

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

And now without further ado I'd like to hand the call over to your moderator for today's presentation, Rosemary Feild. Rosemary, you have the floor.

Thank you. Welcome to the seventh joint CMS and Medicaid and CHIP Dental Association, or MSDA, Oral Health Learning Lab. The topic of this webinar is State Medicaid and CHIP Program Support of Sustainable Oral Healthcare Delivery Models in Schools and Community-Based Settings. This webinar is being recorded and will be posted to medicaid.gov on the Dental Care page, I would say probably within the next month.

Next slide.

The learning objectives for this webinar are to understand, through examples from school and community-based dental providers, how to develop a business plan that supports the delivery of school and community-based oral healthcare services, how billing practices for school and community-based and school-linked dental programs may support dental services for disadvantaged children, and how two states have developed successful school and community-based dental services programs.

Next slide, please.

So these oral health learning labs are intended to support states in achieving the goals of the Children's Oral Health Initiative, which focuses on prevention. The first goal is to increase by ten percentage points by federal Fiscal Year 2015 the proportion of enrolled children who receive a preventive dental service. This includes cleanings, sealants and fluoride treatments as well as any other service billed using a code in the preventive category of the CDT. It does not include trainings or exams. To count in this category, the service must be performed by a dentist or by a dental professional working under the supervision of a dentist. We'll get into more detail in a moment about what these parameters mean.

The baseline for the preventive dental services goal was set in Fiscal Year 2011 at 42% nationally. The national goal is 52%. Each state, though, has its own baseline percentage and goal as well.

The second goal focuses specifically on sealants. We seek to increase by ten percentage points the percentage of children in the six-to-nine-year-old age group receiving sealant on a permanent molar. We do not yet set the baselines or goals for this goal but are close to doing so. For this goal, all sealants on permanent molars in this age group will be counted toward the goal regardless of who provides them.

Next slide, please.

So, on this slide you see that we have identified our faculty that is going to share with us the model of delivering dental services. I will introduce each of these individuals in advance of their speaking. I would ask you just to please remember that you want to type any questions for our speakers into the Q&A box. And it would help us if you would let us know if you want to direct a question to any particular speaker.

Now I would like to introduce Martha Dellapenna. Martha, or as we affectionately call Marty, is currently the Director for the MSDA Center for Quality, Policy and Financing. Marty provides oversight to projects and activities within each of the five center divisions, which are geared toward best practice projects: Research, and Evaluation, Professional Development, Quality in Data, and Policy Efforts that focus on improving state Medicaid and CHIP all health programs.

Marty also chairs the CMS Oral Health Technical Advisory Committee. Marty is a registered dental hygienist who, for almost nine years, served as the Oral Health Program Manager for the Rhode Island Executive Office of Health and Human Services, which houses the Medicaid program. Marty has a Master's in Education degree.

And with that, Marty, are you ready for us?

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

I am ready.

Thank you.

Thanks, Rosemary, and hello everybody. Before we hear from our state and our community-based speakers today, my role on the Learning Lab is to provide some background information and to offer a national perspective around Medicaid and CHIP-recorded school and community-based service delivery.

So we can start with the first slide. Of course, I think a good place to start, really, is at the beginning, and what I'd like to do is first identify two problems. First of all, around access. In federal Fiscal 2011, in the U.S., 44% of Medicaid-enrolled children received preventative dental visits. Only 24% of Medicaid-enrolled children in that same time frame received a dental treatment service despite great strides in improving children's access to quality dental care in the U.S., these access numbers do reflect a great disparity for children covered by publicly-funded programs versus those children who are covered by private dental insurance.

We can look at our next slide.

There are many and very complex factors that contribute to the limited access issue in our country. Some of them include the limited access to providers that participate in Medicaid and CHIP. And then even difficulty finding ones who do, or locating ones who do. Access to convenient service delivery locations or sites for parents and their children. Parents and caretakers who are really unable to take time out of work for dental appointments. And even cost sharing that may exist in some CHIP programs, and that is co-pays or co-insurance, or even premiums.

Other factors, and there are numerous, that could contribute to limited access, things like transportation, language barriers, dental treatment phobias or anxieties that people may have whether it's parents or children. And many folks may think that they don't need to go to the dentist. Perhaps oral health is just not a priority for them. This is certainly not an all-inclusive list, but it does highlight some of the key reasons that accessing regular dental care may not occur for children covered by Medicaid and CHIP.

Next slide.

A solution to the limited access, and why we're here today, is the dental care service delivery models in school and community-based programs. So we bring dental services in school settings. It's really an opportunity to serve vulnerable populations that are less likely to receive private dental care, such as children that are eligible for school reduced or free lunch program and the like. They are a variation of school-based programs that are really designed to deliver these services. Keep in mind that these programs really can vary around the country, and we'll hear a little bit about how that occurs.

To review a few of the definitions that are really key to our program today, let's look at school-based programs, the meaning of that. School-based programs are conducted completely in schools or school settings. School linked programs are connected with schools in some manner but deliver the services at a site other than a school. And then community-based programs really incorporate school-based and school-linked models but take place within the community, such as a WIC program or Head Start or an Early Head Start program. Or perhaps even a community social services organization. Those are the types of sites. And I think it's important to cite here that these programs are generally billed to Medicaid and CHIP programs through generally federally-qualified health centers or other community organizations with which they may be affiliated. These programs we'll learn about today are really models that exist outside the traditional SQHD-affiliated model.

Next slide.

There are multiple dental service delivery models that exist within the range of school- and community-based dental programs, and really, the range of them are from very limited to rather comprehensive. So if

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

we look at dental screening and oral health education, they are a very limited-scope type of a service delivery model.

When we look at dental prevention services models, they're less limited but they are still, nonetheless, limited to preventive dental care. When we look at a dental home model, this is a model that's comprehensive in scope, and it's really designed to be a continuous source of care for children and meet the definition of the dental home as defined by the American Academy of Pediatric Dentistry. The dental services that can be provided in a comprehensive dental home model are things like diagnostic services, which are exams and x-rays, preventative services, like (inaudible) and fluoride treatments and sealants. Restorative services, kind of a Level One category which are simple fillings. Oral health education for parents and children. And then any referrals to specialty services when necessary. The dental home model is really the model that's encouraged because it's (inaudible) to meet the complete needs of the child.

Next slide.

In addition to all of this, Medicaid and CHIP policies across the state support school- and community-based services. In 2013, MRSA surveyed Medicaid and CHIP dental programs across the country. And the next few slides will highlight the specific policies that relate to school- and community-based services. This is a screenshot of our home page for the web-based state profiles.

Next slide.

So to look at our first graph, in 2013, among state and Medicaid programs, we find that almost 61% do accept billing and reimburse for dental services in school-based programs or venues while only about 24% do not. And about 16% indicated neither yes or no. So that's what we're seeing here in these cases of a tie. This result showed that the majority of the Medicaid programs in our country currently do have a mechanism in place to support school-based programs.

