INCREASING ACCESS TO ORAL HEALTH CARE IN MICHIGAN: A DISCUSSION OF THREE POSSIBLE SOLUTIONS

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Post-Conference Memo

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On August 22, 2011, the University of Michigan School of Social Work hosted a one-day mini-conference to discuss the serious problem of access to oral health care for the state’s most vulnerable populations. The conference was co-sponsored by the Michigan Dental Association, The Michigan Dental Hygienists’ Association, the University of Detroit Mercy School of Dentistry, the University of Michigan School of Dentistry, the Michigan Department of Community Health, the Michigan Primary Care Association and the Michigan Oral Health Coalition. The conference was generously supported with funds from Nokomis Foundation.

Oral disease is among the most common ailments in Michigan. Vulnerable populations experience higher levels of disease and lower levels of care than the general population, and access to care is a serious issue for many (adapted from A United Voice for Oral Health). The purpose of the mini-conference was to discuss three possible solutions for increasing access to oral health care for vulnerable residents of Michigan. Co-sponsors do not necessarily endorse these solutions, but do agree that they should be discussed in an open and public way. The three possible solutions chosen for discussion were:

1) Introduction of a Mid-Level Dental Provider
2) Increasing Utilization of Existing Modes of Practice
3) Collaborations Linking Oral Health Providers with Other Care Providers

1 The conference was the result of discussions stemming from a working group convened last year by the School of Social Work and Nokomis Foundation. That session on “Health care for Impoverished Women in Michigan in an Era of Health Care Reform” identified a number of options for improving health care in Michigan, including possible solutions for increasing access to oral health care.

2 Special thanks go to Dr. Norm Palm and Bill Sullivan (MDA), Kathleen Inman and Bonnie Nothoff (MDHA), Dr. Mert Aksu (UD-Mercy Dentistry), Anne Gwozdek, Wendy Kerschbaum and Janet Kinney (UM Dentistry), Chris Farrell (MDCH), Becky Cienki (MPCA), and Karlene Ketola (MOHC), for their dedicated work and insights into the planning of this conference.
In discussing each solution, time was allotted to a speaker in favor of the solution, a speaker voicing challenges and concerns facing the solution, and significant time for audience discussion.

The conference was attended by over 130 stakeholders including dentists, dental hygienists, and dental assistants, representation from the Michigan State Board of Dentistry, the deans and members of the faculty from Michigan’s two schools of dentistry and faculty from numerous dental hygiene programs. There were representatives from the University of Michigan School of Social Work, the School of Nursing, the Michigan Department of Community Health, and a number of Federally Qualified Health Centers (FQHCs) and free clinics in Michigan. There were MDs, nurses, social workers and social service providers, legislative staff, and advocates for vulnerable populations.

The current memo reports on the proceedings of the conference, providing a detailed summary of each session prepared by the lead facilitator of the conference and his research team. In addition, there are reflections on the conference by the lead facilitator. Each co-sponsor and all guest speakers were invited to offer a brief response to the contents of this memo. These responses will be posted to the conference website as they are submitted.

CONFERENCE SUMMARY

Session 1. Access to Care: Defining the Problem
The first session of the day offered an introduction to the issue, and a definition of the problem, nationally and within Michigan. William Maas, DDS, MPH, MS, a consultant with the Pew Children’s Dental Campaign, discussed the access problem nationally. He noted that while there have been actions taken to improve access since the landmark 2000 Surgeon General’s Report on Oral Health in America—and in fact the overall the oral health of Americans has never been better—large gaps remain. Except when an unfortunate event makes headlines, oral health is rarely at the top of the agenda of policy makers and the public at large. Currently, volunteer dentists are called upon to address the issue of lack of access, but they can only help so many. In the coming years the need for affordable oral health care will likely increase as the population ages (and older adults are more likely to still have teeth). A more systematic approach is needed.

Access to oral health care can be defined as “the timely use of personal health services to achieve the best possible outcomes” (Institute of Medicine, 1993). To maintain oral health, individuals need to be able to receive quality oral disease prevention and treatment when they are needed. Maas cited figures, including a 2000 ADA estimate, indicating that 83 million Americans lack access. He noted that few private dentists accept significant numbers of Medicaid patients, and that while raising the reimbursement rate would help, it would not solve the access problem. In fact, cost is only part of the problem. Fear, embarrassment, lack of transportation, low health literacy, and lack of symptoms, interest and motivation all play a role. According to the public health model, dental care is a social process, and hinges on exchanges between provider and patient (the balance of power and/or the weighing of costs and benefits).

