

EXPANDING CALIFORNIA'S DENTAL TEAM TO CARE FOR UNDERSERVED CHILDREN

New Times, New Solutions

By

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Introduction

Good dental health is critical to children's ability to grow up healthy. Yet, millions of California's children suffer needlessly from poor dental health. Certain populations of children—such as those enrolled in Medi-Cal and the Healthy Families Program (California's Medicaid and Children's Health Insurance Programs), young children, and children with special health care needs—are simply not getting the dental care they need. There are not enough dentists to serve these populations.

Moreover, many low-income families have trouble accessing the traditional office-based dental care delivery system. They may not have access to affordable transportation, lose pay when they miss work, are juggling multiple jobs, must arrange and pay for child care for other children, or live in remote areas where no dentists who treat these children are located.

This problem is only expected to get worse. With full implementation of the Patient Protection and Affordable Care Act (ACA), approximately 1.2 million additional children in California are expected to gain dental coverage.

Elizabeth's Story

The following hypothetical scenario illustrates how the reform called for in this Issue Brief—expanding the dental team—could provide California's most vulnerable children with the dental care they need.

Susan and Robert Johnson live with their eight-year-old daughter, Elizabeth, in a small town near the Sierra Nevada mountain range in California. Robert works in construction, but work has been scarce since the economic recession began a few years ago. Susan works part-time at a local grocery store and is going back to school so that she can earn more money to better help support the family. Elizabeth has dental coverage through Medi-Cal, California's Medicaid program.

Elizabeth has been complaining about her teeth hurting for a couple of months. However, there are no dentists in their hometown who accept Medi-Cal, and there are only two dentists in the entire county that take it. One is 25 miles away, the other 50 miles. Both of them limit the number of their Medi-Cal patients so there was a long wait to get an appointment. Susan and Robert were also concerned with having to take off time from work, losing pay and the transportation costs of the long round trip, which they could ill-afford. Therefore, not only was it difficult to see a dentist for the presenting issue, Elizabeth rarely saw a dentist for preventive care.

While the Johnsons tried various home remedies to provide relief, the pain in Elizabeth's mouth caused her to miss several days of school. Eventually, the pain was so severe that they took Elizabeth to the emergency room, where she was diagnosed with a tooth abscess and multiple cavities. She was sent to a dental surgery center more than 100 miles from the Johnsons' home, where the infected tooth was extracted and the cavities in the other teeth were filled under general anesthesia.

Elizabeth's suffering, the missed school, the family's lost income, and the high cost to taxpayers of emergency treatment could have been avoided if Elizabeth was able to get early preventive dental care in her community. Expanded workforce models could fill the dental care gap for children like Elizabeth. More than 50 other countries and many Alaskan Native communities are deploying a different type of workforce model—one that uses an allied dental provider to provide cost-effective, high-quality dental care to their most vulnerable populations. These providers work under the supervision of a dentist and have a carefully defined scope of practice.

If such a provider existed in California, Elizabeth could have received dental health education, preventive care, and routine treatment—such as simple fillings and extractions—at her school, a clinic, or another community site near the Johnsons' home. With treatment accessible locally, Elizabeth's cavities could have been treated early with fillings—preventing an abscess, risk of more serious infection, and tooth loss. She would have had a healthy mouth and been free of pain, and her education would not have suffered. Her parents would not have had to miss work, and taxpayers would have saved money.

While coverage is a necessary step toward access, a new insurance card will not translate into needed dental care. Instead, this will lead to an even greater mismatch between the number and location of available providers and their ability to provide services for the increasing number of children needing dental care.

Addressing the dental access problem requires a comprehensive approach. An essential element is to expand the dental team to include providers whose scope of practice is narrower than that of dentists, but who can safely deliver urgently needed, high-quality preventive and routine restorative dental care in places where children who would otherwise go without care are located.

More than 50 other countries and native communities in Alaska have seen significant increases in access to dental care and improved dental health among children as the result of the deployment of expanded workforce models. In California, which is home to one of every eight children in the United States, expanding the dental team will ensure large numbers of children receive the dental care they so desperately need.

