Assuring Your PCMH Care Team Includes Oral Health

NACHC Community Health Institute
August 25, 2014
What we will discuss

✓ Dental Education & the Role It Plays in Meeting Service, Recruitment, and Retention Demands
✓ The Influence of State Oral Health Workforce Policy on Community Health Centers
✓ Oral Health Integration and the Smiles for Life curriculum
✓ Contracting Strategies between FQHCs and Private Practice Dentists
✓ PCAs: A Resource for Improving Health

✓ Q&A saved until the end of all presentations
Why is NACHC Interested in Oral Health Access?

✓ NACHC's mission:
"To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations."

✓ Triple Aim
✓ Improving the health of the population
✓ Enhancing the patient experience
✓ Bending the cost curve

An efficient and effective care delivery system is integral to achieving optimal health, by providing access to care when and where it is needed and by ensuring that limited care resources are used to maximum advantage to prevent and manage disease.

✓ NACHC is emphasizing a systems approach to oral health integration that is consistent with Patient Centered Medical Home (PCMH) practice transformation.
TODAY’S PANELISTS

PANELISTS

✓ Christopher G. Halliday, DDS, MPH, Dean
  Missouri School of Dentistry and Oral Health
  A. T. Still University, Kirksville, MO

✓ Hannah Maxey, PhD, MPH, RDH
  Assistant Professor & Director of Health Workforce Studies
  Department of Family Medicine, Indiana University School of Medicine

✓ A. Stevens Wrightson, M.D., Medical Director
  Bluegrass Community Health Center, Lexington, KY

✓ Jane Grover DDS MPH, Director
  Council on Access, Prevention and Interprofessional Relations
  American Dental Association, Chicago, IL

✓ Joan Pernice, RNC, MS, Clinical Health Affairs Director
  Massachusetts League of Community Health Centers, Boston, MA

Moderator: Donald L. Weaver, M.D., Associate Medical Officer, NACHC
Missouri School of Dentistry & Oral Health

Christopher Halliday, DDS, MPH
Dean, Missouri School of Dentistry & Oral Health
ATSU’s Missouri School of Dentistry & Oral Health aims to increase access to oral healthcare for Missouri’s most vulnerable populations by addressing the state’s critical shortage of dentists.

Only the second dental school in the state, its goal is to graduate dentists who have an in-depth understanding of and a desire to serve populations in need.
Missouri

• The 2009 Statewide Oral Health Plan estimates that 11% of the population has never seen a dentist.

• Tooth Decay is largely preventable, yet it remains the most common chronic disease of children age 6 to 11 years (25%) and of adolescents age 12 to 19 years (59%).

• Many adults also experience untreated tooth decay (e.g., 28% of those 35 to 44 years, and 18% of those 65 and older).
Missouri

• 63 dentists per 100,000 residents (78:100,000, nationally)
• Approximately 70 dentist leaving full time practice each year
• 45-50 new graduates entering practice annually
• Estimated that 250 additional dentists are needed to address the shortfall
• 101 of the states 114 counties have been designated by HRSA as being Dental Health Professional Shortage Areas (DHPSA)
• The 2009 Statewide Oral Health Plan estimates that 11% of the population has never seen a dentist
Ramifications of Poor Oral Health

- Relationship to chronic diseases
- Physical Development
- Nutrition
- Behavioral Health
- Social Development
- Self-esteem
- School Performance
- Employability
- Economic impact
MOSDOH Program Model

• Years 1 & 2 – Kirksville - didactic and pre-clinical simulation lab training

• Year 3 - St. Louis Clinic – internal rotations with dental specialties

• Year 4 - St. Louis Clinic AND rotations to MO /regional community health center sites
Innovative Four Year Curriculum

• D1, D2 years: focus on basic and health sciences, dental simulation experiences
• Integration of pre-clinical core courses
• D3, D4 years: participate and train in community-based health centers
• MOSDOH places special emphasis on patient care experiences through simulation, integration of biomedical and clinical sciences, and problem solving scenarios
• We emphasize leadership and practice in public health
St. Louis Clinical Model

- Comprehensive Dental Services: the full spectrum of dental care, emergency treatment, preventive services, through complex rehabilitation

- **Unique Partnership** with Grace Hill Health Centers, Inc.

