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This is the final report for the HRSA TOHSS grant from September 1, 2007 through December 31, 2011 with approval of no-cost extension.

SUMMARY

The report on the HRSA TOHSS grant reports information by the listed objectives in the grant application. The report also provides a summary at the end of each objective on an overview of accomplishments as they relate to the objects and an overview of the evaluation results from the questions listed in the evaluation plan for the grant.

Overall the Alaska Oral Health Program accomplished most aspects of the objectives and related activities in the grant. Specifically:

1. The CSHCN coordinator was hired to work on the grant activities by transitioning Sharon Schlicht, RDH, MPH from other duties to work on the grant – this occurred somewhat later than was originally intended due to other commitments. The CSHCN Coordinator organized follow-up meetings to the original CSHCN Oral Health Forum conducted by the Oral Health Program, organized trainings (CSHCN oral health workshop by Dr. Paul Glassman and Early Childhood Caries Prevention workshop by Dr. Jim Crall), and worked on collaborative projects with the Family Voices Agency (Stone Soup Group) to develop educational materials and resources for parents/caregivers of CSHCN as well as for the children themselves. There was not a great need identified to assist in dental referrals for CSHCN – some of that was more resources available in urban areas of the state than seen in rural/remote areas. However, for rural/remote areas the logistics with

small population sizes, lack of roads and expense of travel restrict the ability to easily develop local-based solutions for dental access for special needs populations. These areas have infrastructure to support services for Alaska Native children living in rural/remote areas but infrastructure for non-Native children with special health care needs living in these areas often is met by Medicaid funding for transportation to urban areas for services. Medicaid dental issues were the most common themes presented by CSHCN parents and other stakeholders, thus much of the focus of the Oral Health Program was on attempts to address Medicaid issues. During the grant period Medicaid changes included: the reauthorization of preventive and routine restorative services for adults enrolled in Medicaid, Medicaid reimbursement increases in 2008 and 2009, a regulatory change in 2009 that provides for annual department review of Medicaid dental reimbursement based on changes in the Anchorage Consumer Price Index, Medicaid reimbursement for trained medical providers doing oral evaluation or fluoride varnish and adoption of “Bright Futures” guidelines for Alaska’s EPSDT program. Remaining activities include work with the EPSDT workgroup to formally adopt the age one dental visit for EPSDT guidelines – scheduled to start that process in January 2012. Another aspect is to revisit a training/workshop for dentists/dental hygienists on treatment of CSHCN and adults with disabilities as was done with Dr. Glassman, however if conducted again a longer lead time would be warranted to allow stakeholders to assist in identifying dental providers for the training and encouraging the participation of these providers in the training – the experience with the previous workshops is dental offices are not self-identifying or accessing the training despite the free continuing education provided.

2. While not a core aspect of HRSA TOHSS activities, the Alaska Oral Health Program listed activities to encourage increased dental access for pregnant women. PRAMS data indicates increased access during the grant period – additional analysis will be needed to attribute increased access to the Medicaid coverage for preventive and routine restorative for adults enrolled in Medicaid.
3. Increasing dental access for young children was the other HRSA TOHSS major objective. During the grant period Medicaid claims data illustrate some increased access for children aged 3-5 and younger groups although at lower levels than anticipated. Further, much of the increase was reflected during the FFY2010 period – which could be the result of the increased dental reimbursement in Medicaid (discussed above). The reimbursement coverage for oral evaluation and fluoride varnish did not occur until July 2010 and the CMS416 report for FFY2011 will be the first opportunity to access if this policy change is resulting in increased attention to oral health by medical providers during EPSDT well child exams. As noted above, the program is working with the EPSDT work group to adopt the age one dental visit as guidelines for EPSDT following that work groups adoption of “Bright Futures” guidelines for EPSDT. It is anticipated the change to an age one dental visit will occur in CY2012. The change in guidelines along with the reimbursement coverage for medical providers provide a platform for future increases in early dental visits – however the Oral Health Program and other stakeholders will need to continue to educate, offer trainings and other aspects to increase age one dental visits. Experience in other states has shown slow incremental change in age one dental visits in part due to reluctance of medical providers to adopt oral evaluation and

fluoride varnish as part of well child exams and the reluctance of dental offices to see children younger than age 3. It is anticipated it will be the same slow incremental approach in increasing age one dental visits in Alaska. The Center for Medicare and Medicaid Services (CMS) has proposed an initiative for states to increase dental visits for children – if the CMS initiative moves forward this could assist with accelerating the implementation of age one dental visits, however at the time of this report CMS has not released the “Dear State Health Official” letter that would kick-off the CMS initiative.

4. The Oral Health Program utilized approved carryover to conduct a school-based dental sealant pilot program at Taku Elementary School in Anchorage, Alaska in February 2010 and February 2011. The project was done with assistance of professional services, under contract, with the Anchorage Neighborhood Health Center. The approach of working with the community health center dental program proved feasible if some level of grant/contract/other funding could be identified to assist with the costs for the sealant program and lost revenue from the CHC dental program with staff being out of the dental clinic. The services were well accepted/supported by the elementary school. The only major issues identified with the project, besides ongoing funding, were: 1) the requirement in Alaska for active parental consent for such projects is a barrier to getting services to the target population (low-income children especially non-Native racial/ethnic minority groups); 2) the small class sizes in Alaska elementary schools reduce the efficiency of the school-based sealant approach (most schools have <50 2nd grade students); and 3) there would be the need to assist the health centers in finding/purchasing portable equipment for the sealant programs (the pilot had use of portable equipment from the local Native health corporation in the Anchorage area provided without charge from that organization).

The grant has four major goals for the activities described in the grant application.

GOALS

- I. Increase access to dental care and improve the oral health of pregnant women;
- II. Increase access to dental care and improve the oral health of CSHCN;
- III. Increase the number of children having their first dental visit by age one; and
- IV. Increase dental participation in the Medicaid/SCHIP program as part of the means of increasing access to dental care for CSHCN, pregnant women and children (with a focus on young children and first dental visit by age one).

Grant activities are listed by year for each of the ten objectives below. One additional objective is included at the end.

Objective 1: Assign the current program staff (dental hygienist) to case manager/coordinator role by October 1, 2007 with related support from the Dental Officer and administrative staff.

