Oral Health Advisory Group

Phase I

Report to the Minister of Health and Wellness

Executive Summary

The Minister of Health and Wellness and oral health stakeholders in the province identified the need for an oral health strategy for Nova Scotia. The Minister established an Oral Health Advisory Group to bring the right people together to review existing dental health programs and to do some foundation work to inform a broader oral health strategy. The Group began meeting in September 2014 and finalized its recommendations on Phase I in February 2015.

The Group found the continued age expansion of the insured services component of the COHP has not increased the percentage of eligible children accessing the Program. Furthermore, there is no way to determine whether those who need it the most are using it.

The Group identified the need to understand the barriers that prevent eligible children from accessing the COHP, especially in the early years. This information can be used to improve and expand communication about the COHP. However, increased utilization of the COHP under its current structure is not sustainable in tough economic times. The Group therefore recommends further expansion of age eligibility only be considered in conjunction with a program redesign. Means testing is one such option as it could both target the COHP to those Nova Scotians who need it the most and stabilize the cost of the COHP so it can be restructured to shift utilization from restorative procedures to prevention and improve oral health outcomes. To begin this process, specific areas for restructuring are proposed with the caveat that there is no funding in the existing budget to cover additional costs.

The Group recommends vigilant evaluation as changes are made, so every change to the COHP is examined in terms of its impact on oral health outcomes.

Finally, the Oral Health Advisory Group identified the need to revisit its composition and terms of reference before Phase II work begins.

Oral Health Advisory Group

The Minister of Health and Wellness (Minister) and oral health stakeholders in the province identified the need for an oral health strategy for Nova Scotia. The Minister established an advisory group to bring the right people together to review existing dental health programs and to do some foundation work to inform a broader oral health strategy. The Oral Health Advisory Group began meeting in September 2014 under the terms of reference provided as Appendix A. The Group met eight times from September through January 2015 to complete the Phase I work.

This report details the findings and recommendations for Phase I regarding:

- Further expansion of Nova Scotia's Children's Oral Health Program and improvements/refinements with the current Program that should be considered; and
- Continuation of the Oral Health Advisory Group.

Children's Oral Health Program (COHP)

On January 1, 1997 Nova Scotia introduced the COHP to replace the Children's Dental Plan.

The Children's Dental Plan had been in place since July 1974 and was operated under the authority of the Health Services and Insurance Commission. The Children's Dental Plan provided diagnostic, preventive and restorative services to Nova Scotia residents up to their 9th birthday. In October 1982, eligibility was expanded to include residents up to their 10th birthday. Diagnostic, preventive and restorative services were provided through two components of the Children's Dental Plan:

1. Insured dental services; and
2. Preventive public health initiatives.

Insured Dental Services:

In October 1982, the Children's Dental Plan expanded insured dental services coverage to Nova Scotia residents up to their 16th birthday, but the coverage age was subsequently reduced over a number of years. In July 1990, the coverage age was reduced to the 14th birthday; in May 1991, the coverage age was reduced to the 12th birthday; and in January 1997, it was reduced to the end of the month of the 10th birthday. In 2002, the Insured Dental Services Tariff Regulations were amended to make the COHP the insurer of last resort. This meant the COHP would no longer insure services provided to children with private insurance when their insurance covers those services. However, amounts not covered by private insurance are covered by the COHP.

In April 2013, Government announced it would expand the eligibility age for insured dental services coverage under the COHP. Children would be eligible for the COHP to the end of the month of their 14th birthday. The announcement was implemented in May 2013 with a commitment to increase the age of coverage by one year until 2017 at which time Nova Scotia residents would be covered up to age 17. On April 1, 2014, the COHP was expanded to cover Nova Scotia residents to the end of the month of their 15th birthday.

The Insured Dental Services Tariff Regulations under the *Health Services and Insurance Act* detail the services insured and the tariffs reimbursed to providers under the insured dental services component of the COHP.

Preventive Public Health Initiatives:

Dental public health in Nova Scotia has changed considerably since the COHP replaced the Children's Dental Plan in 1997. It has evolved from a service delivery model to focusing on community-based health promotion and disease prevention initiatives.

Public Health strives to improve the health of the entire population and reduce health inequities. There are many factors that influence health. Some of these include tobacco and alcohol; healthy eating; physical activity; poverty, discrimination and social exclusion; climate change; and healthy childhood development. Thus, in order to address health issues, a multifactorial approach is often required and may require long-term, comprehensive plans. Public Health works with many partners, such as district health authorities, communities, citizens, experts, and other government departments, to help develop policies and create environments that support health.

Public Health employs 16 dental hygienists (14.2 FTEs) across the province who work with their community partners on health promotion and disease prevention initiatives. This includes the provincial Fluoride Mouthrinse Program, which is a disease prevention program that is delivered weekly in targeted elementary schools.

Public Health also:

- Promotes community water fluoridation – 51.2% of Nova Scotians live in an area where the water is fluoridated. (42% of Canadians have access to fluoridated water.)
- Develops integrated oral health key messages (i.e. oral health messages for provincial resources such as pre-natal and post-natal resources (*Loving Care* is a series of four eBooks for parents of children from birth to age 3) and Nova Scotia's Tobacco Strategy.
- Contributes to the development of healthy public policies (i.e. School Food and Nutrition Policy for NS Public Schools)
- Partners with the Department of Education to develop and integrate oral health information and key messages in the Healthy Living Learning Framework for Nova Scotia's Health curriculum and supports the Health Promoting Schools initiative
- Provides support to lay visitors who visit high risk homes through the *Enhanced Home Visiting* parent support program.

Findings

A review of insured dental services utilization for the last ten years (Table 1) indicates:

- Until the eligibility age for the insured dental services component of the COHP expanded in May 2013, the percentage of eligible children accessing the COHP (ranging from 42% to 46%) and the number of services per beneficiary (ranging from 4.2 to 4.5) remained stable year over year. Overall costs and costs per beneficiary grew at, or below, the rate of inflation.
- In May 2013, the insured dental services component of the COHP expanded to include children from the end of the month of their 10th birthday to the end of the month of their 14th birthday. While the number of services per beneficiary and the the average cost per beneficiary decreased, the total cost of the Program increased 31% over the previous year, even though the age expansion was not implemented until mid-May of the year and the percentage of eligible children accessing the COHP did not change.
- On April 1, 2014, the insured dental services component of the COHP was expanded to include children to the end of the month of their 15th birthday. Raw claims data for the first

eight months suggests this one year increase in age eligibility results in a significant increase in both the number of insured services and the cost of the program. Program costs are projected to exceed $6 million for fiscal 2014/15, a 14% increase over the previous year.

- Each expansion of the age eligibility is associated with significant increases in Program costs, but the overall percentage of eligible children accessing the COHP remains fairly constant.

Table 1. Utilization summary for the insured dental services component of the COHP from 2004/05 to 2014/15[1]

Fiscal Year	Number of Insured Services Billed	Amount Insured	Eligible Persons Insured*	Beneficiaries Accessing the COHP	% Insured Persons Accessing the COHP	Number of Insured Services per Beneficiary	Cost per Beneficiary
2004/05	178,197	$3,820,536	95,818	40,452	42%	4.4	$94.45
2005/06	181,173	$3,781,852	94,290	41,092	44%	4.4	$92.03
2006/07	174,143	$3,698,283	91,700	39,851	43%	4.4	$92.80
2007/08	175,725	$3,800,499	89,300	39,165	44%	4.5	$97.04
2008/09	166,985	$3,862,361	84,400	38,669	46%	4.3	$99.88
2009/10	162,460	$3,892,382	89,260	38,516	43%	4.2	$101.06
2010/11	161,083	$3,906,419	89,100	37,612	42%	4.3	$103.86
2011/12	161,107	$3,942,373	90,078	37828	42%	4.3	$104.22
2012/13	160,767	$4,026,471	89,560	37,911	42%	4.2	$106.21
2013/14**	215,470	$5,262,008	124,751	52,606	42%	4.1	$100.03
2014/15*** 8 months	174,872	$4,246,853	149,012	46,950			

* This is the total number of children in the age groups covered by the COHP who have a valid Nova Scotia Health card.

** In May 2013, the insured dental services component of the COHP expanded to include children from the end of the month of their 10th birthday to the end of the month of their 14th birthday. Data for 2013/14 reflects 10.5 months with the additional age groups.

*** On April 1, 2014, the insured dental services component of the COHP expanded to children to the end of the month of their 15th birthday. Raw claims data for 8 months, from April 1 to November 30, 2014, is provided.

