

Health Reform: Safety Net Workgroup
Thursday, March 31, 2011
North Carolina Institute of Medicine, Morrisville
1:00pm-4:00pm
Meeting Summary

Attendees:

Workgroup Members: Benjamin Money (co-chair), Charles Bregier, Robin Cummings, Rob Doherty, Brian Ellerby, Katie Eyes, Elizabeth Freeman Lambar, Chuck Frock, Lin Hollowell, Tom Irons, Chip Modlin, Connie Parker, Marilyn Pearson, Steve Slott, Karen Stallings, Flo Stein, Elizabeth Tilson, John Torontow, Kristin Wade

Steering Committee Members: Elizabeth Freeman Lambar

NCIOM Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Rachel Williams

Other Interested Persons: Mark Casey, D. Gregory Chadwick, Tami Eldridge, Shannon Holcombe, James Hupp, Markita Moore-Keaton, Rebecca King, Rick Mumford, Vince Newton, Uvoh Onoriobe, M. Alec Parker, John Price, Stephanie Ross, Jean Spratt, Laura Vinson-Garvey

Welcome and Introductions

E. Benjamin Money Jr., MPH, CEO, North Carolina Community Health Center Association, Co-chair

Mr. Money welcomed everyone to the meeting.

Future Dental Workforce

James R. Hupp, DMD, MD, JD, MBA, Dean and Professor of Oral and Maxillofacial Surgery, School of Dental Medicine, East Carolina University

D. Gregory Chadwick, DDS, MS, Associate Dean for Planning and Extramural Affairs, Clinical Professor of Endodontics, School of Dental Medicine, East Carolina University

Dr. Hupp and Dr. Chadwick presented information on East Carolina University's new dental school. The School of Dental Medicine, located in Greenville, North Carolina, will begin training students during the 2011-2012 academic year. The Greenville facility will operate as both an academic building and a clinic. There will be areas for pediatric, adult, and emergency dental care. A special care suite will provide dental access for patients with physical disabilities who usually must go to an emergency room or other special location for basic dental procedures.

The school will use a decentralized educational model, making it unique from other dental schools in the country. This education model will be more case-based than lecture-based and provide students with hands-on training. Ten community service learning centers, located in rural underserved areas throughout the state, will address North Carolina's shortage of dental care access, give students extensive clinical experience, and be fully sustainable. The community service centers will also have telemedicine available to connect with students and faculty at other centers.

Their presentation can be found here: [Future Dental Workforce–School of Dental Medicine at East Carolina University](#).

Public Health Dental Practice

Mark Casey, DDS, MPH, Division of Medical Assistance, North Carolina Department of Health and Human Services

Dr. Casey described the current role of the North Carolina Medicaid Dental Program and the impact on the program due to health reform. The program serves mostly children, including those in NC Health Choice, and has received honors for utilization and innovative initiatives.

Currently, safety net providers focus on meeting basic oral health needs for Medicaid/NC Health Choice patients. Preventive services and outreach are also important focuses for safety net dental facilities.

The ACA does not have many provisions specifically focused on oral health; however, oral health is included in provisions for primary care. All new federally qualified health centers (FQHC) will have dental clinics, expansion of school-based health centers to include dental services, and new standards for dental/medical equipment are all included in the ACA. Workforce initiatives are also included in the ACA including loan repayment, dental demonstration grants, and money for dental training.

The ACA's mandatory coverage requirement and expansion of Medicaid will increase the number of people eligible for dental care services under Medicaid/NC Health Choice. This sudden increase in eligibles could place a strain on funding and cause states to reduce or eliminate optional Medicaid benefits, such as dental services for adults. The reduction in services could lead to more emergency department utilization for dental emergencies and higher costs for safety net providers who receive dental patients without dental coverage. It is not yet known if North Carolina will reduce or eliminate optional Medicaid services.

Dr. Casey's presentation can be found here: [Dental Public Health Providers and the NC Medicaid Dental Program](#).

Selected questions and comments:

- Q: Are special needs adults included in Medicaid? A: Yes, Medicaid is available to everyone who is eligible. Dual eligibles, however, are not eligible for dental benefits. There is a problem getting care to them because care has to be brought to those in medical homes or long-term care facilities.
- Dental pain is one of an emergency department's number one complaints. Having a robust dental community is a major strategy for combating problems and referrals.
- Q: Is there data on the total costs of increased emergency department use in states that did away with Medicaid adult dental care access? A: There is some data from Maryland and California. There is not a lot of other good data out there.
- New funding from the ACA for FQHCs will require a new site to have access to dental services. Funding allocated to existing centers is required to be 2/3 for primary care and only 1/3 for oral/behavioral/specialty care and other services. A separate opportunity for oral health has not been announced.

Private Dental Practice

M. Alec Parker, DMD, Executive Director, North Carolina Dental Society

Dr. Parker gave a private practice perspective on access to dental care in North Carolina including trends in private practice and issues related to the workforce. Private practice has seen an increase in the number of group practices, number dental management companies, and utilization of dental auxiliaries. The number of dentists in North Carolina has also increased and will continue to increase as UNC expands its program and ECU begins its program.

