Connecticut Health Foundation
Oral Health Initiative

A Retrospective Evaluation of the Initiative to Improve Oral Health & Access to Care

2008 Next Generation Consulting Group

EXECUTIVE SUMMARY

Evaluation Focus:

What progress has the Connecticut Health Foundation (CT Health) made toward the goal it established in 2000 of doubling the number of children in the Healthcare for Uninsured Kids and Youth (HUSKY)Part A Medicaid managed care program receiving dental prevention and treatment? That is the focus of this report.

Our retrospective evaluation concludes that CT Health's support of community-based collaboration, research practices/policy and advocacy improved dental care access for children under Connecticut's HUSKY Part A program.

This evaluation, which examines the foundation's oral health activities (2001-2006), focuses on three areas:

- Whether the foundation's oral health initiative increased dental care access for HUSKY A-enrolled children in their respective communities
- If CT Health-funded projects developed a sustainable structure that will enable them to continue shaping oral health care and community policy beyond CT Health funding
- CT Health's role in supporting a community's capacity to provide dental services to HUSKY A-enrolled children, as well as strengthen the systems-of care-policies shaping oral health delivery

Background:

From 2001-2006, CT Health provided over $8.7 million in grants to community health clinics, collaboratives, researchers and advocates to improve dental care access by HUSKY A-enrolled children. The foundation provided grants to eight community collaboratives, focused on CT Health's 2000 goal of doubling the number of children in HUSKY A receiving dental prevention and treatment. After 2006, the foundation refined its goal to "Improving the oral health of children on HUSKY," with new objectives:

- Increase use of preventive and treatment visits to the levels achieved by children insured in the private sector
- Identify and promote models of care that improve oral health outcomes for HUSKY A-enrolled children in foundation-funded communities

Evaluation Findings:

Systems of Care

CT Health has galvanized support for improving access to oral health care among academics, practitioners, health care advocates and other service providers. Work has focused on:

- Strengthening reimbursement for HUSKY A providers
- Funding baseline research
- Advocating for funding
- Funding community-based collaborations

CT Health has acquired enough support and evidence to move the Connecticut legislature to increase funding for HUSKY A-enrolled children. This effort also has increased awareness about the need for more dentists to care for these children. A substantial gap, however, still exists in meeting these needs.

Many dentists do not participate in HUSKY a for a variety of reasons, including:

- Business-related issues (high start-up costs, education debt)
- Location of their practice (urban concentration)
- Cultural competency
- Low reimbursement for high-cost care
- Poor knowledge of pediatric dentistry
- Unwillingness to treat HUSKY A-enrolled children

System-wide Capacity Issue

The study's primary finding is that there is a system-wide capacity issue. Specifically, Community Health Centers (CHCs) and other safety-net clinics lack:

- Sufficient skilled personnel to plan and manage efficient systems of care
- Full-time staff focused on developing financial resources to sustain programs

Oral health care also competes against:

- Many other children- and family-oriented health care concerns
- Increasing social service demands for funding too often drawn from the same budget

Workforce Development

Elements that could strengthen the oral health safety net include:

- Enhanced training, licensing and supervision of dental hygienists and dental assistants, who can provide preventive care and conduct screenings
- Increasing efforts to educate general dentists to enable them to see younger children

The evaluation team also became aware of an oral health initiative to enhance efforts to engage pediatricians, the education community and youth media

Sustainability

Oral health care visits and outreach needs increased as community collaboration, advocacy and systems increased access. This put new demands on an organization's staff, office space and other resources. Collaboratives and their members may require support in planning and development to ensure sustainability as their programs expand to meet their community's oral health needs.

INTRODUCTION

Background

The facts speak for themselves:

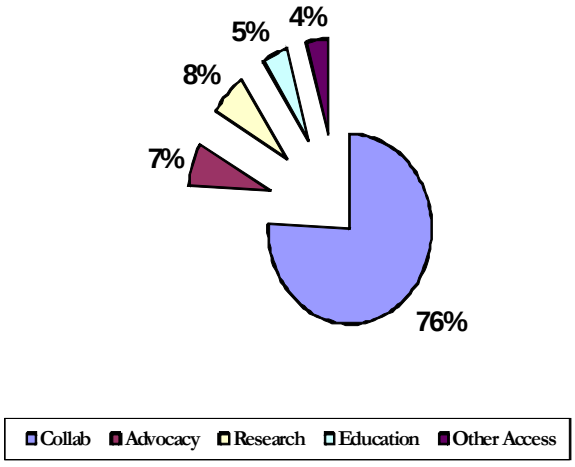
- About 25 percent of Connecticut children are enrolled in HUSKY Part A
- 66 percent of children in HUSKY Part A do not receive dental care
- Connecticut has almost 2,800 dentists
- Only about 100 private providers accept Medicaid insurance covering HUSKY A children
- There is an inadequate safety-net system

To bridge these gaps, CT Health addressed several related issues, such as:

- Increasing reimbursement rates
- Increasing the number of dentists who treat HUSKYA-enrolled children
- Workforce development
- Care coordination
- Research to fully assess the problem
- Advocacy to educate and inform policy-makers
- Building models for community-based intervention

As the adjoining chart illustrates, 77 percent of CT Health's $8.7 million in grants from 2001-2006 supported eight community-based collaborations. The remainder supported education campaigns targeting the community and providers, research, advocacy and other access-improvement initiatives. Table 1 (page 5) illustrates how funding changed from 2001 to 2006.

