

ACCESS TO DENTAL CARE FOR CHILDREN IN RHODE ISLAND

Oral health is a critical but overlooked component of overall health and well-being among children and adults. Dental caries (tooth decay) is the most common preventable chronic childhood disease.¹ The U.S. Surgeon General's report on oral health highlights the problem of oral disease as a silent epidemic in America. Nationally, 17% of children ages 2-4 years, 52% of children under 8, and 78% of 17-year-olds have experienced dental decay.²

Dental disease restricts activities in school, work, and home and often significantly diminishes the quality of life for many children and adults, especially those who are low-income or uninsured. Oral health problems can largely be prevented through a combination of access to timely dental care services, fluoridated public water systems, school-based dental programs, healthy dietary choices and daily oral hygiene practices.

WHY ORAL HEALTH IS IMPORTANT

- Tooth decay and gum disease are infectious, progressive, cumulative diseases that become more complex over time – and which are almost completely preventable.
- Poor oral health has immediate and significant negative impacts on children's health and achievement.
- Pain from untreated dental disease can lead to eating, sleeping, speaking, and learning problems in children and adolescents, which affect a child's social interactions, school achievement, general health and quality of life.^{3,4}
- Chronic poor oral health is associated with failure-to-thrive in toddlers and poor nutrition and dysfunctional speech in children.⁵
- In school-age children and adolescents, chronic dental problems can lead to reduced school performance, poor self-image, lack of concentration and absenteeism.⁶
- There is increasing evidence of associations between oral infections and other diseases, such as pre-term, low birth weight babies and heart disease, lung disease, diabetes and stroke among adults.⁷



CHILDREN AT GREATEST RISK FOR UNMET DENTAL NEEDS



CHILDREN IN LOW-INCOME FAMILIES

- Children from low-income families are at highest risk for tooth decay. About 80% of tooth decay occurs in only 25% of children – primarily those from low-income families.⁸
- In 2000, 17% of children in Rhode Island lived in families with income below the federal poverty threshold. This includes nearly half (47%) of Latino children and 38% of Black children.⁹
- In 2001, 42% of Rhode Island children ages 6-17 had at least one dental sealant (a plastic coating applied to the chewing surfaces of back teeth to prevent decay). Of children enrolled in RIte Care, 30% had sealants compared with 46% of those with private insurance.¹⁰
- In the 2002-2003 program year, 58% of preschool children enrolled in Rhode Island Head Start programs received a dental exam. Of these, 21% examined required dental treatment but only about half (49%) completed treatment by the end of the program year.¹¹
- Of the 1,368 children screened by the Providence Smiles program during the 2003-2004 school year, 42% of kindergartners and 50% of third graders had untreated dental decay and 34% and 35%, respectively, had two or more teeth with dental caries. Over one third (38%) of kindergartners and nearly half (49%) of third graders were referred to a dentist for further treatment.¹²



MINORITY CHILDREN

- In 2000, 27% of children in Rhode Island were children of color, including more than half (58%) of those living in the six core cities (Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket).¹³
- Nationally, 43% of Hispanic children, 36% of African American children, and 26% of White children ages 6 to 8 years have untreated dental caries.¹⁴



YOUNG CHILDREN

- Early childhood caries (ECC), also known as baby bottle tooth decay, is severe decay in the primary teeth of infants and toddlers. ECC is an infectious disease that can be transmitted from adults with dental caries to children. ECC is associated with frequent and prolonged exposure of teeth to carbohydrates in juice, milk or infant formula through bed-time use of a bottle filled with anything other than water or use of a bottle or sippy cup throughout the day.¹⁵
- Treatment of early childhood caries often requires extensive treatment, restorative work, stainless steel crowns, or tooth extraction, with general anesthesia in many cases, which can cost up to \$7,000.¹⁶
- ECC is a serious public health problem that is prevalent among children who live in low-income families.¹⁷ Approximately one in four (23%) of all children ages 2-4 in the U.S. has visible tooth decay.¹⁸ It is estimated that 6% of children under three years of age are affected by severe ECC.¹⁹
- Dental screenings of 912 children enrolled in Providence Head Start in 2003-2004 revealed that 35% had untreated dental decay, 28% had two or more teeth with dental caries, and 20% suffered from early childhood caries.²⁰
- A significant number of Rhode Island parents report behavior that places their child at increased risk for ECC. According to the *2001 Health Interview Survey*, 19% of parents in Rhode Island report that their child sleeps with a bottle in his or her mouth “most of the time” and 9% said “some of the time.”²¹



CHILDREN WITH SPECIAL HEALTH CARE NEEDS

- Approximately 14% (35,265) of Rhode Island's children under age 18 have special health care needs.²² In a 1998 survey, 27% of caregivers of children with disabilities receiving fee-for-service Medical Assistance in Rhode Island identified dental care as an unmet need for their child.²³
- Access to comprehensive oral health care is critical for children with special health care needs, which can be physical, developmental, behavioral and/or emotional. Medications, therapies, special diets, and difficulty in cleaning teeth complicate dental care and treatment. Children with developmental disabilities are more likely to experience delayed tooth eruption, irregularities of the tooth structure, gum disease and oral infections. Dentists may be reluctant to treat children with special needs whose care can be complex and time consuming.²⁴