The Children's Partnership developed this Issue Brief to inform leaders and the public of how innovations in the dental workforce can improve children's access to dental care, while saving taxpayer dollars due to children receiving appropriate care. This Brief provides an overview of the challenges faced by California's children and their families in accessing necessary dental care and outlines a workforce innovation designed to bridge the supply gap between existing providers and California's most vulnerable children.

"There are so many good, hard-working families who are unable to get quality dental care for their children."

— Isabel Najera
Mother of Three
Watsonville (Santa Cruz County), CA

"A recent assessment at our schools showed that two-thirds of kindergarteners had visible tooth decay or fillings. Kids simply aren't getting the dental care they need. This often results in pain, inability to concentrate, and poor school performance. Having a dental provider come to our schools will not only ensure children get the dental care they need, but it will also help close the achievement gap."

— Kimberly Uyeda, MD, MPH
Director, Student Medical Services
Los Angeles Unified School District

The proposed workforce model outlined in this Brief will ensure that providers within it are members of the dental team with a dentist providing supervision. An expanded workforce model may include added duties for existing members of the dental team, such as dental assistants and dental hygienists, as well as the creation of new members. Finally, a training system will be created that allows trainees to enter either at the beginning or at different stages, depending on how much training they have when they enter the program.

As important as expanding the dental workforce, a system that supports such providers must be in place in order for a new workforce model to be successful. This Brief recommends policy changes to ensure the model is financially sustainable, such as ensuring telehealth services are reimbursed and ensuring providers who improve children's dental health through such services as prevention are compensated appropriately.

Dental Health Care Needs of California's Children

Nationally and in California, tooth decay ranks as the most common chronic disease and unmet health care need of children.¹ Despite the recommendation by the American Academy of Pediatric Dentistry that children visit the dentist at the time of first tooth eruption and no later than one-year-old and that they have a dental check-up every six months after that, nearly one-

quarter of California's children between the ages of zero and 11 had never been to the dentist in 2005.²

To illustrate this lack of access to dental care, a 2009 oral health assessment of children's dental care needs in Los Angeles County found that 81 percent of children needed dental care. Seventy-two percent needed early dental care (within 15 days), and 9 percent needed urgent care (within 24 hours).³ Given that a significant portion of California's children do not have access to regular, preventive dental care, it is not surprising that 71 percent of children statewide experience tooth decay by the time they reach the third grade.⁴

While the utilization of dental care is below optimal levels for many of California's children, certain groups—such as minority children, low-income children, those enrolled in public health programs, and young children—experience marked difficulty getting care. For example, Latino and African American children in California are more likely to have never visited a dentist and to have experienced longer periods between dental visits than Asian American and white children.⁵ Furthermore, among children enrolled in the Healthy Families Program, African American children received services at the lowest rate among children of all ethnicities in 2009.⁶

- One in four children in California between the ages of zero and 11 has never been to a dentist, despite the recommendation that children have their first dental visit no later than one-year-old and a dental check-up every six months after that.
- Only one in seven children between the ages of zero and three enrolled in Medi-Cal received dental care in 2008.

Nationally, one-third of Latino children have untreated cavities, compared to 20 percent of white children.⁷ Finally, low-income children experience twice as much dental disease as their higher income peers.⁸

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Children enrolled in California's public health coverage programs face particular obstacles to obtaining dental care. Nearly half of all children enrolled in Medi-Cal and the Healthy Families Program did not have a dental visit in 2009.⁹ This is due, in part, to the limited number of dentists who treat children enrolled in these programs. In fiscal year 2009-2010, only 35 percent of dentists in California treated children enrolled in Medi-Cal. And, of those, only one-quarter saw 80 percent of the children,¹⁰ meaning that there is a limited supply of dentists willing to treat significant numbers of children enrolled in Medi-Cal. This situation is sure to get worse as the State recently reduced Medi-Cal reimbursement rates by 10 percent for dental providers, effective June 1, 2011.

