Impact of Dental Therapists on Federally Qualified Health Center Finances

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National Advisory Committee
Organization

- Goals
- Access Problem
- Background Information
- Methods
- Results
- Discussion
- Policy Implications I - Researchers
- Policy Implications II - PEW
Goal

- Estimate Impact of Dental Therapists (DT) on FQHC Productivity and Finances Treating Children
- Develop Economic Model FQHCs Can Use to Estimate Financial Impact of DTs
28.5 Million Children Enrolled Medicaid/CHIPRA
<30% Utilization for Ever Enrolled
55% Medicaid Utilization - 7.2 Million More Children Need Care
Background
Dental Therapists

- Training Models
  - Alaska
  - Minnesota
  - International
- Services
- Delivery Settings
- Supervision

**Primary Services**

- Screening Examinations
- Prophylaxis Children
- Caries Prevention
- Local Anesthesia
- Restorations
- Simple Extractions
- Impressions
- Pulp Caps/Pulpotomies
Dental Therapists

- Descriptive Literature – UK, Australia, NZ, USA
  - Well-accepted by children and adults
  - Mainly used in school systems
  - Work part-time in private practices
  - GPs claim difficult to cover DT overhead
  - Limited numbers of DTs
  - Few quality studies but technical quality restorations appears adequate
FQHC Dental Clinics, 2009

- 820 FQHCs Provide Dental Care
- Some FQHCs with Multiple Delivery Sites
- Employ 2,500 FTE Dentists, 1,120 RDHs
- Treat 3.2 Million Patients
FQHC Dental Clinics

- Most Clinics <5 Operatories
- 50% Patients under 19 Years of Age
- Payers: 70% Medicaid; 17% Indigent
- Less Productive Private GPs Because Fewer Chairs/Staff per Dentist
- Some Clinics Operate as Efficiently as Best-Run Private Practices
CT FQHCs

- **School-Based Care, 2009**
  - Schools with low income children
  - Consider FQHC patients for reimbursement rate
  - Hygienists screen, provide preventive services
  - 35-40% children require dentist services
  - Restorative care in FQHCs or schools
  - Status: 200+ schools, 12,000 children
Methods
Data

- Partner National Network for Oral Health Access
- Solicit FQHCs with Electronic Records
  - Patient visit data
  - Financial data
- Present Data from Connecticut and Wisconsin
Assumptions

- DT Paid $40/hr and Dentist $80/hr
- DT Wage Rates > Hygienists, so Hygienist Provide Usual Services
- No Supervision Costs
- DTs Provide All Services Trained to Do
- Services Valued at Market Level Fees
- Dentist Salary/Benefits 25%-30% Clinic Expenses
Results
## Number & Value DT Services

<table>
<thead>
<tr>
<th>Services</th>
<th>CT</th>
<th>Value (ooo)</th>
<th>WI</th>
<th>Value (ooo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restorations</td>
<td>5,427</td>
<td>$794</td>
<td>5,682</td>
<td>$1,103</td>
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<tr>
<td>SS Crowns</td>
<td>121</td>
<td>$36</td>
<td>130</td>
<td>$28</td>
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<tr>
<td>Pulp Services</td>
<td>254</td>
<td>$38</td>
<td>152</td>
<td>$23</td>
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<tr>
<td>Extractions</td>
<td>1,021</td>
<td>$141</td>
<td>607</td>
<td>$84</td>
</tr>
<tr>
<td>Subtotal</td>
<td>6,823</td>
<td>$1,000</td>
<td>6,571</td>
<td>$1,138</td>
</tr>
<tr>
<td>Total Child Care</td>
<td>39,951</td>
<td>$2,660</td>
<td>55,259</td>
<td>$3,826</td>
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<tr>
<td>Total All Care</td>
<td>167,691</td>
<td>$9,217</td>
<td>163,091</td>
<td>$14,563</td>
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</table>
## Annual DT Savings

