

To: ODA House of Delegates  
From: ODA Task Force on Auxiliary Utilization and Access to Care  
Subject: Recommendations to Address Access to Care in Ohio  
Date: July 29, 2010

On November 5, 2009, ODA President Dr. Stephen Simpson created the ODA Task Force on Auxiliary Utilization and Access to Care to develop strategies for addressing access to dental care and utilization of dental auxiliaries in Ohio.

Dr. Simpson appointed Dr. Paul Casamassimo, Dr. Henry Fields, Dr. Michael Halasz, Mr. David Owsiany and Mr. Chris Moore to serve on the ODA Task Force on Auxiliary Utilization and Access to Care. The Task Force elected Dr. Fields to serve as chair.

The Task Force met on five separate occasions to conduct its deliberations. The Task Force met with various interested parties, including representatives of the ODA's advocacy team, the Ohio Department of Health, and the Ohio Association of Community Health Centers.

The Task Force developed the following recommendations for the ODA House of Delegates review:

## **Recommendations**

Related to Educational, Dental Delivery, and Interdisciplinary Workforce Enhancement:

- Expanding the Ohio Dentist Loan Repayment Program;
- Maintaining operation of the Dental OPTIONS program;
- Maintaining the operation of the GKAS program;
- Finding innovative ways to secure funding to assist with capital costs for expansion of existing safety net dental clinics and/or establishment of new sites;
- Working with other health care professionals (pediatricians, OB/GYNs, etc.) to encourage the provision of appropriate preventive services (fluoride varnish, etc.) and oral screenings;
- Working to increase oral health awareness in Ohio in targeted communities; Encouraging the adoption of water fluoridation;
- Securing expanded funding for general dentistry and pediatric dental residency programs in Ohio;
- Securing funding to support outreach education for the dental schools at The Ohio State University and Case Western Reserve University;
- Securing funding for the Ohio Department of Development to utilize to provide no-interest loans for the purchase of dental equipment to be used in federally-designated or state-defined Dental Health Professional Shortage Areas to treat under-served populations;
- Securing funding for scholarships for students who commit to provide care in under-served areas for a specific time period upon graduation;
- Exploring facilitating contractual relationships between private dentists and FQHCs in order to have private dentists treat patients from the FQHCs in their private dental practices (Edelstein model);
- Exploring facilitating contractual relationships between educational outreach programs and FQHCs;
- Exploring strategies to assist FQHCs in recruiting dentists;
- Assisting in development of a distance learning curriculum for dentists who wish to learn how to utilize EFDA's in their practices;
- Expanding the use of case management/care coordination, while reducing the incidence of multiple care coordinators with overlapping roles for the same patient/family, including:
  - Identifying successful interdisciplinary case management models;
  - Providing incentives to adopt successful interdisciplinary case management models;

- Engaging Medicaid Managed Care providers in assessing, developing, adapting, or adopting case management/care coordination models;
- Providing reimbursement for case management/care coordination;

Related to Dental Workforce Enhancement:

*Contextual Principles:* Maintaining supervision requirements for dental auxiliaries who provide care makes sense in Ohio, based on the state's dentist population, distribution and relatively modest geographic challenges in terrain, weather and distances. Additionally, optimizing the use of EFDAs in private dental practices, safety net clinics, and community-based prevention programs will create added efficiencies and enhance access to care.

- Allowing EFDAs to provide supra gingival scaling and administer local anesthetic under direct supervision of a dentist;
- Allowing CDAs to provide supra gingival scaling under direct supervision of a dentist;
- Allowing EFDAs and CDAs to apply sealants under general supervision of a licensed dentist;
- Allowing BQPs, with training, to provide sealants and fluoride varnish under direct supervision of a dentist;
- Allowing trained dental hygienists to administer nitrous oxide under direct supervision of a dentist;
- Exploring Community Dental Health Coordinator and Oral Preventive Assistant models for Ohio; and
- Enabling school-based dental disease prevention programs (e.g., sealants, fluoride varnish) to utilize trained CDAs and EFDAs to apply sealants and fluoride varnish.

