A "Health Commons" Approach to Oral Health for Low-Income Populations in a Rural State

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Oral health needs are urgent in rural states. Creative, broad-based, and collaborative solutions can alleviate these needs.

"Health commons" sites are enhanced, community-based, primary care safety net practices that include medical, behavioral, social, public, and oral health services. Successful intervention requires a comprehensive approach, including attention to enhancing dental service capacity, broadening the scope of the dental skills of locally available providers, expanding the pool of dental providers, creating new interdisciplinary teams in enhanced community-based sites, and developing more comprehensive oral health policy.

By incorporating oral health services into the health commons primary care model, access for uninsured and underserved populations is increased. A coalition of motivated stakeholders includes community leaders, safety net providers, legislators, insurers, and medical, dental, and public health providers.

ACCESS TO ORAL HEALTH services for low-income adults is poor and getting worse. Most employers of low-wage workers do not offer a dental insurance benefit. If offered, the employee portion of the premium is not affordable for those earning less than 200% of the federal poverty level. In New Mexico, as in other sparsely populated, rural states, the problems of access and coverage are magnified by a shortage and geographic maldistribution of dentists and other oral health providers. Without a dental school or training program, the New Mexico pipeline is tenuous.

Recently, a group of concerned New Mexico safety net providers, academicians, legislators, public health officials, and other oral health stakeholders collaborated in seeking short- and long-term solutions to the dental crisis. This coalition forged a 5-pronged approach, with the "health commons" at the hub of community-based activity. A "health commons" refers to a pooling of resources from public and private entities to address vexing or complex health issues in a community that cannot be solved by any single entity alone. The health commons sites are enhanced, community-based, primary care safety net practices that include medical, behavioral, social, public, and oral health services provided by different entities. The 5 activities are as follows.

1. *Enhancing dental service capacity.* The collaborative activities were catalyzed by the W.K. Kellogg Foundation's grant initiative Community Voices: Healthcare for the Underserved. Thirteen sites received awards, including the University of New Mexico in 1998. In 2000, the Health Resource Services Administration (HRSA) began a major national initiative called the Community Access Program, with the goal of expanding access to care for the uninsured and reducing health disparity in populations, emphasizing safety net providers and systems. Several New Mexico safety net providers also received Community Access Program awards. Early in these initiatives, oral health was identified as an unmet need. For example, at the University of New Mexico Hospital, the state's largest safety net provider and only academic health center, 7% of all emergency room visits were dental related, yet the Health Sciences Center employed no dentists.

With foundation support, and with the goal of increasing access to dental services in the state's underserved communities, the chair of the University of New Mexico Department of Surgery created the Division of Dental Services and hired its first dental faculty member in April 1999. The division grew quickly and created contractual partnerships through the University of New Mexico Center for Community Partnerships with local community health centers, Indian Health Service sites, and the New Mexico Department of Health and began to address oral health problems within the state on the basis of community need. By the fall of 2001, the University of New Mexico Division of Dental Services had hired its eighth faculty member and consolidated services with the dental hygiene school.

2. *Broadening the scope of dental skills of locally available health providers.* The approach to pipeline development included short- and long-term interventions. Since New Mexico ranks 49th among the 50 states in per capita dentists, other locally available health providers such as family physicians and dental hygienists needed immediate training to expand their scope of oral health practice. The division began to educate physicians, including family practice and emergency room residents, in an expanded rotation through the newly opened university dental clinics. Each resident managed 60 to 80 emergency dental patients under the supervision of dental faculty on the rotation. At the completion of the rotation,

residents gained an understanding of dental anesthesia, treatment planning, diagnosis, and management of dental trauma and infections. Resident graduates who set up practice in New Mexico and completed this training are now able to perform emergency dental procedures in rural emergency departments and practices and to consult with division faculty through the University of New Mexico Physician Access Line.

At the same time, the university's Division of Dental Services created linkages with other dental programs in states with a dental school to increase the number of dental student graduates completing a portion of their training in New Mexico. Data from graduates of other health professions indicate that trainees are more likely to practice in sites where they have received training. Finally, the division has also built a "circuit ride" relationship in several remote New Mexico communities to provide local dental services and to continuously update local provider skills.

3. *Expanding the pool of dental providers serving indigent and uninsured populations.* A key step was to convert an outdated and inadequate Medicaid fee schedule to one based on a percentage of "usual and customary" charges. The coalition was able to convince the New Mexico Human Services Department overseeing the state's 300 000 Medicaid recipients, as well as the state legislature, to support this increase. As a result, many more dental providers participate in the Medicaid program, and enrollees have improved access to locally available dental providers. Work is under way to include an oral health benefit in other publicly sponsored insurance programs through the Human Services Department's State Coverage Initiative (through a Robert Wood Johnson Foundation grant).

4. *Creating new interdisciplinary teams in accessible, community-based sites.* New models of interdisciplinary practice include a more independent practice of midlevel medical and dental hygienists who work alongside primary care physicians. In 1999, New Mexico adopted legislation to allow for the collaborative practice of dental hygienists. Hygienists can now work under the supervision of the medical director of each primary care facility and are part of the primary care team. As a consequence, during prenatal visits pregnant women may receive preventive dental services in conjunction with prenatal examinations. Prenatal, preventive, and primary care may now be provided seamlessly in health commons sites where there is no dentist. Young children may now have dental services at the time of scheduled immunizations, diabetic and cardiac patients can be closely monitored for dental problems, and adult uninsured patients may receive dental services. For cases requiring a higher level of expertise, the university dental clinics accept referrals from their primary care copractitioners, without the hassle of an additional registration or eligibility determination. While the model has been tested in urban community health center sites, it may have optimal utility in rural and remote practices.

5. *Developing oral health policy.* The success of innovative dental practice models was dependent on concurrent work on oral health policies such as Medicaid reimbursement and the expanded scope of dental hygienist practice cited earlier. Incremental steps provide small but important boosts to morale for the coalition. However, many obstacles remain, including an extraordinarily protracted state credentialing process for out-of-state dentists. New Mexico is 49th of the 50 states in per capita dentists, and long delays in the credentialing process result in loss of potential applicants for open dentist positions.

A creative plan to circumvent this obstacle is declaring an "Oral Health Emergency" for the state. Under this plan, the Department of Health, in collaboration with the New Mexico Dental Board, will develop and implement a temporary licensure program to recruit new and young practitioners to areas designated "health profession shortage areas" and areas where the proportion of dentists to patients is below the national average.

Increasing access to dental services in rural states and health profession shortage areas requires a comprehensive approach, including attention to enhancing dental service capacity, broadening the scope of the dental skills of locally available providers, expanding the pool of dental providers, creating new interdisciplinary teams in enhanced community-based sites, and developing more comprehensive oral health policy. By incorporating oral health services into the health commons model, access for uninsured and underserved populations is increased. A coalition of motivated stakeholders includes community leaders, safety net providers, legislators, insurers, and medical, dental, and public health providers. In the future, oral health may be an integrated component of community-based primary care in rural and medically underserved areas. ■

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Contributors

S. Beetstra, D. Derksen, and W. Powell prepared and revised the manuscript. D.E. Fry and A. Kaufman contributed to the "health commons" program design and helped with revisions of the manuscript. M. Ro contributed to the policy portions and the revision of the manuscript.

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