



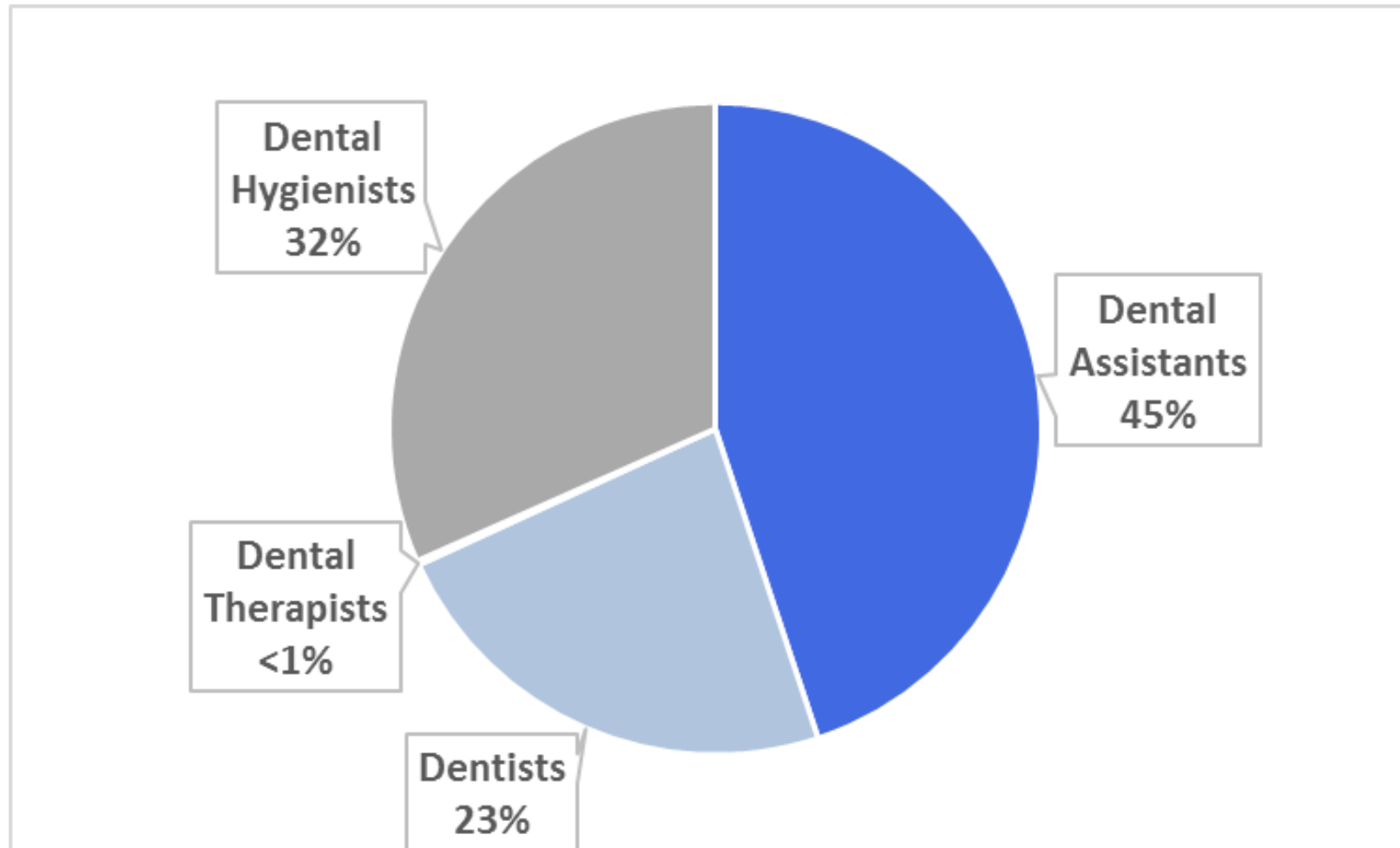
Oral Health Workforce: Trends & Pipeline Incentives

