The National Perspective: States Working on New Providers

Shelly Gehshan, MPP
Director, Pew Children's Dental Campaign
Pew Center on the States
sgehshan@pewtrusts.org

What I'll Cover…

• Cost of Delay report—grades on 3 workforce measures
• Why current workforce is not sufficient
• Models being considered
• Change is coming! Key provisions in national reform legislation (see handout)
The 8 Benchmarks

- Can hygienists apply sealants in a school setting without a dentist’s prior exam?
- Does the state reimburse medical providers for preventive services?
- Has the state authorized a new primary care dental provider?
- Are school sealant programs present in at least 25 percent of high-risk schools?
- Does the state provide fluoridated water to at least 75 percent of its population on community supplies?
- Does the state meet the national average for Medicaid utilization?
- Does the state meet the national average for Medicaid payment?
- Does the state submit data to the National Oral Health Surveillance System?
33 States and DC Received a C or Lower

Benchmark 2: Hygienists in Sealant Programs

<table>
<thead>
<tr>
<th>State allows hygienists to provide sealants without a prior dentist’s exam, 2009</th>
<th>Number of states</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>30</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
</tr>
</tbody>
</table>

Systemic reviews by ADA and CDC have stated that visual assessment – which hygienists are qualified to provide – is adequate to determine the need for sealants.

Prior examination by a dentist is not necessary, and can limit the reach of school-based sealant programs.

Interpretations of laws on this vary—update in 2011 will verify them.
Current system and workforce is not sufficient

- Financing for dental care is likely to grow and will spur demand
  - An estimated **5.3 million** more children will have dental insurance due to national health reform
  - The needs are great

- Shortage and maldistribution of dentists
  - Shortage is getting worse. Too few care for low income, rural patients
  - Dental safety net only reaches 10% of the 83 million who lack access
  - Growing recognition that new providers can competently and safely deliver high-quality care

- Few private practice dentists participate in Medicaid and CHIP programs
  - Medicaid rate increases don’t solve the problem
Children’s Medical Care Coverage

# of children (in millions)

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>Current</th>
<th>After 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>24.8M</td>
<td>27.7M</td>
</tr>
<tr>
<td>CHIP</td>
<td>4.8M</td>
<td>6.5M</td>
</tr>
<tr>
<td>Private</td>
<td>47.1M</td>
<td>47.8M</td>
</tr>
<tr>
<td>Uninsured*</td>
<td>7.3M</td>
<td></td>
</tr>
</tbody>
</table>

* Illegal immigrants and children from families with income <100% FPL are excluded from the mandate

NOTE: In 2006, the number of children without dental insurance coverage was over 15.4 million, according to MEPS’ “Statistical Brief #221” (September 2008)

Practitioners Needed to Remove Designation of Health Professional Shortage Area

Ratio of Underserved to Total Population
- <10%
- between 10% - 20%
- >20%

Numbers = Practitioners Needed to Remove Designation

Benchmark 7: New Primary Care Dental Providers

<table>
<thead>
<tr>
<th>State has authorized a new primary care dental provider, 2009</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>50</td>
</tr>
</tbody>
</table>

An increasing number of states are exploring new types of dental professionals to expand access and fill specific gaps.

In 2009, Minnesota became the first state to authorize a new provider.

And philanthropies – including Pew – are playing an active role in helping states examine their workforce options.
State dental associations are discussing authorizing new mid-levels.

Benchmark 6: Medicaid Payment to Medical Providers for Dental Services

<table>
<thead>
<tr>
<th>Medicaid pays medical staff for early preventative dental health care, 2009</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>35</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
</tr>
</tbody>
</table>

Doctors, nurses, nurse practitioners and physician assistants are increasingly being recognized for their ability to see children, especially infants and toddlers, earlier and more frequently than dentists.
New provider models in dentistry

- Community Dental Health Coordinator (CDHC)
- Dental therapist (DT, DHAT)
- Combined dental hygienist/therapist (DH/DHAT)
- Minnesota dental therapist/advanced dental therapist (MN DT and ADT)
- Advanced dental hygiene practitioner (ADHP)
Community Dental Health Coordinator (CDHC)

- 12 month didactic, 6 month internship
- Certified, not licensed
- Pilot projects operating in CA, OK, PA
- Scope: patient navigation, health literacy, some preventive services
- Like a social worker with a few dental skills
- Pros:
  - May facilitate dentist participation in Medicaid
- Cons:
  - Few reimbursable services make sustainability difficult

Dental Therapist (DT, DHAT model)

- Based on New Zealand model in use since 1920s
- Operating in tribal areas of Alaska since 2003
- Remote supervision by dentists
- 2-year degree, through University of Washington
  - Some countries moving to a modular 3-year dental therapy-dental hygiene program (oral health therapist)
- Close to nurse practitioner—primary care
- Pros:
  - Proven model: many studies supporting safety, quality, effectiveness
- Cons:
  - Alaska lawsuit has polarized opinions somewhat
Minnesota Dental Therapist (MN DT)

