

Oral Health Plan for Virginia Based on the 2003 Statewide Dental Summit

I. Education Recommendations

Why: Dental caries (tooth decay) is the single most common chronic childhood disease. Dental caries is five times more common than asthma and seven times more common than hay fever. Over 50% of 5-9 year old children have at least one cavity or filling and this proportion increased to 78% by 17 years of age. This high disease rate becomes more significant because of the striking disparities that exist in dental disease by income. The burden of oral disease on children in Virginia is seen in the loss of 250,000 school hours per year due to dental-related illness. Poor children suffer nearly 12 times more restricted activity days than children from higher-income families. This pain and suffering due to untreated oral disease can lead to problems in eating, speaking and learning. Increasing the awareness of these issues, the “silent epidemic” of dental disease and the link between oral health and overall wellbeing is crucial to the success of all other strategies outlined in this plan.

Virginia faces numerous challenges to improving the oral health of adult Virginians, particularly those who lack dental insurance and cannot afford to pay for dental services. According to a Virginia Health Care Foundation study, eleven percent of Virginians had not seen a dentist in over four years and six percent indicated they had never seen a dentist. This can be attributed to two basic issues: lack of understanding of oral health and lack of access to dental services.

Many low-income Virginians do not understand the importance of oral hygiene and the necessity of regular dental care in achieving and maintaining oral health. Making people more aware of how they can assume responsibility for their oral health is a critical need. The development of appropriate educational and marketing campaigns to convey this message is imperative.

Education Recommendation 1:

Improve the awareness, perception and advocacy for oral health in Virginia.

How:

- Educate the public and communities as to the need for oral health by conducting a statewide social marketing campaign and/or the use of Public Service Announcements including:
 - Conduct market research to identify appropriate audiences, messages, and medium.
 - Research /evaluate existing oral health education resources.
 - Develop a plan for the marketing campaign with goals, objectives, and timeline.

- Implement the plan using culturally appropriate and effective messages.
- Monitor and refine the marketing campaign, based on evaluation data.
- Educate legislators, administrators and policy makers regarding the value of oral health and it's importance to general health, the implications of the lack of funding for dental health, and the need to strengthen and adopt policies to improve oral health.
- Market a presentation on oral health to other organizations such as American Association of Retired Persons, Virginia Nursing Association, etc.
- Encourage employers to provide dental insurance.

Who: Virginians for Improved Access to Dental Care Coalition, (VIADC), Virginia Dental Association (VDA), Virginia Commonwealth University (VCU) School of Dentistry, Virginia Department of Health (VDH), Virginia Association of Free Clinics, Virginia Primary Care Association, Virginia Dental Hygiene Association, and the Virginia Board of Dentistry.

Lead: VIADC

Timeline: Plan to be developed by 2005, and implementation and evaluation to be conducted by 2008.

Status: VIADC will be meeting in December 2003 to determine the priority of this recommendation.

Education Recommendation 2:

Expand oral health education to stakeholders and targeted populations including preschool, school age, adolescents, adults and older adults.

How:

- Survey dental professionals to determine interest in a speaker's bureau.
- Develop dental education related activities to be used throughout the year, especially targeting Dental Health Month and the Give Kids A Smile programs.
- Provide education to parents regarding caries, diet, oral hygiene and overall oral health, fluorides, maternal/child correlation in caries transmission, playground safety, tobacco, and oral cancer.
- Explore the possibility of an information and referral line for parents.
- Recommend full adoption and funding of Bright Futures oral health guidelines.

- Train caregivers, daycare centers, Women Infants and Children (WIC) nutritionists, pediatricians, nursing homes and head start providers to provide oral health education.
- Begin brushing and fluoride application in preschool programs.
- Work with Community Health Centers, Local Health Departments and faith-based organizations to educate non-English speaking groups.
- Provide culturally and linguistically appropriate educational tools for patients and providers.
- Expand lay health outreach workers to conduct peer education programs.
- Increase the utilization of interpretive services.
- Take advantage of “Back to School” events for public and private sectors to educate parents about oral health.
- Maintain or expand support for an education component for dental students and dental hygiene students in the community.

Who: Virginia Dental Association, Virginia Commonwealth University School of Dentistry, Virginia Department of Health, Virginia Association of Free Clinics, Virginia Primary Care Association, Virginia Dental Hygiene Association, and Virginia Board of Dentistry.

