Office for Oregon Health Policy and Research

Oral Health and the Oregon Health Plan

Medicaid Advisory Committee
Staff Summary and Recommendations

March 2009

March 31, 2009

Bruce Goldberg, MD
Director, Oregon Department of Human Services

Dear Dr. Goldberg:

At the request of several stakeholders, the Medicaid Advisory Committee (MAC) has reviewed key issues surrounding oral health services and the Oregon Health Plan. A brief introduction to the topic and a description of the MAC's deliberation process accompany the recommendations outlined in this report.

The MAC would like to take this opportunity to commend the State of Oregon for its commitment to providing quality health care to its citizens. Providing health care coverage to all children in Oregon has been at the forefront of the state's agenda and continues to be a top priority. Expanding coverage to low-income adults has also become a pertinent matter to the leadership within our state. One issue, however, that is continuously deferred is the importance of access to high-quality oral health care. We believe that health care services should not be segregated based on the part of the body they involve or the qualified health professionals who deliver them.

The prevalence of oral disease among Oregonians is rising. Left untreated, oral disease can lead to costly dental treatments and diminish the general health and well-being of those affected by this condition. Preventive dental care can stop oral disease establishment and progression, thereby reducing the likelihood that an individual will need costly treatments in the future. Access to dental services as well as a culture within state leadership dedicated to oral health education and promotion is critical to achieving and maintaining a population free of oral disease.

The federal government has demonstrated its support in providing access to dental services for children through the recently enacted Children's Health Insurance Program (CHIP) Reauthorization Act of 2009. Using federal matching funds as a means of financing, the Act allows states the option to provide dental-only supplemental coverage for children who otherwise quality for a state's CHIP program, but have other health insurance without dental benefits. The Act also includes provisions related to the development and dissemination of dental education materials, as well as, data reporting on dental access and quality.

In the MAC's 2006 report to Governor Kulongoski regarding the Healthy Kids Plan design, the Committee recommended that all Oregon children be provided with access to comprehensive, affordable health insurance. The MAC continues to support plans to expand coverage, including dental benefits, to all uninsured populations. <u>All</u> Oregonians should have access to comprehensive, affordable oral health services.

While developing these recommendations has been a stimulating process, we realize that this is only the first step in achieving access to oral health services for all Oregonians. We look forward to working with the Department of Human Services on this and many other issues that are central to the delivery of high-quality health care within

the Oregon Health Plan. Please let us know if there are any pieces of these recommendations that require clarification or if we can be of further assistance.

Sincerely,

Carole Romm, RN, MPA
Co-Chair
Medicaid Advisory Committee

Jim Russell, MSW
Co-Chair
Medicaid Advisory Committee

Medicaid Advisory Committee Report

Submitted to Bruce Goldberg, MD
Director, Oregon Department of Human Services

March 31, 2009

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Medicaid Advisory Committee's Recommendations on Oral Health Care

Executive Summary

The following is a summary of the MAC recommendations on Oral Health Care in Oregon. The full recommendations follow this summary including rationale and supporting data for each.

1. All Oregonians should have access to comprehensive and affordable oral health care. This can be accomplished through policies that:
   - Expand access for all children;
   - Fully-fund Oregon's commitment to basic oral health for all Oregonians;
   - Create a dental benefit package to be included in the Oregon Health Plan Standard and Oregon Health Plan Plus; and
   - Increase dental capacity and infrastructure in community health centers, safety net clinics, and local public health departments.

2. Prevention should be prioritized in all oral health activities including:
   - Increasing alternative care delivery models such as community-based prevention strategies; and
   - Establishing school-based prophy-dental clinics staffed by Limited Access Permit Dental Hygienists and Expanded Function Dental Assistants to practice individualized needs-related preventive oral health services.

3. Oral, physical, and behavioral health services should be coordinated as much as possible. A strategy for achieving this goal could include:
   - Improving communication between medical, behavioral, and oral health providers on the importance of oral health for vulnerable populations and creating venues for collaboration to deal with oral access issues.

4. The state should provide leadership in oral health services statewide through coordination of a prioritized strategy including:
   - Establishing a cohesive, coordinated plan to decrease oral disease; and
   - Establishing a dental advisory committee for the Health Services Commission.

5. Oregon needs a long-range oral health workforce strategy to maximize availability and effectiveness of a limited workforce. This could be accomplished through:

- Advocating for policy changes that encourage and/or incentivize qualified oral health workforce providers to practice in Oregon, particularly rural Oregon; and
- Developing policies to foster the "Dental Team" concept.

6. The state should promote individual responsibility for maintaining and improving oral health by:

- Providing Oregonians the tools for good personal oral hygiene practices, appropriate health seeking behavior, good nutritional practices, and the importance of routine dental care in a culturally and linguistically sensitive manner.

7. To ensure that public resources are spent effectively and appropriately, the state should evaluate the provision of oral health services in the Oregon Health Plan. This could be accomplished by:

- Adopting policies that implement utilization of tools such as the "Dental Access Measures" to track oral health care.

