



A DECADE *of* DIFFERENCE



**ORAL
HEALTH**



In 2005, the Health Care Foundation of Greater Kansas began making grants to Kansas City area organizations committed to eliminating the barriers to quality health for the uninsured and underserved. The foundation was created two years earlier through the sale of Health Midwest hospitals to Hospital Corporation of America. Since 2005, HCF has awarded over \$200 million to hundreds of entities.

The past decade has been a difficult period for many individuals and organizations served by the foundation. Yet it has also been a time of unmatched opportunity. Most notably, the passage of the Patient Protection and Affordable Care Act in 2010 represented a landmark event in the evolution of health care reform.

As the foundation completes its first decade, we have looked back across the health care landscape to better understand the obstacles and accomplishments surrounding care to the uninsured and underserved in the Kansas City region. Our objective is to learn from, and reflect upon, past experience in order to better inform and assist the community's collective efforts going forward.

HCF contracted with researchers to conduct a series of interviews and focus groups with health care stakeholders in the oral health arena, in addition to drawing on recent assessment of the oral health system. The results of those conversations represent the heart of this report. More than 50 individuals participated in the process, and their reflections and insights about the past, present and future of oral health care in the region were enormously beneficial.

But even though stakeholder perceptions form the bulk of this document, the final product inevitably has been filtered through the foundation's lens. The contents therefore ultimately are the responsibility of the foundation.

This document is not meant to be an evaluation of HCF or the oral health care grants we've funded over the past 10 years. Nor is this an assessment of population level health needs or secondary data trends. Rather, the goal was to take advantage of our unique perspective in the health care community to examine system level challenges, changes and opportunities.

This assessment has allowed us to more clearly see the enormous strides that have been made in our region since 2005. Too often, those knee-deep in the day-to-day work of bringing about change are unable to pause to appreciate the role they have played in advancing the field. A spirit of cooperation, collaboration and commitment is reflected in these pages and in these efforts, and the HCF is proud to be a part of the progress our community has experienced.



ORAL HEALTH EMERGES AS PUBLIC HEALTH PRIORITY

Increased oral care capacity, improved collaboration among safety net providers and a growing awareness of the relationship between oral and general health all have helped push oral health care nearer to the forefront of public health over the past decade.

Although the supply of oral health safety net services in the Kansas City area still falls short of demand, the availability of services for the uninsured and underserved is far greater than in the early 2000s. In those days, the oral health safety net was small and fragmented; rural areas faced chronic provider shortages and community-based screening and prevention programs were few and far between.

**“IT’S A PRETTY
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ORAL HEALTH CARE,”**
SAID ONE PROVIDER.

Fortunately, the Patient Protection and Affordable Care Act (ACA) — coupled with a better understanding of the links between poor oral health and disease — have helped spur the integration of primary care and oral health locally and across the nation. At the same time, well-organized oral health advocacy efforts have scored important policy successes in Missouri and Kansas.

“We’ve seen remarkable progress over the past decade,” said Jessica Hembree, program officer at the Health Care Foundation of Greater Kansas City (HCF). “Oral health has been transformed from almost an afterthought to an increasingly salient public health issue. As a result, we’ve been able to increase service to thousands who previously would have done without. We still have a long way to go, but momentum is in our favor.”

EXPANDING INFRASTRUCTURE

Access to dental services for low-income populations in the Kansas City region has grown dramatically since the early 2000s. Between 2006 and 2015, the number of safety net providers in Kansas offering oral health services increased from nine to 22, according to the Kansas Association for the Medically Underserved. In Missouri, the number of oral health access points operated by Federally Qualified Health Centers (FQHCs) jumped from 39 in 2008 to 79 in 2015.



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Swope Health Services, Samuel U. Rodgers Health Center, Health Partnership Clinic of Johnson County, and the Live Well Community Health Center of Lafayette County — all FQHCs — currently provide a full range of oral health services. In addition, other non-FQHC public health entities have been established or have expanded oral health capabilities and services.