A controversial topic in dental workforce is the utilization and licensing of mid-level providers such as dental therapists. Advocates argue the mid-level providers will increase access and reduce costs. Opponents are mostly concerned with the scope of practice mid-level providers will have. The American Dental Association argues that only dentists should be able to diagnose, develop treatment plans, and perform irreversible procedures due to educational disparities between dentists and dental therapists (8 years versus 4 years). The ADA goes on to say that mid-level providers could increase access to care if used properly within their scope of education. Possible mid-level providers in North Carolina could include public health hygienists, dental hygienists in nursing homes, community dental health coordinators, and expanded function dental assistants. The North Carolina Dental Society does not currently support mid-level providers performing irreversible procedures such as surgery, but does support the use of mid-level providers to increase access to basic dental services at a lower cost.

Dr. Parker's presentation can be found here: [Dental Safety Nets and Access to Care](#).

Selected questions and comments:

- Q: Have studies shown that a difference in experience and education make a difference in quality? A: No. Several states, including Minnesota and Alaska, have studies that show mid-level providers did procedures as well as dentists. My concern with mid-levels is the intraprocedural decisions that cannot be taught. A provider needs a scientific basis that cannot be learned in a two-year technical program. Accountability is also an issue since the dentist's license is on the line if he/she employs mid-levels to do major procedures.
- I see mid-level providers as doing very simple procedures under supervision, not going out on their own.
- In California, many mid-level providers migrated from rural areas due to bad reimbursement. They ended up in towns and cities instead and the program hasn't stayed true to the model.
- Those who are talking about mid-level dental providers like to grab onto the thought that it is like a physician's assistant (PA) or nurse practitioner (NP), but it isn't. A dental hygienist is a four year degree, if you added two or three years then they would be more similar to NP or PAs.
- Do states that have implemented mid-level providers require them to work under dentists? A: In Minnesota they have advanced dental therapists and dental therapists. Dental therapists have to work under the general supervision of a dentist.
 - There is some trouble because the state is still not sure it can get a national accrediting body to accredit dental therapist programs. Programs need to be accredited before graduates can be licensed.
 - In Alaska, mid-levels work under the general supervision of dentists. The dentists get to define the scope of practice for the mid-level providers since it is the dentist's license that is on the line. Different states are doing it different ways.
- No one has talked strongly about how we are going to pay for this. We need a revenue stream to sustain these individuals. Not hearing enough about what we are going to do to advocate for funding.
 - Society doesn't put a lot of emphasis on oral health. We need to tell the legislators to support oral health, adult Medicaid, and other funding. It will cost more in the long run if oral health is not part of primary care.
 - Hospital foundations might be one way to supplement costs since they do not want the costs associated with dental patients in the ED.
 - Most commercial health plans do not cover oral health and neither does Medicare. That is one area where we need to start making changes. Dental health should be a part of your health plan.
 - Blue Cross Blue Shield recently made dental claims data available to those who can access medical claims data. Children's dental coverage is part of the essential benefit coverage under the ACA. We are currently looking at that for the corporate/adult plans.

- School health centers are an ideal dental access location for children. Sister organizations in other states have dental health care on site. However, it is costly.
 - Prior to 1990 we had oral health treatment in schools. It is expensive and labor intensive for the benefit of a small group of children. Future programs went towards prevention and screening instead.
- More hospitals need to integrate dental care into their systems.
 - Wake Med has closed a program with a dentist on site for consultation and emergencies. Currently, Wake County has only one clinic for emergency dental problems called Wake Smiles.
 - Wake Health Services is a FQHC and has dental services for children.
- There is some disconnection between doctors and dentists. Dentists should be invited to develop things such as informatics systems and should also be more open to integration.
- Q: What are the trends in the type of population coming to large dental events? A: More people are coming now than before. The population is not the historical group that these programs have served. We see a lot of people who once had a job and have had to take a big step down socioeconomically. More middle class instead of just Medicaid, uninsured or underinsured. You can tell by looking in their mouths that at one time they had good dental care. Attendance is up about 30%. We saw 6,752 people last year and gave \$3.1million worth of care.
- Q: Where do you see role of dental care via the health department going? A: Health directors have talked about it and the concern is being able to finance care. Health departments already see public plan patients and the uninsured. Departments probably will not see covered dental patients if private insurers begin covering dental services.
 - The health departments are seeing more uninsured as more private Medicaid dental clinics have popped up. Those private clinics get the reimbursement money. The problem is that if a dental program doesn't break even then it is shut down.

Public Comment Period

- I have not heard anyone talk about free clinics today. Cape Fear HealthNet wouldn't be able to have any oral healthcare in our network without our free clinic partners. The clinics are the only reason people have a place to go after being discharged from the ED for dental care. Also, health professionals have to integrate; we can't treat each health problem like a special condition. We seem to treat anything from the neck up as if it is elective or a luxury. Health and Wellness Trust Fund's Oral Health Initiative, which has expanded capacity in the safety net, has been cancelled. The funding in our clinic for an oral surgeon, a case manager, a patient navigator, an educator, etc. is gone
 - Two years ago we opened the dental clinic. We see about 100 patients a week. Dental supplies are expensive and the funding is gone after June 30th.

- There needs to be more folks in the dental profession giving a voice for advocacy. The profession has to have the same passion that advocates and those needing care do.
- Doctors donate time and patient slots. Are dentists in the state doing that? Wake Smiles is a volunteer clinic with about 60 dentists volunteering time. We have tried to model a program like that it was so complex especially since needed supplies are different between doctors and dentists. There is a wide array of possible treatment needs as dentist.
 - That is a great idea, but volunteerism is not a system of care.
 - Volunteering engages the dental community and lets them see the problems first hand. Seeing the problems can lead to a system change.