Problem, Background, and Approach

The Problem—Access to Oral Health Services

In spite of safe and effective means of maintaining oral health that has benefited the majority of Americans over the past half century, many among us still experience needless pain and suffering compromising our oral and general health and diminishing our quality of life. The same can be said for Oregonians. Great disparities exist in oral disease prevalence. Poverty, race and ethnicity, education, geographic location, language, and insurance coverage play a role in disease rates. Above all, ACCESS to preventive and routine dental care has been shown to be a determinate of disease status.

—Gordon Empey, DMD State of Oregon Dental Health Consultant

Oral disease is affecting a growing number Oregonians and particularly members of the Oregon Health Plan. Recent state-wide trends indicate that since 2002 every major measure of oral health status for children has worsened while one in four children living in Oregon currently goes without dental insurance.[1] An increasing number of adolescents are reporting cavities,[2] and upon reaching retirement age (65-74), one in five Oregonians has lost all of their teeth, essentially making them dentally disabled.[3] There is evidence, however, that improving access to oral health services through Medicaid programs reduces costs within the health system. For example, Medicaid enrolled children who have had an early preventive dental visit are more likely to use subsequent preventive services and experience lower dental-related costs.[4] There is also evidence to suggest that early association with a dentist has the benefit of reduced cost of care, with the difference being attributed to an increased need for treatment services for those who delay the first dental visit.[5] This epidemic is increasing costs to the health system, threatening the livelihood of Oregonians through decreased productivity and raising the risk for other diseases—yet it is also 100% preventable.

Involvement of the Medicaid Advisory Committee

Amid the state-wide oral disease epidemic there has been anecdotal evidence that members of the Oregon Health Plan have been experiencing difficulty accessing services in contracted managed care Dental Care Organizations (DCOs), yet there has been a dearth of empirical or qualitative data to substantiate such claims. In order to address this issue, the executive leadership of the Oregon Department of Human Services (DHS) began discussions with DCOs in 2007 to develop performance measures

[1] Oregon Smile Survey (2007) Oregon Department of Human Services, Division of Public Health.
[2] Oregon Healthy Teens Survey (2007) Oregon Department of Human Services, Division of Public Health.
[3] The Burden of Oral Disease in Oregon (2006) Oregon Department of Human Services, Division of Public Health.
[4] Savage MF, Lee JY, Kotch JB, Vann WF. (2004) Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs. Pediatrics; 114:4:e418-432.
[5] Doykos JD III. (1997) Comparative cost and time analysis over a two year period for children whose initial dental experience occurred between ages 4 and 8 years. Pediatric Dentistry;19:61-2.

and access standards. Over the next year, a workgroup consisting of DCO representatives and DHS Division of Medical Assistance Programs (DMAP) representatives refined performance measures and created a "Dental Access Measures" tool which was released in January of 2009. Prior to its release, the Medicaid Advisory Committee (MAC) began discussing issues related to oral health and the Oregon Health Plan, which created a public forum for the performance measures and measurement tool developed by DMAP. Moreover, the MAC began to develop a plan for improving oral health throughout the state that would include, but was not limited to, performance measurement. The following is a description of the recommendation development process and action steps necessary to reduce the prevalence of oral health disease in the Medicaid population.

The MAC Process

Between June and November 2008, the MAC discussed oral health access issues and gathered input from 13 interested groups and stakeholders including: DMAP representatives, consumer advocates, dental insurance plans and DCOs, OHP Fully Capitated Health Plans (FCHP), DHS Public Health, Oregon Office of Rural Health, Oregon Child Development Coalition (Head Start focused), a rural practicing dentist, Oregon Dental Association, Oregon Dental Hygienists' Association, and the Oregon Board of Dentistry. The committee was also given research on state level dental health status vital statistics, primary care dental capacity, and a national report on oral health access. Both feedback from these groups as well as current research helped to define recommendations the MAC could submit to the legislature.

Recommendations on Oral Health

The following recommendations were developed by the Medicaid Advisory Committee (MAC) under a set of policy objectives:

1. All Oregonians should have access to comprehensive and affordable oral health services.
2. Prioritize prevention in all oral health activities.
3. Oral, physical, and behavioral health need to be coordinated as much as possible. These disparate delivery systems need to work collaboratively.
4. Provide leadership in oral health services statewide through coordination of a prioritized strategy.
5. Oregon needs a long-range oral health workforce strategy so that there will be maximized efficiency of the available workforce.
6. Promote individual responsibility for maintaining and improving oral health.
7. Evaluate the provision of oral health services in the Oregon Health Plan to ensure that public resources are spent effectively and appropriately.

The Oregon Health Plan plays a critical role in improving oral health in Oregon; however, the epidemic of oral health disease also requires activities beyond the state's Medicaid program. It is anticipated that recommendations on oral health can further the goals of the Oregon Health Fund Board's Comprehensive Plan for Health Reform as well as the Governor's Healthy Kids Plan.

