NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
HEALTH PLANNING COMMITTEE
DENTAL/ORAL HEALTH CARE IN THE EMERGENCY DEPARTMENT WORKGROUP

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3:30PM – 5:30PM
VIA ZOOM

Dr. Rugge This group together by saying welcome to this participation of the Planning Committee of the Public Health and Health Planning Council. Just to be clear, this is not an official formal meeting. We will make no resolutions, make no formal recommendations. But it is really critical. As for information gathering today about the use and sometimes many times inappropriate use of dental, dental problems, dental services in the emergency departments across the state and. So welcome to participating members of the committee, to our staff and the Health Department, to our presenters, to our invited guests and members of the public who are here. So by way of. My agenda says that I should be introducing or there should be introductions by members of the committee. People feel comfortable just volunteering their name and any special interest they have. Or should I be off the names? So how to do that. For both of them?

Speaker 3 Jennifer, can you go on mute?

Dr. Rugge Maybe it's best around the table is easier just to go around the table and everybody raise their hand and say who they are. But let me just say my way of committee members. My information is Jo Boufford, Tom Holt, Gary Kalkut, Harvey Lawrence, Peter Robinson, Denise Soffel. And hopefully Hugh Thomas. If I mention anybody who is not here, I hope they would raise their hand and shout out that they're not here. But that may be difficult. What about anybody who has joined us who has not been formally registered? Q Michael? Anybody else that I have neglected to mention? That could do any committee members have any preface remarks. They would like to make any statements of their interest. Anybody with a toothache? Feel free to shout up. Not otherwise. Let me mention and introduce our presenters today. I have a challenge. I'm sure I'm going to be seriously mispronouncing names, but Dr. Enihomo Obadan-Udoh who is a national authority on dental care and a special interest in an emergency care of dental problems. So very well can we have been treated already to articles that you have published, national journals. And also Dionne Richardson, who is general director within our Office of Public Health. Thank you for waving. With that. Any other comments? is Dr. Obadan-Udoh with us. I don't see. Picture.

Speaker 3 She's waving. She is waving there.

Dr. Rugge Yes. Okay. Okay. Thank you very much. My work is done, I can move on. Dr. Morley was on my screen, and we'll begin this discussion by talking about the problem. Summary of the data supporting non traumatic use of the EDs for dental care. John, take it over.

Dr. Morley Thanks very much Dr Rugge. So the most folks I think you're pretty familiar here so I'm going to be pretty brief in my comments. We were approached by the folks from SEMAC and SEMSCO related to the issue that's been around for many, many years. Our friends in the state American College of Emergency Physicians point out that they started crowding in 1989. The problem is, is not staying the same. And COVID certainly

has managed to make it a bigger problem. So one of the things that started happening a few years ago was that instead of taking five or ten or maybe even 15 minutes to transfer patients when EMS would bring a patient in, they're now holding on to patients for over an hour, sometimes two. And occasionally it can reach as long as 3 hours because the EDS staff is just overwhelmed. This isn't a problem that came overnight and nobody is going to come up with any one single solution or any solution that's going to fix it overnight. But we can't allow it to continue to go unabated, unaddressed in some way, shape or form. And it's we need to have a conversation. SEMAC and SEMSCO met with the chair of the planning committee, Dr. Rugge, and Jeff Kraut, the chair of, to discuss this issue. And it is in the minds of the folks, a public health issue now that it's affecting EMS and the response times. So there is there is data on that. We had a first workgroup meeting over a month ago related to patients who come in with mental health issues, and that's one little subgroup. What we're looking at is an elephant heading into the elephant one bite at a time. So the first workgroup addressed mental health. This was going to look at dental issues. We're aware that a very large percentage of patients who come into the ED. They actually do not require emergency medicine, that they can be taken care of most often by other means, by primary care providers or by urgent visits with their primary care provider or somebody else. So what we're looking at is conversations about the pieces of the population that use the utilize the app to see what other options we can come up with. And we did hear some things that the Office of Mental Health is working on the last time to try and reroute some of the patients that are going to the ED and I think we'll hear some other opportunities today related to dental emergencies. 70% is the number that's quoted of patients that go into the ED may not need emergency care and 15% of that approximately are dental patients. So with no further journey to turn it back to our chairman and then we'll hear from some of the experts that have been looking at this issue, studying this issue for quite some time of dental patients, attending the ED dental patients and seeing a dentist in the evening. And that's what they need to hear for ultimate resolution of their issues. So they get antibiotics or they get pain medications, they get help as a safety net. But what they need is dentists to provide relief of the ultimate relief of their care. Dr. Rugge, over to you.

Dr. Rugge Very nice report. And again, in addition to being surprised by the numbers of dental patients appearing at the door of the emergency room, it would seem this is a category of care that is really inappropriate for the elderly. Then certainly in the event of serious trauma, emergent attention may be needed. There are also going to be a need for pain relief. Need for antibiotics on occasion would seem that there are alternatives to going to the emergency department to obtain those services, and hopefully today's discussion will make it more clear what our opportunities might be for improving care by directing people to the right source of care. Any comments from members of the committee. Otherwise. Regarding Dr. Morley's comments. If not, let me proceed. To ask Dr. Obadan-Udoh to explain the problem to us from the perspective. A real expert and someone who has the knowledge base and the national scope to let us know what to think.

Dr. Obadan-Udoh All right. Thank you very much. Really honored to be here. Thank you for the invitation. And I hope that I can shed some light and offer some ideas that you can think about. I'll share my screen. Oh, see? Okay, so. Can you see my slide?

Dr. Rugge Yes, you can.

Dr. Obadan-Udoh Perfect. All right. So I would be discussing some potential solutions. And these are by no means the exhaustive list of all solutions out there, but they're just some thoughts and ideas that I have as present data. My name is any, but I'm a widow

and I'm an associate professor and also the residency director for Dental Public Health at the University of California, San Francisco. So hello from the other side. And I do have some funding sources, but they do not represent any endorsement by these sponsors. My views do not represent an endorsement. All right. So the problem I mean, you all know the problem, right? And some of the literature and research that has been done in this area. Thank you, Jacqui, for giving us that exhaustive list to read and study prior to this meeting. But, you know, we see certain trends that occur over and over again, and they're related to patient demographics. You know, generally adults over children present to the E.D. and really younger adults. And then we also have, you know, some disparities by race, ethnicity, patient co-morbidities. And their oral health status is really indicating use of the ED for non traumatic dental conditions. There are also certain factors like the day of the week, the time of the day, and where the patient is located. So rural versus urban rural counties tend to see more EDI utilization and then just general access, like how close are the dental offices or dental providers and how many dental providers do they have around them? And then economic influences, things like the dental insurance type of dental insurance and whether or not they're stable socially or the homeless, you know, or, you know, what kinds of people generally come to the E.D. over and over again. And we tend to see people who do not have insurance or who are uninsured or people who use Medicaid. And about 60% of all of these visits are covered by Medicaid, according to the literature. So between the uninsured and Medicaid. Majority of those visits are tend to be patients who do not have insurance or Medicaid enrollees. We also know that patients who use the IED tend to come back over and over again. So we have repeat users and a lot of times, like Dr. Morley said, they don't get any definitive treatment. So a lot of times they just receive antibiotics or opioids and this predisposes them to some substance use disorders. And really, they're there. They don't receive the care that they need. And that's why they keep coming over and over again. And they get disease progression and it's coming at a huge cost. So over $2 billion is spent on these types of visits that could be prevented. And like you said, over 70% of these visits really do not need to be they're not urgent. And so they don't need to be seen at the E.D. They can be handled perfectly well in a dental office. And so we see the ambulance delays. We have overcrowding, long wait times in the E.D. and just wasted resources as well. As you know, this is something that was studied with opioids. Some patients who had never received opioids prior to the E.D. visits and became exposed, ended up becoming addicted to it and coming back over and over again just to receive it. So these are some things that we want to avoid by tackling this problem. Some of my work has involved working with the Dental Quality Alliance to develop dental quality measures to assess this issue, especially using Medicaid claims data, because we know that Medicaid pays for a lot of these visits. And so we want them to be able to track how many of their enrollees actually utilize the E.D. for non traumatic dental conditions. So we developed two measures, one, to just assess the number of these E.D. visits that could be handled in the ambulatory care setting. So at a regular dental office. And the second was just to see how many people are after these E.D. visits and go into a dental office within seven days or within 30 days. And this is just a preliminary data that they have. But we had from Oregon using the Oregon Medicaid claims and the issues that shows that we had 209 E.D. visits per 100,000 member months. This translates to about 2.5% of the enrollees were using these using the E.D. for these conditions. Went on to object them on commissions, and then we had about 21% that had a follow up visit within seven days. When we expanded the number to 30 days, only about 30% had seen it done. This means that about 60% were really not getting 60, 70%. We're not getting any definitive dental care. And so those people are likely to return to the. So what can we do? I mean, of course, we know that we can prevent all of these things if people just maintain good oral hygiene, have regular dental checkups, you know, eat healthy. And so those are those are the foundation building blocks. You know, how can we

