Transcript
Improving Access to Oral Health Care in Rural Communities

Kristine Sande
I'm Kristine Sande, and I'm the director of the Rural Assistance Center. I'd like to welcome you to our webinar, "Improving Access to Oral Health Care in Rural Communities." We all know that there is a significant need for improved access to oral health services in many rural communities.

Our speakers today will share their expertise and experiences with you, regarding what makes for a successful rural oral health programs. The NORC Walsh Center for Rural Health Analysis and the Rural Assistance Center recently launched an oral health toolkit that can be found on the RAC website, and we'll hear today from one of its creators about how it was developed, what was discovered about best practices in the process, and how you can use the toolkit to implement an oral health program in your community. We're also very excited to hear about the experiences of our two other speakers, who will tell us about their successes and their lessons learned in implementing oral health programs in their own rural communities.

First, just a few house-keeping items before we get started with the presentation. I would like to apologize for the formatting on a few of our slides today. We had some significant technical issues getting the slides uploaded to the system, and in the process some of the formatting got a little wonky, but hopefully you can forgive that, and still be able to read what's on the slides. We do hope to have time for your questions at the end of the webinar. If you have questions for our presenters, please submit them towards the end of the webinar using the Q&A section of the screen that's directly beneath the slides.

We have provided a PDF copy of the presentation on the RAC webinar page which is http://www.raconline.org/webinars. If you decide to go to that page during this webinar, I would just caution you, do not close the webinar window, because that would force you to have to log back into the event.

If you have technical issues during the webinar, please contact our support area using the phone number listed on the information screen. If you're not seeing the screen, that number is 701-777-6305. Once again, for any technical issues, the number is 701-777-6305.

Now, it is my pleasure to introduce our speakers for today. Our first speaker will be Alycia Bayne. Alycia is a senior research scientist with the NORC Walsh Center for Rural Health Analysis. Alycia designs and implements evaluations of community-based public health programs. Her researched had focused on public health, rural health and health policy. Alycia managed the development of the Rural Oral Health Toolkit project, funded by the federal office of Rural Health Policy. She has also developed a toolkit on community health workers, and is currently working on a toolkit about care coordination. Bayne has a Masters Degree in Public Affairs from Princeton University.

Next, we will hear from Linda Matessino; the Grant Project Director for the Innis Community Health Center, a federally qualified health center that has primary medical and dental care and a school-based health center. Recently retired from the Executive Director position of the FQHC,

which she held for the last 12 years, she remains committed to the Oral Health Program started in the clinic. She works as a part-time Grant Director for the Innis Program. The Innis FQHC currently has a fix-based dental clinic as well as a mobile dental clinic. Oral health has been a critical need in this rural community, especially for the children within the area.

Our final presenter will be Darcy Czarnik-Laurin, who is the Executive Director for Thumb Rural Health Network. Darcy has a bachelor's degree from Saginaw Valley State University, and has worked in a non-profit sector for 13 years. Darcy's health care career started out as an outreach worker for HRSA grant funded program in Northern Michigan. In her role leading the Thumb Rural Health Network, Darcy focuses on emerging collaborative opportunities that address the complex health issues of the Thumb region. Services focus on population health and access to health care for the underserved population that includes emphasis on primary care and dental services, as well as chronic disease management. She also strives to identify and facilitate educational opportunities and leadership development for network members. Additionally, Darcy serves on the executive board of directors for the National Cooperative of Health Networks.

Now, we are ready to hear from our first presenter Alycia Bayne. Alycia.

Alycia Bayne
Thank you Kristine. Good afternoon, and thank you everyone for joining the webinar today. I am pleased to be able to introduce the [Rural Oral Health Toolkit](#), which is a project that is funded by the HRSA Federal Office of Rural Health Policy. The Rural Oral Health Toolkit focuses on improving access to oral healthcare in rural communities. We know the importance of oral health to a person's health and well-being, as well as the range of diseases and disorders that result from poor oral health. As this grantee, on the slide describes in this quote, "Disparities exist in rural communities on a number of levels, and they can make access to care more difficult."

Improving access to oral healthcare in rural communities is an important and challenging issue and the focus of this toolkit. I'm going to briefly describe the background for our project and give you an overview of the toolkit, and I will also describe some of our findings and lessons learned. Then, I'm going to turn it over to two grantees that have experienced implementing oral health programs in rural communities and will offer their perspectives.

The rural health outreach tracking and evaluation program is funded by the Federal Office of Rural Health Policy, ORHP, within HRSA. This evaluation is conducted by the NORC Walsh Center for Rural Health Analysis in partnership with the University of Minnesota Rural Health Research Center. NORC and the University of Minnesota are also working with the National Organization of State Offices of Rural Health, and a National Rural Health Association to disseminate findings from this evaluation.

The rural health outreach and tracking evaluation is designed to monitor and evaluate the effectiveness of federal grant programs under the Outreach Authority of Section 330-A of the Public Health Service Act. The Outreach Authority Program was created as part of the Public Health Service Act of 1991. Approximately, half-a-billion dollars have been awarded to rural communities since this program began. This is a little more information about the 330-A program. There are nearly 900 consortia projects that have participated. Their goals have been to expand access to care, to coordinate resources, and to improve rural health care service quality.

