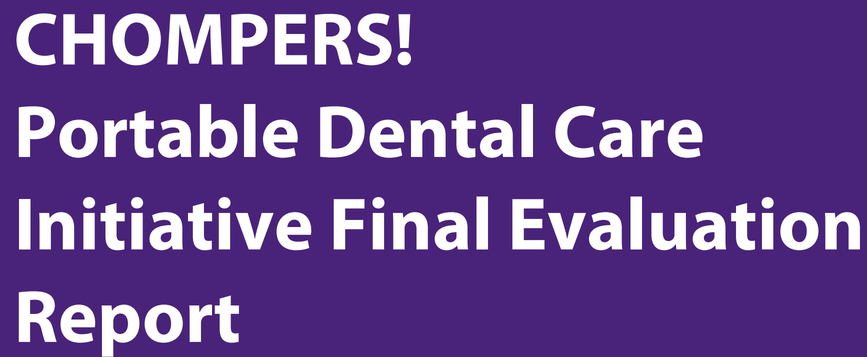

CHOMPERS! Portable Dental Care Initiative Final Evaluation Report

Lessons Learned from Program Implementation

July 2013

harder + company
community research

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Executive Summary

In 2010, the Health Foundation of Western and Central New York (HFWCNY) commissioned Harder+Company Community Research to evaluate *CHOMPERS!* Bringing Dental Care To Kids (*CHOMPERS!*), a multi-year initiative designed to improve dental health among young children living in poverty.

The Portable Dental Care (PDC) component of the initiative has supported efforts to bring dental care to children where they already gather in the community, in order to help eliminate barriers to receiving preventative services and treatment. The Foundation funded four grantees to implement PDC, each located within a different county within Western or Central New York. The grantee organizations were Baker Victory Dental Clinic, East Hill Family Medical Center, Olean General Hospital, and Syracuse Community Health Center. Each of these organizations operated dental clinics serving safety net populations. The PDC funding allowed them to form relationships with schools (primarily Head Start centers and other early childhood education [ECE] sites) to provide dental services onsite to children during the school day. This report presents findings from the first 18 months of PDC, looking at program start up, implementation, and outcomes. Evaluation methods included interviews with grantees, ECE sites, and external stakeholders; and the collection of quarterly data from grantees on program operations, services provided, and outcomes. Below we summarize key findings from the evaluation by evaluation question.

What services were offered, by whom, and who was served?

- **Services offered.** Grantees and associated ECE sites primarily provided preventative oral health services to children. Over 90 percent of services provided were for preventative services, with the remainder for restorative work. Preventative services provided included oral exams, cleanings, and fluoride treatment. Children were referred out to fixed dental clinics for extractions and other more involved dental work.
- **Type of providers.** Each of the three sites in operation reported having dentists, hygienists, and dental support staff available to provide services to children through PDC.
- **Program reach.** The PDC program served close to 1,000 children during its first 18 months of operation, based upon data available from three of the four grantees who had achieved full opeation.
- **Child demographics.** The majority of children served through the program were covered by Medicaid, and the majority were ages 4-5. One site was serving some elementary school-aged children, and the remainder of services were provided to children ages 0-3.

How well-implemented was the program? Which factors enable or constrain implementation?

- **Challenges to program startup.** Most grantees experienced substantial delays in starting up their PDC programs. Two factors that contributed to these delays were issues related to coordinating on purchasing of portable equipment, and difficulty navigating state Medicaid regulations. Grantees addressed these challenges by receiving

support from the Foundation and technical advisors, and by working closely with ECE sites to work through Medicaid reimbursement issues.

- **Challenges to program implementation.** Grantees and ECE site staff reported several ongoing challenges to successfully implementing the PDC program. These included ensuring adequate staffing to manage the program, streamlining enrollment and coordination procedures between grantees and ECE sites, and factoring in the learning curve for providers to operate portable equipment. Strategies that grantees and ECE sites used to address these issues included increasing staff time dedicated to PDC and clearly defining roles, developing outreach strategies to increase parental enrollment in PDC at ECE sites, and offering provider training on the use of portable equipment. Nonetheless, grantees continue to struggle with these issues, particularly as they looked to expand to new locations.
- **Contextual challenges.** Aside from challenges related to the program itself, several key contextual factors also posed barriers to grantees and the populations they were serving. These included an insufficient supply of dental providers (particularly those accepting Medicaid), a lack of pediatric dental providers, and parental anxiety about children receiving services in school. Barriers related to the supply of dental providers go beyond the PDC program, but potential strategies for addressing them within the program include developing relationships with local dental schools to create a pipeline of providers, identifying backup providers, and providing training to PDC providers on the treatment of young children. Grantees and ECE sites addressed issues related to parental anxiety through performing outreach and education with parents, and making dental staff accessible to children and parents.

What changes resulted from PDC, and how did they vary among grantees, children, and ECE sites?

- **Awareness of oral health issues amongst parents and ECE sites.** Grantees and ECE site staff indicated that the PDC program was helping parents to understand the importance of maintaining good oral health habits for their children, thus setting their children up for a relationship with dental care at an early age. ECE sites also expressed enthusiasm for the program, and grantees reported they were becoming more engaged with ensuring adequate oral health of their students.
- **Access to oral health care.** All three grantees in full operation reported seeing an increase in access to oral health care amongst the populations they were serving. They reported increases in the number of children coming in for exams, and increased success in providing services to populations that were particularly hard-to-reach. There is some evidence from the quarterly data that grantees were also reaching children who had never seen a dentist, or hadn't seen one in the past 12 months.
- **Changes in oral health outcomes.** A couple of grantees and staff at their respective ECE sites reported seeing a decrease in the need for restorative services amongst children once they entered the second year of PDC implementation. As a result, they were seeing more children for preventative work. More information on program outcomes will be available in early 2014, when grantees' quarterly data collection is completed.
- **Cavity Free Kids impact.** Three of the four PDC grantees were operating in ECE sites that also participated in the *CHOMPERS!* Cavity Free Kids (CFK) program, which provides oral health education and outreach to children and families. Staff at the ECE sites we interviewed reflected that CFK was beneficial and complementary to PDC. For example, one

ECE site staff person noted that CFK helped children and their parents to understand why dental staff were coming to the schools so they would be more comfortable with services being provided. Others commented that CFK helped their staff to become more comfortable with discussing oral health issues with parents.

What did evaluation findings suggest about how to improve services?

- **Sustainability of the PDC program.** There is some evidence that the PDC *program* (i.e., within the grantees supported by the Foundation) is sustainable, based upon financial data submitted by grantees. The three grantees in operation also expressed optimism that their programs would continue beyond the initial grant funding. However, some grantees also struggled with issues related to Medicaid reimbursement, which made it difficult to determine sustainability. In addition, children, parents, and ECE sites were receptive to the program, suggesting that stakeholders were invested in having it continue.
- **Sustainability of the PDC model.** The evaluation also explored whether the PDC *model* was sustainable (i.e., the value of transferring PDC to other settings). External stakeholders pointed to a couple of ways in which the PDC had the potential for sustainability – it is more cost-effective than other methods from reaching families outside of a dental office, and there's some evidence that it can be replicated successfully in other settings. However, a couple of external stakeholders expressed concern that families would use PDC in lieu of establishing a dental home, despite the fact that the intention and strategy behind the PDC initiative was to use portable dental care as both a bridge to and extension of the dental home. Overall, interviews suggest that it will be important for the Foundation to cultivate awareness of how this model supports linkage of children to dental homes among dental stakeholders in the state.
- **Plans for expansion.** Two of the three grantees with operating PDC programs noted they had plans for expansion to new sites in the 2013-2014 school year. Some ECE site staff and external stakeholders also saw potential to expand the program to different populations, including siblings and parents of children participating in PDC.
- **Implications for future implementation.** Four key implications emerged from the evaluation with relevance to others looking to implement a portable dental care program. These include: (1) considering state policy context and Medicaid reimbursement policies; (2) ensuring sites have adequate support for program startup and ongoing management; (3) understanding that parents may need additional support to buy into the program; and (4) recognizing that documenting program impact can take time.