promote better oral health in the community? The pirates had been having this ED visits. We see some things that, based on the factors that come up over and over again insurance. We want to make sure that those who are uninsured get connected to dental insurance and they we help them register, sign up for dental insurance. And then we want to make sure that once they do that, they get connected to a dental home. So that is just the regular dental office that they can see. They can visit a dentist regularly and they maintain good oral health. We also have school based programs where we can visit the kids in schools and provide care to them, preventive dental care, so that we they don't progress to the point of needing urgent or emergency dental care. However, if they already are past that point and they need to go to the E.D, the couple of things that we can do and these are some E.D. diversion programs that we can use to divert calls, especially the emergency calls. We can also choose to divert the patients and we can offer definitive dental treatment or connect them to a dental home in order to divert the calls. Some things, the calls and things that have been tried in Florida tele dentistry charge platforms. So this is essentially I'll go into them in detail, but this is essentially a platform where we use telehealth to screen patients, and that way we can determine the urgency from that call or video call and decide where the patient needs to go. It also helps with, you know, just assuaging any fears or helping to get prescriptions of the patient's prescriptions so that they don't need to go into the ED with 6 hours only to get antibiotic prescriptions or pain and allergies and then to divert the patient. Some people have tried using mobile, then some. The beauty about mobile bands is they can go anywhere, so you can take them to schools, you can take them to homeless shelters, you can take them anywhere. You can even park them in the parking lot and you can use that to divert patients from the ED. And then another one is a co-located dental office. And there are several models that have been tried with, you know, just trying to partner with dental offices where AEDs and hospitals or EDs and residency programs partnered to offer dental treatment to any patient that needs dental care. And then the last is really just connecting them to the dental home. And this is where we talk about the referral and care coordination, because, again, a lot of these patients come back over and over again. So if after they visit the E.D, there's a mechanism to connect them with a dental home, they don't need to return to the. And this is just an example of how the Taliban, a street here at home, would work and apologize for the small font. But essentially, if a patient calls 911 and they complain of a dental emergency, they get transferred to this hotline or to this platform where they can speak with an advice nurse who would probably be a mid-level dental provider. And that person determines the treatment urgency. And then once that is done, if they need to go to the E.D., they can be picked up or they can connect them to a care coordinator who can ensure that they have a dental visit within 24 hours. Again, full disclosure, I do not have any ties to the company, but this is just an example of a company that is doing something similar. They offer a 24 seven emergency dental emergency access to dental care. They accept insurance. You can also have self-pay patients who pay $50 per visit and where you can chat with a doctor and complain about your symptoms and get prescriptions sent to your local pharmacy. And again, for the mobile dental vans. Like I said, this increases access, it helps to reduce costs. They can be park anywhere. So essentially it helps to build community outreach. It's really flexible and these are some examples. It can be used in rural communities where we don't we struggle to recruit dentists. It can also be used with homeless population schools and universities and with prison populations. And for the cool look at a dental office or offering urgent dental care. There are several models that the ADA, the American Dental Association, have presented. For example, you can have a patient volunteer model where the patient volunteers as a minimum number of hours and then they get a voucher to see a dental provider or a dentist. You can also partner with specialist clinics, you can partner with corporate franchises, you can partner with academic institutions. You can offer vouchers or retainers with dental offices and private practices.

And then for the referral, the key part or the critical component of this is to have a care coordinator, and this is the type of dental provider or personnel that helps to connect the dots. And for a lot of these patients, it's not because they do not have insurance like the Medicaid patients. They just don't know how to navigate the system. And so for those who are uninsured, we can help them register and sign up for dental insurance. For those who are insured, we can help connect them to a dental home for those who visit the ED and do not get any definitive dental treatment. And we can help ensure that they get access to a dentist who can offer or provide definitive dental treatment. And this care could meet up would also receive the referrals from the platform, the telehealth tele dentistry referral system, and call around or use the website to determine which I'll show in the next page to determine which providers are available and connect those patients to the providers that are available. And for providers, they just need to sign up. Why they need to sign up, they need to dedicate time. The providers are not going to sign up unless they know that the patients are going to show up. And Medicaid patients for some reason are not always able to show up. So we have very high initial rates and that's where most dental providers limit the number of Medicaid patients they see or do not see Medicaid patients at all in the dental practices. And so in Alameda County, for example, in California, they developed a care coordinator system whereby the care coordinator worked very closely with all the dental offices, and the dental offices that signed up were free to choose the days and the times they could allocate to the public health department. And once they did that, the care coordinator had that list and it was constantly updated and she ensured that the patients showed up to those dental appointments and made sure that she helped close the loop. And so this position, all the care, credit and coordination is really critical to the success of this program because they can follow up with the providers and the patients, they can send reminders and then they really help the patient establish a regular dental home. Again, this is another website that helps to identify providers, and this is just an example of providers that are that are the availability of providers within 24 hours. And so you can do this every day. You can partner with the company and they can help connect you with providers in your neighborhood. And that is the end of my presentation. I put a couple of resources that is my contact information if you need to reach me for any reason. Thank you.

Dr. Rugge Just a very preliminary question. These slides will be available to us. Is that the case or. Just a little question you mentioned about mid-level dental providers. I understand and I think we're going to hear more about this shortly. There is no such category with licensed providers in New York State. There are a number of other states, but with a background reading, it seems there's only 149 of these providers across the nation. The question then is how effective could we expect that to be?

Dr. Obadan-Udoh Well, if it's an on call system, like I said, the on call system can work with mid-level than other providers. So that could I mean, you don't need too many people to to manage that because it's just one platform and people sign up and then you can also have dentists who sign up. So most of the existing systems just use dentists.

Speaker 1 Elsewhere from the screen around the table, Dr. Boufford. You. You're still on mute.

Dr. Boufford I think I have a logistical problem here. Thanks so much for this presentation. It's really, really interesting. I wanted to ask you before leaving this and sort of a follow on to John's question about sort of the national scene in terms of not just providing, you know, sort of first level dental care around the country. And we see similar challenges in mental health in terms of scope of practice, you know, limitations by states,

obviously, in medicine as well. Some of them have been overcome with nurse practitioners and VA's, but they still sort of have to work under supervision of a doctor. And the only system I've seen where non dentists have been given a good bit of authority is the Union Health Service because of the really remote locations in Alaska and other parts of the country. And I just wondered if you could comment on the degree to which scope or practice issues stand in the way of really having, if you will, primary care dentistry in terms of people that could do screening, prevention and other sort of non-emergency stopgap care.

Dr. Obandan-Udoh Yeah. I mean, that is a challenge, you know, and I think it just varies depending on the state. So there, there exists in like, um, work product reports that compare states across the spectrum. I think with COVID, things were relaxed a little bit, at least to include telehealth and tele dentistry. I feel like, you know, some of those games need to be kept. For example, in California that was reviewed recently and it was going to change, but then there was a lot of lobbying to keep it. So I feel like with telehealth that offers some room for practicing within the scope of licensure. And, you know, it doesn't put as much strain on the system because there are very few providers, but there is a push to have more dental therapists, you know, more, you know, in California we have RDHAPS. So dental hygiene is an alternative practice for expanded function dental assistants. And so we can push for that. We have more people registering for those and we can have I mean, it only takes four months for a dental hygienist to become an RDHAP and they can practice under general supervision. So I think we we need to call attention to the importance of having these mid-level dental providers and what role they can play, especially in screening patients and getting them access to the care that they need. Thank you.

Dr. Rugge Questions. Just another question for me. Are there any states or for that matter, any health systems around the nation that have demonstrated? Performance of success preventing these. Patients move from coming to the E.R. because of alternative sources of care.