There are seven different grant programs that operate under the Authority of 330-A. Through this project, we conduct evaluation activities both within and across the 330-A Outreach Authority programs. Because these programs are so diverse, it's not really possible to evaluate all programs with a single approach. Therefore, each year we conduct four new evaluation projects. As part of our evaluation, we have developed evidence-based toolkits on different topics. This toolkit focuses on rural oral health. We have also completed toolkits on community health workers, obesity, mental health, and we're currently working on toolkits on care coordination and health promotion.

Why are HRSA and ORHP interested in oral health? We know that there are provider shortages in rural areas that make it difficult to recruit and retain dentists. There is a lack of dentists who accept Medicaid or have discounted fee schedules. Geographic isolation can make it difficult for people to get to a dentist. A lack of public transportation is also an access barrier, as well as poverty.

While many communities have developed innovative approaches to increasing access to oral health care, there is a lack of research on the oral health models that work best in rural communities. The 330-A Outreach Authority Grantees, have successfully implemented a range of different program models, and their experiences suggest promising practices that can be adapted. This toolkit is an opportunity to share these practices and to disseminate resources and information to other communities.

Why are evidence-based practices important? We are developing evidence-based toolkits because it's important to know what works, and to invest in programs that do work and will have an impact. Evidence certainly informs the decisions that we make in every step of the planning process for a new program, and it can take multiple forms. Some approaches maybe evidence-based because they have rigorously tested and evaluated in various settings. While others maybe promising, because they work in a particular community, but may not have been rigorously evaluated yet.

In many cases, rural programs don't have the resources to conduct an extensive evaluation of their work. However, they're implementing very promising approaches that may offer important guidance to other communities. Therefore, this toolkit is comprised of both evidence-based and promising practices.

I just want to acknowledge the project team that created the toolkit, and also tell you about our goals for these toolkits. We want to identify models that may benefit grantees, the future applicants and rural communities. We want to document the scope of their use in the field, and then we build an evidence-based model toolkit around topic areas specific to rural health.

Our activities have included reviewing grantee applications for a subset of grantees developing rural oral health programs. We also review the literature to identify models that can improve access to care. For this toolkit, we interviewed a subset of grantees who were funded in 2010 to understand their experiences. Then finally, we used the information from the interviews and from the literature to develop a toolkit, which is now available on the Rural Assistance Center website.

This is a snapshot of the main page of the toolkit, and as you can see, the toolkit is organized by different modules reflecting different topics. There's a clickable menu to direct you to a topic that interests you. Each topic includes information and resources. Resources may include white papers, websites, templates that you can adapt, curricula for training and other informational resources. Within these topics, there are also links to other parts of the toolkit where you can find more information.

This is just a visual of the organization of the toolkit and if you scan it, you will see there are seven modules and this is how the content and the toolkit is organized. The first module provides an overview of oral health in rural communities. The second discusses evidence-based and promising oral health program models, and ways to adapt these programs to meet your communities' needs. Module three provides resources and information that support the implementation of oral health program models. Module four discusses strategies that could help you to sustain your program. Module five is a framework for evaluation and includes methods and considerations and metrics that specifically apply to oral health programs. Module six is about disseminating results from your program. Module seven provides examples of programs that have been implemented in rural communities.

The idea is that, communities can use this toolkit and find information resources wherever they're at in the planning process. Whether it's conceptualizing the program or actually implementing it or perhaps disseminating results.

Next, I want to just describe eight program models that we identified in the literature and in practice. The first is what we're calling the workforce model, and this focuses on recruiting and retaining dentists, as this can be challenging in rural areas. Rural communities have implemented workforce programs that involve encouraging students from rural communities to choose dental careers, offering incentive programs to dental professionals who serve rural populations, introducing students to dentists who practice in rural areas, and also creating linkages between dental schools and dental clinics to increase the number of graduates completing a portion of their training in a rural community.

In the mobile dental services model, a mobile dental unit is used to conduct dental exams, and also deliver fluoride treatment and sealants and take x-rays. Some mobile programs deliver oral health education services as well. Mobile units may also be used to deliver portable dental equipment to schools or other organizations where dentists can deliver oral health care services.

On next slide, there are three additional models. The school-based model is where dental professionals are delivering services to children in school-based clinics. These programs may offer fluoride varnish, sealants and education to students. As needed, there are referrals to local dentists that have agreed to treat more complex cases. The school-based model helps to reduce missed school time for children and can help to reach children and families that may not seek dental care due to a lack of resources.

The dental home model is a comprehensive approach to improving oral health access, by providing a regular source of care. This model emphasizes an ongoing relationship between the dentist and the patient, as well as increased collaboration among providers and the promotion of

oral health education. Rural communities are designing dental homes for both adults and children.

Then in the oral health primary care integration model, rural oral health programs are improving communication between dental providers and primary care providers. Approaches include establishing referral partnerships between dental clinics and primary care practitioners, and creating inter-disciplinary teams where dental hygienists work alongside primary care physicians to provide dental services.

Then finally, on this last slide, the allied health worker model supports rural oral health programs by providing dental care, education referrals, screening, and social support services. Some states have established an Allied Health Professional Training program for mid-level dental therapists, who have more training than a dental hygienist, but less than a dentist. This approach was designed to increase access to care.

