Report of the Staff Task Force on Public Health Dental Services

(City Council on December 14, 15 and 16, 1999, adopted this Clause, without amendment.)

The Policy and Finance Committee recommends the adoption of the Recommendation of the Board of Health embodied in the following communication (November 15, 1999) from the City Clerk:

Recommendations:

The Board of Health recommends the adoption of the joint report dated September 29, 1999, from the Medical Officer of Health and the Commissioner of Community and Neighbourhood Services, subject to adding to Recommendation No. (4) the words "provided that the costs of these services do not exceed the costs of the same services in Public Health clinics", so that such Recommendation reads as follows:

> "(4) clients of the municipally funded, non-mandatory dental treatment program be provided with the option of obtaining dental and oral health services from any fee-for-service dental practitioner or organization that enters into an agreement with Public Health to provide services under the program, provided that the costs of these services do not exceed the costs of the same services in Public Health clinics".

Background:

The Board of Health on November 15, 1999, again had before it a joint report (September 29, 1999) from the Medical Officer of Health and the Commissioner of Community and Neighbourhood Services recommending that:

(1) delivery of the municipally funded, non-mandatory dental treatment program be through a "mixed model", which maximizes the City's investment in the ten city-operated dental clinics and the preventive and school-based clinics, augmented, as required, through agreements with fee-for-service dental practitioners and non-profit organizations to provide coverage for residents in the former municipalities that did not offer these services;

(2) Public Health be responsible for determining client eligibility and for preauthorizing and predetermining the services to be rendered to individual clients under the municipally funded, non-mandatory dental treatment program;

(3) Public Health audit a proportion of cases served through fee-for-service to ensure that all needs were treated and the services claimed were provided;

(4) clients of the municipally funded, non-mandatory dental treatment program be provided with the option of obtaining dental and oral health services from any fee-for-service dental practitioner or organization that enters into an agreement with Public Health to provide services under the program;

(5) as only four of the former municipalities offered non-mandatory dental treatment and each program was different in terms of the target groups served and the coverage provided, the Medical Officer of Health take steps to implement appropriate information and operating systems and mechanisms across the whole City, which will:

(i) monitor the effectiveness of the program amalgamation;

(ii) maximize the efficiency and productivity from the use of scarce resources; and

(iii) accurately capture cost and other information that will reasonably identify cost per unit of services, and facilitate a meaningful comparison with other service delivery methods and models; and

(6) approval of the mixed model of service delivery recommended in this report be subject to Budget Committee consideration of service harmonization as part of the year 2000 budget review process.

Dr. Sheela Basrur, Medical Officer of Health, gave a presentation to the Board of Health in connection with the foregoing matter.

(Joint report dated September 29, 1999, addressed to
the Board of Health from the Medical Officer of Health
and the Commissioner of Community and Neighbourhood Services)

Purpose:

This report responds to a directive from Council to examine methods of providing a harmonized program of municipally funded, non-mandatory dental treatment services for the City of Toronto in the year 2000. It includes a summary of the process adopted by a staff task force convened for this purpose, and the conclusions and recommendations of the task force.

Based on clarification received by staff, examination of any other mandatory dental program directly delivered by Public Health or delivered under Social Service's contract for dental services is outside the directive of Council. A report to review the Social Service's contract will be undertaken in year 2000.

Source of Funds:

The purpose of this paper is to examine service delivery models. The recommendations have no immediate financial impact beyond the 1999 approved budget for Public Health. Pending a decision on this report, a report on service harmonization will be provided to indicate the financial implications for year 2000 and beyond.

Recommendations:

It is recommended that:

(1) delivery of the municipally funded, non-mandatory dental treatment program be through a "mixed model", which maximizes the City's investment in the ten city-operated dental clinics and the preventive and school-based clinics, augmented, as required, through agreements with fee-for-service dental practitioners and non-profit organizations to provide coverage for residents in the former municipalities that did not offer these services;

(2) Public Health be responsible for determining client eligibility and for preauthorizing and predetermining the services to be rendered to individual clients under the municipally funded, non-mandatory dental treatment program;

(3) Public Health audit a proportion of cases served through fee-for-service to ensure that all needs were treated and the services claimed were provided;

(4) clients of the municipally funded, non-mandatory dental treatment program be provided with the option of obtaining dental and oral health services from any fee-for-service dental practitioner or organization that enters into an agreement with Public Health to provide services under the program;

(5) as only four of the former municipalities offered non-mandatory dental treatment and each program was different in terms of the target groups served and the coverage provided, the Medical Officer of Health take steps to implement appropriate information and operating systems and mechanisms across the whole City, which will:

(i) monitor the effectiveness of the program amalgamation;
(ii) maximize the efficiency and productivity from the use of scarce resources; and
(iii) accurately capture cost and other information that will reasonably identify cost per unit of services, and facilitate a meaningful comparison with other service delivery methods and models; and

(6) approval of the mixed model of service delivery recommended in this report be subject to Budget Committee consideration of service harmonization as part of the year 2000 budget review process.