Related to the dental Medicaid program – Medicaid Preservation and Improvements:

- Preserve coverage of adult dental services;
- Enhancing reimbursement levels for dentists who provide the full range of dental services (not just diagnostic services);
- Exploring Medicaid fee differentials for providers whose patient population includes a significant percentage of Medicaid recipients; and
- Contracting with a commercial third-party to administer the dental Medicaid program in a manner designed to increase provider participation and use of needed services. At a minimum, the dental program should have the following features: (1) Fee-for-service payment to dentists at rates competitive with commercial insurance plans, (2) From the perspective of dental offices, make Medicaid patients appear administratively indistinguishable from commercially insured patients, and (3) Ohio Department of Job and Family Services will report to its Medical Advisory Committee and to the ODA the extent to which the third-party administrator meets outcome objectives, including provider participation and percentage of Medicaid beneficiaries receiving quality dental care;

The above recommendations reflect the ODA's continuing commitment to address access to dental care issues in Ohio through a proactive approach to enhance volunteerism, dental Medicaid, workforce development and interdisciplinary partnerships.

## **Appendix**

### **Recommendations of the Task Force on Auxiliary Utilization and Access to Care Background Report**

#### **Historical Overview of Access to Dental Care Issues in Ohio**

In 1998, the Director of the Ohio Department of Health convened a Task Force on Access to Dental Care. The Department of Health's Task Force was made up of a broad group of stakeholders, including members of the Ohio House of Representatives and Ohio Senate, and representatives from the ODA, Ohio Department of Health, Ohio Department of Jobs and Family Services, hospitals, county health departments, Case Western Reserve University School of Dental Medicine, the Ohio State University College of Dentistry, labor unions, and others. The Department of Health's Task Force issued its initial report in 2000 and follow-up reports in 2004, 2006 (dealing with workforce issues) and 2009 and concluded that dental care was the number one unmet health care need in Ohio.

The Department of Health's Task Force defined "access to care" to mean the "ability of all Ohioans to acquire timely oral health care services necessary to assure oral function and freedom from pain/infection." The Department of Health's Task Force made clear that "dental services limited to children or emergency care or prevention and/or screening are insufficient to meet the health needs of vulnerable Ohioans."

The Department of Health's Task Force recognized that access to oral care means access to a dentist, because only a dentist is trained to provide the type of care under-served populations need. Accordingly, to improve access to dental care, the ODA has focused its efforts on finding solutions that provide access to the full range of dental services, including those only a dentist can provide.

First and foremost, the Department of Health's Task Force noted that improving the dental Medicaid program – which is severely under-funded – is central to improving access to dental care for Ohioans. The ODA has been the leader in Ohio in advocating for improvement in the dental Medicaid program. Despite attempts by the previous gubernatorial administration, the ODA has successfully prevented the elimination of the adult dental Medicaid program. The trend across the country has been for states to eliminate coverage for adults in dental Medicaid programs. Ohio remains one of only a handful of states that has maintained a fairly comprehensive adult dental Medicaid program. The ODA has been successful in retaining the adult dental Medicaid program not just because of the importance of oral health and oral health's relationship to overall health, but because we have educated policymakers that dental coverage for adults is cost-effective as well.

The ODA also has a Medicaid Working Group made up of dentists who participate in the Medicaid program. Over the years, this group has made recommendations for improvement of the Medicaid program especially in areas related to administration, coverage, and reimbursement. ODA dentists and staff regularly work with the staff at the Ohio Department of Jobs and Family Services to assist in every way possible to improve the dental Medicaid program.

In 2000, the Department of Health's Task Force also recommended creating incentives for dentists who agree to re-locate in designated under-served areas and treat Medicaid and other low-income populations. In 2003, the ODA worked with the General Assembly to secure passage of legislation creating the Ohio Dentist Loan Repayment Program. This program provides up to \$20,000 annually in loan repayment to recent dental school graduates who agree to relocate in areas designated by the Department of Health as under-served and treat Medicaid and other low-income patients. Currently, five dentists are participating in the loan repayment program providing dental treatment to thousands of patients in under-served areas. Since the program's inception, tens of thousands of low-income Ohioans have received dental care because of the ODLRP. It is important to note that the ODLRP is entirely funded by a surcharge dentists pay on their licenses.