[1] *Annual Statistical Report Supplement: Medical Services Insurance (MSI) Tables*. Government of Nova Scotia (http://novascotia.ca/dhw/annual-statistical-reports.asp)

Research indicates dental visits in early childhood are a cost-effective way to reduce the need for restorative care in later life.[2,3,4] Oral health stakeholders agree dental visits should begin early - around age 1. This gives dental providers an opportunity to provide information on prevention, reinforce good dental practices, and do an early caries risk assessment. Unfortunately, Program data indicates utilization of insured dental services through the COHP is very low in the 0 to 3 age group (Table 2).

Table 2. Utilization of the insured dental services component of the COHP by age in 2013/14

Age	Eligible Persons Insured in this Age Group*	Beneficiaries Accessing the COHP in this Age Group	% Insured Persons Accessing the COHP for any Service in this Age Group
0	8,400	132	2%
1	8,899	1,155	13%
2	9,290	2,471	27%
3	9,267	4,531	49%
4	9,715	5,733	59%
5	9,775	6,320	65%
6	9,903	6,310	64%
7	9,292	6,138	66%
8	9,479	6,102	64%
9	9,374	5,980	64%
10	9,738	4,377	45%
11	9,551	4,080	43%
12	9,875	3,862	39%
13	9,981	3,560	36%
14	10,633	154	1%

* This is the total number of children in each age group who have a valid Nova Scotia Health card.

[2] Hirsch GB, Edelstein BL, Frosh M, Anselmo T. *A simulation model for designing effective interventions in early childhood caries.* Prev Chronic Dis 2012;9:110-219

[3] *CDA Position on Early Childhood Caries*. Canadian Dental Association, 2010

[4] American Academy of Pediatric Dentistry. *Guideline on infant oral health care*. Pediatr Dent 2010; 32:114-118

The type of insured dental service (diagnostic, preventive or restorative) being accessed varies with age (Table 3), but overall, there is a fairly equal distribution among diagnostic, preventive and restorative - 33.1% are diagnostic, 39% are preventive, and 28% are restorative.

Table 3. Utilization of diagnostic, preventive and restorative insured dental services by age in 2013/14

Age	Number of Insured Diagnostic Services Billed	Diagnostic Services as a % of Total for this Age	Number of Insured Preventive Services Billed	Preventive Services as a % of Total for this Age	Number of Insured Restorative Services Billed	Restorative Services as a % of Total for this Age	Total Insured Services for this Age	% of Total Services for this Age
0	139	72.4%	50	26.0%	3	1.6%	192	0.1%
1	1,159	62.5%	540	29.1%	154	8.3%	1,853	0.8%
2	2,491	43.0%	2,005	34.6%	1,300	22.4%	5,796	2.6%
3	4,532	32.9%	5,066	36.8%	4,170	30.3%	13,768	6.2%
4	6,035	29.7%	7,235	35.6%	7,063	34.7%	20,333	9.1%
5	7,301	29.5%	8,560	34.5%	8,922	36.0%	24,783	11.1%
6	7,738	28.7%	10,317	38.2%	8,922	33.1%	26,977	12.1%
7	7,665	29.8%	10,928	42.5%	7,142	27.8%	25,735	11.5%
8	7,723	32.1%	9,949	41.3%	6,399	26.6%	24,071	10.8%
9	7,531	34.6%	8,760	40.3%	5,459	25.1%	21,750	9.7%
10	5,671	37.8%	6,200	41.3%	3,123	20.8%	14,994	6.7%
11	5,596	38.6%	6,017	41.5%	2,870	19.8%	14,483	6.5%
12	5,270	37.9%	5,773	41.5%	2,878	20.7%	13,921	6.2%
13	4,822	34.7%	5,266	37.9%	3,810	27.4%	13,898	6.2%
14	114	18.2%	265	42.3%	247	39.5%	626	0.3%
17*					1	100.0%	1	0.0%
All Ages	73,787	**33.0%**	86,931	**39.0%**	62,463	**28.0%**	223,181	100%

* Service for this beneficiary was commenced within the eligible age, and was approved for completion after the age limit was reached.

Unfortunately, expenditures for diagnostic, preventive, and restorative services show the majority of the cost of the Program (56.5%) is for restorative procedures, while diagnostic and preventive procedures each account for only about half of the remaining 43.5% (Table 4).

Table 4. Cost of diagnostic, preventive and restorative insured dental services by age in 2013/14

Age	Cost of Diagnostic Services	Diagnostic Costs as a % of Total for this Age	Cost of Preventive Services	Preventive Costs as a % of Total for this Age	Cost of Restorative Services	Restorative Costs as a % of Total for this Age	Total Cost of Insured Services for this Age	% of Total Costs for this Age
0	$4,445	77.4%	$1,110	19.3%	$185	3.2%	$5,740	0.1%
1	$30,932	59.2%	$11,999	23.0%	$9,297	17.8%	$52,228	0.9%
2	$60,952	34.2%	$38,208	21.4%	$79,056	44.4%	$178,217	3.1%
3	$100,475	23.6%	$82,716	19.5%	$241,838	56.9%	$425,029	7.4%
4	$117,927	18.7%	$116,670	18.5%	$394,638	62.7%	$629,235	11.0%
5	$128,831	17.2%	$136,950	18.3%	$483,594	64.5%	$749,376	13.1%
6	$122,364	18.0%	$157,885	23.2%	$400,783	58.8%	$681,033	11.9%
7	$114,194	18.7%	$156,261	25.6%	$339,715	55.7%	$610,170	10.7%
8	$111,609	20.4%	$142,615	26.1%	$292,251	53.5%	$546,476	9.6%
9	$104,666	22.0%	$121,892	25.6%	$249,349	52.4%	$475,906	8.3%
10	$75,578	24.3%	$88,972	28.6%	$146,396	47.1%	$310,946	5.4%
11	$73,613	23.9%	$82,831	26.9%	$151,321	49.2%	$307,766	5.4%
12	$70,369	22.5%	$78,895	25.2%	$163,989	52.4%	$313,253	5.5%
13	$67,719	16.9%	$76,186	19.0%	$257,040	64.1%	$400,946	7.0%
14	$1,913	7.2%	$4,270	16.0%	$20,578	76.9%	$26,761	0.5%
17*					$162	100.0%	$162	0.0%
All Ages	$1,185,590	**20.8%**	$1,297,461	**22.7%**	$3,230,193	**56.5%**	$5,713,243**	

* Service for this beneficiary was commenced within the eligible age, and was approved for completion after the age limit was reached.

** Differs from the total for 2013/14 in Table 1 because it is based on date of service from raw claims data rather than date of payment, which is used in Table 1.

Since 2002, the COHP has been insurer of last resort. This means the COHP covers insured services only after any other insurance coverage for which the child is eligible has been utilized. The insurer of last resort insures amounts remaining up to the amount it would insure if the child has no other dental insurance.

While there is no way to determine the rate of private dental insurance in the general population of children in Nova Scotia, the 2007-2009 Canadian Health Measures Survey[5] reported 62% of Canadians had private dental insurance at the time the survey was done. In 2013/14, data for the COHP indicates 52% of insured dental services were provided to children who had some other form of dental insurance that was first payer. Table 5 shows the utilization of insured diagnostic and preventive services follows this pattern, but children without other dental insurance utilize proportionately more insured restorative services under the COHP.

Table 5. 2013/14 utilization of insured diagnostic and preventive services compared to insured restorative services by co-insurance status

Co-Insurance Status	% of all Insured Diagnostic and Preventive Services	% of all Insured Restorative Services
Children with no other dental insurance	47%	52%
Children with other dental insurance	53%	48%
Total	100%	100%

Jurisdictional Scan

A jurisdictional scan of publicly-funded oral health programs across Canada was completed and is provided as Appendix B. The scope for the scan is publicly-funded oral health programs available to children up to age 17. Publicly-funded programs for specific children's oral issues, i.e. cleft palate, are not included as they are not the focus for the Phase I work. Dental services provided through academic clinics associated with dentistry schools are also not included in this scan.

Some common themes that emerge from the jurisdictional scan:

- All jurisdictions insure some 'medically necessary' dental services provided in hospitals. The specific services vary from jurisdiction to jurisdiction.
- Most jurisdictions have some form of preventive oral health services provided through health authorities and/or public health.
- The Children's Oral Health Initiative for First Nations and Inuit, as well as four jurisdictions (British Columbia, Alberta, Manitoba and Newfoundland-Labrador) offer programs that specifically place emphasis on early oral health intervention.
- In jurisdictions that offer insured oral health services, some type of means testing (primarily through enrollment in another publicly-funded disability or assistance program) is used and all of these jurisdictions specifically exclude children with private dental coverage.
- There does not seem to be a program in any jurisdiction that is structured like Nova Scotia's COHP (coverage for all children within the eligible age group regardless of co-insurance status, insurer of last resort, etc.).