“Things looked very different 10 years ago,” one stakeholder said. “Back then, there were basically two safety net clinics that provided dental care. But we’ve seen FQHCs really flourish and area hospitals have taken a larger role as well. There also has been an increase in dental care provided in specific community settings, such as homeless shelters.”

The Kansas City CARE Clinic has expanded its services to include dental care and is today a training site for the University of Missouri-Kansas City School of Dentistry. Through the CARE Clinic, comprehensive dental care is provided to more than 500 patients annually. Seton Center also offers dental services to Medicaid, insured and self-pay patients. In 2013, the organization provided nearly 6,000 dental services to low-income patients in the metropolitan area.

Access to care in rural areas also has improved. In 2009, a multi-sector task force in Cass County began planning a safety net dental clinic for the county. The facility, known as the Cass County Dental Clinic (CCDC), opened in 2011 in Belton and today provides care for low-income, uninsured children ages 0-20. In addition to offering dental services, the clinic works to reduce the risk of dental disease by providing oral health and behavioral education to families and by serving as a community resource on oral health issues.

The success of the clinic prompted the opening of a second facility in July 2015 at the Cass Regional Medical Center in Harrisonville. The new location helps provide much-needed dental access to central and southern Cass County. Both clinics are funded and operated by the Cass Community Health Foundation.

CASS COUNTY DENTAL CLINIC

BEGAN OPERATIONS IN

2011

ONLY
SAFETY NET DENTAL CLINIC IN CASS COUNTY

FIRST
MEDICAID OPTIONS FOR PEDIATRIC DENTISTRY IN CASS COUNTY

PROVIDE **URGENT** AND NONURGENT SERVICES (preventive education, early intervention and comprehensive dental care)

TREATED **2,158** PATIENTS THROUGH **4,826** ENCOUNTERS DURING 2014

**opened additional location in Harrisonville in 2015*

REACHING OUT TO AT-RISK POPULATIONS

In addition to new general service clinics, the area also has benefited from an expansion in dental care access for special needs and elderly populations. Oral Health on Wheels, a 40-foot mobile dental clinic operated by Johnson County Community College, provides professional dental cleaning and other maintenance services to special needs populations.

A dental services van operated by Truman Medical Center-Lakewood travels throughout Missouri to provide free oral health services to children and adults with disabilities. Oral health services for seniors also have been strengthened: Five oral health clinics in Johnson County now serve 12 long-term care communities.

Oral health education and prevention services targeting school-age children likewise have expanded on both sides of the state line. In Missouri, Miles of Smiles, Inc. has offered portable dental health in Clay and Platte counties since 2002. Through the program, dentists and dental assistants provide free care to low-income children at schools and social service organizations throughout the two counties.

The Missouri Preventive Services Program (PSP) provides oral health education, supplies, screening and fluoride varnish to schools, day care centers, Head Start programs and other groups. Participation in the voluntary program has grown from 4,377 children served in 2005-2006 to over 72,000 students in 2012-2013. Significantly, the proportion of third-grade students in the state with untreated decay declined from 27.0 percent in 2004-2005 to 25.6 percent in 2012-2013.

In Kansas, the number of students between 3rd and 12th grade screened through a similar program — Smiles Across Kansas — increased from 34,511 in 2008-2009 to 92,177 in 2011-2012. The proportion of Kansas third graders with untreated decay, meanwhile, fell dramatically from 25.1 percent in 2004 to 9.4 percent in 2012.

Five oral health clinics in Johnson County, Kansas, now serve

12
LONG-TERM CARE
communities.



WORKFORCE IMPROVEMENTS

Important developments throughout the dental workforce have played an essential role in supporting the expansion of the area's oral health safety capacity. Increasingly, dental schools are reaching out to engage students from underserved areas in the hope that the students will return to their communities upon graduation.



At the same time, a growing number of dental graduates are seeking work in clinics rather than setting up solo or partner practices. This change has been attributed to a desire among dentists to spend more time providing services and less managing the business side of dentistry. Another contributing factor has been the increased exposure to public clinic settings that students have received during their rotations.

“It used to be that we would have an advertisement for a children’s dentist in a clinic for a year without filling it,” said one provider. “Now we get 20 to 30 qualified applicants.”

