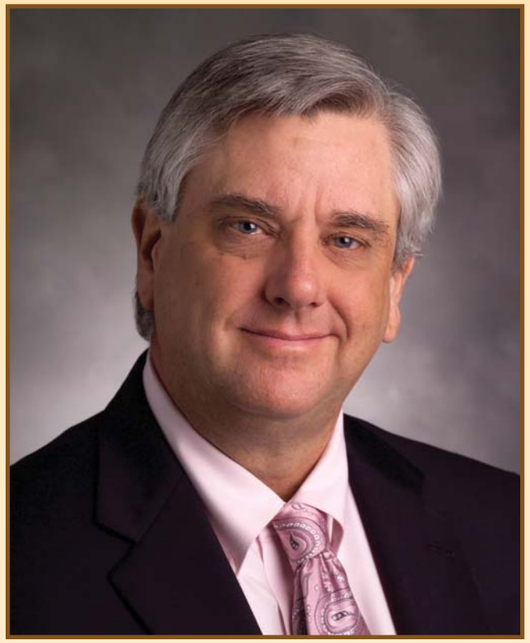
Improving the Oral Health of the Underserved: You Can't Cure What You Misdiagnose



By Carter Brown, DMD

Vice Chair, ADA Council on Communications; Chair, Access to Care Work Group

Dr. Brown is a private general dentist in Greenville, South Carolina.

I was asked to share my thoughts and experiences as an individual, private practice dentist, as well as a state dental society leader, on how workforce issues affect access to oral health care for the underserved. Whenever this topic comes up, I ask, "Exactly what are we trying to accomplish?" For my part, our ultimate goal should be achieving optimal oral health for everyone who seeks it.

I remain frustrated and saddened that so much time, resources and debate surround one proposed solution—the so-called midlevel provider—which focuses exclusively on treating disease that has already occurred. This is essentially increasing the speed at which you're bailing a very leaky boat. It ignores the need for a comprehensive strategy that diagnoses the full extent of the driving factors. Access to clinical care is just one of many factors needed to improve oral health. Workforce is but a small part of the access factor.

The patient base in Greenville, S.C., runs the full spectrum, as does the local economy. We have international corporations but also abandoned textile mills and their displaced workers. During my 27 years in general practice here I have treated patients that reflect this cross section. For the most part patients show similar oral

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"Access to clinical care is just one of many factors needed to improve oral health. Workforce is but a small part of the access factor. What does "access" really mean? Is it the number of patients who receive care, the ability of patients to get care, the degree to which patients get care, or the ease with which they can get care? I believe that a lack of clarity has caused us to lose sight of what we are trying to accomplish."

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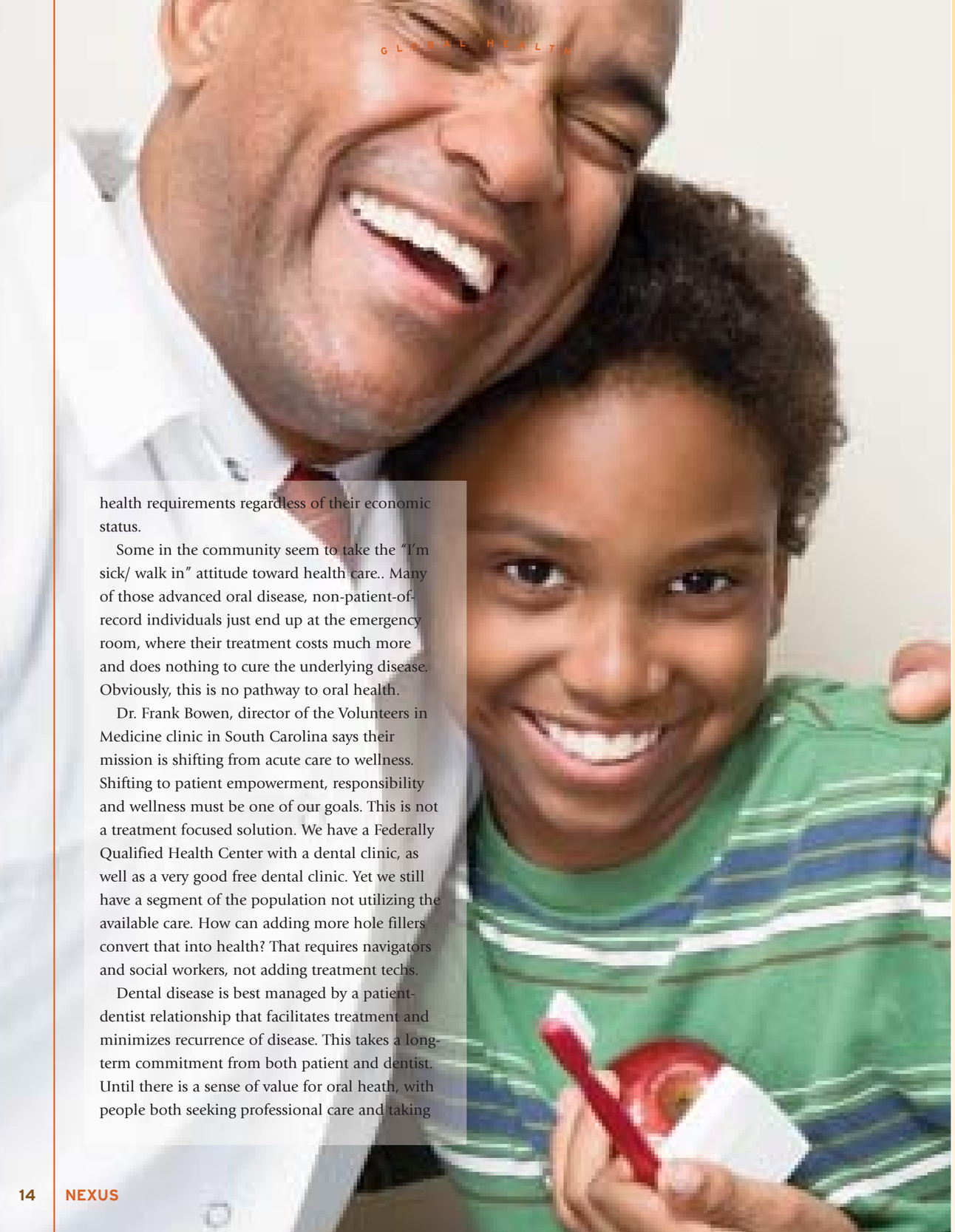