Because of the success of the program, the ODA Task Force on Auxiliary Utilization and Access to Care recommends expansion of the Ohio Dentist Loan Repayment program to create additional incentives for dentists to relocate to under-served areas and provide care to low-income Ohioans.

Dental residency programs have emerged as important participants in addressing access to dental care in Ohio. Organized dentistry has taken the lead in spearheading efforts to create and expand dental residency programs in Ohio. In 2005, the ODA Foundation provided a \$10,000 grant, which was combined with a \$20,000 grant from the dentists of the Cincinnati Dental Society, to assist in expanding the dental residency program at the University of Cincinnati Hospital. In 2006, the ODA Foundation provided a \$10,000 grant, which was combined with \$100,000 provided by the dentists of the Stark County Dental Society to assist in the creation of a dental residency program at Mercy Hospital in Canton. In 2007, the ODA Foundation gave a \$10,000 grant to City Hospital in Akron for its new dental residency program. These grants help create additional facilities so that dental residents can provide much needed dental care to under-served populations in Cincinnati, Canton, and Akron. Since its inception in 1995, the ODA Foundation has given a total of nearly \$500,000 in grants and scholarships to support dental education and improve access to dental care.

The ODA also administers several programs that allow its members to provide direct care to low-income Ohioans. The dental OPTIONS program is a public-private partnership between the ODA and the Ohio Department of Health in which dentists agree to provide free or reduced fee dentistry to low-income Ohioans. Nearly 1,000 dentists participate in the program providing over \$1 million in donated dental care annually to uninsured Ohioans who do not qualify for Medicaid.

The ODA administers Give Kids a Smile Day, a program in which dentists provide free care to low-income children across Ohio. This program provides an additional \$1 million in free care on an annual basis. And in some areas, Give Kids a Smile has expanded so children can receive care throughout the year, not just during the program kick-off month of February.

The Ohio State University College of Dentistry administers the OHIO Project whereby dental school faculty and senior dental students provide dental care to under-served populations in 15 clinic sites throughout central and southern Ohio. In addition, the OSU College of Dentistry runs geriatric programs that provide dental care to thousands of senior citizens in central Ohio and south eastern Ohio.

Case Western Reserve University has a school-based sealant program whereby more than 280 dental school faculty and students visit 100 Cleveland-area grade schools annually to provide free exams and sealants. The clinics at both schools are important parts of the dental safety net in the Cleveland and Columbus areas, providing care to thousands of Medicaid children and adults. And again the ODA has worked to support those efforts through advocacy and more than \$150,000 worth of grants and scholarships to assist Ohio's dental schools in their educational and outreach efforts.

In addition to the dental schools' outreach programs, the ODA has developed the Smiles for Seniors program, which is designed to improve awareness of the unique oral health issues the elderly may experience. The ODA has distributed more than 1,000 program modules, including CD-ROMs with video content and printed materials to long-term care facilities, assisted living programs and senior centers to educate care-givers on maintaining the daily oral hygiene of the residents. This new program has received national attention, including being awarded the prestigious American Dental Association Golden Apple Award of Excellence for promoting public awareness of the importance of oral health. Dental associations and health care facilities in 26 other states have requested permission to utilize and replicate the Smiles for Seniors program as well.

In recent years, Federally Qualified Health Centers have emerged as important partners in the overall commitment to providing dental care to under-served populations in Ohio. Accordingly, the ODA's Task Force on Auxiliary Utilization and Access to Dental Care met with representatives from the Ohio Association of Community Health Centers to discuss challenges to providing access to dental care and potential solutions. As a result of these discussions, the ODA's Task Force made a series of recommendations to help enhance the ability of FQHCs to address access to dental care issues,

including exploring the possibility of FQHCs contracting with private dentists in order to assist in providing dental care to patients that are serviced by FQHCs and exploring the possibility of partnerships between FQHCs and the dental schools' outreach programs.