The next speaker was Christine Farrell, RDH, BDH, MPA, Oral Health Director Michigan Department of Community Health’s Oral Health Program. Farrell addressed the access issue in
the state of Michigan from the perspective of three questions: Where is the state’s dental workforce located? Who are they? Whom do they serve?

Currently, more than half of the state’s dentists are located in the southeast corridor. Fifty percent can be found in just 4 counties, where a third of the state’s hygienists are also located. Fifty-seven out of the state’s 83 counties have been designated as Health Professional Shortage Areas, disproportionately clustered in the northern parts of the state. There are two dental schools in Michigan, both located in the southeast. There are 13 dental hygiene programs, none of which are located in the Upper Peninsula or even the northern part of the lower Peninsula. This is significant because individuals tend to stay where they receive their training, rather than return home.

The PA 161 initiative (discussed in more detail later on) is expanding, and currently stands at 55 active programs, with 93 supervising dentists, and 182 dental hygienist providers. At the same time, the recession has made it hard for dental hygienists to find adequate employment, with experienced providers losing out to newly trained hygienists, and others leaving the state.

Farrell explained that the majority of Medicaid enrollees are located in southeast Michigan, but that only 28 percent of recipients are being seen, with the City of Detroit experiencing the most disparities. Michigan is the only state that is losing population while the Medicaid population is increasing. In fact, Medicaid is currently the largest health insurance provider for children in the state. Farrell did note, however, that access should be considered as more than insurance – office hours, and the ability to make and keep appointments, for example, are also important for understanding access.

Norman Palm, DDS, MS, Vice President of the Michigan Dental Association, also discussed the issue of access to oral health care in Michigan. He reiterated that there are numerous barriers to obtaining care, and that increasing capacity won’t necessarily lead to an increase in care provided.

Palm stated that the MDA believes in one standard of care, led by a dentist, and emphasized the need to build capacity within Medicaid. He noted that a work group was convened in Michigan back in 2009 to assess needs and set priorities with respect to access. Palm cited statistics reporting, among other things, that 80% of Michigan dentists provide uncompensated care, and that over 150,000 emergency room visits have something to do with oral health.

Palm expressed reservations with the existing state PA161 law, noting that patients seen in such clinics appeared less likely to receive comprehensive care. Moving forward, he recommended replicating “proven” programs such as the state’s Healthy Kids Dental, allowing physicians to do pediatric dental screenings, and educating parents via Head Start.

Proposed Solution 1: Introduction of a Mid-Level Dental Provider

Introduction: Mid-level dental providers (MDPs) are generally permitted to perform basic preventive and restorative procedures (fillings and simple extractions) under the supervision of a dentist, who can be off-site. The goal of establishing a MDP in the state would be to reduce the
cost of basic dental care by introducing a new group of low-cost providers, which in turn could make care more accessible to underserved populations. MDPs currently practice in a number of other countries, and serve native populations living in remote areas of Alaska. Minnesota is currently the only U.S. state with an MDP licensure. MDP licensures can take many forms, but this session focused on a combined Dental Hygienist-Dental Therapist model (which is the trend internationally).

Ron Nagel, DDS, MPH, United States Public Health Service (retired) began this session by describing how mid-level dental providers (also referred to as dental therapists or alternative dental providers), currently work in 52 countries, with New Zealand having 90 years of experience and Canada 40. They function as part of the dental team, providing education and prevention services, restoring teeth to function, screening for disease, extracting teeth, and managing dental emergencies. All existing evaluations find these providers have an exceptional safety record. In fact, to Dr. Nagel’s knowledge, there is not a single evaluation with a negative finding about the quality of care provided by dental therapists.

Nagel noted that dental therapists work under the supervision of dentists, who still monitor care and set out dental plans. But to supervise, a dentist need not be in the same building, or even within 500 miles. Images and data can be transmitted in real time, and the dentist can easily consult with the patient and provider via phone, internet, or something like the AFHCAN (Alaska Federal Health Care Access Network) Cart. Quality assurance has been an important aspect of the dental health aid therapist (DHAT) program in Alaska, and is assured through chart reviews, patient satisfaction, and direct observation.