CHILDREN IN OUT-OF-HOME PLACEMENT

- Children in out-of-home placement suffer more frequent and more serious medical, developmental and mental health problems than nearly any other group of children. As of December 31, 2003, there were approximately 1,200 children under age 21 living in foster care homes in Rhode Island.²⁵ One-third (34%) of Rhode Island foster parents surveyed in 2004 reported difficulty in obtaining dental care for children in their care, ranking it as their number one unmet need.²⁶



YOUTH AT THE RHODE ISLAND TRAINING SCHOOL

- There were a total of 1,060 youth in the care and custody of the Rhode Island Training School at some point during calendar year 2003.²⁷ All youth at the Training School are required to receive a dental examination within seven days of admission and every six months thereafter. Many report that this is the first time they have ever visited a dentist. Out of a total of 1,131 dental office visits at the Training School in 2003, 8% included the removal of at least one permanent tooth from a young person (90 extractions).²⁸

HOSPITALIZATIONS AND EMERGENCY ROOM CARE FOR UNTREATED DENTAL DISEASE

◆ Between March 2003 and August 2004, 159 children received dental treatment in an operating room at Our Lady of Fatima Hospital. They had to be treated under general anesthesia because of the extent of their dental problems and their young age (the average age is 3 years). Approximately 25% of the children had special health care needs. Emergencies are given priority but this site has the capacity to treat only three children per week, resulting in a waiting list of 145 children with urgent need as of August 2004.²⁹ Rhode Island Hospital provided dental treatment in the operating room to 35 children in 2003.³⁰

◆ An average of 541 children under age 21 were treated for a dental-related condition in Lifespan Emergency Departments (Rhode Island Hospital, Hasbro Children's Hospital, The Miriam Hospital, and Newport Hospital) in each of the past 3 years.³¹

◆ Between 1998 and 2002, an average of 47 children (ages 18 and under) were hospitalized each year with a diagnosis that included an oral health condition in Rhode Island. An oral health condition was the main reason for the hospitalization for an average of 14 of those children each year.³²



SPECIAL SENATE COMMISSION ON ORAL HEALTH

The foundation for much of the recent progress in oral health in Rhode Island was laid by the Special Senate Commission on Oral Health. Chaired by Senator Elizabeth Roberts, the Commission issued 22 recommendations in a November 2001 report. Progress has been made on several of the recommendations, including:

- ◆ Enhancement of Medicaid reimbursement for hospital based dental centers.
- ◆ Establishment of a collaborative community effort to address barriers to early childhood oral disease.
- ◆ Expansion of the Providence Smiles model of school-based prevention, screening and treatment services.
- ◆ Pursuit of additional funding from federal and state sources to expand dental services to underserved patients, to improve dental professional compensation at community-based safety net agencies, and for oral health professional practice incentives.
- ◆ Establishment of pediatric and general practice dental residency programs in Rhode Island.
- ◆ Review of the Rhode Island Dental Practice Act for changes that promote access to quality dental care.
- ◆ Development of alternative models for dental assistant recruitment and training.
- ◆ Environmental assessment of existing oral health resources to match underutilized dental equipment and dental operatories with volunteer oral health professional support.

RECENT ACTIONS TAKEN ON RECOMMENDATIONS OF THE SENATE ORAL HEALTH COMMISSION

◆ **The Dental Assistant Training Partnership Program**, currently in its formative stages, is a collaboration of the Rhode Island Dental Association, Rhode Island Department of Human Services Family Independence Program (FIP: RIte Works) and Cranston Alternative Programs. Once instituted in 2005, up to ten FIP participants per session will enroll in an abbreviated dental assistant training program, consisting of seven weeks of classroom, lab and on-the-job clinical training provided by dentists who hire the students during the program. RIte Works will perform all trainee recruitment, pre-screening and testing and will provide employers with wage reimbursement up to a maximum of \$2,600. The dentists will be asked to provide a permanent position for the trainee at prevailing market entry-level rates at the conclusion of the training.

◆ With support from the Centers for Disease Control and Prevention and the federal Maternal and Child Health Bureau, the **Rhode Island Department of Health** has established new communication mechanisms and collaborations for oral health. The Department's **Oral Health Program (OHP)** has: 1) Provided training and technical assistance to facilitate improved oral health access; 2) Developed a web page and newsletter; 3) Expanded surveillance capacity and conducted statewide oral health workforce surveys; and 4) Convened the Rhode Island Head

Start/Early Head Start Oral Health Forum, in collaboration with the Rhode Island Head Start Association. This Forum produced an action plan that will help guide the work of the **Rhode Island Early Childhood Oral Health Coalition**, a public/private partnership that seeks to improve oral health and reduce disparities for young children and their families by increasing awareness of the unmet oral health needs of preschool children, increasing oral health promotion/disease prevention resources for professionals working with young children and their families; promoting access to dental services for underserved preschool children; and promoting integration of oral health with primary care providers. The OHP plans to conduct a statewide basic screening survey of third graders in the next school year and to improve evaluation of school-based/school-linked dental sealant programs.