- **ATSU** responsible for education, while **Grace Hill** will manage the **day to day operations** of the clinic
St Louis Clinical Facility

• The design will address access to care challenges, and oral health disparities, experienced by urban and rural populations in Missouri

• The program has been reviewed extensively and awarded initial accreditation, without further requirements, by the Commission on Dental Accreditation (CODA) – the highest level that can be attained by a new program
St. Louis Clinical Facility

- 92 dental operatory on the first two floors, most of which will be dedicated to general dentistry
- GHHC dentists will be practicing along side of D3&4 students
- Staffing - 92 FTE faculty, staff, and dentists from ATSU and Grace Hill Health Centers combined
- Services include the specialties of pediatric, special needs patients, oral surgery, endodontics, periodontics and urgent care dentistry
MOSDOH at Grace Hill

• For the first time ever, all clinical education will be located in a CHC setting.
• Grace Hill will be the CHC in which that clinical education is delivered.
• St. Louis clinic at Truman Parkway and Park Avenue will be operated by GHHC. It will be a GHHC clinic and the patients will be GHHC patients.
### Impact on Oral Health

<table>
<thead>
<tr>
<th>MOSDOH Students in St. Louis Clinic</th>
<th>Total Active Patients to Satisfy MOSDOH Educational Requirements</th>
<th>Total Patient Encounters</th>
<th>Adult Patients with No Medicaid/Other Coverage (~ 35% of Total)</th>
<th>Adult Patient Encounters</th>
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<tr>
<td>42 D3 Students</td>
<td>5,250</td>
<td>22,680</td>
<td>1,838</td>
<td>7,938</td>
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<td>42 D4 Students</td>
<td>4,148</td>
<td>16,590</td>
<td>1,452</td>
<td>5,807</td>
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<td>Total Impact</td>
<td>9,398</td>
<td>39,270</td>
<td>3,290</td>
<td>13,745</td>
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</table>
MOSDOH at Grace Hill

“ATSU’s partnership with Grace Hill is the first of its kind in the country and an exciting development for the community health center movement. “We hope it will be a model for other dental schools of how to make oral health care an integral part of primary care services.”

Dr. Gary Wiltz, chair of NACHC
MOSDOH at Grace Hill

“A brilliant aspect of the ATSU model is that it benefits the patients we serve from day one. And, the students will be able to develop an unusually nuanced understanding of the skills needed to care for our patients in their communities. This is a remarkable opportunity for Grace Hill and other participating CHC’s, and we are very thankful for it.”

Alan O. Freeman
Institute of Medicine

• The MOSDOH at Grace Hill model is in direct alignment with recommendations regarding the development of an improved and responsive dental education system that the Institute of Medicine made in their 2011 report *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*
D4 Year – Community Health Center Rotations

• ICSP = Integrated Community Service Partnership

• D4 year, the student will complete 4 rotations lasting 4-6 weeks.

• Each external rotation is followed by an equal amount of time in the MOSDOH St. Louis clinic.

• Participation in all assigned rotations is required.