health requirements regardless of their economic status.

Some in the community seem to take the "I'm sick/ walk in" attitude toward health care.. Many of those advanced oral disease, non-patient-of-record individuals just end up at the emergency room, where their treatment costs much more and does nothing to cure the underlying disease. Obviously, this is no pathway to oral health.

Dr. Frank Bowen, director of the Volunteers in Medicine clinic in South Carolina says their mission is shifting from acute care to wellness. Shifting to patient empowerment, responsibility and wellness must be one of our goals. This is not a treatment focused solution. We have a Federally Qualified Health Center with a dental clinic, as well as a very good free dental clinic. Yet we still have a segment of the population not utilizing the available care. How can adding more hole fillers convert that into health? That requires navigators and social workers, not adding treatment techs.

Dental disease is best managed by a patient-dentist relationship that facilitates treatment and minimizes recurrence of disease. This takes a long-term commitment from both patient and dentist. Until there is a sense of value for oral heath, with people both seeking professional care and taking

ownership of their own health, we will never see the increase in utilization that should be a natural driver for oral health.

As a profession, we still suffer from a Rodney Dangerfield syndrome. Politicians, comedians, and other public figures routinely joke that something awful is "about as pleasant as a root canal!" Even in matters of public health, dentistry often is not taken seriously. Excessive soft drink consumption, combined with poor oral hygiene can devastate the teeth, a condition that some dentists refer to as "Mountain Dew Mouth." Dentists in many states have long lobbied to remove soft drink machines from schools, but it was not until obesity became a major concern that schools took action. We shouldn't quibble when people finally get around to doing the right thing, no matter what drives them to do it, but the societal failure to value oral health is chronic and at times crippling.

Dentists are the doctors of oral health. Dentists diagnose and cure disease. We eliminate pain and infection. Our continually broadening scope of clinical training, along with salivary diagnostics and improvements in technologies such as imaging, are allowing dentists to diagnose some systemic diseases early in their development, with potentially life-saving outcomes. Most importantly, with the possible exception of vaccinations, modern dentistry evinces the most successful model of prevention in all of health care.

Unfortunately on the policy side, oral health remains perennially short-changed, and the consequences of that neglect on the most vulnerable Americans are accordingly profound and tragic. I do not believe that surgical intervention, especially given realistic expectations of public oral health funding; will ever end the epidemic of untreated oral disease. Prevention with oral health education as its foundation can. You can't drill your way to oral health.

Does the mom who gives her kids candy at the check-out line know how to keep their teeth and gums healthy? Are diabetics aware of the particular importance of monitoring and maintaining their periodontal health? How many parents know to get a baby to the dentist when her first tooth erupts? The federal government spent millions educating the nation about digital TV conversion. How much does it spend on oral health education? The government offered coupons for digital converter boxes for those who couldn't afford one. Where are the dental care coupons?

This pervasive, societal failure to understand, value, and act on the importance of oral health is a far more meaningful factor than workforce. I base this on years of experience as an advocate for better oral health in South Carolina, a state with historically strong rates of dentist participation in Medicaid.

