Responding to California's Dental Health Care Crisis

Thursday, June 26, 2008
1:00 p.m. To 3:00 p.m.
Capitol Building
Room 112
Sacramento, California

Agenda

Welcome and Introductions
1:00 p.m. Gilbert Ojeda, Director, CPAC, U.C. Berkeley, School of Public Health

Presentations
1:10 p.m. Oral Health Disparities among Latinos in California: Implications for a Binational Agenda
Francisco Ramos-Gomez, DDS, MPH, Professor, UCLA School of Dentistry

1:35 p.m. Improving Access to Care for California's Adult Immigrants and Their Children: Empirical Analyses, Policy Simulations, and Recommendations
Tim Brown, PhD., Professor, Associate Director of Research, Petris Center, UC Berkeley

2:00 p.m. Registered Dental Hygienists in Alternative Practice:
Current and Future Contributions to Increasing Access to Dental Care
Beth Mertz, MA, Project Director, Center for Health Professionals, UCSF

2:25 p.m. Reactor Panel:
Dental Health Foundation:
Jared Fine DDS, MPH, Dental Health Administrator, Alameda County Public Health Department

California Dental Association:
Liz Snow, Chief Strategy Officer for the California Dental Association

2:45 p.m. Questions and Comments

3:00 p.m. Adjourn
Oral Health Disparities among Latinos in California: Implications for a Binational Agenda

Francisco Ramos-Gomez, DDS, MS, MPH
Professor UCLA Section Pediatric Dentistry
CPAC-UC California Program on Access to Care
Frg@dentistry.ucla.edu
Sacramento June 26th, 2008
Latino Demographics in CA

• One out of 3 Californians is Latino

• 44% of US Mexican immigrants live and work in California

• San Diego has the largest binational population in the entire country
Percent of Population 2006
Hispanic or Latino

Source: U.S. Census Bureau, Population Estimates, July 1, 2006
Tooth decay is the single most common chronic childhood disease...

Five times more common than asthma
Seven times more common than hay fever
51 million school hours lost annually

12 X lost days for children from low-income families
Background and Significance

- Latino children have higher rates of untreated dental disease than any other children in California.
- Poor oral health has been associated with multiple medical problems.
- Oral health problems can also lead to pain, poor nutrition and development, impaired speech, loss of employment, time away from school, and low self-esteem.
EARLY CHILDHOOD CARIES

Chronic Infectious Disease that is transmissible but PREVENTABLE
Poor children and children of color are more likely to have tooth decay and suffer the consequences of untreated disease.
Key Statistics (General Health)

• Only 65% of Latino children reported a “very good” health rating (compared to 90% of white children)

• 87% of Latino children showed “poor or fair” health ratings
Key Statistics (Dental)

- Latino children are at the highest risk of not having seen a dentist
- More than 50% of Latino children showed a “suboptimal” condition
  - 72% had dental caries
  - 26% had rampant dental caries
  (this figure is nearly twice the rate for non-Hispanic whites)

* 2006 California Smile Survey
Findings

The following factors contributed to the unmet dental needs of California’s Latino population:
1. Lack of dental insurance
2. Lack of education about dental care
3. Lack of diversity and cultural competency among dental providers
4. Lack of access to dental care, including transportation and work leave time
Lack of Insurance

• Latinos are the most uninsured ethnic group in the United States

• The percentage of employers who offered health insurance fell from 69% in 2000 to 60% in 2005

• Lack of dental insurance leads to many low income Latinos to avoid preventive dental visits, and it puts added strain on emergency departments
Lack of Education

Due to lack of education about dental care:

• Latino mothers often do not understand the connection between diet and tooth decay

• Many Latino families avoid drinking household tap water
  – Latino children do not receive the recommended levels of fluoride found in most California water supplies
Lack of Diversity and Cultural Competency among Dental Providers

• In 2000, only 4.6% of the licensed dentists in California are Latino.

• For every one Latino dentist there are 9,446 Latino individuals, compared to 950 non-Latino individuals for every non-Latino dentist.