Year 1

- Sharon Schlicht, RDH, MPH transitioned to full-time work on grant activities and planned case management/coordinator role. The transition came after Sharon was

impaneled on a federal jury and following turnover in staffing with the Maternal Child Health Specialty Clinics.

- Sharon assisted in organizing “CSHCN Oral Health Forum” in September/October 2007 (see Objective 2).
- Sharon attended the March 2008 TOHSS grant work-shop and will be moving toward management of the TOHSS grant with assistance from Dr. Whistler in Year 2 of the grant projects.
- Dr. Whistler assisted with Year 1 grant activities to keep on schedule.

Year 2

- Sharon assisted in development of materials for the CSHCN parent notebook (see Objective 3).
- Sharon, along with Dr. Whistler, presented information at the 2008 annual meeting of the American Academy of Pediatric Dentistry – Alaska Chapter; discussion primarily was on Medicaid issues encouraging first dental visits prior to age 2 at least for at-risk children (e.g., Medicaid/SCHIP).
- Sharon is working with the Oral Health Program on development of a dental sealant pilot in Anchorage along with referrals for treatment for children without a routine course of dental care (the project is a collaboration with the Anchorage Neighborhood Health Center dental program).

Year 3

- Sharon organized the annual meeting of the “CSHCN Work Group” in December 2009 to provide updates on Medicaid changes, review the “CSHCN Oral Health Action Plan” and set priorities for 2010-2011 (see Objective 2).
- Sharon attended the Special Care Dentistry Annual Meeting in Chicago in March 2010 to learn more about dental treatment of patients with complex needs.
- In April 2010 Sharon attended TOHSS workshops at the National Oral Health Conference, where the program provided updates on HRSA TOHSS-related program activities.
- Sharon continues work with “Stone Soup Group” (Family Voices state agency) to address needs for care coordination, provision of resource materials to parents/caregivers and to improve access to dental care for CSHCN (see Objective 5).
- Sharon worked as the project coordinator for a school-based dental sealant pilot program in February 2010 and February 2011—along with the partnership of the Anchorage Neighborhood Health Center (ANHC) dental program.
- Sharon ensured data collection with the sealant pilot and assured access to dental treatment services at ANHC for children who lacked a dental home.

Year 4

- In April 2011 Sharon and Dr. Whistler attended TOHSS workshops at the national Oral Health Conference to provide updates on HRSA TOHSS-related program activities.
- Sharon organized a workshop and continuing education for treatment of CSHCN in the dental office—presented by Dr. Paul Glassman (UCSF) in June 2010. He discussed various CSHCN conditions, specific issues related to conditions and how to address treatment in the dental office. Dr. Glassman noted the need for care with the same

provider for familiarity in working with the child and to avoid parent/caregiver need to repeatedly give health histories. Southcentral Foundation staff attended the workshop along with several private dentists and dental hygienists—UAA dental hygiene students also participated in the workshop (see Objective 4).

- Sharon assisted with the organization of an April 2011 workshop on early childhood caries prevention with a focus on early dental visits, oral evaluation and fluoride varnish application. The workshop was for both dental and medical providers and was funded by the Alaska Dental Society with support from the Alaska Native Tribal Health Consortium. The workshop speaker was Dr. Jim Crall, UCLA School of Dentistry. There were 32 participants including 8 physicians, 3 nurse practitioners, and 1 physician assistant. This meeting represents an early step to expand medical provision of oral evaluation and fluorides as part of EPSDT well child exams – the reimbursement for these services was authorized by Medicaid starting July 2010 (see Objective 7).

Accomplishments

Sharon Schlicht, RDH, MPH, transitioned to fulltime work on grant activities working with Dr. Brad Whistler. She assisted in organizing a CSHCN oral health forum and two annual follow-up meetings for parents and providers. She also worked with Stone Soup Group (Family Voices agency) to develop oral health resource materials for parents and caregivers of CSHCN. Sharon and Dr. Whistler attended TOHSS grantee workshops each year of the grant. They presented at the 2008 annual meeting of the American Academy of Pediatric Dentists – Alaska Chapter, primarily discussing Medicaid issues and encouraging first dental visits by age two, at least for high-risk children. The Oral Health Program collaborated with the Anchorage Neighborhood Health Center to develop and implement a school-based dental sealant pilot in 2010 and a follow-up in 2011 that included treatment referrals for children without a dental home. Sharon organized a continuing education workshop for dental providers and students on treating CSHCN in the dental office in June 2010; Dr. Paul Glassman (USCF) presented. Sharon assisted with organizing an April 2011 workshop on early childhood caries prevention and fluoride varnish application for medical and dental providers; Dr. Jim Crall (UCLA) presented.

Evaluation

The case manager position was filled in Year 1 of the TOHSS grant and was maintained throughout the grant period. The position remains with the Oral Health Program after the end of the TOHSS grant; other duties have been assigned to the case manager.

Objective 2: Conduct follow-up meeting to “CSHCN Oral Health Forum” by November 2007, to finalize an action plan, discuss this grant application and activities and integrate the stakeholder activities from the forum into the related activities of this grant application.

Year 1

- A follow-up meeting was held on November 2, 2007. Dr. Jane Bleuel discussed changes at the Alaska Native Medical Center/Southcentral Foundation (ANMC/SCF) in relation to working with CSHCN. They have improved coordination to identify records of children and adults with special needs so dental staff can coordinate care in the appropriate facility (e.g., appointing patients in wheelchairs at the clinic that accommodates wheelchairs). They have made an effort to include notes in charts on

what procedures patients can tolerate in the clinic setting. Additionally, they have regularly scheduled days for individuals with special needs to coordinate dental cleanings, exams and treatment. They have found that dental hygienists can often do prophylaxis and/or scaling in the clinic if it is coordinated so they have an assistant. At the meeting it was arranged to begin coordination with the University of Alaska, Anchorage dental hygiene program to have students gain experience and comfort working with special needs patients when they rotate through the SCF dental clinic for training. Although students are not scheduled specifically for the special needs clinics, they are included in those clinics when their rotation coincides with a clinic day (see Objective 4).

