

Comprehensive Oral Health Services Through School-Based Health Centers: Expert Workgroup Meeting Summary

November 2–3, 2011

Sponsored by Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau.

Summary prepared by Julia Lear, PhD and Donna Behrens, RN, MPH, Center for Health & Health Care in Schools, GW School of Public Health and Health Services, Washington DC

The purpose of the meeting was for those in attendance to provide guidance for a new HRSA grant program that support oral health programs in school-based health centers (SBHCs).

The objectives of the meeting are:

- Identify policy implications of health care reform as well as the opportunities health care reform offers for provision of comprehensive oral health services through SBHCs.
- Identify promising practices for the delivering of comprehensive oral health services in SBHC that target children and adolescents at high risk for dental caries.
- Identify stakeholders and other essential partners to initiate and sustain the delivery of comprehensive oral health services in school-based health centers.
- Identify financial and non-financial support to sustain comprehensive oral health services delivered in SBHCs.
- Identify existing indicators and/or develop new indicators to measure processes and utilization, guide quality improvement, and report program outcomes.

Welcome and Opening Remarks:

Mark Nehring, DMD, MPH, Maternal and Child Health Bureau, Health Resources and Services Administration: As background to the program that MCHB will launch in 2011, Mark noted that this initiative is suitable follow-on to the targeted oral health services system program that MCHB has funded during the past five years. Under that program, sealant programs in a number of states were supported. With the new initiative, MCHB will test out SBHC as a vehicle for helping kids receive comprehensive oral health care that can build on earlier sealant programs.

A year ago the DHHS Secretary expressed interest in bringing primary care into schools. Within that initiative, Mark was asked if he would like to participate with an oral health program. Mark saw this as a well-timed possibility. It would be a logical follow-on to the previous program as well as an opportunity to follow up on general interest in school-based health. It also seems a logical response to recent discussions about requiring dental screening for entry into schools. The health care reform debate has raised workforce issues and access issues related to children's oral health. And there has been emerging interest in integrating oral health into primary care. HRSA funded two IOM studies that included oral health. Cross-bureau collaboration has led to creation of an Office of Strategic Priorities within HRSA. School-based initiatives have also begun to pop up around the department.

So it's time. We don't know what the future holds, but we need to move forward on health care reform and workforce issues. And we are starting the process.

The goal of the proposed MCHB program is to decrease oral health disparities that affect children and adolescents from families with low incomes by increasing their access to oral health education, preventive care and treatment services provided by school-based health centers.

Meeting Overview and Charge:

Burton Edelstein, DDS, MPH, Founding Director, Children's Dental Health Project facilitated the first day of the meeting. He opened the meeting by offering the charge to the group:

The job, as experts, is to help the Bureau refine the guidance it will issue when it announces the new SBHC Oral Health Initiative. The goal is to move beyond the literature and build on our collective experience. MCH priorities for this meeting include:

- Guidance on how MCHB can encourage projects with maximum effectiveness and value
- Technical assistance for the Bureau, clarifying likely grantee needs, supporting/featuring best of the best, disseminating best among grantees
- Identifying problems that need solutions. Oral health is consequential – what suggestions do we have for MCHB to help it write guidance that will make a difference

In supporting the development and expansion of SBHC dental clinics, we are trying to revive an old idea. In Rochester, NY George Eastman put dental clinics in schools in the early part of the 20th century. But this is not just about oral surgery or dental restorations; this school-based dental program must focus on effective education as well as treatment.

The group must also focus on policy implications. There are possibilities: CHIPRA includes oral healthcare expansion as does health reform legislation. Medicaid has also increased the number of children covered. As a result of the most recent legislation, 98% of kids will have some source of coverage. How much can policy be shaped and implemented to maximize good oral health for children? School-based programs offer opportunities in prevention (sealants & public education), collaboration (partnerships), and evaluation (what works & why).

Policy Implications and Opportunities

Presenter: Meg Booth, MPH, National Maternal and Child Oral Health Policy Center – notes not available

Presenter: Shelly Gehshan, MPP, The Pew Charitable Trusts, Pew Children's Dental Campaign

There is a broad array of health policy issues that need to be considered in thinking about child oral health and the role of schools. These include: Capacity issues – particularly those related to defining what or who a dental provider is; prevention for school-age children beyond the initial stage of dental problem-onset; opportunities for collaboration & innovation; quality issues; workforce challenges; connecting school-based treatment and education programs to school-based sealant programs; and definitions of school-based oral health programs so that their fit within policies, such as Medicaid guidance, is clear.

