Rhode Island KIDS COUNT

Issue Brief

ACCESS TO ORAL HEALTH 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 (the disease process that causes cavities) is the most common preventable chronic childhood disease.[1] Nationally, 28% of young children ages 2-5 years and 51% of children ages 6-11 years have dental caries in their primary teeth.[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, access to fluoridated water systems and topical fluoride treatments, healthy dietary choices and daily oral hygiene practices.[3,4]

Rhode Island has made tremendous progress in improving access to oral health care for children in Rhode Island over the past decade. Widespread and sustained collaboration, the establishment of school-based and mobile dental programs, improved capacity among safety net providers to serve children, and an emphasis on access to care for children under age three, combined with a managed care dental benefits program for low-income children have positioned Rhode Island as a leader among states.[5]

ORAL HEALTH IS KEY TO OVERALL HEALTH

- Pain from untreated dental disease can lead to eating, sleeping, speaking and learning problems in children and adolescents. This affects a child's social interactions, general health and quality of life.[6]
- Poor oral health has immediate and significant negative impacts on children's general health, school attendance and academic achievement.[7]
- Oral health infections are linked to other health problems and diseases, including preterm and low birth weight babies, as well as heart disease, lung disease, diabetes and stroke among adults.[8,9]
- Tooth decay is an infectious and transmissible disease that can be prevented and treated without expensive interventions.[10]

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CHILDREN AT GREATEST RISK FOR UNMET DENTAL NEEDS

MINORITY CHILDREN AND CHILDREN IN LOW-INCOME FAMILIES

◆ In the U.S., minority and low-income children experience the highest rates of dental caries and the lowest rates of dental care.[11]

◆ Between 2007 and 2009 in Rhode Island, 74% of children under age 18 were White, 8% were Black or African American, 3% were Asian, less than 1% were Native American, 10% of children were identified as Some other race and 4% as Two or more races. Nineteen percent were Hispanic (Hispanics also may be included in any of the race categories).[12]

◆ In Rhode Island between 2007 and 2009, 17.1% (38,604) of children under age 18 lived in households with incomes below the federal poverty threshold ($17,607 annually for a family of three with two children in 2010). This includes 38% of all Hispanic children, 30% of Black and Native American children, 17% of Asian children and 12% of White children in Rhode Island.[13,14,15]

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

◆ Approximately 17% of Rhode Island children (and 14% of U.S. children) have special health care needs, which can be physical, developmental, behavioral and/or emotional. Dental care is the health service that is most commonly reported as "needed but not received" by children with special health care needs (CSHCN) in Rhode Island (4% do not receive it) and in the U.S. (6% do not receive it).[16]

◆ Access to comprehensive oral health care is particularly important for children with special health care needs. Medications, therapies, special diets and difficulty in cleaning teeth complicate dental care and treatment. Dentists may be reluctant to treat CSHCN, whose care can be complex and time consuming.[17]

◆ Access to dental care for CSHCN with Medicaid/RIte Smiles coverage has improved over the past decade in Rhode Island, but some access problems still remain.[18]

DENTAL DECAY AMONG THIRD GRADERS IN RHODE ISLAND

During the 2010-2011 school year, the Oral Health Program at the Rhode Island Department of Health conducted a statewide oral health survey of third grade children enrolled in Rhode Island's public elementary schools. Screenings were completed at 79 randomly selected elementary schools with 68% of all enrolled third grade students in the participating schools receiving a screening.

Dental decay was found to be a significant public health problem for Rhode Island's children in this survey, particularly those who are minority or live in low-income families.

◆ Half (50%) of third graders had decay experience (previous cavities and/or fillings).

◆ One out of four (26%) children had tooth decay that was untreated and needed dental treatment.

◆ Minority children and children in schools with higher free and reduced price school meal program eligibility status were twice as likely as their peers to have untreated tooth decay and five to six times more likely to have rampant decay (defined as more than six untreated decay or filled teeth) than their peers.

◆ Nearly two out of five (39%) third graders had dental sealants (an evidence-based clinical intervention that prevents tooth decay in molar teeth). The national Healthy People 2010 Objective is 50% of eight-year-olds receiving sealants. There was no disparity between children from different races and ethnicities or socioeconomic status for dental sealants.

Source: Oh, J. & Fuller, D. (2011). *The oral health of Rhode Island's children.* Providence, RI: Rhode Island Department of Health.

YOUNG CHILDREN

◆ Early childhood caries (ECC) 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 also 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 a sippy cup throughout the day. The treatment of ECC can be extensive and costly, and sometimes requires sedation or general anesthesia.[19,20,21]

◆ Approximately 6% of new mothers in Rhode Island in 2009 reported that they put their baby to bed with a bottle with "something other than water," a practice that can lead to ECC.[22]

CHILDREN AND YOUTH IN OUT-OF-HOME PLACEMENT

◆ Children and youth in out-of-home placement suffer more frequent and more serious medical, developmental and mental health problems than children who are not in state custody.[23] As of December 31, 2010, there were 2,293 children and youth under age 21 living in out-of-home placements (foster homes with relatives or non-relatives, group homes, residential facilities or other settings) in Rhode Island.[24]

◆ In Federal Fiscal Year 2010, 108 youth "aged out" of foster care in Rhode Island, which means that they were not in a permanent placement at age 18.[25] Generally, youth who age out of foster care experience high rates of economic hardship, low educational attainment and poor physical and mental health.[26]

◆ The ASPIRE Initiative of the Rhode Island Foster Parents Association supports Rhode Island youth between the ages of 14-24 who are in or who have aged out of foster care. ASPIRE provides support to youth to find employment, access education assistance services and provides financial literacy training.

