Task Force on the Future of Dentistry in Ohio
2015 Annual Report

Background
In response to Resolution 16-14, as passed by the 2014 ODA House of Delegates, ODA President Dr. Thomas Paumier appointed the Task Force on the Future of Dentistry in Ohio, consisting of the following members: Dr. Thomas Paumier, chair, Dr. Paul Casamassimo, Dr. Matt Messina, Dr. Henry Fields, Dr. Jacinto Beard, Dr. Lori Fitzgerald and Dr. John Hudec. ADA Treasurer Dr. Ron Lemmo and ADA Seventh District Trustee Dr. Joe Crowley participated as representatives of the ADA. Case Western Reserve University School of Dental Medicine Dean Kenneth Chance and The Ohio State University College of Dentistry Dean Patrick Lloyd participated as consultants. Other member dentists who participated included Dr. Chris Connell, Dr. Jerry Goldberg, Dr. Michael Halasz, Dr. Bert Jacob, Dr. Ronald Occhionero, Dr. L. Don Shumaker, and Dr. David Waldman

Process
Dr. Paumier met with each ODA Council and Committee to review the ADA Environmental Scan and charge them with studying areas where they could take action relative to concerns identified in the scan. Each Council and Committee provided a report of their recommendations and areas of action to the ODA Ad Interim Committee. Areas where action has already been taken include the following:

1. The Annual Session Committee has scheduled CE courses in Pediatric and Geriatric dentistry, areas identified with increases in utilization. Additionally, a course on how to run an efficient Medicaid practice, another major growth area, has been scheduled. Practice management courses to enable more efficient delivery of care have also been scheduled, recognizing reimbursements are declining and practice efficiencies are essential to maintain current income levels.
2. The Council on Dental Care Programs and Dental Practice is studying continual changes in the insurance marketplace.
3. The Council on Access to Care and Public Service is looking at local pilot programs to divert patients from hospital emergency departments to dentists in the community who have the capacity to treat them.
4. The Executive Committee is continuing lobbying efforts to increase Medicaid fees with an effort to incrementally raise them to 65-70 percent of average fees in the state.

The Task Force met on March 26, April 22 and May 6, 2015. The goals of the Task Force were to (1) gain a common understanding of the changing dental practice environment, (2) identify opportunities for the dental profession in tomorrow's practice environment and (3) explore possible strategic action areas for organized dentistry.

Topics were discussed during the three meetings based on background information compiled from various sources and the opinions of taskforce members. The discussions were led by either invited guest experts or knowledgeable task force members. The topics and their presenters are listed below:

- Review of the ADA Environmental Scan – Dr. Marko Vujicic, ADA Health Policy Institute (HPI)
- Demand for dental care -- ADA Health Policy Institute
- Delivery care models –Drs. Beard, Fitzgerald and Hudek
- Value-based and outcome-based reimbursement -- Dr. Susan Moffat-Bruce, OSU Wexner Medical Center
- Medicaid – Dr. Casamassimo
- Inter-professional relationships – Dr. Goldberg, Case School of Dental Medicine
- Role of organized dentistry – ODA and ADA Leadership
Key Conclusions Which Can Lead to Opportunities in the Future

Organized dentistry must be the purveyor of responsible data on facts about the dental profession (e.g. workforce, the patient pool, disease rates, etc.). We must be the generators and controllers of the data, proactively directing the message on important oral health issues. Otherwise, we will be forced into a reactionary position having to respond to agenda-driven misinformation. The ADA State Public Affairs Program along with its public relations partners must take a more aggressive and proactive stance on setting any dental agenda.

1. Recognizing that the utilization trends outlined in the ADA Environmental Scan related to 19-64 year olds visiting the dentist less often are likely the new normal, the task force feels strongly the ADA HPI should do further research related to consumer behavior and dental care seeking habits, especially in the 19-64 year old age group. Issues and actions relative to these findings are listed below

   • Finding what may motivate these individuals to seek routine preventive care and then developing marketing materials to be used throughout the tripartite as well as by individual members may help to reverse these disturbing trends.
   • It would appear an educational component would be necessary to help patients who traditionally have not regularly sought routine dental care to understand the value and necessity of preventive care. The ADA, with data from focus groups and other research, could craft effective messaging that would be usable by all members.
   • The increasing numbers of providers in the marketplace further complicates the utilization issue. The task force feels the HPI must gather workforce data in each state by county or zip code to give accurate and reliable information when policy makers and dental schools are considering increased class sizes, new schools and mid-level providers. This will hopefully minimize the anecdotal and arbitrary assumptions about provider capacity and access issues.
   • Given the constant pressure from foundations and some in government, organized dentistry should advocate for changes in our dental team when the facts merit and analysis supports the evolution of the workforce. It is essential that the dentist leads a technically evolving, well-trained and competent team of caregivers who educate, prevent and treat disease.

