

Report of the
Michigan Department of Community Health
Oral Health Work Group

November 2014

Executive Summary

In July 2014 the Director of the Michigan Department of Community Health called for the establishment of an Oral Health Work Group. The Oral Health Work Group was charged with developing a coordinated and comprehensive approach to ensuring access to oral healthcare services across the life span for all Michigan residents. The invited participants represented an array of stakeholders, including representatives from private dentistry, safety net dental providers, dental education, dental hygienists, medical and dental plans, Medicaid administration, and public health.

The goals of the MDCH Oral Health Work Group were to:

- Identify the care delivery, policy, financing and community factors that impact the delivery of oral health care services in Michigan, with special attention to the needs of at risk populations;
- Identify best practices and emerging strategies being employed in Michigan and in other states to enhance access to oral health care; and
- Identify and prioritize recommendations that support a patient-centered, integrated, evidence-based, and data-driven oral healthcare system.

Through a series of four in-person meetings, supported by information sharing between meetings, the Oral Health Work Group participants discussed key issues affecting the availability and delivery of oral healthcare, and generated a series of potential action steps that would move Michigan along the path toward a more coordinated and comprehensive approach to oral healthcare services for all residents. During the final in-person meeting, participants voted on the importance and feasibility of each proposed action step. All action steps recommended by the participants were included, without consideration of the legislative, fiscal, or policy factors that could be necessary to implement the action steps as proposed. The top ten action steps as determined through a participant voting process based on rankings of importance and feasibility are presented on pages 3-5.

Top Ten Action Steps toward a More Coordinated and Comprehensive Approach to Oral Healthcare

Expand Healthy Kids Dental to Kent, Oakland and Wayne Counties in Fiscal Year 2016

The Healthy Kids Dental program has been shown to increase the participation of private dentists in Medicaid, which improves children's access to dental care. Expanding Healthy Kids Dental to the remaining three counties will move Michigan toward more equitable access to dental care for all children.

Appoint an MDCH Oral Health Advisory Committee to oversee the implementation of activities recommended by the Oral Health Work Group.

The administration and provision of oral health care are spread across many different types of providers and service delivery settings. An Oral Health Advisory Committee should be charged with the responsibility for planning, advocating for and tracking progress on implementing the key recommendations from this Work Group, and for coordinating with other oral health initiatives in the state.

Add questions regarding oral health status and/or dental services utilization to the standard Health Risk Assessment for Healthy Michigan Plan enrollees

The Health Risk Assessment is a tool to help patients and providers recognize health issues and establish plans to improve health behaviors. Incorporating oral health into the Health Risk Assessment may help to promote the use of preventive oral health interventions and to identify the need for dental treatment among underserved populations.

Modify Medicaid policy to ensure that all adults enrolled in Medicaid Health Plans have the same dental benefit administration as those enrolled in the Healthy Michigan Plan.

Currently, Medicaid Health Plans administer the dental benefit for Healthy Michigan Plan enrollees, but not for their other adult Medicaid members. Establishing a standard dental administrative structure for all adults enrolled in Medicaid Health Plans will decrease the administrative burden for providers, broaden quality improvement opportunities, and improve access to dental services for adults.

Add preventive dental visit to list of healthy behaviors that qualify for cost-sharing reduction under the Healthy Michigan Plan.

Establishing a consistent pattern of preventive dental care is essential to long-term oral health, and to avoiding costly emergency or inpatient care for untreated dental disease. The inclusion of preventive dental visits in the options for cost-sharing reduction will reinforce the importance of preventive dental care to Healthy Michigan Plan enrollees.

Incorporate pediatric quality measures for dental care and oral health prevention into the Healthy Kids Dental and the Medicaid Health Plan contracts.

Recently, national organizations have generated evidence-based, field tested quality measures for

dental care and oral health preventive services among children. Incorporating quality measures into Medicaid performance monitoring efforts will support the tracking of data trends over time and identification of areas for improvement.

Require screening programs (e.g., mobile dentistry, Public Dental Prevention Programs) to submit data to the Michigan Department of Community Health on numbers screened and referred, source of referral, and the number receiving follow-up dental care.

The value of oral health screening is limited if patients do not receive follow-up care for identified problems. Requiring data on screening and follow-up care will clarify the responsibility of screening programs and provide a mechanism for tracking progress and identifying areas or programs in need of improvement.

Implement payment reform modification for dental services under Medicaid.

Payment for health care typically involves standard fee-for-service reimbursement for services rendered, without regard to the value. In contrast, pay-for-value structures may be used to

promote certain aspects of care (e.g., enhanced reimbursement for preventive dental services or for care coordination), to discourage high-cost care (e.g., financial penalties for preventable emergency department use), or to reward high-quality care (e.g., payments based on dental quality measures or patient outcomes).

Create and disseminate materials to educate Medicaid beneficiaries about their dental benefits and the process for finding a dental provider.

Currently, Medicaid dental benefits may be administered through the enrollee's Medicaid Health Plan, through a separate dental plan, or by the Medicaid program itself. Providing clear and easy-to-understand guidance about how to obtain dental care under Medicaid may help to address confusion among Medicaid beneficiaries and providers.

Evaluate different strategies to activate Medicaid beneficiaries to seek preventive dental care.

Many Michigan residents – particularly those in low-income groups – do not have established patterns of preventive dental care, which can lead to painful and costly dental problems. Strategies to encourage Medicaid beneficiaries to seek preventive dental care range from assigning beneficiaries to specific dental providers, involving medical providers in referrals, or creating targeted strategies based on age or health condition. Evaluation will help to identify the most effective strategies.

In addition to the top ten action steps, the Oral Health Work Group recommended other action steps in the following areas:

- additional areas of oversight of Michigan's efforts around oral health to ensure coordination across initiatives;

- improving Medicaid dental benefits administration for providers and beneficiaries; connecting people with available services for screening, prevention, and treatment;
- educating and activating Michigan residents around oral health to ensure that all persons understand the importance of regular dental care;
- enhancing data support for oral health to facilitate the identification of problems and the measurement of progress;
- improving the quality of oral health services through performance measurement and technical assistance;
- embedding oral health across state programs to ensure linkages with health and human services across the lifespan;
- leveraging local public health to incorporate oral health into programs that interface with vulnerable populations;
- expanding the oral health workforce, both dentists and support personnel; and enhancing oral health collaboration between medical and dental providers around screening, referral and emphasizing the role of oral health in overall health.

Summary of the Michigan Department of Community Health Oral Health Work Group

Background on the Oral Health Work Group

In summer 2014, the Director of the Michigan Department of Community Health called for an Oral Health Work Group to chart the path toward a coordinated and comprehensive approach to ensuring access to oral healthcare services across the life span for all Michigan residents. A coordinated and comprehensive approach:

- assesses community needs and expectations in order to dedicate adequate and appropriate resources in support of an effective oral health care system;
- encourages cost-effective care delivery models that enable access to care for all segments of the population;
- educates and supports a diverse healthcare workforce that is prepared to deliver comprehensive and team-based oral healthcare that emphasizes outcomes; and
- aligns payment and systems approaches toward a value-based model that reimburses for prevention and reduced risk, and integrates oral health into overall health (primary care approach).