- ANMC/SCF has residency programs in both pediatric dentistry and general dentistry. Residents from these programs receive training in working with CSHCN at their quarterly clinics. They regularly attend state-sponsored pediatric Cleft Palate Clinics to gain expertise in working with cleft-affected children, and periodically they attend state-sponsored Genetics Clinics to learn about the needs of children with genetic conditions.
- The November 2007 meeting then focused on priority recommendations/strategies for the state oral health plan and next steps from the forum meeting and follow-up. Stone Soup Group (Family Voices agency) and the Oral Health Program took input on focus areas to assist parent/caregivers with prevention of dental decay, oral hygiene and information on accessing dental care for a parent/caregiver resource section in the existing parent resource notebook offered by Stone Soup Group (see Objective 3).
- Finally, the meeting discussed possibilities for continuing education for general dentists for treatment of adults with disabilities – noting that many individuals continue to see pediatric dentists into adulthood as there are limited general practitioners to refer these individuals to (see Objective 4).

Year 2

- See Objective 3 report for progress on CSHCN caregiver resource information. The Oral Health Program is planning the next follow-up meeting for CSHCN stakeholders in the fall of 2009. Progress has been made on a number of the Medicaid/SCHIP issues outlined in the November 2007 meeting. Medicaid/SCHIP related activities are reported under Objective 4.

Year 3

- The annual follow-up meeting of the CSHCN Oral Health Workgroup was held in December 2009 in Anchorage. The meeting included a presentation from Dr. Jim Singleton and Judy Oyler, RDH, on the ANMC/SCF project to coordinate preventive and restorative care for CSHCN at the agency facilities. Four-hour clinics utilizing four dental teams allow them to see up to 16 special needs patients. These regularly scheduled clinics allow for ease in appointments for patients needing follow-up procedures at the next clinic (see Objective 4). Services have been limited to Anchorage Alaska Native beneficiaries at this time.
- The December meeting noted priorities for offering training to dentists and dental hygienists on treatment of CSHCN and adults with disability in the dental office setting (see Objective 4). Another priority is to increase efforts to let parents/caregivers of CSHCN understand the importance of keeping dental appointments. Short-notice

cancellations and missed appointments are significant issues limiting private dental participation in Medicaid/Denali KidCare (CHIP program).

Year 4

- There was no annual meeting of the CSHCN Oral Health Workgroup, but activities identified from the workgroup and action plan from this period include:
 - Early childhood caries prevention workshop with medical and dental providers – discussed above;
 - Dr. Whistler has been invited to discuss water fluoridation, oral evaluation and fluoride varnish with pediatric medical providers at Providence Children’s Hospital grand rounds in January 2012;
 - Dr. Whistler, has been invited to discuss oral health and dental access issues with the CSHCN work group in January 2012;
 - Medicaid dental reimbursement increase on October 2011 – part of now continuing process to review dental reimbursement increase needs in tracking changes in Anchorage CPI;
 - Dental workforce report, developed under contract from the State Primary Care Office with Dr. Paul Glassman, highlighted additional dental workforce training and/or general practice residency programs to encourage more private dentists seeing CSHCN and adults with disabilities on an outpatient basis (see Objective 4);
 - PEW state dental report card listed Alaska at an “A” – primarily due to sealant utilization in 3rd graders, Medicaid dental reimbursement rates, dental participation in the Medicaid program and the July 2010 Medicaid coverage of fluoride varnish for medical providers;
 - September 2011 CDC MMWR was released noting the high prevalence of early childhood caries in rural Alaska Native children – along with associations of caries with soda consumption and reduced caries in villages with community water fluoridation; and
 - EPSDT Work Group has adopted “Bright Futures Guidelines” for EPSDT guidance – Dr. Whistler has submitted a new dental periodicity schedule to the group. This will move Alaska EPSDT provisions to an age one dental visit (see Objective 7).

Accomplishments

Follow-up meetings were held in November 2007 and December 2009. At the 2007 meeting Dr. Jane Bleuel reported on work at ANMC/SCF to improve the experience for their dental patients with special needs by coordinating care in the appropriate facility, including chart notes regarding procedures patients can tolerate, scheduling quarterly clinics specifically for patients with special needs, and including dental hygiene students in special needs clinics when they rotate through SCF for training. Dr. Jim Singleton and Judy Oyler, RDH, gave an update on their clinics at the December 2009 meeting. Services are limited to Anchorage Alaska Native beneficiaries at this time. ANMC residents in pediatric dentistry and general dentistry programs receive training in working with CSHCN at their quarterly clinics, at state-sponsored pediatric Cleft Palate Clinics, and periodically at state-sponsored Genetics Clinics. The November 2007 meeting focused on priority recommendations/strategies for the state oral health plan and next steps. The CDHP recommendations on CSHCN will be included in the revised plan. Stone

Soup Group (SSG) and the Oral Health Program took input for a parent/caregiver oral health resource section in the existing parent resource notebook offered by SSG. There was a discussion of options for continuing education training for general dentists to gain expertise in treating patients with special needs, and for educating parents/caregivers on the importance of keeping dental appointments. Funding for training is not currently available, and more stakeholder involvement to identify/encourage dentists to take the training is needed before training will be offered. The Oral Health Program will continue work with stakeholders to maintain progress on activities to increase private dental participation in the program. In rural areas dental access likely will remain difficult due to distances and travel costs. In many cases CSHCN in rural and remote areas of the state will still need to travel to more urban areas to gain access to care. Progress was made on a number of Medicaid/SCHIP issues outlined in the 2007 meeting (see Objective 4). Other activities/actions coming out of the meetings include: Early Childhood Caries prevention workshop for medical and dental providers in April 2011; Dr. Whistler will speak at pediatric medical providers at Providence Children’s Hospital grand rounds in January 2012 on water fluoridation, oral evaluation and fluoride varnish; Dr. Whistler will discuss oral health and dental access issues with the CSHCN work group in January 2012; Medicaid dental reimbursement increased in October 2011 and future increases will be linked to Anchorage CPI; dental workforce report, developed under contract from the State Primary Care Office with Dr. Paul Glassman, highlighted additional dental workforce training and/or general practice residence programs to encourage more private dentists seeing CSHCN and adults with disabilities on an outpatient basis; PEW state dental report card listed Alaska at an “A”; September 2011 CDC MMWR was released noting the high prevalence of early childhood caries in rural Alaska Native children; and as a result of EPSDT Work Group adopting “Bright Futures” for EPSDT guidance, Dr. Whistler submitted a new dental periodicity schedule to the group that moves Alaska EPSDT provisions to an age one dental visit.