◆ **Delta Dental of Rhode Island** sponsors a multi-faceted public health education campaign designed to alert parents to the dangers of **Early Childhood Tooth Decay** through advertising, public relations and community outreach. To broaden its reach, Delta Dental is partnering with Neighborhood Health Plan of Rhode Island, Rhode Island KIDS COUNT and the state Department of Health, and is working alongside the state's medical and dental communities to educate other health care professionals.

THE RHODE ISLAND ORAL HEALTH ACCESS PROJECT (RI OHAP)

Funded by the Robert Wood Johnson Foundation, the RI OHAP is a unique partnership between the Rhode Island Department of Human Services, The Rhode Island Foundation, and Rhode Island KIDS COUNT. Rhode Island was one of six states selected to increase access to dental services for children and families covered by Medicaid/RIte Care and for those underserved for dental care. The total grant award for all aspects of the initiative was \$940,000 over three years. An additional \$940,000 in federal Medicaid matching funds was leveraged by the state, bringing the total investment to \$1.88 million.

The Rhode Island Oral Health Project has three components:

- ◆ The Rhode Island Department of Human Services will restructure the Medicaid dental benefit from a fee-for-service benefit to one that is offered through a Dental Benefits Manager (DBM). The DBM will be awarded through a competitive bid process in 2005. A DBM will allow for a more commercial-like dental benefit, in which the selected insurer(s) pay claims to providers, offer a network of participating dentists, and provide referral, transportation, and interpreter services to members. Providers who treat children and adults who are in Medical Assistance programs other than RIte Care will continue to be paid on a fee-for-service basis.
- ◆ Grants totalling \$737,308 were awarded to support increased access to dental care through fourteen programs at eleven organizations, including:

Dental Workforce Development

Rhode Island Hospital /
General Practice Residency
St. Joseph Health Services /
Pediatric Residency

Safety Net Provider Service Capacity Development

CareLink, Inc.
Crossroads Rhode Island
Donated Dental Services / RI Foundation
of Dentistry for the Handicapped
Federal Hill House
Providence Community Health Center
Rhode Island Health Center Association

St. Joseph Health Services / Ronald
McDonald House Charities Care Mobile
Thundermist Health Center / West Warwick

School-Based Dental Services

East Bay Community Action Program
Northwest Health Center
St. Joseph Health Services / Pawtucket Smiles
Thundermist Health Center / Woonsocket

- ◆ Rhode Island KIDS COUNT is managing public engagement efforts to keep the issue of access to oral health services in the forefront for policy makers and the public.

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THE COST OF DENTAL CARE

Dental services can be paid for by private/commercial dental insurance, public dental insurance (Medical Assistance/Medicaid/RItE Care), or directly out-of-pocket by the patient (for those with insurance that does not cover all services or those without dental insurance).



DENTAL INSURANCE

Medical insurance is a strong predictor of access to dental care. Uninsured children are 2.5 times less likely than insured children to receive dental care. Children from families without dental insurance are 3 times more likely to have dental needs than children with either public or private insurance. For each child without medical insurance in the U.S., there are at least 2.6 children without dental insurance.³³

The percentage of Rhode Island children with dental insurance has been increasing with 62% in 1990, 67% in 1996, and 73% of parents reporting dental insurance coverage for their children in 2001.³⁴



DENTAL CARE IN RHODE ISLAND'S MEDICAL ASSISTANCE PROGRAM

Comprehensive dental services are a covered benefit under Medical Assistance in Rhode Island, for both children and adults. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit of the federal Medicaid program mandates that states provide comprehensive, preventive, restorative and emergency dental services furnished according to state-defined periodicity schedules to eligible children up to age 21. States are required to recruit dentists to provide dental services under EPSDT, to locate eligible families and inform them about EPSDT services and to assure that providers perform the required services.

Currently, dental services provided to RItE Care enrollees are paid (with a federal-state funding match) on a fee-for-service basis, in which Medical

Assistance directly pays dentists who choose to participate in the program. Unlike medical services, dental services are not coordinated by the three RItE Care managed care health plans.

Analysis of claims data shows that one-third of children enrolled in RItE Care during the past three fiscal years received any dental services. Fewer than one-third (30%) of children enrolled received diagnostic services, 26% received preventive services, and 16% received treatment services in Federal Fiscal Year 2003.³⁵ However, Rhode Island's rates are better than national figures. Only one in five U.S. children enrolled in Medicaid sees a dentist each year.³⁶

RHODE ISLAND MEDICAL ASSISTANCE SPENDING ON DENTAL CARE

In state Fiscal Year 2003, the Rhode Island Department of Human Services spent \$12.8 million in state and federal funds on dental services for children and adults enrolled in Medical Assistance programs (RItE Care and Medicaid fee-for-service). Of this, \$9.5 million (74%) was spent on children and adolescents under age 21, for an average of \$8.61 per child per month. This is less than 0.63% of the total state Medical Assistance expenditures for the year.³⁷



DENTAL PROVIDER PARTICIPATION IN MEDICAL ASSISTANCE

People receiving public insurance have greater access problems than the general population because many private dentists do not accept Medical Assistance for payment. Statewide, there were 320 RIte Care members for each dental provider who accepted Medical Assistance in Federal Fiscal Year 2003.³⁸