Lead: To be determined by strategy.

Timeline: Short and long term strategies to be determined with action plan by June 2004.

- **Status:** Strategies need to be prioritized and each partner needs to determine which strategies can be accomplished short and long term.

Education Recommendation 3:

Educate providers in the value of development of a network and participation in public funded programs.

How:

- Train pediatricians and appropriate pediatric staff to provide basic oral health education and to do oral screening and basic preventive services (fluoride varnish application.)
- Increase non-traditional education (medical and nursing students) to screen and provide basic preventive education and services.

Who: DMAS, Division of Dental Health, VDA

Lead: VDH

Time Frame: 2004

Status: The Division of Dental Health is working on training allied health professionals regarding anticipatory guidance and the use of fluoride varnishes.

II. Legislative Recommendations

Why: While there has never been an ideal dentist to population ratio established, it would appear that Virginia has an adequate number of dentists. The dentist to population ratio in Virginia is one dentist to 2,084 citizens. Although this appears to be a favorable number, a maldistribution of those dentists exists throughout the state. Of the 3,485 licensed dentists practicing in Virginia, 570 are listed as specialists. Only 82 pediatric dentists specialize in the treatment of children. There are 46 areas of need defined as dental Health Professions Shortage Areas and 90 of these areas qualify as Dental Scholarship and Loan Forgiveness Program Areas of Need. In developing strategies to deal with these issues, economic and tax incentives should be explored. There are laws, rules and regulations that could be changed to increase the number and the efficiency and effectiveness of the present dental workforce. For example, the law and the rules and regulations in Virginia were recently enacted to allow dental hygienists to practice under the general supervision of a dentist. Because other professions such as medical and nursing may have an impact on the delivery of oral health services they also should be reviewed.

Relatively few dentists in Virginia accept Medicaid/FAMIS patients. Although dentists cite low Medicaid/FAMIS reimbursement rates as only one of several reasons that they are not participating providers, results from other states show clearly that significant increases in reimbursement rates result in significant increases in numbers of dentists who participate. Experience in other states has shown that increasing reimbursement rates to the 75th percentile will help increase the number of participating providers.

Legislative Recommendation 1:

Review the Practice Act and Regulations for dentistry as well as other allied health professions to insure the most effective use of personnel to address dental services.

How:

- Appoint a VIADC committee of appropriate representatives to review state practice acts, credentials, and reciprocity as well as those of other allied professionals to make recommendations to VIADC.
- Endorsing a private practice preceptorship program in dental underserved areas.

- Improve access to temporary and restricted volunteer dental licenses.
- Allowing dental hygienists to practice independently in dental underserved areas.
- Change regulations for dentistry and nontraditional oral health providers targeted at low-income populations to increase providers to provide screening, examination and prevention.

Who: VIADC

Lead: VIADC and Virginia Board of Dentistry with input from the Virginia Dental Association, Virginia Dental Hygienists' Association and Virginia Dental Assistants Association.

Timeline: Complete action plan by June 2004.

Status: VIADC will establish a committee at the December 2003 meeting. VIADC is currently working on changes to volunteer and restricted licenses.

Legislative Recommendation 2:

Increase the number of dental personnel serving in "areas of need" to improve access to care.

How:

- Appoint a committee of appropriate representatives to review present measures and to make recommendations to VIADC regarding:
 - Economic incentives, partnerships and educational opportunities that would encourage dentists and other dental personnel to practice in areas of need.
 - Funding the dental hygiene scholarship and developing allied health professional scholarships.
 - Increase funding for dental scholarship / loan repayment programs.
 - Private/foundation sources for scholarship / loan repayment.
 - Funding for dental clinics to assure access for dental underserved communities.
 - Increasing reimbursement for providers in dental underserved areas.
 - Developing mentoring program for new providers in underserved areas.

Who: VIADC

Lead: VIADC, with input from the Virginia Dental Association, Virginia Dental Hygienists' Association and Virginia Dental Assistants Association.

Timeline: Complete action plan by June 2004.

Status: VIADC will establish a committee at the December 2003 meeting.

Legislative Recommendation 3:

Increase funding for dental care and insure adequate funding for dental educational institutions and other agencies providing oral health services.