Concluding thoughts

In summary, the CHOMPERS! PDC successfully brought needed dental care to 1,000 children, the majority of whom were Medicaid-eligible. Though slow to start, providers currently see the model as sustainable and two plan to expand it. The CHOMPERS! PDC experience offers multiple lessons to others interested in this model.

1. CHOMPERS! Bringing Dental Care to Kids Evaluation

The Community Health Foundation of Western and Central New York (the Foundation) launched *CHOMPERS! Bringing Dental Care To Kids* in January 2010. This $1.1 million, three-year initiative is designed to improve children's oral health in Western and Central New York through education, treatment and preventative work. The portable dental care (PDC) component of the initiative supports efforts to bring dental care to children where they already gather in the community, in order to help eliminate barriers to receiving preventative services and treatment. PDC was envisioned as a program that would begin operating at early childhood education (ECE) sites, but had the potential to expand and reach older children at elementary schools.

In November 2010, the Foundation commissioned Harder+Company Community Research to evaluate the *CHOMPERS!* initiative, including the PDC component. This report summarizes findings from our evaluation of the program's implementation, and is organized as follows:

- Summary of the evaluation purpose, questions, and methods,
- Status of PDC implementation across each of the sites in operation,
- Rationale for the PDC program,
- Challenges experienced by grantees and recommended solutions,
- Early evidence of program outcomes and sustainability,
- Plans for expansion, and
- Summary and implications.

The appendices include the theory of change for the *CHOMPERS!* initiative (Appendix A), data snapshots for the two grantees that have submitted complete data on program operations, patients served, and financial status during the first year of PDC implementation (Appendix B), a list of external stakeholders interviewed (Appendix C), Francine Jacob's Five-Tiered Approach to evaluation (Appendix D).

Evaluation Purpose, Questions, and Methods

The *CHOMPERS!* evaluation has several purposes: (1) to provide the Foundation, grantees and the technical advisors with information that can be used to improve program implementation and promote learning, (2) to document key outcomes and accomplishments, and (3) to identify lessons learned that are relevant to the Foundation and other stakeholders. Our evaluation design is based on Francine Jacob's Five-Tiered Approach to evaluation (Appendix D). The primary guiding questions for the *CHOMPERS!* evaluation include:

- What services are offered, by whom, and who and how many are being served? *(Tier 2: Monitoring and Accountability)*

- Are services well-implemented and do they match the model? Which factors enable or constrain implementation? (*Tier 3: Quality Review)*
- What changes have occurred, and how do they vary by characteristics of grantees, children and parents, early childhood education (ECE) settings, and the broader community? (*Tier 4: Achieving Outcomes)*
- What do evaluation findings suggest about how to improve services? (*Tiers 2, 3, and 4: Program Improvement)*

Although the CHOMPERS! initiative was launched in 2010, the PDC grantees experienced delays in implementation. Thus, Harder+Company's interim evaluation report, submitted in July 2012, explored lessons learned from early implementation, and focused on Tiers 2 and 3 of the research questions. At the time of this report, most grantees' programs had been in operation for at least one year. Thus, the final report further explores lessons related to program implementation (Tiers 2 and 3), as well as any evidence of program outcomes and suggestions for how to improve service delivery (Tier 4).

Our evaluation methods included:

- Two rounds of interviews with staff members from each of the five initial PDC grantees conducted from April-May of 2012, and the four continuing PDC grantees from March-May of 2013,
- Interviews with Foundation staff in April of 2012,
- Interviews with four staff members at early childhood education (ECE) sites implementing the program from April-May of 2013 (one per grantee organization);
- Interviews with six external stakeholders familiar with the oral health policy context in New York State from April-May of 2013;
- A review of grantee and Foundation documents, and
- A review of quarterly data collected from grantees. The quarterly data included information on program operations and financials, the number of patients served and their demographics, and the needs of the population served.

Limitations of Evaluation

The evaluation has a couple of key limitations to consider when reviewing the findings:

- **Delays in implementation impacted data collection.** Due to the delays grantees experienced in implementing the program, much of the data collection for the evaluation took place while grantees were still getting their programs off of the ground. Most notably, only one year of quarterly data for three of the grantees was available at the time of this report. We will submit an addendum to this report in early 2014 when more complete data are available.
- **Interview responses were subject to social desirability bias.** Much of the evaluation data comes from interviews. Interview respondents may have been inclined to answer how they thought they were expected to, rather than disclosing their true opinions. Thus, they may have been inclined to provide more positive responses to the interview questions.

2. Status of Implementation

In September of 2010, the Health Foundation for Western & Central New York funded five programs to bring Portable Dental Care to their communities. Currently, there are four programs implementing the CHOMPERS! grant: Baker Victory Dental Clinic; East Hill Family Medical; Olean General Hospital – Gundalah Dental Center; and Syracuse Community Health Center.[1] The status of PDC implementation across each of the four programs is summarized below and in Exhibit 1. All sites experienced significant delays in rolling out their programs. Olean was the first to begin operating in September of 2011, followed by Baker Victory and Syracuse in January and February of 2012, respectively. The remaining program, East Hill, was still getting their program off the ground at the time of this report, but anticipated seeing patients by the spring of 2013. The program experienced delays due to issues with acquiring equipment, staff turnover, and the departure of their identified PDC dental provider. Appendix B provides a more detailed summary of program operations and patient demographics for three of the sites, Baker Victory, Syracuse, and Olean.

Type of providers. Each of the three sites in operation reported having dentists, hygienists, and dental support staff available to provide services to children through PDC. Syracuse reported having the most dental staff time dedicated to providing PDC services to children.

Program reach. Of the three sites in operation, Syracuse had the largest program, providing portable dental care to close to 500 children at eight early childhood education sites, and operating three to four times a week. Baker Victory Dental Clinic implemented portable dental care at nine ECE sites and elementary schools, and Olean General Hospital implemented the program at six early childhood education sites.[2] East Hill anticipated operating in one site once every other week. In total, the three sites in operation served close to 1,000 children during their first year of implementation.

Types of services provided. The three sites in operation were primarily providing preventative services to children (i.e., oral exams, cleanings, and fluoride treatments). Just about six percent of services provided, on average, were for restorative work. The PDC programs referred children elsewhere for extractions and more involved dental work.

Child demographics. The majority of children served through the program were covered by Medicaid. Syracuse reported seeing the smallest proportion of Medicaid children, as close to one-third of the children they saw were covered by private insurance. Children ages 4-5 were the most common age group to receive PDC services, followed by children ages 0-3. One grantee, Baker Victory, was operating in some elementary schools, and thus close to one-third of the children served by the grantee were over the age of 5.

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[1] One of the five original grantees, Oak Orchard Community Health Center, did not continue with the CHOMPERS! grant.

[2] Olean operated the PDC program in just one of the six sites, and children from the other 5 sites were transported to that location.

Exhibit 1: Status of PDC Implementation, Services Offered, and Population Served in First Year

Grantee Name	Date Started	Sites in Operation	Days per week	Type of Providers (# of FTEs)	Total Served (Year 1)	Percentage of Services for Preventative Care*	Percentage of Children Served on Medicaid	Percentage of Children Served Ages 4-5
Olean General Hospital	September 2011	6	1 – 2	Dentist (0. Hygienist (0.08 Support Staff (0.	203	91%	71%	55%
Baker Victory Dental Clinic	January 2012	9	3 – 4	Dentist (0.1) Hygienist (0.1) Support Staff (0.5)	319	95%	78%	46%
Syracuse Community Health Center	February 2012	8	3	Dentist (0.3) Hygienist (0.3) Support Staff (0.2)	477	96%	45%	79%
East Hill Family Medical Center**	Spring 2013	1	<1	N/A	N/A	N/A	N/A	N/A

*Preventative services provided include oral exams, cleanings, and fluoride treatment.
**East Hill anticipates being in operation by spring 2013, with a dentist on staff to see patients once every other week.