In the Alaska DHAT program, quality assurance is evaluated through 400 hours of supervision, the demonstration of practical professional competencies, and by a requirement of 24 hours of continuing education every two years. Competency-based credentialing is demonstrated through frequent sampling of skills over time and review of day-to-day services. Scope of practice is individually assigned based on competency and the federal board oversees this process.

The Alaska dental therapists are trained for two years and are required to participate in community-based preventive programs and training. They are trained using simulation and have extensive patient contact. Moreover, Nagel argued that the Alaska DHAT program is the most scrutinized dental program out there, and that there is no lack of data to support its quality. Instead, there is a lack of data on the quality of work of dentists.

Nagel next discussed the issue of patient acceptance of dental therapists. He argued that most patients are motivated by how they interact with their care providers over time. With vulnerable populations, it is important to build this relationship over time (making belonging to a dental home important), which will help with treatment adherence and continuity of care, which is linked to quality. Because dental therapists are often drawn from underserved communities, they can be more effective in this regard.

Nagel briefly discussed some of the issues concerning the education and training of MDPs. He pointed out how the University of Washington DENTEX program that trains Alaska DHATs includes public health skills. He noted that it doesn’t make sense to compare therapists to dentists.
because they are not the same, and do not do the same thing. Dentists, he argued, should be the leader of the team, but can delegate more than they currently do.

Finally, Nagel closed by sharing a quote from a former Executive Director of the ADA from 1947-1969, Dr. Harold Hillenbrand, who said, "When the dental history of our time is eventually written, I believe the New Zealand Dental Nurse program will be considered one of the landmark developments in the practice of dentistry and dental public health."

Jon Holtzee, the Director of State Government Affairs for the American Dental Association, was the next to speak. He discussed “Challenges and Concerns about a Proposal for a Mid-Level Provider for Michigan.” He stated that it was “undeniable” that DHATs were good for Alaska, but questioned whether that necessarily meant they would be good for the rest of the country. He added that with respect to the cultural competency of MDPs, he has no argument, but when it comes to surgical procedures, he does. He maintained that it isn’t correct to compare MDPs to nurse practitioners or physician assistants because the latter do not do hard tissue surgery or permanent interventions, and that the surgical aspect is integral to who dentists are.

He argued that there was a disconnect across the nation regarding what supervision means, and that new workforce models create “disruptive change” that those within the system will have questions and resistance to. It is important to acknowledge and understand this.

Holtzee acknowledged that the geographic distribution of the dental workforce is an issue, but that pure numbers don’t tell the entire story, since dental productivity has increased since the 1970s. He acknowledged that work was needed with respect to provider composition/cultural competency, participation in public programs, and outreach, but argued that the hodge-podge nature of the safety net, and funding issues (in particular) were also to blame. He also noted that statistics can be misleading – some counties without a dentist also lack many other services and people routinely cross county lines to get what they need.

With regard to new workforce models, Holtzee expressed how important it is to understand that defining a scope of practice calls for balancing comprehensive and analytic knowledge, technical ability, patient protection, and politics. The supervisory relationship, he argued, is one of the primary issues in dental workforce policy. Holtzee discussed how a primary barrier to care is communication – and that we need to educate ourselves, the community, and policymakers. The ADA has proposed a Community Dental Health Coordinator, an individual who goes into the community as a primary education source and advocate. He also called for social workers and physicians to become involved as there is a need for integration between medical and dental care.

Holtzee recognized that traditional models of small private dental practices work for some but not for all, and acknowledged that we need to extend services to where patients are. However, he argued that public programs will not work if no one accepts them, and that they need to work for providers as well as patients. Workforce and access issues are multifaceted: “We will need more than one tool to solve this issue of access.”

Highlights from Discussion / Q and A session:
• There was some back and forth on the issue of the “evidence” on the safety/efficacy of
MDPs. One speaker commented that the ADA prides itself on being evidence-based, but chooses to ignore the evidence with respect to dental therapists. In response, Holtzze said that they would like to see longitudinal evidence, and also commented that the ADA simply would never support non-dentists doing surgical procedures. Another speaker added that access-to-care could actually suffer if a new provider began to provide a sub-standard level of care, which would lead people to lose faith in the provider community.

• A speaker commented that Healthy Kids Dental, in addition to raising reimbursement rates, provided recipients with the same dental card as those with private insurance, and that the recipients now act like private patients with respect to no-shows.