Council Reference:

At its April 26, 1999 meeting, City Council approved the following recommendations regarding the municipally funded, non-mandatory dental treatment programs delivered by Public Health:

"(168) The provision for the level of service for the Dental Program as recommended by the Board of Health on January 25, 1999 in the Report entitled "Harmonization of Dental and Oral Health Services" dated January 15, 1999 (Reference #1.3.LL) to harmonize in 1999 across the City by extending the hours of some or all of current clinics be approved with the exception that no capital monies be included and that the following items be adopted to facilitate the Budget Committee review process for the 2000 budget process:

(1) $800 thousand be added for the expansion of the Dental Program for children and seniors in 1999 and the Commissioner of Community and Neighbourhood Services be requested to report on whether, with this expansion, the pilot program for dental services can be included, providing the Community and Neighbourhood Services Committee with a full review of the expanded program, including its successes and failures, prior to year-end;

(2) a Dental Advisory Committee be established to set up and examine the methods of providing dental services for the City of Toronto in the year 2000, to include an Action Plan and the cost of same, and report thereon to the Board of Health and the Community and Neighbourhood Services Committee in that regard;

(3) the aforementioned Dental Advisory Committee be comprised of the Chief Administrative Officer, Chief Financial Officer and Treasurer, Commissioner of Community and Neighbourhood Services, the Medical Officer of Health, and representatives from the University of Toronto's Faculty of Dentistry, the Ontario Dental Association, Ontario Dental Hygienists' Association, and the Society of Denturists, include a representative from the Community Health Centre;

(4) the Commissioner of Community and Neighbourhood Services and Medical Officer of Health be requested to report within three months to Community and Neighbourhood Services Committee on the new management structure for dental services;

(5) The City Auditor be requested:

(i) to report back to the Budget Committee on a system of control for the eligibility of clients requesting dental services; and

(ii) review the dental services that are now in operation and report back to the Board of Health prior to the Year 2000 budget deliberations;

(6) The Ontario Dental Association be requested to:

(i) report back to the Budget Committee on the costs related to referrals and administrative fees;

(ii) provide Members of the Budget Committee with a copy of the FDA "Table of Benefits"; and

(iii) consult with the City to work out a plan whereupon every resident in the geographic area requiring dental services could be looked after at a reasonable cost; and

(7) the Ontario Dental Association be requested to report back to Budget Committee and advise whether or not dentists who are members of the Association who acquire work from the City, are prepared to do pro-bono work for the City."

Further to Motion No. 168 (iii), the Commissioner of Community and Neighbourhood Services received clarification from the Chair of the Budget Committee that the report was to be a staff report with input from the stakeholder groups whose names were listed in the motion (collectively, the "Advisory Committee").

Background:

Dental Programs Administered and Delivered by Public Health:

Dental public health services consist of provincially mandated programs and services (funded 50 per cent by the province) and non-mandatory dental treatment services administered and delivered by Public Health (funded 100 per cent by the City).

(1) Provincially mandated services delivered through municipal public health include:

(a) annual school-based dental and oral health surveys;

(b) monitoring of the fluoridation of the local municipal water supply;

(c) education resources and oral health aids targeted to the school-age population;

(d) teacher in-service oral health education (or equivalent) in high-risk schools and ESL classes;

(e) the Children in Need of Treatment program (CINOT); and

(f) clinical preventive services for children aged 0-14, including the application of topical fluoride and fissure sealant(s); and

(2) non-mandatory dental treatment services are delivered by municipal public health for identified target groups. The former municipalities initiated these services, but not on a consistent basis. Non-mandatory dental treatment services include:

(a) clinical preventive services, including cleaning and scaling, and denture cleaning and identification (e.g., for seniors);

(b) basic dental care, including diagnosis, x-rays, fillings, extractions, dentures, root canal on critical teeth, and predetermination for other services; and

(c) emergency dental care to relieve immediate pain and suffering and correct an oral health problem; emergency dental care may include the provision of one or more of the above basic dental care services.

