

Addressing Dental Workforce in the State of Michigan

Michigan Department of Community Health ~ Oral Health Program
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Michigan Department of Community Health – ***Director Janet Olszewski***

Public Health Administration – ***Chief Administrative Officer Jean C. Chabut***

Bureau of Family, Maternal, and Child Health – ***Director Alethia Carr***

Division of Family and Community Health – ***Director Brenda Fink***

Director of Oral Health – ***Dr. Sheila Vandebush***

MDCH Oral Health Coordinator – ***Jill Moore***

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Goals 15 and 17 of the Michigan Oral Health Plan address workforce issues. Goal 15 focuses on how to, “increase access to oral health services in medically underserved communities and for underserved populations by allowing the provision of high quality dental care through qualified health care providers.”¹ This was placed as a goal because, “there is a serious shortage of dentists willing to care for the uninsured and publicly insured populations. In addition, a number of communities lack enough dentists to care for even the commercially insured population. This strategy will allow us to increase the number of people who receive regular, high quality oral health care from qualified individuals.”¹ Goal 17 is to, “create and maintain a process for assessing and responding to the supply of and demand for oral health professionals.”¹

In order to complete these goals, Michigan must be able to effectively and efficiently track Michigan’s oral health providers and the population. It is necessary to look at how many oral health providers there are in the state, where they are located, their long term plans (ie: retiring, moving, changing occupations), and how many students our dental and dental hygiene schools are graduating each year. We also need to look at where our new graduates are working (private practice, military, specialty) and if they are working within the state of Michigan or moving out of state. It also is necessary to track how many new providers are moving into Michigan. Most importantly, it needs to be determined how many providers are able and willing to treat the underserved community. The data collected then must be compared to the general population of Michigan and its readily changing needs.

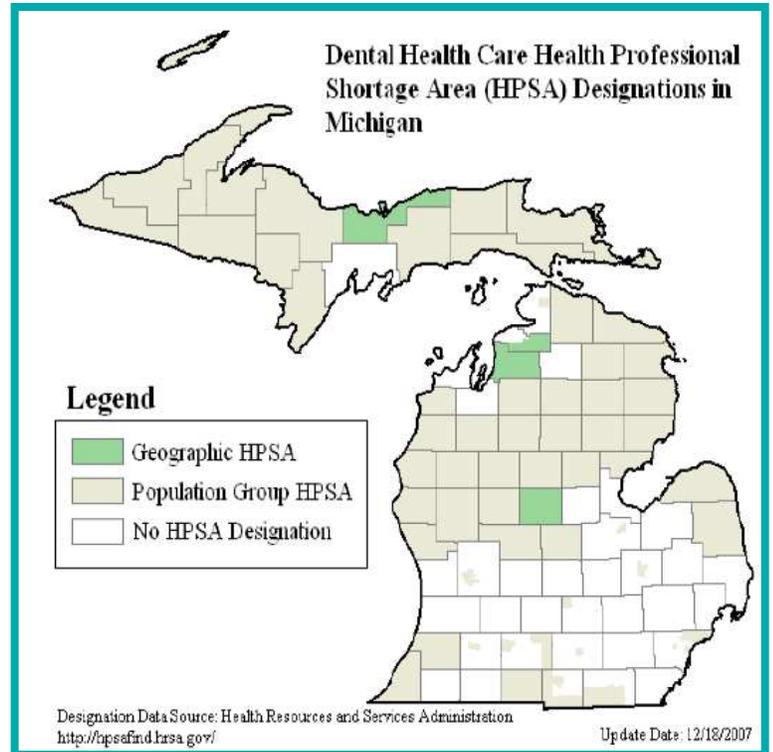
Obtaining a majority of information can be accomplished through the Board of Dentistry, the Michigan Dental Association, and the MDCH Bureau of Health Professions. Michigan has 20,213 dental professionals with a current license. However, it is not clear how many professionals are practicing within the state. The majority of licenses issued are for general dentists. There also are 113 pediatric dentists, 165 endodontists, 236 oral surgeons, 372 orthodontists, 149 periodontists, 7 oral pathologists, and 59 prosthodontists. The state has 9,931 dental hygienists and 1,328 registered dental assistants.

The Bureau of Health Professions includes a licensing survey with 1/3 of the professional license renewal forms annually. A copy of the surveys may be viewed at http://www.michigan.gov/healthcareworkforcecenter/0,1607,7-231-45863_42471---,00.html. The 2006 and 2007 surveys show high rates of workforce attrition in the next 10 years, lack of diversity in the oral health field, and limited oral health care options for Medicaid patients and the uninsured. Key findings from the 2007 survey can be found at <http://www.mohc.org/files/Workforce%20presentation%20-%20Steve%20Creamer.ppt#11> and indicate the following:

- 43% of dentists and 38% of hygienists plan to practice for only one to 10 more years. In comparison, 33% of registered nurses and 34% of physicians plan to practice for only one to 10 more years.
- 7% of dentists plan to retire in the next three years.