It is also important to recognize what professional dentists are doing in their communities. According to a survey conducted by an independent survey research firm, the typical ODA member annually provides more than \$13,000 worth of free dental services to the under-served. That means that ODA members provide more than \$40 million in free services to the needy every year. This is just dentists doing what they do every day – taking care of the oral health of families in their communities who are in need. However, volunteer programs are not substitutes for integrated government-sponsored programs addressing the oral health of society's poor, neglected, and under-served populations.

With this background the ODA's Task Force on Auxiliary Utilization and Access to Care spent the first half of 2010 developing its recommendations to further address access to dental care issues in Ohio in the future

### **Use of Dental Auxiliaries**

#### *The Ohio Experience*

The state of Ohio has been progressive in promoting expanded use of auxiliaries while maintaining the supervision and oversight of the dentist in the provision of comprehensive dental care. For more than three decades, Ohio's laws and rules have permitted expanded function dental auxiliaries to, under the supervision of a dentist, perform all tasks and procedures involved in the art or placement of preventive or restorative materials, limited to (1) pit and fissure sealants, (2) amalgam restorative materials and (3) non-metallic restorative materials, including direct-bonded restorative materials. The ODA's Task Force believes that better use of EFDAs can create efficiencies in the private dental office and in public health settings.

Ohio's laws also provide for general supervision of hygienists – i.e., dental hygienists seeing patients when the supervising dentist is not physically present – provided specific safeguards are followed, including that the supervising dentist has examined the patient in the previous 7 months. Ohio's laws permit trained dental hygienists to administer local anesthetic and trained dental assistants to polish the clinical crowns of teeth and provide sealants under the supervision of a dentist.

On May 27, Governor Ted Strickland signed into law House Bill 190 – a legislative initiative of the ODA – that would permit dental hygienists to commence treatment on patients in specifically defined dental access settings provided specific safeguards are followed, including requiring the dentist to examine the patient within six months of the provision of hygiene services.

The Task Force has reviewed the current dental practice act and rules and has made several recommendations related to additional delegable duties for dental auxiliaries practicing under the supervision of a dentist in the state of Ohio. These recommendations continue the ODA's long-standing tradition of allowing well trained and economically feasible auxiliaries to perform services to the full extent of their potential while also maintaining the integrity of the dentist-led dental care delivery team concept.

#### *Alaskan Dental Health Aide Therapist*

The challenges of providing dental care to remote areas of Alaska are daunting. Approximately 85,000 Alaska Natives live in small villages accessible only by small aircraft, boats, or snowmobiles. In 2003, the federal government launched the Dental Health Aide Therapist Program to provide dental care on tribal lands to native Alaskans. Generally, DHATs can provide preventive services and treatment of emergent dental infections and basic restorative procedures. They may also perform extractions with the approval of a dentist. Generally, DHATs work on a general supervision/standing order arrangement with the dentist. The DHAT can use telecommunications to interact with the dentist regarding patient care.

Education for DHATs generally consists of 2 years of post high school training. Originally, training was conducted in New Zealand under a program that has existed there for several decades. Currently, the

Alaska Native Tribal Health Consortium is partnering with the University of Washington School of Medicine's ME-DEX Northwest to train DHATs for the Alaska program.

The ODA's Task Force on Auxiliary Utilization and Access to Care notes that a report from the American Academy of Pediatric Dentistry found that there is no evidence-based materials addressing comparisons between dentists and dental therapists on the broad set of competencies, knowledge and skills (e.g., diagnosis, general health assessment, treatment planning and behavior management) required in the delivery of comprehensive care. In light of the risks related to under-trained personnel seeing patients without any significant involvement of a dentist, the ODA Task Force has serious reservations related to the therapist model. Moreover, the Task Force believes that the focus of solutions in Ohio should be on finding strategies to ensure all patients have access to a dental home with the full range of comprehensive dental care available. The ODA's Task Force also notes that while Ohio may have some areas where there is a limited number of dentists, there are no areas in Ohio akin to the remote areas of Alaska where hundreds of small villages with only 300 – 400 people are accessible only by small aircraft, boats, snowmobiles, or dog sleds. Solutions in Ohio should focus on getting patients into the dental home where they can have access to comprehensive dental services directed by a dentist. In contrast, the Alaska DHAT model has the potential to undermine the dental home concept, while not providing a substantial impact on the actual clinical needs of the patients.

