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REGISTERED DENTAL HYGIENIST IN ALTERNATIVE PRACTICE: A LOST OPPORTUNITY OF DENTAL CARE FOR THE SAN JOAQUIN VALLEY UNDERSERVED POPULATION

PREPARED BY:

HAYAM MEGALLY, MPH, CHES, CPH

YESENIA SILVA, BS

MARLENE BENGIAMIN, PHD

RACHEL DOHERTY, RDHAP, MPH

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INTRODUCTION

Access to oral health care has multiple social determinants that affect an individual seeking dental services to successfully access those services. One of these factors is providers' availability. In Fresno County, one of the largest counties in the San Joaquin Valley (SJV), there are 33 Dental Health Professional Shortage Areas (DHPSA).¹ The number of Medi-Cal Dental providers in Fresno County is substantially less than those who accept commercial dental insurance. In addition, not all Medi-Cal Dental providers accept new Medi-Cal Dental patients.² For many vulnerable and underserved populations, such as older adults, individuals with special health needs, and individuals that live in rural areas, finding a dentist and accessing dental care are very challenging. Mid-level dental providers would increase the number of access points to dental care. The Registered Dental Hygienists in Alternative Practice (RDHAP) is the midlevel dental provider model authorized to practice in California since 1996, with the first RDHAP licensed in 2003.³ This model aimed to improve access to preventive dental care services, screening, case management, education, and referral to dentists for the underserved populations in California. They can practice independently in DHPSAs, nursing homes, residencies of the homebound, hospitals, and other public health settings.³ The training they receive focus to improve the dental hygienist knowledge and ability to treat people with complex physical, medical, psychological or social situations such as older adults, patients with developmental disabilities, and children with special health needs.⁴ As of December 2019, there are 665 RDHAPs licensed across the state.⁵ Despite the high need in the SJV area for dental providers, there are less than a handful of RDHAPs serving in the SJV counties.⁵ There is a need to understand the challenges that are hindering those professionals serving in the Valley and the public perception about this model among the SJV residents. This report provides findings of focus groups that the Central Valley Health Policy Institute has conducted with residents in an attempt to gauge their awareness and their general perception about the RDHAP model.

METHODS

The Central Valley Health Policy Institute (CVHPI) conducted a series of focus groups with residents (n=30) in Fresno County. The priority populations were: parents of children with special health needs (CSHN), older adults, Native Americans, and rural areas' residents. Table 1 shows the number of participants from each group. CVHPI obtained Institutional Review Board approval before reaching out to participants. CVHPI developed a fact sheet, in both English and Spanish, to share general information about the RDHAP model with participants in their preferred language. The fact sheet included information about their training, scope of practice, and a map that shows their distribution across California. The facilitators went over the fact sheet and offered answers to participants' questions about its contents.

The focus group guide had questions to gauge the level of previous awareness about the model, acceptance to be treated by them, the model pros and cons, and how to improve the model to best serve their community.

The data collected from the focus groups were analyzed to identify common themes and supporting codes. The strength of each code depended mainly on the frequency of its mention.

Table 1. Number of participants from each priority population

Parents of CSHN	Native Americans	Older Adults	Rural Areas
5	7	2	16 (conducted in Spanish)

FINDINGS

EMERGENT THEMES FROM FOCUS GROUPS

- **Lack of previous awareness about the RDHAP model among the general public.**

There was a complete lack of awareness about the existence of this model in CA among all focus groups' participants. Some had a misconception that the RDHAP came to schools with the mobile dental clinics. The information provided in the focus groups about the model was new for all participants. Some participants questioned the reason their health insurance, primary physician, and dentists have never mentioned that dental provider model before.

"... [Medical providers] ask if you have seen the dentist regularly, but I don't think that they know that there is a resource like this out there." Parent of a CSHN

- **Acceptance.**

Most participants have shown a general acceptance to receive dental services by an RDHAP, especially after they learned about their training, scope of practice, ability to provide mobile dental services, and acceptance to public and private dental insurance. This was especially true among parents of children with special health needs, as their kids are in many cases very apprehensive going to a dental clinic and providing dental services at the convenience of their homes is very much needed. However, parents whose kids have private insurance were more open to the idea of receiving services at home, assuming that the co-pay, if there is any, would be affordable. On the other hand, parents whose kids have public insurance expected that they may not find a provider that is willing to treat their children and the cost may be expensive if they would have to pay out of pocket.

"I hate the dentist and I would not mind if they came to my house and look at my teeth, use it for myself and child." Parent of a CSHN

- **Benefits of the RDHAP model**

Convenience. Participants in all focus groups agreed that the RDHAPs most advantageous aspect is that they provide dental services at the convenience of geographical location, for example rural areas, residencies, community centers, and schools. Participants in rural areas

mentioned that currently some children receive mobile dental services while at school, and for many this is the most effective way to reaching children. Parents of CSHN expressed that the receiving routine oral health services from those professionals would be beneficial for their children. This convenient option would decrease the anxiety that children may experience in an unfamiliar space, in this case the dental office, and for parents as well who would be more involved in the treatment of their children.

