THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Testimony

of

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Deputy Commissioner for the Bureau of Health Care Access and Improvement
New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Health

regarding

An Update on the Department of Health and Mental Hygiene's Restructuring of School-Based Oral Health Services

April 10, 2008

City Hall
New York City

Good afternoon Chairperson Rivera and members of the Health Committee. I am Louise Cohen, Deputy Commissioner for Health Care Access and Improvement at the Department of Health and Mental Hygiene (DOHMH). Thank you for the opportunity to testify regarding the oral health program. This morning I will provide progress updates since the last hearing on this topic and discuss our re-structured oral health program.

In the months since the last hearing we have had the opportunity to meet with 9 City Council members to discuss the changes to our program, and help in both identifying new sites and publicizing the program. The response was positive and we appreciate the offers of assistance.

The Oral Health program provides services in several different types of locations. We have five full-service sites located in DOHMH Health Centers which operate year round. We also have forty-three full-service school-based sites that run from September until June. Each year, the program assesses each of these school sites to determine if the site will remain open the following year. Criteria include whether the principal continues to support the program and will make the space available the following year, the number of parental consents relative to the size of the student body, the location of the school in relation to other dental sites, and program staffing.

Full service school-based sites operate on average one to three days per week for between four and-eight hours per day and provide-examinations, x-rays, cleanings, sealants, fillings, and,-on a limited basis, specialty care procedures.

The sealant program, which is new this school year, offers a more intensive, short-term, prevention-oriented public oral health program that reaches more students in more schools. Our current plan is to operate up to 30 school-based sites each academic year, visiting 10 schools per trimester from September through June.

The first seven months (September 07 – March 08) of the sealant program has been a success and we are continuously evaluating and improving the program. The sealant sites have served approximately 2500 children from September to March. Of the total number of children treated in all our sites, over a quarter of children seen are from our sealant sites.

I would like to describe the process we use to establish and run a sealant site. First, the principal is contacted and offered the opportunity to participate in the program, based on their ability to provide adequate space for the three months, including a sink and appropriate electrical outlets. Principals then organize school or grade-wide assemblies at which we teach children about oral health and sealants and distribute parental consent forms for them to take home. School staff assists with the collection of the written parental consents, some holding competitions or offering incentives. Once a batch of parental consents is received, we move equipment into the site and start seeing children. We continue to collect parental consents for approximately two months.

The most important factor in the success of any particular site is the active participation and commitment of the principal. Many of them have been very engaged in assisting the program by finding space, holding assemblies, and offering incentives for participating children. In these sites, we have found that the rate of return of parental consents is higher. In sites where the principal is less enthusiastic or less involved, we have found that we receive fewer parentalconsents.

Once the consents are received, the equipment is set up and the staff are prepared, we begin to see children. Each child is called by the dental assistant to come to the dentist. She or he receives a thorough examination by a dentist, including x-rays as needed, followed by a cleaning of the child's teeth, application of sealants as determined by the dentist, and a fluoride treatment. The dentist then determines if the child needs further treatment. If so, they are given a letter to take home, directing their parent/guardian to call one of our Regional Administrative Offices for information on referral sites. The parent/guardian is given several potential sites that they could visit to get the needed care and an appointment within our own system of oral health Clinics – including both schools-based sites that accept outside students and Health Centers. We also refer children to HHC and New York University, both of which see children without regard to insurance status, and other convenient community providers. We transfer the child's dental records to the new provider upon request.

In our full-service school-based sites and Health Center Clinics, we also provide examinations, cleanings, x-rays as necessary, sealants, fluoride treatments, fill cavities, and as appropriate, more extensive specialty care procedures. If a dentist conducts an examination and determines that the child requires dental work that cannot be performed in that clinic, the child is given the DOHMH Oral Health Program's Referral for Consultation Treatment Form to take home to their parent/guardian. The form is completed by the dentist and up to three (3) referral sites are offered, giving the parent/guardian options of where their child can be seen. A copy of this form is placed in the child's dental chart and the referral is noted in the progress section of the dental chart.

In the past 7 months, dentists from the sealant sites have referred approximately 14% of children that they have seen for further care. In addition, during the same time period, dentists have made referrals for further treatment to approximately 6% of children seen in all other DOHMH sites.

We look forward to continuing to implement and improving the sealant program. We appreciate the time that City Council members have taken to meet with us individually and at this hearing, and especially for the outreach that you all have done in your communities to identify potential new schools sites. We look forward to continuing to work collaboratively with you to improve children's oral health.

