RI EOHHS Healthcare Workforce Transformation Committee
HWT Oral Health 12/1/2016 (3:00 – 4:30 pm)
DLT Conference Room (73-1)

Facilitator: Rick Brooks
Presenter: Laurie Leonard, Program Manager, Oral Health, *Department of Health*
Prepared by: Cheryl Wojciechowski
Participants: Marie Jones-Bridges (RI Oral Health Commission), Michael Weitzner (UnitedHealthcare), Sam Zwetchkenbaum (RIDOH), Eric Franklin (CareLink/Wisdom Tooth Mobile Dentistry), Laurie Leonard (RIDOH), James Rajotte (RIDOH), Jim Berson (ProvPlan)

Agenda Item	Key Discussion Points
Welcome & Introductions	Rick Brooks opened the meeting with the purpose of the HWT Committee. The goal of the committee is to identify the workforce needs in the state as we transform the healthcare system and move toward the Triple Aim. One objective is to think about what the schools can do to better prepare their students and those already in the healthcare workforce. Rick went on to provide background on today's subcommittee meeting: The full HWT Committee met on October 7th to begin to plan strategies to transform Rhode Island's healthcare workforce development system. Elizabeth Roberts, Secretary, EOHHS, Nicole Alexander-Scott, MD, MPH, Director, DOH, Rebecca Boss, Acting Director, BHDDH, and Marti Rosenberg, Director, RI SIM Project each spoke to provide a sense of direction and the overarching goals derived from Reinvent Medicaid and SIM. Seven HWT goals were extracted from that meeting: 1. Primary Care 2. Behavioral Health: Practice & Integration 3. Social Determinants of Health/Cultural Competency & Diversity 4. Data Quality, Reporting & HIT 5. Community and Home-Based Care 6. Chronic Disease 7. Dental Care This Chronic Disease subcommittee meeting is the last of the seven. The full group will come together again on December 6th to develop concrete workforce development strategies with the likelihood of having the greatest impact and of being accomplished. In addition to these meetings JFF (Jobs For The Future) has been engaged to conduct an analysis of labor market data and best practices in workforce transformation, and interviews to follow-up on ideas from the subcommittee meetings. JFFs work will identify the most critically important issues and some best practice strategies to inform healthcare workforce

	transformation in Rhode Island. Rick added that this week the Governor announced an additional CMS fund matching authority that will support: work at state institutions of higher education to support system transformation in general, infrastructure for what Medicaid calls Accountable Entities (AEs), and also to support healthcare workforce development. The work of the HWT Committee is not just theoretical but will guide the use of those resources. The SIM operational plan incorporates the population health goals of the state and this will also be woven into healthcare workforce development.
Issue Overview (Laurie Leonard, Program Manager, Oral Health, *Department of Health*)	Laurie opened her presentation by reading from a letter from an individual from the National Alliance on Mental Illness to set the tone on the importance of oral health because it affects all aspects of life including overall health, school success, employability, etc. Laurie's presentation included the following highlights: **Reviewed Health System Goal: Expand access to dental care areas for improvement** **1. Establish licensure &/or education requirements for:** **• Dental Assistants** **• Laboratory Technicians** **2. Increase the number of dental residencies (specifically oral surgery) and/or residency slots** **3. Establish/increase oral health training in non-dental healthcare education programs, such as MDs, RNs, LPNs, CNAs** **4. Establish referral system between dental providers & non-dental healthcare providers** **5. Change Medicaid reimbursement structure from fee-for-service to managed care** **6. Increase opportunities for population-specific education for current oral health professionals; ideas include:** **• Special needs** **• Pediatrics** **• Cultural Competency** **• Geriatrics** **Access to Dental Services for RI Children: Why Dental Insurance Coverage Matters** Data is collected was from the BRFSS (Self-reported by kids under 18 seen in last 12 months) and Medicaid claims. Both showed that fewer children on Medicaid receive dental services than those with private insurance. **Access to Dental Services for RI Adults: Why Dental Insurance Coverage Matters** Data shows a similar pattern as for children. Fewer adults on Medicaid receive dental services than those with private insurance. **Access to Dental Services for RI Adults: Why Dental Insurance Coverage Matters (Benefits ≠ Access)**