Costs and Utilization:

The gross budget for the activities undertaken by the Board of Health to meet provincially mandated requirements is $7.0 million operating and 61.0 FTE staff. The costs of the non-mandatory dental treatment services are the full responsibility of the City. The 1999 budget for these services is $4.4 million operating and 76.0 FTE staff. The $4.4 million includes $800 thousand operating approved in 1999, for the purpose of harmonizing non-mandatory dental services for children and seniors across the whole city. The net cost after cost sharing of all dental and oral health services delivered by Public Health is estimated to be $8.6 million in 1999. (See Table 1 in the appendix for a breakdown of the funding and staffing levels for the programs.)

In the former municipalities of North York and Toronto, a significant percentage of CINOT/OW cases elect to receive treatment in the school- and community-based dental clinics. The province reimburses the City for 50 per cent of the cost of treating CINOT clients, and Social Services reimburses Public Health for 100 per cent of the cost of treating OW clients.

Origin:

Municipally funded, non-mandatory dental treatment services were initiated by four of the former municipalities prior to amalgamation, and pre-dated the provincially mandated CINOT program which was introduced in 1987. The four former municipalities that provided non-mandatory dental treatment services were Etobicoke, North York, Toronto, and York. The non-mandatory programs in the former municipalities of North York and Toronto were the largest of the four programs and served the bulk of the clients receiving non-mandatory dental treatment services.

Eligibility Criteria:

Four groups of persons are eligible to receive non-mandatory dental treatment services through municipal public health. These groups are: non-CINOT eligible school children, aged 0-14; ESL and other new immigrant adolescents; high-risk mothers, who are referred by a public health nurse or nutritionist; and seniors aged 65 and over (55 and over in Etobicoke) living independently in the community or in long-term care facilities. To be eligible for services, a person must meet the target group definition, be assessed/diagnosed as needing dental treatment, have no dental insurance, and no financial means to obtain this service privately. For seniors,

lack of financial means is defined as persons whose sole source of income is OAS/GIS (or equivalent) (1999 rate - $16,750.00 (single); $25,500.00 (couple). For persons in other groups, lack of financial means is determined through a declaration method by the parent/guardian in the case of children, and, in the case of high-risk mothers, by the mother herself.

Service Summary:

In 1998, approximately 15,700 persons received dental treatment under the non-mandatory municipal program (see Table 2 in the appendix). Of this number, 46 per cent were children aged 0-14, and 44 per cent were seniors. The other 10 per cent were adolescents (7 per cent) and high-risk mothers receiving services from other public health programs (3 per cent). Comparable figures for 1999 are not available.

Clinical Arrangements for the Delivery of Dental Public Health Services:

Both provincially mandated and non-mandatory municipal dental treatment programs are delivered through the same municipal public health dental clinics. The specific clinical arrangement in each former municipality is listed in Table 3 in the appendix. The ten full-service community-based dental clinics in the former municipalities of Etobicoke (1) and Toronto (9), the preventive clinics in East York and Scarborough (which are not full-service dental clinics), and the three school-based clinics in York are identified on Map 1 in the appendix. Not identified on Map 1 are approximately seventy elementary schools in the former municipality of North York that have dedicated space and hook-ups for dental equipment which serve as part-time, single-chair dental clinics.

The approach of extending the operating hours of existing community-based clinics has had the advantage of making maximum use of city-operated facilities without a major increase in capital costs. The disadvantage of using this approach is that clients (i.e., children and seniors) are required to absorb the cost and inconvenience of traveling to the existing ten sites in the former municipalities of Etobicoke and Toronto; and, given the level of demand for these services, to be on a waiting list.

For the long term, Public Health staff should examine the desirability of streamlining the school-based clinics in York and North York and re-allocating some of the resources to establish community-based clinics. The former municipality of Toronto reorganized its dental services from a school-based program to a community-based program, which achieved significant cost savings. As well, community clinics were found to offer more flexibility in hours of operation and suitability of space for the different client groups that need access to dental services.

Task Force/Advisory Committee Process:

As per the April 26, 1999 Council directive, a staff task force was convened, consisting of representatives from the CAO's Office, Finance, Community and Neighbourhood Services, Public Health, and the Toronto District Health Council (see Figure 1 for terms of reference). The Commissioner of Community and Neighbourhood Services chaired the task force. Also, an advisory committee of external stakeholders was convened (see Figure 2 for the terms of

reference and a list of organizations represented). The staff task force and advisory committee of external stakeholders had four joint meetings in the period May 31 to July 27, 1999, (see bottom of Figure 2 for the dates of the joint meetings).

The meetings addressed issues such as: (i) the mandate of the task force and Advisory Committee; (ii) the definition of mandatory and non-mandatory dental and oral health services; (iii) the scopes of practice and services provided by the three oral health professions and two organizations that provide dental services (see Table 4 in the appendix); (iv) the type and level of services provided under the municipally funded, non-mandatory dental services program; (v) the target groups and eligibility criteria of individuals served under this program; (vi) models of service delivery; and, (vii) criteria for evaluating/selecting the models.