To confirm these statistics, an evaluation of a statewide oral health education and training program in California revealed that, of parents who reported problems with finding a dentist, almost half cited not being able to find a dentist who accepted Medi-Cal.¹¹ Similar to statewide data, a study of dentists in Solano County found that only 18 percent of dentists in the county accepted Medi-Cal, and, of those, the majority only saw a small number of children enrolled in Medi-Cal. At the time of the study, most were not taking new Medi-Cal-enrolled patients.¹² Finally, only 18 percent of dentists surveyed for this study treated children enrolled in the Healthy Families Program.¹³ Of great significance is that one-third of the dentists surveyed said that no changes to Medi-Cal (such as higher reimbursement rates or changes to the administration of the program) could encourage them to participate in it.¹⁴

In addition, young children disproportionately face barriers to obtaining dental care. A 2003 national survey by the American Dental Association (ADA) of general dentists found that, while approximately 90 percent of respondents claimed to treat children, in reality, general dentists were not seeing children younger than age four.¹⁵ An oral health evaluation in Los Angeles County identified less than half (44 percent) of clinics participating in the study as serving children two-years-old or younger.¹⁶

These realities contribute to the low utilization of preventive dental care by young children. For example, children enrolled in the Healthy Families Program under the age of six were the least likely to have received any type of dental service in 2009,¹⁷ and less than 14 percent of children between the ages of zero and three enrolled in Medi-Cal received dental care in 2007-08.¹⁸ For this and other reasons, most of California's children who end up in the emergency room for preventable dental conditions are five and under.¹⁹

The Importance of Good Dental Health for Children

Poor dental health can disrupt normal childhood development, seriously damage overall health, and impair children's ability to learn, concentrate, and perform well in school.²⁰ In rare but tragic cases, untreated tooth decay can lead to death as it did for 12-year-old Deamonte Driver of Maryland, who died in 2007 from a brain infection due to untreated dental disease.²¹

Close to half of California's counties had higher rates of emergency room visits for dental conditions than for asthma and diabetes.

While Deamonte's story is not typical, many children suffer with pain, abscesses, facial swelling, sinus infections, and sleep loss. Dental disease can lead to children's limited ability to eat certain foods, leading to poor nutrition.²² Moreover, decay in primary teeth is a significant

"What goes on in your mouth shapes and forms your whole being, in my opinion. If we're concerned about our kids' overall health, dental care is important. If we want them to grow into productive members of society and get employment and get further education, this is important."

— Leah Davis
Guardian of Two Nieces
Camarillo (Ventura County), CA

predictor of decay in permanent teeth, meaning children with poor dental health grow up to be adults with poor dental health.²³ In addition, poor dental health is increasingly being linked to long-term, costly chronic conditions, such as heart disease, stroke, and Alzheimer's disease.²⁴

In 2007, more than a half-million of California's school-aged children missed at least one school day due to a dental problem—a total of 874,000 missed days—which translates to a statewide average loss of nearly \$30 million in attendance-based school district funding.²⁵ Aside from financial losses to California's struggling school districts, poor dental health impairs students' ability to learn, hindering efforts to close the achievement gap. It is well known that missed school days are linked to poorer achievement, especially for low-income children.²⁶

Many of the children who miss school due to dental problems live in families without the resources to afford necessary preventive and therapeutic treatment. A study showed that, among California's children who missed school for dental problems, those who needed dental care but could not afford it were much more likely to miss two or more school days than those whose families could afford it.²⁷

When their children experience pain, fevers, and infections as a result of poor dental health, families with limited access to dental care often have little choice but to bring their children to the emergency room for care. In 2007, there were over 83,000 emergency room visits for preventable dental problems at a cost of \$55 million.²⁸ This rate of emergency room visits for

preventable dental problems is a 12 percent increase from 2005. Close to half of California's counties had higher rates of emergency room visits for dental conditions than for asthma and diabetes.²⁹

In comparison to counties with large urban centers, rural counties experienced proportionately higher rates of emergency room visits for dental problems.³⁰ However, urban areas still experience significant rates of emergency room visits for dental problems. A study of underserved families in Los Angeles County found that 9 percent of parents reported visiting the emergency room or their child's medical doctor for dental care after failing to access dental care from a dental provider.³¹

Untreated decay not only harms children and families, but emergency room and hospital-provided care for preventable dental problems is a poor use of taxpayers' and families' dollars. Hospital-provided dental care, including emergency room care, ranges from \$172 to \$5,044 per encounter compared to a \$60 comprehensive dental exam.³²

On top of burdening an already overloaded system with avoidable costly care, emergency room dental care is often inappropriate and ineffective. A Minnesota study on preventable emergency room visits due to dental problems found that while acute pain and infection were treated, the underlying dental problem was often not resolved.³³ Instead of performing fillings and providing other restorative care, emergency room physicians may be limited to prescribing antibiotics, which provide temporary relief but not a permanent solution.