• Graduation Requirement - Student must complete a minimum of two (2) ICSP rotations
Missouri CHC - ICSP SITES (14)

- Community Health Center of Central Missouri
- Family Health Center of Boone County
- Jordan Valley Community Health Center
- Family Care Health Centers
- Missouri Ozarks Community Health
- Myrtle Hilliard Davis Comprehensive Health Centers
- Southeast Missouri Health Network
- Southern Missouri Community Health Center
- Betty Jean Kerr People’s Health Centers
- Crider Health Center
- Grace Hill Health Centers
- Katy Trail Community Health Center
- Northeast Missouri Health
- Missouri Highlands Health Center
ICSP Site Logistics

• Travel cost to be covered for student through financial aid package
• MOSDOH provides some assistance with gas costs if a student is driving to a site
• Living expenses (food, entertainment, personal effects, etc...) are the responsibility of the student
• Housing is covered or arranged by the site and may be
  – individual apartment, dorm room, or host housing
  – with or without room mates and co-ed
Elements of a Successful ICSP Site

• Hosting and welcoming the student
• Being prepared for the student when they arrive
• Housing
• Organizational commitment
• Student Introduction and Orientation
• Expressing confidence in student to the patient
• Using “Student Doctor” with introductions
• Providing an effective Orientation for the student for maximum effectiveness
St. Louis Clinic
Groundbreaking-April 25, 2014
Interprofessional Education Building
Kirksville
Happy Holidays
Interprofessional Experience
MOSDOH Class of 2017
AVAILABILITY, ACCESS AND ORAL HEALTH: THE INFLUENCE OF STATE ORAL HEALTH WORKFORCE POLICY ON COMMUNITY HEALTH CENTERS

Hannah Maxey, PhD, MPH, RDH
Assistant Professor & Director of Health Workforce Studies
Department of Family Medicine
Indiana University School of Medicine
OBJECTIVES

• Briefly describe the profession of dental hygiene and variations in state policy and practice environment

• Describe the influence of state policy environment on Community Health Centers and present findings

• Discuss implications opportunities for dental service delivery at Community Health Centers
DENTAL HYGIENE WORKFORCE

• PROFESSIONAL FOCUS:
  • Prevention and disease maintenance

• NATIONAL LEVEL:
  • Education and clinical training

• STATE LEVEL:
  • Practice regulated through licensure
  • Wide variations in regulation between states are quantified in Dental Hygiene Professional Practice Index (DHPPI) of 2001
    • Clinical tasks,
    • Supervision requirements,
    • Governance structure,
    • Reimbursements
Table 1

State Policy Environment as Categorized by Dental Hygiene Professional Practice Index (DHPPI)

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Note. DHPPI was generated as of state policy environment in December of 2001. Therefore these categories represent a baseline policy environment. Statistical analyses are adjusted for state level policy changes and clustering of Community Health Centers at the state level.
COMMUNITY HEALTH CENTERS AND STATE POLICY

Understanding whether State policy environment (quantified by DHPPI) is a predictor of:

1. **AVAILABILITY** - Dental Service Delivery Status reported to UDS by Grantees of U.S. Health Center Program

2. **ACCESS** - Proportion of health center patients accessing dental services

3. **ORAL HEALTH** - Proportion of dental patients accessing certain types of dental services (preventive, restorative, emergent)
AVAILABILITY:
PROPORTION OF CHC’S DELIVERING
DENTAL SERVICES DIRECTLY

Figure 12. Proportion of FQHCs Delivering Dental Services by DHPPI Rating
ACCESS: PROPORTION OF CHC PATIENTS ACCESSING DENTAL SERVICES

Figure 12. Proportion of FQHCs Patients Accessing Dental Services by DHPPI Rating
Fig. 12. Proportion of Reported Emergent Encounters by DHPPI Category
STATISTICS AND DISCUSSION

• State policy environment is a predictor of the availability and access to dental care and the oral health status of medically underserved communities that CHCs serve
  • As compared to health centers located in states with the most supportive policy environments, grantees located in states with the most restrictive policies:
    • Were 72% less likely to deliver dental services
    • Deliver dental services to -0.07 or 7% fewer patients
    • Provide proportionately fewer preventive and more restorative and significantly more emergent (0.03 or 3%) patient encounters
  • Grantees located in states with “FAVORABLE” and not “EXCELLENT” policy environment report the best outcomes
UNREALIZED OPPORTUNITIES FOR LEVERAGING THE DENTAL HYGIENE WORKFORCE?

