MATERNAL AND CHILD HEALTH ACCESS

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Educate and Advocate: Oral Health During Pregnancy for Low-Income Women in California

"I've been doing research on the internet and I came across mchaccess.org. I'm about 4 ½ months pregnant and I'm in severe pain in my lower jaw. I know there's something going on in my molars. And I've noticed that you're . . . an advocacy group to help pregnant women with their dental issues and I was just seeing if you could help me or guide me where I could get treated or see a dentist. I've been calling around [to] a few dentists and they don't want to see me – they say that Medi-Cal doesn't cover..."

MCHA client, early January, 2014 — link to her voicemail on our website

Introduction

In 2009, Maternal and Child Health Access (MCHA) partnered with the Community Clinic Association of Los Angeles County (CCALAC) to create the Oral Health Advocacy for Pregnant Women and Children "Project". Funded by First 5 LA's Community Opportunities Fund, the project focused on increasing access to dental care for pregnant women and for children up to five years old. The project's main goals were to reduce or eliminate policy and administrative barriers to oral health care for these two populations, help integrate prenatal and oral health services in community clinics and other practices, and ensure dissemination and implementation of national evidence-based guidelines for oral health care for pregnant women. An important aspect of the project was the technical assistance MCHA provided to low-income pregnant women and providers with questions or a coverage issue. This activity gave us the platform for our policy advocacy work and connected us with the real issues pregnant women face.

Importance and Need

Most low-income pregnant women do not receive oral health care in California, even when they are in pain.[1] Yet dental services during pregnancy are both necessary and safe, according to the American College of Obstetricians-Gynecologists and the American Dental Association.[2]

Research emerging nationally in the mid-1990s showed that dental disease is associated with premature births and low birthweight births,[3] which, combined, are the second leading cause of infant death in the United States.[4] Preterm deliveries also put the mother's health at risk. Although causation has not been established, some experts note that very few resources have as yet been allocated for research on oral health during pregnancy. Moreover, there are definite relationships between poor oral health and cardiovascular disease, diabetes, and respiratory diseases, each of which increases the risk of complications in pregnant women. Insurance companies have found that providing dental coverage for pregnant enrollees has lowered overall costs for women's medical coverage while reducing hospitalizations and improving overall health.[5]

Adding to the need for care, early childhood caries are more likely in the children of mothers with their own high levels of oral bacteria and poor oral health; dental caries can be passed on to newborns and children through bacteria in the mother's saliva.[6]

The New York State Department of Health released practice guidelines for pregnancy and early childhood in 2006. In 2010, California released *Oral Health During Pregnancy & Early Childhood: Evidence-Based Guidelines for Health Professionals*, an effort of the California Dental Association and the American College of Obstetrics and Gynecologists, District IX. The guidelines provide information, dispel myths and educate and provide guidance on the safety and importance of oral health during pregnancy and for young children for all providers who interact with these groups, from prenatal professionals to community-based program providers. The Project relied on these guidelines and specifically the consensus statement, "*Dental treatment including dental radiographs can be undertaken during pregnancy with no additional fetal or maternal risk when compared to the risk of not providing care*",[7] to educate community providers and increase access to care.

Despite resources and recommendations available, pregnant women and providers who treat them continue to be unaware of or unable to use two essential pieces of information: 1) that Medi-Cal benefits include dental services and 2) that pregnant women can safely access oral health services during any trimester and it is in the interest of the woman's health to do so.

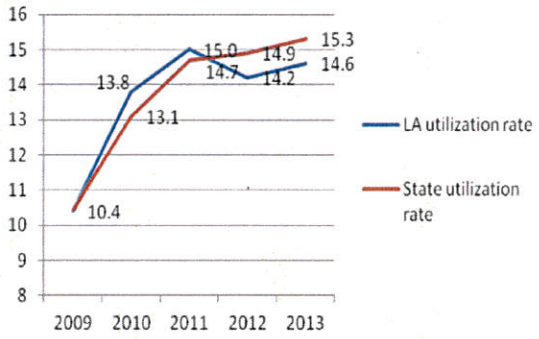
This attitude could change in the foreseeable future, however, given the numbers of older dentists who are nearing retirement age in 2012 and the fact that among newly licensed dentists in California in 2012, 46% were female.[12] Pregnant women should be referred to dentists "as would be the practice with referrals to any medical specialist".[13] Although it is changing slowly, educational challenges among dentists and at dental schools remain.

MCHA and CCALAC Partnership, 2009-2014

The Oral Health Advocacy Project offered a key opportunity to educate broadly in Los Angeles County about providing oral health services to pregnant women with Medi-Cal during a time period when most adults had no dental coverage. MCHA developed and broadly distributed oral health posters and other educational materials among prenatal and dental providers as well as consumers. MCHA and CCALAC identified several local best practice models and shared them with providers, and provided oral health education and referrals to dental services to hundreds of women. The project culminated in a conference attended by over 100 providers, clinic representatives, home visitors and social service staff and, included the Director of Medi-Cal's Dental Division and other top state staff. Attendees shared information and best practices, identified recommendations, and developed related action plans that were later sent to them as a reminder of their commitments.

In addition, MCHA tracked utilization of oral health services accessed by pregnant women with Medi-Cal to see if our efforts were effective. This was a difficult task. A pregnant woman may receive services under one or two of approximately one hundred "aid codes" which categorize the benefits received and continuity of the benefit after pregnancy. Several different methods were tested to estimate pregnant women's dental utilization, the first time an analysis of this type has been conducted.

The most targeted method tracked utilization in all "pregnancy-only" aid codes, which is by its nature an undercount since some women are in full benefit aid codes. These data show the percentage of pregnant women ages 21-49 who received both a pregnancy-related medical service and a pregnancy-related dental service over the course of one calendar year. These data showed significant improvement in the percentage of pregnant women receiving dental services, although the actual percentage remains low. In Los Angeles, the utilization rate improved from 10.4 percent to 14.6 percent from 2009 to 2013. It should be noted that the 2013 rate may be an undercount since there is a lag time of six months or more in receiving all claims.



Policy Recommendations Going Forward

The policy recommendations are a direct result of the lessons learned from the project. Despite the necessity and the satisfaction of assisting individual women to access dental benefits to which they have a right, policy reform is needed to ensure progress is not achieved one woman at a time and to reach all women, not just those connected to a community-based organization. The following are the principal recommendations to ensure pregnant women get the dental care they need, stemming from our groundbreaking conference in February of this year and from the over 10 years total of this project:

1. Medi-Cal's adult dental benefits should be fully restored, and women with pregnancy-only Medi-Cal must be included in the restoration.

2. Simplify the ability for pregnant women to access dental procedures not on the state's list of benefits. Until adult dental benefits are fully restored, pregnant women are entitled to all medically necessary dental services, under the federal test for services to treat "conditions that might complicate pregnancy."

3. The Medi-Cal provider claim form should be modified to better capture information about pregnant beneficiaries seeking oral health services, and the state should regularly report such utilization data to the public. This will assist in providing policymakers and advocates with reliable data to effectively monitor problems and chart progress.

4. Medical and dental school curricula should be modernized to incorporate the latest research and standards on oral health services during pregnancy as well as best practice models for referrals.