Evaluation

An Oral Health Forum for CSHCN was held in February 2007; follow-up meetings were held in November 2007 and December 2009. The meetings had good participation by parents of CSHCN and dental providers. Surveys showed participants were satisfied with the meetings. An action plan was developed, revised and implemented. Overall most of the objectives and activities were accomplished.

Objective 3: Develop resource materials and navigation tools for parents/caregivers of CSHCN by June 2008.

Year 1

- Topics for resource materials and navigation tools discussed at the November 2 meeting include fluoride rinses, use of bite blocks and/or powered toothbrushes to assist with oral hygiene, medications with sugar-substitutes, scheduling appointment times that are best for the child and cooperation, requesting the same dentist at each appointment to avoid repeated interviews on medical history, and speaking with legislators/policymakers to improve oral health care.
- Oral Health Program staff met with staff from Stone Soup Group (SSG) in January to begin preparing information. SSG decided to keep oral health information in the parent-

navigation notebook to two sheets of paper with references to information that would be provided on a DVD (e.g., use of bite blocks).

- Draft information for the notebook and DVD is planned for completion by June 2008 – with preparation of video information over the summer.

Year 2

- Oral Health Program staff met with Stone Soup Group over the past year to finalize resource materials. Sharon Schlicht compiled and drafted information for the Paper Trail Notebook that Stone Soup Group gives to parents of CSHCN. The notebook is used to collect and organize health records, resources, educational records and other important papers for and about the child as he or she grows through childhood and beyond. Prior to this project, the notebook did not include oral health information. Initially the oral health section was to be limited to two to four pages. Because of parents' enthusiasm for the project and requests for more information, Stone Soup Group expanded the section to a total of more than 20 pages.
- Stone Soup Group developed a DVD with additional oral health information and filming. They acquired new video equipment and used this as a training project. Filming was done in three stages: (1) parents of children with special needs were interviewed about dental experiences with their children, (2) filming was done in a dental office to demonstrate what to expect at a dental visit, and (3) children with special needs were filmed in their homes brushing their teeth with and without the assistance of an adult. The DVD is being distributed to all parents and providers who attended the CSHCN Oral Health Forum. It is also available by request to any family who receives services from Stone Soup Group. The Oral Health Program assisted in developing interview questions and identifying families to participate.

Year 3

- Resource materials and DVDs were completed and mailed to the Project Officer and MCH Oral Health Resource Center – some of the materials utilize information from the resource center and Katrina Holt has indicated she will forward appropriate citation/reference for the materials when the information is available.

Accomplishments

Topics for resource materials and navigation tools were discussed at the November 2007 CSHCN meeting, and in January 2008 Oral Health Program (OHP) staff and Stone Soup Group (SSG) met to begin preparing information. Originally SSG limited printed information to two to four pages; at the request of parents of CSHCN it was expanded to more than 20 pages with additional information on a DVD. The OHP assisted in developing interview questions and identifying families to participate in making the DVD. The DVD was distributed to all parents and providers who attended the CSHCN Oral Health Forum. It is also available by request to any family who received services from SSG. Resource materials and DVDs were mailed to the Project Officer and MCH Oral Health Resource Center. Some of the materials were adapted from the resource center and Katrina Holt forwarded appropriate citation/reference for the materials.

Evaluation

Resource materials were developed by Stone Soup Group with input from the Oral Health Program and focus groups made up of parents/caregivers of CSHCN. The original plan was to prepare two to four pages of information; due to parents' request for additional information more than 20 pages were prepared along with a DVD. Resource materials were distributed; key informants said they were very useful.

Objective 4: Increase dental services for children with special health care needs.

Year 1

- As a result of discussions at the February 2007 “CSHCN Oral Health Forum”, Southcentral Foundation (Anchorage-based Tribal health organization that also receives referrals for specialty services from other Tribal health organizations in Alaska) and Alaska Native Medical Center have improved coordination of dental appointments for CSHCN and adults with disabilities. Specifically, they implemented processes to ensure individuals in wheel-chairs are appointed to the appropriate facility; are having three to four clinics per year focused on exams and cleanings for individuals with disabilities in the dental clinic setting (utilizing a dental assistant with the dental hygienist) and exams the same day. Prior to seeing patients, dental teams consisting of general dentists, pediatric dentists, oral surgeons, dental residents, dental hygienists and other appropriate clinicians meet to discuss each case and determine the best course of treatment. Appointments average one to two hours depending on the treatment and how well the patient responds.
- Assistance as outlined in Objective 5 will begin with work on the parent resource materials and ongoing collaboration with Stone Soup Group (Family Voices agency).

Year 2

- Dr. Whistler and Sharon Schlicht met with the American Academy of Pediatric Dentistry – Alaska Chapter in September 2008. Topics included increasing age one dental visits and identification of general practitioners that would be interested in training for treatment of CSHCN and/or adults with disabilities. General practitioners were not identified, but follow-up with pediatric dentists continues.
- The program undertook a number of activities and/or policy changes to increase dental access for all children enrolled in Medicaid/SCHIP (including CSHCN). These activities include:
 - With assistance of the Alaska Dental Action Coalition legislative approval of a dental reimbursement increase took effect July 1, 2008 under a \$4 million authorization. The Dental Officer worked with the Division of Health Care Services in review and pricing of reimbursement by dental codes. Under the authorization dental codes could not all be increased using the same method (e.g., target for Medicaid is 80% UCR) – so the first priority was to increase codes that encouraged dentists to see new Medicaid patients (e.g., D0145 – oral evaluation for a patient under three years of age; D0150 – comprehensive oral evaluation for new or established patients; and routine restorative).