[5] *Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007-2009*, Health Canada. Government of Canada, 2010

Recommendations

Eleven recommendations are presented for the Minister's consideration. Consensus on the wording of all but three was attained. The College of Dental Hygienists of Nova Scotia (CDHNS) provided their concerns with the wording of these three recommendations. To inform the final review of this document, the CDHNS comments are footnoted with the applicable recommendation.

Recommendation 1

Redesign the COHP to incorporate a form of means testing to target the Program to those in need.[6]

Each time the eligibility age of the COHP has been expanded, Programs costs increase at double digit rates even though the percentage of eligible children accessing the Program remains at less than 50% (Table 1). Program costs are projected to exceed $6 million for fiscal 2014/15, a 14% increase over the previous year. Continued age expansion under the Program's current structure (coverage for all children within the eligible age group regardless of co-insurance status, insurer of last resort, etc.) is not sustainable.

There is no information to confirm why less than 50% of eligible children access the program. The Group speculated families who do not have other dental insurance may not be accessing regular dental care and, therefore, may not be aware that insured services are available to their children. Data indicates children with no other dental insurance utilize more restorative care (Table 5) suggesting families may not understand the availability of insured dental services until they have a dental problem. The COHP does not utilize a tool to:

1. Proactively identify eligible individuals/families; and
2. Target services to those in the greatest need.

In the Canadian publicly-funded health care system, 'need' is conceptually defined as the inability or incapacity to afford basic health services not provided through the *Canada Health Act*. Means testing is an effective method of targeting services to need. It typically utilizes family income and family size to calculate a needs threshold. It can be an expensive method of targeting services to need because the enrollment and re-enrollment processes are administratively intensive and costly. Means testing can also be a barrier to participation if the process creates stigma for families who apply.

The Group agreed that exploring means testing to determine eligibility for the COHP could accomplish two things:

1. Stabilize the cost of the COHP, allowing it to expand the insured preventive services offered to the target group; and
2. Target the COHP to those who need it the most.

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[6] Consensus on wording was not attained with the CDHNS. From Patricia Grant's email received on January 9, 2015 at 12:24pm:

> *The CDHNS recommends that all possible options be explored to enhance program design and to target dental services to those most in need while still containing the cost of the program. All options, including means testing, should be further investigated for their suitability for the Nova Scotia Children's Oral Health Program.*
>
> *Rationale: This committee has not had the mandate or the time to consider all options that could manage costs while providing care to children that need it most.*

The Group cautioned that unintended consequences of a means testing process must be considered and weighed against these intended consequences as further work on this recommendation proceeds.

The Group also agreed a means testing-type process for the COHP should include an appropriate tool for income testing and an appropriate tool to identify eligible individuals/families.

The Group considered the most appropriate options for identifying eligible individuals/families. They considered the possibility of having providers identify those in need based on defined parameters – for example, a barrier to employment, bleeding, pain. This option was dismissed due to concerns that:

- Providers do not typically have the skills to do assessments beyond those of a clinical dental nature.
- Assessments would only be done when a child is accessing the COHP. Parents may avoid access because they are uncertain about the outcome of the assessment.

The Group concluded that Government is the most appropriate option for identifying eligible individuals/families. An analysis of existing programs that incorporate income testing tools and/or eligibility tools was conducted to identify potential options for further investigation. Levering an established income testing and eligibility identification process was deemed to be the most cost and administratively effective approach to introducing means testing.

As indicated in Table 6, the Department of Community Services (DCS) Low Income Pharmacare for Children is an example of a program that uses both eligibility identification and income testing. It is a viable option for further investigation by a group specifically tasked with investigating means testing. As the Partnerships and Physician Services Branch is responsible for the insured dental services component of the COHP, they are the most appropriate group to lead this work.

Table 6. Existing insured services programs that incorporate income testing and/or eligibility identification

Existing Program	Pros	Cons	Viable Option for Further Investigation
DCS Income Assistance	Incorporates an income testing tool	Does not incorporate an eligibility identification tool - families self-identify Income is only one of a number of factors used to determine eligibility – eligibility determination is complex and staff intensive Eligibility is for entire family, not just the children Eligibility is intended to be short term and is reassessed frequently	No
DCS Low Income Pharmacare for Children	Incorporates an income testing tool (identifies families with an annual income of about ≤ $25,000) Incorporates an eligibility identification tool - Canada Revenue Agency (CRA) identifies	Family must file an income tax return to be eligible The DCS Memorandum of Understanding (MOU) with CRA is currently specific to Low Income Pharmacare for Children	Yes

Existing Program	Pros	Cons	Viable Option for Further Investigation
	and mails applications to eligible families who: 1. Receive the Nova Scotia Child Benefit; and 2. Have children ≤ 17 years of age Re-enrollment occurs annually		
Department of Health and Wellness (DHW) Family Pharmacare	Incorporates an income testing tool Re-enrollment occurs annually	Does not incorporate an eligibility identification tool – families self-identify Income testing tool does not determine eligibility – all applicants are eligible; income determines the level of their out-of-pocket deductibles and copayments Eligibility is for entire family, not just the children	No
DHW Seniors' Pharmacare	Incorporates an income testing tool Incorporates an eligibility identification tool – Nova Scotia Health Card holders are mailed an enrollment kit 90 days prior to their 65th birthday Re-enrollment occurs annually	Income testing tool does not determine eligibility – it determines the amount of the annual premium paid by the beneficiary Eligibility identification tool is not appropriate for the COHP	No

Recommendation 2

Do not expand the age eligibility of the COHP on April 1, 2015.[7]

In making this recommendation, the Group discussed three options:

1. Continue expanding the eligibility age until children up to age 17 are covered
    - Program costs are projected to exceed $6 million for fiscal 2014/15. This is a 14% increase over last year. Annual increases in this magnitude are not sustainable.
    - Each expansion of the age eligibility is associated with significant increases in Program costs, but the overall percentage of eligible children accessing the COHP remains fairly constant. It appears that increasing the age eligibility is not broadening access rates in the early years when the COHP could have a significant impact on prevention.

[7] Consensus on wording was not attained with the CDHNS. From Patricia Grant's email received on January 9, 2015 at 12:24pm:

> *The CDHNS recommends a suspension on further increases to the age limit for the COHP until a comprehensive Oral Health Strategy is in place regardless of the outcome of Recommendation 1.*
>
> *Rationale: It would be inappropriate to continue to making changes to the age limit of the COHP which are not based on best evidence and are not part of an overall affordable strategy for the province. One of the options referenced in the CDHNS's Recommendation # 1 to contain the cost of the program, at least for the interim is to freeze or roll back the age limit.*

- In 2013/14, 48% of insured dental services were provided to children who had no other form of dental insurance. This rate has been constant over the past several years so there is no indication expansion of the age eligibility is targeting those in the greatest need.

2. Reduce the eligibility age

   The Group considered two lower age maximums:

   - Less than 10 years of age
     Until May 2013, the COHP only covered this age group. The level and types of services insured under the Program are based on this age group and have never been revised to meet the needs of the older children now covered under the Program. For example, the number of insured radiographs, examinations and preventive care are appropriate for children under age 10, but not for children age 10 and over.
   - Less than 13 years of age
     The Program would be available to children to cover sealants for 12-year molars and it would provide the opportunity for oral health counselling and care as children enter junior high school.

   Although there was general agreement to recommend reducing the eligibility age to one of these levels on April 1, 2015, the Group was concerned the short timeframe would be insufficient to explain the change and its rationale to Nova Scotians.

3. No further expansion of the eligibility age

   The Group concluded the age eligibility for the COHP should not be expanded beyond the end of the month of the 15th birthday until implementation of Recommendation 1.

Recommendation 3

Structure the COHP to shift expenditures from restorative procedures to prevention.

A Nova Scotia oral health survey was completed by Dr. Amid Ismail in 1995/96.[8] The survey noted that compared to a 1982 survey, the percentage of children in Nova Scotia who were caries[9] free had significantly increased and the average number of decayed, missing and filled (DMF) teeth had declined. However, Nova Scotians age 6 to 7 had higher mean DMF scores than children in Norway, the UK, Denmark, Finland and the Netherlands, but lower mean DMF scores than 1990 figures for children in Quebec. While childhood caries are highly preventable, the COHP is not structured to emphasize prevention; the majority of expenditures now being spent on treatment (Table 4). Not every child needs the same level of prevention and diagnostic services, but doing a risk assessment for each child can provide a good estimate, especially since risk assessment considers factors such as the social determinants of health. Refer to Recommendation #4.

