Workforce Innovations in Oral Health

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The Center for Health Workforce Studies at the University at Albany, SUNY

- Based at the University at Albany School of Public Health
- Conducts studies of the supply, demand, use and education of the health workforce
- Committed to collecting and analyzing data to understand workforce dynamics and trends
- Goal to inform public policies, the health and education sectors and the public
- Broad array of funders

Today's Presentation

- Oral health workforce research experience
- Making the case for oral health workforce research
- Key themes from our work
- Using research findings to inform workforce strategies to increase access to oral health

Oral Health Workforce Research Experience

- The Professional Practice Environment of Dental Hygienists in the 50 States and the District of Columbia, 2001 (HRSA),
- Dental Hygiene Master File Project, 2006-08 (ADHA),
- White Paper, The Oral Health Workforce in the U.S. in 2010 (IOM), and
- The Oral Health Curriculum in Physician Assistant Education Programs (NccPA) 2014

Oral Health Workforce Research Experience: State Oral Health Care Access and Workforce Assessments

- New Hampshire (2011)
- North Dakota (2011-12)
- Maine (2012-13)
- Michigan (2014-15)
- Kentucky (2015)

Oral Health Workforce Research Center under a Cooperative Agreement with HRSA

- **Year 1 Projects (2014-15):**
  - Update the Professional Practice Index for Dental Hygienists in the 50 States and the District of Columbia,
  - Comparison of Medicaid Dental Claims Data in Two States with Different Adult Dental Benefits,
  - A Study of the Dental Assistant Workforce in the U.S. ,
  - Case Studies of Eight Federally Qualified Health Centers to Describe Oral Health Services Delivery and Oral Health Workforce Innovation, and
  - Case Studies of Oral Health Service Delivery Models Used in Long-term care Settings.

Making the Case for Oral Health Workforce Research

Increasing Evidence of Links Between Oral Health and Physical Health

- Periodontal disease and dental caries are associated with:
  - Coronary artery disease, including stroke and endocarditis,
  - Diabetes
  - Pre-term birth and infant mortality,
  - Systemic infections in patients with implants and joint replacements, and
  - Substance abuse.

Medical and Dental Services Tend to be Siloed

- Different delivery systems
- Different insurance systems
- Limited communication between systems
  - EMRs don’t interface with EDRs
  - Referral networks between physicians and dentists are limited
- FQHCs are a notable exception
  - Statutorily required to provide or refer for oral health services

Oral Health Disparities Are Challenging

- Population-specific:
  - The poor, minorities, including American Indians, children, people with special needs, the elderly, among others,
  - Oral health literacy is lower for groups with limited access to oral health services.
- Geographic:
  - Rural
  - Inner city urban

Uneven Access to Oral Health Services is a Public Health Crisis

- The most common (and preventable) chronic disease of childhood is dental caries
- Contributes to employability, productivity and lost time from work (adults) or school (children/adolescents)
- Manifested by an increasing number of costly ambulatory–care sensitive ED visits for oral health problems

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 care
  - Even those with dental insurance may be subject to high co-pays or limited service coverage
  - Limitations on Medicaid dental coverage, particularly for adults

Key Themes Emerging from our Research

What makes a positive impact on oral health access and the oral health of the population?

- Integration of oral health and primary care
- 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
- Team based approaches to oral health service delivery
- Local solutions to oral health access issues

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

- Study findings from this research highlights all of the key themes
- FQHCs are uniquely positioned to provide integrated, patient centered health and oral health services
- FQHCs have exceptional opportunities to innovate, especially novel workforce that increase access to oral health services for underserved populations

FQHCs Use Team Based Approaches to 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, Dental hygiene therapists
  - Expanded function dental assistants

Dental Residents And Student Externs and Interns Contribute to FQHC Staffing

- FQHCs benefit from precepting dental residents and students
  - Enhances capacity to meet demand for oral health services
  - An important tool for recruitment of new oral health professionals

    - Use incentive programs such as loan repayment

- Students (dentists, DHs, and DAs) and residents benefit from rotations in FQHCS
  - Increases awareness of the need for services among the underserved

