



## Interviews of Oral Health Stakeholders in Kentucky: An Executive Summary

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## PREFACE

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This executive summary of the February 2016 report, *Interviews of Oral Health Stakeholders in Kentucky*, summarizes common themes derived from personal telephone interviews with 28 oral health stakeholders in Kentucky between September and November 2015.

The information about gaps in access and barriers to oral health services in the state was compiled by Margaret Langelier at the Center for Health Workforce Studies (CHWS). Layout design was completed by Leanne Keough at CHWS.

This report is funded in part by The Pew Charitable Trusts. The findings and conclusions are exclusively the work of CHWS and do not necessarily reflect the views of Pew or represent the positions or policies of the School of Public Health, University at Albany, or SUNY.

Established in 1996, CHWS is a not-for-profit research organization, based at the School of Public Health, University at Albany, State University of New York (SUNY). The mission of CHWS is to provide timely, accurate data and conduct policy relevant research about the health workforce. The research conducted by CHWS supports and promotes health workforce planning and policymaking at local, regional, state, and national levels. Today, CHWS is a national leader in the field of health workforce studies, and the only center with a focus on the oral health workforce.

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## BACKGROUND

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The Center for Health Workforce Studies (CHWS) at the School of Public Health, University at Albany, New York, with funding in part by The Pew Charitable Trusts, conducted a study to describe the current oral health status of the population in Kentucky. The research included an extensive review of literature describing oral health in Kentucky and analyses of relevant state and national surveillance data. The goals of the research were to:

- Describe rates of oral disease in the population
- Determine levels of oral health service utilization
- Understand disparities in oral health status among population cohorts
- Define gaps in oral health service availability

A background report was compiled to describe the literature review and the secondary data analyses. Project activities also included interviews with oral health stakeholders in Kentucky. The January 2016 report, *Interviews of Oral Health Stakeholders in Kentucky*, summarizes common themes that resulted from those interviews.

From September 2015 to November 2015, staff from CHWS conducted interviews with 28 oral health stakeholders in Kentucky. Interview participants were identified by project advisers and other interview participants representing a cross-section of dental professionals, including dentists and dental hygienists, medical providers, executive staff of safety-net provider organizations, oral health researchers, advocates for children and families, educators from oral health professions education programs, clinic administrators, and others. Participants were identified in various regions of the state including rural areas in the east and west and urban areas such as Louisville. Interviewees were selected based on their interest in improving oral health service delivery in Kentucky.

The telephone interviews each lasted approximately one hour and were arranged and conducted at the convenience of the participants. An interview protocol was developed and shared with the interviewees; however, the protocol was used only as a broad guide for individual discussion, providing an unstructured approach that allowed interviewees to discuss topics related to their particular perspectives on oral health access issues in the state.

All interviewees were assured of confidentiality with no direct attribution of their remarks included within the report. Interviewees were also advised that benchmark programs would be cited as examples of

successful strategies to meet demand for oral health services in the state. The following summarization elaborates on the resulting common themes from the interviews based on discussions with interviewees. Opinions of interviewees are not necessarily reflective of opinions or attitudes of their employers or the author of this report.

The executive summary is followed by Appendix A which lists the organizational affiliation of interview participants. The list documents the wide array and geographic diversity of organizations in Kentucky with an interest in oral health. Appendix B contains the interview protocol provided to interview participants.

## COMMON THEMES

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Interview participants held various perspectives on the status of oral health in Kentucky's population and the availability of oral health services in each of their local areas. Although there were geographic differences in the oral health care delivery systems in the areas in which informants lived and worked, there were similarities in interviewees' perspectives regarding the availability of oral health services for underserved populations throughout the state. The themes that emerged from the interviews include the following:

- Oral health literacy, an important determinant of oral health status and of care seeking behaviors, is lacking in some Kentucky populations.
- Poor oral health outcomes are a concern in all states; but particular circumstances in Kentucky impact oral health status and outcomes. These circumstances must be considered in state and local efforts to improve population oral health.
- Integration of all health services must be a primary goal of the delivery system in Kentucky to manage the complex population health issues created by the incidence and prevalence of chronic disease including dental caries and periodontal disease.
- Kentucky has made strides in improving access to oral health services for underserved populations; however, there remain population groups with significant unmet need for services.
- Geographic disparities in access to and utilization of oral health services in Kentucky are well known. People living in certain areas of the state are chronically underserved for dental care.
- Increasing access to and utilization of oral health services in Kentucky will require thoughtful change in reimbursement policy, program availability and delivery, and public education.
- Kentucky embraced Medicaid expansion in the Affordable Care Act (ACA) and as a result, many of the previously uninsured now have dental insurance.
- Medicaid expansion had challenging repercussions on patient caseloads in dental practices.
- The safety net for oral health services in Kentucky is growing in response to a need for service providers in some communities.
- School based and school linked oral health programs are growing in number and appear to have a beneficial impact on oral health outcomes for children in Kentucky.
- Interview participants expressed concern about the quality of services provided in mobile dental vans operated by for profit dental groups in certain areas of the state.

- Many interviewees felt the supply of oral health professionals in Kentucky was adequate; however, they cited poor distribution of oral health workforce across the state, particularly in rural areas.
- Interviewees discussed opportunities to strategically locate oral health services in communities and also recognized the need for changes in scope of practice regulation to support delivery of services in public health settings.

