

## **Quality Care Should be Accessible to All: Expanding Access through Innovation and Employing Mid-level Providers in the Medical and Dental Fields**

### **Introduction**

In 2007, Maryland's Medicaid dental-care program came under fire after a Prince George's County boy died from an untreated tooth infection. (1) An abscess in the 12-year-old boy's tooth spread to his brain, and six weeks and two neural surgeries later he was dead. An \$80 tooth extraction could have saved his life. This young man's death exposed a disjointed dental-care program in the state of Maryland: Thousands of Maryland children weren't connecting with Medicaid-sponsored dentists, and those dentists were receiving little reimbursement for treating Medicaid patients. The year before this incident, just one-third of Maryland's more than 500,000 Medicaid-covered children had received dental-care treatment.

While this tragic story is not a definitive snapshot of the entire U.S. dental-care system, it nevertheless illustrates that there exists a myriad of gaps in state and federal dental-care programs, which may form barriers to a child's healthy life. The lack of common-sense reimbursement policies for dentists and the challenges dentists face with Medicaid participation, the dearth of education in minority communities regarding the importance of oral hygiene and general dental health standards, the absence of affordable basic dental services, along with limited access for poor and minority children to dental providers, can all play their part in lapses in urgently needed care.

### **The broader problem of poor oral health**

Barriers to care can leave patients with serious conditions that threaten their overall health and quality of life. These barriers are numerous and multifaceted. They can be financial, social, cultural, linguistic, geographic, and educational, among others. For children, these seemingly intangible barriers to care are quantifiable. Eventually, the lack of access to dental care in childhood leads to far more costly infections, poor sleeping and eating habits, poor school attendance and performance, and ultimately retards social development. This, in turn, leads to worse job prospects and ultimately perpetuates a negative cycle. (2) Unfortunately, nowhere is the impact of these barriers seen more readily than among poor and minority children.

### ***Lack of supply***

One of the main challenges in providing quality dental care to poor and minority populations is the gradual decline in the number of available dentists. As of June 19, 2014, there were 4,900 Dental Health Professional Shortage Areas (HPSA). (3) It would take 7,300 additional practitioners to meet every HPSA's need for dental providers (a population to practitioner ratio of 5,000:1) (4) Currently, 47 million Americans are affected by barriers to care and more than

16.5 million children in the U.S. were not taken to a dentist in 2009. Meanwhile, the number of active U.S. dentists has almost peaked. (5) As the anticipated number of dentists retiring rises above the number of dental school graduates, the total number of dentists in the U.S. will begin a slow decline. According to Dental Economics, by 2020, the number of dentists per capita will be the lowest in more than 100 years. (5) Dentistry will become the only major health profession with decreasing numbers of practitioners at some point in the next decade. (6) This will exacerbate the already inadequate access to quality dental care among poor and minority populations; as the share of the U.S. population comprised of ethnic minorities grows, a larger percentage of Americans will be impacted. (7)

### **Examining Solutions**

In a 2006 article published in the Journal of the American Dental Association, Howard Bailit, D.D.S., and his colleagues wrote, “The underserved population consists of 82 million people from low-income families. Only 27.8 percent of this population visits a dentist each year. The primary components of the safety net are dental clinics in community health centers, hospitals, public schools and dental schools. This system has the capacity to care for about 7 to 8 million people annually.” (8) While the author posited some solutions to closing this gap in care (i.e., expanding the system of community clinics, requiring dental school graduates to receive one year of residency training, requiring senior dental students and residents to work 60 days in community clinics and practices, etc.), he and his peers acknowledged that even such an increase in capacity would still fall far short of meeting the needs of the vast majority of underserved patients who would still lack a source of care.