Dr. Obandan-Udoh I think several states have tried different things with varying degrees of success. And so it all depends. You know, so like the voucher model was tried, I believe, in Minnesota and let's see. And then there was one in Maryland. Oh, and I can send that resource. But yes, they've all tried different things, you know, depending on a lot of times. The problem is that these things tend to be ground funded. And once the ground goes away, then it's gone. You know, and so we're trying to figure out what we can do to make it sustainable. Until, like I said, in California, we tried this care coordination system, and that has been a huge success. Right. That has that has really helped to get patients in and to get them stabilized and connected with a dental home. Right. So I think I feel like another state has tried the mobile dental van. But, you know, that has its challenges with recruiting and recruiting dentists to work in a mobile than a van, But that has been used with success in schools to them to provide preventive care. And I believe that's been used in New York to. Right, right. Yeah. So. So several of these models we have try the telehealth model for our rural counties. And we've been working in one rural county and that has been successful. So we're trying to expand to other rural counties in California. But, you know, it's a slow process.

Dr. Rugge It would seem that by diverting dental patients from the needy, there would be savings achieved. And the question one question is whether any agency, state, municipality has tried calculating those savings and then directed at least some of those savings to support the alternative systems.

Dr. Obadan-Udoh Oh, I'm not aware if there's any report on savings yet. Yeah, but that, that that would that would be true. You know, if we're able to divert patients from the ED, then, you know, those savings can be passed on. To the patient or to the system.

Dr. Rugge It could be a mechanism to consider as a as a committee and as a council and as a health department in terms of how to how to redirect the care by simply redirecting it to a to someplace where there is no support, which seem problematic. My other questions. Reaching beyond the two hands up.

Speaker 3 Dr Soffel has her hand up.

Speaker 5 Right?

Speaker 1 Dr Soffel, yes.

Dr. Soffel Yeah. Hi. Yeah. My question. Folks are Medicaid. And in New the overwhelming majority of them are in a Managed Care plan and their dental care is provided as a part of their managed care plan benefit. And their managed care plan in some sense, has a responsibility for making sure that their Members. Are linked to a dental home and know how to access those services and where to go and that access is available and that it's available around the clock. I mean, Dr. Obadan-Udoh, you know, you said that both day of week and time of day and rural are a major access barriers. But that is exactly why we in New York have contracted with managed care plans to overcome those access barriers. So it's I'm sort of curious about whether. In other parts of the country the Managed care plans play this crucial intermediary role, linkage role, and whether it's more effective in other places than it appears to be here in New York. And, oh, by the way, I did my postdoc at UCSF. So I am a fellow. San Franciscan, although I live in New York with qualified ethical policy studies.

Dr. Obadan-Udoh Yeah, Yeah. So, I mean, ideally, you know, in an ideal situation, the managed care plans would, you know, do the work, you know, care coordination and ensuring that these patients have access and care and are connected to the dental homes. But in reality, we find that there hasn't been a lot of success with getting the patients to see the dentist regularly. And so they wait until they have an emergency. And by then, you know, they don't have a dental home, so they just show up at the e.D. I feel like Oregon has been successful somewhat in getting this done. You know, they still have cases, but they they look at the data regularly. And so they have been able to push for for improvements, you know, in their system. But if we did not and that's why we created the the quality measures. So now we can compare from state to state and have an idea. Didn't look at the data before coming here, but I can look at it and send it to you. But essentially if if we measure, then we can determine how successful these plans are in getting the patients in. I think the big issue is just having that regular follow up with the patients. And a lot of times the patients have other issues that prevent them from seeing the dentist that we need to tackle. Right. And the dentist also, even though they're registered, I think the ADA Health Policy Institute did a recent study that showed that even though some dentists are registered to see Medicaid patients, they really don't. And so some see just one patient. You know, a very the spectrum was really wide from state to state and from dentist to dentistry. It wasn't enough to just capture that a dentist was registered to see Medicaid patients. You needed to follow up to see how many patients they see and encourage them to to dedicate a good section or a portion of their practice to see a medicaid patient. And if the plans are not following up to make sure that these dentists actually accepted these

patients or not given them, like if a patient calls and they get like six months to see a dentist, then they're going to go to the E.D.. Right. So if so, we need to make sure that the dentists actually creating space for these patients when they call so that the patients can get seen promptly. So and a lot of that is just data collection. And following up on the data.

Dr. Soffel It does sound like another. I'm sorry. Let me just follow up quickly. I think this is part of the conversation for later. But it seems to me that as a state, given how much we have invested in Medicaid managed care, that making sure that every Medicaid managed care plan in the state has a connection with every emergency department in the state so that they know the needs, know exactly how to link those people walking in back to their plan and back to the care coordination that is meant that we are paying for, that is meant to connect people to care.

Speaker 1 Yep. Dr, Morley your hand is up. Is that for real?

Speaker 3 It is that you really think I'm going to stray into an area that I really, really didn't want to? Because this is really just a massive issue? And I'm going to ask Dr. Obadan-Udoh if this is the topic I'm going to open up that could be talked about for hours. I'm hoping we can keep it short. It just cries out, though, is there? Can you just comment on the impact where they have improved dental care access? The impact on general health. There's so many studies that connect dental health to general medical health in terms of the inflammatory process, cardiovascular atherosclerosis and the impact on diet and nutrition. The states that have been hit managed to do something in terms of improving access. What are they seeing in terms of improvement in health?

Speaker 2 I think I think generally we know that if we improve oral health, you know, the general health improves. So I think once we're able to increase access, it feels like a perennial problem that everyone is trying to solve. I feel like we don't have that much data link in both, you know, So we have generic data. We know that, you know, once we improve oral health, the general health, improve sport, specifically a link in the E.D. like diversion programs or increase in access to care. I feel like there's, you know, anecdotal evidence here and there, but no one like nation wide or even state wide programs that actually address those issues or connections.

Dr. Rugge We will try to be the exception in New York. Thank you. Betsy Bray, New York State Dental Association.

Dr. Bray Hi, everyone. Thanks for having me. This wonderful conversation that we've been having internally for quite some time. I just wanted to address Isabel's comments. In theory, the way you describe Medicaid, managed care would be perfect. In fact, we have found that it is contributing to you know, I can't sort of quantify this, but I feel like that the switch from fee for service to Medicaid managed care is actually contributed to this issue. The provider panels are very weak. In theory, the Medicaid managed care programs have to provide care coordination and provider panels, and I think they do a pretty good job showing that on paper. But the reality is people have to travel great distances for and add on to care or oral surgery and even general dentistry. I think it is a contributing factor to this compounded problem. And I think that, you know, later on in the conversation, we're going to contribute a little bit to some solutions after we hear from the other presenters, from our perspective, from the New York State Association, the New York State Dental Foundation, we have them putting our heads together and think we have some solutions that really line up. And two to what Dr. Obadan-Udoh is talking about. But I want to just say that as far as Medicaid managed care, we need more regulation. When I was fee for

service Medicaid, it was very straightforward. You had the green binder, you knew what the the codes were, you knew the corresponding reimbursement. Everybody knew what they were getting. With the 16 plans that are out there, it has been described to us by providers as the Wild West. There is not an overarching regulation to how they do business. You know, the provider panels and the what they're presenting to the public. So I do know it was probably a fiscal decision that made a lot of sense to utilize the Medicaid managed care. But I will tell you, many of our members from the dental association are dropping out of these plans because their reimbursement rates are just not sustainable. So it's leaving a lot of New Yorkers in pockets without care and a proper parietal patient provider. Panel, I will tell you 100%, they are not looping people back. They are not linked. It's it's really all about making money from where I stand.

Dr. Rugge It's well taken. Dr. Boufford.

Dr. Boufford I was going to say that does not surprise me at all. Just a quick, quick comment because it's I know this is a medicaid conversation, but there's a group called the Santa Fe Group of Dentists National Organization, that's been working for about four and a half years to get an oral health benefit under Medicare. And we just had a meeting yesterday of the master Plan on Aging group, the Health and Wellness Committee. And this is a big issue for us under benefits available. And I think there is definitely very, very strong evidence base for the relationship between oral health and medical care costs for older persons. And to the degree actually that there was an agreement that this group were on the cusp of having the entire panoply of dental association signing on to a request for seems to recognize oral health in, you know, in the recent sort of revisions of Obamacare. And at the last minute, I'm sorry to say this, but I think it's you know, we can't step aside. The American Dental Association pulled out of the consortium and the program was not taken forward. So there's a lot of consensus in the national dental community about this area, in the Medicare area. And the concern and I part of this is I do global health and part of this is really a global problem. Dentists around the world really don't deal with public and public insurance very well. I mean, there really are have been the last holdouts with the National Health Service and others. So it's a sort of professional, I guess, culture, etc., not to be negative about it, but I think the minority of dentists probably maybe it's an unfair statement, are really are not necessarily sort of open to public health insurance and for reasons that are completely understandable in terms of their own incomes, which is fine. But it sort of leads me again, I don't want to lose the notion of the mid-level practitioner conversation, at least because I think that, you know, and again, this has happened in medicine. I don't want to point the finger at dentistry, but we don't have the providers at higher level accessible in rural areas, in other areas. But there is the profession resists having people who aren't that profession be able to provide certain services. And I just think that's an interface that we should keep alive in this conversation.

