Executive Summary of the Report of Interviews of Oral Health Stakeholders in Maine

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Better Information for Better Outcomes

The Center for Health Workforce Studies is a not-for-profit research organization whose mission is to provide timely, accurate data and conduct policy-relevant research about the health workforce. The Center's work assists health, professional, and education organizations; policy makers and planners; and other stakeholders to understand issues related to the supply, demand, distribution, and use of health workers.

Preface

In 2012, the Center for Health Workforce Studies (the Center) at the School of Public Health, University at Albany with support from Medical Care Development (MCD) and the Maine Oral Health Funders (MOHF) completed a study of the oral health status of the people of Maine to identify barriers to oral health services in the state. The study was conducted to address the questions posed in Maine Legislative Resolve #1105 and to answer questions posed by MOHF.

This paper summarizes the common themes drawn from telephone interviews with 66 oral health stakeholders in Maine. These interviews were completed between April and July 2012. The interviews were conducted by and this report was written by Margaret Langelier of the Center. The author can be contacted with any questions about the content of the report at (518) 402-0250. The perspectives in this report are those of key informants. These comments do not necessarily reflect the attitudes or opinions of their employers or the author, or of MCD, or MOHF or its individual members.

Special appreciation is extended to Margaret Gradie of MCD and to Barbara Leonard and Karin Anderson of MOHF for their help with identifying many of the stakeholders who were interviewed. The author is especially grateful to all stakeholders, including the dentists, dental hygienists, dental assistants, education program directors, oral health program managers, facility directors, medical professionals, government officials, and policymakers in Maine who participated in the interviews.

The Center, established in 1996, is a not-for-profit research organization whose mission is to provide timely, accurate data and conduct policy-relevant research about the health workforce. The Center's work assists policy makers, planners, and other stakeholders to understand issues related to the supply, demand, distribution, and use of health workers. Today the Center is a national leader in the field of health workforce studies. It supports and improves health workforce planning and access to quality health care through its collection, tracking, analysis, interpretation, and dissemination of information about health professionals at national, state, and local levels. Additional information about the Center can be found at http://chws.albany.edu.

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Background

The Center for Health Workforce Studies (the Center) at the School of Public Health, University at Albany, with support from Medical Care Development (MCD) of Augusta, Maine and the Maine Oral Health Funders (MOHF), a statewide philanthropy collaborative, conducted an assessment of oral health needs and access to oral health care in Maine.

The work described below was completed as part of two separate but complimentary research studies. The first study was commissioned by MCD in response to LD #1105, "Resolve to Study Oral Health Care in Maine and Make Recommendations Regarding How to Address Maine's Oral Health Care Needs". The second study was commissioned by MOHF, which has a prevailing interest in improving oral health in Maine. The MOHF sought to better understand the impact of changes and expansions in Maine's oral health workforce on access to oral health care, particularly for low income and uninsured people in Maine. This second study, although separate, was designed to complement the activities related to LD #1105 and its results will be used to inform the required reporting related to the legislative resolve.

The two studies entailed an extensive literature review, analysis of secondary data, including surveillance data and insurance claims and eligibility data, surveys of the oral health workforce and safety net provider organizations in the state, and interviews of a wide array of oral health stakeholders in Maine. During the course of the interviews it became clear that creation of two separate reports would be impractical. Therefore, this report is a summary of the common themes identified from the key informant interviews conducted for both studies.

In the period between April 26, 2012 and July 5, 2012, Center staff conducted 66 interviews with stakeholders in Maine who were selected with the help of project funders, advisory groups, and others for their perspectives on the issue of oral health access. Additional informants were subsequently identified by interview participants as people who were knowledgeable about provision of oral health services or in policymaking related to oral health care delivery in Maine.

Informants were drawn from all regions of the state and represented a broad cross-section of professionals, including licensed general and specialty dentists, registered dental hygienists, denturists, dental hygienists working under public health supervision status or in independent practice, physicians, registered nurses, social workers, nutritionists, attorneys, oral health consultants and advocates, researchers, education program directors, oral health program managers, directors of community clinics and other safety net programs, educators, representatives of professional associations, government officials, health care administrators, policymakers, and an oral health care consumer.