Testimony of Harold Appel, M.D., Contract Administrator for Doctors Council SEIU
Before the New York City Council Health Committee
April 10, 2008

Good morning Mr. Chair and members of the Committee. My name is Dr. Harold Appel, Contract Administrator and Treasurer for Doctors Council SEIU. Thank you for once again providing Doctors Council with the opportunity to testify on a very important and endangered program, the century-old Oral Health Program which operates within the New York City public school system. I am here to offer brief testimony on behalf of our president, Dr. Barry Liebowitz who is a passionate defender of this vital program but could not be here due to a death in the family.

Doctors Council SEIU represents more than 3,500 attending physicians and dentists at nearly every HHC hospital, at Mayoral agencies, in the School Health Program and in the Oral Health Program where our dentists provide full dental care to the city's public schoolchildren. More than 51 million school hours are lost each year to dental-related illnesses and studies have demonstrated that poor oral health has been related to decreased school performance, poor social relationships and less success later in life. According to a 2000 Surgeon General's report as well as the New York State Oral Health Coalition, school-based dental programs may be the best way to reduce the oral health disparity that currently exists among children of poverty.

Yet despite these findings, the City's Oral Health Program is in jeopardy. Its mission has been changed. It has been made clear to us over the last few years that the Department of Health favors an Oral Health Program that focuses on sealants rather than comprehensive dental care. More and more, our patients now have to make their own arrangements for comprehensive dental care. We strongly disagree with this approach. In fact, we believe that by restricting access to comprehensive dental care which our dentists have been providing as part of the Oral Health Program for over a century, the Department of Health is violating New York State Dentistry guidelines, Section 29.2(a)(1) of the Rules of the Board of Regents, specifically relating to "Patient Abandonment."

This section defines as a basis for unprofessional conduct, "abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, or abandoning a professional employment by a group practice, hospital, clinic or other health care facility, without reasonable notice and under circumstances which seriously impair the delivery of professional care to patients or clients."

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We need to keep comprehensive dental care in our schools. In many cases, it is these children's only option.

The Department of Health has not hired new dentists for its Oral Health Program in a long time. Dentists are being attritted out of the program. Soon, with no intervention, the program will be limited to sealants and who knows what will happen after that. If the rationale is that these children should go to outside clinics for their dental care, then why wouldn't that extend to sealants. Soon, there will be no program.

I am joined today by three dentists in the Oral Health Program, Dr, Charles Pellicane, Dr. Margaret Mahoney and Dr. Gary Peters who will each offer brief testimony from their experiences in the program. With the Chair's permission, I would like to hand it over to Dr. Peters.

Testimony by Dr. Charles Pellicane
Before the New York City Council
Health Committee
Oversight on the Oral Health Program
April 10, 2008

Good morning. My name is Dr. Charles Pellicane. I am a dentist in the City's Oral Health Program and a member of Doctors Council SEIU.

The sealant site programs initiated in 2007 have afforded protection to hundreds of NYC school children. To those in the field, the program is not without obvious shortcomings. My greatest concern deals with the problems we encounter referring patients for restorative, endodontic and other treatments. The current system for the 30 – 40% of children who fall into this category is far from foolproof. As a result, parents who have been notified that their child need additional treatment at a dental facility must deal with an unreliable, cumbersome procedure to secure the treatment their child needs,

After screening and sealant procedures, patient charts are collected at the sites and sent to DOH's respective Regional Offices, many times after a 2 – 3 month delay. If the parent has received a notification letter in the mail or from their child, and <u>if</u> they wish to respond, they must contact the regional office to arrange the time and place for the treatment. This clinic will <u>NOT</u> be where the child was first seen. And the child's records must be sent to the designated treatment site. As you can easily see, there are many areas in the chain of referral that may cause delays or lack of treatment. While sealants are an invaluable preventive measure, they are but an adjunct to full dental care as they no nothing to ameliorate existing dental cavities.

NYC school clinics should continue to provide full service dentistry at one location, not just preventive measures. It is also inaccurate, misleading and disingenuous for the Department of Health's parental notification letter to parents to call sealants "the dental immunity." They are not a vaccination, inoculation or the magic bullet. To order and insist that sealants take precedence and replace comprehensive dental care at our facilities does a serious disservice to the school children of New York City.

In conclusion I would like to make the following recommendations:

1) All notifications indicating further treatment should be mailed directly to the parent - not given to the teacher or child.
2) Establish a parent-dental coordinator to follow up and ensure that the treatment recommendation has been followed.
3) Expedite follow up treatment by streamlining the record keeping.

