Final Report

COMMISSION TO STUDY PATHWAYS TO ORAL HEALTH CARE IN NH (Chapter 313, Laws of 2014; SB 193)

November 1, 2015

In 2014, the Commission to Study Pathways to Oral Health Care in New Hampshire (Chapter 313, Laws of 2014) was established for the purpose of analyzing and evaluating barriers to and coverage for dental care for underserved New Hampshire residents, the impact of the implementation of Expanded Function Dental Auxiliary and Certified Public Health Dental Hygienists, and how adding these two new professions to the dental team will meet the need for oral health services in New Hampshire.

The Commission is required to report its findings and any recommendations for proposed legislation to the President of the Senate, the Speaker of the House of Representatives, the Senate Clerk, the House Clerk, the Governor, and the State Library on or before November 15, 2015. This report shall serve as the Commission's findings and recommendations.

MEMBERSHIP:

The following members were named to the Commission:

The Honorable Jeb Bradley – Chair (Senate)
The Honorable Donna Soucy (Senate)
The Honorable Susan Emerson (House)
The Honorable James MacKay (House)
Mary Ann Aldrich (Public member)
Charles Saia (Governor's Commission on Disability)
Dr. Puneet Kochhar (NH Dental Society)
Pamela Delahanty (NH Dental Hygienists Association)
Dr. Arthur McKibbin, Jr. (NH Board of Dental Examiners)
Erika Argersinger (NH Kids Count)
Gail Brown (NH Oral Health Coalition)
Dr. Roger Achong (NH Academy of Pediatric Dentistry)
Dr. Margaret Snow (NH Medicaid Dental Director)/*replaced by Dr. Sarah Finne upon retirement.*
Janet Laatsch (Bi-State Primary Care Association)
Robert Ritchie (State Committee on Aging)

The Commission met 7 times between December 2014 and November 2015 on the following dates:

December 3, 2014
February 13, 2015
March 27, 2015
May 8, 2015
June 19, 2015
September 11, 2015
October 16, 2015

CHARGE OF COMMISSION

Under the provisions of Chapter 313, the commission was charged with analyzing and evaluating barriers to and coverage for dental care for underserved New Hampshire residents, the impact of the implementation of Expanded Function Dental Auxiliary and Certified Public Health Dental Hygienists, and how adding these two new professions to the dental team will meet the need for oral health services in New Hampshire.

The Commission's evaluation shall include a review of oral health access data and needs and coverage needs for dental services for underserved New Hampshire residents.

The Commission was allowed to solicit and obtain information, presentation, or testimony from any person or entity with expertise or experience relevant to the commission's study.

LITERATURE REVIEW OF NATIONAL RESEARCH/REPORTS

The Commission thanks Gail Brown for providing the following overview of the literature and national reports specific to key characteristics of oral health access. The citations for the review are located in Attachment B.

A National Call to Action to Promote Oral Health (2003) from the US Department of Health and Human Services, a milestone in oral health policy, identifies five actions needed to increase oral health access:

- Change perceptions on oral health;
- Overcome barriers by replicating effective programs and proven efforts;
- Build the science base and accelerate science transfer;
- Increase oral health workforce diversity, capacity, and flexibility; and

- Increase collaborations. [i]

A subsequent report, Improving Access to Oral Health Care for Vulnerable and Underserved Populations (2012) from the Institute on Medicine and the National Research Council of the National Academies further defined key characteristics impacting access to oral health care and culminated in a vision for delivery of oral health care to the underserved. The authors concluded that:

- Improving access to oral health care is a critical and necessary first step to improving oral health outcomes and reducing disparities;
- The continued separation of oral health care from overall health care contributes to limited access to oral health care for many Americans;
- Sources of financing for oral health care for vulnerable and underserved populations are limited and tenuous; and
- Improving access to oral health care will necessarily require multiple solutions that use an array of providers in a variety of settings. [ii]

