NATIVE ORAL HEALTH NETWORK

POLICY BRIEF

Oral Health Policy and Improvement Strategies in Oklahoma

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Oklahoma Oral Health Statistics

Despite being a large contributor to overall health and wellness, oral health care is an overlooked and underprovided service in Oklahoma. Oklahoma's oral health statistics reflect a population with high rates of childhood tooth decay, adult tooth loss and avoidance of regular oral health appointments due to cost. Only 72% of Oklahoman children have received one or more dental visits compared to 80% nationally, and 66% of third graders have experienced tooth decay compared to only 52% of the national population.[1] The statistics are no better for adults: 60% of Oklahoman adults visited the dentist in 2019 compared to 68% nationally, and only 35% of pregnant women had their teeth cleaned during pregnancy compared to 46% nationally.[1] Additionally, 42% of Oklahomans aged 65 or older have lost at least six teeth to decay or gum disease.[2] Inequities in oral health access and outcomes for Oklahomans show that some populations experience greater barriers than others. Cost is frequently cited as the main reason for avoiding dental care, with dental care being less financially accessible than other health care services.[3,4] The likelihood of seeing a dentist is lower for both low-income adults and children in low-income families in Oklahoma. Low-income older adults in Oklahoma are also more likely to experience tooth loss.[5,6] Much of the oral disease Oklahomans experience can be prevented by routine dental care;[7] however, accessing oral health care in Oklahoma can be expensive and difficult.

Barriers to Oral Health Care Access

Financial Access to Care

According to the U.S. Census Bureau, the percentage of American Indian or Alaska Native (AI/AN) people living in poverty in 2019 was estimated to be 23.0%. This compares to 10.5% for the U.S. general population, and in Oklahoma, poverty affects more than 19.5% of AI/AN peoples.[8] The cost of dental care is a significant barrier. Currently, 25% (885,000) of Oklahoma's population receive Medicaid benefits from the Oklahoma Health Care Authority. AI/AN people living in Oklahoma make up 17% of the total Medicaid enrollment for the state.[9] In 2020, 533,000 Oklahomans were uninsured, the second highest rate in the nation, leaving many Oklahomans without realistic options for dental care.[10] Of patients who are insured, 16% of adults avoid oral health care due to costs not covered by insurance.[11] For patients who are uninsured, 30% of adults do not receive the dental care they need due to cost.[3] From a recent report outlining the challenges and potential solutions for oral health improvement in Oklahoma, 68% of respondents stated cost as one of the biggest barriers for improved oral health in their communities.[12]

Physical Access to Care

Physical access to oral health care is also a burden for Oklahomans. Oklahoma, a largely rural state, encompasses approximately 70,000 square miles and has approximately 4 million residents, 45% of whom live in rural areas. According to data published in 2017, 66%

of AI/AN people live in rural areas of Oklahoma.[13] Further, many rural areas in Oklahoma do not have adequate oral health care providers. According to the U.S. Health Resources Service Administration, 1.3 million Oklahomans live in counties considered dental health professional shortage areas, further hindering access to care.[14] The lack of oral health providers in these areas leave residents with few options other than to travel long distances for care.[15] Those with inadequate transportation resources are even more likely to receive inadequate or no care. Oklahoma, in general, does not have the number of oral health providers needed to support the population, with 55.3 dental care providers per 100,000 people compared to 61.2 nationally.[11] Combined with that issue, fewer than half of dentists in Oklahoma accept Medicaid.[16] Those who already face oral health care expense obstacles are even more challenged when an oral health provider is physically distant or inaccessible.

Workforce Vacancies

In both private and Tribal health systems—in Oklahoma and nationwide—employers are challenged to fill dental provider positions. The national workforce is estimated to need over 10,000 more dental health professionals to meet the current population's needs.[17] As a result, over 80% of dental practices report recruitment challenges.[18] A recent search of the Indian Health Service (IHS) open positions database shows dozens of dentist, hygienist and assistant vacancies, with multiple open positions at some practices. This indicates a true and unacceptable deficiency in the ability to provide adequate care to the American Indian population.[19] Oklahoma's Indian health care delivery systems include federally managed direct service clinics, urban Indian organizations and Tribally owned and operated health care systems, hereafter referred to as I/T/U. Forty-five I/T/U systems are found in Oklahoma's rural areas, and they serve 381,087 patients statewide.[20] As previously mentioned, widespread staffing shortages within the IHS contribute to long appointment wait times and delayed care. Aside from staffing shortages, I/T/U systems often offer limited services, due to a lack of funding and capacity. According to data released by the National Indian Health Board, 36% of Oklahomans needed a referral from their Tribal health clinic because the provider could not perform the needed procedure.[21]