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My name is Dr. Margaret Mahoney. I have been a dentist in the Oral Health Program for 22 years. I have worked in school clinics as well as health center dental clinics. Presently I am serving a school clinic and a "sealant site" in the Bronx.

The Sealant Program is an excellent initiative. Comprehensive exams accompanied by x-rays are a great diagnostic tool to evaluate the patients. Incorporating prophylaxis, fluoride treatment, nutritional counseling and oral hygiene instruction with sealants is the way to prevent oral disease and make the childrens' future a much healthier one.

Unfortunately some of the children that we diagnose have dental problems that need to be addressed. Some are small others are more serious. Dental problems do not go away. They get worse and become more costly to fix. Dental diseases have been linked to systemic diseases like diabetes and heart disease. Infections can spread. Poor oral health and untreated oral diseases and conditions have a critical impact on the child's quality of life. Pain and disfigurement caused by these conditions affect a child's ability to eat and get proper nutrition, affect the child's appearance and self esteem. It can lead to learning and speech problems and compromise a child's ability to perform school work.

I am concerned that the children we diagnose with problems will not get treated. Children are not always reliable to give their parents and guardians the letter that we send home with them indicating that they need further treatment. In addition, how many of the parents or guardians that get a letter will follow-up? I have been working at a Sealant Site since January 2008 and have not had one patient come to get their work completed at the nearest school clinic - only seven blocks away. Children who can not seek care on their own are the ones who suffer the most.

The best course of action would be to leave the portable units in the sealant sites for an additional month or two and provide basic dental treatment to the children who need it before moving on. Basic dental treatment such as restorations can prevent expensive procedures like the need for orthodontics, root canal therapy, periodontal therapy and crowns and bridges. Parents are not required to be present or arrange appointments, lose time from work or transport children.. There would be a minimal loss of class time for the patients. Procedures that can not be completed there should be referred appropriately by mail and/or a telephone call.

Access to dental care is no good unless the child is able to utilize the available dental care.. The School Based Dental Programs are an effective way to deliver preventative and primary dental care services to vulnerable low income children.

Additionally, the NYC schools should require students to have dental examinations upon entry to school and follow-up examinations every one to two years.

Testimony of Dr. Gary Peters, DDS Before the New York City Health Committee
Oversight Hearing on the Oral Health Program
April 10

My name is Dr. Gary Peters. I was one of the dentists chosen by the Oral Health Program to participate in their Sealants initiative, which means that my duties are limited to performing dental examinations, cleanings, fluoride treatments and sealants. While I personally feel the best way to serve our children is to treat active disease in school during school hours, I have worked very hard to try to maximize the number of children seen and number of sealants done and make the program a success as that is my job.

To briefly summarize what is evident since the last oversight hearing:

- A significant number of dentists, including at least two of only about half a dozen full time dentists, have left and not been replaced.
- The amount of paper work to be done has increased, sharply reducing time for patient care.
- School clinics have been designated as sealant sites, where treatment of dental disease – even if an emergency and if the child is in pain - is prohibited by orders from Management.

To the credit of the Department, I must say that they have made some innovations in order to save time, including a much faster system for performing fluoride treatments, but it seems that for every step forward the Department takes two steps back. Though I believe they are acting with the best of intention, I don't believe their protocols are properly serving the real needs of the children.

Of particular note, which affects both the sealant program and the regular full service clinics equally, is the unbearable increase in the amount of paper work that now must be done each time a patient is seen, more than ever before. In short, this is bringing our ability to take care of the children to a grinding halt, and it is unnecessary.

Let me first start with a brief discussion of the dental charts, which are cumbersome and unnecessarily redundant, as follows:

On a first patient visit when an examination is usually performed, the redundancies are such that they reduce productivity substantially, make errors much more likely, and are demeaning to staff. The date must be entered 11 times. The dentist's signature or initials must be placed 8 times. The patient's ID number must be entered 8 times. Any medical conditions the patient has must be written 4 times, and sometimes this list can be lengthy. The dentist's examination and treatment list must be written 4 times, a task that can be extremely daunting if the patient has a moderate number of cavities. The patient's birth date must be entered twice, and then the patient's age must be calculated and entered on the patient encounter form – totally unnecessary since the computer into which this data is being entered can instantly figure that out. Lastly, the patient's name must be entered 8 times. Though the patient charts have been around for a number of years, nothing has

