
Addressing Oral Health Needs A How To Guide

Revised and Expanded 2002

*This report was written with
support from The Nathan
Cummings Foundation.*



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Acknowledgements

Compilation of this guide was a collaborative effort between Health Care For All and Community Catalyst with support from the Nathan Cummings Foundation. Written by Allison Staton, Denise Lau, Ben Wertheimer, Melinda Elias and Deborah Katz, it was edited by Deborah Cowan and Susan Sherry. A special thank you to all the program administrators for spending time to explain their efforts.

Community Catalyst is a national advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality, affordable health care for all. Community Catalyst's work is aimed at strengthening the voice of consumers and communities wherever decisions shaping the future of our health system are being made. Community Catalyst strengthens the capacity of state and local consumer advocacy groups to participate in such discussions. The technical assistance we provide includes policy analysis, legal assistance, strategic planning, and community organizing support. Together we're building a network of organizations dedicated to creating a more just and responsive health system.

Health Care For All is a nationally recognized, nonprofit membership organization dedicated to making affordable and quality health care available to everyone, regardless of income or social status. The goal is to empower people to know more about the health care system and to become involved in changing it. The organization is particularly concerned about the most vulnerable members of society - the uninsured, low-income elderly, children, people with disabilities and newcomers. Health Care For All's work combines policy analysis, information and referrals, public education, personal, legal and legislative advocacy and community organizing in an integrated approach aimed at building a grassroots movement for health care reform.

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Addressing Oral Health Needs: A How-To Guide

Executive Summary

The United States now faces an oral health crisis. Approximately 150 million Americans have no dental insurance coverage, triple the approximately 43 million Americans who lack health insurance. The U. S Surgeon General has described the oral health situation in the United States as a “silent epidemic of dental and oral diseases.”ⁱ There is no single solution given the magnitude of the need and the many facets to the problem. A combination of policy initiatives and community approaches is needed in order to have the greatest impact.

This guide is intended to give organizations and communities ideas for addressing oral health needs by profiling the success and challenges of various programs developed to increase access and reduce the ever growing unmet need for dental health services. Although many of the programs are community or countywide, they often depend on policies and resources generated at the state and national level. The guide also describes coalitions that seek to influence public policy and state public health programs that are especially active in addressing oral health issues. A brief description of major developments and issues in the policy arena are also included.

Community Catalyst and Health Care for All hope that this guide will strengthen existing dental health advocacy and foster new initiatives to improve dental health, especially for low income people, linguistic and cultural minorities, persons with disabilities, rural families, the elderly and other underserved communities.

What is the oral health problem?

Despite tremendous advances in dental technology, research and understanding, and a significant overall decline in childhood cavities, essential preventive care and treatment of dental disease is out of reach for many.

To fully understand the impact oral health has on the nation, consider the following statistics:

- 11% of the U.S. rural population has never seen a dentist.ⁱⁱ
- Adults miss more than 164 million hours of work each year due to dental concerns.ⁱⁱⁱ
- Poor adults are much more likely to have lost six or more teeth to decay and gum disease than higher-income adults.^{iv}
- Children in low income households have five times more untreated dental caries (cavities) than children in higher income families.^v
- Children above poverty level are almost 20 times more likely to receive dental sealants than those below poverty level (ratio 6:1).^{vi}
- Fewer than one in five Medicaid children receive preventive dental services each year.^{vii}
- Increasingly, state Medicaid programs are eliminating adult dental services or limiting them to extractions and other urgent care.
- Over 90% of dentists report they provide care in private practices, leaving few providers in health centers, hospitals and other alternative “safety net” settings more accessible to the underserved.^{viii}

Think about the impact on individuals:

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Ten-year-old Qwan was helping his teacher set up chairs for a special event. When he complained to her that his teeth hurt, she asked him to open his mouth and was going to tell him she hoped he felt better. When Qwan opened his mouth, the teacher saw black, broken teeth. His breath was horrible. He said he was in constant pain and that he had never brushed his teeth or been to a dentist. Neither his mother nor grandmother owned a toothbrush.

Sixty-four-year-old Mrs. Jones, a Medicaid client, was fitted by her dentist for dentures, a service covered by Medicaid. However, before delivery she turned sixty-five and transferred to Medicare, which does not cover dental services. Mrs. Jones could not afford to pay for her dentures and they sit on a shelf at the dentist's office.

Sally received cash assistance for several years and was required to find employment under welfare-to-work programs. Although she did not finish high school she had some filing experience, was comfortable working on phones and able to use basic computer programs. Qualified to be an office receptionist or administrative support person, she was too embarrassed to interview for office work because her top front teeth are missing.

Good oral health is the gateway to overall health and general wellness. The Surgeon General's Oral Health Report of 2000 noted that poor oral health incurs costs and reduces productivity in "school, work, and home, and often diminishes the quality of life." Yet enormous disparities exist in dental health status and access to services. According to Edelstein,

Children who are disadvantaged by poverty, minority status, and social conditions experience higher rates of dental caries, more extensive destruction of their dentition when affected, higher rates of untreated disease, and a higher frequency of dental pain than do their more advantaged peers.^{ix}

Exacerbating this 'silent epidemic', the number of dental school students declined nationally by close to 40% over the past 15 years. Due to this trend and to retirement, the number of practicing dentists is expected to decrease by 10% over 20 years from the current 58 per 100,000 to less than 52 per 100,000. Relatively few of these dentists participate in Medicaid; a 1998 survey indicated that an average of 16 percent of dentists participated actively in Medicaid in the 35 states responding.^x Compounded by an increased demand for dental services, this trend severely compromises access to oral health care. Current oral health resources are insufficient to care for the needs of the nation.

Why this guide?

In the United States there is currently no universal system for delivering oral health care. Approximately 90% of licensed dentists provide care in private offices that operate like small businesses with all of the associated costs and prerogatives. There are few incentives to accept uninsured or Medicaid patients into private dentists' offices, and there are minimal, if any, dental safety net options in many areas. Thus, communities throughout the nation are seeking to address their growing dental crisis, in most cases with limited resources.

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This guide briefly profiles different types of oral health programs in the United States. It is intended to give organizations and communities ideas for extending current programs or starting new oral health initiatives. The highlighted programs aim to increase access and reduce the ever-growing, unmet need for dental services. Although many programs are community or countywide, they often depend on policies, programs and resources inaugurated at the state or even national level. One section of the guide addresses effective dental coalitions that seek to influence state or regional policy related to oral health. Overall, the guide highlights successes and challenges associated with different approaches to the oral health access problem.

What is the How-To Guide?

Intended as an “idea book” for addressing oral health needs on a community level, the guide presents successful dental programs across the country, highlighting:

- Program start-up and brief history
- Service provision
- Target population and location
- Administration
- Funding mechanisms, including Medicaid and innovative state programs
- Budget
- Achievements and obstacles
- Assessment
- Contact information for further assistance and inquiries.

The profiles exemplify varied innovations and approaches for effectively targeting different populations. Yet, each program includes one or more of the following features:

- It focuses on providing services to underserved members of the community.
- It deals with prevention of oral diseases through education, screening, or prophylactic care in dental offices, health centers, mobile stations, or school-based clinics.
- It treats existing diseases through dentists, dental hygienists or other professionals in a dental care setting.

Addressing community's needs

Creating a comprehensive response to a health access crisis takes time, resources and commitment by a variety of community members and institutions. Whether the “community” in need is geographic (e.g., a county or a town) or a population (e.g., linguistic minority or socio-economic group), a comprehensive assessment is needed to understand barriers to care and potential solutions to alleviate them. This guide is designed to point the way towards possible solutions. Programs can be replicated in their full form, specific aspects of a program can be used, or pieces from different programs can be combined to create a unique response that fits a particular community's needs.

Many steps must precede the development of specific programs to address community needs. To begin, an organization or individual should:

- Convene local stakeholders to discuss identified problems
- Conduct meetings with members of the affected community for consumer input, and seek to include consumers in the ongoing planning and implementation process

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- Conduct some form of needs assessment (for example, surveys, one-on-one interviews, review of school nurse visits, review of emergency room visits, use of public health data)
- Compile results and share them with local stakeholders, other policy makers (e.g. state Medicaid administrators, city and state elected officials, public health officials, medical and dental providers) and the affected community
- Keep stakeholders together to collaboratively design a program tailored to the identified gap or gaps
- Develop a timeline for fundraising, seeking in-kind donations, developing volunteer opportunities, networking, and other program development work
- Publicize both assessment results and the proposed program in the local media
- Secure funding, staff and other resources to establish the new program
- Unveil the new program with much fanfare
- Maintain collaboration and support to ensure program viability

A community response to the lack of oral health access need not be a freestanding dental clinic with multiple chairs. It could be a case management program to help clients keep their dental appointments. It could be a fluoride rinse program at one elementary school. It could involve collaboration with other communities to share costs and administration of a screening program for Head Start children. Or it could be a training program for pediatricians to screen for oral disease in young children and provide preventive procedures. The best programs will address the specific gaps identified in the needs assessment.

Though initiatives are often community-based, state policy will have an important influence on what is possible. The state Medicaid program, public health department and Dental Licensing Board all develop policies that affect dental access and, in the case of Medicaid and the health department, have the ability to creatively leverage funds to enhance access for targeted populations or in targeted areas. (The project descriptions included within indicate how they are financed and many identify Medicaid and health departments as crucial sources of funds.)

Ultimately, oral health needs to be better integrated into a system that ensures overall access to health care. A comprehensive solution to oral health access problems, especially for those on Medicaid and SCHIP, as well as those who are uninsured, is necessary. Until that is achieved, local communities will continue to develop their own initiatives to increase access for low-income individuals and families, linguistic and cultural minorities, persons with disabilities, the elderly, and other underserved communities.