Major Issues Discussed:

Following is a list of the major issues that emerged from the discussions:

Under current provincial legislation (the *Health Protection and Promotion Act*), the Board of Health, through the City of Toronto, has direct delivery responsibility for the following services:

(i) annual school-based dental and oral health surveys;

(ii) monitoring of the fluoridation of the local municipal water supply;

(iii) education resources and oral health aids targeted to the school-age population;

(iv) teacher in-service oral health education (or equivalent) in high-risk schools and ESL classes;

(v) the Children in Need of Treatment program (CINOT); and

(vi) clinical preventive services for children aged 0-14, including the application of topical fluoride and fissure sealant(s).

The responsibility to deliver these services cannot be delegated to a third party. (See Figure 3 for a detailed description of the provincially mandated services.)

The majority of stakeholders were of the view that there is value in retaining the municipally funded, non-mandatory dental treatment programs delivered by Public Health. These are services of "last resort" for children, youth, and adults in the identified target groups (i.e., school children, adolescents enrolled in ESL classes, high-risk mothers enrolled in other Public Health programs, and seniors). The people served by these programs have no dental insurance, no financial means to obtain services privately, and do not qualify for social assistance.

The majority of stakeholders recognized that the level of coverage provided by Public Health under the municipally funded, non-mandatory dental treatment programs is quite different from the coverage available through fee-for-service dental plans, including those for some social

assistance recipients. For example, under these former municipal programs, dental care is provided to address an immediate problem, which if not treated, is likely to result in an acute/emergent episode. Clients are eligible for one complete course of treatment. When treatment is complete, they are encouraged to seek ongoing care from another provider (e.g., private practice dentist or denturist). Clients are not eligible to receive services on a regular basis. For example, there is no provision for routine callbacks as is standard practice in the industry, and which is reflected in the dental coverage available to beneficiaries under the province's Ontario Disability Support Program (ODSP). As a result, the cost per patient for public health services will tend to be higher than average, reflecting both the type of service provided and the client base.

There are three principal criteria for determining the most appropriate method of service delivery – i.e., access, outcomes and cost:

(1) Access, includes factors such as proximity to public transit, languages spoken by staff, a user-friendly environment, and linkages to other community health and medical services;

(2) Outcomes, includes factors such as waiting times for appointments, ensuring services provided are those that will lead to a significant improvement in oral health, and patient satisfaction; and

(3) Cost, includes factors such as capital investment, efficiency of service provision, and cost containment.

Four models were considered appropriate for the delivery of non-mandatory dental services – (i) salaried staff; (ii) purchase of service contracts of two types (a) fee-for-service; and (b) managed care; (iii) grant(s) to a not-for-profit organization(s), and (iv) a "mixed model", combining two or more of the above models (see Figure 4 for a definition of each of these models).

Only four of the former municipalities offered non-mandatory dental treatment and each program was different in terms of the target groups served and the coverage provided. The majority of stakeholders were of the view that, at this time, there is not enough data on the number, type, and location of potential clients and the service mix they require for them to make an informed choice about which method(s) of service delivery would best meet the need.

The recommended approach was a "mixed model" of service delivery, which maximizes the use of the ten city-operated dental clinics and the preventive and school-based clinics, augmented, as required, through agreements with fee-for-service dental practitioners and non-profit organizations such as community health centres (CHCs) and the Faculty of Dentistry, University of Toronto, to provide coverage in the former municipalities that did not offer these services.

Under this model, Public Health would determine eligibility and preauthorize/predetermine the services to be rendered to individual clients. Fee-for-service providers would be remunerated by Public Health according to a predefined schedule of benefits approved by the City. Non-profit organizations would be remunerated under a dental services agreement with Public Health. A proportion of cases would be audited to ensure that all needs were treated and the services

claimed were provided. Clients would have the option of obtaining services from any practitioner or organization that agrees to provide services under the program.

Comments:

Capital Investment:

The current clinics in the former municipalities are good, up-to-date facilities and it would be wasteful to mothball them. The current clinics also are used by Public Health in the delivery of mandatory dental and oral health services. There is a need to streamline the school clinics in the former municipalities of North York and York and redistribute some of the staff and equipment to address treatment needs in the former municipalities that did not offer these services. Fee-for-service and not-for-profit clinic models could be used to provide services to seniors in Scarborough and Etobicoke without significant capital investment by the City.