Chart 1: Grantee Percentage of Total Oral Health Initiative Funding ($8,707,360)



Methods

Measuring the impact of CT Health's program required examining its implementation each year, from 2001 to 2006.

The Next Generation Consulting Group evaluation team assessed each community's dental care capacity in terms of provider availability, whether the providers were easily accessible and are geographically close to the target population.

Additional information was gathered through:

- Interviewing project staff
- Identifying and reviewing key documents
- Interviewing grantees and consultants

Data collection entailed:

- Examining community engagement (i.e., networking established by clinics and their collaborators to improve children's oral health)
- Types of dental procedures most necessary and/or delivered

Other key evaluation areas included:

- Analyzing patient access to care and service delivery
- Identifying barriers to service
- Realizing a dental facility's full capabilities (capacity realization)

Document Review

CT Health provided several documents and reports, including:

- Grant descriptions and funding allocation
- Strategic planning documents
- Logic models
- Grant continuation application
- HUSKY A data on how many children grantees served
- Grantee annual and semiannual progress reports
- Research and policy papers funded or developed by CT Health (e.g., Crall and Edelstein report: *Elements of Effective Action to Improve Oral Health and Access to Dental Care for Connecticut Children and Families*, which began the oral health initiative; journal articles published by foundation-funded researchers).

The eight community collaboratives receiving CT Health support from 2001-2006 also provided materials describing their work, such as:

- Newsletters
- Fact sheets
- Patient information forms
- Client satisfaction surveys

Key Interviews

Interviewing CT Health's leadership provided an in-depth understanding of the oral health initiative. Interview questions were designed to:

- Assess program goals, objectives and expectations of CT Health's oral health initiative from the foundation's perspective
- Assist in developing the proposed prospective evaluation

CT Health also provided names and contact information of key current and former grantees and contractors. Those selected represented all aspects of CT Health's 2001-2006 funding strategies. Table 1 (page 6) represents the funding percentage for each CT Health oral health initiative.

Grantees interviewed represented:

- The eight funded community collaboratives
- Connecticut safety-net providers
- Health-policy researchers
- Advocates
- State public health officials
- Other CT Health consultants

Appendix A lists the names and titles of key individuals interviewed and questions they were asked about CT Health's work and its impact on improving oral health in Connecticut from 2001-2006. Interviews were qualitative, open-ended and informal.

Questions and analysis of documents and reports were guided by two key questions:

- Has the foundation's oral health initiative improved access to care in the funded communities (i.e., more clinical and preventive care visits, more providers, new programs or systems developed)?
- Have the projects funded by the foundation developed a sustainable structure that will enable them to exist beyond CT Health funding and continue to shape oral health care and policy in the community?

Table 1: Percentage of Grantee Funding Received From 2000-2006. See page 3.

	2000	2001	2002	2003	2004	2005	2006	
Collaboratives	0	90%	54%	90%	95%	67%	7%	
Advocacy	0	0	13%	10%	0	33%	0	
Research	0	0	11%	0	0	0	74%	
Education	41%	10%	12%	0	2%	0	9%	
Other Access Effort	59%	0	9%	0	3%	0	10%	
Total Dollars Granted	**$297,960**	**$1,000,000**	**$792,310**	**$3,380,450**	**$1,886,150**	**$600,000**	**$750,470**	**$8,707,360**

During the oral health grant-making initiative from 2001-2006, CT Health's goal was to "Double the number of children utilizing preventive and treatment services in the community over a period of five years."

This report focuses on the foundation's role of facilitating change in two areas:

- *Community capacity* to provide dental services to HUSKYA-enrolled children
- *Systems and policies* that shape oral health care delivery

Both questions were examined through CT Health's:

- Investments in community-based collaboration
- Research on systems of care and measures of the state of oral health
- Advocacy to impact policies and legislative decisions related to oral health

Related Issues

Specific issues related to the above areas include community capacity, and systems and policies.

Community Capacity Inquiry:

- Has the use of community collaboratives resulted in:
  a) Infrastructure that serves more HUSKYA-enrolled children?
  b) An integrated system of care that systematically considers all HUSKYA-enrolled children, identifies age-specific entry points to the dental care system and ensures children are actively linked with the most appropriate providers?
  c) Double the number of HUSKYA-enrolled children served?
- What could ***not*** have been achieved without the collaborative format?

- Have the collaboratives developed capacity (process, structure) to continue increasing care access beyond current CT Health funding? Measures of effectiveness could include:
    - Joint agreement about roles
    - Implementing organizational changes to promote billing
    - Adopting best practices
- Did CT Health's additional interventions, such as technical assistance and challenge grants, increase access to care?

Systems and Policies Inquiry:

- What oral health-related policies and legislation have been adopted since 2001 and what has been the impact on increasing access (e.g., new resources, services, methods to deliver care)?
- What were the major drivers of any adopted policy or legislative changes?
- How has CT Health's published reports and policy activities informed decision-makers?
- Since 2001, have stakeholders more frequently worked together and agreed on common agendas to promote increased access to oral health care than before 2001?

Key Findings

The following information is compiled from responses to the two primary evaluation questions (page 5) and highlights findings from each area of CT Health's oral health initiative: community-based collaboration; research; policy and advocacy.

