A Private Dental Practice Model For School-based Oral Health Services

Frank J. Courts, DDS, PhD

Our Mission

- Increase the oral health in children from North Carolina's low-income families

Barriers

- North Carolina has:
  - Limited financial resources
  - A low dentist to population ratio
  - A rapidly growing number of at risk children

How are we doing now?

- Dentist/Population ratio – 48/50
- Medicaid reimbursement – 25/50*
- Patient Utilization Rate – 8/50*

- Conclusion: Dentists of NC and DMA are doing pretty well!

- We can and must do better!

Solutions

- No one approach will remedy our oral health deficit
  - **Attitudes** of families and providers must change
  - Adequate **Funding** of oral health services must be addressed
  - **Mechanisms** to deliver efficient and affordable services must be developed
  - **Manpower** to deliver quality care must be available

Presentation?

- This presentation seeks to explore both delivery **mechanisms** and **manpower** issues that may help increase children's oral health in our state

Mechanisms

- Private Practice
- Public Health
- Mobile Vans
  - Comprehensive Care
  - For Profit
- School-based

Private Practice

- The Private Practice Model is an efficient method for provision of dental care. The culture of dentists and low-income families often reduce the effectiveness of this model. This model is best at providing a dental home for patients.

Dental Home AAPD

- The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

Private Practice

- Single Practitioner
- Group Practice
- Corporate Practice

- Private practices are transitioning toward larger business entities

10

Public Health

- North Carolina has a strong Dental Public Health program
- Resources are limited and unlikely to improve significantly
- Public Health has extensive experience with the delivery of school-based oral health programs

Mobile Vans
“Comprehensive Care”

- Examples in Western and Coastal North Carolina indicate that this model is effective
- Is very effective in low density population areas
- Cost? Without subsidies this model struggles to be viable

Mobile Vans
"For Profit"

- Move from school to school
- Provide limited services
- A corporate "For Profit" model
- "Cherry Pickers"
- Comprehensive care and the Dental Home concept?

School-Based

- **Preventing Dental Caries Through School-Based Sealant Programs November 2009** vol. 140no. 11 **1356-1365**
- "The evidence supports recommendations to seal sound surfaces and noncavitated lesions, to use visual assessment to detect surface cavitation, to use a toothbrush or handpiece prophylaxis to clean tooth surfaces, and to provide sealants to children even if follow-up cannot be ensured."

Manpower

- Dentists
- Mid-level Providers
- Dental Hygienists

Dentists

- UNC and ECU will soon graduate 130 dentists per year.
- ECU will graduate their first Class in 2014. Program shows great promise in the production of Graduates for underserved areas
- Sheps Center projections indicate that this rate will only maintain the status quo in a rapidly growing NC.

Mid-level Providers

- Extremely Controversial
- Quality issues
  - Reversible Procedures
  - Irreversible Procedures
- Two Levels of Care?
- North Carolina is a conservative State...

Dental Hygienists

- North Carolina currently possesses a large number of skilled licensed dental hygienists (RDH) that are under-employed or unemployed. This group of dental professionals are well-trained in the concepts of oral health and traditionally have provided services for an adult population.

How Can We Increase Services?

- One way to expand oral preventive services with existing manpower would be to utilize Dental Hygienists in a School-Based program. By linking the Hygienists to private practices, the initial expenditure, risk and reward would be borne primarily by the private sector.

Proposed Pilot Program

- **Use of Private Sector Dental Hygienists and Dental Assistants in a School-Based Oral Health and Sealant Program**

Proposed Model

- The RDH would be employed by the dental practice which would provide the dental home and more involved treatment for all the children served in the school-based program.

Services Performed

- Limited Oral Exams
- Prophylaxis
- Fluoride Varnish
- Oral Hygiene Instruction
- SEALANTS

Training for the “Pediatric” RDH

- Pediatric Certification to include:
  - Pediatric oral growth and development
  - Cariology
  - Pediatric behavior management
  - Contemporary Sealant placement techniques
- Mechanism?
  - UNC
  - ECU

Delivery Model?

- RDH and CDA team
- Mobile Dental Equipment
  - Chair, Light, Dental unit (6-8K)
- Dental Van
  - Much higher cost
  - Probably not practical in most instances

School Selection

- High Subsidized School Lunch Population (>85%)
- Under-served Areas
- Use of DMA data
- Guidance from Public Health Program

25

Upside

- Each team should provide:
  - 1200 exams, varnishes, cleanings and OHI per school year
  - 600 children sealed per school year
- Limited training of an existing health professional
- Limited expenditure of State Resources
- Would assist rural practice starts

Downside

- Need School Co-operation
- Unknown provider enthusiasm
- Activity would need approval by North Carolina Board of Dental Examiners

First Steps

- Get Support of North Carolina Dental Society
- Get approval for pilot study by NCBDE
- Develop Certification Criteria for RDH
- Identify Pilot Sites
  - Pediatric Dentist
  - General Dentist
  - ECU Learning Center
  - Public Health Participation

Thank You!

- Questions and Comments?