- 37% of dentists are 55 or older, and 80% of those who plan to retire or reduce patient care hours cite age as a factor in their decision.
- 81% of dentists are male, and more than 99% of dental hygienists are female.
- 85% of dentists and 95% of hygienists are white.

Both the 2006 and 2007 surveys found the “vast majority of Medicaid and uninsured dental patients are seen by a small minority of dental providers.”² The 2007 Licensing Survey of Dentists showed that only, “three percent have a primary practice site in a local health department or other government agency and 2 percent practice primarily in a community-based nonprofit.”³ Adults enrolled in Medicaid have the most difficulty obtaining dental care, as 81% of dentists reported that in a typical month they don’t see any adult patients who have Medicaid as their coverage and 90% of dentists don’t see any patients in a typical month who pay on a sliding scale. This is especially troubling as nearly 1.7 million Michigan residents are enrolled in Medicaid and some 1.1 million state residents are uninsured.



Non-special needs children in the state of Michigan have an easier time obtaining dental care within a dental office due to coverage provided by Healthy Kids Dental. Healthy Kids Dental is available to Medicaid-eligible children in 61 of the 83 Michigan counties.

Although the dentist survey asks many meaningful questions, it does not ask where the newer dental graduates are planning to practice dentistry. This question has not been included in the survey because it was under the general postulation that the dental schools, University of Michigan (U of M) and University of Detroit Mercy (UDM), would ask this question on exit surveys. Upon investigation, it was discovered that this information currently is difficult to obtain.

UDM surveys its students prior to graduation about their plans after graduation (specialty, private practice, military etc.), but does not ask where they plan to practice. U of M’s information was unobtainable at this time. It is recommended that this question is asked, tracked, and information gathered is made readily available by the dental schools on a yearly basis. Having the question asked through the state licensing survey only reaches those who obtained a Michigan license. Each entering dental class at U of M generally is comprised of 60% of Michigan residents, however, the inability to track graduation data leaves a significant gap in the workforce data. With the current economic condition of the state, it would be pertinent to ask where graduates plan to practice, as it

may be discovered that we are losing a higher number of dental professionals than anticipated.

One-third of dental hygienists also are surveyed annually upon license renewal. According to the Health Resources and Services Administration (HRSA), “the required level of supervision for hygienists is a central aspect of access to care. If hygienists are required by law or rule to be directly supervised, hygienists are limited in the circumstances in which they can provide service. Direct supervision confines the hygienist to situations where the dentist is physically present.”⁹ Due to the regulations put upon dental hygienists, parallel trends are seen in the survey results when it comes to treating the underserved. “Less restrictive supervision requirements most often apply in public settings where dental services are not traditionally offered such as schools and long-term care facilities.”⁹

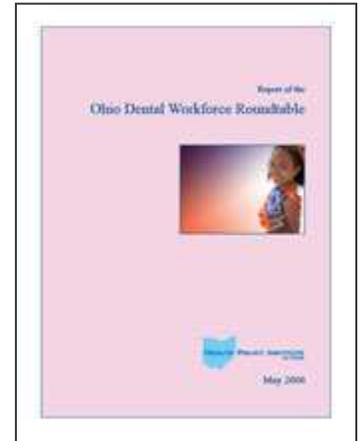
The majority of dental hygienists are working within a private practice and, “about 1 percent work secondarily in a community-based non-profit; another 1 percent work in a local health practice in another setting.”⁴ Michigan has 13 dental hygiene schools. Therefore, the state has the resources to produce dental hygienists. Allowing dental hygienists more individual freedom to provide care to the underserved populations would be a significant step toward providing additional care for the underserved. However, “access to care is directly affected by the reimbursement policies mandated in law and regulation.”⁹ HRSA reports that, “the ability to be reimbursed for services is essential to the provision of any service by a health professional. Almost universally, oral health services are billed by dentists to public and private payers. Dentists, therefore, receive the professional reimbursement for the prophylactic and preventive services provided by the hygienists in their employ. Since reimbursement is generally contingent upon an arrangement with a dentist, hygienists are limited to providing services to locations and patients with whom their employing dentists are engaged.

