Local Dental Pilot Project Annual Report: 2018

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Program Activities

The California Rural Indian Health Board, Inc. (CRIHB) Local Dental Pilot Project (LDPP) partners with 12 Tribal/Urban Indian Health organizations, as well as with three Tribal Head Starts and one Women Infants and Children agency, serving children ages 0-20 across 13 counties. As the lead entity, CRIHB maintains communication with the participating sites and other relevant stakeholders. CRIHB works with each site's designated Oral Health Care Coordinators (OHCCs), who are responsible for implementing our LDPP, as well as with the dental directors and medical providers. CRIHB also provides training and support to the employees responsible for maintaining and accessing data from the Electronic Health Records (EHR).

Communication: In 2018 CRIHB hosted a series of six webinars to train our OHCCs in Care Coordination and Case Management. The topics in this series included the Teach-Back Method, Determinants of Health, Behavior Change Theory, Motivational Interviewing, Oral Health Literacy, and Care Coordination. In addition to the Care Coordination series, CRIHB hosted one webinar on outreach, two group check-in calls, and numerous individual check-in calls. All webinars were recorded for those unable to participate in the live sessions.

In 2018 the CRIHB Dental Support Center Newsletter, published quarterly, included updates of the CRIHB LDPP, an article encouraging the clinics to see young children upon eruption of the first tooth, and resources for learning Minimally Invasive Dentistry techniques to treat children.

The DTI Coordinator presented on oral health and disease prevention at the mid-year Head Start in-service meetings for all of CRIHB's Head Start sites.

Advisory Committee: CRIHB held advisory committee conference calls in January, April, June, and August, with face-to-face meetings in February and May. After the August meeting, CRIHB made plans to reformulate the advisory committee to better reflect the needs of the program. Until then we had been sharing an advisory committee with CRIHB's Dental Support Center, but as the groups have two different focuses, we decided to form a unique committee to better advise the LDPP. The first conference call of our new advisory committee occurred in November 2018.

Presentations: In addition to the monthly webinars, the Annual Dental Conference and the Annual Best Practices Conference for medical providers featured sessions supporting CRIHB's LDPP.

Pertinent Dental Conference Topics:

- Silver Ion Antimicrobials and Minimally Invasive Dentistry
- Pediatric Dental Trauma and Pulpal Therapy
- Health Literacy
- Nitrous Oxide Sedation
- Solving the Caries Puzzle
- Motivational Interviewing
- Pit and Fissure Sealant Refresher

Pertinent Best Practices Conference Topics:

- Medical/Dental Integration
- Health/Medical Literacy

General Activities—2018

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Advisory Committee meeting conference call	X			X		X		X			X	
Advisory Committee face-to-face		X			X							
Educational webinar or check-in for OHCCs	X	X		X	X		X	X	X	X	X	
Individual check-in calls			X									
Annual Best Practices Conference presentation					X							
Annual Dental Conference presentation					X							
Annual Head Start in-service	X											
Email blasts	X	X	X	X	X	X	X	X	X	X	X	X
DSC newsletter	X			X			X			X		

Individual Program Activities—2018

Program Site	Assigned OHCC at end of 2018	Attended Case Management Training	Site Visit	Caries Risk Assessment Training	Meet or Exceed Annual GPRA Goal 2018	Earned DTI Challenge Award (Clinics Only)
Chapa-De	X	X	10/4/18	9/27/17	no	X
Greenville	X	X	1/26/18	9/27/17	no	
Indian Health Council	X	in progress	12/20/18	12/20/18	yes	
Karuk-Yreka	X	X	5/31/18	9/27/17	partial	X
Karuk-Happy Camp	shared		5/31/18	5/31/18	partial	X
Lassen	X	X	7/12/18	9/27/17	partial	
Pit River	X	X	7/13/18	9/27/17	partial	
Round Valley	X	X	10/8/17	9/27/17	partial	
San Diego	no	no	2/26/18	2/26/18	no	
Shingle Springs	X	X	7/3/18	3/7/18	no	
Toiyabe-Coleville	no	no	4/6/18	4/6/18	partial	
Toiyabe-Bishop	X	in progress	4/5/18	4/5/18	partial	
Tule River	X	in progress	6/12/18	6/12/18	no	
Tuolumne Me Wuk	X	no	8/10/18	9/27/17	no	n/a
Tuolumne WIC	X	X	8/10/18	9/27/17	n/a	n/a
Elk Valley Head Start	X	no	12/19/17	9/27/17	n/a	n/a
Lytton Head Start	X	in progress	9/27/18	9/27/17	n/a	n/a
Manchester/Point Arena Head Start	X	X		9/27/17	n/a	n/a