In 2013, a new school of dentistry and oral health was established at A.T. Still University, a Kirksville, Missouri-based private graduate school focusing on health sciences. The program was created to help address disparities in oral health care in Missouri and across the nation. Under the school’s doctoral program, fourth-year students split their time between a St. Louis clinic and a community health center or other safety net clinic.

DENTAL **HYGIENISTS AND ASSISTANTS** ARE TAKING **A BROADER ROLE TO PROVIDE** ADDITIONAL **SERVICES** THROUGH **EXTENDED CARE PERMITS.**

In Kansas, an extension of the scope of services that dental hygienists are allowed to provide also has contributed to enhanced access. Extended Care Permits (ECP) enable hygienists to place temporary fillings, use local anesthetics, extract baby teeth and provide other expanded duties. In 2009, 89 of 1,593 Kansas registered dental hygienists had ECPs. As of December 2012, a total of 143 ECPs were active at Kansas practice locations.

“DENTISTS IN OUR COMMUNITY ARE VERY GOOD ABOUT OFFERING SERVICES TO THE UNDERSERVED, BUT THERE IS A LIMITED NUMBER OF DENTISTS,” SAID ONE PROVIDER.

A sufficient number of dentists, at least in urban areas, has helped support safety net care. The ratio of dentists to population in the metropolitan counties on both sides of the state line continues to exceed levels used by the federal government to identify dental health provider shortage areas. That said, the proportion of private dentists in both Kansas and Missouri who accept Medicaid adult and children patients – approximately one in five — has remained virtually unchanged over the past decade.



Concerns exist about future capacity, given an aging dental workforce. In 28 Missouri counties, more than half of practicing dentists plan to retire within 10 years, according to the Missouri Department of Health and Senior Services.

One area that has seen positive policy developments has been the promotion of broader clinical roles for dental hygienists and dental assistants. In 2003, Kansas amended its state Dental Practice Act to allow Extended Care Permits (ECPs) for dental hygienists. This change enabled dental hygienists to work in the community with the signature (rather than sponsorship) of a dentist.

In 2012, the law was expanded to permit hygienists to provide additional services, including temporary fillings and extraction of loose primary teeth. Since 2001, dental hygienists in Missouri who've been in practice for at least three years and who are working in a public health setting can provide fluoride treatments, teeth cleaning and sealants to Medicaid children without supervision of a dentist.



“IF YOU ARE A PATIENT WITH PRIVATE DENTAL INSURANCE, YOU ARE OK – THERE IS ENOUGH SUPPLY,” SAID ONE PROVIDER.



THROUGHOUT THE ORAL **SAFETY NET** COMMUNITY,
A **GROWING SPIRIT** OF COLLABORATION IS **CREATING**
NEW SYNERGIES AND **OPPORTUNITIES.**

GREATER COLLABORATION

Throughout the oral safety net community, a growing spirit of collaboration is fueling new synergies and opportunities. Clinics increasingly are working together to coordinate efforts and match resources. Oral health programs are being integrated with primary care through patient-centered medical homes. New relationships between local dental schools and safety net providers are enabling dental students to have rotations in practices that serve low-income patients.

Yet even with these strides, the availability of acute and specialty care remains limited for lower-income individuals, stakeholders say. Care for special needs patients also can be difficult to access on a consistent basis. And fragmentation is still a major issue throughout the system.

Part of the problem stems from divisions created by the state line. Missouri and Kansas differ in the structure and coverage of their Medicaid programs, the scope of practice for mid-level providers, oral health screening requirements for schools and practice ownership regulations. These factors inevitably influence how dental health providers operate and how care can be accessed.



LONG WAIT TIMES

Other challenges remain. Existing services are still insufficient to meet the demand for low-cost oral health services. Long wait times for appointments, incomplete care, transportation challenges, insurance paperwork confusion and lack of access to oral health specialists were identified as major concerns in a 2014 regional oral health needs assessment conducted by HCF.