Within these broad dimensions, the policy environment varies radically from place to place for individual children or groups of children.

For example, while Medicaid managed care has generally increased dental coverage all state environments are unique. Currently states do not reimburse directly for school-based dental care. Where reimbursement occurs, it is not for a specific school-based provider type but for a provider type that is a recognized provider that happens to delivery services in schools. NY State has a Medicaid carve-out so NYC school-based health centers can be reimbursed for dental health care. Under the New York carve-out, SBHCs can get can get \$89 per service. That helps some with sustainability.

Even in grant programs, such as the new CDC sealant program, the funding may go directly to the schools and not to dental providers – making linkages among oral health services difficult. Additionally, it appears that CDC only has money to fund 19 states to develop infrastructure for statewide sealant programs.

While restrictive state laws & practices may constrain the use of dental providers other than dentists, program developers might look at some state accommodations to scope of practice definitions for nurse practitioners. In some states, “public health nurse practitioners” are permitted a broader scope of practice (eg. Off-site supervision by physicians)

Participant Discussion: Among key points made in the policy discussion were the following -

- There is no single solution to the problem of reimbursement – the contexts vary too much.
- Concerning prevention in SBHCs, the degree of untreated pathology will overwhelm the practice.
- SBHCs are on stronger footing and will be a more promising home for school oral health programs now that they have their first federal definition in the health care reform legislation (Affordable Care Act)
<http://www.schoolhealthcenters.org/docs/HCR-final-lang-sbhc.pdf>
- The school-based oral health programs to be supported under the MCHB initiative must provide comprehensive services.
- Creativity in dealing with the schools’ typical 10-month year is important. Some programs operate 10 months a year; others are open year-round
- A focus for the guidance should be direction as to whether the oral health services are simply co-located in the SBHC or are they integrated into the SBHC comprehensive service package. For example, is oral health records part of the

child's health record? Do oral health providers participate in chart reviews and case conferencing?

- Demonstrations are definitely the way to go. Pew gave up on replicating successful sealant program. Comprehensive programs require dentists or new dental providers (dentists hate) & they are hard to get.
- In the end, policies that support oral health initiatives must operate at all three levels of government: local, state and federal.

PROMISING PRACTICES

Panel Presenters:

Adria Cruz, MPA, Children's Aide Society

Mark Doherty, DMD, MPH, CCHP, DentaQuest Institute

Sara Rich, MPA, Choptank Community Health System

Carrie Stempski, RDH, BS, CDHC, Brown County Oral Health Partnership

Mark Doherty, DentaQuest Institute: Mark talked about how in their experience, referral does not work. He feels that case managers that "do everything but drive them to the appointment" is what works. He feels that school based services can be effective and that any school program needs to have memorandum of understanding in place with private dental providers or a university dental program to provide for the care that cannot be provided on site in the school. He also endorses a "hub and spoke" approach where a dental operatory can be located in one school and use staff and portable equipment to travel out to other schools. Some of the essential pieces need to include: public private partnerships; well defined scope of services that is decided ahead of time; how many kids will be seen and procedures to be done.

DentaQuest Program Lessons Learned:

- Before any child is seen, do an environmental assessment. Know up front what is allowed and what is reimbursed. Pay attention to the rules, regulations and allowed scope of services for provider types.
- Take care of all the children regardless of insurance coverage or lack of coverage. Bill the uninsured to be in compliance with Medicaid regulations but you do not have to pursue the family for payment.
- Make sure you have the right dentist to treat the right population of students
- Have a business plan in place before starting
- Delineate responsibilities and define who does what and when
- Be seamless in care
- Have a champion at the school who talks about your dental program
- All program elements need a policy related to it and a written plan for who will do what.
- Make sure to present ahead of time to all the stakeholders remembering to include the superintendent of education, the school board, parents and allow all to weigh in before services started.
- Do not use electronic records; use triplicate records instead.