• Between 1983 and 2000, the number of Latino dentist obtaining licenses to practice in California dropped by nearly 80%.
Lack of Language Ability

• Half of California’s Latinos reported “difficulty speaking English” or speaking English less than “very well”

• However, fewer than 2% of non-Latino dentist speak Spanish

• In contrast, more than 33% of Latino dentists speak Spanish, but the low numbers of Latino dentists can’t serve the large Latino population
Lack of Transportation and Time

• Taking time off from work to bring a child to dental visits is often too high price for Latino parents
  – Loss of income and fear of dismissal from employment may cause parents to postpone a child’s dental treatment
  – Some parents may postpone their children’s dental needs until they qualify for Denti-Cal
• Postponing dental treatment may turn minor dental problems into major dental complications and urgent care
Binational Oral Health Task

Dental health areas in need of binational efforts:

Implementing advocacy and policy programs to improve the dental health of Latinos focusing on pregnant women and their infants

Providing culturally sensitive dental education to Latino patients and providers

Exploring new dental services and new access options for Latinos

Expanding the dental health workforce to include more Latinos
Policy Implications and Recommendations

The State of California and the Mexican Ministry of Health should focus in four specific partnership areas:
1) Develop binational community based models to provide oral health services for pregnant Latino women and their infants

• Prenatal care during the first trimester of pregnancy is essential

• Dental professionals should educate expectant mothers about how their own health directly affects the health of their baby

• Because parenting is often a collaborative effort in Latino communities, community based models are essential to improving oral health among Latino children
MAYA PROGRAM COLLABORATION UCSF-UCLA WITH SYHC CANDO
2) Encourage dental providers to offer oral health services for children ages 0-3

• Many dental associations recommend that children have their first dental visit by age one, but few providers are performing this visit

• Addressing dental problems at an early age can prevent the need for more costly and invasive dental treatment in the future
Prevalence of Dental Decay

Dental decay is the most common chronic disease of childhood

- **1 Year Olds**: 8% decay, 92% no decay
- **2 Year Olds**: 22% decay, 78% no decay
- **3 Year Olds**: 35% decay, 65% no decay
- **4 Year Olds**: 33% decay, 67% no decay
Lactobacilli
• Infant Oral Care programs including fluoride varnishes and fluoridation of community water supplies = low cost options that reduce dental caries

• Anticipatory Guidance and Self-management goals targeting Latino caregivers

• Starting prevention early (during pregnancy and in the first years of life) and providing early dental treatment can yield cost savings in the treatment of other medical conditions
PROMOTING INFANT ORAL CARE VISIT
TWO IS TOO LATE !!!
3) Develop binational programs exploring alternative options

- Different System Change - Re-Design models
- School based clinics
- Teledentistry / Telemedicine
- CAMBRA- RISK ASSESSMENTS in pediatricians offices
- Training the medical/nursing community
- WIC, Early HeadStart and Mobile dental clinics
- DIFFERENT MODELS OF ACCESS AND DELIVERY
- Binational collaboration with Mexico and other border states
- UNIVERSAL HEALTH CARE PLAN INCLUDING DENTAL
CAMBRA - RISK ASSESSMENT TOOL
4) Develop binational programs to increase the diversity and cultural sensitivity of the dental workforce

• Increased cultural competency allows dental providers:
  – To draw out relevant patient information
  – Makes patients more willing to follow a dentist recommendations
  – Makes patients less likely to postpone necessary treatment

• California Pipeline Project

• Address issues of lack of Latino representation in dental schools in CA
Oral health means much more than healthy teeth. Oral health is essential to the general health and well-being of all Americans and can be achieved by all.

The costs and consequences associated with unmet dental needs among California Children are too great to ignore!
Thank You!
Preliminary Findings
Access to Dental Care for California’s Adult Immigrants and Their Children

Timothy T. Brown, PhD
Tracy Finlayson, PhD
Salar Jahedi

June 26, 2008
Responding to California’s Dental Health Care Crisis
Funding

California Program on Access to Care

Nicholas C. Petris Center

June 26, 2008
Access to Dental Care

• Introduction: The Importance of Oral Health

• Does Immigrant Status Really Matter?

• Access and Need among Immigrants

• The Demand for Dental Care

• Conclusions and Policy Implications
The Importance of Oral Health

- Oral diseases are major cause of
  - Infection
  - Tooth loss
  - Debilitating pain

- Dental care associated with
  - Lower cardiovascular disease risk
  - Better birth outcomes

- Dental habits begin in childhood
  - Self-care
  - Professional care
Does Immigrant Status Matter?