Community-based Collaboration/Building Capacity

CT Health grants supported eight community-based collaboratives:

1) Bridgeport (Bridgeport, Stratford)
2) Danbury
3) New Britain
4) New Haven (New Haven, East Haven, West Haven, Branford)
5) Hartford (Hartford, East Hartford)
6) Waterbury
7) Stamford
8) Southeastern (New London County)

CT Health grant support has helped generate results by the collaboratives, which include:

- Stronger community relationships and dialogue related to increasing access to care
- Program and system development to provide more screenings
- Some system-of-care changes to provide more restorative care
- Modifications to improve care coordination (i.e., verification and scheduling processes)
- Increased dialogue with dentists to provide care (either reimbursed or pro bono)
- Increased knowledge about how to work with the CHC system to expand care
- Sustained or expanded school-based prevention
- Enhanced referral relationships between pediatric clinics and the dental programs

At least three of the eight collaboratives produced multiple positive results, helping establish a well-organized, community-integrated dental care system. But it is too soon to determine their overall impact on improving oral health.

The collaboratives' successes resulted from resource-intensive efforts. Grant funding has helped build several programs from the ground up. Consequently, grantees have focused on:

- Establishing and strengthening their collaborative relationships
- Establishing school-based dental clinics
- Creating integrated systems of care
- Developing care coordination
- Increasing clinic productivity

But, little has been done to determine how these efforts will improve oral health.

Since collaboratives usually are volunteer relationships, several felt it important to learn efficient use of time to develop their ideas and establish an action plan. This forced collaboratives to identify their needs and focus on activities to meet them.

The working assumption has been, "If you build it, they will come." Indeed, many have come for more services. The next step is to determine how the parts fit together to improve oral health (e.g., reduce dental decay, increase use of sealants, complete more treatment plans, increase the number of children making their first dental visit before age three, improve diets).

Key Points

HUSKY A-plan providers in the collaboratives have experienced an increase in families receiving care. These providers and the collaboratives in general have emphasized that HUSKYA-enrolled children can obtain the same quality care as those with private insurance. The need, however, for increased availability of the more costly restorative services still exists. Meeting this need involves several challenges:

1. Need to Decrease "No-Show" Rates

Most collaboratives have worked on reducing no-show rates to improve access to care. Reasons for no-shows include:

- Transportation
- Child care
- Employment
- Language barriers
- Fear of a bill (misunderstanding about HUSKY A coverage)

Many collaboratives have changed their overall systems of care to ensure a patient can schedule an appointment in one to two days after calling. But a patient may be unable to schedule a "make-up" visit in that timeframe if they miss their initial appointment.

- At one collaborative, this results from emphasis on scheduling as many new patients as possible. Although no-shows are rescheduled, they fall to the end of the new-patient list.
- At another collaborative, patients with a treatment plan receive immediate follow-up when they need additional care. An automated reminder system calls families, followed by a call from the care coordinator. This collaborative has reduced its no-show rate from 35 percent to 13 percent, a result primarily of changing the scheduling system.

Without question, the Connecticut Health Foundation has impacted investment in community-based collaboration, research practices and advocacy relating to dental care access for HUSKYA-enrolled children.

System changes included:

- Greater flexibility in changing an appointment if a patient calls ahead
- Calling to remind patients of their appointment
- Maintaining open times between appointments for late-shows to deter no-shows

2. Role of School-based Health Clinics

Dental care through the School-based Health Clinics (SBHCs) has proven essential for educating parents and children about the importance of preventive oral health, such as routine brushing, proper diet and regular dental care. Further, SBHC or mobile van services are providing services to students that have never visited a dentist and report tooth discomfort or pain.

A challenge for many youngsters, especially those with substantial tooth decay or more complex needs, is ensuring their parents return the treatment-approval forms and follow treatment schedules. Often, treatment was delayed because of missed appointments, incomplete forms and inadequate parental follow-up.

3. Focusing on a Target Population

Three key interviewees asked: "Is there a conflict in priorities for some collaboratives in focusing on building capacity for HUSKYA-enrolled children versus a system-wide emphasis on building capacity for all children and the rest of the population for a variety of services?"

Although CT Health did not prohibit grantees from treating all children, regardless of financial means, the focus on HUSKYA-enrolled children encouraged providers to discuss better ways to accommodate children with private insurance, as well as those with neither HUSKY A nor private insurance. Treating other populations, as well as HUSKYA-enrolled children, will substantially improve total care capacity.

4. Dental Reimbursements

Opportunities were identified that could increase reimbursements to grantees if oral health providers could better implement treatment plans and prevention at current reimbursement levels. In other words, while CT Health, grantees and advocacy groups work to increase reimbursement levels to the 70^{th} or 75^{th} percentile for services and procedures, providers should try to maximize care provisions at current reimbursement levels. The challenge is properly tracking and coding treatments, and submitting reimbursement requests on time.

5. Role of Educating Oral Health Caregivers

All key interviewees expressed the need for strategies to educate parents and children about oral health, especially about preventive care.

For example, children with significant tooth decay have complex treatment needs. This often requires multiple appointments and provides many opportunities to teach preventive oral health techniques. At the same time, care coordinators can educate parents and other caregivers about the importance of oral health home care and routinely schedule appointments during each contact.

This increased knowledge should increase compliance and contribute to reduced new oral health infections.