◆ A 2010 survey of 229 youth participating in ASPIRE indicates that most have dental insurance coverage (90% of youth ages 18-24 reported that they have dental insurance) and over half have dental care (59% of 18-20 year olds and 52% of 21-24 year olds reported seeing a dentist in the previous year). These results show that youth in out-of home placement and those who have aged out can access care with sufficient coverage and support.[27]

YOUTH AT THE RHODE ISLAND TRAINING SCHOOL

◆ There were a total of 821 youth in the care and custody of the Rhode Island Training School at some point during calendar year 2010.[28] All youth at the Training School are required to receive a dental examination within seven days of admission and every six months thereafter. This dental visit at the Training School is the first time that some youth report ever visiting a dentist.[29]

RHODE ISLAND HEAD START DENTAL HOME INITIATIVE

Since 2009, Rhode Island has participated in the Head Start Dental Home Initiative (DHI), which aims to develop a national network of dentists to provide dental homes for very young children enrolled in Early Head Start and Head Start. The St. Joseph Pediatric Dental Centers and the Rhode Island Head Start Association partnered together to establish dental homes for all underserved children and implement effective prevention strategies that will improve oral health outcomes for underserved pregnant women, children and their families.

Rhode Island's seven Head Start sites reported that between 87% and 100% of their nearly 3,000 enrolled children had a dental home in 2010.[30]

CONSEQUENCES OF UNTREATED DENTAL DISEASE

DENTAL CARE UNDER GENERAL ANESTHESIA IN HOSPITAL OPERATING ROOMS

◆ Some children in Rhode Island must have dental treatment that is administered under general anesthesia because of the extent of their dental problems, their young age and/or health status.

◆ **St. Joseph Health Services** performs dental treatment in the operating room at Our Lady of Fatima Hospital in North Providence five days a week, seeing an average of 18 patients per week. In 2010, 754 children received dental treatment in the operating room. Nearly two-thirds (64%) of children treated in the operating room were ages five years or under and one-third (36%) of patients ages six to adults had special health care needs. There is currently no waiting list for an appointment for treatment in the operating room.[31]

◆ **Rhode Island Hospital** provided dental treatment in the operating room to 122 patients (children and adults) in 2010. There is currently a two to three month waiting list for appointments for children needing treatment in the operating room at Rhode Island Hospital.[32]

HOSPITALIZATIONS OF CHILDREN DUE TO ORAL HEALTH CONDITIONS

◆ Each year between 2005 and 2009 in Rhode Island, an average of 52 children under age 19 were hospitalized with an oral health condition. During this time period, an average of 13 children under age 19 per year were hospitalized with an oral health condition as the primary reason for the hospitalization.[33]

EMERGENCY ROOM VISITS DUE TO ORAL HEALTH CONDITIONS

◆ Between 2005 and 2009, an average of 864 children under age 21 were treated for a primary dental-related condition in Rhode Island emergency departments annually. Forty-one percent of these children had public insurance (Medicaid/RIte Care) and 25% had private/commercial health or dental insurance. Nearly one-quarter (24%) were self-pay patients, which could mean that their health or dental insurance did not cover the cost of the emergency department visit or that they were uninsured.[34]

RISK-BASED PREVENTION OF DENTAL CARIES

National guidelines recommend that young children be assessed for early childhood caries (ECC) risk no later than one year of age so that future preventive dental visits can be tailored to a child's risk level. Children who are at high risk for ECC may need preventive treatment more often than the standard recommendation of a dental visit every six months. Dental providers are not currently positioned to manage dental caries as a chronic disease (like asthma or diabetes) because of a lack of training in behavioral counseling, inexperience with young children, limited time and little or no reimbursement for counseling and risk-based management.

The **St. Joseph Pediatric Dental Center** is one of seven sites nationally utilizing a quality improvement model called the ECC Project. Dental providers conduct a Caries Risk Assessment for children under 60 months of age to determine their risk for dental caries. Children deemed at high-risk for ECC are seen monthly for appropriate preventive and restorative treatment, until the dental caries is under control. Families are counseled on how to reduce the risk for ECC in their child through changes in diet, feeding practices and careful home applications of fluoride. At each visit, parents set specific self-management goals. Dental residents receive training to conduct caries risk assessments, provide counseling and develop risk-based strategies with the parent to manage dental caries as a chronic disease. The project is developing ECC chronic disease management model protocols. While outcome data are not yet available, anecdotal results indicate that a large proportion of children have improved oral health and parents are more confident in their ability to manage their child's ECC at home and through frequent disease management visits to their dentist.[35,36]

INSURANCE COVERAGE FOR DENTAL CARE

◆ Dental services can be paid for through commercial dental insurance that is available through employers, 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 and those without dental insurance).