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[8] Ismail A. *Nova Scotia oral health survey of children and adolescents (NSOHS) 1995-1996*. Halifax, NS: Dalhousie University, Faculty of Dentistry, 1997.

[9] **Dental caries** is the medical term for tooth decay or cavities. It is the breakdown of teeth due to the activities of bacteria.

Recommendation 4

Consider how caries risk assessment can be used to target or provide additional coverage to those children at the highest risk.

Providers use a process for assessing a child for risk of developing caries. There are a number of excellent risk assessment tools available. Dalhousie Faculty of Dentistry uses the American Academy of Pediatric Dentists (AAPD)[10] tool. Regardless of the tool selected, the assessment determines whether the child is at high, moderate or low risk of developing caries. Many criteria are assessed to make this determination. Some criteria are self-reported or based on observation, while others are objective. A risk assessment done at one time may change if the risk factors change. The AAPD caries risk assessment tool can also be used to develop caries management protocols for different age groups which may be useful for work that will be done in Phase III as part of a provincial oral heath strategy.

The Group agreed using a risk assessment tool is a more proactive way to assess risk than waiting for the appearance of a cavity, which then qualifies a child for fluoride treatments. Phase III work should consider how to use risk assessment tools to proactively determine the appropriate array of insured procedures for each child.

Recommendation 5

Adjust insured dental procedure codes to provide more preventive services to high risk beneficiaries and to better reflect the services delivered to beneficiaries.

Consistent with the recommendation to shift expenditures in the COHP from restorative procedures to prevention, the Group identified specific additions, deletions, and adjustments to the insured dental procedure codes that will require an investment in the COHP to begin this process. The recommended adjustments will also better reflect the services delivered to beneficiaries, thereby improving data quality for monitoring and evaluation.

Four adjustments are recommended with cost estimates based the current program structure. However, it is important to note there is no existing funding in the base budget to cover these adjustments.

1. Continue to insure procedure code 13211 (Caries prevention service), but remove reference to rubber cup polishing and minor scaling procedures.

   Rationale:

   > Most patients require de-plaquing, but Dalhousie School of Dentistry teaches it is better to de-plaque using a brush rather than a rubber cup. Scaling procedures, typically only for older children, should be billed and tracked as a separate procedure.

   Proposed new wording for procedure code 13211 (Caries prevention service):

   > *Oral hygiene instruction/plaque control, including instructions on brushing and/or flossing and/or embrasure cleaning, (MSI: allowed once every 335 days.)*

   Estimated annual budget impact:

   > The cost associated with changing the definition is calculated in 2 below and is due to insuring a separate unit of scaling (procedure code 11111) for older children.

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[10] *Guideline on caries-risk assessment and management for infants, children, and adolescents*. American Academy of Pediatric Dentistry, 2014 (http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf)

2. Insure one unit of scaling (procedure code 11111) for all children age 10 and over once per year and monitor utilization of this procedure code in the context of its expected frequency.

   Rationale:

   Scaling procedures, which have been recommended for removal from the proposed wording change to procedure code 13211 (Caries prevention service) would be billed separately. Scaling is typically not required for children under 10 years of age. It is unknown what percentage of children age 10 and over require scaling, but 80% is an acceptable estimate.

   Estimated annual budget impact:

   $237,336[11]

3. Insure procedure code 00011 (First Dental Visit) for age 0 to 3 (MSI allowed once per lifetime) in conjunction with:
   a. eliminating one examination code (01101, 01102 or 01103) currently being billed for the first dental visit for these children; and
   b. de-insuring procedure code 13101 (Nutritional dietary counselling).

   Rationale:

   Assuming the COHP would insure procedure code 00011 (First Dental Visit) at 80% of the NSDA fee of $47 (= $37.60), this is a $1.40 saving on the $39 examination codes (01101, 01102 or 01103) currently being billed for first dental visits for these children. The saving would be $5,090 per year[12].

   Procedure code 13101 (Nutritional dietary counselling) is used to supplement both procedure code 13211 (Caries prevention service) and examination codes (01101, 01102 or 01103). The Group agreed that if high risk children could be insured for additional units of procedure code 13211 (Caries prevention service) – refer to 1 above – and procedure code 00011 (First Dental Visit) is insured, procedure code 13101 (Nutritional dietary counselling) could be eliminated. Based on 2013/14 data, de-insuring procedure code 13101 (Nutritional dietary counselling) will save $74,570 per year.

   Estimated annual budget impact:

   Savings of $79,660

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[11] Assumptions:
- 16,058 children aged 10 to 15 accessed the COHP in 2013/14
- 80% of these beneficiaries will need scaling = 12,846 beneficiaries
- 48% (6,166 beneficiaries) have no other dental insurance so the COHP covers 100% of the cost of procedure code 11111 ($30.29 x 6,166) = $186,768
- 52% (6,680 beneficiaries) have private dental insurance that is first payer so the COHP covers about 25% of the cost of procedure code 11111 ($7.57 x 6,680) = $50,568

[12] Assumptions:
- 3,636 children aged 0 to 3 accessed the COHP in 2013/14
- savings to insure procedure code 00011 (First Dental Visit) instead of examination codes (01101, 01102 and 01103) for age 0 to 3 ($1.40 x 3,636) = $5,090

4. Insure the revised procedure code 13211 (Caries prevention service) up to 4 times per year ***only*** for children approved for fluoride treatments. Monitor utilization of restorative services in the cohort of children for whom the additional caries prevention services are insured.

   Rationale:

   Approval for fluoride treatments is one proxy for high risk and high risk children will benefit from additional caries prevention services[13].

   While it may take years to see significant changes in the overall utilization of restorative services under the COHP resulting from this change, it may be possible to see reductions in the utilization of restorative services sooner in the cohort of children for whom the additional caries prevention services are insured.

   Estimated annual budget impact[14]:

   $793,970 if all children approved for fluoride receive 1 additional procedure

   $1.588M if all children approved for fluoride receive 2 additional procedures

   $2.382M if all children approved for fluoride receive 3 additional procedures

Recommendation 6

Address COHP plan rules that create limitations for delivering appropriate care.

The Group recommends a review of the COHP plan rules to identify those that create limitations for delivering appropriate care. For example, limits on how many of each procedure are insured in a specific time period or procedures that cannot be billed on the same day may not be appropriate in all circumstances. A specific example is provided:

If a child falls and breaks teeth, the COHP plan rules do not allow the provider to bill an emergency examination and an emergency procedure on the same day. In practice, however, there may be instances when there is a good clinical reason to do the procedure immediately after the examination to stop the bleeding, provide comfort, etc. In these situations the provider will do both but is only able to bill one of the two procedures, probably the emergency procedure. This has a financial impact on the provider and creates data quality issues as there is care being delivered that is not being tracked. For this example, the Group suggests estimating the cost of changing the COHP plan rules to permit the billing of a percentage of an emergency exam along with an emergency procedure on the same day and, if implemented, monitoring utilization with the potential to implement a maximum number of emergency examinations and diagnosis procedures (01205) per beneficiary per year.

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[13] As described in Recommendation 4, using a risk assessment tool is a more proactive way to assess risk than waiting for the appearance of a cavity, which then qualifies a child for fluoride treatments.

[14] Assumptions:

- 35,910 beneficiaries were approved for fluoride treatments in 2013/14
- Because the COHP is payer of last resort, it covers 73% of the cost of procedure code 13211 ($30.29 x 73%) = $22.11
- Cost to add each additional service (35,910 x $22.11) = $793, 970

Recommendation 7

Develop a communications plan for the COHP that targets multiple audiences.

Parents often don't understand how the COHP works: what is insured; what is not insured; and, how many of each procedure are insured per year. The Program is often referred to as 'universal', but this is an inappropriate description that creates unrealistic expectations. There is limited information about the COHP on the Government website and no new materials have been developed since it has been expanded so some providers have developed their own materials to explain the COHP to their patients. This creates fractured messaging about the Program.

Data shows an increase in utilization of the COHP in school age children (Table 2), but prevention should start much earlier, ideally around age one. There is no research to provide insight as to why utilization of the COHP is so low in the preschool years. The Group speculated that because parents are uncertain of the scope of the COHP, they may not bring children to dental providers for fear of potential out-of-pocket costs. A 2011 survey of clients eligible for government-funded dental services in Alberta indicates common reasons for not accessing services:[15]

- Their child did not have problems so they did not think there was a need to see the dentist.
- They did not understand what was covered.

Nova Scotia should undertake research to understand our population and the barriers that are preventing eligible children from accessing the COHP, especially in the early years. This information can be used to inform a communication plan that targets multiple audiences: providers, parents, children, and the administrator. Ideally, this work would be done in conjunction with the implementation of Recommendation 1.