- Consider doing consent forms every two years rather than annually. Much time is lost in getting annual consent forms done

Anita Cruz, MPA, Children's Aid Society Based on 2 decades of CAS experience, Ms Cruz urged_MCHB to base its programs in SBHCs rather than linking a school-based oral health program to a community-based sponsoring organization. She talked about how their program has been more successful in SBHC-located oral programs than in the school linked programs. She felt that their school based programs that link to community clinics have not been as successful at addressing students oral health needs even when the clinic is across the street from the school. CAS has 5 SBHCs, 3 of them provide oral health services in 5 schools. Regarding comprehensiveness and quality of care, more preventive care is provided in SBHCs when compared to community dental clinics. Possibly parents may feel that going to the community clinic is for care & not prevention. The school location also helps with referral from the dental chair to the nurse practitioner or social worker.

Financial considerations: CAS has found that the school based dental programs have a number of benefits. These include: Free use of space within the schools; in New York , a Medicaid carve-out that allows the dental clinic to get a higher rate; low no-show rate and the provider has very little down time. CAS has compared service delivery at their school sites and community site. They found it is less expensive to provide services through a SBHC dental clinic when compared to the community clinic. Other benefits have included help in managing the appointments and the help of school staff in securing consent forms. There are also advantages for parents. The school based dental services eliminates transportation issues and the need for time off for parents from work, CAS found follow up to dental visits to be more reliable and the fear of the students of the dentist is reduced because the dentist is seen in the halls daily.

Other lessons learned: Sustainability – CAS learned to ensure there is a mix of Medicaid, insured and uninsured students. Right now they only get paid for the Medicaid visits. They make sure they cast a wide net in the school to get students enrolled and seen in the dental clinic. They send the dental hygienist into the classrooms to do a one minute “no touch” screening and prioritize who should be seen in the dental clinic. They also know that the dental hygienist can do more and cost less. They are offering orthodontic care on site and the services have been donated by St Barnabas. Government support is needed and the rate of reimbursement in New York for CHIP coverage needs to be equal to reimbursement for Medicaid services. They also feel it is important to link uninsured kids to state insurance programs for coverage.

Sara Rich, MPA, Choptank Community Health System Their school-based dental programs serve as access points for the community FQHCs and does prevention care only and refer students to the FQHC dental site for care. There are 7 SBHCs in Caroline County Maryland. The Choptank Health System provides primary care, mental health and dental care.

The lessons learned in the Choptank school based program include:

- Develop your partnerships before you begin.
- Involve the local dentists in planning. Choptank met with community pediatricians and dentists. The community dentists have mixed feelings about Choptank and their dental program. Some of them like the program and others were against having a school based program. Choptank did not want to be seen as competitive.
- If seen in the school based oral health program, Choptank will send dental visit information to the student's dental home if they have one.
- Develop a business plan. It is important to know how you are going to pay for services. They have a "no margin, no mission" mantra. They go into their projects knowing the estimated revenues for services, the payor mix and what is reimbursable from Medicaid.
- Although they have electronic medical record system, the providers in the schools often have problems connecting to the system because of the way the school buildings are built.
- Have policies in place before your program goes "live" and make sure you include chart reviews and policies for infection control.
- The school based program is a unique opportunity for educating students about dental care and oral health both in the classroom and school wide but there is no reimbursement for education.
- Case management is really important and they do not have anyone on staff to do this critical piece. They have found that case managers are essential both to get appointments and get to the dentist. Resources developed here is great but there is a continued need to educate policy makers about what more is needed.

In summary, there are two main recommendations based on Choptank's experience: develop a "how-to" manual that defines the school-based oral health care models and provide support for a public health media campaign that promotes public awareness in oral health issues.

Carrie Stempski, RDH, BS, CDHC, Brown County Oral Health Partnership. Carrie Stempski, Brown County Oral Health Partnership Brown County Oral Health Partnership (BCOHP) was founded in September 2007 and serves children in the Green Bay area who are uninsured and underinsured. Children are seen at Howe Family Resource Center five days a week and portable equipment is brought into the schools to treat children. Since BCOHP's establishment, 12,000 oral health visits have been served including preventive, restorative, and extractions. Carrie Stempski is the Executive Director and has been in public health spectrum all of her career. She is a Regional Oral Health Consultant and teaches for the CDHC program. She graduated in 1982 from the University Of Minnesota with a BA in Adult Education and a GDH Degree.

