Promising Practices #8

Open Wide: State Initiatives to Expand the Oral Health Workforce

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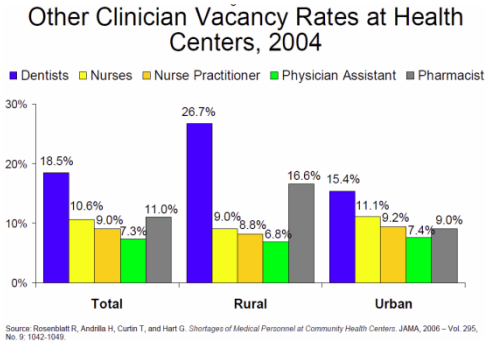
Open Wide: State Initiatives to Expand the Oral Health Workforce

In recent years, Community Health Centers (CHCs) have seen a rapid growth in their oral health programs. This growth was accelerated due in part to the 2002 initiative requiring that all new health centers assure access to oral health services, the oral health service expansion grants offered by the Health Resources and Services Administration (HRSA) in 2008 and 2009, and the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) which mandated that dental services be covered under CHIP. Over 3 million patients sought dental services from Federally Qualified Health Centers in 2008, more than double the number seeking such services in 2001.[1] However, the oral health workforce has not kept up with this growing demand and health centers record higher vacancy rates for dentists than for other medical professionals.[2] Nationally, HRSA has designated 4,230 Dental Health Professional Shortage Areas (HPSA), affecting 49 million Americans. HRSA further estimates that it would take over 9,600 dental practitioners to fill this need.[3]



Opening the Provider Network for Preventive Oral Care

The uninsured or publically insured are particularly vulnerable to provider shortages as many oral health professionals are not willing to accept these patients.[4] This lack of access particularly to preventive dental care, however, can lead to serious and costly complications including a need for intensive dental services or emergency care, and the development of chronic illnesses including cardiovascular disease, stroke, and diabetes.[5,6] CHCs are positioned to serve as a primary resource to address this need as all provide patient referrals and nearly 74% of all health centers provide preventive dental services on site.[7] To enhance their workforce several states have expanded service definitions to allow providers other than dentists to perform many preventive oral services. For example, an issue brief released earlier this year by the National

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[1] HRSA. (2007) Uniform Data System: Health Center National Data. Available at: http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2007/2007_nat_tot_summary_data.html

[2] Rosenbl**att**, Roger, et al. (2006) Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion. Journal of the American Medical Association. 295: 1042 - 1049

[3] HRSA. (2009) Shortage Designation: HPSAs, MUAs & MUPs. Accessed April 01,2010 Available at: http://bhpr.hrsa.gov/shortage/

[4] Ruddy, Ginger. (2007) Health Center's Role in Addressing the Oral Health Needs of the Medically Underserved. NACHC.

[5] NACHC. (2010) Under One Roof: The Role of Community Health Centers in Delivering Behavioral and Oral Health Services. *PENDING*

[6] Wu, Tiejian, et al. (2000) Examination of the Relation between Periodontal Health Status and Cardiovascular Risk Factors: Serum Total and High Density Lipoprotein Cholesterol, C-reactive Protein, and Plasma Fibrinogen American Journal of Epidemiology. 151: 273 - 282.

[7] HRSA. (2007) The Health Center Program: 2007 National Aggregate UDS Data: Services Offered and Delivery Method. Available at: http://bphc.hrsa.gov/uds/2007data/national/nationaltable2.htm

Academy for State Health Policy outlines several states that have expanded service definitions to reimburse medical providers for services including fluoride varnish applications, oral examinations, screenings, and caregiver education.[8] Other states, like California, have sought to broaden the capabilities of dental hygienists, including them as reimbursable providers for certain services even if not under the direct supervision of a licensed dentist. Expansion of hygienist scope-of-service is particularly significant considering that health centers are becoming increasingly reliant on hygienists to address dental workforce shortages,[9] and CHCs are missing funding opportunities if these providers are left out of their reimbursement calculations. Such provider expansions serve not only to augment health centers' abilities to provide preventive care, they free dentists to work with patients with more complicated oral health problems like periodontal disease, common in many patients who have delayed dental care.[10]

Opening FQHCs to the New Dental Workforce

One solution to bring new providers into a state is to create new opportunities for educational programs out of which a state can grow its own workforce. In the last year, Maine and Wisconsin launched successful campaigns to secure funding for new dental educational programs that emphasize a public health approach to dentistry, and service of populations in underserved communities. Other states, like Oklahoma, Minnesota, and North Dakota have opted to assist new providers by offering loan repayment opportunities to dental providers who agree to practice in areas of need within the state. A 2004 study found that new dental graduates are burdened with an average of $80,000-$100,000 in educational debt,[11] and with the new exception of state loan repayment money as taxable income under the Patient Protection and Affordable Care Act, loan repayment programs are apt to be even more appealing for new providers.