These themes are further discussed below in short summary paragraphs that support each finding.

### **Oral health literacy, an important determinant of oral health status and of care seeking behaviors, is lacking in some Kentucky populations.**

Interviewees agreed that an important component of any initiative to improve population oral health is public education about the importance of oral health to an individual's health status. Interview participants described a fundamental need for improved oral health literacy in the state identifying the following manifestations of poor oral health literacy:

- High demand in many areas of the state for dental services to address urgent or emergent oral conditions;
- High no show rates in safety net organizations for dental appointments particularly for preventive services;
- Cultural beliefs and intergenerational myths about poor oral health as an expected life outcome that cannot be prevented;
- Poor nutritional choices, especially carbonated beverages, for and by children that impact oral health, and
- A lack of recognition of the need for routine preventive care or of interest in establishing a dental home.

A low level of oral health literacy is a pervasive problem affecting attitudes about the need for oral health services that persist across generations. Interviewees asserted that not understanding the value of oral health impacts the care-seeking behaviors of people at all educational levels and varied socioeconomic groups. Some participants stated that a need for better oral health literacy is most apparent in specific Kentucky populations. Interviewees remarked that a culture of dental care is lacking in some rural areas where a generalized culture of not going to the dentist was common and in populations with a fatalistic belief that teeth are not retained. Normal behavior in some populations was described as only seeking episodic care for urgent problems.

**Poor oral health outcomes are a concern in all states; but particular circumstances in Kentucky impact oral health status and outcomes. These circumstances must be considered in state and local efforts to improve population oral health.**

Interviewees were thoughtful about the importance of designing local solutions to address the problem of poor oral health outcomes, and of considering the varying needs of particular populations in the state. Many participants commented on geographic and socioeconomic disparities in Kentucky that impacted oral health status. Interviewees commonly observed that parts of Kentucky were flourishing and while some populations living in those areas had limited access to oral health services, many had unimpeded access. The availability of and access to oral health services was characterized quite differently for those in the more rural and economically depressed areas of the state.

The interviewees cited several societal shifts that are impacting oral health status in Kentucky. High school students can now purchase soda from vending machines in schools which, according to some, has reversed previous improvements in children's oral health. Caries in younger generations are now at historic levels after noticeable improvement in oral health outcomes in the previous generation of children. Use of smokeless/spit tobacco is as common in some populations as cigarette smoking was in the past, especially in younger age groups. Young female teenagers are apparently using cigarettes more often than even their male peers.

The high rate of substance abuse in Kentucky populations was a frequent point of discussion. Some interviewees commented that many people who worked in heavy industry and coal mining had physical injuries from their strenuous jobs that resulted in enduring and sometimes, intractable pain. The use of legal pain medications had led some to addiction of either legal or illegal substances. Certain prescribed medications, including anti-depressants and heart medications, or the abuse of illegal substances greatly increase the potential for developing oral disease. Substance abuse is not concentrated in rural areas, nor is it specific to coal miners. However, it is perceived to be disproportionately prevalent in the economically depressed areas of the state where rates of joblessness and underemployment are high.

Drug use among parents has downstream repercussions for the oral health of their children. Interviewees described some custodial parents as not actively engaged in caretaking but refusing to surrender formal custody because government benefits for the children provide resources, which the custodial parent is unwilling to forego. Some children live in precarious situations and are moved from house to house; some are cared for by grandparents. Interviewees described this situation as additionally problematic because engaging older generations to ensure dental services for children in their care was difficult because of their own ingrained misconceptions about dentistry.

One participant discussed the common perception that children have more access to oral health services than adults because of the focus on children in fluoride and sealant programs and oral health education and literacy efforts in Kentucky. The interviewee felt that this observation is a fallacy stating that children, particularly children and young children on Medicaid, lack access to treatment services in many communities.

While prevention programs are necessary, assessment services provided in these programs reveal untreated disease that must be addressed. To assure that needed treatment services are received, a robust referral network must be available for children to ensure that parents can obtain services. In many communities there are no dentists or very few dentists who will treat Medicaid insured children. The interviewee commented that the system often blames the parent for not following up on treatment; however, the system does not provide the means for many of these children to easily receive services in their communities. The interviewee concluded that the system must demonstrate the value in receiving oral health services in order for the public to embrace that value.

**Integration of all health services must be a primary goal of the delivery system in Kentucky to manage the complex population health issues created by the incidence and prevalence of chronic disease including dental caries and periodontal disease.**

Many participants spoke of poor *health* outcomes in Kentucky with an emphasis on linkages to oral health status including high rates of infant mortality and morbidity, increased incidence of oral cancers, high rates of obesity, and increasing rates of substance abuse. Many interviewees suggested that in order to mediate existing health disparities and poor outcomes, Kentucky needed a community-based, integrated approach to health and oral health care delivery.

Participants cited the importance of screening pregnant women for periodontal disease and other conditions that are linked to pre-term birth; of screening and counseling for tobacco use; of monitoring periodontal disease in the diabetic population; and of identifying, counseling, and referring substance abusers who are identified in the dental office as evidence of the importance of building integrated community health delivery systems. Interviewees emphasized that until oral health is acknowledged as important by health care delivery systems and funders of health services, making progress in improving oral health and other health outcomes for the state's population will be difficult.

