

# The Children's Dental Health Plan – A Success Story to Build On

A review of the importance of Children's Oral Health, what Newfoundland and Labrador are doing to support optimal oral health of children, and what needs to be done in the future.



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# Objectives for Today

- How have we (the Provincial Government and the Dentists) provided for the children with the existing CDHP?
- How is that plan working?
- How do we plan for the future?

Good oral health is essential to overall health and quality of life.

- Canada is among the world leaders in the oral health of its population, with significant decreases in dental decay over the past 40 years.
- However, there are specific groups of vulnerable populations where Canada struggles to provide access to regular dental care:
  - Seniors
  - Low income populations
  - Special needs
  - Indigenous people
  - New immigrants/refugees
  - **CHILDREN**

# Current state of children's oral health in Canada



- 2.26 million school days are lost annually due to dental visits or dental sick days.
- 4.15 million work days for adults are lost annually due to dental visits or dental sick days, for themselves and their families.
- Dental decay (caries) is the most common chronic disease, and is 5 times more common than asthma.
- Nationally 56% of children between 6-11 have dental decay.
- Nationally 6-8% of preschoolers suffer from dental decay.
- Dental caries is the single most common reason that children are seen in the hospital for day surgery.

# Dental caries

- A chronic, transmissible, but PREVENTABLE disease.
- Risk is dependant on many factors:
  - Environmental – parental knowledge, healthy habits, timing and frequency of dental visits, exposure to fluoride
  - Presence of infectious agents
  - Genetic modifiers such as tooth shape, position and salivary flow.



Why do we care about  
our children's oral  
health?



# Pain

- lost sleep
- Poor concentration
- Affects behavior and appropriate nutrition
- Leads to poor communication and socialization



# Severe Infection

Dental infection can easily and quickly spread into adjacent soft tissue, leading to a potentially life threatening situation.



In 2007, in Maryland, a 12 year old boy, Deamonte Driver, died due to chronic, untreated dental infection. This event has been used to highlight the necessity of universal dental care for children in the US.





Disruption of normal growth and development, space loss and malocclusion.

Baby teeth are very important in the development of proper speech patterns, proper nutrition, the growth and position of the developing adult dentition.



# Mental Health – psychosocial effects

*American Journal of  
Orthodontics and  
Dentofacial  
Orthopedics*



Study out of Europe surveyed 900 children aged 11-12, boys and girls. 40% of girls and 55% of boys reported being bullied. Of the children who reported being bullied:

- 26% due to the clothes they wore
- 30% due to their hair
- 31% due to their weight
- 50% due to the look of their teeth

# Morbidity and Death

Severe dental infection can lead to death, as can complications of the General Anaesthetic used for dentistry done in the OR (neurotoxicity and over sedation).



Deamonte Driver of Maryland – 12 years old

- Abscessed upper permanent molar
- Over \$250,000 in medical treatment including emergency surgery and IV antibiotics. He still died.
- An \$80 extraction could have saved him.
- Journal of Endodontics study states that between 2000 and 2008, there were 61,000 hospitalizations in the US for severe dental infections. Of those 61,000 patients, 66 patients died.

# Cost of Care

- \$21.2 Million is spent annually on a national basis to treat children in the hospital for dental related disease.
- 19,000 day surgeries nationally per year due to dental disease in children – likely under reported due to lack of regional data.
- These numbers increase in aboriginal (8.6X), low socioeconomic(3.9X) and rural populations (3.1X).
- 2.26 million lost school days due to dental disease
- The average cost to the medical system of dental treatment performed in a hospital setting (National averages) –
  - General Anaesthetic \$200 - \$1000 per case
  - Facility Fee \$500-\$1000
  - Dental Fees \$500-\$3000
  - Emergency room visits???

**These costs are PREVENTABLE.**



## FIRST VISIT, FIRST TOOTH

We see infants by age 1  
*or*  
within 6 months of eruption  
of the first tooth.



# Canadian Dental Association

## First Tooth – First Visit



- Only 1% of children are seen by a dentist by their first birthday.
- Why? Primarily cost, and secondarily parent education of importance.
- In NL, cost of examinations and this first visit is covered by the Children's Dental Health Plan, but this does not address the oral health education of the parents.
- Why is it important?
  - Establishing a dental home within the first 6 months of the eruption of the first tooth gives opportunities for prevention and parent education.
  - Assessments of oral hygiene, diet, fluoride exposure.