- Nearly one million children in California live in Dental Health Professional Shortage Areas.
- Of California's 58 counties, only five do not have Dental Health Professional Shortage Areas.

The Cost of Poor Dental Health

- California's 874,000 missed school days due to dental problems in 2007 translate to a statewide average loss of nearly \$30 million in attendance-based school district funding.
- In 2007, there were over 83,000 emergency room visits for preventable dental problems in California at a cost of \$55 million.
- An average comprehensive dental exam in the Pacific region costs \$60, whereas an emergency room visit for preventive dental problems costs \$172 and surgical care or hospitalization costs \$5,044.

Why Children's Dental Care Needs Are Not Being Met

There are a number of reasons why children's dental care needs are not being met. For example, nearly one-fifth of California's children (1.8 million) lack dental insurance.³⁴ Furthermore, because there is not enough investment in education and prevention programs, some parents do not understand how crucial dental care is for their children and/or do not know at what age to start bringing their children in for care.

A primary reason, however, is that the current dental workforce does not have the capacity to meet the dental care needs of California's children, especially underserved children. As mentioned above, there is a limited number of providers who treat certain groups of children.

While California is home to 14 percent of the nation's dentists, California has 333 federally designated Dental Health Professional Shortage Areas—areas designated as having a shortage of dental providers on the basis of availability of dentists and dental auxiliaries.³⁵ Nearly one million children live in them.³⁶ In fact, of California's 58 counties, only five do not have Dental Health Professional Shortage Areas.³⁷

The lack of access to dental care is prevalent in both rural and urban areas. For example, eight rural communities in Del Norte, Humboldt, and Trinity Counties in northwest California have less than one full-time equivalent dentist serving low-income people.³⁸ According to a recent study, one in ten children in Los Angeles County had never been to a dentist; for children between the ages of two and five, the ratio is one in five.³⁹

Parents in Los Angeles County who cannot obtain dental care for their children report that they have difficulty finding a dentist near their home, finding a dentist who speaks the language spoken in their home, and/or getting an appointment. The average waiting time for an appointment at the 64 free or low-cost community dental clinics identified in Los Angeles County at the time of the study mentioned previously, was 34 days, with a waiting time as high as 135 days.⁴⁰

Families face socioeconomic barriers to obtaining care that compound the fact that there are not enough dental providers to care for the state's most vulnerable children. For example, in Los Angeles, 40 percent of underserved families did not access the dental care system for their children because they could not afford care.⁴¹ Furthermore, while Medi-Cal pays for some transportation, many low-income families do not have affordable transportation options.⁴²

In addition, low-income workers are more likely to lose pay when they miss work. A survey conducted by the Henry J. Kaiser Family Foundation found that two-thirds of low-income women (family incomes below 200 percent of poverty—about \$37,060 annually for a family of three) and three-quarters of very poor women (incomes below 100 percent of poverty—about \$18,530 annually for a family of three) do not get paid when they miss work to care for a sick child.⁴³

According to a study in Los Angeles County, the average waiting time for an appointment at 64 free or low-cost community dental clinics was 34 days, with a waiting time as high as 135 days.

The situation is not likely to improve until California's leaders take steps to bring dental care within the reach of children in need. In fact, unmet need will only grow with the implementation of ACA.

Fulfilling Promise of Federal Health Care Reform

Indeed, one barrier to obtaining dental care is the lack of dental coverage. Most low-income children without dental insurance do not receive preventive dental care.⁴⁴ The federal government has recognized this need, and (as mentioned previously), under ACA, approximately 1.2 million additional children in California will secure public or private dental coverage over time beginning in 2014.

However, California will not be able to fulfill the promise of improving children's dental health if there are not enough dental providers to meet this growing demand. This is in addition to the need for dental care for children who currently are not obtaining care, regardless of insurance status.