The Oral Health Work Group was structured to be limited in size and scope. The period of activity was July to September 2014, consistent with the focus on developing an approach, rather than developing a detailed implementation plan. The invited participants represented the key constituencies responsible for delivering, administering and advocating for oral health services: private dentistry, safety net dental providers, dental education, dental hygienists, medical and dental plans, Medicaid administration, and public health. A full list of Work Group members and their affiliations is found in the Appendix.

The goals of the Oral Health Work Group were to:

- Identify the care delivery, policy, financing and community factors that impact the delivery of oral health care services in Michigan, with special attention to the needs of at risk populations
- Identify best practices and emerging strategies being employed in Michigan and in other states to enhance access to oral health care
- Identify and prioritize recommendations that support a patient-centered, integrated, evidence-based, and data-driven oral healthcare system.

Work Group Process

The Work Group proceeded through a series of four in-person meetings in July and August 2014.

Meeting 1: Factors Impacting Oral Health in Michigan

An opening presentation by MDCH Oral Health Program staff served to document the need to improve the oral health status of Michigan residents, from childhood (e.g., incidence of early childhood caries, school-age oral health surveillance results) to adults (e.g., dental-related hospitalizations, tooth extractions, cost barriers among seniors). Other key evidence included a map of Michigan counties designated as Dental Health Professional Shortage Areas.

A group brainstorming activity allowed all Work Group members to describe the current status of four components of Michigan's oral health care system:

- *Care*: the provider groups, locations, and systems involved in delivering oral health care
- *Community*: the programs, policies and stakeholders who support community engagement on oral health issues
- *Policy*: the combination of state and federal policies and regulations that facilitate oral health
- *Financing*: the array of mechanisms that form the financial underpinnings of public and private oral health care delivery

The final product of this brainstorming activity is found in the Appendix .

Meeting 2: Enhancing Capacity

A group discussion about Michigan's oral health capacity clarified which provider groups provide specific types of service (screening, prevention, treatment/ restorative) in which settings. The group discussed the differences between usual sites and special programs.

Usual sites – private dental offices, dental clinics in Federally Qualified Health Centers or local health departments, and dental professional schools – are staffed by dentists, often alongside dental hygienists, and offer a consistent schedule for the full range of dental services. As such, they offer all services of a dental home; however, many usual sites limit their patient population based on insurance status.

Special programs—including screening programs, mobile clinics, and free clinics—typically serve all populations, operate in more varied settings, rely more on dental hygienists and other allied professionals, have an irregular and more limited schedule of service in any single location, and often have a limited set of services. Due to these limitations, special programs are not well suited to serving as an individual's dental home; yet they provide valuable oral health care to many underserved populations.

Work Group members broke into small groups to discuss potential strategies or action steps in three areas: increasing capacity in usual sites, increasing capacity in special programs, and coordinating care delivery between usual and special sites.

Meeting 3: Working through Challenges

A group discussion about patient activation around oral health highlighted the importance of educating the public about when and how to seek dental care, but also noted the limited activity and lack of designated responsibility for this area.

Work Group members broke into small groups with sets of questions designed to promote the identification of potential strategies to address barriers that had been raised in prior meetings.

Group 1 discussed how to promote great involvement of private dentists in caring for Medicaid populations; options for restructuring reimbursement and incentives; the benefits and drawbacks of expanded scope of practice; and the challenge of expanding safety net clinics without creating unhealthy competition.

Group 2 discussed strategies to strengthen the link between screening programs and usual dental sites; the role of state and local oral health coalitions; options to review and coordinate the funding of the patchwork of special sites; and priorities for screening and surveillance activities.

Group 3 discussed the appropriate role of medical providers in oral health and related training needs; strategies for increasing collaboration across medical and dental providers; options for implementing resources to connect patients with available dental services; and how to enhance surveillance and screening activities to ensure participants receive needed follow-up care.

Brainstorming exercises, small group discussions, and suggestions contributed by Work Group members outside of the meetings, led to the creation of 70 proposed action steps that could enhance Michigan's framework for oral health care.

Meeting 4: Recommendations

The Oral Health Work Group's final meeting involved discussion of the 70 proposed action steps, followed by confidential, electronic voting by each Work Group member on the importance and feasibility of each action step.

After the final meeting, votes were verified to correct a small number of technical difficulties. For each proposed action step, an overall average was calculated. To mitigate the influence of a single outlier vote, an adjusted average that excluded the single highest and lowest scores was calculated. This adjusted average is the basis of the final Work Group recommendations: Strongly Recommended (average in the top ten of proposed action steps), Recommended (average in the top half of proposed action steps), Supported (average in the lower half excluding the lowest ten), and No Rating (average in the bottom ten of proposed action steps).

For purposes of presentation, the action steps are grouped into ten thematic categories. In a small number of cases, action steps with similar themes and the same ranking have been combined.

1. Oversight of Michigan's efforts around oral health
2. Improving Medicaid dental benefits administration
3. Connecting people with available services
4. Educating and activating Michigan residents around oral health
5. Enhancing data support for oral health
6. Improving the quality of oral health services
7. Integrating oral health across state programs
8. Leveraging local public health
9. Expanding the oral health workforce
10. Enhancing collaboration between medical and dental providers

A discussion of the MDCH Oral Health Work Group recommendations, by category, follows.

1. OVERSIGHT OF MICHIGAN'S EFFORTS AROUND ORAL HEALTH

The goal of the Oral Health Work Group was to identify and prioritize recommendations toward a more comprehensive and coordinated system for oral health care. The critical next step is to designate the responsibility for following through on the steps toward implementation of the Work Group's recommendations.

The Work Group *strongly recommends* that an MDCH Oral Health Advisory Committee be appointed to oversee implementation of its recommendations. Currently, many agencies and organizations play a role in delivering, administering or advocating for oral health care; however, no single entity has broad responsibility and authority for the direction of enhancements to Michigan's oral health systems. The Advisory Committee should include representation from dentists in both private and safety net settings, dental education, dental benefit administrators, medical providers, state and local public health, Medicaid, oral health advocates such as the Michigan Oral Health Coalition, and state policymakers. The Advisory Committee should have responsibility for planning and tracking progress on implementing the key recommendations from this Work Group, in coordination with other oral health initiatives in the state, such as the State Oral Health Plan.

In addition, the Work Group *recommends* establishing a report card on key oral health outcomes, to assess progress toward achieving goals. The report card would include access measures (e.g., dental home, coverage for dental services), utilization measures (e.g., receipt of ≥ 1 preventive dental visit per year), and oral health status measures (e.g., early childhood caries, restorative dental service). Importantly, the report card would incorporate measures targeted to different age groups (young children, school-age children, adults, seniors) to facilitate tracking of progress across the lifespan.

2. IMPROVING MEDICAID DENTAL BENEFITS ADMINISTRATION

The administration of Medicaid dental benefits varies across the program. Depending on the age, county of residence, and program eligibility of the beneficiary, as well as the location of dental service, dental benefits may be administered through a Medicaid Health Plan, through a separate dental plan, or by the Medicaid program itself.

The Work Group *strongly recommends* the expansion of the Healthy Kids Dental program to the remaining three counties (Kent, Oakland and Wayne) in Fiscal Year 2016. The Healthy Kids Dental program has been shown to increase private dentist participation in Medicaid, which improves children's access to dental care. Expanding Healthy Kids Dental to the remaining three counties will move Michigan toward more equitable access to dental care for all children, and will set the stage for future examination of dental capacity in Michigan's most populous counties. This action step was the highest rated recommendation of the Work Group.