- In 2008 Dental Officer initiated a work order for coverage of D3240 at the request of the American Academy of Pediatric Dentistry – Alaska chapter. This code covers pulpal therapy (resorbable filling) for posterior, primary molars.
- Dental Officer received support from the State Medicaid Director and Deputy Commissioner over the Medicaid/SCHIP programs for future coverage of D1206 (topical fluoride varnish) provided by medical providers in the course of well child exams (EPSDT). The programs are working towards implementing coverage when the new Medicaid MIS (claims processing system) is implemented (scheduled for July 2010).
- In 2007 the Alaska Dental Action Coalition supported passage of HB136 which includes dental hygiene practice under collaborative agreements. The bill passed and regulations were adopted for provision of dental hygiene services under supervision. This will allow dental hygienists to provide services in pre-school, daycare and school settings and allow for home visits for CSHCN without a dentist present. The Oral Health Program will be working with the University of Alaska and Alaska State Dental Hygienists' Association to encourage dental hygienists to do screenings and cleanings in these other settings for earlier referral of children at-risk for development of early childhood caries and more frequent cleanings and/or topical fluoride services for CSHCN.
- A common complaint by private dentists with Medicaid/SCHIP is non-kept appointments; the Oral Health Program is working with the Medicaid program to develop a method to track non-kept appointments utilizing voluntary submission of claims by providers (e.g., use of D_999 such as D2999). The claims with these codes would not be reimbursed by Medicaid but would allow staff to track the extent of the problem and identify families that repeatedly miss appointments. Future initiatives may involve development of some form of case management for those that repeatedly miss appointments – a commitment for next steps by the Medicaid program has not been achieved at this time.

Year 3

- At the December 2009 meeting ANMC/SCF staff highlighted their ongoing CSHCN clinics (discussed above in this report). The meeting affirmed the priority for offering dental continuing education/training for dentists and dental hygienists on seeing CSHCN in the dental office setting. Sharon Schlicht has organized a training program by Dr. Paul Glassman to be held in Anchorage on June 11, 2010 – invitations were sent to private dentists through the Alaska Dental Society, to dental hygienists through the Alaska State Dental Hygienists' Association, to ANMC/SCF dental staff and will include participation of faculty and students from the dental assisting, dental hygiene, and medical assisting programs at the University of Alaska, Anchorage.
- The program undertook a number of activities and/or policy changes to increase dental access for all children enrolled in Medicaid/SCHIP (including CSHCN). These activities include:
 - With assistance of the Alaska Dental Action Coalition legislation was approved for a dental reimbursement increase effective July 1, 2008 under a \$4 million authorization, and another \$4 million was appropriated for increases effective July

1, 2009. The Dental Officer worked with the Division of Health Care Services in review and pricing of reimbursement by dental codes.

- After developing a white paper for fluoride varnish coverage for non-dental providers (e.g., physicians, nurse practitioners and physician assistants) and Tribal health corporation requests for Medicaid coverage the Commissioner’s Office directed Medicaid/SCHIP to implement coverage (planned for July 2010). The Oral Health Program is assisting with implementation.

Year 4

- A common complaint by private dentists with Medicaid/SCHIP is non-kept appointments (and/or short-notice cancellations); the Oral Health Program completed a professional services contract to track short-notice cancellations and non-kept appointments utilizing voluntary submission of information from private practice dentists in March – June 2010. The project found wide variation in failed appointment rates for dental offices. Combining all scheduled appointments for the participating dentists, Medicaid failed appointments were 8.5% as compared with 4.0% for non-Medicaid patients. If the failed appointments were averaged from the 21 reporting dental practices, Medicaid failed appointments were 17.8% as compared with non-Medicaid at 6.3%. Practices with 10% or less of total appointments as Medicaid had significantly higher Medicaid failed appointment rates than practices that had 30% or more of total appointments as Medicaid appointments. While all the dental offices reported similar appointment processes, reminder processes and consequences for failed appointments (e.g., delayed booking for a new appointment), the results seem to indicate that practices with a higher percentage of Medicaid appointments likely devote more resources to patient reminders. Short-notice cancellations were 35% of the Medicaid failed appointments – this was higher than anticipated as typically dentist complaints have been on “no shows.” The short-notice cancellation percentage speaks to modification of education materials for Medicaid parents/caregivers to note the need to inform dental practices as soon as they know they may not be able to keep an appointment – this allows an opportunity for dental practices to book other patients into the appointment slot. This information was presented at a roundtable session at the 2011 NOHC. The report was shared with the Alaska Dental Society and Medicaid program.
- June 2010 workshop by Dr. Paul Glassman provided training on treatment of CSHCN in the dental office. See information above in Objective 1.
- 2011 increase in Medicaid dental reimbursement based on increased Anchorage CPI (low reimbursement rate is often the most common reason cited for low private dental participation in Medicaid)
- September 2011 Alaska Dental Action Coalition employed use of the Children’s Dental Health Project “Policy Tool” for identification of five priorities for the next 2-3 years – provider training for treatment of CSHCN and/or financial incentives for treatment of CSHCN in the dental office were combined into one of the five priority areas identified by the coalition. Discussion noted the possible need to narrow the definition of CSHCN for financial incentives (e.g., a child with a vision impairment may not present any more difficulty for dental treatment than a child without such an impairment).
- Executive Director of Stone Soup Group (Family Voices agency) joined the Alaska Dental Action Coalition in June 2011.

- Dental Officer invited to speak/discuss issues at the January 2012 CSHCN work group meeting.

Accomplishments

As a result of discussions at the February 2007 “CSHCN Oral Health Forum”, SCF/ANMC improved coordination of dental appointments for CSHCN and adults with disabilities. Also in 2007 the Alaska Dental Action Coalition supported passage of HB136 that allows dental hygienists to practice under collaborative agreements without a dentist present in locations like pre-school, daycare and school settings and allows for home visits for CSHCN. The dental case manager and Dental Officer would like to meet with Tribal dental chiefs to discuss staff and capacity for treatment of CSHCN within regional health corporations. To date meetings have been held with Southcentral Foundation (SCF), but not other Tribal health corporations. SCF serves the largest population of Tribal beneficiaries and has the largest dental team to provide services. The dental case manager and Dental Officer continue to look for opportunities to work with other Tribal health organizations.