In other words, investing additional money in a delivery system that is poorly designed to meet the oral health care needs of the nation's underserved and vulnerable populations would produce limited results and would be fiscally irresponsible. Whereas transformations through targeted (actions) and investments in programs and policies that will have the greatest impact will most likely yield the greatest impact. [iii]

A review of relevant literature reveals the following key components to access:

- Social determinants: "the ability to access oral health care is associated with gender, age, education level, income, race and ethnicity, access to medical insurance and geographic location. Addressing these determinants is key in reducing health disparities and improving the health of all Americans" [iv]
- Workforce: this includes considering the type, training, scope of practice, supervisory needs and opportunities, and geographic distribution of various workforce members. [v]
- Settings: both traditional and non-traditional settings can be used for preventive and restorative oral health services. Oral health has expanded into many additional community-based settings including schools, child care programs, nursing homes and senior settings, human service agencies, retail settings, and more. [vi]
- The role of finance: understanding oral health financing systems is critical to understanding access. Alignment of need, services reimbursed, and providers available is a critical factor in funding care within the safety net of oral health services. [vii]

The Institute of Medicine study culminates in outlining a vision for oral health care in the US where everyone has access to quality oral health care across the life cycle through the following actions:

- Eliminate barriers that contribute to oral health disparities
- Prioritize disease prevention and health promotion
- Provide oral health services in a variety of settings
- Rely on a diverse and expanded array of providers competent, compensated, and authorized to provide evidence-based care
- Include collaborative and multidisciplinary teams working across the health care system; and
- Foster continuous improvement and innovation. [viii]

This examination of the components of access and review of national work and recommended actions to increase access and improve outcomes, provided by Ms. Brown, provided a useful framework for Commission's work and recommendations for New Hampshire.

TESTIMONY

The Committee requested testimony from various stakeholders about the oral health of New Hampshire's residents, including data on oral health access and outcomes, the status of implementation of the Expanded Function Dental Auxiliary and Certified Public Health Dental Hygienist, and information about programs which are promoting access to oral health care. The committee heard testimony from the following entities/organizations listed below. Presentations provided to the Commission are available through its website http://nhoralhealth.org/sb-193-commission/. The website is hosted by the NH Oral Health Coalition. The Commission members thank the Coalition for this work.

- December 3, 2014 – Introductions, general discussion of scope, election of Chair (Sen. Bradley), and organizations for outreach and presentation.

- February 13, 2015 – Presenters:
  - Margaret Snow, DMD, NH Medicaid Dental Director; and
  - Nancy Martin, RDH, Oral Health Program manager for NH Division of Public Health Services.

- March 27, 2015 – Presenters:
  - Charles Albee, DMD, Board President of NH Board of Dental Examiners and Constance Stratton, Executive Director; and

- Margaret Ray, RDH, M.ED. Professor, NHTI, New Hampshire Community College System

- May 8, 2015 – Presenters:
  - Eleanor Jaffee, Carsey School of Public Policy, University of NH, commissioned by NH Kids Count; and
  - Gail Brown, NH Oral Health Coalition

- June 19, 2015
  - John P. Ahern, DDS and Kristine Blackwelder, DMD, NH Dental Society;
  - Lawrence Hill, DDS, MPh, Dental Public Health Consultant, sponsored by NH Kids Count/Pew Children's Dental Campaign; and
  - Roger Achong, DMD, MS, NH Academy of Pediatric Dentistry.

GENERAL FINDINGS of FACT

Overall:

- Oral Health is important for overall health.
- New Hampshire ranks at the top in numerous national oral health status surveys for the good oral health of its citizens.
- New Hampshire's oral health status performance varies substantially by county.
- Accessing oral health care, preventive and restorative care, is particularly challenging for low income families in the sparsely populated regions of the state.
- Educating the public on the importance of oral health and prevention is crucial.

Coverage/Benefits:

- New Hampshire has a limited adult Medicaid dental benefit which covers only treatment of trauma, pain, and infection and is usually limited to services associated with extraction only.
- Medicare does not provide a dental benefit.
- The latest available data (2009) show there were 15,797 hospital emergency discharges for non-traumatic dental conditions; the majority of these occurred during typical dental practice office hours and were self-pay, indicating that a lack of dental insurance is one of the primary factors steering patients into hospital emergency departments.

