Comments from Statewide Planning Council (SPC) Meeting on January 15, 2009

WORKFORCE/DIVERSITY

What does the oral health workforce look like today?
- Focused primarily on treating dental disease in private practice settings, with dentist, hygienists and dental assistants.
- Not very diverse workforce. Does not reflect society
- Dental assistants – generally clinical, future: could expand into access-to-care (example: head start, apply preventative procedures)
- Rural regions – demand for oral care from the people
- Cannot get practitioners to go into rural areas

What would the ideal workforce look like?
- Would reflect the demographics of society.
- Would have new technology and techniques available to all.
- Would facilitate cooperation between private practitioners, community health centers, dental school and others.

Solutions
- Alaska example, tax incentives for student loans
- Not one … but a multi-hit

Goals
- Work force mimics population
  - Explore admissions improvements
  - Grow your own
  - Priorities
    - Increase diversity
    - Increase service to rural areas
    - Novel scope-of-work, prescription, and supervision arrangements

Practice at “top of training”
- Potentially expand D.A. curriculum
- Modest statutory changes
- Maximize tele-dentistry & tech use

Services in rural areas
- Explore admissions improvements
- Grow your own
- Teach for America model
- Untapped socialization early in training

Responsible
- Community leaders
- Clinician leaders
- IUSD and ed/training programs
- Statewide
- AHECs
Work-in-progress
- IUSM admissions
- Dental board
- Clinicians
- Training programs & CE providers
- Partnerships across disciplines & agencies
- Riley tele-health project – Evansville

The Multi-hit Formula
- Community-based learning
- GPR – general practice residency
- Re-evaluate admissions criteria

How can we go about creating the ideal workforce?
- Recent changes in licensure procedures for dentists have helped.
- More collaboration with the dental school and other entities.
- Have student loan reimbursement more available. Currently not available in Indiana.
- Increase oral health information in the public school curriculum. This would raise the awareness of the importance of oral health.
- Provide opportunities for hygienists to become dentists and dental assistants to become hygienists.
- Improve the diversity of the workforce.
- Look at initiatives for increasing the diversity of nurses, teachers and other professions to see if there are any successful activities that can be used to promote diversity in dentistry.
- Significant pay disparity for those working at the dental school and facilities treating the poor as compared to private practice. If this pay difference were less, more individuals might work in the public health sector.
- Consider tax incentives for practitioners to locate in underserved areas.
- Need to increase the availability of bilingual providers.
- Opportunities to work with AHECs to increase diversity and encourage youth to enter dental professions.
- Need more role models to encourage under-represented youth to enter profession.
- Need to collect data on the diversity of the workforce. There could be an optional check off or data collection at time of license renewal for dentists and hygienists or when renewal of radiology certification for dental assistants.
- Dentists tend to be very independent. When they work with schools or health centers, they may feel they lose this independence. If this perception could change, more dentists might work with community health centers.
SAFETY NET

Goals
- Move like a tight rope – need more resources to make a net
- No specialty programs – must fit an existing program, dental practice
- Programs we have do not meet needs of homeless
- Resources too low for adults $600
- HIP stops @ 19 --- no dental care due to cost of dental care
- Prevention doesn’t happen
- Target population: start at maternity ward, prenatal care very important
- Access due to jobs lost – must take off from my job, more accessible dental hours
- Education -- parents + children employers
- MUST KEEP CURRENT PROGRAMS

    Era of single bullet is over
    Early intervention – fluoride varnish, sealants
    Availability

Accessibility
- Education – Indiana Dental Association educate other healthcare providers
- Talk to mid-level providers
- Maintain/enhance current programs
- Develop PSAs – public service on Oral Health Announcements
- Go where the need is – nurses are the advocates, 1st line private dentist – often after school nurse referral
- Sealants programs are very successful
- Building incentives into the system
- PSA – collaborative groups led by Health Dept, state and national

Collaborations
- Prenatal medical groups, AHA, PSAs in collaboration with other health groups
- Partner with Indiana State Health Department
- Require health professions to include dental health or they lose funding

Economic Development Program
- Use incentives that make sense to families – with reasonable requirements
- Incentives to dental care providers
- Rewarding healthy behaviors
  - Acute pressing need 5 to 7%
  - Leave some needs
  - Totally healthy
- Give school nurses resources for those who have additional pressing needs
- Goal of these services is worth the effort
- Should we focus on 95% who wants service but don’t have access

Goal
Facilitate school nurses and social workers - priority #1

Responsibility
- State Professional Associations
- State Dental Director
- IUSD including Auxiliary programs
- Mobile preventative care
Work in Progress – mobile programs @ work

Necessary resources
- State referral system
- School nurse oral education
  - Screening tools
  - resources
  - Interventions
  - Help line – 211 info/referral, refine existing and update
- Public Service Announcements
- Provider incentives
- Reward healthy behavior

Goal
Public Service Announcements - priority #2 – systemic Dx, xerostomia, etc.