	Data shows an increase in ED claims for adults on Medicaid suggesting that providing dental coverage will reduce ED claims. **Dental Workforce – Dentists** • **572 dentists practice in RI, or 54 dentists per 100,000 residents (2015)** • **RI's dent:pop ratio is ↓ than national average (61:100,000)** • **RI's dent:pop ratio is 2nd lowest in New England, following Maine** • **Rhode Island's dentist ratio has had a decreasing trend for the last 15 years, while US overall & most of other New England states' ratios have increased** **Dental Workforce – RDHs, DAs & Lab Techs** Supervision for Registered Dental Hygienists (RDH) is more restrictive in Rhode Island. Here they must work under a dentist. A new law will allow RDHs to work offsite from a dentist's office but must be affiliated. Use of RDHs in this manner is a potential strategy for increasing access to dental services. **Dental Workforce – Medicaid Participation** Laurie pointed out that in 2012, 6 dental practices accounted for 45% of all Medicaid claims payments and most if not all of these practices are Federally Qualified Health Centers (FQHCs). **Dental Education in Rhode Island** Laurie explained that dental residents choose an area of specialty to learn more about after finishing dental school, and that dental residencies are not required. The residencies are paid for in various ways including federal dollars. **Dental Education in Rhode Island – Population Specific** Laurie described the RI Dentistry Mini-Residency Program that RIDOH has been convening annually for 10 years. These educational opportunities focus on underserved populations. It was pointed out that the CEU requirement for dentists 40 per year. A participant asked if corrections provides dental services and the answer is yes. Another participant asked if nursing homes provide onsite dental services. Participant Eric Franklin of CareLink described the Wisdom Tooth Mobile Dentistry program that provides limited dentistry onsite to 50 nursing homes. Nursing homes are required to provide access to dentistry so if they cannot transport a resident offsite they provide onsite. Another question was asked about dental services within the refugee health program. St. Joe's dental clinic services mostly children and now sees some of the adult refugees that come through the program. **Dental Education in Rhode Island – Non-Dental Health Providers**

	Laurie pointed out that nursing students at RIC come to RIDOH to receive 3 hours of training annually and that this is the first year that oral health will be included. **Referral System between Medical and Dental** Laurie pointed out that there is currently no formal referral system between private medical and dental providers and that only some community and/or hospital-based health centers have internal referral systems with few written into internal policies.
Large Group Discussion of Workforce Strategies	Rick opened the discussion by focusing the discussion on concrete recommendations to help drive healthcare workforce transformation, expand access to dental services, and integrate oral health into the rest of the healthcare system. The group discussed proposed workforce strategies in a large group rather than breaking into small groups. The discussion included: ▪ The question was asked if oral health incorporated in AEs. The answer is that this is happening in other states. ▪ A participant asked about the average age of dentists in Rhode Island. Their concern is that the number of dentists in the state is decreasing knowing the average age of dentists could inform strategies to increase the numbers. It was pointed out that the ADA has data that shows dentists are aging. The point was made that the recruitment of dentists in Rhode Island is challenging due to reimbursement rates, both private and Medicaid. Furthermore, dentists that are considering relocating to Rhode Island are concerned about their spouses' ability to find employment in the state. ▪ A participant asked about the level of urgency for increasing the population of dentists in the state and a reply centered on the fact that about 50% of dentists are 50 years or older and that we should be focusing on this because it will take a while to increase the dentist population. It was also pointed out that a Maine dental school reserves 10 slots for Rhode Island students each year. Another comment focused on how the amount of debt that dental graduates face guides their decision on where to practice. ▪ It was acknowledged that Rhode Island does have dental shortage areas and that the general trend is for dental graduates that first work at an FQHC leave for private practices right after they have worked the prerequisite amount of time. ▪ James Rajotte (RIDOH) listed three areas for further discussion: 1. Developing an oral health or dental measure alignment set as a specialty or imbedded in primary care. This could be an incentive for ACOs or MCOs to work on increasing the supply of dentists; 2. Exploring the use of public health dental hygienists within Community Health Teams; and