• Several questions related to the uniqueness of Alaska. One asked whether the technology used in Alaska was unique to that program. Nagel responded yes, but that similar technologies are already being used in medical practice, so it wouldn’t be hard to adapt to dentistry. Another, after noting that the number of public health dentists in the state has been increasing dramatically in the past few years, perhaps eventually leading to an increase in access, asked whether the rules and standards in Alaska were too different due to being on sovereign land. Nagel responded that in Alaska they actually practice under federal statute, but that in any case therapists are supervised by dentists, and that the therapists meet the same standard of care expected of dentists for the procedures they preform.

• A question was posed to Nagel about how it was possible to get such good results when therapists have just two years of training when dental school is much longer? Nagel responded that it has to do with the training being focused on skills, and asked, rhetorically, who is better at cleaning teeth – the dentist or the hygienist?

• Questions were raised as to how and whether therapists would be able to help with populations with co-morbidities (eg prisoners, elderly). Nagel responded that therapists would not be called upon to treat difficult, complex cases – this is what dentists are for. With respect to the general adult population, therapists can help by doing basic work, and another speaker noted that MDPs could lead to increased early intervention, reducing the need for complex procedures (root canals, crowns) later. Somebody else noted that the elderly are complicated patients, and many treatments are too aggressive for octogenarians.

**Proposed Solution 2: Increasing Utilization of Existing Modes of Practice**

*Introduction: Michigan already has a number of structures in place that could be better utilized to expand access to care among underserved populations. For the purpose of this session, these were broken down into two general domains: prevention, and increasing efficiency in the dental office.*

**Subtopic 1: A Focus on Prevention:**

*The PA 161 program allows RDHs in Michigan to provide preventive care outside of the dental office (in schools, Federally Qualified Health Centers and in other public and non-profit settings) under the remote supervision of a dentist. Through these programs, RDHs have served several thousand underserved children and adults. The PA 161 RDHs have performed screenings, prophylaxis (cleanings), fluoride and sealant applications, and referral for dental treatment.*
The first speaker in this session was **Ann Battrell**, RDH, MSDH, Executive Director of the American Dental Hygienists' Association, who was asked to provide a national perspective. She noted that nationally the number of hygienists is going up, but that the economy is negatively impacting the number of positions available. Addressing the issue of MDPs, she argued that taking advantage of the existing skill set of hygienists is a good idea because they bring advanced preventive skills and the education infrastructure is already developed. Dental hygienists can already initiate patient care without the presence of a dentist in a number of settings. She noted that direct access for hygienists has been growing, and is now available in 35 states.

Battrell stated that the ADHA view toward new providers is that they are flexible, and are no longer insisting that the minimum degree be a M.A. They support the idea of an extra year of training for dental hygienists in order to increase access. She emphasized that many states are considering new models, whether this means starting fresh or building on the dental hygienist model. With any new model, it is important to involve both the education community and the public. She said there are several things to consider with new models including the educational setting, accreditation, reimbursement, competency, licensure, and continuing education.

**Chris Farrell** provided the Michigan perspective on prevention with a focus on the PA 161 program. PA 161 began in 2005; there are currently 55 programs in the state, and it continues to grow. Under the program, dental hygienists work with underserved populations and patients that are not assigned to a dentist. They are supervised by a dentist, and remote supervision is allowed; their scope of service is the same as that of other hygienists. She clarified that programs are granted this status, not individuals, and that hygienists work within that setting. Farrell discussed PA 161 requirements, services, application, data collection methods, and reviewed the annual report of the program.

**Kathleen Inman**, RDA, RDH, BS, Michigan Dental Hygienists' Association, expanded on the Michigan perspective. She discussed the state of dental hygienist practice in Michigan including workforce, services, and settings. After discussing PA 161, Inman talked about several ways that MDHA hopes the program can be enhance in the future: direct payment to hygienists, being granted authority to supervise an individual (i.e. dental assistant) as a second pair of hands, being given limited prescription-writing authority (i.e. for fluoride supplements), alternative modes of supervision (i.e. MDs), and not creating any inhibiting legislation that would change PA 161 (i.e. rules, permits). Inman reiterated that it is MDHA’s position that this is a program that works well, and focuses on providers that are appropriately qualified and personally committed to patients. The dental hygienist workforce is underemployed and can extend its reach. Dental hygienists are committed to collaboration for the good of patients, and are “ready to come to the table.”