The telephone interviews lasted between 40 and 90 minutes and were arranged and conducted at the convenience of the participants. Although interview protocols were developed and shared with informants, the protocols were used only as a guide to the discussion. This unstructured approach allowed informants to talk about topics related to their particular perspective on oral health access issues in Maine.

Informants were assured that all information shared during the interview would be considered confidential. They were told that the report of findings from the interviews would identify key

themes and that comments would not be attributed to individuals. The opinions cited are those of individual participants and do not necessarily reflect the opinions or attitudes of their employers or of the authors or funders of the study.

This report summarized and describes the common themes that emerged from the interviews. The interview protocols are Appendix A of this report.

Common Themes

Informants were asked to discuss their knowledge of and interest in oral health and, in many cases, their personal experiences with the oral health delivery system in Maine. Some informants directly provided oral health services while others were in policymaking or management positions that directly affected delivery of oral health services.

A significant outcome of the interviews was the identification of common themes that emerged throughout the discussions about oral health Maine. These themes are listed and elaborated on below.

- Maine has made progress in its efforts to increase access to oral health services but there are still barriers that impede access.
- There are underserved populations in Maine that have notable issues with lack of access to oral health services.
- Inadequate oral health literacy is a substantial barrier to improving oral health outcomes.
- There is a need to better integrate oral health care with physical health care.
- Oral health reimbursement policy affects oral health outcomes, especially for MaineCare-insured adults.
- Maine's weak economy creates challenges to improved access to oral health services.
- The rural geography of the state is a significant barrier to increased access to oral health services for populations living in northern and central Maine.
- There is a well-established safety net for oral health services but there is concern about its long-term sustainability and its ability to meet increasing need for oral health services.
- Previous oral health workforce initiatives in Maine have increased access to oral health services. For example, dental hygienists in public health settings have contributed to improved access to oral health care for children.
- While there is interest in implementing new oral health workforce models in Maine, there is concern that there has not been sufficient time to fully understand the impact of previous oral health initiatives on access to oral health care for Maine's residents.

Maine has made progress in its efforts to increase access to oral health services but there are still barriers that impede access.

Informants discussed the significant progress in oral health access in Maine over the last decades. Many believed that more people have access to oral health services now than in the past. More children in the state routinely receive preventive oral health services and the number of safety net organizations providing oral health care has increased. However, some populations continue to struggle to obtain oral health care.

There are many economic, social, demographic, and geographic variables in Maine that impede efforts to reduce access barriers especially for underserved populations. The rural geography in Maine, limited public funds for oral health care, an aging population, the weak economy, and changing population demographics were all cited as factors that negatively affect access to oral health services in Maine.

Maine continues to encounter difficulty with improving access to care especially in the more remote areas of the state and for populations at risk for limited access to health services. Informants agreed that there is no single solution to the problem of access to oral health services and no magic bullet to improve oral health outcomes.

There are underserved populations in Maine that have notable issues with lack of access to oral health services.

Informants often identified children, rural residents, immigrants, refugees, domestic violence victims, people who are HIV positive, marginalized populations with special needs, and the elderly as populations with compromised access to oral health services in many areas of Maine. Pregnant women and young mothers were a particular concern because of the risk of mother-to-child transmission of dental caries and the increased risk of pre-term birth and low-birth weight babies for mothers with poor oral health.

Informants were remarkably consistent in identifying low-income working adults as the population for whom obtaining oral health care is most difficult. The economic underpinnings of dentistry, including the cost of materials required for dental procedures, limit the amount of free or discounted care available to people without a dental insurance benefit. Low-income uninsured or underinsured adults must self-pay for care and even when a sliding fee scale is available, dental care may be cost prohibitive. In addition, MaineCare's fee schedule was considered by many to be too low to attract a sufficient number of dentists to participate with the MaineCare program, furthering limiting access for some populations.

Interview participants frequently commented on a noticeable gap between normative or expected need for oral health services and current demand for care. Dentists practicing in various locations

across the state spoke about the availability of appointments in their practices. In addition, safety net providers in some areas commented on excess appointment capacity due to reduced demand currently for oral health services. The economic downturn was cited by many as a contributing factor to diminished demand for oral health care.