Dr. Rugge 1 Dr. Obadan-Udoh for the help you've given us. We're suggesting any number of options that we might pick by way of taking action before. Bringing the conversation about two reasons I need to mention that I made a big mistake and forgot to mention Jean Moore, the one presenter who I've known for many, many years. Very well and don't want you to think, Gene, that I've been taking you for granted. You'll be coming along soon. But in any case, Dr. Richardson, can you help us, given your position and status and expertise in New York?

Dr. Richardson No, thank you. So I am with the Department of Health, as mentioned, and FIT and the Division of Family Health. And my unofficial title is state Dental Director, and I am among at least 39 others counterparts across the country who oversee oral health

initiatives and programs within the Departments of Health. So I have a few slides here to share. Whenever we're ready. The. Are you able to see my slides yet? Not yet. Okay. Let me tell. You. I'm glad not to be the only one with computer transmission problems. May another second here. Okay. Here we go from there. Okay, so let's change this. All right. So everybody can see the slides, right? You think so? Okay. All right. So as I mentioned, I am with the Division of Family Health within the Department of Health and or oral health interventions are really managed primarily within the Division of Family Health. Those are the interventions and programmatic activities that address a lot of what that all but I would just mention to us. So I'm. So I'm going to talk a little bit about the key drivers and the strategies that we use to address oral health within our Department of Health. So primarily. As mentioned. And I think that Dr. Amy actually said a lot of what I'm going to say, so I'm going to make it brief so we can hear my good friend and colleague, Jean talk about the issues. I think that gets us back to the crux of the matter. We mentioned oral health is integral to overall health. And all of the surgeon generals that I can recall that Dr. Everett Koop have mentioned it formally or informally, and I think it was most highlighted or highlighted the greatest and the surgeon general report of 2000, where Dr. David Satcher really kind of coined the term about oral health disparities and the need for us to address them formidably in the context of overall health. So we know that tooth decay is really one of the most common chronic diseases in children. And access to care, as we have all mentioned, has been discussing, and communities there's a great need and access can be considered the proximity to a dental office as well as utilization of the services that are available in the community. And as I mentioned, sometimes navigating these systems can be difficult for individuals that may not have the agency to do so, which is why health care overall, we're starting to look at the social determinants of health as underlying reasons and factors as to why some of these challenges exist that we're talking about today. And also mentioned in oral health, we pretty much have a direct. Line of defense against the primary disease that I would say, and oral health, which is dental decay. And prevention, is key to ridding individuals of oral diseases, of primarily dental decay that can also exacerbate and other oral burdens. So this is a collage that is basically just a snapshot of the individuals and families that. We served within the Department of Health's Division of Family Health through our maternal and child health emphasis programs and enabling services that we support. And our goal, as in the division, is to have oral health initiatives and services integrated into the other maternal and child health offerings that the division supports. And I'll talk. A little bit about how we're doing that and the next slide. So this is really just a list, laundry list or, if you will, of the types of initiatives and activities that the Department of Health has been engaged in around oral health for the past decade or so. Community water fluoridation being one of the mainstays of school based prevention programs, as were mentioned, along with a slew of oral health, education and promotional activities related to pregnancy and oral health. You know, addressing these these overarching medical issues that can be escalated, exacerbated by oral health. We have engaged in campaigns, both social media wise and otherwise, to address this issue and certain populations. We have developed a learning collaborative where we've worked with community health centers. FQHC primarily to address early childhood carry. So we've been able to do that through some of the work that we've done and medical dental integration where we are now. Well, I'm skipping around a little bit, but we're now urging and encouraging medical providers to provide fluoride varnish, which is another preventive medical to 0 to 5 year olds. And Medicaid supports that. So we work collaboratively with the Office of Health Insurance Programs to promote that offering. And as technology advances, that's a lot of technology. And certainly we're right in step with the move towards more and more uses of intelligence to. So again, just more about the what we are really kind of laser focused on within the Department of Health. And it's basically just addressing this issue of of tooth decay primarily in children, which because we're with the

Division of Family Health, that's more or less our focus. And again, Dr. Amy did mention several things about preventive services. And sealants have been a mainstay in public health programs for over 30 years, probably 40 years or so. And it's an effective means to reduce the burden of dental decay on children, especially school aged children. Drinking water fluoridation also reduces a person's risk for developing tooth decay at a quarter of that proportion of reducing decay happens over the lifetime, along with other things like having access to a provider. Really good oral hygiene at home and those types of things. So the initiatives that we primarily focus on or school based health center, dental programs, school based selects, as I mentioned, within the school based health center dental programs. I'm going to elaborate on that a little bit more. And again, drinking water fluoridation where we are offering a grant that I'll tell you about in a little bit. So in terms of the preventive interventions, our goal really is to increase the number of second and third graders who are receiving these dental sealants because we know that they are effective and also because and second grade, which is around the time that you're eight or nine, that for the most part. That is the time that we are pretty certain, you know, unless there are some underlying issues, first, molars or molar teeth are starting to erupt. And so we really attempt to catch those molar teens right up those molar teeth right after they erupt and place these preventive dental sealants on those children's teeth. Our school based programs, the school based sealant program, is supported by funding that we have through her her through Title five grant that also funds our other division of family health activities. And we have currently 21 of our school based health center dental programs that we have a small grant from us to help them increase their sealant efforts or the preventive intervention efforts. And just in case it's been a little while since you may have had a sale in or taken a child for a dental appointment. For us, it just. Here's just the illustration of what it is. It's really basically a thin plastic coating that goes on both the biting surface of the tooth and to the grooves and surfaces so that it protects against dental decay, because that's where bacteria love to reside, right in those grooves. I've already mentioned the effectiveness of it. So let's go on and talk a little bit more about the schools health center dental programs in general. And they basically they are the programs that actually provide these dental sealant initiatives within their school based health centers. And we also heard about modes of operation. And they also have some illustrations of how we deliver the services here in New York. Most of our providers are and are utilizing portable equipment, and we do have several mobile bands that are also registered to provide services. And I think we have a handout for you included, that shows you the list of providers that we have. Are we fixed? Mobile operations are also a part of our program. And for those that are fortunate enough, fortunate enough to have a fixed site at their school, you know, it certainly is a surefire way to really establish a dental home within the school. And I do also think that any mentioned mobile vans, we have them listed here as the least cost effective, and I must say that. We have used this lot over the years to share about our school based health center programs. But since COVID, there has been a resurgence of interest in mobile, as I recall. Maybe about 15, 20 years ago when I was getting a lot of pictures and for sale signs on local bands. But since COVID and during the period when we went through the public health shutdown, those mobile vans became a lot more operational. And a little bit there was a little more interest in them since then. So these are just a just a little bit of stats on the services that we are able to provide with the programs that we have. So currently we have about 43 sponsoring organizations that are able to do so many school based health centers in 2457 schools. And at our last count, during the 20 2122 school year, we served about 100 and almost about 120,000 children. And I also have, you know, just the list of the services that are provided. Some are preventive service care only operations, and others are also providing restorative care. And so what to the extent they can, some urgent care. And throughout Division and our Bureau of Child Health, we monitor the activities of these school based health centers, and

they are monitored through site visits as well as through performance measures that they report to us quarterly. Now I want to move on to the community water fluoridation, which really is the primary way to prevent dental decay. And it's the most equitable in terms of public health interventions and was touted by CDC and the Federal Government health agency as one of the top public health interventions of the 20th century. And it has been for over 75 years. And so what we are doing is trying to reach healthy people goals and our own goals, our own prevention agenda objective, which is to have 77.5% of our population benefiting from community water fluoridation. And so we have supports for community water fluoridation. As municipalities and towns decide to provide this source of prevention in their towns and communities. And we also provide. The supports that kind of maintain the challenges which can occur when you're dealing with. High tech equipment, maintenance and maintenance and aging equipment often require attention. And we have opponents of fluoride that we're having to almost consistently or constantly contend with. And we certainly rely on the evidence base to help us to dispel any misinformation and disinformation that is shared through some of these opponents, as well as we rely on our community partners to help educate the town councils and the officials when they come up against some of the opposition. This map gives you an idea of where water fluoridation exists in the state and that the blue it's blue, almost like the kind of darker blue is representative of the colonies that are providing. Fluoride in the water and the light green, yellow, the light green and the yellow or yellowish green kind of represent where we're not providing water for irrigation. So if you can pick out your county, that's. To give you an idea of kind of where we are with some of our water fluoridation efforts. And basically. As many of you know, that there is no state mandate to Florida. You may not know, but we don't have a state mandate and the decision to provide water for the ocean, really? Remains in the hands of the local the local officials. And so, as I mentioned, our goal is a little over 77% and currently we're fluoridated at about 71.1%.