The Bigger Picture: Advocating for Policy Changes to Expand Access

As noted above, local initiatives depend not only on mobilizing community assets to expand provision of services, they also depend on a wide range of policies adopted on the state and national levels. These may include efforts to

- expand the dental workforce and encourage dentists to practice in underserved areas or with underserved populations
- strengthen the safety net (e.g. health center and public health clinics)
- provide preventive services in schools and communities
- expand dentists' participation in Medicaid through rate increases and administrative improvements
- expand the scope of practice for dental hygienists

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- enlarge the oral health component of pediatric medicine
- educate consumers and providers to reduce barriers to dental care
- mandate fluoridation of water systems

There is no single solution given the magnitude of the need and many facets to the problem. Thus, a combination of policy initiatives is needed in order to have the greatest impact. A range of government and private organizations [such as dental schools and professional associations] can influence or implement different aspects of the solution. . At least 120 pieces of legislation with varied approaches were enacted at the state government level in 2000 and 2001; at least double as many bills were introduced during those years.^{xi} Action at the state level is robust.

At the same time, state budget shortfalls are jeopardizing public programs. Public health and Medicaid programs are especially vulnerable to budget cuts because they comprise a large portion of state budgets. Adult dental services – an ‘optional’ Medicaid benefit – have been cut or eliminated in many states. Children’s dental care is guaranteed within Medicaid as part of the Early and Periodic Screening, Detection and Treatment benefit [EPSDT]. But there is concern that the current administration’s [fill in] waiver program may allow states to circumvent EPSDT requirements and undermine core Medicaid services such as dental.

State health departments all have an Oral Health Director and many use Maternal and Child Health Funds to support local initiatives. Medicaid and SCHIP programs can facilitate community models either with direct funding or by easing administrative policies and practices in order to allow community projects to bill for individual services. Dental schools can include and promote training in community settings serving the underserved. They can also recruit students from racial, ethnic and economic groups who are more likely to participate in Medicaid, SCHIP and other public programs and practice in community settings. County and local health departments can play an important role in facilitating projects.

Dental Associations and their members, including those affiliated with the American Dental Association, the Association of Community Dentistry, the Association of Public Health Dentistry, and the Association of Pediatric Dentistry, are vital to the success of many community projects. State and local Primary Care Associations and affiliates of the American Academy of Pediatrics have been active in many locales. Consumer groups, consumer health groups, and other community organizations play a key role in developing support for dental initiatives designed to address oral health disparities. Community, statewide and national foundations – hearing dental access identified as a primary medical problem more and more frequently – are funding programs and focusing more attention on oral health.

On the policy screen are several federal initiatives that can influence and strengthen efforts to increase access on the state and local level.

- Healthy People 2010 includes a number of oral health goals to be reached by that year. State health departments, in particular, will be undertaking initiatives in order to reach these goals and progress towards these goals is being tracked on a state by state and national basis.^{xii} Linking efforts to this framework may enhance support and funding.
- As an outgrowth of *Oral Health in America: A Report of the Surgeon General*, the federal Department of Health and Human Services is developing an “Action Plan” that is likely to affect National Institutes of Health directions and funding for oral health programs and services.

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- As part of its Consolidated Health Center Program, the Department of Health and Human Services (HHS) announced in July 2002 that it had awarded over \$11 million to 75 health centers^{xiii} to develop and expand oral health services.
- The U.S. Senate is considering legislation, currently known as the Children's Dental Health Improvement Act [SB1626], to increase participation of dentists and dental hygienists in the National Health Service Corps, streamline designations of dental health professional shortage areas, and appropriate \$50 million for innovative oral health programs, especially those designed to increase access for children enrolled in Medicaid or SCHIP.

Increasingly, the policy options and initiatives to address access gaps have been identified; officials are more aware of the problems; active, consumers and advocates have begun to develop a track record in developing policies and programs that address gaps. These are positive changes. Yet, at a time when the number of Americans with no health insurance is rising, and fewer dollars are being made available to support public programs, potential progress on addressing the oral health crisis is stalled. It is the new alliances being forged among a broader group of stakeholders that must forge a political will; only then can we use the well-established strategies we possess to eliminate oral health disparities and the health and social ills they impose.

ⁱ US Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General—Executive Summary*. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

ⁱⁱ *Oral Health Facts*, ASTDD, www.astdd.org

ⁱⁱⁱ NHIS, 1989

^{iv} Op cit

^v Ibid

^{vi} Ibid

^{vii} Department of Health and Human Services, Office of Inspector General. *Children's dental services under Medicaid: Access and Utilization*. April 1996.

^{viii} American Dental Society. Survey conducted in 1996 found that out of the 152,205 active dentists, 90.1 percent claimed that they were active in private practices.

^{ix} Edelstein, B.L., *Disparities in Oral Health and Access to Care: Findings of National Surveys*. Ambulatory Pediatrics. Volume 2, No. 2 (Supplement), March-April 2002

^x Guiden, M. *Dental Health for Kids Moves to the Forefront*. State Health Notes 19 (280) Forum for State Health Policy Leadership. National Conference of State Legislatures; 1998 July 6

^{xi} Crall, J., *State-level Policy Development*, presentation notes, National Oral Health Conference, April 27, 2002.

^{xii} For a list of goals related to oral health, see the Healthy People website at <http://www.health.gov/healthypeople/>. Choose 'search', select 'objectives', select 'key word'; scroll down and select 'oral health' under 'topic'.

^{xiii} See website, <http://newsroom.hrsa.gov/releases/2002releases/serviceexpansion.htm>

SCHOOL-BASED PROGRAMS



School-based dental programs are among the most efficient ways to reach children. These programs can provide access to oral health services and education. Access to dental care can be via mobile dental services or onsite dental clinics linked into a school health clinic.

The scope of services offered and availability of referral resources are key to an effective program; preventive and screening programs provide benefit, but without the capacity to treat dental disease, their effectiveness is limited. State and local public health agencies and education officials can facilitate these local programs by providing technical and financial support.

The University of Rochester's Collaborative School-Based Dental Program and the Calaveras Children's Dental Project are just two of the many effective school-based oral health programs in the nation

COLLABORATIVE SCHOOL-BASED DENTAL PROGRAM

Administrator

University of Rochester Eastman Dental Center
Division of Community Dentistry

Program Description

A collaborative, school-based outreach dental program that targets Inner City and neighboring rural communities. Established a network of both school-based and non-school-based outreach dental clinics, which consisted of year-round, part-time satellite clinics, mobile dental trailers (Smilemobiles) and on-site portable school dental units.

Program Location

Rochester, New York

Brief History

- The first Smilemobile school dental program was initiated by Eastman Dental Center, in 1970.
- In 1993 a Monroe County Health Department sponsored school dental health survey revealed pockets of children at high risk of dental caries, especially among recent immigrant children, in Rochester schools. In response to this and because of a serious lack of dental services for underserved children, the current collaborative outreach dental program began in 1994. The program was developed primarily to provide preventive and primary dental care to Medicaid and other underserved school children that have no dentist of their own.

Demographics

- Rochester, Monroe County, and its six neighboring rural counties in western New York
- The target population is school-aged, underserved urban and rural child recipients of Medicaid and Child Health Plus who have no access to dental care
- Seven to twelve-year old children were treated, specifically targeting schools identified by a "Dental Care Needs Acuity Index" as "most needed"

Administration of Program

- Originally 11 service sites serving a total of 2200 underserved schoolchildren in 1994, it has now grown to 37 sites serving over 10,000 children in year 2000.

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- Services are currently administered at 24 urban and 13 rural service sites, which include two permanent “Hub” satellite clinics (one urban and one rural) for providing basic dental care to both children and adult underserved populations, including homeless populations.
- Pediatric/general dentists, post-graduate dental residents and dental hygienists provide all preventive and basic dental treatment including dental prophylaxis, fluoride, sealants and restorative treatment at the site. More comprehensive dental work is referred to the University of Rochester Eastman Dental Center Main Clinics.
- All necessary treatments are completed within one month with minimum loss of class-time, and children receive follow-up dental care each year
- There are no missed appointments or waiting list
- The inner-city program consists of three Smilemobiles (2 full-time and one part-time mobile dental clinics) each serving five or six schools. In addition, seven year-round, part-time satellite clinics and one permanent “Hub” clinic have been established.
- The rural program consists of two portable dental programs (part-time school based clinics), each serving four to five different sites. This is coupled with one year round, part-time satellite clinic, one “Hub” clinic and three Smilemobile clinics used in the summertime.

Community Support

- The school district provides clinic space, utility and custodial services for 6-12 weeks each year at no cost to the program, and assists with enrollment and scheduling of appointments.
- County/State health and social service departments assist with necessary permits/waivers, regulatory inspections, etc. for opening clinics in schools. They also help with the enrollment of Medicaid-eligible school children for dental treatments. Also, the New York State Bureau of Dental Health provides Maternal and Child Health block grant funding for the sealant program.
- The Rochester Primary Care Network provides funding through federal grants to subsidize sliding fee scales for dental care to uninsured children. The RPCN also provided a three-year grant funding for the expansion of the school program to four neighboring rural counties.
- The Daisy Marquis Jones Foundation awarded \$250,000 in year 2000 to fund the purchase of a third fully-equipped Smilemobile and \$350,000 in year 2001 to build a 3000 square feet outreach dental facility at one of Rochester’s elementary school campus.
- Other community partners includes: Unity Health St. Mary’s Hospital, Corning Hospital, BOCES Geneseo Migrant Center, rural county health departments and school districts, and 3 rural county Departments of Social Service
- Parents appreciate the program; in addition to its clear health benefit to their children, it costs no money for transportation, and requires no loss of the parents’ work time.

Annual Budget

Over \$2 million per year

Financial support

- The primary source of funding is Medicaid and Child Health Plus reimbursements. Secondary sources include sliding fee scale reimbursements from federal grants through Rochester Primary Care Network, New York State Bureau of Dental Health, and Maternal and Child Health Block Grant, as well as the Monroe County Health Department and grants from local foundations including the Daisy Marquis Jones Foundation who provided \$600,000, during the past two year.
- Currently, the program is self-supporting through per diem-based Medicaid reimbursements, Child Health Plus and other third-party reimbursements.

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Assessment

The program has developed its own assessment technique known as the Dental Care Needs Acuity Index (DCNAI). The children at schools with dental programs generally scored better than those at schools without these programs in such DCNAI parameters as tooth decay, percent of children with active caries, presence of sealants, and enamel fluorosis (chalky appearing enamel due to excessive fluoride during tooth development).