- Children's Medicaid services are provided in private offices (largest safety net), FQHC's, community programs, school based and linked programs.
- NH has an engaged pediatric dental community but needs more specialists.
- NH Medicaid reimbursement rates for pediatric dental services have not been increased since 2004.

Workforce:

- Certified Public Health Dental Hygienists (Est. in 2012) are currently being trained at New Hampshire Technical Institute in Concord (Community College System). Graduates are certified by the Board of Dental Examiners and deployed in public health settings. There are 21 Certified Public Health Hygienists permitted as of the final writing of this report (10/16/15).
- Expanded Function Dental Auxiliary (Est. in 2012) will be trained at the Business Training Center at Community College System. Expected to begin training in Fall 2016 when appropriate funding is in place. There are 2 Expanded Function Dental Auxiliaries currently permitted.
- New Hampshire has collaborative programs in place (DHHS, Bi-State Primary Association, NH Dental Society) to recruit new dentists to New Hampshire.
- According to the federal Health Resources & Services Administration (HRSA), four (4) practitioners are needed to remove the Dental Care Health Professional Shortage Area (DHPSA) designation in New Hampshire.
- Minnesota, Alaska and Maine have authorized the introduction of dental therapists. Dental Therapists are currently deployed in Minnesota and Alaska. Commission discussions included arguments for and against authorizing dental therapists in NH:
  Against:
    - Based on NHDS survey data, there is underutilized excess capacity in existing dental practices;
    - Concern that dental therapists may not be able to provide level of services needed by the underserved and fragile populations and should not be authorized to perform irreversible procedures;
    - NH has recently authorized two new expanded function/mid-level workforce models whose deployment has just begun thus there is no need for another workforce model;

- ~~o~~ According to ADA's Health Policy Institute studies, the supply of providers is not the barrier to increasing access to care, funding for underserved populations is the paramount issue;

For:

- Existing research , including a review of numerous studies published in the International Dental Journal, as well as the Minnesota Department of Health and Minnesota Board of Dentistry's evaluation of dental therapists, indicates that dental therapists both in the US and abroad deliver safe and effective care, increase access to care (decreased wait time/travel time) and increase a practice or clinic's ability to see Medicaid patients;
- The Commission on Dental Accreditation, at its February 2015 meeting, adopted the Accreditation Standards for dental therapy education programs, providing standardized guidance for training dental therapists. At the August 2015 meeting, the Commission directed that a process be implemented for accreditation of dental therapy education programs.
- Dental therapists could be deployed in a variety of settings (i.e. school clinics, nursing homes) that help get services to those populations not currently well served.
- The Minnesota Department of Health and Board of Dentistry evaluation of dental therapists found that use of dental therapists provides a cost benefit that helps practices offset low Medicaid rates.

Access to Prevention & Treatment:

- New Hampshire has 163 school programs where dental hygienists provide preventive services (fluoride), sealants and referrals to dentists for restorative treatments, if necessary. This represents over 75% of high need schools.
- There is excess capacity in many New Hampshire dental practices and the ability to serve more patients (i.e. lack of utilization of oral health services).
- Statewide, 46% of residents have access to Community water fluoridation which is an evidence based strategy to prevent tooth decay; Coos and Cheshire counties are the lowest, with just 8% and 20% respectively.
- There are geographic areas (specifically rural and northern) in New Hampshire that lack access to oral healthcare in the immediate vicinity. For example, there are low-income populations in Plymouth, Northern Grafton, and through Coos County that are designated as underserved.

These designations indicate access issues above and beyond the dentist-to-population ratio as noted in the DHPSA ratio.

