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Expand Access to Oral Health Services

Too many Americans lack access to dental care, especially in underserved areas. Forty-four percent of people below the federal poverty level have untreated dental decay compared to just 9.5 percent of those above 400 percent of the federal poverty level.[1]

The consequences of untreated decay and periodontal disease – slowly destructive gum infections – include increased risk of cancers,[2] cardiovascular diseases,[3] Alzheimer's[4] disease, and pre-term delivery among pregnant women.[5]

Furthermore, poor oral health can change how people eat, work and live their lives.[6] Oral health reflects people's social determinants of health and can reinforce poverty.

People with tooth pain often present themselves at emergency departments even though EDs are poorly equipped to handle oral health issues. Emergency room visits for dental problems cost the U.S. health care system roughly $2 billion in 2015.[7] Thirty percent of dental related ED visits were from adults with Medicaid and 40 percent were by uninsured individuals.[8]

One reason for lack of access in some places – such as remote parts of Alaska – is a maldistribution of providers. A bigger reason in many areas, however, is that residents don't know how to access the provider resources that already exist. Even among those with employer-sponsored coverage, only 40 percent utilize their dental health benefits; and according to the Kaiser Family Foundation (KFF), there is little difference in dental visits between adults with Medicaid and the uninsured.[9]

People simply don't know how to navigate the dental health system, long held separate from the traditional medical system. And navigating an unfamiliar system full of dental terminology and clinical jargon can leave patients confused and underserved.

One way to ensure people are aware of existing dental care resources is to target grant funding for community-based approaches to dental care access. So-called community dental health coordinators (CDHCs), for instance, might be one promising model. Like their forbearers – community health workers – CDHCs focus on patient education, disease prevention, and health system navigation. CDHC programs build on the successes of community health workers but integrate dental health. They are not mid-level providers but rather navigators that help to educate patients and connect them to resources already available.

A LACK OF ACCESS TO ORAL HEALTH CARE PARTICULARLY IN UNDERSERVED AREAS

It's an accident of history that dental care is held separate from traditional medical care. When early dentists wanted to professionalize they sought entry into the Medical College at the University of Maryland. The physicians refused, and dentists set up their own line of study.[10] Today, that divide lives on.

There is a persistent and unmet need for dental care in the U.S. Roughly 114 million Americans[11] don't have insurance that covers dental health services, more than twice the number (46.5 million) who were didn't have health insurance in 2010.[12] The American Dental Association (ADA) found that only 37 percent of adults visited a dentist within the past year in a 2015 survey.[13] About a third of adults aged 20 to 44 have untreated dental decay.[14]

Traditionally, Medicaid was not required to cover oral health. However, after the implementation of the Affordable Care Act (ACA), children received preventative dental health services through Medicaid. Unfortunately, many children with dental coverage still don't use those benefits, and untreated dental decay continues to be a significant problem for children with public insurance coverage.[15] The Centers for Disease Control and Prevention (CDC) reports that one in five children between the ages of five and 11 have at least one untreated cavity.[16]

More Americans could benefit from increased access to dental health.

Oral health is interconnected with overall physical and emotional wellbeing. Early detection and prevention can mitigate the effects of dental decay and periodontal disease. Additionally, studies have found that the earlier people received preventative dental care, the less they spent, on average, on dental care.[17] People with bad teeth also face social stigmas and employment challenges. Employers report that bad teeth is a disadvantage for applicants of client facing opportunities.[18]

MAXIMIZE EXISTING RESOURCES TO IMPROVE THE ORAL HEALTH OF UNDERSERVED POPULATIONS

There is a shortage of dental providers in a few very remote areas of the U.S. In the case of rural Alaska, Alaskan Natives faced a dental health crisis as a result of too much sugar in their diets, lack of community water fluoridation and an extreme shortage of dentists – in 1998 there were only 20 dentists to serve more than 200 villages with some 85,000 people.[19] Because recruiting dentists to these isolated communities would have likely been an expensive, decade-long endeavor, policymakers created a new two-year training program for

"dental health therapists" to help fill in provider gaps. While this made sense in Alaska and helped to reduce[20] the rates of tooth extractions in these communities, elsewhere in the U.S. it's not just as simple as adding more dentists to the workforce, as those with and without coverage continue to forgo needed dental care.

Instead, community health centers all around the country are increasingly employing and partnering with dental health care workers. Roughly 80 percent of these clinics now offer dental services.[21] These clinics often provide free or discounted care to low-income communities – but potential patients often don't know that dental care is readily available at these facilities.

Often times communities don't need more dentists but rather, people need help finding and navigating the existing oral health resources and overcoming individual barriers to care. For example, a lack of awareness of dental benefits, how to find a quality dentist, and oral health literacy all prevent people from seeking treatment – as well as the ongoing perception that dental health is secondary to medical care.