How:

- Appoint a task force of appropriate individuals to assemble an action plan to address this issue and offer concrete recommendations to VIADC regarding:
 - Support a tax increase on tobacco and/or alcohol for oral health.
 - Provider incentives for preventive and education services.
 - Increase the incentive for fluoride varnishes through Medicaid coverage and increased reimbursement.
 - Increase insurance for oral health education.
 - Mandate public dental care to localities.
 - Expand access to public/private insurance programs to maximum allowable funding level.
 - Expand dental insurance coverage for children with special health care needs.
 - Expand the pediatric focus and funding at VCU School of Dentistry for dental students and residents, continuing education of general and public health dentists.

Who: VIADC working with other agencies.

Lead: VIADC

Timeline: Action plans to be developed by June 2004.

Status: A statewide coalition exists to deal with tobacco issues. VIADC needs to partner with them to increase the support base for taxation of tobacco.

Legislative Recommendation 4:

Foster improved oral health prevention through legislative action and policy changes.

How:

- Address vending machines and soft drinks at school.
- Explore tying certification of daycare centers to dental prevention.
- Mandate preventive dental services for target populations.
- Raise dental prevention dollars from companies that make money from vending machines.
- Expand statewide school health education Standards of Learning (SOL) for oral health.

Who: VIADC with input from the Virginia Dental Association, Virginia Commonwealth University School of Dentistry, Virginia Department of Health, Virginia Association of Free Clinics, Virginia Primary Care Association, Virginia Dental Hygiene Association, and Virginia Board of Dentistry.

Lead: To be determined by strategy.

Timeline: Short and long term strategies to be determined by VIADC by June 2004.

Status: Strategies need to be prioritized by VIADC and each partner needs to determine which strategies can be accomplished short and long term.

Legislative Recommendation 5:

Support legislation to increase Medicaid/FAMIS dental reimbursement to 75th percentile of Usual and Customary Rates (UCR) for the most current year.

How:

- VIADC will propose necessary legislation to effect the recommended increase in reimbursement rates.

Who: VIADC with input from the Department of Medical Assistance Services, Virginia Dental Association.

Lead: VIADC.

Timeline: During the 2004 General Assembly.

Status: Currently, Medicaid and FAMIS reimbursement rates to participating dentists are predominantly below the 20th percentile. Low reimbursement rates continue to be a barrier to Medicaid and FAMIS provider participation.

Legislative Recommendation 6:

By 2010 all adults in Virginia will have access to dental services that result in an infectious free and functional state of oral health through legislative action and policy change. .

Why: Unlike medical care, the majority of standard insurance plans do not include dental benefits or severely limit the coverage. The result is forty-one percent of Virginians with no dental health coverage. Another part of the problem is an inadequate dental “safety net” in Virginia. Virginia’s Medicaid program does not provide dental coverage for adults. Because dental services are not mandated by state regulation, a limited number of health departments provide dental services. Thus, poor dental health and its consequences disproportionately affect low income and uninsured Virginians.

In addition, there are an inadequate number of private and public dentists in underserved areas, as well as an inadequate number of dental clinics or practices with a sliding fee scale or other means to care for the indigent and those lacking insurance. There is also a broadening gap in communication between provider and patient as a result of the increasing number of immigrants and migrant laborers. The must be addressed through the development and expansion of programs in cultural competency and linguistic services.

How:

- Promote the purchase of dental insurance.
- Advocate for the provision of dental insurance plans with variable pricing options.
- Expand Medicaid coverage to include adults.
- Increase Medicaid reimbursement for oral health services.
- Expanding and supporting the safety net dental providers, including free clinics, community health centers, Mission of Mercy Projects, local health departments, etc.

Who: VIADC, Joint Commission on Health Care, General Assembly, Secretary of Health and Human Resources, VDH, DMAS, VDA, VCU School of Dentistry, VDHA, VPCA, Virginia Health Care Foundation and Area Health Education Centers (AHEC).

Lead: VIADC

Timeline: Strategies will be developed by 2005. Recommendations will be accomplished by 2010.