It also was clear that clinics must:

- Inform parents about HUSKY Part A plan dental care benefits through concise coverage information that curbs fears about co-payments or billing
- Develop a specialty-care network of private-care dentists for HUSKYA-enrolled children

6. Community Health Center Staffing Challenges

Another expressed concern was the shortage of auxiliary staff – nurses, hygienists and public health personnel – especially for preventive care and screenings.

Several individuals also discussed having staffed capable of adapting to changing demographic needs. Our increasing non-English-speaking population requires services and several communities face a more transient population. This requires records to be shared among providers, clinicians and educators.

7. Community Health Center Organizational Challenges

CHCs have several issues impacting their ability to sustain access to care, such as:

- Timely and sufficient payment from the state Department of Social Services
- "Know-how" to develop relationships with potential dentists, and contract with them
- Staff dedicated to capacity-building and resource development
- Full-time program planners
- Workers/staffing (adequate training, retention, consistency)
- Social service coordination
- Operational capacity, such as adequate treatment space and state-of-the-art equipment

Half the CHCs expressed management concerns. Several individuals raised concerns about the lack of sound management practices to improve quality. Examples include:

- Ineffective department policies and practices
- Lack of follow-up support for patients
- Inability to extract and use data
- Wasteful resource management

Despite challenges facing several CHCs, foundation funding has improved access, including:

- Expanded preventive services in schools
- Increased preventive care numbers and reduced dental decay at several CHCs

A primary challenge for CT Health will be helping CHCs strengthen program sustainability. Some of this will entail helping CHCs better understand program costs, such as:

- Variable costs associated with transportation and social-service support
- Management strategies for fixed costs associated with capacity issues, such as space
- Finding payments for uninsured care
- More effective management of existing budgets

Research Practices/Putting Knowledge into Action

Oral health research is a CT Health priority. Over the last six years, CT Health has commissioned a number of key reports by Dr. Crall and Dr. Edelstein[1], and provided funding for a study of the statewide safety net, conducted by Dr. Beazoglou and colleagues[2], as well as other reports and policy briefs.

The Crall-Edelstein report is especially useful because it lists four strategies that have shaped CT Health's approach to the oral health initiative:

- Public finance (i.e., increased HUSKY A reimbursements)
- Workforce capacity to meet patient needs
- Systems-of-care enhancements
- Prevention

These recommendations for community collaboration and advocacy are central to CT Health's oral health initiative.

---

[1] Crall, James J. and Edelstein, Burton L. Elements of Effective Action to Improve Oral Health and Access to Dental Care for Connecticut Children and Families. Connecticut Health Foundation. 2000.

[2] Beazoglou T., Heffley D., Lepowsky S., Douglass J., Lopez M. and Bailit H. The Dental Safety Net in Connecticut. JADA 2005; 136; 1457-1462.

Public Finance
Increasing HUSKY A reimbursements has been the main theme in finance. Additionally CT Health's finance studies also recommend encouraging dentists to recruit others to treat HUSKY A patients (accepting existing reimbursements) and provide more volunteer service. These strategies address dentists' concerns about compensation strategies based on existing structure.

Workforce Capacity and Systems-of-Care Needs
The evaluation identified a need to increase the role of auxiliary staff in oral health care. Currently, dental assistants are limited in the care they can provide and what qualifies for reimbursement. The responsibilities of state dental assistants and hygienists should be expanded to national norms (see American Dental Association state-by-state reference sheet).

CT Health has provided research to support concerns about quality issues involving CHC provider staff. For example, Bina Katechia, University of Connecticut School of Dental Medicine Division of Pediatric Dentistry, received a $67,000 CT Health grant, which supports her work with six CHCs to improve pediatric dental patients' access to care.

Prevention
Private practitioners can improve their efficiency and cost-effectiveness with more hygienists conducting preventive care. This approach will enable dentists to focus on more the more complex restorative care.

Another prevention strategy drawn from the research is to increase the number of dentists seeing children under age three, which would require additional education of the dentists to treat this age group.

Research also focused on how best to improve oral health care access, quality and use, and increase public-private partnerships. One example is for CT Health to explore performance monitoring, oral health surveillance and quality improvement to advance oral health.

Recently, the Community Health Center Association of Connecticut (CHCACT), previously called the Connecticut Primary Care Association (CPCA), received a $287,615 research grant in conjunction with Safety Net Solutions to help eight CHCs develop and implement strategies that will improve dental service efficiency. This includes examining management and billing-related issues.

CT Health research also identifies the need to strengthen the dental workforce, especially recruiting and educating under-represented minorities. The foundation, however, has provided only limited funding for recruitment and education.

Advocacy / Shaping Oral Health Care Delivery

Advocacy's primary impact has been the Connecticut legislature's addition of $20 million to increase HUSKY A reimbursement rates to the 70th percentile.

A recent *Hartford Advocate* article noted that the Connecticut State Dental Association (CSDA) believes increasing dental-care HUSKY A reimbursement to the 70th percentile would result in another 300 dentists treating HUSKY A-enrolled children and that the 90 dentists already doing so would add more patients.[3] Much of this effort's success is because of CT Health.

One hurdle is moving dentists to advocate among colleagues. But anticipated changes in resources to cover HUSKY A-enrolled children create an opportunity for CT Health to encourage dentists to see more of these children.