Informants also discussed the several levels at which integration must occur including reform of health care delivery processes and structures; improvements in payment methodologies to make reimbursement more equitable; education of health clinicians about the importance of screening and assessing the oral health of their patients; and increasing the availability of oral health services in public health settings such as nursing homes, homeless shelters, and programs for the mentally ill.

Federally qualified health centers (FQHCs) were cited as synergistic organizations that co-locate a variety of health services including primary medicine, oral health, behavioral health, eye health, and ancillary services including laboratory and pharmacy. FQHCs were described as facilities that have a unique opportunity to create a triage system in oral health that might be managed at many different levels beginning with primary care clinicians referring to dental providers and vice versa.

Interviewees noted that the absence of interoperability between electronic medical record (EMR) and electronic dental record (EDR) systems is a barrier to integration of oral health within the larger health care delivery system. The US health care system is moving towards meaningful use of data including data driven performance and benchmarking that engages hospitals and physicians in evidenced based care. Dental records often do not interface with medical records, which not only separates the disciplines, but also separates dentistry from active participation in broader health care initiatives.

**Kentucky has made strides in improving access to oral health services for underserved populations; however, there remain population groups with significant unmet need for services.**

Interview participants acknowledged that identifying barriers to oral health services is a challenging task because there are numerous factors that inform patient and provider behaviors and create gaps between actual need and expressed demand. Interviewees cited financial barriers for patients with no dental insurance, expensive out of pocket costs, or lack of transportation to services as factors that limit even a knowledgeable patient's ability or willingness to access services. Interviewees acknowledged that there are times when oral health services are not available, and at other times, even when they are available they are inaccessible to particular patients (eg, Medicaid beneficiaries).

Identification of the root causes of lack of access to oral health services is sometimes challenging and further complicates the selection of possible strategies to improve population oral health outcomes. One interviewee identified an insufficient supply of clinics and dentists to address need for oral health services among indigent populations, children and adolescents, and nursing home patients as a barrier to access to oral health care in Kentucky. Still another interviewee commented on a trio of factors: *"Transportation is a problem; insurance status creates difficulties in getting care; people live in areas where there are simply no providers or none willing to treat them."*

According to several interview participants, poverty and poor oral health are often coincidental. More than a quarter of the population of children in Kentucky lives in a household that is classified as in poverty and another 20% live in low income families. One interviewee called for understanding that children are dependent on others for good oral health. Another interviewee offered that poverty is the most substantial access barrier to oral health services. The interviewee urged stakeholders to study poverty,

move to change its progress, and work with low income people to encourage a culture of health. The interviewee also stated that it is imperative to collect and monitor data about oral health and make changes based on that data to improve outcomes.

Interviewees expressed particular concern about oral health access for poor children and adults in rural and remote regions of the state, special needs populations, the elderly, especially those confined to home or a nursing facility, and diverse populations including immigrants and refugees. Several interviewees cited pregnant women as a population of concern. Some interview participants described past programs focused on pregnant women, especially those with gestational diabetes because of its relationship to premature birth and other unfavorable birth outcomes. Other participants expressed concern that undocumented pregnant women in Kentucky had limited or no access to oral health services because they do not qualify for Medicaid under federal guidelines. Interviewees also expressed concerns about the population of migrant workers in some areas of Kentucky who lack access to oral health services.

### **Geographic disparities in access to and utilization of oral health services in Kentucky are well known. People living in certain areas of the state are chronically underserved for dental care.**

Geographic and socioeconomic disparities in access to oral health services exist, especially in eastern, western, and southern Kentucky and in some urban areas of the state. Interviewees commented on a noticeable contrast between the prosperous Golden Triangle area and the depressed economies in both eastern and western Kentucky. According to interview participants, progress in meeting the oral health needs of the population is most apparent in areas of the state that are doing well economically.

Interviewees expressed special concern about rural populations in Kentucky, indicating that the majority of counties in the state are classified as rural. Geographic and economic factors in Kentucky impact the availability of oral health services within some of these rural counties, several of which qualify as among the most economically depressed in the US. Interviewees reported that the availability of oral health workforce is changing, especially in rural areas, due to the aging of oral health professionals, a trend in dentistry to reduced work hours or part-time practice, and the preference of many newer dentists to locate in more populated areas. Many of the rural regions in the state are losing population share making dental practice more challenging and even less sustainable than in the past which may further discourage young dentists from locating in rural Kentucky. Interviewees reported that limited access to oral health services might be a regional (eg, Appalachia) or a local issue (eg, inner cities).

Interviewees also recommended caution in appraisals of the sufficiency of providers in rural regions. Several interview participants suggested that there are areas in Appalachia and the Delta that are considered well served, especially towns that act as service centers for a region. Interviewees

acknowledged that patients living in remote geography experienced greater variability in access to oral health services than those living in small towns. Patients in some regions were described as willing to travel to Virginia, Tennessee, Ohio, and other bordering states for services because it was easier to access care out of state than in Kentucky.

