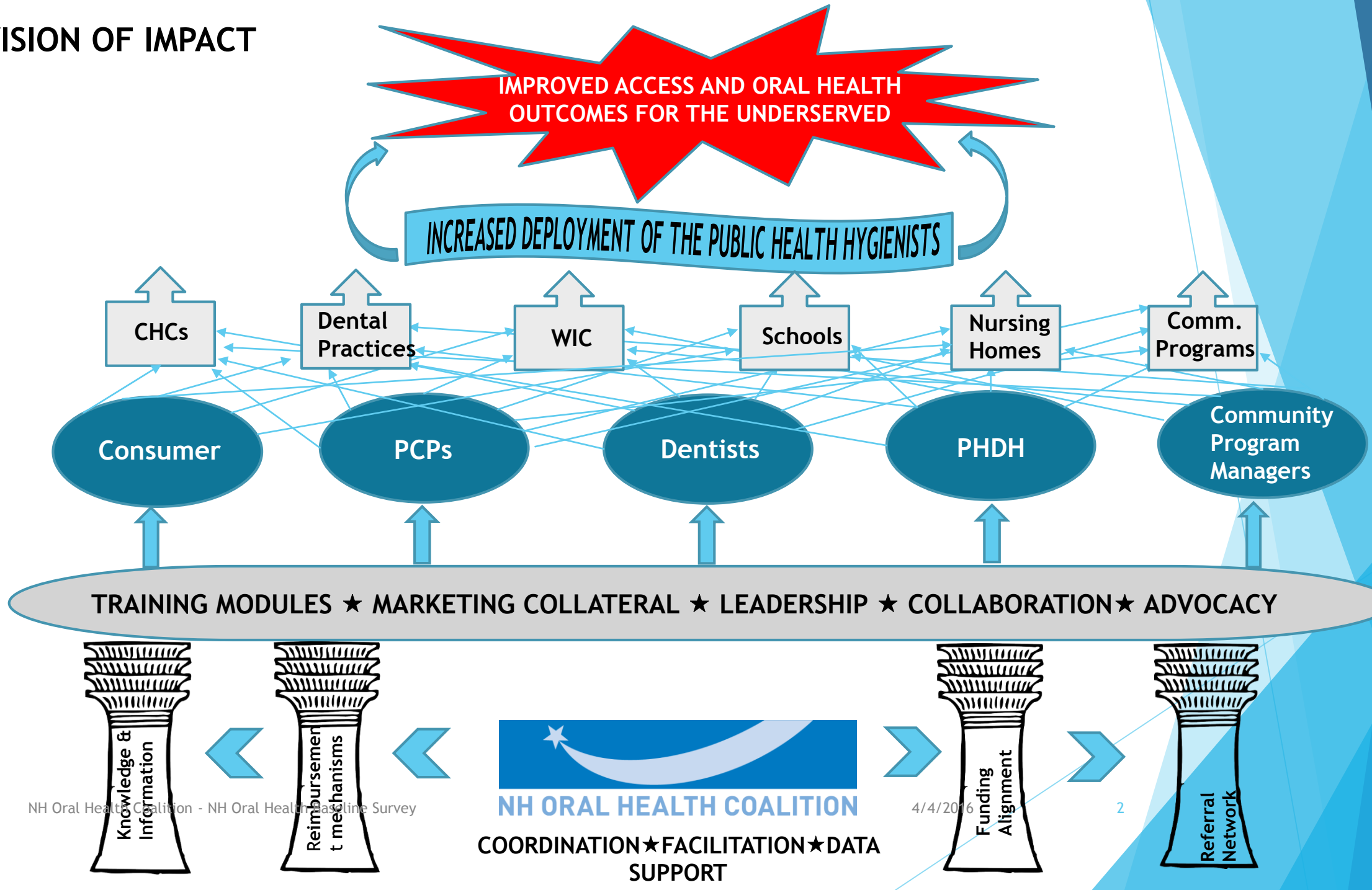
Establishing the Base: Identifying NH's Non-Traditional Oral Health Settings

March 29, 2016

New Hampshire Oral Health Coalition

VISION OF IMPACT



Establishing the Base

- What types of community-based, nontraditional types of programs do we have?
- Where are they?
- Who do they serve?
- What types of services do they provide?
- What are the gaps either geographically, categorically or in service?
- How is the program paid for? Services, supplies, labor, etc.