1. **<u>Objective</u>: All Oregonians should have access to comprehensive and affordable oral health services.**

   <u>Strategy:</u> Establish policies that expand access for all children.

   The proposed Healthy Kids program will maximize enrollment of the uninsured into private or public programs that will include oral health services as well as utilize safety net clinics and school-based health settings.

   <u>Strategy</u>: Fully fund Oregon's commitment to basic oral health for all Oregonians.

   Dental benefits should be aligned and integrated with the Prioritized List of Health Services to secure funding for preventive oral health procedures and ensure that Oregonians have access to basic oral health care. Oral health treatments should be given equal parity with medical treatments when seeking cost-savings and considering benefit cutbacks.

   <u>Strategy:</u> Through the Health Services Commission (HSC), create a dental benefit package to be included in both OHP Standard and OHP Plus.

   A refined dental benefit package would free resources that could be distributed in an effective manner across both OHP Standard and OHP Plus. The new benefit package should be appropriate for the population it is meant to serve. An evidence-based benefit package should increase oral health by providing increased access to effective treatments.

   <u>Strategy:</u> Increase dental capacity and infrastructure in community health centers, safety net clinics, and local public health departments as part of the proposed Community-Centered Health Initiatives Fund (CCHIF).

   The Oregon DHS Division of Public Health has proposed, and the Oregon Health Fund Board has endorsed, creating an expanded revenue base for public health activities at the community level. These activities are based on the following:

   - Require a minimum level of community investment to match state investment;
   - Be based on community input;
   - Be based on evidence and data, including population health measures reported and an evaluation component;
   - Address behavior change at the individual, community and system levels;
   - Coordinate efforts of local county health departments, community-based organizations, schools, employers and health care delivery system entities;
   - Work to reduce health care disparities; and

- Be contingent on effectiveness and require evaluation for effectiveness on an ongoing basis.

Action Steps:

1) Implement the proposed Healthy Kids Program that will expand oral health services to all children.
2) Integrate dental treatments with the Prioritized List of Health Services.
3) Redesign the OHP dental benefit package and implement in both OHP Standard and OHP Plus.
4) Implement financial incentive programs using CCHIF resources to encourage more dental providers to participate in the OHP.
5) Invest resources from the CCHIF in programs to address oral health access in community health centers, safety net clinics, and local public health departments.
6) Include culturally-specific approaches to disease prevention and treatment in oral health services as well as targeted outreach to members of racial, ethnic, language minority communities; individuals living in geographic isolation; and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency, and individuals experiencing homelessness.

2. **Objective: Prioritize prevention in all oral health activities.**

Strategy: Enhance access by increasing alternative care delivery models such as community-based prevention strategies.

Creating and maintaining a bridge between population health, the oral health delivery system, and communities is an essential part of improving access. To maximize success, there must be involvement between public and private sector professionals in population evaluation and decision-making, particularly in strategizing how to effectively promote oral health and prevent disease. This includes conducting health impact assessments of projects in non-traditional health care delivery sectors such as education. DHS is currently proposing that investments be made in the current Oral Health Program run by the Division of Public Health as part of a policy option package (POP) for the 2009-11 budget. This program provides critical prevention strategies throughout the state.

Strategy: Establish school-based prophy-dental clinics staffed by Limited Access Permit Dental Hygienists and Expanded Function Dental Assistants to practice individualized needs-related preventive oral health services.

A needs-related dental caries preventive program was introduced for all 0–19 year-olds in the county of Värmland, Sweden in 1979. This serves as an example of a community that has made great strides in overcoming prevalent oral health problems, even without fluoridating the water. This program integrates prophy-dental clinics directly into elementary schools "enabling preventive dentistry assistants or dental hygienists to practice individualized needs-related preventive dentistry." In placing these providers in the schools, cost-savings were realized with decreased utilization and a dramatic reduction in the treatment time by dentists.[6]

Action Steps:

1) Invest in the DHS Oral Health Program in order to create opportunities for local public health departments to invest in public health programs such as community water fluoridation, school-based fluoride and dental sealant initiatives, and other activities sought by communities to improve oral health.
2) Emphasize the delivery of preventive dental care services, particularly to pregnant women, children under age 3, and other vulnerable populations, by advocating for policy changes that provide incentives for OHP enrollees to access these services.
3) Improve collaborations to deal with access issues for special needs OHP enrollees, particularly in rural settings.
4) Build infrastructure for oral health prevention program data collection and evaluation.
5) Develop a pilot program of school-based, needs-related preventive prophy-dental clinics targeted to schools with a large free-and-reduced-lunch program population that would possibly otherwise qualify for Medicaid.

   These clinics will be administered by public health departments and funded through Medicaid. The clinics will be staffed by Limited Access Permit Dental Hygienists and Expanded Function Dental Assistants as well as a limited number of dentists.

3. **Objective: Coordinate oral, physical, and behavioral health services as much as possible. These disparate delivery systems need to work collaboratively.**

   Strategy: Improve communication between medical, behavioral, and oral health providers on the importance of oral health for vulnerable populations and create venues for collaboration to deal with oral access issues.