2. The projected increase in the number of Medicaid patients seeking dental care as identified by the ADA HPI provides an opportunity for growth, but in its present form in Ohio, much work needs to be done to make that opportunity a real one for Ohio dentists and Medicaid patients.

   • Fees are so low in the Ohio Medicaid system that it is unlikely that dentists will be able to engage patients covered by this program. The ODA needs to continue its legislative efforts to raise fees, target pilot programs, and improve processes.
   • The MCOs who contract with the State of Ohio need to be held to a level of performance that provides real access to care for covered citizens. The ODA needs to work with the Office of Medicaid to implement ADA proposed contractual principles for MCOs so that coverage is both reasonable for providers and beneficial to citizens.
   • Experience in other states demonstrates that when Medicaid reimburses at closer to market fees, access to care substantially improves.
   • The Medicaid Fee Study provided for in House Bill 463 may create the opportunity for enhancing and reforming Ohio’s dental Medicaid program.
   • In certain communities where Federally Qualified Health Centers (FQHCs) have become important parts of the safety net, organized dentistry and the health centers should work together to find innovative ways for FQHCs to contract with private community dentists to provide dental care to the underserved.
3. The HPI has indicated consumers are not visiting the dentist as often as in the past due to cost and the perceived lack of need. When they do make choices about seeing a dentist, they are looking for value and want to know fees up front. The ADA should help dentists to ethically and appropriately provide fee information according to legal and ethical practices.

- The ADA should research ways to inform the consumer about "average" fees related to dental care as well as the relative cost of routine care versus other normal consumer health care and non-health purchases.
- A marketing campaign educating consumers that "you don't need dental insurance to see the dentist" should be investigated. Again, cost comparisons for routine household purchases that are similar to average yearly dental costs would emphasize the message that dental care is affordable.
- It is equally important to educate consumers that routine preventive dental care is not only important for good oral health but also good general health.
- The ODA's statewide advertising campaign on ONN-affiliated radio stations will include a new ad in the fall of 2015 with the theme "you don't need dental insurance to see the dentist."

4. Payment reform, no matter the public or private model, must tie quality, evidenced based care to reimbursements. While this new value agenda payment system likely will be integrated much more slowly in dentistry than medicine, the ADA must take the lead in establishing the outcomes assessments and quality measures that are both patient and dentist friendly.

- Organized dentistry needs to investigate developing insurance products which can be purchased by the consumer or employers that are reasonable in cost and benefits.
- If organized dentistry is going to have any influence or success in the dental insurance marketplace, it must lead the way in developing practice-level quality measures. The Dental Quality Alliance (DQA) should lead this effort. This is the only way new dental benefits products will be able to compete against traditional dental insurance products which offer employers quality measures. As part of this overall look at insurance products, the ADA should do an environmental scan of the marketplace for individual consumers and develop a rating system to help consumers (and dentists) understand the various products (discount, in-office and association sponsored plans (AARP) etc.). Based on the evidence the ADA can then rate the relative value for the consumer in participating in these products. Dental benefit plans should actually provide a true benefit to enrollees by ensuring their premiums return value to them in terms of a robust choice of providers in any network and covered services that will truly meet routine needs. By creating a rating system, the ADA will add transparency into the dental benefits system so that patients and employee benefit managers can make informed decisions.
- Developing metrics and quality measures for existing dental insurance plans and providers is also important. These measures must include provisions related to adequacy of network providers, reasonable location of providers to insureds, appropriate specialist referral networks, adequate fees for providers, and appropriate percentage of premiums directed to paying for care versus administrative costs. The DQA can lead this effort for all public or private plans.

5. The task force asked whether organized dentistry can adopt new roles in how it offers practice products and services, including endorsements. For example, can organized dentistry act as the dental services organization (DSO) for the solo and small group practices? Evaluating what corporate and large group practices offer their dentists would provide a framework for where organized dentistry can help individual and small group practices succeed. Much of this may be simply re-packaging and marketing what the ADA Center for Professional Success (CPS) and ODA already provide. The ODA already provides exhaustive materials for members to comply with all regulatory and OSDB requirements. Other areas of interest encompass clinical and non-clinical components. Organized dentistry already is the leader in continuing education (CE) at
state and national annual sessions. However, an online “mentor” or "second opinion" style interactive forum similar to DentalTown might be a great member benefit and could take advantage of the ADA Dental Product Guide and individual members’ clinical experiences. It is time to be creative in how organized dentistry provides CE and mentoring to help members (especially in solo practices) tackle more complex clinical cases in a timely manner.

- Other areas where DSO's help their doctors include HR and hiring/teamm building, IT, insurance, receivables, accounting, practice management, marketing, payroll, and communication. Clearly the ADA/ODA addresses many of these areas and where they do not, directing members to best-in-class businesses that can meet these needs should be the priority. Organized dentistry should be the first place members look when they have any needs related to their dental practices.