**Subtopic 2: Increasing Efficiency in the Dental Office:**

**Introduction:** More attention could be paid to the efficiency of delivery of care within dental offices. If attention were paid to improving efficiencies of practice through shared fixed costs and other mechanisms, the cost of care per patient might be reduced, making care more broadly accessible. One specific proposal focuses on better use of registered dental hygienists (RDHs) and registered dental assistants (RDAs) in the dental office. Michigan's dental practice act
allows for expanded duties by RDHs and RDAs in assisting dentists while performing restorative care. If a serious commitment was made to expand the number of dentists in underserved areas, and if dentists better utilized the capacity of RDH/RDAs in restorative procedures, care might be provided more efficiently, thus lowering the cost of care and making care more broadly accessible.

Mert Aksu, DDS, JD, MHSA, Dean of the School of Dentistry, University of Detroit Mercy, spoke about “Increasing Efficiency in the Dental Office.” He discussed the need for a single national standard of education for every member of the dental team and a single standard of care for dentistry as state-by-state solutions create disconnects in care across the country, and prove challenging to educational programs. Dentists, he argued, should be the sole member of the team to exam, diagnose, and plan treatment. At the same time, he noted that educational institutions are the right places to be looking at potential change. He noted that the US population is mobile, and so it is incumbent upon Dental Schools to teach to models that have been adopted in other parts of the country, even if they are not currently available in the School’s home state. He further acknowledged that there is territorial protectionism going on within the profession. He spoke in favor of more extensive use of a combined RDH/RDA providers in assisting dentists in restorative care, stating that he was of the opinion that this would make the dental office more efficient, and allow dentists to concentrate on the most complicated patients.

With respect to access, Aksu noted that every dentist in the state of Michigan could see more patients – so it is not simply a matter of lack of capacity, while also reminding us that new dentists are graduating with over $200,000 in educational debt. However, he recognized that there is a rising percentage of the population without care, and that this is something that needs to be acknowledged. He noted the need to explore the possibility of new workforce models, especially with rigorous research, which dental schools could conduct.

Aksu cited figures from a survey of dentists and dental school deans that he conducted; among the more interesting findings are that while more than 90 percent of practicing dentists believe that the introduction of MDPs will lower their income; a similar proportion of dental school deans believe it will not. Similarly, a large majority of Deans believe MDPs would increase access to care, while virtually all surveyed practicing dentists say they would not. He made clear that as the head of the team, it is the dentist who bears ultimate responsibility for the oral health care delivery system, and must take a leadership role in considering reforms with an evidence base.

William Maas offered a few comments in regards to the session topic. He noted that in Colorado, dentists who employ expanded-function dental assistants earn much more money than those who do not. He went on to describe his own experience working on an Indian reservation as a young dentist. He talked about the productive and efficient environment, but noted that he arrived with no supervisory skills and quickly saw different—and competing—supervision styles at play. Maas argued that we need to better train dentists to supervise staff and discuss standards of care. He added that dentists are not trained to know if something should be considered “acceptable work” or not. He said “there are so many missed opportunities for supervisory skills and we need to make an effort to equip our oral health professionals with these skills.” In closing, Maas shared information from a British study about dental therapists. Many dentists
reportedly did not know therapists existed, but a third said they would be interested in working with one. Maas urged us to “push our chairs together” to provide care to the underserved.

**Highlights from Discussion / Q and A session:**

- Dean Aksu was asked how increasing efficiency could improve access. He argued that increased efficiency could lead to reduced costs and increased capacity, thus allowing dentists to see more patients at a lower cost. He said that dentists, as they set their prices, need to think about (1) associated costs associated with that procedure as well as (2) what economists refer to as elasticities [of price and demand] – not just base them on the average charges in their zip code.
- A dental assistant brought up the fact that of 13,000 DAs, only about 1300 are RDAs – and she argued that this is because dentists don’t approve.

**Proposed Solution 3: Collaborations Linking Oral Health Providers with Other Care Providers**

*Introduction:* There is some evidence that increased collaboration linking oral health care providers with care providers in other domains -- such as doctors and social workers -- can be an effective means of improving access to oral (and physical) health care services. For example, collaboration between oral health care providers and social workers holds the possibility of helping patients to better navigate systems of care, and to promote better adherence to treatment plans. Better collaboration with medical providers might lead to better identification of need for treatment. And a system that allows providers from different realms to share fixed costs may lead to greater efficiencies in service delivery, which may reduce cost and increase access.

