California Dental Association: Phased Strategies for Reducing Barriers to Dental Care in California

Phase 1 — Establishing State Oral Health Leadership and Optimize Existing Resources (Years 1-3)

Objective	Strategy	Rationale
1. State oral health infrastructure	a. Assist the state to hire a state dental director and staff responsible for developing, funding, and coordinating oral health activities. The dental director and his/her staff will be responsible for achieving the following: i. Developing a comprehensive and sustainable state oral health action plan ii. Securing funds to support infrastructure, and statewide and local programs iii. Advancing and protecting the importance of oral health within the Administration iv. Encouraging private and public collaboration v. Promoting evidence-based approaches to increase oral health literacy vi. Establishing a system for surveillance and oral health reporting	To effectively build and execute statewide oral health activities, the state needs a dental director, preferably a dentist with public health experience, an oral health epidemiologist, an administrative assistant, an analyst, and a program coordinator. Key to the success of this effort is sufficient staff to carry out essential functions of the office, including surveillance, program coordination and fund development. Additionally crucial is the strategic placement of the dental director within the state structure, ensuring the dental director is part of the executive team, intimately involved in the decision making process, and able to work across programs to ensure oral health inclusion. This recommendation is made first as it provides the foundation for key Phase 2 objectives.
2. Expand capacity within dental public health	a. Encourage and support dental professionals to obtain advanced degrees in public health	Dental public health leaders are needed to plan and implement programs, and advocate for the oral health of Californians. As the infrastructure at the state is rebuilt, more dental public health leaders will be needed to fill key roles at the state and local level in addition to filling advocacy roles at the federal level.
	b. Support incentives for dentists to establish practice in the public health sector	Dental loan repayment programs have proven to be a successful incentive for dentists to locate their practice in remote locations or dental public health settings, resulting in increased dental care to underserved populations. Though the large dollars required for each loan repayment grant effectively limits the scope of this type of program, each dentist provides essential dental care to thousands of patients over the loan repayment period. As such, loan repayment incentives continue to play an important role in bringing more dental care to underserved Californians.

2. Expand capacity within dental public health (continued)	c. Develop a pipeline for expanded function dental assistants to work in dental public health	There is strong evidence that allied dental personnel increase productivity of dental offices and clinics. In 2010, via AB 2637, California Registered Dental Assistants in Extended Functions (RDAEF) received additional restorative functions, allowable under the direct supervision of a dentist. This education and training is currently taking place in just a few locations and is expensive. This recommendation seeks to identify dental assistants in underserved communities who are interested in RDAEF practice, but are limited by financial barriers, and provide assistance in exchange for a commitment to work in a community health clinic or other public health setting.
3. Safety net expansion of dental services	a. Promote expansion of dental care in safety net settings; remove any perceived or real barriers to FQHCs providing dental care beyond their "4 walls" including contracting with private dental providers	In 2009, the U.S. Congress determined that federally supported health clinics (FQHCs) may contract with private dentists to provide dental services to health center patients in the dentists' private offices. The benefits of contracting include: • Dentists are able to – address the needs of their community by serving those who have the most need and the least access to care – provide services to Medicaid patients in their offices without enrolling in the program themselves, allowing them to avoid the billing and administrative burdens of the Denti-Cal program – predetermine through a contract with the FQHC the amount of time, number of patients, and/or number of visits they will devote to clinic patient care • Health centers are able to – meet their requirement to provide dental services – reduce the burden of expensive capitalization of dental facilities and equipment – reduce staffing requirements, expand the number of available dental providers in their communities, and stabilize their dental service costs • Patients have shorter wait times for appointments and more geographically diverse locations for care
4. Volunteer provision of care coordination	a. Support a coordinated process for the volunteer-based provision of care at the local level; optimize the contributions of retired dentists	Many individuals and organizations focus charity efforts on low-income and disadvantaged populations that experience barriers to dental care, and dentistry, with its strong commitment of service to the public, participates in many of these events. In order to organize and optimize the dental profession's participation in charitable events, CDA has endorsed Missions of Mercy (MOM) and moving forward will support community-based efforts in partnership with MOM. Additionally, many retired dentists are interested in staying active in a profession they love and willingly donate their time and expertise to "give back" to their communities. As a largely untapped and valuable resource for providing dental care to disadvantaged populations, engaging retired dentists more fully in charity care is mutually advantageous.