# MCP – Children's Dental Health Plan

Newfoundland and Labrador's plan to remove barriers to care.

*“Poor oral health negatively affects growth, development and learning for children, nutrition, communication, self-esteem and various general health conditions.”*

Oral health is a lifelong health issue beginning with the unborn child and carrying on throughout a persons life”

- Go Healthy-Keep Smiling  
Discussion Document 2006

In 2006, the Government of NL presented a discussion document –

### **“Go Healthy: Keep Smiling – Developing and Oral Health Plan for Newfoundland and Labrador”**

- acknowledged oral health as a critical component of overall health and wellness, and that early intervention and prevention of dental disease would allow individuals to understand the value of prevention and take responsibility for their oral health.
- provided additional funding to ensure access for children up to the age of 12 for basic diagnostic and treatment services.



# History of Childrens Dental Health Plan

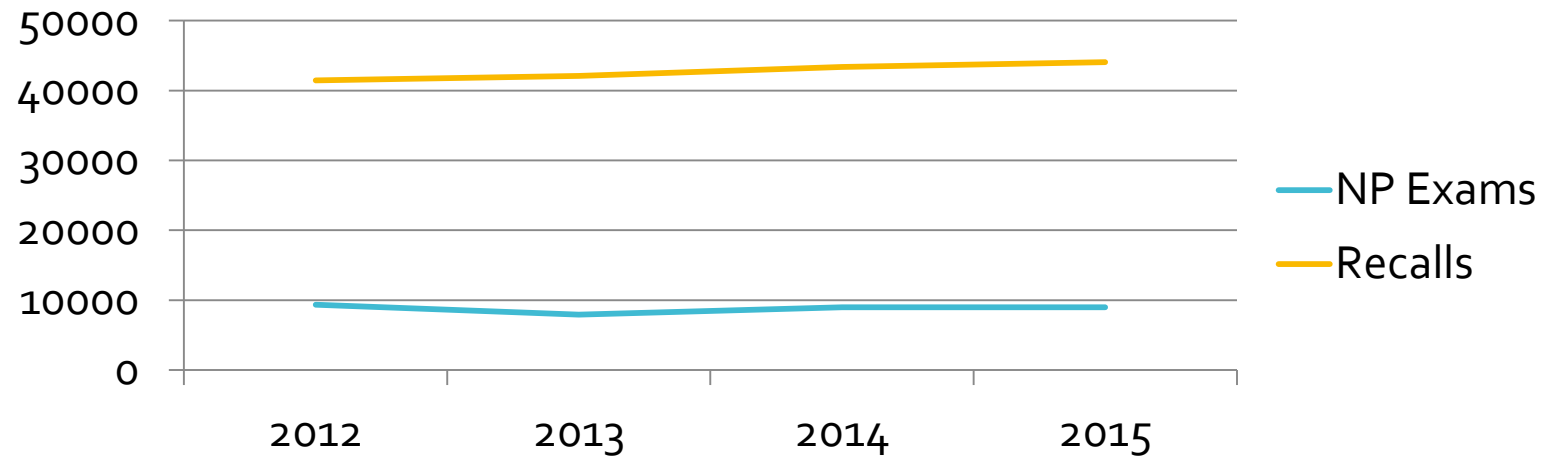
- Initially NLDHP for 0-12.
- 2004 uptake was declining.
- Why? Plan reimbursement levels were very low, sitting at 1992 rates, resulting in necessity to balance bill the patients.
- This was leading to decreased usage rates, and families staying away from the dentist.
- Additional funding in 2006 allowed an increase in the reimbursement rates to dentists, eliminating the need for balanced billing.

# MCP CDHP

As of 2007

- Addresses financial aspect of access to care issue by covering preventative and restorative services to children age 0-12.
- Universal access to eligible dental services for children aged 12 years and under, with a focus on prevention. The eligible services are:
  - Examinations at six month intervals (prevention)
  - Cleanings at 12 month intervals (prevention)
  - Fluoride applications for children aged six to twelve years at 12 month intervals (prevention)
  - Routine fillings and extractions (treatment)
  - Sealants (prevention)
- The coverage of follow up care allows the dentist the ability to treat, and prevent the progress of the disease, not just diagnose.

