Oral Health Care Workforce Policy: Innovation, Tradition, and Challenges

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Why vision matters

Vision → Strategies → Plans
Vision: Improving the Oral Health Care Delivery System

Possible Areas of Strategic Focus

- Workforce shortages, distribution, cost of education
- Access to care
- Oral health disparities
- Financing streams and costs of care
- Delivery of evidence based solutions
- Isolation of dentistry

One Strategic Approach: The Workforce

• Why focus on the oral health workforce?
  – Labor is a fundamental component of the health care system
    • *Both as an investment and a cost*
  – The workforce is impacted by every system element
  – Evolves as science, regulation, society change – has the ability to make changes
  – May be an explicit strategy – or may be imbedded within strategies focused on other key issues
Overview

LEARNING OBJECTIVES

1. Understand the **policy environment** for health workforce proposals, laws and regulations, and practice
2. Review trends in the dental workforce and understand the implications for the safety net sector
3. Discuss the range of policy tools and options to improve the supply, utilization and effectiveness of the dental workforce
4. Evaluate the various workforce proposals and policy items in the context of improving oral health care services in the safety net sector
Current Policy Environment

- Health care reform will roll out over next 2-4 years
  - Increase funding for safety net services (NHSC, FQHC, Medicaid)
  - Changes for dental sector yet unclear and evolving
- Broader push for inter-professional education and practice
  - PCMH, Collaborative Practice Models
- Financing models changing, cost reduction still elusive, quality and value are paramount
  - ACOs, Bundled payments, outcomes based, accountable
- Changing practice models will be the key to meeting these challenges
What is a Practice Model?
Workforce Regulation: Scope of Practice*

- Legislated and regulated at state level
  - Exceptions are US Military, VVA, IHS
- Wide variation, based on lawmaking processes not evidence of quality, access or cost
  - Several promising state models to de-politicize process
- Inefficiencies occur when providers are not utilized to their full capacity in terms of education, training, & competence
  - Collaborative practice models have evolved as compromise between autonomy and supervision
  - New technology, travel, means of communication enhance ability to expand the delivery of health care services

*Dower et al, 2007 Promising Scope of Practice Models for Health Professions, Center for the Health Professions
Regulatory Decision-making: Scope of Practice*

• Propose a process for addressing scope of practice evolution that is focused on patient safety
  – Can a profession provide a proposed service in a safe and effective manner? Nothing else is relevant to the regulatory discussion
    • Protect public from unscrupulous, incompetent and unethical providers
    • Offer assurance to the public the provider is competent
    • Provide a means for discipline
  – Foundation in four areas ensures public interest being served:
    • a) established history, b) education and training, c) supporting evidence, and 4) appropriate regulatory environment

*Changes in Healthcare Profession’s Scope of Practice: Legislative Considerations
Financing and Workforce*

- Finance policy at federal, state and private levels has major influence on workforce
  - Encounter rates, FFS, HMO services- all incentivize the workforce differently and have positive and negative outcomes
- New models, including primary care medical homes, accountable care organizations, seek to bundle payments for services, or provide episode based payments **focused on outcomes**
  - Defining and measuring outcomes in dentistry continues to be a major challenge

Dental Education Policy

• Supply, experiences, practice location, debt…
• Expansions of dental schools
  – A dozen or so more on horizon, in southwest, northeast
• Reformulating dental education
  – RWJ Pipeline to Professions Program
    • Increasing community rotations, class diversity
    • WA – Regional Initiatives in Dental Education
  – Arizona School of Dentistry and Oral Health
    • New model of recruitment and training. 25-30% of first graduating classes are employed in community health centers
Organizational Policy

• Accreditation and regulation of organizations
• Payor requirements
  – i.e. 330 Grant requirement
• Education program decisions
• Professional association policy and advocacy
• Research / Foundation led innovations
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Trends in the dental workforce