[6] Axelsson, P. (2006) The Effect of a Needs-Related Caries Preventive Program in Children and Young Adults – Results after 20 Years. BMC Oral Health, 6(Suppl 1):S7.

Integration of oral health with physical health care and within primary care is an essential goal of a reformed delivery system. A recent report from the Institute of Medicine's Quality Chasm series suggests that system transformation should progress from care collaboration to care coordination to care integration.[7] Accomplishing this goal can and should occur in a progressive fashion over a reasonable period of time. Raising awareness of oral, physical, and behavioral health needs across provider disciplines through enhanced communication and referral strategies is fundamental to successful system transformation.

Action Steps:

1) The relevant divisions within DHS (DMAP, and Public Health's relevant offices), along with their constituent providers and consumer/advocate organizations, should collaborate to complete work that has evolved over the past five years to promote clinical integration. DHS and other relevant state agencies should develop policies, performance standards, and incentives that require contracted publicly-funded and commercial plans to develop effective care integration strategies.
2) Develop a formal referral system and protocol that can be used by hospital emergency rooms, physicians, dental offices, DMAP, and others for referring patients who have oral health needs. This program should include:
    a. Written instructions on who to call or how to access dental plans that patients may be enrolled in,
    b. A common referral form for oral health care providers to track referrals,
    c. A program to educate physicians, hospital staff, FCHPs, oral health care providers, DHS case managers, and others in the referral process.
    d. Procedures for collaboration between dental plans to provide access for patients when plans are closed for enrollment or other emergent needs arise.
3) Develop a Dental Access Council to include medical providers, dentists, FCHPs, DCO representatives, MHO representatives, etc. in order to address access difficulties and possibly a 1-800 referral "coach" program.

4. Objective: Provide leadership in oral health services statewide through coordination of a prioritized strategy.

Strategy: Through state government leadership, establish a cohesive, coordinated plan to decrease oral disease.

Part of the Oral Health Program DHS POP for the 2009-11 budget is to revise the 2005 State Plan for Oral Health. The State Plan for Oral Health is a roadmap for

[7] Institute of Medicine, Improving the Quality of Health Care for Mental and Substance-Use Conditions.

partners as they develop policies and implement programs, yet it can also serve as a needs assessment for oral health facilities in communities. A rural dentist that gave testimony to the MAC stated that in his community there is a "bricks and mortar mentality in the social system that is counter-productive to our goals." In his opinion, the focus should be aimed at coordinating existing services, rather than building new ones.

There is also a DHS POP for the 2009-11 budget to create a State Dental Health Officer in DMAP which would serve 0.5 FTE as the State Dental Director. This individual would provide much needed guidance in assessing oral health status, implementing surveillance, developing plans and policies, mobilizing community partners, and conducting research and supporting demonstration projects. The individual would also provide vital clinical support, make dental policy recommendations, and act as an external, clinical, and professional liaison with staff, contractors, dental professionals, and dental organizations.

Strategy: Establish a dental advisory committee for the Health Services Commission.

It is imperative that qualified professionals are involved in the review process of treatments to be added or removed from the Prioritized List of Health Services. A dental advisory subcommittee composed of stakeholders from the oral health community should review evidence relating to the safety, effectiveness, and cost-effectiveness of dental technologies and procedures to ensure that dental treatments are properly prioritized according to the objectives of the Prioritized List.

Action Steps:

1) Expand dental expertise and infrastructure at the Oregon DHS to include a State Dental Director position which would develop and implement state initiatives related to oral health.
2) Bring all stakeholders together into a collaborative process to address the issues identified by the State Dental Director (in many cases this may be best done community by community)
3) Create an oral health advisory committee composed of stakeholders from the dental community to act as an advisory body to the HSC.

5. **Objective: Oregon needs a long-range oral health workforce strategy to maximize availability and effectiveness of a limited workforce.**

Strategy: Advocate for policy changes that encourage and/or incentivize qualified oral health workforce providers to practice in Oregon, particularly rural Oregon.

Oregon lacks a coherent strategy to assure an adequate and highly trained oral health care workforce to meet the needs of the 21st Century. Important work done by DHS to examine primary care dental capacity as well as work done by Oregon Health & Science University and other groups to provide information on all dental workforce practice patterns could be coordinated into the implementation of the Oregon Health Fund Board's proposed Health Care Workforce Strategy. This is critically important in rural areas where providers are less common and available.

Strategy: Develop policies to foster the "Dental Team"[8] concept.

The Dental Team concept is akin to the "Medical Home" in that the underlying theme is that the whole is greater than the sum of the parts. Testimony given to the MAC by a DCO indicated that ideally the designation would include: one or more Limited Access Permit Dental Hygienists, Expanded Function Dental Assistants, Denturist, Dentist and others. The team described can effectively manage a larger patient panel size as well as work in multiple locations at the same time, while a solo dentist practitioner is usually limited to one venue.