Many interviewees described finding oral surgery services for Medicaid patients in rural areas as particularly challenging. It was thought that many oral surgeons participated with Medicaid funded insurance plans, but the limited number of these dentists, their caseloads, and often distant locations limited availability of services for patients from rural areas. In addition, high demand for oral surgery services from the newly insured who had long neglected oral health care was a current problem described by several interviewees.

**Increasing access to and utilization of oral health services in Kentucky will require thoughtful change in reimbursement policy, program availability and delivery, and public education.**

One topic that consistently arose in discussions about factors influencing access to oral health services in Kentucky was the impact of public financing for services on both the availability of care and on the ability of patients to find providers. Some interviewees felt that reimbursement reform was key to increasing access; other interviewees expressed concern about the singular focus on public financing for oral health and its centrality in discussions about access to care. Interviewees noted that a reasonable list of covered services and adequate Medicaid reimbursement are essential to enable improvements in oral health because many of those with the poorest oral health qualify for Medicaid coverage. Therefore, the fee schedule and list of covered services in Medicaid programs shape access for the poor.

Some interviewees cited the importance of recognizing that public resources are limited. Appropriate stewardship requires thoughtful attention to financial allocation. When benefits or fee schedules are increased in one area of clinical care there must be concomitant reductions in another. Interview participants suggested a need to think creatively, approach the problem from many directions, and encourage innovative oral health programming.

Medicaid was described as one of many tools that can be used in combination with others to improve access. Several interviewees noted that there are inherent limitations in the emphasis on increased public funding as a singular solution to access. The literature suggests that raising Medicaid payments does not always improve access unless other changes in the delivery system also occur.

One interviewee suggested a need for fundamental change in the thinking about oral health service provision, suggesting conversion from a fee for service payment paradigm to value based care focused

on prevention. This paradigm shift might result in an improved product and better outcomes and allow providers to reap the rewards from the adjustments in care delivery. Value was described as the foundation of the new health care system and the cornerstone of a stronger health economy.

### **Kentucky embraced Medicaid expansion in the Affordable Care Act (ACA) and as a result, many of the previously uninsured now have dental insurance.**

Kentucky was described as experiencing positive impacts from provisions in the ACA and as having one of the most productive state marketplaces in the nation. According to the Centers for Medicare & Medicaid Services (CMS), there were more than 560,000 additional Medicaid and CHIP enrollees in the state between 2013 and 2015. The enrollment of hundreds of thousands of previously uninsured people through KYNECT introduced a large number of adults with serious dental issues from past neglect into the Medicaid system. Many of the newly insured Medicaid populations lived in areas where access to oral health services was already limited. Interviewees expressed concern that the already uneven distribution of the oral health workforce and the resulting insufficiency in capacity in certain areas of the state was exacerbated by demand for services from the Medicaid expansion population.

At the same time as enrollment was increasing, Kentucky undertook an administrative conversion of its Medicaid program to the auspices of additional managed care organizations (MCOs). The MCOs that contracted with Kentucky Medicaid were required to integrate a dental benefit into the health care insurance products offered to Medicaid eligible people. Both the Medicaid expansion and the MCO conversion impacted oral health service delivery in Kentucky in notable ways.

The change in the Medicaid program was identified as significantly impacting service availability and as confounding transparency for patients in obtaining oral health services. Patients selected their health insurance carrier and were passively assigned to a dental insurance product. Dental provider networks were not robust or well established in all regions of the state, which created difficulties for the newly insured with finding MCO participating dentists in their local areas.

In addition, dentists encountered problems with the conversion associated with administrative issues including complex and varying credentialing processes, service pre-approval requirements, variation in covered services, and differences in reimbursement rates among the various MCOs. The variation in plan coverage was not well understood by the patients, or by the dentists providing services.

In the opinion of some, the oral health system for the publicly insured in Kentucky has never been as fragile as currently. One interviewee described recent events in Kentucky as, *"a triple whammy"*. There was an increase in joblessness and poverty in many regions of the state due to the economic downturn; there

was an associated loss of private dental insurance; and the oral health delivery system experienced significant changes in how care for the poor was managed and reimbursed.

Several interviewees noted the fragility in the current oral health delivery system with many factors straining infrastructure. Interviewees emphasized the importance of collaborating with a variety of stakeholders to identify and resolve the systemic issues that are barriers to care. On a positive note, interviewees suggested that some of the MCOs were listening to and working with providers to increase system efficiencies so that overtime, providers and patients would be more satisfied with administrative processes.

### **Medicaid expansion had challenging repercussions on patient caseloads in dental practices.**

The population that gained insurance under Medicaid expansion presented the existing oral health care delivery system with new challenges related to severity and complexity. Clinicians reported treating new patients with intense, chronic dental infections. Some patients were so unhealthy and medically debilitated that it was necessary to refer them to a physician for evaluation before initiating dental treatment services. The increased severity in patient caseloads was attributed to newly insured patients who had not had dental or health services for prolonged periods and as a result experienced medical and dental complications from neglect.

Interviewees observed that the percentage of publicly insured adults noticeably increased in their practices. Because many children in Kentucky were already insured by Medicaid or CHIP, Medicaid expansion mainly increased the number of adults with dental insurance. As a result, the mix of patients in practices that accepted Medicaid has changed.