The Affordable Care Act recognizes the need to expand the workforce to accommodate the current and growing demand for dental health care. The Act establishes a five-year, \$4 million, 15-site demonstration program to train or employ alternative dental health care providers. To date, this program has yet to be funded, but, when it is, California ought to be ready to apply for and take advantage of these funds.

Expanding the Workforce to Meet the Dental Care Needs of California's Children

A necessary solution to meeting the current and future dental health care needs of California's underserved children is to expand the capacity of the dental team. As mentioned previously, dental workforce models that train additional providers with carefully defined scopes of practice—sometimes called dental therapists—have proven to be a successful strategy in Alaskan Native communities and in over 50 other countries.

15 States Now Use or Are Considering New Dental Workforce Models

- Alaska (Alaska Native Tribal Health Consortium)
- California
- Connecticut
- Kansas
- Maine
- Minnesota
- Missouri
- New Hampshire
- New Mexico
- Oklahoma
- Ohio
- Oregon
- Pennsylvania
- Vermont
- Washington

While these types of providers are relatively new to the United States, they have a track record of increasing children's access to needed high-quality dental care in other regions.⁴⁵

- According to a 2008 study published by the Journal of the American Dental Association, Alaskan Dental Health Aide Therapists (DHATs) were more effective in reaching younger children than dentists were. (Alaskan DHATs treated children who were an average of 7.1 years younger than those treated by dentists.)⁴⁶ The services provided by Alaskan DHATs play an important role because younger children are more likely to go without needed care.⁴⁷
- A 1981 University of Toronto study found that from 1974 to 1980, the Saskatchewan Dental Health Plan, largely staffed by dental therapists, was responsible for reducing the incidence of dental caries by 25 percent in Saskatchewan youth.⁴⁸
- Dental therapists in New Zealand provide dental care to 95 percent of school children under age 13 and 56 percent of preschoolers.⁴⁹

Other states are also exploring new dental workforce models. In 2009, Minnesota became the first state in the nation to authorize new provider models. In May 2011, the Missouri State Dental Board became the first state dental board to endorse the concept of a dental therapist and an advanced dental hygienist practitioner.⁵⁰ And, in August 2011, the Governor of

Oregon signed into law a bill that will allow the state to establish pilot projects for dental therapists and community dental health educators.⁵¹

While there are variations in these workforce models across the country and the world, one common theme is the utilization of practitioners who come from and return to practice in communities that have difficulty attracting and retaining dentists. What is unique about these workforce models is that these providers cater to the communities' needs. They go to where children are (such as schools, preschools, and other community sites) and can work with parents and the community to identify the best way to meet the children's dental care needs.

These dental team members are supervised by dentists and focus on preventive and routine dental care, such as cleanings, fillings, and simple extractions. They receive in-depth training in specific dental procedures, are trained to manage emergencies, know when to refer the patient to a dentist, and ensure that patients who need care beyond their scope receive that care from a qualified dentist.

This workforce model enables all members of the dental provider team to work to the full extent of their education and training, allowing dentists to focus on more complicated procedures, while ensuring that patients who need more routine treatment receive high-quality care. Such a model can make the dental delivery system more effective and efficient.

Workforce innovations in other health care sectors, such as primary care, are common to the point where they are no longer regarded as new or experimental.

Nurse practitioners are a prime example. Since the late 1970s, nurse practitioners have worked under various levels of supervision in many settings, including medical offices, community health centers, and hospitals. Today, nurse practitioners are respected and valued members of the medical team, and it is hard to imagine the health care system functioning efficiently without them.⁵²

Dental Health Aide Therapists

To increase access to dental care for Alaska's population, the Alaska Native Tribal Health Consortium (ANTHC), in collaboration with tribal health organizations, began the Alaska Dental Health Aide Therapist Initiative in 2003, which is modeled after the dental therapy program that began in New Zealand in 1921. Dental Health Aide Therapists (DHATs) provide preventive and restorative dental care to children and other underserved populations in some of Alaska's most remote communities.