3. Rationale for Portable Dental Care Program

Portable Dental Care in Context: Oral Health Policies in New York State

The strength and viability of the portable dental care model depends in some part on the oral health policies and receptivity of the state. According to external stakeholders, New York has not only been a leader in terms of oral health policies, but it also has a Medicaid program that reimburses relatively generously for oral health care. Furthermore, external stakeholders highlighted that the state has established infrastructure through the Health Department's Bureau of Dental Health, which has served as a champion for oral health. These factors suggest that the state would be receptive to a program such as PDC, which seeks to experiment with different ways of bringing oral health care to children.

Children's Oral Health Snapshot: New York State

	State Average	National Average
Percentage of high-risk schools with dental sealant programs	25-49%	25%
Percentage of Medicaid-enrolled children receiving dental care	38%	38%
Percentage of population living in Dental Health Professional Shortage Areas (DHPSAs)	11%	16%
Medical providers reimbursed for early preventative dental health care	Yes	Yes

Source: Pew Center on the States, data from 2009-2010.

Established credibility as an oral health leader. External stakeholders noted that New York State has long been a leader in creating oral health guidelines and programs. For example, the state was one of the first to create dental rehabilitation programs and guidelines for oral health care during pregnancy and early childhood. In addition, many of the fluoridation, sealant, and school-based programs used nationally were developed in New York.

Favorable Medicaid policies. The state of New York is one of a minority of states offering full dental benefits to adults participating in Medicaid. Primary care providers can also get reimbursed for fluoride varnish treatments through Medicaid. Although the state's Medicaid program is receptive to oral health services, external stakeholders highlighted that the reimbursement process can be challenging due to bureaucratic processes in the state, described in more detail in Section 4.

Established state-level infrastructure for oral health. A couple of external stakeholders noted that the Bureau of Dental Health, housed within the State Department of Health, provided strong oral health infrastructure in the state. The Bureau staffs a full-time state dental director, and one stakeholder noted the department was staffed more heavily than comparable departments in other states. In addition, the state has an Oral Health Plan that was adopted in 2005. In 2013, the Bureau convened a group of oral health stakeholders to revise the plan and the state's oral health priorities.

Strengths of the Portable Dental Care Model

The Foundation launched the Portable Dental Care initiative under the rationale that such a program would eliminate transportation and other barriers that can prevent children and their families from accessing needed preventative services and treatment. The interviews with grantees, ECE site staff, and external stakeholders confirmed that the program had these benefits for children and their families. Almost all interview respondents believed that portable dental care was a promising model for providing access to oral health care in areas of Western and Central New York, as outlined below.

"If you are low-income and worried [simply] about providing your children with basic needs, the least of your worries [is going to be] trying to search for a dentist."

Addresses barriers to accessing oral health care. Grantees and ECE site staff have witnessed the impact PDC has had on reducing common barriers to families accessing oral health care, including making oral health care a priority, as well as finding the time to take children to the dentist. Interview respondents also expressed that by providing oral health care to children onsite, families do not have to worry about carving out time from work and/or driving long distances just to take their child to see a dentist (often an issue in rural areas). Additionally, interview respondents noted that the program reaches families that are typically the victims of oral health disparities. One external stakeholder explained, "Many of the children who are victims to oral health disparities [already] go to Head Start, day care, or WIC sites. That is the niche portable dental care fills."

Reaches children at a young age. Some interview respondents also pointed to the benefits of providing access to oral health care and treatment to children at a very young age. These stakeholders emphasized that targeting young, disadvantaged children through PDC could translate into lasting oral health impacts. One external stakeholder explained, "The greatest window of opportunity to prevent dental disease is from the emergence of the first tooth to five years old. That is where the biggest bang for the buck [can be found]."

4. Addressing Portable Dental Care Challenges

Despite New York's positive oral health policy context, and the promising nature of the PDC model, grantees and ECE sites experienced many challenges when it came to implementation. The following section highlights the main challenges they faced, as well as strategies that grantees were either using, or interview respondents suggested could be used, to address them. The challenges and strategies are organized into three sections: 1) Challenges related to program set-up, 2) Challenges related to program implementation, and 3) Contextual challenges that impacted the PDC program. Exhibit 2 (page 14) summarizes the challenges and strategies.

Challenges to Program Setup

Acquiring Dental Equipment

Acquiring portable dental equipment was a significant barrier for grantees during the startup phase of their programs. The Foundation had an arrangement with the Eighth District Dental Society (Eighth District Dental), whereby Eighth District Dental would purchase and own the equipment, and the grantees would then lease it back. However, grantees were still responsible for communicating with equipment vendors to receive proper equipment. All but one of the grantees expressed initial confusion over how the purchasing process worked. As one grantee noted, "We thought the process of purchasing equipment would be less complicated than it was…by the time we figured out how to lease equipment from the [vendor], it was already late in the school year." Some grantees also found that it was challenging to communicate with equipment providers and obtain the proper equipment. Grantees were ultimately able to overcome this barrier, but still experienced delays in implementation as a result. Some grantees noted that the support the Foundation offered through technical advisors to the project helped them to sort out issues around equipment purchasing. Grantees did not report any further issues related to acquiring equipment at the time of the follow-up interviews.

Navigating State Medicaid Regulations

Given the complexities of New York's Medicaid policies, and particularly those around reimbursement for portable dental services, grantees and ECE sites faced challenges in setting up appropriate billing systems. As one external stakeholder explained, "There is no rule book on addressing billing and coding for a school-based [dental] program." It took time in early implementation for grantees to establish a system that complied with state guidelines.[3] The Foundation worked with grantees to address this initial confusion and negotiate changes to the state's Medicaid policies. At the time of the follow-up interviews, most grantees and ECE sites did not report significant challenges related to reimbursement. However, one grantee was still struggling with reimbursement issues, and as a result had not yet received Medicaid payment for services provided through PDC. The grantee faced a long delay in receiving appropriate billing codes for PDC services on the part of the state's Medicaid office. In addition, the ECE site staff person interviewed who was associated with this grantee reported difficulty coordinating with families to accurately complete paperwork. Parents were required to call

[3] See Harder+Company's interim evaluation report for more detail on the challenges grantees faced, particularly around unbundling of services and APG payments.

their insurance companies and specify a site code to use for billing of portable services. It took time for the ECE site to understand this, and figure out the best way to communicate the requirements to parents. Given these challenges, many interview respondents emphasized that grantees should consider providing ECE sites with more support and education on Medicaid eligibility and reimbursement policies.

Challenges to Program Implementation

Ensuring Adequate Staffing to Manage Program

Implementing the portable dental care program required a greater amount of staff time than grantees had initially anticipated. Thus, some of the delays experienced by grantees were due to them not having adequate staff capacity to manage the program. Although most grantees had one person assigned to coordinate the PDC program, those staff members also had other responsibilities. These delays led to frustration on the part of some ECE sites. One ECE site staff person explained, "We have had a lot of holdups and I am not sure why. We had the room ready, but there was quite a long [wait before they set it up]. Part of it had to do with equipment, but a lot of [the hold-ups] were bureaucratic." Furthermore, with so much responsibility for the program falling on one staff member, some sites struggled with staff turnover delaying, stalling, or halting program operations. For example, when the PDC coordinator at one site went on temporary leave, the program chose to cease service delivery at ECE sites until she returned.

> "It takes a special person to [manage] a portable dental care program… [you need to] spend a lot of time planning, and thinking about how the program manager should be setting the program up for success."
>
> -External stakeholder

Grantees have found some strategies for addressing these staffing challenges. Some sites allotted more staff time to working on PDC coordination. For example, one site shifted a staff person into a role as the full-time coordinator of PDC mid-way through their program, which allowed them to focus on seeing more children and expanding their program. Another grantee established one staff person dedicated to coordinating PDC equipment issues. In addition to dedicating more staff time, grantees also reported addressing staffing issues through establishing strong management procedures and communication with ECE sites. For example, the grantee that had to halt service delivery when a staff person went on leave helped to manage that challenge by staying in good communication with ECE sites about it. "We just planned for a slower time when she was on leave," noted a staff person at one of the associated ECE sites. "We took her time off as an opportunity [to focus on] other things."

