

Leading Chicago Children to Oral Health Improvement: A Health Equity Approach Case Story

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The Oral Health Forum (OHF) in collaboration with the Chicago Department of Public Health (CDPH) and the Chicago Public School System (CPS) developed an intervention to address the increased number of children with urgent dental care needs in a specific area of Chicago. The intervention included elements crucial to a health equity approach such as: diagnosing disparities, linking what was learned through a root cause analysis to available resources, and gaining commitment from a variety of stakeholders to implement change.

Background

CPS is the third largest school district in the nation with around 400,000 students registered in the 2015-2016 school year. Approximately 86% of CPS students are considered economically disadvantaged with 39% of them identified as African American and 46% as Latino.

In 2000, CDPH initiated the School-Based Oral Health Program (SBOHP) within CPS. The program has grown over the years from one to 18 providers, becoming the largest SBOHP in the nation. Now, every CPS student, at all grade levels, has the opportunity to receive oral health services in the school setting at no cost. In 2014-2015, approximately 115,000 students received preventive services through the SBOHP.

OHF is a community-centered initiative that is housed in Heartland Health Outreach and committed to improving oral health programs and services for all Chicago residents through education, assessment, policy/program development, and collaboration. OHF is a leader in oral health advocacy and planning in the city. Collaboration among the three organizations in different projects has been taking place over the last seven years.

A Common Situation in Our Community

Clarissa, the mother of Fred, a 4th grader in CPS, answers a call from Lilliana, a case manager with OHF:

“Lilliana, thank you for calling me. Fred has been complaining of pain in his mouth for two months; he can’t sleep, he has trouble being in school. I have run into dead end after dead end trying to get help for him. First my dentist told me Fred needs to see a specialist and she said she’d send a referral. That was a month ago and I heard nothing from her. So I called again and found out the referral was lost or something and has to be redone. I gave up on them and went to another dentist, only to find they don’t accept Medicaid.

I feel horrible that I can’t help my son other than by giving him pain meds. I don’t like this at all. It’s not right.”

Which children have the most urgent dental needs in our city? And why?

While the SBOHP had been successful overall, severe disparities remained. In 2015, we decided to take a more targeted approach to meeting the needs of the children who are experiencing the most urgent dental needs in Chicago. We realized we did not know enough about who these children are or why they are experiencing such a severe level of urgent dental needs. We knew that we could not design a successful intervention to reduce these disparities without first taking the time to learn more about what was going on and why.

We launched a case management pilot in the two Chicago zip codes with very high numbers of children with urgent dental needs. While our goal was to improve oral health outcomes for these children by connecting them with dental providers to receive treatment and establish a dental home, the priority objective during the first year was to better understand *why children in this specific area of the city were highly affected by urgent dental needs.*

Our initial efforts focused on doing an environmental scan of health resources and opportunities in these two zip codes, as well as developing relationships with schools, community organizations, and community dental

providers. The environmental scan revealed that there are two school-based health centers, seven Federally Qualified Health Centers (FQHC) sites, and one hospital in these zip codes, but none of these facilities provide dental treatment. *Residents in the two zip code areas rely solely on services provided by 56 private dentists; however, 16 of them do not take Medicaid and others have limited availability for Medicaid patients.*

Detailed analysis of the children with urgent dental needs after the first year of the pilot revealed that 97% were Latino children whose parents have limited or no ability to communicate in English. This was a surprise to us, as we had previously guessed that the majority of the children with the most urgent dental needs would be African American. Interestingly, we found that 50% of those children with urgent need were clustered in three schools. Additionally, a very high number of children with non-urgent dental needs that could potentially become urgent in the near future were also found in the three schools. We were astonished to learn how intensely concentrated the urgent needs were in such a small geographic area.

Key Lessons from this Story

1. Start by collecting and analyzing data to understand where the disparities exist.
2. Once you know *where* the disparities exist, find out *why* they exist.
3. Design interventions to meet the needs of the specific groups of people who are experiencing the greatest level of urgency and lack of access.
4. Equip people who have the most skills, connections, and culturally-specific knowledge with the tools to educate and serve people who are most affected by the disparity (for example, bilingual case workers well versed in immigration issues, and classroom teachers who may have deeper relationships with students and parents).
5. Try out some strategies, and continually adjust them to ensure that they are reducing, not reinforcing disparities.