Next slide.

In this graph we see about 41% of state Medicaid and CHIP programs report they do not have payment limitations on reimbursements to school-based programs. And, again, this is 2013 data. Thirty-one percent of the programs report they do have some kind of payment limitation, but in most cases this limitation does correspond to the usual or the standard dental service frequency limitations that apply to any actually any service, any dental service, regardless of where it's actually delivered in your state.

This shows that the majority of states really do have an open door for the delivery of dental services in school-based settings.

Next slide.

Here we see that a percentage of state Medicaid programs that reimburse for dental services rendered by first, dentists, in the first bar, by hygienists in the second bar, and then by other types of healthcare workers or healthcare providers in school-based programs, particularly, again, 2013 data. So the majority of states, it's about 72.6%, reimburse for services provided by a dentist, 43% by hygienists. Now these might be services that are still billed by the dentist but the services are actually being rendered by the hygienist in a school-based setting, so keep that in mind. And then about 17.6 – almost 18% of states that may reimburse for other types of providers in school-based settings as well. And keep in mind as well, states did have the option of checking off more than one provider in each of these categories being that they might exist as such in their state.

Next slide.

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

Now let's look at a simple program, Medicaid dental program, to reimburse for dental services provided in community-based settings that aren't necessarily taking place in schools. So this graph shows that 80% of Medicaid dental programs do allow for reimbursement for dental services provided by mobile dental units. And by mobile units, meaning van or the like where patients are treated in a place where equipment is already outfitted, and that equipment and that venue moves from location to location.

Next slide.

And finally, the same percentage, or 80%, of state Medicaid programs do reimburse for dental services provided by portable dental units. And by portable dental units we mean a system of (inaudible) that are set up in various locations where patients either live or where they would regularly be found. It might be a nursing home, it might be a community-based center, etc. So from a state Medicaid program perspective we can see that policies that support the existence of school-based and school-leads and community-based dental service delivery and venues as such are in place nationwide.

Next slide.

And lastly, looking at that second problem I mentioned in the beginning, although the Medicaid and CHIP policies exist, and community- and school-based clinics really have demonstrated success in reaching these vulnerable populations, Medicaid and CHIP programs do have (inaudible). I mean, it's an ongoing sustainability issue. And the (inaudible) are due to potential funding that's limited for supporting startup, ongoing management, or perhaps even sustainability, ongoing sustainability.

So traditionally these programs in states have been limited to seed money or startup money only. Grants from philanthropic organizations or perhaps the Center for Disease Control, or the state or local health departments, can't really support the continuous stream of funding necessary to keep these sites up and running long term. So as a result, these sites have had to establish a business model, if you will, to consider all of their annual operating expenses and incorporate them into a sustainability plan. However, many of them really lack the experience in developing a business protocol, and some of failed.

Well, the purpose of today's learning lab is to showcase a couple of programs that have gone through this experience and have learned how to establish an effective business model and sustaining their own program. Keep in mind, however, that sustainability is demonstrated by the providing organization. For example, some need to have their business model to reflect an income-expense ratio of zero, where one washes out the other. However, some can afford to modify their business plan as a result of available in-kind funds, perhaps, or other available resources.

So I'm going to stop here, and I'm hoping that this was information that really helped to set the stage for our state and our program speakers today. And at this point, keeping all of this information in mind, I'm going to turn it back over to Rosemary Feild from CMS.

Thank you very much, Marty. And just a reminder to our audience that if you have questions, please type them into the Q&A box to your right.

And now I'm going to introduce Jolene Perkins. Jolene is the Manager of the Future Smiles Dental Clinic at Wakefield Elementary School in Little Rock, Arkansas. She was instrumental in the planning phases of opening the first elementary school-based dental clinic in Arkansas and has run the day-to-day operations of the clinic since it's opening in 2005. Jolene?

Hi. Good afternoon. As Rosemary said, my name is Jolene Perkins, and I'd like to share the story of the Future Smiles Dental Clinic, a school-based dental clinic.

Next slide.

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

Since 1994, Children International and the University of Arkansas at Little Rock have been working in partnership to provide health and dental care, educational support, and family assistance to help empower children and families in their efforts to break through the barriers of poverty. Children International is a child sponsorship organization based in Kansas City, Missouri. The Children International mission is to bring lasting change to children living in poverty by providing them with the opportunity to grow up healthy, educated, and self-reliant while improving their communities.

Wakefield Elementary School, located in the heart of southwest Little Rock, has been a partner school with UALR Children International since the beginning of the UALR and Children International partnership. It was the site of an after-school program and school-based dental screening and sealant program. The school, originally built in 1959, was destroyed by fire in 2002. A newly-rebuilt school opened in 2004. With approval from Little Rock School District, during the remodeling of the school, one classroom was constructed specifically for a dental clinic. There are currently 601 students attending school at Wakefield. 66.4% are African-American, 33% are Hispanic. 97.9% of our kids are on free or reduced lunch.

After some initial stopping challenges, UALR Children International opened the clinic in 2005 as the first elementary school-based dental clinic in the state of Arkansas. At the time the clinic opened, there were very few dental providers accepting Medicaid patients. After doing dental screenings and a sealant project in schools for several years, it was very apparent that the 30% to 40% of children screen who were referred for dental care were not getting the needed dental treatment.

Next slide.

Future Smiles is a state-of-the-art facility with three patient chairs. We use Eaglesoft dental software, which is the same as what is used in many private dental offices for scheduling and billing. We also use the Scanex digital imaging system. Our patients do consider us their dental home.

Each school year we begin by doing a screening project. This is how we prioritize patients as well as assess our outcomes from the previous year. We are also present at the schools during school registration with information for families about the clinic and oral health.

Next slide.

The clinic is minimally staffed by myself, as the Clinic Manager, and one dental assistant. I am employed by the University of Arkansas at Little Rock and Children International. Through a contract with Arkansas Children's Hospital, the dentist works in the clinic three days a week.

The clinic also serves as a rotation site for senior and junior dental hygiene students from the University of Arkansas for Medical Sciences, which allows us to provide preventive services without having the cost of a dental hygienist. Future Smiles is open from 8:00 to 4:00 three days a week from August to June each year. This is the school year plus one month of summer camp which is held at the school.

Children who attend Wakefield are pulled out of the class for their appointment and then returned to class. The clinic is closed in July when there is no direct access to children. During our closure, the dentist is available for emergencies at Arkansas Children's Hospital.

We serve children in the Little Rock School District who are on Medicaid or have no dental insurance and do not have a current dental home. About 71% of our patients have Medicaid, and the remaining 29% have no dental insurance. Transportation is provided from four other elementary schools one day each week.