<table>
<thead>
<tr>
<th>Variable</th>
<th>CT (000)</th>
<th>WI (000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Services</td>
<td>$9,217</td>
<td>$14,562</td>
</tr>
<tr>
<td>Child Services</td>
<td>$2,660</td>
<td>$3,826</td>
</tr>
<tr>
<td>Services Provided by Dentist</td>
<td>$999</td>
<td>$1,002</td>
</tr>
<tr>
<td>Dentist Services Replaced by DT</td>
<td>$299</td>
<td>$300</td>
</tr>
<tr>
<td>DT Total Savings</td>
<td>$149</td>
<td>$150</td>
</tr>
<tr>
<td>FTE Dentists</td>
<td>14.4</td>
<td>19.0</td>
</tr>
<tr>
<td>DT Savings/Dentist</td>
<td>$10,412</td>
<td>$7,918</td>
</tr>
<tr>
<td>DT % Children Services</td>
<td>5.6%</td>
<td>3.9%</td>
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</tbody>
</table>
DT Savings School Program

- **Delivery Model**
  - Hygienists provide preventive services and identify children need dentist services
  - DTs substitute for dentists providing care in schools

- **Upper Boundary Savings**
  - Save $80,000 per dentist
  - DT save 5% total school program costs

- **School Program Reduces Per Patient Costs from $500 to $250**
Goal – Increase Medicaid Child Utilization to 55%
7.2M More Children Need to Obtain Care
2.5 Million with Caries etc.
Require 1,200 Dentists or DTs
@$250/Child Need $1.8 Billion
Discussion
FQHC Four Walls

- DTs Positive but Limited Impact FQHC Finances
  - Most children healthy - not require many DT services
  - Dentist only account 25% clinic expenses
- Other Barriers Use DTs in Clinics
  - Space
  - Training
  - Management
Opportunities for DTs

- **FQHC – Four Walls**
  - DT staffed satellite clinics in frontier areas (i.e., Alaska)
  - Open dentist positions cannot fill

- **FQHC - School Programs**
  - Minimal financial barriers
  - Low capital investment
  - Reduce social access barriers
  - Major reduction disparities
Conclusions

- DTs in FQHCs Have Limited Financial Impact for Children
- DTs Have Greater Potential in School-Based Programs Run by FQHCs
- Findings Support International DT Literature
- Yet, Never Underestimate American Creativity
Policy Implications
Policy Implications I

- Need More Research
  - Estimate DT impact on FQHC adult patients
- Premature to Develop Training Programs for Several 1,000 DTs
- Need Demonstration Programs to Assess Impact of DTs in Different Delivery Arrangements
Policy Implications II—Pew thoughts

- This analysis is a good beginning. More research is needed to determine impact of therapists on all services and with all ages.
  - 53% of FQHC patients are adults.
  - 48% of services therapists can provide are diagnostic and preventive
  - Analysis looks only at restorative services and at children

- Focus needs to be on the impact on the entire dental system
  - Enabling services and social support critical to success
  - Therapists and other models may have impact on prevention
Policy Implications—Pew thoughts

- FQHCs need solutions to chronic workforce shortages. New providers could help.
  - 39% of rural FQHCs have a dental vacancy as of 2010, up from 26% in 2006
  - Shortages persist, but vary according to the economy
  - FQHCs may prefer therapists to hygienists; offer more flexibility
- FQHCs likely to see influx of new patients due to the affordable care act. Are they ready?
  - 5.3 million more children will have dental coverage by 2014, most with Medicaid and CHIP
  - Current safety net serves only about 10% of underserved
Policy Implications—Pew thoughts

- Medicaid coverage is a key issue in deployment of any new providers.
  - States need to ensure that clinics can bill for their services
  - Adult dental Medicaid benefits are a critical issue for FQHCs. Could new providers limit losses for adult care?
- Little is known about programs outside the 4 walls.
  - FQHCs may need training to plan and operate them
  - Potential for new sites (nursing homes, retail clinics)
- Research is needed to estimate impact of other models (CDHC, advanced hygiene models)
  - Would a combination of models help reduce costs and improve health outcomes in a community?