- Statewide, 35% of NH 3rd grade students experience tooth decay; there is variation by county – i.e.in Coos County 56% experience tooth decay.
- NH ranks #1 in the country for lowest percentage of 3rd grade students with untreated tooth decay (12%) according to 2011 indicators from the National Oral Health Surveillance System (NOHSS).
- In April 2015, New Hampshire received an "A" grade from the Pew Charitable Trusts for its work in protecting kids from tooth decay, specifically with the use of dental sealants. NH also received an "A" grade for its sealant benchmarks in 2012.
- Statewide, 8% of NH 3rd grade students need treatment, with variation by county – in Coos and Strafford Counties 14% need treatment.
- Approximately a quarter of NH adults have not visited a dentist or dental clinic in the past year. 73.1% have visited a dentist or clinic. NH ranked 5th best in the country for adults visiting a dentist or dental clinic, according to 2014 indicators from Healthy People 2020 as documented by America's Health Rankings, United Health Foundation.
- 22.1% of older adults surveyed in NH were found to have untreated tooth decay; low-income respondents were significantly less likely than other participants to have a regular provider of routine care.
- There are multiple barriers that contribute to the underutilization of dental care including factors such as financial stress, long work hours, lack of child care, oral health literacy, and transportation.
- Evidence shows that Medicaid-enrolled children who have an early and comprehensive preventive dental visit are more likely to continue with preventive services and have lower dental costs. For example, the Women, Infants and Children (WIC) Pay for Prevention Pilot Project is a privately-funded collaboration between the NH Department of Health and Human Services, local WIC programs, and local dental practices that uses certified public health dental hygienists to provide six preventive dental services (oral assessment, parent education, Medicaid reimbursed fluoride varnish and dental sealant application, temporary fillings, and referrals for treatment at participating local dental offices) to eligible at-risk children ages 0 to 4 years, and to pregnant women, at local WIC agencies.

Issues Specific to NH's Adult Dental Medicaid Benefit:

The Commission listened to several presentations where the issue of New Hampshire's lack of a comprehensive adult Dental Medicaid benefit was highlighted as a significant barrier to care for low income populations. New Hampshire currently provides limited benefits for adults that cover only emergency care and the treatment of trauma, pain and infection. The current benefit is generally limited to services associated with extraction only. The Commission heard further testimony that in many cases, these services are provided in hospital emergency rooms, not in a more cost effective dental home where follow up care is delivered.

The Department of Health & Human Services was asked to provide information about an adult Medicaid benefit and the cost associated with providing a more comprehensive benefit which could include preventive services. Preventive services are considered less expensive than restorative services and can be provided in dental offices and public health settings throughout the State.

The following information was provided by Dr. Peg Snow, former DHHS NH Dental Medicaid Director, from previous projections by the Department in the effort to establish a comprehensive adult Medicaid benefit:

- **Adult Dental Medicaid Benefit Developed for SFY2010-2011**
  The adult dental Medicaid benefit model in Attachment A is a cost projection from several years ago which depicts the cost of providing dental care for Medicaid eligible adults. It is important to note that to introduce a new member into the dental workforce team, without creating a sustainable funding strategy for reimbursement, will not accomplish an increase in access to dental care for adults.

- **Program Description:** The current Medicaid coverage for dental treatment for adults is limited to treatment of trauma, pain, and infection and is usually limited to services associated with extraction only.

  A proposed adult Medicaid dental benefit would add coverage for a specific scope of services: preventive, restorative, and prosthetic services. It would be limited to $1000 per fiscal year per adult enrollee and the current benefit for extractions related to pain/infection would remain unchanged. Procedures such as fixed crown and bridge, endodontia, and periodontal surgery would require prior authorization. Specific

procedures such as cosmetic services, orthodontia, and implants would be excluded from the coverage.

- **Need:** The need for an adult dental benefit is related to access to care and reducing the economic burden of oral disease among adults. The current limitation of covered adult dental services to extraction was developed in an era before people knew how to maintain oral health throughout the lifespan, and tooth loss seemed inevitable. The value of routine or preventive dental care was unknown. The cost of extractions to payors was much less than for restorations (fillings). Teeth were extracted even if they only had moderate decay which prevented the development of serious infection. Tooth loss is now less common in adults and missing teeth have a more serious impact on social wellbeing, particularly employability. The current limitation of treatment to pain and infection may lead to postponement of dental treatment and may actually contribute to the development of severe or life threatening dental infections. There is growing evidence highlighting the association between poor oral health and chronic health conditions such as diabetes and cardiovascular disease.