- CHCs Required to provide preventive dental services since 2003
  - defined by regulation (42 C.F.R. §51c.102 (h) (6)) to include “services provided by a licensed dentist or other qualified personnel, including: (i) “oral hygiene instruction; (ii) oral prophylaxis, as necessary; (iii) topical application of fluorides, and the prescription of fluorides for systemic use when not available in the community water supply”. 
THE DENTAL HYGIENIST AS PART OF THE PRIMARY HEALTH CARE TEAM AT COMMUNITY HEALTH CENTERS

- A new model in which dental hygienists deliver the required preventive dental services practicing as part of the interprofessional primary care team
  - Benefits to CHCs and Medically Underserved Communities
    - Enhance number of CHCs delivering required dental services (AVAILABILITY)
    - Improve reach of dental services among patient population (ACCESS)
    - Improvement of oral health among patients populations (ORAL HEALTH)
  - Preventive dental services may be easily delivered in adapted primary care patient room in conjunction with well-child visits and physical examinations
POLICY IMPLICATIONS

• National Association of Community Health Centers (NACHC), State Primary Care Associations (PCA), and Community Health Centers
  • Engage discussions at the national, state and local levels on the effect of state policy
  • Advocate for policy to enhance availability to preventive dental services and access to care which lead to better population oral health
  • Petition for federal and state support to develop and implement workforce/delivery models
NOTES

• The information used in this presentation represents only a small part of dissertation work by the author/presenter.

• Additional information is available upon request from the author.

• Please direct questions and comments to Hannah Maxey at: hlmaxey@iupui.edu
Oral Health Integration into the Patient Centered Medical Home

A. Stevens Wrightson, M.D.
Medical Director
Bluegrass Community Health Center
Lexington, KY
Call to Action

• Surgeon General’s Report in 2000
  – Dental Care is the most common unmet health need
  – Oral disease can severely affect systemic health
  – Much oral disease is preventable or at least controllable
  – Profound disparities in oral health and access to care exist for all ages
Call to Action

• Healthy People 2000, 2010, 2020
  – Oral health objectives
• IOM reports 2011
  – Advancing Oral Health in America
  – Improving Access for Oral Health for the Vulnerable and Underserved
    • Children
    • Elderly
    • Disabled
    • Mentally ill
Why Engage Primary Care

- Children are seen in a primary care provider’s office 8-10 times or more before they see a dentist.
- Patients are more likely to be able to identify a medical home than a dental home.
- Urgent dental needs, like abscesses or fractures, are very likely to be seen by a medical provider before the patient sees a dentist, especially for those without dental insurance.
- Patient centered medical home principles support integration.
Oral Health Needs

• Childhood caries
  – Incidence is rising, 24% in 1994, 28% in 2004
  – Pain, poor school performance, absenteeism
  – Speech and language development problems

• Adult caries
  – 27% of young adults have untreated decay
  – Work loss and costly ER visits
  – Ultimately chewing and nutrition related issues

• Periodontal disease/Tooth loss
  – Glycemic control is hindered in patients with active oral disease
  – 24% of older adults are edentulous
  – Associated with an increase in all cause mortality

• Oral cancer
  – In 2010, the majority of oral cancers were stage 3 or 4 at detection.
  – 5 year survival drops from 83% to 37% depending on stage
Oral Health Disparities

• Children
  – 2.5 times more likely to lack dental coverage than medical coverage
  – 30-50% of low SES children have ECC
  – 80% of the decay is in 20% of children

• Elderly
  – 43% of the elderly visit the dentist
  – 70% lack dental insurance
  – Poverty, lack of mobility, disability and institutionalization all contribute to poor access to oral health care

• Rural and poor
  – Geographic and economic barriers to care

• Minorities
  – Hispanics at all ages have a higher rate of caries and caries experience compared to non Hispanic whites
  – Survival rates of oral cancer lower in African Americans compared to whites
Oral Health Education

• Traditionally lacking in medical and other non-dental health professional schools

• Dental education focused on repairs
  – Less emphasis on assisting patients with prevention and self management skills
  – Certain demographics may have difficulty seeing dentists (children, prenatal patients, elderly)
Smiles for Life is the nation’s only comprehensive oral health curriculum. Developed by the Society of Teachers of Family Medicine Group on Oral Health and now in its third edition, this curriculum is designed to enhance the role of primary care clinicians in the promotion of oral health for all age groups through the development and dissemination of high-quality educational resources.

