New Mexico Dental Therapy Task Force 4 Sept 2015 Meeting Notes

Summary

The Task Force met at the Cesar Chavez Community Center in Albuquerque. Five of the six New Mexico Dental Hygienist Association (NMDHA) representatives, all of the New Mexico Dental Association (NMDA) representatives, and three of the five legislators attended. The meeting commenced at 12:15 pm and concluded about 5:45 pm.

As an introduction, the participants were asked to

- identify themselves
- state what had brought them to the Task Force
- share their hopes they had for the first meeting.

The responses to the last point were typically positive:

> "A conversation engaging directly with all players"
> "Create dental health for rural New Mexicans; "
> "Hope we can come together; "
> "Able to move forward, so we can work on other issues."

The bulk of the meeting consisted of three small-group discussions, designed so that the members of each association could meet and talk with all the members of the other team, as well as the three legislators present.

Three questions were presented for the discussions:

> 1. Which problems (not solutions) outlined in the Memorial are high-priority issues?
> 2. How can Dental Therapy address these issues?
> 3. What issues must be addressed by other means? What are complementary or alternative means?

Points of general agreement:

1. There are a number of barriers which affect New Mexicans' access to dental care.
2. A form of Dental Therapy could be part of a comprehensive approach to dental care in NM.
3. A low rate of reimbursement and difficult bureaucracy discourages many NM dentists from accepting Medicaid.
4. Existing programs could be expanded to meet more needs of New Mexicans.

Which problems (not solutions) outlined in the Memorial are high-priority issues?

Task force members were asked what they felt were high priority issues from the memorial. There was a strong consensus that there was a lack of services in rural areas. A number of barriers to service were identified and general agreed upon:

- Distance from dental providers.
- Poverty.
- Office hours that don't accommodate working families very well.
- Lack of education regarding the need for dentistry.
- Delay in treatment so simple problems become compounded. Reliance on the ER.
- Low payment schedule for Medicaid.
- Difficultly receiving reimbursement from Medicaid due to bureaucracy.
- Difficulty keeping dentists in rural areas.

There was discussion in the need for data regarding the number of dentists in New Mexico and their distribution. It was agreed that data would be more closely examined and evaluated by the Task Force.

It was also noted that even in urban areas, there was a shortage of dentists that accept Medicaid. This was also attributed to:

- Low payment schedule for Medicaid.
- Difficultly receiving reimbursement from Medicaid due to bureaucracy.

How can Dental Therapy address these issues?

A number of members felt that Dental Therapy (DT) could be part of a solution to these issues.

- Dental Therapists could provide coverage in rural areas that are not well served.
- DTs can decrease costs.
- Decreased costs could benefit urban populations that rely on Medicaid.
- DTs can improve prevention which mitigates emergency situations.
- Increased access to dental care for those in need.

Related discussion included:

- Some discussed expanding the scope of practice for Registered Dental Hygienists (RDH's) or utilizing Expanded Function Dental Assistants (EFDA's) more.
- The Indian Health Care Improvement Act envisions for Dental Therapy on tribal lands, but the tribes must coordinate with the state.
- Some areas a DT could serve the needs; in other areas a CDHC would be valuable.
- DT would have more education than a DA who is also a CDHC.
- Hygienists are currently underutilized but could train and become DTs to provide more coverages.

Concerns included:

- Some questioned how to keep Dental Therapists in rural areas.
- The cost of opening a new clinic could still be high, so the cost of procedure might still be high.
    - Some felt the cost could be lessened depending on the scope of work as equipment for surgical procedures is expensive, but some of the other procedures less so.
- Most felt that there were other parts to a solution as well Dental Therapy.

3. What issues must be addressed by other means? What are complementary or alternative means?

Members discussed other barriers to dental health in rural areas, as well as Medicaid patients in urban areas. Complimentary measures included:

- Financial incentives for DTs to stay in rural areas.
- Medicaid reimbursement could be increased.
- Medicaid is difficult to interact with to receive reimbursements and that could be improved.
- Reduced barriers to getting rural health care tax benefit.
- Elementary schools could require students to have a full checkup prior to entry, to improve education.
- Increase funding for school sealant program.
- Require fluoride in community H_2O.
- Smoking cessation program.
- Removing collaborative practitioner billing barriers.

Members discussed some alternatives:

- Expanding practice of RDH's or EFDA's. Various models of collaboration and supervision were discussed.
    - It was pointed out that the Indian Health Care Improvement Act used the term Dental Therapist.

Meeting Attendees

Task Force Members—(* unable to attend)

From NM Dental Hygienist Association:

Cathy Sovereign	Christine Nathe	Pamela Blackwell
Barbara Posler	Pete Jensen	* Lionel Candelaria

From NM Dental Association:

Michael Law	Joe Valles	Dale Goad
Kimberly Martin	Julius Manz	Tom Schripsema

Legislators:

Sen Benny Shendo, Jr	Rep Dennis Roch	* Rep Sharon Clahchischilliage
* Sen Daniel Ivey-Soto	Rep Debbie Armstrong	

Observers--

Michael Moxey-- NMDA	Michael Bird-- AARP
Lucia Delgado-- NMDHA	Colin Baillio-- HANM
Debbie Maestas-Traynor-- NMDHA	Mary Ellen Smith-- HANM
Erik Lujan-- Pueblo of Ohkay Owingeh	Tara Marie Hedrick-- HANM

Transcription of Notes from Small Groups—Unedited

Note: These are <u>not</u> complete transcripts of the conversations that took place, in the smaller or larger groups. (*NB: * denotes action items – call for data or other information; ** denotes important points in discussions*)

<u>Responses to Question #1—Which problems (not solutions) outlined in the Memorial are high-priority issues?</u>

Domino effect—Address the cause then subsequent solutions come

** Poverty is the biggest barrier!

* Facts—Reports on Dental needs and shortages in NM, Valete,

Why patients seek care,

Sovereignty of Indian Health Dental Care

"Health Care Services shortage"—Disagreement on data and the reality of actual "shortage."