	3. Including dental requirements in AE standards. ▪ A participant asked for the average dental patient load. The answer is 1.8K but that geographic distribution and socioeconomic distribution is more of an issue. ▪ Questions were asked about using RDHs for screening and referral. One idea is to consider mid-level clinicians like dental therapists freeing up dentists to work at the top of their license. Minnesota uses dental therapists and data shows an increase in access as a result. A question was asked about how current reimbursement rates would affect dental therapists. ▪ There was discussion about how the cost of setting up dental schools deters Rhode Island colleges from starting dental schools and that dental schools out-cost nursing schools. As a result dental school tuition is higher and graduates need to base their decision of where to practice on income that will be sufficient to cover their debt. ▪ The question of whether we have a profile of new licensees was asked. Laurie responded that they are mostly all new graduates and that she will obtain this information. ▪ A question was asked about whether high school seniors can enroll in dental hygiene classes at CCRI. It was thought that because it is a 3-4 year program with prerequisites that high school student can only enroll in the pre-requisite courses. Also, CCRI has more demand than they can meet resulting in full classes every year. ▪ One participant pointed out that hygienists often find it difficult to find employment. One reason is that many of the available positions are only part-time. Another participant added that some dentists say they cannot find hygienist that they want to hire. ▪ A concern was raised that dental hygiene graduates are geared more towards private practice and that their education does not prepare they to work in public environments. It was also pointed out that there is no easy step up to a master's in public dental health. Dental hygiene students at CCRI graduate with an associates and there is a link to RIC but only a handful of students have taken advantage and the degree at RIC is not concentrated in dental hygiene. ▪ It was pointed out that it is important to know if the problem is that we cannot keep existing dentists in the state or if not enough new graduates are choosing to practice here. This prompted a question that still needs to be answered about how many Rhode Island natives go out of state to dental school and do not come back.

	▪ A loan repayment program was discussed. And it was pointed out that new dentists in these programs work off their loan repayment at FQHCs and then go to other states or private practices. ▪ The importance of finding opportunities for older dentists that no longer want to run a practice but still want to practice dentistry was stressed. CareLink's Wisdom Tooth Mobile Dentistry program was cited as an example. ▪ Physician morale can be considered the fourth point of the "Triple Aim" and we should be mindful of how ACOs and such impact this. Insurers are getting pressure to assess the quality of dental practices in their networks. ▪ It was pointed out that a frustration for dentists at FQHCs is that they cannot perform all the procedures that they learned in school because Medicaid does not pay for them so they are not working at the top of their license. Most of those that leave FQHCs stay in RI but go to private practices that do not accept Medicaid. ▪ The relationship between ED diversion and the lack of dental benefits for adults enrolled in Medicaid was discussed. Willingness to develop and employ an adult benefit is critical. It was pointed out that it takes 6-10 years to see a benefit after beginning coverage of restorative procedures. ▪ Laurie pointed out that the oral surgery residency collaboration at Brown could be an option. ▪ Strategies for incenting the enrollment and recruitment of dentists to practice in RI was discussed. Suggested strategies include keeping dentists in FQHCs and advancing their skills, keeping older dentists working part-time, and adding dental therapists as a covered benefit. ▪ Dental therapists' role in private practice and how this could benefit dentists was discussed. They could bring more patients into a practice enabling dentists to work at the top of their license. In Minnesota, at least 50% of a dental therapist's patients must be covered by Medicaid. This could help with the access issue in Rhode Island. ▪ RI DOH will be finalizing the Rhode Island Oral Health Plan 2017-2021 by February 2017. Rick stressed that the plan should be integrated into the overall healthcare workforce transformation plan rather than crafting parallel oral health strategies. It was also stressed that we need to include other professionals from other healthcare disciplines. It was pointed out that included in the Oral Health Plan is including oral health in Current Care and APCD and a section on training for non-dental providers. ▪ Rick offered that as we crystalize our recommendations, interagency workgroups could be employed to drive the initiatives. Laurie agreed this would be integral.

	▪ What it would take to develop a dental therapist or master's hygienist program was discussed. Some thought it would be great to get a hygiene program back at URI as it was closed in 2006. Before 2006 one could earn a bachelor's at URI or an associate's degree at CCRI. Delta Dental has given generously to the CCRI clinic. The Rhode Island Foundation filters money from other donors. ▪ It was pointed out that in Rhode Island there is no minimum requirement for dental assistants. They can be hired without experience and receive on-the-job training and receive no infection control courses prior to work. They then need only one hour of this type of training after employment but this is not enforced. It was unclear if licensure would be a barrier for potential assistants, though a participant felt strongly that a patient's well-being is more important. One suggestion is to think about increasing what dental assistants can do with additional training as in other states. Other states require them to be licensed; as of 2014 in Massachusetts. In Rhode Island the Board of licensure wants to go for a registry rather than licensure but a registry list does not yet exist. CCRI assistants take the certification exam but those who do not have a degree and just receive on-the-job training do not take the certification exam. The question of whether insurers require licensure for assistants when credentialing dental practices was asked and the answer from one such participant was "no".
Next Steps	Rick Brooks thanked participants for their time and input and reminded the group that the next large HWT Committee meeting will be on December 6th.