Participants in a recent focus group of community residents offered sometimes-pointed descriptions of the difficulties they frequently encounter when accessing dental care. One noted: “I had better dental care when I was in prison.” Quality of care emerged as a prominent theme. “They try to take the cheapest way out and pull it, rather than deal with filling it,” another participant said.

Others expressed concerns about receiving incomplete care and providers’ tendency to limit their focus to just one aspect of a problem. The difficulties are undeniably complicated by the fact that dental hygiene and preventive care remain low priorities for many who face major challenges in their daily lives.

THE AFFORDABLE CARE ACT

Changes affecting the health policy landscape over the past decade have been dramatic. At the federal level, passage of the Patient Protection and Affordable Care Act (ACA) in 2010 has led to a substantial expansion of the health care safety net, including oral health services, nationwide.

With support of ACA funding, Federally Qualified Health Centers (FQHCs) have been able to increase access by expanding facilities and establishing satellite sites in underserved and largely rural areas. Dental services provided by FQHCs increasingly are being integrated with primary health care and, more recently, behavioral health services. New funding also has helped FQHCs invest in technology, including electronic health records, to enhance efficiency and support quality care.

Yet even with the many positives associated with the ACA, most stakeholders believe the landmark legislation fell short by failing to establish dental coverage as a mandated insurance benefit. Pediatric dental services, by contrast, are defined as an essential health benefit and must be offered by all plans in the individual and small-group markets. But because dental insurance may be sold as a separate policy, adults buying a plan that does not include dental coverage do not face any repercussions if they do not obtain dental coverage for their children.



DESPITE **MANY POSITIVES** ASSOCIATED WITH THE ACA, IT FELL SHORT IN ITS FAILURE TO ESTABLISH **DENTAL COVERAGE** AS A MANDATED **INSURANCE BENEFIT.**

MEDICAID CHANGES

In both Missouri and Kansas, policy progress in the oral health arena has been hampered by reductions in state revenues and ongoing budget cutbacks. In 2005, Missouri’s Medicaid program eliminated comprehensive dental benefits for adults. Although pregnant women, the blind, developmentally disabled adults and nursing home residents continued to be covered, other adults were covered only by emergency services. An estimated 300,000 Missouri adults lost coverage.

Some of the damage done by the 2005 cutbacks was reversed in 2015, after advocacy efforts helped secure the reinstatement of adult dental benefits. This development marked a significant win for oral health access in Missouri.

In Kansas, oral health coverage for Medicaid enrollees expanded in 2013 with the creation of KanCare, the Medicaid managed care program in the state. Previously, only emergency dental services for adults were covered. KanCare, however, provides coverage for two cleanings, one exam and X-rays each year. However, KanCare does not cover restorative dental care, such as filling cavities, orthodontia or crowns.

And even with the expansion of Medicaid oral health coverage, low reimbursement rates in both states create little incentive for providers to accept Medicaid patients. In 2013, the pediatric dental Medicaid fee-for-service reimbursement rates in Kansas and Missouri were, respectively, 47.2 percent and 40.2 percent of the commercial dental insurance rates charged for equivalent services in each state. The national rate was 48.8 percent. Unfortunately, these percentages decreased substantially between 2003 and 2013, from 68.2 percent in Kansas and from 50.5 percent in Missouri.

Both Missouri and Kansas’ Medicaid programs are required to provide comprehensive dental care to children through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. In 2008, Kansas passed legislation requiring that every child receive a dental exam before starting school.

Unfortunately, neither state has adopted a statewide sealant program. Both Missouri and Kansas policies relating to children’s dental health were graded “C” in 2011 by the Pew Center on the States. Lack of schools with sealant programs and low Medicaid rates for dental care were among the reasons cited for low scores in both states.