Need and demand are market based concepts and it is widely believed that the difference between need and demand becomes most obvious during economic recession. Typically during difficult economic periods there is far more need than manifest demand for services and commodities. While people may need oral health care, they may not seek services because of the cost of care. In oral health, there is the risk that delays in seeking preventive or basic restorative care will ultimately result in demand for more expensive and extensive treatment for urgent dental problems.

Inadequate oral health literacy is a substantial barrier to improving oral health outcomes.

If the informants who were interviewed had a single point of agreement, it was that there is a fundamental lack of oral health literacy among many populations in Maine. Too often, people lack an appreciation for the systemic impacts of inconsistent oral hygiene and poor nutrition on their health. People are also not aware that dental caries is a disease process that is preventable. Lack of oral health literacy manifests itself in many ways. People seek care only when they experience pain or infection in their teeth or they disregard appointments for preventive or restorative services.

Many of the current initiatives in oral health focus on facilitating treatment of disease. Informants commented that it is a fallacy to operate solely on the premise that provision of quantities of oral health services today will improve oral health and reduce costs over the long term. Treating existing disease is very different from preventing it from occurring. Good oral hygiene combined with routine prophylaxis and early restoration of diseased teeth would produce better results over a patient's lifetime.

Several stakeholders commented on the importance of coupling strategic initiatives with programmatic initiatives in oral health. While immediate policy interventions to improve access to oral health care and address unmet need in the population were viewed as important, many felt that selected interventions should be combined with a sustained population-based strategy to educate the public about oral health and prevent the development of oral disease. This would improve oral health outcomes in the future. Prevention and early intervention programs in schools are an example of a successful strategic effort in Maine to enhance the oral health of young people through education and regular preventive care. However, those programs end in early adulthood with no further efforts to support and maintain the positive oral health status that has been achieved to that point.

It is possible to change behavior and alter outcomes. People of all ages need better information about the systemic implications of dental caries. Informants recommended a system-wide

commitment to educate people about the importance of regularly brushing teeth, making good food choices, and routinely obtaining preventive oral health services.

Informants suggested a need for a public media campaign about the inherent importance of good oral health. Many informants commented on the success of social marketing campaigns about breast cancer, smoking, diabetes, and obesity. One difference of note was that messages about these diseases are framed as life or death issues. People don't view oral health the same way. There is, however, a need to debunk generational myths, correct misinformation, and change fatalistic attitudes about teeth that all lead to poor oral health outcomes. Messages about the importance of oral health must be delivered in the larger environment, not just by oral health professionals during a patient encounter. One interview informant succinctly summarized the issue of literacy with the following comment:

> *Most people currently believe that the cost of care is the major barrier to access to care, which is certainly a legitimate perspective. However, the most important reason for the access issues in oral health is lack of understanding of the value of oral health care. Care seems expensive to people because society has failed to establish awareness of the intrinsic value of oral health to overall systemic health. Shame, embarrassment, and fear are also major factors motivating people to avoid dentistry until they have advanced dental disease. Fear of the unknown keeps people from walking through the door of a dental office.*

Informants also spoke about a widely held societal perspective that oral health care is elective and dispensable. These stakeholders emphasized that increased access to affordable preventive and restorative oral health care might address immediate dental problems. It does not, however, improve the overall oral health status of the population. They emphasized that the culture of oral health must be changed to make people accountable for necessary care of their teeth and personal oral well-being. That change would produce better oral health outcomes across the population.

There is a need to better integrate oral health care with physical health care.

Informants discussed the systemic implications of poor oral health. There was concern for people in Maine with chronic health conditions such as diabetes and heart disease and for pregnant women whose risk for preterm birth is greatly elevated if they have oral disease. Informants discussed patients with serious medical conditions linked to streptococcus mutans and the poor oral health in some young mothers that places their children and infants at risk.

Informants emphasized the importance of engaging health care professionals in oral health care screening and prevention activities. They also underscored the importance of building professional networks that would enable appropriate referral from medical to dental providers. This would improve outcomes for patients and enable more seamless transitions to suitable providers.