Presentation to: Healthy Teeth. Healthy Baby

Nitika Moibi and Deb Jahnke | Office of Rural Health & Primary Care

March 16, 2018

Oral health workforce

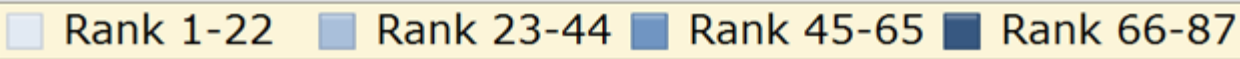
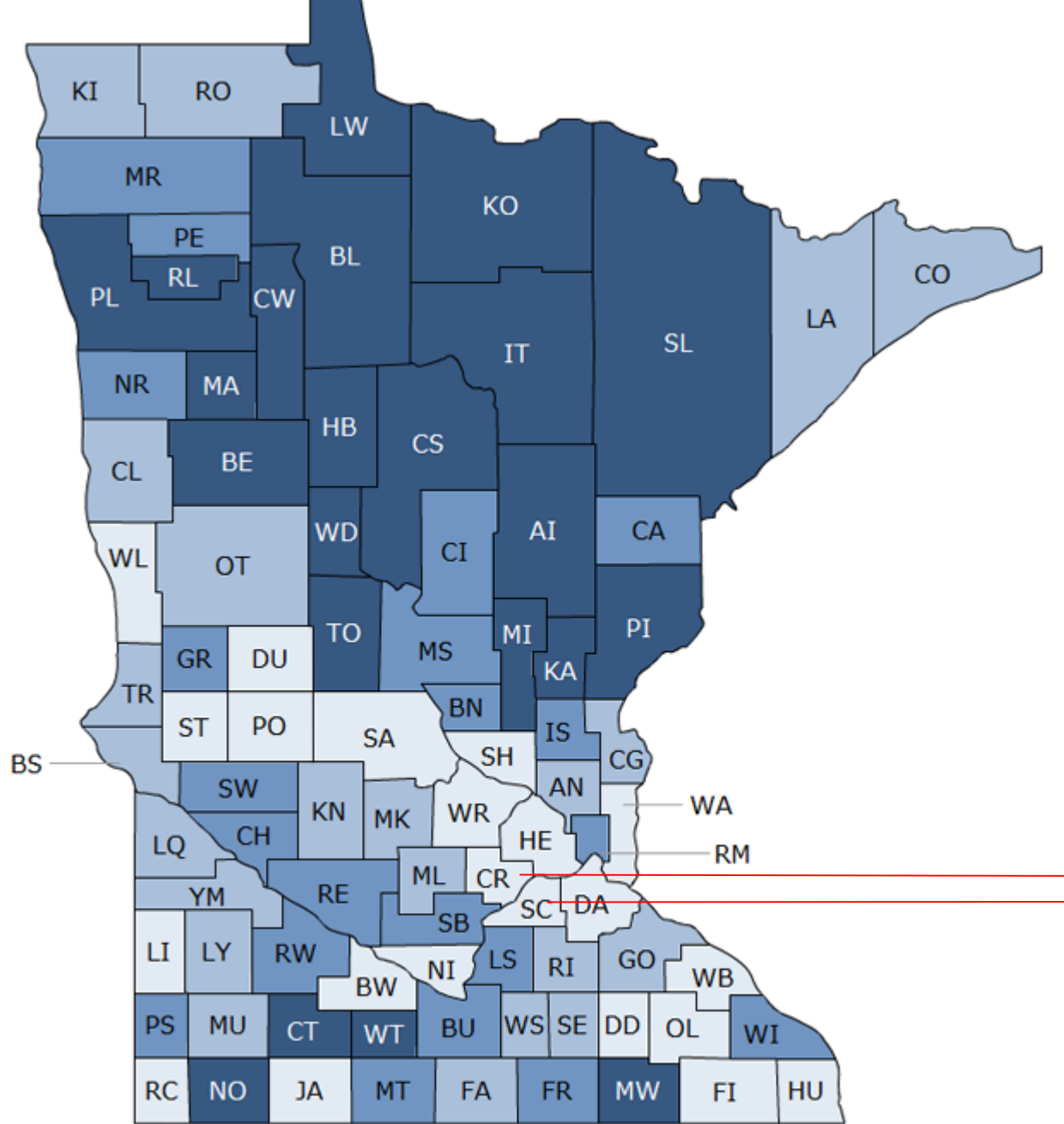


Source: Board of Dentistry, December 2013. Includes all professionals who have an active license and report practicing in Minnesota ("Active Practice In State." N=12,961). Of these, 5,819 were dental assistants; 4,101 were dental hygienists; 3,013 were dentists, and 27 were dental therapists

Top 10 healthiest Counties

(in order): Carver, Scott, Washington, Dodge, Stevens, Nicollet, Lac qui Parle, Fillmore, Red Lake and Wright.