Ms Stempski began working on oral health issues as a volunteer. She was asked by governor to serve on an advisory council. As part of the work, she was located at a resource center. While at resource center, she reported "I saw 5 cases in 5 minutes". The dentists in the area had all discontinued taking Medicaid patients. She brought together non profit groups who were involved in any way with children --United Way & Salvation Army, Rotary Club, to meet. It was the beginning of the oral health partnership. For the

first 3 years she volunteered her time. She realized right away that the key was to educate the dentists. They also needed to hire a dentist and initially had trouble. To provide the needed dental care for children, she knew she would be unable to get volunteers from her community. They wanted to force the state to raise the dental reimbursement rates by not seeing children on Medicaid until the rates were increased.

She began working in schools. She realized that many of the children they were seeing did not have the basics like a toothbrush.

To make her project work, she said that it was important to have a good business model and make sure the services are sustainable and replicable. She found it was important to identify community partners they will work with you. She also thought partners needed to include representatives from the state and local level as well as a partner from Medicaid. When working in the schools, it is important to have the space as required, to know what the policy opportunities and constrains are; to have the needed community dental partners and to focus on the opportunities afforded by being in school (classroom education; access to hard-to-reach families).

She found that people are looking for good models and that you have demonstrated that you have an established infrastructure that will assure that models can be implemented and the elements in place that indicate that you are likely to be successful. Other recommendations include establishment of a referral mechanism for after hours, strong partnership with your state Medicaid office, the capacity to provide data requested, the knowledge of is the local oral health capacity and need, the demonstrated ability to have meaningful outcomes, a strong feasibility/business plan and an existing relationship with schools.

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KEYS TO SUCCESS: Partnership and Collaboration

Panel Presenters:

Dana Carr, MPH, Department of Education, Office of Safe and Drug Free Schools

Donna Behrens, RN, MPH, BSN, Center for Health and Health Care in Schools

Harry Goodman, DMD, MPH, Maryland State Department of Health and Mental Hygiene, Office of Oral Health

Larry Hill, DDS, MPH, American Association for Community Dental Programs

Dana Carr, MPH, US Department of Education, Office of Safe and Drug Free Schools:

The US Dept of Education Integration of School Mental Health program may provide a useful model for states interested in launching an oral health initiative to follow. In the Integration of School Mental Health program, the federal dollars fund states to figure out how they want to address mental health services. What's funded is more of a community process. Started with 18 month grants; has become 24 month grants. It's a different approach.

- Partnership: at ED level, we have little decision-making authority. At state level, more impact. Most impact at superintendent or local level. Get applicant to tell you who the most important decision-makers; involve student voice.
- Policy at state & local levels – licensure, reimbursement, zoning, space.
- From school perspective, develop concrete messaging for school communities (parents, teachers, school administrators etc). Space competition a big issue. Need to have messages about why it matters – oral health & long-term achievement. Why will it not bankrupt the schools. Applicants need to describe how they will do consent, info sharing. Consent for services, info-sharing.

Donna Behrens, RN, MPH, BSN, Center for Health and Health Care in Schools: Donna talked about how in order to be successful in school based health centers, success lie in the ability to have true collaboration versus “parallel play” with the various provider groups (medical, dental, mental health) within the center. Years ago, former Surgeon General Jocelyn Elders cited the cheek-in-tongue definition of collaboration as "an unnatural act between non-consenting adults." She went on to say: "We all say we want to collaborate, but what we really mean is that we want to continue doing things as we have always done them while others change to fit what we are doing."

Each center and schools partnership and collaboration will be unique with no one recipe that insures success. Each school based health center needs to be asking the question of what will be needed to get things done? Some of the partnerships will bring together stakeholders who never imagined collaborating with each other yet when given the opportunity and a shared vision, they are able to find common ground and work well to accomplish that which needs to be done.

The goal will be to achieve true partnerships, and to avoid people engaging in “collabo-babble”. This requires deliberate and formalized relationships that outline what each brings to the mix for achieving the shared vision and mutually compatible goals and how each agency will be accountable and responsible. Some ways to achieve this might be a commitment to hold case conferences to coordinate services for at-risk school children.