Recommendation 8

Evaluate changes made to the COHP to link changes to any change in oral health outcomes.

The Group discussed the lack of evidence linking public dental coverage with better outcomes. The Group also noted there is no evidence indicating the recent expansion of age eligibility has had a positive impact on outcomes for the COHP. The Group agreed oral health goals and metrics should be established for any recommendation implemented in this report and there should be systematic monitoring and evaluation to determine the degree to which goals are achieved. Examples of metrics that can be used to measure outcomes include: rates of day surgery for early childhood caries[16]; pediatric oral surgery wait times at the IWK; and, relative expenditures on preventive and restorative procedures.

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[15] Amin MA, Perez A, Nyachhyon,P. *Barriers to Utilization of Dental Services for Children Among Low-Income Families in Alberta.* J Can Dent Assoc 2014; 80: e51 (http://www.jcda.ca/article/e51)
[16] *Treatment of preventable dental caries in preschoolers: A focus on day surgery under general anesthesia*, Canadian Institute for Health information, 2013 (https://secure.cihi.ca/free_products/Dental_Caries_Report_en_web.pdf)

Recommendation 9

Continue the COHP as insurer of last resort.[17]

Since 2002, the COHP has been insurer of last resort. An insurer of last resort is an entity that insures amounts remaining after any other primary programs have paid amounts covered under their programs. For instance, after a primary insurance company, a secondary or even tertiary program, the insurer of last resort pays the remaining amount up to the amount it would insure for a beneficiary with no other insurance. In some cases, the beneficiary can no longer be billed for services after the insurer of last resort has paid their eligible portion.

Based on coinsurance rates, approximately 52% of the children who access the COHP have private insurance. Under the current structure of the COHP, participation of private insurers is critical to sustaining the program. Insurer of last resort should be retained, but can be revisited in conjunction with the implementation of Recommendation 1.

Recommendation 10

Address the COHP administrative rule that can create issues for providers when they coordinate benefits with private insurers.

Because the COHP is insurer of last resort, providers are required to coordinate benefits with private insurers when eligible children have other insurance. As indicated in Recommendation 9, this involves billing the private insurers first, and then billing any balance to the COHP. If the private insurance has a copayment, the insurer expects the provider to collect the entire copayment. However, a COHP administrative rule coordinates benefits up to the 2012 fee guide (not the current fee guide), so there is often a small portion of the copayment that is not paid by the COHP and the provider is not allowed to collect the remaining balance because of requirements under the *Health Services and Insurance Act*, putting the provider in the position of being unable to collect the copayment required by the insurer.

The Group agreed it is important to retain private insurers as first payers (Recommendation 9), so this issue requires further investigation. The cost implications, if any, of addressing this issue will need to be determined as there is no existing funding in the base budget to cover any required adjustment.

Recommendation 11

Revisit the Oral Health Advisory Group's composition and terms of reference before Phase II begins.

As indicated in Appendix A, the Phase II work involves considering further recommendations for the other publicly-funded dental programs in Nova Scotia (including MSI [Medical Services

[17] Consensus on wording was not attained with the CDHNS. From Patricia Grant's email received on January 9, 2015 at 12:24pm:

> *We do agree with the minutes which state that Recommendation 9 should only address insurer of last resort and that the Group agreed it should recommend continuing the COHP as insurer of last resort. However the reference to recommendation #1 in the minutes may not be appropriate.*

Insurance], DCS [Department of Community Services], and public health programming). This covers three broad areas:

1. The other publicly-funded MSI dental programs:
   - Mentally Challenged
   - Cleft Palate/Craniofacial
   - Maxillofacial Prosthodontics
   - Dental Surgical
2. Various dental coverage provided through DCS
3. Public Health Programming

The Group agreed both its composition and terms of reference need to be revisited before Phase II begins. In particular, Phase II work should not proceed until the insured dental services program vacancy is filled and a District Health Board Patient Representative is identified. Other key resources that will be needed to complete Phase II work are:

- Pediatric and adult oral surgeons
- Craniofacial defect specialist
- Maxillofacial prosthodontic specialist
- DCS staff involved with the dental coverage offered through their various programs
- Public Health staff and their partners involved with delivering preventive public health initiatives

Summary

Continued age expansion of the insured services component of the COHP has not increased the percentage of eligible children accessing the Program. Furthermore, there is no way to determine whether those who need it the most are using it.

The Oral Health Advisory Group identified the need to understand the barriers that prevent eligible children from accessing the COHP, especially in the early years. This information can be used to improve and expand communication about the COHP. However, increased utilization of the COHP under its current structure is not sustainable in tough economic times. The Group therefore recommends further expansion of age eligibility only be considered in conjunction with a program redesign. Means testing is one such option as it could both target the COHP to those Nova Scotians who need it the most and stabilize the cost of the COHP so it can be restructured to shift utilization from restorative procedures to prevention and improve oral health outcomes. To begin this process, specific areas for restructuring are proposed with the caveat that there is no funding in the existing budget to cover additional costs.

The Group recommends vigilant evaluation as changes are made, so every change to the COHP is examined in terms of its impact on oral health outcomes.

Finally, the Oral Health Advisory Group identified the need to revisit its composition and terms of reference before Phase II work begins.

Appendix A
Terms of Reference
Oral Health Advisory Group

Committee Name: Oral Health Advisory Group

Executive Sponsors: Rob Strang, Chief Medical Officer and Frances Martin, Associate Deputy Minister

Project Lead: Dawn Frail

Co-Chairs: Until November 7, 2014 - Steve Jennex and Angela Arsenault
After November 7, 2014 – Steve Jennex and Sandy Goodwin

Responsible to: Minister, Department of Health and Wellness

Purpose:

To generate a report and make recommendations for the Minister of Health and Wellness regarding a plan for an oral health strategy for Nova Scotia, with the initial focus (Phase I) a review of the Children's Oral Health Program (COHP) as it currently exists, followed by the development of options to consider for other publically funded dental programs in Phase II. The long-term goal is to develop a plan for an oral health strategy for the province.

Background:

The Minister and oral health stakeholders in the province have identified the need for an oral health strategy for the province. This advisory group has been established to bring the right people together to review existing dental health programs and inform a broad oral health strategy. This work will compliment direction from Treasury & Policy Board (TPB), which includes:

- Program refinements and changes to enable a longer-term agreement with the Nova Scotia Dental Association (NSDA)
- Enhancements to program design such as means testing

Timeframes and Deliverables:

- **Phase I** (completed by December 2014): Review the Children's Oral Health Program (COHP) with recommendations to the Minister regarding:
    - Eligibility for the COHP and improvements/refinements within the current Program that should considered; and
    - Continuation of the Oral Health Advisory Group.
- **Phase II** (January 2015 – March 2015): With the above recommendations, consider further recommendations for the other publically-funded dental programs in Nova Scotia (including MSI, DCS, and public health programming), with recommendations to the Minister outlining options.
- **Phase III** (April 1 2015 onward): Development of a plan for an oral health strategy for the province

Authority:

For each phase of work, the advisory group is responsible to develop a report and make recommendations for the Minister of Health and Wellness. Authority to implement recommendations rests with the Minister.

In Scope:

To gather sufficient information to provide advice and recommendations on areas related to oral health in Nova Scotia. This could include:

- Best practices
- Jurisdictional comparisons of publically-funded dental programs and initiatives
- Evaluation approaches and methodologies
- Analysis (financial, utilization, and wait times data)

Out of Scope:

- Negotiations with the NSDA or other oral health providers
- Implementation of program changes
- Addressing patient or client-specific issues

Governance:

As this is an advisory group, a consensus approach will be used to develop recommendations. In the absence of consensus, the majority opinion will form the recommendation. When consensus cannot be achieved, this will be noted in the recommendation.

Guiding Principles:

Each member is expected to

- Attend or send a designate to meetings, or review minutes of meetings not attended
- Keep confidential and private any information discussed
- Remove organizational 'hats' and work in the best interest of Nova Scotians

Communications:

Members will communicate via e-mail and telephone. A working group email contact list will be developed with expectation of 72-hour turnaround typically expected on requests. For each phase, a final report with recommendations will be developed by the project lead to be presented to the Minister by the Co-Chairs on behalf of the group.

Composition:

Group composition will vary depending on the phase and nature of the work involved.