- We need to advocate for advanced, proven technology that meets the standards of improving care outcomes in a cost effective manner. Organized dentistry can be the arbiter of this clearing house as a business service for members.

6. When planning CE for members, organized dentistry must continually provide courses on areas involving the trends for growth in utilization, including pediatrics, geriatrics, and Medicaid.

- The recent rapid evolution in dental practice and dental care utilization pointed out by the ADA HPI point to a period of continued and rapidly accelerating change. The ODA needs to develop CE and communication methods to keep members apprised of these changes and their implications for the membership. This effort would include the ODA Today, the Leadership Institute, the ODA Annual Session, local dental society meetings, and other innovative approaches to make members nimble and ready for the inevitability of change in the dental healthcare system. In short, the ODA needs to make its members better able to anticipate change, be ready to adapt, and thrive in a new and ever-changing health care environment.

- Organized dentistry's approach to CE must encompass clinical education as well as practice management to increase efficiency as reimbursements continue to decline. Additionally, as the busyness issue for many general dentists worsens, the likelihood is they will seek to provide expanded specialty care and treat more complex cases. This could be an opportunity for organized dentistry to provide more intense didactic and hands on CE in "tracks" or continuums by specialty, some of which may almost be considered "mini residencies."

- As we look at CE, more offerings related to integrated, patient centered models of care would be beneficial. Organized dentistry, in collaboration with state dental boards needs to examine the scope of practice for dentistry. The question of whether dentistry will or should be part of primary health care must be evaluated. Interprofessional collaboration and education will not only potentially expand the scope of services dentists might provide, but also should lead to better outcomes for patients. Should or could dentistry be doing screenings for diabetes/A1C levels, cholesterol, and hypertension and providing vaccines? To do so, would require expanded education for dental students and dentists alike and standardized curriculums developed by the ADA would be beneficial. This expansion in the scope of practice will be slow to develop and must be embraced by both the dental and medical communities, but organized dentistry should be the leader in this movement. Part of this transformation may be leveraged by the emergence of value-based payment reform in medicine. In areas where outcomes measures in certain diseases may be impacted by improved oral health (diabetics, pregnancy, oncology, cardiac), payers and providers may be incentivized to include dentistry in their patient-centered treatment approaches. The ADA Council on Scientific Affairs should provide brief white papers on areas of medicine where improved oral health may impact medical
outcomes. A realistic approach may be to start where the science is clear and medicine is most comfortable integrating dental care such as oncology.

- The natural progression of this interprofessional collaboration is an opportunity for dentist/physician and physician/dentist referrals. Considering that on average 108 million patients see a physician but not a dentist and 27 million patients see a dentist but not a physician in a given year, there is a huge opportunity to educate these individuals on the value of seeing a dentist or physician for preventive care. In addition, each year on average, nearly 20 million people see a physician for well care and have dental insurance, but do not see a dentist. So, our messaging to our physician colleagues must be to ask their patients when was the last time they saw a dentist and to discuss the value of routine preventive dental care. The CDHC could help coordinate care between disciplines.

- The ADA should investigate a marketing or advertising campaign aimed at primary care and pediatric medicine that educates physicians on the value of preventive dental care and the oral health/overall health connection.

7. Entry to the profession is largely controlled by dental education and licensure. Recent scrutiny of professions in general, and dentistry in particular, has resulted in a reexamination of the methods and processes for licensure and practice restrictions and their legitimacy regarding demands, needs, professional protectionism, and quality of services.

- Our workforce size is not clear and there are many variables involved with how it should be optimally sized in the future. As other health care disciplines have discovered, market forces often lag behind reality. The key is to ensure there are enough dentists to meet the needs of patients without creating an oversupply. Dental education is a key factor in workforce supply. Nontraditional models of dental education can be innovative and offer some hedge on increasing educational costs. However, in many instances, certain institutions have already increased enrollments and/or changed methods of training students by moving to alternative models using satellite clinics with questionable rigor and noncalibrated faculty. The benefits and risks of these models must be examined by the profession. Dental education programs must include contributions not only to learning, but also research that advances knowledge in oral health and dental techniques. Otherwise, dental schools may actually diminish the profession by producing practitioners with questionable futures and transforming dentistry into a lower tier of education and a strictly technical status. Organized dentistry needs to support quality education and science in an environment where dental schools are innovative and conscious of educational and financial realities for the institution, patients and students. Analysis and recommendations regarding workforce should be driven by organized dentistry.

- We should monitor student testing and licensure so that we simplify entry to the profession and promote portability while maintaining high standards. These methods must reduce bias and conflict of interest on the part of the licensing bodies. A side effect of rational licensure methods could be improved access to dental care as practitioners can more easily cross state lines and provide care in various settings.