CT Health Investment

CT Health's primary advocacy funding is to the Connecticut Health Initiative (COHI), which began in 1993 as a CSDA committee.

CT Health provided $100,000 annual grants in 2001 and 2002 to promote sound oral health policies and advocate for systemic changes that would resolve the oral health crisis facing Connecticut low-income families. Through 2006, COHI received $610,000 to sustain operations, develop communications and raise awareness, which comprised over 90 percent of CT Health funding used for advocacy.

Accomplishments

In 2003, COHI also received funds from the Anthem Foundation of Connecticut, Inc., becoming an independent, nonprofit organization dedicated to oral health issues. Among their accomplishments are:

- Helping pass legislation simplifying dental care delivery within the HUSKY A plan and requiring the Connecticut Department of Social Services to submit a waiver to implement any major HUSKY A program changes to both the Human Services and Appropriations committees for public feedback
- Developing a train-the-trainer oral health curriculum with the state Department of Public Health for professionals and nonprofessionals

---

[3] "A Crisis of Care" *Hartford Advocate*, April 2007, Vol. 34:16, pp 18-19.

- Increasing public awareness about oral health issues through presentations, an electronic newsletter (COHI Online) and legislative breakfasts throughout Connecticut
- Compiling an oral health needs assessment for state children from birth to 48 months in five cities to create a comprehensive oral diseases prevention plan
- Creating a Bristol community empowerment project to give residents the skills, tools and opportunities to improve access to quality, affordable oral health care

Future Challenges

COHI leadership noted that the struggle is not over, despite state funding support for HUSKY A-enrolled children (to be distributed in June 2008), Pressuring the state to follow the legislature's move to increase dental provider fees to the 70th-75th percentile is central to making proposed increases a reality.

The next step is determining how funds will be spent assessing the impact of the additional resources. Once state funding is approved, and service and assessment provisions are enacted, advocates and other stakeholders will support the new administrative service organization's dental provider recruitment activities to increase the number of providers caring for HUSKY A-enrolled children.

The immediate focus for advocacy activities will be on two priorities:

- Addressing providers' reimbursement concerns
- Highlighting the value of existing program models and safety-net providers, such as school-linked programs with a full care-coordination component and CHCs

Achieving Sustainability

Overview

Several grantees among the collaboratives view sustainability as one of the more challenging issues. They dealt with existing reimbursement rates, while trying to increase access and expand services, which usually led to added costs. Half the grantees sought a financial consultant, but they appeared to be inadequately prepared to ask questions related to all areas of program sustainability.

Issues

1. Beginning grantee programs without sustainability in mind

To have grantees begin their programs with sustainability in mind would have required planning for program expansion and leveraging relationships. Financial sustainability also was the only area of sustainability on which the grantees focused. Strategies for sustaining community networks, building social capital (effort devoted to community activities) and collecting and disseminating data also are important.

2. Diminished returns on investment

Table 2, for example, presents 2001-2006 prevention and treatment data for the collaboratives' patients, ages three to 18. Notice that:

- Five of eight collaboratives saw decreased prevention and treatment for HUSKY A-enrolled children in 2006 compared to 2004 and 2005
- Two collaboratives had a decrease in 2005 compared to 2004
- All collaboratives saw a service decrease in at least two of the six years of funding

This is an example of increased access or number of visits, without the capacity to meet the need. And need is related to having both:

- Adequate supplies of dentists or hygienists
- Sufficient social-social service coordination, transportation, staffing, scheduling and translation services

3. Funding gaps

Gaps the collaborative grantees anticipated covering were overwhelming.

According to some grantees, school-based clinics can lose $100,000-$300,000 providing care. If the collaborative cannot approach the school system or other benefactor to cover these losses, they often have no other means of maintaining oral health services along with other, more profitable program areas.

Table 2: HUSKY Prevention and Treatment for Collaboratives between 2001-2006.

Collaborative	3-18-yr-olds	Baseline YR % Change 2001	Previous YR % Change 2002	Previous YR % Change 2003	Previous YR % Change 2004	Previous YR % Change 2005	Previous YR % Change 2006	Six-Year Percent Increase
Bridgeport	Prevention	16.30%	22.96%	21.86%	5.90%	-1.58%	-6.61%	46%
	Treatment	14.47%	20.21%	10.92%	14.31%	-3.72%	-6.72%	37%
Danbury	Prevention	-3.39%	21.35%	38.31%	29.63%	24.60%	10.87%	201%
	Treatment	-5.86%	20.88%	27.58%	22.33%	23.50%	1.10%	136%
New Britain	Prevention	21.00%	12.01%	13.36%	-2.09%	5.56%	13.32%	49%
	Treatment	-10.00%	8.64%	14.77%	0.91%	16.23%	6.82%	56%
New Haven	Prevention	15.15%	8.53%	13.06%	2.95%	14.05%	-4.07%	38%
	Treatment	15.06%	10.48%	22.86%	-2.62%	10.41%	-5.12%	38%
Hartford	Prevention	17.58%	14.20%	15.93%	-0.53%	-1.68%	-2.87%	26%
	Treatment	-0.92%	8.33%	4.89%	-1.49%	1.28%	-5.16%	8%
Waterbury	Prevention	19.04%	17.87%	9.07%	7.64%	5.14%	3.24%	50%
	Treatment	11.62%	14.13%	12.05%	12.43%	7.15%	-3.40%	49%
Stamford	Prevention	-2.88%	32.35%	19.57%	7.82%	-10.53%	-2.11%	49%
	Treatment	-2.88%	26.53%	19.56%	2.49%	-8.30%	-8.36%	30%
Southeast	Prevention	-7.07%	21.32%	8.32%	41.62%	0.83%	-20.51%	49%
	Treatment	-8.23%	14.11%	-4.00%	45.98%	-0.83%	-21.14%	25%

An innovative contractual agreement is to subcontract under the CHC, enabling dentists to protect time (i.e., dedicating time for HUSKY A-enrolled children) at little to no loss.