Interviewees from FQHCs discussed the impact of Medicaid expansion on delivery of oral health services in clinics. Expansion was described as lowering the rate of the uninsured in the state and reducing the number of patients who paid on a sliding fee scale. One interviewee remarked that in the past, dental services represented about eight percent of total health services, but, due to increased demand, it now represents about 18 percent of all services provided at the health center.

Interview participants discussed low cost recovery from Medicaid services and an inability to cover overhead costs. Interviewees indicated that in general, a practice would be sustainable if the percentage of publicly insured patients on the caseload approximated 25 percent or less. Some interviewees suggested that current caseloads included between 40 percent and 50 percent of patients enrolled in Medicaid. One clinician noted that the current caseload had reached 70 percent Medicaid, calling into question the sustainability of the dental practice under current reimbursement levels.

## The safety net for oral health services in Kentucky is growing in response to a need for service providers in some communities.

The safety net for oral health services in Kentucky comprises a variety of provider types including private practice dentists, especially those in rural communities who see high volumes of Medicaid insured patients. According to interviewees, until a few years ago, the safety net for oral health services, especially in rural communities in Kentucky, was limited. In many areas, people relied heavily on emergency departments (EDs) in critical access hospitals and on the few available dentists when urgent problems arose. Interviewees remarked that while the number of oral health safety net providers has grown in recent years there are still areas of the state where the population has limited access to oral health safety net services.

Interviewees described the oral health safety net in Kentucky as including the mobile programs and fixed clinics sponsored by the University Of Kentucky, outreach programs of the Kentucky Primary Care Association and its members, FQHCs, local departments of health and their public health dental hygiene (PHDH) initiatives, school based and school linked oral health programs, the Smile Kentucky program, and many private practice dentists who participate with the Medicaid program. In approximately 100 of the 120 counties in Kentucky, there is some level of safety net dental service available to the public. However, the safety net was described as more robust for children than for adults.

The need for safety net services in Kentucky was described as obvious since a geographic dental health professional shortage area (DHPSA), a facility DHPSA, or a special population DHPSA is designated in nearly every county. Currently, there are 23 FQHCs and look-alike clinics and approximately 60 rural health clinics in Kentucky. FQHCs are mandated to provide a full complement of oral health services to children and also preventive oral health services for adults, either through direct delivery of services or by referral to community providers. Interviewees related an impression that most of the FQHCs in the state were located in southern or eastern Kentucky, and remarked that until a few years ago there did not seem to be an immediate need for FQHCs in the western part of the state, but that need is increasingly evident.

## School based and school linked oral health programs are growing in number and appear to have a beneficial impact on oral health outcomes for children in Kentucky.

Interviewees viewed school linked or school based oral health programs as important because of the emphasis on preventive services, dental referrals, and case management services to assure that needed treatment is received. Several interviewees commented on the fundamental importance of school linked and school based oral health services to building better oral health outcomes for the younger generation. Oral health outreach programs were described as helping children and changing attitudes among parents and other caregivers about the importance of prevention.

Interviewees described the need for oral health services among children enrolled in schools, particularly in certain areas of the state, as great. One interviewee commented on an oral health survey of fifth graders in Kentucky earlier in the decade. The survey asked if the student owned a toothbrush to which only 20 percent to 25 percent of the 10 year olds responded yes. The interviewee remarked, *"It is hard to prevent tooth decay if you don't even have the most basic tool in the fight against caries"*.

Interviewees described children as conduits for change and as very receptive to messages about the importance of oral health. One interviewee remarked that children learn new things at school and become the messengers to their parents and caregivers. Providers commented that in many instances, children are raising themselves and must take the initiative to act on what they learn. Interviewees also noted that currently children seem to have less dental fear than in the past. Many children have no problem with having someone examine their mouths and are willing to help other children deal with their anxieties. One interviewee commented that children want their teeth to *"sparkle"* because they recognize how good it feels to have a clean mouth.

Interviewees were complimentary of safety net provider organizations and local departments of health and their efforts to build school based or school linked oral health programs. Many interviewees viewed family resource centers in Kentucky schools as invaluable assets to the success of school based and school linked oral health programs. Such centers were described as very helpful in encouraging families to obtain needed oral health services for their children and in helping them to find willing dental providers in local communities.

Interviewees discussed the difficulty of ensuring that children who were identified as needing treatment services through school based screening programs were followed appropriately in the community. Some dentists will not see Medicaid patients. Other dentists refuse to see children referred from school linked programs. Interviewees commented that school based and school linked oral health outreach programs

generally focus on children who are not receiving services, who are publicly insured, and who are not linked to a dental home. Many of these children are unable to access services in their communities due to lack of transportation or difficulties with parents taking time from work for dental appointments.

### **Interview participants expressed concern about the quality of services provided in mobile dental vans operated by for profit dental groups in certain areas of the state.**

Interviewees cited mobile dental vans and portable dental programs as contributing to improved oral health access throughout Kentucky. Interviewees also noted that mobile and portable oral health service programs, particularly those targeting children in schools, were a current topic of discussion and a source of concern in some communities. Interviewees clarified that this controversy is mainly about for-profit companies using dental vans to provide oral health services in some areas of Kentucky. Mobile dental vans and portable dental programs, including those managed by the University of Kentucky, by local FQHCs, and by PHDHs working for departments of health, received many positive comments.