In a 2004 survey of parents of children enrolled in RIte Care, dental care was rated the number one unmet health care need. Eleven percent (11%) of respondents with continuous RIte Care coverage during the previous year reported being unable to get dental care and additional 16% were able to get it, but experienced problems in obtaining it. Among those with intermittent RIte Care coverage, nearly 38% reported difficulties (including 21% who were unable to get care).³⁹

Administrative difficulties, including high rates of “no-show” appointments and low reimbursement rates that fail to cover the cost of services are two reasons cited by dentists for limiting or not serving patients with Medical Assistance. Nationally, 23% of dental Medicaid appointments result in no-shows, which is nearly twice the rate among those with private insurance.⁴⁰ Private dentists, community health centers, and hospital based dental centers in Rhode Island all report similar or higher no-show rates for patients who have Medical Assistance. Providers cannot bill Medical Assistance or patients for “no-show” appointments.

In Federal Fiscal Year 2003, 55% of licensed dentists in Rhode Island were paid for providing at least one service to at least one recipient of Medical Assistance. However, only 30% of licensed dentists provided services to at least 50 unduplicated Medical Assistance patients and only 25% of dentists were paid in excess of \$10,000 for services rendered to Medical Assistance patients during that time period.⁴¹ According to dentists and agencies who make referrals, there is an acute shortage of oral surgeons who are willing to accept patients with Medical Assistance.

In spite of this, private dental practices continue to be the largest provider of dental services to the population receiving Medical Assistance. In state Fiscal Year 2003, private dental practices accounted for 66% of all Medical Assistance dental expenditures for children under age 21. However, private dentists accounted for 72% of expenditures in state Fiscal Year 2000, which may reflect both a reduction in private dentists who accept Medical Assistance and the increasing service capacity of Federally Qualified Health Centers (FQHCs, also known as Community Health Centers) and hospital based dental centers at St. Joseph Hospital and Rhode Island Hospital. FQHCs accounted for 12% and hospital based dental centers for 21% of Medical Assistance dental expenditures for children under age 21 during state Fiscal Year 2003.⁴²

NATIONAL SPENDING ON DENTAL CARE

Less than 5% of all health care spending for children and adults is for dental care.⁴³ Dental care accounts for a significant portion of health care expenditures for children. Twenty-two (22%) of total national health care expenditures for children ages 3-12 and 28% among children ages 13-18 are for dental care. The percentage of expenditures for all children dedicated to dental care is nearly 30%.⁴⁴ In contrast, an average of 2.3% of state Medicaid expenditures for children are for dental care.⁴⁵

A 1998 actuarial study of health care costs for children calculated that 21% of expenditures for a comprehensive package of health services should be dedicated to dental services (excluding orthodontic care). This study suggested that \$21.35 per child per month must be expended in order to meet the dental care needs of covered children. A similar study conducted in 1999 by the Reforming States Group determined that \$17 to \$18 per child per month is necessary for dental care, assuming that providers accept a modest discount on their fees when serving low-income children.⁴⁶

MEDICAL ASSISTANCE REIMBURSEMENT RATES

SAFETY NET PROVIDERS

Because they serve a high volume of patients enrolled in Medical Assistance and uninsured patients, dental safety net providers are reimbursed by Medical Assistance at higher rates than private dentists. In response to one of the recommendations of the Special Senate Commission on Oral Health, rates paid to the two hospital based dental centers were increased in July 2003. While these rates were

enhanced, they still remain below the reimbursement rates paid by commercial insurers. Community health centers are paid a federally mandated encounter rate for dental services. Although each community health center is paid its own cost reimbursement rate, all are paid per dental visit, regardless of the type or number of procedures performed.

PRIVATE DENTISTS

Rhode Island's Medical Assistance dental reimbursement rates for private dentists were last increased in 1992.⁴⁷ As of November 2001, for the 50 most frequently performed dental procedures, Medicaid reimbursement was 45% of Rhode Island dentists' average fees, compared with a reported reimbursement rate of 75% by commercial insurers.⁴⁸ Recent national estimates indicate that overhead costs (fixed costs for equipment, staff salaries and supplies) for dentists average 61% for general practice dentists and 56% for specialists, which means that dentists lose money each time they treat a patient with Medical Assistance.⁴⁹

According to the American Dental Association, when comparing Medical Assistance payment rates and average fees charged by private dentists in the New England region, for 15 of the most commonly performed procedures, 14 out of 15 of Rhode Island's rates rank at or below the 4th percentile. This means that fewer than 4% of dentists in the region would consider the Medical Assistance rate as equal to or greater than their current charge:

Procedure Code	Procedure Description	RI Medicaid Rate	NE Region 2001 Avg. Fees	NE Region 2001 75th Percentile Fees	RI Medicaid vs. NE Region Fees (percentile)
Diagnostic					
D0120	Periodic Oral Exam	\$10.00	\$28.35	\$ 32	1st
D0150	Initial/Comprehensive Oral Exam	\$20.00	\$52.85	\$60	<2nd
D0210	Complete X-rays, with Bitewings	\$40.00	\$91.22	\$99	<1st
D0272	Bitewing X-rays – 2 Films	\$14.00	\$28.76	\$32	3rd
D0330	Panoramic X-ray Film	\$32.00	\$81.54	\$91	<2nd
Preventive					
D1120	Prophylaxis (cleaning)-child	\$22.00	\$45.34	\$50	<1st
D1203	Topical Fluoride (excluding prophylaxis)	\$18.00	\$25.14	\$30	16th
D1351	Dental Sealant	\$18.00	\$34.58	\$39	3rd
Restorative					
D2150	Amalgam, 2 surfaces, permanent tooth	\$37.00	\$100.44	\$116	<2nd
D2331	Resin, 2 surfaces, anterior tooth	\$44.00	\$121.19	\$134	<2nd
D2751	Crown, porcelain fused to base metal	\$450.00	\$728.17	\$800	4th
D2930	Prefabricated Steel Crown, primary tooth	\$88.00	\$184.53	\$200	<3rd
Endodontics					
D3220	Removal of tooth pulp	\$59.00	\$118.06	\$135	4th
D3310	Anterior Endodontic Therapy	\$175.00	\$478.97	\$525	<1st
Oral Surgery					
D7110	Extraction, single tooth	\$39.00	\$100.42	\$110	<1st

Source: *State Innovations to Improve Access to Oral Health Care for Low-Income Children*, 2003

Many states offer low Medicaid reimbursement rates to dental providers. In 2001, the Director of the Federal Health Care Financing Administration wrote in a letter to state Medicaid Directors, “Section 1902(a)(30)(A) of the [Social Security] Act (which requires EPSDT services, including dental) requires that payments for medical services ‘be consistent with efficiency, economy, and the quality of care and are sufficient enough to enlist enough providers so that such care and services are available under the plan at least to the extent that such care and services are available to the general population of the geographic area.’ Inadequate Medicaid non-institutional provider rate structures may expose a State to serious litigation risk.”⁵⁰



ACCESS TO CARE: RHODE ISLAND'S DENTAL WORK FORCE

Quality oral health care is provided by a team including dentists, dental hygienists, and dental assistants. An adequate workforce is a critical element to ensuring access to care. Oral health can be seen as the sole responsibility of dental professionals, but other health care providers (e.g., physicians, nurses, childbirth educators, and nutritionists) also have opportunities to promote oral health, facilitate timely referrals (especially for the recommended first visit to a dentist by the age of one), and introduce the concept of a dental home to children and their parents.



DENTISTS

As of June 2004, there were 551 actively practicing licensed dentists in Rhode Island, working in approximately 400 offices.^{51,52} Twenty (20) of Rhode Island's 39 cities and towns are federally designated as dental health professional shortage areas (DHPSAs), based on an insufficient number of dentists to serve low-income or special populations.⁵³

Dental Specialty	Number Actively Practicing as of June, 2004
Prosthodontists	9
Pediatric Dentists	14
Endodontists	17
Periodontists	24
Oral / Maxillofacial Surgeons	33
Orthodontists	42
Total Dental Specialists	139
General Dentists	412
Total All Dentists	551

Source: Rhode Island Department of Health

As of June 2004, over half (53%) of actively practicing dentists in Rhode Island were aged 50 years or older (22% were over age 60).⁵⁴ The average age of retirement for U.S. dentists is 62.5, therefore, approximately 300 dentists in Rhode Island will be at or close to retirement in the next ten to fifteen years.⁵⁵ There also has been little growth in the number of dentists in the past several years in Rhode Island. Between 2000-2003, an average of 21 dentists were newly licensed in Rhode Island each year, while an average of 18 dentists did not renew their licenses (due to retirement, relocation, or death).⁵⁶ These facts indicate that there may be a shortage of dentists facing Rhode Island.

Rhode Island has no dental school and only 8 Rhode Island residents were enrolled in out-of-state dental schools during the 2002-2003 academic year.⁵⁷ Because dental school graduates often practice in close proximity to their training site, Rhode Island is at a disadvantage in recruiting and retaining dentists.

There has been progress in the number of in-state educational opportunities in Rhode Island, although the number of graduates is small. A pediatric residency program established in 2003 at St. Joseph Hospital in collaboration with Lutheran Medical Center in Brooklyn, New York will graduate two pediatric dentists each year starting in 2005. A general practice residency program planned at Rhode Island Hospital will graduate two dentists annually starting in 2006.

While restrictive dental licensure requirements may have been a barrier to recruiting dentists to Rhode Island in the past, a 2002 modification of dental licensure rules and regulations has made it easier for new/relocating dentists to practice here. Since then, oral health professionals licensed and in good standing in other states can apply for licensure by credentials. Also, at the time of writing for this publication, the Rhode Island Board of Dental Examiners is considering additional rule changes to facilitate ongoing dentist recruitment and retention efforts.