• Likelihood of adult dental visit in past year?
  – Does English fluency matter?

• Likelihood of child dental visit in past year?
  – Does parental English fluency matter?
Access and Need among Immigrants

Responding to California's Dental Health Care Crisis

June 26, 2008

CPAC
Dental Health Foundation

Petris Center analysis of 2003 California Health Interview Survey
Responding to California's Dental Health Care Crisis

June 26, 2008

CPAC Dental Health Foundation

Petris Center analysis of 2005 American Community Survey

Median Earnings

Thousands of $ (2004)

- Immigrants
- US-born

Men

Women

Petris Center analysis of 2005 American Community Survey
Responding to California's Dental Health Care Crisis

Petris Center analysis of 2005 American Community Survey
Responding to California's Dental Health Care Crisis

June 26, 2008

CPAC
Dental Health Foundation

Petris Center analysis of 2005 American Community Survey
The Demand for Dental Care

• Economic demand ≠ need

• Demand is function of
  – price/insurance
  – family income
  – preferences (demographics, social capital)

• Are immigrants any different?
  – Citizenship
  – English fluency
  – Time in U.S.
The Demand for Dental Care

• Data
    • Adult samples: 55,500(2001); 42,000(2003); 44,500(2005)
    • Child samples: 12,500(2001); 9,000(2003); 9,000(2005)
  – County Business Patterns – Petris Social Capital Index
## The Demand for Dental Care (Dental visit in previous 12 months)

<table>
<thead>
<tr>
<th>Adult</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dental insurance</td>
<td>• Dental insurance</td>
</tr>
<tr>
<td>• Poverty level</td>
<td>• Poverty level</td>
</tr>
<tr>
<td>• Years in U.S.</td>
<td>• Years in U.S.</td>
</tr>
<tr>
<td>• Citizenship</td>
<td>• Citizenship</td>
</tr>
<tr>
<td>• English fluency</td>
<td>• English fluency (of RA)</td>
</tr>
<tr>
<td>• Social capital</td>
<td>• Social capital (of RA)</td>
</tr>
<tr>
<td>• Gender</td>
<td>• Gender</td>
</tr>
<tr>
<td>• Age</td>
<td>• Age (of RA also)</td>
</tr>
<tr>
<td>• Race/ethnicity</td>
<td>• Race/ethnicity</td>
</tr>
<tr>
<td>• Marital status</td>
<td>• Marital status (of RA)</td>
</tr>
<tr>
<td>• General health status</td>
<td>• General health status (of RA also)</td>
</tr>
<tr>
<td>• County-level fixed effects</td>
<td>• County-level fixed effects</td>
</tr>
<tr>
<td>• Year fixed effects</td>
<td>• Year fixed effects</td>
</tr>
</tbody>
</table>

RA = responsible adult
The Demand for Dental Care
(Dental visit in previous 12 months)

- **Key Findings - Adults**
  - Citizenship (naturalized)  No difference
  - Non-citizen  No difference
  - English fluency  No difference
  - Years in U.S.  No difference

- **Key Findings - Children**
  - Citizenship (naturalized)  No difference
  - Non-citizen  No difference
  - English fluency  No difference
  - Years in U.S.  (difference in some models)
Important Characteristics Associated with Dental Care

**Adults**
- Dental insurance
- Education
- Gender
- Poverty level
- General health status
- Marital status
- Age
- Race/ethnicity

**Children**
- Age
- Dental insurance
- Education (of RA)
- Age of RA
- Race/ethnicity
- Poverty level

Ordered by importance. RA = responsible adult
Conclusions & Policy Implications

• The same set of characteristics are associated with whether immigrants or U.S. born seek dental care

• Policies aiding the disadvantaged among the U.S. born will aid immigrants that are eligible (and those currently ineligible provided policy changes make them eligible)
Conclusions & Policy Implications

• Education campaign:

\textit{Medi-Cal = Denti-Cal}

• Expand Children’s Dental Disease Prevention Program
Increasing Access to Dental Care in California
Registered Dental Hygienists in
Alternative Practice (RDHAP)