The Work Group *strongly recommends* a modification of Medicaid policy to ensure that all adults enrolled in Medicaid Health Plans have the same dental benefit administration as those enrolled in the Healthy Michigan Plan. Currently, Medicaid Health Plans administer the dental benefit for Healthy Michigan Plan enrollees, but not for their other adult Medicaid beneficiaries. Establishing a standard dental administrative structure for all adults enrolled in Medicaid Health Plans will decrease the administrative burden for providers, broaden quality improvement opportunities, and reduce confusion among beneficiaries who move across programs. Together, these benefits may serve to improve access to dental services for adults enrolled in Medicaid.

The Work Group *strongly recommends* implementation of pay-for-value payment reform modifications for dental services under Medicaid. Payment for health care typically involves standard reimbursement for services rendered, without regard to the value or effectiveness of those services. In contrast, pay-for-value structures may be used to promote certain aspects of care (e.g., enhanced reimbursement for preventive dental services or for care coordination), to discourage high-cost care (e.g., financial penalties for preventable emergency department use), or to reward high-quality care (e.g., bonus payments based on dental quality measures or patient outcomes). Payment reform may be employed strategically across Medicaid programs, to address key oral health issues in different populations.

The Work Group *recommends* the provision of guidance and sharing of best practices for dental administration to the Clinical Advisory Committee of the Medicaid Health Plans. Michigan’s current Medicaid Health Plans are experienced in administering medical benefits: assessing the adequacy of their provider networks, monitoring utilization patterns of providers and beneficiaries, and encouraging beneficiaries to seek preventive medical care. However, the same Medicaid Health Plans lack knowledge and experience in conducting those same processes for administration of dental care. MDCH could support Medicaid Health Plan efforts to effectively administer dental benefits by providing a forum to learn, collectively, about the strategies and resources that can be employed in the area of dental services. Building this support into the existing Clinical Advisory Committee, a group of medical directors of the Medicaid Health Plans who meet quarterly with Medicaid officials, will establish a familiar and functional framework for this type of support.

The Work Group *recommends* identifying opportunities to include dental services as part of the Dual Medicaid-Medicare Demonstration Project. Providing dental care to seniors is a unique challenge, because Medicare—the primary source of seniors’ insurance for medical care—does not cover routine dental services; Medicaid coverage for dental care is limited for this age group; and screening and surveillance programs are directed at other age groups. Michigan has been selected by CMS to participate in a demonstration project to integrate and improve physical and mental health care for seniors who are dual-eligible for Medicare and Medicaid, yet dental is not currently included in the menu of services to be integrated. Striving to incorporate dental providers and oral health services in this demonstration project may require creative partnerships and/or financial adjustments, but has the potential to make a positive impact on a key population who is underserved for dental care.

In addition to the recommendations described above, the Work Group *supports* the following action steps in the area of improving Medicaid dental benefits administration:

- Create a Medicaid Dental Advisory Committee that would parallel the Clinical Advisory Committee, but with a sole focus on dental services.
- Improve the user-friendliness of the system by which dental providers check Medicaid enrollment, which is perceived by private dentists as an administrative burden that deters participation in Medicaid.

3. CONNECTING PEOPLE WITH AVAILABLE SERVICES

Michigan’s oral health capacity includes established dental private and public dental clinics, as well as a broad array of special programs targeted to specific age groups, geographic locations, or services. The absence of a system to connect Michigan residents with available services in their community was identified as a significant gap in Michigan’s oral health framework.

The Work Group *strongly recommends* creating materials to educate Medicaid beneficiaries about their dental benefits and the process for finding a dental provider. From the patient perspective, Medicaid dental coverage can be confusing, with different programs based on age, county of residence, or other program eligibility; many beneficiaries have fee-for-service dental coverage upon initial enrollment, with a subsequent change to another program once eligibility is confirmed. While the selection of a medical provider is supported by a defined enrollment process, there is little guidance in finding a dental provider that matches program eligibility. There is a great need for materials that explain Medicaid dental benefits in simple language and direct beneficiaries to sources that can assist with finding a dental provider.

The Work Group *recommends* the assignment of specific roles and responsibilities for the creation and maintenance of a central registry of dental services. Special programs offering oral health services to targeted populations range from school-based screening and cleaning programs, to free clinics that provide much-needed dental treatment a limited number of patients on selected dates. However, their variable schedules and narrow eligibility parameters make it a challenge for referral sources (e.g., health and social service agencies) to connect patients in need of dental with these special programs. While the Michigan Oral Health Coalition and the Michigan Dental Association both produce excellent resource guides that describe many of these special programs, no single entity has responsibility for maintaining a centralized, up-to-date registry of dental services that could serve as a real-time clearinghouse to connect Michigan residents with available dental services. Initiatives in other states, such as Washington State's 2-1-1 oral health program, may represent best practices that will inform Michigan's efforts.

The Work Group *recommends* the development and dissemination of a simple guide for medical providers to assist patients in linking to a dental home. There is emerging recognition of the link between oral health and other aspects of physical health, yet when medical providers identify dental problems, they typically have few resources and limited time to connect patients with dental care. Clear and simple guidance is needed to support medical providers in this role.

The Work Group *recommends* incorporating oral health into the patient navigation activities of Community Health Workers and Home Visiting staff. Many programs through the Michigan Department of Community Health feature staff designated to help residents sign up for insurance, connect with social services, and navigate the health care system. Too often, oral health is missing from this menu. Training and resources are needed to prepare community health workers and other navigators for a role in linking Michigan residents to needed oral health services, and in emphasizing the importance of seeking preventive dental care.

The Work Group *recommends* pilot testing a system for referral to dental care after an emergency department visit for a dental problem. Lack of routine dental care can lead to untreated dental

problems that eventually cause significant pain and decay. Often, those who seek emergency care for dental problems were unable to access routine dental care in their community. To ensure necessary follow-up care and reduce the likelihood of future emergency dental visits, there is a need for a process to link patients to a designated dental home. Pilot programs, perhaps in conjunction with initiatives of the American Dental Association, will be useful in identifying the most effective strategies for such linkages.

In addition to the recommendations described above, the Work Group *supports* the following action steps in the area of connecting Michigan residents with available oral health services:

- Require all special programs to maintain current information in the central registry of dental services once it is created, to support real-time referrals.
- Establish common expectations for Medicaid dental benefits administrators regarding matching beneficiaries with dental providers to ensure consistent processes and support services across Medicaid programs and populations.

4. EDUCATING AND ACTIVATING MICHIGAN RESIDENTS AROUND ORAL HEALTH

Improvements in oral health capacity and process will have limited impact unless Michigan residents understand the need for regular dental care, and seek dental services accordingly. Numerous opportunities exist to promote patient activation around oral health.

The Work Group *strongly recommends* adding questions about oral health status and/or dental services utilization to the standard Health Risk Assessment for Healthy Michigan Plan enrollees. The Health Risk Assessment, a core component of the Healthy Michigan Plan, is a tool for primary care providers to help patients recognize their own health issues and establish plans to improve health behaviors. Adding oral health questions to the Health Risk Assessment will serve to identify patients in need of referral for dental treatment based on current symptoms or recent emergency department dental visits, and will provide an opportunity for the health care team to emphasize the importance of regular preventive dental care.