The community outreach and engagement model is a model about increasing knowledge and awareness of the importance of oral health. Examples include conducting targeted outreach and hard to reach rural areas, and providing oral health education at community events.

Then finally, the community fluoridation model is a public health intervention to prevent tooth decay. This is a healthy people 2020 oral health objective. Rural populations are less likely to have access to adequately fluoridated drinking water. We found few rural oral health programs have focused on community water fluoridation, because of the challenges associated with changing policy.

I just want to note that these models definitely complement one another, and they're often implemented together. Programs may implement a school-based model and a mobile dental model together. Or community outreach and engagement maybe implemented as part of several of these models. I think it's important to know that even though they're presented separately in the toolkit, there is a lot of blending going on.

I also want to present some lessons learned from our experiences developing the toolkit. The first is that partnerships were a critical facilitator of success. Collaboration is the name of the game. The outreach authority grantees reported that their programs would not have been successful without a combination of talented staff and expertise, and contributions from a range of organizations. Partners donated funding, staff time, technical assistance, space and supplies. As you can see, I listed a number of different partners that commonly work together on rural oral health programs.

We found one grantee's partner donated space for a dental clinic. Another grantee's partner financed a mobile dental van. Grantees also work with their partners to identify champions in the community to help to engage providers, educators and policy makers to participate in or support their program. Grantees also commented on the importance of publicly acknowledging the contributions of their partners.

In terms of challenges, certainly grantees experienced challenges. One of the challenges we heard about was, identifying a dentist to serve in a dental clinic. Some programs relied on retired volunteer dentists, as well as dental students from residency programs. Grantees implementing

the mobile dental programs had to establish referral networks with local dentists that could treat more complex cases that could not necessarily be addressed during a mobile unit visit, such as a root canal or surgery.

Some grantees also dealt with issues of stigma in their programs. For example in some cases, even though a program is offering services that the community needed, people were reluctant to use them because of issues related to stigma.

Then finally on note on evaluation, grantees are engaging in evaluation, and in all types of evaluation, process, outcome and impact. They did find that it was difficult to demonstrate the true impact of their programs in the short term. They have identified many, many promising practices and outcomes.

I'm going to provide our contact information, and I'll stop here and hand it back over to Kristine. Thank you very much.

Kristine Sande
Thanks so much for that information Alycia. At this point, I just like to remind everyone that you will have the opportunity to submit your questions through the Q&A box on your screen, and we'll address those questions once all speakers have presented. Now, here to tell us about her efforts with the Innis Community Health Center is Linda Matessino. Linda.

Linda Matessino
Thank you. Hello everyone. Thank you again for the opportunity to just tell our story today. I know all of you that are listening have great stories about the wonderful work you're doing in your communities. We're just excited to share our story with you today. Let me tell you a little bit about us and who we are, at the Innis Community Health Center.

We are, as they said earlier, a Federally Qualified Community Health Center located in rural Louisiana. We're about 70 miles from Baton Rouge. We provide care to three rural parishes. We call our counties down here parishes, and mainly the parish that we mostly serve is what they call Pointe Coupee Parish. We provide medical and dental and mental health services as an FQHC, and school-based health. Then of course, we have the dental, both fixed-based clinic and the mobile dental unit.

We got involved in the oral health grant. The initial grant we had was in 2009 to 2011, and we were going to provide that evidence-based fluoride varnish, and we were going to try it on infants and toddlers in a primary care setting. Not just leave it to a dental office kind of thing. We wanted to do this to improve oral health education in the community, and get to our parents on getting these kids early on in life. We were going to try this in our medical clinic by our medical providers. In this grant, we also were going to partner with the LSU School of Dentistry and two other rural FQHC's in South Louisiana.

Out of all this, we wanted to increase the preventive dental care, and influence dental health habits in children even early on, and hopefully get children to establish with a dental medical home, and of course that's as an FQHC, we had that ability to offer that to our families that were coming in for their primary medical care. We also wanted to improve the primary care provider's

oral health assessment during the medical visit. One of our practitioners always told me, it's the whole idea of "don't take the mouth out of the body", or just leave it for the dentist to evaluate, but really to engage in oral health assessment during that medical exam.

We wanted to provide the fluoride varnish, and in this first year, or the outcomes of this first grant, we did 319 infants and toddlers. We were using the age range from six months to six years coming into clinic, in the primary care setting. We also did educate our primary care providers, our nurses, nurse practitioners, medical assistants, because we can do that in the state of Louisiana. The medical assistants can learn the technique of the application of fluoride varnish on the children's teeth. We were able to do that as well as to engage in using that dental caries risk assessment.

The last of the outcomes there was to increase the oral health education with our children and our families during that visit. We knew that as primary care providers, if we could realize early on issues, and influence that, and refer early-on and get that child established, then we've got a much more promising outlook on that child's oral health as they begin to grow and then go on to school advancing in their years in school.

The lessons we learned was that, we thought that the well-child visits was the best portal for the access. We still believe that to a certain extent, but I'll come back to that point in just a minute. We had to rethink this, because we were experiencing, as many of our colleagues were, that we had a high no-show rate in that population. We saw that early on in the grant period and we knew that if we didn't sort of course-correct that time, trying to reach out and get more children, then we weren't going to be able to touch that many children.