Oral health reimbursement policy affects oral health outcomes especially for MaineCare-insured adults.

Informants were universally concerned about the economic issues that affect oral health access in the state. Dental providers discussed their perceptions that public money allocated for dental care was insufficient. They commented on the difficulty of treating publicly insured patients when reimbursement for dental services does not cover the cost of the services. Safety net providers expressed concerns about continuing cuts in dental subsidies that were hampering efforts to treat the poor in the state. There was also significant concern about proposed changes in MaineCare eligibility for childless adults and the financial eligibility threshold for parents of children on MaineCare. Informants suggested that these changes would be a step backward in the effort to improve the oral health status of the population.

The limited adult dental benefit in MaineCare was cited by many as a misguided strategy aimed at limiting the costs of oral health in the state. Since adults on MaineCare have no benefit for prevention or basic restorative care, they often wait until dental disease is sufficiently progressed that treatment is required for an emergent condition, which is a covered benefit. Not only is extensive reparative or therapeutic care more expensive at this stage, it is less effective overall. Caries is a progressive disease that spreads within the mouth and failure to obtain care when the disease is localized or contained within a single tooth foreshadows the need for more widespread reparative dental procedures in the future and inferior oral health outcomes over time.

MaineCare reimbursement policy for adults encourages tooth extraction. While MaineCare will pay for the endodontic treatment of an extensively decayed tooth, it will not pay for the cost of the final restoration to that tooth. This policy may contribute to the high rate of partial and total edentulism in some areas of the state. When provided with the choice of paying out-of-pocket for a crown, many patients will instead choose to have the tooth extracted. A tooth with a root canal that is not protected by a crown is at greater risk for fracture and eventual extraction anyway.

Uninsured adults or adults on MaineCare were more likely than others to seek care for dental problems in an emergency department since they may not have a customary dental provider and may lack the financial means to seek care at a private dental practice. Expenditures for care in emergency departments or in outpatient settings for extensive dental repair in Maine are high. Informants consistently suggested that public expenditures for emergency department and outpatient hospital care might be better allocated to pay for preventive services and early restorative care for the adult population on MaineCare.

Maine's weak economy creates challenges to improved access to oral health services.

Maine's economy has been affected by the recent economic downturn. For several decades the state has been moving from a manufacturing economy to a service-based economy. Informants in many areas of Maine, particularly in northern and coastal Maine, commented on the fact that many of the towns in their geographic areas were old mill towns where factories had closed and

labor unions were no longer influential. Manufacturing mills typically provided both a living wage and health benefits to workers, which allowed more access to health and oral health services in the past. The population in many of these mill towns is aging. This presents particular challenges to the oral health care system since many older people do not have dental insurance.

Informants from the urban centers in the state were concerned about changing demographics in those areas. Increasingly diverse populations that now include immigrants and refugees were complicating efforts to provide affordable and accessible oral health services. Jobs are scarce and available jobs often do not provide a subsistence wage or employee benefits. In addition, the requirement for medical translation services for non-English speaking patients increases the cost of providing dental care, especially in the oral health safety net.

Informants in coastal Maine expressed concern that the underserved in their areas were overlooked because of the apparent affluence in many seaside communities. These informants commented on the noticeable dichotomy in economic levels of the population in their towns. While these communities are not generally identified as underserved, there are people living in those areas with limited access to health and oral health care. It was important to many informants that the needs of these lower-income populations living in seaside communities be recognized and addressed.

The rural geography of the state is a significant barrier to increased access to oral health services for populations living in northern and central Maine.

Maine is one of the most rural states in the nation with large geographic areas and low population density in the northern and central regions of the state. A common discussion point in the interviews was the lack of availability of oral health services in many rural areas. Some informants offered that rural residents must drive distances to obtain any services so traveling to dental services is not an undue or unexpected hardship for rural residents. The proffered explanation is that people make a choice to live in remote regions of the state and in making that choice commit to driving distances to work, school, shopping, and other services. However, other informants disagreed with that perspective stating that dental services are commonly available only during the week and then only during work hours. Residents of rural areas may drive a distance to get groceries but they do so in the evening or on weekends when traditional dental providers are closed. The current oral health delivery system is not generally well structured to meet the needs of the population living in rural areas.