NH Statewide Baseline Survey of Nontraditional, Community-based Oral Health Programs

- Purpose and Goals
  - Develop a *single statewide* database of community-based oral health services;
  - *Identify gaps* in preventive oral health service;
  - Acquire an *understanding of the reimbursement and funding* patterns that support *efficient and effective* use of resources;
  - Illuminate *"best practices"* in community-based oral health programs;
  - Define the numbers and related *training needs* of the oral health prevention workforce;
  - *Create metrics for improvement* in service and economic efficiencies; and
  - *Consolidate the data gathered* for use in local, regional and statewide program and policy planning; and informing the 2015 NH Oral Health Plan 2015 Update and the Pathways – Oral Health Study Commission.

Process

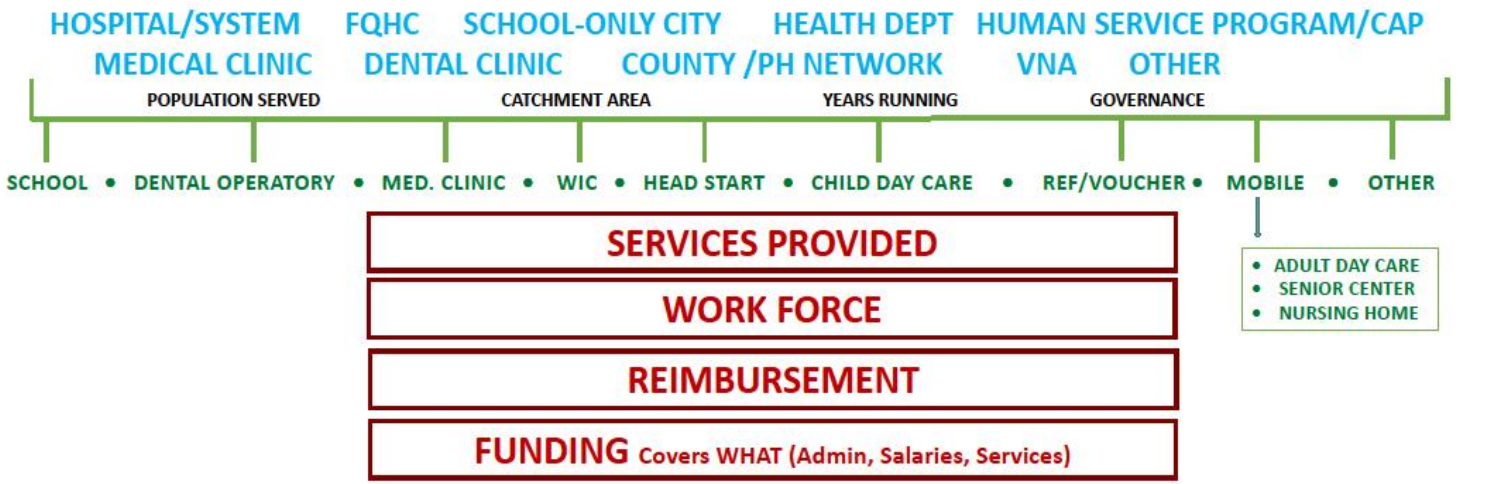

Baseline Survey Data
Analyze to Best Practice Criteria
Program and Workforce Models

Setting the Standard: The Association of State and Territorial Dental Directors Criteria for Evaluation

- (1) Impact and Effectiveness – e.g. specific measures and surveillance, #'s served, # services, reduction in disease, new policies, new programs, etc.
- (2) Efficiency – e.g. cost/benefit, reduction in delayed care, right place – right time, leverage of resources, "service piggy-backing," using reimbursement to when available to expand grants/funding, etc.
- (3) Demonstrated Sustainability – e.g. public and private reimbursement mechanisms versus limited grant funding, service or funding incorporated into the state health budget, length of time in operation, etc.
- (4) Collaboration and Integration – e.g. partnerships, leveraged resources, co-location, "piggy-backing" services, formal operating agreements, etc.
- (5) Objectives and Rationale – e.g. needs identified and verified through surveillance and research, policy, regulatory, and practice authorities understand and support development and services, supported by local and national organizations, and recognized authorities, e.g. Healthy People 2020, etc.
- (6) Extent of use within the Nation and the State

"A national non-profit organization representing the directors and staff of state public health oral health agencies using proven and promising practices.

BASELINE SURVEY STRUCTURE



Baseline Metrics	Service Gaps/Maps	Funding Models	Workforce (PHDH)	Resources 211	Best Practices

HNH FOUNDATION
Healthy Kids. Healthy Places.