Streamlining Enrollment and Coordination Procedures

Streamlining the enrollment and coordination of services was a concern among grantees and ECE sites during early phases of implementation. For a few ECE sites, the collection of paperwork from families was difficult, either because families were unsure of how to complete the paperwork, or because they were hesitant to participate in the program. Ensuring enrollment is critical to the program's sustainability; thus, staff at all of the ECE sites we interviewed noted they had dedicated a large amount of time to doing follow-up with families and coordinating outreach activities in order to ensure adequate enrollment numbers. In collaboration with ECE sites, grantees have developed strategies to increase awareness and enrollment, including developing

targeted posters for parents, having PDC enrollment staff present during parent drop-off times, and offering parental incentives to complete the paperwork. One grantee noted that the best time to distribute enrollment paperwork was during orientation week at the beginning of the school year. A couple of grantees also noted the importance of establishing good working relationships with ECE sites at the outset of the program. These grantees had addressed initial confusion around enrollment and scheduling procedures by clearly defining roles and responsibilities. For example, in most sites, the ECE staff was responsible for collecting paperwork, scheduling visits, and following up with families. The grantees were responsible for verifying families' Medicaid eligibility and managing equipment logistics.

Accommodating to Portable Dental Care Equipment

Grantees did not anticipate the learning curve associated with using portable dental equipment in a non-clinical setting. The equipment used for PDC is very different from what is used in a typical clinical setting. Thus, providers unfamiliar with portable equipment had to set aside time to learn and familiarize themselves with it as well as accommodate to transferring it. One grantee noted, "Looking back [at initial implementation] we were in a crunch with the equipment. The equipment was not as portable as I thought." Grantees and external stakeholders recommended allocating sufficient time to train new providers on how to use the portable dental equipment. Training providers on portable equipment has been an ongoing challenge for grantees, as new providers come into the program.

"I'm concerned that we'll have too many schools [to serve through PDC] next year. We are talking to providers to try to increase hours, but we need another doctor."

- PDC grantee

Contextual Challenges

Insufficient supply of dental providers

The regions of New York State served by the portable dental care program face an insufficient supply of dental providers overall, and an even greater shortage of dental providers who accept Medicaid and are willing to see young children. As a result, grantees struggled with finding dental providers to whom they could refer children prior to this initiative. Multiple ECE sites noted that the PDC grantee organizations in their areas were some of the only providers accepting Medicaid. One external stakeholder explained, "Grantees are really isolated, especially in western New York, and it makes it very hard to recruit dentists in this region." Another external stakeholder noted that due to headaches related to Medicaid reimbursement, many dentists in the state either choose not to see low-income children, or decided to offer their services pro bono instead.

This issue impacts children in the region, but it also impacts the programs that serve them. This is because the shortage of providers makes it challenging for programs to recruit and maintain staffing. Several grantees and ECE sites noted that they struggled to maintain their level of services. For example, one ECE site was unable to operate even one day a week because they lost their dentist and had not yet found a replacement at the time of this report. Another grantee with plans for expansion expressed concerns about having enough provider time to meet demand. As a potential short-term solution to provider turnover, one grantee noted that their site had tried to secure a "back-up" dentist and dental hygienist from the community. An external stakeholder suggested fostering relationships with local dental schools in the area. She pointed to a success she'd had in

establishing such a relationship with a school of dentistry, in order to create a pipeline of providers for a school-based dental program she was implementing.

Lack of Pediatric Dental Providers

In addition to insufficient supply of dental providers in the region, grantees and ECE site staff also pointed to the limited number of pediatric dental providers (or pedodontists) as posing a challenge. Across all sites, none of the PDC providers were pedodontists. At the same time, ECE site staff expressed the importance of having providers with experience working with children, to improve how children and families responded to dental care. One ECE site staff person explained, "It is not that the dentist [currently working on PDC] is not qualified, but pedodontists have extra training to work with kids. I think there would be less referrals [for services that couldn't be provided onsite] with a pedodontist [on board]." While the ECE staff we interviewed expressed overall satisfaction with the providers working on PDC, they also believed that more could be done to prepare them for working with children. As a potential solution to this challenge, one ECE site staff person noted that some of the PDC dental providers they were working with had reached out to pedodontists on their own to ask for advice or training.

Parental Anxiety

Grantees and ECE site staff noted that some families were hesitant to participate in the portable dental care program because of their own fear of the dentist, poor experience with previous dental providers, and/or a lack of awareness of the health benefits and importance of early oral health care. A few parents declined dental treatment for their child because they were worried about dental work being provided at school. One ECE site staff person explained, "[There are] a few parents that aren't keen on the [PDC program] because they don't want their kids to be afraid of going to school." Parental anxiety and fear that their child will not respond well to a dental visit has also prevented children from accessing dental services. One ECE site staff person recalled an experience with a mother who had not taken her child to see a dentist until he was five years old because "the mother thought that the experience would be too difficult for him." To ease parental anxiety, some ECE sites began holding parent education groups or providing home visits to increase awareness on the importance of oral health. In addition, some sites eased children's and parent's anxiety by having dentists visit classrooms and get to know the students prior to providing treatment.

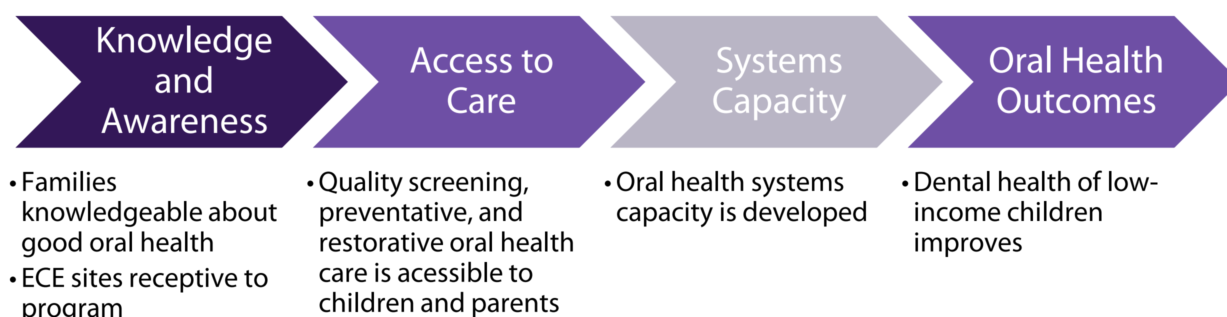
Exhibit 2: Challenges Faced by PDC Programs and Strategies for Overcoming Them

Challenge	Description	Strategies
Challenges to Program Setup		
Coordinating on purchasing equipment	▪ Confusion on procedure for coordinating equipment purchases ▪ Difficulty communicating with dental equipment vendors and understanding the best equipment to purchase	▪ Receive support and guidance from technical advisors with expertise in using portable equipment
Navigating state Medicaid regulations	▪ Changes in state Medicaid policies create confusion around eligibility and reimbursement processes for grantees and ECE sites ▪ Confusion impacts both children's enrollment in Medicaid and grantees' ability to receive reimbursement	▪ Receive support from Foundation on navigating state policies ▪ Work closely with ECE sites to ensure paperwork is completed accurately ▪ Ensure ECE sites communicate with families about accurately completing paperwork
Challenges to Program Implementation		
Ensuring adequate staffing to manage program	▪ The demand of coordinating and managing the program was greater than anticipated ▪ Staff did not have the capacity to fully implement the program ▪ Staff turnover or departures impacted service delivery	▪ Increase staff time dedicated to PDC program and define roles ▪ Develop strong management procedures and maintain good communication with ECE sites about staffing issues
Streamlining enrollment and coordination procedures	▪ Completion of enrollment and eligibility paperwork required heavy follow-up by ECE staff ▪ Grantees and ECE sites were confused on coordination procedures	▪ Increase the number of opportunities families have to enroll and learn about the program (e.g., outreach during drop-off times) ▪ Identify appropriate timing for seeking paperwork (e.g., include paperwork in beginning-of-school year packets) ▪ Develop clear procedures delineating roles and responsibilities
Accommodating to portable dental care equipment	▪ Dental providers needed time to adjust and familiarize themselves with portable dental care equipment	▪ Provide training to PDC providers using the equipment ▪ Ensure implementation plan has adequate time allotted for training and adjustment for new equipment
Contextual Challenges		
Insufficient supply of dental providers	▪ Regions such as those served by PDC have a limited supply of dental providers, particularly those that accept Medicaid ▪ Grantees are unable to find dentists to staff the PDC program	▪ Foster relationships with dental schools in the area ▪ Secure "back-up" dentists and dental hygienists
Lack of pediatric dental providers	▪ Very few pediatric dental providers located in the regions served by grantees ▪ Grantees and ECE sites are interested in having pediatric dental providers provide care	▪ Develop a relationship with pediatric dental providers to staff or train PDC providers
Parental anxiety	▪ Parents have a "generational" fear of the dentist and the anxiety is transferred to children ▪ Parents are hesitant to have children treated at their ECE site ▪ Parents are unaware of the importance of oral health care	▪ ECE sites hold parent education groups and home visits to increase awareness ▪ Dental staff visits classrooms and develops a relationship with children prior to providing treatment