Collaboration is a cooperative investment of resources, (time, funding, material) and joint risk-taking, sharing of authority, and benefits for all partners

Some of the things one might look for in true collaborative relationships:

- Clear operational goals
- Regularly scheduled meetings both before and during the funding period
- A broad membership from the beginning of the grant application process
- Involve the (stakeholders) partners in the grant planning process
- Defined roles for each the partner?
- An ability to adapt over the course of the grant to the changing needs and conditions
- An ability to draw on the strengths and contributions of all the partners
- An ability to maintain and sustain momentum over the course of the grant
- Representation from community members, parents and school leadership

Some of the barriers to successful collaboration can include

- Language – how we use jargon unique to ones professional sphere
- How one practices professionally -
- How one is funded
- Professional hierarchies and silos

What are the strategies to be successful?

- Shared vision and goals
- Shared power
- Investment of time to form relationships
- Creating time and space for communication

Harry Goodman, DMD, MPH, Maryland State Department of Health and Mental Hygiene, Office of Oral Health – Harry talked about what he considered the “low hanging fruit” for evaluation of successful oral health programs. He does not feel that completion of a treatment plan is the best measure and cautioned against using that. He felt that too many factors play into why a treatment plan does not get completed. He prefers a system that identifies the higher risk population and doing aggressive prevention programs and measuring the outcomes of the prevention program looking at things such as whether the student got an oral health exam, was fluoride varnish or sealants placed. No matter what is measured, he feels it is time to raise the bar on data collection in oral health and would call for greater clarity of oral health program goals and higher expectations for outcomes.

He recommended with any new program that is started the measures need to include the number of kids who get in to see a dentist whether on site or off school grounds. He feels that another measure should be the elimination of disease and/or completion of a treatment plan if that is part of what is needed to be disease free. Other measures should include caries risk assessment and the number of children who need sealants who actually get them.

Currently, the measures being used in dentistry are all encounter data points or counting the number of kids with sealants. He stressed that these are not “quality” measures. The field current uses information that they normally collect in their data systems but it is not necessarily what should be measured. Harry felt that the Indian Health Services has good measures for access to oral health care. But again, the bigger question is “Are these programs making a difference?” Right now the first measures are access.

His last point that going into this program, the expectations need to be calibrated. The sophistication of the data collection becomes a proxy for the sophistication of the overall program.

Larry Hill, DDS, MPH, American Association for Community Dental Programs – notes unavailable

KEYS TO SUCCESS: Financial and Nonfinancial Support

Panel Presenters:

Larry Hill, DDS, MPH, American Association for Community Dental Programs
Linda Juszczak, DN.Sc, MPH, MS, CPNP, National Assembly on School-Based Health Care
Judi Wallace, Centers for Medicare & Medicaid Services

Larry Hill: notes unavailable

Linda Juszczak, DN.Sc, MPH, MS, CPNP, National Assembly on School Based Health Care: Linda talked about the various opportunities for making investments in SBHCs and in the larger community health center world. The Affordable Care Act (health care reform) includes \$100 million for grants to build or equip SBHC. She pointed out that these funds could be used to build or expand space for dental health services. The amount of the grant funds to be available is \$200 million over 2 years. The eligibility for these new grant funds will not be limited to community health centers only but to those who sponsor SBHCs. Release of the grant notice is delayed because of some discussion within federal government on how the money can be allocated. Additional grant funds from the federal government will be through the Full Service Community Schools Act and those grants can be used for a variety of health services however those interested in applying for oral health support in the schools will have to wait for the 2nd round to apply. Linda also pointed out that at this time, any authorized but un-appropriated funds for programs are uncertain in light of growing concerns about the federal deficit. It is unlikely that new appropriations will be made.

At state level, the situation has been bleak. Despite this, Linda pointed out that SBHCs have managed to survived over the past 2 years but feels in the coming year there may be serious cuts to state funds for SBHCs (maybe up to 25% of state funds could be cut). She feels that it is going to require a huge advocacy effort on the part of each state program to survive in this economy.

Linda feels that local foundations appear to be backing away from SBHCs support. However, she thought that oral health especially when sponsored by the FQHCs are generating revenues sufficient to sustain their oral health and other services in SBHCs as well.

From the national SBHC census, Linda talked about who currently sponsors SBHCs. The data shows that community health centers sponsor 28.4%, hospital/medical center – 24.6%, local health dept – 15.1%, school system 11.9%, private nonprofit organization 8-9%, university including medical & nursing schools 2.8%, mental health agencies – less than 1% tribal government – less than 1 %. She said that California is an exception to the state funding and in that state the counties fund SBHCs.