DHW:

- Angela Arsenault (Insured Programs) – until November 7, 2014
- Sandy Goodwin (Policy)
- Keith Dares (Policy and Planning) – until November 5, 2014
- Christine Gibbons (Policy and Planning) – until November 12, 2014
- Joëlle Désy (Policy and Planning) – beginning December 17, 2014
- Jason Sidney (BIAP, data analyst)
- Helen Pitman (Public Health)
- Steve Machat (Public Health) – beginning December 3, 2014
- Valerie Tracy (Finance)

DCS:

- Bev Corbin, Director
- Dave Williams, Manager

NSDA:

- Steve Jennex , Executive Director
- Dr. Phil Mintern, Chair, Tariff Negotiation Committee

- Dr. Graham Conrad, President
- Dr. Terry Ackles, Manager Clinical Affairs

Quikcard Solutions Inc.:
- Shawn Stals, President
- Lyle Best, Chairman

Subject Matter Experts:
- Patricia Grant (Registrar and CAO) College of Dental Hygienists of Nova Scotia
- Dianne Chalmers (Community Oral Health Consultant) College of Dental Hygienists of Nova Scotia
- Joyce Lind (Council Chair), College of Dental Hygienists of Nova Scotia
- Dr. Chris Lee, Dalhousie Faculty of Dentistry
- Dr. Ferne Kraglund, Dalhousie Faculty of Dentistry
- TBA, District Health Board Patient Representative
- Dr. Marc Plante, Dental Policy Manager, First Nations and Inuit Health

A pediatric oral surgeon from the IWK (Dr. Anderson) and an oral surgeon from Capital Health will be engaged as needed.

Secretariat:

- Secretariat provided by DHW

Other resources: (budget, office space, etc.)

- There is no budget for this advisory group. Meeting space will be provided at the DHW with teleconference arrangements when appropriate. Catering will not typically be needed and will adhere to current DHW catering policies if required.
- Materials will be made available to advisory group members for the purposes of their work.

Approval/Review date:

Oral Health Advisory Group – September 24, 2014

Appendix B

Jurisdictional Scan

Publicly-Funded Children's Oral Health Programs

Across Canada

Jurisdictional Scan of Publicly-Funded Children's Oral Health Programs Across Canada

This scan identifies publicly-funded oral health programs available to children up to age 17. Publicly-funded programs for specific children's oral issues, i.e. cleft palate, are not included. Dental services provided through academic clinics associated with dentistry schools are also not included.

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
British Columbia	Ministry of Health	Medical Services Plan in accordance with the *Medicare Protection Act* and Regulations	Surgical dental services requiring hospitalization	Staff in hospitals	All British Columbians enrolled in the Medical Services Plan	No cost to beneficiary
		Early Childhood Dental Program (one of the Early Childhood Screening Programs in accordance with the Child Health Screening Regulation under the *Public Health Act*)	Education, prevention activities, dental assessments, and family support and population surveys	Health authority public health staff in licensed childcare facilities and school settings	Children 0 to 5 years of age	No cost to beneficiary
	Ministry of Social Development and Social Innovation	BC Healthy Kids Program	Basic diagnostic, preventive and restorative services Emergency dental treatment is also available if the child's biennial limit ($1,400) has been reached. Emergency treatment is only available for the immediate relief of pain.	Private practice providers	Dependent children 0 to 19 years of age in families in receipt of the Medical Services Plan premium assistance	Means testing determines eligibility for the Medical Services Plan premium assistance Coverage is $1,400/child/2 years Additional assistance for emergency dental treatment is available if the child's biennial limit ($1,400) has been reached
		Other dental supplements in accordance with the Employment and Assistance	Orthodontic services	Private practice providers	Dependent children in families in receipt of income assistance or disability assistance who have severe maxio-facial dental deformities	Means testing determines eligibility for the Medical Services Plan premium assistance

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
		Regulation and Employment and Assistance for Persons with Disabilities Regulation				
Alberta	Ministry of Health	Alberta Health Care Insurance Plan (AHCIP)	Specific medically necessary dental, oral and maxillofacial surgical services listed in the Schedule of Medical Benefits and the Schedule of Oral and Maxillofacial Surgery Benefits Routine dental care is not covered, such as cleaning, fillings and the extraction of wisdom teeth.	Staff in hospitals and, for some procedures, private practice providers	All Albertans with AHCIP coverage	No cost to beneficiary for services covered under the AHCIP. The patient, or their secondary insurer (if applicable), is responsible for paying additional costs not covered under the AHCIP
		Early Childhood Oral Health Services	Various preventive services	Dental providers in 19 Health Centre locations in the Edmonton area	Children 0 to 36 months identified as high risk through a questionnaire completed at a Child Health immunization clinic	No cost for these services
		Healthy Teeth for a Healthy Start	Dental screenings, referrals and fluoride varnish applications Educate and provide parents/caregivers with key oral health information Parent counseling discussions may also be included to reduce risk factors for early childhood cavities	Public health dental assistants and dental hygienists in 53 Health Centre locations across Alberta (Public health employs approximately 32 dental hygienists and 39 dental assistants)	Children 12 to 35 months of age covered under the Alberta Child Health Benefit Plan	Means testing determines eligibility for the Alberta Child Health Benefit Plan There is no cost to join the Alberta Child Health Benefit Plan
	Ministry of Health in conjunction	School Fluoride Varnish Service	Fluoride varnish	Public health dental assistants and dental	Children in kindergarten to grade 2 in selected elementary schools	No cost for this service

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
	with the Ministry of Education	School Dental Sealant Service	Dental sealants	hygienists in selected elementary schools	Children in grades 1 and 2 in selected elementary schools	No cost for this service
	Ministry of Human Resources	Alberta Child Health Benefit Plan	Basic diagnostic, preventive and restorative services not available through the AHCIP	Private practice providers	Children covered under the Alberta Child Health Benefit Plan up to age 18, and up to age 20 if they live at home and are attending high school up to grade 12	Means testing determines eligibility for the Alberta Child Health Benefit Plan There is no cost to join the Alberta Child Health Benefit Plan
		Assured Income for the Severely Handicapped (AISH)	Basic diagnostic, preventive and restorative services not available through the AHCIP	Private practice providers	Dependent children of a parent receiving AISH assistance up to age 18, and up to age 20 if they live at home and are attending high school up to grade 12	The parent must meet the eligibility criteria for AISH, which includes income limits
		Income Support through Alberta Works	Basic diagnostic, preventive and restorative services not available through the AHCIP	Private practice providers	Dependent children in families receiving Income Support up to age 18, and up to age 20 if they live at home and are attending high school up to grade 12	Family must meet the eligibility criteria for Income Support, which includes employment status and income limits
		Child and Youth Support Program	Basic diagnostic, preventive and restorative services not available through the AHCIP	Private practice providers	Children in foster care up to age 18	No cost for these services
Saskatchewan	Ministry of Health	Medical Services Plan under the *Saskatchewan Medical Care Insurance Act*	Specific medically necessary dental, oral and maxillofacial surgical services carried out in a hospital and listed in the Payment Schedule for Insured Services Provided by a Dentist or a Dentist Holding a Specialist License Routine dental services are not covered.	Staff in hospitals	All individuals with a valid Saskatchewan Health Services card	No cost to beneficiary for services covered under the Medical Services Plan. The patient, or their secondary insurer (if applicable), is responsible for paying additional costs not covered under the Medical Services Plan.
		Northern Health Regions' Children's Dental Program	Dental sealants, fluoride varnish applications, community water fluoridation, and public education	Various dental providers	Children under age 16 in the three northern health authorities: Mamawetan Churchill River Health Region;	No cost for these services

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
			Basic diagnostic, preventive, restorative and oral surgery services		Keewatin Yatthé Health Region; and, Athabasca Health Authority	
		Fluoride Varnish Program	Oral health assessments and fluoride varnish	Staff in child health clinics and dental public health clinics	Children aged 2 months to 5 years identified as being at risk of dental disease	No cost for these services
	Ministry of Health in conjunction with the Ministry of Education	Fluoride Mouthrinse Program	Once a week, students rinse with a fluoride solution for one minute and then discharge the liquid for disposal	Dental health educators in the selected schools	Children in selected elementary schools (grades 1 to 6)whose parents have consented to their participation	No cost to children
		Sealant Program	Dental sealants	Dental health providers in the selected schools	Children in grade 1 and grade 7 in selected schools	No cost to children
	Ministry of Social Services	Supplementary Health Program	Diagnostic, preventive and restorative, oral surgery, removable prosthodontics, limited endodontic and orthodontic on a case by case basis	Private practice providers	Dependent children in families in receipt of the Saskatchewan Assistance Plan Foster children	No cost to beneficiary, but family must meet the eligibility criteria for the Saskatchewan Assistance Plan, which includes employment status and income limits; or child must be in foster care
		Family Health Benefits	Examination and diagnosis, x-rays, cleaning and fluoride, sealants (molar) for age 13 and under, space maintainers, amalgam (silver) filling, extractions	Private practice providers	Dependent children under age 18 in low income families or families receiving the Saskatchewan Employment Supplement or the Saskatchewan Rental Housing Supplement.	Means testing determines eligibility for low income families and for eligibility for the Saskatchewan Employment Supplement or the Saskatchewan Rental Housing Supplement. Beneficiaries are required to contribute to the cost of dental services not completely covered under Family Health Benefits.