5. Early Evidence of Program Outcomes

In addition to examining challenges and successes of program implementation, the evaluation also explored early evidence of program outcomes. Exhibit 3 below highlights outcome areas of interest for PDC, based upon the overall Theory of Change for the CHOMPERS! initiative (Appendix A). ECE site staff and grantees reported seeing progress in several of these areas – knowledge and awareness; access to care; and oral health outcomes.[4] The design of the PDC program itself is helping to develop oral health systems capacity in regions of the state that lack adequate infrastructure for providing children with needed oral health services. Exhibit 4 (page 16) summarizes the accomplishments of the PDC program.

Exhibit 3. Outcome Areas for the PDC Program



Knowledge and Awareness	Access to Care	Systems Capacity	Oral Health Outcomes
• Families knowledgeable about good oral health • ECE sites receptive to program	• Quality screening, preventative, and restorative oral health care is accessible to children and parents	• Oral health systems capacity is developed	• Dental health of low-income children improves

Increased knowledge and awareness of oral health by parents and ECE sites. Several of the grantees and ECE site staff expressed that with the PDC program they had seen an increase in families' awareness of the importance of oral health. Some also observed that families were becoming more engaged in their children's oral health. One ECE site staff person reflected on parents' growing awareness of the importance of oral health within her schools: "When I [am visiting] sites, parents will stop me and show me their kid's teeth or tell me about [their oral health]." Grantees also noted that ECE sites were receptive to and enthusiastic about the program and saw the benefits of improving the oral health of their students. "A lot of teachers have commented to [our] staff that they see the benefit [of the program]," noted one grantee. "They'll call parents of children with [oral health issues] to make sure families have the information they need to enroll [in PDC]."

> "[The PDC program] is creating awareness within the family that is about more than just serving a child, but about creating a dental relationship with an office. [We are] letting them know that dentistry is important, and it seems like we are getting that message across."
>
> - PDC grantee

Increased access to oral health care. Consistent with the goals of the PDC program, all three grantees that have been in operation for over a year reported seeing increased access to oral health care amongst the populations they were serving. They reported increases in the number of children coming in for exams, increased success in

[4] The quarterly data submitted by grantees will provide further information on the extent to which the program is increasing access to care and impacting children's oral health outcomes. In early 2014, we will have more complete information to report from the quarterly data.

reaching families in rural communities, and in reaching those who otherwise may not have been able to receive dental care. This information on increased access to care is supported by the quarterly data submitted by grantees. The two grantees with complete data on children's dental history, Baker Victory and Olean, reported that 22 percent and 39 percent of children, respectively, seen through the program in the first year had never seen a dentist (see Appendix B). Thus, the program was demonstrating early success in reaching children most in need of services.

Impact on oral health outcomes through a decreased need for restorative services. A couple of grantees and staff at their respective ECE sites reported seeing a decrease in the need for restorative services once they entered the second year of PDC implementation. As a result, they were providing more preventative services. While this trend cannot be attributed directly to PDC, ECE site staff and grantees believed that services received through the PDC program had helped to alleviate the need for restorative work. One grantee stated: "Compared to the first school year [of PDC implementation], when well over 75-80 percent of kids needed restorative work, this year [that number is] less than 40 percent." An ECE site staff person associated with the grantee reiterated that trend, stating that, "The number of kids with completed exams is higher than the previous year. There was a time when we saw kids with all silver teeth [but] now we are seeing less tooth decay. [There has been] a decline in the serious cases."

Exhibit 4. Early Evidence of PDC Program Accomplishments

Outcome Area	Early Evidence of Program Accomplishments	Description
Knowledge and Awareness	▪ Increased knowledge and awareness of oral health by parents and ECE sites	▪ Grantees and staff observed an increase in families' awareness of the importance of oral health. ▪ Grantees noted that ECE sites were receptive to and enthusiastic about the PDC program.
Access to Care	▪ Increased access to oral health care	▪ Grantees in operation for over a year reported increases in the number of children coming in for exams ▪ Grantees reported increased success in reaching families in rural communities and in reaching those who otherwise may not have been able to receive dental care.
Oral Health Outcomes	▪ Reduced need for restorative care services	▪ Grantees and staff reported observing a decrease in the need for restorative services upon entering the second year of PDC implementation. ▪ One grantee stated that 75-85 percent of kids needed restorative work in first year of the program, but in year two that number was less than 40 percent.

Cavity Free Kids Impact

Three of the four Portable Dental Care grantees had ECE sites that were also participating in the CHOMPERS! Cavity Free Kids (CFK) curriculum. The CFK program brings a best practice oral health curriculum to early child care settings. The curriculum includes oral health activities for young children, as well as parent outreach and education.

Overall, ECE sites found that the CFK curriculum was highly beneficial and complementary to the PDC program, because it reinforced the importance of preventative oral health practices. ECE site staff noticed the impact it was having on children participating in PDC. In particular, some ECE site staff believed CFK was

helping to reduce children's fear of the dentist. For example, one ECE site staff person said "If [kids] know more about oral health, they are less fearful. We can explain what is going to happen [during their dental visit] and why. The goal is not to let dental care be an unknown. [With CFK and PDC] we have so many methods to reemphasize the importance of dental hygiene." A grantee also pointed to the complementary nature of the two programs: "[CFK] helps children understand why [the PDC dental staff] is there and why they are trying to provide them with a healthy mouth." In addition to the impact CFK has had on children, ECE sites reported feeling more prepared in educating parents on the importance of oral health through their participation in the program. One ECE site staff person explained, "[CFK] provides us with responses for [parent] comments like 'they have baby teeth, they don't matter'. CFK gives us great responses and I think parents are starting to get the message, which helps with our success."

6. Sustainability of Portable Dental Care

Two key questions of interest to the Foundation related to sustainability are: (1) whether the PDC *program* will be sustainable for grantees beyond the initial support provided from the Foundation; and (2) whether the PDC *model* demonstrates enough promise to be replicated or otherwise used in different contexts. For the purpose of the evaluation, we defined sustainability as the capacity to exist beyond initial support provided for the program, and explored the sustainability of both the PDC program and the model.[5] Evidence of sustainability in both of these areas is summarized below and in Exhibit 4. Grantees and ECE sites provided information on the sustainability of the program, while external stakeholders commented on the sustainability of the PDC model.

Defining the Terms

Sustainability is defined as the capacity of a program to exist beyond the termination of initial support that was used to develop it, and to offer continued benefits (e.g., human, social, or economic).

Evaluation of sustainability can focus either on evidence that the program itself *can continue to exist* after removal of initial resources, or on the value of *maintaining, replicating*, *or otherwise exporting* a program to different contexts.