Responding to California’s Dental Health Care Crisis
California Program on Access to Care

Beth Mertz, MA
June 26, 2008
Project Funding

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- California Dental Association
- HRSA, BHPr, Center for Health Workforce Information and Analysis
- NIH, NIDCR, Center to Address Disparities in Children’s Oral Health at UCSF
- California Dental Hygiene Association
Overview

• History of Independent Dental Hygiene
• Legislation and Regulation in California
• RDHAPs and Access to Care
  – The people
  – The business of practice
  – The practice environment
  – Patients and systems
• Conclusions & Recommendations
Brief History of Dental Hygiene

Who are RDHAPs and how did they get here?

- 1900s – Resistance to assistants
- 1950s / Post-WWII – Desperation for assistance
- 1970s – Increase in female workforce
- 1980s & 1990s – Health care markets and access to care
- 2000 and beyond – Health disparities mar the oral health landscape
- 2008 – New workforce models, including advanced and independent hygiene, gaining traction nationally

Nothing radical or new about the idea of independent dental hygiene, has been in development for 50+ years.
Legislative/Regulatory Background

  - Two Health Workforce Pilot Projects (HWPP)
  - Two lawsuits filed by CDA to stop implementation
  - Final compromise to enactment restricted independent practice to underserved areas
  - Five years “legal” before implementation of an education program
- Ongoing issues include:
  - Denti-Cal payment, prescription requirement, referral agreement, scope of practice, self-regulation
### Comparison of Professional Practice Agreements in California

<table>
<thead>
<tr>
<th></th>
<th>Supervision Requirement</th>
<th>Expanded Scope of Practice</th>
<th>Agreement Type</th>
<th>Institution Role in Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>RDHAP</td>
<td>No</td>
<td>No (limited)</td>
<td>Documented DDS Relationship (for licensure)</td>
<td>No</td>
</tr>
<tr>
<td>Public Health Hygienists</td>
<td>Yes-General</td>
<td>No</td>
<td>Standing Orders or General Supervision</td>
<td>Yes</td>
</tr>
<tr>
<td>Direct Entry Midwife</td>
<td>No</td>
<td>No</td>
<td>MD Referral Agreement (for practice)</td>
<td>No</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>No</td>
<td>Yes</td>
<td>Standardized Procedure</td>
<td>Yes</td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
<td>No</td>
<td>Yes</td>
<td>Standardized Procedure</td>
<td>Yes</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>Yes - Direct</td>
<td>Yes</td>
<td>Delegation of Services Agreement</td>
<td>Yes</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>No</td>
<td>Yes</td>
<td>Standardized Procedure</td>
<td>Yes</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>No</td>
<td>Yes</td>
<td>Standardized Procedure</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The Process of Expanding Access

- **Who does it and why?**
- Which people need access?
- What is the process required?
- How does the environment impact practice?
RDHAP Distinctive Workforce Characteristics

- As a group, compared to RDH’s they:
  - Are more educated
  - Are more racially/ethnically diverse
  - Are more active in the labor market
  - Work longer hours per week with more administrative time
  - Are more likely to consult with other health care providers
  - Are more likely to see special needs patients
  - Provide a broader range of services within their scope
  - Are more likely to work in non-traditional settings
  - Express a commitment to professional growth, access to care and service to underserved populations and communities
Motivations

Pushes

– Dissatisfaction with private practice
– Concerns regarding quality of care they can provide in dental offices
– Frustration with not being able to see patients with special needs in private practice

Pulls

– Mission driven – desire to serve communities, freedom to develop own business
– Independence - pioneering, resilient
– Professional rewards - autonomy, choice, agency, teamwork within other health systems
The Process of Expanding Access

• Who does it and why?
• **Which people need access?**
• What is the process required?
• How does the environment impact practice?
RDHAP Patients & Settings

- Homebound and institutionalized elderly
- Developmentally disabled / residential care homes
- Denti-Cal patients
- Rural children and families
- Migrant farm workers
- Pregnant women and their children / WIC
- Community clinic clients
- Public health clients
- State institutionalized adults
The Process of Expanding Access

- Who does it and why?
- Which people need access?
- **What is the process required?**
- How does the environment impact practice?
The Business of Practice

• Business plans
  – Developed in RDHAP education programs; sometimes specialty studies are pursued by RDHAPs
  – Clinicians, case managers, multiple roles and sites

• Developing payment structures
  – What will I charge?
  – Who will I charge and how?