Acces to Care Solutions

Financial Access to Care

After the Medicaid expansion on July 1, 2021, an additional 200,000 adult Oklahomans will be eligible for Oklahoma Medicaid coverage.[22] Ten to 20% of the total Medicaid population is predicted to be American Indian.[22,23] Historically, Oklahoma Medicaid's oral health care services have been limited to children.[22,23] However, in 2021, the Oklahoma State Legislature approved an additional $17 million to expand the adult oral health benefit.24 Effective July 1, 2021, the Oklahoma Health Care Authority's adult oral health care services will be substantially expanded to include dental examinations, x-rays, dental cleanings, fluoride, dental fillings, treatment of gum disease, and dentures and partial dentures.[25] The cumulative effect of the Oklahoma Medicaid expansion and the addition of adult oral health services will provide new and robust services to the underserved adult Medicaid population, which will partially solve the previous oral health care coverage issues. Increased utilization of and demand for preventative services are expected.

Fortunately, with the latest Oklahoma Medicaid budget changes, the I/T/U systems that receive the Oklahoma State Medicaid Office of Management and Budget rate can expect a significant increase in revenue for adult services already provided. This change will directly improve the services available for Medicaid recipients. It may indirectly improve oral health services by increasing clinical capacity through increased funding to Tribal and urban facilities, as well. Further, oral health insurance coverage options and equitable policies should continue to be explored, as I/T/U systems may still find it difficult to provide the services needed and meet optimum staffing levels.

Physical Access to Care

In the absence of a significant increase in the number of oral health care providers in Oklahoma, innovative care delivery options should be explored. The COVID-19 pandemic forced health care providers of all types to transition some or most services to telehealth. The result of this trend was significant improvements in access to health care, including easing transportation issues and assisting those with the physical inability to attend appointments. These services were initially made available under COVID-19 emergency authorizations and were not intended to be permanent. In the last year, however, many states and the U.S. Congress have passed legislation defining telehealth and/or requiring reimbursement parity for telehealth services. In 2021, the Oklahoma State Legislature officially defined telehealth modalities and coverage mechanisms,[26] as well as basic teledentistry;[27] however, further statutory verbiage is needed to support remote oral health care appropriately. Supporting the need for specific teledentistry options, the

American Dental Association issued a position statement that supports the use of teledentistry to provide oral health services, including patient care and education.[28] To maximize teledentistry use in Oklahoma, further legislation and regulation to solidify insurance coverage and reimbursement requirements are necessary.

Workforce Expansion

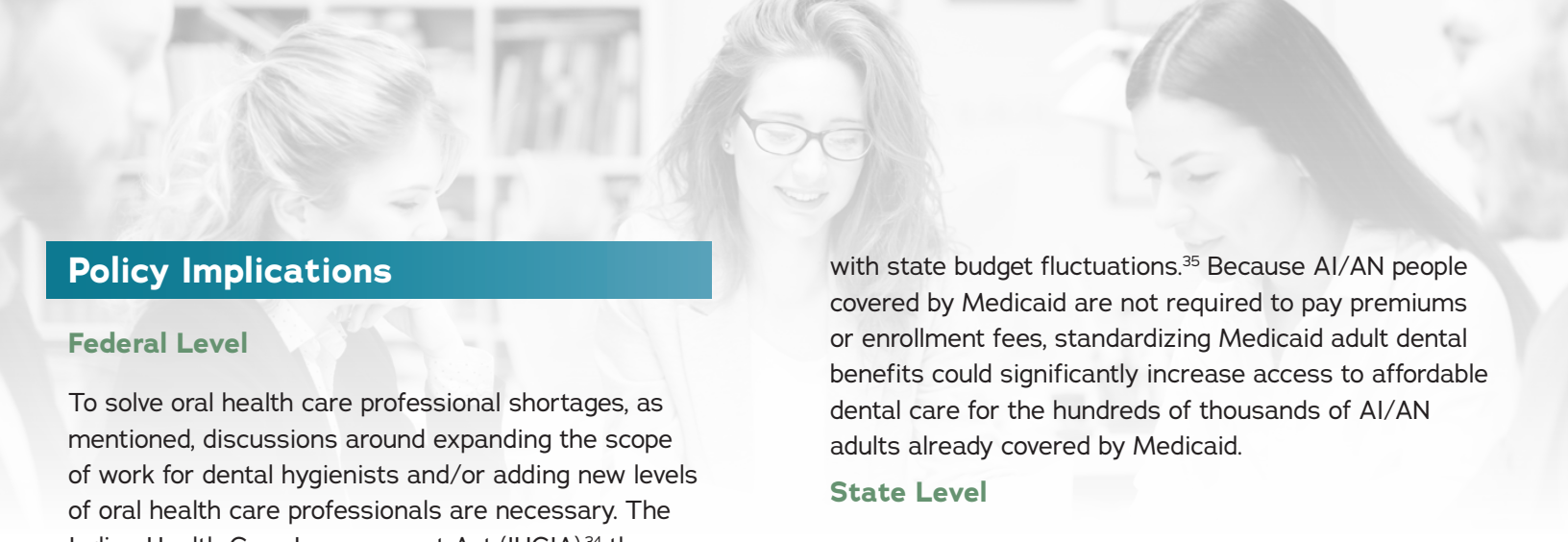
To address deficiencies in access to care and oral health care provider shortages, especially in the overburdened I/T/U system, it is necessary to examine the workforce and care delivery. Expanding the services existing providers like dental assistants and dental hygienists can perform and authorizing a new provider type, the dental therapist, could allow more people to get the dental care they need, particularly in rural and Tribal communities. Dental therapists are licensed professionals that provide some of the most common dental procedures, such as exams and fillings. Dental therapists work under the supervision of a dentist, but with telehealth technology and off-site (i.e. general) supervision. They are able to bring care directly to people where they are, whether that is schools, nursing homes, Tribal communities or rural towns. Dental therapists have been working in the U.S. for 17 years and are currently authorized to work, in varying capacity, in 12 states.