Comparative Costs of Different Service Delivery Models:

The consultation process was unable to fully address the issue of comparative costs in regard to possible methods of service delivery for the non-mandatory programs. In this regard, two key issues emerged: (i) the lack of agreement on what is an appropriate measure of cost; and (ii) the difficulty of making direct comparisons of the cost of different models of service delivery due to significant differences in the design of programs (i.e., the purpose and objectives), the populations served, and the level of dental benefits provided.

In regard to the issue of an appropriate measure of cost, the Ontario Dental Association (ODA) has repeatedly stated that cost per patient is the most appropriate measure for comparing costs in regard to methods of service delivery. The majority of stakeholders could agree that cost per patient may be an appropriate basis of comparison when the underlying programs are the same - i.e., the program objectives, the population served, and the level of dental benefits are all the same. However, as was noted in the discussions, in comparing the cost of delivery of non-mandatory services under Public Health and, for example, dental services to social assistance recipients (through private practice dentists), allowance needs to be made for the significant differences between the program objectives, the populations served, and the level of benefits provided. For example, the children of long-term welfare clients have routine access to dental care, and can be expected to receive more dental services such as pit and fissure sealants and have generally healthier dentition than children served by municipal programs who evidence suggests have not had regular access to these services. Furthermore, research has shown that the children being seen in the City's dental clinics are more likely to have been born outside of Canada, have parents who have resided in Canada for comparatively few years, and present evidence of past decay in much higher proportions than do children using private practice dentists. These examples serve to highlight the problem of using a single measure – e.g., cost per patient – as the only measure of cost when comparing different populations and different service delivery methods.

Another method of comparing costs, suggested by staff in Public Health, is the Relative Value Unit (RVU) method. This is a simple formula developed by the ODA that permits calculation of

the relative values of different services. The ODA assigns a relative time factor to complete each dental service. Services are then classified into groups, and a responsibility factor assigned to each group. The product of these two factors - time and responsibility - gives a relative value for each service. For example, a simple filling on the chewing surface of a premolar tooth has a RVU of 1.0, but a complicated crown on a molar tooth has a RVU of 14.0. Using the current ODA fee guide, the average cost of one (1) RVU is $31.61. This amount is the basis of comparison. The services under a particular model can be converted to RVUs and the cost per RVU calculated using the total cost of the program.

In 1998, a staff task force in Public Health used the RVU method to compare the costs of three models of service delivery - i.e., staff model, used by Public Health to deliver non-mandatory dental treatment ($15.42 per RVU); an insurance/fee-for-service model, used by Social Services for adults on social assistance who require emergency treatment ($19.47 (per RVU)); and the CINOT model, used by Public Health for children who require urgent care (Public Health determines eligibility and authorizes treatment which is provided by fee-for-service dentists or by staff in city-operated clinics) ($22.16 per RVU). The methodology and findings of the analysis were subjected to an external review by a health economist, a member of the Institute of Clinical Evaluative Studies, and a consultant in health program evaluation, to ensure the approach and interpretations were valid.

The conclusion drawn by the majority of stakeholders is that an investment needs to be made in a good information system that will collect the data needed to do a meaningful analysis of the cost differences between different service delivery methods. No single method of cost comparison will suffice as a basis for determining which method of service delivery is most efficient and cost effective.

In this regard, the dental programs in the former municipalities of North York and Toronto had well-developed information systems that captured data on clients' demographic and service utilization characteristics in electronic format. In the next year, Public Health intends to build on these existing information systems and establish a City-wide system that will: (i) monitor the effectiveness of the program expansion, (ii) maximize the efficiency and productivity from the use of scarce resources, and (iii) accurately capture cost and other information that will reasonably identify cost per unit of services, and facilitate a meaningful comparison with other service delivery methods and models.

Other Issues:

The Ontario Dental Association (ODA) in a letter dated June 16th, 1999, to the Commissioner of Community and Neighbourhood Services, indicated that, among its reasons for not proceeding with a pilot project, were insufficient information regarding how much money the City was making available for a pilot project, and how many individuals would be eligible to access dental care. In addition, during the stakeholder discussions, the ODA expressed the opinion that the City should review (and presumably open to tender) the administration of all the mandatory and non-mandatory dental services it currently provides, including dental services to social assistance recipients. Other stakeholders felt that if a review was warranted, it should be undertaken at another time and by another committee. Staff clarified that a review was beyond the mandate of

the task force, and stressed that there were contractual obligations that prohibited the City from conducting such a review unilaterally and without due notice. Staff acknowledged that while it was important that such a review be conducted, this was not the appropriate time and method for doing so.