Program Data

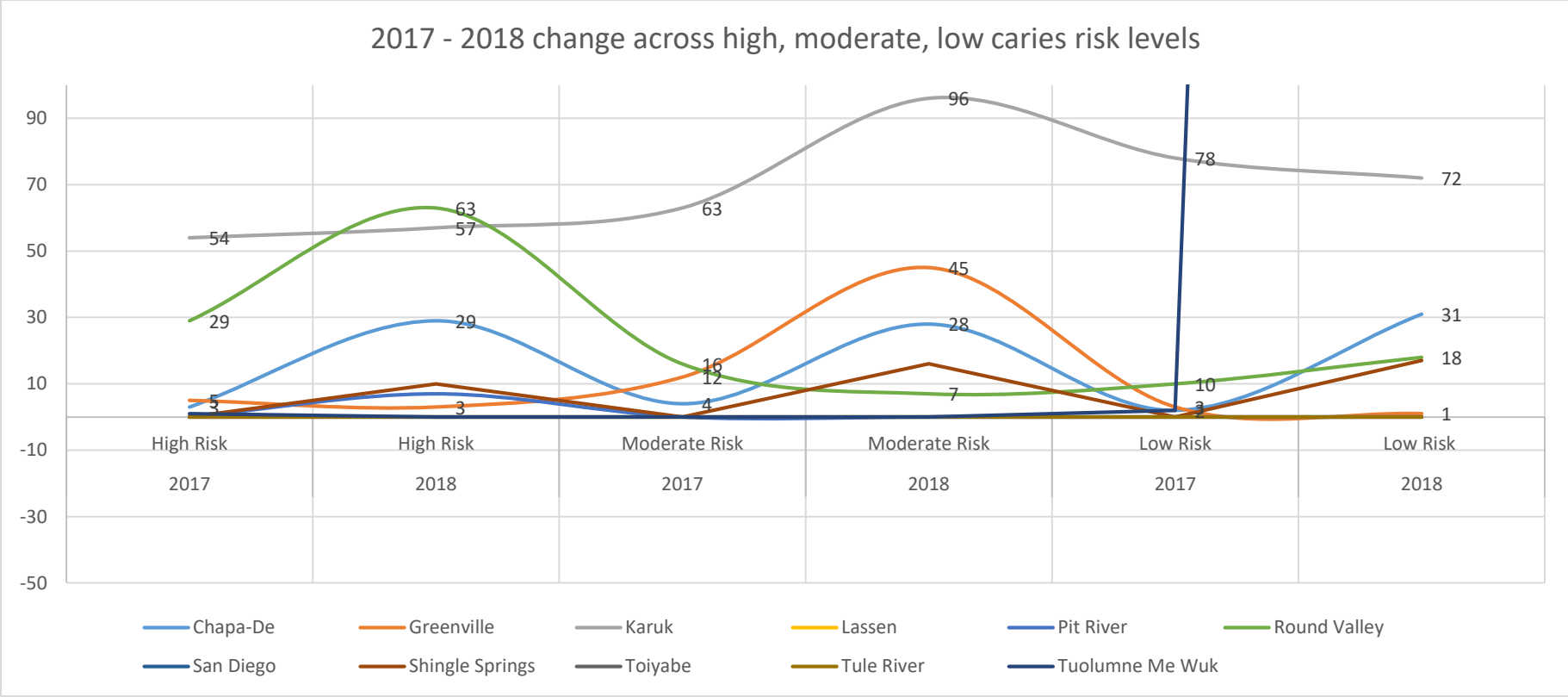
Short-term Self-Reported Data—2018

Program Site	# of Children Referred for Dental Services	# of Children Received Dental Services	# of Children Received Oral Health Education	# of Fluoride Varnishes Performed in Medical/Head Start	# of Caries Risk Assessments Performed in Medical/Head Start	# of Completed Dental Treatment Plans
Chapa-De	1175	336	103	34	101	192
Greenville	56	46	93	52	56	16
Karuk	17	14	36	5	11	3
Lassen	9	6	10	4	5	5
Pit River	39	418	207	35	7	19
Round Valley	151	311	154	24	149	40
San Diego	8	0	8	1	8	0
Shingle Springs	52	28	54	28	53	27
Toiyabe-Coleville	0	0	0	0	0	0
Toiyabe-Bishop	8	19	25	24	25	11
Tule River	1	1	29	29	29	24
Tuolumne Me Wuk	99	34	104	83	104	20
Tuolumne WIC	94	0	94	0	21	0
Elk Valley Head Start	15	38	50	0	101	8
Lytton Head Start	2	22	20	14	17	1
Manchester/Point Arena Head Start	3	4	20	0	0	2
Totals	1729	1277	1007	333	687	368

Short-term Goal Tracking	INDICATES ANNUAL GOAL ATTAINMENT										
DTI - Challenge 1 ($500)											
% Caries Treatment to Preventative Treatment	**Chapa-De**	**Greenville**	**Karuk**	**Lassen**	**Pit River**	**Round Valley**	**San Diego**	**Shingle Springs**	**Toiyabe**	**Tule River**	**Tuolumne Me Wuk**
Baseline: 2016	51.03%	41.88%	58.22%	36.84%	61.16%	23.85%					54.64%
2017 (2% higher than baseline)	48.25%	42.16%	52.71%	69.94%	81.30%	35.27%	68.75%	52.49%			63.08%
% change	2.78%	-0.28%	5.52%	-33.10%	-20.14%	-11.41%					-8.44%
2018 (4% higher than baseline)	45.65%	54.95%	11.64%	75.38%		33.33%	68.75%	51.79%			66.13%
% change	5.38%	-13.08%	46.58%	-38.54%		-9.48%					-11.48%
DTI - Challenge 2 ($1000)											
% Caries Treatment to Preventative Treatment	**Chapa-De**	**Greenville**	**Karuk**	**Lassen**	**Pit River**	**Round Valley**	**San Diego**	**Shingle Springs**	**Toiyabe**	**Tule River**	**Tuolumne Me Wuk**