• Start up money and equipment
  – Mobile equipment runs $25K, need small business loan, and must develop patient charting systems

• Building the business
  – Strategies vary by setting and community
  – Diversification of activities helps mitigate risks
  – Creating awareness of services for consumers as well as health care systems

• Overcoming resistance / Building relationships
The Process of Expanding Access

• Who does it and why?
• Which people need access?
• What is the process required?
• How does the environment impact practice?
Structural Conditions of Practice

• Laws/Regulations
  – Allow RDHAP practice but also limit it
  – Title 22/OBRA (nursing home regulations) – vague construct creates confusion

• Care systems
  – Nursing homes, long-term care settings, schools, clinics, etc

• Payment systems
  – Denti-Cal, patient self-pay, insurance companies

• Local (anti)-competitive practices
  – Lawsuits, exclusion from local health care institutions, slanderous marketing, betrayal of trust, exclusion of suppliers or collaborators, etc...
Conclusions

- The *combination of professional independence and a required focus on underserved populations* is powerful in both motivating and structuring RDHAP practice.
- The *diversity of strategies* employed by RDHAPs in developing their practices has opened up multiple pathways to creating and improving access to dental care.
- The independence of RDHAPs as providers allows them the *freedom and flexibility to reach out to patients* in new and creative ways.
- New *collaborative practice models*, with dental, medical, and other caregivers will be needed to transform these innovations into comprehensive care delivery for patients.
- Meeting the challenge of transforming the system and reconnecting oral health with overall health will require a *professional commitment* to ensuring a high quality workforce, a *regulatory environment* flexible enough to allow for innovation, and a *care delivery system* that is consumer-responsive and affordable.
Policy Recommendations

1. The State should grant licensure for RDHAPs based on qualifications, and should eliminate prescription requirements for dental hygiene services provided by RDHAPs. Patients should have their choice of a dental hygiene care provider, and the public should not need a prescription to receive basic preventive care.

2. The State should appoint an independent committee to review, and make recommendations to the legislature on “scope of practice” matters. This practice allows for a less politicized review of efforts to increase the capacity of the health workforce, and it is operating successfully in many other states and countries. In addition, the State should encourage competency based health care practice models which are flexible and responsive to community health care needs. The State should also restructure professional boards in a way that allows each profession to regulate its own members.

3. The State should encourage reciprocity across state lines for all new dental workforce models. New models include the Advanced Dental Hygiene Practitioner model developed in Minnesota, and the Dental Health Aide Therapist model developed in Alaska. New models for dental and hygiene education can help ensure a high quality workforce.
Policy Recommendations

4. Denti-Cal should maintain reimbursement rates at levels that sustain dental hygiene services, and should expand reimbursement to RDHAPs for non-clinical services, such as case management, health education, and prevention services. RDHAPs should be able to bill for their services as a corporation.

5. Denti-Cal and Medi-Cal should be integrated to develop a comprehensive data infrastructure. Such an infrastructure would be capable of tracking health care expenditures, health care utilization, health diagnoses, and health status. Integration could lead to new research for quality of care improvements, and shed light on health care savings attributable to preventive dental care (i.e. examining health cost savings for diabetes treatment resulting from preventive dental care treatment). Policy makers might consider incentives for the oral health community to develop better quality of care measures, such as developing health outcomes measurements.
6. The State should revise regulations within long-term care and skilled nursing facilities to include more specific oral health standards, and allow more flexibility to meet these standards through collaborative dental service models.

   RDHAPs should be eligible to fulfill the Title 22 provider requirement for a dental program in nursing homes. RDHAPs are well suited, both in skill set and practice model, to be on-site primary dental care practitioners, providing preventive and educational services in these settings.

7. The State should continue to encourage doctors and dentists to work with underserved populations.

   For RDHAPs, working with underserved populations is a practice requirement. A set of similar mandates for other dental practitioners may go a long way towards improving access to the restorative and surgical treatments needed by many underserved individuals.
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