Next slide.

Future Smiles is only successful because of a group of organizations who come together to promote oral health in central Arkansas. We call this group the Dental Health Action Team. These organizations began

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

working together in 1999 and were instrumental in the planning and opening of the clinic. The mission of the Dental Health Action Team is to work together to improve oral health outcomes and reduce disparities among children. Originally this group met monthly, but we are now established and find it necessary to meet formally only twice a year. However, we are in constant contact throughout the year by other methods. UALR Children International coordinates the coalition and the daily operations of the clinic, but each member contributes to planning, evaluation, and the overall success.

Next slide.

Our motto is quite unique and utilizes the strength of each partner on the Dental Health Action Team. It's really important to note the role each member plays. Little Rock School District provides the space, utilities, custodial services and Medicaid biller. As I said before, we're a rotation site for the University of Arkansas Medical Sciences Dental Hygiene students, and the hygiene students rotate through our clinic during three rotations each year for a total of 35 weeks.

Arkansas Department of Human Services Medicaid provides support through funding. The Heart of Arkansas United Way designated \$150,000.00 in seed money to launch the opening of the clinic in 2004 and includes the clinic in its annual campaign as a specific designation.

The Arkansas Department of Health has supported the clinic throughout the years with funding and data analysis. Delta Dental of Arkansas has provided over \$80,000.00 in grant funding throughout the past ten years in support of the clinic. Pulaski Technical College has a dental assisting program, and their students do a 4A varnish program and provide oral hygiene instruction to children in the Little Rock School District who did not attend Wakefield. A contract between Arkansas Children's Hospital and UALR Children International was formed in 2004 to provide the dentists at the clinic.

Finally, UALR Children International handles administration, management, and provides some financial support for the operation of the clinic.

Next slide.

Our annual costs of operation fall into five categories. Thanks to our partnership with the School District, we do not incur overhead costs. Our primary expense is payroll and fringe for the clinic manager, dentist, and dental assistant. That accounts for 83% of our budget. Supplies are the next expense at almost 13%. The remaining four percent of our budget is used for equipment, technology, volunteer recognition, transportation, meetings and travel.

Next slide.

At Future Smiles we provide full preventive care including prophylaxis, sealants, oral evaluations, oral hygiene instruction, fluoride and fluoride varnish. Restorative care provided includes both composite and amalgam fillings, stainless steel crowns, extractions, and very few root canals. In 2012-2013, there were 1,318 patient visits to Future Smiles. During these visits, 2,427 preventive services were provided, 618 restorations and 106 extractions

Next slide.

Our billing method is quite unusual. Little Rock School District had been contracting with a Medicaid biller for vision services for years, so when we opened the clinic we opted to continue with the same method. After the dental visit is coded into Eaglesoft and printed, the claim form is sent to the contracted biller. She submits the claims at a ten percent fee of all remittals. The School District then sends the remaining 90% to UALR Children International to support the dental clinic.

Next slide.

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

As far as Medicaid reimbursement goes, our top billing codes paid by Medicaid are, first, B2140, one surface amalgam, then B0120, oral evaluation. Next is B1120, child prophylaxis. And following close behind those are D1351, sealants. And rounding out the top five is D0272, bitewings. The same codes are also our top billing codes in terms of procedures completed, just in a slightly different order, as you see here.

Next slide.

In addition to funding from Medicaid reimbursements and UALR Children International, Future Smiles has received generous financial support from public and private sources. As I said before, United Way designated the seed money to launch the opening of the clinic and continues to designate the clinic as part of its annual campaign. The Arkansas Department of Health, Office of Oral Health, has contributed grants totaling more than \$200,000.00. We do not see patients with insurance, so we continue to seek outside funding from local grantors each year in order to cover the cost of services provided to those without Medicaid. The families who have no Medicaid are not billed directly. We have received financial support from Blue and You Foundation for a Healthier Arkansas, Delta Dental of Arkansas, Plum Creed Foundation, Union Pacific, Cardinal Health, and the Wal-Mart Foundation. You can see that overall Medicaid billing has accounted for 32% of our total funding.

Next slide.

However, when you compare funding sources from last year to our overall totals, you can see an increase in the Medicaid income. Last year Medicaid funds accounted for 51% of our revenue. This increase is partially because of the increase in Medicaid reimbursement rates here in Arkansas and the reduction of an availability of other local funding.

Next slide.

Future Smiles has had a very successful nine years of servicing Medicaid children as well as children without insurance. Our clinic has increased access for children, and over 28,000 children have benefitted from dental screenings, oral hygiene instruction, and toothbrush kits. Thirty-six hundred children have received over 11,000 dental sealants. Thirty-seven hundred children have received two treatments of fluoride varnish, and there has been a total of 8,867 patient visits to Future Smiles Dental Clinic. Each year we screen about 2,000 children to assess the impact our dental services are having on our population. We have seen very positive results. In 2000, only 2.5% of children had sealants present at screening. Last year, in our 2013 screenings, 30% of students had sealants present. Children with untreated carries dropped from 37.6% to 21.3%. And children referred for routine dental care dropped from 27.9% to 19.2%. Children referred for emergency dental care has decreased from five percent to 1.8%.

Next slide.

In conclusion, Future Smiles has been a successful school-based clinic model for nine years. We increase access for children by utilizing the strengths of our partnerships. The Future Smiles Dental Clinic would not have been possible without the true commitment of every member of the Dental Health Action Team.

Finally, each year we screen a portion of our population to assess the impact and outcomes. It's also important to report every summer I produce an annual report for all of our partners on the Dental Health Action Team that includes screening results, clinic statistics, and financial status.

Next slide.

Again, my name is Jolene Perkins. I can be reached at 501-447-6645 or by email at jkperkins@ualr.edu. Thank you very much.

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

Thank you, Jolene.

Our next speaker is Chawnte Booker. Chawnte is with the Arkansas Medicaid agency. She is currently the Program Manager for Arkansas' Division of Medical Services overseeing the Provider and Beneficiary Assistance Dental and Visual Care Unit. She's been an employee for the Department of Human Services since 2004. Within the ten years that Chawnte has been employed with the State of Arkansas, she has worked her way through the ranks, starting as a file clerk. Her hard work and vast understanding of programs and policies has made her a key player in Arkansas Medicaid. Chawnte?

Thank you, and good afternoon. I first want to say that we are just here to let you know how Arkansas Medicaid supports the Future Smiles Clinic. It has definitely been a welcome addition in our dental community of central Arkansas.

As Jolene explained in her presentation, Arkansas Medicaid has been supportive of Future Smiles since its inception and has been an active member on the Dental Health Action Team.

Next slide.