DENTAL HYGIENISTS

With their training as prevention specialists, dental hygienists play an important role in increasing access to preventive oral health care. In Rhode Island, dental hygienists practice under "general supervision," which means that a dentist must authorize the procedures to be performed but need not be present while the dental hygienist provides the services. Regulations, promulgated by the Board of Examiners in Dentistry, define the scope of practice for both dentists and dental hygienists. Broadening the scope of practice to allow dental hygienists to perform more procedures within dental offices and/or public health settings (e.g., schools and nursing homes) is a strategy that many states have utilized to enable dentists to focus on delivering the most complex oral health services.

There were approximately 600 hygienists practicing in Rhode Island as of May 2003.⁵⁸ This occupation is projected to grow 25% between 2000-2010, with 24 openings annually.⁵⁹ This growth rate makes dental hygiene one of the fastest growing professions in the state. While some private dentists, hospital based dental centers and community health centers currently report difficulties in hiring dental hygienists, it appears that there is an adequate supply of hygienists in Rhode Island. The Community College of Rhode Island on average annually graduates 28 dental hygienists and another 20 hygienists who graduated from out-of-state schools apply for Rhode Island licensure each year.⁶⁰



DENTAL ASSISTANTS

Dental assistants work chair-side with dentists to facilitate the efficient delivery of oral health services. Dental assistants are not licensed, thus it is difficult to quantify the number currently practicing. In May 2003, an estimated 920 dental assistants were employed in Rhode Island.⁶¹ This occupation is projected to grow by 14% between 2000-2010, with 29 openings annually.⁶² The Community College of Rhode Island offers a dental assistant certificate and on average graduates 18 certified dental assistants annually through its year-long, nationally accredited program.

Dental assistants may also receive “on the job” training or attend the semester-long training at Cranston Alternative Programs, which graduates between 36-40 students per year. At least two new dental assistant training programs are also currently in the planning stages. One is a collaboration among the Rhode Island Dental Association, the Family Independence Program and Cranston Alternative Programs. A dental assistant track is under consideration at the new Job Corps in Exeter as well, which will open in November 2004. Some states have begun to use Expanded Function Dental Assistants (EFDAs), in which assistants who have completed additional training may perform expanded duties.



THE DENTAL SAFETY NET WORKFORCE

As of August 2004, both hospital based dental centers reported staff vacancies, and four of eight Community Health Center dental centers reported vacancies, some for as long as one year.⁶³ Community health centers and hospital based dental centers may have difficulty recruiting and retaining all levels of oral health professionals, due to lower salaries, longer hours of operation and patients with high “no-show” rates and more severe dental needs. The consequence of vacancies is delayed access to care, allowing existing oral disease to become more severe as it remains untreated.

DENTISTS WORKING WITH THE UNDERSERVED

It may be that dentists’ willingness to accept lower paying positions in public health or to accept Medical Assistance could be limited by the amount of student debt they have accumulated. In 2004, the average debt for graduating dental students was \$118,720 (\$105,350 for public dental school graduates and \$152,525 for those from private dental schools).⁶⁴ Nationally, the average cost of starting a new dental practice in 1998 (the most recent year for which data is available) was \$174,190.⁶⁵ Dentists willing to commit to practicing in designated underserved areas for a minimum of two years may be eligible for reimbursement of student loans through programs supported by the National Health Services Corps (i.e., the federal loan repayment program) or the Rhode Island Health Professional Loan Repayment Program (RI HPLRP). Since its inception in 1994, nearly 30% of RI HPLRP participants have been oral health professionals.⁶⁶ However, funding for this program has been declining in recent years because of limited non-profit contributions and restricted state budgets. In addition to oral health professionals, the RI HPLRP supports medical professionals engaged in primary care practice, thus the resources are allocated across a broad range of provider groups.



HOSPITAL BASED DENTAL CENTERS

St. Joseph Health Services operates two pediatric dental centers. Both centers offer a full range of preventive and restorative services for children with public insurance, commercial insurance and those that are uninsured (a sliding fee scale is available). Opened in 1995, **St. Joseph Hospital's Pediatric Dental Center in Providence** provided 9,651 dental visits for children in 2003. **Fatima Health Center's Pediatric Dental Clinic in Pawtucket** provided 1,467 patient visits between its opening in February 2004 and August 2004. Typically, initial appointments are scheduled with a dental hygienist. The current wait time for dental hygiene appointments is 7.5 months in Providence (up from two to three months just two years ago) and 2.5 months in Pawtucket. Children with emergency oral health problems can be scheduled promptly at both locations.⁶⁷

The Joseph Samuels Dental Center at Rhode Island Hospital provides dental services for all children and specializes in treating children and adults with special health care needs such as autism, cerebral palsy, Down syndrome and other medical, psychiatric and/or behavioral conditions. Approximately 60% of patients served are children and 40% are adults, some of whom are referred by Rhode Island and Hasbro Hospitals. In 2003, the Center provided 8,500 on-site visits, as well as over 150 consults to in-house hospital patients. For established patients, the average wait time for a routine dental hygiene visit is over two months and a waiting list continues to grow for new patients.⁶⁸



COMMUNITY HEALTH CENTERS

Seven Community Health Centers offer dental services for children and adults at nine sites in Rhode Island including: **Bayside Family Healthcare** (North Kingstown); **Blackstone Valley Health Center** (Pawtucket); **Crossroads Rhode Island** (Providence); **East Bay Community Action Program** (Newport); **Northwest Health Center** (Pascoag); **Thundermist Health Center** (Wakefield, West Warwick, Woonsocket); and **Wood River Health Services** (Hope Valley).