The Surgeon General’s 2000 Report expressed “concerns about a declining dentist-to population ratio, an inequitable distribution of oral health care providers, a low number of underrepresented minorities applying to dental school, the effects of the costs of dental education and graduation debt on decisions to pursue a career in dentistry, the type and location of practice upon graduation, current and expected shortages in personnel for dental school faculties and oral health research, and an evolving curriculum with an ever expanding knowledge base”
National workforce strategies

• Surgeon General’s 2003 Call to Action identified three goals for the dental workforce
  – Diversity, Flexibility, Capacity
• What progress has been made since 2000?
  – Increase *diversity* in dental education
  – Expand *capacity* within the public sector
  – *Flexibility* in workforce and in practice model?
    • New workforce models in dentistry and medicine
    • Alternative or mid-level provider expansion

Expanding the Role of Dentists

• Electronic medical records allow for
  – Expanded approaches to interdisciplinary disease management

• Use of teledentistry and community based modalities
  – Can increase access, efficiency of population based interventions and use of risk management

• Expanding evidence base
  – Need for design and management of systems to implement, track and report best practices and oral health outcomes
Expanding overall system capacity

• Developing roles and tools for physicians, nurse practitioners, nurses, social workers
  – the risk assessment, prevention and education, identification of oral disease, appropriate referrals and in some cases treatment
• The 2010 Patient Protection and Affordability Act
  – Expansions of funding to FQHCs
  – Demonstration projects for new workforce models
  – Expanding Medicaid eligibility and requiring pediatric dental benefit
Changing Dental Workforce Models

• Two states (AK, MN) have dental therapists
  – DHAT in AK – DT and ADT in MN
  – Model used in over 30 other countries in world, general focus on pediatric dental care – education, preventive and basic restorative care

• Most states now have multiple levels of dental assisting
  – entry, licensed/registered, expanded function

• 31(?) States now have ‘direct access’ to hygienists
  – Scope of practice is variable – have been actively pursuing new opportunities for over 90 years

• Small number of states have denturists
Current & Proposed Workforce Models

- Community Dental Health Coordinator (CDHC)
- Advanced Dental Hygiene Practitioner (ADHP) & Minnesota Oral Health Practitioner (OHP)
- Pediatric Dental Therapist & Dental Health Aide Therapist (ANHTC)
- Independent hygiene, public health hygiene and assisting, extended function hygiene and assisting
- Each is rooted in an organizational agenda and each has its own advantages and drawbacks
Understanding ‘new’ workforce models

• 3 basic categories of change
  – Expanding scope of practice of existing providers
  – Changing supervision requirements for existing providers
  – Developing new providers (scope and supervision)

• Goals*
  – Increase access to more services in more places
  – Create a more culturally competent workforce
  – Career ladders for allied personnel
  – Cost effectiveness of care
  – Strengthen the dental safety net

*Edelstein B. *Training new dental health providers in the US. *Battle Creek, MI: W.K Kellogg Foundation; December 2009.
Implications for safety net

• Must tie policy agenda to organizational or association vision, strategy and goals
  – How you approach dealing with each of these issues will depend on what practice model you are promoting

Examples:
  – Existing model: increase provider supply and reimbursement
  – New model: train existing providers differently and reimburse different services
Typical questions reframed

• Do we have enough?
  – Markets tend to response – nursing increased capacity in 18 months and now is oversupplied – same with dental hygiene
  – *Do we have the right people in the right places?*

• Who will be in charge?
  – Control does not = quality and does not = leadership.
  – *Is there a collaborative team approach with outcomes focus?*
Typical questions reframed

• Does the workforce have adequate skills?
  – Dental education is expanding, but is the educational model changing?
  – *How do we ensure continued competency and use of updated knowledge?*

• Are we meeting demand?
  – Focus on those seeking care
  – *How do we address needs of the population in a way that reduces demand and improves health*
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Questions policy makers may ask regarding workforce issues

- Needs assessment – baseline data – where are gaps in service?
- Current infrastructure – education and workforce – what can you build from?
- Delivery system analysis – where would new skill mix fit?
- Financial resource analysis – how will services be paid for?
- Political landscape assessment – is change feasible?