Responsibility
- Professional organizations
  - Cardiology
  - Ob-gyn
  - Diabetes
  - Education (Public Health)
  - Geriatrics
- Corporate foundations

Work in Progress
- ?

Necessary resources
- Money
- PR firm
- Media cooperation
- Cartoonist/songwriter (kids audience)

Goal
Provider Incentives tied to Safety Net - priority #3+

Responsibility
- IDA: Public & private incentives
- IUSD
- State legislature – Medicaid

Work in Progress
- Some nursing home mobile units
- ?

Necessary Resources
- Provider educators
- Suppliers

Goal
Reward Healthy Behavior - priority 3-

Responsibility
- All dental program directors 3+
Work in Progress
- ?

Necessary resources
- Off-hour facilities
- $ from added license or associated dues tax
- License plates
- Gas tax ($2.00 gal)

- Safety net is an organization trying to help underserved; also can be used for education and prevention
- Safety net is not good for our broken health care system, due to more and more people falling through the cracks (people getting laid off or losing jobs – no health insurance).
- We have to find safety nets within private sector; private offices need to be more accessible and available financially
- Problems w/staffing and retention at safety nets
- Do we need a safety net for Medicare recipients? (special program)
- We cannot continue to drill and fill w/o education
- Prenatal visit to the dentist
- Having a pediatrician use fluoride varnish on a child won’t work unless they explain to parent about modifying behavior at home and continue to explain the ins and outs of prevention. The parent has to be educated on dental prevention in order for this to work. Varnish alone won’t help w/o the other components.
- OB doctors and dentists have to be able to communicate in order to give OB patients the best care
- Cost effective to provide treatment to kids early in life
- Dental students should get more exposure to non-traditional dental clinics
- Mobile units offer no dental home, no emergency care and no interaction w/parent
- How effective is Born to Smile?
- We try to educate parents on oral health care but WIC is giving out free juice and sippy cups.

Goals
1. Prevention w/education
2. How to make people value oral health care
3. Interaction w/child and parent about oral health care
4. Expose students to federally-funded clinics

Not addressed
1. Disease prevention/liability in kids
2. WIC – giving out vouchers for juice
PREVENTION

Assets & Problems
- School based fringing
- Sealants programs
- Water fluoridation
- OH instructions, education emphasis, by Dental School students – WIC & Elderly
- Education in dental school (need more) + outCAD campaigns
- Born to Smile -> increase 1-year visit
- Healthy Choices – partner with others (ex: Diabetes Association), OB/GYN, nursing students, pediatricians, school nurses, school administrators

Reasons lack prevention
- Low income/reimbursement
- Dental belief
  - Need of prevention
  - Consequences

Opportunities
- Access to “in need” populations ….minorities, rural
- Community driven
- Fairs/festivals/church

Workforce
- Hygienist
- Assistants
- School nurses

How to Fix it
- Increasing prevention “valve” knowledge + comfort in treating young children in (dental education, legislators (funds)
- Helping replace water fluoridation pumps – matching Grants
- Partnering with Associations (eg: Diabetes, Heart), community centers, other health professionals (pediatricians, OB/GYN) -> consistency of message
- Nature of dental disease (mom transmitting to baby)
- Nursing students, pediatricians, school nurses, school administrators

Things we know about Prevention
- Good fluoridation
  - Diligent/maintenance
  - Investments
- Underrepresentation of ethnic groups/diversity
  - AA
  - Latinos
  - Community barriers
  - Culture/wave of immigrants
  - Diet & effects on Oral Health
  - Disabilities-cognitive
- Poverty
- Lack of insurance
- Lack of outreach programs
  - Educating on prevention @health fairs, etc
Marion County has a program where hygienists go out to schools, daycare, camps, dental prevention health fairs, F/u w/smile mobile

- Best management practices
- Head Start programs
- Programs that allow Oral Health providers to go out to the kids/parents have to miss work

**Summary work**

- Fluoridation – strength
- Head Start programs/Marion county dental service
- Born to smile

**Weaknesses**

- Finances, funding/lack of money
- Lack of diversity/cultural sensitive
  - Program & professionals educational
- Lack of insurance/outreach problems with access

**Fix**

- Best management models
- Non-traditional settings
- Education/public/dental professional
- Picking a target audience
- ID target population for prevention education
  - Mom/infants
  - Dental decay-> cardiovascular risks
  - 20’s – 40’s year olds
  - 50’s & older
- Increase referrals from physicians
- Increase dental workforce to provide services
- Public service announcements
- Access to care – no insurance
- Value of dental care
  - People perceive low value & don’t want to pay
- TV commercials to include all groups
- Specialty training programs for foreign trained professionals
- Teach dental professionals on OH education
- Make public health more desirable
- More nontraditional dental settings
  - Churches
  - Daycares
  - Social clubs
  - Associations
- Foster Care programs – these kids don’t get needs met
- Born to Smile program – Fort Wayne
  - Brochure/reply card/gift @ 1 year
  - Dental visit – free exam
  - 2nd brochure @9 months on
  - Pilot program
- Find a way to get the message of OH to the population (people don’t fear dental disease)
- Mom/infant OH education
- Coordinate w/prenatal visits
- Increase referrals from physicians
- Educate public on infectious nature of dental disease (mom transmitting to baby)
FINANCE

What are the strengths & weaknesses of how we currently finance dental care in Indiana?