Three of these sites (Bayside, Northwest, and Thundermist-West Warwick) opened within the past three years. **Providence Community Health Center** plans to re-establish its dental practice in late 2004.

Crossroads Rhode Island (formerly known as Travelers Aid) operates a volunteer dental clinic for adolescents and adults who are homeless or at risk for homelessness. Since the opening of its new headquarters in August 2004, the dental clinic is staffed with seven volunteer dentists, one dental hygienist, one full-time dental assistant and one full-time dentist assigned for three years by the National Public Health Service Corps Ready Responder Program. This program pays the dentist's salary and malpractice insurance is covered by the Federal Torts Program.⁶⁹



DENTAL HYGIENE CLINIC

The **Dental Hygiene Clinic** at the **Community College of Rhode Island's Lincoln Campus** was newly renovated in 2004. Dental exams, cleanings, x-rays, and sealants are available for a fee of \$10 each. Services are provided by dental hygiene students under professional supervision between September and May each academic year. Between September 2003 and February 2004, there were 4,121 patient visits at the clinic (including repeat

visits). However, dental procedures that are beyond the scope of dental hygiene practice (e.g. fillings, dentures, etc.) are not available at the clinic. Because so few dentists accept patients enrolled in Medical Assistance and because dental care for those without dental insurance can mean high out-of-pocket costs, treatment options for patients referred for further care can be limited.⁷⁰



SCHOOL-BASED DENTAL SERVICES

Using a mobile dental team, St. Joseph Health Services operates the Providence Smiles and Pawtucket Smiles programs, which provide examinations, cleanings, dental sealants, and simple restorations (fillings), and connect children and their families to on-going primary dental care in their local community. Working in collaboration with the local school department, Smiles programs are operating in ten elementary schools and several Head Start sites in Providence and six schools in Pawtucket.

DENTAL SERVICES PROVIDED BY SMILES PROGRAMS IN 2003-2004 SCHOOL YEAR

	Providence Smiles	Pawtucket Smiles
Number of Elementary Schools Served	10 (of 24)	2 (of 10)
Number of Dental Exams	4,635	1,265
Number of Cleanings	1,406	777
Number of Children Receiving Sealants / Number of Sealants Placed	306 / 844	386 / 1,024
Number / Percent of children referred to a dentist for further treatment	2,043 / 44%	716 / 57%

Source: Providence and Pawtucket Smiles, 2003-2004

In an effort to replicate the success of the Smiles programs in Providence and Pawtucket, three community health centers will launch school-linked dental programs in 2004 through funding by the Rhode Island Oral Health Access Project. East Bay Community Action Program will work in elementary schools in Newport and Middletown; Northwest Health Center will work in elementary schools in Burrillville; and Thundermist Health Center will work with elementary schools, a middle school, Head Start programs, the Boys and Girls Club and the Housing Authority in Woonsocket.



SCHOOL-BASED HEALTH CENTERS

Thundermist Health Center operates school-based health centers at Coleman Elementary School and the Middle School in Woonsocket. Blackstone Valley Community Health Center provides dental care services at its school-based health center at Central Falls High School. In both communities, students receive dental examinations and cleanings on-site at the school and are referred to the community health center for further treatment. Because, nationally, more than half of all children have dental caries by the second grade, elementary schools and preschools are ideal sites for preventive activities including dental sealants and fluoride varnishes or rinses. Prevention opportunities may be limited for high school students. Teens are more likely to have gum disease and untreated decay in permanent teeth requiring treatment in a dental office.

DENTAL SCREENINGS

Each school district in Rhode Island is required to conduct a dental screening of all children entering school for the first time, K-5 students annually, and at least once between the 6th and 10th grades. A dental screening is a visual inspection of a child's mouth designed to identify obvious unmet needs; it is not a dental examination leading to a detailed diagnosis and treatment plan. Each school district is responsible for contracting with a dentist to perform screenings for children with no dental home and/or no written documentation from parents of a dental exam at the prescribed intervals. Schools are required to notify the parent of screening results, to document the screening in the child's health record and to maintain a referral list for children without a dental home. There is currently no system to track referrals and assure that children with oral disease receive necessary treatment. Currently, uniform data collection, analysis and reporting are limited and not available for school districts statewide.



RECOMMENDATIONS

FINANCING

Increase the amount of Medical Assistance funds dedicated to dental services for children.

Approximately \$9.5 million was spent during state Fiscal Year 2003 to provide dental care to 33% of children eligible for RIte Care. This amount is 0.63% of the total Medical Assistance budget. Good oral health for children will require investment of more resources in order to ensure access to timely, high quality care. If Rhode Island were to allow a minimum of \$21.35 per child per month (the amount recommended in a 1999 study), an additional \$14.5 million would be needed; the \$24 million total spent on children's dental care would then be 1.6% of Rhode Island's total Medical Assistance budget.