Recommended Action:

In view of the Advisory Committee's recommendation that the City pursue a "mixed model" of service delivery for the municipally funded, non-mandatory treatment program, there is a need to maximize the use of the ten full-service dental clinics as well as the preventive and school-based clinics in the former municipalities. Dental treatment available through the city-owned clinics would be augmented, as required, through agreements with fee-for-service dental practitioners and non-profit organizations to provide coverage in the former municipalities that did not offer these services.

In addition, there is a need for a city-wide information system that can provide standardized data on the clients, services, and costs of providing dental treatment under the non-mandatory program. A standardized information system will allow the City to effectively monitor the implementation of harmonization in the former municipalities that did not offer these services, and will facilitate comparison of different approaches to the delivery of service.

Conclusion:

This report has responded to a directive from Council to examine methods of providing a harmonized program of municipally funded, non-mandatory dental treatment services. The report recommends that the program continue to be delivered using a “mixed model” of service delivery which maximizes the City's investment in the ten city-operated dental clinics and the preventive and school-based clinics, augmented, as required, through agreements with fee-for-service dental practitioners and non-profit organizations to provide coverage in the former municipalities that did not offer these services. Public Health would determine eligibility and preauthorize/predetermine the services to be rendered to individual clients. Public Health would audit a proportion of cases to ensure that all needs were treated and the services claimed were provided.

Currently, across the amalgamated City, there is not enough data on the number, type, and location of potential clients and the service mix they require to know whether other providers are needed, and, if so, which ones to choose (e.g., fee-for-service practitioners or non-profit organizations). Public Health intends to utilize the well-developed information systems in the dental programs of the former municipalities of North York and Toronto to establish a City-wide information system that will: (i) monitor the effectiveness of the program expansion, (ii) maximize the efficiency and productivity from the use of scarce resources, and (iii) accurately capture cost and other information that will reasonably identify cost per unit of services, and facilitate a meaningful comparison with other service delivery methods and models.

Contact Name:

Dr. Hazel Stewart, Public Health Division, Tel: 392-0442.

Table 1

Budget and Staffing for Public Health Dental Program, 1999

Program	FTEs	1999 Budget (in $'000s)
Administration	8.0[1]	$ 703.6[1]
Provincially mandated services		
- Prevention and education	56.0	$ 5006.0
- CINOT	5.0	$ 1977.3
Sub-total	61.0	$ 6983.3
Non-mandatory services		
- Treatment services	51.0	$ 3639.8
- Harmonization for children and seniors		
Sub-total	25.0	$ 800.0
	76.0	$ 4439.8
Total Budget	145.0	$12126.7
Less: Estimated Provincial Reimbursement[2]	n/a	$ 3491.6
Net Cost	n/a	$ 8635.1

Notes:

[1] The management structure of the dental program is still under review and a final budget for administration has not been finalized. The 1999 budget is $703,600.00 for 8.0 FTE administrative positions.

[2] Estimate is based on reimbursement of 50 per cent of the budget for provincially mandated services.

Table 2

Number of Clients Served by Municipally Funded
Non-Mandatory Public Health Dental Programs
City of Toronto, for Years 1997 and 1998

Client Group	1997	1998
Children (0-14) (Non-CINOT)	6666	7256
Adolescents (14-18)		
- ESL	1057	892
- Non-ESL*	205	174

High-risk mothers	334	515
Low-income seniors**	3301	4567
Institutionalized seniors***	3499	2307
Total	15062	15711

* Emergency dental services only.

** In the former municipalities of Toronto and York, low-income seniors includes persons aged 65 and over; in the former municipality of Etobicoke, low-income seniors includes persons aged 55 and over.

*** Program provided only in the former municipality of Toronto.

Source: Dental Program, Public Health Division

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Table 3

Number and Location of City-Operated Dental/Oral Health Clinics

Former Municipality	Clinical Arrangements
East York	One (1) community-based preventive clinic
Etobicoke	One (1) community-based clinic
North York	Approx. seventy (70) school-based clinics
Scarborough	One (1) community-based preventive clinic
Toronto	Nine (9) community-based clinics
York	Two (2) school-based clinics

Source: 1998 Dental Resources Survey

Insert Table/Map No. 1
dentalclinics-sep'99

Figure 1

Terms of Reference

City of Toronto
Task Force on Dental Services

Purpose:

To assure the delivery of cost effective and efficient non-mandatory public health dental services.

Objectives:

To assemble information from Public Health, the Ontario Dental Association, and other members of the Advisory Committee on service costs, service utilization, methods of payment (e.g., fee-for-service, sessional fees, global budget, etc.), and the organization and delivery of services and administration of dental treatment services.