Baseline: 2016	51.03%	41.88%	58.22%	36.84%	61.16%	23.85%					54.64%
2017 (3% higher than baseline)	48.25%	42.16%	52.71%	69.94%	81.30%	35.27%	68.75%	52.49%			63.08%
% change	2.78%	-0.28%	5.52%	-33.10%	-20.14%	-11.41%					-8.44%
2018 (5% higher than baseline)	45.65%	54.95%	11.64%	75.38%		33.33%	68.75%	51.79%			66.13%
% change	5.38%	-13.08%	46.58%	-38.54%		-9.48%					-11.48%
% Receiving Dental Care	**Chapa-De**	**Greenville**	**Karuk**	**Lassen**	**Pit River**	**Round Valley**	**San Diego**	**Shingle Springs**	**Toiyabe**	**Tule River**	**Tuolumne Me Wuk**
(% dental/primary care integration)											
2017	70.35%	93.72%	70.26%			36.10%	40.98%	59.43%			26.92%
2018	71.15%	91.59%	47.00%			65.50%	40.98%	66.53%			87.70%
Increase in Caries Risk Assessment	**Chapa-De**	**Greenville**	**Karuk**	**Lassen**	**Pit River**	**Round Valley**	**San Diego**	**Shingle Springs**	**Toiyabe**	**Tule River**	**Tuolumne Me Wuk**
(GOAL: 2% increase year over year)											
2017	9	20	195			55					3
2018	26	49	225		7	87		43			0
% increase 2018 vs. 2017	188.9%	145.0%	15.4%			58.2%					-100.0%

Long-term Self-Reported Data—2018

CRIHB's LDPP is looking for a change over time in the ratio of high caries risk to low caries risk. As indicated below, we are seeing an uptick in moderate risk, however, there really isn't enough data yet to see a meaningful trend.



Challenges and Obstacles

We began 2018 with the challenge of recruiting new sites to replace the two sites of Northern Valley Indian Health when they withdrew from CRIHB's LDPP. It has been difficult to communicate the value of participation to the Tribal Health Programs (THP). We ultimately were able to add Indian Health Council and the Grass Valley site of Chapa-De Indian Health Program, Inc..