Interviewees recognize that these dental health programs are important to the oral health of the communities they serve, especially to the children in underserved areas.

Interviewees commented that mobile and portable school linked or school based programs sponsored by government and public health organizations are designed to work themselves out of existence. A main objective of these public programs is to help underserved children find a community dental home. Interview participants were concerned about dental van programs that provided limited services to children in schools and did not provide records or referrals for necessary therapeutic services. Interviewees noted that some van programs engaged schools to participate, provided certain basic services, and then departed without leaving treatment records, completing referrals, or without establishing partnerships with local providers to offer follow-up services for the children treated in the vans.

### **Many interviewees felt the supply of oral health professionals in Kentucky was adequate; however, they cited poor distribution of oral health workforce across the state, particularly in rural areas.**

Discussions with interviewees about the oral health workforce focused on the adequacy of supply, local and regional distribution, and the utility of expanded scopes of practice or new oral health workforce models to enable better access to oral health services.

While many interviewees acknowledged that there might be enough dentists and dental hygienists currently practicing in Kentucky to meet demand for oral health services, many agreed that oral health

professionals are unevenly distributed across the state. Demand in many areas of the state now exceeds supply of professionals, especially dental specialists, to serve the population. In addition, many interviewees acknowledged that teams of oral health professionals, consisting of professionals with a variety of competencies and scopes of practice, are needed to address existing problems with oral health access and poor oral health outcomes, especially in some rural areas of the state.

According to the interview participants, the distribution of dentists in Kentucky is increasingly affected by growth in corporate practices in many metropolitan areas and also by the overall growth in population in a concentrated area of the state. Many newer general dentists and specialty dentists are thought to be locating in the Golden Triangle or contiguous areas that are experiencing population growth and economic prosperity. Interviewees were concerned about limited access to dentists in other areas of the state, especially access to pediatric dentists and to oral and maxillofacial surgeons in the areas of far eastern and far western Kentucky.

The Appalachian Rural Dental Education Program (ARDEP) was cited as an important initiative in Kentucky. The partnership which includes Morehead State University and the University Of Kentucky College Of Dentistry is funded through the Appalachian Regional Commission (ARC). One program goal is to increase the number of practicing dentists in ARC counties. ARDEP offers undergraduate oral health education, dentistry and dental public health courses, a campus oral health literacy and student oral health services program, and an enhanced dental pipeline, including mentoring for potential dental students from ARC counties.

Dental loan repayment programs including The Shaping Our Appalachian Region (SOAR) repayment program for new dentists willing to practice in the Appalachian region were cited by interview participants as important in Kentucky. High levels of dental student indebtedness at graduation make loan repayment programs attractive to new graduates while rural communities benefit from the increase in dental capacity.

### **Interviewees discussed opportunities to strategically locate oral health services in communities and also recognized the need for changes in scope of practice regulation to support delivery of services in public health settings.**

One interview question asked about the usefulness of implementing a mid-level provider workforce model to improve access to oral health services in Kentucky. Interviewees offered mixed reactions to the question: some saw no need for such a model; others could envision limited usefulness; and others felt Kentucky would benefit from enabling such a model. One interview participant commented that although dental therapy might be a useful model, there were other changes that needed to occur before that could happen. Another participant thought that from a policy perspective creating a new oral health provider

might be a useful solution. The interviewee commented, however, that an alternative strategy involving system level improvements might have more profound effects on access and delivery of oral health services.

Several interviewees suggested that the current model for public health dental hygienists (PHDHs) is a first step towards expanding access to oral health services delivery. Interviewees noted that they believed nurse practitioners did *"a good job in medicine"* and are indispensable in rural areas. PHDHs were cited as having important roles in oral health service delivery, especially in school based programs. Some interviewees stated that dental hygienists (DHs) are underutilized in the state.

Several interview participants indicated that the PHDH model appears to be working well and to be benefiting the children who receive screenings, preventive services, and subsequent referrals for treatment by community dentists. In one region, interviewees noted that PHDHs working for a Department of Health were excellent at case management and at following up with families to ensure that treatment plans were completed.

The PHDH in its current form is described as a limited model because it restricts employment to Departments of Health and limits the patients that PHDHs can serve. Interview participants suggested that the PHDH model should be expanded so primary care safety net and university affiliated oral health programs could also employ these professionals. Incorporating teledentistry into oral health service delivery was also suggested. Current American regulations limit the American Society of Anesthesiologists (ASA) physical class of patients that can receive services to healthy patients or those with mild systemic disease. As a result, many nursing home residents are excluded by their health status from eligibility for preventive services from a PHDH. In addition, other safety net entities including FQHCs are not permitted to employ PHDHs. Several interviewees commented on initial resistance to the PHDH model reflecting that in the past there was resistance to allowing DHs permission to administer local anesthesia. According to some of the interviewees, many dentists will not hire a DH now unless they are certified in the use of local anesthesia.

Interview participants discussed Kentucky's policies about expanded duty dental assistants (EDDAs) remarking that EDDAs enable some dentists to have caseloads constituted of large numbers of publicly insured patients because EDDAs contribute to increased capacity, productivity, and efficiency.