The Work Group *strongly recommends* adding preventive dental visits to the list of healthy behaviors that qualify for cost-sharing reduction under the Healthy Michigan Plan. Regular preventive dental care is essential to oral health, and to avoiding costly emergency or inpatient care for untreated dental disease, yet many low-income adults receive no preventive dental care. Including preventive dental visits in the options for cost-sharing reduction will provide an additional incentive for Healthy Michigan Plan enrollees to seek preventive dental care.

The Work Group *strongly recommends* evaluating different strategies to activate Medicaid patients to seek preventive dental care. It is unclear whether the low rate of preventive dental care among

Medicaid enrollees is due to financial or access barriers, lack of understanding about the need for regular dental visits, or lack of patient initiative to seek care. The relative importance of these and other factors may differ by age and other characteristics. Testing different mechanisms to activate patients around preventive dental care, measuring success in terms of completed visits, will help to identify the most promising strategies.

The Work Group *recommends* including a dental assessment as part of requirements for kindergarten entry. Michigan children entering kindergarten have a standard set of health-related requirements including hearing and vision screening, immunizations, and a health appraisal from a medical professional. Adding a dental assessment to these requirements will provide a consistent mechanism to screen all children for caries or other tooth decay and identify those in need of dental treatment.

The Work Group *recommends* developing an educational/ media campaign around oral health across the lifespan. Many Michigan residents have limited experience with dental care. A coordinated educational campaign should aim to present a lifespan approach to oral health, including self-care, preventive dental services, and having a usual source of dental care.

The Work Group *recommends* identifying characteristics of children who do not utilize dental services through their Healthy Kids Dental benefit. By tracking the number of children who receive dental services in counties with Healthy Kids Dental compared to those with fee-for-service dental, the Department of Community Health has documented the increase in dental utilization associated with Healthy Kids Dental. However, little is known about the roughly 40% of children who have the Healthy Kids Dental benefit but do not utilize dental services. Focused research on this population may help to identify new strategies to promote dental care.

5. ENHANCING DATA SUPPORT FOR ORAL HEALTH

Consistent and comprehensive data are needed to document patterns of dental services utilization across different populations and geographic areas, as well as to monitor the impact of new programs. Currently, oral health data are insufficient to fully support these functions.

The Work Group *strongly recommends* requiring oral health screening programs to submit data on the number of persons screened, the number referred, and the number who received follow-up dental care. An effective oral health screening program identifies persons with evidence of tooth decay or other oral health problems, and links those persons with appropriate follow-up care. Policies for oral health screening conducted through Public Act 161 (“PA 161 programs”) and Michigan’s recent law governing mobile dentistry articulate the need for linkages with follow-up care. Oral health screening programs should collect and submit annual data on their screening, referral and follow-up rates, by screening site, to allow the State to ensure that follow-up services are received.

The Work Group *recommends* that special oral health programs be required to transfer clinical data to patients' usual dental provider. The services provided through special oral health programs can include preventive care (e.g., administration of sealants and fluoride varnish, teeth cleaning), diagnostic care (e.g., x-rays), or treatment (e.g., fillings). To ensure continuity of dental care without duplication of services, it is essential that special programs transfer clinical information to patients' usual dental providers.

The Work Group *recommends* assessing the technical feasibility and provider acceptability of including oral health services in the Michigan Care Improvement Registry (MCIR). MCIR is used widely by child health providers and local public health staff to track children's receipt of immunizations and lead screening; to a lesser extent, MCIR is used by adult medical providers to review their patients' immunization status. Careful consideration should be given to incorporating oral health information into MCIR, through assessment of data quality from providers in different oral health delivery settings, availability of specific data fields that can accommodate both manual and automated data entry, and acceptability to medical, dental and public health providers.

The Work Group *recommends* disseminating annual county-specific utilization data across all age groups and Medicaid programs. Comparing dental utilization rates by county offers a useful perspective on access to dental care, yet current data dissemination for Medicaid beneficiaries provides county-level data by age group, by Medicaid program category, and/or by health plan. Synthesizing data across ages, programs and plans would serve as an additional measure each county's dental access.

The Work Group *recommends* data aggregation efforts that include both medical and dental claims. The Michigan Department of Community Health is involved in several multi-payer initiatives, including those that strive to combine healthcare administrative data (i.e., "claims data) from both public and private payers. Efforts are needed to ensure that aggregated data efforts include both medical and dental administrative data.

In addition to the recommendations described above, the Work Group *supports* the following action steps in the area of enhanced data support:

- Pilot test and evaluate a system for tracking follow-up care for those referred from special programs to identify strategies that are effective and efficient.
- Provide technical assistance for dentists to achieve incentives by meeting electronic health record Meaningful Use requirements to support improvements in the dental data environment.
- Pilot test the sharing of electronic dental records in Michigan's health information exchange (HIE) efforts to establish a consistent and technically sound platform for coordinated storage and analysis of medical and dental data.

6. IMPROVING THE QUALITY OF ORAL HEALTH SERVICES

Quality improvement is commonplace in medicine, to assess the performance of providers, hospitals and health plans, identify areas for improvement, and monitor the impact of policy and programmatic changes. Broader use of quality improvement techniques for oral health can support these same goals.

The Work Group *strongly recommends* incorporating pediatric quality measures into Healthy Kids Dental and Medicaid Health Plan contracts. Key quality indicators for dental care provided through Healthy Kids Dental may include annual dental visits, continuity of care (e.g., dental visits in consecutive years), and follow-up care after emergency room dental visits. Other quality indicators may focus on oral health services from medical providers (e.g., fluoride varnish administration). Implementation of quality indicators should build on recent efforts to develop and test measures, notably those generated through the Dental Quality Alliance.

The Work Group *recommends* incorporating dental quality measures for adult Medicaid populations. As Michigan's adult Medicaid population expands, dental quality indicators will be useful to monitor the performance of Medicaid Health Plans and their contracted dental partners. Implementation should build on efforts by the Dental Quality Alliance and others who are developing and testing measures for adult populations.

The Work Group *recommends* providing technical assistance for school-based oral health care. Schools are an ideal setting for delivering oral health services: ready access to populations who need ongoing screening and opportunities to educate students on oral health behaviors. However, if school health staff are going to expand their involvement in providing oral health services, technical assistance is essential to ensure that services are delivered with consistency and technical competence. Best practice guides for sealant administration and oral examinations, as well as state-specific guidance for billing and reporting, should be included.

In addition to the recommendations described above, the Work Group *supports* the following action steps in the area of improving the quality of oral health services:

- Provide training for dentists and allied oral health professionals in the care of special populations to enhance their comfort with seniors, very young children, persons with special health needs, and persons with special behavioral health needs.
- Assess the quality of clinical practices for special oral health programs, and disseminate best practices to establish a paradigm for continued assessment and improvement in delivery oral health services.

7. INTEGRATING HEALTH ACROSS STATE PROGRAMS

Oral health affects all age, ethnicity, geographic and socioeconomic sectors. As such, sustained and systematic efforts should be made to weave oral health into the planning, implementation and evaluation activities of programs offered by the State of Michigan and its partners.

The Work Group *recommends* identifying specific oral health liaisons to programs for young children, school-age children, adults and seniors. The State of Michigan serves its residents through various programs administered by the Departments of Community Health, Education, and Human Services. Key programs include WIC, Maternal and Infant Health Program, Children’s Special Health Care Services, Immunization, Head Start, Great Start, Early On, Child & Adolescent Health Centers, hearing and vision screening, chronic disease, cancer prevention, HIV, family planning, perinatal, community mental health, and home visitation. The identification of a specific individual to serve as liaison will yield a more consistent and comprehensive approach to promoting the inclusion of oral health into these programs.