◆ In 2008, 89% of children in Rhode Island had dental insurance that pays for routine dental care (commercial insurance, direct pay or public coverage), up from 73% in 2001 and 62% in 1990.[37,38]

◆ Insurance status is a strong predictor of access to and utilization of health and dental care.[39] More than one in four (27%) uninsured children in the U.S. has unmet dental needs, compared with 7% of those with Medicaid and 4% of those with private health insurance.[40] National estimates indicate that the number of children without dental insurance is 2.6 times greater than the number without medical insurance.[41]

◆ Insurance coverage for dental care is typically offered and paid for separately from health insurance coverage.[42]

◆ Dental insurance is not available to many working families in Rhode Island. In 2009, half (52%) of Rhode Island employers reported offering dental insurance to full-time employees and 15% offered it to part-time employees (compared to 73% and 15% who offer health insurance, respectively).[43]

◆ The types of dental services covered by dental plans vary widely among private plans and between various public plans. Currently, there is no standard set of essential oral health benefits. Some plans may include "comprehensive" care such as routine diagnostic and preventive services, X-rays, restorative services, and oral surgery, while others may cover more limited services such as emergency care only.[44]

ORAL HEALTH CARE FOR PREGNANT WOMEN

◆ Ensuring good oral health during pregnancy improves women's overall health and contributes to improving the oral health of their children.

◆ Pregnant women, new mothers and other caregivers who have past or current tooth decay can transmit cariogenic bacteria that cause dental caries to their child. Treatment to eliminate tooth decay can help to stem the transmission from caregivers to children.

◆ Poor oral health during pregnancy has been shown to be a potential risk factor contributing to poor birth outcomes, including preterm birth and low birthweight infants. Research also indicates that good oral health during pregnancy can control some pregnancy complications, including gestational diabetes and preeclampsia (pregnancy-induced hypertension).

◆ Although oral health care can be safely delivered during pregnancy, many women do not receive it. Approximately half (53%) of Rhode Island women report having a dental visit during their pregnancy. Women with low incomes are less likely to see a dentist; 41% of women with RIte Care coverage and 42% of women participating in WIC (Special Supplemental Nutrition Program for Women, Infants and Children) reported a dental visit during their pregnancy.

◆ Prenatal care providers (such as OB/GYNs, nurses, midwives and others) in Rhode Island can play an important role in identifying risk factors for dental disease among pregnant women, as well as promoting and making referrals to dental care during pregnancy.

Source: Oh, J., Leonard, L., Fuller, D. & Miller, K. (2011). Less than optimal oral health care during pregnancy in Rhode Island women: Oral health care as a part of prenatal care. *Health By Numbers, 94*(5), 141-143.

DENTAL CARE FOR CHILDREN WITH MEDICAID COVERAGE IN RHODE ISLAND

◆ Comprehensive dental services for both children and adults are a covered benefit under RIte Care and Medicaid Fee-For-Service in Rhode Island.[45,46]

◆ In State Fiscal Year 2010, the Rhode Island Department of Human Services spent $26.7 million in state and federal funds on dental services for children and adults enrolled in Medicaid programs (RIte Care, RIte Share and Medicaid fee-for-service). Of this, $15.5 million (58%) was spent on children and adolescents under age 21. This is less than 0.78% of the total Medicaid expenditures for the year ($1.987 billion).[47]

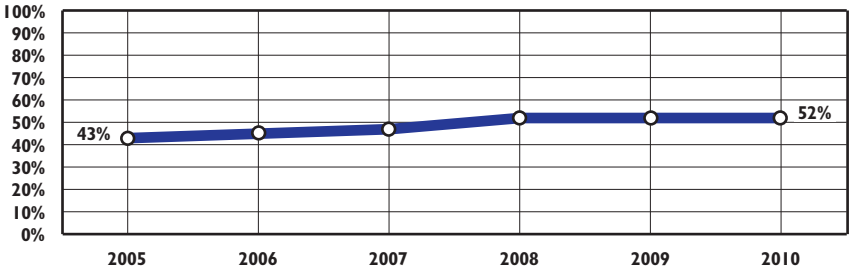
◆ The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate requires that all children under age 21 who have Medicaid coverage in the U.S. have access to preventive health (medical, dental and behavioral) care as well as medically necessary specialized care or services. For oral health, states must provide comprehensive, preventive, restorative and emergency dental services according to state-defined periodicity schedules, which determine which treatment is recommended, allowable and reimbursed by Medicaid. States are required to recruit dentists to provide dental services, to locate eligible families and inform them about EPSDT services and to assure that providers perform the required services.[48]

◆ Rhode Island established an oral health-specific EPSDT periodicity schedule in 2009. This schedule established an age one dental visit, and recommends periodic dental examinations, preventive services and necessary oral health follow-up services at intervals based on risk assessments.[49]