Dental Health Aide Therapists, who are recruited from Alaskan Native communities, receive approximately 3,000 hours of training as well as a preceptorship consisting of a minimum of 400 hours. This training prepares them to provide dental education, prevention, and urgent and routine restorative care. During the preceptorship, the supervising dentist gains a close understanding of the DHAT's skills and decides when he or she is ready for certification. The supervising dentist then establishes standing orders for the DHAT based on his or her observation of the DHAT's skills and clinical competence. The DHAT can then perform only those services that are listed in his or her standing orders without being at the same site as the supervising dentist.⁵³

After training, DHATs return to their communities in remote Alaska to provide dental care to the population. They work under general supervision; that is, their supervising dentists do not have to be in the same physical site as the DHATs. However, the supervising dentists are always available for consultation.⁵⁴ A variety of methods of communication are used to facilitate supervision, including daily phone calls and e-mails. Telehealth—the use of technology to provide health and dental care at a distance—is also an important tool for communication, allowing DHATs and the supervising dentists to use various Web-based technologies to share images, radiographs, and dental and medical records and to collaborate via videoconferencing. As a result of the DHAT program, tens of thousands of children and other underserved populations are getting high-quality dental care to which they previously did not have access.⁵⁵

New Workforce Models on the Move in California

California Children's Dental Workforce Campaign

The California Children's Dental Workforce Campaign is a coalition-based effort aimed at increasing access to high-quality dental care for large numbers of underserved children in the most cost-effective way by expanding the capacity of the dental team. The Campaign—involving dentists, clinics, school-based health leaders, and advocates for children—is based on the concept that it is necessary to expand the dental workforce to include providers whose scope of practice is narrower than that of dentists, but who can deliver urgently needed preventive and routine restorative services in places where children and other underserved populations with limited access to dental care live.

A new workforce model will ensure that the provider is a member of the dental team with a dentist providing supervision. It may include added duties for existing members of the team, such as dental assistants and dental hygienists, as

well as the creation of new members. Building on the evidence and best practices from around the world, the Campaign developed the following essential components that ought to be incorporated as leaders in California expand the dental team.

1. An expanded dental team will ensure that newly trained providers are supervised by a dentist and are part of the dental team.
2. New workforce models may include new duties for existing members of the dental team as well as the creation of new members of the dental team.
3. Providers within an expanded workforce model will be trained to understand the limits of his or her scope of practice and to know when to make a referral or seek a consultation.
4. Providers within an expanded workforce model will serve primarily underserved children.⁵⁶
5. To help overcome economic and other barriers families face, providers within an expanded workforce model will be deployed

primarily in community-based settings where children receive other health and social services, such as schools, local clinics, and other community locations.

6. The duties and scope of practice of providers within an expanded workforce model should give priority to preventive and routine care, such as education, sealants, fillings, and simple extractions.
7. Newly trained providers should be appropriately educated to perform their scopes of practice competently. Educational requirements should conform to national and international experience. Educational costs to the student should be minimized to help lessen economic barriers to serving in underserved communities.
8. Technology, such as telehealth, should be used to facilitate supervision by and collaboration with the supervising dentist.
9. The development of an expanded workforce model should be based on research and evidence from both domestic and international sources, while keeping in mind unique circumstances in California.
10. Expanded workforce models should include sustainable payment mechanisms that enable these providers to be paid within a system of care.

The Campaign is pursuing policy change to ensure an expanded workforce is developed in California in time for the implementation of ACA. For more information about the California Children's Dental Workforce Campaign and its efforts to increase access to dental care for California's children, visit <http://www.childrenspartnership.org/dentalworkforce>.

Evidence of Effective Models

A variety of expanded dental workforce models that utilize practitioners with carefully defined scopes of practice have been functioning in other countries and Alaskan Native communities.

- A 2010 evaluation of the DHAT Workforce Model in Alaska by the Research Triangle Institute demonstrated that DHATs are technically competent to perform the procedures within their scope of work and are doing so safely and appropriately, successfully treating cavities and helping to relieve pain for people who often had to wait months or travel hours to seek treatment. Furthermore, patients are highly satisfied with that care.⁵⁷
- A study published in November 2008 of five dental clinics in Alaska found “no significant evidence to indicate that irreversible dental treatment [such as fillings] provided by DHATs differed from similar treatment provided by dentists.”⁵⁸
- In New Zealand, dental therapists providing preventive and restorative services have significantly reduced permanent tooth loss through the School Dental Service.⁵⁹
- A 1988 study commissioned by Health and Welfare Canada found the quality of restorations done by dental therapists and federal dentists to be equal.⁶⁰
- A 1974 Australian study found dental therapists and dentists' diagnosis and treatment-planning decisions to be comparable in quality.⁶¹
- A 2011 Institute of Medicine report found that experiences with new types of dental professionals do not raise concerns about the quality of care provided.⁶²