What was happening was that, during the well child exam, we could do that, but again, high no-show rate influenced our ability to do that. Then mama was bringing them in for just an episode-of-care, like a sore throat or runny nose or something. She really doesn't want to fool with us doing that varnish on an already sick or kind of cranky child at that time. Really, we were missing out on the opportunity to teach more oral health and to apply the fluoride varnish. Her goal was just to get in the clinic, get treatment and get out. We were rethinking how we could reach out and get to this population, and we weren't the only ones experiencing that high rate. It seems pretty characteristic in our well-baby visits that we were experiencing, sometimes even a greater than a 50% or 60% no-show rate on the well-child exams.

Other lessons we learned was thinking that, again that was the best access for portal. When we changed our course and said "Gee, we're learning things in our networking with others." Was there another access point that we could get to these children and put on the fluoride varnish, and do the preventive dental caries assessment with our kids? When we decided that we were going to focus on our Head Start kids, we could take that school-based health portal to reach out and get more children, because they were our captive audience. They were really the access point that was key to success, since the children were already there. We could pull them out of the Head Start class and do the varnish, and send them back to class again.

We were successful in our first year grant go-around. We really believe that the school-based was the key, and so we had an opportunity then to go into an expansion grant when it was offered through the Office of Rural Health Policy. What we did in that second year grant was to

expand the concept of the use of the school-based portal to reach more children. We now expanded the age to go from the little bitty ones, the three-year olds on up until about age 13. We also wanted to continue partnering with our FQHC's in the area or even a little bit further south than us. We wanted to go after the FQHC's that had school-based clinics within their program of offerings of services.

We said "Well, if we could get these children during the comprehensive physical time, and complete the dental caries risk assessment and apply the fluoride varnish, we would really be making some head way." We also wanted to continue our partnering with the LSU School of Dentistry that we did in the first grant go- around, because we really connected with them, and Dr. Janice Townsend came down and actually lectured and taught our primary care providers more about the issue of oral health assessments and fluoride varnishes and evidence-based practice.

We wanted to continue that focus in the second grant objective. This time we had an opportunity to also partner with the LSU Pediatric Residents that were in the Baton Rouge area. We had the chairman of the residency program who was very interested in oral health. She really liked the idea of what we were doing and was eager for us to get the pediatric residents involved in more of the oral health assessment and the dental caries risk assessment, using those tools during those well-child visits.

If we could then in those objectives increase the knowledge based of the primary care providers to other professionals. We also wanted to produce the webinar that was going to be done by Dr. Townsend, and we didn't want to just do that for our own benefit, but we wanted to offer that out into the state to any other providers through the Oral Health Coalition, that might want to start to implement this type of program in their setting.

We set out to partner with our Louisiana Primary Care Association. Since they're used to doing webinars and hosting them, people being able to access education through their portal, they were very interested in us having the webinar, be produced by them, and also being the continuous hosting of that. Dr. Townsend taught on caries pathology and good oral health and early on detection, and issues about referrals, so that they could get established with a dental home.

Now, with this expansion and now we've got two other FQHC's. One in North Louisiana, and one in way South Louisiana with their school-based program. We've got them partnered with us to do it through the school-based health center portal of access. With the numbers that they're doing in our first year, we really made some good progress.

Just in our first year alone, we've been able to hit our mark of 585 total physical visits on this age group, that we were focusing on. We were doing the fluoride varnish application, and our dental caries risk assessment, and trying to identify if the child did indeed have a dental home, and if not, refer them to our own FQHC dental services in any of these FQHC's, or to a dentist of their liking in the community. Again, as it was stated earlier, it's hard to find dentists that would see these children, and for us take Louisiana Medicaid.

We also branched out in this year one and conducted our health fairs, where we did some dental caries screening, and application of the fluoride varnish. We also have been out with our Head

Start and able to get in there because they have routine parent monthly meetings, and we've been able to teach them a little bit more about oral health, and hopefully influence maybe other children in the family or even their own. We've also completed our training with the pediatric residents that Dr. Townsend taught, and that happened back in March.

What we're continuing to see is, we've got that webinar up now and we will be able to provide that to any of you all that want to go to the LPCA website and listen to that webinar. She makes it quite easy to understand and be very easy I think even for the medical assistants and the other non-primary care providers to try to listen to and see the advantages of what we were doing.

We've done our meetings with our partners throughout the year and our training. What we're seeing now as we go into year two is that we think we have an opportunity to plan with the Head Start all across our parish. We were only hitting three of the schools with Head Start, now we have increased with six. We are also recognizing that there are some issues with our teachers, and some of those center around just influencing their attitude about school-based health, and the value of the oral health screening time, as the child gets pulled out of class, and to value that as much as they do the vision and the hearing. I mean, they wouldn't dare have a child and have those kinds of screenings. Why wouldn't they allow that to happen with the oral health screening? We've got some opportunities to change some thinking on the part of our teachers. All in all, we have a very good relationship with our superintendent with our fluoride varnish program in the school-based health center, and have a lot of support with them.

Lastly, I guess I want to say to you all, is just keep the faith and persevere. We're going to have our little planning session as we go into year two. We know that you're out there and you had your challenges ahead, just like we do. Just keep persevering in every little bit of impact that you have in the community. You may not see the outcome of that right now, but the child will feel it down the line. I hope that you've enjoyed the few minutes I've had with you to tell our story. I know you'll have questions at the end, and an opportunity to conference those in. I'll turn it over now back to Alycia, and for her to introduce Darcy and have her spend time with the audience. Thank you all very much.