Statistics

- Rochester's current school based outreach dental program has provided preventive and primary dental care to over 10,000 "difficult to reach" underserved Medicaid and Child Health Plus school children, over 90% of whom would otherwise not have received care.
- Free screening and referral services have been given to over 2500 non-Medicaid school children annually.
- A research study about the program reported at the International Association for Dental Research meeting that on a long-term basis, school-based dental delivery systems were more cost-effective than a traditional delivery system.

Other comments

- It has been difficult to initiate full-time on-site school-based dental programs because of a number of regulatory barriers that block their establishment.
- Local dentists have occasionally opposed the program because of a fear of losing patients.
- The program would not be able to self-sustain if it were not for the per diem-based Medicaid reimbursements that New York State provides hospitals, community health centers, diagnostic center, etc. The rates, however, vary from one institution to other, based on their costs for delivering the services.

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CALAVERAS CHILDREN'S DENTAL PROJECT

Administrator

Calaveras County Office of Education

Program Description

School based dental sealant, cleaning and fluoridation program.

Program Location

- Calaveras County, Northern California
- Rural – extends from ranches in the Central Valley to Sierra Mountains

Brief History

The program was initiated in 1996 after the Calaveras Partnership for Healthy Children conducted a community needs assessment and found dental care to be in the top three concerns.

Demographics

- \$18,500 per capita income
- 11 practicing dentists county-wide
- Mostly seasonal and minimum wage employment, including agricultural work and services to accommodate large tourist population
- Almost entirely White with small Hispanic and Native American population
- Almost entirely English speaking community
- Program targets elementary school children (aged 5-11)

Program Management

- Collaboratively managed
- Administrative costs paid for by grants
- Two part-time staff (1 full-time equivalent)
- Volunteers: dentists, clinical staff, and advisory board
- Covers all 10 elementary schools in the county
- The dental unit moves school to school, spending varying periods of time at each location. At the first visit to school, one entire grade is screened and notes are sent home offering additional services when necessary to low-income (those receiving reduced price lunches) and Medicaid-eligible students.

Community Support

Due to collaborative management, wide support was garnered in the public school, community, and political spheres.

Annual Budget

Approximately \$60,000 for salaries, printing costs and supplies (including toothbrushes, floss, and sealants).

Start-Up Costs

A two-year grant from The California Endowment administered through the Dental Health Foundation's Children's Dental Health Initiative provided two portable dental units¹.

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Financial Support

According to the program administrator, the Dental Project is “patched together with so many grants and programs” including Proposition 10, Head Start, and a state grant for weekly flossing and fluoride rinses in the schools and some Medicaid reimbursements. An additional \$92,000 grant comes from Sierra Health Foundation’s grant program, *brightSMILES*, and two private foundations provide additional small grants.

Assessment

Program effectiveness is assessed by tracking the number of children screened and the number receiving sealants and fluoride treatment.

Statistics

- In three school years, over 3,000 children -- more than half of the elementary school population -- were screened. Cleanings, sealants or fluoridation treatments were provided to 700 children.
- In the first year, the program screened all kindergarten, second and fifth grade students in the county. Dental sealants were offered when indicated.
- In the second year, the program expanded to include the fourth grade students.

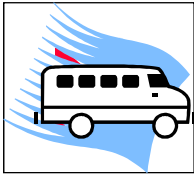
Other Comments

- The program is extending beyond the school to include partnerships with Head Start and private day care providers. These partnerships plan to establish early childhood and infant screening and oral health careⁱⁱⁱ.
- For first school visits, tacit or default permission is used. This means that legal guardians must return forms if they *do not* want their child to be screened and have a cleaning. This method of permission has a 99% positive yield.
- For follow-up visits, positive permission and health records are required. This means that legal guardians must return forms if they do want their children to receive treatment. The form is only sent to eligible students comprising 25% to 30% of the class (low income or Medicaid-eligible). Of this portion, only 15-20% return the forms.
- Every school has a broad socio-economic spectrum. (Medicaid children are not all at one school in one community). Each school has an approximately 25% to 30% low income student body.
- The schools are so small and the program has not looked at the ‘Medicaid stigma’. However, this may be a concern since children offered additional services sometimes tell their parents they don’t want to be called out of class for this care.
- The program does not address urgent treatment needs and can only inform parents of such problems.

Contact Person

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MOBILE PROGRAMS



Mobile dental programs create immediate access to oral health care by taking the services to the populations in need. Mobile programs can involve either moveable equipment that is transported from one location to another and set up on-site, or portable trailers containing dental equipment. Mobile programs usually offer more basic services such as dental sealants and other preventive treatment that can be tailored to meet individual populations' needs in quite diverse settings.

Because mobile programs have the flexibility to serve patients in a variety of locations, they are particularly effective for serving rural communities, homebound or institutionalized individuals, persons with disabilities, and children and working adults who have the most difficulty in accessing oral health care services in dental offices or clinics. Challenges presented by these programs include high costs and less continuity of care than with more traditional, fixed programs. As in school-based and other preventive programs, capacity to provide restorative services is key to effectively addressing dental disparities.

The Chopper Topper Dental Sealant Program, the Community Partnered Mobile Dental Services, and the Dorchester House Health Center are three examples of mobile dental programs.

CHOPPER TOPPER DENTAL SEALANT PROGRAM

Administrator

Administered by an advisory committee made up of representatives from each partner organization and key individuals from the community

Program Description

Created in 1998, Chopper Topper is a public/private partnership that provides dental sealants and education with the aim of reducing the prevalence of dental caries found in low-income children (mostly non-Medicaid around the ages of 7-9).

Program Location

- Metro Denver, Colorado
- urban

Brief History

A pilot study examining first molars in elementary school age children in the Denver schools found that molars were in good shape for 1st and 2nd graders, but by 3rd grade many children had caries.

Chopper Topper was originally designed through the collaboration of five different organizations: HEALTH S.E.T, KIND, the Metropolitan Denver Dental Society, the Colorado Department of Health and Environmental Oral Health Program, and the Cheltenham Elementary School (Denver Public Schools). Now, Chopper Topper is a partnership between KIND and HEALTH S.E.T. in which all activities, support, and responsibilities are shared.

Demographics

- The program targets low income, second grade children (ages 7-9) who reside in the Denver Metro area. Participating schools are selected by the number of families that qualify for the Free and

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Reduced Meals Program (~70%). All the second graders in the selected schools will receive the service, independent of which families are eligible for free and reduced meals.

- 33% of children seen have never been to a dentist.
- Serves around 1,600 to 2,000 children a year.
- The target population is over two-thirds Hispanic, with a significant number of African American, and smaller numbers of White, American Indian, and Asian/Islanders.
- The languages spoken by the target population are English (40%), Spanish (59%), Vietnamese (<1%), and Russian (<1%).

Program Management

- An advisory committee made up of representatives from each partner organization and key individuals from the community at large oversees the program.
- Program relies on volunteer dentists, hygienists, dental assistants and other health professionals to carry out screening and all day-to-day activities.
- There are five components to the program: dental screening to identify tooth decay and teeth to be sealed, application of sealants, education of parents and children, referrals for those children who need urgent care, and a follow-up and evaluation process. Services are provided on-site at the school.
- In the 2000-2001 school year the Denver Dental Society volunteered 73 hours, hygienists volunteered 517 hours and dental assistants volunteered 220 hours.
- Staff includes a full-time program director (a hygienist), two full time hygienists, one part-time dentist and one part-time volunteer coordinator.
- The program has a 60-80% return rate for consent forms.
- During the first day the project enters a school, students with a completed consent form are screened to identify tooth decay and any teeth that require sealants. One or two dentists with an administrative staff person usually do this.
- Parents are invited to attend a presentation on oral hygiene and the importance of prevention. Children are educated on the importance of brushing by volunteers dressed up as characters such as “Plaque-a-saurus,” “Dr. Sluggo” and “Count Plaquala.”
- During the next one to two days (dependent on class size), sealants are placed, with five stations set up and staffed. Each child takes approximately 15-25 minutes using the light cured system.
- The sealants are placed by a hygienist and by dental hygiene students, under the supervision of a preceptor hygienist. (In Colorado dental hygienists are allowed to place sealants. This varies from state to state).

Community Support

- Volunteers collaborate with individual school nurses, administrators, and school coordinators.
- The program is promoted through direct contact with individual school nurses and administrators.

Annual Budget

\$90,000

Start-up costs (1998)

\$115,000

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Equipment break down in budget in 1998 (program first initiated)

Equipment Type	Initial Capital Costs (in 1998)
Basic Aluminum Patient Chairs	4 purchased for \$6,272.00 (\$1,568.00 each)
Portable Halogen Light	4 purchased for \$2,224.00 (\$556.00 each)
Air Compressors	2 purchased for \$2,456.00 (\$1,228.00 each)
Dental Delivery Units with Suction	4 purchased for \$4,368.00 (\$1,092.00 each)
Light sealant Curing Units	4 purchased for \$2,192.00 (\$548.00 each)
Patient Chair Carrying Case	4 purchased for \$592.00 (\$148.00 each)
Halogen Light Carrying Case	4 purchased \$672.00 (\$168.00 each)
Supply Storage Cases	\$1,000.00
Repair/Maintenance	\$1,000.00
Total Costs = \$20,776.00	

Financial Support

The program is solely supported by grants from private foundations. Direct costs and most all operation and supply expenditures (e.g. rent, postage, phones, office and program supplies) are covered by donations to HEALTH S.E.T from Saint Anthony Hospital and Saint Joseph Hospital. Partners are currently working to get Medicaid reimbursement for services as well as corporate support.

Assessment

The Chopper Topper is the first and only mobile dental sealant program in the Denver metro area. After each project there is an evaluation process. The assessment component seeks to:

- 1) calculate the number of children and parents served and type of services provided;
- 2) quantify the ability of the Chopper Topper project to reduce cavities in high risk groups;
- 3) demonstrate that providing dental services “on-site” can be an effective, efficient way to prevent cavities. The data collected will be both quantitative and qualitative.