The first speaker in this session, providing the national perspective, was Frank Catalanotto, DMD, Department of Community Dentistry and Behavioral Science, University of Florida. He talked about the role, value, and importance of collaboration, identifying communities and patient representatives, other health care providers (nurses, MDs), school systems, WIC programs, churches, court systems, etc all as potential partners. The advantages of collaboration are sustainability, the removal of the appearance of self interest, and the bringing together different perspectives and areas of expertise; “you are only limited by you or your group’s imagination and creativity.” Catalanotto reviewed several collaborations in Florida and elsewhere including Oral Health Florida, Gator Kids Healthy Smiles, and Forsyth Kids. He noted that coalitions can be doomed if they try to be perfect. He also noted that they need an independent entity to run them. He then gave some examples of successes, including allowing Medicaid reimbursement to doctors in Florida for early caries detection. This makes perfect sense since most children on Medicaid see a doctor in their first year, but not a dentist -- but it required extreme persistence to get the enabling legislation passed.

A useful resource suggested by Catalanotto is the Frameworks Institute, in Massachusetts. It is an organization that helps develop collaborations, as well as package and sell the group’s message. In closing, he noted that indeed, collaborations are hard work and require compromise, but with small achievable goals change is possible.
Kevin Hale, DDS, FAAPD, Executive Director Points of Light project, spoke next, highlighting an example from Michigan, and the importance of connecting children with dentists earlier. The latter often requires behavior change on the part of parents and families. Doctors need to refer, Head Start and school nurses need to be involved, and children need to get in as babies, since by age 5 it is often too late. He argued that prevention is not adequately valued, arguing that “if we create it, they will NOT come.” Hale shared information about the Points of Light project, which identifies a “point dentist” in a community who recruits a group of dentists willing to accept patients. The point dentist then initiates a partnership with a pediatrician who agrees to promote the program within the community and refer young children. He talked about the need to empower individuals to take care of their own communities, as well as to provide the tools, and allow communities to implement interventions in the ways that fit their particular circumstances.

Samantha Pearl, Executive Director Community HealthCare Connections, spoke next, discussing another Michigan example. She talked about the importance of the local community determining what is needed, and how to address the gaps. Community HealthCare Connections was started four years ago in Battle Creek when there were about 115 adult ER visits/month that were related to dental problems. By definition, all were uncompensated. They found that dentists were willing to help the underserved (money was not the main issue), but that patients were not showing up, not prepared, and/or not following through on plans, and that there was no place to refer them if there were complications.

Pearl discussed how people do not always value what they are given for free. Using ideas from Pay it Forward and “sweat equity” (Habitat for Humanity), patients do not pay the dentist for their treatment, but do pay by volunteering with other charities. Individuals must provide four hours of service to get an initial cleaning and visit with a dentist, and then four more hours for every $100 of dental work that follows-- the service is done first, then the dental work. As a result, over a thousand patients have been given dental care, and nonprofits have received hundreds of valuable service hours. Through this initiative, volunteerism is making a difference for the individual and impacting the community in large ways. Pearl argued that we need to change the way we are looking at providing services and think more about a collaborative, or partnership, approach.

Finally, Ann Battrell, discussed the “Challenges and Concerns about Collaborative Strategies.” She talked about issues inside and outside the oral health profession, and the need to pull together. Inside the profession there are major implications to how dental education is structured today; oral health professionals (i.e. dentists and hygienists) are typically educated in isolation of each other. It is therefore hard to learn how to collaborate with one another – what do you do if you don’t agree? Outside the profession it is important not to re-invent the wheel, and to learn from what other states have done. She offered that facilitators can help this process, and also noted the benefit of finding a champion legislator for your cause. Getting the right people together matters. Finally, she noted the importance of having an open mind. She said that “but” is a conversation stopper, which needs to be replaced with “and.”
FACILITATOR REMARKS

H. Luke Shaefer, PhD, School of Social Work, University of Michigan

I greatly appreciate the hard work of the planning committee, representing the eight co-sponsors of this conference, and the thoughtful remarks offered by each of the speakers. Further, I greatly appreciate the large group of stakeholders who participated and offered insightful comments throughout the day of the conference. What we did on August 22 was uncommon and completely necessary in order to tackle any major social problem, in this case, improving access to oral health care for vulnerable populations in Michigan: we came together from a wide range of different—and in some cases competing—perspectives to discuss our views about possible solutions to the access-to-care problem in a public and open way. While there were considerably differences in views in the room, from my perspective, there was also widespread agreement about a number of critical points. Here are some of the points that I have come away with that I think are of critical importance to moving forward.