Sustainability of the PDC Program: Evidence of Sustainability from Grantees

Grantees optimistic about sustainability, despite challenges with Medicaid reimbursement. All three of the grantees with fully operational programs expressed optimism that the PDC program was financially sustainable for their organizations. However, most sites had also struggled with obtaining Medicaid reimbursement for services provided. One of these grantees anticipated at least breaking even over the first few months of the program, but was unable to provide more definitive information due to complexities with Medicaid reimbursement. Another noted the program was going better than initially anticipated, and expected the program to be in a sound financial position after having expanded to new sites. The third grantee had not yet received Medicaid reimbursement for any PDC services offered, but pointed to enthusiasm on the part of the organization's CEO to continue the program. Appendix B includes financial data from the first year of operation for the two sites reporting information (Baker Victory and Syracuse). The data grantees provided suggest that they are in a position to sustain the program beyond the initial grant funding.[6]

"Our CEO is very eager to continue the PDC program because he thinks it is needed. [Thus], I believe the program would continue without grant funding." - PDC grantee

Children, parents, and ECE providers receptive to the program. As highlighted in Section 3, families and ECE providers were generally receptive to and appreciative of the PDC program, suggesting that stakeholders see enough value in the program for it to continue over time. As one grantee reflected, "The ECE sites love [the program]... [the sites function as] community centers. The more things you can put into one place, the better. They see it as a good thing." When reflecting on whether other schools or ECE centers in the

[5] Definitions from: Schroter, Daniela. "Sustainability Evaluation Checklist." Western Michigan University, August 2010.

[6] Early next year, we will have more data available to report financial information for three sites over two years, to provide a more complete picture of financial sustainability.

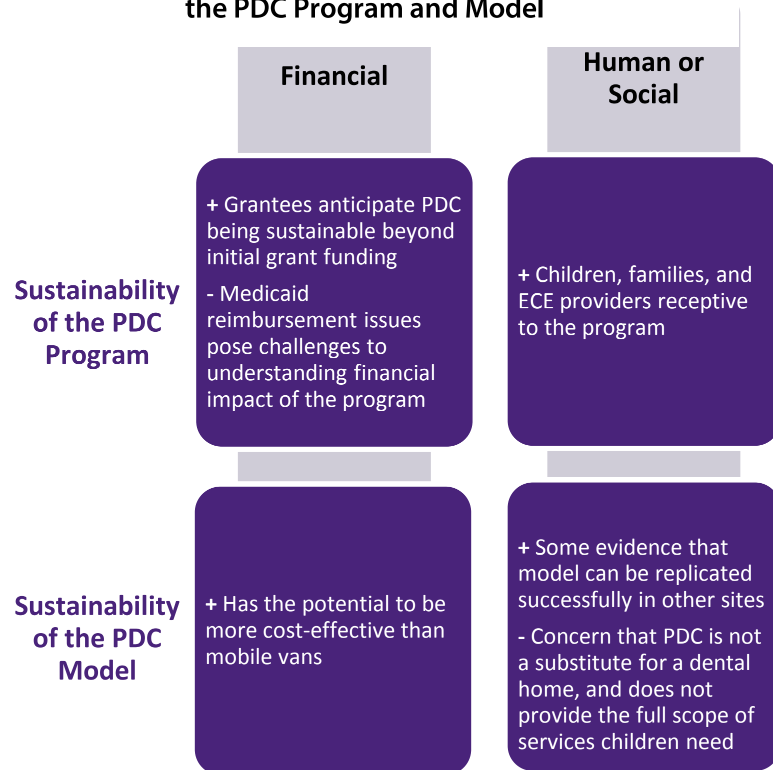
community would be receptive to the program, an ECE site staff person noted: "I don't see why anyone wouldn't be [interested in the program]. The only barrier I see would be space." While parental anxiety posed some issues, as discussed in Section 4, most ECE site staff also reported receiving positive feedback on the program from families. One ECE site noted that "parents that have been [present for their child's PDC appointment] have been very happy [with the treatment] and say [the program] is so terrific. [In fact], I haven't had negative feedback [on the program]."

Sustainability of the PDC Model: Reflections from External Stakeholders

Potential to be more cost-effective than other approaches to reaching families outside of a dental office. A couple of external stakeholders believed that portable dental care was a cost-effective model for delivering oral health services to hard-to-reach populations. In particular, these stakeholders noted that compared to an alternate model for delivering services to similar populations outside of a dental office – the mobile van – portable dental care offered greater benefits relative to the costs. One of these stakeholders explained, "Portable dental care is much more economical [than a mobile van]. It also allows us to follow up on treatment plans and dental care that the children need [rather than providing one-off services]."

Potential to be replicated. In addition to being cost-effective, one external stakeholder highlighted her experience replicating the PDC model in a different area of New York State. She noted: "My clinics are out of the CHOMPERS! area, but we decided to mirror the initiative." Her organization had successfully implemented a portable dental care program with ECE sites through her own clinic, and had begun to expand the program to another county as well as to school-aged children.

Exhibit 5. Evidence of Sustainability of the PDC Program and Model



Concern that PDC will be used in lieu of a dental home. While some external stakeholders pointed primarily to the value of providing portable services, others expressed concern that families would access PDC in lieu of establishing a regular dental home, a service they still view as vital for families to receive the full scope of dental services needed.[7] One external stakeholder explained, "Families need to establish a relationship with one place [a dental home]. My concern is that PDC will not be there when kids really need [services], and instead they will go to the ER or not be seen." This stakeholder also noted that Head Start sites are required by law to establish dental homes for children in their care, and expressed concern that children being seen through PDC may not be establishing dental homes and meeting these regulations. Another external stakeholder noted that, "Once we provide preventative services [through PDC], then we want to get people to treatment, and that's a huge challenge... you either need to take them to a fixed facility or to private dentists." Nonetheless, these stakeholders also saw the value of using the PDC model to get preventative care to children when they may not otherwise receive it. It is important to note that the intention and strategy behind the Foundation's initiative was to use portable dental care as both a bridge to and extension of the dental home, rather than a substitute for it. Overall, interviews suggest that it will be important for the Foundation to cultivate awareness of how this model supports linkage of children to dental homes among dental stakeholders in the state.

"Portable dental care isn't really a dental home for the child, so that gets into equity issues…. [But] the fact is we can't get more pediatric dentists to rural parts of the state… So if we can plug that hole with PDC, [we should]. "

- External stakeholder

.

[7] The American Academy of Pediatric Dentistry (AAPD) defines a dental home as "an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way." (AAPD Reference Manual, Vol.34, No. 6, p. 12-13. Adopted 2006, reaffirmed 2010.)

7. Plans for Expansion

All three grantees in operation plan to continue their *programs* for the full two years, and most also reported plans to further expand to new sites. In addition, grantees, ECE sites, and external stakeholders pointed to potential ways in which the PDC *model* could be expanded to best address access to oral health care issues for children and families.

Plans for expansion of the PDC program. Two of the three grantees in operation all reported they were planning to expand their PDC programs for the 2013-2014 school year. Baker Victory had the largest expansion plan with four to eight sites identified for expansion. Syracuse planned to expand to four additional sites. Olean did not report any further plans for program expansion. Although East Hill was not yet in full operation, the grantee had identified two additional sites interested in the PDC program. Each of these grantees was targeting additional ECE sites. Baker Victory was already operating the program in some elementary schools, and anticipated expanding into more of them. The two other grantees saw opportunities to coordinate with care being received by elementary school-aged children. One grantee was also operating a school-based sealant program, and reflected on synergies with PDC: "One of our objectives is to create a dental home. Most of the kids [at our ECE site] end up going to the elementary school [where there are school-based dental programs] that provides similar services. There is continuity [in dental services for the child]."

Potential to expand PDC model to serve other family members, including siblings and pregnant women. Creating more opportunities for siblings and parents to access PDC was highlighted as an area for potential expansion by a couple of ECE site staff and an external stakeholder. One ECE site staff person explained, "I had a mother that had lost seven teeth, but had not gone to the dentist because either she couldn't afford it or it was not a priority. It would be great to be able to support [people like her on-site with PDC]." An external stakeholder saw the value of also serving parents, and pregnant women in particular, through PDC. The stakeholder noted that many dentists choose not to see pregnant women because they are concerned with liability, but that it's crucial for pregnant women to maintain good oral health to prevent passing on dental disease to their children.