While dental therapy providers have been working globally for a century, the dental therapy profession was brought to the U.S. by Alaskan Tribal leaders seeking to improve oral health in their communities, which were beset by a chronic shortage of dentists. Under federal authority, these leaders created a program that focused on educating Alaska Natives to deliver the care their communities needed most. By focusing the scope of dental therapists on a small set of commonly needed procedures, they were able to create an education program that was accessible and affordable. The result has been a sustainable, culturally appropriate dental therapy program that creates well-paying jobs in underserved communities while increasing access to dental care and improving oral health outcomes.[29]

In 2015, the Commission on Dental Accreditation (CODA), the organization responsible for accrediting education programs for dentists and dental hygienists in the U.S., issued dental therapy standards.[30] Having CODA accredit dental therapy education programs ensures the providers are educated to the same high standards as other dental providers and takes the burden off individual states to set the education requirements for dental therapists.[30] Dental therapists have been shown to not only improve access to care for underserved communities, decreasing travel and wait times for appointments, but to actually improve oral health.[29,31] Transferring lower-level dental procedures to dental therapists would allow dentists to focus on more complex care, making the entire dental team more efficient and allowing more high-need patients to get care.[32] Their lower employment cost means that employing dental therapists would allow community health centers and I/T/U clinics to stretch their limited budgets to treat more patients and makes private practice dentists more profitable.[33] Because dental therapy education is shorter and less expensive than that of general dentistry and because it can be offered at Tribal or community colleges, dental therapy has created accessible workforce pipelines from underserved communities.

Community of Perspective of Access to Care Solutions

It is important to note that deficiencies in oral health care are felt beyond the oral health care professions. A survey of AI/AN people and adults from the general population found that the lack of oral health care services in rural populations and lack of covered benefits for oral health care services were of highest concern. As solutions, approximately 61% of the respondents felt that expanding the scope of practice for Oklahoma dental hygienists would help address the provider shortage, while 58% were in favor of expanding the oral health care profession types in Oklahoma. The addition of a dental therapist to the oral health care team was supported by 96% of the respondents; however, the need for advocacy of the dental therapy profession was shown by 31% of the survey participants, who expressed inadequate knowledge of dental therapists. These survey results exhibit an awareness of the oral health care needs in Oklahoma and favorable reception of advocacy for improved oral health care funding, expanded oral health care professions and expanded scopes of work.[12]