While it may not be economically feasible for a dentist to establish a private dental practice in a more remote area of the state where there may not be a sufficient population base to sustain a practice, there were a number of strategies identified to address the need for oral health services in those areas. Assuring the availability of safety net services that are centrally located, convenient, and accessible to rural populations was considered important. Creative use of mobile dental services and teledentistry were suggested as possible strategies to address need. School-

based oral health programs were described as especially valuable in rural areas. In addition, several informants suggested using alternative dental providers in rural areas as a useful strategy to increase the availability of oral health services.

There is a well-established safety net for oral health services but there is concern about its long-term sustainability and its ability to meet increasing need for oral health services.

Maine has a well-developed safety net of organizations that provide oral health services in many regions of the state. Services in the safety net are also supplied by many private practice dentists and dental hygienists who work either under public health supervision status or in independent practice. There are also denturists working within the safety net providing affordable dentures to people in need.

There are inconsistencies between the reimbursable services that can be provided in the safety net and the services needed by the populations accessing care. While children on MaineCare have a comprehensive dental benefit and can be supplied with a full range of oral health services, adults on MaineCare have a restricted dental benefit that only permits treatment of dental complaints related to pain and infection; they have no coverage for preventive or basic restorative dental services. While patients without an insurance benefit can self-pay for necessary services, the cost of those services, even on a sliding fee scale, may be prohibitive to low-income families.

Safety net organizations struggle with the payment case mix because a high percentage of the population accessing oral health services in these organizations are either uninsured or enrolled in MaineCare. The revenues from treatment of MaineCare patients are generally less than the cost of providing the services. If the caseload is predominately MaineCare patients, dental care is often provided at a financial loss to the organization. Safety net providers rely on grants and philanthropy to supplement insurance payments, but additional funds from these sources may not be sufficient to sustain the oral health programs nor are they a predictable source of income long-term. In addition, dental subsidies from the state which helped with uncompensated care have been cut by state government and providers are concerned about the impacts of these cuts on service delivery.

Services available in the safety net may also be limited by workforce availability. Safety net organizations report difficulty recruiting and retaining dentists. Dental students who graduate with high levels of educational debt seek employment that can either provide loan repayment or offer a salary that is sufficient to service student loans.

Dentists also find that their professional scope of practice is restricted in safety net organizations because these organizations may not offer the full range of dental services. Safety net organizations may limit the scope of services to those permitted by MaineCare. For example, some safety net providers choose not to offer denture services or crowns because of the limited insurance benefits for patients or their limited ability to self-pay for dental care. Dentists have

been trained to provide a comprehensive set of services and feel constrained by such policies. In addition, turnover is high and patients may see a different provider each time they present for care. Informants discussed the issue of patient dental anxiety and recognized the importance of having consistent providers with whom patients feel comfortable.

One effect of past innovation in Maine is that providers in the safety net are now struggling to integrate expanded workforce models into the existing systems of care. There was ongoing discussion in Maine at the time of the interviews about how best to create a delivery system that incorporates both accessible and transparent care for patients while still providing the continuity of care that is offered in a dental home.

This discussion pivoted on the school-based oral health programs in which dental hygienists working under public health supervision status provide services to mainly low-income and MaineCare-insured children. Safety net organizations and dentists expressed concern that some of their patients were receiving preventive services at school while also accessing those services in their dental home. The outcome is that patients receive redundant preventive services and one or another provider is denied payment for the “duplicated” service. Dental hygienists working under public health supervision status indicate they are as diligent as possible to ascertain whether the child has an established dental home but parents are not always forthcoming about prior oral health care.

This is a troublesome issue since many safety net providers and school-based programs are operating on small margins and cannot afford to be denied payment for delivered services. These survival economics are fueling assertions about the importance of centralized care. Some dentists and safety net providers emphasize that services provided to their patients in school-based programs undercut treatment plans and distance patients from a dental home. They advance the argument that receiving care from a variety of providers is inconsistent with the philosophy of a dental home. Others protest that these arguments advance provider-centric not patient-centered care. Dental hygienists in schools stress that the services they provide to children in schools have significantly increased access for children and improved their oral health outcomes. Dental hygienists affirm that they refer for dental services and try to act as cooperative members of a dental team.