The ability to be reimbursed directly for services would provide hygienists some autonomy in practice and would permit some self-determination about work locations and patients served.”⁹ Dental hygienists could be utilized in schools providing prevention, treatment and education, and in nursing homes treating the disabled and elderly. Hygienists could be an effective work force provider that could help ensure that all Michigan citizens in need are screened, and could greatly assist in placing people in a dental home. Changing the laws regarding dental hygienists would, of course, require legislative intervention.

Upon researching the workforce of dental professionals in other states, it was found that other states are in the same situation – or worse – than Michigan. Many experience the same issues when it comes to access to dental care for the underserved and are struggling with the shortage of dental professionals. Many also find tracking the workforce is an extremely difficult task to effectively complete. Some other states are working to develop innovative methods to better utilize the dental health professionals they do have, along with trying new programs to either lure dental professionals to their state or keep the ones already there.

The State of Ohio established the Ohio Dental Workforce Roundtable to address workforce issues. “Throughout 2005, the Roundtable met to consider workforce concerns that involve a complex range of public policy and professional practice issues.”⁵ The discussions were led by a professional facilitator hired by the Health Policy Institute of Ohio (HPIO) for the project. “Among the challenges addressed by participants were state budget cuts, longstanding “turf” concerns, and the increased need for cultural competence in order to adequately serve ethnically diverse populations. Roundtable membership included representatives spanning the oral health care workforce, as well as the public and private not-for-profit sectors. Among the participants were:

- Association of Ohio Health Commissioners
- Ohio Dental Expanded Functions Association
- Case School of Dental Medicine
- Ohio Department of Health
- Ohio State Dental Board
- Ohio Coalition for Oral Health
- Saint Luke’s Foundation of Cleveland
- The Ohio State University College of Dentistry
- Ohio Dental Association
- Ohio Dental Hygienists’ Association
- ODH Director’s Task Force on Access to Dental Care”⁵



One of the Roundtable’s meeting goals was to isolate some recommendations which would move the state forward in the name of oral health. Some of those recommendations are:

- “Increase the number of dental students and general practice residents (GPRs) who provide care in safety net dental clinics (e.g., expand The Ohio State University College of Dentistry’s OHIO project).
- Collect data to monitor dental workforce trends through surveys that accompany licensure renewal.
- Expand existing workforce and economic development strategies in Ohio to include education and training for oral health care personnel, as well as incentives to develop appropriate local business strategies to increase access to care.
- Expand the scope of practice for oral health care personnel by increasing allowable duties/functions so as to increase the capacity of dental practices and clinics.”

All of the recommendations, as well as background about the project and the comprehensive policy options discussed by the Roundtable, are included in the Report of the Ohio Dental Workforce Roundtable which can be located at <http://www.healthpolicyohio.org/dentalroundtable.html>.

The State of Kansas brought together the Kansas Dental Workforce Study to address how the state could improve access to oral health care. It was noted that “policymakers

could attempt to increase the supply of dentists, target services toward underserved populations of the state, and/or support the development of new dental practice models, including expanding the types of services that hygienists and other allied professionals can provide.”⁶ The study group stated that, “Dental workforce needs are difficult to predict and can take many years to address, suggesting the need for policymakers to monitor the dental workforce and update policies on an ongoing basis.”⁶

Scotland has put together an extensive package that came from widespread in-depth discussions on oral health workforce issues. The document can be studied at http://www.nes.scot.nhs.uk/documents/publications/classa/NES_Dental_Workforce_250908.pdf. Section 5 of the document is titled *Forecasting the Dental Workforce*. Forecasting dental workforce is discussed in numerous variations. “The project aims to inform workforce planning in dentistry by using robust data to analyze the trends in the supply of dentists, the trends in the utilization of dental services and forecast the demand for and supply of dentists.”⁷ This way of forecasting may be a new approach for Michigan.

Nationally, we have a need for an expansion of Dental Safety Nets Clinics (DSNC). These are non-profit dental facilities where low income families can go for dental care. Most accept insurance and Medicaid, and some have payment on a sliding scale. Nationally, the DSNC serve fewer than “10% of 82 million underserved people”⁸ Michigan has a crucial need for the ability to treat dental emergencies. Emergency room visits for dental needs are absorbing massive amounts of state funding.

