State Case Study:
Mid Level Providers in Connecticut

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Case Study:
Mid Level Providers in Connecticut

<u>What we will cover:</u>

- About Connecticut
- Setting the Stage: The Landscape Prior to 2008
- CSDA's Response to Access to Care
- Workforce Models: Making Sense of Alphabet Soup
- CSDA Recommendations
- Final Thoughts

About Connecticut

- Third smallest state in the US
- Population = 3,405,000 (2000 census)
- Birthplace of Dental Hygiene
- Dental Hygienist as Legislator
- Enrollment in Medicaid (2009)
  - 261,600 children (< 21 yrs. of age)
  - 253,700 adults (> 21 yrs. of age)
- It is estimated that approximately 750,000 CT residents lack "access to care"

Setting the Stage

CT Landscape Prior to 2008

Prior to 2008:

Scope of Practice

- Dental Practice Act revised in 2005; added local anesthesia for hygienists
- Hygienists push for additional expansion of scope of practice; effort fails but leads to "consensus meetings"
- Legislators grow weary of "turf battles", don't want to hear scope arguments any longer
- "Access to Care" becomes fashionable term

Prior to 2008:

Status of Dental Medicaid

- CT had some of the lowest Medicaid dental reimbursement rates in the nation
- Only 150 CT dentists participated in "HUSKY" Medicaid program
- Less than 30% utilization by kids on Medicaid.

Prior to 2008:

Class Action Lawsuit

- Class Action Lawsuit against DSS on behalf of children
- 2006: CSDA joins coalition to enact dental Medicaid Reform
- Perception of legislators:
  - Dentists created the Access problem
  - "Dentists Don't Care"
- In 2007, CSDA Pledges to Increase number of providers

CSDA Challenges and Strategies

- Challenges: Perception is reality
  - Perception that there is a shortage of dentists
  - Perception that dentists are obstructionists
  - Perception that dentists don't care

- Strategies:
  - Be the "leader and voice of oral health care in CT"
  - Utilize capacity that exists in the system
  - Develop a proactive legislative agenda
  - Recruit participants in Medicaid Program
  - CT Mission of Mercy (began in 2008): "Charity is not a health care system"

Fruits of Our Labors

- In April 2008, Medicaid rates increased to 50th percentile
- In September 2008, Dental Medicaid Carve-out program Implemented; reduces administration, includes case management
- Dentists DO care! More than 1,100 dentists in just 2 years.
- Utilization increased by nearly 50% since carve-out
  - Prior to 2008, 30% utilization
  - As of June 2010, approximately 45% utilization

Fruits of Our Labors

- Improved relationship with legislators and other key stakeholders due to proactive legislative agenda (even better…no $$!)
  - Support school based dental services
  - Support volunteer dental licenses for charitable or catastrophic events
- CT Mission of Mercy a home run

CSDA Response to Access To Care

Legislators and Policy Makers	Dentists
Work backwards	Process oriented
Address treatment before addressing education and prevention	Education and prevention cannot be overlooked
Legislate out of the problem without data or evidence	Use evidence to make decisions on how to solve the problem

Different Perspectives

Do Something!

- Legislators tired of hearing "no"
- Challenged by Public Health Committee to propose a model that would truly affect access, if we do not believe in ADHP
- Be at the table, or be on the menu!
- Need to define the problem, and figure out what might work in CT
  - Small state
  - Largely urban/suburban

CSDA's Access to Care Committee

- Charged with reviewing proposed models that may affect access, and make recommendations
- Primary findings:
  - Financial barrier is greatest barrier
  - Dentists cannot treat while losing money, but Government isn't interested in paying
  - Community doesn't value oral health or education about oral health
  - Current delivery system has capacity to increase utilization

Capacity

- Connecticut has 2nd highest dentist to population ratio in the US
- Current dental work force aging
- However, 10 new dental schools will open in the next decade
- 10 more being considered

How is Success Defined?

- Changed the discussion from "number of providers" to *utilization of services*
- Any change, fee, administrative or workforce augmentation should have a positive affect on *utilization* as well as recruitment of providers

Work Force Solutions

- Currently the Committee believes there is enough capacity in Connecticut to adequately address the issue
- Private practice model should be maximized before augmentation of the current work force
- While these are our findings, legislators and policy makers want to increase providers regardless of their effect on Access
- Committee went back and asked the question which models made sense

Workforce Models

Making Sense of Alphabet Soup

Models

- EFDA-Expanded Function Dental Assistant
- CDHC-Community Dental Health Care Coordinator
- ADHP-Advanced Dental Hygiene Practitioner
- DHAT-Dental Health Aid Therapist

EFDA

- No recent studies that show any positive affect on Access
- Used properly increases productivity and net
- Mostly used delivering prosthetic services

CDHC

- ADA's version of a dental extender
- Recruits from the community of interest
- Only model that works from education/prevention paradigm
- Does not diagnose or treatment plan
- Lacks support and buy in from government, policy makers and health foundations
- Pilot studies on going anyway, funded by ADA

ADHP

- True mid-level provider
- 2-3 year Masters program
- Same scopes as a dentist-Diagnosis, Treatment plan, restorative, simple exo's , minor ortho movement, prescriptive ability independent of a dentist
- 12-18 months short of a dental school education
- Exist internationally
- Not recruited from community of interest
- Affect on target populations minimal and migrates into private sector due to costs of education and lack of government funding
- Major Health Foundations have not bought into this model

Dental Therapist

- Two year post high school training
- Duties include prophylaxis, restorations, pulpotomies, stainless steel crowns, exo of primary teeth
- Procedures must be performed to the same standard of care of a dentist
- Recertification every two years
- Recruited from within the community of interest

Educating CSDA Members

- 6 week education campaign to CSDA members in preparation for November 2009 House of Delegates
- Each week, information on one model forwarded to members electronically
- At the end of 6 weeks, member survey disseminated; included workforce models

CSDA Recommendations

Committee Recommendations

- Fast track motivated students into UCONN Dental School where they and the public would benefit from a full dental education
  - More cost effective than private hygiene schools
- Hygienists are important frontline assessors of oral health
- CSDA recommends training hygienists in Intermediate restorative technique(ITR)
  - ITR is safe effective technique
  - Easy to train effect would be immediate
  - Final diagnosis and treatment rendered by a dentist

Committee Recommendations

- Access Committee believes that the Dental Therapist model will be the emerging work force model in the near future
- HOWEVER, CSDA ***not convinced*** this model is needed in Connecticut
- Therapist model must be pilot tested to examine efficacy before it is adopted

Any Dental Extender In CT MUST:

- Function under the supervision of a dentist
- Not diagnose or treatment plan
- Function mainly in Public Health settings
- Enhance Capacity and Increase Access
- Have support from major health foundations

How do we close the gap?

- School based clinics
  - Address kids who cannot access the system through traditional means
  - Captured audience
  - In Connecticut 80% of kids need prophy and sealants
  - Foster partnerships between private dentists, clinics and FQHCs to care for the 20% of kids needing restorative care

Final thoughts

- Change is coming in dental work force; additional ADHP/midlevel legislation expected in CT
- Regardless of the provider, adequate government funding is a MUST in order to affect Access
- Increase utilization=Increase government expense
- Paradigm should shift *to* Education/Prevention/Treatment
- Adults and Elderly remain problematic

Thank You!