8. Summary and Implications

In sum, the evaluation suggests that portable dental care is a promising solution for providing oral health care to children and families who may not otherwise have access to services. Although it is not a substitute for the full scope of services provided in a dental office, there is some evidence that the *CHOMPERS!* PDC program helped to prevent children's oral health issues from progressing, and increased families' and ECE providers' awareness of the importance of oral health. At the same time, PDC grantees struggled with issues related to starting up and running their PDC programs, which impacted the speed at which they were able to roll out their services and demonstrate impact. Thus, the evaluation also highlights areas for others to consider when looking to either implement or support the implementation of portable dental care programs, in New York State or elsewhere. These include:

- **Consider state context.** The existing oral health infrastructure and policy context within a state can impact receptivity to a program such as PDC. For example, the extent to which the state's Medicaid program is both supportive of oral health issues and has clear procedures for reimbursing for portable dental care services can impact sites' ability to roll out a program successfully and receive reimbursement for services provided. In addition, portable dental care programs are often targeted to communities with limited access to dental services. By nature, these communities may lack an adequate pipeline of dental providers. Thus, sites have to be creative about recruiting and retaining providers to staff a PDC program.

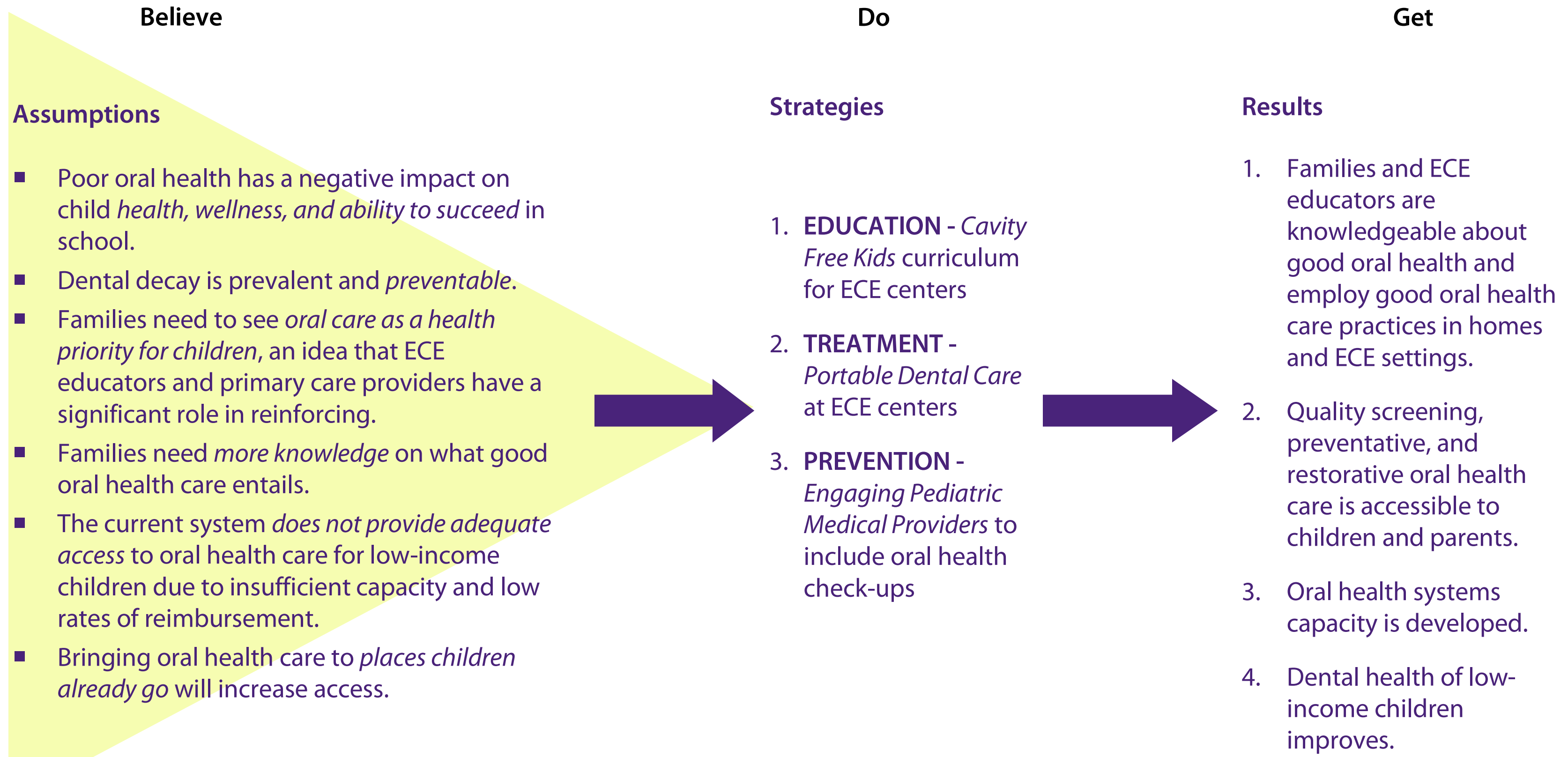
- **Ensure sites have adequate support to set up, run, and manage their PD C programs.** Most PDC grantees struggled with issues related to purchasing equipment at the outset of their programs, and faced ongoing challenges around staffing. Grantees benefitted from technical support offered through the Foundation to help them sort out these issues at the outset of the program. Still, most continued to face staffing challenges, which they addressed at least in part through increasing staff time dedicated to PDC and clearly defining roles.

- **Understand that parents may need additional support to buy into the program.** Parental anxiety around having their children receive dental care, and in particular receive care in the school setting, was a barrier for some programs. In a couple of cases, parents actually refused services through PDC due to this anxiety. In the case of *CHOMPERS!*, the simultaneous administration of PDC with the CFK curriculum was a beneficial way to help ease this anxiety. Complementing the service delivery component (PDC) with an education component (CFK) helped families understand the importance of oral health and feel more comfortable with their children receiving services in the school setting.

- **Recognize that documenting program impact can take time.** A couple of external stakeholders were interested in seeing outcomes from PDC programs, in order to demonstrate the program's effectiveness, sustainability, and potential to be replicated. Obtaining this type of data from a program such as PDC can take time, given what it takes to get a PDC program up and running, and the capacity challenges that sites face around collecting data on their programs' outcomes and financial status.

Appendices

Appendix A. CHOMPERS Theory of Change



Revised December 2010.

Appendix B: Site Snapshots

The pages that follow provide snapshots of three sites - Baker Victory General Hospital, Syracuse Community Health Center, and Olean General Hospital - based upon quarterly data they submitted for the first year of PDC implementation. At the time of this report, East Hill had not yet begun implementation and thus did not have data to report. In early 2014, we will have two years of data to report for the three sites currently in operation. In addition, we will continue to verify data quality. Thus, these data are pending revision following our receipt of two full years of data from each of the sites.

Site Profile: First Year of Operation

Baker Victory Dental Clinic

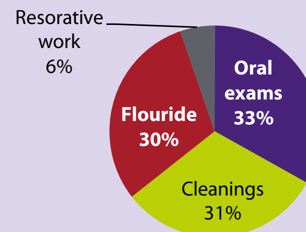
Site Characteristics

- Dental center within a nonprofit service provider
- Operates in 9 sites, 3-4 days per week
- Staffing (# of FTEs): 0.1 dentists, 0.1 hygienists, 0.5 dental support staff

Patient Served and Services Provided

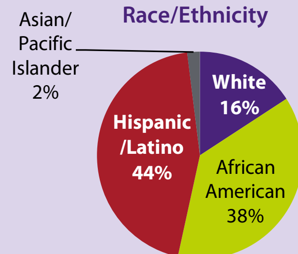
- Total patients served: 399
- Total Visits: 618
- Never seen a dentist: 22%
- No dental visits in 12 months: 41%

Proportion of Visits Provided by Type



Patient Mix

Race/Ethnicity



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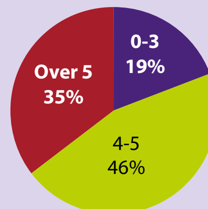
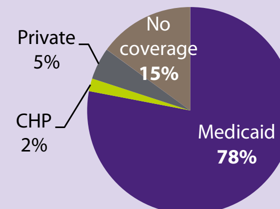