Dimensions of the debate

- Training/skills (=quality ?)
- Agendas / Turf
- Politics / Stakeholders
- Filling specific needs, overcoming barriers
- Public/private disconnect

Left out:
- Appropriate payment mechanisms
- Evidenced based care - CQI
- Effectiveness of top down vs. bottom up innovation
  - Changing laws to enact new jurisdictions vs. changing laws to allow for more innovation
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Questions for Safety Net Dental Leadership

• How can the new provider type fill an organizational or system need?
  • *Access to care / Health disparities*
    – Efficiency
    – Geography
    – Cultural
    – Behavioral

  – What dimension of the problems you’ve identified are going to realistically be solved?
    • By workforce? By concurrent strategies?

  – What metrics are you going to use to measure the impact of a change?
Evidence to date

• Quality
  – Studies dating back to the 1950’s have shown consistently that non-dental providers can provide equivalent or better quality care with training
    • Quality is defined as technical competence…

• Productivity
  – Literature on has documented productivity of extending capacity in various settings
    • New studies being done on FQHC by Bailit et al. and on private practice by Scott et al. – Funded by Pew
Evidence to date

• **Costs**
  
  – Allied providers tend to ‘cost’ less than dental providers, but evidence as to reducing cost of care is mixed due to settings and patient populations
  
  – Whose costs?
    
    • *Patients* – *cost in time, pain*?
    
    • *Payors, - lower payments for same services*?
    
    • *Taxpayers* – *value for dollars*?
    
    • *At point of service, for state (regulation), for education*
Evidence to Date

• Access to (what?)
  – Evidence varies by the “what”
    • *Utilization of care by patients previously unable to get care*
    • *Health outcome data is not available in most cases*
      – *New models are being evaluated*
    • *Dental coverage – may or may not impact provider availability*
      – *depends on coverage structure and acceptance*
    • *Type of care:*
      – *Education, Prevention, Basic Restorative, Advanced Restorative*
Reducing oral health disparities through workforce innovations

Example of evaluative approach:

• Does the current workforce contribute to the problem?

• How might changes to the workforce be a strategy to overcome those contributing factors?

• How would we measure medium and long term impacts of workforce innovation on reducing oral health disparities in access and/or health outcomes?

1. Racial/Ethnic Minority Health Status Issues  
   (i.e. preventable morbidity & premature mortality)
2. Racial/Ethnic Health Disparities
3. Need for a Systems Approach

1. Increased quality and years of healthy life for racial/ethnic minorities
2. Reduced and, ultimately, eliminated racial/ethnic health disparities
3. Systems approach to racial/ethnic minority health improvement and health disparities reduction

A STRATEGIC FRAMEWORK FOR IMPROVING RACIAL/ETHNIC (R/E) MINORITY HEALTH & ELIMINATING R/E HEALTH DISPARITIES

(Source: Office of Minority Health, U.S. Department of Health and Human Services, January 2008.)
Parting thoughts

• The workforce should be assessed at all levels with reference to effectiveness of interventions and oral health outcomes
  – Access, disparities not just technical precision

• Ability to maximize workforce utilization is essential within existing and new models
  – Under-employment of many assistants and hygienists

• Organizational assessment of patient needs is most rational driver of workforce innovation
  – Incremental approach to change is not supported in regulatory environment
    – If you build it, will they come?

• Leadership is critical in managing change
Opportunity for Positive Change

• Capitalize on current pressures to overcome institutional and organizational inertia

• Provide organizational venues for some innovation in care delivery
  – Cost and quality progress are possible

• Steer the dominant professions toward more accountability and team based approaches to care delivery

• No shortage of need for dental care in the population
More Information At

http://futurehealth.ucsf.edu

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