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
Manitoba	Manitoba Health, Healthy Living and Seniors	Manitoba Health Services Insurance Plan under the *Health Services Insurance Act of Manitoba*	Certain dental procedures when hospitalization is required	Staff in hospitals	All individuals with a valid Manitoba Health card	No cost to beneficiary for services covered under the Manitoba Health Services Insurance Plan. The patient (or their private health plan insurer) is responsible for paying for dental surgery performed outside a hospital.
		Healthy Smile/Happy Child Early Childhood Tooth Decay Prevention Project	Educate young parents and mothers-to-be about the importance of proper nutrition and dental hygiene Targets at-risk infants and preschool children and their families	Led by public health using community development approaches to reach young children and their parents in settings where they interact with service providers, such as early childhood education facilities.	Infants and preschool children and their families in settings targeted by the project	No cost for these services
	Manitoba Family Services	Employment and Income Assistance Program under the *Manitoba Assistance Act* and Regulations	Basic dental care costs such as exams, cleaning and extractions	Private practice providers	Dependent children under age 18 in families receiving benefits under the Manitoba Employment and Income Assistance Program	No cost to beneficiaries
		Health Services Dental Program	Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic and oral surgery services	Private practice providers	Children under age 18 who have a disability or are wards of the state	Coverage is $500/child/year
	Winnipeg Health Region	SMILE plus Children's Oral Health program's	Includes: • Oral health needs assessments • School and community cased oral health promotion • Dental pit and fissure sealants • Topical fluoride	Dentists, dental hygienists, dental assistants, and senior dentistry students from the Faculties of	Children enrolled in several selected elementary schools in the Winnipeg Health Region.	No cost to the children

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
			• Assertive follow-up for children in need of treatment • School based clinical treatment	Dentistry & the School of Dental Hygiene		
Ontario	Ministry of Health and Long Term Care	Ontario Health Insurance Plan (OHIP) under the *Health Insurance Act*	Medically necessary surgical-dental services listed in the Schedule of Benefits – Dental Services in Regulation 552 of the *Health Service Insurance Act*	Staff in hospitals	All individuals with a valid Ontario Health card	No cost to beneficiary for services covered under the OHIP. The patient (or their private health plan insurer) is responsible for paying for insured dental services performed outside a hospital.
		Elementary School Screening and Surveillance	Provides parents/guardians with information on children's oral health prevention and treatment needs; streamlines children into publicly-funded care; collects surveillance data	Elementary schools by staff in the 36 public health units	Children in junior kindergarten, senior kindergarten and grade 2 in all schools Children in grades 4, 6, and 8 in high need schools Children in grades 2 and 8 in medium need schools	No cost for these services
		Healthy Smiles Ontario	Preventive and basic treatment services	36 public health units work with local partners such as primary care providers, dentists, dental hygienists, hospitals, schools and universities to deliver these programs	Children age 17 and under	No cost to beneficiary, but family must meet the eligibility criteria for Healthy Smiles Ontario, which include family income and no access to any form of dental coverage
		Children in Need of Treatment Program	Diagnostic, preventive, restorative, endodontic, prosthodontic, oral surgery and adjunct services such as general anesthesia and conscious sedation Intended for one-time coverage with no ongoing coverage		Children age 17 and under requiring emergency or essential dental care Children are identified by public health dental staff providing annual dental screening in all publicly funded elementary schools. Parents/caregivers can also call their local public health unit to arrange for a dental screening.	No cost to beneficiary, but family must meet the eligibility criteria: the treatment would result in financial hardship or they have no access to any form of dental coverage

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
	Ministry of Community and Social Services	Ontario Works Health Benefits	Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, and oral surgery services	Private practice providers	Dependent children 0 to age 18 in families receiving support from Ontario Works Dependent children over 18 years of age may be eligible for dental coverage through Ontario Works discretionary benefits	No cost to beneficiary, but family must meet the eligibility criteria for Ontario Works, which include employment status, family size and income
		Clinical Preventive Services	Topical fluoride, fissure sealants, and scaling	Private practice providers	Dependent children 0 to age 18 in families meeting the low-income eligibility criteria	No cost to beneficiary, but family must meet the low-income eligibility criteria
		Ontario Disability Support Program Income Support	Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, and oral surgery services	Private practice providers	Dependent children o to age 18 in families receiving Ontario Disability Support Program Income Support	No cost to beneficiary, but family must meet the eligibility criteria, which includes nature of disability, employment status, family size and income
		Assistance for Severely Disabled Children	Basic diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, and oral surgery services	Private practice providers	Children under age 18 with a severe disability living at home in a low income family	No cost to beneficiary, but family must meet the eligibility criteria, which includes nature of disability and family income
Quebec	Régie de l'assurance maladie du Québec (Ministère Santé et Services sociaux)	Medically necessary insured services	Certain oral surgery services in the event of trauma or an illness conducted in hospital. Related examinations, local or general anesthesia and X-rays are also covered. Costs related to tooth and root extractions are not covered	Staff in hospitals	All individuals with a valid Health Insurance card	No cost to beneficiary for the insured services covered by the Régie de l'assurance maladie du Québec. The patient (or their private health plan insurer) is responsible for paying for insured dental services performed outside a hospital.
		Quebec Public Health Program	Provides counselling on optimum fluoridation measures, tobacco use, and eating habits.	Public health providers in schools	Children from kindergarten to age 18 who have been identified as high risk when they were in kindergarten to grade three and selected for follow-up	No cost for these services

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
			Application of a dental sealant to the surfaces of permanent molars with sulcus and fissures in children aged 5 to 15			
		Services dentaires pour les enfants	Includes: • one examination per year • emergency examinations • X-rays • local or general anesthesia • amalgam fillings for posterior teeth • fillings using esthetic materials (white) for the anterior teeth • prefabricated crowns • sedative dressings, i.e. temporary fillings intended to reduce pain • endodontics • tooth and root extractions • oral surgery services Cleaning and applying fluoride are not covered.	Staff in hospitals or participating private dentists	All children under age 10 with a valid Health Insurance card	No cost to beneficiary for the services covered by the Régie de l'assurance maladie du Québec. The patient (or their private health plan insurer) is responsible for services not covered.
		Recipients of last-resort financial assistance through the Ministère de l'Emploi et de la Solidarité sociale	Persons who have been recipients of last-resort financial assistance for at least 12 consecutive months: • one examination per year • emergency examinations • X-rays • local or general anesthesia • amalgam fillings for posterior teeth • fillings using esthetic materials (white) for the anterior teeth • prefabricated crowns • sedative dressings, i.e. temporary fillings intended to reduce pain	Hospitals or participating private dentists	Dependent children of recipients of last-resort financial assistance through the Ministère de l'Emploi et de la Solidarité sociale	No cost to beneficiary for the services covered by the Régie de l'assurance maladie du Québec. The patient (or their private health plan insurer) is responsible for services not covered.

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			• certain root canal treatments, such as pulpectomy, pulpotomy and emergency opening of the pulp canal • tooth and root extractions • root canal and apexification treatments, before age 13 • cleaning of teeth and teaching hygiene procedures, from age 12 • application of fluoride, age 12 to 15 inclusive • scaling, from age 16 Only in emergencies, the following services may be provided to persons who have been recipients of last-resort financial assistance for less than 12 months: • tooth and root extractions • opening of the pulp chamber • drainage of an abscess • hemorrhage control • repair of a laceration • reduction of a fracture • immobilization of a tooth loosened by trauma • re-implantation of a tooth Persons who have been recipients of last-resort financial assistance for at least 24 consecutive months: • the above services • one lower dental prosthesis and one upper acrylic dental prosthesis every 8 years • one re-coating every 5 years • half the cost of replacing lost or damaged dental prosthesis			

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
			• replacement of prostheses following surgery • repair of prostheses • addition of a structure Removable partial dentures with a metal framework are not covered.			
New Brunswick	Department of Health	Dental-Surgical services under the *Medical Services Payment Act*	Various oral and maxillofacial procedures	Staff in hospitals	All individuals with a valid NB Medicare card	No cost to beneficiary for services covered under the *Medical Services Payment Act.* The patient (or their private health plan insurer) is responsible for paying for insured dental services performed outside a hospital.
	Department of Health in partnership with the Department of Education and Early Childhood Development	Fluoride Mouthrinse Program	Once a week, students rinse with a fluoride solution for one minute and then discharge the liquid for disposal.	Teachers and volunteers in participating schools prepare and administer the mouthrinse	Children in participating elementary schools whose parents have consented to their participation	No cost to children
	Department of Social Development	Healthy Smiles, Clear Vision Program administered by Medavie Blue Cross	Basic dental coverage, such as regular exams, X-rays and extractions, with some focus on preventative treatments such as sealants and fluoride treatments	Private practice providers	Dependent children 0 to age 18 in a low income family not receiving dental and vision coverage through any other government program or private insurance plan	No cost to beneficiary for covered services, but family must meet the eligibility criteria for the Healthy Smiles, Clear Vision Program, which include income and no access to any form of dental coverage.
Nova Scotia	Department of Health and Wellness	Dental Surgical Program	Medically necessary surgical-dental services listed in the Insured Dental Services Tariff Regulations under the *Health Services Insurance Act*	Staff in hospitals	All individuals with a valid Nova Scotia Health card	No cost to beneficiary for services covered under the Insured Dental Services Tariff Regulations under the *Health Services Insurance Act.* The patient (or their private health plan insurer) is responsible for paying for insured dental services performed outside a hospital.