“They [RDHAPs] can go slow, I can monitor how everything is going along, we can give breaks as needed. I do not know how that would go with the pediatric dentist.” **Parent of a CSHN**

“Yes, because there is a lot of necessity, one of them is transportation.” **Resident of Rural area.**

Training. After learning about the training that the RDHAP receive to prepare them for their licensing exam, many participants showed more confidence in those professionals' capacity to provide dental services within their scope of practice. The additional training on how to provide preventive dental services to the special health needs population and older adults was seen as an additional value to the model. Many parents of CSHN went on and shared that they struggle finding specialized dentists who are able to treat their children and RDHAPs can at least provide the minimum care for their children. However, many expressed that they would need to do more research of the RDHAP's scope of work in order to reach out to them for their children's oral health.

“In this case the fact that they do have hours training with special needs adults and children I think is very important.” **Parent of a CSHN**

Communities that can benefit the most. All focus groups expressed the need for their community for such mobile and convenient service that the RDHAP can offer. The parents of CSHN expressed that need will help minimize their kids' apprehensiveness associated with being in a strange place like the waiting room of a dental office. One parent shared that even the lighting of the dental operatory is causing a discomfort to her child. For older adults, this service will be most convenient if they are provided at home or at a community center. The Native American group mentioned that this service can be very convenient if provided at home, in rural

areas, or at the Indian Health Clinic. For rural areas residents, they expressed that transportation and gas prices are major barriers that RDHAP can help alleviate by providing mobile preventive services at a location they can access conveniently. Some acknowledged the services provided for their children through the mobile dental clinic that come to their children's schools and sometimes near their houses. However those are solely for children and not for adults who also are in need for similar services.

*“If somebody came to the senior center once every two or three months to do screenings, people will come if they know it enough in advance of when they will be here, I know my friends will come.” **Seniors’ focus group***

*“I live in the rural area, there are a lot of people that have limited access, and they count their gas that they need to go into town, if there was an area that they provided in like a community center that would be helpful.” **Rural area resident***

- **Concerns about the RDHAP Model**

Cost of care. While participants mentioned that the RDHAP model has positive aspects that would increase the access to dental care, many participants also raised some questions about the cost of their services. Participants discussed that delivering services to homebound patients could potentially cost more because of the additional accommodations. The cost of care was an important concern for many participants, especially for patients without immigration status. It was observed that participants who shared that they have private insurance showed less concern about the cost compared to participants who had public insurance. Few participants noted that for some women, they can only have dental coverage while they are pregnant. Some also had concerns about how they can know or estimate the cost of their services and there is a lack of transparency about this issue as it is not posted online where you can connect with an RDHAP.

*“Be more transparent about the costs” **Rural area resident***

Background information. RDAHPs ability to visit homes to deliver service raised concerns on the lack of awareness for a resource to verify information about the person they will invite to their house. Some participants discussed the hesitance older adults would have allowing inside

their house a medical professional to deliver oral health services without having background information about that provider.

“The con is the trust factor because you have an unknown person in your house” Native American Focus Group

“I would do a lot of research before I call to make an appointment because you have to be cautious as a parent about everything.” Parent of a CSHN

Uncertainty about the RDHAPs capacity to deliver oral health services. Throughout the series of focus groups, it was clear that participants did not know about midlevel providers in dentistry. For many of the participants the dentist and the registered dental hygienists make the qualified dental team. During the focus groups, parallel comparison was made among other midlevel providers in the health care system, such as the physician assistant, to introduce to the participants where RDHAPs are in the professional ladder. Participants expressed that although they understand that RDHAPs have extensive training, they still do not fully trust receiving dental care from them because of the lack of enough history about this model. On the other hand, some participants pointed out that they did not have good experiences with other mid-level providers in the healthcare field, therefore they were hesitant about RDHAPs.

Lack of awareness of the RDHAP model among the medical profession and health insurance companies. The role of medical professionals is key in understanding the RDHAP model for many participants. Many participants went on and discussed that for all of their health care needs and the health care needs of their children they reach out to their primary provider. Some parents of CSHN expressed that if their child’s primary physician would recommend or refer them to one of those RDHAP, this will add more credibility to the model and they would trust them more. Participants pointed that providers and health insurance have never referred them nor their children to RDHAPs in the area and this causes patients to miss a potential opportunity of receiving prompt preventative oral health care and potential direct referrals to the dentist.