Many collaboratives depend on CT Health funding to sustain most aspects of their relationships.

Establishing a Common Agenda and Executing a Plan

In the most successful collaboratives, leadership unites to establish a common agenda and execute a plan. One collaborative struggled because leadership could not find common ground. In another, top-level managers did not have a dentist, hygienist or safety-net provider information. Managers promoted their own interests; personality conflicts and agency disagreements developed; and some organizations ended their involvement.

As a result, the group has been unable to develop comprehensive informational or marketing tools. Key interviewees also felt:

- Collaborative members did not support the collaborative concept.
- Service demands conflicted because of local needs and oral health wasn't a priority
- "Bridge building" is needed between collaborative participants and organizational leaders, and among collaborative members

Sustainability plans included:

- Grant and provision requests to the local school board
- Grant submissions to local foundations
- Increased subcontracting arrangements with local private-practice dental providers
- Requests to funding partners

Other Issues

1. Lack of Department of Children and Family Services (DCFS) representation

Collaborative leadership should include representation from the Department of Children and Family Services (DCFS) or parent of a HUSKY A-enrolled child, yet several collaboratives had no such representative.

Finding a way to build the collaborative relationship without demanding meeting time is another challenge.

2. Sustainability not always an issue

Some collaboratives find sustainability less of an issue because their organizational structure can fill unexpected funding gaps. In one instance, a CHC in northeastern Connecticut had CT Health fund a mobile van in 2002 ($75,000) only to find the project required another $50,000 in support during 2004-2005, and $50,000 more for a pediatric dental program. Section 330 federal funding enabled the CHC to expand the program, which is now self-sustaining.

3. Expanding capacity may not be a top priority

Some CHCs interviewed do not feel expanding their oral health capacity is a priority, given their need to meet competing service demand. This is especially true of service demands where expanding capacity will boost revenue through increased reimbursements or volume. This may not be true for dental services, especially given the relatively high no-show activities. This means oral health will have to be a higher priority in the overall mission or strategic growth plan of the center or organization,

Maintaining Sustainability

Ensuring sustainability requires program changes that improve clinic efficiency and productivity to increase revenue. Examples of changes include:

- Verifying insurance and eligibility
- Patient information or consent forms
- Care coordination
- Clinic per-patient productivity
- Staffing continuity
- Adjusting operating hours to more productive periods based on availability of children

Investments in staff, organization structure and processes focused on how best to approach such changes also are essential, as the following two examples illustrate:

Since school-based clinics are essential to providing preventive care, program sustainability depends on efficient intake and processing procedures, such as dental claims reimbursement. Organizational and individual expertise about system integration of insurance verification, billing and eligibility checks also is key to building and sustaining effective care coordination.

Some CHCs are paid by the visit, regardless of the workload completed. So, there is a tendency to improve revenue by limiting the number of procedures completed per visit, which increases the visits required to complete treatment. The increased number of visits often becomes a deterrent. Follow-up becomes more costly in time and resources devoted to encourage a parent to return. Helping eliminate these inconveniences for provider and patient could be a CT Health advocacy area.

Establishing a Format: Forums

Helping oral health providers build sustainability should be a primary CT Health priority over the next two or three years. Although CT Health provides collaboratives with technical assistance related to program development, including sustainability, impact varies with each program. Missing is a tailored approach, specifically a format that allows organizations to work as a group more frequently and purposefully, and helping develop individual solutions.

One way collaboratives can build more capacity is developing educational modules, presented in a series of teach-ins and real-time, problem-solving forums. Topics covered would include:

- Defining and benchmarking objectives
- Effective resource management
- Resource development in a competitive environment (federal and other nonprofit/private support)
- Gathering/communicating lessons-learned information between colleagues and public
- Adapting to demographic changes and population needs

- Creative thinking
- Strengthening partnerships

Groups could use forums to discuss creative ways to engage dental students in community-based learning activities related to a specific community. Emphasis would be on ensuring each student's time furthers a program's objectives, which would avoid "busy-work" or activities that don't advance the group's agenda.

Forums also could help the group promote early intervention benefits by developing a unique demonstration project in an urban area like Bridgeport, New Haven or Hartford that highlights the benefits of a school-based program engaging youth in oral health education and advocacy.

Committing Time and Staff

Committing time or staff to address sustainability issues is essential for programs to continue having an impact. Programs staffed with hygienists alone are ineffective for expansion or sustainability.

Increasing access requires a full-complement dental team, including dentist, hygienist and a staff person responsible for developing and managing the system of care.

Looking Ahead

CT Health is committed to revamping its oral health initiative so all funding efforts are committed to creating systems change.

Early in 2008, successful collaboratives are expected to continue receiving core funding to develop sustainability in their organizations, programs and finances. Other areas of CT Health's strategic initiatives also will be funded.