RITE SMILES AND MEDICAID FEE-FOR-SERVICE

◆ Currently, there are two programs that provide dental benefits to children enrolled in Medicaid in Rhode Island, depending on their age. Unlike medical services, dental services are not coordinated by the two RIte Care managed care health plans. Children born on or after May 1, 2000 who are enrolled in RIte Care, RIte Share, or Medicaid Fee-For-Service are enrolled in the RIte Smiles managed care dental benefit program. As of July 31, 2011, there were 54,451 children enrolled in RIte Smiles. Children born before May 1, 2000 (as well as parents) with Medicaid coverage receive their dental benefits under Fee-For-Service Medicaid, in which Medicaid directly pays dentists. As of July 31, 2011, there were 57,549 children with Medicaid Fee-For-Service dental coverage.[50]

CHILDREN UNDER 21 YEARS ENROLLED IN MEDICAL ASSISTANCE* PROGRAMS WHO RECEIVED ANY DENTAL SERVICE, RHODE ISLAND, STATE FISCAL YEARS 2005-2010



Source: Rhode Island Department of Human Services, State Fiscal Years 2005-2010. *Medical Assistance includes RIte Care, RIte Share or Medicaid Fee-For-Service.

◆ Half (52%) of the children who were enrolled in RIte Care, RIte Share or Medicaid Fee-For-Service on June 30, 2010 received a dental service during State Fiscal Year 2010.[51]

◆ The Centers for Medicare and Medicaid Services (CMS) reports that Rhode Island ranks sixth best in the U.S. for the percentage of children under age 21 enrolled in Medicaid who received dental services in Federal Fiscal Year 2008.[52]

DENTAL PROVIDER PARTICIPATION IN MEDICAID

Nationally, children and adults with public insurance coverage have greater access problems than the general population because many private dentists do not accept Medicaid for payment. Dental providers cite low reimbursement rates, administrative requirements and patient-related issues (e.g., missed appointments) as the main reasons that they do not see more patients with Medicaid coverage.[53,54,55,56]

Community health centers, hospital-based dental centers and dentists and specialists in private practice in Rhode Island report similar or higher no-show rates for patients who have Medicaid.[57] Per federal law, providers cannot bill Medicaid or the patients for "no-show" appointments.[58]

PROVIDER PARTICIPATION IN RITE SMILES

◆ RIte Smiles improved provider reimbursement rates and dental claims processes for participating providers. As of July 31, 2011, there were 202 dentists in 380 locations in Rhode Island and Massachusetts participating in RIte Smiles, up from 27 before RIte Smiles began.[59]

◆ Dentists in private practice represent the largest segment (55%) of providers of dental services for children in RIte Smiles, followed by providers working in dental centers at community health centers (30%) and providers based in hospital dental centers (15%).[60]

PROVIDER PARTICIPATION IN MEDICAID FEE-FOR-SERVICE IN RHODE ISLAND

◆ General dentists and specialists providing oral health services to Medicaid-enrolled children who do not qualify for RIte Smiles continue to be reimbursed at the Medicaid fee-for-service reimbursement rate. Fewer than 1% of dentists in Rhode Island report that this rate is equal to or greater than their standard rate. Rhode Island's fee-for-service Medicaid reimbursement rates have not been increased since 1992, and continue to be the lowest in New England and lag behind much of the nation.[61,62,63]

SAFETY NET PROVIDERS

◆ Dental safety net providers are public and private non-profit organizations in Rhode Island and the U.S. that provide oral health care services to children and adults, particularly those who have Medicaid/RIte Care coverage, those who are uninsured, and/or those who are otherwise disenfranchised. Because they serve a high volume of patients with Medicaid coverage and patients who have no insurance coverage at all, dental safety net providers are reimbursed by Medicaid programs at higher rates than private dentists.

◆ Federally qualified community health centers are paid a federally mandated encounter rate for dental (and medical) services. Although each community health center is paid its own reimbursement rate based on its own costs, all are paid per dental visit, regardless of the type or number of procedures performed. Medicaid reimbursement rates paid to the two hospital-based dental centers in Rhode Island were increased in July 2003. While these rates are enhanced compared to those paid to dentists in private practice, they remain below the reimbursement rates paid by commercial insurers.[64]

DIFFICULTIES IN ACCESSING SPECIALTY DENTAL CARE

◆ Despite the increase in the number of providers who will accept patients with RIte Smiles coverage, private practice dentists and safety net sites who make referrals for specialty dental care report an ongoing acute shortage of oral surgeons in Rhode Island who are willing to accept patients (children and adults) with any types of Medicaid coverage, including RIte Smiles and Medicaid Fee-For-Service.