In September 2008 Dr. Whistler and Sharon Schlicht met with the American Academy of Pediatric Dentistry (AAPD) – Alaska Chapter to discuss increasing age one dental visits and to identify general practitioners for training in treatment of CSHCN and/or adults with disabilities; none were identified, but follow-up with pediatric dentists continues. Dr. Whistler initiated a work order for coverage of D3240 (pulpal therapy) at the request for AAPD – Alaska Chapter. The Oral Health Program undertook a number of activities and/or policy changes to increase dental access for all children enrolled in Medicaid/SCHIP (including CSHCN). The Oral Health Program worked with the Alaska Dental Action Coalition to get legislation approved to increase dental reimbursement in 2008 and 2011 based on Anchorage CPI, the Dental Officer worked with the Division of Health Care Services in review and pricing of reimbursement by dental codes, the Dental Officer received support from the State Medicaid Director and Deputy Commissioner over the Medicaid/SCHIP program’s coverage of D1206 (topical fluoride varnish) provided by medical providers in the course of well child exams (EPSDT). Coverage became effective July 1, 2010; the Oral Health Program assisted with implementation. The Oral Health Program completed professional services to track short-notice cancellations and non-kept appointments in private dental offices. The project confirmed dentists’ concern that there is a higher percentage of failed appointments and short-notice cancellations among Medicaid patients than non-Medicaid patients. These findings speak to modification of education materials for Medicaid recipients to emphasize the need to inform dental practices as soon as they know they will not be able to keep an appointment. Information was presented at the 2011 NOHC and the report was shared with the Alaska Dental Society and Medicaid program. The Oral Health Program is working with the Medicaid program to develop a method to track non-kept appointments utilizing voluntary submission of claims by providers. Although the claims would be non-reimbursable, it would allow tracking of the problem and identification of families that repeatedly miss appointments. A June 2010 workshop by Dr. Paul Glassman provided training to dental providers and students and faculty in dental program on treatment of CSHCN in the dental office. In September 2011 Alaska Dental Action Coalition employed use of the Children’s Dental Health Project “Policy Tool” and identified “provider training for treatment of CSHCN and/or financial incentives for treatment of CSHCN in the dental office” as one of five priorities for the next two to three years. Executive Director of Stone soup Group (Family

Voices agency) joined the Alaska Dental Action Coalition in June 2011. The Dental Officer was invited to speak/discuss issues at the January 2012 CSHCN work group meeting.

Evaluation

Many CSHCN are Medicaid recipients. The Oral Health Program is working with the Medicaid program to develop a method to track non-kept appointments (a common complaint of private dentists); a non-kept appointment code would not be reimbursed, but would allow tracking and identification of families who repeatedly miss appointments. This could lead to solutions for decreasing missed appointments. In response to providers complaints that Medicaid reimbursement was too low, the Oral Health Program worked with the Alaska Dental Action Coalition to get legislation approved to increase Medicaid reimbursement in 2008 and 2011. Dentists asked for modification or clarification of the liability provision in the Medicaid provider agreement. The final determination of the State of Alaska Department of Law was that it is standard contract language for state contracts and would not be removed from standard Medicaid provider agreements. Southcentral Foundation/Alaska Native Medical Center developed a program that works well for treating Alaska Native beneficiaries with special needs in the dental office. More needs to be done in the private sector. The Oral Health Program sponsored a continuing education course for dental providers to become familiar with techniques for treating CSHCN in the dental office.

Objective 5: Begin assistance with case management/coordination for parents/caregivers of CSHCN to assist with dental appointments by June 2008.

Year 1

- Case manager/coordinator began providing spin-brushes (remaining brushes from the 2005 and 2007 dental assessments) to parents/caregivers at cleft lip/palate clinics for those anticipated to benefit from use of these brushes by the supervising dentist at the clinics. More active case management/coordination activities are anticipated with completion of the parent resource information (Objective 3) and ongoing collaboration with Stone Soup Group (Alaska's Family Voices agency).

Year 2

- Case manager/coordinator continued work with Stone Soup Group (SSG) on the development of resource materials for parents/caregivers (see Objective 3). Additionally, the program provided spin-brushes (remaining brushes from the 2005 & 2007 dental assessments) to SSG to provide to parents/caregivers that would benefit from use of these products to assist with oral hygiene care of CSHCN. Bite blocks and floss aides were also purchased and donated to SSG for demonstrations on use of these aides. The case manager/coordinator is working with SSG to identify other areas where further assistance is needed in making dental referrals. Dental referrals at this time are almost exclusively to pediatric dentists practicing in Alaska.

Year 3

- Stone Soup Group (SSG) developed a Health Care Provider List made up of dentists and a wide range of other providers recommended by parents of CSHCN. SSG contacts the recommended dental providers and asks if they would like to be on the list. If they are

interested, SSG sends them a survey requesting their location, payment options, languages and office hours. The list is updated periodically. When families contact SSG for assistance in finding a dental provider, the provider list is used to match them with a provider who best meets their needs. Parents are expected to contact providers and schedule appointments unless they are unable to do so. In that case a parent navigator will assist with case management/coordination of appointments.

Year 4

- There were no specific activities on this objective during Year 4 – Case manager/coordinator has maintained contact with Stone Soup Group (SSG). The Executive Director of SSG joined the Alaska Dental Action Coalition in June 2011 and the Dental Officer has been invited to discuss oral health/dental access at the January 2012 CSHCN workgroup meeting. Additionally, as noted in Objective 4 – the Alaska Dental Action Coalition included activities to improve dental access for CSHCN as one of the top five priorities for the next two to three years.

Accomplishments

Case manager/coordinator provided spin brushes remaining from 2005 and 2007 dental assessments to cleft lip/palate clinics; they were distributed to parents/caregivers when the supervising dentist at the clinic anticipated their children would benefit from using them. Other case management/coordination activities include working with Stone Soup Group (Family Voices agency) to develop oral health resource materials for families, purchasing and donating bite blocks and floss aides to them for demonstrations on use of these aides, and working with them to identify areas where further assistance is needed in making dental referrals. The Executive Director of Stone Soup Group joined the Alaska Dental Action Coalition (ADAC) in June 2011, and the Dental Officer was invited to discuss oral health/dental access at the January 2012 CSHCN workgroup meeting. As noted in Objective 4, ADAC included activities to improve dental access for CSHCN as one of the top five priorities for the next two to three years.

Evaluation

The case manager/coordinator worked with Stone Soup Group (SSG) to provide spin brushes to special needs children receiving services at state-sponsored specialty clinics. SSG parent navigators attend the clinics to assist families with resources and appointments. They continue their services as needed outside of clinics. Resource materials are provided to parents/caregivers of CSHCN. At this time Medicaid does not offer case management services to their recipients; there is a need to continue working for case management for those most in need of this service including those who have difficulty getting to appointments.

Objective 6: Increase first dental visits by age one 10% per fiscal year from FY2008 – FY2011.