How did we begin implementing a program that would reduce these disparities, creating increased self-empowerment of families and teachers as well as increased access to quality oral health services?

Tailoring quality improvement efforts to meet the needs of marginalized populations.

Based on findings from the first year, we implemented a few new strategies to enhance the ability of families to improve their oral health:

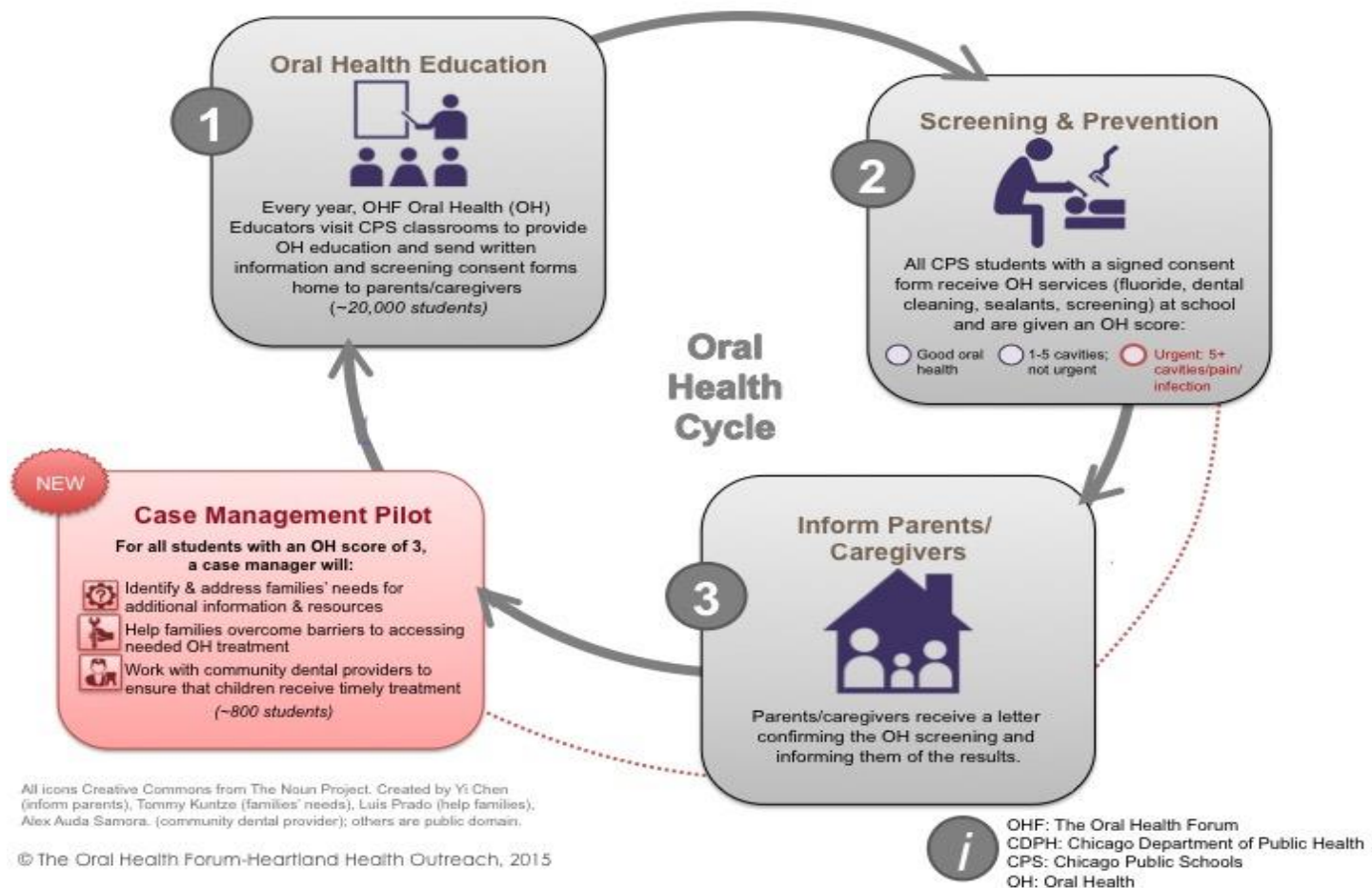
- We hired two bilingual case managers that could communicate with immigrant families and understand the difficulties these families face navigating the US health care system.
- An incentive model was developed, targeting the three schools where 50% of the children with urgent needs were clustered. This Oral Health Champion program was designed to involve the whole school community: children, parents/guardians, families, teachers, and school personnel. Through the program, OHF has been developing a more in-depth relationship with these schools, increasing awareness

about the importance of oral health as an integral component of general health and reinforcing community knowledge about healthy oral health habits.