  The full economic burden of untreated dental disease in adults includes over-use of hospital ED's, missed days of work or impaired work performance, reduced employability due to disfigurement from decayed or missing teeth, long periods of hospitalization due to systemic infection, and morbidity/mortality of nursing home residents. Parents with uncontrolled oral disease have children at greatest risk of poor oral health.

- **Description of Data in Attachment A**
  The Yellow Model shows the predicted total cost of an adult Medicaid dental benefit based on the following assumptions: Full use of a $1000 per year dental benefit for preventive, restorative, dentures, in addition to current emergency expenses; with utilization **two** times the current rate in each age group, and no predicted rise in the cost of emergency treatment. Total Cost = $10.7 M annually.

  The Orange Model shows the predicted total cost for an adult dental program based on the following assumptions: Dental Benefit of $1000 plus emergency treatment, as above, with utilization predicted to be equal to Healthy Kids Gold. Cost=$30.9M. No way this could happen because the model so far exceeds the risk experience of both groups.

The Green Model: Predicted cost if the utilization for adults were the same as for Healthy Kids Gold (about 50% of the total enrolled), and the costs were the same per average treated HKG patient, plus current emergency expense. Cost=$13M.

The true cost of an adult benefit plan with a $1000 limit would be around $11M to $13M, but also propose that it would begin at about $8M and rise over about 5 years to the full cost of $11 to $13M due to utilization and capacity constraints.

RECOMMENDATIONS:

- The State should consider, if funding is available, the establishment of a comprehensive Adult Dental Medicaid benefit that offers low income and underserved populations, including individuals with disabilities, access to preventive and restorative oral health care services. A "comprehensive" benefit would be defined to include preventive and restorative services as well as dentures/partials. Strategies to be considered in advocating and adopting a comprehensive adult Dental Medicaid benefit should include, but not be limited to, the review of and cost projections for, staggering benefits, incentivizing benefits based on wellness behaviors, phase-in benefits based on population (i.e. pregnant women), and maximum benefit caps.

- Stakeholders should increase education efforts to promote the link between oral health and overall health, targeting efforts through existing programs, particularly in public settings. Educational efforts should continue to focus on prevention strategies for good oral health (brushing, flossing, fluoride, reduction of refined sugars in the diet, and regular visits to the dentist).

- Promote research-based strategies, including those actions identified in the literature review, to improve the oral health of and bring services to vulnerable and underserved communities and populations.

- The Department of Health & Human Services should review and report on the current status of pediatric Medicaid rates which have not been

increased in over a decade. Efforts should be considered to raise the rates in the next budget cycle.

- Stakeholders should continue to study issues related to older adults (seniors) who may have an increased risk for oral conditions such as edentulism, oral cancer and periodontal disease.

- The new workforce models that have been added to the dental team, regulated by the Board of Dental Examiners (Certified Public Health Dental Hygienist and Expanded Function Dental Auxiliary) should continue to be monitored for their impact in meeting the need for oral health services in New Hampshire, including among high need populations. At this time there are a small number of providers trained and deployed so measurable outcomes are not yet available.

- The State should create a Dental Medicaid reimbursement mechanism that allows payment for the Certified Public Health Dental Hygienist performing currently authorized interim therapeutic restoration (ITR) and radiographs under public health supervision consistent with payments currently made for other authorized services. Without reimbursement, it is not possible to meet the Commission charge of evaluating effectiveness of the Certified Public Health Dental Hygienist.