Speaker 3 I'd just like to point out that quite a few of the areas that are low in some of their fluoridation have well water. So we have on our water systems in New York State for anybody that's from not in New York State. There is a significant portion of the state in geography that is predominantly, well water.

Speaker 5 Right. And to that point, Dr. Heslin, actually this map kind of doesn't it doesn't exactly hit it. But most of the member of the population that benefits from fluoride is in New York City. So the rest of the rest of the state, there's only about 46% of the population benefiting from water fluoridation. So there's still a lot of work for us to do. And this area.

Speaker 3 So, you know, if we were to do quick math, that would mean that 48% of the population is in New York City. That means that roughly 25% of the population is on well, water. Full stop.

Speaker 5 Right. Right. And there's some new innovations coming out to give systems or communities that are on well, water an opportunity for fluoridation for the first time ever. So stay tuned for that. There's a new tablet system that will be attached to all the water systems to give them the benefits as well. So this is just this next slide here is just sharing with you what the Department of Health is allowed throughout state funding to support water fluoridation plants or water systems that are interested in maintaining their efforts and are implementing, which is something that we have struggled to get, is new systems to come on board. We have a field threatening to do it, but they are doing this strategically so that they may initially educate communities about the importance of water fluoridation and, you know, go through their town and council regulatory processes to get a yes vote. And so our grants, we have two types of grants and one grant is for planning and feasibility

because you certainly need to study based on the different water systems that exist throughout the state. You know, what the feasibility would be for you to add a water fluoridation systems in your to your systems, your town's water supply. And we also provide implementation and maintenance grants. And thus for that program has been funded since 20 a little bit before I. Came on board, which was 2015. So since then we have awarded 51 grants to water systems to help them upgrade their fluoridation systems. And so this is my last couple of stock slides, and this is just a sampling of the types of resources that we published or have produced with some of the grant funds that we've received over the years. And these resources were developed to help the public consume information about oral health so that we can increase health literacy, hopefully change some health behaviors around oral health. And it also provide we also have literature that provides age appropriate guidance to support dental health and hygiene. And if you'll notice, I don't know if you can see my person here. This is one of my favorite little productions here. And it's a it's a mirror clean that reminds everyone who brushes their teeth in front of the mirror, the bathroom mirror. Primarily. It's a brush in the morning and at night. And I think this is my last slide here. And this is just just a list of the training opportunities that we have. And these are primarily around preventive services. We are working with our local health departments to support engagement and oral health promotion in communities and the communities that they serve. And the topics include evidence based interventions that offer access to preventive services and address challenges with providing care for patients. As was mentioned previously, for instance, like and opioid overuse and abuse. So these resources are very helpful to our local health departments as they are are working with us slowly but surely to get engaged in this work.

Dr. Rugge Thank you very much, Dr. Richardson. This is an apparent critical observation. You would note that hearing that 15% of the avoidable visits are ascribed to one small body part with only a few diagnoses. It was tempting to think there should be some really available simple solution, some one or two actions that could impact them. But it seems like dental care is just like the rest of health care. This affects all of us in many ways and in the solutions are complex and require continued attention and follow through.

Speaker 5 Absolutely.

Dr. Rugge Other observations from members of. Of our group, not only committee members, but staff members. Outside counsel's. Providers. We can then move on to Jean Moore. Addressing health workforce issues. Jean, the floor is yours. The screen is yours.

Ms. Moore Thank you, John. Hi, everyone. So my name is Jean Moore. I'm the director of the New York Center for Health Workforce Studies, based at the New Albany School of Public Health. I'm also the PI for the Oral Health Workforce Research Center, and it's a cooperative agreement with Hearst. So we've been studying oral health workforce for the last eight years and just got a renewal. So we plan to continue to do so. I don't have slides. I actually have a couple of infographics I want to show you a little later on. But I think that, you know, based on the research we've conducted at the Oral Health Workforce Research Center, it's very clear to us that an available, competent, well distributed oral health workforce is required to assure access to needed oral health services. So what can we do? And again, I'm going to share with you some things we've learned from our work. And I will also tell you that we have lots of reports, manuscripts, whatever, based on some of this that we are happy to share with you. So. One of the things we think is really important and it's actually been touched on a bit earlier, is integrating oral health with primary care and behavioral health, for that matter. Federally qualified health centers are best suited for such integration. As many of you may know, nurses supported the addition of or expansion

of dental services back in 2016 for FQHC. So the opportunity to make dental services accessible and the safety net is an important consideration. So I will tell you that we've done a number of case studies of FQHC's who are considered sort of implementing best practices. One of the places where they integrated primary care and oral health, they had hygienists sitting in on well-child visits actually starting with, well, baby visits. And so we had a chance to kind of observe that talk to a hygienist who said, you have no idea how rewarding it is to see kids who you've been talking to their parents since they were infants and they don't have bombed out mouths. You were able to reach the parents to get them to do the right thing early on, and it was incredibly rewarding. Another area is deploying new oral health service delivery strategies and both presenters mentioned it. But mobile and portable dentistry, tele dentistry. These are really critical. And as Dion mentioned, there are vans that are operating. There are folks using portable equipment. The University of Buffalo has a the School of Dentistry has a mobile van that services Chautauqua County with tablet industry Finger Lakes. I'd say that serves many, many migrant families. Has a Tesla dentistry link to pediatric dentist, said Eastman, so they can engage more effectively in treatment planning and to get kids into needed oral surgery. So one of the things I have to tell you, you know, so that all sounds very good, right? But, you know, one of the things I have to tell you is we one of the site visits we went on was a mobile van operated by a hygienist in a state where hygienists have more autonomy. And so this hygienist was going into nursing homes, schools, Head Start programs, and she was connected to a dentist. And sometimes the dentist came with her. But often times when she was doing the assessments, she was communicating via Toledano straight around the treatment planning pieces. So, you know, again, I think that a lot of these are good ideas, but it's important to think about the workforce component. Another thing mentioned by everyone improving oral health literacy. Many, many, many people say, I go to a dentist when I have a problem. And those are the folks who oftentimes end up feet first in the end. Clearly, we need to promote the value of prevention any ways we can. And again, I think that working with parents to improve the oral health of infants and children is an important place to start. Another thing I have to say is that we need better data on the states oral health workforce. A law was passed in 2021 requiring that licensed health professionals complete reregistration surveys and the law was passed and there was no funding made available to implement. So right now we have great data on the states nurse practitioners. We've been collecting data on them since 2015. We've just recently added reregistration services for RN's and LPN's, but unfortunately that's where our resources end. So I think being able to understand supply distribution of dentists, hygienists, knowing what they're going to do next. Typically you're looking at aging workforces and knowing planned exits can be really useful to figuring out next steps. Another area is offering provider incentives for practice in underserved communities, and I'm sure many of you know both state and federal programs, including NHSC, then Primary care service Core, provide loan repayment for dentists and hygienists. And in fact, currently we have 115 dentists and 22 hygienists fulfilling service obligations in underserved areas of the state. Another important area is improving oral health workforce diversity. We've made great strides in increasing the gender diversity in dentistry, not so much in terms of improving the racial ethnic diversity of the dental workforce. And I think it's clear that improving the racial ethnic diversity of the oral health workforce is critical to efforts to reduce disparities in access to care and health outcomes and to a better and to better address the oral health needs of an increasingly diverse US population. So we did a study a couple of years back looking at who serves dental, what, who, what dentists serve Medicaid patients in New York. And what we found in this study is that black dentists are 2.5 times more likely to serve Medicaid patients. Hispanic dentists over to two times. More likely Asian dentists 1.5 times more likely. So I think that there is something to be said for the value of diversity in getting improving access to care for underserved communities and also racial ethnic

minorities. Provide training opportunities for students in oral health professions. I think it's important to promote interdisciplinary collaboration when we talk about integrating oral health with primary care. We also need to help the health professions, the workforce learn about each other and feel comfortable working collaboratively and providing opportunities to conduct training. And the safety net is important, and it can help students better understand the needs of the underserved and also to explore the feasibility of hospital based dental residencies. So a while back, New York changed its licensing requirement for dentists and said You have to complete a one year residency. And I have not followed this, but way back when, when this was happening. My understanding was that some hospitals actually developed residency programs and I heard about one. I honestly don't know if it's still around, but where the dental residency was kind of attached to or nearby the EDs, so that when folks came in with problems that they had a chance of actually being seen. And again, maybe it's urban legend at this point, but way back when, when this started, my understanding was that something like that was actually happening. Remove regulatory constraints on scope of practice. So we've been studying dental hygiene and scope of practice for many, many years. And hang on, I have a screen share. Okay, let's see if this works. Can you see this?