Opening Opportunities for Experienced Providers

States are unique in their recruitment and licensing practices for dental providers within their borders. This can translate into great differences among states when it comes to license examinations, outreach initiatives, and the influence of various state dental associations on the legislature. Several states have established statutes to adapt their licensing procedures, particularly for providers willing to serve a state's indigent population. Legislation in Iowa and Oklahoma, for example, extend "volunteer licenses" to out-of-state dentists to practice in-state without taking the state dental exam. Hawaii has similarly made a special licensure procedure

[8] Hanlon, Carrie. (2010) Reimbursing Medical Providers for Preventive Oral Health Services: State Policy Options. National Academy for State Health Policy.
[9] NACHC. (2010) Under One Roof: The Role of Community Health Centers in Delivering Behavioral and Oral Health Services. *PENDING*
[10] NACHC. (2010) Under One Roof: The Role of Community Health Centers in Delivering Behavioral and Oral Health Services. *PENDING*
[11] Bolin, Kenneth et al. (2004) A Nationwide Survey of Dentist Recruitment and Salaries in Community Health Centers. 15: 161-169

for out-of-state dentists, however, Hawaii's license grants that out-of-state dental providers can practice as fully licensed and reimbursable providers without qualifying for a state specific license, if they agree to work at CHCs or other facilities serving in-need populations. When interviewed on the issue, several Primary Care Associations (PCAs) noted less success with state licensure expansions, especially for volunteer providers, citing concerns over liability coverage, continuing education requirements, and competition with charity care facilities. The Oklahoma PCA has taken up some of these issues, recently pushing tort reform legislation to cover volunteer dental providers in Federally Qualified Health Centers (FQHCs). While adapting licensure rules may be a means for some to expand workforce capacity at CHCs, it is important to address these issues in order so that such reforms can be successfully utilized by CHCs.

Leveraging the State to Address Oral Health Needs

The oral health needs of FQHCs are growing and PCAs play an important role in advocating for state legislation to ensure that their health centers will have the workforce needed to meet the growing demand. Below are a few examples of successful state initiatives to bolster the oral health workforce:

California: Including Hygienists in the Provider Mix

CMS guidelines define "physician" as inclusive of doctors of medicine or osteopathy, podiatrists, optometrists, and chiropractors.[12] Limiting reimbursable providers to this definition neglects the myriad of additional medical professionals that work to provide care to patients in health centers. This issue was recently taken up in California where the California Primary Care Association (CPCA) sought to include dental hygienists as billable providers in their payment structure. Under the previous system, health center patients would, upon visit, need to have a face-to-face encounter with a dentist for any oral health issue in order for the health center to be reimbursed for the visit. This practice was problematic in that it required dentists to take time away from more critical patients in order to be present at all dental visits, including those that could easily be facilitated by a dental hygienist alone. CPCA sought to create a more logical and efficient system to increase the capacity of their own dentists, lessen overall workforce demands and ensure adequate payment for services rendered by hygienists, with or without direct supervision of a dentist.

CPCA worked with State Senator Sam Aanestad to draft legislation to include hygienists as reimbursable providers for FQHC and Rural Health Centers. With additional support from the Dental Hygienists Association, a partner in CPCA's Oral Health Coalition, and a letter of support from the California Dental Association, the measure was passed in 2008. Since its passage,