#### *Minnesota Dental Therapists*

In 2009, the state of Minnesota authorized two new categories of dental providers: the dental therapist and the advanced dental therapist. According to the Minnesota Dental Association, a dental therapist will be allowed to perform basic preventive and restorative procedures with the on-site supervision of a dentist. With additional training, a dental therapist can qualify as an advanced dental therapist and perform additional procedures with the permission of the supervising dentist, including non surgical extraction of permanent teeth. An advanced dental therapist may also assess a patient's condition, although a licensed dentist must authorize any treatment plans. The targeted patient population for the dental therapists are qualified low-income patients in dental health professional shortage areas or other populations identified by law as having access barriers.

Generally, the education for a dental therapist would be a BS in Dental Therapy. A licensed dental therapist with 2000 hours of clinical practice may then apply for the Masters in Dental Therapy program, which would include an additional 2 years of training. The University of Minnesota School of Dentistry has created a curriculum for the Dental Therapy and the Advanced Dental Therapy programs.

The ODA's Task Force on Auxiliary Utilization Access to Care has concerns related to diverting resources away from traditional dental education programs and other access to dental care initiatives to fund an educational program for an entirely new dental care provider, which will likely face the same barriers to the provision care to under-served populations that currently exist for dentists (low reimbursements, administrative burdens, missed appointments, etc.) Reforming and fully funding Medicaid and other access to dental care programs and enhancing the dental home concept would leverage the entire existing dental care system while providing patients with access to the full range of dental services only a dentist can provide and would not fragment the dental delivery system.

#### *Community Dental Health Coordinator and Oral Preventive Assistant*

The ADA has proposed the creation of two new dental care providers. The first, called the Community Dental Health Coordinator (CDHC), will work under a dentist's supervision but will primarily work outside of the dental office. The CDHC will work in health and community settings such as clinics, schools, churches, senior citizen centers, Head Start Programs and other public health settings with residents who have ethnic and cultural backgrounds similar to the CDHC. According to the ADA, aside from working in health and community settings, the CDHC will collect information to assist the dentist in the triage of patients and address the social, environmental, and health literacy issues facing the community's population. Another important role of the CDHC would be educating community members on preventive oral health care and assisting them in developing goals to promote and manage their own personal oral health. Linking patients to avenues of oral health care will also be an important role for the CDHC in working with under-served populations going through the maze of health and dental care systems.

The CDHC is to receive 18 months of training. According to the ADA, the first part of the training will focus on the foundation of working within a community and building oral health capacity within that community. The program also proposes to train CDHCs to provide preventive services including screenings, fluoride treatments, placement of sealants, placement of temporary fillings and simple teeth cleanings (selective scaling for periodontal type I [gingivitis] such as removing gross debris, stains, and calculus using anterior and posterior sickle hand scalers until the patient can receive comprehensive treatment from a dentist).

The other new category of provider recommended by the ADA is the Oral Preventive Assistant. The OPA has two points of impact. The first is within the private dental office. The OPA would be trained to provide a wide variety of preventive services within the dental office, allowing the dentists and/or dental hygienists to provide care to patients requiring services that are more complex. The second area of impact is that the OPA would have expertise in providing patient oral health education. This will permit the OPA to work directly in schools, community health centers and other appropriate venues to raise oral health literacy.

Specifically, the OPA would perform the following services: collection of diagnostic data such as medical histories, vital signs, charting, and radiographs, preventive services for all types of patients, including preventive and oral hygiene instruction, application of fluoride and sealants, coronal polishing for all patients, scaling for plaque induced gingivitis patients and general office duties.

The OPA model requires the development of a new educational program that will encompass approximately a three-month time period to complete based on the following eligibility requirements:

- Graduate of a dental assisting program (accredited by the Commission on Dental Accreditation (CODA)); or
- Dental assistant certified by the Dental Assisting National Board (DANB); or
- Graduate of a non-accredited (by CODA) dental education program who is a Certified Dental Assistant by DANB; or
- On-the-job trained dental assistant who is a Certified Dental Assistant by DANB.