## CONCLUSIONS

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Interview participants in Kentucky were thoughtful about the issues confronting both the oral health care delivery system in the state and the patients who lack access to a dental home or to any dental service provider. Many of the participants commented on systemic issues that impeded innovation in the delivery system, social equity issues that inhibited access for the underserved, limited population oral health literacy that depressed effective demand for services, and regulatory limitations that impacted workforce, reimbursement, and service availability. While many of the concerns of Kentucky stakeholders mirrored those of other national stakeholders interested in improving oral health outcomes, there were state specific issues identified by the interviewees that might be addressed to improve the oral health of the population.

Interview participants commonly noted that the story of oral health in Kentucky resembled a tale of two cities. In some areas, especially those regions benefiting from recent economic prosperity and a robust oral health delivery system, it was among the best of times for service availability while in others, especially the coal mining and agricultural regions of eastern and western Kentucky, it was the worst of times. These areas were described as suffering from declining economies and outmigration of younger people leaving remaining residents with dwindling health and oral health resources. However, even in areas typically identified with poor health outcomes, like Appalachian Kentucky, there were bright spots and emerging innovation in oral health care service delivery that promised improvements in access to services for the local population.

Interviewees were especially concerned about the Medicaid expansion population described as high need patients with complex medical and oral health treatment needs. Most were adults since many children in Kentucky were already insured through a range of publicly supported insurance programs in existence prior to the ACA.

The entry of large numbers of these adults into the oral health delivery system coincided with the conversion of the Medicaid health and dental program to managed care. The transition from fee for service to an integrated MCO platform was difficult administratively for many dentists. While demand for services was increasing, the pool of available professional workforce participating with public insurance was experiencing erosion. In addition, the severity of oral health conditions in many of the newly insured created high demand for specialty dental services in areas that were already lacking in access to specialty care. Many interviewees commented on long waits for appointments with specialty providers and long distance travel to obtain needed care. As a result, for the last several years, the oral health service delivery system in Kentucky has experienced major disruptive changes.

Several patient populations appear to be of special concern to the clinical providers who participated in the interview process. Children, especially those at risk from unstable homes or living in poverty; pregnant women, especially those from lower socioeconomic groups; the elderly, especially those confined to homes or institutional nursing care; and young people with poor nutrition, high soda consumption habits, and rising use of tobacco and related products. These populations were repeatedly mentioned as at risk for poor health and oral health outcomes. One recurrent theme was the issue of substance abuse in the population. Clinical providers and others expressed concern that rates of substance abuse are on the rise in the state and that abuse is accompanied by devastation to the teeth and the oral cavity. Despite concerns about particular population groups, certain special populations such as people living with HIV/AIDS, appear to be well served in Kentucky through federally funded programs that support provision of a broad range of oral health services.

In conversations with stakeholders across the nation about issues that affect access to oral health services, low reimbursement rates for publicly funded oral health services commonly emerge as a systemic barrier to oral health service delivery. Predictably, this was also the case in Kentucky. However, the impact of low payment rates for services to Medicaid patients was compounded in Kentucky by other difficulties including considerable variation in administrative policies, credentialing requirements, pre-authorization for services, and payment rates among the 5 MCOs (3 dental MCOs) providing dental insurance to the Medicaid population. Over time, some of the initial difficulties with the MCO conversion were resolved and providers were learning how to best accommodate the differing requirements of the individual insurance carriers. However, dental providers remain concerned about reduced payments and withholds.

Several interviewees offered the opinion that the oral health service delivery system in Kentucky, including professional workforce and organizational providers, is adequate to meet demand for services if appropriate adjustments to reimbursement rates for the publicly insured are made. Other interviewees expressed concern that continuing emphasis on reimbursement rates is a wasteful discussion since public resources are recognized as both limited and fungible, meaning that oral health benefits in Medicaid programs are subject to elimination in favor of other spending when government budgets are in negotiation. These interview participants encouraged innovation and strategic thinking that accommodates, but does not emphasize, the limitations and vagaries of public financing for oral health services.

Opportunities for workforce innovation, a topic discussed in each of the interviews, elicited mixed opinions from interviewees. Some felt that current workforce configurations worked well. Many participants commented on the positive impact of expanded duty dental assistants both in private practices and public clinics. Other interviewees felt that well prepared workforce, especially dental

hygienists, are currently underutilized relative to their competencies. The public health dental hygiene model in Kentucky received positive reviews for its impact on access and case management especially for at risk children. However, many of the interviewees felt that the PHDH model, in its current form, is limited, which in turn restricts the potential impact of the workforce. Discussions about a mid-level or dental therapy model elicited mixed opinions. Some interviewees felt strongly that the dental therapy model is unnecessary; some felt the dental therapy model might be useful but untimely; others felt that the need for oral health services in some areas of the state is so great that it would be very helpful in increasing capacity and opening access.

Ultimately, it became apparent that a cadre of interview participants recognized the need for adaptive change in the oral health service delivery system in Kentucky to increase access to needed services and to improve oral health status and outcomes for the population.