These are just a few reasons why Arkansas Medicaid supports the Future Smiles Clinic. First, it's a dental home model. The clinic's model is consistent with the dental home model that is supported by the American Academy of Pediatric Dentistry. This was very important to us in that many of times provision of services in the schools leads to push back from the local provider community or there are concerns about what happens when children need restorative care. The Future Smiles Clinic is an actual dental clinic with dental operatories within a school that does not move.

Next is improved access to dental care. The Future Smiles Clinic has provided dental services in areas of Little Rock that are generally underserved with high populations of Medicaid eligible children and minorities. In a state like Arkansas that struggles with health disparities and does not have a dental clinic, it actually provides a unique approach to improving access to dental care. As a result of efforts by Future Smiles and other programs, and a rate increase for dental care, Arkansas Medicaid has seen marked improvement in its performance on the HEDIS metrics for an annual dental visit and the CMS 416 reports.

Then there are the partnerships with major stakeholders and community. With the help of Children International, the University of Arkansas at Little Rock, and their partnership with Arkansas Children's Hospital, they are able to cover much ground while keeping the overhead costs low. The partnership with Arkansas Children's Hospital delivers a convenient link for dental care for the Future Smiles children during the summer months when the clinic is closed. Additionally, it makes great sense for Arkansas Children's Hospital and the University of Arkansas for Medical Sciences, in their Dental Hygiene and Pediatric Dental residencies. This is an important component for Arkansas Medicaid in building access to dental care for children for years to come.

And finally, the Dental Health Action Team, which Medicaid is a proud member of, Jolene's expertise and leadership is invaluable to this team. It was important for Arkansas Medicaid to be considered a partner in this effort and not only a payer of claims. Additionally this effort recruits other supporters to the program to help share the costs and responsibilities for improving oral health in central Arkansas.

In conclusion, Arkansas Medicaid is in full support of the Future Smiles Clinic. Thank you.

Thank you so much, Chawnte.

Okay, our next speaker is Kathryn Dolan. Kathryn graduated from the Forsyth School of Dental Hygiene in 1977, received her Bachelor's in Science Degree from the University of Massachusetts in 1979, and her Master's in Education from the University of Massachusetts in 1990. Ms. Dolan is the Director of the Tufts Community Dental Program and an Assistant Professor at the Tufts University School of Dental Medicine. She began her career in public health over 30 years ago, establishing community-based dental

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

programs for children and adults with intellectual disabilities in the Boston area. Ms. Dolan oversees the Oral Health Across the Commonwealth Project, which was selected by the Association of State and Territorial Dental Directors, or ASTDD, as a best practice approach for both coordinated school health programs and early childhood tooth decay. Kathy?

To share with you the business model for the Tufts School and Community-Based Oral Healthcare Programs.

Next slide.

The Tufts Community Dental Program has been in existence since 1996. Between the period of 1996 and 2004, the program, which was funded at the time by the Massachusetts Department of Public Health in collaboration with Tufts, served individuals with intellectual and developmental disabilities in the community. It was a program that provided screening, education and referral services to these individuals across the state. The purpose of the program was to be out in the community and identify those special needs individuals in need of treatment and refer to one of the Tufts specialty clinics or to other dental sites in the community. It was a program utilizing dental hygienists to provide screening, education and referral services.

In 2004, the program took a major turn. Funding became quite limited and we were at risk of losing the program. So it was at this point in time when our program evolved from providing screening referral services to providing actual preventive services in the community. We went from an education and screening program to a service delivery program. We also expanded our patient population to include Head Start, Early Head Start, and public school programs.

Shortly after we recognized that our program was identifying a large percentage of children who were in need of restorative services. Although we had referral sites in place, the follow through on behalf of the families was not always happening. We wanted to implement the true dental home model, so in 2005 we began a partnership with Commonwealth Mobile Oral Health Services, a private, portable dental program in Massachusetts that had dentists available to provide the restorative care. This partnership allowed us to complete the circle of care and become a true dental home.

Also in 2005, we recognized that our seed funding would not always be available, and we began to implement our business model. And I'll discuss the business model in more detail in upcoming slides. Between 2005 and 2014, we have expanded geographically and are currently serving about 10,000 patients across the Commonwealth of Massachusetts.

Next slide.

(Inaudible) in our timeline, major growth expansion and changes occurred in our community-based program between 1996 and 2014. The reason for the changes were basically because there were some significant needs of the population that we were recognizing. There were needs of our institution. Needs for program sustainability. And then there were other environmental factors such as the impact of 9/11 on the State budget, which had traditionally supported the Tufts program, and more recently the Affordable Care Act, which has changed benefit eligibility for our service population.

It's important to note that the reasons for change are fluid, and we are continuously reacting and responding as it impacts our program and directly impacts our business model. So each year we continuously assess and prepare for these changes.

Next slide.

Today we provide comprehensive dental services under the dental home model. As part of this model, we provide preventive, diagnostic, and basic restorative services. We also refer children and our adults with special needs for specialty services when needed. Those referral sites include the Tufts dental school,

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

the Tufts seven regional dental clinics serving persons with special needs, local federally-qualified health centers, local hospital dental clinics, and other specialty dentists in the community. Last year we provided services to 254 program sites across the state. One hundred fifty-two of those sites were school based, and 102 were community-based programs such as Head Start, Early Head Start, WIC and adult programs for individuals with intellectual and developmental disabilities.

The total number of children and adults served in 2012 to 2013 was 10,153. This year our anticipated number of children and adults to be served will likely reach 11,000.

Next slide.

To give you an idea of our infrastructure and our cost of setting up a program like this, I'd like to go over a few things. There's a basic capital outlay for equipment and supplies. Tufts has 12 delivery service setups. A delivery service setup includes a portable dental patient chair, an operator's stool and a dental assistant's stool, a portable dental light, a dental compressor and delivery unit, a sterilizer which may be portable or at a fixed location, and a portable dental x-ray machine if you're providing comprehensive care.

Other one-time purchases include restorative and preventive instruments, laptops, smart phones and emergency medical supplies.

There's also a cost associated with consumables such as office supplies and dental material.

Next slide.

We also have costs associated with the staffing of our program. Currently Tufts has one full time licensed dentist, 4.5 FTE licensed dental hygienists, 2.5 FTE certified dental assistants. Equally important is the administrative staff. We have one full time billing manager, a half-time outreach coordinator, and four FTE office dental assistants, who are not certified dental assistants but their roles are equally important.

We also have student involvement as Tufts dental school has a mission to educate students to serve the community. There are 195 third year dental students and 66 dental hygiene students from the Forsythe School of Dental Hygiene who rotate through the school-based program annually. The students are supervised by a faculty member at a six-to-one ratio in a dental setting utilizing three portable dental chairs.

Next slide.

Another cost of the program is maintenance and replacement of equipment. We've had our portable equipment for ten years with no major issues, and that can probably be attributed to an annual on site dental maintenance visit that we set up with the manufacturer. The cost of this is approximately \$1,000.00 per year and covers all of our equipment with the exception of the portable dental x-ray machine.