[12] Centers for Medicare and Medicaid Services. (2005) The Medicare Rural Health Clinic and Federally Qualified Health Center Manual. CMS. Available at: http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021925

however, CPCA has faced several problems in implementing the new regulation, mainly pertaining to the recalculation of the PPS rate. For one, currently the system only allows for one medical and one dental visit per patient per day. In this case, if a patient were to need to see both a dentist and a hygienist, only one of those encounters would be reimbursed if the patient saw both on the same day. Second, the state and CPCA are having difficulty agreeing on how to calculate the "cost" of a hygienist visit. The state wishes to utilize the productivity standard assigned to midlevel practitioners which grants 15 minutes per visit at the rate of 2,100 visits per year. A typical visit to a dental hygienist, however, averages 30 minutes due to the lengthy procedures (ex. teeth cleaning) that hygienists typically undertake. The state and CPCA are in negotiations to resolve this issue, with CPCA and Medi-Cal currently working through trial periods in which they are tracking the issue of same day encounters and the number of actual overall hygienist encounters conducted in FQHCs and RHCs. Hopefully the data will serve to provide a better reimbursement standard. In the meantime, CPCA continues to advocate for PPS practice models that will enhance and support the efficient delivery of primary care in its health centers.

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Maine: Establishing a New Dental School

Three years ago, a new and innovative president, Danielle Ripich, came to the University of New England (UNE), who sought to expand UNE's School of Osteopathic Medicine in a way that would bring better access to health care for Maine's population. Recognizing the oral health needs of the state, she teamed with the school's board of trustees to begin planning for a dental school modeled after A.T. Still University in Arizona, with the fourth year of education spent completing residency training at a health center site. When looking to finance the school, however, UNE reached a roadblock in trying to secure state funding for the new dental program, largely because the state legislature was hesitant to allocate public funds to a private institution. After encouragement from Rev. Robert Carlson, president of Maine's largest health center Penobscot Community Health Center (PCHC), and the willingness of UNE to carve out $1 million for CHC dental infrastructure expansion, the proposed measure put a greater emphasis on the role the state's CHCs would have in UNE's dental program.

The enhanced inclusion of CHCs in the funding measure provided for enough political leverage and in 2010 $7 million in funding for the dental program was included as part of a bond issue (LD 1798). The issue was incorporated into the larger bond package (LD 1826) negotiated during the waning days of the legislature after great advocacy efforts by UNE, the Maine PCA, PCHC, as well as community members. Specifically, advocates emphasized Maine's long struggle with oral health workforce issues, citing Maine's low ratios of dental providers located in medically underserved areas, that most of the state's CHCs had dental Full Time Equivalent

(FTE) vacancies that were often open for over a year, and the current dental workforce was aging with 41% of Maine's dentists over the age of 55. Advocates were also able to show documentation of the rising need for dental services in Maine, with PCHC alone boasting 3,600 new dental patients in 2009. Because of these efforts, the measure received a unanimous ought-to-pass from the legislature's Health and Human Services Committee, and, in spite of an overall cut of the total bond package from $85 million to $59 million, $3.5 million was allocated for a teaching clinic for the school and $1.5 million in competitive grants for CHCs to become teaching centers.

Overall, UNE's dental program is expected to cost $20 million, with the University committing $15 million to the program, along with the $5 million of allocated state funds. It is anticipated that UNE will enroll its first dental class in 2012 and anticipates the program will provide for tens-of-thousands of dental encounters through the residency training.

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WI: Building Partnerships to Expand Educational Opportunities

For several years Greg Nycz, director of the Family Health Center of Marshfield, Inc. (FHCM), has had an eye on expanding educational opportunities for dental providers in Wisconsin, with great potential for expansion in FHCM's parent health care facility, the Marshfield Clinic (MC). Mr. Nycz proposed this idea of bringing dental education to Marshfield with the clinic's board and laid the foundation for later talks with the state senate on the issue. Sen. Bob Jauch, the democratic senator who represents some of MC's sites, proved especially instrumental during these talks, becoming one of the greatest advocates for advancing dental health education and drafting legislation to support a feasibility study on increasing access to dental education in northern Wisconsin. The 2009-11 biennial state budget was approved in the summer of 2009, and later that year a contract was awarded to Dr. Howard Bailit, who had recently completed a study for the state dental association, to complete the report.

The feasibility report, released in March 2010, analyzed both educational and non-educational options for expanding Wisconsin's oral health workforce making several recommendations on initiatives the state could pursue in its efforts to increase dental access in the state, including increased use of dental hygienists, building dental residency programs, and expansion of the safety-net, including FQHCs.[13] In regard to the proposal for a dental school at MC, the report noted that the clinic lacked sufficient infrastructure with which to host a dental school, but by building educational and clinical resources it would be "well-positioned to become a national leader in preparing a dental workforce for rural America."