Year 1

- The program will evaluate age one dental visits for federal fiscal year 2007 with the preparation of the CMS 416 (EPSDT utilization) report in April 2008. The program worked with the MCH section for inclusion of information on dental visits in the “Child Understanding Behavior Survey (CUBS)” for infants/toddlers – this survey is a follow-up to the Pregnancy Risk Assessment Monitoring Survey (PRAMS). Utilization of results

from CUBS along with the CMS 416 reports will be the primary surveys for assessing changes in age-one dental visits and evaluation of related grant activities.

Year 2:

- The Dental Officer and/or case manager met with Alaska pediatric dentists to encourage early dental visits in September 2008. The Dental Officer also presented to the Alaska Tribal Dental Chiefs in November 2008 noting the need for early dental visits, Medicaid coverage for early dental visits and the need to increase early visits for Medicaid-eligible children given the number of hospital dental cases being done for early childhood caries treatment. The Dental Officer is also participating in a work group supporting an epidemiology investigation by the CDC, Arctic Investigations on early childhood caries in the Yukon-Kuskokwim region (SW) of Alaska. The CDC investigation, once published, should assist in education/advocacy for increased access to community water fluoridation, decreased soda consumption and earlier intervention on early childhood caries (ECC) to reduce the need for hospital-based dental care for ECC.
- Reasons for the slight decrease in dental utilization in FFY2006-FFY2007 are speculative. The Medicaid fiscal agent (First Health) was scaling back operations with a new fiscal agent developing a new Medicaid Information System (MIS) during this period and there were some claims processing problems. DHCS has since moved for the new fiscal agent (ACS) to assume MIS operations while completing the new system. Additionally, Medicaid reimbursement for dental claims had not increased since 1999 (based on CY1997 claims experience) so this could have had some impact on decreasing provider participation. As noted above the Oral Health Program worked with DHCS to implement a dental reimbursement increase July 1, 2008 – it is not clear at this time the impact of the reimbursement increase on provider participation in Medicaid/SCHIP.

Year 3

- FFY2007 would be the baseline year for the projects in this grant (started September 2007) – with a 1% increase in each of the FFY2008-FFY2009 periods. This is well below the 10% increases anticipated with the grant. There has been slow movement by Tribal and pediatric dental programs for age one dental visits, despite presentations and discussions with the Oral Health Program. Recent direction by the Commissioner's Office to implement reimbursement for fluoride varnish and oral evaluation by EPSDT providers should assist with early oral evaluations and referral of young children with treatment needs. On March 2, 2010 the Program worked with the Commissioner's Office on a press release highlighting early childhood caries along with the release of a state "Epidemiology Bulletin" on Alaska's high prevalence of ECC. The American Academy of Pediatric Dentistry "Head Start Dental Home Initiative", beginning the fall of 2010, should also promote age one dental visits for children (including children enrolled in Medicaid/CHIP).
- The Dental Officer presented to the Alaska Tribal Dental Chiefs again in November 2009 noting the need for early dental visits, Medicaid coverage for early dental visits and the need to increase early visits for Medicaid-eligible children given the number of hospital dental cases being done for early childhood caries treatment. The Dental Officer continues participating in a work group supporting an epidemiology investigation by the CDC, Arctic Investigations on early childhood caries in the Yukon-Kuskokwim region

(SW) of Alaska. The Dental Officer also did presentations with Parish Nurses (February 2010) and School Nurses (April 2010) to highlight nurse roles in oral evaluation, preventive services and supporting local dental referral networks to address child dental decay (including ECC).

Year 4

- Between FFY2007 and FFY2010 dental utilization for any dental visit for children aged one to two increased by 5.2% (from 10.9% in FFY2007 to 16.1% in FFY2010).
- In the fall of 2011 an EPSDT workgroup in the department adopted “Bright Futures” for EPSDT guidance. The Dental Officer drafted a new dental periodicity schedule for review and discussion in January 2012 – these activities are moving towards formal adoption of the age one dental visit. It is anticipated first dental visits will typically occur at or after 12 months, however policies are continuing to move forward encouraging early childhood dental visits. The Indian Health Service is currently working on an early childhood caries initiative which will promote early dental access for American Indian/Alaska Native populations in the state – Dr. Whistler specifically discussed the need for early dental visits to reduce early childhood caries prevalence at the November 2011 Tribal Dental Chiefs meeting. Additionally, the Southcentral Foundation/Alaska Native Medical Center pediatric dental residency program has continued to expand and during this grant period it resulted in 3 additional pediatric dentists in Alaska (bringing the total up to 17).
- In 2006 Alaska Childhood Understanding Behaviors Survey (CUBS) began sending follow-up surveys to participants in Alaska Pregnancy Risk Assessment Monitoring System to collect information on Alaska toddlers. CUBS data for 2008 show that 23.1 percent of toddlers had their first dental visits before 24 months of age. This is unweighted data and could differ by 1 to 3 percentage points when weighted to the total population. CUBS data for 2009 has not been released at the time of this report.
- The program evaluated age one dental visits for federal fiscal years 2002-2010 through review of the CMS 416 (EPSDT utilization) reports. Dental utilization increased from FFY2002 – 2005 for all children enrolled in Medicaid/SCHIP in addition to the younger age groups. Utilization decreased slightly for all children in FFY2006 and for the 3-5 year olds that year. FFY2007-2009 dental utilization showed a further slight decrease in utilization for all children and children in the 3-5 age group – however, slight percentage increases in the 1-2 year old age group. Dental utilization increased in FFY2010 – up to 42.9% for any dental visit for all children and up to 47.8% for any dental visit for children in the 3-5 age group. FFY2010 dental utilization for 1-2 year olds showed a further increase – up to 16.1% for any dental visit for this age group. For all years the dental utilization for children aged <1 is extremely low.