This debate is now in the public forum and new regulations may limit the children who can be seen in schools by dental hygienists to those who have not been seen by another dental provider for at least a year. These arguments are especially difficult in Maine because the recent economic downturn has negatively affected overall demand for oral health services both in the private and public sector. The solvency of any dental practice depends on high utilization rates and full dental chairs. Private dental practices are advertising for patients and many suggest that there is very little wait time for appointments. The safety net is also experiencing diminished demand for oral health services. Informants attribute this to patients electing to defer dental services or to prolong the periods between preventive visits to save money. It is important that decreased

demand is not confused with unmet need. Need for oral health services in the community may, in fact, be greater now than in the past, but the ability of the populace to pay for oral health care may be more impaired currently than in a more prosperous economy. In addition, structural aspects of the safety net and broader oral health delivery systems include barriers such as hours of operation that limit the ability of people to obtain services during times that fit with their schedules and responsibilities.

Previous oral health workforce initiatives in Maine have increased access to oral health services. For example, dental hygienists in public health settings have contributed to improved access to oral health care for children.

Maine has been one of the most progressive states in the nation in its oral health workforce policy. While there were a variety of opinions about the success of past oral health workforce innovations, in general, stakeholders acknowledged that access to care, particularly for children, has increased as a result of changes in scope of practice and supervision requirements for dental hygienists working in public health settings.

During the time the interviews were conducted, there was ongoing debate at the dental board about children treated by dental hygienists working under public health supervision status particularly in school-based programs. At issue were children with dental homes who were also accessing dental hygiene services in schools. The fact that this discussion occurred suggested that the established delivery system is examining how to integrate this workforce innovation into the existing system of care delivery. Conventional providers are attempting to rationalize their interaction with the new provider model.

Informants did not usually debate the positive outcomes of school-based oral health programs, either from an educational perspective or from a preventive care viewpoint. What concerned informants was how this model of delivering care would interface with both the safety net and private dental practices in the communities where these programs operate. While informants described their desire that children receive seamless and transparent oral health care, they acknowledged that this goal was difficult to achieve in a system that does not operate on a spectrum but in differentiated siloes that do not share responsibility for care.

Independent dental hygiene practice was generally viewed with more concern. The model has enabled dental hygienists to increase access to care but the support structures to insure its success were not put in place when the initial enabling legislation was passed. Independent practice dental hygienists (IPDHs) were not permitted to bill for services to MaineCare patients until quite recently. So in the formative years, IPDHs were limited to treatment of self-pay or commercially insured patients.

Informants and IPDHs indicated that dental hygienists working independently encounter many of the same financial problems with the cost of materials and equipment that private dental practices also encounter. Independent practice entails renting space, buying equipment, and

purchasing supplies that must be paid by practice proceeds. Informants suggested that some IPDHs will eventually build sustainable practices, but initially these practices struggle to attain financial stability.

According to informants, IPDHs who have been successful in maintaining practices are gradually gaining acceptance both from patients and dentists in the communities where they work and their practices are increasing access to cost-effective preventive services. Informants suggested that it may be too soon to satisfactorily evaluate this model and understand its eventual place in the delivery system.

Dentists who worked with extended function dental assistants (EFDAs) were universally pleased with the increased efficiency and capacity that EFDAs provided in their practices. When trained appropriately and used as designed, the EFDAs model is useful. EFDAs work under the direct or indirect supervision of dentists so their applicability is limited to situations where dentists are present.

While there is interest in implementing new oral health workforce models in Maine, there is concern that there has not been sufficient time to fully understand the impact of previous oral health initiatives on access to oral health care for Maine's residents.

Informants expressed a wide range of opinions about the utility and practicality of trying to create a midlevel oral health provider in the state of Maine at this time.

