The Oral Health Forum

Implementation of a Dental Case Management Pilot Project Targeting Chicago Public School Children with Urgent Treatment Needs, 2015

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INTRODUCTION

Public health attention to oral health care remains inadequate as evidenced by prevalence of dental caries and periodontal disease in general and especially in low-income communities. These common oral infections are almost completely preventable with education, effective self-care and timely access to professional oral health intervention. The Oral Health Forum (OHF) works with the public health system, key oral health care providers and community leaders to coordinate, expand, and improve existing oral health resources in health promotion, prevention and treatment.

School based prevention services are convenient, efficient and can effectively reach low-income children that are at high risk for dental diseases such as dental caries, gingivitis and periodontal disease. Chicago Department of Public Health (CDPH) through its School-based Oral Health Program has identified challenges obtaining follow up care for the Chicago Public School (CPS) children identified as having urgent dental treatment needs. A major barrier to treatment plan completion has been that the CDPH case management system is limited by staffing capacity to conduct year-round, multiple follow-up interactions with families. This recognition and concern led to restructuring and creation of the Dental Case Management (CM) Pilot Project. This project is an intensive collaboration between CDPH and OHF with the focus in two zip code areas of the city (60629 and 60632) where children are highly affected by urgent dental needs.

PROJECT OBJECTIVE

The Dental CM Project is a fluid intervention, organized to understand, identify and overcome systemic and individual barriers to completing follow up dental care for identified children. The CM project aims to provide comprehensive follow-up services, including case management tools, which ensure CPS students with urgent care needs receive follow up treatment and an opportunity to establish a dental home.

PROJECT METHODS OR ACTIVITY/PROCESS

Two bilingual Spanish fluent case managers hired by OHF actively worked at the programmatic, community, and implementation level.

Programmatic level:

- Case managers designed specific accountability/tracking forms to facilitate their work. These included developing:
  - tracking system to manage students
  - call script
  - schools and dental offices mapping spreadsheet
  - Schools' profiles of the 39 schools in 60629 & 60632 and
  - barriers to dental care/ solutions chart

Community level:

- Case managers established relationships and disseminated information about the program
- Emailed and visited all schools (39) in the designated communities and additional schools in the surrounding areas (5)
- Informed staff about the program and identifying at-least one go-to person at each school
- Completed an service site assessment of dental offices in the two zip codes (55); details on each dental office included eligibility criteria, payment, appointment process and other variables
- Completed a program presentation and listening session with community dental providers and dental insurance representatives
- Developed relationships with community-based organizations in the target area to address additional barriers

Active case management implementation:

- Case managers contacted parents/caregivers of child(ren) identified with urgent dental needs in the assigned 39 schools

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and parents of children with non-urgent restorative treatment needs in 3 highly affected schools
- Case managers assisted parents in overcoming various barriers to care
- Case managers documented each contact with parents. Data collected were compiled and analyzed for barriers to care: insurance status, non-receipt of referral letter, transportation, knowledge of health status, where to go for care

FINDINGS

Infrastructure assessment revealed the lack of publically supported Federally Qualify Health Centers or School Based Health Centers with dental services in 60629 & 60632. Thus, children from these communities rely solely on private practice dental clinics/providers to access dental services in their community.
- 95% of children in these school are from low income families with 86% identified as Latinos and 7% African Americans

Of the total of 1,715 children in the 39 schools targeted in this CM intervention
- 1,069 children were identified as having urgent dental needs
- Approximately 50% of the children with urgent needs (533) were from 3 schools
- There was also a very high number of children in these same 3 schools with non-urgent restorative treatment needs (646) with the potential of becoming urgent care cases in the next school year
- Case managers were able to contact & inform parents/caregivers of 1,349 children (79%)
- Case managers provided late afternoon/night hours to enable contact with many of the parents
- A total of 1,220 parents/caregivers reported having taken their child(ren) to the dentist
- Parents report of insurance status: 77% Medicaid, 13% private, 10% un-insured

Community Provider Findings
- Parents need education on length of dental appointments, education and support to carry out effective prevention practices at home.
- Parents need to understand their own high risk behaviors (snacking, consumption of sweetened beverages) do not support their child's health status.
- Community providers found it difficult to refer specialty care for cases that could not be handled in their office.
- Providers felt that the paperwork and processes mandated by HFS delayed treatment and was a point of frustration.

LEARNING & CONCLUSION

OHF used a health equity lens in the formulation of this project design. This orientation facilitated a comprehensive and robust CM model designed to meet the treatment navigation needs of high risk CPS children. In this first year, significant progress was measured: 1,220 of 1,715 or 71% of children were taken to a dental provider to obtain follow up dental care. In the pilot region, there are very limited numbers of Medicaid accepting dental providers. In addition, dearth of FQHC and other publically supported programs grossly limit access points for care, as up to 77% of children are Medicaid recipients.

In the 2016 school year, OHF targeted intervention is being further refined and will focus on the 3 schools identified with the highest number of children with urgent and non-urgent dental needs. Significant programmatic resources will be dedicated to increasing the priority of optimal oral health in these schools, including an OHF supported parent Oral Health Champion at each of the three schools. Additionally, the CM model will be expanded to a geographically adjacent, high need zip code of 60623.

Concerted policy efforts are needed to increase the very low Medicaid reimbursement rates for dental services. Increasing reimbursement to national median and ease of provider enrollment can result in more Medicaid enrolled dental providers, thus increasing number of access points. In addition, provider enrollment in publically funded programs needs to be streamlined. OHF anticipates that findings reported here will mobilize partners to empower children, parents, school staff, dental providers and community organizations. This project has led to a better understanding of specific needs of children in these disadvantages areas of Chicago and will help to address social determinants of equity.