California Dental Association

The California Dental Association (CDA) has also recognized the need to improve access to dental care for California's children and other underserved populations. In 2008, the CDA House of Delegates—the Association's highest governing body—passed a resolution to support improving access to dental health care and analyzing potential solutions. In 2010, two workgroups within the Association were tasked with researching access and workforce issues. The groups developed a comprehensive report, which included research and recommendations for improving the dental health of California's residents. The research and recommendations, which were approved by the House of Delegates in November 2011, address workforce issues, among others.

Innovative Uses of Technology

Advances in technology are enabling children to get the dental care they need in places where access to dental services is limited. For example, the Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry has created the Virtual Dental Home to demonstrate how technology can be used to bring dental care to our most vulnerable populations.

Through the Virtual Dental Home, dental hygienists and assistants collect dental information from patients in community settings and send that information electronically via a secure Web-based system to the supervising dentist who creates a tentative dental treatment plan for the hygienist or assistant to carry out. The hygienists and assistants refer patients to dental offices for procedures that require the skills of a dentist.⁶³

California's Leadership in Workforce Innovations

California has a history of developing new workforce models to extend dental care to more Californians. For example, in 1998, California officially recognized the Registered Dental Hygienist in Alternative Practice (RDHAP). Registered Dental Hygienists in Alternative Practice may practice in homes, schools,

residential facilities, and other institutions as well as in Dental Health Professional Shortage Areas.⁶⁴ To date, there are approximately 300 licensed RDHAPs.⁶⁵

In January 2010, new duties were added to the scope of practice for various levels of dental assistants—called Extended Function Dental Assistants (EFDAs)—allowing them to further assist in the provision of care. With these extended duties come new training requirements, enabling dental assistants to advance educationally and creating a career ladder for them.⁶⁶

Finally, the Health Workforce Pilot Projects Program was developed in 1972 to allow organizations to test, demonstrate, and evaluate new or expanded roles for health care professionals or new health care delivery alternatives before changes in licensing laws are

Teledentistry: A Critical Tool for Improving Access to Dental Care

Teledentistry—the use of technology to provide dental care at a distance—is rapidly becoming a viable solution to meet the dental care needs of patients in rural and other underserved areas. Through video-conferencing, a dentist can examine a patient from a distance and interact with the provider onsite. Teledentistry also involves the transfer of data, such as an x-ray or a digital image of the mouth and teeth, allowing a dentist to assist and make recommendations to an allied dental provider examining a patient.

In addition to increasing access to dental care, teledentistry brings other benefits, such as reduced patient costs for travel and reduced absences from school and work to go to dental appointments. Teledentistry can also lead to dental health system efficiencies and potential cost-savings from improved care management and coordination and local economic gains as residents remain in the community for care.

To learn more about teledentistry and telehealth, in general, visit <http://www.childrenspartnership.org/telehealth>.

made by the Legislature.⁶⁷ The Pilot Projects Program was used to test the feasibility of RDHAPs and is currently being used to test components of the Virtual Dental Home.

The Virtual Dental Home, RDHAPs, and EFDAs provide a very strong start. We now need to build on these advances with additional steps that can quickly and significantly expand the capacity of the current workforce.

Necessary Next Steps: A Five-Point Action Plan

Most dental disease can be prevented if children get regular preventive and routine dental care. However, the existing supply of dentists does not match the current and future needs of California's children. As a result, millions of children are not getting the dental care they need, and the demand for care will only increase when ACA is fully implemented in 2014. We must act now and build on the success of dental provider models that are providing cost-effective, high-quality dental care to children nationally and internationally. The following recommendations outline what actions need to be taken to improve the state's dental workforce so that California's children can get the dental care they so desperately need and taxpayers' dollars can be used as efficiently as possible.

