Wynne Health Group

Exploring the Addition of Mid-Level Dental Providers: A Report to the Colorado Dental Association

JANUARY 2022

Key Takeaways

Colorado Still Has Work to Do Before Proposing or Implementing New Policies

A Strategic Oral Health Vision is Needed

- Colorado needs to first decide what specific oral health goals it is trying to achieve before developing policy solutions

Views on Mid-Levels Are Generally Neutral

- Majority of stakeholders did not yet have a perspective on mid-level providers
- Generally endorsed investments in existing programs over the creation of a new provider type

Important Considerations

- Current landscape, including new data from state and federal reports
- ROI of potential policies
- Input from the communities served by proposed policy solutions

Oral Health Status

Despite Gains in Coverage, Workforce Shortage and Other Barriers Remain Ongoing Challenges in Colorado

Dental Insurance Coverage

- 76.8% in 2021 compared to 61.6% in 2013

Dental Care Utilization

- 73.6% in 2019 compared to 61.3% in 2013

Workforce Shortage

- 1 in 5 Coloradans live in dental Health Professional Shortage Areas (HPSA)
- 142 more dentists needed to remove HPSA designation (population to provider ratio must be at least 5,000 to 1; or 4,000 to 1 for areas with high needs)

Impact of COVID-19 on Dental Care

Pandemic Has Taken an Unprecedented Toll on Dental Care Utilization and Dental Industry

At the Beginning of the Pandemic, Emergency Dental Care Only and No Preventive Dental Services

- March 19, 2020 – April 26, 2020: Colorado Executive Order D 2020-009 ordered temporary cessation of all elective and non-essential procedures

Colorado Dental Practices Have Not Fully Returned to Pre-Pandemic Operative Levels

Week	Completely Closed	Seeing Emergency Patients Only	Open But Seeing Lower Patient Volume	Open and Business as Usual
April 6, 2020	15.7%	82.4%	--	--
May 4, 2020	8.7%	31.2%	57.2%	--
July 13, 2020	--	--	50%	50%
Feb. 15, 2021	1.8%	--	55.5%	42.6%
June 14, 2021	0.7%	--	34.7%	64.6%
July 12, 2021	--	--	32.4%	67.6%

According to CHI Survey (Feb. 1-June 27, 2021), COVID-19 Pandemic Continues to Affect Access and Use

- 22.7% reported skipped dental care due to concerns about catching COVID-19
- 16.9% said their dental office or clinic was closed due to COVID-19

Oral Health Status

Disparities Often Correlate with Age, Geography, Socioeconomic Status, and Racial/Ethnic Identity

Barriers to Dental Care in 2021, According to Colorado Health Institute (CHI) Survey

- 9% cited fear of pain from procedures
- 7.5% did not understand dental benefits
- 6.4% faced challenges finding a dentist or hygienist to relate to
- 5.0% did not have a dental office or clinic in their community
- 4.3% encountered a dental office or clinic that was not accepting new patients
- 4.2% did not have a way to get to a dentist's office or clinic

Fluoridated Water

- 1 in 4 Coloradans rely on public water systems that do not receive fluoridated water

Children and Adolescents

- Students at schools with the lowest socioeconomic status (75% or more Free and Reduced Lunch (FRL) eligibility) were more likely to have tooth decay and less likely to have preventive sealants than students at schools with the highest socioeconomic status (less than 25% FRL eligibility)
- Students of color generally experienced a higher prevalence of tooth decay compared with White students
- Kindergarten students of "other" and Hispanic/Latino(a) race/ethnicity had a higher prevalence of untreated decay (31.2% and 18.5%, respectively) compared with White students (13.8%)
- Third grade students of "other" and Black/African American race/ethnicity had a higher prevalence of untreated decay (27.2% and 25%, respectively) compared with White students (12.5%)

Older Adults (65 and Older)

- 24.8% lost six or more teeth and 9.9% lost all of their natural teeth due to decay or gum disease in 2018, compared to 34.0% and 13.4%, nationally

Oral Health Innovations

Initiatives Have Improved Dental Care Access and Oral Health Outcomes in Colorado by Addressing Barriers to Care

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General Population

- Coverage Expansions
- Expanded Scope of Practice for Dental Hygienists
- Colorado Medical-Dental Integration Model
- University of Colorado School of Dental Medicine Emergency and Dental Care Clinic
- Colorado Mission of Mercy