Kristine Sande
Thanks so much Linda. With that, we'll pass it over to our final speaker, Darcy Czarnik-Laurin. Darcy.

Darcy Czarnik-Laurin
Hi, everyone. I just want to thank you for taking time on your day and in respect of everybody's time, I'm going to move through some of this slides kind of quickly, I talk fast anyway. Just a quick overview of Thumb Rural Health Network - the Network seeks to improve comprehensive services by exploring and facilitating innovative collaborative approaches with and among network members. We are a non-profit rural health organization. Our aim is to design and implement population health in the neighborhood of Thumb Region that can succeed in any payment system. Our membership consists of three public health departments, six critical access hospitals and two tertiary-level hospitals. Our support comes through annual membership dues and grants.

Michigan Thumb Region: here's a little bit about that. Its three counties; Huron, Tuscola and Sanilac Counties, roughly 2,613 square miles, about the size of New Hampshire geographically. It's very sparsely populated, rural, and agricultural in nature. Most of the manufacturing that existed in the region has left within the last couple of decades. There is poor economy, high poverty rates, some of the worst in Michigan and while some of Michigan's regions are rebounding, the Thumb kind of has stayed stagnant and it's even gotten worse than some areas.

There's high population of out-migration. We are about a 131,000 people in that three county region. 53% of the population is aged 19 to 64, so they're considered adults. That kind of creates a big problem, because with Medicaid in the state of Michigan, it's really hard to get coverage or to qualify adults for Medicaid. Then, in fact in the past year, 17.4% didn't receive a medical care that they needed due to cost, because they could not afford it and did not have any insurance.

A little bit about access to dental care in the region, as a result of different surveys, focus groups etcetera, the data has showed that access to oral health care for the uninsured is a huge primary focus area, so that's what the Network members decided to focus on. In fact, the Thumb Region has very few programs that provide service and care for that population. There are no Federally Qualified Health Centers. We have no free or low-cost dental clinics. There's not one practicing dentist in the region that will accept an adult Medicaid patient. They see the kids because they get the Delta Dental rates for reimbursement, but the Medicaid rates just aren't high enough, so they don't want to see anybody.

As mentioned before, there is a pretty big provider shortage in that area too. As the local economy continues to decline, the magnitude of the problem just continues to grow. The lack of a support system for that population, has resulted in huge pressure on hospitals, public health departments and private practitioners to meet the needs of that population. The care provided that has been provided, has been an inefficient, fragmented and financially burdensome for those patients.

A unified effort was required to meet the needs of the low income uninsured population, especially those adults, so Thumb Rural Health Network applied for a Rural Healthcare Services Outreach grant, with three primary focus areas; primary care, dental and vision services.

What I'm going to talk about today is the dental focus of the program that we were able to implement through that grant. The objectives of our dental program were to see a region where all people can enjoy good oral health that contributes to leading a healthy satifying life, increased access to oral health services for the vulnerable population, and also create an oral health care home, reduce visits in hospital emergency rooms for preventable dental conditions, to prevent and control oral decay and disease, and to provide leadership at the local level, and encourage collaborative initiative, volunteer dental professionals - you know those retired professionals, and even ones that are still working that may want to donate some of their time - and increased community support.

The Network's role in our dental program was that we were the grantee and fiscal agent. We staffed the program. The primary role of the Thumb Rural Health Network staff was to coordinate the project, grant management, recruitment and training of additional providers, and identifying additional opportunities for collaboration. We also partnered with existing models

and community agencies, including the University of Michigan School of Dentistry, local private dentists, Michigan Community dental clinics and other human service providers, who are able to provide assistance to low income individuals and families in that region.

Quick overview of the program; it was just to help meet the oral health needs of adult patients who are low income and uninsured with an income at or below 200% of the federal poverty level. Our partnership included a private dentist, local public health departments, University of Michigan School of Dentistry, and local community colleges provided dental services that complement other outreach initiative in the Network's grant program.

We split our dental focus into two components basically. One was the Thumb Dental Plan – that's what we called it. The other were Free Dental Clinics. Component one, the Thumb Dental Plan, I like call this the 50-50 Program. Our partners were private local dentists, provided services to the low income uninsured adult patients. Each patient received an initial visit, x-rays an exam and a treatment plan. All subsequent appointments were charged according to the Delta Dental DPO, which is a reduced fee schedule.

The patient, this program was a year … They had to apply every year basically. Let's say they applied on August 6th of 2013, they would have until August 6th of '14 to get the care at that reduced fee schedule. The grant was able to provide 50% match for dental care up to $500 per year for the patient. In essence, the patient was getting $1,000 worth of care in a year. They had to pay the other 50%, but it was done at that reduced fee schedule. I would like to say that it was probably about 40% of what it would typically cost, and there was an annual renewal on that. That's a little bit about the Thumb Dental Plan.

Component two of our dental program were the Free Dental Clinics. These are very popular. We worked with the University of Michigan School of Dentistry through their community outreach program. University dental students were able to come in and work with private local dentists, and also with the dental assisting and hygiene students from local community colleges, to kind of get that, that workforce component fulfilled where they would come and work in a rural area, and hopefully going to stay and work there.