Judi Wallace, Center for Medicare & Medicaid Services: Judi talked about the use of Medicaid & SBHCs. She said that viable Medicaid reimbursement for school-based health center services could be negotiated. When she was involved in Baltimore County in Maryland, she secured Medicaid support for SBHCs. Since Medicaid does not cover the cost for all students seen in SBHCs, additional support for patient care can be supplemented by grant support.

CMS establishes payment categories that cover what the dentist does or what a dentist will supervise. Dental hygienists, where their license permits them to practice without dental supervision, can be reimbursed. In school-based setting setting, these rules will still apply.

The federal & state combined Medicaid payments for oral health is now up to 5 – 6% of total payments. In 2009 the amount totaled about \$100 billion.

Judi reminded the group that Medicaid remains the payer of last resort. All other insurances must be billed first and all students seen must have a bill generated for their care in order to be in compliance with the Medicaid regulations. She did point out that even if you generate a bill for all students it does not mean that you also need to pursue families for payment.

What are model programs for CMS? They will get listed under a new CMS website, www.insurekidsnow.gov. This site will have information on what will be included in any grant programs or SBHC models. The CMS Division of Reimbursement and State Financing (DRSF) was formed in order to consolidate in one CMS component responsibility for all state Medicaid payment policy and state Medicaid funding issues. A central responsibility of this Division is to ensure consistency in the nationwide application of Medicaid payment and funding policy. The Division now comprises three Teams that are responsible for institutional reimbursement, non-institutional reimbursement, and state funding policy and oversight. It is at state level that services get defined and the reimbursement rates for services vary among the states. CMS is there to help individual projects work through local agencies,

And lastly, all local programs need to be engaged in enrolling students in Medicaid and CHIP.

Day 2

Keys to Success: Evaluation

Panel Presenters:

Anita Chandra, DrPH, RAND Corporation

Denise Davis, DrPH, MPA, Robert Wood Johnson Foundation

Stephen Marshall, DDS, MPH, Columbia University

Julia Graham Lear, PhD, Center for Health and Health Care in Schools

Anita Chandra, DrPH, RAND Corporation: Anita talked about what are the questions to be considered in evaluating pilot programs. She made the following points around readiness for evaluation:

- Programs need to have a clear understanding of the population it will serve and defining the denominator (population) is essential.
- It is important to develop a logic models and pay attention to it when developing an evaluation of the pilot.
- It is important to know who will be served by the project.
- Take into consideration the realities of the staff mix and the likelihood of turnover
- Know what are the process outcomes as well as the short-term and long-term outcomes one wants to accomplish

Other things to be considered in developing an evaluation plan include: are there already services being provided? Is there some existing on-going service delivered by school nurses that you will be building on? Does the project have buy-in among school staff, school nurses?

Anita talked about setting expectations for evaluation. Some of the questions she thinks are important to be asking ahead of time include:

- What can be reasonably expected?
- What are your metrics?
- How many students getting services?

She talked about the importance of outcomes and pointed out that the long-term outcomes are the hard ones and are harder to track. Anita recommended looking first at what you can get in the first 6 months to 2 years. Some outcome areas to consider include things like are patterns of behavior being changed for staff & students; are attitudes towards oral health care changed? Has program seeped into climate of school and do more kids show up for oral health care over time.

In planning for evaluation, Anita recommends that one ask – what’s do-able and what’s excessively cumbersome to measure or collect. Are there modes of data collection that are less burdensome? Can you get data from only one or 2 sources? Who is getting trained to collect data? What is the centralized process by which data are collated & given back and how do you ensure the quality? Anita suggested that one can get the most from evaluation if you ask yourself the following questions:

- Are you generating data that you can use?

- How will you document lessons learned?
- What are the core components of program?
- What are 3 -5 indicators that would capture success or not?
- How do you measure stakeholder buy-in and sustainability?
- Are there templates or tools?
- What are the common questions and common ways to track lessons learned
- Tools that are intuitive and self-explanatory.

Denise Davis, DrPH, MPA, Robert Wood Johnson Foundation: Denise talked about how RWJF has funded dental projects over past 35 years and most recently the focus of grants has been on prevention, training of providers, and exploration of the dental therapist model of care in oral health programs. Several seminal reports have guided RWJF in their decisions around grant funding and includes “Oral Health in America: A Report of the Surgeon General” released in May 2000, “Dental Education at the Crossroads: Challenges and Changes” Released in January 1995 and “A National Call to Action to Promote Oral Health” released in May 2003.