1. Identify Ways to Expand the Dental Workforce.

Identify ways to expand the dental workforce to deploy providers who—under the general supervision of dentists—provide preventative and restorative dental care to underserved children in places where there is little or no access to dental care.

State policy-makers should identify how to expand the dental team before full implementation of ACA and enact policies accordingly. This will enable children who currently need care and the additional children who obtain dental coverage through ACA to access much needed care.

2. Ensure State-of-the-Art Training Programs Are Established.

Ensure state-of-the-art training programs are established so that training can begin as soon as possible after the policy is enacted.

With ACA set to fully go into effect in January 2014, there is no time to waste to begin to expand the dental workforce. State leaders and stakeholders should work with dental schools and community colleges now training allied dental providers to: (1) identify funding; (2) develop a curriculum; (3) identify faculty; (4) develop a strategy for recruiting students; and (5) create the necessary partnerships with clinics, other higher educational institutions, and other entities to ensure students graduate equipped to provide children in underserved areas with high-quality dental care.

3. Build on California's Existing Efforts to Expand the Health Care Workforce.

Build on California's existing efforts to expand the health care workforce in preparation for health care reform.

In preparation for the full implementation of ACA, the State created the Health Workforce Development Council to identify current and future health care workforce needs and develop a comprehensive strategy to prepare California's workforce to meet those needs. The State's workforce strategy should make an expanded dental workforce a priority and include measures to effectively deploy newly trained dental providers to meet the needs of California's children.

4. Ensure Policies Are in Place to Support an Expanded Workforce Model's Ability to Provide Dental Care.

Ensure policies are in place to support an expanded workforce model's ability to provide dental care where and when care is needed, and ensure an expanded workforce model is financially sustainable.

While California has fairly robust telehealth policies, certain teledentistry activities, which are critical to supporting newly trained providers, are

not currently funded by Medi-Cal or other payers. Therefore, policy-makers should support wider deployment of teledentistry by paying for store-and-forward teledentistry (the transfer of data, such as an x-ray or a digital image of the mouth and teeth), which would allow a dentist to assist and make recommendations to an allied dental provider examining a patient.

Furthermore, there are restrictions on and a lack of clarity around which services certain health clinics can provide outside of their four walls and how these clinics will be paid for those services. Policy-makers and stakeholders should seek the needed clarification and potential policy changes to ensure that newly trained members of the dental workforce who are employed by clinics can work in the community, such as schools and other community sites.

Finally, Medi-Cal and other payers do not pay for the range of recommended preventive services that children need, such as education and case management. State leaders and stakeholders should pursue changes to ensure that Medi-Cal and other payment systems support the critical prevention and early intervention activities that the newly trained provider will perform.

5. Advocate for Federal Funding.

Advocate for federal funding for dental health provisions in the Affordable Care Act.

While ACA includes many provisions aimed at improving the dental health of children and adults, most of these provisions have yet to be funded or implemented. One provision would directly support the creation of an expanded dental team by establishing a demonstration program to train or employ new dental health care providers.

Policy-makers and stakeholders in California should reach out to California's Congressional delegation and urge them to advocate for funding for and implementation of this provision. Implementing this program will allow California to leverage federal dollars to meet the dental care needs of its children through workforce solutions.

The Time to Act is Now

Unlike many problems that seem too complex or expensive to solve in these challenging economic times, getting children the dental care they need is a problem that can be solved now. The need is clear. The evidence supporting what ought to be done is sound.

Public and private sector leaders can join together to put forward-looking workforce solutions in place without large investments. Policy-makers can ensure policies are enacted as soon as possible, and philanthropy can help design and support needed training.

California can lead the way nationally by demonstrating how we can successfully bring needed dental care to our most vulnerable children through workforce solutions. The Children's Partnership and its partners stand ready to work with all of these players to accomplish this goal, which will benefit millions of children and use taxpayer dollars far more efficiently.

"In spite of our best efforts, we still cannot reach many of the children who need dental care in rural areas like Mendocino County. In addition, we have to realistically address the cost of reaching those new patients. Addressing this problem requires a new approach. Training a provider that can treat the underserved in a cost-effective manner under the supervision of a dentist is critical to meeting the dental care needs of our children."

*—Doug Lewis, DDS
Dental Director*

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