Policy Implications

Federal Level

To solve oral health care professional shortages, as mentioned, discussions around expanding the scope of work for dental hygienists and/or adding new levels of oral health care professionals are necessary. The Indian Health Care Improvement Act (IHCIA),[34] the federal legal authority for the provision of health care to AI/AN people, provides guidance for increasing the number of oral health care professionals. The IHCIA specifically identifies dental therapists as a profession that Tribes can utilize to expand access to oral health care. However, the IHCIA requires that Tribes outside Alaska not employ dental health aide therapists under the Community Health Aide Program unless the Tribe is in a state with a dental therapy licensing law. Tribes and national organizations such as the National Indian Health Board are currently advocating for Congress to remove this restriction, as the requirement infringes Tribal sovereignty and because dental health aide therapists practicing under the Community Health Aide Program receive federal certification, not necessarily state licensure.[34] Urban Indian clinics are also specifically excluded from accessing this benefit within the IHCIA,[34] thus limiting the benefit to the AI/AN patients accessing Tribal health services.

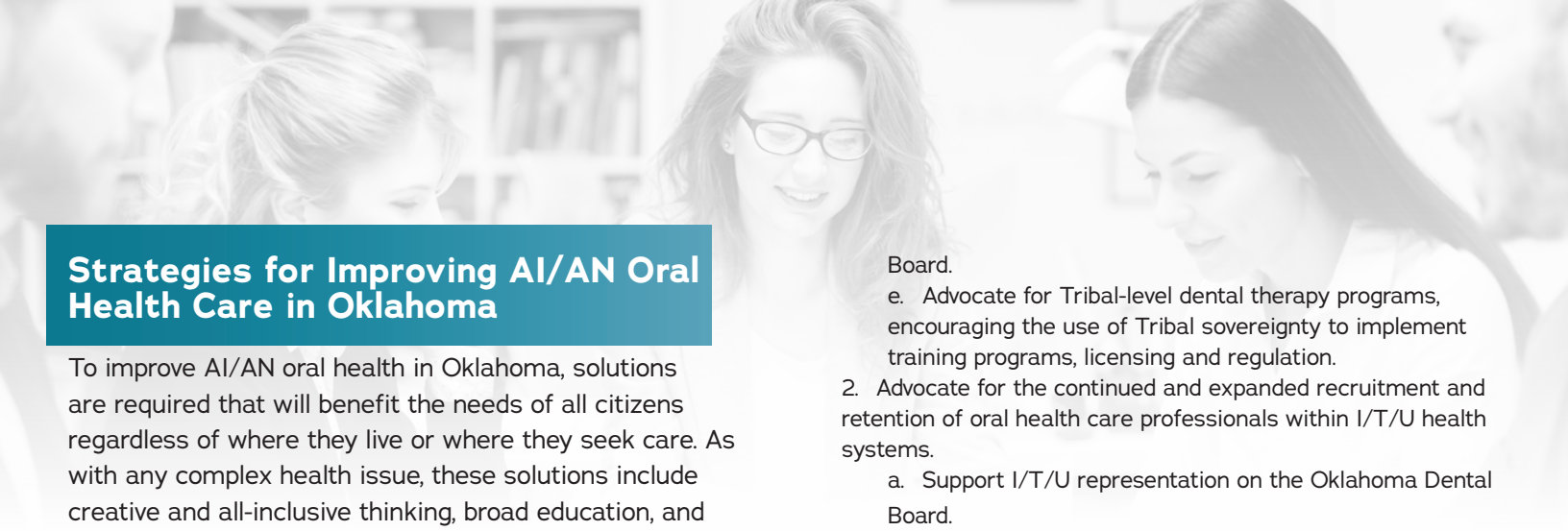
States have the flexibility to determine what dental benefits are provided to adult Medicaid enrollees. There are no minimum requirements for adult dental coverage. Making adult dental services mandatory in Medicaid would expand access to dental care for millions of low-income AI/AN peoples outside the I/T/U system while improving the ability of I/T/U systems to meet their patients' oral health needs. The optional status of Medicaid adult dental coverage means that states can take away these benefits at any time. Medicaid adult dental benefits are often subject to state budget cuts during economic downturns, especially in states with more comprehensive coverage. This also means that states may offer different oral health coverage to people in different eligibility categories, such as pregnant people or people with disabilities. This narrow definition of benefits can be confusing for enrollees and oral health providers, especially when covered services change with state budget fluctuations.[35] Because AI/AN people covered by Medicaid are not required to pay premiums or enrollment fees, standardizing Medicaid adult dental benefits could significantly increase access to affordable dental care for the hundreds of thousands of AI/AN adults already covered by Medicaid.