Quantitative data will include:

- 1) number of children served and services provided;
- 2) demographics;
- 3) retention rates;
- 4) number of children needing restorative care and the number that received care;
- 5) number of parents attending the educational component;
- 6) funds and other resources used in the project.

Qualitative data will identify perceptions and attitudes of the parents and information about why (and why not) children received restorative care. The data collected will include:

- 1) parents’ understanding of and attitudes toward dental health before and after the education presentation and parents’ opinions about barriers to receiving dental care;
- 2) reasons or barriers preventing children from receiving restorative dental care.

Assessment Results

	2000-2001	1999-2000	1998-1999
Number of Schools Visited	34	36	28
Children screened	1,682	1,808	1,524
Children receiving sealant	1,357	1,508	1,298
Number of teeth sealed	4,466	5,160	4,281
% of children in need of urgent dental care*	15%	17%	24%

* Urgent dental care defined as abscesses and rampant decay

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During 2000-2001, 15 schools from the previous year were revisited and checked for both sealant retention and completion of dental treatment. Approximately 80% of those children in need of urgent care received no treatment. The reasons parents/guardians cited for why treatment was not completed included:

- 28% unable to pay for treatment
- 18% “lack of concern by parent/guardian” (program’s language)
- 3% lack of transportation
- 1% unable to find a provider
- 16% other (moved, language and cultural barriers, personal problems, etc.)

The program was unable to reach 34% of the families.

Challenges

- Illiteracy and limited English-proficiency are big barriers.
- Finding dental services for children residing in the U.S. without documentation is difficult. Can get emergency coverage for immigrant children under Medicaid.
- Mobile equipment is not as durable as stationary equipment.
- Lack of available space limits schools’ ability to host the program.
- High capital and operating costs relative to other models.

Other Comments

- Use of “freebies” and pizza can encourage parents to attend information sessions.
- Found “incredible” dental needs among parents including untreated tooth decay and periodontal disease.
- Often, Mexican children who are identified as in need of treatment return to Mexico for care.
- The number of school visits depends on participation by volunteer dentists and paraprofessionals and the amount of cooperation from the school nurse and administration.

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COMMUNITY PARTNERED MOBILE DENTAL SERVICES (CPMDS)

Administrator

This program is managed with a three-way partnership with the Utah Department of Health's Family Dental Plan, the Central Utah Area Health Education Center (AHEC), and local communities.

Program Description

Collaboratively, mobile clinics are brought to targeted populations in underserved rural and frontier counties in Utah. Families under 200% of the federal poverty line or those who qualify for free/reduced lunch, individuals awaiting a determination of eligibility for Medicaid or CHIP, and seasonal/migrant workers are eligible to receive care. Each client receives an oral examination and bitewing x-rays; patients are relieved of active pain and infection, and educated on oral health issues including correct diet, proper brushing techniques, and baby bottle tooth decay. Additional services (predominantly preventive measures for children), such as sealants, cleaning and fluoride, are offered when appropriate.

Program Location

- Started in Millard and Juab counties, expanded to include Sanpete, Sevier, Piute & Wayne counties
- Other rural/frontier areas

Brief History

In 1994 a self-funded pilot clinic was opened to target low-income populations. Now there are six clinics with total staffing of more than 30. In 1996 portable equipment was purchased from military surplus. In 1999 dental care services were expanded to rural and frontier areas in Central Utah.

Demographics

- It provides 16% of all Medicaid dental services in Utah.
- Targets families, primarily children who are under 200% of poverty.
- Citizenship is not required.
- As of September 2001: 29 clinics, 3324 encounters, including: 321 ages 0-4, 2150 ages 5-19, 547 ages 20-44, 111 ages 45-65, 36 ages 66>; American Indian 398, Caucasian 2086, Hispanic 635, African American 34, Pacific Islander 11, Other 11; Medicaid 918, CHIP 81, None 2093, Other Insurance 83. Data on two additional clinics in 2001 has not been compiled yet.
- All counties are federally designated Health Professional Shortage Areas.
- Dentists in the area are not accepting new Medicaid patients. Many patients must travel 100 to 180 miles to get treatment, occasionally on dirt roads. Residents of the Goshute Indian Reservation had to travel 360 miles round trip to Elko, Nevada for dental services offered 4 hours a month.

Program Management

- The Family Dental Plan Manager determines the locations of clinics based on input from Central Utah AHEC staff and communities.
- AHEC is the primary liaison with community leaders, local high schools, and health professions institutions and coordinates student clinical placement and local volunteers. Affiliation agreements with institutions are in place before clinics start.
- Two to four day missions at each site, seven missions in the first year, 12 in the second year and 12 in the third year.
- Medicaid eligibility workers enroll new families at clinic sites.
- Dental Residents, Dental Hygiene students, Dental Assistant students, and interested high school students participate in clinical and educational experiences as their scope of practice and schedules allow.

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- Because of weather considerations and school calendars, the clinics are normally scheduled from March to November except the summer months of July and August.

Community Support

Involved key community members including:

- local volunteers
- public health departments
- commissioners
- businesses
- dentists (as available)

Budget

- Bureau of Primary Care, Rural, and Ethnic Health grant of \$47,000 first year, \$35,000 second year, and \$25,000 third year. Funding in year four is very uncertain.
- Start-up equipment was already owned by the Family Dental Plan but local contributions and grants allowed for equipment expansions and sustainability.
- Local donations were received from agencies, businesses, and the public health department.
- \$309,967 total treatment value to date, with approximately 8% billed to Medicaid/CHIP (Medicaid \$24,025, CHIP \$1,911).
- Approximate Cost per Mission
 - ◆ Dentists \$2,000
 - ◆ Dental Assistant \$760
 - ◆ Dental Technician \$600
 - ◆ Disposable Supplies \$800
 - ◆ Equipment Maintenance \$200
 - ◆ Equipment Transport \$800
 - ◆ Meals/Lodging \$200
 - ◆ Records/Office Supplies \$200
 - ◆ Total approximate cost: \$5560 (Note: This amount may vary depending on volunteers and donations)

Assessment

- The project will collect specific data regarding treatment services delivered to better understand severity and nature of disease processes occurring in the service population. The program assesses their effectiveness by the reduced number of follow-up treatments required at each site in subsequent years.
- The results are already apparent in the communities who now receive regular service, with more children now needing only preventive services rather than the 85% to 90% who initially needed services for untreated disease.
- The CPMDS won the National AHEC award in 2001 and the Rural Health Association of Utah "Best Project" award in 2000.

Other Comments

- Recently, the mobile clinic obtained an almost \$300,000 grant to integrate dental care with primary care services. Its partners now include three rural Community Health Centers and they are establishing a standard annual schedule of rural dental-care delivery.
- There was only one dentist in the 29 communities not supportive of the clinics because he felt it drew patients away from his practice. The other dentist in the same community volunteered his time in a

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neighboring community. All other local dentists have been supportive and many have volunteered time.

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DORCHESTER HOUSE MULTI-SERVICE CENTER

Administrator

Administered by Dorchester House Multi-Service Center with financial and organizational support offered by the Massachusetts Department of Public Health, the Delta Dental Foundation, and the United Way of Greater Attleboro/Taunton.

Program Description

The Dorchester House Multi-Service Center (as well as the Mobile Dental Program) provides comprehensive oral health services as well as screening and treatment for the Department of Youth Services (the Massachusetts agency caring for incarcerated youth), Department of Social Services, Department of Mental Health, and the Taunton Massachusetts School System, for a total of 19 schools.

Program Location

- Dorchester, Massachusetts, an urban neighborhood in metro Boston
- Although the administering clinic is located in Dorchester, the mobile clinics travel throughout the state including the central and western sections.

Brief History

Changes in Department of Youth Services policy dispersed the incarcerated youth population from large reform school settings to small group (10-30 individuals) programs. It was no longer economically feasible to equip each site with a dental chair and clinical equipment. Dental care was reduced to transporting individuals to local private practices when emergency needs arose. This was not efficient and proved to be offensive to private patients when the youths from secure facilities were shackled in the waiting room. The Massachusetts Department of Public Health, Department of Youth Services, and Dorchester House created a mobile cline to provide care to incarcerated youths. The program has since expanded to include Department of Social Services, Department of Public Health, schools in Taunton, MA, Head Start programs, and special schools for developmentally disabled youth.

Demographics

- All are recipients of either Medicaid or Massachusetts Free Care
- Clients ages range from 4-21
- Many different races and ethnicities are reflected in the patient population including White, Native American, African American, Vietnamese, Hispanic, and others

Program Management

- Supported financially and with organizational oversight by the Massachusetts Department of Public Health Oral Health Division.
- One of the participating dentists serves as coordinator.
- Other independently contracted dentists participate with payment through reimbursements from Medicaid or the Massachusetts Free Care Pool.
- Each site receives the clinic at 2 to 6 month intervals, with the duration of the stay dependent upon local need.
- On-site nurses help schedule, set-up and screen individuals.
- All preventive care and most restorative procedures are offered. Orthodontia and oral surgery are never offered because of time constraints and mobility concerns. These needs are met by transporting youth to local private practices.

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Community Support

- The Massachusetts Department of Public Health Oral Health Division has been instrumental in establishing, sustaining and insuring political support for the program.
- Few community members recognize the unmet needs of this population because they are not visible. However, the cost of serving this population was very little and did not require any private support.

Annual Budget

- \$12,500 for administration only provided by the Massachusetts Department of Public Health.
- Medicaid and Massachusetts Free Care reimbursement rates.

Start-up Costs

\$1,000 cost for construction of a hook-up facility at each site. Massachusetts Department of Public Health already owned and provided mobile clinics and other necessary program equipment.

Financial Support

All financial support comes from the Massachusetts Department of Public Health, Medicaid and Massachusetts Free Care reimbursements, the Delta Dental Foundation and the United Way of Greater Attleboro/Taunton.