What does this mean for oral health access?



Carver County - 42 dentists
 Scott County - 53 dentists

32 counties <5 dentists

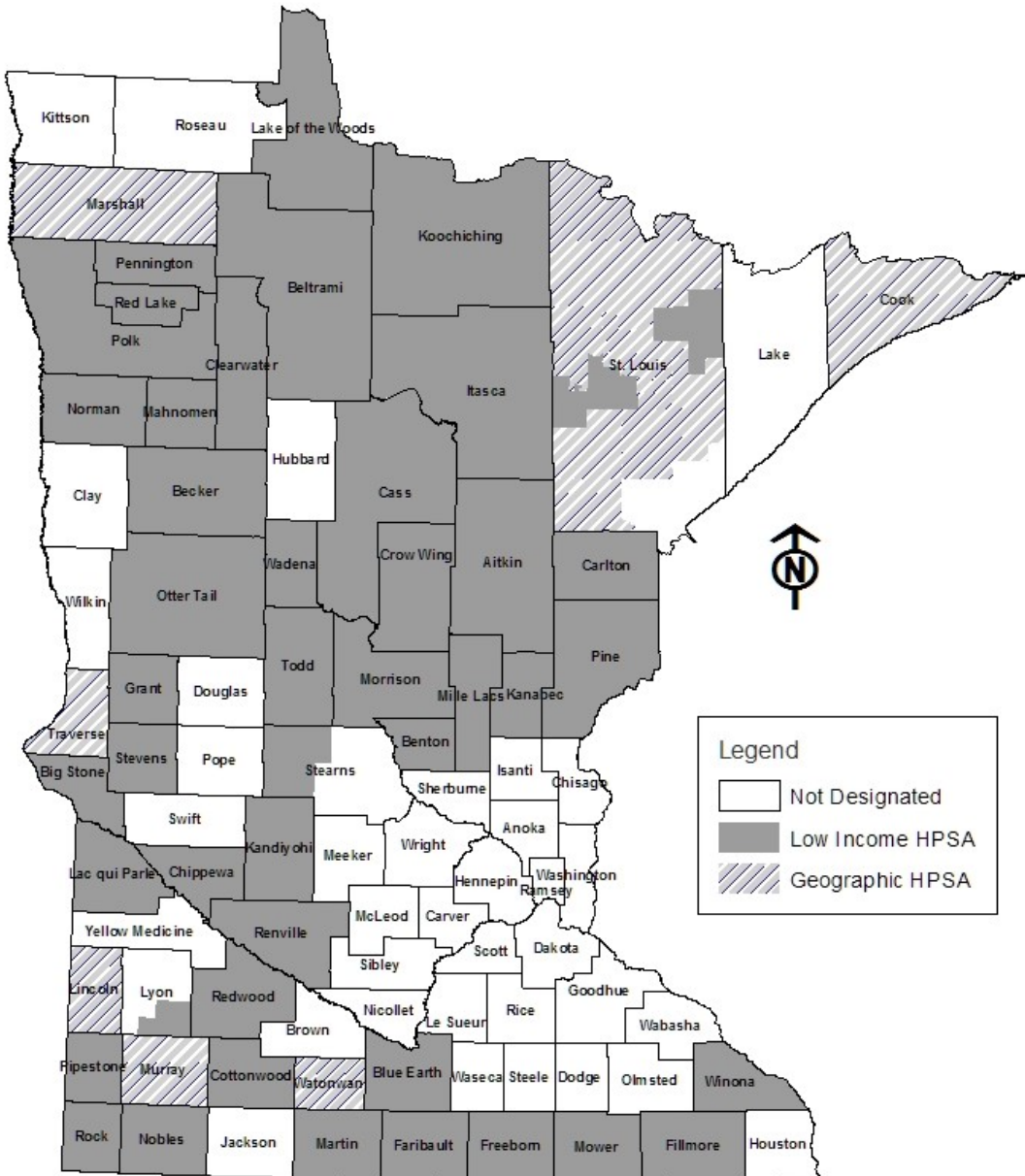
Source: 2018 County Health Rankings report released by RWJF & University of Wisconsin Population Health Institute
<http://www.countyhealthrankings.org/> Note: The rankings are based on more than 30 factors that influence health, including smoking, alcohol and drug use, obesity, teen births, high school graduation rates, income inequality, access to health care, and air and water quality.
 Dentist counts are based on MDH analysis of data from Minnesota Board of Dentistry. Includes Dentists who are Active in 2015.