The Work Group *recommends* identifying specific oral health liaisons to key demonstration projects. The Department of Community Health participates in numerous demonstration projects that strive to transform care, including the State Innovation Model, Health Innovation Grants, Integrated Care for People Eligible for Medicare and Medicaid, Michigan Primary Care Transformation (MiPCT), Emergency Department High Utilizers, and Michigan Pathways to Department of Community Health Better Health. The identification of a specific individual to serve as liaison will yield a more consistent and comprehensive approach to promoting the inclusion of oral health into these demonstration programs.

The Work Group *recommends* disseminating a directory of Department of Community Health oral health programs across the lifespan to health and human service agencies statewide. The state’s oral health program encompasses a broad array of activities, including oral health surveillance, screening and preventive services delivery, collaborative agreements with other MDCH programs, community water fluoridation advocacy, oral health education, and technical support. Dissemination information about the oral health program’s services and personnel to agencies across the state will establish a two-way street for linkages across programs.

The Work Group *recommends* disseminating oral health educational materials via the Department of Community Health website, local health departments, and oral health liaisons to other programs. High-quality educational materials contain evidence-based information, up- to-date statistics, language targeted to the intended audience, and culturally appropriate graphics and text. The Department of Community Health Oral Health Program should create a reference library of high-quality educational materials, and actively disseminate these materials to public and private partners.

In addition to the recommendations described above, the Work Group *supports* the following action step in the area of embedding oral health across state programs:

- Strengthen oral health education requirements for licensure of daycares and long-term care facilities to increase staff knowledge on key oral health principles and to present best practices around oral health screening.

8. LEVERAGING LOCAL PUBLIC HEALTH

Michigan's local public health departments interface daily with residents through programs for mothers and young children (e.g, WIC, Maternal and Infant Health Program), high-risk populations (e.g., Children's Special Health Care Services, HIV clinics), school-age screening programs (e.g., hearing & vision screening), and immunization delivery for all ages. Many health departments have dental clinics onsite. Still, opportunities exist to further enhance oral health education and service delivery by local health department staff.

The Work Group *recommends* supporting local health departments in billing for oral health services provided in conjunction with other programs. The funding model for local public health includes a focus on billable services. To facilitate the sustained ability to deliver oral health services during interactions for other local public health programs, it is critical to facilitate reimbursement for those services through Medicaid.

In addition to the recommendations described above, the Work Group *supports* the following action steps in the area of leveraging local public health:

- Utilize local health departments to educate consumers about dental benefits and coverage through staff trained as patient navigators.
- Establish minimum oral health requirements for local health departments to ensure a consistent level of involvement in oral health promotion, outreach, education, and service delivery.
- Explore models and disseminate best practices for offering dental services through local health departments, building on the experiences of successful clinics in Michigan, including those operated by the Michigan Community Dental Clinics, and in other states.

9. EXPANDING THE ORAL HEALTH WORKFORCE

More than half of Michigan counties are designated as Dental Health Professional Shortage Areas for Medicaid-enrolled or low-income residents. A lack of dentists and allied oral health professionals limits the ability of Michigan residents to receive regular dental care, placing them at increased risk for untreated disease.

The Work Group *recommends* increased funding for the expansion of safety net dental clinics where there is demonstrated need. Dental clinics in Federally Qualified Health Centers and local health departments offer a consistent source of affordable dental care, co-located with other critical health and social services. In many cases, these safety net clinics are the only dental home option for Medicaid or uninsured residents. Federal and state funding is critical for expanding safety net dental clinics where demand exceeds current capacity, and establishing new clinics in communities with very limited access to dental care for underserved populations.

The Work Group *recommends* ensuring that state telehealth policy covers dental care in a manner equivalent to medical care. Teledentistry is used successfully in other states to extend dental care to underserved areas by providing consultation on challenging cases and supporting referral decisions for oral health screening programs. Michigan has established policy to allow the use of telemedicine in medical care; the extent to which this policy encompasses dental care needs to be clarified.

In addition to the recommendations described above, the Work Group *supports* the following action steps in the area of expanding the dental workforce:

- Integrate funding for oral health services in Community Health Worker and Home Visitation programs to establish a financial model for training these staff members to deliver basic oral health screening and preventive services during home visits.
- Change state policy to allow dental hygienists to work under the remote supervision of private dentists, rather than the current policy of supervision by a non-profit organization, to expand the involvement of private dentists in screening activities.
- Change state policy to allow dental hygienists to work under the supervision of medical professionals to facilitate co-location of oral health and medical services.
- Create a new state policy for Advanced Dental Therapists (i.e., mid-level dental providers), modeled on the experiences of states such as Minnesota and Alaska.
- Pilot test and evaluate strategies to recruit private dental providers to accept Medicaid patients, addressing barriers related to administrative complexity, caring for special need populations, and reimbursement.
- Fund targeted scholarship or loan forgiveness programs for dental students who practice in designated underserved areas to ensure an adequate number of dentists to staff all dental safety net clinics.
- Evaluate strategies to recruit private dental providers to have a more formal/ consistent role in delivering care through special dental programs, both to facilitate program planning and to offer structured opportunities for dentists willing to care for underserved populations outside of their private office setting.
- Provide technical assistance around teledentistry so that logistical issues around billing, equipment, and health information technology do not impede the use of this strategy to expand capacity.

10. ENHANCING COLLABORATION BETWEEN MEDICAL AND DENTAL PROVIDERS

The Work Group *recommends* encouraging collaboration across health professional schools around oral health education. Substantial opportunities exist to offer both didactic instruction and patient-care experiences around oral health as part of health professional training. Physicians and nurses in training should learn to conduct an oral examination, understanding the signs and symptoms that require immediate referral to a dentist. Similarly, dentists and dental hygienists in training should learn about oral health symptoms that suggest referral to a medical professional. Opportunities for trainees to interact with their peers in other disciplines may lead to greater collaboration in their future practice.

The Work Group *recommends* partnering with Michigan chapters of health professional organizations to provide training on oral health needs across the lifespan. Collaboration with health professional groups can be useful in planning and delivering training mechanisms that are acceptable to physicians and other health care providers, including onsite workshops at state medical conferences and training modules that meet recertification requirements.

In addition to the recommendations described above, the Work Group *supports* the following action steps in the area of enhancing collaboration between medical and dental providers:

- Advocate for changes in hospital policies to facilitate the provision of dental services in hospital settings, particularly in the operating room setting.
- Survey Medicaid pediatric providers to understand barriers to fluoride varnish administration to identify possible strategies to increase the proportion of child health providers who deliver this important preventive service.

Implementation/Future steps

The MDCH Oral Health Work Group was a time-limited effort to identify the pathway toward a more coordinated and comprehensive approach to ensuring access to oral healthcare services across the life span for all Michigan residents. This report from the Work Group is intended to advise the Director of the Michigan Department of Community Health on prioritized action steps that should be considered in advancing a coordinated system.

As an initial step, the Work Group strongly recommends constituting a MDCH Oral Health Advisory Committee, with responsibility for planning, oversight, and monitoring progress through a state report card on oral health. Another critical role of the Advisory Committee is to coordinate with key oral health initiatives within state government, such as the State Oral Health Plan, initiatives sponsored by professional organizations such as the Michigan Dental Association, and efforts of advocacy groups such as the Michigan Oral Health Coalition.