PEDIATRIC DENTAL MEDICAID FEE-FOR-SERVICE REIMBURSEMENT RATES
as a percentage of the commercial dental insurance rates charged for equivalent services in each state



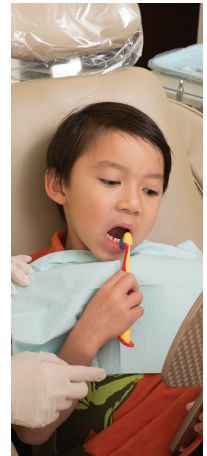
	KANSAS	MISSOURI	NATIONAL
2013	47.2%	40.2%	48.8%
2003	68.2%	50.5%	

EFFECTIVE ADVOCACY

A stronger advocacy infrastructure has helped contribute to the elevation of oral health as a significant public policy issue in both Missouri and Kansas over the past decade. Through the infusion of funding from foundations in 2010, the Missouri Coalition for Oral Health was reshaped from an organization focusing on oral health education to one that plays a more active role in policy advocacy.

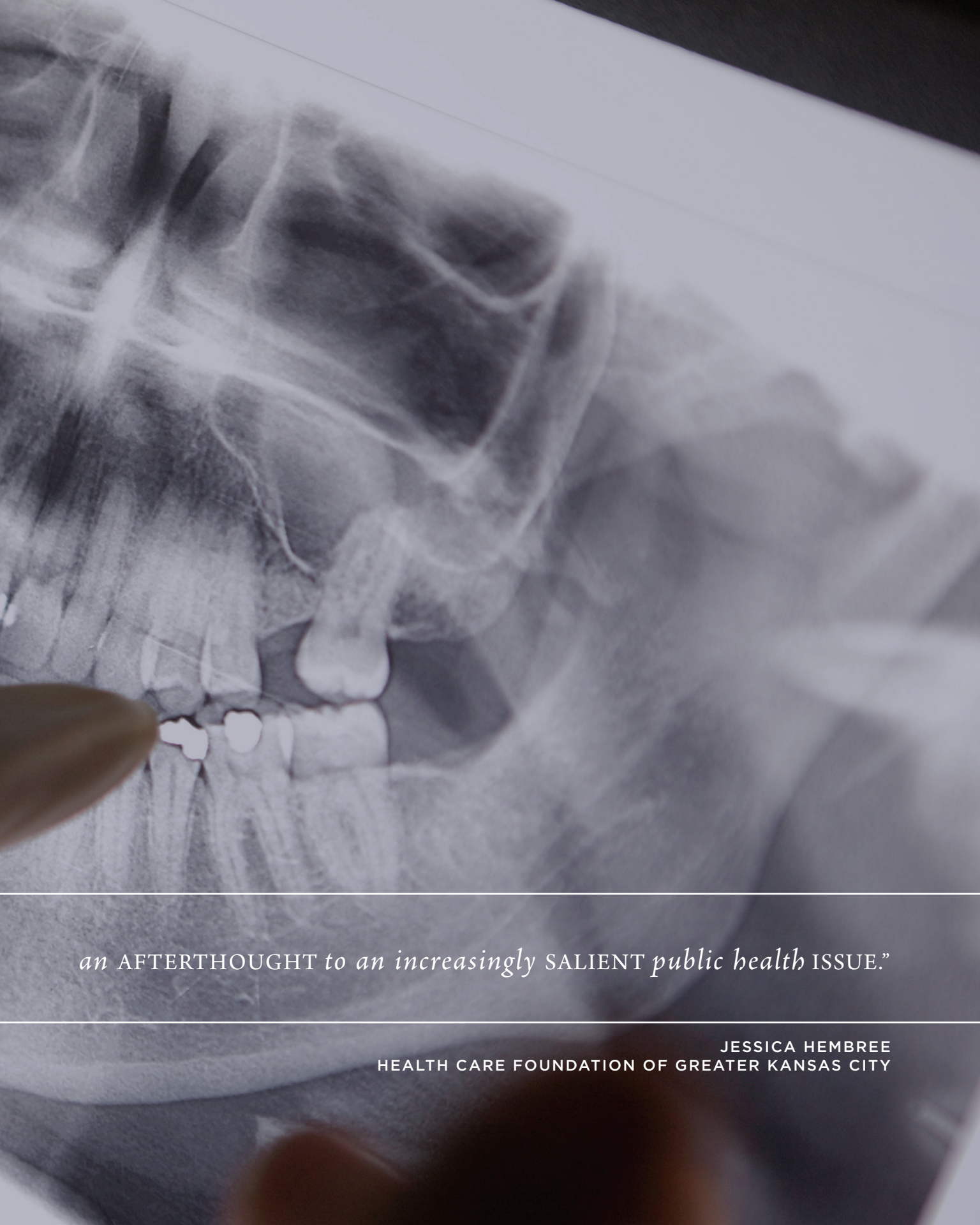
The reconstituted group helped secure several important policy wins over the past few years, including securing funding for the state Dental Director after a 10-year vacancy at the post. The group also helped ensure that adult oral health coverage was reinstated in the state Medicaid program.