[13] For complete report details please see: http://www.wda.org/media/06/1716-wisconsinrfpreport3.pdf

Armed with the study's recommendations, advocacy networks through MC and the Wisconsin PCA, and the support of several state senators, a $10 million bond authority was proposed to assist MC in funding a "rural dental educational facility" (SB 656). The measure received strong opposition from state republicans, weary of expending state funds on a new project during this volatile fiscal climate. Also during the legislative process, both Marquette University's School of Dentistry and the WI Dental Association privately raised need and cost concerns about the dental facility proposal.

In spite of a partisan vote, the measure passed the state assembly in April 2010 and was signed by the Governor in early May. The issue, once signed, will grant MC the funds for a new dental facility on campus, and 5 years during which the clinic must match state funds for the dental education program.

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Oklahoma: Incentivizing New Providers through Loan Repayment

In 2006, the Oklahoma Dental Association spearheaded an initiative, supported by the Oklahoma PCA, targeted toward recruiting dentists to practice in underserved areas. Legislation, to be known as the Oklahoma Dental Loan Repayment Act, was authored by State Senator Cal Hobson, a reform advocate who saw the initiative as a way of addressing the needs of Oklahoma's medically vulnerable populations, particularly uninsured children. The Act was passed in that year, creating the Oklahoma Dental Loan Repayment Program (ODLRP) financed through an earmarked appropriation of state funds and overseen by the Dental Health Service of the Oklahoma State Department of Health. Each year ODLRP provides four licensed dental providers up to $25,000 per year to practice in an underserved area for a designated 2-5 years. Recipients of the loan, along with practicing in a designated shortage county, must also make sure that 30% of all patients he or she treats during the established time of service are Medicaid patients. The program's requirements make qualifying dentists prime candidates for CHC employment, and the Oklahoma PCA is currently developing an outreach program to recruit soon-to-be practitioners to work in CHCs under ODLRP. Currently 16 dental practitioners are serving in Oklahoma's shortage areas thanks to the program.

For more information, please see:
http://www.ok.gov/health/Child_and_Family_Health/Dental_Health_Service/Oklahoma_Dental_Loan_Repayment_Program/index.html

Hawaii: Creating a Community Health Service License

The Hawaii Primary Care Association (HPCA) has faced a long history of contending with the state's powerful dental groups who have worked to limit the number of dental providers in the state. While these groups claimed that there existed a high concentration of dentists within the

state, most of the providers were not located in areas of high need and/or were not willing to serve publically insured or uninsured patients. Without access to new providers for these populations, the state would continue to see large numbers of unmet dental need. In 1999 HPCA worked with several other oral health groups in the state to form the Hawaiian Islands Oral Health Task Force (HIOHTF) to address Hawaii's oral health needs; however, conflict ensued particularly over the state's licensing exam which exhibited high rates of failure, even for currently practicing dental providers from other states. Oral health professional groups sought to keep tight restrictions on the state's licensing procedures to limit workforce competition within the state.

In 2002, HIOHTF reached a compromise and drafted the Community Service License Bill which would establish a three-year pilot program by which out-of-state dentists and dental hygienists could qualify for a license to practice in FQHCs, Native Hawaiian Health Systems Centers, or auxiliary training programs, without taking the state licensure exam. By making the license so exclusive as to where providers could practice, new providers would be incentivized to work in areas of Hawaii's highest need without creating undue competition for Hawaii's current providers. Practitioners under this license meanwhile, are required to pay only half of the state's normal registration fees when applying for the license and practice in FQHCs as fully reimbursable providers. The sunset provision on the pilot was repealed in 2006 and the community service license stands as state statutes §448-9.6 (for dentists) and §447-1.5 (for hygienists).

Since its passage, the community health service license has facilitated the recruitment process for bringing dental providers into the state's health centers and, in part, because of the passage of this law, the number of dentists employed at health centers has nearly doubled since 2004, and the number of hygienists employed has more than doubled. Furthermore, the state's FQHCs have gone from serving slightly more than 12,000 patients in 2004 to serving well over 28,000 last year. HPCA considers the passage of the community service license bill a major success in enhancing its dental workforce, and a necessary step in compromising with the state's powerful dental groups to enhance dental care for those most in need.

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