Here are some key findings from a five-year assessment of 5,732 children in 73 schools done by the state Department of Health using standards developed by the Association of State and Territorial Dental directors: Children enrolled in Medicaid were 32 percent more likely to have "caries experience" than those not enrolled. However, children in the Medicaid group showed no significant difference in untreated caries from those in the general population. The same held true for the treatment urgency summary. Rates were the same as those for the privately insured population. And children enrolled in Medicaid were more than 35

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percent more likely to have sealants than non-enrolled children. The study concluded that "parent involvement and transportation" were the big drivers of utilization of care, not the availability of dentists, and not income level.

This is not to say that workforce isn't a significant factor, one that can positively affect the oral health of the underserved. Ten years ago the South Carolina Dental Association received a Robert Wood Johnson Foundation grant to test patient navigators. We targeted counties with few dentists and low utilization. The navigators were from the target communities and knew who needed care. They helped patients make and keep appointments and follow-up appointments when indicated. With very little money and very little training time, utilization rates increased to match those of surrounding counties.

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We now provide training for school nurses and have created a new position, the Community Oral Health Coordinator. The issue was not the availability of dentists. Multiple factors—chiefly logistical and administrative barriers and lack of oral health literacy—were creating oral health crises in pockets of the state. The introduction of these simple and low-cost innovations helped these communities lift themselves up to a better state of oral health.

South Carolina's Rural Dental Incentive plan helps repay student loans for dentists who locate in designated areas and treat Medicaid patients for three years. Most of the participating dentists have stayed beyond that three-year commitment.

We started a free dental clinic using senior dental students on a rotation to provide free, comprehensive care. We use a technical college's hygiene department and space at the free medical clinic. Supplies are donated and local dentists donate their time as adjunct faculty. A mobile van donated by a hospital allows us to travel to nursing homes and other locations. We plan to add a hospital rotation to help with pre-surgery oral health issues and collaborate on oral systemic research with diabetic patients. Medical University of South Carolina (MUSC) College of Dental Medicine Dean Jack Sanders, DMD, says these programs help the students "grow their hearts" for community commitment.

The key is not the number of dentists; it is treatment capacity. The decades old ratio of 1:2,000 is out of date. The Health Resources and Services Administration standard is now 1:5,000. Advances in technology and practice efficiency, along with increases in both the number and scope of practice of auxiliaries within the dental team have increased the oral health system's capacity to deliver care. Microeconomics 101 tells us not to increase capacity until we maximize our existing production. In a March 2011 national survey by the Academy of General Dentistry, more than 50 percent of the dentists said they could take on as many as 11 percent to 25 percent more patients with the capacity they already have.

If there is not a shortage of dentists, then why doesn't everyone get care?

Without insurance, cost can be a barrier. If you need help making appointments, just finding a dentist can be a barrier. If you lack basic oral hygiene, disease is almost inevitable. If you feel stigmatized by oral disease, you're a lot less likely to seek help. If you can't get a ride to the dentist, or time off from work, or find someone to watch the kids, you can't get care. Increasing workforce size does nothing to address those basic needs. Most of the factors separating patients—or more accurately, people who should be patients—from dentists are not in our control. The real barriers to care, or drivers for utilization for care, reside in the realms of education, social services, societal and cultural norms, ancillary needs such as transportation or child care, a systemic failure to value oral health and, ultimately, the financial commitment to overcome these barriers.

Canada and New Zealand have learned the hard (and expensive) way that therapist programs oriented almost exclusively toward restorative procedures did not reduce the caries rate. Without educating patients, instilling a sense of the value of oral health, implementing widespread prevention programs, providing the ancillary support that people need to participate in the oral health system and—sorry folks—coming up with the funding needed to make all of that happen, all the therapists in the world will not create health. Think again about obesity. Would anyone in his right mind suggest that the way to control that epidemic is to train non-physicians to perform liposuction?

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Remember that our goal is the best possible oral health for as many people as possible. We need to quit arguing about whether therapists might hurt patients or what the definition of access is. Existing, available services are underutilized for multiple reasons. Focusing only on untreated disease leads, I believe erroneously, to the conclusion that we need more people to fill and pull more teeth. We need better information for our diagnosis. Midlevel providers have after decades failed to improve the oral health of the underserved populations or save money in the very countries that their advocates hold up as shining successes that should be replicated here.

Positive workforce ideas like patient navigators, programs that train school nurses and physicians to assess risk and refer to dentists, and expanded function auxiliaries are all proven successes. They promote oral health by empowering people to take care of themselves. They bring people into a proven system based at its heart on the doctor-patient relationship, and are very cost effective.

We have made significant progress in South Carolina. Much work remains. The biggest barrier of all is the need for societal recognition of the value of oral health and that oral health is achievable for all those who seek it. Creating a second tier of care is a treatment plan based on a faulty diagnosis. You cannot cure what you misdiagnose.