#### ***Increasing access to dentists for poor and minority children***

It is well known that access to quality dental care for the poor and minority populations presents a serious challenge to underserved communities. (9) Due to financial and geographical constraints, poor and minority children have a harder time getting to the dentist than other children. Moreover, getting newly trained dentists to set up their practices in underserved areas is challenging. Fewer people are living in rural communities, and the high costs necessary to start and maintain a viable dental practice tend to steer recent graduates toward higher-income population centers. (9)

Even where dentists are available, access to care for low-income patients is often limited by the small number of dentists who accept Medicaid. For example, in the state of Kansas, less than a quarter of dentists statewide accept Medicaid because, among other reasons, reimbursements are so low that they lose money on each patient. (10) (11) When dentists do choose to be included in the Medicaid network, cumbersome preauthorization and paperwork processes, and slow payment mechanisms limit their incentives to provide care to families on Medicaid. (12) This current provider model explains in part why currently almost 59 percent of all children experience dental caries (tooth decay), and why dental issues are a major cause of school absences. (13)(14)(15)

### ***Prevention***

Dental problems have been shown to affect poor and minority children's academic performance. It makes sense to go where the problem lies for treatment and prevention of these issues—the schools themselves. Many low-income and minority families are unaware of dental treatments available to their children. Educators and parents need to be informed of what services and materials are available to reinforce good oral hygiene practice. Some providers, such as Kool Smiles and Education World, offer free school curriculum on oral health as well as toothbrushes and basic care. (16) In addition, overall oral health programs must be more integrated into other health, educational and social programs, especially those that are school-based. This helps to ensure that parents and students know the best steps for at-home care, as well as what health and dental options are available to them.

Another notable area of recent success is the School-Based Sealant Programs (SBSP). Sealant programs based in schools are an optimal way to reach children—especially low-income children who have trouble accessing dental care. (17) School-based sealant programs are typically run by dental hygienists using portable equipment, a mobile dental van, or a clinic to deliver care. Notwithstanding, programs of this type which provide preventative care for low income and minority children remain insufficiently implemented in many areas.

Based on an April 2015 Pew Charitable Trusts analysis, most states are failing to enact policies that provide sealants to low-income and at-risk children. (17) While several states have made improvements in delivering dental sealants to low-income children over the past two years, the study found that most states are still not meeting national goals. Additionally, there remain concerns that implementation of the SBSPs is being hampered by restrictions set out in various states' regulatory requirements; one such restriction notably specifies that a dentist must examine a patient before treatment by dental hygienists in the program. (18) 29 states and 53 other countries permit expanded function to dental assistants, thus it is unclear why some states are participating in adding a hurdle - seeing a dentist - as a precursor for a preventative treatment. (19) SBSPs were designed precisely because these low-income minority children, even those on Medicaid, were in the category of those who lacked access to a dentist to receive even the most basic type of care. (20) Requiring pre-examination by a dentist despite parent pre-approval of basic dental treatment seems unnecessarily burdensome.

### ***International models***

A report from the W.K. Kellogg Foundation looked at 26 nations and territories' experiences with mid-level dental therapists, and found that they provide good quality, cost-effective care and, in many countries, provide improved access to care for children. (21) The study spanned 1,100 documents from 26 of the 54 countries and territories that use the mid-level dental providers. Some countries, such as New Zealand, have dental therapists which concentrate on children's dental health, often working through the public school systems. The result: over 60 percent of children ages 2 to 4 years were enrolled in and utilized the publicly funded child oral health services and the average cost of school-based dental services was \$99 (U.S.) per child. (21)

More than 50 million Americans lack access to dental care, but only two states – Minnesota and Alaska — allow mid-level dental providers to practice basic dental services on low-income, low-access communities. (22) Proponents in at least 15 states are pushing their legislatures to license mid-level dental providers as a way to extend basic oral health care access to thousands who have none.

### *Mid-level providers in the medical field*

We have seen access for Medicaid beneficiaries expanded in the medical field – specifically, through the advent of support organizations and midlevel providers. Using the example of one such of these emerging mid-level providers—the nurse practitioner—we can illustrate how instituting a mid-level network of care and encouraging cost-saving innovation in the dental field will provide a significant increase in access to poor and minority communities.