Composition of the Advisory Committee should include balanced representation from dentists and dental hygienists in private and safety net settings, dental educators, dental benefit administrators, medical providers, public health and Medicaid officials, oral health advocates, and policymakers.

Real progress toward a comprehensive and coordinated system of oral health care will require a sustained commitment to identifying successful strategies, creating financial and structural opportunities to implement those strategies, and conducting routine surveillance and evaluation activities to determine their effectiveness. Support from the leadership of the Department of Community Health will be an essential component of future success in creating meaningful improvements in the oral health status of Michigan residents.

Appendix A

Recommendations of the Oral Health Work Group

OVERSIGHT OF MICHIGAN’S EFFORTS AROUND ORAL HEALTH

Appoint an MDCH Oral Health Advisory Committee to oversee implementation of recommended activities	Strongly Recommended
Establish a report card on key oral health outcomes, to assess progress toward achieving goals	Recommended

IMPROVING MEDICAID DENTAL BENEFITS ADMINISTRATION

Expand Healthy Kids Dental to Kent, Oakland and Wayne Counties in Fiscal Year 2016	Strongly Recommended
Ensure that all adults enrolled in Medicaid Health Plans have same dental benefit administration as those in HMP	Strongly Recommended
Implement pay-for-value payment reform modifications for dental services under Medicaid	Strongly Recommended
Provide guidance and sharing of best practices for dental administration to the Clinical Advisory Committee of the MHPs	Recommended
Identify opportunities to include dental services as part of the Dual Medicaid-Medicare Demonstration Project	Recommended
Establish a Medicaid Dental Advisory Committee for ongoing review and action on dental issues	Supported
Improve the “user-friendliness” of the system by which dental providers check Medicaid enrollment	Supported
Incentivize private dental providers who exceed a certain threshold for number of Medicaid patients seen	No Rating
Pilot test and evaluate strategies to reduce no-show appointments among Medicaid beneficiaries	No Rating

CONNECTING MICHIGAN RESIDENTS WITH AVAILABLE SERVICES

Create materials to educate Medicaid beneficiaries about their dental benefits and the process for finding a dental provider	Strongly Recommended
Assign specific roles and responsibilities for the creation and maintenance of a central registry of dental services	Recommended

Incorporate oral health into patient navigation activities of Community Health Workers and Home Visiting staff	Recommended
Develop and disseminate a simple guide for medical providers to assist patients in linking to a dental home	Recommended
Pilot test a system for referral to dental care after emergency department dental visits	Recommended
Require all special dental programs to maintain current information in the central registry of dental services	Supported
Establish common expectations for Medicaid Dental Benefits Administrators regarding matching beneficiaries with dental providers	Supported
Fund a specific entity to act as a centralized referral source, modeled on successful strategies	No Rating
Pilot test physician e-referral for dental services via the Medicaid dental benefits administrator	No Rating

EDUCATING AND ACTIVATING MICHIGAN RESIDENTS AROUND ORAL HEALTH

Add questions about oral health status and/or dental services utilization to the standard Health Risk Assessment for the Healthy Michigan Plan	Strongly Recommended
Add preventive dental visit to list of behaviors that qualify for cost-sharing reduction under the Healthy Michigan Plan	Strongly Recommended
Evaluate different strategies to activate Medicaid patients to seek preventive dental care	Strongly Recommended
Include dental assessment as part of requirements for kindergarten entry	Recommended
Develop an educational/ media campaign for oral health across the lifespan	Recommended
Identify characteristics of children who do not utilize dental services through their Healthy Kids Dental benefit	Recommended
Support targeted research on why certain populations do not seek dental care	No Rating

ENHANCING DATA SUPPORT FOR ORAL HEALTH

Require screening programs (mobile, PA 161 sites) to submit data on number of clients screened, referred, & with follow-up dental care	Strongly Recommended
Require transfer of clinical data from special programs to dental homes	Recommended
Assess the technical feasibility and provider acceptability of including oral health services in the Michigan Care Improvement Registry (MCIR)	Recommended
Disseminate annual county-specific utilization data across all age groups and Medicaid programs	Recommended

Promote data aggregation efforts that include both medical and dental claims	Recommended
Pilot test and evaluate a system for tracking follow-up care for those referred from special programs	Supported
Pilot test the sharing of electronic dental records in Michigan's health information exchange (HIE) efforts	Supported
Provide technical assistance for dentists to achieve incentives by meeting electronic health record Meaningful Use requirements	No Rating

IMPROVING THE QUALITY OF ORAL HEALTH SERVICES

Incorporate pediatric quality measures into Healthy Kids Dental and Medicaid Health Plan contracts	Strongly Recommended
Incorporate dental quality measure(s) for adult Medicaid populations	Recommended
Provide technical assistance for school-based oral health care	Recommended
Provide training for dentists and allied oral health professionals in the care of special populations	Supported
Assess the quality of clinical practices for special oral health programs, and disseminate best practices	Supported
Tighten review criteria for state-funded oral health programs	No Rating
Assess business practices of special oral health programs and provide technical assistance as needed	No Rating

EMBEDDING ORAL HEALTH ACROSS STATE PROGRAMS

Identify oral health liaisons to programs for young children, school-age children, adults and seniors	Recommended
Identify oral health liaisons to MDCH demonstration projects	Recommended
Disseminate a directory of MDCH oral health programs across the lifespan to health and human service agencies statewide	Recommended
Disseminate oral health educational materials via the MDCH website, local health departments, and liaisons to other programs	Recommended
Strengthen oral health education requirements for licensure of daycares and long-term care facilities	Supported

LEVERAGING LOCAL PUBLIC HEALTH

Support local health departments in billing Medicaid for oral health services provided in conjunction with other LHD programs	Recommended
Utilize LHDs to educate consumers about dental benefits and coverage	Supported

Establish minimum oral health requirements for LHDs	Supported
Explore models and disseminate best practices for offering dental services through LHDs	Supported
Assign LHDs the overall responsibility for documenting availability of dental services and identifying gaps in dental services	No Rating

EXPANDING THE ORAL HEALTH WORKFORCE

Support increased funding for expansion of safety net dental clinics where there is demonstrated need	Recommended
Ensure state telehealth policy covers dental care in a manner equivalent to medical care	Recommended
Integrate funding for oral health services in Community Health Worker and Home Visitation programs	Supported
Create a new state policy for Advanced Dental Therapists, modeled on the experiences of other states (e.g., Minnesota, Alaska)	Supported
Create a new option to allow dental hygienists to work under the supervision of private dentists	Supported
Change state policy to allow dental hygienists to work under the supervision of medical professionals	Supported
Pilot test and evaluate strategies to recruit private dental providers to accept Medicaid patients	Supported
Fund targeted scholarship or loan forgiveness programs for dental students who practice in designated underserved areas	Supported
Evaluate strategies to recruit private dental providers to have a more formal/consistent role in delivering care through special dental programs	Supported
Provide technical assistance around teledentistry	Supported