III. Administrative Recommendations

Why: Dentists cite cumbersome administrative processes as an important reason for not participating in Medicaid/FAMIS programs. Patients/parents/sponsors and participating providers report frustration in dealing with different policies and forms used by different Managed Care Organizations (MCOs), exacerbated by the fact that patients undergo frequent eligibility changes and migrate from one program to another. Providers express dissatisfaction with having to hire and train additional office staff to deal with different claim forms, different dental procedure codes, different filing and preauthorization procedures, different coverage for reimbursement of procedures and more. These inconsistencies make it difficult to collect and analyze comparative data and to estimate true program costs and to project the cost of changes. Participation by patients and providers at all levels should be made as seamless as possible.

Many children in Virginia suffer dental pain needlessly because their parents do not seek appropriate care for their children, fail to show for scheduled appointments or do not impose parental controls to ensure compliance with instructions for oral health maintenance. Models implemented at local levels have demonstrated success when outreach programs are established to educate parents and assist families in dealing with issues such as lack of transportation, lack of child care for other siblings, conflicts with work hours etc. Implementation of an effective case management system will lead to increased compliance, improved oral health and a reduction in long-term costs by preventive care before small dental problems become big dental problems or far more costly systemic medical problems.

Administrative Recommendation 1 :

Undertake a collaborative initiative to streamline and standardize Medicaid/FAMIS administrative processes and forms for dental providers and improve data collection analysis and reporting.

How:

- Establish a single vendor system for the dental Medicaid program.
- Reduce administrative hassle through the Department of Medical Assistance Dental Advisory Committee including: streamline application, electronic filing, tax credits and increased reimbursement for “Critical Access Providers.”
- Develop educational programs to improve patient/parent compliance regarding dental care by addressing issues such as breaking appointments and short notice cancellations, following instructions regarding dental care and office procedures, recognizing the importance of oral health as a significant component of general health, accepting responsibility for the oral health of their children and completing necessary care.

- Continue collaboration with all stakeholders including Medicaid Dental Advisory committee, dental vendors, providers and state policy makers.
- Remove financial barriers to recipients including establishing a medical leave policy for dental care, encouraging providers to have “off hour” appointments and allowing the use of designated guardians.
- Expand eligibility for care for children with special needs not presently covered.
- Train dental providers in effective reimbursement strategies for working with public programs.
- Train providers in alternative and flexible office management practices including block scheduling and flexible office hours.
- Expand the number of providers, including non-traditional providers, offering basic screening and preventive services.

Who: Department of Medical Assistance Services

Lead: Department of Medical Assistance Services

Timeline: Discussion in progress.

Status: Attempts at streamlining processes have been underway for over a year, but few changes have been made. A standardized claim form is nearing completion. Discussions regarding the change from a multi-vendor to a single vendor system have been initiated.

Administrative Recommendation 2:

Develop an effective case management system to targeted areas overcome barriers to appropriate and timely care, including transportation, child care and other non-compliance issues.

How:

- Virginians for Improved Access to Dental Care Coalition (VIADC) will work with Children's Health Improvement Partnership (CHIP) of Virginia to study case management to provide education, information, referral, and outreach.
- Explore developing case management for Medicaid programs.
- Conduct a cost benefit analysis for establishing a dental home.
- Investigate alternative practice models to improve access to dental care for children with special needs including a hospital based regional children's dental program serving as a referral site for children which would provide hospital care, treatment for preschool children and those with special needs.

- Educate health care providers and childcare workers about support systems in communities to assist in providing dental care to low-income children.
- Develop an advocacy program to provide advocates for clients and include key stakeholder representatives.

Who: VIADC, DMAS, and CHIP

Lead: VIADC

Timeline: Develop proposal by 2005 and implement target by 2009

Status: At present in the Commonwealth there are several case management programs that include oral health of children, implemented by savvy and creative administrators in local communities, that complement existing programs in Head Start, schools, social services etc., but there is no centralized, coordinated programs to ensure statewide coverage.

IV. Prevention Recommendations

Why: Dental disease is preventable and less expensive when prevented rather than treated. Prevention strategies are critical to cost effective, efficient systems of dental care delivery systems. Prevention is an important long-term strategy to reducing treatment needs. Oral conditions are common, sometimes life threatening, costly, and potentially preventable. Primary prevention services are those designed to prevent the initiation of diseases including dental caries, periodontal disease, oral cancer and craniofacial injury. There are already a number of systems serving young children and their families that could be a more integral part of oral health awareness and access. Challenges to prevention and education include insurance and provider issues, changing public perceptions, prioritizing oral health, using alternative prevention measures, funding, cultural and linguistic barriers.