Assessment

Program effectiveness is assessed by:

- The approval of on-site nurses
- Keeping the costs to a minimum
- Political support (both from State government and individual program sites)
- Eventually plan to utilize dental records to review successful treatment of patients

Statistics

- \$670,000 worth of care since the program's inception

Other Comments

- The program coordinator warns that in every aspect of any mobile program (i.e. equipment, procedure and staffing) it is essential to consider what will best serve the target population but is also realistic.
- The program coordinator could have used more early guidance. The Massachusetts Department of Public Health offered him a mobile clinic in exchange for undertaking the program. Being able to discuss problems and solutions with managers of similar programs would have prevented setbacks.
- The program coordinator stresses the need for committed and qualified people to work with this population. Nurses at the individuals sites must be well prepared to ensure that the dentists (with limited time and equipment) can come in with the patient prepped and "just be dentists."

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CLINICS IN A HOSPITAL OR HEALTH CENTER



Dental clinics and services can be established in existing hospitals or health centers. This may be easier than creating a freestanding or mobile program as existing facilities have available resources including space, utilities, staffing, billing and medical record systems, medical interpreters, and accommodations for people with disabilities. These facilities may have regulations regarding non-discrimination based on ability to pay, and a commitment to care for the underserved.

The Health Resources and Administration (HRSA) requires that community health centers that receive federal funding (“federally qualified health centers”) provide dental screening for children and emergency dental care. As part of HRSA’s current emphasis on strengthening and building the capacity of health centers, the agency in 2002 made available funds to FQHC to add or expand dental services.

The Cuba Memorial Hospital is one example of a hospital-based clinic while the Voice of Detroit Initiative is a federally qualified health center.

CUBA MEMORIAL HOSPITAL

Administrator

Cuba Memorial Hospital

Program Description

A dental clinic within a community hospital.

Program Location

- Cuba, rural community in western upstate New York

Brief History

The program was developed to address a county health department study identifying dental care as one of the most important health care needs within the hospital’s two-county service area. The counties were designated as a dental HPSA (Health Professional Shortage Area) along with a neighboring county. Only one area dentist accepted new Medicaid patients, resulting in inadequate access for Medicaid patients.

Demographics

- Rural area with less than 50 people per square mile
- Almost entirely English speaking population, 95% white population
- Clinic has no economic requirements but largely serves Medicaid patients

Program Management

- One local dentist closed a private practice to become director of the clinic
- Two dentists work in the clinic. In addition, one local dentist works one day per week in the clinic
- Two hygienists (one part-time, one full-time)

Community Support

Parents, children, schools, health departments, city and county government, legislators, Governor, dentists, hygienists, pediatrician

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VOICES OF DETROIT INITIATIVE (VODI)

Administrators

- Community Voices
- University of Detroit
- University of Michigan Dental School

Program Description

Adult dental services are provided at a federally qualified health centers. Efforts to train more pediatricians to provide oral health screening and to develop a low-cost dental insurance product are also underway.

Program Location

- Urban Detroit, Michigan

Brief History

- Over the course of the last decade, the Michigan Department of Public Health's Dental Program went from employing 13-15 FTEs down to just 1 dentist and 2 supporting staff. Such staffing shortages meant that the MDPH could serve only children. There was no longer any place for low income adults and families.
- The University of Detroit Mercy Hospital had served as an emergency clinic where a retired dentist performed extractions. Health Care for the Homeless, which ran another dental program, could only see a handful of individuals as it was staffed by a teaching externship for the University of Detroit.
- The community needed to increase access to oral health for more of the impoverished. A three-tier Federally Qualified Health Clinic (FQHC) was created under the name Voices of Detroit Initiative (VODI). VODI was initiated adjacent to the MDPH-run federally qualified health center (FQHC) that served children.

Demographics

- Clients range in age from 18-64 years. The adjacent children's clinic serves younger children. The clinic does see those older than 64 years from time to time, especially as the Area Agency on Aging is interested in expanding the elderly programs. The average age of clients is 38 years.
- Ethnic breakdown of clients: ninety-three percent African-American; two percent Caucasian; two percent Native American; one percent Hispanic (expected to pick up soon, as VODI has recently formed a new relationship with the Latin Community Health Center), and roughly one-half of one percent Arab.
- Individuals with incomes under 250 percent of the federal poverty level (FPL) are eligible to receive oral health care from VODI.
- The average household size of those served is 3.3 and the average monthly income is \$1000. (Private insurance would cost at least \$94 dollars per month.)
- English and Spanish are the major languages encountered, but Arabic is on the rise. VODI is looking to form a new coalition with the Arab-American Council to reach out to the needy in the Arab community and is willing to provide dental services on location in the Arab neighborhood).

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Program Management

- An executive committee consisting of a member from each of the participating organizations meets monthly. The executive committee then reports to an oversight committee consisting of Detroit Mayor Kilpatrick, CEO Eliot Joseph of St. John's Clinic, Dr. Port of the Detroit Medical Center, and President Gayle Warden of the Henry Ford Clinic. The oversight committee meets quarterly.
- VODI does not have its own volunteers, but volunteers are obtained through the Tri-county Dental Association (Oral Health Coalition).
- Staffing includes: one full-time dentist, one full-time dental assistant, one part-time oral surgeon (who visits two times a week), and one full-time clerk. VODI has a relationship with a School of Dental Hygiene that provides students as part-time help. Finally, VODI partners with the Detroit Community Health Connection, which has two part-time locations, one dental assistant, and one PTE.
- Dentists do the initial screening. There is interest in having more doctors trained to perform oral screening so dentists can spend more time on restorative work. Hygienists can do initial screening when they are available. Personnel are mostly paid by the city.
- Administrative functions are performed by all, including dentists.

Community Support

- VODI has an incredibly strong relationship with the city government. A substantial amount of funding is generated from the city and the Director of Public Health has ensured that VODI initiatives remain in the budget.
- The University of Michigan has been another great partner. UM has helped to assess community needs, recruit dentists, and to work out the rotation of students at the clinic.
- FQHCs in the area, including St. John's Clinic, Henry Ford Clinic, a Latino clinic, and a homeless clinic, participate in a broad-based coalition which includes VODI.
- Detroit Medical Center and University of Detroit are two other partners in VODI's operation.
- VODI has faced no political or commercial opposition whatsoever. There was a terrible need for oral health access in the area which VODI is able to partially remedy.
- The only support problems revolve around the difficulty in locating funding to pay for personnel and the task of attracting new dentists.

Annual Budget

- The federal CAP program has covered expenses of \$250,000. The rest of the budget is provided by the city and foundation grants.

Financial Support

- At the time VODI was established, the organization expected to rely on the dental school students for dentists, the city for staffing, and the public health department for working out a liberal, sliding fee scale based on income. The federal Community Access Program (CAP) has been instrumental in getting VODI off the ground. Unfortunately, the current administration has cut back on the amount of money allowed to flow through CAP, creating potential financial roadblocks in the foreseeable future. If other funding does not make itself available, the operation may not be able to stay solvent.
- St. John's Clinic is owned by Ascension Health (a Catholic philanthropy) which matched the CAP dollars of the first year (\$900,000) dollar for dollar and has agreed to fund \$300,000 per year for the following years.
- The City of Detroit funds the support of VODI personnel.

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- Adulthood Dental Foundation (Delta Dental Foundation) provides funding for most of the equipment and supplies through the University of Michigan.
- St. John's Clinic gets additional funding from the Carl Foundation and the Saint Vincent Society.
- The organization holds one event a year where the oversight committee makes presentations and the annual report (activities report) is released.

Assessment

- Short term: Increased knowledge of dental caries/oral cancer screening in providers; increased access to oral health care for uninsured individuals; oral health is considered as part of primary care needs; an oral health infrastructure is established.
- Long Term: Increase in medical compliance and disease improvement in clients; decrease in undetected oral health problems; increase in treatment of oral health problems; closing the tap in safety net for target area providers.

Statistics

- In its first year, VODI saw 1,300 patients (September, 2001 to July, 2002). The numbers have now jumped to 30-40 patients per day.

Related Initiatives

- VODI has created a CD-ROM that serves as a training module for physicians who are interested in learning to screen for oral health concerns as part of routine check-ups. This CD-ROM may be viewed online at <http://oralhealth.dent.umich.edu/VODI/html/index.html>. VODI considers basic oral health to be a vital component of primary care. This training module is currently being utilized at Detroit Medical Center to train new medical students to conduct oral health screening. The module is also offered at no cost through continuing medical education.
- A partnership between the Delta Dental Foundation, the University of Michigan and VODI is developing a low-cost insurance product, which may be made available once their research is complete. This insurance product would be initially funded by small and medium-sized businesses that do not currently offer dental coverage. The initial monies would go to pay for the work necessary to bring the patient's dental hygiene to a healthy level. After that point, the patient would pay premiums of 5-10 dollars per month- these premiums could be deducted from the paychecks by employers. It is expected that once the initial care is given to repair any damage incurred after years of neglect, the insurance would only go to pay for the routine maintenance work at a dental hygienist.

Other Comments

- "It is difficult to recognize how badly a community may need this service. It would have been nice to have known more about the level of need before creating VODI."
- It is challenging to get dentists and hygienists to work in a public setting. The most common complaint is that the pay is not competitive.
- VODI used to permit emergency walk-ins, but the demand was too great to handle. People have traditionally gone to University of Detroit/ Detroit Medical Center (Detroit Receiving -- trauma center) for emergency dental care.
- Regular appointments are facing greater and greater wait-times, as the number of patients increases. One may expect to wait at least 30 minutes for one's appointment.
- There are very few no-shows at VODI. More than 90 percent of all appointments are kept (one woman even came to an appointment terribly ill on one occasion). Appointments are typically scheduled one and a half to two months in advance.

- VODI is convinced that additional staff members (through increased funding) would decrease the wait lines. The number of clients is expanding so quickly that VODI feels the numbers will continue to swell for some time.

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REFERRAL PROGRAMS



Referral programs serve as an intermediary between the patient and the dental provider. They help reduce the challenges for patients and participating dentists by addressing concerns including transportation, childcare, and appointments.



These programs don't necessarily increase overall capacity; if an insufficient number of providers are available or if few dentists provide care to Medicaid, SCHIP and other low income individuals, these programs may have little impact. However, by making it easier for patients to access care, they can reduce "no-shows" and other patient behaviors that may deter some dentists from participating in public programs.

Highlighted examples of referral services are the Access to Baby and Child Dentistry Program and the Red River Valley Dental Access Project.