5. Fluoridation	a. Complete community water fluoridation in San Jose	Community water fluoridation (CWF) in California has tripled over the last 20 years – from 17 percent in 1990 to 58.8 percent in 2008 (the last year for which recorded data are available). In February 2011, the city of San Diego initiated CWF, providing fluoride's preventive benefits to an additional 1.3 million people. The next big effort, to bring CWF to San Jose, the largest non-fluoridated city in California, would raise the percentage of Californians with access to fluoridated drinking water to approximately 65 percent, or a total of 24,233,176 million people.
6. Expand capacity to provide children's care, especially to young children	a. Increase the ability of general dentists to provide care to children, especially children ages 0-5	The Affordable Care Act will provide dental benefit coverage to more than one million additional children in California by 2014. General dentists are an important resource for providing care for this newly insured population. However, studies show that relatively few general dentists have children enter their practices for regular care before the age of three years and 69.5 percent report that children were 20 percent or less of their patient pool. The CDA Foundation Pediatric Oral Health Access Program (POHAP) was developed specifically to address this and provides specialized training for dentists on dental care for very young and special needs children. In the seven years since its inception, 389 POHAP dentists have provided care for over 73,000 children under the age of 12. Increasing dentists' participation in POHAP, or other similar training programs, will increase the capacity of existing providers to care for children.
	b. Increase utilization of best practices in caries management by dentists and dental hygienists	A paradigm shift over the last decade in the management of dental caries recognizes caries as a chronic, infectious disease. Protocols that require early caries risk assessment, and prevention and treatment tailored to risk, are now best practice in dentistry (CAMBRA). This recommendation seeks to utilize resources in the most effective and efficient manner by increasing the number of dental professionals who employ best practices for risk assessment, prevention and management of dental caries.
7. CDA Foundation	a. Align the CDA Foundation's priorities and strategic plan with these phased strategies	The CDA Foundation's commitment to its mission *to improve the oral health of Californians by supporting the dental health profession in its efforts to meet community needs* has resulted in exciting and impactful research and programs. The Foundation plays an important role in the success of this proposal to reduce barriers to dental care and alignment of its strategic plan will be essential in the plan's implementation.

8. Workforce Capacity

a. Promote initiatives that utilize community health workers, such as promotores, in local oral health programs to provide case management, and other services that support improved oral health and oral health literacy	Community health workers, such as promotores, are highly effective at working in their communities to improve health outcomes. They are typically respected members of their communities who understand the cultural and social norms and are effective at helping people change their health behaviors. Their oral health literacy and case management activities increase health seeking behaviors, access to prevention, and receipt of comprehensive care.
b. Advocate for a scientifically rigorous study to answer questions regarding the safety, quality, cost effectiveness, and patient satisfaction of irreversible dental procedures. Limit study to California licensed RDHs and RDAEF2s with modular training on specified new duties for limited time and conducted under auspices of a California university. Any permanent changes to scope of practice require separate future legislation, and CDA's position on any future scope of practice change would require approval by the CDA House of Delegates. Study parameters were further defined by the CDA House of Delegates. See Resolution 1S6-2012-H	Study rationale: • The capacity does not exist to care for the 30 percent of Californians who suffer a disproportionate burden of dental disease. • Significant need calls for significant change; a comprehensive and multifaceted approach will be necessary, employing many strategies that individually and together address multiple barriers. • Additional dental providers who provide basic preventive and restorative oral health care to low-income children, in or close to where they live and go to school, when included as part of comprehensive approach to reducing barriers, have the potential to reduce the disease burden in the population most in need. These providers must be part of an integrated system that provides access to comprehensive care with the dentist as the head of that system. • The safety and quality of irreversible dental procedures delivered by dental providers worldwide has not been established through qualified research — research that is needed to make an evidence-based recommendation with regard to dental workforce changes. This research should commence immediately and, consistent with CDA's commitment to an evidence-based process, when the research is complete, CDA recommends that the research results be used to guide any further action regarding the dental workforce.