In the 1970s, Community Health Workers (CHWs) evolved as frontline public health workers to help address health and social issues within their communities. Today, they serve as liaisons between health and social services and the community to help patients navigate the system and improve access, quality and cultural competency of service delivery. In 2018, the Migrant Health Services CHWs led a cancer prevention program which saved $3.16 for every $1 spent on Medicaid-eligible adults.[22]

Community efforts to expand access to dental care have built on these earlier models. A new type of health worker, known as the community dental health coordinator (CDHC), was developed to help patients better access dental care and navigate the health care system.

Like CHWs who help patients bridge the gap between clinical and community services, CDHCs provide community-based prevention, care coordination, and patient navigation to connect people with available services in their community.

CDHCs can work for health centers, private dental practices and schools to better connect patients with the care they need. They may be able to perform some preventative services such as sealants and fluoride applications, as their state licensing laws allow, but they are not mid-level providers and must work under the supervision of a dentist. Their main function is to help patients navigate the system and access care and programs that they may already be eligible for.

CDHCs typically come from the types of communities they will serve – underserved rural, urban or American Indian communities. They focus on oral health education and disease prevention, to help people in underserved communities manage their oral health. They connect patients with dentists who can provide treatment and pull together the other types of services that may also be necessary to access care such as child care, transportation or prescriptions.

There are CDHCs in communities across 40 states where they have improved care for patients with diabetes in tribal communities, increased access to private dental services in rural communities, connected pregnant women to care and conducted screenings, cleanings and sealants for children in school-based outreach programs.

Getting patients into care – and keeping them on track for their periodic preventive visits – can improve quality and decrease disease while reducing overall care costs.

FEDERAL POLICY LEVERS: TARGET FEDERAL SUPPORT FOR COMMUNITY-BASED MODELS TO IMPROVE DENTAL CARE ACCESS

To-date, community-based efforts to expand access to dental care have largely been privately funded. Most federal efforts to expand access has been about putting more providers into underserved areas and not necessarily about care coordination or increasing access to existing services.

There are a variety of ways that lawmakers can increase access to CDHCs.

Encourage the CDC Division of Oral Health to determine how CDHCs can implement sealant programs in school-based settings

The CDC Community Preventive Services Task Force recommends school-based sealant delivery programs because it is an effective way to reach millions of children. These programs help prevent cavities in school-aged children and save tax payer dollars in Medicaid. The CDC could work with federal authorities to engage stakeholders and determine how CDHCs can support education and preventative care in school-based settings.

Add CDHCs and oral health to Health Resources and Services Agency (HRSA) maternal and infant health home visiting program

HRSA funds voluntary home visiting services for parents with young children. They send nurses, social workers, or early childhood education experts into program enrollees' homes and have found public health and cost benefits. Integrating early dental screening and oral health education into the Maternal, Infant and Early Childhood Home Visiting Program, (MIECHV) could improve upon an already successful model.

Fund and research CDHC work in Community Health Centers

As discussed above, health centers also often integrate oral health services in certain areas with economic, geographic or cultural barriers that limit access to affordable health services. Community Health Centers should continue to expand their oral health services by partnering with CDHCs with cultural understanding of the population that the health centers serve. Further research on the effectiveness of these programs could help build support and improve the CDHC model.

Explicitly integrate oral health as a factor for the models chosen by the Centers for Medicare and Medicaid Innovation (CMMI)

Lawmakers could amend Section 1115(a) of the Social Security Act, which created the Centers for Medicare and Medicaid Innovation (CMMI) under the ACA. CMMI was tasked with supporting and testing new care models to improve outcomes. Lawmakers could amend the law to add the improvement of oral health among the goals for the models tested under CMMI's grants. The current language focuses on health system delivery and payment reform, but also encourages models aimed at specific populations or conditions (e.g. dementia) which could be interpreted to include ED diversion or other priorities related to the integration of oral health into primary care settings.

STATE POLICY LEVERS: ENCOURAGE STATES TO EXPAND ACCESS TO CDHCS UNDER MEDICAID

Have the dental option for the "Medicaid Health Homes" be in areas of dental shortages

The ACA encouraged better coordination of care through "health homes" where physical, behavioral health, and long-term services and supports is coordinated for high-need, high-cost Medicaid beneficiaries. However, oral health is often overlooked. Lawmakers could integrate CDHCs into the model, specifically focusing on areas with dental care health professional shortage areas (HPSAs).

Pilot reimbursing CDHCs under Medicaid

States could set up pilots that would reimburse CDHCs under Medicaid for a defined study period (i.e. three years). Pilots could help policy makers evaluate utilization, outcomes and value of the CDHC model for Medicaid recipients under the age of 18.

Reimburse CDHCs for case management of pregnant women who receive dental services

Dental benefits under Medicaid are piecemeal and vary state-to-state. Pregnant women are at increased risk of pre-term delivery if they don't have access to oral health care services. States could cover CDHC case management services for pregnant women enrolled in Medicaid to increase access to care to help improve maternal and infant health outcomes.

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