ACCESS TO BABY AND CHILD DENTISTRY PROGRAM (ABCD)

Administrator

Collaboratively established, principally by the state Medicaid office, the University of Washington, the Spokane District Dental Society, the Washington State Dental Association and the Spokane Regional Health District. The program originated in Spokane County and expanded through collaborations with additional local agencies.

Program Description

This is a multi-pronged, community-based intervention that links providers and Medicaid clients. It offers both policy and case management support. Increased Medicaid reimbursement rates were offered for providers who completed a specialized training program about barriers to care and ways of treating underserved or inexperienced populations within the oral health care system. Dental office staff was also trained and given assistance in billing procedures in order to substantially reduce delays in payments. Local health districts help locate at-risk children and provide parent education about the need for regular dental services and appropriate office behaviors (the importance of keeping appointments, waiting room conduct). Local health district staff act as case managers for patients, and help dentists in order to retain Medicaid patients.

Program Location

It originated in 1995 in Spokane County in eastern Washington State. Since then it has been implemented in additional counties including Stevens County (1996), Yakima County (1999), Benton and Franklin Counties (1999), Thurston County, Whatcom and Mason Counties (2000). Snohomish and Island Counties will be implemented in December 2001. There are 12 other counties in development.

Brief History

In 1994 students, faculty and staff of the University of Washington, in collaboration with local school districts and members of the Washington State Dental Association, performed dental exams in third grade classes in all 39 of Washington's counties. Concurrently, the Washington State Department of Health did a statewide evaluation of low-income children's oral health. Data stemming from this work was utilized in a statewide conference on Medicaid. Due to the efforts of the Spokane District Dental Society and others, the ABCD program was established in Spokane County in 1995. Two-thirds of Spokane dentists, participated in the program, providing a strong base for subsequent expansion.

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Demographics

- 400,000 primarily urban/suburban residents in Spokane
- Program works to increase access to dental care for preschool children from birth to 5 years of age served by the Medicaid program (200-250% of poverty according to state standards)
- Of the approximately 5.6M people in the State, estimated demographics include 3% African American, 6% Asian, 1% American Indian, 6% Hispanic and 84% White.

Program Management

- All dentists in the state are eligible to become certified providers by completing the special training course.
- Health district staff conduct out-reach, contacting parents at health fairs, WIC Supplemental Nutrition Program centers, Head Start, food banks, churches, welfare offices, and immunization clinics.
- Case Management support offered by health district staff includes orientation and follow-up for families about how to identify a provider and use care appropriately.
- University of Washington Dental School provides education to dentists and certifies them to receive enhanced payments for many dental services included under Medicaid.
- The Department of Social and Health Services visits dental offices to help staff with billing.

Community Support

Collaboration among many organizations, including:

- Local and state dental societies
- Washington Dental Service (the Delta Dental of Washington) – three-year grants for administrative component at 50% of cost
- University of Washington Dental School (training and assessment)
- Local health districts (case-management and follow-up)
- Washington State Department of Social and Health Services- Medicaid (predominant funder of dental services and 50% match for administrative functions)
- Local businesses

Annual Budget

The program is paid for by a combination of local, state, and federal tax dollars.

Start-up Costs

Start-up funding included staffing for program development, media, training of dental providers and regular meetings with local task forces.

Assessment

Program effectiveness is assessed by:

- Improved services to Medicaid patients and provider participation in Medicaid reimbursed care
- University of Washington investigators conduct surveys with Medicaid patients to assess their experience and response.

Statistics

In Spokane County:

- According to a 1997 survey 43% of participants visited a dentist in the past year versus 12% of Medicaid-enrolled children not in the program
- 11,000 children under age four have been served

Other Comments

- Program leadership comes from dentists.
- Program administrator acknowledges the work of dentists and does not blame them for the current access problems, but rather asks for their help in creating solutions.
- Clear data revealing a need in each county was instrumental in gathering political support.
- According to a 2000 U.S. Department of Health and Human Services Public Health Report, “an ABCD child was 5.3 times as likely to have had at least one dental visit as a child not in the program. ABCD children were four to 13 times more likely to have used specific dental services. Parents of ABCD children were more likely to report having tried to make a dental appointment, less likely to report that their children were fearful of the dentist, and were more satisfied, compared to parents of non-ABCD children.”
- Program administrators would have liked more complete county-based statistics on the charges and expenditures of dentists providing care to Medicaid patients.

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RED RIVER VALLEY DENTAL ACCESS PROJECT

Administrator

The Red River Valley Dental Access Project is a private, non-profit organization with one full-time and two part-time staff.

Program Description

Collaborative effort with public, private and philanthropic groups working to develop strategies at the local level to improve access to dental care. The program does not provide direct treatment services, but offers case management support to a referral network of participating dentists.

Program Location

- 25 counties in eastern North Dakota, western Minnesota
- Area includes both urban and rural communities

Brief History

Formed in 1997 to address a critical and growing problem of access to oral health care in a 25 county region, primarily for low-income families, children and the elderly. The goal of the organization "is to improve access to basic and urgent dental care for families and children in the Red River valley who are living below 200% of the poverty level, the uninsured, the homeless population, Native Americans, seasonal farm workers and recent refugees."

The organization includes health and dental professionals, legislators, representatives from Minnesota and North Dakota Departments of Health and Departments of Human Services, representatives from local human service programs, county health departments, Dakota Medical Foundation, Managed Care representation from Minnesota, Northwest Technical College, University of Minnesota Dental School, and non-profit community dental service providers.

Demographics

- 14 county area in North Dakota and an 11 county area in Minnesota within an 80-mile radius of the Fargo-Moorhead area. This region includes Dakota's most populous areas and Minnesota's more rural areas.
- Just under one-half (45%) of North Dakota's population resides in the catchment area while 5.1% of Minnesota's population resides in the area.
- 38 percent (24,000) of North Dakota's Medicaid eligibles reside in the catchment area, while in Minnesota 7.1% (53,000) of the Medicaid eligibles reside in the area. Of the Minnesota eligibles, 51% are enrolled in a managed care program. North Dakota currently does not have a managed care program for dental services.
- The population of the area is approximately 93% white, 1% Latino, 1% African American, and 5% Native American.
- Predominately English-speaking population.
- Project addresses access needs of vulnerable age groups.

Program Management

- Seeks to stimulate program and policy solutions to dental access issues including the lack of dental manpower, the lack of education and preventive services, the low reimbursement rates, and the inability of low-income clients to access dental care.
- Seeks to address the shortage of providers by supporting community recruitment efforts and incentive programs.
- Around 25-30 dentists participate by accepting referrals for treatment into their private practices

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- The project does no outreach but relies on social service and housing agencies to identify clients in need of service.
- Oral health screening and education is offered to programs serving children from low-income families, such as Head Start.
- The project has advocated to increase the Medicaid reimbursement rates and to augment funds for repayment of dentists' student loans. The group successfully lobbied the North Dakota legislature to appropriate funds for the loan repayment program.

Annual Budget

Approximately \$160,000

Start-up costs

The initial startup costs were \$25,000 for program expenses and strategic planning.

Financial support

Financial support is provided through grants for screenings; federal funds support education and prevention programs. The local dental society helps, and the organization is considering private fundraising.

Statistics

- Clay County is one of the two counties in Minnesota with the lowest utilization rate of 9% or less of eligible recipients.
- In a survey done by the North Dakota Dental Association, over 40% of dentists plan to retire or sell their practice within the next 10 years. Over 25% of Minnesota dentists plan to retire or sell within the next 10 years. There is no dental school in ND and enrollment dropped to 86 students at the University of Minnesota Dental School.
- The population to dentist ratio for North Dakota in the Red River Region is 2155:1 and the ratio for the Red River Region in Minnesota is 2419:1. Both ratios are higher than the US average of 1859:1.
- Only 3% of the dental providers in the state of Minnesota practice in west central Minnesota. Less than 24% of the dentists in the region accept Medicaid patients on a regular basis, and this percentage continues to decline.
- Anecdotal evidence shows that many families covered under Medicaid or a managed care program have to spend several hours on the phone to locate a dentist who will provide dental services.
- Many families have to travel 20-60 miles to access dental care.
- Overall the Red River Valley Dental Access Project seems to be fairly beneficial, even though it is fairly new, only two years young.

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VOLUNTEER PROGRAMS



Volunteer Services

Volunteer programs offer dentists, dental hygienists and other oral health providers opportunities to help underserved populations – to ‘give something back’ to their communities. As one dentist notes, the medical profession is “ahead of the dental profession [because] dentists have no place to volunteer”. However such programs may have limited capacity and resources and may be unable to provide consistent or comprehensive services. One example is the St. Anne’s Free Medical Program.

ST. ANNE’S FREE MEDICAL PROGRAM

Administrator

The Worcester District Dental Society sponsors the program. St. Anne’s Church houses the program in neighboring Shrewsbury, MA.

Program Description

Free dental screening and referral service. Two local community health centers provide dental work for patients referred by the clinic. In addition, social workers aid individuals enroll patients in public benefit programs for which they qualify. Physicians in general practice volunteer at St. Anne’s and work closely with participating dentists.

Program Location

- Shrewsbury, Massachusetts, in the central part of the state
- Serving suburban and rural areas

Brief History

St. Anne’s Church houses a medical clinic for uninsured and underinsured individuals. Patients at the clinic had a high incidence of dental emergencies but few dentists in the area accepted Medicaid. Early in 2000, a recently retired dentist donated three dental chairs and other clinical equipment. Shortly thereafter the program opened its doors every Tuesday evening staffed by volunteer dentists, hygienists and social workers.

Demographics

- The program serves many diverse communities, including the White working-class, Brazilians (Portuguese speaking), Hispanic, African American, Vietnamese, Chinese, Indian, Armenian and immigrants from the African nations of Kenya and Ghana.
- The service area includes Worcester and Shrewsbury although patients have traveled from other communities in the area.
- The program is open to those who do not have insurance and those who have Medicaid insurance but cannot find a dentist to treat them.
- Patients range in age from four to 70 years of age.