Understanding oral health (in)access

Dental Health Professional Shortage Area (HPSA)

65 Dental HPSAs in 54 counties
- Mostly Low Income Population HPSAs

Plus “some” Dental Facility HPSAs



Understanding oral health (in)access

Geographic Dental HPSAs

- Approved geographic service area
- Counting all population within the service area
- Ratio to all clinical dentists by FTE, ratio must be $\geq 5000:1$
- Inaccessibility to Nearest Source of Care

Population Dental HPSAs (i.e. Low-Income)

- Approved geographic service area
- Counting only population subset within the service area
- Ratio to clinical dentists FTE serving the population subset, ratio must be $\geq 4000:1$
- Inaccessibility to Nearest Source of Care

Understanding oral health (in)access

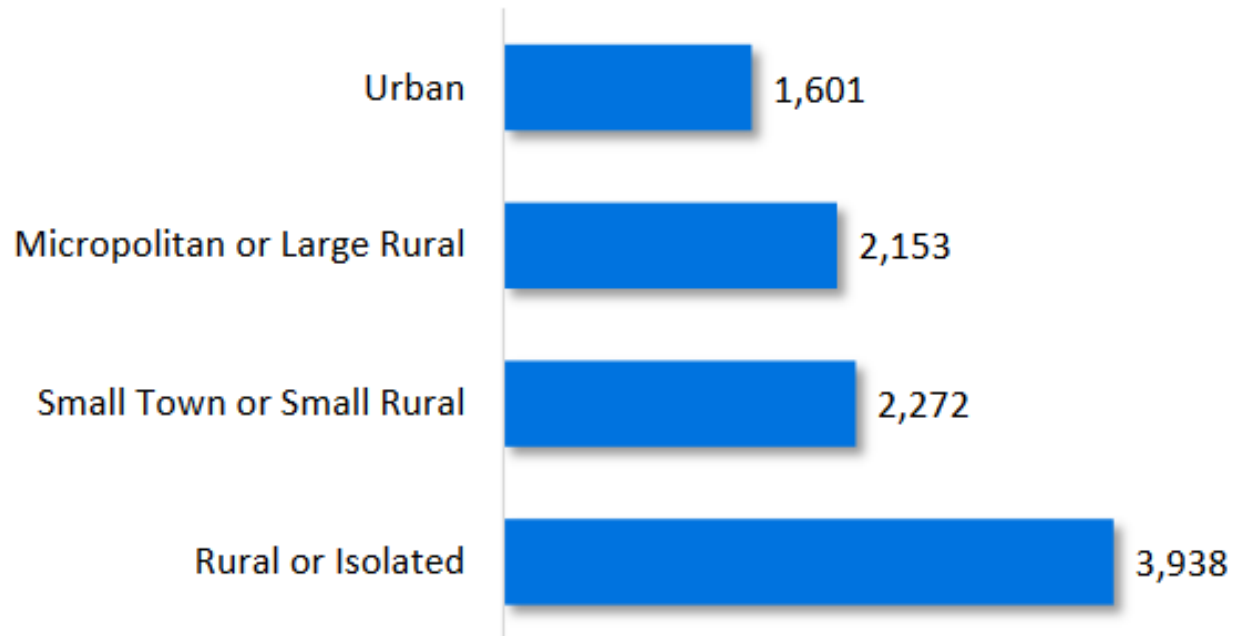
Facility HPSAs

- Automatic Facility HPSAs (not all provide dental services)
- Correctional Facility HPSAs
- Other Facility HPSAs, aka OFACs
 - Free-standing outpatient dental clinic
 - Located within proximity of Geo or Pop HPSA or serving HPSA population
 - Demonstrate Insufficient Capacity (excessive visits or waiting time)

Understanding oral health (in)access

Population-to-dentist ratio by rural-urban regions

Minnesota Population-to-Dentist Ratio



**“How often do physicians provide care that a different specialist might otherwise provide if they were available/accessible?”
(Rural physicians only, 2016)**

	Type of Care
	Oral Health*
	(N=167)
	15.6%
	64.5%
	8.1%
	1.6%

What does access truly mean?