◆ Generally, Rhode Island children with private dental insurance are the easiest to refer for specialty dental care, while children with Medicaid coverage (including those with RIte Smiles as well as those with Medicaid Fee-For-Service coverage), uninsured children and children with special needs are more difficult to refer.[65]

RHODE ISLAND HAS IMPROVED ACCESS TO ORAL HEALTH CARE FOR CHILDREN WITH MEDICAID COVERAGE

RITE SMILES

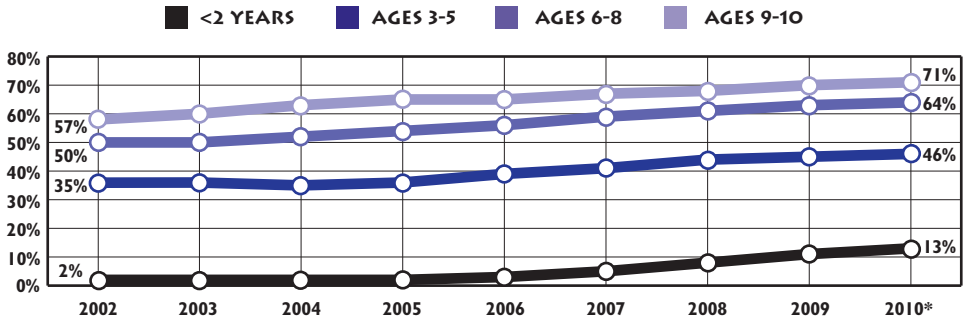
◆ Launched in 2006, RIte Smiles is Rhode Island's managed care oral health program for children with Medicaid coverage. RIte Smiles was designed to increase access to dental services, promote the development of good oral health behaviors, decrease the need for restorative and emergency dental care and decrease Medicaid expenditures for oral health care.

◆ RIte Smiles offers higher reimbursement rates for participating providers, an improved network of providers willing to treat young children and assists clients with transportation and interpreter services, if needed.

◆ There is currently a single RIte Smiles dental plan – United Healthcare Dental. All children enrolled in RIte Care who meet the age criteria for RIte Smiles are covered by United, regardless of which RIte Care health plan they have for medical coverage.

◆ RIte Smiles has been credited with improving access to dental care (both preventive and treatment services) for young children in Rhode Island.[66,67,68,69]

CHILDREN AGES 0-10 WITH MEDICAID COVERAGE WHO RECEIVED ANY DENTAL SERVICE BY AGE, RHODE ISLAND, 2002-2010



*2010 are provisional estimates from claims paid through December 2010
Source: Rhode Island Executive Office of Health and Human Services, 2011

◆ Between 2002 and 2010 in Rhode Island, there were gains in access to dental care among children under age 10 with Medicaid coverage, with the largest increases coming since 2006, when RIte Smiles began.

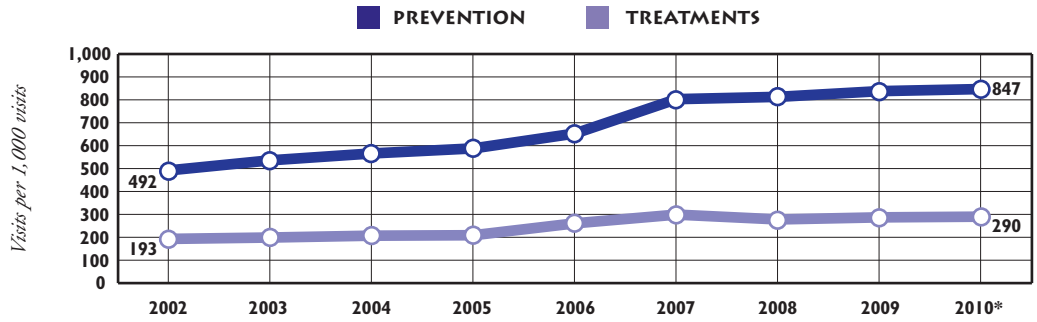
◆ Thirteen percent of children ages two years and younger with Medicaid coverage received any dental care in 2010, marking a 597% improvement since 2002 and the first time that over 10% of this age cohort received dental care.

◆ The percentage of children ages three to five years with Medicaid coverage who received dental care increased by 31% between 2002 and 2010, from 35% to 46%.

◆ School-age children had comparable increases in dental care access, with 27% more children ages six to eight and 24% more children ages nine to ten with Medicaid coverage receiving dental care in 2010, compared with 2002.

◆ Approximately 70% of children ages nine and ten with Medicaid coverage received at least one dental service in 2009 and 2010.[70]

DENTAL VISITS AMONG CHILDREN AGES 0-10 WITH MEDICAID COVERAGE BY CATEGORY OF CARE, RHODE ISLAND, 2002-2010



*2010 are provisional estimates from claims paid through December 2010
Source: Rhode Island Executive Office of Health and Human Services, 2011

◆ The launch of RIte Smiles in 2006 marked the beginning of an upward trend in preventive dental services among children with Medicaid coverage, including a 33% increase in preventive visits between 2005 and 2007. A major objective of RIte Smiles is to improve access to preventive care for young children in order to reduce dental disease and the need for costly restorative treatment later in life.