been done to streamline them for the sake of spending less time with the paper and more time with the children, and the changes in the encounter form and creation of a separate registration form simply compounds an already existing roadblock to productivity. As far as relevance of the charts to the sealant program, I am required to perform a full examination on children for whom I will not be allowed to treat their dental disease. A complete examination in this instance is irrelevant when only performing sealants and therefore is unnecessary. Since any child with dental decay or other disease is to be referred anyway, all that is necessary is to see if ANY ONE SINGLE problem exists and make note of it along with the referral rather than spending time to note and prepare a treatment plan for every problem the child has. If – and that is a BIG IF – the child eventually goes to where referred, the dentist who will perform the treatment can perform the full examination and treatment plan. Why should the dentist who will NOT be performing treatment have to waste time with this when the overwhelming majority of children will NOT go to where referred, or will not go soon enough for all this treatment planning to still be relevant? It is a waste of precious clinic time. Even for those dentists in the Department who are assigned to perform full treatment, these charts are still overly redundant and waste valuable time that can be used to treat disease.

Secondly, note that the Department has changed the encounter forms. An encounter form is a form on which data is entered by the practitioner each time a patient is seen, including specific information about what procedures were done for the patient that day. These forms were expanded to include a section for charting existing teeth, existing fillings, decay and which teeth have been diagnosed for sealants. The dental chart already asks for this information, and so this is just an additional redundancy which, I might add, is substantially time consuming. Also, one must calculate the patient's age each time the patient is seen – not just on a first visit, even though the date of birth is entered and the computer into which this data is going can calculate the age.

Thirdly, the Department created a new patient registration form to be completed whenever a patient is seen for the first time or when personal information changes. Originally, the information in this new form was included on the encounter form. By creating this separate paper, the amount of paper has gone up substantially, and filling out this paper, which is also fraught with redundancies, also wastes a tremendous amount of time. I don't believe that this increase in paperwork is justified by any significant change in data sought, and unless this is remedied, I fear it will be used as an excuse to claim that the Department is not productive and should be eliminated.

Fourthly, a new patient consent and health history form was created, which are now two pages instead of one, and are so user unfriendly that nearly 50% of them are not filled out correctly. When mistakes of this magnitude are made, it is the form that is at fault and not the persons filling them out. The original consent form, which wasn't perfect but was better and which resulted in less errors being made, asked the parent/legal guardian to sign consent for general dental treatment and lists the types of treatment that are included. The new form offers the parent/guardian a menu of choices to pick from, but these choices come under the category of ordinary general dental care, and therefore it is unnecessary to cause this mass confusion. When a parent doesn't check off any boxes for

any treatment, or certain ones but not others, Management has instructed us to call the parent via telephone to get verbal permission from them. Aside from the fact that obtaining verbal permission via telephone from someone we cannot identify poses legal issues, it is a very time consuming process that further slows down clinic operation, further reducing the number of children we can see. It is hard to understand why the original consent form had to be made so much longer and so much more complicated. They had an opportunity to make the form more user-friendly, yet somehow made it worse. With regard to the sealant sites, this new consent form presents another problem. Since it gives the parent the options to choose from a menu of treatment options, that menu includes options that are not performed at sealant sites, including fillings and extractions. Because of this, expectations on the part of parents and school staff have been falsely raised, and they often are disappointed to find out that only preventive procedures will be performed despite the fact that other options were chosen. I have been told that Management is planning to fix this by making a consent form tailored to sealant sites, and we can only hope that the new form will take care of the problem because none of us to my knowledge has been asked for their input on the matter.

In the sealant clinics, if a child is found to need treatment of cavities or other problems, a note is sent home with the child informing the parent that further care is needed, and a telephone number of a local administrative office is provided for the parent to call and find out what sites the parents can bring the children to for free care. It seems, however, that only a small amount of children are seen elsewhere. Though I cannot say for sure that no follow up system exists, there is no evidence of any. Perhaps management will today reveal to us how they follow up on children who receive referral letters and let us know exactly how many letters were sent and how many children actually went to continue on for treatment. The original problem addressed by this committee still remains – that children who need dental treatment are being denied the ability to be treated in their own school while they are already there, instead forcing parents to have to take them elsewhere, possibly having to miss time from work as well as more time missed from school. There is nothing wrong with dental sealants. They are an essential part of a comprehensive treatment plan for most children – but when they take priority over treating disease, we must reconsider what our priorities and motivations are.