Access =
“goodness of fit”
between provider
and patient

(Penchansky and Thomas 1981)

Access Measure	Meaning	In MN
Affordability	Extent to which provider’s charges relate to willingness to pay by patient	Dental insurance coverage limited IF offered; self-pay/OOP costs high
Availability	Provider has the requisite resources, such as personnel and technology	Unknown
Accessibility	Geographic	-128 dental HPSAs -High population to dentist ratio by RUCA
Accommodation	Extent to which the provider’s operation is organized in ways that meet the constraints and preferences of patient	-Dentists median hours worked (34) < physician median hours worked (50) -Common for private practices to close on Fridays/weekends/no evening hours
Acceptability	Extent to which patient is comfortable with the more immutable characteristics of the provider and vice versa	Unknown -92% of dentists identify as White/Caucasian vs. 19% MN residents identify as POC -Asians are fastest growing group (likely immigrants with acute & unmet oral health needs; cultural beliefs about US healthcare system)

- Aging population with comorbidities & complex needs
- Mouth is part of the body. Yet oral & medical divide remains in delivery, insurance
- Dental workforce:
 - Overwhelmingly white, non-Hispanic, aging
 - Rural dentists are among the oldest
 - ~1,000 licensed dentist are either practicing out of state or not practicing in MN - can they be incentivized to practice in MN?
 - Younger cohorts of dental students are female – labor market implications
 - 46% of male dentists work in their own solo practice compared to 26% female dentists
 - Younger dentists want to practice in small or large group private practices instead of solo practices. Gen X/Y attributes & attitudes
 - 1 out of 3 DTs is employed in a non profit clinic
 - Dental providers not working at the top of their license, education, training
 - Under utilization of expanded function dental assistants & collaborative practice hygienists
 - Still some resistance to dental therapists despite successful track record of opening up access, meeting needs safely, providing quality care in a cost effective manner
 - Maldistribution - regional differences

Minnesota Statute 144.1481

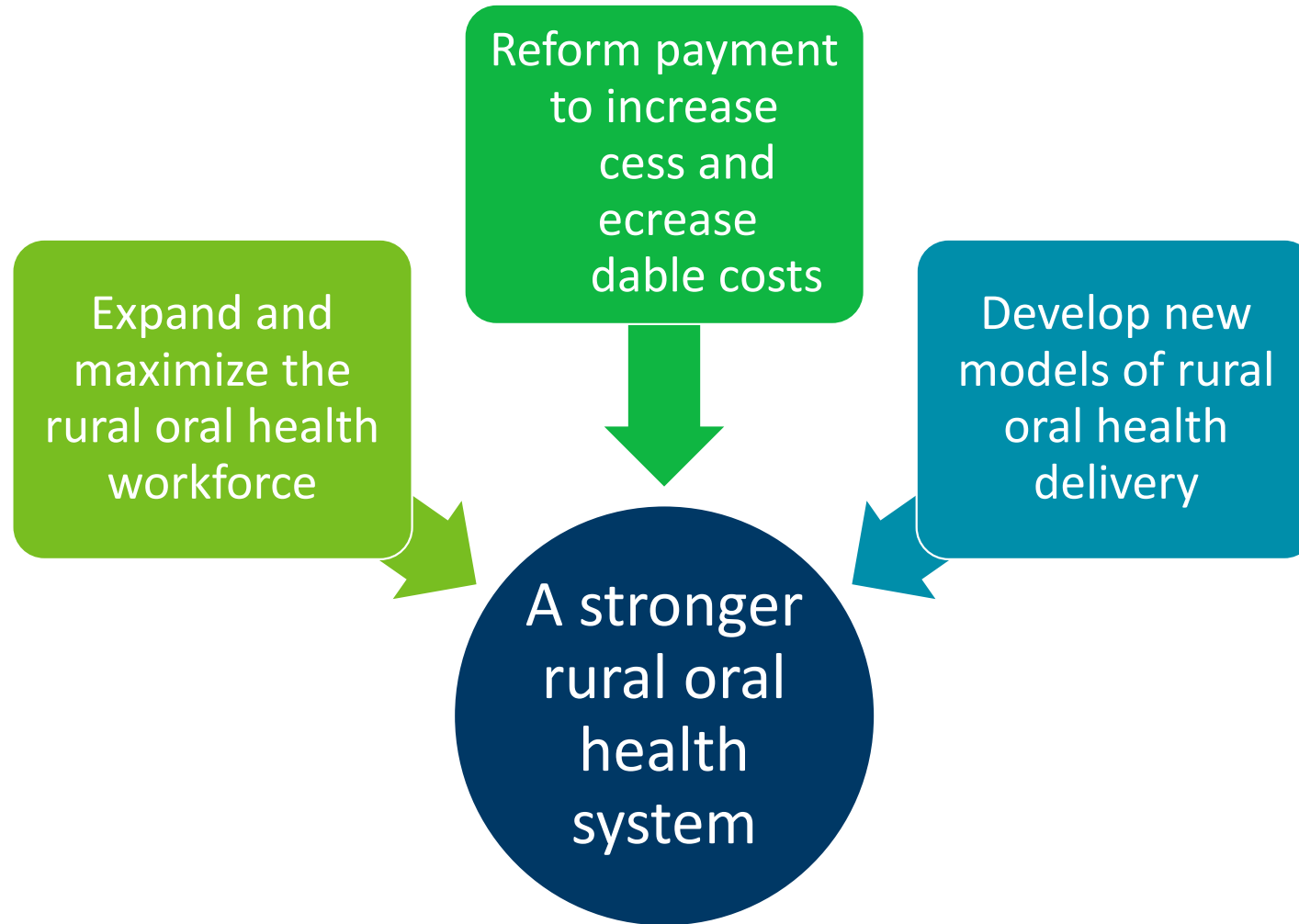
The Rural Health Advisory Committee (RHAC) was created as part of Minnesota's landmark 1992 health reform legislation.