◆ Dental treatment (for dental problems) had remained at approximately 200 visits per 1,000 visits between 2002 and 2005, before RIte Smiles. The treatment rate has remained steady at about 300 visits per 1,000 visits since (an increase of 50%), indicating that more children are gaining access to oral health care.[71]

◆ One important type of preventive service are dental sealants. Between 2002 and 2010, there was an 84% increase in the percentage of children ages six to nine with Medicaid coverage who had at least one dental sealant, increasing from 1,905 children in 2002 to 3,504 children in 2010.[72]

◆ There were several concurrent dental access initiatives that occurred in Rhode Island in the mid-2000s which also may have contributed to access gains for children with Medicaid coverage during this time period. These include the expansion of school-based dental programs in core cities; growth in two hospital-based dental residency programs; increases in staffing and dental operatories at safety net sites; a two-day "mini-residency" training program to build the knowledge, skills and confidence of general practice dentists to treat young children; grand rounds and other training presentations for pediatricians to improve their knowledge and skills in oral health assessment, topical fluoride treatments and referrals to a dental home); and allowing Medicaid reimbursement to primary care providers for fluoride varnish.[73,74,75,76]

ORAL HEALTH PROVISIONS IN HEALTH REFORM

◆ The federal *Affordable Care Act* (ACA, commonly referred to as health reform) presents Rhode Island with many opportunities and challenges to improve access to health care, including oral health services. Because of the existing EPSDT provisions, the scope of dental services for children covered through public insurance programs such as RIte Care/RIte Smiles will likely remain protected and unchanged under the ACA.

◆ However, the ACA is likely to increase access to private dental insurance for children accessing health care through the Rhode Island health insurance exchange that will be established starting January 1, 2014. Plans offered through state health insurance exchanges will be required to cover pediatric dental benefits as "essential health benefits." While further definition of the full scope of medical and dental "essential benefits" will be issued by the U.S. Department of Health and Human Services, the inclusion of a pediatric dental benefit as a mandatory requirement is a historic policy victory for children's oral health advocates.[77,78,79]

RHODE ISLAND'S DENTAL WORKFORCE – PROVIDING ACCESS TO CARE

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.

DENTISTS

◆ There were 614 actively practicing licensed dentists in Rhode Island in 2010. Sixteen 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. It is estimated that Rhode Island needs to recruit 31 primary care dentists to provide dental care to 112,316 residents who are currently underserved.[80]

DENTAL SPECIALTY	NUBER ACTIVELY PRACTICING AS OF DECEMBER, 2010
Pediatric Dentists	24
Prosthodontists	7
Endodontists	17
Periodontists	25
Oral / Maxillofacial Surgeon	30
Orthodontists	41
Dental Anesthesiologist	1
Undetermined Specialists	24
Total Dental Specialists	*169*
General Dentists	445
Total All Dentists	***614***

Source: Rhode Island Department of Health, Oral Health Program

◆ Mirroring a national trend, a large proportion of actively practicing dentists in Rhode Island are nearing retirement age. As of December 2010, 44% of actively practicing dentists in Rhode Island were aged 55 years or older (16% were over age 65).[81]

◆ In-state education and training programs for dentists are in limited supply in Rhode Island. There is no dental school and only seven Rhode Island residents were enrolled in out-of-state dental schools during the 2009-2010 academic year anywhere in the U.S.[82] However, St. Joseph Health Services and Blackstone Valley Community Health Care do host dental students from neighboring states for practice rotations.[83] Because dental school graduates often practice in close proximity to their training site, Rhode Island is at a disadvantage in recruiting and retaining dentists.

DENTAL RESIDENCY PROGRAMS IN RHODE ISLAND

◆ Dental residents are fully trained, licensed dentists who have graduated from dental school and are enrolled in a postdoctoral training program. Dental residents increase the capacity of the dental centers at which they are trained to treat more patients and also serve to recruit dentists to Rhode Island.

◆ There are three dental residency programs in Rhode Island. The Advanced Education in Pediatric Dentistry (AEPD) program at the St. Joseph Health Services' Pediatric Dental Center in collaboration with Lutheran Medical Center in Brooklyn, New York annually graduates four pediatric dentists. The General Practice Residency (GPR) program at the Samuels Sinclair Dental Center at Rhode Island Hospital and the Advanced Education in General Dentistry (AEGD) Program at the Providence Veteran's Affairs Medical Center each graduate two dentists annually.[84,85]

INVOLVING OTHER PROFESSIONS IN ORAL HEALTH

◆ Oral health is often seen as the sole responsibility of dental professionals, but other health care providers (e.g., pediatricians, primary care physicians, nurses, OB/GYNs, childbirth educators, nutritionists, community health workers and others who see children and families regularly) also have opportunities to promote oral health, facilitate timely referrals (especially for the recommended first visit to a dentist by the age of one), provide preventive measures (such as fluoride varnish) and introduce the concept of a dental home to children and their parents.[86,87]

RHODE ISLAND'S DENTAL WORKFORCE – PROVIDING ACCESS TO CARE

DENTAL HYGIENISTS

◆ With their training as prevention specialists, dental hygienists play an important role in increasing access to preventive oral health care. While there are currently no reliable data on whether hygienists practice full or part time, there were 807 registered dental hygienists with active licenses in Rhode Island in December 2010, 661 of whom have practice addresses in Rhode Island.[88]