Most recently, much discussion at the foundation has been around health care reform as it has taken shape. They have been exploring the links between models of service delivery and health care workforce. RWJF has also been exploring inter-professional training and how primary care providers affect access to oral health care. There is much interest in what might be changed in health care delivery if one varies the provider mix within the system. RWJF feels that training the workforce is essential to improving access and improving quality. Inter-professional training is essential to systems improvements and policy changes that will sustain long-term impact. RWJF efforts have been focused on understanding what works and what are the right combination of factors. In funding oral health providers, RWJF has asked:

- What kind of training might enhance provider capacity to contribute to oral health access & outcomes?
- What trainings are providers already getting & where are the gaps?
- How do we ensure that participants in new service models have “skin in the game” to motivate performance

Denise said that RWJF has learned many lessons from previous investments. One important lesson is that there must be the capacity in a multi site program, to be able to gather and analyze data across the various grantees organizations. RWJF has used field evaluators that can oversee multi-site programs and assess performance across the various programs. RWJF also ensures that the outcome measures identified can be tracked over time and believes in the use of qualitative measures as well as quantitative. Lastly, RWJF feels that the provision of technical assistance during the life of programs is essential. RWJF invests in continuous learning through the use of CQI process.

Stephen Marshall, DDS, MPH, Columbia University. Columbia started planning the Community DentCare program in 1994-1995 with a grant from the W. K. Kellogg Foundation and began providing services in 1996. Today the program operates in 7 school buildings that serve a total of 10 schools. Four of the sites are comprehensive and include a

full range of dental services in 2-chair operatories. The other 3 sites provide prevention and sealant programs. Last year the combined visits totaled 17,000 and the operating budget was \$2 million.

The experience with evaluation is “what gets measured gets done”. They found that it is important to define the data you want to collect upfront and that the evaluation should match what the program goals are i.e. access programs should have access measures. Program goals and evaluation goals may be different in start up phase. Project development occurs in “blocks” of time. Establish goals for each block within the timetable. Implementation should have a start 6 months from the start of the program. Once a program achieved a “steady state” of operation, there will be specific goals and measures such as follow up care delivered within a specific period of time.

Stephen’s recommendation was to keep the evaluation simple. He does not recommend investing or budgeting for a lot of money and time for evaluation in first year. After the first year, know what you want to do and make evaluation part of program but pick a small number of important goals to measure and then be realistic.

Participant Discussion:

Adria Cruz from the Children’s Aid Society said that they had one important rule in the organization: One child, one chart.

At Columbia, they had two separate service entities each with their established separate charts and they couldn’t dislodge the practice.

Linda Juszczak described her experience as a nurse practitioner in a school based health center in New York. She said that in one center the primary care providers were not automatically referring the students for oral health care even though it was part of the center services. She felt it was important to train the providers in linking with oral health services.

Other points made were that it is hard to get data from the sponsor organization’s high volume clinic when the programs have multiple reporting requirements. These include their institution, other outside funders, and the state. It was recommended that whatever MCHB designs for its new initiative, to fit their reporting requirements into the reporting requirements that already exist.

A point was made that most SBHCs do not have combine medical records. There is a movement towards trying to collaborate more around sharing information. One person felt that the best way was to develop a registry of patients for medical and dental and share registry across programs. This facilitates tracking of patients as well as population outcomes. Moving forward, there is hope that new technology to bridge the different registry platforms is due out imminently.

Overall, with evaluations, the important thing to keep in mind is ultimately, what is the outcome that we are trying to achieve? And also to keep in mind whether it is this about individual patient outcomes or project outcomes.

Quality measures remain important and will be a challenge for project. While there is a CQI tool for SBHCs, it does not include an oral health measure. There will be a need to develop/identify measures that may be adapted for SBHC-sponsored oral health programs. The participants engaged in a lively debate about what constituted a useful measure of cost-effective, improved-access care. One participant noted that “treatment plan completed” (TPC) as a measure is a proxy for saying that the patient is in a healthy oral health state. The measure deals with quality as well as access.” Another participant found TPC to be “problematic” as a measure of success. TPC targets those kids who are most diseased and partner with doctors to address serious problems. To use this as the measure means you must find the most serious problems. Additionally, it was argued, there are so many factors that impact TPC that it is a set up for failure. This includes issues around historically transient populations where children move from school to school as their families move and may leave before their next appointment. In New York, the quality measure is whether the child had a dental visit during the year.