ORAL HEALTH 2014

Key Point

Umbrella entity may do one or more types of oral health service (programs)-

Greater Derry Oral Health Collaborative
- School-based - 2 different models that results in 2 interviews

Lilac City Pediatrics
- Fluoride varnish applied by the medical provider – 1 interview

Families First Health and Support Center
- Dental operatory,
- Primary care medical,
- School-based programs,
- Nursing homes, and
- Child care program – resulting in 5 or more interviews.

How many entities? How many programs? How many sites?

Preliminary Model Frames

- Federally-qualified Health Centers with and without dental operatories
- School-based and school-linked programs, WIC and Head Start
- Nursing homes and seniors, portable contract services
- Medical offices; and medical offices plus hygienist

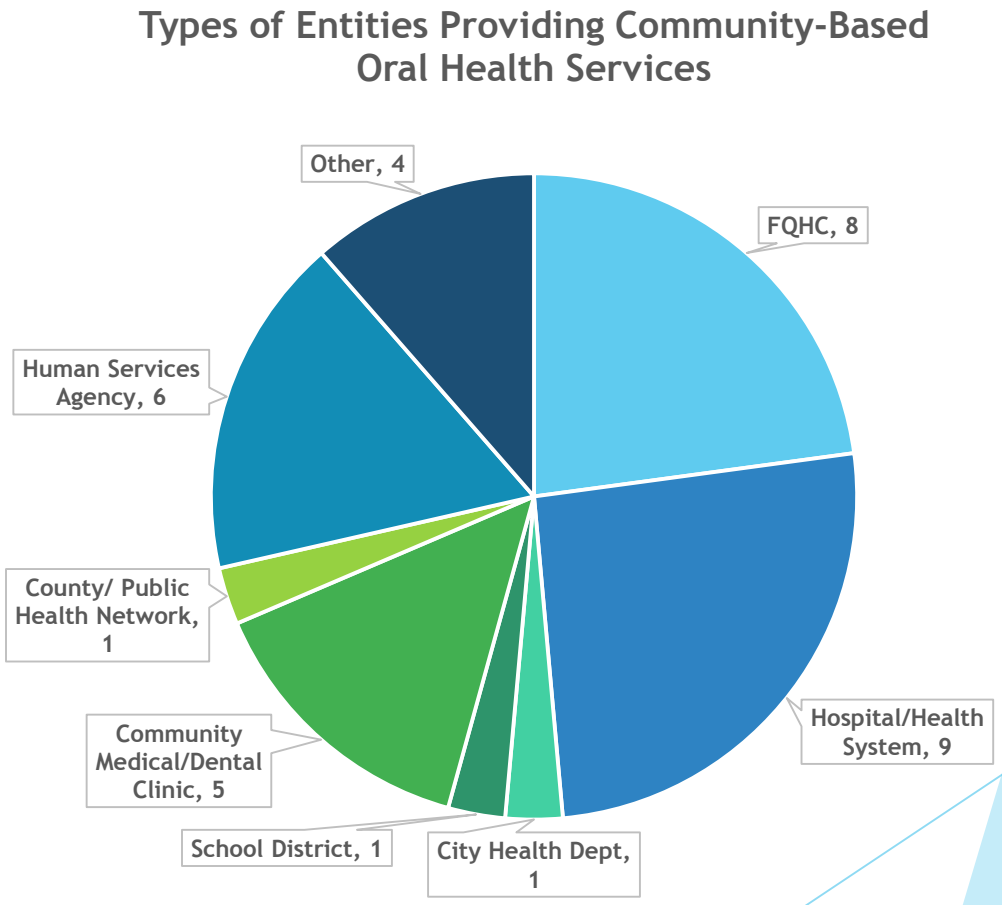
Status of Survey and Analysis

Identified and interviewed

- 60 “umbrella entities,” e.g. health systems/hospitals, FQHCs, human service agencies, primary care medical practices, etc. offering 1 or more community-based OH program(s).
- 161 primary care medical sites including the primary care medical sites, Federally-qualified health centers, and clinics. Range from free-standing offices to full health systems, e.g. Dartmouth.
- Currently doing final accuracy checks and preliminary analysis.