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 2008, 1,048 dental assistants were employed in Rhode Island. Dental assistants may be trained in ADA-accredited programs and become certified by the Dental Assisting National Board (DANB), or they may be trained on the job. In 2011, DANB reported that there were 330 certified dental assistants (CDA) in Rhode Island.[89]

THE DENTAL SAFETY NET WORKFORCE

◆ In early 2011, nearly 157 full-time equivalent (FTE) dentists, dental residents, dental hygienists and dental assistants were employed by dental safety net providers (such as community health centers, hospital-based dental centers, and mobile dental programs) in Rhode Island. This total is nearly double the approximately 83 FTEs dental safety net clinicians reported in 2005-06. This increase in staffing has allowed the number of children receiving dental care at these sites to improve dramatically.

In 2011, seven dental safety net sites in Rhode Island reported having at least one staff vacancy. Across the Rhode Island dental safety net, there were vacancies for 4.15 FTE dentists and 3.9 FTE dental assistants, for a total of 8.05 FTE vacancies. The consequence of vacancies is delayed access to care, allowing existing oral disease to become more severe as it remains untreated.

Dental safety net providers report that more competitive salaries and benefits, tuition reimbursement, in-state training programs, expanded loan repayment, referral bonuses and a more qualified applicant pool could help them to better recruit and maintain dental professionals.[90]

LOAN REPAYMENT FOR DENTISTS WORKING WITH THE UNDERSERVED

◆ 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 Service 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. 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.[91]

EXPANDING THE DENTAL WORKFORCE

◆ Many states are considering ways to maximize the scope of practice for existing types of dental providers in order allow them to be most productive and provide the highest quality care. Some states are broadening the scope of practices of current dental providers, while others are establishing new types of practitioners. Rhode Island should carefully examine the various options and experiences in other states as it plans how to best meet the oral health needs of children, adults and elders in the future.[92]

DENTAL SERVICES FOR CHILDREN IN RHODE ISLAND

DENTISTS IN PRIVATE PRACTICE

◆ Most dentists in Rhode Island and the U.S. practice in private practices, which are small businesses that are comprised of a single dentist or a small group of dentists with a shared dental team. In 2010, 52% of Rhode Island dentists reported being solo practitioners and 35% were group practitioners (while 8% practiced at community health centers and 2% at hospital-based dental centers).[93]

HOSPITAL-BASED DENTAL CENTERS

◆ **St. Joseph Health Services** operates three pediatric dental centers, all of which offer a full range of dental services for children from birth through age 18 with public insurance, commercial insurance and those that are uninsured (a sliding fee scale is available). Some adults with special health care needs also are treated at St. Joseph and approximately 20% of all patients treated there have special needs.

Together, the three St. Joseph Health Services Pediatric Dental Centers treated 13,248 children ages 18 and under in 2009. Depending on the office locations, between 45% and 80% of patients served were children younger than 6 years old.

Established in 1995, St. Joseph Health Services Pediatric Dental Center in Providence has 13 dental operatories and hosts a program specifically for infants and toddlers. There are three dental operatories at St. Joseph Dental Center at Fatima Health Center in Pawtucket (opened in 2004) and at St. Joseph Pediatric Dental Associates in Johnston (which was opened in 2009).

The current wait time for dental hygiene appointments at St. Joseph Health Services Dental Clinics is six weeks (an improvement from the 7.5 months waiting time reported in 2004). The wait time for restorative appointments with a dentist or specialist is two to three months. Children with emergency oral health problems can be scheduled the same day or within 24 hours at all locations.[94,95]

◆ **The Samuels Sinclair Dental Center at Rhode Island Hospital** in Providence provides a full range of dental services for 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. Opened in 1931, Samuels Sinclair has 11 dental operatories.

Among the 5,716 patients treated at the Samuels Sinclair Dental Center in 2009, two-thirds (67%) were children under age 18 and one-third (33%) were adults ages 19 or older. Of all patients, 14% were children under age six.

The current wait time at Samuels Sinclair is one month for new pediatric patients and three weeks for pediatric restorative appointments with a dentist. Children with emergencies can be scheduled the same day.[96,97]

SCHOOL-BASED DENTAL SERVICES

◆ School-based dental programs are programs conducted within the school utilizing portable dental equipment or existing facilities. They may serve as a dental home for some children and/or can refer children to a fixed-site dental center. In 2009, four dental safety net providers (Comprehensive Community Action Program, East Bay Community Action Program, Thundermist Health Centers and St. Joseph Health Services) provided school-based dental services in a total of 90 elementary schools, 20 middle schools and three high schools in Rhode Island, as well as at the school at Bradley Hospital. A total of 11,797 students were served by these four dental programs in 2009, a 24% increase from approximately 9,500 students reported served by school-based dental programs in Rhode Island in 2005. Most of the children treated through these school-based programs were covered through Medicaid or were uninsured.[98]

COMMUNITY HEALTH CENTERS

◆ Nine community health centers offer dental services for children and adults at 15 sites in Rhode Island, including: Blackstone Valley Community Health Care (one site in Pawtucket), Block Island Community Health Center (one site in New Shoreham), Comprehensive Community Action Program (two sites in Cranston and Warwick), East Bay Community Action Program (one site in Newport), Providence Community Health Centers (two sites both in Providence), Thundermist Community Health Centers (three sites in Wakefield, West Warwick and Woonsocket), Tri-Town Community Action Agency (one site in Johnston), WellOne Primary Medical and Dental Care (three sites in Foster, North Kingstown and Pascoag) and Wood River Health Services (one site in Hopkinton).