Next slide.

Looking at the business model, Tufts collects roughly \$600,000.00 a year from billing. \$500,000.00 is for Mass House, the Massachusetts Medicaid program. It is important to note that this is from direct billing claims, not from a block grant. Private insurance is billed when we receive the information from the patients. This past year we collected approximately \$100,000.00 from private insurance, and you can note that that is less because the areas that we are targeting usually have 50% or higher free and reduced lunch and tend to be a population that is covered by Medicaid.

The annual expenses include personnel, consumable supplies, and the annual equipment maintenance, and it comes, roughly, to \$775,000.00. The difference between the income and expenses last year as approximately \$175,000.00.

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

Because Tufts is an educational institution utilizing the community-based program as a clinical site for the dental students and because Tufts University has a mission that promotes civic engagement and community service, the dental school is willing to provide in-kind support to sustain the operation. Each year the in-kind support varies. While we don't always break even, the program has been sustainable because the University is willing to play a role and pay a small price to support its mission of community service.

Next slide.

In the next few slides I'd like to go over some major variables that need to be included in the business model. The first is the number and location of program sites, the number of potential patients at those sites, and their insurance coverage. As I mentioned earlier, we target schools that have 50% or higher of students with free and reduced lunch.

There's the patient flow at each site. Is there nap time and lunch periods when you will not be able to see patients? You need to know your break-even costs per day, per provider, and whether or not that provider is a dentist versus a hygienist will affect your breakeven costs for the day. And what are your actual services billed? Making sure that you have the providers working to the top of their license. For instance, in Massachusetts we have our Certified Dental Assistants providing fluoride varnish, and it's a better business model to have the hygienist providing preventing services and the dentist providing restorative services.

Next slide.

At Tufts we use Axion for our patient management system. Because we do not have Axion wirelessly in the field, our providers do use a hard copy and then transfer that information to the billing manager daily. The billing manager then enters the procedures into Axion. The actual services billed include exams, radiographs, dental cleanings, fluoride varnish, sealants, behavior management fees, if applicable, and Level One restorative.

Next slide.

This slide is an example of a dashboard. The purpose of the dashboard is to closely monitor the activities in the costs of the program. We use several different dashboards in monitoring our program, and we can look at the daily, weekly averages by site, or the daily and weekly averages by provider. The dashboard allows us to self-monitor by site and by provider and then to implement changes to the program based on what we find.

Next slide.

Here we have the impact of the business model. If you follow the graph, the blue line is the production based on the usual and customary fees for Tufts. It's the actual charge that we bill Medicaid or private insurance. The red line is the adjusted production based on the allowable fee for Mass Health in Massachusetts. So this is what we can collect for those services. The Mass Health fees in Massachusetts are approximately 68% of the Tufts usual and customary fee. The difference between the blue line and the red line shows the difference of the Mass Health rate and the Tufts fee.

Finally, the green line is the collections, and because we do see children who do not have insurance, our collections are slightly lower than our adjusted production.

Next slide.

In this slide we have the same three columns as the previous slide, Production, Adjusted Production, and Collections. If you look at the purple line you can see the rate of collections to the actual amount billed. From 2005 to 2008, there was a steady increase as we were implementing our business model. Since

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

2008 it has leveled to approximately 82%, and it's kind of important to note that in 2008 was when we implemented Axion.

Next slide.

In the next two slides I'd like to summarize what you might need to get started. If you have a dental program that has been funded by seed money and you want to move to a more sustainable model, you can follow these steps.

The first, kind of the most important thing you can do, is to submit an application to become an eligible provider for both Medicaid and for private insurance. This can be a lengthy process so I recommend that it gets started immediately. While this is moving through the system, you can be doing other things. You can establish your service rate schedule. And remember to update that regularly. You should obtain the allowed fee schedules from the various payers so that you'll know what to expect for your collections. You should establish your service sites and get the necessary agreements in place and signed. You should estimate the delivery of services by site, by day and provider so that you have a strategic plan of where and when you are going, as well as who and how many patients you will treat at those sites.

Next slide.

As I mentioned before, you want to assign program personnel to the highest degree of their license. You need to assess for other unexpected cost variables that may be part of your business model that is not part of my business model. Most importantly you need to develop your dashboards in order to monitor your activities daily, weekly, and monthly. When you see red flags, you need to bring in your staff and develop solutions because this is what ongoing quality improvement is all about. And following these guidelines should help you set up a quality program that is both cost effective and efficient.

Next slide? Thank you.

And my contact information is provided on this slide. Thank you very much.

Thank you very much, Kathy.

Okay, so for our last presenter this afternoon is Dr. Brent Martin. Dr. Martin earned his dental degree from the University of Missouri at Kansas City as an early graduate with High Honors. He earned an MBA from the University of Dallas magna cum laude, and brings to his role 17 years direct participation experience, private sector experience with Cigna and Delta, and public sector experience with federally-qualified health centers and now Mass Health, the Massachusetts Medicaid agency, as its Dental Director. Thank you, Dr. Martin.

Good afternoon. Well, we had a lot of great presentations and a bunch of information, so I'll be very, very brief.

Next slide, please.

We are quite fortunate, here in Massachusetts, that we have these results. We are proud of our FFR13 416 data that says two out of every three kids that are school age have had a dental visit. However, there are still over 113,000 children who did not have a visit, and it is imperative that we take a fair amount of care out to them. And we're in a good place. We're on track to make our CMS goals at least a year ahead. Dr. Mouden, if you're on the phone, you don't get to change the goals.

Next slide, please.

And the reason why people don't access care has been very important to us as we try to determine how we can treat this. If you look at this slide, you will see these are reasons that non-utilizers, this graph

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

shows non-utilizers having no claim – I think it's in the prior two years. So no time, too busy, did not need to go. (Inaudible.) Eight percent was only the ones that were having trouble of finding a dentist. Fear of dentists and so on. So these data tell us that over 75% of the reasons non-utilizers are non-utilizers is really not so much under our control. So we believe very, very strongly that the right thing to do is through associations with like Tufts where we take care to where the children are, in this case in the school system, for the good of the patient, keeping him at the center of our radar screen, and that way we can really help the so-called non-utilizers which otherwise, and in these particular cases, would not have had care.

So this is what we have found works very successfully for us here in Massachusetts. And of course we will all take questions.

Next slide.

I think that's all I wanted to add. Yep. That's it. Thank you.

Thank you so much, Dr. Martin. So this concludes our presentations, and now we will respond to questions that have been submitted to the Q&A box. And you can continue to submit them. Again, the Q&A box is on the right side of your screen. And just so you, also, the contact list is up there, so if you would like to follow up with any question with any of the individual presenters, please feel free to do so.