“I think it is more reassuring when you have your physician recommending this as an alternative because they are medically trained and they would know what these people’s training is.” Parent of a CSHN

“If you live that far away but you have options like this, if my insurance could give me that option I would use it.” Parent of a CSHN

The scarcity of the RDHAP in the San Joaquin Valley. According to the map that was shared with participants, there were only 3 RDHAPs that are actively working in the SJV area. Most participants wondered why in the SJV there were very few RDHAPs compared to the Bay area and Southern California. Some suggested that the main reason is that the higher percentage of Medi-Cal population that reside in the SJV and the lower average income of residents compared to the Bay area and the Los Angeles area. They assumed that Medi-Cal pay less to their providers than private insurance. One participant went on and shared that we need providers who are willing to make less money to serve in the SJV.

“There are not enough RDHAP in the area, if you look at the map and I was in the Los Angeles area you will be able to find many more, and the bay area. In the central valley there are not enough people doing it.” Older adults’ focus group

“Mostly there are a lot of families on Medi-Cal than on private pay. Medi-Cal pays out a lot less to providers than private pay insurance. So I think that is one of the reasons why not a lot of providers want to work in the Central Valley, because they are going to get more patience in Medi-Cal than private and therefore make less money.” Parent of a CSHN

RDHAPs oversight entity. Oral health care providers normally follow particular infection control guidelines. RDHAPs ability to work independently brought concerns to the participants on whether they follow those guidelines effectively. They also questioned about the existence of an entity to oversee if they effectively follow those guidelines and measures. In addition, few participants raised the concern about if there is an entity that oversees those professionals and to be known for the public for potential grievance. Some participants showed agreement that they need to be aware of this oversight entity to build trust and to ensure patients’ safety.

“...how I know they are not going to use the same material that they used on other people when they run out of material.” Rural area resident

“...since we do not know that person or we would probably not see them again, we would not know where to go if anything were to happen.” Rural area resident

- **Participants' suggestions to improve the RDHAP model**

Raise awareness among the public and medical professionals. Participants recommended that primary care providers should be aware of the existence of those professionals and provide referral to them. Some participants also suggested that the information about this model should be available at places people already go to such as community centers, senior centers, and nursing homes. Some also suggested posting information on different social media platforms.

*“...posting education like this in community centers, senior centers to get the word out.” **Older adults' focus group***

Ensure collaboration between established local organizations and programs with RDHAPs. Participants recommended that organizations like schools and community based organizations should work together to bring RDHAPs to their communities. Participants in rural areas mention that such events should take in consideration providing services for adults with and without insurance. Many participants mentioned that they have built trusted relationships with those local community-based organizations and they would be more likely to participate in these events if they heard the announcement from those trusted entities.

Transparency with their cost of services. Participants mentioned the RDHAPs should post their pricing list online. This could help patients to compare prices and shop around for the most affordable dental care.

Increase the number of RDHAPs. Some participants suggested that this can be a health career option for their high school students in their community. This was especially true for the Native Americans and rural focus groups participants. They mentioned that increasing the number of students from underserved communities would increase the likelihood of having more dental care providers in the San Joaquin Valley.

CONCLUSION

Access to dental providers is a key component of ensuring good oral health and general health. Residents in Fresno County and in most of the SJV experience barriers related to social factors that impede their ability to receive dental care such as: transportation, poverty, lack of specialized dentists, geographic isolation, and insurance status. The RDHAP model can help address some of those barriers by their ability to provide dental services at the convenience of the patients' location, their ability to become a Medi-Cal Dental provider, and their specialized training. Currently, 665 RDHAPs are actively practicing in California, however, there are less than a handful of them serving in the SJV, despite the need for their services. This model was established to meet some of the dental needs of the underserved population in California.

Although this model has been existent since 2003 with the first licensed RDHAP, there is a total unawareness among the public, primary care providers, and health insurance about this model as expressed by most participants. The SJV population is missing the opportunity to fully benefit from the RDHAP model. To improve how this model can benefit the SJV population, there is a need to explore how it is serving the underserved population in the bay area and southern California to help understand the lacking support that may be needed in the SJV.

Raising awareness about this model among the medical profession is crucial to establish the needed trust and credibility. The California Dental Hygienist Association can further play a crucial role in supporting this model. The association can increase the awareness among the public and the medical professions, protect the RDHAPs' interest as well as the interest of their patients, and can serve as a hub for those professionals to educate the public about their services. There is a need for more studies to explore the challenges experienced by the RDHAPs that are hindering them from serving in the SJV. In addition, policies that can address those

challenges are needed so that the underserved population in the SJV would benefit from a mid-level dental provider that would help improve their access to dental care in the Valley.

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For more information please contact Hayam Megally, MPH hmegally@mail.fresnostate.edu or Yesenia Silva, ysilva@csufresno.edu