**For Individual Clinicians**

We’ve made it easy for individual physicians, physician assistants, nurse practitioners, students, and other clinicians to access the curriculum and learn on their own time and at their own pace. Each of the courses is available online. Free CME credit is available.

**For Educators**

The curriculum is available in a presentation format easily implemented in an academic setting. Included is a comprehensive set of educational objectives based on the Accreditation Council for Graduate Medical Education (ACGME) competencies, test questions, resources for further learning, oral health web links, an implementation guide, and detailed outlines of the modules.
Steering Committee

**Alan B. Douglass, M.D.**  
Middlesex Hospital FMRP  
University of Connecticut

**Russell Maier, M.D.**  
(Group Co-Chair)  
Central Washington FMRP  
University of Washington

**Melinda Clark, M.D.**  
(Editor and Group Co-Chair)  
Albany Medical College

**Mark E. Deutchman, M.D.**  
University of Colorado

**Wanda C. Gonsalves, M.D.**  
Medical University of South Carolina

**Maria Dolce, Ph.D., R.N., NEA-BC**  
New York University

**Jonathan Bowser, M.S., PA-C**  
University of Colorado

**Rocio Quinones, D.M.D., M.P.H.**  
University of North Carolina

**Hugh Silk, M.D., M.P.H.**  
University of Massachusetts

**James Tysinger, Ph.D.**  
University of Texas, San Antonio

**A. Stevens Wrightson, M.D.**  
University of Kentucky

**Joanna Douglass, B.D.S., D.D.S.**  
University of Connecticut
Curriculum Overview

8 annotated 50 minute modules - web and PowerPoint

1. The relationship of oral to systemic health
2. Child oral health
3. Adult oral health
4. Dental emergencies
5. Oral health in pregnancy
6. Fluoride varnish
7. The oral examination
8. Geriatric oral health

Interactive cases, test questions, CME credit with certificate
Resources for further learning
Endorsed By

Smiles for Life is endorsed by the following healthcare organizations who support the role of medical clinicians in promoting good oral health:

- American Academy of Family Physicians
- American Academy of Pediatrics
- Society of Teachers of Family Medicine
- American Dental Association
- Physician Assistant Education Association
- American Association of Physician Assistants
- Association of Faculties of Pediatric Nurse Practitioners
- National Association of Pediatric Nurse Practitioners
- Gerontological Advanced Practice Nurses Association
- American Association of Public Health Dentistry
- National Association of School Nurses
- American College of Nurse-Midwives
Reimbursement

• 43 states reimburse for oral health care in the medical office
• Fees paid range from $11-78
• Screenings, fluoride varnish application or both
• Nevada
  – 20 pediatric patients a week at $53.30 a visit = $55,432 in additional revenue annually
• Washington
  – 20 pediatric patients, separate reimbursement for fluoride varnish, oral exam and oral risk assessment =$73,102 annually
• Kentucky
  – 20 pediatric patients a week at $15.00 a visit = $15,600 annually
Oral Health is a Fit for PCMH

- Engaged leadership
- Quality improvement strategy
- Empanelment
- Continuous and team-based healing relationships
- Organized, evidence-based care
- Patient-centered interactions
- Enhanced access
- Care coordination

- Safety net medical home initiative May 2013
Patient-Centered Interactions

• Whole person
  – puts the mouth back into the body

• Self-management and prevention
  – Diet and oral hygiene are under the patient’s control
  – Easy to track self directed goals
Enhanced Access