Program Management

- Two to three volunteer dentists (from a pool of 3 dentists) staff the program each week.
- Two to three volunteer hygienists work each clinic evening.
- One to two volunteer social workers help individuals enroll in public benefit programs.
- Clerical staff is shared with the established free general health program.
- Dentists and doctors work together to give a comprehensive medical report to the patient.

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- No appointments are made and patients are seen on a first-come, first-serve basis. Any patient not seen is given a slot in the next week's session.
- Patients are asked to bring interpreters with them as necessary. However, Spanish and a Portuguese-speaking interpreters are available at the program.
- Dentists screen for problems, diagnose and make referrals to local clinics or private providers for dental care including emergencies, cleanings, x-rays and treatments.
- Appointments are available at Quinsigamond Community College hygiene program for regular check-ups, x-rays, etc. The volunteer dentist will read the x-rays if they are brought back to him.
- Participating local practices have donated two emergency appointments each week so dentists at St. Anne's can offer up to four emergency procedures under their own care.

Community Support

The problem was clearly present, and the volunteer free clinic was quickly accepted. The next step – expansion of services to additional clinics each week – will require further community support and provider participation.

Annual Budget

Costs are minimal for a modestly scaled program relying primarily on volunteer time and in-kind donations of equipment.

Financial support

The Worcester District Dental Society will be applying for grants to extend the program.

Assessment

Originally a pilot program to prevent and determine emergency room use for oral health problems, the program has proven to greatly benefit the Worcester community. Statistics are maintained regarding the number of patients seen. Tracking for referrals includes the number referred and the type of referral.

Other Comments

- It can be advantageous to go into an existing program like the medical clinic at the church that already has program administrative systems and space for appointments.
- MassHealth (Medicaid) patients consistently go to the clinic for services since they either cannot find a dentist or they cannot obtain an appointment soon enough and their dental problem becomes an urgent care need.
- Due to the proven need for the clinic, expansion plans will include minor changes in program management. The clinic will only have hygienists performing assessments. Any patients needing dental work will be referred to dentists at the local health centers and the local community college that have donated time for dental work.

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CHARLOTTESVILLE (VA) FREE CLINIC

Program Description

Drawing on a base of approximately 400 volunteers, the Charlottesville Free Clinic, a private nonprofit organization, provides primary medical care to the working uninsured. The dental program was added in 1994.

Program Location

Charlottesville, Virginia.

Brief History

Founded in 1992 by two medical resident from the University of Virginia who saw the need to help patients without health insurance who cannot access health care services. Originally, the clinic used donated space that was redesigned for free by an architect and remodeled – also pro bono – by area contractors. In 1994 the Free Clinic added the dental portion to address the lack of free or affordable oral health care. The Free Clinic works in a public/private partnership with its local health department to provide both its medical and dental programs. The clinic has separate administrative space in offices attached to the health department and borrows the health department's medical and dental exam rooms for its evening clinics.

The Free Clinic will celebrate its 10th anniversary in 2002. As of the end of fiscal year 2001, the Free Clinic had seen approximately 6,800 patients, dispensed 49,415 free prescriptions and provided over 23,699 visits.

Demographics

- University town with surrounding rural areas.
- No geographic limits but the majority of patients are from Charlottesville and Albemarle County.
- Ninety-five percent of patients are employed or have other sources of income but their employers do not offer health insurance or the employee cannot afford it.
- The majority are families with full-time employment and an annual income of \$10,000 to \$15,000.
- Patients report they have no other health care resource and say they would have to visit hospital emergency rooms - or not go to the doctor at all - if the Free Clinic did not exist.

Administration of Program

- Patterned on a medical clinic
- Have 5 volunteer dentists, 3 hygienists and a variety of dental assistants who provide services 3 nights per month.
- Patients fill out a screening form – mostly to learn about how they heard about the clinic, where they usually go for care, emergency room use, family size, income
- No charge to the patient however the clinic does encourage donations
- Appointment basis with a 2 year wait to get into the dental clinic
- University of Virginia in Charlottesville can handle dental emergencies
- Medical College of Virginia/Virginia Commonwealth University (Richmond – 1 ½ hour drive away) has dental school with sliding fee scale
- Once in program care provided for the 10-15 (on average) appointments for 1-2 hours including restorative care, extractions and dentures. Cosmetic care is not available.
- To limit the no show rate the Clinic has a strict “don't show up once, you're off the program” policy. The Clinic sends reminders, place phone reminders and require participants to sign a “one strike you're out” form

Community support

- Dentists have sought them out to participate and have also recruited colleagues to volunteer.
- There is another community program, which offers dental care through a screening process and then referral to local dentists' offices.
- Community organizations include the Free Clinic in fundraising efforts. For instance a local horse show donated \$150,000 in proceeds to the clinic in 2000.
- Majority of donations come from individuals.

Other comments

- When starting a program, definitely look for any possible partnerships with other agencies and providers. Visit other low-income or sliding fee scale or volunteer-based dental programs. Think about what the administrative needs are in addition to the provider needs.
- Clinic doesn't charge for dental services, yet some believe it should charge a nominal fee. No-shows are devastating; some other clinics use a block scheduling method to avoid this. Having enough hygiene appointments can be challenging, especially for 6-month or annual visits. Clinic doesn't have a good system for tracking dental patients, for example, knowing when someone is due back for a follow-up appointment.
- Because the need is so great, it's important to make decisions at the beginning as to what kind of care will be provided and to whom. If an agency is adding dental services to an already existing program, it is critical to have someone who can dedicate significant time to the dental program; do not simply add the dental program onto an already existing staff position.
- Need to expand services because the need is so great. Staff time is currently the biggest challenge.

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COALITIONS

Coalitions give diverse members of a



community the opportunity to work collaboratively, pool their expertise and efforts and start planning an initiative with limited resources. Coalitions can focus on discrete, finite projects (e.g., a legislative campaign) or convene over a long-term goal (e.g., increasing diversity in the dental profession). Coalitions give all stakeholders a means to participate in shaping a community's response to an emerging issue, and it is crucial that they include dental professionals, medical and public health providers, consumers, social service providers and others with diverse perspectives and input. Examples of effective oral health coalitions are the Kaua'i Dental Health Task Force in Hawai'i and the IFLOSS Coalition in Illinois.

KAUA'I DENTAL HEALTH TASK FORCE (KDHTF)

Administrator

Collaboratively run coalition with representatives of different stakeholder groups, including dentists, dental hygienists, physicians, government officials, private businesses, service providers, parents, students and community educators.

Program Description

The KDHTF seeks to create a comprehensive, countywide dental health strategy through convening, programming, and providing education. There are four subcommittees:

- 1) School dental health – education, fluoridation, required examination for enrollment, assist Department of Education to develop more oral health education in K-12 curriculum;
- 2) Community education – use media to educate, outreach to selected populations (e.g., Hawaiian and Filipino), train primary care providers, and educate parents about preventive oral health care such as baby bottle tooth decay (BBTD) and fluoride supplements;
- 3) Dental care – identify gaps in services and insurance plan coverage, advocate for adequate services; and
- 4) Fluoridation – conduct regional assessment and strategic plan for fluoridation for Kaua'i, and pilot a demonstration fluoridation project on Kaua'i.

Program Location

- Kaua'i, Hawai'i - a 553 square mile Pacific island in the northern part of the Hawaiian archipelago
- Primarily rural and remote communities

Brief History

In November 1994 a planning committee recognized dental health as a priority for Kaua'i. In May of 1995 the legislature passed a resolution, "Requesting a Report on the Dental Health Problems on Kaua'i and Ni'ihau (a 73 square miles, privately owned island within Kaua'i County)". In response to these concerns, the KDHTF held its first meeting shortly thereafter. From a core group of health and social service agency staff, a Hawaiian health organization, and a dentist, it has expanded to include childcare providers, parents, legislators, physicians, dental hygienists, health insurance representatives, students, and volunteers.

Demographics

In Kaua'i County (including Kaua'i, and Ni'ihau):

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- Total population in 1996 was 56,435 (with an additional 15,500 visitors)
- The population is very diverse mix of White, Filipino, Japanese, Hawaiian, and Mixed and other race/ethnicities.
- The age distribution within the county is: under 5 years (8.7%), 5-19 (22%), 20-39 (28%), 40-64 (27.6%), 65-84 (12.4%), over 85 (1.2%)
- Inhabitants are primarily English speaking, with some native languages spoken within different ethnic groups.

Program Management

- There are monthly KDHTF meetings and the minutes from these are mailed to project participants each month.
- The KDHTF initially had approximately 15 to 20 active volunteers and 40 interested individuals on the mailing list.
- Yearly conferences focus on a variety of access issues including cultural differences, outreach strategies and fluoridation. The KDHTF has hosted local and national speakers.
- Originally, the KDHTF established a 5-year plan, but subsequently decided to extend the work in order to fully address the oral health challenges in its community.

Community support

Involving diverse representation in planning program goals and activities has allowed widespread support and participation in the KDHTF, including:

- Local health and social service agencies
- Kaua'i Dental Society
- Dental hygienists
- Physicians
- State and county legislators
- Private businesses
- Health insurance providers
- AHEC staff and students
- Head Start parents
- Kaua'i Rural Health Association
- Kaua'i District Health Office

Annual Budget

In-kind donations, grants and conference support

Start-up costs

None – begun entirely with volunteer efforts and in-kind contributions.

Financial support

An alliance with the Kaua'i Rural Health Association allowed for financial support from America's Promise, Area Health Education Centers (AHEC), Hawai'i Dental Association, Hawai'i Medical Services Association Foundation, Hawai'i State Department of Health, Kaua'i Dental Society, and Meadow Gold Dairies. Funding is used to sponsor conferences and finance community education initiatives.

Assessment

- Reviewing health statistics from the community (A 1999 survey showed improvement in oral health status in the community.)
- Tracking attention paid to oral health issues on the state legislative agenda.