Implement the dental benefits manager to reduce barriers to care and to increase accountability for providing the comprehensive dental prevention and treatment services required under federal Medicaid law. A Dental Advisory Committee to the Department of Human Services recommended in 1999 that DHS use this strategy and, through the Rhode Island Oral Health Access Project, the state has received funds to implement it by the end of 2005.

Increase reimbursement rates paid by Medical Assistance for dental and oral health services.

Improved rates stimulate more comprehensive care for children already receiving services, increase the number of patients seen by dentists who already participate, and keep currently participating providers from "dropping out" (which is important because they are difficult to re-engage or replace once they do so). The experience of other states (e.g., Alabama, Delaware, Georgia, Indiana, Michigan, South Carolina, and Tennessee) has shown that matching (or nearly matching) the rates paid by commercial insurers often results in significantly higher rates of participation by dentists.⁷¹ Rates should be reviewed automatically by the legislature on a regular basis to ensure they remain at market-based levels.

INFRASTRUCTURE

Continue to strengthen the dental services infrastructure of dental safety net providers.

Community health centers and hospital based dental clinics are a critical resource for health and dental care for the most vulnerable children and families in this state. These safety net providers have provided a growing proportion of children's dental services in the past several years. Sufficient resources are needed for capital improvements and additional staff in existing dental clinics, new clinics in underserved communities, recruitment and retention of dental professionals and services for the uninsured.

ORAL HEALTH DATA

Develop local and statewide surveillance systems for oral health. Rhode Island is lacking oral health data that could be used to inform policy change and measure program success. A periodic statewide assessment of children's oral health status would provide an accurate picture of the level of untreated dental disease. There are many existing, but unexamined and unlinked, sources of data in the state (e.g., Medical Assistance claims, community health centers, hospitals and their dental clinics, school-based programs, school screenings, the Health Interview Survey, the Pregnancy Risk Assessment Monitoring System, the Youth Risk Behavior Survey, the Behavioral Risk Factor Surveillance Survey, the Basic Screening Survey, and DHPSA/Workforce Surveys) that could be useful in such efforts. A regular periodic assessment of the service capacity of safety net providers and private dentists also would allow for appropriate allocation of resources, including referrals within the dental system to increase service capacity and other mechanisms to increase access.



RECOMMENDATIONS

WORKFORCE DEVELOPMENT

Implement recruitment and retention strategies for dental professionals in Rhode Island, especially those who participate in the Medical Assistance program and treat the underserved.

Incentives: Support for the Rhode Island Health Professionals Loan Repayment Program, which has been less than optimally funded for the past two years, must be solidified. Other incentive programs, such as scholarship programs, tax credits, and innovative reimbursement strategies should be explored. For example, Mississippi and Oklahoma offer deferred compensation plans, in which payments to participating dentists are placed into a pre-tax deferral account similar to a 401(k) plan.

Dental education: The average cost for all four years for non-residents at U.S. dental schools in 2002-2003 was \$135,546, while the average for residents was \$92,795.⁷² Agreements with dental schools in other states that would allow Rhode Island residents to attend at reduced tuition cost should be pursued. The feasibility of establishing a dental school in Rhode Island (either a new dental school or a satellite site for an existing school in a nearby state) should be examined.

Licensing: The Rhode Island Board of Dental Examiners is currently considering a change to licensure processes which would allow dentists who are licensed and in good standing in another state and who have taken a clinical exam in another region of the United States to become licensed in Rhode Island without having to also take the Northeast Regional Board Examination. This change, along with eliminating the requirement of at least five years of practice in the other state, would allow dentists trained elsewhere to more easily establish practices in Rhode Island, which is key to recruitment efforts.

Expand the role of dental hygienists and dental assistants in increasing access to preventive services.

Expanding the scope of practice of dental hygienists to allow them to administer injectable local anesthesia would allow dentists to focus on delivering more complex oral health services. Rhode Island is one of only 15 states in which this is not yet allowed. There are several other options that may hold some promise of increased access to preventive care, including the Advanced Dental Hygiene Practitioner position recently approved by the American Dental Hygiene Association (in which hygienists who have completed an advanced educational curriculum can provide diagnostic, preventive, restorative and therapeutic services directly to the public), Limited Access Permits/Public Health Supervision (in which hygienists who have completed additional training may provide preventive services in certain locales without supervision by a dentist), and Expanded Function Dental Assistants (in which assistants who have completed additional training may perform sealants and polish teeth).

Involve primary medical care providers (pediatricians, family practice physicians, and nurse practitioners) in oral health.

Primary care physicians routinely examine children according to a specified schedule for well-child visits. Yet most physicians lack knowledge about oral health. Between 38% and 63% of physicians report receiving no oral health training during medical school and most specialists report deficient residency experiences and limited continuing medical education opportunities in dental education.⁷³ Training in risk assessment, prevention activities, patient education and making appropriate referrals related to oral health must be offered to physicians and other health care providers. Because physicians are pressed for time with patients, financial incentives (e.g. reimbursement by Medical Assistance and private insurance) to include oral health screenings and preventive activities (such as applying fluoride varnish) are critical. Primary care providers have an important role to play in educating parents about oral health as a regular component of anticipatory guidance.



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