An ongoing challenge has been obtaining data from the EHR of each THP. Many of the programs do not have anyone on staff knowledgeable enough about the EHR to retrieve the data. Some THPs use the Resource and Patient Management System (RPMS) and some use NextGen® Enterprise. In many cases, they have been slow to create the codes and templates that will make data retrieval easier. We have made great strides in mitigating this problem in 2018. This difficulty in obtaining annual data has delayed this 2018 annual report and the annual DTI Challenge incentive awards. Compounding the challenge of obtaining the data is that in some cases the accuracy of the data is skewed by the fact that often our clinics lack pediatric dentists, necessitating referrals to outside dentists. Since we can only gather data from our participating sites, we cannot accurately measure movement between caries risk levels, or even changes in the ratio of restorative to preventive procedures since we are only measuring children who are not referred.

An additional ongoing challenge is the problem of no-shows to both medical and dental appointments, so that even with the referrals or warm hand-offs from the OHCCs, the patients don't return for their appointments. This is being addressed in 2019.

An obstacle we faced initially was the reluctance of the dental departments to "share" with the medical department; some dental directors feel that only dental personnel can or should do a Caries Risk Assessment or place fluoride varnish. As the program year progressed, the departments got used to working with each other and this obstacle has largely dissipated. On the other side, many of the long-term medical providers have been resistant to adding yet another procedure to their already busy schedule. Though this obstacle has been slower to eradicate, we are making progress, with more medical providers agreeing to provide this service.

One challenge we have not successfully mitigated is that several THPs have lost their medical providers, and it has been difficult for them to recruit permanent replacements. The OHCCs have continued performing their duties with temporary providers while replacements are sought. The staffing problems also exist in the dental departments to a lesser degree. Additionally, some of the clinics are understaffed with auxiliaries, causing the OHCCs to be pulled away from their duties to fulfill other roles. This has been a particular problem at Toiyabe—Coleville and San Diego. CRIHB continues to work with those sites to help them mitigate the situation.

Another challenge is a lack of dental providers who are knowledgeable and competent in minimally invasive dentistry (MID) and treatment of children who need sedation. The Decay Reduction Mini-Grants started in January 2019 have begun to address that issue. Additionally, the 2018 CRIHB/Indian Health Service Annual Dental Conference included courses in MID, pediatric dentistry, nitrous oxide sedation, and pit and fissure sealants.

One obstacle CRIHB experienced was the lengthy process to submit and receive approval for our 2018 budget revision. The late approval meant we were unable to institute the changes approved in the revision until late in the year, including bringing on the new sites.

A continuing challenge has been lack of clear guidelines on evaluation from the California Department of Health Care Services (DHCS). Because our LDPP does not operate on a county-wide basis, we are uncertain of the criteria by which we will be evaluated by DHCS. In the absence of baseline data, we solicited self-reported baseline data from the THPs in order to measure progress toward goals. CRIHB has been in communication with DHCS about this challenge.

Program Modifications

We began our LDPP with the idea of incorporating dental assistants into the medical office to serve as OHCCs. We immediately ran into some problems with this approach:

1) The dental assistants were so busy in the dental office that they often could not get away when they have a target child patient in the medical office.
2) The medical offices have been slower to accept or to cooperate with having a dental assistant working among them.
3) The medical offices have not taken as much responsibility for the program as they need to, considering that the intervention happens in their arena. They have deferred it to the dental department, which does not have any authority over what occurs in the medical department.

For these reasons, we have modified our approach. Now, for new sites coming on board or replacing an OHCC, we are urging them to designate multiple medical assistants to perform the duties of an OHCC, with one of them designated as the lead for communication, care coordination, and reporting purposes. We feel that this approach will be more sustainable long-term. Those sites that have been doing it this way find it to be much less disruptive to their flow of work. It just becomes part of what the medical assistants *do* during a well-child visit, which is more likely to continue beyond this LDPP. Further modifications need to be implemented to more fully incorporate the medical providers themselves into the program.

Progress

The end of the 2018 program year marks the first 18 months of the program, and we are beginning to see progress. At the end of 2018 we have trained OHCCs at all sites. We have seen

an increase in the number of children served. With more team members taking ownership of the program, more children are being screened and referred.

With the approval of our 2018 budget revision, we were able to institute some of the changes included in the revision.

