Connecticut Health FOUNDATION

In-Depth

Executive Summary of a CT Health Evaluation

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ORAL HEALTH CARE COORDINATION PROGRAMS

A Retrospective Examination of Models and Progress

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OVERVIEW

Oral health care coordination is a relatively new concept, designed to serve the oral health care needs of the underinsured and underserved. Children and their families without regular at-home and preventive oral health care are subject to:

- An array of oral health diseases
- Attending school with caries
- Abscesses
- The need for major restorative treatments

This report reviews the eight oral health care coordination programs funded in 2002 by the Connecticut Health Foundation (CT Health). Each program developed a collaborative of community agencies and organizations to address oral health care needs of underserved and unserved children, birth through age 19. Collaboratives identified the children by enrollment in the Healthcare for Uninsured Kids and Youth (HUSKY) statewide insurance program in their city or region.

MEASURING PROGRESS

In 2007, CT Health identified five questions to determine:

- How the programs designed their oral health systems
- How well they met CT Health's goals

The questions were:

1. How is "oral health care coordination" defined by the collaborative?
2. What models of care coordination exist within the oral health collaborative?
3. Does care coordination increase access to care for children in the community? Does care coordination increase patient attendance?'
4. Are there best practices that clearly achieve superior results?
5. Are there financial sustainability models for care coordination that can be identified?

Various data collection methods were used, including:

- On-site visits and observation
- Surveys
- Interviews
- Document reviews

Each program developed a collaborative of community agencies and organizations to address oral health care needs of underserved children, birth through age 19.

THE RESULTS

The questions and a summary of results follow, along with recommendations for program development and public policy.

1. How is "oral health care coordination" defined by the collaboratives?

Common elements of each project were identified and the following general definition was developed:

- An oral health care coordination program is a system of community organizations, providers and partners that agree to give support and autonomy to the oral health care coordinator so that the target population of underserved and unserved children and their families is identified and linked to appropriate oral health care services.

Oral health care coordination is an established, ongoing relationship between the oral health care coordinator and a family with a child in need. The relationship promotes oral health care through:

- Education
- Assisting families through the insurance process
- Linking the child to appropriate oral health services, with follow-up treatment

2. What models of care coordination exist within the oral health collaboratives?

Two models of oral health care coordination emerged from the data.

Model 1: School-based Direct Prevention and Restorative Services: Centralized Oral Health Care Coordination

Here, schools are the lead agency and centralize all preventive and some basic restorative services at the schools.

Using portable equipment, oral health care coordination programs schedule services at each school during the academic year. Children enrolled in the program are excused from classrooms for preventive and some restorative treatments.

The strength of this program is its access to children. This model is excellent for communities lacking oral health service programs. The concern is that services may become limited if proper steps to expand the program and add partners with access to the target population are not added to the collaborative.

Model 2: Community Health Center/Hospital and Public School Prevention and Restorative Services: Partnership Oral Health Care Coordination

The lead agency here is the community health center or hospital with a strong partnership in delivering services to the public schools, such as those in Model 1.

Children can be treated in schools and other locations. Families also may be included. Accessing dental health care also provides access to other medical care. Types of treatment may be expanded to include restorative work and that of specialists, such as oral surgeons.

The strength of this model is that it reaches out effectively to the medical and educational communities, thereby:

- Identifying more children and their families for treatment
- Providing a greater range of treatment

A weakness is that its work may be eclipsed by the medical programs. The oral health care coordination program must demonstrate its:

- Effectiveness as a 'stand alone program'
- Ability to collaborate with other agencies and organizations

3. Does care coordination increase access to care for children in the community? Does care coordination increase patient attendance?

Results show that:

- Mobile school dental clinics eliminated wait time for preventive services.
- Children were seen on the day of the visit.
- No appointments were missed.
- No dental appointment slots were left without a patient.

In addition:

- Access to restorative treatment varied among the programs.
- All were unable to meet the needs of children with high oral health demands due to many factors, including,
    - Not enough partners recruited by the collaborative
    - Families traveling great distances to obtain needed services
    - Wait time for appointments not reduced significantly

More definitive results were not possible because of insufficient resources to comprehensively track children and collect data.

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STEPS TO ORAL HEALTH CARE COORDINATION

Results show that the most effective programs follow similar steps to increase the target population's access to oral health care services.

The following are the sequence of steps to oral health care coordination that most programs followed. These steps correspond to the definition of oral health care.