Action Steps:

1) Integrate oral health into the state's Health Care Workforce Strategy.
2) Recruit practitioners to rural areas by providing loan payment, debt forgiveness, and/or tax incentives to support private practitioners taking a minimum level of OHP patients.
3) Explore ways to increase involvement and reimbursement of Limited Access Permit Hygienists.
4) Promote the "Dental Team" concept of providing care through DHS activities, including those of the State Dental Director.

6. Objective: Promote individual responsibility for maintaining and improving oral health.

Strategy: Provide Oregonians the tools for good personal oral hygiene practices, appropriate health seeking behavior, good nutritional practices, and the importance of routine dental care in a culturally and linguistically sensitive manner.

Throughout Oregon there are cultural and linguistic barriers to understanding the steps needed to maintain and improve oral health. Testimony to the MAC indicated

[8] The Dental Team concept of care focuses on best meeting a patient's oral health needs by providing comprehensive, coordinated, team-based care. This is accomplished by expanding the function of dental hygienists, dental assistants, and others to provide the primary dental practitioner additional time for direct patient care.

that many enrollees and state caseworkers feel that the dental community does not accommodate these barriers as routinely as the physical health community. The Oregon Health Fund Board is proposing that the state should create a state-wide pool of qualified, certified interpreters and programs that can utilize and build on technologies being developed for telemedicine or telehealth.

Action Steps:

1) Raise awareness of OHP enrollees and their caregivers on how to access dental care and how to effectively raise issues of access and voice concerns through increased communication with case managers that is culturally and linguistically appropriate.
2) Coordinate the DHS Oral Health Program with the Oregon Department of Education's health education programs to ensure that they include comprehensive oral health education.
3) Strengthen ombudsman and other customer services for OHP clients, advocates, and providers by establishing a system to track and resolve problems with access to services including removal of barriers for both applicants and clients. The system needs to ensure communication between those lodging the complaints and/or concerns and those who can resolve them. This strategy was a component of DHS' 2009 – 2011 Policy Option Package.

7. **Objective: Evaluate the provision of oral health services in the Oregon Health Plan to ensure that public resources are spent effectively and appropriately.**

Strategy: **Adopt policies such as the "Dental Access Measures" tool to track oral health care.**

The Dental Access Measures tool represents a tremendous amount of work and consensus-building between DMAP and oral health care providers to create an evaluation tool that will identify areas for improvement and raise red flags where appropriate. It will also provide the ground work for relevant health planning agencies such as the Health Authority (proposed by the Oregon Health Fund Board) to identify oral health metrics in accountable care communities. In order to complement and improve these efforts, DMAP should also conduct a qualitative evaluation of oral health care and develop methods for tracking patient experience of care.

Action Steps:

1) Implement quantitative assessments of care such as the Dental Access Measures tool *(see definition below)* to evaluate oral health care provider performance.
2) Develop a qualitative evaluation of oral health care providers.
3) Develop an assessment to track patient experience of oral health care.

The Dental Access Measures tool was created in a collaborative effort by representatives from DHS, DMAP, and local DCOs to define a common set of dental access measures. The measures will be based upon EPSDT (Early Periodic Screening Diagnosis and Testing) and will include the following four basic measures:

- Percentage of clients receiving dental services in a year
- Per member per month utilization for dental services
- Preventive dental measures for both continuous and ever enrolled age groups
- Percentage breakdown of services provided, segregated by plan

Medicaid Advisory Committee Oral Health Access Stakeholder Summary Highlights

On September 24th and October 22nd of 2008 the Medicaid Advisory Committee (MAC) convened stakeholders regarding improving oral health access in the Oregon Health Plan. Below is a summary of public testimony presented to the MAC during these meetings.

MAC Meeting September 24, 2008

Dr. Gordon Empey, a dental consultant to the Public Health Division work in the Office of Family Health Oral Health Program:

- Emphasize the delivery of preventive dental care services, particularly to pregnant women and children under age 3 by advocating for policy changes that incentivizes access for these services to OHP enrollees.
- Bring all stakeholders together into a collaborative process to address the issues (In many cases this may be best done community by community).
- Get our fair share of the limited national workforce by advocating policy changes that make it easy for qualified dentists to settle in Oregon, particularly rural Oregon.
- Increase dental capacity and infrastructure in community health centers and safety net clinics and local health departments.
- Explore ways to increase involvement and capacity of Limited Access Permit Hygienists.
- Implement incentives to encourage more dental providers to participate in the OHP.
- Increase community based prevention strategies, including CWF; School- based fluoride and dental sealant programs.
- Advocate for dental infrastructure at DMAP, including dental leadership and expertise.
- Increase education of, and communication between, medical and dental providers on the importance of oral health for vulnerable populations and improve collaboration to deal with dental access issues.
- Improve collaborations to deal with issues of access for special needs OHP enrollees, particularly in rural settings.
- Raise awareness of OHP enrollees on how to access dental care and how to effectively raise issues of access and voice concerns.
- Establish a system to deal with and solve specific access complaints and concerns lodged by enrollees, advocates, and providers. The system needs to ensure communication between those lodging the complaints and/or concerns and those who can resolve them.

