UNIVERSITY OF THE PACIFIC
Arthur A. Dugoni School of Dentistry

Community-Based Oral Health Programs

IMPORTANCE

In California in 2008, 39% of the population had no dental insurance, while only 13% were without health insurance.[1] Individuals bear the entire cost of dental care and often go without care. This may change with health care reform.

More than 45% of children ages 0-20 who were eligible for Denti-Cal comprehensive dental services had one or more dental visits in fiscal year 2010-11.[2] A legislative briefing in October 2011 noted California needs to increase access and utilization rates of dental care by providing services where people are and achieving sustainability and efficiency in public dental health program models.[3]

However, even if all access barriers were removed, professional dental care is necessary but not sufficient to prevent dental diseases and oral conditions - many of which are due to behavioral, dietary and other factors that need culturally relevant and effective public health and personal prevention approaches.

Given the lack of current state health department leadership in oral health and the vast size and diversity of the state, local community-based solutions and advocacy are crucial for improving the oral health of the public.

WHAT ARE COMMUNITY-BASED ORAL HEALTH PROGRAMS?

There is no definitive definition of "community-based oral health programs," often referred to as "safety net programs," but many are developed from a shared vision and values of some segment of a community. Usually a needs assessment is performed and an individual or small group takes the lead to plan a program to meet some of the identified needs. Community input from diverse groups, including local dental professionals, is sought throughout the formation of the program, and capacity is built initially with the use of local assets and resources.

An advisory board including members of the target population(s) usually provides oversight and helps locate additional resources.

One component lacking from many community based programs over the years has been a sound evaluation plan to document oral health improvements and how well they are meeting community needs, especially as the needs may change.

Community-based oral health programs can be free-standing dental clinics, co-located with other health or supportive services, or use mobile or portable systems (or no dental equipment) in WIC or Head Start programs, well child clinics, home visits, schools, community centers, hospitals, homeless shelters, workplaces, and many other sites depending on the target population.

Programs are generally targeted to specific groups based on age, income, ethnicity, geography, special healthcare needs or a combination of factors. Some focus on people who are at high risk of having unmet oral health needs or who could benefit from a variety of prevention programs that may not involve clinical services.

These programs can be administered by non-profit organizations, city/county health departments, hospitals, universities, etc. Funding may be from a variety of sources: grants, donations, state/local funds, Medi-Cal/Healthy Families or private insurance reimbursement. Staffing can be employees, contractors, volunteers or students; not all need to be dental professionals.

Some combination of the following services are usually provided:

- Oral screening, risk assessment, counseling and anticipatory guidance, case management , referral to needed clinical services, assistance enrolling in any other programs (e.g., Medi-Cal, WIC)

- Preventive services with accompanying education (e.g., dental sealants, topical fluorides, mouthguards, tobacco use cessation)
- Basic or emergency dental treatment to restore/heal damaged teeth or tissues
- Comprehensive care with access to some specialty services (e.g., oral surgery, orthodontics)
- Dental laboratory services such as denture relines or repairs

No single model is going to meet every community's needs. Current workforce models may meet the needs of some groups but not others, especially as their needs change, technology increases and health financing and care systems are affected by economic, political and other factors. Multi-sector and multi-disciplinary collaborations and coalitions are important for any community-based model.

WHAT ARE SOME EXAMPLES OF COMMUNITY-BASED ORAL HEALTH PROGRAMS IN CALIFORNIA?

Dientes Community Dental Care was started in 1992 by a few local private dentists in Santa Cruz who wanted to provide care for the HIV infected population who had no other place to go. Over the years it was able to expand its facilities, staff and services to other populations and apply to become a "dental only" FQHC providing nearly 20,000 dental visits per year. The patient population includes diverse families as well as elderly, HIV positive, disabled, and homeless children and adults, 96% of whom live at or below the poverty level. Dientes accepts Denti-Cal, Healthy Families and Healthy Kids insurance, some private insurance, and offers payment options such as a sliding scale fee schedule for low-income uninsured patients. The outreach program provides preventive dental services and education in schools, WIC, Migrant Education and Head Start. Dientes also partners with the Pajaro Valley Health Trust, Monterey Bay Dental Society and Salud Para La Gente clinic to coordinate pro-bono care from private dentists for uninsured patients.[4]

Alameda County Public Health Department WIC/Oral Health Initiative focuses on the fact that 60% of California's children are born eligible for WIC services. Dental visits in WIC programs started in July 2008 and occur one day per

week at each of two sites. During group sessions, caregivers participate in group education (10-15 minutes), clinician encounters for risk assessment, fluoride varnish and counseling (10-12 minutes each), and case management (10 minutes). WIC nutrition assistants provide the education sessions. More than 50% of the children have dental appointments for necessary follow-up dental treatment facilitated through the use of a case manager. The client population is more than 50% Hispanic. Federal Maternal and Child Health Bureau grant monies were used to provide start-up funding for supplies, but now funding is diversified, including federal/local Federal Financial Participation (Title XIX funding for MCH), Denti-Cal reimbursement, First 5 and foundation funding. The program is moving to acquire cost-based FQHC reimbursement through the county's own 330h grant.[5]

First 5 Oral Health Programs: The First 5 Commission has invested significant resources (more than $80 million) in local oral health programs in most California counties since 2005. In 2008-09, when the last oral health survey of county commissions was conducted, $28 million was allocated to oral health: 49% to infrastructure, 30% to direct services, 8% to consumer education, 8% to support services and 5% to provider capacity building. Some counties contributed to fluoridation costs. Much attention is paid to use of bilingual staff and educational materials for parent education in the major language groups, and use of dental vans and portable equipment in rural areas. Many performed screenings accompanied by preventive services for the purposes of linkages to dental care, but lack of dentist participation in Denti-Cal proved to be a significant barrier. Provider training was one component coordinated by the Dental Health Foundation in conjunction with the California Dental Association Foundation to address this problem.[6]

CHARACTERISTICS OF SUCCESSFUL AND SUSTAINABLE COMMUNITY BASED PROGRAMS

- A coordinated system that constitutes a "dental home" or leads to one via referral and case management for those who don't have a source of regular professional oral health care
- An effective marketing plan and someone

responsible for community relations
- Culturally sensitive staff who can relate to and respect the target population(s)
- A solid, transparent business plan with a diverse funding base and flexibility for managing resources
- An infection prevention and control program for oral screenings and clinical services that meets state and federal standards
- A comprehensive record system that meets HIPAA and other confidentiality requirements
- Frequent and candid feedback from patients and people in the community who receive services and those who are eligible for the services but are not seeking them
- A comprehensive evaluation plan that measures effectiveness and quality of the services as well as client/patient and staff satisfaction
- An active, committed advisory board/local oral health coalition with well -connected oral health champions
- Use of new technology such as telehealth, electronic records, linguistic/cultural translation services, wellness/disease management tools.

RECOMMENDATIONS

- The California State Department of Public Health should create a database of community-based oral health programs and a listserv to share relevant information.

- First 5 Commissions and other funders should base their grants to counties and communities that can demonstrate evidence-based, culturally relevant approaches that are evaluated using specific and realistic outcome measures, not just process measures, that look at how well the programs are addressing community needs.

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RESOURCES

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