ORAL HEALTH CARE COORDINATION DEFINITION	STEP	ACTION	ORAL HEALTH CARE COORDINATION STAFF
A system of community organizations, providers and partners	STEP 1	Build a network of providers that offers preventive and restorative services through recruitment and education of community providers and partners	Oral health care coordination and/or program director
Identifies underserved/ unserved children and their families	STEP 2	Access target population through network of providers and partners	Oral health care coordination and/or program director
	STEP 3	Screen all children through reverse consent forms; provide oral health status report for family and oral health care coordinator	Dental hygienist
Establishes an ongoing relationship that mentors and educates families to bring providers and children together	STEP 4	Contact and work one-on-one with individual families to help interpret oral health care status report results; recommend taking appropriate action and why; help with insurance eligibility, transportation, etc.	Oral health care coordinator
	STEP 5	Enroll child in oral health care coordination program	Oral health care coordinator
	STEP 6	Link family to network provider appropriate to need; set up appointments	Oral health care coordinator
	STEP 7	Follow-up on treatment	Oral health care coordinator

4. Are there best practices that clearly achieve superior results?

Several best practices were identified throughout this review. They include:

A. A collaborative with representation from the dental health community, as well as public schools, community health clinics, hospitals, social service agencies, colleges and universities. The most successful collaboratives are those in which attendance is regular and members participate in a wide range of collaborative activities.

B. An adequate staff for the oral health care coordination program that includes:

- An oral health care coordination program director, who oversees recruitment of providers and partners, works directly with the collaborative and reports to various stakeholders on program quality and progress
- An oral health care coordinator who works directly with families, and partner and provider staff to ensure that children's oral health needs are met
- A dental hygienist who identifies children through screening and documents needs for the oral health care coordinator

C. A visible, autonomous oral health care coordination staff that is in direct contact with the provider and partner network, as well as having direct access to the target population. Successful enrollment and treatment were completed when oral health care coordinators were known to school personnel, administration and parents.

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D. Classroom pullout for dental care services that reduced wait time to same day/next day services and left no appointment times unfilled. Absent children are prioritized for next scheduled mobile visit to the school. Some programs offered basic restorative services at reduced wait time.

E. Use of effective recruitment/enrollment practices that included:

- Written communication to parents at the beginning of the school year to ensure returned forms and early insurance verifications
- Consent forms that allow screenings
- Oral health status reports to parents that communicate treatment needs for their children
- Videos/CDs to parents, staff, etc. demonstrating the program's purpose and process
- Oral health care coordination program materials in languages that reflect the community's population

5. Are there financial sustainability models for care coordination that can be identified?

While programs had goals and objectives in place to find additional funding, little action was taken by any of the programs early enough to determine a 'model of financial sustainability.'

POLICY RECOMMENDATIONS

Three recommendations are offered for policy development and program planning. These address:

- Program structure
- Program interrelatedness within the community and region
- Funding

Recommendation 1: Oral health care coordination is a program, not just a single person, and programs must demonstrate a structure that is adequately staffed with a program director, oral health care coordinator and dental hygienists.

Staffing is NOT a single person but a group of professionals with unique roles and responsibilities that interact with each other to tie the community of services to the community's children.

- Program directors should oversee all program operations, including supervision of the oral health care coordinator and dental hygienist.
- The directors should focus on:
    - Recruiting providers and partners, including private dentists and oral surgeons
    - Working with the collaborative as a group and individually
    - Networking with the community to establish the oral health care coordination program as a vital community program
- Oral health care coordinators should focus on linking children to appropriate providers.
- Hygienists should focus on identifying children with needs.

Recommendation 2: Oral health care coordination must be interactive with the community, typically through a collaborative.

- Achievable oral health goals must be established.
- Both the value as an essential community program that improves oral health and the value of the created partnerships within the community must be evaluated and ongoing.

Recommendation 3: An oral health care coordination program must be supported through community funding to ensure its goals are met and the target population is being served.

- In becoming a community priority, an oral health care coordination program will link to other community resources and professionals serving populations with the same medical, educational and social service needs.
- These links build community awareness of the importance of oral health care and its relationship to the overall well-being of each child.

Evaluations like this one reflect CT Health's commitment to collecting and disseminating knowledge, and ensuring that the foundation continues to pursue the most effective course in achieving its mission of improving the health of Connecticut's residents.

For a copy of the complete report, email: info@cthealth.org.