Donalda Dodson, Executive Director for Oregon Child Development Coalition, a private non-profit organization designated to do migrant Head Starts located in 12 counties:

- The Coalition sees about 3,500 children aged 6 weeks through kindergarten and 50-60% are in the infant and toddler population. At least 10% of the families seen must have a disabled child.
- The Coalition does education, health services, mental health, psycho-social and family services. They are required to see that children get services within 45 days of coming into the center.
- At least 92% of the families say they have a medical home of which 54% say it is the community clinic. About 84% are enrolled in Medicaid and 2% have private insurance. To qualify for Head Start individuals can't be over 100% of the poverty level. Three

years ago $40,000 was spent treating baby bottle mouth so education about that is being emphasized.
- About 73% needing treatment are getting it, but there is a need to increase that to at least 90%.
- The Coalition is active in the Varnish Program and all their centers are trained to do dental varnish, which has been well received by the families.
- Some families who have been identified as being able to get access to a provider may be given one in another county or city.
- Dental access in rural communities is the main goal the Coalition has identified and would like to see improved.

MAC Meeting October 22, 2008

Rural Oregon:

Scott Ekblad, Director Oregon Office of Rural Health:
- Data on oral health in rural Oregon is disconcerting.
- Since the first Smile survey in 2002, every major measure of oral health among Oregon school children has worsened.
- School children living outside the Portland metropolitan area experience more tooth decay and decay severe enough to require urgent treatment than their urban counterparts.
- Capacity is a major issue in rural areas. The number of dentists retiring is greater than the number being trained. There is 1 dentist for every 1,302 urban Oregon and 1 for 1,879 in rural areas. 38% of Oregon is considered rural.
- Economics is the major factor in recruiting dentists, making a living after incurring large school debts and practicing in a rural area where no insurance or Medicaid patients are higher. State loan repayment programs are underfunded and government reimbursement rates are often lower than the services cost.

J. Kyle House, DMD, Pediatric Rural Dentist and Oral Health Consultant for Region 10 Head Start:
- There is a need to focus on high risk, special needs patients that come into the clinics; patients on multiple medications for example.
- The OHP population can be higher maintenance in terms of social and language skills along with economic barriers.
- The answer lies in prevention first.
- Building more clinics will not necessarily create more access when already-established private practitioners and practices can be engaged in the process to create a partnership.
- Reimbursement should at least allow a provider to break even on care. Social services need to increase to get patients into clinics for needed preventative care.

Deborah Loy, Director of Professional Affairs Capitol Dental Group:
- Capitol is in rural and urban areas and is part of a partnership that expanded with 4 dental plans into a new coalition called Dental Outreach of Oregon.
- The coalition looks at how to do community partnering around the state to solve and identify each community's problems.
- An outreach program will be started in Coos County for expanding capacity and access for young children and potentially pregnant women, not just those eligible for OHP.
- Rather than competing for a single resource, the county or community-level conversations should address sharing resources.

- Medicaid is highly relied upon in this system for funding everything whereas other states have grants and payment resource systems and are consistently committed to oral health.
- Oregon needs to decide that oral health is a priority that needs to be invested in.

Oral Health Workforce:

Beryl Fletcher, Director of Professional Affairs Oregon Dental Association:

- The dental workforce is on the decline but there are task forces dedicated to the issue of increasing this through expanded numbers of dental schools.
- The Safety Net Advisory Council (SNAC) presented recommendations including dentistry, such as increasing funds for the loan repayment program.
- The scope of where limited-access permit hygienists, dental hygienists, and dental assistants can practice has been expanded.
- The main issue is funding. Along with increasing the numbers of the dental workforce, there has to be adequate reimbursement and incentives to keep them in business.
- There needs to be a protocol for patients who go to the emergency room with a dental problem and a protocol and tracking system for referrals.
- There is a need for a dental access council that would address issues that come up.

Kelli Swanson-Jaeks, MA RDH, President Oregon Dental Hygienists' Association:

- Prevention is the key to lowering dental costs.
- The ADA came up with a plan for the ways to meet the need for more practitioners.
- The limited-access permit hygienists need to be allowed to work to the maximum level of licensure.
- One way to increase access is to utilize programs already in state where people are already gathered, such as Head Start, WIC, and school-based clinics.
- There are mobile-service centers, but are run by volunteers and cannot be expected to meet all the needs without adequate reimbursement.
- Money given to emergency rooms for dental emergencies could be given in part to preventative services, and studies could be done to see how much emergency rooms are receiving for treating dental emergencies.