In Kansas, advocacy initiatives have been led by Oral Health Kansas, a statewide coalition formed in 2003. The group has achieved several notable policy successes over the past decade. These include efforts to broaden the dental hygienist Extended Permit Law (2007), securing funding for Medicaid dental services for pregnant women (2008), incorporating a Medicaid preventive dental benefit for adults in the state's new Medicaid managed care program (2012), and defeating legislation that would have compromised water fluoridation (2014).





“ORAL HEALTH *has been* TRANSFORMED *from almost*



an AFTERTHOUGHT to an increasingly SALIENT public health ISSUE.”

JESSICA HEMBREE
HEALTH CARE FOUNDATION OF GREATER KANSAS CITY

LOOKING AHEAD

Stakeholders point to a number of major difficulties that continue to confront the oral health safety net in the Kansas City area. Most importantly, demand still exceeds supply for free or low-cost safety net services. As a result, increasing access to care, at both the policy and programmatic levels, remains a primary objective. Ensuring funding for adult Medicaid dental coverage in Missouri and boosting Medicaid reimbursement rates for dental services in both states were viewed as important steps in achieving this goal.

“Anything we can do to increase access to care is important,” one advocate said. “But 99 percent of the time, greater access is about better coverage and increased reimbursement.” Indeed, a 2013 survey of oral health providers indicated that increased reimbursement rates for low-income patients represented a critical need.

Expansion of dental outreach programs offered through community-based organizations also is vital, stakeholders say. Challenges surrounding transportation, time and convenience make it important to provide services at locations that people can easily access. These settings could include schools, health departments, WIC offices, childcare centers, pharmacies and churches.

“Anywhere there are large numbers of people would be the right place,” one stakeholder said, noting that schools are an especially valuable location for oral health services. “The school district is a vital point because we have kids for an entire day and can catch them young. We can also access parents and families.”

But even with the promise school-based services offer, concerns exist about limitations surrounding the types of oral health care that can be provided, as well as the potential difficulties that may arise when more complex cases need to be referred elsewhere.



STAKEHOLDERS SUGGEST **EXPANSION OF DENTAL OUTREACH** PROGRAMS OFFERED **THROUGH** COMMUNITY-BASED ORGANIZATIONS **IS VITAL** TO INCREASE **ACCESS TO CARE.**





Continued support for on-the-ground services, particularly in seriously underserved areas such as Wyandotte County, will be important. This includes expanding services provided by non-dental community providers, such as schools, nursing homes and organizations serving special needs populations.

Public education about oral health also remains a pressing need. As one advocate noted, “There haven’t been any comprehensive public education and awareness programs. We haven’t done a good job helping people who need dental care figure out how to get it.”

Education initiatives could take the form of both specific access guidance and broader messaging, such as an oral health awareness month. Information could be disseminated through WIC offices, schools and churches. The continued integration of primary and oral health care also creates opportunities for providers to share information and educate patients. Given the demographic changes that have occurred over the past decade across the metropolitan area, providing educational information in multiple languages undoubtedly would be beneficial.

The pervasive idea that dental care “is just something you think about when you have pain” can be overcome by pushing to make oral health a central element in the larger public health dialogue, advocates say.

“Oral health should be on the radar screen in public health circles with the same intensity, passion and frequency that now accompany obesity and chronic disease,” said HCF’s Jessica Hembree. “Elevating oral health and integrating it within public health will not only improve the lives of many low-income residents in the Kansas City area, it will also draw more partners together into synergistic, community-wide collaborative efforts.”



HCFDecadeofDifference.org