- 4-year bachelor’s degree
- First class now being trained at UMN Dental School
- Authorized to work with underserved populations
- Basic DT would operate in dental clinics under limited general supervision of dentist, and indirect supervision for restorative care
- Pros:
  - First new primary care dental provider to be authorized by a state
- Cons:
  - Similar scope to international DT, but twice the training, reducing cost effectiveness

Minnesota Advanced Dental Therapist (MN ADT)

- 2-year master’s degree, and 2,000 hours of work as basic DT
- First class now being trained at MNScU; Board of Dentistry determining accreditation of this program
- Authorized to work with underserved populations, provide non-surgical extraction of loose permanent teeth
- ADT could operate without a dentist in more settings than basic DT (e.g., nursing homes), under collaborative practice agreements
- Pros:
  - Able to be deployed in more settings
- Cons:
  - Very high level of education for few added services, reducing cost effectiveness
Advanced Dental Hygiene Practitioner (ADHP)

- Currently a proposed model; ADHA has finalized curriculum
- 2-year Masters program for bachelor’s level hygienists
- Close to nurse practitioner
- Pros
  - Pool of RDHs ready to train
  - Could be supported by reimbursable services
- Cons:
  - Very high level of education for few added services, reducing cost effectiveness
  - Evokes long-standing turf battles between dentists and hygienists

Dental Hygienist /Dental Therapist

- Three-year modular approach (1 yr basic sciences, 1 yr hygiene, 1 yr dental therapy)
- Used in Great Britain, New Zealand, Australia
- Could be easily deployed; several states considering this
- Pros
  - Pool of 2-year RDHs ready to train
  - Could be supported by reimbursable services
- Cons
  - Evokes long-standing turf battles between dentists and hygienists
  - May trigger same objections as dental therapists
Three main variables for new provider models

- Scope of practice
- Education levels
- Supervision

But there are more considerations to keep in mind

- How will the new provider fit into existing systems of medical and dental care?
  - Dental clinics, CHCs, hospitals, nursing homes?
- Where will new providers locate?
  - Will the model address maldistribution?
- Who is the new provider intended to serve?
  - Low-income, children, elderly, rural?
## Scope: Restorative Capacity of Providers

<table>
<thead>
<tr>
<th>Procedures</th>
<th>CDHC proposed</th>
<th>EFDA proposed</th>
<th>ADHP proposed</th>
<th>DHAT (AK model)</th>
<th>MN DT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atraumatic Restorative Technique (ART)</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Placement of temporary restorations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Simple restorations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prefabricated crowns</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Simple extractions</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lab processed crowns</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulpotomy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulp capping</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Categories of Intraoral Procedures ordered from most to least restrictive**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Advanced Restorative Care</th>
<th>Diagnosis &amp; Treatment Planning</th>
<th>Basic Restorative Care</th>
<th>Preventive: Scaling and Root Planning</th>
<th>Preventive: Coronal Polishing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td><strong>Combination Dental Therapists/Dental Hygienists</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Dental Hygiene Practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Hygienist-Therapist, International</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Therapists</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Therapist, International</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska Dental Health Aide Therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minnesota Advanced Dental Therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minnesota Basic Dental Therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Hygienists</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expanded Function Dental Hygienist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Assistant</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expanded Function Dental Assistant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Assistant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Preventive Assistant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community Dental Health Coordinator</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Dental Health Coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


---

**Education: Length of Training (Post High School): US and International Dental Providers**

- Assistants
- Hygienists
- Therapists
- Hygienist-Therapists
- ADHP
- Dentist

Proposed Supervision Levels

- CDHC: General/indirect
- DT, DHAT: General, under standing orders of a dentist (use teledentistry for remote areas)
- DH/DT: General, under standing orders
- MN DT: Indirect, general for some services
- MN ADT: General, through collaborative practice agreements
- ADHP: General, collaborative practice

NOTE: depends on state law and regulation, will vary

Pew Guidelines on what models we support
(see www.pewcenteronthestates/dental)

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

- Economics of private practice—a model to estimate potential impact of new providers on productivity, costs, income of private practices (Scott Inc.)

- How will collaborative practice work?—reimbursement for consultations, oversight technologies, malpractice (UCSF, Mertz, Dower)

- Economics of safety net clinics—will examine impact of new providers on productivity, costs, income with public funds (Bailit, Beazoglou)

---

Pew Children’s Dental Campaign

Mission:
To promote policies that will help millions of children maintain healthy teeth, and come to school ready to learn.

www.pewcenteronthestates.org/dental