Again, we were able to provide services for that low income uninsured adult patient population. What we did was, we scheduled with University of Michigan one two-day session per month. That was what one clinic consisted of and a variety of work was performed and it ranged from exams and cleanings, to fillings and extractions. The nice thing about this program was there is no cap on services, and there was no renewal. The bad thing about it was there was a waiting list.

The quick results for the Thumb Dental Plan, we did have eight participating dental providers. We enrolled 287 patients through the life of the grant, and they were able to renew on an annual basis. 45% of those patients reached the six month checkup for cleaning status by the programs end, and which is pretty incredible, especially when you can take into consideration some of those patients hadn't seen a dentist even for a cleaning or a checkup, some of them in 20 years or longer.

Results for the Free Dental Clinics in the life of the grant, we kind of sorted this about halfway through the life of the grant, because we had to make some changes due to changes with the

adult Medicaid in the state of Michigan and as far as dental coverage and things like that. We had 12 clinics. We only had one dental provider that wanted to participate in these free clinics. However, we were able to service 168 patients who received a wide relative care, and nearly $300,000 in oral health care services were provided with us in about a year-and-a-half in 12 clinics. I think that's pretty incredible.

Just like anything else, there were some significant problems and barriers that we encountered. The overwhelming need for dental care in the Thumb region, I mean it was huge then and it's huge now. It's big everywhere, and there just is not enough to offer as far as services, providers, things like that. A continued lack of access to oral health care of the uninsured in adult Medicaid recipients was a significant problem. We had difficulties in getting private dental provider buy-in, recruiting those dentists and also, once we kind of got there buy-in getting them to actually participate was kind of difficult.

Transportation, I have that listed here because we had have problems with no-shows, people not calling to cancel their appointments and things like that. Because they just don't have, either they don't have reliable transportation or they don't have money to put fuel in their vehicles, you know if they have to travel a significant distance to participate in the program. We had some problem with staffing changes in the network. In fact, the executive director changed positions, so I came in to working with this program, just over a year into that grant. That made things kind of difficult.

The changes in the Medicaid Adult Dental Program was something that we experienced. We had to change some of our grant, and not enough interest by local dentists to host those free clinics. I mean, if we could have at least had one in each county, you can just imagine - we did nearly $300,000 worth of work with one provider - the impact we could have had! The waiting list to getting those clinics was over one year long. That was a pretty significant barrier as well.

In all, we didn't have some barriers, we also had significant successes. The one provider that was staffing the free clinics, he is continuing those, and hopefully some of his counterparts will want to do so as well. Some of the private dentists are continuing the low cost fee structure for the patients that participated in the 50-50 Program. The community college dental assisting and hygiene students continued to volunteer at the free clinic, and they are now, through some work that I did with them, conducting oral health screenings at the regional health fairs. In an average health fair, they get about 500-600 participants throughout a day-long health fair, so they were at least getting some of the screenings, and if somebody has some significant problems, they can do a referral. It would be out of region, but possibly to another free clinic or an FQHC clinic.

Something else that came out of this was the creation of the Thumb Area Dental Clinics. It's a non-profit dental group, with some of those dentists that did not want to participate in our program, they decided they would like to put up a Medicaid Dental Clinic based on the Michigan Community Dental Clinic model. I am providing them some support with just knowledge sharing, best practices, kind of some of the things we're doing with this group that's on the phone today - what worked, what didn't work - things like that.

I know you guys are probably thinking "Would a similar project would be successful in other rural settings?" I really think that it can. We've had some pretty good successes with this. The

oral health aspect of the program has been very successful, and I think it can be replicated to meet the needs of other rural communities with high members of uninsured residents. The most important thing to remember is communities that have existing oral health resources in place and providers that are willing to set aside competitiveness to work together, are very key to making this successful.

For those of you that are in your initial planning stages, kind of think about that when you're putting your plan together. For those of you that are already working on this, just remember communication is important. Let them know what you're doing, what you're planning and hopefully they'll reciprocate that and be in contact with you, and open to collaborative efforts with you.

I'm sure there is probably a lot of question and if you're looking for any information, this is my contact information. I'll try to help you as best as I can. I have one final thought, "To keep the lamp burning, we have to keep putting oil on it." It doesn't matter if you're in the initial stages, or if you're at the end of a program. Keep up the good work. You just kind of have to roll with the changes, break down barriers, and all the work we're doing is for a good cause. Keep it up. Thank you.

Question and answer
Kristine Sande
Thanks so much Darcy. That brings us to the end of our presentation portion. We have just a few minutes for some questions. If you want to enter your questions in that Q&A section, we can try to get to as many of those as we can. The first question, I believe is for Linda. It says, "With the program course change from the well-child visits to the school-based program, you have lost the contact with and the chance to educate the parents. How are you addressing that now?"

Linda Mastessino
I think what's happening now, is because we've expanded the program to beyond age six. We are seeing a difference in the attitudes of the kids when they come back for their physical. Each year they go "Are you going to look at my mouth again? Are you going to look at my teeth?" They're starting to ask those questions when we are doing the physical again. On the older kids, we're making a difference with them on a one-to-one basis. On the little bitty ones, the Head Start, we still have an opportunity to catch up with the parents in the Head Start parent meetings, because there is a lot of requirements with the Federal Program of Head Start, that they have parent meetings and that they have to attend. We get an opportunity there. We're not stopping what we're doing in medical clinics, but we just don't get the success rate that we get seeing them in school.