Currently in Virginia 81% of the population receives water adjusted to the optimal level of fluoride of 0.9 ppm. Virginia has met the Healthy People 2010 Objective for community water fluoridation. For those individuals in areas with out the potential to fluoridate, the school fluoride rinse program operates in 50 counties where 50,000 children rinse with a topical fluoride solution for one minute a week. Community based oral health education includes developing materials, training teachers, school nurses, nutritionists and other health professionals as well as participation at community events. Clinically based prevention includes caries risk assessment, prophylaxis, topical fluorides, sealants, oral health education and hygiene instruction, dietary counseling, fluoride supplements and early diagnosis and intervention.

Prevention Recommendation 1:

Promote and expand utilization of primary prevention modalities, clinical and population based.

How:

- Promote Caries Risk Assessment (CRA) and find ways to get medicine interested in CRA through financial incentives, training dental and medical students.
- Promote preventive modalities including sealants, community water fluoridation and the school fluoride rinse program.
- Use non-dental providers with appropriate training and reimbursement including pediatricians, pediatric nurse practitioners, family practice physicians, family practice nurse practitioners, physician assistants, nurses, medical students, and dental students.
- Use non-dental sites where appropriate such as WIC, Head Start facilities, hospital pediatric clinics, pediatric offices, medical school and medical residency programs and medical students and pediatric resident rotations in pediatric dental offices.

Who: Virginia Dental Association, Virginia Commonwealth University School of Dentistry, Virginia Department of Health, Virginia Association of Free Clinics, Virginia Primary Care Association, Virginia Dental Hygiene Association, and Virginia Board of Dentistry.

Lead: To be determined by strategy.

Timeline: Short and long term strategies to be determined with action plan developed by June 2004.

Status: Strategies need to be prioritized and each partner needs to determine which strategies can be accomplished short and long term.

V. Data Recommendations

Why: Improving the quality of data and surveillance includes tracking disease trends, selecting interventions, targeting high risk populations, identifying resources, evaluating the programs, and conducting statewide assessments. Currently in Virginia data is collected through the Behavioral Risk Factor Surveillance System (BRFSS), the National Oral Health Surveillance System, and the Cancer Registry.

This data shows that over the last 50 years in Virginia the prevalence of dental decay has declined and the distribution of decay on tooth surfaces has changed. The overall decay in the population has changed with decay moving

from a disease of all individuals to one that is concentrated in low-income and minority populations.

Decisions regarding the dental workforce need to be based on accurate data. At the present time we have incomplete or nonexistent data regarding dental hygienists, dental assistants and laboratory technicians.

Data Recommendation 1:

Develop a systematic method of collecting dental data statewide to monitor the distribution of dental workforce.

How:

- Develop a suitable questionnaire for distribution and collection by the Board of Dentistry.

Who: VIADC working with the Virginia Dental Association and the Virginia Board of Dentistry. VIADC needs to meet with the appropriate partners to determine the parameters on collecting data from safety net organizations.

Lead: Virginia Board of Dentistry

Timeline: By 2005 licensure.

Status: The VDA is working in cooperation with the Board of Dentistry, the Virginia Department of Health, and the Virginia Dental Hygiene Association on developing a questionnaire to be mailed with license renewal applications.

Data Recommendation 2:

Improve and enhance data collection and evaluation for oral health delivery, education and promotion.

How:

- Monitor the provision of oral health services by educational institutions, volunteer, federal and state agencies and the private sector to assure the proper distribution of such services.
- Appoint a committee through VIADC to determine appropriate parameters of information needed.
- Develop a system to track the use of preventive services.
- Track the utilization of vending machine use and or consumption rates in schools.

- Support preventive program evaluations.
- Give patients vouchers or coupons, track numbers and see if the vouchers encourage the use of preventive services.
- Investigate the potential for statewide school based screenings.

Who: Virginia Dental Association, Virginia Commonwealth University School of Dentistry, Virginia Department of Health, Virginia Association of Free Clinics, Virginia Primary Care Association, Virginia Dental Hygiene Association, and Virginia Board of Dentistry.

Lead: To be determined by strategy.

Timeline: Short and long term strategies to be determined by June 2004.

Status: Strategies need to be prioritized and each partner needs to determine which strategies can be accomplished short and long term.