Speaker 1 Yes.

Ms. Moore Okay. So this is actually an infographic on dental hygiene scope of practice by state. And essentially what we did is we picked out seven or eight variables where we said, okay, what would a dental hygienist need to be able to do to practice as autonomously as possible? And we or I'm sorry, more community based as possible. And obviously autonomy is certainly part of it. And so this is what we found that. You know, these are the variables we looked at. And, you know, I think at times people say, well, we should let health professionals work at the top of their license. But I think what this figure illustrates is that if your scope of practice is restricted, you're not going to get very far. So I think the point is letting people, you know, do what they're trained and capable of doing is is the real message that I think we want to send. Okay. Next, I will show you. Can everyone see the Dental Therapist infographic?

Speaker 1 We can't see the graphic very well. It's kind of half off the screen. Okay.

Ms. Moore How's that Better?

Speaker 1 Yes.

Ms. Moore Okay. Okay. So, I mean, the overall recommendation is let's support workforce innovation. And it's not just dental therapists, but it's deploying community health workers or community dental health coordinators who can reach into communities and get to people before things get out of hand. Expanded function. Dental assistants, advance practice, dental hygienist. We've done a great deal of research on dental therapists, and we've been. So if you look at this map, you see that where it says dental therapists practicing in the state, you've got Minnesota. Arkansas, which is the team means tribal. It means that the dental therapists in that state are only available in tribal communities. Oregon. Washington. Connecticut. So I think that. Dental therapy is happening slowly. Like somebody had said earlier, Why are there only 150 or whatever? You know, many states actually got laws passed but have had real trouble getting the education program in place. I'm sorry, the Maine the ME is Maine. There is one dental therapist, that dental therapist trained in Minnesota. Minnesota has like two programs, and the Board of Dentistry in Maine actually recognized that credential. So the dental therapist we know of is practicing

at a federally qualified health center in Maine. So, again, it's in the process of happening. It's getting rolled out in many areas. We've done some work where we looked at the impact of dental therapists in a safety net provider. So what happened? What a dentist do? What did hygienist do? Because dental therapists kind of have a foot in both worlds. And what we found was that the dentist were able to do more higher level things. The dentists were able to kind of hand off some of the basic restorative things to the dental therapist, and then they could do more higher level things. We also looked at. We did some satisfaction surveys. So we asked patients, we asked dentists, we asked dental hygienist, we asked administrators, you know, what is it like working with a dental therapist? And the response was generally quite positive. So, again, I mean, these are small studies. And again, it's a fairly small profession that's getting rolled out. But again, I think that they make some important contributions. So. That's my presentation. Thank you. And I'm happy to answer any questions you might have.

Dr. Rugge Thank you very much. I couldn't help but notice your comments about Efficaces is so important and I wouldn't want to snap my suspenders over that one. But whenever you have rose to hand here, Rose, do you have any. Any thoughts or additions to make to the Jean's remarks?

Speaker 4 Yeah, absolutely. Thank you. Thank you, Jean. I do agree 100%. More than 90% of our health centers in New York State do offer dental services. And it really is an excellent way to advance an integrated model of care. We think there are some things that could be done to help support that integration. I will say going back and in terms of the workforce, can mean health centers would love to see a dental therapist model. The workforce challenges are really the primary limitation. One of the primary limitations to health centers expanding their capacity. And it was mentioned earlier about dentists that take Medicaid. I mean, health centers, some two thirds of our patients are Medicaid patients. We have a rate of uninsured patients that's much higher than the statewide average. So really, community health centers are where Medicaid patients have access to care. And yet health centers still just have tremendous waiting lists because they just do not have the workforce. They don't you can't expand the capacity. They would love to be able to, but they just cannot find the dentists and hire the dentists. And probably some of that relates to kind of what they can pay the dentists and where dentists want to live in rural areas. It's an especially challenging we have. And Doctor Rugge you can speak to that. But, you know, we certainly have areas of the state where health centers have had to close their dental sites because they lost their one dentist. And so that that's really a challenge. So the things that we can think about in terms of trying to really increase the supply of dentists and other kinds of providers that can that can provide dental care, dental hygienist being dental therapists being important, dental hygienist also increased increasing opportunities for dental hygienist training, especially in rural areas. We think that that would both attract and retain rural residents to have the dental hygienist training that they could then stay in their community and that would increase the supply of dental hygiene. So possibly partnering with community colleges. We do think there's an opportunity to partner with SUNY around creating a dental therapy program, as you said, that seems to be very limited in terms of nationally where they have dental therapy programs. In terms of thinking about some of the work with the Medicaid managed care plans. I think there is some opportunity to create some that the state could work with the plans to create incentives for creating a medical dental home for incentive quality measures around preventive care and making sure that people are connected to a dentist. So those are some of the things that that we think would help to enhance that preventive care. Again, you know, the having the dental home be matched with their primary care provider at an accuracy would go a long way. Right now the way the Medicaid managed

care benefit is administered the usually the dental portion is kind of subcontracted out. So there's not necessarily a coordination between the dental benefit and the medical benefit, but trying to match those up so that know where possible. There's the dental home is match with the medical home. We think that that would really help in terms of the care coordination and in terms of the continuity of care.

Speaker 1 Many members received a map of the state showing the location of the dental sites. And I will be very careful not to complain about my personal data. Leaving practice to join DOH dr.

Speaker 2 By the way, in case you don't know, a bill, a bill has been introduced two years in a row now that would authorize dental therapy in New York. I'm not sure. Well, obviously, the it's out of session right now and I'm not sure where it stands or how much momentum it got, but it's been out there. Dick Gottfried introduced it a couple of years ago before he retired, and it got reintroduced this year by other legislators.

Speaker 1 It's not. Here comes Greg Hill. Yeah. Hi. Greg Hill, executive director of the New York State Dental Association. Certainly appreciate the opportunity to be here. This presentation and looking at solutions to these challenges. You know, we've I just do want to briefly speak on the dental therapy piece. I mean, it's something that certainly we're following and tracking across the country.

Speaker 5 And, yes, there is some legislation.

Speaker 1 You know, currently within the state legislature. One of the things that we're looking at really is, you know, what is the effectiveness of that program? What have we seen so far in other states? And you know, what we what we haven't really seen is that except in kind of a limited situation, you know, primary in Alaska and somewhat in Minnesota, the program really hasn't seen the, you know, the impact out in rural and underserved areas. And so what we are trying to do is work to increase, you know, some of the Medicaid reimbursement, things like that. Because what we do know is that the dental therapies primarily have kind of you know, it's very it's kind of gone into the larger cities. And so we are trying to reduce those other barriers and things like that. It is kind of a short term solution because there will be a pretty significant amount of time from the legislation was brought forward with respect to the training for the training programs for the dental therapy, you know, type of model is going to is going to take time. And so kind of looking at where can we better, you know, better connect dentists into those rural areas, we'll see loan repayment and things like that or some of the things that we're looking at. I just wanted to comment on that real quick. But yeah, certainly, I mean, I think, you know, some possible solutions that that are in this presentation I think has been very, very helpful to kind of see the broader scope of where things are in New York. So definitely appreciate that. I just want to comment real quickly on kind of some of those challenges that that we have seen in other states with respect to that dental therapy model. Very well taken. This is the kind of background clearly we have needed to pass through for the council, together with the areas listed as to make selections decide which of these opportunities is real. Knowing there is no one, action is going to solve all the problems we have to have. I think a blend of short term actions with short term impact and longer term efforts that may take some time to be realized but may make a more profound difference. We have our work cut out for us. John, if this is Peter Robinson. If I may actually am delighted that there is this kind of focus on dental services and want to thank you, John and the Department for making this a pillar of the strategy for delivering health care, particularly to underserved communities. I want to suggest that we do have an asset in the state, which are the five

academic dental programs, dental schools who have really substantive clinical programs in addition to their training programs. And that is they represent another point of access and care and would very much suggest that in whatever plan we put together, we make that we create the opportunity for them. So for the solution, I think that both as a part of the delivery system but as also a part of the workforce development needs that we have here in the in the state. Now the challenge is how to how to pull these resources together to cover all those blank areas on our map where there is currently just isn't there? Kind of. Accessible resource for people in need. Right. I think that some of that is being addressed through mobile dental programs that the schools run. I know we in Rochester, through the Eastman Dental Institute, do have programs that go both to schools and to rural communities. And but obviously, those have limitations. You need much more capacity and more robust delivery capabilities. But I think that's that could be a piece of the solution as well as to expand that those kinds of programs to. We need for more mapping. Are multiple approaches. Other thoughts conclude.