Phase 2 — Focusing on Prevention and Early Intervention for Children (Years 3-5)

Objective	Strategy	Rationale
1. Reach children in school-based/linked programs, WIC, Head Start and other public health settings	a. Support the re-establishment and expansion of school-based/linked programs for low-income children, focusing first on prevention and oral health literacy, with a long-term goal of comprehensive care	A successful school-based/linked program increases the number of children receiving preventive and restorative oral health care by providing care to children where they are located: at schools. Such programs eliminate many of the barriers that keep underserved children from receiving essential care, including lack of parental understanding of need, inability to find a dentist who accepts the child's dental insurance, or inability of the parent to leave work to transport the child to the dentist. National healthcare reform has made school-based dental disease prevention a priority and includes funding to all states to support these programs. Further, as it is most effective and efficient to *prevent* dental disease, early access to children is essential to reducing disease burden and the need for treatment. Partnerships with agencies responsible for the early care and education of children and families, such as Women, Infant and Children (WIC), Early Head Start and Head Start, and state preschools, should be established to reach children as early as possible. The goals of a California school-based/linked program are to: – Increase early prevention and decrease the rate of dental disease in children – Increase the number of children with a source of continuous, comprehensive dental care (dental home) – Establish a system of care at the local level – Decrease absenteeism
2. Utilize proven technology	a. Evaluate and support the expansion of quality and cost-effective technology solutions for providing oral health services to those who face difficulties accessing the dental office	Technology now exists to support distance collaboration between dentists and allied dental health professionals working in community settings, such as schools and long-term care facilities. Electronic collaborations are frequently used in medicine, but have been slow to be adopted in dentistry. However, they hold potential to bring more patients into the dental delivery system. In dentistry, allied dental health professionals working in community settings could collect diagnostic information, such as x-rays, photographs, and charting, and electronically transmit these records to a supervising dentist for diagnosis. This arrangement allows patients, while still in the community setting, to receive the care that is within the scope of the allied professional, and facilitates the provision of more complex care by the dentist by completing record collection and treatment planning prior to transporting patients to the dentist's location.

3. Expand early prevention through reimburse-ment incentives	a. Advocate for the augmentation of Medicaid rates for select services provided by dentists certified through an Access to Baby and Child Dentistry (ABCD) type program	The principle of the ABCD program is that starting dental visits early will yield positive behaviors by both parents and children, thereby helping to control the caries process and reduce the need for costly future restorative work. It focuses on preventive and restorative dental care for Medicaid-eligible children from birth to age six, with emphasis on enrollment by age one. Enrolled families receive case management and coaching about the need for early and preventive dental care, and dental office etiquette, including the need to keep appointments. Dentists and their teams receive training on techniques for examination, risk-assessment, prevention and treatment for very young children. ABCD certified general dentists receive enhanced Medicaid reimbursement for selected procedures for enrolled children.
	b. Support expansion of augmented rates program to commercial benefit plans	Promotion and support of best practices for risk assessment and prevention of dental disease in young children should be applied to all children, regardless of the payer source.
4. Fluoridation	a. Protect and preserve community water fluoridation throughout California; support efforts at the local level where opportunities arise	Fluoridation remains key to dental disease prevention in all sectors of the population. As challenges to community water fluoridation are likely to continue, support of community water fluoridation must be consistent and ongoing to maintain optimal fluoridation throughout California.