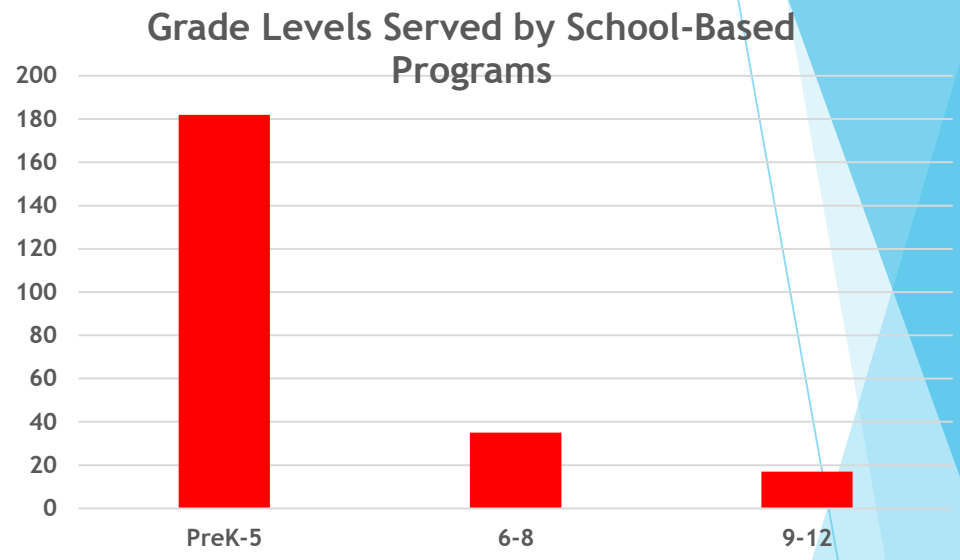
Cutting the Data

- 35 of the entities provide OH services in 68 programs e.g. nursing homes, school-based programs, mobile vans etc.
- By far, the most services are provided in schools and dental operatories**.
- ** For the purpose of this study and report: One operatory is a single/or multi-chair set-up with a dentist-based model.



Who is Being Seen in School

- Range from pre-K to grade 12
- As expected, vast majority cover Pre-K to grade 5
- Middle school approximately 14%
- High School, very limited
- Tops on the wish list – "go to the next grade level". Need additional staff, funding, space.
- Research Idea?: Examine against "Reduced and Free Lunch"



- Head Start (7), WIC (5) and Child Care (1) Programs are closely aligned with School Programs in terms of services provided and funding sources.

Who is Providing Service in Schools

Entity Type	# School Programs
FQHC	5
Hospital/Health System	5
City Heatlh Dept	1
School District	1
Community Medical/Dental Clinic	2
County/ Public Health Network	1
Human Services Agency	4
Other	1

Services Provided in Schools

- Range from education only to comprehensive services
- Most are "portable"
- Students identified as in need of care during screenings can receive services in school, on mobile vans, at community clinics…
- Services provided by 50% or more of programs:

Visual Screen
Hands on Hygienist exam
Prophy
Fluoride Varnish
Sealants K-8
Referral for Care
Referral to Dental Home

School-based: How is it funded?

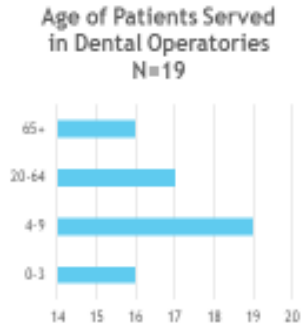
School Based Oral Health Programs Revenue Sources	# Entities	Avg % Revenue	% Range
NH DPHS	10	40.9	10-90
Federal Grants	3	51.6	40-75
Private Foundation/Philanthropy	11	38	1-99
Commercial Insurance	3	4.7	2-10
Medicaid/CHIP	16	17.6	3-60
Self Pay/Sliding Fee	6	2	1-5
Contracts	1	15	n/a
Local/Civic Funding	8	21.7	1-90
Other	13	38.2	1-100

20 school programs:

- 15 bill Medicaid:
- 9 using a Dental Provider Number
- 6 using a CHAP Provider Number
- 4 do not bill Medicaid
- Average Program Revenue from Medicaid = 17.2%

