



## ***Executive Summary***

### ***Dental Utilization in Eight Central California Children's Health Initiatives' Healthy Kids Programs***

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#### ***Background***

In April 2006, the California HealthCare Foundation (CHCF) awarded Diringer & Associates, a Central California based health policy consulting firm, a grant to analyze dental utilization in Healthy Kids programs administered by eight Central California Children's Health Initiatives. The eight Central California counties that were the focus of this study were: Fresno, Kern, San Joaquin, Tulare, Yolo, San Luis Obispo, Santa Barbara and Santa Cruz.

Delta Dental, the dental plan for the Healthy Kids programs, provided adjudicated claims data for the six month period of January through June 2006. This was a period when a number of the counties were in the start-up phase of their programs which may have affected utilization. Additional data were obtained from the Denti-Cal (Medi-Cal) program and the Healthy Families program.

#### ***Key findings***

- 1. What are the rates of utilization of dental services by children enrolled in the individual county Healthy Kids programs, as measured by at least one dental visit in past year?*

The percentage of enrolled children who received at least one dental service varied between counties ranging from 14.7% in Fresno County to 48.8% in Santa Cruz County with an average of 32.6%.

Overall, the percentage of Healthy Kids enrollees with a dental visit during the study period was less than the percentage of children with Healthy Families who received a dental visit within the past year. When compared to Medi-Cal utilization, Healthy Kids utilization for both

age groups (0-5 and 6-18) was substantially lower than Medi-Cal utilization in Fresno, Tulare and Yolo Counties. For older children, Healthy Kids utilization was substantially lower than Medi-Cal utilization in Kern and Santa Barbara Counties. The Healthy Kids programs in San Joaquin, San Luis Obispo and Santa Cruz Counties had higher utilization rates for the youngest age cohort, perhaps reflecting their efforts in targeting young children. Nevertheless, the percentage of Healthy Kids enrollees that had a visit is comparable to the national statistics which show that only 30% of low income children had annual dental visits.

The percentage of children under age 3 receiving services is extremely low and enforces the need of CHI programs to educate both parents and providers on the importance of finding a dental home and receiving dental care at a very young age.

2. *What are the types of dental services being utilized by children enrolled in the individual county Healthy Kids programs, by age of child?*

Nearly all children who had a dental visit received diagnostic (88%) and preventive (83%) dental services and about half (49%) received some type of restorative dental care (fillings). The percentage of children who had oral surgery (predominately extractions) ranged from 11% in Yolo County to 21% in San Luis Obispo County, with an average of 16%. The data show large numbers of children who are having teeth extracted, indicating severe dental disease.

Yet, not all children received preventive services. Of the 2,120 children age 6 years and older who received dental care, only 527 (25%) received dental sealants, ranging from 13% in Kern County to 33% in San Luis Obispo County. Statewide, California ranks very low in the prevalence of children with dental sealants. Given the efficacy of dental sealants in preventing disease, efforts should be made to increase the use of dental sealants in CHI enrollees in all counties.

3. *Which participating dentists in each county are providing services to children enrolled in Healthy Kids, and what is the intensity of their participation?*

The percentage of participating dentists on the Healthy Families/Healthy Kids panel who saw Healthy Kids enrollees ranges from 19% in Kern County to 100% in Santa Cruz County, with an average of 36%.

In Fresno, Kern, San Joaquin, Santa Barbara, Tulare, and Yolo counties, the largest single provider of care was a private dentist; while non-profit clinics were the largest providers in Santa Cruz and San Luis Obispo Counties. Overall, 68% of the dentists saw fewer than 10 children; although this percentage varied widely from 31% in Santa Cruz County to 93% in Fresno County.

Having a large panel size does not mean that these dentists will be seeing Healthy Kids enrollees. The county with the largest panel, Fresno County, had one of the lowest participation rates and had the lowest utilization rate. Conversely, Santa Cruz had the smallest panel size, but all the providers on the panel saw children, and Santa Cruz County had the

highest percentage of children seeing a dentist. Similarly, in San Luis Obispo County, 21 of 23 participating providers saw Healthy Kids enrollees.

The results suggest that concentrating on increasing the intensity of participation of dentists on the provider panel may result in more children being seen than merely trying to enlarge the pool of providers. Of course, geographic access is necessary and is more difficult to achieve in rural areas.

## **Recommendations for improving access to dental care**

- **Increase dental provider participation:** To increase provider participation, CHI programs must develop a good working relationship with local dentists. Ways to do this include:
  - Recruit a local dentist (preferably a private practice dentist) to serve on the CHI board or advisory committee.
  - Work with the local dental society to identify ways to increase the number of children served by each dentist on the CHI panel.
  - Contact dentists on the panel who have not served Healthy Kids children to find out why they are not participating.
  - Listen to the concerns of local dentists and try to address their concerns.
  - Take time to thank those dentists who provide care to a large number of children.
- **Work with medical providers:** Young children are more likely to receive medical care than dental care. Because of this, it is essential that CHI programs increase the extent to which physicians, nurses and physician assistants provide oral health screenings and referrals, especially for infants and toddlers.
  - Involving the medical profession is so vital to the oral health of young children that the American Academy of Pediatrics has released a policy that states “Every child should begin to receive oral health risk assessments by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional.”
  - Send a list of participating dentists to local medical providers so that they can make direct referrals.
  - Develop a medical-dental network whereby dentists agree to take patients referred by specific medical providers.
- **Reduce broken appointments:** Eliminating broken appointments is essential in order to maintain dental providers in the panel. One successful approach to reducing broken appointments is to educate parents on the importance of attending scheduled appointments. Washington State’s Access to Baby and Child Dentistry (ABCD) program has produced several educational pamphlets for parents on dental office “Dos and Don’ts”.
- **Educate parents:** Many CHI parents do not understand the dental care system or the importance of regular dental care. Educating parents is a vital component in an access improvement campaign.
  - Develop and distribute a written list of dental providers.

- Provide enrollees with a written guide on how to contact a dentist, make an appointment, and the importance of not missing appointments.
  - Have one-on-one conversations with parents to review written materials.
  - Send letters to parents reminding them to schedule a dental visit at least once a year.
  - Encourage parents to seek dental care for all of their children, regardless of age.
- **Develop/strengthen local dental safety net providers:** Become an advocate for dental safety net providers, including community health centers.

## Conclusion

The Children's Health Initiatives in the eight study counties have provided dental coverage to nearly 2700 previously uninsured low income children. Many of these children have accessed dental services with this coverage, often to treat serious dental disease.

These data only cover the first few months of most of the CHIs and further investigation into the utilization of the coverage over a longer study period will yield more comprehensive information. However, it is obvious that coverage alone does not ensure the actual utilization of services or the receipt of appropriate preventive services. The tasks for the CHIs are to:

- ensure that parents are educated about the needs for early and continuous dental care for their children,
- minimize barriers to the receipt of that care,
- encourage dental providers to see young low-income children, and
- work with medical providers to refer children to dentists at a young age.

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