To do a comparative analysis of service costs relative to methods of payment, the organization and delivery of services and administration, and the use of para-professionals in the provision of dental treatment services.

To do a systematic comparison of the available options for the delivery of non-mandatory public health dental services, including the use of para-professionals, and to recommend to the Board of Health and the appropriate Committees of Council on sustainable, cost-effective methods of delivering non-mandatory public health dental services.

To obtain input from relevant stakeholder organizations and associations on options for the delivery of non-mandatory public health dental services.

If necessary, to establish and recommend a framework for a Request for Proposals (RFP) process for the administration and delivery of non-mandatory public health dental services.

Key Deliverable:

Report(s) to the Board of Health and the appropriate Committees of Council on the options, preferred approaches, target groups, and cost ranges for the delivery of non-mandatory public health dental services.

Chairperson:

Commissioner of Community and Neighbourhood Services

Membership (One representative from each group):

Chief Administrative Officer

Commissioner of Community and Neighbourhood Services
Medical Officer of Health
Chief Financial Officer
City Auditor
Toronto District Health Council

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Figure 2

Terms of Reference

Advisory Committee on Dental Services

Purpose:

To advise the City of Toronto Task Force on Dental Services on matters relating to the provision of cost-effective and adequate non-mandatory public health dental services.

Objectives:

To assist the Task Force in its deliberations by:

(1) facilitating the provision of information on matters such as service capacity, patterns of service delivery, and costs, which is timely and relevant to the Task Force's process;

(2) identifying opportunities for using para-professionals in the provision of non-mandatory public health dental services; and

(3) identifying the strengths and challenges of various service delivery models in relation to the provision of non-mandatory public health dental services.

To identify specific characteristics of the population and urban environment of the City of Toronto which affect the need for, access to, and provision of, non-mandatory public health dental services.

To contribute to innovation and best practices in the delivery of non-mandatory public health dental services.

Reporting Relationship:

Reports to the Task Force on Dental Services through the Chairperson.

Membership (One representative from each organization):

Association of Ontario Health Centres
Faculty of Dentistry, University of Toronto

Ontario Dental Association
Ontario Dental Hygienists' Association
The Denturist Association of Ontario

Dates of Joint Meetings of Task Force and Advisory Committee:

May 31, 1999
June 22, 1999
July 8, 1999
July 27, 1999

Table 4

Figure 3

Description of Provincially Mandated Services
Delivered Through Public Health

Under provisions of the *Health Protection and Promotion Act (HPPA)*, Part II, Section 5, boards of health must provide, or ensure the provision of a minimum level of public health programs and services in specified areas. Sub-section 5 (4) of the *HPPA*, entitled Family Health, requires boards of health to provide a range of services intended to protect and promote the health of families, including, for example, under sub-section 5 (4) (iii), health services to infants, pregnant women in high risk categories and the elderly; and under sub-section 5 (4) (iv), preschool and school health services, including dental services. Section 7 of the *HPPA* authorizes the Minister of Health to develop and publish guidelines that represent minimum standards for the mandatory programs and services (A Mandatory Guidelines. In addition, under Section 9 of the *HPPA*, it is expected that boards of health will deliver additional programs and services in response to local needs.

Provincial Mandatory Guidelines[1] require boards of health to provide a program to promote the health of children and youth. One of the objectives for the program is to reduce the prevalence of dental diseases in children and youth. To meet this objective, the Mandatory Guidelines state that boards of health:

> "6. Shall provide the Children in Need of Treatment (CINOT) Program in accordance with the Ministry of Health CINOT Protocol (August 29, 1997);
> 7. Shall provide, or ensure the provision of, monitoring of the fluoridation of the local municipal or regional water supply in accordance with the Ministry of Health Fluoridation Protocol (August 29, 1997);
> 8 Shall identify, on an annual basis, high-risk schools and high-risk individuals in other schools through the conduct of oral health screening in accordance with the Ministry of Health Dental Indices Survey Protocol (August 29, 1997);
> 9. Shall:
> (a) Provide dental health education resources, on an annual basis, to all high-risk schools, schools with ESL classes and other schools who request such materials; and
> (b) Conduct at least one teacher in-service session for teachers in high-risk schools and teachers of ESL classes [or] an equivalent option, approved by the Ministry, must be delivered;
> 10. Shall provide, or ensure the provision of, clinical preventive services, on an annual basis, as defined in the Ministry of Health Protocol (August 29, 1997); clinical preventive services are defined as topical fluoride application and fissure sealant(s). These shall be provided to children identified through dental screening examinations and children referred to

[1]Ministry of Health, Mandatory Health Programs and Services Guidelines, December 1997.

the board of health who meet eligibility criteria listed in the Ministry of Health Protocol (August 29, 1997)."[2]

Figure 4

Options for the Delivery of Services

The staff Task Force and Advisory Committee examined four approaches the City could take in the delivery of the non-mandatory dental treatment services. These approaches are:

(1) Salaried Staff Model:

This is the current model used by Public Health to provide both provincially mandated and non-mandatory dental public health services. Staff are hired to work in municipally owned facilities and are accountable in a line relationship to managers/directors.