ENHANCING ORAL HEALTH COLLABORATION BETWEEN MEDICAL AND DENTAL PROVIDERS

Encourage collaboration across health professional schools around oral health education	Recommended
Partner with Michigan chapters of health professional organizations to provide training on oral health needs across the lifespan	Recommended
Advocate for changes in hospital policies to facilitate the provision of dental services in hospital settings	Supported
Survey Medicaid pediatric providers to understand barriers to fluoride varnish administration	Supported

Appendix B

Oral Health Work Group Members

James D. Forshee, MD, MBA
Chief Medical Officer
Molina Healthcare of Michigan

Karlene Ketola, MHSA
Executive Director
Michigan Oral Health Coalition

Carol Ann Murdoch-Kinch, DDS, PhD
Associate Dean for Academic Affairs
University of Michigan School of Dentistry

Kim Singh, MA
Director of Community and Government Affairs
Michigan Community Dental Clinics

Christopher J. Smiley, DDS
Smiley Family Dentistry

Linda Yaroch, RN, MPH
Health Officer
Health Department of Northwest Michigan

Jed J. Jacobson, DDS, MS, MPH
Chief Science Officer/Senior Vice President
Delta Dental of Michigan

Janet Kinney, RDH, MS
Director of Dental Hygiene Program
University of Michigan School of Dentistry

Norm Palm, DDS, MS
Past President
Michigan Dental Association

Kim Sibilsky
Executive Director
Michigan Primary Care Association

Gary Vance, DDS
Dental Director
Blue Cross Blue Shield of Michigan

Amy Zaagman, MPA
Executive Director
Michigan Council of Maternal and Child Health

MDCH Staff

Christine Farrell
Director
Oral Health Program

Nancy Gurzick
Medicaid Dental Policy Specialist
Medical Services Administration

Elizabeth Hertel
Director
Office of Health Policy and Innovation

Linda Scarpetta
Acting Director
Division of Chronic Disease and Injury Control

Susan Moran
Director
Public Health Administration

Rashmi Travis
Director
Bureau of Family, Maternal and Child Health

Beth Anderson
Epidemiologist
Oral Health Program

External Partners

Sarah Clark, Facilitator
Matthew Foley, Technical Support
Child Health Evaluation and Research (CHEAR) Unit
University of Michigan

Appendix C

Oral Health Work Group Agendas & Meeting Materials

MDCH ORAL HEALTH WORKGROUP

AGENDA

July 21, 2014

Capitol View Bldg, Conference Rm A

10 am-12 pm

10:00	Welcome and Introductions	Sue Moran
10:10	Overview of purpose and goals	Sue Moran
10:20	The Michigan Landscape of Oral Health	Chris Farrell
10:3-11:45	Group Discussion: Reaction to the landscape	Sarah Clark

A) Discussion of four key systems that influence and are interdependent:

- a. Community: Expanded community engagement on oral health issues
- b. Care: Strengthening the delivery of oral health care and prevention
- c. Policy: public policy that improves oral health
- d. Financing: Increased public and private financing for oral health initiatives

B) What does an Oral Health System look like?

- a. What do we have?
- b. What is missing?

11:45 a.m.	Next Steps/Assignments	Sarah Clark
------------	------------------------	-------------

Meeting dates: July 28, August 4, August 20

MDCH ORAL HEALTH WORKGROUP

AGENDA July 28, 2014 10 am-12 pm

10:00	Welcome and Introductions	Sue Moran
10:10	Brief review of workgroup goals Roadmap for next three meetings	Sue Moran
10:20	Michigan's Oral Health Capacity Framework	Sarah Clark
10:35-11:00	Large Group Discussion: Capacity, gaps, and barriers to matching capacity with need	
11:00-11:30	Small Group Discussion: #1: Increasing capacity among usual sites #2: Increasing capacity among special sites #3: Coordinating care delivery between usual and special sites	
11:30-11:50	Small group reports	
11:50 a.m.	Next Steps/Assignments	Sarah Clark

Future Meeting dates: August 4, August 20

MDCH ORAL HEALTH WORKGROUP

AGENDA August 4, 2014 10 am-12 pm

10:00	Welcome and Introductions Brief review of workgroup goals	Rashmi Travis
10:05-10:20	COMMUNITY: Educating & activating Michigan Residents around oral health	Sarah Clark
10:20-10:30	Large Group Discussion: Action Steps to promote patient activation	
10:30-11:30	Small Group Discussions: Specific questions to inform crafting of draft OHWG recommendations #1: Increasing capacity among usual sites #2: Increasing capacity among special sites #3: Coordinating care delivery between usual and special sites	
11:30-11:50	Small group reports and discussion	
11:50 a.m.	Next Steps/Assignments	Sarah Clark

Final Meeting date: August 20

MDCH ORAL HEALTH WORKGROUP

AGENDA
August 20, 2014
10 am-12 pm

- 10:00-10:05 Brief reminder of the OHWG charge and our review process

- 10:05-11:25 Review of goals and potential action steps

- 11:25-11:30 Instruction on voting mechanism

- 11:30-11:55 Vote on each proposed action step

Component Systems of Oral Health – OWHG July 21, 2014

Care	Community	Policy	Financing
<p>Private dentists/practices FQHCs Michigan Community Dental Clinics Dental School clinics School-based and tribal health centers Free care clinics Hospital clinics for special populations Mobile dentistry Dental student clinics WIC Head Start Schools Child and adolescent health centers Long-term care facilities Missions of Mercy Adult dental service program School-based sealant programs PA-161 sites Fluoride varnish for 0-3 year-olds in medical centers (Babies Too) Veterans Administration facilities Targeted programs (e.g., homeless veterans) Co-located medical/dental care Good infrastructure (private-state collaboration) Capacity in private offices Expanded use of dental hygienists for dental care</p>	<p>Oral Health Coalitions - Statewide - County - Perinatal - Geriatric - smoke free, oral cancer, etc Great Start Head Start Insure Kids Now County Health Net Integrated health initiative (dental-medical) for Kent County Donated dental services Connection between private practice and schools Home visits with nurse/family interactions Pregnant women assessment and education Community Health Workers Medicaid Health Plans Community education PA-161 Local health departments School nurses Municipal fluoridated water supplies Community Health Assessment (ACA requirement) MCIR – potential expansion for oral health data FQHCs</p>	<p>Advisory committee to MDCH Healthy Kids Dental PA-161 Leaders support oral health Mobile dentistry law State ER Diversion Group Healthy Michigan plan Diabetes and tobacco (DCDIC) Chronic disease division Affordable Care Act Oral health performance measures Dental loan repayment for underserved areas Public health code - potential for oral health to be in rewrite Inter-professional training in communities (University policy) Kindergarten entry requirements MCIR Perinatal-Infant Oral Health Advisory Committee</p>	<p>Dental reimbursement (State Planned Amendment); enhanced reimbursement for local health dept./clinic Fee-for-service EHR incentive (Meaningful Use) SEAL! Expanded Medicaid (increase cutoff to 185% FPL) Foundation grants (Delta, BCBS) Dentaquest 2014 & 2020 Research Data Institute HRSA grants for public clinics & expansion</p>