◆ In 2009, 31,194 patients (10,768 children and 20,426 adults) were treated at the fixed dental sites of seven of the community health centers (those that responded to a survey designed to assess service delivery in safety net sites in Rhode Island). About one-third (35%) of patients served by community health centers were children ages 0–18 years and two-thirds (65%) were adults ages 19 years and older.

◆ Most community health centers saw more adult patients than children in 2009, with the exception of Providence Community Health Centers, which focuses on serving children and pregnant women only. Children under age six comprised between 3% and 7% of patients at community health centers in 2009, with the exception of Providence Community Health Centers, at which 40% of patients were under age six. Most children served by the seven community health centers in 2009 were covered by Medicaid/RIte Smiles or were uninsured.[99]

THE MOLAR EXPRESS – MOBILE DENTAL CARE FOR CHILDREN

◆ The Molar Express is Rhode Island's Ronald McDonald Care Mobile, a mobile van that has two dental operatories in which children ages two to 21 can receive preventive and restorative treatment. The Molar Express is a collaborative among the Comprehensive Community Action Program, East Bay Community Action Program and Thundermist Health Centers. Since it first opened its door in October 2006, the Molar Express has served 7,700 children at nearly 100 school, Head Start and community sites in 20 cities and towns.[100]

DENTAL SCREENINGS FOR SCHOOL-AGE CHILDREN

◆ Every 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 sixth and tenth 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 (who can be in private practice or through a hospital-based dental center or community health center) to perform screenings for children with no dental home and/or with no written documentation from parents of a dental exam at the prescribed intervals.

◆ Schools are required to notify the parent of dental screening results, to document the screening in the child's health record and to maintain a referral list for children without a dental home. However, there is no uniform statewide system through which data are collected, analyzed or reported on referrals needed or made to dental homes.[101]

RECOMMENDATIONS

ACCESS TO ORAL HEALTH CARE

◆ Promote and support a **dental home by age one** for all Rhode Island children, regardless of insurance status.

◆ Encourage and support professional education and funding mechanisms to support early intervention, risk assessment, prevention and a **chronic disease management approach** to dental disease for young children.

◆ Identify ways to **involve primary health care providers** in providing oral health assessment, referrals, and preventive measures for children and pregnant women.

◆ Promote the use of **evidence-based preventive measures** for children, including topical fluoride treatments (fluoride varnish) and dental sealants.

DENTAL INSURANCE COVERAGE

◆ **Build on the success of RIte Smiles by increasing the age range** of children who are eligible.

◆ Identify **solutions for the shortage of oral surgeons** who will accept children with RIte Smiles/Medicaid coverage or those with no insurance, as well as ways to improve access to **other specialty care.**

◆ Ensure that **pediatric dental benefits are available through Medicaid and the Rhode Island Health Insurance Exchange** (starting in 2014) at an affordable cost, in order to ensure that all children have insurance coverage for oral health services.

WORKFORCE

◆ Implement **workforce recruitment and retention strategies** to ensure an adequate supply of high quality dentists, dental hygienists and dental assistants, especially those who will treat very young children and participate in RIte Smiles and Medicaid.

ORAL HEALTH PROMOTION

◆ Improve **health promotion and disease prevention** efforts to increase knowledge and skills among Rhode Islanders in order to improve their oral health status.

◆ Improve **knowledge and eliminate barriers to access to care** by families with young children.

SAFETY NET

◆ Continue to **strengthen the infrastructure of dental safety net providers** by investing in capital needs for the maintenance and expansion of existing sites and establishing new dental centers in underserved communities.

RHODE ISLAND ORAL HEALTH COMMISSION

The Rhode Island Oral Health Commission has been the foundation of many efforts to improve oral health in Rhode Island over the past decade. The members of the Commission represent private practitioners, safety net providers, community organizations, educational institutions, state agencies, insurers and other oral health advocates. The *Rhode Island Oral Health Plan, 2011-2016* released by the Commission in January 2011 offers detailed recommendations in the following areas:

- ◆ Improving Access to Oral Healthcare
- ◆ Implementing Evidence-Based Oral Healthcare
- ◆ Preventing Oral Disease, Promoting Oral Health
- ◆ Maintaining the Dental Safety Net
- ◆ Sustaining the Oral Health Workforce
- ◆ Informing Oral Health Policy Decisions

For more information about the Commission, go to www.oralhealth.ri.gov (which is scheduled to be launched in September 2011).

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