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

Increasing Capacity of Primary Care Workforce to Conduct Oral Health Assessments

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% provided didactic instruction and 60% also provided clinical training in conducting an oral examination and identification of oral disease
- 25% of respondents reported using inter-professional training opportunities with their students
- Future study will survey active PAs on barriers and facilitators of integrating oral health evaluation and examination into clinical practice

Expanded Function Dental Hygienists and Dental Assistants

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

- The Dental Hygiene Professional Practice Index (DHPPI) is a numerical scale that quantifies the 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 dental hygienists (DHs)
- This project updated the state-specific DHPPI scores to reflect SOP in 2014

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

Does SOP Matter?

- Conditions for practice affect patients' access to services
- In 2001, the DHPPI was significantly correlated with a number of indicators of utilization of oral health services 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

Existing Scale May Not Accurately Assess Current Ideal Practice for DHs

- 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:
  - The ability to supervise dental assistants (some services require two handed dentistry)
  - Provision of basic restorative services that benefit from dental oversight, supervision, and consultation
  - The ability to provide local anesthesia without direct supervision for certain periodontal procedures

Dental Assisting Workforce Study Findings

- Limited data sources on dental assistants (DAs)
- DAs characterized by variability:
  - Multiple educational pathways into dental assisting, from OJT to formal dental assisting training programs
  - Variation in state requirements for DA training, titles, and allowable tasks; e.g. identified over 40 titles based on tasks, training and qualifications

Expanded Function Dental Assistants (EFDAs)

- EFDA is an emerging DA classification
- Permitted to perform more complex tasks:
  - Preventive functions - coronal polishing, fluoride varnish, sealant application
  - Restorative functions – placing and finishing dental restorations, 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

State and Local Strategies to Expand Access to Oral Health Services

Workforce Innovations in Maine

- Enabled several types of dental hygiene practice 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
- Maine has a medical initiative, Into the Mouths of Babes, that trains primary care providers to screen and place fluoride in the mouths of young children

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, mobile dental vans, migrant farm worker programs, among others.
  - DHs in this program annually treat tens of thousands of safety net patients
- Michigan has contracted with Delta Dental to manage all dental services for Medicaid eligible children in the state through the Healthy Kids dental program
  - The program has received national attention because of the sustained increased utilization of dental services by children

Local Solutions in Michigan

- Points of Light – linking pediatricians and community dentists willing to treat children through a web based application that permits referral in real time
- Altarum Project – uses a state immunization surveillance system to build a referral network for oral health services
- Calhoun County – pay it forward oral health initiative that engages community social service providers, dentists, and patients in earning points to receive oral health treatment services
- Michigan Community Dental Clinics – a consortium of approximately two dozen county and regional departments of health that created the largest group dental practice in the state

Local Solutions in California

- Virtual Dental Home
  - permits registered dental hygienists in advanced practice to screen, assess, and seek dental consultation about children's oral health treatment needs
  - Demonstration prompted passage of legislations to pay for teledentistry services

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Local Solutions in Kentucky
North Fork Valley Community Health Center

- An Appalachian initiative
- A consortium between the University of Kentucky School of Medicine and a local FQHC
- Uses a mobile dental van (Ronald McDonald Charities)
- Provides screening, assessment, and treatment services in conjunction with a fixed clinic at an FQHC for more complex services

Using Oral Health Workforce Research to Inform Programs and Policies

- **Who are the stakeholders?**
  - Federal government
  - State planners and policy makers
  - Health and oral health professionals
  - Health care providers and their associations
  - Consumer advocates
  - Oral health coalitions
  - Educators
  - Patients

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.

Resources (con't)

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

Oral Health Curriculum in Physician Assistant Education Programs

- 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.

2001 Dental Hygiene Scope of Practice Study

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

http://bhpr.hrsa.gov/healthworkforce/supplydemand/dentistry/dentalhygieneenvironment.pdf

Resources (con't)

The following state-specific reports are posted to Center for Health Workforce Studies website at

http://chws.albany.edu/reports/

Michigan

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

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.

Resources (con't)

Maine (con't)

- 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.
- 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.

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.

Questions?

For more information,

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