The training will require didactic, laboratory and clinical elements with an emphasis on not only the preventive care directly rendered to patients, but patient education, teaching and communication techniques. Didactic and laboratory instruction may be presented in a traditional classroom setting or online, followed by in-person supervised clinical experience. Allied dental educational programs should consider granting credit or advanced standing for previously completed course work in lieu of program requirements.

The ODA's Task Force believes that the CDHC and OPA models maintain important safeguards for patient care, provide promise for improved access to care while maintaining the dental team concept, and, accordingly, merit further study for application in the state of Ohio.

### **Medicaid Reform**

As the Department of Health's Task Force recommended a decade ago, reform of the dental Medicaid program is essential to addressing access to dental care in Ohio. In 2008, the National Academy for State Health Policy examined dental Medicaid reforms adopted in six states. The report concluded that "rate increases are necessary" but not enough. States should also pursue reforms that ease administrative burdens and otherwise work with patients and their families to educate them on how to use dental services.

One very successful model reform of Dental Medicaid was adopted by Michigan in 2000 called the Healthy Kids Dental (HKD) program. HKD includes 61 of Michigan's 83 counties, covering more than 200,000 children. The program is administered by the Delta Dental Plan of Michigan and dentists are paid the Delta PPO fees and claims administration is the same for HKD patients as it is for other Delta PPO

patients. Stephen A. Eklund, DDS, DrPH, MHSA, a professor emeritus of the University of Michigan School of Public Health, studied the HKD program and concluded the following:

- access to dental care has improved under HKD
- more children and an increasing proportion of children received dental services each year from 2001 – 2007
- The number of dentists providing care has increased under HKD
- The number of children treated per dentist has increased under HKD
- Many HKD children appear to have a regular dental home and to be entering regular recall patterns.

The success of HKD shows that to truly improve access to dental care in a meaningful way – dental Medicaid programs need to be reformed. No other solution has the potential to dramatically increase the number of under-served individuals having access to the full range of dental services provided by a dentist. Accordingly, included in the ODA's Task Force on Auxiliary Utilization and Access to Care's recommendations is an outline of Medicaid reforms that might be modeled after the Healthy Kids Dental program.

In recent years, the ODA's advocacy has focused not just on trying to reform the current system but trying to maintain what Ohio currently has in place. For example, during the last four state budget cycles, policymakers have considered proposals to eliminate or significantly limit coverage for adults in the dental Medicaid program. According to the Center on Budget and Policy Priorities, Medicaid expenditures for dental care for adults, seniors and the disabled comprise less than one-half of one percent of overall Medicaid expenditures nationally so the potential for budgetary savings through elimination or reduction of dental services is quite limited. Moreover, the Center points out that "eliminating dental coverage in Medicaid can lead to higher costs in other parts of the Medicaid budget because, as patients' dental problems worsen and become more acute, some eventually seek care in hospital emergency rooms." The emergency rooms "provide care in a much more costly fashion than dentists' offices and may offer poorer quality care than dental facilities." In light of the importance and cost effectiveness of Medicaid dental coverage for adults, another one the recommendations of the ODA Task Force on Auxiliary Utilization and Access to Dental Care is to maintain current coverage for adults.

### **Conclusion**

Despite the substantial success that Ohio has experienced in addressing access to dental care in Ohio, challenges remain. The under-funded and administratively burdensome Medicaid system in Ohio has diminished participation by dentists and made patient access more difficult. Poor oral health literacy, especially in under-served populations, keeps needy populations from practicing proper oral health habits and from seeking necessary care. Recently, outside entities, including the Kellogg Foundation and the Pew Foundation, have begun activity in Ohio related to access to dental care and other dental-related issues. The ODA has led the efforts in Ohio on these issues for decades and certainly welcomes additional resources into the state to foster positive change for the oral health of all Ohioans. However, in light of today's scarce resources, it is essential that we pursue solutions that will have positive impact and use resources efficiently while promoting quality patient care. The ODA's Task Force on Auxiliary Utilization and Access to Dental Care has proposed a blue print for addressing access to dental care in Ohio in an effective, efficient and a responsible manner that will maintain the highest level of oral health care for all Ohioans.