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
		Children's Oral Health Program	Basic preventive, diagnostic, restorative, periodontics, prosthetics – removable, and oral & maxillofacial surgery	Private practice providers	Children 0 to age 14 with a valid Nova Scotia Health card	The Children's Oral Health Program is insurer of last resort. There is no cost to the beneficiary for insured benefits.
		Mentally Challenged Program	Basic preventive, diagnostic, restorative, periodontics, prosthetics – removable and oral & maxillofacial surgery	Private practice providers	All individuals with a valid Nova Scotia Health card who have been certified by a physician to be severely mentally challenged	The Mentally Challenged Program is insurer of last resort. There is no cost to the beneficiary for insured benefits.
		Public Health Programming	Provincially mandated Fluoride Mouthrinse Program: Once a week, students rinse with a fluoride solution for one minute and then discharge the liquid for disposal.	Public Health Services administers the program and Public Health Dental Hygienists work with trained community volunteers in selected schools to deliver the program	Children in selected elementary schools whose parents have consented to their participation	No cost to children
			A variety of education and health promotion activities; population level oral health assessments	Public Health Dental Hygienists	All Nova Scotian children	No cost for these services
	Department of Community Services	Emergency Dental Care for Income Assistance Recipients	Emergency dental care under certain circumstances: • There is pain • There is bleeding in the mouth that will not stop • Gums are swollen • Dentures require repair • There is a dental problem that interferes with getting a job	Private practice providers	Dependent children of families receiving Income Assistance	Family must meet the eligibility criteria for Income Assistance, which includes family size, income and employment status Note: Income Assistance is designed to provide transit support, so families do not remain in this program for long periods of time. Eligibility is reassessed frequently. 80% of the cost of approved services are covered. The

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
						beneficiary is responsible for paying the remaining 20%
Prince Edward Island	PEI Department of Health and Wellness	In-Hospital Surgical-Dental Services	Various oral surgical and dental procedures that must be done in hospital or in an office as a result of the patient's medical condition	Staff in hospitals, private practice providers	All procedures must have prior approval from the Hospital Services Commission	No cost to beneficiaries
		Dental Preventative Services Program	Assessment of risk of developing oral disease and referral to a dentist, oral health education, cleaning, topical fluoride application, and dental sealants	Provided in schools or dental public health clinics	Children age 3 to 17 with a Prince Edward Island Health card	No cost to children
		Dental Treatment Services Program	Basic dental services, including annual examinations, x-rays, filings, extractions, and root canals on front teeth	Private practice providers	Children age 3 to 17 with a Prince Edward Island Health card	Children who have private dental insurance plan are not eligible. Annual registration fee of $15/child to a maximum of $35/family, and patients pay 20% of the cost of the treatment. Families that have a net family income under $30,000 per year are exempt from paying the 20% copayment.
		Orthodontic Preventative Program	Preventive and interceptive orthodontic treatment	A designated clinic in Charlottetown	Children age 3 to17 with a Prince Edward Island Health card who are referred by their private dentist or a dental public health clinic	Children who have private dental insurance plan are not eligible. Patent pays for the laboratory fees for the appliances provided
		Pediatric Specialist Services Dental Program	Dental treatment services provided by a pediatric dental specialist, including in-hospital dental treatment	Pediatric dental specialist offices and/or hospitals	Children age 3 to17 with a Prince Edward Island Health card who need to be treated by a pediatric dental specialist	Children who have private dental insurance plan are not eligible. There is no cost to children

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					because of medical and/or behavioral problems	
Newfoundland and Labrador	Department of Health and Community Services	Surgical Dental Program	Insured services under the *Medical Care Insurance Act*. An insured service is defined as one that is: 1. Listed in Section 3 (b) of the Medical Care Insured Services Regulation 2. Medically necessary. The clinical need of the provision and claim of an insured service may be evaluated by the Dental Monitoring Committee of Medical Care Plan (MCP).	Staff in hospitals	All individuals with a valid Medical Care Plan (MCP) card	No cost to beneficiary
		Children's Dental Health Program	Children age 0 to 12: • examinations at 6-month intervals • cleanings at 12-month intervals • fluoride applications for children age6 to 12 at 12-month intervals • some x-rays • routine fillings and extractions • sealants Children age 13 to 17: • examinations every 24 months • some x-rays • routine fillings and extractions • emergency examinations when a patient has pain, an infection or experienced trauma.	Private practice providers	All children o toage 12 with a valid Medical Care Plan (MCP) card are eligible for the insured dental services for that age group Children age 13 to 17 with a valid Medical Care Plan (MCP) card are eligible for insured services for that age group if they are a dependent of a family in receipt of income support or a dependent of a family with an annual net income of $30,000 or less but not in receipt of income support benefits.	The Children's Dental Health Program is insurer of last resort. For dependent children aged 13 to 17, the family must meet the eligibility criteria for income support or confirm they meet the low income criteria
Nunavu t	Department of Health	In-Hospital Surgical-Dental Services	Specific oral surgical and dental procedures	Staff in hospitals Oral surgeons are brought to Nunavut on a regular basis, but for medically	All individuals with a valid Nunavut Health Care card	No cost to beneficiaries

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				complicated situations, patients are flown south		
		Oral Health Pilot Project	Dental examinations, some preventive treatments, including fluoride, sealants, and temporary fillings Children receive a free dental kit including a toothbrush and toothpaste	Depending on the community, dental services are available all year, or are provided by travelling dental clinics that visit several times a year. Information about dental services is available from the Community Health Nurse.	Children up to age 7	No cost for these services
Northwest	Department of Health and Social Services	Insured Surgical Dental Services	Specific medically-required procedures related to jaw injury or disease provided on an inpatient or outpatient basis	Staff in health facilities	All individuals with NWT health care card	No cost to beneficiaries
		Métis Dental Program administered by Alberta Blue Cross	Clients are eligible for any procedure that is covered by the Non-Insured Health Benefit Dental Program (Health Canada) – see below	Community-based dental therapists Private practice providers	Registered Métis	No cost to beneficiaries
Yukon	Department of Health and Social Services	Insured Surgical Dental Services	Certain hospital dental-surgical procedures	Staff in hospitals	All individuals with a valid Yukon Health Care card	No cost to beneficiaries
		Preschool Dental Program	Pre-school/home-school clinics are held each month in Whitehorse and various communities outside Whitehorse. At the clinic, children receive a dental examination and oral health education.	Dental therapists in Pre-school/home-school clinics	Children 0 to age 5 with a valid Yukon Health Care card	No cost to children

F/P/T	Department or Organization	Program Name	Coverage	Providers and Location	Eligibility	Design
		Children's School-Based Dental Program	Provides diagnostic, preventative and restorative dental services	Dental therapists provide dental services to both urban and rural communities	Children from Kindergarten to either Grade 8 or Grade 12, depending on the community in which the child resides with a valid Yukon Health Care card	No cost to children
Government of Canada	Health Canada	Non-Insured Health Benefit Dental Program	Emergency, diagnostic, restorative, endodontic, periodontal, prosthodontic, oral surgery and orthodontic services	Community-based dental therapists Private practice providers	Registered First Nations and Inuit	No cost to beneficiaries
		Children's Oral Health Initiative (COHI)	Annual screening, topical fluoride applications, placement of dental sealants, alternative restorative treatment, oral health information sessions and referrals to other dental care professionals	Dentists, dental therapists, dental hygienists, and dental assistants deliver services in the community with the assistance of a COHI Aide	Children age 0 to 7 Note: This initiative also provides services to parents and caregivers of eligible children as well as pregnant women.	No cost to beneficiaries