1. Increasing access to oral health care is a complex and multifaceted challenge that will require changes in the ways providers deliver care, the ways patients perceive care, and the ways the public at large values oral health. There is no single solution, no silver bullet, but rather it demands a multifaceted approach.

2. Numerous speakers focused on the centrality of the relationship between oral health care providers and patients—this seems to be central for improving treatment adherence. Having a relationship that allows provider and patient to communicate with each other clearly, and to trust each other, is key. So a key question is, how can we better foster strong relationships between providers and patients? Throughout our various systems of health care delivery, and especially among our safety net providers, how do we improve continuity of care?

3. There seemed to be significant interest in the room in accessing more information on how oral health care providers can do this for a diverse group of patients. How do providers move past cultural differences to build strong relationships with their patients?

4. As Jon Holtzee said, “disruptive change” is hard. It is natural for people inside systems to be cautious of change to that system. There is a concern that changes that are not well thought through could lead to problems, which in turn could lead the public to lose faith in the caregiving community. As we consider changes, there should be efforts to preserve the strengths of the current system.

5. In the discussion of mid-level providers, strong evidence was noted that these providers provide safe and competent care, and enjoy high patient satisfaction rates. Much of the evidence, although far from all of it, is international (from outside the US). No evidence was cited by any of the conference speakers or participants that indicates that these types of providers provide sub-standard care, relative to dentists. The strong performance of mid-level providers is likely a result of two things: 1) they work under the close supervision of an off-site dentist who consults on and approves all treatment plans; and 2) their scope of practice is always limited, which likely leads them to become highly proficient at the few tasks they can do. They do only a few
procedures over and over again.

6. While there is considerable evidence regarding the quality of care provided by mid-level dental providers, an area in need of further research is the extent to which the introduction of such providers in US system would lead to increased access to oral health care. There is no guarantee that the introduction of a mid-level provider would improve access to care in Michigan. There may be unique characteristics about the US system (and Michigan in particular) that might lead to these types of providers being ineffective in expanding access. In this way, it may be more a matter of how we do things, rather than what we do.

7. Numerous speakers and participants stressed that we need more empirical evidence on the impacts on access of these types of providers, and the implications of them on the broad provider community. I think a number of the comments point to the fact that this research would be strongest if it occurred within Michigan, as there are always concerns about whether successful programs in other states can transfer successfully to new settings. Numerous other speakers noted interest in longitudinal research that would track patients over time. It was mentioned that the schools of dentistry would be well-positioned to conduct this type of research, given the flexibility that they are allowed within the practice act of most states.

8. There has been some discussion that certain components of the care delivery system already in place might be better used to increase access to care, by providing preventive care in more settings, and by more efficiently using the expanded functions possibilities that are already currently possible.

9. There was considerable interest in the room in the extent to which collaborations between oral health providers and other care providers can increase access to care, with a number of strong models presented. It’s time to bring overall health and oral health back together again. However, as the speakers made clear, collaborations in and of themselves can be challenging and require work and dedication.

In the end it’s important to bring our discussion back to the lives of people. Over the next few weeks, someone in Michigan will miss work because of dental pain. In an already tough economy, this may be precarious to their family’s economic well-being. Further, we know that more than one will find their ability to get a job hampered by their teeth. Lots of people will be in some pain and have difficulty finding care.

In the next few weeks/months a child will miss school because of oral disease, and more than one will be too embarrassed to fully participate in the classroom because of their oral health. At the same time, I know many of you will be out there serving these individuals, and as a relative new comer to this area, I appreciate your efforts greatly.

But we, as a group, obviously think we need to do more, or we wouldn’t be here, and today has made clear that there are some possible solutions that we can consider. We need to continue to work together to examine these, find common ground, think about what would work best in Michigan, and then we have to move beyond talking and act.
Taking steps to seriously increase access to oral health in Michigan will likely take considerably more discussion. It will most likely take compromising, and some risks in trying new things. But if we find some things that work in Michigan, I think it will be worth it for ourselves, but most importantly, for the people who we are here to serve.