Children

- SMILES Dental Project (telehealth connected teams)
- Cavity Free at Three
- Smart Mouths Smart Kids

Seniors

- Dental Lifeline Network in Colorado
- Colorado Dental Health Care Program for Low-Income Seniors

Pros and Cons of Adding a New Mid-Level Provider

Stakeholder Feedback on Perceived Advantages and Disadvantages

Potential Advantages	Potential Disadvantages
• Improved access to dental services in rural and underserved communities • Increased affordability of oral health care • Increased job opportunity for individuals from rural and underserved communities • Increased diversity among the dental workforce • Opportunity to furnish care in a more culturally competent manner • Opportunity to allow all providers to practice at the top of their scope • Potential for career advancement for dental hygienists	• Could limit job growth and earning potential for individuals from rural and underserved communities targeted to fill the profession, increasing workforce inequities • Potentially lower standard of care for rural and underserved communities • Potential that the profession would be limited by the same barriers currently faced by dental hygienists and dental assistants • Potential that the profession would exacerbate current problems in the provision of unnecessary care • Limited impact due to the expansive scope of practice for dental hygienists in Colorado • Resources that could otherwise be used to address immediate needs would be redirected to the creation of a new profession

Overview of Currently Implemented Models

States Have Implemented a Wide Variety of Dental Therapist Models

Education & Licensing

- States generally rely on CODA's educational standards (3 years of study; no degree necessary) but typically also include additional requirements such as dual licensure, a certain number of clinical practice hours, or passage of a comprehensive exam
- A few states (AK, OR, WA) only require completion a two-year certificate program and 400 hours of clinical practice. DTs in these states are focused on serving Tribal patients

Certificate Program (Tribal Only)	CODA	CODA + Exam	CODA + Preceptorship	CODA + Dual Licensure	CODA + Dual Licensure + Exam
AK; OR; WA	ID	MI; MN	MN (for ADTs); MT	AZ; CT	ME; NV; NM; VT

Population Served

- Roughly a third of states are using DTs to deliver services to Tribes (AK, ID, MT, OR, WA), nearly all of the remaining states are more broadly utilizing DTs to provide services to underserved populations, with some limiting the settings of care and others requiring the majority be Medicaid or uninsured patients. Only VT does not restrict the populations DTs can serve

Supervision

- Many states require only general supervision (dentist not required to be present), but most include the additional stipulation that the DT provide a certain number of hours of care under direct supervision first

General	General After # of Hrs.	Direct
AK; OR	AZ; CT; ID; MI; MT; NV; VT	ME

Overview of Currently Implemented Models, cont.

States Have Implemented a Wide Variety of Dental Therapist Models

Scope of Practice

- Scope of practice for DTs typically includes diagnostic, preventive, and most restorative services, although the specific services authorized varies state-by-state. Several states permit extractions of primary teeth (AZ; CT; MN; VT), while most only allow extractions and pulpectomies after consultation with a dentist (AK; ID; ME; MI; NV; OR)

Billing

- About half of states allow DTs to bill independently, the other half restrict DTs to employment by certain entitles such as Tribes/Tribal programs (AK; ID; MT; OR; WA) or FQHCs/CHCs or practices serving CHC-referred patients (AZ)

Uptake

- While 13 states have passed legislation to implement DT models, only 5 have any practicing DTs. The states with the most practicing DTs (AK and MN) have had models in place since 2005 and 2009, respectively

Year Authorized	State	# of Currently Practicing DTs
2005	AK	35
2009	MN	100
2014	ME	0
2015	WA	8
2016	VT	0
2018	MI; AZ	0; 0
2019	CT; ID; MT; NV; NM	0; 1; 0; 0; 0
2020	OR	3

Evidence of Effectiveness

Access to Care and Dental Health Outcomes Do Not Meaningfully Differ Between Colorado and States with Dental Therapists