Insurance Coverage



Financial Data

- Net Revenue: $66,569
- Grants: $27,712
- Expenses: $56,942
- Margin (including grants): $9,627

Site Profile: First Year of Operation

Syracuse Community Health Center

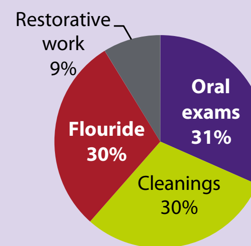
Site Characteristics

- Community health center
- Operates in 8 sites, 3 days per week
- Staffing (# of FTEs): 0.2 dentists, 0.3 hygienists, 0.2 dental support staff

Patient Served and Services Provided

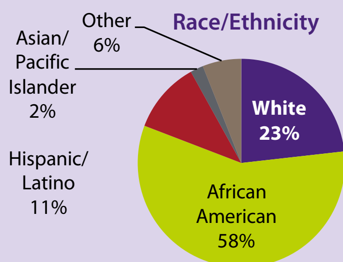
- Total patients served: 477
- Total Visits: 1,370
- Never seen a dentist: n/a
- No dental visits in 12 months: n/a

Proportion of Visits Provided by Type



Patient Mix

Race/Ethnicity



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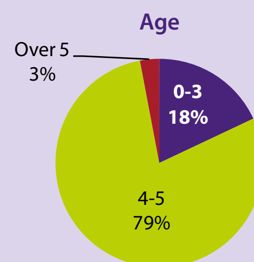
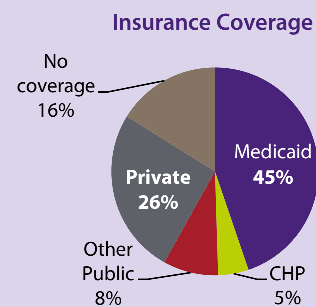


Insurance Coverage



Financial Data

- Net Revenue: $106,666
- Grants: $60,000
- Expenses: $34,230
- Margin (including grants): $72,437

Site Profile: First Year of Operation

Olean General Hospital

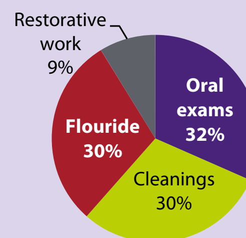
Site Characteristics

- Dental center within a nonprofit hospital
- Operates in 4 sites, 1-2 days per week
- Staffing (# of FTEs): 0.1 dentists, 0.08 hygienists

Patient Served and Services Provided

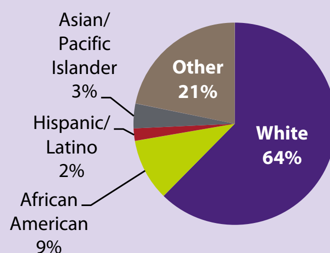
- Total patients served: 203
- Total Visits: 304
- Never seen a dentist: 39%
- No dental visits in 12 months: 81%

Proportion of Visits Provided by Type



Patient Mix

Race/Ethnicity



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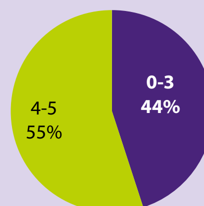
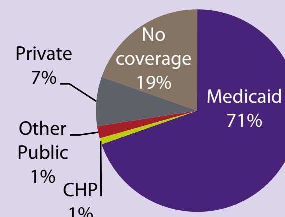


Insurance Coverage



Financial Data

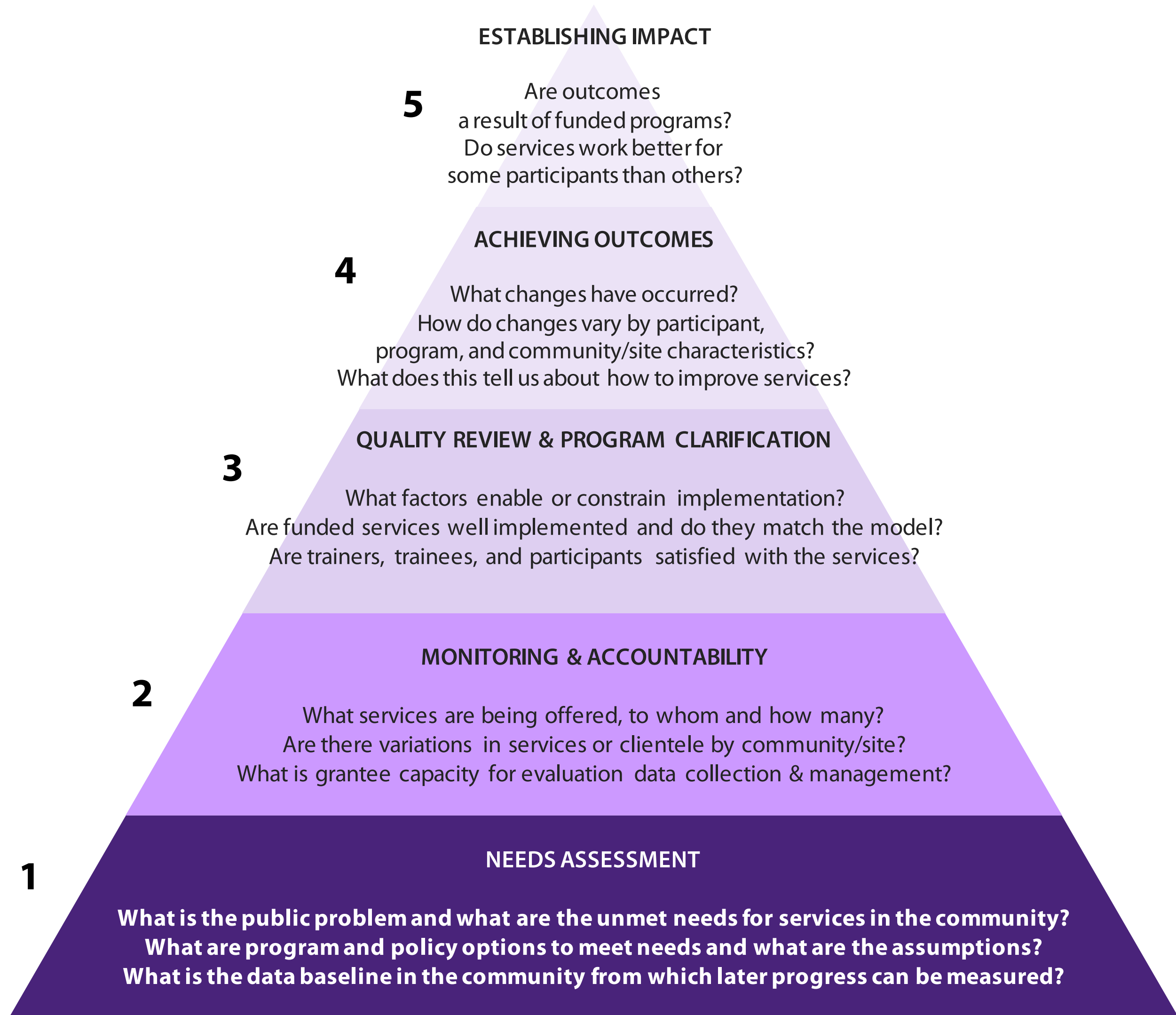
- Net Revenue: n/a
- Grants: $60,000
- Expenses: $32,944
- Margin (including grants): n/a

Appendix C: List of External Stakeholders

Six external stakeholders were interviewed for this evaluation. The names, titles, and organizations for each interview respondent are listed below.

Name	Title	Organization
Mark Doherty	Executive Director	Safety Net Solutions at the DentaQuest Institute
Kelly Hunt	Chief Program Learning Officer	New York State Health Foundation
Jay Kumar, DDS, MPH	Director	Bureau of Dental Health, New York State Department of Health
Judy Overton	Director of Dental Services	North County Children's Clinic
Patricia Persell	Director	Head Start of New York State Collaboration Office
Bridget Walsh	Senior Policy Associate	Schulyer Center for Analysis and Advocacy

Appendix D: Francine Jacob's Five-Tiered Approach



RESEARCH QUESTIONS BY TIER

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