Okay. So our first question asks about the CMS oral health initiative. And the person wants to know about the goal, the first goal, which has to do with preventive services. The goal is to increase by ten percentage points the portion of Medicaid and CHIP children ages one through 20 who are enrolled for at least 90 days who receive a preventive dental visit. And the person wants to know, can this be only one or two of the three services identified in the preventive category that is prophylaxis, fluoride and/or sealant?

So the answer is right now what you're talking about is state reporting on the CMS 416 form. And so a child is identified once for a service, and so it wouldn't matter whether there were one service or all three services being provided to that individual child. It would be counted once as preventive service. So each of them individually could be counted if the person only got prophylaxis and nothing else, they would be counted as a preventive service to the child. If they got all three, it would be counted as a preventive service. One preventive services child. Okay?

Next question.

Is it (inaudible) to anybody?

Okay, Jolene.

Okay, this is for Jolene Perkins. Jolene, what is your method of transportation to the schools and how is the liability handled?

All of the children that are transported are in a van, an eight-passenger van that is insured through the University of Arkansas at Little Rock. All the children, families, have completed advance consent for transportation. Does that answer the question?

Thank you. And, actually Kathy, did you want to respond at all to that in terms of how you handle it?

Could you – I'm having trouble with the questions here, so I'll pass.

Okay. We'll go on to another question.

Okay. Thank you.

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

For Kathy, for you. Are there any issues with your programs and local private dentists? How do you include them in your system, private dentists that is?

Yes. The answer to the question is yes, we have had issues with private dentists. We try to be proactive and reach out to the dentists in the areas that we are servicing and utilize them as our referral points. As I mentioned in one of the slides, in some cases we're not able to provide specialty care, so if we can provide linkages to the dentists in the community for that specialty care, we're able to build a positive relationship with the dentists, instead of a negative. But being able to be proactive and getting together with those dentists through the local dental society when you're setting up the program.

Okay, thanks Kathy.

Okay, for Jolene. Out of the 2,400 preventive patients, do you have any sense of how many patients received complete treatment?

Well, that's not a number we actually tracked, treatment to complete for preventive services. However, they should have all been treated to completion here unless the child moved. Very rarely do we have to refer a child – maybe one a year – to Arkansas Children's Hospital to complete treatment. Otherwise we see them all unless they move out of district and we can't reach them.

Okay, if they do move out of district, how do you handle that?

We try to find them –

Do you try to find where they went?

Yes. We try to locate the family with the phone number that we have, and that's how we go about that.

Okay. All right. Thank you.

The next question is, the person says, I want to be clear I heard correctly. The school dental clinic, and this is yours, Kathy, but this can apply to everybody, does not – I'm sorry, Jolene. The school dental clinic does not bill parents of children who do not have Medicaid or private insurance. (Inaudible.)

(Inaudible.)

Oh, sorry.

Our control Medicaid program reimburses for care even though the care is provided for free?

The care is not considered provided for free because we have to bill our grantors. We have to use our grantors to cover that cost for those families. We're only able to do so by using the grant money to cover those costs.

Okay.

(Inaudible.)

Okay. Thank you, Jolene.

The next question is please provide the CMS definition of dental home. Okay, there is no CMS definition of a dental home. However, the American Academy of Pediatric Dentists does have – that's AAPD – they do have a definition of dental home. But actually I'd like to ask Jolene, since you started your talk and

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

mentioned that you consider your clinic to be a dental home for your children, can you talk a little bit about what you consider a dental home to include?

Yes. As a matter of fact, when we have our families complete a consent, we have on there – we ask them – they must not be an active patient in a dental home, and we provide the definition of a dental home as a place where your child's oral healthcare is provided by a licensed dentist on an ongoing basis. So that's really what we consider a dental home.

Thank you. That's very helpful, Jolene.

Okay. The next question is for Kathy. How does "in kind" offset expenses? That is, what kind of expenses might Tufts pay for directly?

Tufts will pay the payroll expenses above and beyond what we're not able to pay from the income. So it works out to be – it varies from year to year, but it could be a low of five percent to up to – it's been up to 20% that Tufts will pay for payroll expenses, because that's our major expense for the year so it usually ends up the in-kind for payroll.

Okay, thanks. And we have another question for you, Kathy. Could you please elaborate on the dashboard and how folks can obtain this resource?

If they want to email me directly it's probably something that I can go over with them, but it's basically setting up things in Excel, you know, your providers with their weekly – it's having our Axion information going into an Excel sheet that goes into the dashboard, so it's a little technical to talk about over the phone, but I'd be more than happy if somebody wants to email me directly and I can talk to them and we can go over it.

Thanks. That's really kind of you, Kathy. Can I ask you, is there any kind of like a website that folks could go to to learn more about dashboards that you know of? Or any resources that you used in trying to develop one?

I worked with my IT people that know Axion, so I, again, would be more than happy to look for some resources, give it to you, and you might be able to then disseminate it to the listeners.

Okay. Thank you.

Okay.

I have a question now that I would like actually to pose to both Jolene and to Kathy, and we can go in that order if you'd like. Is parental informed consent obtained for treatment services?

Absolutely. Absolutely.

The answer is absolutely on my end, too.

I mean we would not perform anything – we won't even screen a child without active consent.

Yes.

Okay. Can you tell us, then, how is it obtained?

Well, at our clinic we work at school registration and so we see a lot of the parents at the beginning of the year through that. We send them home then. And then after our screenings, we also send the consents home with students, and at our other schools. And then they'll send them back to the teachers, and the

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

teachers, they'll throw them back to us. And then we'll contact the parents about scheduling an appointment for their child.

And we have a similar setup where we send consents via the children at the beginning of the school year. We attend the open house events. At the Head Start programs the health coordinators work with their parents to get the consent forms returned for us. And we, with WIC programs we're working with the parents directly. But everything is a signed informed consent. And we have our dental healthcare coordinators that will follow up with parents on missing information because it's a medical, dental health history as well as the informed consent.

Thank you. And so the next question I'd actually like to pose to our two providers as well as our Medicaid agency representatives. So for all running school-based health centers, do you offer services for free for those without Medicaid or private insurance, and if so – remember we're talking about all school-based health centers – so how do you deal with the free care rule that requires billing everyone if you offer for free services that Medicaid is being billed for? And anybody can jump in, I guess.

That's very similar – this is Jolene – that's very similar to what I explained before is we have to have a third party grant funding other than Medicaid to cover those costs. That's how we do it here in Arkansas. So we're not billing the families, but we're billing – like Cardinal Health will come in one year and cover those costs. Or another, Delta Dental, some other private funding source that we utilize to cover those costs.

And the answer is similar. Over the ten years that Tufts has been running the program, we've had different grants from year to year, some from different foundations, and we do a similar thing with the billing to the foundation.