Speaker 5 I would. I just want to. Can you hear me? I think I turned off my phone. I just wanted to say we are going to look a little bit closer at the list of mobile providers that have operating certificates in the state. As mentioned, several of them are connected to our school based health centers. But there are some non-school based health center certified mobile bands that are in existence. But we didn't have a lot of time to vet the list to see kind of where they are. It appears just from my initial glance that some of them are connected to hospitals. So I'm hoping that I can work with some at our dental unit to help figure out where those mobile vans exist. And they are.

Speaker 1 I would hope that this exercise, these studies by Fitbit, is an opportunity to do just that, you know, have really a comprehensive understanding of resources where they are and by implication, maybe by direction where more is necessary. Yes, it's great.

Speaker 6 I'm not sure if this is the appropriate time that you're interested in hearing solutions, Some solutions. I'm not sure if we're moved on to that part of the know.

Speaker 1 Bad time to hear about solutions. Okay.

Speaker 6 So this is really excellent timing because we have been working at the dental association that our foundation on some possible solutions and all the information that we've heard today sort of line up to what we're thinking as some possible solutions. And I'm just going to give you a brief overview of what we're working on and then see if you'd like to maybe invite us back to more formally present on some ideas that we have. We'd love to be partners, certainly with the Department of Health and the New York City or Health Coalition and bikinis. I know that she had to step out, so I'd be really interested in talking with her more. I'm not sure if you know this, but into someone's comments earlier. You know, I think that the dental association certainly cares about oral health of all New Yorkers. I'm not sure what percentage of our members sort of have that public health lens, if you will. But certainly as an organization, we're focused on it so much so that we have formalized a program over the last nine years called the Dental Demonstration Project. It's really it was sort of out of this effort nationally to have these mission of nurses where they were a free event where people can receive free care. We really wanted to take that one step further and close the loop, because having those free events really brings the population to us. But then it's like, Well, what do we do now and how do we close that loop? So over the past nine years or so, we've been building on what we've learned in this demonstration and we've written about it. And one of the things that's really been interesting is we started to quantify a little bit about what types of people come to these

events. And what was really interesting to us is that, of course, you can imagine 52% cite their main reason for not having care is financial. That makes sense. But an interesting 48% fell into the categories of 13% said they had no perceived problem. So they didn't have a problem. They didn't go to the dentist. There was nothing wrong. 13% was based on fear and 22% was based on other. That could be physical ailments, transportation caregiver either for their children or a family member. And so we really started looking at that and building on sort of the opportunities for that 48% with care coordination. And I know Jean Moore had mentioned the utilization of community dental health coordinators, the community health coordinators, two eyes are really play a crucial role in some of the things that we heard today, like repeat years, users of emergency rooms for oral health related issues, diversion, accessibility and prevention. We can utilize the this workforce model to sort of be a diversion to use for oral health related issues. And so we started dabbling with that during COVID. COVID didn't allow us to have in-person events, so we had to start being creative with how we're going to use our funding, which by the way, is a line item in the state budget each year. And we hope to expand this. And perhaps if this group likes some of the ideas we have, we can get your support in expanding some of this work that that we're focused on. But when we started utilizing tele dentistry and triaging, we noticed and we partnered with some of the people that Jeanne also mentioned out in Finger Lakes, Dr. Tony, Mendocino, University of Buffalo, and those academic centers you mentioned, too, we are deeply rooted in sort of the academic centers, the work that they're doing, community based care with UHC. So what we anticipate trying to do is train more community dental health coordinators. It's not associated with licensure. It's really a certified a registered dental assistant excuse me, or registered dental hygienist that goes for some extra training. And that extra training is a certificate of completion. Now, what that's really focused on is that on that anticipatory guidance piece, the socioeconomic barriers, the motivational interviewing, really that care coordination model under. Standing, the barriers of care and the socioeconomic climate of different populations. And we can provide and send some of you, if you're interested, a some overview on what other states have done with community health coordination. We're a little bit slow to the uptake in New York. We do have about 20 of these type of workers that are out there. But we feel with more training and positioning in communities, we can sort of fill that void a little bit for some of that diversion, reduce those repeat users and triage with some of that care coordination, get them signed up with facilitated and rollers. So just briefly, what we hope to do and we're working on formulating a plan right now is to establish like a community dental health coordinator and create regions that correlate with a regional public health department, because that makes sense to us. You have regional health departments that already exist that we could establish regions that line up with that capital, central, metro, Western and things of that nature, identify and train these care coordinators in the region and then really have those CDHC's work with all of your county health departments, understand what identify and target, what those issues are specifically in those regions, and partner with the academic centers and the hospitals and the regions and try to connect them to an A dental health home. We've been doing a lot of work over the last five years on medical, dental integration. Somewhere in the turn of the century, we got on two different paths and we've been trying ever since to get on the same road. So it's really exciting for the association to see this cross-pollination of public health advocates. You know, oral health advocates and medical health advocates really on the same page. So thank you so much for inviting us to be part of this discussion. We'd like to work towards formalizing this plan. Right now, we're trying to put it together. We do have a cell phone app that is sort of sitting idle waiting for its debut. And we really are very optimistic on this. And one of the things that's occurred to me is that with care coordination, we're always trying to get a hold of the patient. And it's just this painstaking work. What have we did it in reverse, where we had this website and resource where patients could go. I need I think I

need to bring my child to emergency room. What do I do? And there's a place because they've seen the billboard or they know the app or they can go and find it and there is someone there to help triage them and to answer their questions. And populated with Dennis or some of those really awesome ideas we heard earlier with incentives and vouchers and partnering with offices and ZocDoc and things like that. So, you know, those are just a few of the things that we think could work in addition to the awesome ideas of the presenters today with already the programs that are in place with the Department of Health and certainly the work that Jean Moore is doing too, and all of you, the excellent work you do. New York City has one of the most robust Medicaid programs in the country, and we're really proud of that. So it's about just really sort of leveraging what we already do well and trying to connect the dots. So we think we have some good ideas to do it.

Speaker 1 It seems striking that so much of what you're describing as needs and dental services is exactly what we've been experiencing in the primary care field. It's no longer the doctor in the exam room being all the primary care means a team. The team includes educational services, preventive services, triage care coordination can't be done by any single person needs to be done by a bland and inclusive approach. And if there's something that we can help to promote so we're not going to happen overnight, maybe that's it. It's a helpful step toward better care, lower costs the same time. Dr. Heslin.

Speaker 3 Yeah. Thank you so much and really very informative. The whole day has been informative. I think I have to brush my teeth more frequently or something like that, but I'm way over the age of three, so I'm pretty sure that I'm in a fairly good spot. But that being said, Miss. Bray, can you talk a little bit about what the oral health strategy is for the Dental Health Association? Because you talked about the academic centers, and I do have to admit I did have to leave the room twice during the 2 hours, so I might have missed it. But, you know, you talked about your academic involvement. You talked about the kind of the regional plan that you're building now, as with primary care, I was with Dr. Rugge. You know, I've, you know, gone through this with, you know, you know, certified. And how do we start to think about that rural strategy? Because as we saw with the picture that I put up on the dental clinics, even with community health centers, they're mainly based geographically in our more populated areas. Yet there is a huge need because as a matter of fact, and the areas that we don't have city water and we don't have chlorination, those are the areas that happen to also be our more rural areas as well.

Ms. Bray I really think that's awesome that you would draw attention to the rural population. I raised my kids in Delaware County, and so that's basically Appalachia. And I worked in school baseball for 15 years. So saw firsthand, you know, as a dental hygienist, I saw firsthand what you're talking about. I think that it's so important to plan and think about this with the rural communities in mind. I know Dr. McLaren has his hand up, too. He can shed some light on this as well. But some of those ideas that were shared today with bringing the services to them with mobile and portable equipment, utilizing tele dentistry for a triage model and doing some of that care coordination. So many times, especially with like an IDD population, they're having to travel great distances and they're going all the way there and they get there and they get the person out of the wheelchair and they get them in there. And then it's like, yep, they go over the medical history and send them back. Oh, come back when we have to get to the next step of treatment. So some of that, you know, can be sort of triage and streamlined a little bit. Dr. McLaren Did you have something to add there?