Patrick Braatz, Director Oregon Board of Dentistry:

- With the national trend in the decrease in the dental workforce, Oregon is about the same that it was 2 years ago as far as the number of those licensed.
- There are 71 Limited Access Permit Dental Hygienists LAPs: 1/3 work in nursing homes and public and non-profit clinics, 13 do not practice and 29 work in private practice because there is no reimbursement for them to work elsewhere.
- Expansion of the dental workforce will not be the solution without reimbursement.
- Facilities also need to be available via public transportation and need to be opened at more expanded hours.
- Fluoride is the least expensive answer to preventative care.

Managed Care:

Janet Meyer, MHA, Director, Tuality Health Alliance, Tuality Healthcare:

- A health education district was opened on the Tuality campus in Hillsboro that includes dental programs. There is a 4-year college program in dental hygiene offered, and a dental clinic was opened that provides critical access.
- A federally-qualified health center was built on the Hillsboro campus and serves the Head Start programs in Washington and Yamhill counties. In the hospital there are 2 emergency rooms which often serve individuals with neglected dental issues. Diseases of

the digestive systems are in the top 3 diagnoses, and in diseases of the digestive system, dental health is the #1 reason patients are in the ED.

- Tuality is also involved in the Salud program that raises money providing physical and dental health resources for migrant health workers.
- Measuring access is a task as families with children on OHP have separate appointments for each step of the dental process, requiring multiple trips to the dentist and possibly requiring language interpreters, the child's needs should be taken care of while the child is there.
- There is a need to define access and what is meaningful access.
- There is currently a system in place to educate enrollees along with a grievance system, which should be looked at before discussing building additional education systems.

Bill Ten Pas DMD, Senior Vice President, ODS:

- ODS pays the $200,000/year for the dental hygiene school to provide free dental care due to the need for dentists in rural areas. It may be viewed as competition for the current rural dentists who barely make a living, yet the intent would be for the students to take the patients with no access or insurance.
- Due to the problem getting those who most need the access to travel to the dentist, they are creating ways to bring dental services to the patients using a traveling dental clinic where they care for patients in an area for a week.
- It costs about $500,000/year to run this program without reimbursement.
- There needs to be an education in the truths and myths of fluoride as this is needed in preventative care.
- With the low reimbursement it is becoming harder to afford to stay in the dental workforce.
- There is a need to educate DHS on the dental model so better decisions can be made.

Gayle Pizzuto, Program Manager, MultiCare Dental:

- Emphasized the need for all delivery systems to cover dental. The different types of delivery systems: The open-panel model such as ODS and Advantage, combination plans such as Capitol Dental, and then the staff model plan such as Willamette and MultiCare Dental. In MultiCare's staff model, all dental staff is employed.
- MultiCare's DNA (did not arrive) rate is 25-30% so they keep a standby schedule. Their patients are 70% children.
- The outreach effort to pregnant women involves cultural issues. Some aren't getting on OHP until late in pregnancy.
- Community involvement is necessary as far as dental plans sitting down with stakeholders.
- Children need to be seen in settings outside of clinics. MultiCare has a project going into nursing homes and care facilities to identify patients who haven't seen a dental provider and sending staff to see those patients without reimbursement. Over 20% have been screened and ½ have dental issues.
- Community-based prevention strategies should encompass fluoride and dental sealant programs.
- According to performance measures, every dental plan has gone up in the number of prevention services being provided.
- With children ages 3-5, 64% of the ones on their program have had the prevention services program.

- There needs to be an advocate/dental director for dental structure at DMAP. DMAP could look at utilization and prevention services and should put out reports to hold dental plans accountable.

Gary Allen DMD, Dental Consultant, Willamette Dental:

- There is a lack of a cohesive, coordinated definition of the problem and prioritized strategy to deal with it.
- DMAP could take on a dental advisory board to advise on prioritized strategies for the issues.
- School-based program for fluoride and sealants need to have a cohesive strategy and a model that works. In Sweden they developed a needs-based program on children aged 0-18 focusing on preventative strategies, focusing also on education for pregnant mothers, and delivering sealants on children. If there is a concentration of effort and resources and prevention it will be possible to achieve such a model.

November 17, 2008

To: Medicaid Advisory Committee (MAC)

From: Dental Stakeholders Workgroup

Re: Recommendations for Oregon oral health

The Dental Stakeholders Workgroup is responding to your request to review the recommendations made by many interested parties at the October 22, 2008 MAC meeting and prioritize the recommendations.

Introduction:
While many recommendations were offered from numerous interested parties, clear policy needs were conveyed. These policies included:

1. Oral health is an important part of overall health and should be a priority for statewide policy. The vision for dentistry is to be a part of the integrated health system.
2. Prevention is the number one cost containment factor in oral health and should be the foundation for oral health solutions.
3. Stabilized funding for oral health needs to be made a priority.
4. Dental infrastructure within DMAP is needed in order to effectively coordinate access strategies. This would include:
    - The addition of a Dental Director
    - Training and credentialing of DMAP Pre-Paid Health Plan Coordinators in dental practices
5. Implement more incentives to encourage dental providers to participate especially incentives for loan repayment, debt forgiveness and tax incentives for qualified dentists to settle in rural areas regardless of where they intend to practice (private practice or FQHC).
6. Development of meaningful utilization reports (review our data, utilization, reports category in the prioritized recommendations below).
7. Allow clients to access their Dental Care Organization (DCO) dental plans statewide rather than within a mileage radius.