So, Dr. Martin, do you have any thoughts about other school-based health centers in the state and this issue?

Well, the only thing that might be helpful to some of the attendees is we also have in Massachusetts not only a huge source of pride in what Tufts is doing, but we have public health dental hygienists that are licensed to go to schools because Tufts can't cover all of the schools in the state. There's more of a demand that they can possibly meet. So we have public health dental hygienists and we also have the Department of Public Health that tries to go into some schools that are otherwise not served. And we treat both of those entities as regular providers. So we have enabled a process that they can bill the Medicaid agency directly and that those add, for instance, to the Department of Public Health, a very high level of so-called sustainability. It's public information that the Massachusetts Medicaid agency will pay to the Department of Public Health for their hygienists, this year probably about \$400,000.00 for what they do out in the school systems. So there's plenty of demand equation – go back to my original thought. There's over 113,000 children that have no claim whatsoever. So we are far from arriving, but there's a huge demand equation to do more in the school system for these kids.

Thank you. And Chawnte, is there anything more that you want to add?

No, ma'am. They pretty much covered it all.

Okay, that's fine. Thank you.

The next question, again, I would like to give to the panel. So the question is, I work for the Medicaid agency in Washington State. Can you talk a little bit about what work was required, if any, to get CMS approval to offer these services at the school? Did you have to do a SPA or waiver? So I guess –

This is Chawnte and I could start out by speaking to that. For Arkansas, we did not have to do anything special when it comes to approval or to making any changes to our policy because actually the Future Smiles Clinic is not a mobile clinic or anything like that. It is a dental clinic that is inside of a school, and

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

the dental operatories are there and it doesn't move. So they actually, when they were built, they just applied as a normal dental provider, and that's how we pay them. So there was nothing else that we had to do.

And I would imagine that Arkansas already had in its state plan the provision of school-based services, probably under its ETSDT benefit. So there would be a – I mean, all states would have this service. But I think what's implied here is that an additional state plan amendment would not be required.

That's correct. We didn't have to do anything additional.

Okay. And Dr. Martin, do you have anything that you would want to add?

No. What Chawnte said is exactly right. We did not do anything additional. We treat the Tufts Clinic as any other type provider, and we did not have to make any modifications to our SPA or anything like that at all. They are a valued partner and provider in Massachusetts.

Thank you. Our next question is to anyone who would like to answer. Mid-level providers such as dental therapists have been proven to increase access to care for underserved populations and are economically viable. Has this avenue been explored to increase access to children in your state, and if not, why not?

Well, this is Brent Martin. I'll start with that. You know, you're always cautious when you say these things, but right now our access issues appear to be minimal. Ninety-six percent of all of our members have at least two dentists within five miles of their home zip code. And I have used geo-mapping data to overlie the provider zip codes and the members' zip codes, and so we are constantly monitoring through DataQuest to see what our access issues are, for GPs and specialists. And very often we will see two or three thousand non-utilizers who would also see 30 or 40 dental offices within five miles of their home zip code. So what keeps me awake at night are getting the non-utilizers to become utilizers. But it's not a – adding 50 more dental offices doesn't appear to make any difference in so-called access or utilization.

(Inaudible.)

That's okay. I just wanted to say in Arkansas we are always looking for new things, kind of like Dr. Martin said, you kind of want to be careful with these. That's just not an avenue that we have even attempted to go down just yet, but we definitely will look towards different things in the future.

This is Lynn Mouden, Chief Dental Officer at CMS. Obviously the ability for mid-levels, such as dental therapists, to provide services is based on state dental practice acts and other statutory and regulatory issues.

Thank you, Dr. Mouden. So our next question is, what is the best way to get our state contact? Any suggestions or resources for a California-based model? And I would just – if you look on the screen, you'll see the contact list, and just send me an email because I don't know that I can contact you directly from this. So send me an email with this question, and I will help you find the answers.

And the next question is, are there any school-based health centers in Arkansas which offer primary care and behavioral health care? If yes, which state agency is it under?

I have no idea, so I would have to actually look into that. The school – most of them are based through community health centers, and I know Dr. Mouden just chimed in, and I know he's very familiar with what we do here, probably more so than I. But that actually go through the Medicaid program, I'm not familiar with any, but I will definitely look into that if someone wants to contact me by email and find that information for you.

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

Okay. The National School-Based Health Center Alliance is a resource. Again, that's the National School-Based Health Center Alliance. So I would Google that and see if they have some information for you.

Our next question is for Kathy Dolan. What do you consider level one restorative treatments?

It's usually one or two surface composite fillings.

Okay. And also for you, Kathy, can you recommend any resources for development of a business plan?

Not off the top of my head, but I can look into it for the person that's asking. You know, the things that I mentioned, the slides, were things that we did. I'm a dental hygienist. I don't have a degree in business, but it was one of those things that you kind of learned on the job in order to make sure that the program kept running. We knew we had – we had good people doing a great program and a lot of the patients in need, so we learned a lot just on-the-job training. But that's why when I was asked to participate in this I was happy to just share some of my lessons learned.

Thanks, Kathy. Okay, Jolene. Your 2013 data showed you're no longer getting money from the Department of Public Health. Can you share with us why that might be?

Our local Arkansas Department of Public Health Office of Oral Health has recently lost a lot of their funding, and their office has been minimized quite a bit. So they don't have that funding to help provide us right now.

So that really puts the squeeze on you as well then, correct?

Well, most of the funding that came from the Department of Health came in the early days, probably the first four years of our establishment. And we really haven't had any since then. But we haven't needed it either.

Yeah, that's great. So next question is for both Kathy and Jolene. How do parents feel about not being present during treatments?

This is Jolene. We give them the option to be present if they want. We have after school appointments available, or they're welcome to come in the day. Most of them that have some sort of hesitancy about their children will come to the first visit and then they're comfortable and have no issues with us pulling their students out during the day.

We have a similar thing. Most of the time – we don't have a lot of requests from parents to come for the appointments, but when they do we will work around their schedules. We have before and after school hours. And, again, like Jolene said, usually when they come and they meet the provider, they come on a first time and they don't usually ask to come on subsequent visits.

Okay. So there's a next question about the involved parents. If consent is captured at the beginning of the school year, how is the treatment plan and costs explained to the parents?

I can answer that for the Tufts program. On the initial visit we send home a parent letter that will explain the findings of the screening and the treatment plan. If it's going to be restorative, we will get another sign off from the parent for a local anesthesia.

And similarly, at their first visit we send home all the information with the child to the family.

Okay. Thank you.

I want to give some information. Some of our audience members have very kindly given us additional information for folks.

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

So we talked about the National Alliance for School-Based Health Centers. I said it incorrectly. Well they changed their name anyway. It's now called the School-Based Health Alliance, and so the address looks to be sbh4all.org. S – B – H – it's the number four – all.org. But it's called the School-Based Health Alliance.