ATTACHMENT A

Adult Dental Medicaid Benefit Developed for SFY2010-2011

		Enrolled SFY08	With Pd Dental Service 08	% With a Pd Dental Service 08	SFY 08 Medicaid Payments	Avg payment Per Person
Totals	Ages 21 to 44	28,351	3,269	12%	$ 1,094,212.50	$ 334.72
	Ages 45 to 64	15,063	1,107	7%	$ 378,153.38	$ 341.60
	Ages 65 to 74	5,465	119	2%	$ 38,913.00	$ 327.00
	Ages 75 to 84	5,335	76	1%	$ 17,856.00	$ 234.95
	Ages 85 and over	4,589	25	1%	$ 6,407.00	$ 256.28
	Total	58,803	4,596	8%	$ 1,535,541.88	$ 334.10

	Assumed % of Adults Who Would Access Dental Services	Number Who Would Use Benefit @ Assumed Util Rate	Cost at (Benefit Amount X Assumed Utilization)+ Current Emergency Amt	Cost at Benefit Amount + Current Emergency @ HKG Utilization Rate	Cost if Avg Cost Per Pt and Utilization for Adults All Ages Were Equal To HKG Avgs for 2008 Plus Emergency Services	Cost if Benefit Limit is $500, Utilization is Equal to HKG + Emergency Services
Ages 21 to 44	23%	6538	$ 7,632,212.50	$15,269,712.50	$ 6,567,247.27	$ 8,181,962.50
Ages 45 to 64	15%	2214	$ 2,592,153.38	$ 7,909,653.38	$ 3,285,998.70	$ 4,143,903.38
Ages 65 to 74	4%	238	$ 276,913.00	$ 2,771,413.00	$ 1,093,907.00	$ 1,405,163.00
Ages 75 to 84	3%	152	$ 169,856.00	$ 2,685,356.00	$ 1,047,754.08	$ 1,351,606.00
Ages 85 and over	1%	50	$ 56,407.00	$ 2,300,907.00	$ 892,293.09	$ 1,153,657.00
Total	8%	9192	$10,727,541.88	$30,937,041.88	$12,887,200.15	$ 16,236,291.88
Change Budget						$ 14,700,750.00

Assumptions:

1. Factor of Utilization Increase Over Current: 2
2. Benefit Amount: $1000.00
3. Change in Emergency Use: 0
4. HKG Utilization: 50%
5. 2008 Avg. Cost For HKG Per Child Using Dental Services: $386.09

ATTACHMENT B

LITERATURE REVIEW OF NATIONAL RESEARCH/REPORTS CITATIONS

[i] A National Call to Action to Promote Oral Health, US DHHS – Public Health Service, Centers for Disease Control and Prevention, National Institutes of Health NIH Publication No. 03-5303, May 2003. p.12-28.

[ii] Improving Access to Oral Health Care for Vulnerable and Underserved Populations, Institute of Medicine and National Research Council of the National Academies, The National Academies Press, Washington, CD, www.nap.edu, 2011. p.230.

[iii] Ibid.

[iv] Healthy People 2020, http://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Oral-Health/determinants.

[v] Best Practice Approaches for State and Community Health Programs, Access to Oral Health Care Services: Workforce Development, ASTDD; Breaking down Barriers to Oral Health for all Americans: The Role of Workforce, American Dental Association, 2011.

[vi] Improving Access to Oral Health Care for Vulnerable and Underserved Populations, Institute of Medicine and National Research Council of the National Academies, The National Academies Press, Washington, CD, www.nap.edu, 2011. p.157-192; Breaking Down Barriers to Oral Health for all Americans: The Role of the Tattered Safety Net, American Dental Association, 2011.

[vii] Improving Access to Oral Health Care for Vulnerable and Underserved Populations, Institute of Medicine and National Research Council of the National Academies, The National Academies Press, Washington, CD, www.nap.edu, 2011. p.193-228; Breaking Down Barriers to Oral Health for all Americans: The Role of Finance, American Dental Association, 2012.

[viii] Improving Access to Oral Health Care for Vulnerable and Underserved Populations, Institute of Medicine and National Research Council of the National Academies, The National Academies Press, Washington, CD, www.nap.edu, 2011. p.231.