They also in our community are seeing that the mobile unit has been going to the schools for about four years now. With us going into the school-based health center doing the physical with the oral health component, and then them seeing the actual dental bus being there. We think we kind of hit the kids from all angles. You're right, I mean we're not getting the one-on-one with the parents, but we are making a difference in the older kids; six, seven, eight, nine-year olds, because they're asking more questions.

Kristine Sande

Great. Thanks. Another question is "Who covers the liability for retired volunteer dentists, and we assume that they have to maintain current licensure, correct?"

Darcy Czarnik-Laurin
I'm going to try to answer that question as best as possible, because we did not have anybody actually volunteer. Yes, they have to maintain their licensure, and I guess it would have to go under whatever your clinic facility is. If you have a stand-alone clinic, it would have to be covered under your insurance somehow. Or if somebody is hosting the clinic and they come in to participate in that, they would have to be covered under that somehow. I know that wasn't a real clear answer, but those are some of the things that I was thinking about when we were trying to recruit some of those volunteers.

Kristine Sande
Great. Darcy another question for you – "How did you get that private dentist to buy-in? Was there a particular method you used for that?"

Darcy Czarnik-Laurin
Again, it's just as I mentioned during my presentation. It's just the openness to communication. What we experience in our region, we're fairly larger region, but at the same time it's a pretty small town and there's a lot of direct compete with one another. When we came in with different proposed ideas, those dentists weren't included in the initial planning stages, so they were taken by surprise and almost felt like they were being attacked – if that sounds right?

What I did when I came on board as the director of the program, was I set up appointments with each individual dentist. I went in, introduced myself, gave the history of why the grant was written, and the things we wanted to do. Just made sure that they knew everything that was happening, that we weren't trying to eventually take patients away from them if we were to ever open a Medicaid clinic, things like that. Just being open, transparent and communicating is key.

Kristine Sande
Great. Another question is, "Currently it seems that you're measuring the number of fluoride treatments, the number of appointments and the use the caries risk assessment tool. What are measures of success that you would use in the future and how are you intending to track them?"

Linda Mastessino
Some of the measures that we're also looking at is the presence or absence of an identified medical home. Again, we're trying to gain that information on our permission slips, when those are sent home to the family through the school-based health center. If we are indeed getting them, say assigned if they don't have a dental home, if we're referring them to our own dental programs, and if indeed that appointment was kept. We're tracking those referrals to know whether we're keeping the appointments for the referral of coming in for some routine cleanings, etcetera.

The other way that we can track in our school system, is through mobile dental unit to see if indeed when that unit went to their school, did they then come out and have their regular exams, semi-annual exams and routine cleanings done or sealants put on out there. The other item that we're tracking is, again, some of the parameters of you know, just who are we hitting, male,

female, gender, race, etcetera. Those are some and what we call our PIMS data measures. Then the number of comprehensive physicals that we're doing, we match that to see what percentage of those that had the comprehensive physical did indeed have the documented oral health assessment in the EMR. Hope that answers it for you.

Kristine Sande
Great. We got a few more questions here. One is for Darcy, "In the Thumb Free Clinics, where were those held? Was it a private office, mobile or a tech school? Then also, do you have a dental sealant program that travels into school-based health centers?"

Darcy Czarnik-Laurin
The Free Clinics were held at one private provider. He was gracious enough to open up his clinic for those two day clinics, once a month for the dental students to come in and see those patients. We were kind of blessed to have him, that provider on board because he's very community minded. He sees the need in the region and he just wants to give back as best as possible. We do not have a mobile sealant, and if I remember the question correctly, they tried to create a mobile dental program to come into the schools, back a few years ago or so, and it was really … it was not welcomed, because of the private dentists, so that kind of sizzled out, and that was another facet of the overwhelming need in our region. Trying to get some of these other, programs created to take care of the parents and hopefully if the parents are coming in, they'll bring their kids in.

Kristine Sande
Great. Looks like another question for you Darcy. "Were the participants in the 50-50 Program eligible for coverage under Medicaid, and how did the program compared in cost with Medicaid? Also, did you encounter any stigma with dental care where folks don't prioritize dental and how did they address the stigma?"

Darcy Czarnik-Laurin
I'll talk about the Medicaid portion first. No, we did not see anybody that was Medicaid eligible, because that's considered coverage. That was kind of difficult at times because of the, what they call the Medicaid spend down, because if they reach that amount, then they would have the dental coverage as well as primary care coverage. Those people fell even further through the cracks. No, we didn't see anybody that had any form of dental coverage.

As far as how it compared to the Medicaid pricing, I can't really tell you how it compared. What the dentist would do is they would charge the Delta Dental DPO rate, which is a reduced rate schedule and it's like about 40% of what they would typically charge. The way to explain it to a potential patient was, if you have a $100 worth of care done, you're only going to pay 40% of that, or that's what you will be charged. Then you as the patient is responsible for 50% of that. They would be paying $20 for $100 worth of care.