Systems Framework for Achieving Optimal Oral Health



MICHIGAN'S ORAL HEALTH CAPACITY FRAMEWORK

Type of service	Provider groups	Sites of care – usual	Sites of care - special
Oral Health Services (limited preventive): Fluoride varnish, sealants, screening	Public health nurses Medical providers Dental hygienists Dentists	Primary care practices FQHC dental clinics LHD/MCDC clinics Dental professional school clinics Dental offices – private	SEAL! Michigan Schools, Head Start WIC, MIHP PA 161 sites
Basic Preventive & Treatment: oral health services + prophylaxis (cleaning), x-rays, and periodontal services	Dental hygienists Dentists	FQHC dental clinics LHD/MCDC clinics Dental professional school clinics Dental offices – private	Free clinics Donated dental Mobile dental units PA 161 Other programs, vary by target population, type of services offered
Restorative & Specialty Care: oral surgery, periodontics, endodontics	Dentists	FQHC dental clinics LHD/MCDC clinics Dental professional school clinics Dental offices – private Hospital residency & clinics	Emergency rooms Some special clinics

Appendix D

Oral Health Work Group Resource List

Michigan Reports and Program Descriptions

- Michigan Department of Community Health, Burden of Oral Disease in Michigan, March 2013
www.michigan.gov/documents/mdch/Burden_of_Oral_Health_Annual_Report_416501_7.pdf
- Michigan Department of Community Health, Michigan Oral Health Plan, March 2010
www.michigan.gov/documents/mdch/Michigan_State_Oral_Health_Plan_FINAL_2_326169_7.pdf
- Michigan Department of Community Health, Michigan Oral Health Plan Mid-Term Progress Report, 2012
www.michigan.gov/documents/mdch/Mid-term_report_FINAL_397405_7.pdf
- Michigan Department of Community Health, Count Your Smiles 2011-2012, May 2011
www.michigan.gov/documents/mdch/2010_CYS_Final_Report_Booklet_416499_7.pdf
- Michigan Oral Health Coalition: 2013 Michigan Check-Up on Oral Health, 2014
www.mohc.org/files/2013%20Oral%20Health%20Check%20Up.pdf
- Nebeker CD, Maturo RA, Piskorowski WA. Michigan Dentists' Attitudes toward Medicaid and an Alternative Public Dental Insurance System for Children. *Pediatric Dentistry* 2014;36:1
- Michigan Dental Association, Survey of Michigan Dental Practitioners, September 2012
www.drbcusp.com/user/documents/content_documents/nws_rad/2013_04_16_16_26_43_642_MDA_Survey.pdf
- Michigan Developmental Disabilities Council, Community Dental Programs, August 2009
www.michigan.gov/documents/mdch/Dental_Resources_317196_7.pdf
- Anderson Economic Group, The Cost of Dental-Related Emergency Room Visits in Michigan, April 2014
www.andersoneconomicgroup.com/Publications/Detail/tabid/125/articleType/ArticleView/articleId/8068/The-Cost-of-Dental-Related-Emergency-Room-Visits-in-Michigan.aspx
- Michigan Community Dental Clinics, Inc., 2013 Annual Report
www.midental.org/wp-content/uploads/2014/05/2013-Annual-Report-Final.pdf
- Kent County Oral Health Coalition, Kent County Oral Health Exam, 2013
www.firststepskent.org/wp-content/uploads/2014/02/final-2013-Kent-County-Oral-Health-Exam.pdf
- Michigan Dental Association, School-Based Oral Health Care: A Choice for Michigan Children, 2014
www.smilemichigan.com/Portals/0/Teaching%20Aides/A%20Choice%20for%20Michigan%20Children.pdf

Michigan Dental Association, Best Practices for the Application of Dental Sealants in School-Based Oral Health Programs, 2012
www.smilemichigan.com/Portals/0/Teaching%20Aides/Best%20Practices%20Dental%20Sealants.pdf

Michigan Dental Association, Selecting a School-Based Oral Health Care Program, 2014
www.smilemichigan.com/Portals/0/Teaching%20Aides/Selecting%20a%20School-Based%20Program_13.pdf

State and US Reports and Program Descriptions

Academy of General Dentistry, Definitions of Mid-Level Oral Health Care Providers, 2006
<http://www.agd.org/files/webuser/website/advocacy/definitionsmidlevelproviders.pdf>

American Student Dental Association, Midlevel Provider Model Reference Chart,
<http://www.asdanet.org/midlevel-providers.aspx>

Centers for Medicare & Medicaid Services, Innovative State Practices for Improving The Provision of Medicaid Dental Services: Summary of Eight State Reports, January 2011,
<http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/8statedentalreview.pdf>

Centers for Medicare & Medicaid Services, Learning Lab – Improving Oral Health Through Access, Quality Improvement Processes: An Introduction for Medicaid and CHIP Dental Programs, January 2013
<http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/LearningLabSlides3.pdf>

Centers for Medicare & Medicaid Services Learning Lab- Improving Oral Health Through Access, Successful Beneficiary Outreach Strategies, September 2012
<http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/LearningLabSlides2.pdf>

Colorado Oral Health Plan, Oral Health Colorado, 2012
<http://www.oralhealthcolorado.org/wp-content/uploads/2011/06/OralHealthPlanWeb.pdf>

Connecticut Voices for Children, Dental Services for Children and Parents in the HUSKY Program: Utilization Continues to Increase Since Program Improvements in 2008, July 2013,
<http://www.ctvoices.org/publications/dental-services-children-and-parents-husky-program-utilization-continues-increase-progr>

Connecticut Coalition for Oral Health, Oral Health Improvement Plan for Connecticut 2013-2018,
http://www.ct.gov/dph/lib/dph/final_oral_health_book.pdf

IFLOSS Coalition, Oral Health Care in Illinois: Comprehensive Care for Children & Families, Spring 2007,
<http://www.astdd.org/docs/ILCSHCNActionPlan.pdf>

Minnesota Department of Health Oral Health Program, Minnesota Plan to Reduce Oral Disease and Achieve Optimal Oral Health for All Minnesotans: 2011-2020, February 2011
<http://www.health.state.mn.us/oralhealth/pdfs/OralHealthPlan2011draft.pdf>

National Governors Association, The Role of Dental Hygienists in Providing Oral Health Care, August 2014, <http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-dental-hygienists-in.html>

National Oral Health Alliance, Summary of the Sixth Leadership Colloquium: Strengthening the Dental Care Delivery System, June 2013
http://www.usalliancefororalhealth.org/sites/default/files/static/Summary%20of%20the%206th%20Leadership%20Colloquium_web.pdf

National Academy for State Health Policy, The Effects of Medicaid Reimbursement Rates on Access to Dental Care, March 2008 www.nashp.org/Files/CHCF_dental_rates.pdf

Ohio Department of Health, Oral Health Section 2013 Plan,
http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/ohs/oral%20health/2013%20OHS%20Plan%20FINAL%203_14.ashx

PEW Charitable Trusts, Expanding the Dental Team, June 2014
http://www.pewtrusts.org/~media/Assets/2014/06/27/Expanding_Dental_Case_Studies_Report.pdf

Scandrett M, Minnesota's Dental Therapist Law: Conception to Implementation,
<http://www.nationaloralhealthconference.com/docs/presentations/2010/Michael%20Scandrett%20AACDP%20The%20Latest%20in%20Dental%20Workforce%20Models.pdf>

Texas Department of State Health Services, Oral Health in Texas 2008,
<http://www.dshs.state.tx.us/dental/Oral-Health-in-Texas-2008-Report.doc>

US Alliance for Oral Health, Help Wanted: A Policy Maker's Guide to New Dental Providers, May 2009
http://usalliancefororalhealth.org/sites/default/files/reports/Dental_Report_final_Low%20Res.pdf