Dr. McLaren I was just I was just going to say, you know, as you go through and you're thinking about your coordinators and the kind of system approach to how you're

addressing some of the community needs that you include that whole system approach on the rural side of the equation, because we're most interested truly in a whole state solution. And yet we recognize that New York, you know, goes from very urban all the way to far for regions. And so we really need to, you know, think through that, that that proscriptive leave rather than, you know, as we hit upon it.

Speaker 6 I agree with you. And I think that some of the initial piloting is should definitely include North country because, you know, it's so challenging in North Country and we sort of like shy away because it's hard to be successful there. But those folks live there. And we need to thank you, Karen, for that message. I know we definitely think that working with public health departments that really understand their community and really understand where the gaps are and trying to fill those gaps. So I, I think it's great. One of the things, too, before the concern goes, we're talking about, you know, not tuition forgiveness, but what were what did we come up with a new title not long ago. I can remember it. I got to start saying it every day. So I get used to it. But like tuition and service incentive, like service reward. So in other words, you know, creating those incentives for those docs to come to those rural areas, I know that there has been a little bit more work on this on the medical side, and we would like to see dentists and dental students and dental residents, you know, wrapped up in that. That would be very helpful to get more dental residents in those rural areas.

Dr. McLaren Dr McLaren So thanks for including me. I think I'm probably wearing a couple of hats here today. I was. The former Council chair for the furniture store, for the hospital, dentistry and dental health planning. But I also the medical director here at Eastman Institute for Oral Health, and I'm a pediatric dentist. By training. I have you mentioned Tony. Tony and I have Traveled around the country kind of talking about our tele dentistry program and the successes we've had with it. I couldn't agree with Betsy more that the community health workers are more integral in that we publish some stuff on it. Tony used to refer all the patients to Eastman, and they had about a 15% completion rate after we instituted of the Tele dentistry program with the Community Care Coordinators. We completed 93% of the treatment plans of the kids that needed to go to the O.R. and then it kind of decreased from there. But our lowest was 57%. I think of that of the complete treatment plans completed. So it was a very well designed plan with that. And I think there's definitely something to be said for the Taliban street aspects, along with a well thought out community health coordinators role in that. I also couldn't agree with Peter more. I need to talk to the academic. There's six academic dental centers in the state of New York. You need to get the deans involved in this. They do have a consortium where they Talk routinely and help with these issues because I think that, you know, LER Dean here may have a little bit different perspective than the dean at NYU inside of New York City. Right. But I think it's really important to get them the academic dental centers see an enormous amount of the Medicaid patients throughout the state and just with how stuff is here. It's not uncommon at all for me. I'm in the O.R. tomorrow. I think I've got two out of my four are coming from over 2 hours away just because of how our you know, the geography of New York State is good. But I think it's really important to include those.

Dr. Rugge The deans or their reps on something like this. Presenters. They've given us lots of information, lots of suggestions and. Your work goes next, I thank, to Jackie Sheltry and her colleagues for preparing a summary so that we as committee members can look at this. We reflect on our own experience and come to our committee meeting on June 26 with more specific proposals, least initial proposals, in terms of what can we do next? What can we do after that? We can't let this opportunity go away. Having heard all this information today, Denise, can you help here?

Speaker 2 I just have two observations, John, before we wrap up today. And one is. One of the comments that Jean Moore made, which is that members of communities of color who work in dentistry are more likely to serve underserved communities, which is something that we know from all kinds of other health care primary care and all kinds of But I think it's something that that we need to keep in mind when we look at the underserved area that there's a deliberate strategy that we need to think about of how to recruit minorities and people of color into dental professions to improve access. I think that's an essential piece of any strategy here. And the other is, again, I want to come back to the managed care plans who are being paid to do this and clearly are not doing as good a job as we would like them to be doing and Rose spoke about this a little bit about thinking about are there ways to either incentivize or penalize plan? She didn't say penalized, but I am saying the plans that don't do a good job at meeting the criteria of quality care that, you know, 90% of all your patients have seen a dentist in the last 12 months. And if you don't meet that threshold. Then you get a financial doing. It seems to me we have accountability mechanisms within our managed care programs that we are not seeing as effectively as we might. So that's my as somebody who spent my life sort of thinking about Medicaid managed care in New York State and how it doesn't work for patients. It seems to me we could do a lot more on this front and I would suggest it is counting on you do these to make sure we don't forget any of these elements.

Speaker 5 Thanks, John.

Dr. Rugge So you've got your job cut out for you and you've laid it out for Jackie very nicely. Dr. McLaren, is your hands still up? No, no. Are there others?

Speaker 5 I just want to just let you know that share the message of being gracious. She had to leave for another meeting, but she's grateful for the opportunity to share. And ell, the gratitude that you're allowing.

Dr. Rugge Goes both ways. We're very grateful to her. And also for you, Diane Loud and also to Jean, that you've laid out the background that we need to make progress and now we need to take that progress and turn it into concrete recommendations that can be actionable and that may not have emerged without exactly this kind of attention and focused by feedback. Thanks to the referrals from from DOH. It's all together that we made make this possible. With all that we have, still at least a minute. I have to go. That's a great.

Speaker 6 Question for Dr. Morley. When you cited the percentages. 70% of the patients seen in the E.D. may not need emergent care and 50% were dental patients. Do you have a number that goes with those percentages? Like the total number of visits or patients seen.

Speaker 3 In numbers.

Speaker 6 In the beginning at that, you teed up the meeting by talking about utilization rates. How 15% were dental patients? Do you have the total number of visits or any other demographics like what ages or things like that?

Speaker 3 I do not. Dr. has some additional. So let me take a shot at it. There are about 2 million. We have AC transports a year and they make up between 60 and 70%. So it's about 2.6 2.7 million ED visits a year at this point in time. And our ED colleagues will tell

you that it may be 70% that don't really need to be there, but they don't really know that when they walk through the door, it may be a smaller number that actually didn't need to be there when they walk through the door. Okay. So just that caveat on on that. And then on the dental side of the equation, I'm not quite sure how old that information is, but I know that there has been some data published. I can't find it at the tip of my fingers right now about that 50%. What I can say anecdotally is that at least in some communities where we've seen dental clinics built, we've seen, you know, of them very popularly attended.

Speaker 6 I will say that for any program that you're going to establish in order to be able to measure, as we all know, I think that that's a really important number to know, because then you you know, how do you know you've moved the needle on, you know, these interventions with ED utilization for dental specific. So it would be great to know those specific numbers. And even if it's possible to get a breakdown of users and more, you know, demographic, you know, demographics on the users, I do know that there is a top ten. Some of the things we've done, we've done some programs through the years with utilization with like Little Falls Hospital and things of that nature. And we have we sort of figured out what the top like. 30 codes were in the ad for oral health related issues. So if that's helpful for you to have that, I'm not sure if that's helpful information for you, but I could get that to.

Speaker 3 Yes. So that's helpful information. I think one of the things that is important is to recognize that New York State is a great melting pot and there is many, many, many different ecosystems that exist. And in that, depending upon what services are available in a community and also what insurances are taken by different services, whether it's dentistry or otherwise, it makes a a huge, huge difference. One thing and I noted it in my head and I'm going to say it explicitly because Jean brought it up about, you know, dental therapists and otherwise is the notable exception in the room as we did not have as here, a state education department. And as we all know, state Education Department controls licensure and scope of practice in New York State. And so while we are thinking through all of these type of issues at work for scope of practice and working on licensure, that becomes important to make sure that we perscriptively make sure that they're at the table and also involved in the solutions.

Speaker 1 Absolutely. And there are recipients of these of these very recommendations. I suspect we will have recommendations and it's all made possible by this kind of deliberation and people coming together in ways that, to my knowledge, hasn't happened recently. So I want to thank all our participants. And together, we will come up with more solutions, more recommendations for accounting and council members and committee members, but also the experts who have been helping us prosper. We'll move together. With that list. There are other pressing comments I think we can close for this evening, knowing that we will be receiving meeting summaries from staff from Jackie as well, and we will be meeting again more officially so that we can actually take action and go on record. Thank everyone for this. Background session means a lot. Thank you.