Dentist: Serving Privately Insured

Exhibit 4

Allied Providers’ Impact on a Solo General Dental Practice

**PROFIT IMPACT**

- Baseline (No Allied Providers) $337,242
- Adding 1 Dental Hygienist $395,505 +17%
- Adding 1 Dental Therapist $428,599 +27%
- Adding 1 Hygienist/Therapist $511,446 +52%

**PRODUCTIVITY IMPACT**

- Baseline (No Allied Providers) 10,051 Total Procedures
- Adding 1 Dental Hygienist 12,315 +23%
- Adding 1 Dental Therapist 13,057 +30%
- Adding 1 Hygienist/Therapist 15,208 +51%

Solo Pediatric Dentist Serving Medicaid Enrollees

Exhibit 3

Profit Impact on a Solo Pediatric Dental Practice Serving 20% Medicaid Patients

- Baseline (No Allied Providers and No Medicaid) $320,593
- Adding 1 Dental Hygienist $317,587 -1%
- Adding 1 Dental Therapist $298,126 -7%
- Adding 1 Hygienist/Therapist $343,641 +7%
- No Allied Providers 20% Medicaid Caseload $277,705 +1%
- Adding 1 Dental Hygienist $270,123 -13%
- Adding 1 Dental Therapist $298,126 -7%
- Adding 1 Hygienist/Therapist $371,021 +30%

30% reimbursement rate 60% reimbursement rate
### What does this mean for your state?

**Expanding the dental workforce may mitigate health related costs for states**

- It is estimated that at least 100 million Medicaid dollars are spent annually on hospitalizing children because of dental issues. (Edelstein, Burton L., DDS, MPH, “Dental Care Considerations for Young Children,” *Spec Care Dentist* 22(3): 115-255, 2002.)

- Minnesota legislators enacted a law authorizing new providers in 2009 despite their $4.8 billion dollar budget deficit. ([Round One: Governor’s Initial Budget Proposal Focuses on Spending Cuts and One-time Measures,” Minnesota Budget Project, 2009,](http://www.mncn.org/bp/09GovFirstBudget.pdf)}
Guidelines Supported by Pew

- Based on evidence, international and domestic
- Model addresses a states’ needs
- Scope of practice should fit gaps in the system
- Education should be adequate and cost-effective (not excessive for scope)
- Least restrictive level of supervision to ensure safety AND expand access

The Current Workforce Landscape

States that have authorized a new provider | States considering a new provider

www.pewcenteronthestates.com
Minnesota: Dental Therapist (DT)/Advanced Dental Therapist (ADT)

- Licensed by the Board of Dentistry
- Education programs approved by the Board of Dentistry
  - DT: Baccalaureate degree
  - ADT: Masters degree
- Supervised by a dentist through a collaborative management agreement
- Must be in practice where 50% of the patients and populations are underserved

Alaska: Dental Health Aid Therapists

- Proven model in more than 50 other countries including Australia, Canada, Great Britain, Hong Kong, Ireland, Netherlands, New Zealand, Singapore and Switzerland
- Local people
- Economic and social benefits
- Cost effective
Dental Health Aid Therapist Impact

Making a difference
• 35,000 people in rural AK now have access to care
• People are experiencing what it is like to have a provider located in their community for the first time
• Provide continuity of care and cultural competency

Institute of Medicine Report

• Quality of new providers is not a concern. Research could be done to estimate impact on access.

• Recommends using existing providers to the top of their license, revising state practice laws to conform to evidence.
Focus on Who This is For!

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