One of the highly anticipated innovations in oral health in Maine is the planned opening of a new dental school on the Portland campus of the University of New England. Maine's citizens and state government have expressed support for this initiative with a dental bond providing money for dental school infrastructure. The dental school curriculum has been designed with a public health and community service orientation that is expected to educate and graduate dentists with an interest in working in communities where there is currently unmet need for oral health care. The program is designed so that beginning in their third year, students will participate in clinical externships in safety net organizations and community practices in underserved areas. The dental school will open in the fall of 2013, with the first graduates entering the workforce in 2017. The student dental clinic, which will provide services to the Portland area, will be open in 2015 and will supplement the safety net in that metropolitan area.

There was ambivalence on the part of some stakeholders about the current interest in installing a new oral health workforce model in Maine in light of the expected production of more dentists in the state. These informants identified midlevel workforce initiatives as ill-timed and premature. They commented that trying to educate, credential, license, and situate a new oral health provider model concurrent with the production of more dentists was unnecessary. These informants advised a delay in further workforce innovation until the effect of the dental school on the supply of dentists in the state and how it addresses the need for oral health care in underserved areas are revealed.

Other stakeholders commented that increasing the supply of dentists in Maine would not on its face resolve all barriers that limit access to care. Not all dentists accept MaineCare-insured patients and many limit the number of those patients in their practices. These informants felt that supplying more dentists to Maine would not necessarily improve the availability of affordable care, which is a major barrier for many low-income adults, nor would it address the need for better prevention of oral disease.

Informants expressed a variety of opinions about further workforce innovation in Maine. Some stated that it was imprudent to insert another provider model into an already complex mix of professionals providing oral health care services in the state. These informants felt that until the fundamental economic issues in oral health were resolved there would be no further success with efforts to increase access to oral health care. This opinion was grounded in the argument that there is currently no extra money to pay for oral health care and that existing public resources are inelastic. Creating a new provider would simply create further economic burdens for an already challenged system that is having difficulty subsidizing care.

Others felt strongly that a midlevel provider could make a significant contribution to more affordable oral health care but only if the training and education were of sufficient quality to provide safe and effective care. Many informants commented on the excess supply of dental hygienists in the state who represent well-educated, available capacity and who could be retrained to offer expanded services to patients. The idea of a provider whose education was grounded in prevention and who could also provide some basic restorative services was appealing to many. Such a provider might be more easily integrated into existing care systems and might effortlessly transition to a dental team.

Some informants felt that the resources directed to a new workforce model would be better used to further develop the already existing expanded workforce models in Maine. One stakeholder commented that the state can't keep just adding hands. Patients need to be provided with better tools to make better choices about their oral health care. The informant commented that people aren't even accessing what is already available so creating more may not be better.

Other informants commented that Maine should wait until a midlevel oral health model is more developed and a curriculum and certification process is in place in other states before considering using a midlevel in Maine. While many felt that solutions to oral health access should be locally designed and deployed, they would feel more secure if a new provider model was more widely established before it was locally implemented.

Discussion

Maine has a wide array of concerned stakeholders who have given thoughtful consideration to the issue of how to improve the oral health status of the state’s residents at a time when state funds to support care are limited. Many of the interview informants recognized that there are

finite resources for oral health care and that it is important to utilize them efficiently and effectively.

Maine's stakeholders have worked for many years at the local, regional, and state level to find ways to provide for the oral health needs of the population. The challenges have expanded as the population has become increasingly diverse, state residents have aged, and the state and national economy have struggled to recover from the recent recession.

There was significant consensus among stakeholders that future initiatives must be multipronged and should address the need for better oral health literacy, use existing workforce capacity and capability wisely, and reallocate financial resources to better treat patients. There was a prevailing concern that current cutbacks in state subsidies and efforts to change eligibility for MaineCare would erode the progress already achieved in increasing access to oral health services. There were also assertions that instead of treating adults with extensive or progressed dental disease in hospital outpatient or emergency department settings, those resources would be better allocated to provide a routine dental benefit through MaineCare for adults that would encourage less expensive preventive and early treatment services.