• Brings oral health services into the medical home:
  – Insurance coverage=oral care?
  – Education
  – Screening for oral disease and correlation with systemic health
  – Fluoride

• Urgent/emergent care

• Same day access
Organized, evidence-based care

• Oral health has a strong evidence basis
• Outcomes and be identified and quantified:
  – Caries rates
  – Periodontal disease rates
  – Correlation of oral health with chronic diseases like diabetes.
US Preventive Services Task Force

• The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. Grade: B recommendation.

• The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. Grade: B recommendation.
  • May 2014
Integration of Oral Health and Primary Care Practice

• HRSA report February 2014
  – Creation of core clinical competencies for providers
    • Risk Assessment
    • Oral Health Evaluation
    • Preventive Interventions
    • Communication and Education
    • Interprofessional Collaborative Practice
  – Systems analysis
  – Implementation strategies for change
Bluegrass Community Health Center

% of 1-6 yo who Receive 1 Application of Varnish

Goal 75%

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• References


Oral Health in Primary Care

Contracting Strategies between FQHCs and Private Practice Dentists– NACHC CHI August 2014

Jane Grover DDS MPH    Director
Council on Access Prevention and Interprofessional Relations
Goals of Oral Health Integration – The “Why”

• Patient benefits from health care “team”
• Providers share patient information
• Increased care coordination and compliance
• Strengthens health center patient satisfaction
• Emphasis on prevention and other cost reducing strategies
Dental Services : Not Just “Kids Stuff”
The “How” of Oral Health Integration

• Medical Providers Talking “Word of Mouth”
• All Health Center Staff with Dental “Familiarity”
• Dental Providers Meeting with Medical
• Health Center Board Supports Oral Health Services
• Patients are Directly Scheduled into “Dental”
• Community Visibility/Promotion of Oral Health
Basics of a Good Contract
Benefits of Contracting with Local Dentists

- Utilizing established and experienced practitioners—quality assurance
- Increased visibility for health center operations
- Ability to avoid purchasing and maintenance of dental equipment
- Decreased employee costs with an outside dental team
Early Childhood Caries - an avoidable disease
Essential Tips for Contracts

• A respectful relationship between parties
• Experienced legal counsel
• Specifications regarding patient load, chart review methods, ownership of records, liability issues, patient satisfaction surveys, reimbursement protocols
• Dispute resolution process established
• Per Benjamin Franklin- “The art of what is possible”
Why “Baby Teeth” are important
Contract Samples and How to Get Started

- Meeting with medical providers to gauge dental “demand” and need
- Community assessment with Head Start, hospital and State Primary Care Association input; also United Way input
- Attend a local dental society meeting- or invite local dental leaders to dinner
- Review ADA Contracting Handbook for FQHCs
For Patient Benefit: Education and Experience
• Review Contract Samples
• Begin with a draft contract: negotiation is welcome
• What dentists need: reimbursement details; attendance at provider meetings; QI indicators; patient load expectations
• What health centers need: Quality, cost, patient satisfaction information
Health Center Dental Programs Need “Dental”!
CHC Oral Health Programs & Primary Care Associations:

Working Together to Improve Health

NACHC CHI 2014

Joan Pernice, RNC, MS
Clinical Health Affairs Director

Oral Health Affairs Manager
How Did The League Get Involved With Dental?

- Saw a 20% increase in dental sites in the last 15 years
- 38 members organizations (73%) have dental at 53 sites
- Saw it as a major need in the community.