The dental community including the Oregon Dental Association (ODA), private practitioners, DCO's, foundations, the Oregon Board of Dentistry and public and private sources have all contributed significantly toward developing Oregon's unique dental benefits and delivery

system. It is our desire to continue to work for the oral health of all Oregonians and be a part of the integrated health home. We must be cautious in the wave of economic conditions not to lose the dental system we have created but to stabilize it and work to further develop it.

Prioritized Recommendations
We have prioritized the recommendations into five specific categories with some recommendations bolded to represent key priorities. The categories include:

1. Access Development and Education
2. Funding
3. Data, Utilization and Reports
4. Services
5. Workforce

1. Access Development and Education

a. Develop a formal dental referral system protocol to be used across the state by hospital emergency rooms, physicians, medical plans, and others for referring patients who have dental needs. This referral protocol would include written instructions on who to contact both during and after business hours especially for those patients who may already be enrolled in a dental plan. This would include a referral form for DCOs to use to track referrals.

b. Educate and collaborate with physicians, hospital staff, medical plans and DHS case managers in the referral process, the importance of oral health to increase the communication between medical and dental providers.

c. Develop a Dental Access Council to include medical providers, dentists, FCHPs, DCO representatives, etc. in order to address access difficulties and possibly a 1-800 referral "coach" program.

d. Set up a referral process between plans so that they may collaborate with each other for one time referral between plans to provide access for patients when plans are closed for enrollment or there are emergency needs.

e. Improve collaborations to deal with issues of access for special needs OHP (esp. in rural settings)

f. Raise awareness of OHP enrollees on how to access dental care and how to effectively raise issues of access and voice concerns.

2. Funding

a. Reimbursement, for dental services in fees and on a per capita allocation, needs to be increased. Use dental provider taxes and the federal matching dollars from the dental provider tax for dental services.

Funding recommendations continued

b. Do not cut dental benefits or adult dental. It will not save money but will result in a cost shift to the emergency room, physician's office or other medical providers providing only short term palliative care.

c. Reimbursement is a barrier for out of network dentists and LAP hygienists.

d. Provide same balanced reimbursement levels to practitioners that are seeing large number of DMAP clients regardless of whether in private office or FQHC.

e. Establish a Community Oral Health Program Fund which will provide a pool of money where all DCOs and some small part of the hospital emergency room reimbursement dollars contribute to the fund. The fund would be for preventive services by Limited Access Permit Hygienists (LAPs).

f. Provide and fund more direct case management of families.

g. Restore ENCC (Exceptional Needs Care Coordination) funding to DCOs and improve collaborations to deal with access for special needs especially in rural OHP.

3. Data, Utilization and Reports

Develop meaningful utilization reports in the following specific areas using dental code categories from data provided to DMAP from the DCOs and fee for service client data:

- **Prevention services**
- **Emergency services including hospital ED visits**
- **Restorative care**
- **Failed appointments**
- **Monitor compliments as well as complaints**

Reports should be developed in the above areas not only by DCO and fee for service (FFS) clients but also by county reflecting client appointments, age categories, services provided etc. All these reports should be provided on a quarterly and annual basis in order to develop new access strategies based upon the data evidence.

We understand DMAP is working with the DCOs on developing a plan to initiate these types of reports.

4. Services

a. Prevention is the number one cost containment factor through sealants, fluoride treatments, early intervention, intermediate restorative treatment and education. Change the paradigm to one of intense prevention with diminishing emphasis on repairing the damage.
b. Emphasize the delivery of preventive dental services, particularly to pregnant women and children under age 3 by advocating policy changes that incentivizes access for these services to OHP enrollees.
c. Increase community based prevention strategies, including Community Water Fluoridation; school-based fluoride and dental sealant programs.

d. Limit the covered services within the DMAP structure so that resources are going to where they will do the most good for the greatest number and that have long term scientifically proven outcomes.

5. Workforce

a. Increase involvement of the Limited Access Permit Hygienist in community based health centers, WIC, Head Start and other locations.

b. Develop a broader partnership and collaboration with private practitioners especially in rural areas to utilize efficiencies to improve access.

c. Support the maintenance of the dental team concept of providing care. While we can support the expanded functions of auxiliaries, the full accompaniment of care will need to come from a team. Dilution of our workforce into smaller and less effective units will not address the needs of the OHP population.

d. Encourage the use of Expanded Function Dental Assistants (EFDA).

e. Use Mobile Dental Vans in rural and frontier areas.

There are many other data, utilization and program recommendations that were made but have not been specifically categorized in the above recommendations. We would be happy to share these in an addendum or continued conversations with the Medicaid Advisory Committee.

Thank you for the opportunity to provide recommendations.