Successes

- Advocated successfully for a state bill that strongly recommends that Kaua'i children entering school for the first time get dental check-ups and necessary treatment
- Helped to initiate dental rinse programs in four elementary schools
- Developed a mass media public education campaign on oral health that runs every February
- Provided training for primary care providers (physicians), preschool teachers, and parent groups
- Provided outreach to Hawaiian and Filipino populations through bilingual health aides
- Coordinated five successful dental health conferences that have attracted people statewide
- Developed and distributed dental health flipcharts to 110 preschools, early childcare providers, and health and social services agencies
- Advocated for those who have inadequate dental health access and for funding services for the uninsured
- Currently working with communities on Kaua'i to pilot a demonstration fluoridation project
- Achieved modest improvements in BBTD and early childhood caries occurrence according to preliminary results of a 1999 Hawai'i Department of Health oral health survey

Other Comments

- Kaua'i is a small community where people know each other. Residents collaborate on a number of different projects, so there is a level of trust that allows them to bypass territorial issues.
- Problem "was so glaring and the resources so small when we started".
- The timing was right with the state health plan and AHEC's involvement including staff and monetary support.
- Future plans include potential for expansion through grants and other funding sources.

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IFLOSS

Administrators

Division of Oral Health, Illinois Department of Public Health
Springfield Department of Public Health

Program Description

The IFLOSS Coalition is a public-private partnership whose mission is to improve oral health for Illinois residents. The Coalition's focus is access to oral health care including prevention, education and awareness, and treatment, especially for families that are uninsured and underinsured.

Program Location

Throughout Illinois.

Brief History

In June of 1998, the Illinois Department of Public Health, Division of Oral Health provided time at a statewide oral health conference for dental clinic directors and those interested in providing oral health care to the underserved to meet informally and to network. A formal convening of IFLOSS began in November 1998. The Coalition is open to anyone interested in access to oral health care and involves approximately 150 organizations with nearly 80 active participants.

Demographics

- Both urban and rural residents
- Twenty-eight of the 29 Illinois communities completing oral health needs assessments identified access to oral health care as a priority health problem.
- More than one-half of Illinois children ages 6-8 and 15 year olds continue to experience dental decay. More than one-third of these children have untreated cavities.

Administration of Program

- Maintain contact through regular mailings and faxes.
- Coalition meets at least quarterly.
- Hold other special meetings and workgroup sessions.
- Alternate meetings between a central location and other sites.
- Create and support recommendations to the administration and legislature regarding increasing oral health access.
- Allow additional time at each meeting to network.
- By-laws were drafted and approved by the membership in an effort to institutionalize the coalition.

Community support

Key players on the Coalition include the Illinois State Dental Society, Campaign for Better Health Care, health department administrators, Division of Oral Health, dental clinic directors, Head Start, Department of Public Aid (administers Medicaid and SCHIP) as well as advocates for children with special needs, people with developmental disabilities, school nurses, migrant workers and federally qualified health centers, and other state agencies.

Assessment

Successes have included:

- Raised Medicaid reimbursement rates
- Added restorative Adult services to Medicaid
- Created a Used Equipment Sharing system through the Illinois Public Health Association website

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- Developed a marketing plan to raise public awareness about the importance of oral health
- Established three workgroups – Reimbursement, Clinics and Marketing & Data that plan interventions that focus on legislation, policy development and community capacity building.
- Sent recommendations to the Governor and General Assembly, the Department of Public Aid, the Department of Public Health and the Department of Human Services.
- Developed a Public Health Oral Health Clinic manual.

Challenges have included:

- Medicaid: further increases in rates; adding more services to for adults, especially preventive.
- The Medicaid Advisory Committee needs one public health administrator for its membership.
- Develop a system for SCHIP/KidCare Outreach through oral health programs throughout the state.
- Give public health clinics Medicaid provider status to allow dentists to provide services through public facilities rather than on their own.
- Improve public health clinic development grant conditions so the grants are more sensitive to the needs of individual communities.
- Increase the public health oral health care workforce
- Implement the marketing plan developed by the Coalition

Other comments

- Coalition success attributed to being rooted in communities where there was only frustration.
- Everyone is brought together and discussions are kept open.
- Difficult at times to have everyone's voice heard.
- Need to secure consistent resources to maintain mailings and other communication.
- Many accomplishments have been achieved in a short period of time.
- Credibility has been established as new partners join.
- The Coalition supports issues that all members agree on or are neutral on.

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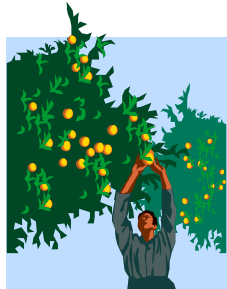
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POPULATION TARGETED PROGRAMS



Population targeted programs specialize in serving certain population groups within a community that have trouble accessing appropriate oral health care or may not be eligible for dental coverage. Such programs help overcome barriers influenced by race, age, language, income, or ethnicity. It is important that they be targeted based on an accurate assessment of the greatest needs and the existing barriers. If overly narrow in defining those they serve, they may exclude other populations with high need.

Targeted populations may include migrant workers, Native Americans, persons with disabilities, elders or homeless people. The two programs highlighted are Call For Health and the University of Maryland College of Dental Surgery Externship

CALL FOR HEALTH

Administrator

National Center for Farm worker Health

Program Location

- Grand Junction, Colorado
- College town with surrounding farming communities

Program Description

Bringing dental services to children of migrant farm workers with screening and education in summer school programs (school-based), and treatment at local dental offices and clinics.

Brief History

Developed in response to a 1962 federal government citation of a lack of migrant worker care due to high mobility, the program has existed for over 20 years.

Demographics

- Year-round program since farming “season” is becoming constant work.
- Average per capita (or per family) yearly income less than \$7500, with 5% decrease in recent years.
- 85% of participants are Mexican-Americans and Hispanic.
- Spanish is the predominant spoken language.
- Program targets 5-21 year old children.

Program Management

- Summer school oral health initiative at four sites is part of a larger social service program.
- School nurse provides education about good oral health practices.
- Five volunteers, including high school students and foster grandparents, help in each classroom
- Sealants and cleanings are provided at local health centers and a private practice with transportation offered.
- Private practice dentist provides restorative treatment for children in need. Program administrator meets with him each year to assess his participation.
- School nurse collaborates with local health departments, physicians, dentists, pharmacies, hospitals and other providers to seek other health care services for children.

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- End of summer school parent night is used to thank local dentists, funders, and supporters. It includes a potluck dinner and student talent show. Over 300 parents attended the summer 2001 event.

Community Support

There is widespread community support because the program addresses a pressing problem with minimal financial costs and the children enjoy themselves in a summer school program with recreational elements. It minimizes disruption for (hourly) working parents by offering transportation for children.

Financial Support

- During 2000, local dentist donated \$23,000 in care for children.
- During 2000, local health center donated \$3,000 in care.
- Most funding is from local, state and federal government programs (originally funded by federal government's Migrant Health Program).
- Local Wal-Mart donates swimsuits.
- Considerable in-kind donations (including toothpaste and toothbrushes for children).

Assessment

Program effectiveness is assessed by tracking:

- Outcome of individual treatment
- Growth in collaboration within the community
- Percentage of children successfully referred for treatment

Statistics

- 150 children served at four sites in 2001.
- At one representative site, all 94 children were screened and given fluoride treatments, all urgent care and restorative services were completed and 90% had been treated with sealants at the conclusion of a six-week program

Other Comments

- Dedicated and hard-working program staff who address needs for program and children.
- If more funding were available the program could treat more children. In the summer of 2001, treatment was provided for 150 of 300 eligible children.

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EXTERNSHIP AT THE COLLEGE OF DENTAL SURGERY, DENTAL SCHOOL, UNIVERSITY OF MARYLAND, BALTIMORE

Administrator

College of Dental Surgery, Dental School, University of Maryland, Baltimore

Program Description

Students and faculty from the University of Maryland Dental School and volunteer practicing dentists travel to a rural 'site' for two to three week periods to provide dental care, especially denture construction and installation for Navajo Indian clients.

Program Location

- Currently in two rural sites, one each in Arizona and New Mexico (an earlier service site in Alaska was discontinued).
- Rotate in different clinics as needed within the Navajo Nation.

A Brief History

All students in their final year must complete at least two weeks of volunteer outreach work. In 1991 a student on an externship program realized that Indian Health Services were not making dentures and that patients who made the trip to distant denture service providers incurred a prohibitively expensive charge of \$150-\$200 for lab work alone. The University of Maryland developed an externship program to address this need.

Demographics

- Navajo Indians in rural communities
- Very low income, most eligible for federal assistance programs
- Many prefer not to speak English
- Population served is between 45-93 years of age

Program Management

- The Dental School at the University of Maryland carries out administrative work, including documentation of professionals and waivers for outreach workers.
- 10-12 students in their senior year of study participate in each trip.
- Four faculty members from school (two at a time, each for half of the time of trip) also participate and provide supervision.
- Indian Health Services staff screen patients, provides case management and translates when necessary, and completes follow-up care.
- All equipment is supplied by federal agencies and local clinics - Indian Health Services already had dental chairs and students also set up temporary clinics in the boarding school where they stay.
- Patients are seen from 8:00 am –5:00 pm and the group agrees to finish all treatment that gets started. This sometimes requires 14-16 hour days, with lab work completed after the clinical appointments.
- No transportation is offered and some patients walk as far as 5-10 miles for appointments.

Community Support

- Indian Health Services appreciates getting this service at the allowable Medicaid rate.
- The school administration supports the program because students offer favorable feedback. Externships are mandatory, and this particular program is considered cost effective and helpful as well as offering good clinical experience.
- There is no competition with local dentists.

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- The program coordinator has recruited several private dentists in Maryland to join for part of the trip as volunteers.

Financial Support

Annual Budget

- \$12,000-\$15,000 grant awarded each year by Indian Health Services to pay for transportation including airfare and the renting of a van.
- Students and faculty pay for their own food. Housing is offered at a local boarding school.

Start-up costs

No more than annual budget costs, i.e. \$12,000-\$15,000 for transportation.

Assessment

- Program effectiveness is assessed by considering feedback from participating students on the value of their clinical experience.
- Other assessment measures are the number of individuals treated and the number of sites and trips completed.

Statistics

- 40-50 patients are seen on each trip (80-100 per year)

Other comments

According to the coordinator, dedicated administrative support would help considerably with paperwork and other arrangements.

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