- We were able to add the new site of Indian Health Council and the Grass Valley location of Chapa-De Indian Health.
- We purchased much-needed educational and oral health supplies for the sites. We released our Request for Proposals for our first round of $10,000 Decay Reduction Mini-Grants, which will begin in February 2019.
- We held the first meeting of our reconstituted Advisory Committee.
- We completed our webinar series on care coordination and have made the recordings available for review by anyone.

Expenses

The expenditures of 2018 totaled $470,266.35, of which $294,797.15 went to Oral Health Care Coordinator salary reimbursements to the sub-contracted sites. Salaries for administration and Tribal Head Start staff totaled $156,578.15. Facilities expenses totaled $7,493.45. Advisory Council and staff travel totaled $6,665.39. Office, program, and educational supplies came to $3,671.49. The remaining $1,060.72 was comprised of postage, membership/dues, printing, and training space rental for the Advisory Committee meeting. See the financial statement on the following page.

California Rural Indian Health Board
Monthly Revenue & Expense Summary
For Calendar Year January 1, 2018 to December 31, 2018

		Calendar Year 2018 Budget 1/1/2018 to 12/31/2018	Calendar Year 2018 Actuals 1/1/2018 to 12/31/2018	Balance Remaining	% Spent
INCOME					
Grant & Contract Income					
	State Grant Revenue	$1,019,390.00	$470,266.35	$549,123.65	46.13%
	Total Grant & Contract Income	$1,019,390.00	$470,266.35	$549,123.65	46.13%
Total Income		**$1,019,390.00**	**$470,266.35**	**$549,123.65**	**46.13%**
EXPENDITURES					
Payroll Expense					
	Salary & Wage Expense	$137,916.00	$126,336.73	$11,579.27	91.60%
	Taxes & Benefits	$44,134.00	$30,241.42	$13,892.58	68.52%
	Total Payroll Expense	$182,050.00	$156,578.15	$25,471.85	86.01%
Supply Expense					
Supplies - Budget Only		$128,206.00	$0.00	$128,206.00	0.00%
	Office Supplies	$480.00	$20.14	$459.86	4.20%
	Program Supplies	$6,200.00	$334.38	$5,865.62	5.39%
	Education Supplies	$0.00	$3,316.97	($3,316.97)	0.00%
	Total Supply Expense	$134,886.00	$3,671.49	$131,214.51	2.72%
Other Operating Expense					
	Postage Expense	$0.00	$56.40	($56.40)	0.00%
	Total Other Operating Expense	$0.00	$56.40	($56.40)	0.00%
Travel Expense					
	Staff Travel	$6,705.00	$2,912.22	$3,792.78	43.43%
	Advisory/Policy Council Travel	$3,500.00	$2,814.55	$685.45	80.42%
	GSA Vehicle Usage	$0.00	$938.62	($938.62)	0.00%
	Total Travel Expense	$10,205.00	$6,665.39	$3,539.61	65.31%
Contractual Service Expense					
	Membership/Dues	$0.00	$40.00	($40.00)	0.00%
	Total Contractual Service Expense	$0.00	$40.00	($40.00)	0.00%
Outreach Expense					
	Outreach Printing	$0.00	$64.32	($64.32)	0.00%
	Total Outreach Expense	$0.00	$64.32	($64.32)	0.00%
Board and T&TA Expense					
	Training Space Rental	$0.00	$900.00	($900.00)	0.00%
	Incentives	$18,000.00	$0.00	$18,000.00	0.00%
	Total Board and T&TA Expense	$18,000.00	$900.00	$17,100.00	5.00%
Facilities, Fixtures & Equipment Expense					
	Building Rental	$0.00	$4,868.45	($4,868.45)	0.00%
	Facility Operating Expense	$6,880.00	$2,625.00	$4,255.00	38.15%
	Total	$6,880.00	$7,493.45	($613.45)	108.92%
Direct Payment Expense					
	Sub-Contract Expense	$547,369.00	$294,797.15	$252,571.85	53.86%
	Mini Grants	$120,000.00	$0.00	$120,000.00	0.00%
	Total Direct Payment Expense	$667,369.00	$294,797.15	$372,571.85	44.17%
Total Expenditures		**$1,019,390.00**	**$470,266.35**	**$549,123.65**	**46.13%**