October 9, 2019

Rural Access to Health Care Services RFI
Response submitted by American Dental Association

Primary Contact: Jane Grover D.D.S., M.P.H., groverj@ada.org, (312) 440-2751

OVERVIEW

Over time, the way people tend to access goods and services changes. This is no different with health care. Technology has evolved to afford us the ability to be precise – with great accuracy and responsiveness. A one-size-fits-all approach to measuring need across rural communities is a disservice to patients. Real solutions are necessary to improve access to and utilization of health care services.

When shortage areas are incorrectly defined, human and capital resources are improperly disbursed, policy is improperly focused and bad proposals move forward. Thus, those most in need are likely left behind in favor of others who may not need as great a degree of help.

The current model of defining where the greatest needs lie in respect to number and distribution of providers is sorely outdated and inflexible. With an updated, technology-driven approach, we can better allocate resources to enact responsive policy that meets the unique needs of each community.

The ADA’s Health Policy Institute (HPI) conducted a two-year research initiative to examine a more responsive approach to determine dental access shortage areas. This was based on a novel, peer-reviewed methodology that specifically addresses the Medicaid population separately from the population in general. Their approach geo-locates all providers and uses geo-analytics to measure the proximity of providers to beneficiaries, including Medicaid providers and patients. This data tells a very different story of need compared with the Health Resources and Services Administration’s (HRSA) current method of defining dental Health Professional Shortage Areas (HPSAs). You can learn more about HPI’s approach in the answer to question 4.

Please also read on to dive deeper into the ADA’s perspectives on current weaknesses in the system and potential solutions to redefine how to measure access to care.

ANSWERS TO SPECIFIC QUESTIONS:

1. What are the core health care services needed in rural communities and how can those services be delivered?

Core oral health services needed in rural communities include predictable and consistent preventive strategies such as Community Water Fluoridation, prophylaxis services (both
simple and complex), restorative services, tooth extraction, and limited rehabilitative services.

These services can be delivered in a variety of ways, all of which need navigation/case management services by dentally informed personnel who are familiar with dental terminology and appointment protocols. Community Dental Health Coordinators (CDHCs) can play this important role.

Some oral health services can effectively be delivered by some of the technologically sophisticated mobile dental vans which are staffed by dental providers to address local needs without brick and mortar investments.

2. What are the appropriate types, numbers, and/or ratios of health care professionals needed to provide core health care services locally for rural populations of different compositions and sizes?

Dental care teams can efficiently cover many areas of a state and provide recall or treatment visits depend on the population in question. A study in the *Journal of the American Dental Association* found that rural dental health needs depended on a number of factors including the number and type of schools in the area, presence of Community Water Fluoridation, and the Rural-Urban Commuting Area (RUCA) score of the area in question.1 The ability of practices to have satellite locations is important since Federally Qualified Health Centers (FQHCs) could contract with those providers to maximize efficiencies rather than incur the costs of beginning (and maintaining) a dental department.

3. What other factors are important to consider when identifying core health services in different rural communities, such as current and projected population size, distance to the nearest source of care, availability of telehealth, and sustainability of services?

Sustainability of health services is important as Medicaid dental benefits typically comprise 3% of a state Medicaid budget. Additionally, federally designed dental services, such as those within the Indian Health Service (IHS), may not be staffed at full capacity, but private practices with professional flexibility can supply a relevant professional team.

Telehealth can be an effective screening and examination tool to assist dental offices in providing needed care by reducing transportation needs.

CDHCs can reduce disease burden through community prevention strategies and navigating patients into existing, but underutilized care. Because CDHCs are typically recruited from the same types of communities in which they serve, and often the actual communities in which they grew up, they are also effective in reducing cultural barriers to care.

---

CDHCs can connect patients to care outside of Emergency Departments (EDs). In 2016, there were 2.2 million visits to EDs for dental conditions at a cost of $2.4 billion. Patients only receive limited dental care in EDs, and by instead referring patients to a dental home (often a FQHC or private dental practice), CDHCs help ensure that the patients receive comprehensive care. Additionally, because these patients are receiving care to alleviate, rather than manage, the cause of their oral health issues and pain, ED referral helps to reduce opioid abuse.

CDHCs are also effective at integrating oral health considerations into primary care settings. This has been seen in several states, such as Montana, where preventive services are provided in many pediatrician practices as well as long term care settings.

4. How should we measure access to health care services in rural communities? What are the best ways of measuring quality of care in rural communities?

As detailed in a Government Accountability Office (GAO) report, there are shortcomings to HRSA’s methodology for determining primary care HPSAs. This is also true for HRSA’s dental HPSA designations. The current method of determining a dental HPSA is outdated and does not take into account other factors that influence access to dental care. For example, a report on the dental workforce in Georgia found that all of the state’s counties that have no dental practice or have one dental practice are surrounded by counties that have multiple dental practices. Isolating and analyzing populations by county does little to provide policy makers and other stakeholders with an accurate picture of patients’ access to care. As mentioned above, the ADA’s HPI has developed a new approach to measuring access to dental care at the state level.

This two year effort involved creating a new, unique proprietary database of all locations in the United States where dentists practice, merging detailed population data, and then analyzing the geographic proximity of dentists to the population using sophisticated geo-mapping techniques. Through a partnership with the Centers for Medicare and Medicaid Services (CMS), HPI researchers were able to identify locations where dentists practice and where at least one dentist participates in Medicaid or the Children’s Health Insurance Program (CHIP), allowing HPI to analyze geographic access for the publicly-insured population as well as the entire population. The analysis is at the Census tract level and uses transportation networks to calculate travel times. The detailed methodology, including

---


4 A Snapshot of the Dental Workforce in Georgia, July 2019.
limitations, and analysis for every state is available online.\textsuperscript{5} Also online is as a side-by-side comparison between HRSA HPSAs and HPI’s estimates in one state.\textsuperscript{6} The main advantage of HPI’s approach to measuring geographic access to dentists is that it takes account of where the population lives, including Medicaid-insured populations, relative to where dentists are located, and incorporates travel time data. This presents a more accurate picture of true geographic proximity. HPI’s analysis also presents several measures of geographic access using alternative threshold measures rather than simply arbitrarily choosing a single threshold. The rationale is that there is little empirical evidence to support a single threshold measure that represents “adequate” geographic access to dentists. More importantly, HPI has recently developed an updated 2.0 version of analysis that goes further and assesses open chair time as well as meaningful participation in Medicaid among enrolled providers. The HPI team is currently working with state Medicaid agencies in 3 states, at their request, to implement this new methodology and use the results to help shape policy.

Volunteer services can also be a factor in measuring access to dental care as seen in many rural areas which may be providing periodic Mission of Mercy (MOM), Dentistry from the Heart, Dental Lifeline Network (DLN) services, and Give Kids A Smile (GKAS) events or community screening programs such as Head Start examinations.

Measuring quality of care in rural communities could include examination of Medicaid claims data for preventive services for children under age 18, number of mobile programs which are operating within a defined area, and dental student/resident provision of services as part of their educational program.

\textsuperscript{5} American Dental Association Health Policy Institute, Geographic Access to Dental Care, https://www.ada.org/en/science-research/health-policy-institute/geographic-access-to-dental-care.