A participant underscored the importance of an outcome measure. “Looking at outcomes as a specific measure (TPC) is important to make sure we do things differently. Yes, this will be hard but we need to build on prevention as foundation but we want to eliminate disease.” Another participant wrapped up the conversation with the following comment “When we raise bar, we can achieve a lot more.

Suggested measures from the group included:

- Percent of children who have never seen dentist (that resonates well with state & foundation)
- Data on those who haven’t seen dentist in past year.
- Children who haven’t had a dental plan completed
- Number of students with caries-risk assessment
 - % of children who need sealants who get sealants.
 - Number of kids enrolled in CHIP/MEDCAID programs receiving service

Some additional points were made on data collection. These included: The Indian health service has good oral health measures. That it is important to include trend data as well. To be cautious about high expectations from data collection yet recognize it is important to collect. Having data can reflect modest but real improvements so one would want data to demonstrate improvement over time. When you are piloting, you want to give yourself credit for identifying data that helps show what has been done to change systems especially when you are testing a model of care and its relationship to changing outcomes.

Mark Nehring: Mark talked about the need to do something that’s simple—that gets at the low-hanging fruit initially in the project and be careful not to be asking for more detail than we need. He felt that everyone is assuming there are one or more data elements that are going to be key indicators.

- A possibility -- what about survey monkeys to gauge teacher, staff, administration opinions.
- Technical assistance – we are planning to include some entity to provide TA

Key points from discussion

1. DATA MANAGEMENT. This will be essential to have grantees demonstrate their capacity to collect data. An important component of this criterion: To what extent does the SBHC's involvement in a sponsoring organization's data management system make it difficult to pull out data elements relevant to school-based oral health?

2. FROM AN EVALUATION PERSPECTIVE, what do you do about a missing denominator, e.g. changing student base, -- it will make it very difficult to calculate an impact using student body as the unit of analysis since mobility rates are high and the student group turns over in the course of an academic year.

3. QUALITY IMPROVEMENT. Currently, the CQI tool used for SBHCs does not include indicators for oral health. This can be developed but then it would not have been tested in SBHCs before the grants are in place.

3. PRACTICE MANAGEMENT -- SBHCs & managing diverse health services: There can often be a culture clash between medical & dental service delivery in school based health centers. The successful blending of medical/mental health services with oral health care requires some hard thinking and planning up front about how to make it work.

3. SBHC CULTURE – Typically SBHCs don't have community based medical partnerships. There is a sponsoring organization for the school based health center that establishes policies, procedures for the center itself. From that point on, the SBHC tends to operate independently of other community institutions providing care.

4. PARTNERSHIPS FOR PROGRAM & POLICY as well as for practice. The importance of partnerships to establish a school-based oral health program was discussed as well as the importance of engaging other kinds of organizations. To support pilot projects and move them from being demonstrations to being the mainstream, SBHCs will also need to develop politically attuned collaborations.

5. BILLING. The discussion highlighted the need to include the oral health billing component into the project from the very beginning. Currently and on average, State Medicaid is currently paying about 50% of the usual and customary fees. However, in Massachusetts, they are paying a very high rates. This is not the national norm and most states haven't done this.

6. POLICY IMPLICATION & OPPORTUNITIES

The impact of health care reform theoretically will lead to increased eligibility and enrollment for many currently uninsured children. More insured children using services should allow for higher reimbursement for care and allow the school based oral health program to also focus prevention as well as treatment.

One must be sure and look at the impact of Medicaid managed care enrollment and the rates of reimbursement for oral health care in a managed care system are very low and will

limit impact of health care reform because providers will not take care of newly covered children.

And finally, workforce issues could potentially be a problem in the era of health care reform. Will there be enough providers to care for the newly enrolled and eligible population?

The MCHB guidance needs to secure as much information as possible from prospective grantees that will enable the Bureau to assess the capacity of the applicant to design and implement a viable program AND recognize the external factors – policies and funding opportunities – that will facilitate or impede successful negotiation of a difficult terrain.