Follow-up of this evaluation will include subsequent interviews and review of materials from grantees to assess their impact at least one year after the current funding cycle ends.

Recommendations

Following are recommendations for CT Health drawn from this analysis and evaluation. In line with its history of funding initiatives that foster change, CT Health can leverage its investments to create more integrated oral health care models in Connecticut.

1. Expand access to care through collaboration

Goal: Increase involvement of dentists, public-health agencies, dental educators, state dental associations and state Medicaid representatives to work together to better facilitate the delivery of resources to meet the dental needs of state HUSKY A-enrolled children. Collaboration could be strengthened through increased communication among oral health care providers, CHC directors, academic leaders and the social service community.

Other considerations include:

- Addressing transportation and interpreter coordination for dental visits
- Expanding first-year pediatric screening education for parents and caregivers through family programs, such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Support school-based dental care to sustain existing capacity and maximize the impact of school-based health care on children's oral health
- Support educational opportunities in pediatric dental school programs, such as increased community-based learning activities, to increase interest in safety-net care

2. Sustain organizational capacity

One way to sustain organizational capacity is to fund full-time resource developers within oral health organizations. CT Health could expand its efforts in teaching oral health organizations how to subcontract dentists, providing templates for models that streamline contracting.

3. Continue advocating for HUSKY A reimbursements

This can be achieved by remaining diligent in requesting oral health appropriations in the state budget and ensure inclusion of cost-of-living and inflationary provisions tied to Medicaid appropriations, which would make oral health care for HUSKYA-enrolled children attractive to more dentists.

A related funding strategy is to maximize federal matching funds for program operation through contracts with a local government agency. CT Health can inform grantees and CHCs about the possibilities of such agreements and how this can benefit children's oral health care.

4. Facilitate discussions and provide resource support on cultural competence issues

Examples of this include training opportunities and materials, to raise awareness of Connecticut's unique cultural and socio-economic differences. Specifically, CT Health could initiate forums to reduce the stigma associated with serving HUSKY patients.

5. Increase awareness of oral health needs in nonurban Connecticut areas

The high concentration of dentists in urban areas creates substantial service gaps in nonurban communities, where many HUSKY patients reside. CT Health can help increase awareness of oral health needs and provide collaboration models that could benefit these communities.

6. Supporting public education campaigns

This can be accomplished, in part, by encouraging dental offices to hold family-oriented oral health education events, such as recruiting dentists for "Give Kids a Smile Day" and recording the costs of care delivered.

Public education messages can include:

- The importance of dental visits and early prevention from the child's first birthday
- The importance of dentists seeing children younger than age three
- Dental techniques that emphasize positive dental experiences for children and parents

Conclusions

Improved Access

Retrospective evaluation findings demonstrate that CT Health's support of community-based collaboration, research practices, policy and advocacy have improved access to dental care for HUSKY A-enrolled children. Results include:

- Increased dental visits among HUSKY A-enrolled children
- Systems-of-care development
- HUSKY A reimbursement changes
- Increased awareness and dialogue about HUSKY A -eligible children's oral health needs

As discussed previously, prevention and treatment of these children doubled in at least one collaborative. But, the ability to sustain the impact and further the work remains to be seen, as CT Health looks to expand its systems-of-change model.

Key Challenges

Key challenges that will need addressing to continue increasing access and maintain systems enhancements necessary to improve the oral health status of Connecticut children include:

- Financial management practices and limited revenue streams
- Insufficient numbers of child-centered dental providers
- Gaps in public awareness of oral health's importance to overall health
- Limited oral health surveillance and available data resources

But, it is unclear or too early to determine their overall impact on oral health.

For example, the collaborative grantees tracked increased dental visits of HUSKY A-eligible children only. Activities during the grant period did not include measuring the difference between these children and those covered under private insurance or uninsured children in the number of visits or the number of completed treatment plans.

Assessing treatment plans needed and those completed, along with following preventive screenings collectively, will help determine the overall impact on children's oral health.

The evaluation team hopes this report will provide CT Health with additional information to better leverage its strategic investments in oral health and provide essential information for developing future performance measures to understand the potential impact on oral health.

GLOSSARY

System of care: Service delivery that builds partnerships, creating a broad, integrated process to efficiently guide patients to the care they need

Safety net: Clinics defined by their mission to provide health care services to patients that may not be able to obtain care in other traditional venues such as the private sector

Community health center: A nonprofit agency that delivers primary health care services in medically underserved areas.

Care coordination: Process that helps identify children with health care needs and links them to needed services

Technical assistance: Assistance provided to grantees and other organizations to help them increase their effectiveness

No-show: A patient who does not keep a scheduled appointment.

School-based health centers: Clinics within schools that provide comprehensive preventive and primary health care services

Dental reimbursement: Payment to dentists from insurance companies or public agencies for services performed

Auxiliary staff (or ancillary or allied): Dental office staff that directly help the dentist provide clinical care, either by assisting the dentist or providing direct clinical care

Train-the-trainer curriculum: Used to teach key trainers, who then teach others using the designated curriculum

Sustainability: Ability to continue a project beyond the funding period

Preventive care: Care delivered to prevent a disease from starting or becoming worse

Restorative care: Comprises fillings, crowns and pulp treatments for teeth

System change: Changes in a health care system that improve access or delivery of care

75th percentile: Indicates that 75 percent of providers charge this fee or less as their normal office fee

Social capital: The individual and communal time and energy available for community activities.