State Level

Within the state of Oklahoma, the oral health policy landscape is largely directed by the Oklahoma Dental Act,[36] which is enforced by the Oklahoma Dental Board. Currently, dentists and dental hygienists are recognized as oral health care providers within the state of Oklahoma. Changes to this statute, such as the addition of a mid-level oral health care provider or changes in scopes of practice, must be approved by the Oklahoma State Legislature and the Oklahoma Dental Board.[36] The Oklahoma Dental Board currently consists of nine dentists, one dental hygienist and two at-large members.[37] Sixty-four percent of the current Oklahoma Dental Board represents urban communities, and no one on the board represents Tribal or urban Indian clinics. Due to this lack of representation, the current board makeup presents challenges to AI/AN health care advocacy. Oral health care in Oklahoma can be improved through the unified efforts of the many stakeholders, including Tribes, urban Indian organizations, dental associations and others.

Tribal Level

Tribal health systems, by virtue of sovereignty, have the option to expand and self-regulate health care professionals within their employment. Tribes, in conjunction with the Health Resources Service Administration and following CODA standards,[38] may exercise Tribal sovereignty and train, license and employ dental therapists. Precedent for this process has been set by the Swinomish Indian Tribal Community of Washington state.[39] However, this solution does not extend to non-Tribal Federally Qualified Health Centers, urban clinics, or private practices; therefore, it does not comprehensively address the oral health care needs in Oklahoma or the AI/AN population. Excluding Tribal sovereignty, the best route for expanding the types of oral health care professionals in Oklahoma is a change in the statute to authorize dental therapists to practice statewide.



Strategies for Improving AI/AN Oral Health Care in Oklahoma

To improve AI/AN oral health in Oklahoma, solutions are required that will benefit the needs of all citizens regardless of where they live or where they seek care. As with any complex health issue, these solutions include creative and all-inclusive thinking, broad education, and strong advocacy. Strategies designed to address each of the deficiencies discussed above are outlined below.

Financial Access to Care

1. Advocate for standardized, mandatory Medicaid adult dental benefits
2. Support I/T/U represevntation on the Oklahoma Dental Board.
3. Advocate for defined coverage and reimbursement parity for teledentistry services for all payers.
    a. Leverage recent Medicaid oral health inclusion language to support the need for expanded benefits.
4. Advocate for the broad uptake and utilization of available oral health CPT codes within all I/T/U health systems.

Physical Access to Care

1. Advocate for defined coverage and reimbursement parity for teledentistry services for all payers.
    a. Leverage recent Medicaid oral health inclusion language to support the need for expanded benefits.
2. Advocate for technical support for the uptake and utilization of teledentistry services.
3. Advocate for broad coverage and reimbursement for transportation options to oral health care providers.
4. Advocate for the continued and expanded recruitment and retention of oral health care professionals within I/T/U health systems.
5. Support I/T/U representation on the Oklahoma Dental Board.

Workforce Deficiencies

1. Advocate for addition/expansion of scopes of practice for oral health care providers.
    a. Provide education about cost savings, revenue streams and services of mid-level oral health care providers to community/professional partners, medical and dental associations, and policy authorities.
    b. Provide education about the rigor and requirements of CODA educational standards for dental therapy programs.
    c. Provide education and support for state-led efforts for addition/expansion of scopes of practice for oral health care providers.
    d. Support I/T/U representation on the Oklahoma Dental Board.
    e. Advocate for Tribal-level dental therapy programs, encouraging the use of Tribal sovereignty to implement training programs, licensing and regulation.
2. Advocate for the continued and expanded recruitment and retention of oral health care professionals within I/T/U health systems.
    a. Support I/T/U representation on the Oklahoma Dental Board.

Conclusion

Oral health is critical for overall health and wellness. Improving access to dental care by adopting strategies and policies that increase access can help decrease medical costs associated with chronic conditions that continue to put Oklahoma in the top rankings for various leading causes of death.[40] Timely advances in Oklahoma's oral health policies, including the recently added adult Medicaid oral health benefit, will increase patient-driven demands for oral health care services. For facilities that receive the Office of Management and Budget rate, significant increases in revenue are expected. If reinvested back into oral health care services, this additional revenue will increase the depth and breadth of services provided, which may directly address some of the access-to-care barriers discussed. However, improved financial access to care may further strain an already understaffed workforce. Further discussion of solutions to workforce shortages is necessary now, as they are predicted to become more significant in the near future. Successfully finding solutions for this problem requires a unified voice and open-minded discussions between Tribal and non-Tribal entities, dental associations and legislators to support Oklahoma's unique needs and sustained education campaigns.

About the Authors

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