In 1965, in response to a demand for primary care services and nursing’s potential to meet that need, in addition to a physician shortage, Loretta Ford and Henry Silver, a nurse and a physician, created the first training program for nurse practitioners. (24-27) At the time, some nurses and physicians opposed the nurse practitioner model. Certain nursing leaders believed that nurse practitioners were no longer practicing nursing, that the title was “ambiguous and misleading,” and that such training in primary care medicine would “control and devour nursing education and practice.” (28) Organized medicine expressed opposition to the concept of a nurse “functioning in an expanded role not under [physicians’] direction,” labeled the concept bad doctoring, and would concede only that these independent practitioners were physician extenders. Some in both nursing and medicine viewed this type of collaboration with alarm, suspicion, and distrust.

In response to these challenges, nurse practitioners began to define and legitimize their profession. Over the course of 30 years through articles and reports, they collected evidence and documented that contrary to fears in the medical world, the nurse practitioner model in fact: (1) increased the availability of primary care services; (2) provided patient and physician satisfaction of care; and (3) provided services that were equivalent or superior to that provided by physicians. (29-39) While this evidence was vehemently disputed by many physicians, these findings spurred increasing utilization of nurse practitioners and would prove vital in establishing policies validating the profession.

To date, nurse practitioners continue to increase in number and autonomy in response to a growing need for accessible, cost-effective care. (40) Some providers, including Walgreens and other branded pharmacies, have expanded to include nurse practitioners in their walk-in clinics as well. In addition, nurse practitioners have been officially recognized and utilized as primary health care providers since the granting of their Medicare provider status in 1997. (41) The advent of nurse practitioner demonstrates that establishing new networks of mid-level providers can be very good for poor and minority consumers, by providing greater access and less-costly treatments. In addition to nurse practitioners in the medical field, other mid-level providers are being employed to support the primary care needs of the population (e.g., physician assistants, clinical officers, midwives, branded pharmacies, etc.). This created a “multiplier effect,” allowing a single doctor to provide more care to more people at a lower cost. The need for

greater access to care at lower prices has driven progress and innovation in the field of dental health, as well.

### ***Access through innovation: Dental service organizations***

In the dental world, a newer care model—known as the dental service organization (DSO)—has been increasingly utilized since the 1990s, and similar to the mid-level support providers in the medical world, this support construct is designed to make the treatment of low-income populations, including Medicaid beneficiaries, accessible to all. DSOs are individual dentist owners which have joined together, typically with the support of an independent business support center, pooling resources in order to improve efficiencies and share best practices. (42) DSOs separate the business aspects of running a practice - from human resources, to billing paperwork, to accounting - from patient care. The increased efficiencies allow DSO providers to charge lower prices, or perform less work and still remain viable. One study in Texas found that DSOs, on average, charged \$225 less per treatment than non-DSO dentists, where nearly a third of Medicaid enrollees receive their dental care from DSO dentists. (42-43) In turn, DSO providers are able to treat a large proportion of Medicaid beneficiaries.

### **Conclusion**

We have seen over time in the medical field that adding new avenues of care have allowed for much needed access and treatment of underserved poor and minority populations. Moreover, many dentists around the country are beginning to see the benefit of establishing a strong network of mid-level providers or to joining DSO-model practices, especially to reach the underserved poor and minority community. (44) The Kellogg Foundation study found support within the dental profession for the role of dental therapists in countries that have them and that “once dental therapists have been introduced in a country, professional support for them increases over time.” (45)

As policy debates continue, poor and minority children in many states in America go with no care at all. It’s time the industry examines innovative solutions in our dental system that has been achieved in our medical system. States need to put in place or expand programs that allow for widespread access to dental sealant programs and mandate oral health literacy become part of the education program. Finally, state regulators should examine in detail the opportunities emerging for allowing mid-level providers and DSOs to fill in the gaps to care. Doing so will help to ensure that all children, regardless of race or socio-economic status, to get the care they need.

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**Reassessing the Dental Care Paradigm:  
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**Reassessing the Dental Care Paradigm:  
A National Minority Quality Forum White Paper  
November 2015**

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