Agreed that there are barriers to access, including Medicaid payment (willingness of dentists to accept Medicaid), office hours, prefer ER, live too far away, fear, poor distribution of dentists.

Dental Hygienists under-utilized—Agreed

* Shortage—with data

Is there a shortage? How will providers stay in underserved areas? How will it be funded?

* Want documentation of dental health care services shortage: Federal Health Resources & Services Administration, NM Healthcare Workforce Committee

In approximately 4 years, there may be a Dental School in Las Cruces by a private entity. Needs to graduate first class of the Medical School before Dental School can open.

Have students in the WICHE [Western Interstate Commission for Higher Education] program who will come back into the workforce.

There still will be areas that have an access problem.

* Need to find out from the entire group what reports are current and accurate.

Key is prevention: Need to start with children so they can value dental care.

Reasons dentists have dropped out of the Medicaid/Medicare plan

No mandate for people to have care done—see the same decay over and over. Have to double-book schedule

Why do some people not utilize the services—do not see the value yet. Need to have generations getting care.

Repayment of loans only requires provider stay in community for a limited time.

* NM Dental Board's regulation of DT, Tribal lands and other areas in NM? Need to research this. Sovereignty issues.

Why do people live in rural areas? What do they value about these areas?

School-based care difficult to sustain. Need jobs as well.

Guarantee to keep DT in the underserved areas? How is this done?

Financial considerations need to be addressed.

Need RDH educated to the level that they can meet the needs in rural areas. Need policy & funding:

- Advanced level RDH?
- Already have EFDAs: Utilize these more?
- Code for this provider to "diagnose" without the DDS not being able to bill for Dx.
- 400 hours—not enough hours for competency for their scope?
- Need different courses at the level for DDS to be able to diagnose and treat?
- Need Medicaid reimbursement increased.

<u>Priority Issues—</u>

Scope, education, supervision, and the regulation of these providers.

Funding for services

Documentation of shortages

<u>Responses to Question #2—How can Dental Therapy address these issues?</u>

DTs can decrease costs by improving prevention and mitigating emergency situations

DTs could decrease likelihood that folks go without care, but need a guarantee they stay in underserved areas, perhaps through practice settings.

* Need whole dental team

Dental Therapists can increase the supply and distribution of dental services, though Dental Therapists are not the "end all and be all" to solving the access issues.

Terminology: Expanded Function RDH [EFDA], Collaborative Practice

There are pockets in communities (rural and urban) that could benefit from this provider.

Those with high need would have access.

Similar to CNP and Pas, economics affects their ability to stay in business.

Medicaid expansion—can all who qualify get care?

Model where providers can work where people already are; i.e., schools, hospitals,

A CDHC can do some limited care.

Advanced education RDHs have the credentials to go into alternative practice settings—would DT be more willing to serve in underserved areas?

** If funding is there, DT could be given incentives to live in rural areas.

DT would have more education than a DA who is also a CDHC.

Some areas a DT could serve the needs; in other areas a CDHC would be valuable.

** DT could be part of an overall access problem—a question of resources.

Expansion of Collaborative Practice RDH model.

<u>Responses to Question #3—What issues must be addressed by other means? What are complementary or alternative means?</u>

Increase Medicaid payments for dental care.

Reduced barriers to getting rural health care tax benefit.

DDS loan forgiveness for rural service.

* Possibly expand RDH practitioner program:

- Conjunction DMD-contracted
- Indirect supervision
- Prevention
- Education to community
- Advanced training—perhaps Masters
- Limited scope to be the dental home
- Reporting requirements
- Loan forgiveness

84 Reform Medicaid payment and administration (billing) procedures

85 Increase reimbursement by Medicaid

86 Expanded hours [of dental services] to divert patients from ER

87 Expanded practice of Dental Hygienists (but only with in-person direct supervision)

88 Collaborative Practice Hygienists (expand numbers and make them billable

89 Expanded residency slots and rural placements

90 Better utilization of hygienists

91 Utilization of Community Dental Health Coordinators (CDHC)

92 Required dental exam prior to entering school

93 Increase funding to expand EFDA program at UNM

94 Procedures related billing, paperwork for Medicaid need to change.

95 If Medicaid is patterned after private insurance, it limits the incentive for getting care.

96 No incentive to get comprehensive, preventive care.

97 In Canada, DT education was funded by the government but these programs closed due to not
98 going to rural areas.

99 Can limit "settings" but not geographic areas.

100 RDHAP (RDH Advanced Practice) but only hygiene procedures, no restorative.

101 Need vs. demand/funds for care.

102 ** Negotiate global fee with the Managed Care Organization (MCO) (change of funding mechanisms
103 for Medicaid)

104 Comprehensive Bill to include a broader scope, to overcome other recognized barriers.

105 ** Medicaid: increase reimbursement, administration issues

106 ** Increase funding for school sealant program

107 ** Require fluoride in community H_2O

108 ** Smoking cessation program

109 ** Collaborative practitioner billing barriers

110 ** Incentive for CDHCV model

111 ** Increased DH utilization