Exhibit 1: Adults 18+ with a Dental Visit in the Past Year, 2012-2018

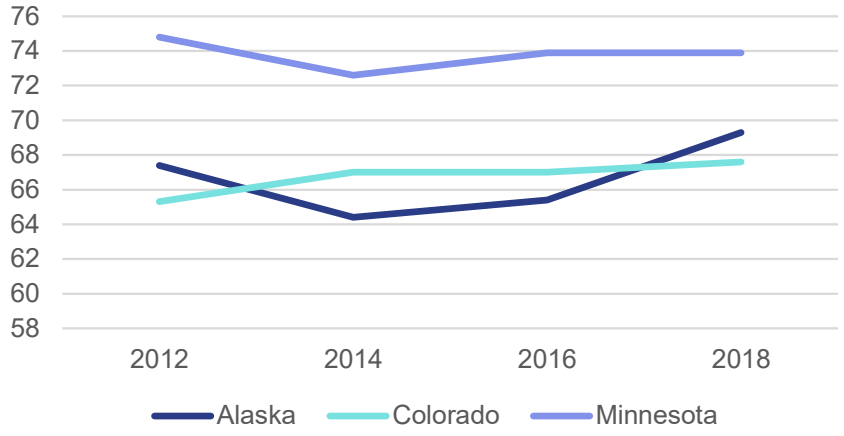


Exhibit 2: Adults 65+ Who Have Lost 6 or More Teeth Due to Decay or Gum Disease, 2012-2018

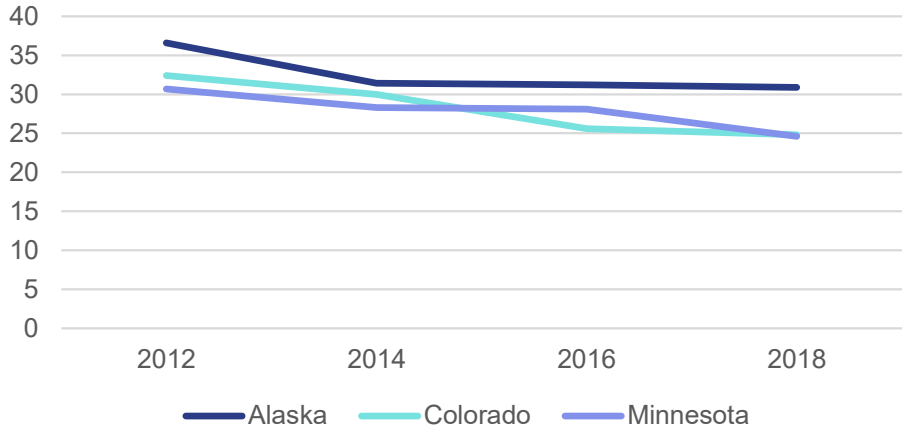
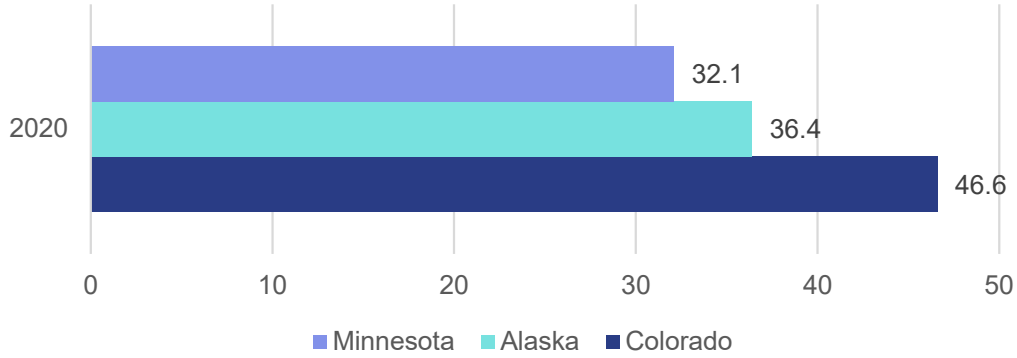


Exhibit 3: Percentage of Medicaid-eligible Individuals Ages 1-20 Receiving Preventative Dental Services, FFY 2020



Source: CDC

Recommendations

The Legislature Should Work with Stakeholders to Develop and Implement Targeted Policy Solutions

1. Create a Data-Driven, Stakeholder-Informed Vision for Oral Health in Colorado
2. Implement and Expand Innovative Delivery Models
3. Invest in Prevention and Patient Education
4. Increase Workforce Capacity and Diversity
5. Test Payment Reforms
6. Mid-Level Provider Considerations
7. Integrate Community Voice

Questions?

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