The commissioner of health shall establish a 15-member Rural Health Advisory Committee, appointed by the Governor.

The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area.

- **Legislators:** Two members from the MN House and Senate from both majority and minority parties.
- **Health care representatives**
 - Volunteer member of an ambulance service
 - Hospital representative
 - Nursing home representative
 - Medical doctor or doctor of osteopathy
 - Midlevel practitioner
 - Registered nurse or licensed practical nurse
 - Licensed health care professional from an occupation not otherwise represented
- **Higher education** representative, from program that trains rural health providers.
- **Three consumers**, at least one of whom is an advocate for persons who are mentally ill or disabled.

RHAC Oral Health Project: Three overall recommendations



Recommendation Set 1

Increase reimbursement and types of services covered by MN Health Care Programs (MHCP)

Simplify MHCP administrative processes

**1.
REFORM PAYMENT TO
INCREASE ACCESS AND
DECREASE AVOIDABLE COSTS**

Invest in expanded pediatric prevention and treatment services

Position rural oral health providers for alternative payment models

Recommendation Set 2

Develop an online service to "match" rural dental practices and professionals

Encourage greater use of Collaborative Dental Hygienists

**2.
EXPAND AND MAXIMIZE
THE RURAL ORAL HEALTH
WORKFORCE**

Expand understanding of how Dental Therapists can add to a dental team



Recommendation Set 3

Develop rural center(s) for training and testing of new models

Pilot hub-and-spoke or other multi-site / regional models

3. DEVELOP NEW MODELS OF RURAL ORAL HEALTH DELIVERY

Expand use of portable systems and teledentistry

Workforce and Grant programs

- Loan Forgiveness/Loan Repayment/Scholarship (direct benefit to clinician)
- Community Clinic Grant Program
- Dental Safety Net Grant Program
- Clinical Dental Education Innovations Grant Program

Loan Forgiveness and Loan Repayment

- MN Dentist Loan Forgiveness and MN DT/ADT Loan Forgiveness
 - Contact: Brenda Flattum Brenda.Flattum@state.mn.us, 651-201-3870
- MN State Loan Repayment Program
 - Contact: Deb Jahnke Debra.Jahnke@state.mn.us, 651-201-3845
- National Health Service Corps – Loan Repayment, S2S, Scholarship
 - Contact: <https://nhsc.hrsa.gov> or Deb Jahnke for technical assistance

MDH Grant Programs

- Community Clinic Grant Program
 - Public or non-profit clinic that ensures access regardless of ability to pay
- Dental Safety Net Program
 - Non-profit Critical Access Dental providers serving uninsured low-income, aged 21-under
- Clinical Dental Education Innovations Grant Program
 - Affiliated with training program for dentists, therapists, hygienists and/or assistants

<http://www.health.state.mn.us/divs/orhpc/funding/index.html>

Thank you!

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