# Appendix A

## ORGANIZATIONS WITH WHICH INTERVIEW PARTICIPANTS WERE ASSOCIATED

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American Academy of Pediatrics  
Kentucky Chapter  
Frankfort, Kentucky

Cumberland Family Medical Centers  
Burkesville, Kentucky

Foundation for a Healthy Kentucky  
Louisville, Kentucky

HealthPoint Family Care  
Covington, Kentucky

Kentucky Community & Technical College  
System  
Versailles, Kentucky

Kentucky Dental Association  
Louisville, Kentucky

Kentucky Dental Hygienists' Association  
Louisville, Kentucky

Kentucky Department for Medicaid Services  
Frankfort, Kentucky

Kentucky Primary Care Association  
Frankfort, Kentucky

Lincoln County Schools  
Stanford, Kentucky

Northern Kentucky Health Department  
Edgewood, Kentucky

Private Dental Practice  
Harlan, Kentucky

Private Dental Practice  
Martin, Kentucky

Private Dental Practice  
Paducah, Kentucky

Private Dental Practice  
Pikeville, Kentucky

Purchase Area Health Education Center  
Murry State University  
Murry, Kentucky

Purchase District Health Department  
Frankfort, Kentucky

Smile Center Professionals  
Louisville, Kentucky

University of Louisville School of Dentistry  
Louisville, Kentucky

University of Kentucky College of Dentistry  
Western Kentucky Dental Outreach Program  
Madisonville, Kentucky

University of Kentucky College of Dentistry  
Center for Oral Health Research  
Lexington, Kentucky

University of Kentucky North Fork Valley  
Community Health Center  
Hazard, Kentucky

# Appendix B

# INTERVIEW QUESTIONS FOR ORAL HEALTH STAKEHOLDERS IN KENTUCKY

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Conducted by:

The Center for Health Workforce Studies

University at Albany, School of Public Health

One University Place, Suite 220

Rensselaer, New York 12144

Contact: Margaret Langelier (Margaret.Langelier@health.ny.gov)

This interview is being conducted to inform a review of oral health workforce in Kentucky to describe barriers to access to oral health services, and to recommend pathways to increased access to dental care. This research is conducted by the Center for Health Workforce Studies at the University at Albany in partnership with the Pew Charitable Trusts. The interview is voluntary and with your consent, will take approximately 45 minutes to one hour to complete. Please tell me at any point if you wish to or must discontinue this interview.

Although the following questions are meant to guide the interview process, only some of the questions may be asked depending on the time allotted. Any information provided during the interview will be confidential. A report on the interviews will be compiled when all interviews are complete. The report will provide no information that could be specifically linked to you. The name of your organization and its location will be listed in the report to provide information about the geographic and organizational diversity of those interviewed. The report will identify common themes from the interviews and describe novel or innovative solutions that are discussed related to increased access to dental services.

Do you have any questions or concerns about this interview before we begin to talk?

## Questions:

1. Describe your personal or professional interest in oral health in Kentucky.
2. What do you perceive to be the major barriers to access to oral health care in the state?
3. Do you have concerns about lack of access to oral health care for certain populations? Who is at risk for not receiving dental care? What geographic areas in the state experience limited access to oral health care?

4. Are you aware of any successful initiatives or collaborations that have addressed the need for increased access to oral health services in the state? What strategies were employed by those initiatives to improve access to care?
5. Can you describe the coalitions who implemented these projects, their funding sources, and the patients served by these initiatives? What kinds of oral health workforce were employed to achieve the project objectives?
6. How do current regulatory limitations on scope of practice for dental auxiliaries impede access to care for those at risk for not receiving oral health services? Are there particular examples of regulatory barriers to care?
7. How have past initiatives in the state to expand the scope of practice of dental auxiliaries (including dental hygienists and dental assistants) or to decrease incumbent levels of supervision for these professionals affected access to oral health care? Have these initiatives had appreciable impacts on increasing access to oral health care? If not, why not?
8. Describe your perceptions of stakeholders' concerns about efforts to expand access to oral health care through workforce initiatives? How have oral health professionals historically responded to proposed legislation to elevate scope of practice for either dental hygienists or dental assistants or to decrease supervision requirements for these personnel or to institute separate regulatory boards? What are the main concerns expressed by oral health professionals about such regulatory change?
9. What is your perception of the sufficiency of supply of oral health workforce in the state? Is there a need to recruit more dentists, dental hygienists, or dental assistants to work in specific locations in the state?
10. What educational programs in the state or out of state might be engaged to train new oral health professionals? Are partnerships among educational programs easily achieved?
11. What could be done by government stakeholders, from a policy perspective, to encourage increased access to oral health care in the state? How does funding for oral health care affect access to dental services in Kentucky?
12. Are there any issues that we have not discussed today that you feel are relevant to this discussion?

Thank you for talking with me today. If you have any questions about this interview at any time please contact me (Margaret Langelier) at [margaret.langelier@health.ny.gov](mailto:margaret.langelier@health.ny.gov) or by phone at (518) 402-0250. If you have questions about your participation as a research subject, you may contact Tony Watson, New York State Department of Health, Institutional Review Board, (518) 474-8539 or via email at [tony.watson@health.ny.gov](mailto:tony.watson@health.ny.gov).





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