- The licensing bodies will also need to carefully define the scope of practice and the challenges that technology brings through digital imaging, 3-D printing and teledentistry. Licensing and regulations must keep up with modern society. Organized dentistry has the expertise and experience to develop recommended guidelines that keep up with technological advancements and a more mobile society.
8. While this task force’s priority was the future of the profession, some discussion of membership in organized dentistry is appropriate since to achieve much of what we have outlined requires a strong tripartite.

- Membership market share trends must be reversed if we are to not only survive but thrive as an organization. This will require out of the box thinking and abandoning the traditional categories of membership. Membership in the tripartite should be inclusive. For example, organized dentistry might consider special membership categories for those dentists who also belong to certain recognized (will require definition) dental organizations (Asian Dental Association, Indian Dental Association, Women’s Dental Association, etc.). Dues may be prorated or modified dependent on the other organization’s dues. As our profession becomes more diverse, many younger dentists may join a dental group which more closely identifies with their unique cultural or practice interests. This makes the ADA seem less likely to be the first choice for many “joiners.” This type of membership may benefit all parties. All dentists benefit from the advocacy ability of organized dentistry, where interests are likely to overlap, while certain dentists’ social and cultural needs might be better met by the smaller, parochial organizations. The structure could be similar to the Bar Association which has Sections to meet the specialized interests of its members, who while practicing in very different styles all share the commonality of being lawyers. This may require a more a la carte style of membership, where there is a minimum basic cost for the “intangible” benefits of advocacy, CDT coding, promotion of professional ethics and professionalism, etc. Access to additional products or services (insurance, brochures, ADABEI products) may have an additional cost associated with them. Clearly there would be much work to develop such a system for membership and representation, but unless we embrace corporate dentists, dentists married to dentists, and diverse ethnic dentists, we will not reverse the market share decline of the last decade. To those who say this is unfair to those who pay full dues, as an association we have already philosophically accepted reduced dues categories with special benefits of all types (new dentists, retired dentists, life members, etc.), with only slightly more than half of the membership paying full dues today. This approach is not a large leap, but may produce dramatically positive results.

- Finally, the ADA must develop a marketing plan to ensure members and the public think of organized dentistry FIRST. Organized dentistry must be the source for reliable unbiased information on oral health for the public. And organized dentistry must be the first source for any dentist who needs information or has a question related to their practice (assistance with third party payer issues, regulatory compliance, practice management, etc.) Unfortunately, too often we hear of members who search the marketplace when they face a question about practice issues, both clinical and non-clinical. No business or organization has more to offer our members than the tripartite, yet we are not always the first place to which they turn. Often times they are paying other outside entities for information or services that they could get from organized dentistry. This should be easy to reverse with simple messaging. Consider it the “Who ya gonna call?” campaign. Smart marketing, consistently aimed at all members at every level of the tripartite can make organized dentistry the FIRST place dentists look with questions about their practices. This does not require listing all the services the tripartite offers. As a matter of fact, just the opposite is needed. It does not matter the issue, if the ADA/ODA cannot provide the product or service, we will direct you to a best in class business or organization that will do so. Just call us first. This simple message could help retention and ultimately increase membership as word of mouth spreads the message of how easy it is to manage a dental practice with organized dentistry on your side – just call the ODA/ADA! This collaborative effort, spearheaded by the ADA partnering with the state and local dental societies, will demonstrate the Power of Three.
Next Steps
This report shall be submitted to relevant ADA and ODA bodies for consideration of implementation of the recommendations. Continued monitoring of progress of implementation shall be a priority within all levels of the tripartite.

Task Force Bios
Dr. Thomas Paumier is a general dentist in Canton and previously served on the ADA Strategic Planning Committee. He is currently serving as President of the ODA.

Dr. Paul Casamassimo is a member of the Section of Dentistry at Nationwide Children's Hospital, a Professor of Pediatric Dentistry at The Ohio State University College of Dentistry and the Immediate Past President of the ODA.

Dr. Matt Messina is a general dentist in Fairview Park, Executive Editor of the ODA Today, and an ADA spokesperson. He participated in the 2013 ADA Environmental Scan as an external thought leader.

Dr. Henry Fields is Professor and Vig/Williams Endowed Orthodontics Division Chair at The Ohio State University College of Dentistry, Chief of Orthodontics at Nationwide Children’s Hospital and a Past President of the ODA.

Dr. Jacinto Beard is a Columbus-area general dentist who maintains both a Medicaid practice and a non-Medicaid practice. He is a former member of the Ohio State Dental Board.

Dr. Lori Fitzgerald is a general dentist in Canfield and former dental director of an FQHC.

Dr. John Hudec is a general dentist and the owner and founder of Hudec Dental, which has 17 locations throughout Northeast Ohio, employing more than 200 dental professionals.