And also, for a business plan resource, there is something called Safety Net Solutions, and this is actually something that's, I guess, offered by DentaQuest.

Yes, Rosemary, now that you mention it, that's a good resource. It's something I'm familiar with and I didn't think of it, but it would be a good resource for people.

Okay. Well you're doing very well at responding to these questions right off the cuff.

So here's a question. We're in the process of working with our local school district to provide dental services. Do you have a checklist of how we should prepare?

Yes. I have – actually it's funny that you mention DentaQuest and Safety Net Solutions. I've been working with Dr. Mike Doherty, and with his permission I might be able to share that checklist, but it's something that I've done with DentaQuest, and I'm sure that it probably would be something that we could share and send to you that you could send out to the participants.

Thank you. Okay, Kathy, I do have a couple other questions for you. What is Tufts' service area?

Massachusetts. And we go from Boston – our major cities are Boston, Springfield, Lowell, and Pittsfield. So we go from the eastern part of the state right to Pittsfield, which is on the New York border.

Okay. And for both Kathy and Jolene. Is there a separate consent for preventive and diagnostic treatment? In other words is there (inaudible).

(Inaudible).

This is Jolene.

Did you understand?

Yes, I understood. We just use one consent; it's a blanket for everything.

We have one consent with the exception of our programs that the dental students rotate through, and we actually use a second consent that's a little bit more specific for the restorative students that the dental students are going to do under the supervision of the faculty dentist.

Okay. Jolene. If – and maybe this hasn't happened, but if grant funding is not there and runs out, and students are still needing to be seen, how do you – do you bill the parents? If you do, how do you bill them? How do you explain the grant funding has run out? I don't know that you've ever experienced that, but we'd like to know.

No, in nine years we haven't experienced that, and you may have heard, our parent organization is Children International, so a lot of our funding as a child sponsorship organization comes from there, so if that were to happen, we would apply for more funding through them to cover those costs. However, I haven't faced that yet.

We have not faced that yet either.

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

Okay. Are there any school-based or school-linked dental programs that are sustainable purely on billing revenue from Medicaid and private insurers? Do any of you on the phone that can answer know of any that are able to be sustained without support from other sources, private sources.

Rose, it's an interesting question, and it's something I'd like to go back to the dashboard. I actually have sites that are more sustainable, or that are sustainable, and sites that aren't quite as sustainable depending on the patient mix. Because I kind of collect all my data and, you know, all the income goes into one pot, the programs that have a higher percentage of patients that are on Medicaid and that are sustainable help in some of those areas where the mix isn't so much. As I said, we will go to any school that we're invited into that feels like they have a need, and we've used some data from our most recent survey of third grade children on which schools need services because of the condition of their oral health. So we have individual schools that are sustainable. But collectively, because we have some schools that the patient mix is a little bit different, as I showed in earlier slides, overall this particular – you know, last year we were not. We've had years that we have been sustainable. We've had years where we've had a little bit of a surplus and we've been able to give back in other services to the community. So it's so important to watch it from day-to-day, week-to-week, month-to-month because it's like a moving target when you go in places, you know, just to reach that number that you need, that's – it's a tough thing to do and it doesn't – things change from year to year. And other variables could be the covered services. There might be a change in what Medicaid is covering in your state from year to year. So there's just a lot of variables.

Thanks so much.

Okay, so I think this is probably more directed to you, Kathy, but Jolene you can respond, too, if you want to. So what type of push backs, if any, have you noticed in the schools? For example, sometimes schools in high-need areas don't want to have their students or the school stigmatized or have a label on it. Have you experienced anything like that?

Yes. One of our school systems we have – they have low MCAT scores, so that's our way of putting the report card on the school system. So their children in those schools, their students are not doing as well academically. So those schools want their children, their students, in class, you know, time on learning is very important. So in those schools we've had to make an extra effort to be able to be available before school hours, not to take students out of the classroom during the academic sessions. So we will work with them, but it is – sometimes it's a struggle to be able to – because these schools happen to also be the highest need for oral health, so we know from our survey that those are the children in need of oral health services, but they're also the children who are getting the low MCAT scores so there is some push back. You have to meet with the school nurse leaders, the superintendent of the schools, provide them with the information that, you know, the 51 million school hours being lost every year because of dental pain. So when you're able to give them, educate them, on the effects of poor oral health in their school, and if we can get in there and improve that, then we will probably improve the ability of their students to learn academically. It's a win-win for both. But it can sometimes take a long time and several meetings before they get it and we can come to a mutual decision on how best to provide services.

And being a statewide program, and having all those sites, the thing that I've noticed is that you really do have to customize the program to the school system you're going in. They are all a little bit different, and you have to treat them differently.

This is Jolene, and that's exactly the same here. Each of our schools we have to treat differently and make concessions based on their needs. There are some schools that we can transport in the morning. Some schools we have to do in the afternoon. Basically we just share data and make sure that they are aware of their school's needs, and as long as we maintain that relationship, then it's mutually beneficial.

And I actually have a follow-up question for both of you. Do you feel that over time that the parents have, through education, have demonstrated an appreciation for being able to have their kids' dental needs met at school?

Mathematica Policy Research, Inc.
Oral Health Webinar 5.14.2014

Yes.

I believe so, yes.

I've also seen where parents have – they've then realized that it's so important that we've actually had an opposite effect where we've had programs that we've been in, but because we have done a good job at educating the parents, that they then are assuming more of a responsibility and sometimes finding their own dentist in the community, which is fine, because as Jolene said, we're there to serve children that don't have a dental home. And if they have a dental home in the community, that's fine. So sometimes you're doing your job so well educating the parents that you don't need to hold their hand any more. So it's a very good thing.

Okay. Thank you.

So I'm afraid that we've run out of time, and I just want to thank – actually I want to thank everybody because I think the audience has submitted great questions and our panelists have been very generous with their time and with their information.

So in closing the session, I do want to thank our panelists for sharing their stories with us. We hope that you found this learning lab useful in your efforts to improve oral health access for children. There are still so many children who are not receiving dental services and the approaches shared today in developing and supporting sustainable school- and community-based dental services for children and youth, particularly in geographic areas with limited access, is a great way to give kids a dental home, improving access and utilization of preventive and dental treatment services.

CMS and MSDA are always available for technical assistance for state, Medicaid and CHIP programs. In addition, for state for other entities that would like to delve deeper into a discussion on today's topic with our faculty, we are offering a few slots to first comers for a 60-to-90 minute call. You can see the contact list. My email address up there: rosemary.feild@cms.hhs.gov. So please, if you're interested, send me an email and we will arrange to have an opportunity for you to speak with our faculty about they've developed their programs and how they might help you.

And so I just want to thank everyone for joining us today, and all the best in your oral health improvement efforts. Thank you.