The other question was did you encounter any stigma? Yes, as Linda mentioned earlier. There is oftentimes a stigma attached with all kinds of facets of oral health care. If you don't get the care that you need and you have a bad mouth, bad teeth, and things like that, it's hard to find employment. People don't seek employment because oftentimes they're embarrassed of that. As far as going for care, one nice thing about the way our program we setup, was these patients got

to go into a regular private dental office. They had a private dental home, you know, there was no stigma attached with going to an FQHC clinic, a Medicaid clinic, a low-income clinic, whatever you want to call it. They got to go in just like anybody else. Any other patients sitting in the waiting room, most of the time they probably weren't even aware that they were participating in a grant funded low-income program. That was really nice and I think encouraged people to start going, because, you know the region is small enough and I have gone to the health fairs, and I've actually gotten to talk one-on-one with some of these patient who, some of them at the beginning were really reluctant, and or they thought "Okay, what's the catch? Am I going to be out of bunch of money if I go into this?" Then, even seeing them six months or a year later, the difference in…they smile and they just look healthier and just so thankful. I think that's part of it, you know there was no stigma attached to this problem and they just got to go in like anybody else and nobody new otherwise.

Kristine Sande
Great. We've got quite a few more questions, but we'll maybe just do one or two more and then we'll probably need to wrap it up. To any of you, I guess. "What are some best practices to address no-show appointments?" I know that's a difficult issue. Did you find any best practices in that regard?

Darcy Czarnik-Laurin
This is Darcy. With the 50-50 Program, it was a call, just like a reminder appointment. With the free dental clinics, there was a reminder call, but if that patient did not show up, or they called and canceled, the next person on the waiting list was called because you could fill them. Those people who drive an hour, hour-and-fifteen minutes to come to that clinic. That was a couple of the things that we did. Something else, I didn't mention when I was going through my slide and I wanted to - I said we partnered with public health departments. They had staff that donated time as part of their commitment to the grant. They would involve the patients for both of the facets of the program, and they would sometimes come in for other things, you know WIC programs, breast feeding programs, things like that. The nurses, it would be in their chart, and they would say "Hey, you remember you have to go to the dentist?" Or, "Have you been keeping your appointments?" Things like that.

Linda Mastessino
We oftentimes used those queuing mechanisms in our regular medical clinic to say "You know you've got an upcoming dental appointment." What we did with our high no-show rate in the well-child visits, we still just send out the reminders to them. We use our little pre-printed post card about your next visit, because they're on a schedule, kind of developmental cycle, that it tracks with.

We try to call, but we also know that very few people anymore in this area have landlines, and telephone numbers weren't always good. The issue for us, a big challenge, is that when they do have a cell phone or whatever, their cell phone that maybe throw away or limited minutes, and we don't always capture that number. It's very hard, and that's why school-based healthcare, when they go in at three years old into the Head Start Program, then at least we're seeing the kids and we're seeing that in this rural area, as well as in North and South Louisiana, the Head Start Programs are full. At least we get the child from three years old on. We routinely schedule those well-child visits, those comprehensive physicals.

Kristine Sande

All right, great. One question here, it looks like it's probably for Alycia. "When discussing the toolkit, one of the models included inter-disciplinary teams which might include hygienists working within primary care. Can you or do you know of any states that allow that specifically? Currently in our state, hygienists must work under some sort of supervision of a dentist, and even public health supervision does not include medical offices as an allowable setting. Just curious what states might allow that, so we can look at their practices acts?"

Alycia Bayne

That's a great question. I actually don't know, off the top of my head, which states in particular you might be able to reference. That's certainly something we can look into.

Linda Mastessino

In Louisiana, the hygienists have to work under the direction of a dentist if they're doing hygiene, the sealants and the hygiene cleanings. In terms of the application, for instance, of fluoride varnish, we do have in the Dental Practice Act that the medical providers or nurses or medical assistants can apply that varnish. I know that every state is unique.

Darcy Czarnik-Laurin

I mentioned the PA-160 Program in my presentation. This Public Act in Michigan that allows hygienists to work within a PA-161 Program to provide preventive services for the underserved population. They can do certain things, I want to say sealants is included, but cleanings, x-rays, things like that. The dentist doesn't have to physically be there for those services, but you do have to have a supervising dentist, if that makes any sense. Basically someone who can come in and it sounds somewhere to what Linda was talking about.

Linda Mastessino

Yeah, that's the way it is. They don't have to be on-site or there are so many days that they can do that, but it can't be on an ongoing basis that the dentist is never there. He or she has to provide oversight to the treatment plan.

Kristine Sande

Well thank you so much for those answers. I know that there were other questions that we didn't get to. I believe all of the speakers do have their contact information included in the slides that you can download off of the RAC webinar page on the RAC website. If you have a question for one of the presenters that we didn't get to, I'd encourage you to go ahead and contact them. If you have any trouble finding that information, please contact RAC and we can find that information for you.

On behalf of the Rural Assistance Center, I'd like to thank our speakers for the great information and insights that they shared today. Also, for our participants, I'd like to thank you for joining us today. There will be a survey that will be e-mailed to you following the webinar, and we really hope that you'll take the time to complete that survey and provide us the feedback, so that we can make our future webinars even better. Once again, the slides used in the webinar are available at http://www.raconline.org/webinars and the recording and the transcript of today's webinar will be made available on the website and sent to you by e-mail in the near future. Thanks again and have a great day.