# By the Numbers



- Stats are lacking, and what we do have is inadequate and prompts many questions.
- Important to note that Recall Exams are permitted 2X per year. So we can't simply add these numbers for total children accessed.
- Due to population decline, the number of children eligible to access the plan has not changed much since its inception in 2006.
- 2016 census – 63940 children between 0-12 eligible for coverage with CDHP

# Examinations



- Exam frequencies has gone from approximately 62,000 in 2006 to 50,000 in 2018.
- When program was introduced in 2006, there was a significant initial uptake in dental visits for children. Now it is the lowest we have seen in the 12 years. We expect that the exams will flatten out and stay at the 45-50,000 range into the future.
- 70,000 children are getting 50,000 exams. HOWEVER, some children are seen for exams twice per year.
- Estimate that approximately 40,000 children are accessing the plan, which is just higher than the 36,000 we had in 2006.
- Why are we not getting more?

# Extractions



- In 2006 we removed approx 16,000 teeth.
- In 2017-18 we removed approx 8,000.
- The reduction in extractions shows that saving a tooth is the goal.
- The financial barrier of restoration has reduced.
- We are getting closer to a point where rampant decay in a child's mouth is becoming a thing of the past.
- We are told by our members that that is the case.

# Restorations



- Routine restorations have remained the same from 2006 to 2018.
- Major restorations have more than doubled in the 12 year period.
- Teeth previously too expensive to restore would have been extracted.
- CDHP allows parents the choice to restore using more extensive measures such as pulpotomies and stainless steel crowns.

## Things to keep in mind...



- Approximately 10% of children age out of the program each year and a new batch enter from the bottom.
- The new children often come with new parents who need a lot of dental education.
- On average, over the past 12 years, there are approximately 60,000 children eligible for coverage with CDHP.
- We are still only accessing 47% of the children's population.

# Is the program working???



- Allows dentists to provide the follow up care, not just diagnosis.
- Removes the financial barriers to care.
- Reduction in extractions – more focus on restoration.
- Reduction in required extractions means less infection and less pain.
- While our numbers for First Tooth-First Visit are low they are increasing slowly.
- While we do not have hard data from the Janeway, we are told that fewer children are showing up to emerg in dental distress.
- Again - no hard data - but our members tell us that rampant decay becoming a thing of the past.



# What is holding us back from true success?

- The CDHP is a funding mechanisms for diagnosis and clinical procedures – this breaks down financial barriers, but is limited in its success as an oral health plan because it misses the public health promotion and education side of healthcare. Currently there is no provincial funding to reimburse for public oral health education or monitor oral disease.
- After the patient's 13<sup>th</sup> birthday, they often “disappear”. These are still children but the barriers are still there. Dentists work with the families for 12 years to help keep the children healthy, and at 13, they are cut off.
- We don't have appropriate provincial data to determine where the limitations lie.
- We still are not able to access the most remote areas of the province.
- Oral health education of the public is not being addressed.
- Finite number of providers accessing the same groups, and staying where the main populations are. Numbers of providers don't fluctuate much year to year.

# The Future

- We must maintain what we have. We can not go backwards.
- Any negative change in the program would be interpreted as a lack of concern for our children, and that oral health is not important.
- We need usage data – numbers of patients in each age group, where they are from, not just numbers of procedures performed.
- With less than 50% of the Children accessing the program we need to improve awareness of its existence and its benefits.
- Parental and patient education is imperative.
- We must use a unified, team approach to oral healthcare in this province – involve physicians, public health nurses, allied health professionals, and the caregivers.
- Come up with a plan to access remote communities.

# Necessary Partnerships



- The NLDA and Government have just gone through a strong set of negotiations where Government wanted to reduce the Program.
- After much push and pull, and a little bit of yelling, the NLDA was able to present a position that kept Government from stripping the Program.
- The dentists will, however, take a zero increase in fees for the next four years.
- The cost of providing the service will rise with at least basic inflation.
- The average dentist will utilize 60% of fee guide to provide a service.
- The fee to dentists will drop to below 70% of current fee guide levels over the next 4 years. Dentists are willing to make that commitment to provide a standard of care to the children.
- There is a partnership between the Dentist, the Government and the Patient/Parents - together we can build on a successful program.

- Thank you.

**COMING TOGETHER IS A BEGINNING;  
KEEPING TOGETHER IS PROGRESS;  
WORKING TOGETHER IS SUCCESS.  
~HENRY FORD**