If the City were to continue with this model, enhancement of the clinical infrastructure will be required. Some of the existing clinics in schools and the community will need to be upgraded or closed. In addition, some new clinics may have to be created, as there is not sufficient clinic space in all parts of the city to accommodate an expanded program.

(2) Purchase of Service Contract Model

In general, this model would involve contracting for specific types and levels of dental treatment services. The City could elect to administer the purchase of service contract directly or through an administrative agent - e.g., insurance company, benefits manager, etc. for a fee. There are at least two types of purchase of service model.

(a) Fee-for-Service:

Under this type of service contract, treatment facilities owned and operated by private practice dentists would be the sites of care for clients deemed eligible for the services. The dentists would bill the city directly or through a third party depending on how the City chose to administer the plan (i.e., through self-administration or through a plan administrator). It is assumed that Public Health would continue to be responsible for client eligibility determination. This approach would require a method to be developed through which dentists or the plan administrator (if any) could verify the eligibility of clients on a timely basis.

[2]Mandatory Guidelines, pp. 45-47. The Protocol criteria state that clinical preventive services should be offered to children with no dental insurance and no financial means to obtain this service privately.

Also, the City would need to develop basic operational policies for the program B e.g., defined schedule of benefits, payment methods for practitioners and plan administrator (if any). If the City elected to administer the plan directly, claims processing and verification procedures also would be required.

(b) Managed Care:

Under this type of service contract, the municipality would tender for dental treatment of a specific group(s) of individuals (e.g., all eligible individuals or specific groups of persons living in a defined area of the city or seniors in selected long-term care facilities requiring clinical preventive treatment). Dentists, benefits management consultants, or non-profit agencies such as community health centres would be invited to tender on the provision of care to the prospective client group(s). Contracts with successful candidates would be developed concerning matters such as the services to be provided, amount and method of payment (e.g., capitation, annual approved budget, etc.), hours of service availability, waiting times for regular and emergency appointments, etc. The City, through Public Health, would be the purchasing agent, and Public Health would audit a proportion of the services rendered by the contractor(s). It is assumed that Public Health would continue to be responsible for client eligibility determination. This approach would require a method to be developed through which the contracting agencies could verify the eligibility of clients on a timely basis.

(3) Grant to a Not-for-Profit Organization:

Under this model, the City would provide an annual grant to a non-profit organization to provide services for all or some of the target groups in a specific geographic area of the City. While the city would have less control over the provision of services under this model compared, for example, to the service contract model, it remains a viable model for which there is a precedent. For more than forty years, the former city of Toronto, through Public Health, provided the Faculty of Dentistry Clinic at the University of Toronto, with an annual grant (currently $15,000.00) to cover the cost of specialized dental treatment for children who are eligible for care under the municipally funded, non-mandatory dental treatment program. A grant could be given to a community health centre or other social or community health agency to provide services to selected client groups. Provision for performance criteria could be included as part of the terms under which the grant was offered to the agency.

(4) Mixed Model:

The mixed model would utilize two or more of the above models, which maximizes the use of the ten city-operated dental clinics and the preventive and school-based clinics, augmented, as required, through agreements with fee-for-service dental practitioners and non-profit organizations such as community health centres (CHCs) and the Faculty of Dentistry, University of Toronto, to provide coverage for residents in the former municipalities that did not offer these services. Under the "mixed model", Public Health would determine eligibility and preauthorize and predetermine the services to be rendered

to individual clients. Dental treatment would be provided in city-operated clinics and by private practice dentists and other oral health care providers (e.g., dental hygienists and denturists) who agree to provide services under the program. Fee-for-service providers would be remunerated by Public Health according to a predefined schedule of benefits approved by the City. Non-profit organizations would be remunerated under a dental services agreement with Public Health. A proportion of cases would be audited to ensure that all needs were treated and the services claimed were provided. Clients would have the option of obtaining services from any practitioner or organization that agrees to provide services under the program.

(Councillor Berger, at the meeting of City Council held on December 14, 15 and 16, 1999, declared an interest in the foregoing Clause, in that his son-in-law is engaged in the dental profession.)