In 2008 MLCHC wanted:

- To establish a permanent position for an Oral Health Affairs Manager (OHM) at MLCHC.
- OHM to play a key role in the management structure of the PCA, focusing specifically on the oral health needs of CHC’s and the integration of oral health into all PCA activities.
Goals of the MLCHC Oral Health Initiative

DentaQuest Foundation awarded us a 3 year pilot grant to develop the OHM position and to focus on the following:

- Improve Communications
- Improve Infrastructure
- Improve Quality and Efficiency
- Improve Policy and Advocacy Activities

* For all CHC oral health programs in our state
Strengthening the Oral Health Safety Net Initiative

- DentaQuest Foundation is invested in 15 PCAS to focus on the oral health needs of their state CHCs.
- Each state in the grant receives dental consulting for 5 CHCs in their state from Safety Net Solutions dental consulting.
- The Mass League is the lead PCA and created a learning curriculum for the PCAS to learn and share from each other.
- NNOHA and NACHC are also organizational partners.
LESSONS LEARNED
Four Areas PCAS Should Focus On:

- Technical Assistance
- Policy & Advocacy
- Workforce Development
- Partnerships
Focus Area 1: Technical Assistance

**Step 1: Engage with the CHCS** to find out what ARE the TA needs of the dental program and staff. Our PCA did this through site visits, one on one stakeholder interviews with variety of staff, surveys and phone calls.

**Step 2: Prioritize and respond.** By engaging with the CHCS we found that most of the dental departments were operating at a loss and had huge TA needs around patient scheduling, payer mix, sliding scale fees and billing for dental. As well as a desire for more clinical and leadership development for staff. Those TA needs became our focus and work plan.
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<th>After</th>
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<tr>
<td>PCA did not offer any CEU and training programs for dental staff</td>
<td>Created dental director meetings that rotate between Boston and Central MA to highlight best practices, leadership development, and peer networking. Meetings come with CEUS and are free. Also offer specific clinical workshops throughout year.</td>
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<tr>
<td>Dental Directors were not aware of each other and had no forms of communication.</td>
<td>Creation of a dental list serve for staff to pose questions to promote peer learning</td>
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<td>Dental was not always on the agenda</td>
<td>PCA started elevating the importance of dental by having dental be an agenda item at our CEO, CFO, Govt. Affairs, Clinical, Quality Improvement meetings, etc.</td>
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Focus Area 3: Policy & Advocacy

There are many political issues affecting oral health CHC programs such as:

1. Whether or not the state Medicaid program covers dental benefits for adults - many do not.
2. The different state practice acts that either promote or inhibit dental providers to be working to their full scope of service.
3. Capacity and Access issues – long wait times at CHCs.
4. Low reimbursement rates for dental
Policy and Advocacy-PCA’s role

- **Collect Data**: When Medicaid cut adult dental benefits in our state the League surveyed the CHCS on the impact of these cuts and published a report that went to all Senators & legislators.

- Allowed us to show the immediate impact to CHCs and patients. Easy to link specific data to district representative

- **Managed to get incremental restoration that same year.**
Policy and Advocacy-PCA’s role

Give Dental Issues a Voice by:

• Sharing stories via media outlets

• Having dental staff and patients participate in PCA statehouse days.

• Inviting policymakers to your dental department- developing “oral health champions”.

• Letting your members know when hearings on Medicaid, workforce, rates and other dental issues are coming up so they can testify.
Focus Area 4: Partnerships

- **Internal Partnerships to Consider:**
  - Not every PCA can hire staff to focus on oral health
  - However think of how oral health can be integrated into current clinical committees, programs and meetings.
  - Consider having an advisory committee made up of executive leaders and dental staff to help guide the PCA.
  - Educate current PCA staff on the oral health status of your state and the CHC programs so they are aware and more informed.
Focus Area 4: Partnerships-External

- State Dental Society
- State Licensing Board for Dentistry
- Local and State Department’s of Public Health
- Dental Schools and Hygiene Schools
- Lutheran Dental Residency Program
- State Oral Health Coalition
- Dental Vendors
Big changes take time…

• In 2009, there were no CHC dentists involved in leadership roles at MDS. But now…..

Guest Board Members (2012-2013)
Thank You!

Please complete your session evaluation forms before you leave