Other states are exploring different avenues to increase their dental health providers. These include:

- State loan repayment programs for rural dentists and registered dental hygienists
- Licensing strategies
 - Foreign dentists in safety net settings
 - Licensure by credentials
 - Licensure after service, residency
 - Working toward a national license for dental professionals
- Payment incentives
 - Higher Medicaid fees in rural areas
 - Increasing fees for treating persons with special needs
- Integrating oral health into primary care
 - Dentist to population ratio shrinking; Primary Care Physician (PCP) to population ratio is growing
 - Prevention is cheaper and better
 - More frequent, earlier use of primary care services for young children and the underserved
 - Patient has an increased trust and comfort level
- Oral health services PCP can provide:
 - Oral health evaluation (visual screening)

- Early prevention intervention
- Application of fluoride varnish
- Patient and parent education
- Dispensing oral health supplies (toothbrushes, dentifrice, floss)
- Referrals⁸
- Additional suggestions would be:
 - Teledentistry
 - Tax incentives
 - Continuing education credits (CEUs) in trade for clinical volunteer hours
 - Mandatory residency in a safety net clinic for one year out of dental and dental hygiene school

Curricula or training for primary care providers is currently seen in Alaska, Arkansas, California, Kentucky, Maine, New Hampshire, Nevada, New York, Oregon, South Dakota, Washington, and Wisconsin. Medicaid payment for physicians to provide fluoride varnish currently is established in at least 10 states. South Carolina has joint initiatives for screening and referral. Many states are gradually changing their supervision laws regarding dental hygienist scope of practice in public health settings. “Direct access to patients in some settings in 22 states (Arizona, California, Colorado, Connecticut, Iowa, Kansas, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Mexico, Nevada, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Washington)”⁸ and “Medicaid can reimburse hygienists directly in 12 states (California, Colorado, Connecticut, Maine, Minnesota, Missouri, Montana, New Mexico, Nevada, Oregon, Washington, Wisconsin).”⁸

There are various dental provider models surfacing in the U.S. and around the world. New Zealand, Australia, Canada and 51 other countries have the Dental Therapist – now available in Alaska – called the Dental Health Aid Therapist. The Oral Health Therapist is a three-year program which combines dental hygiene and dental therapy. Some states have expanded functions for dental assistants. Minnesota is now the first state in the lower 48 to pass legislation for a new dental provider. The legalities of this measure are still being worked out.

When it comes to access to oral health care for the underserved population, the lack of care is felt world wide. It is clear that in one way or another it is imperative to develop an effective and efficient oral health workforce model in Michigan. With steadily increasing research linking oral health to total body health, it is now evident that oral health care must be a priority. Prevention and treatment of oral disease will make healthier people and save in health costs. However, in order for the dental workforce to be able to meet the demands of the general population, changes need to be made.

Many of the states in the U.S. – as well as different countries – are creating innovative ways to get the much needed dental care to its citizens. Michigan is home to some impressive oral health resources, but the need among our state residents is great. That’s

why Michigan will continue to move forward with a sense of urgency and work diligently to create the best possible way to provide dental access to all of our citizens.

References

- ¹ MDCH (September, 2006). *Michigan oral health plan*. Retrieved March 3, 2009, from:
http://www.michigan.gov/documents/oral_health_work_plan_final_color_140634_7.pdf.
- ² Bucholz, T.J. (June 20, 2007). *MDCH surveys provide comprehensive data on Michigan's oral health workforce*. Retrieved January 14, 2009, from:
<http://www.michigan.gov/mdch/0,1607,7-132-8347-170739--,00.html>.
- ³ MDCH (March, 2008). *Survey of dentists 2007*. Retrieved January 14, 2009, from:
http://www.michigan.gov/documents/healthcareworkforcecenter/2007DENTISTreport_230004_7.pdf.
- ⁴ MDCH (March, 2008). *Survey of dental hygienists 2007*. Retrieved January 14, 2009, from:
http://www.michigan.gov/documents/healthcareworkforcecenter/2007DENTALHYGIENISTreport_230002_7.pdf.
- ⁵ Health Policy Institute of Ohio (May, 2006). *HPIO completes work with Ohio dental workforce roundtable*. Retrieved March 6, 2009, from:
<http://www.healthpolicyohio.org/dentalroundtable.html>.
- ⁶ ASTDD (May, 2005). *Kansas dental workforce study*. Retrieved March 6, 2009, from: http://www.astdd.org/dynamic_web_templates/sactivities.php?id=180.
- ⁷ ISD Scotland (September, 2008). *Dental workforce project*. Retrieved March 16, 2009, from: <http://www.isdscotland.org/isd/1442.html>.
- ⁸ Gehshan, S (January, 2008). *Dental workforce trends-opportunities for rural leadership*. *National Academy for State Health Policy*. Retrieved March 6, 2009, from:
http://www.nosorh.org/events/files/NOSORH_1-08.ppt.
- ⁹ U.S. Department of Health and Human Services (April, 2004). *The professional practice environment of dental hygienists in the fifty states and the District of Columbia*. Retrieved March 31, 2009, from:
<http://bhpr.hrsa.gov/healthworkforce/reports/hygienists/dh6.htm>