Strengths
- Compared to other states we have a fairly strong program – Medicaid
- HIP legislation – currently supporting expansion for funding dental care to children & adults as well
- Leg. & admin. support dental Healthy Indiana
- Privatized or universal – not solved
  - 48 health centers
  - 90 sites – sliding scale
  - 18 federally qualified health centers – have dental
  - 30 state funded w/o dental
- Some employers have dental insurance for the employees
- Coverage for prenatal women

Weaknesses
- No data to understand financing
  - How many dental uninsured?
- Unknown needs?
- What is cost to not provide needs? – health, economic, social
- Can capture some costs – chronic diseases
- Dental community doesn’t understand all of coverage available.
- Some DDS think Medicaid reimbursement is easier to get
- Fragment reimbursement systems
- Not enough money in the system doesn’t cover overhead for dental offices

To what extent should the financing of dental care be integrated with medical care?
- A system that covers all health – medical, dental, vision
- Dental has separate packages than medical
- Advantage – easier for Medicaid & personal
- Dental codes handles differently than medical codes
- Some states have dental covered under their medical managed care

What steps need to be taken to improve the financing of dental care in Indiana?
- Fluoride program paid by federal funds
- Shouldn’t the state invest in the fluoride program
- Workforce & financing issue RDH – underutilized, scope of practice
- Government needs to understand importance of Oral Health
- Mid-level practice utilized
- Quicker way to review reimbursement
- MD reimbursement hasn’t been raised since 1994—Jan ‘08
- Managed care organizations will have to look@ can DDS handle the influx in certain areas
- General overhead ~70%
- Typical DDS office 1 or 2 clinicians
- DDS – independent – like autonomy
- Future may see shift of dentists to larger corporations
- Mental health was in legislation required years ago – must be provided.
- Who will fund the raises in reimbursement
- Should we look at services reimbursed and re-evaluate
Focus on preventative care

- Healthy Indiana Plan
  - $500 for preventative care
  - Include dental services
  - Managed care took care off
- Medicaid covers 1 cleaning a year—could we change that to twice a year
- People financing health care wait for their reward
- Prevention doesn’t save money just improves quality of life—medical
- Educations standpoint – indigent peoples don’t choose dental insurance, education needed
- There have been movements to include dental health in medical health
- Could it be to dentist advantage to have them combined?
- Dentists could shift paper work to manage care – maintain control of practice get access to new stream of funding
- Which states have done this?
- Physicians doing some dental treatments – fluoride varnish –to address access to care
- If DDS was part of managed care they wouldn’t need referrals
- Medicaid doesn’t come close to private insurance reimbursement.

DATA

- Indiana has limited data sources for oral health care and health status.
- Oral data items are needed to determine levels of access-to-care, including the availability of care providers, the ability to find a provider, and the variation across clients in terms of language and dental literacy
- Full-fledged survey and clinical exams are unlikely to take place at the state level, because of funding constraints. More desirable proxies could be abridged direct data collection, validated telephone surveys, and limited data collection for high needs or special groups. Besides establishing proxies for normative standards (number of teeth present, presence of pain in the last 12 months, tooth loss in last 12 months, and so on) it should be desirable to ascertain whether dental care is available, or perceived to be available; what are perceived barriers/supports (including dental phobias); what kind of quality and diversity expectations exist for clinical services.
- Oral health surveys and data collection are not mandated school-based exams, such as PTA mandated eye exams. A change in relevant regulations could afford state-wide basic information collected in the school environments from K thru 12 grades (number of teeth present by age, number of restorations and missing teeth, services obtained at most recent dental visit and date, presence of dental pain in the last 12 months, and availability of a dental home).
- Other data sources (outside the school environments, and for older age groups) could be dental care emergencies treated in the Emergency Department; reports of care delivery and incidents in long-term care facilities and nursing homes; national databases, or state-specific data from national databases – when available (BRFSS, for example).

- Ability to find a provider
- Level of dental literacy/IQ
  - Use of pictorial

Direct data collection vs. telephone
Health fairs; IBE
Governments already interested
PTA mandated eye exams

- Number of states that mandate oral care
- Support structure
  - Access; ER (trauma)
- Regular nursing home care
- Gap in regulation of special needs and long-term care facilities

Access to care (availability of care, quality, desire)
Last visit treatment
Clinical: decay, missing, perio, oral cancer, how many times, barriers, time lapse?

How important is dental health
Use YRBS or some other Department of Education survey
YRBS Survey High School to provide random sample and provide teenager data

- Dental phobias (avoid dentists)
- ATOD (alcohol, tobacco, drugs)

Geriatric population is difficult to survey
Consider using AARP
Central Indiana Council on Aging