- Some of the activities employed in the three schools include: interactive presentations at parents' breakfasts and teachers' institute days, classroom oral health education for all children, community health fairs, and one-on-one connection with parents at report card pick-up day.

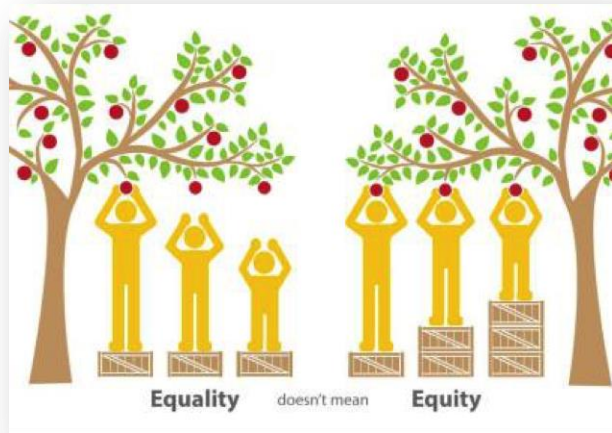
Through the support of the school and Oral Health Champions, we organized a dental van visit at each of the schools to provide treatment for uninsured children and children facing difficulties accessing a community dental office. *After receiving urgent treatment from the dental van provider, case managers assist parents with identifying a dental home in their community for on-going care.* We have also been developing relationships with community providers to enhance access to care for these children.

Our School Year Oral Health Cycle Model



This infographic illustrates the Oral Health Cycle that takes place at CPS every school year. If a child has an oral health score of 1 (healthy), the cycle is complete and the child restarts the oral health cycle in the following school year. However, if the child resides in the target area and has an urgent (oral health score of 3) or non-urgent (oral health score of 2) dental need, CDPH sends the list of students to be enrolled in the case management pilot to OHF. The desired outcome is that a child entering the case management pilot with a score of 3 or 2 will move to an oral health score of 1 in the following school year because needed care was completed and the child is maintaining good oral health.

A Health Equity Approach



Health equity is defined by the Oral Health 2020 network as the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address inequalities, historical and contemporary injustices, the elimination of disparities, and the assurance of the structural and personal conditions needed to support optimal health for all people (Adapted from Healthy People 2020 and Dr. Camara Jones). As illustrated in this image, achieving oral health equity requires the redistribution of resources and efforts to enhance the opportunities that disadvantaged populations have to attain better oral health. The intervention described in this case study uses a health equity approach by promoting and facilitating a

comprehensive model that can meet the needs of the children that are more affected by dental diseases in the CPS system. Extra blocks have been put under the feet of the most disadvantaged children to give them the opportunity to attain better oral health. Hopefully, because of the efforts to restore their health, those children will not only be able to reach the apple, but to bite the apple and enjoy a healthier life.

A Common Situation in Our Community (continued)

Lilliana, the case worker, responded to Clarissa's all too familiar challenge in getting Fred the care he needs:

"I hear you; and I am sorry that you've spent so much time trying to solve this problem only to come up against so many road blocks. I think I can help. My job is to help parents like you get the services you need. We are set up to help children with multiple cavities, swelling, and pain or abscesses; we have an agreement with UIC's Dental Clinic to expedite access to their dental services."

Clarissa thanked Lilliana,. That very same day, Lilliana contacted OHF's DDS director and arranged for her to make a referral to UIC's Dental Clinic; she completed and faxed a form to the dental clinic that included a brief description of Fred's oral health issues as identified in his CDPH SBOH examination; and she received confirmation from UIC that very same day that Fred would be given an appointment and that his mother would be notified.

Lilliana then called Fred's mom back and left her a message that she had confirmed that UIC would be in touch to schedule an appointment for Fred. Lilliana then stayed in touch with Clarissa to check-in and see if she had indeed been contacted.

When Clarissa did connect with UIC to arrange an appointment for Fred she called Lilliana, leaving a voice mail thanking her and OHF for their help. Clarissa said in her message: "I have been so worried about his oral health and I couldn't get anywhere. Thank you all so much."