Phase 3 — Delivery System Innovations (Years 4-7)

Objective	Strategy	Rationale
1. Adult dental care	a. Advocate for the re-establishment of systems that provide adult dental care for Medicaid beneficiaries.	The recognition that oral health is integral to overall health grows steadily as scientific evidence mounts that the mouth is truly a window into the rest of the body. Further, there is pressure within the healthcare system to reduce costs and more effectively manage costly chronic diseases, such as diabetes and cardiovascular disease. National healthcare reform, mounting cost and health outcome pressures, and ongoing oral health advocacy at the federal level, are all likely to lead to dental coverage becoming a mandatory benefit for adult Medicaid beneficiaries within the next 5-10 years. When this occurs, there must be a functional network of providers who can provide that care.
	b. Identify and support initiatives that expand care to institutionalized, medically compromised and frail elderly	According to the U.S. Census Bureau, by 2030, approximately 18% of Californians will be over age 65, totaling over 8 million people. The Surgeon General's 2000 Report, *Oral Health in America*, identifies the frail elderly as an underserved population and notes that at any given time, approximately 5% of adults are living in a long-term care environment that faces challenges in meeting the oral health needs of its residents. California has Registered Dental Hygienists in Alternative Practice (RDHAPs) authorized to provide periodontal care in long-term care facilities now, but the need is much greater than is being met, must include a fuller range of essential care, and will only continue to grow as the first full generation of dentate Californians age. Providing oral health care to seniors, especially in institutional settings, is a complex problem that will require greater collaboration of skilled dental teams, relevant agencies, and stakeholders to address. Non-profit and public partnerships at the local level become especially important in optimizing resources necessary for sustainability of non-traditional delivery models that provide care to impacted populations (e.g. Apple Tree Model).

2. Hospital-based treatment	a. Identify and promote initiatives to increase the capacity of hospitals to provide dental treatment	Significant inefficiencies now exist with regard to hospital emergency rooms' response to patients presenting with treatable dental conditions. Without on-site ability to provide dental care, ERs are limited to providing prescriptions to alleviate pain and infection, along with a recommendation for the patient to seek the care of a dentist. This often results in a revolving door of visits to the ER – a costly and inefficient use of resources. This recommendation seeks to impose a requirement for hospitals to dedicate space for dental services if/when they expand their facility or build new facilities, and partners with a recommendation outlined below for a required post-graduate year of residency for dental licensure in California.
3. Workforce capacity	a. Support optimization of the dental workforce's capacity to provide care	CDA policy is committed to the dentist as the head of the dental team in a single integrated system of oral health care, supports programs that improve the delivery of oral health care to California's underserved populations, and encourages the use of well-trained dental team members in the provision of care. Research shows that use of highly trained dental teams results in increased care. California has some of the most highly trained allied dental personnel anywhere in the country. Policies and activities that promote the full utilization of dental team skills will maximize the dental delivery system's capacity to provide care. This Phase 3 dental workforce recommendation takes into consideration that five to seven years after initial implementation of the proposal allows sufficient time for the research proposed in Phase 1, and the impact of early initiatives to be evaluated.
	b. Support increased graduate residency opportunities for general dentistry in California	This recommendation seeks to increase the number of graduate residency opportunities for general dentistry through increased funding, incentives, and information sharing with dental students regarding issues of access/barriers to care. *(Modified recommendation by CDA House of Delegates)* Residency programs increase learning opportunities for dental school graduates and increase confidence and skill, especially in the provision of complex care and care to people with complex needs. Residency programs are also an opportunity to expose new graduates to non-traditional work environments such as hospitals and community clinics. Findings from research by the Center for California Health Workforce Studies at the University of California, San Francisco on the impact of a requirement for a year of "service and learning" in an accredited residency program indicate residency programs increase oral health services to underserved populations.