APPENDIX A. KEY INFORMANTS AND INTERVIEW QUESTIONS

Community Collaboratives:

Names and position:

New Haven

- Annette Hird, Project Director
- Elaine Spinato, Care Coordinator
- Sharon McCreven, Dental Hygienist

Waterbury

- Christine Bianchi, Project Director

Bridgeport

- Meredith Ferraro, Chair
- Joan Lane, Project Director

New Britain

- Jesse White-Friese, Project Director

Stamford

- Jody Bishop-Pullan, Project Director/Care Coordinator

Hartford

- Sharon Joseph, Project Director
- Ronald Kraatz, Former Chair

Southeastern

- Sue Peters, Project Director

Danbury

- Kim Doan, Project Director

Following is the series of interview questions posed to representatives of the eight collaboratives:

- ✧ How were the collaboratives defined? How was your collaborative formed?
- ✧ Describe your collaborative process. How are priorities determined?
- ✧ Describe the goals of the collaborative and specific activities aimed at reaching those goals.
- ✧ What were the types of measurable access to care concerns defined for the grant and how were they developed?
- ✧ Please describe the specific access to care impacts for the collaborative that have resulted from Foundation funding.
- ✧ What other partners do you have that support the work of the collaborative?
- ✧ Describe your current systems of care and any challenges that it faces.
- ✧ Was there enough funding to adequately support the work of the collaborative?
- ✧ What are the next steps for the collaborative in the next year? Plans for subsequent years?

Foundation Leadership interviewed:

1. Pat Baker, President &CEO
2. Will Crimi, VP of Programs & Evaluation
3. Joanna Douglass, Program Officer/Oral Health Consultant

Below are the series of interview questions posed to the foundation's leadership.

Question orientation: Strategy and Leadership

- ✧ How were the foundation's initial goals derived?
- ✧ How would CT Health leadership characterize the relationship between its "theory of funding" and its "theory of change or impact"?
- ✧ How did CT Health leadership see its support for sustainable collaboratives evolving? In other words, would support remain consistent for a sustained period of time at current levels? Would there be more strategic complexity added to the overall funding plan to expand impact or strengthen the model?

Question orientation: Benchmarks and Program Impact

- ✧ How were the collaboratives defined?
- ✧ What were the types of measurable access-to-care changes CT Health was looking for from the grantees as it relates to the objectives set forth by CT Health?
- ✧ How were the recommendations/strategies from the Crall and Edelstein report integrated into the work with the oral health grantees, specifically the collaboratives?
- ✧ How was sustainability for the collaboratives and other grantees defined and what population-based impacts were anticipated from having sustained collaboratives?
- ✧ What kinds of resources did either CT Health, the collaboratives/grantees or both identify as necessary for both organizational sustainability and population-impact sustainability (i.e., maintaining or increasing the access improvements already realized)?
- ✧ Were performance measures defined by grantees to follow progress of objectives set forth in Project Fact Sheets? If so, what role did they play in each of the grantees' strategic planning and continued funding?
- ✧ What were the population-specific results expected for grantees (i.e., the ends – how much of an impact was expected to be seen)? Were expectations defined for each unique community? What were the performance-related results expected for grantees (i.e., the means – how efficient and effective were the collaboratives)?
- ✧ What were CT Health's expectations for organizational sustainability? For example, were collaboratives asked to develop long-term funding plans (perhaps as independent entities and/or existing collaboratives)?
- ✧ Were collaboratives provided with any technical assistance on where to look for or how to develop a strategy or plan for acquiring sustainable funding for both the collaborative itself and the population-centered work?

Key Informant Interviews

1. Donna Balaski, State Medicaid Director Connecticut-
2. Dr. Fred Thal, Pediatric Dentist with New Britain Collaborative and CSDA
3. Peggy Smith, Dental Director Generations CHC
4. Burton Edelstein, Children's Dental Health Project
5. Tryfon Beazoglou, University of Connecticut Dental School
6. Marty Milkovic, Connecticut Oral health Initiative (COHI)
7. Dr. Cliff O'Callahan, Pediatrician
8. Linda Ferraro, Connecticut Dept. of Oral Health
9. Kristina Mika, Consultant, Care Coordination
10. Jack Rustico, Connecticut Primary Care Association

Below are the series of interview questions asked of the key informants:

- ✧ What has been the impact of the foundation's oral health initiative?
- ✧ Has there been significant delivery of dental care issues following recent changes in the Medicaid contract?
- ✧ Please provide us with your perspective on needed access to care and oral health improvement studies or performance measures that should be undertaken with this initiative.
- ✧ Please provide us with background information on advocacy relationships, activities and policy changes relevant to increasing access to care.
- ✧ What role have state agencies played in advancing oral health and access to care in children in Connecticut? Please provide for us some context and background on the 2012 Connecticut Oral Health Plan.
- ✧ What role will public education play in increasing access to care in Connecticut?
- ✧ From a clinician's perspective, why aren't more private dentists covering HUSKY kids?
- ✧ Please provide for us your perspective on where oral health lies in terms of state budgeting priorities.
- ✧ In what capacity have you worked with the foundation?
- ✧ Please describe the role that you play in oral health care for children in the state.