Many informants expressed concern about the lack of consensus among stakeholders on how to move an oral health agenda forward. They felt that achieving consensus on the next steps would better assure the success of future programs and innovations. While all stakeholders appeared to understand the complexity of the problem confronting the state, not all stakeholders agreed on appropriate solutions. Points of strong agreement included the need for improved oral health literacy among diverse populations; the need to devote more economic resources or reallocate resources to improve outcomes; and the need to install creative, local programs that address the oral health deficits of local populations. While the opinions about strategy to improve oral health in the state varied greatly, there was widespread agreement that Maine must move forward with public policy to further improve oral health.

Informants acknowledged that the current momentum for change was important but also challenging because previous workforce innovations are still evolving, such as independent practice for dental hygienists, and oral health programs, like school-based initiatives, are still being integrated into established systems of care. While there was openness to further innovation, there was also caution about undertaking new initiatives that might not be useful or sustainable. There was widespread expectation among informants that the next step for Maine was either expansion in current scope for existing professionals (dental hygienists and/or dental assistants) or introduction of a midlevel dental provider. There was both support for workforce innovation and concern about the effort and expense of creating new education programs and credentialing systems to assure that a new provider offers evidence-based quality care.

Ultimately all stakeholders who participated in the interview process expressed concern for the oral health of the people of Maine. Informants were clear that better prevention education and

increased access to oral health services must remain at the forefront of policy discussions in the state and that new initiatives should build on the momentum for innovation that is characteristic of past efforts in Maine.

Appendix A.

Interview Questions for Stakeholders in Oral Health in Maine

Conducted by The Center for Health Workforce Studies
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This interview is being conducted to inform a review of oral health workforce in Maine, to describe barriers to access to oral health services, and to recommend pathways to increased access to dental care. The research is conducted by the Center for Health Workforce Studies at the University at Albany in partnership with Maine Oral Health Funders and Medical Care Development. This interview is voluntary and will take approximately 45 minutes to one hour to complete. Please tell me at any point if you wish to or must discontinue this interview. Although the following questions are meant to guide the interview process, only some of the questions may be asked depending on the time allotted. Any information provided during the interview will be confidential. Do you have any questions or concerns about this interview before we begin to talk?

Questions:

1. Describe your personal or professional interest in oral health in Maine.

2. What do you perceive to be the major barriers to universal access to oral health care in Maine?

3. Do you have concerns about lack of access to oral health care for certain populations? Who is at risk for not receiving dental care? What geographic areas in the state experience limited access to oral health care?

4. Are you aware of any successful initiatives or collaborations that have addressed the need for increased access to oral health services in the state? What strategies were employed by those initiatives to improve access to care?

5. Can you describe the coalitions who implemented these projects, their funding sources, and the patients served by these initiatives? What kinds of oral health workforce were employed to achieve the project objectives?

6. How do current regulatory limitations on scope of practice for dental hygiene and dental assisting professionals impede access to care for those at risk for not receiving oral health services? Are there particular examples of regulatory barriers to care?

7. How have past initiatives in Maine to expand the scope of practice of dental hygienists and dental assistants or to decrease incumbent levels of supervision for these auxiliaries affected access to oral health care? Have these initiatives had appreciable impacts on increasing access to oral health care? If not, why not?

8. Describe your perceptions of stakeholders' concerns about efforts to expand access to oral health care through workforce initiatives. How have oral health professionals historically responded to proposed legislation to elevate scope of practice for either dental hygienists or dental assistants or to decrease supervision requirements for these personnel? What are the main concerns expressed by oral health professionals about such regulatory change?

9. What is your perception of the sufficiency of supply of oral health workforce in the state? Is there a need to recruit more dentists, dental hygienists, or dental assistants to work in specific locations in the state?

10. What educational programs in the state or out of state might be engaged to train new oral health professionals? Are partnerships among educational programs easily achieved?

11. What could be done by government stakeholders from a policy perspective to encourage increased access to oral health care in the state? How does funding for oral health care affect access to dental services in Maine?

12. Are there any issues that we have not discussed today that you feel are relevant to this discussion?

Thank you for talking with me today. If you have any questions about this interview at any time please contact me (Margaret Langelier) at MHL02@health.state.ny.us or at (518) 402-0250. If you have questions about your participation as a research subject, you may contact Tony Watson, New York State Department of Health, Institutional Review Board, (519) 474-8539 or via email at TMW05@health.state.ny.us.