In Comparison: Dental Operatories** in nontraditional sites or models

** For the purpose of this study and report: One operatory is a single/or multi-chair set-up with a dentist-based model.

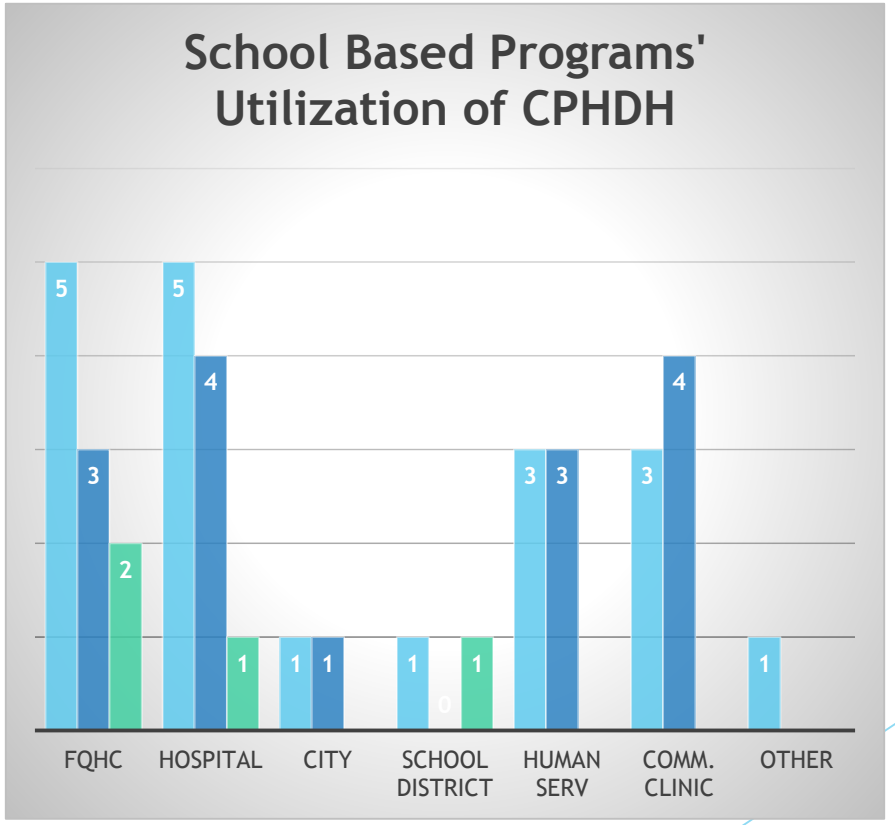


Community Based Dental Operatories Revenue Source	# Entities	Avg % Revenue	% Range
NH DPHS	9	7.4	2-17
Federal Grant	4	28.5	5-94
Philanthropy	9	2.5	1-5
Commercial Insurance	10	18.4	5-40
Medicaid/CHIP	15	29.4	1-92
Self-pay/sliding scale	14	17.8	1-42
Contract	3	14.6	1-43
Local/civic funding	6	12	1-58
Other	9	45.3	3-100

NH Oral Health Coalition - NH Oral Health Baseline Survey 3/28/2016 17

Focusing Down

- NH Board of Dentistry identifies 24 Certified Public Health Hygienists
- RSA 317-A:21
  - 16 C-PHDH identified in *school-based settings*
  - 4 additional in training/process for certification
  - Of the 16 identified, several work in additional settings; e.g. a dental office, non-school program, etc.



Emerging Observations to be Tested

Workforce Allocation – see below for example

Funding Practices and Sustainability

Hygienist heavy models

- School-Based Programs
- Head Start
- WIC
- Child Care
- Mobile

Dentist heavy models

- Hospital-Based Operatories
- Community-Based Clinics
- Nursing Homes
- Contract Services

Medical Settings – Introducing Oral Health Services

- Purpose: To identify a baseline count of the number of medical settings providing fluoride varnish application to children.
- Who was included?
  - FQHCs
  - Health systems such as Dartmouth, Elliot, Catholic Medical Centers, Littleton Regional, etc.
  - Private, free-standing offices
  - Etc.
- How many contacted? Interviewed?
- What is happening?
  - Identified 161 offices statewide providing primary care to children
  - Queried if provided fluoride varnish and related oral health services
    - If Yes, define further.
    - If No, why not?

Findings

- Of the 161 sites queried, only 9 (approx. 5%) reported providing fluoride varnish
  - 2 sites in a single town under a large health care system
  - 5 sites under one FQHC
  - 1 site under a second FQHC
  - 1 site in a hospital setting

"Truly defined the baseline at near 0"

WHY NOT?

- Two most common reasons
  - "Had no policy or procedure in place"
  - "Did not know this service was available in the medical setting care"

OPPORTUNITY

- In 2015 NH readiness changed
  - Advancement of the Affordable Care Act and the recommendations from the USPSTF;
  - In-state changes allowing reimbursement for fluoride varnish in medical settings by NH Medicaid; and
  - The availability of "From the First Tooth" project through Hugh Silk, MD; provided funding to train 10 medical offices – 150+ to go...

Next Steps

Sharing and Applying the Baseline Data

- Complete analysis with NE Survey Services and the UNH Survey Center;
- Review and Revise with the Baseline Advisory Team;
- Prepare print and online links to the data for providers, program planners, policy-makers and the public;
- Develop workforce models; and
- Bring the information to targeted groups to begin to apply the data and the best practice modeling.

Peer Training on “From the First Tooth”: 5 sites in process.