I must point out that implementation of the sealant program has already been at the expense of the children. In the months I have been working in various schools under the sealant initiative, I have had many children walk into the dental rooms in pain and in need of urgent care. Many if not all of these children already had completed consent forms on file. Upon telephoning my supervisor, she told me that it was the Bureau's policy that I NOT take care of the child, but refer them instead. If this is truly their policy, then the Bureau has neglected the needs of the children and treated them with casual indifference. There was no practical reason that these children couldn't have been taken out of pain immediately. They were present in a dental clinic that was staffed with a dentist and assistant and equipped with proper dental equipment, and the parents had already given consent and in most cases expected comprehensive care. Instead, the Bureau's response was to force the child to wait to be taken elsewhere, and there is no way for me to know how long it took the parent to take their child elsewhere for care or if

they were able to at all. What this does, aside from harming the children, is sending a false message that this Department cannot perform important functions and is not needed. Whether intentional or not, it also sends the message that placing sealants is more important than taking care of a child in pain. This Department can and DOES perform vital health care functions – when it is ALLOWED to do so – and certainly IS needed. What it does not need are constraints that harm the children we are supposed to be serving.

After all that has been said and done, it still remains true that the best place to take care of children's dental needs is in school when school is in session. Treating dental disease in the schools has proven itself effective for the over 90 years this program has been in existence. To tamper with something that is tried and true at the expense of our children makes no sense at all – not to me as a health care provider, and perhaps not to any of us. I challenge management to come forth with the statistics: how many children were seen at the sealant sites who needed and were referred for further treatment, and of those who needed further treatment and were referred, how many of them actually received treatment? If management doesn't have the answer to that, then why are they tampering with the system and the dental health of the children? As I stated at the last hearing, dental sealants are an important part of providing comprehensive dental care, but they do not replace it, and treating active disease is far more important than preventing disease that does not exist. Management has been responsive to us in the past, and we hope they will continue to do so now. Thank you for your understanding.

Gary Peters, DDS

TESTIMONY BEFORE THE CITY COUNCIL COMMITTEE ON HEALTH

Darryl Ramsey,
President of Local 768 Health Services Union, DC37, AFSCME
On the Department of Health and Mental Hygiene's Oral Health Program

Thursday, April 10, 2008

10:00 AM

Good afternoon. My name is Darryl Ramsey, and I am President of Local 768 of District Council 37, AFSCME, AFL-CIO. I represent over 4,000 City employees in allied health services, including Dental Hygienists and Dental Assistants in the Department of Health and Mental Hygiene (DOHMH). I'm here today to reiterate the importance of supporting the Oral Health Policy and Program.

Last year, the City Council and its Health Committee prevented layoffs in this program, and held a hearing on the restructuring of the program. Since the furloughs of Dental Assistants in the summer of last year, we have not received any updates on the program from the agency. We have not been contacted to discuss any ideas. It is essential that DOHMH provide

the City Council and the Union with an update on their restructuring plan.

The school-based clinics are a life-saver for all kinds of kids, no matter where they come from. These clinics were developed in the 1980s to increase access to dental care and help working parents. We're not just talking about check-ups and cavities. We're talking about gum diseases, braces, and root canals – major dental problems that can lead to speech problems, chronic pain, malnutrition and other severe health problems for kids.

Today, the program only cares for the simplest and easiest cases. If the child has a serious infection or needs surgery, the program sends them on their way, and refers them to other dentists. Parents are told to take their kids somewhere else for major dental problems. It doesn't matter to the agency if the parents work or go to school, or if the children don't have proper dental insurance or even if they can't even find a good local dentist. That is incredibly ironic. This was the exact problem we faced in the 1980s. It was the reason the program was created in the first place.

Why is the agency moving backwards, destroying 30 years of work? Why are they letting services dwindle away at a time when dental coverage for children is a major problem in this city?

Sooner or later, this program will disappear if things continue on this road. The OHHP staffing is on the brink of extinction. In 2006, at the time of the proposed layoffs and furloughs, there were 18 Dental Hygienists in the entire agency. Today, there are only seven.

It is a shame that the Oral Health program is always vulnerable to cuts. The program is an under-appreciated success story that deserves more support and investment.

The lack of communication is a clear message that the agency and the OHHP leaders are not concerned with improving their own program. They are not working with the workers or their unions or the community to improve the program – and they seem like they don't intend to, either.

The leaders and managers of DOHMH all come from public health backgrounds. This is their area of expertise. I hope that they soon come to realize what they are possibly throwing away.

Thank you.