Accomplishments

The Dental Officer and/or case manager met with Alaska pediatric dentists in September 2008 to encourage early dental visits. In the fall of 2011 an EPSDT workgroup in the department adopted “Bright Futures” for EPSDT guidance. The Dental Officer drafted a new dental periodicity schedule for review and discussion in January 2012. It is anticipated first dental visits will occur at or after 12 months, but policies are continuing to move toward encouraging early dental visits. Dr. Whistler specifically discussed the need for early dental visits to reduce

early childhood caries and decrease the number of hospital dental cases related to early childhood caries when he spoke at the Tribal Dental Chiefs meeting in November 2008, 2009 and 2011. The Indian Health Service is working on an initiative that promotes early dental access for American Indian/Alaska Native children in the state. The Southcentral Foundation/Alaska Native Medical Center pediatric dental residency program continues to expand and during this grant period resulted in three additional pediatric dentists in Alaska bringing the total to 17. The Dental Officer participated in a work group supporting epidemiology investigation by the CDC, Arctic Investigations Lab on early childhood caries in the southwest region of Alaska. The results, once published, should assist in education/advocacy for increased access to community water fluoridation, decreased soda consumption and earlier intervention on early childhood caries (ECC) to reduce hospital-based dental care for ECC.

The Oral Health Program worked with the MCH Epidemiology Program for inclusion of dental visits in the Childhood Understanding Behaviors Survey (CUBS) for infants/toddlers; this survey is a follow-up to PRAMS. In 2006 CUBS began collecting data on Alaska toddlers. Unweighted data for 2008 show that 23.1 percent of toddlers had their first dental visits before 24 months. This could differ by one to three percentage points when weighted to the total population. CMS 416 (EPSDT utilization) reports show that dental utilization increased from FFY 2002-2005 for all children enrolled in Medicaid/SCHIP in addition to the younger groups. In FFY 2006 utilization decreased slightly for all children and for 3-5 year olds, and FFY 2007-2009 dental utilization data showed a further slight decrease for all children and children in the 3-5 age group but a slight increase in the 1-2 year old age group. Dental utilization increased in FFY 2010—up to 42.9% for any dental visit for all children and up to 47.8% for any dental visit for children in the 3-5 age group. Dental utilization for 1-2 year olds showed an increase from 10.9% in FFY 2007 to 16.1% in FFY 2010 for any dental visit. For all years the dental utilization for children aged less than one year is extremely low.

Evaluation

Age one dental visits remain well below the anticipated 10% increase per fiscal year from FY2008-FY2011. There are only 17 pediatric dentists in Alaska, and most general dentists do not see patients this young. The pediatric dentistry residency program brings a few pediatric dentists to Alaska for training but not all of them remain in the state. Medicaid reimbursement rates for dentists increased in 2008 and 2011 to encourage more dentists to see Medicaid recipients. As of July 1, 2010, medical providers can be reimbursed by Medicaid for early childhood caries evaluations and fluoride varnish application. The Oral Health Program worked with the Alaska Dental Society, University of Alaska and Alaska Native Medical Center to offer training to medical providers.

Objective 7: Change EPSDT guidance to dental referral by age one by October 1, 2009.

Year 1

- Activity is not planned until discussions have occurred with Tribal dental programs and pediatric dentists and some capacity for earlier referrals has been identified. October 1, 2009 is an aggressive timeline for this change and is only feasible to the extent that Tribal and pediatric dentists have capacity to increase early referrals.

- The Oral Health Program discussed the issues with the Medicaid program and received support to move forward with reimbursement of topical fluoride varnish for medical providers as part of EPSDT screens. The Oral Health Program will look at adoption of a training program for medical providers on oral evaluation for children under 3 years by medical providers (along with Medicaid reimbursement) late in Year 2 or Year 3 of the grant projects. Training of medical providers should be in place before providing the Medicaid reimbursement (D0145).
- When reimbursement for these dental services is implemented, the Oral Health Program will work with Medicaid staff to identify reporting for services provided to children under 3 years.

Years 2 and 3

- This activity is delayed until we see there is more progress on Tribal and pediatric dentists seeing children prior to their 2nd birthday on a passive basis. Changing EPSDT guidance means Early Head Start Programs will have to comply with the new guidance – not feasible until there is some capacity for these programs to refer children for dental exams and/or treatment.
- The program is working on implementation of Medicaid coverage for fluoride varnish and enhanced screening as noted in this report. The Dental Officer was appointed by the State Medicaid Director to serve on the MCH Oral Health Technical Advisory Group to the Center for Medicare and Medicaid Services (CMS). The advisory group has recommended changes to the CMS 416 (EPSDT) report to capture data on medical provider provision of fluoride varnish and enhanced screenings in the future.
- The Alaska Oral Health Program is working with DHCS to implement coverage for these services for medical providers by July 2010. At that time it is anticipated the Medicaid program will move forward with reimbursement of topical fluoride varnish for medical providers as part of EPSDT screens. The Program will look at adoption of a training program for medical providers on oral evaluation for children under 3 years by medical providers (along with Medicaid reimbursement) immediately upon Medicaid coverage for these procedures. Training of medical providers should be in place before providing the Medicaid reimbursement (D0145).

Year 4

- With the Year 3 annual report it was not assured this change would occur in the next few years, however meetings of the EPSDT workgroup over the past year resulted in adopting “Bright Futures” for EPSDT guidance in the fall of 2011. The Dental Officer drafted a new dental periodicity schedule that will be discussed in January 2012 and will then go out for advisory group review with dental provider participation. This should lead to formal adoption, and regulation changes to an age one dental visit in calendar year 2012.
- Other states’ experience has indicated the dental home for children under age 2 is typically the medical home. This will likely be the experience in Alaska with the geographically isolated communities and distribution of dentists in the state. The Medicaid reimbursement coverage of medical providers for oral evaluation and fluoride varnish should assist with connection of the medical home to a dentist as triage is done through oral evaluations, however this will likely be a slow incremental process. The adoption of the EPSDT change to the first dental exam at age one will assist efforts for an

age one dental visit, however the expectation is the change will mostly be seen in first dental visit by 24 months.

- The Oral Health program will continue to work with medical providers, dental providers, Medicaid and other stakeholders to increase dental visits by age one along with other activities to reduce early childhood caries.
- Additionally, the program will be working with Medicaid on a forthcoming initiative from CMS to increase preventive dental visits for all children enrolled in Medicaid.

Accomplishments

The Dental Officer was appointed by the State Medicaid Director to serve on the MCH Oral Health Technical Advisory Group to the Center for Medicare and Medicaid Services (CMS). It was not assured that EPSDT guidance would be changed to dental referral by age one during this grant period. However meetings of the EPSDT workgroup resulted in adopting “Bright Futures” guidelines for EPSDT in the fall of 2011. The Dental Officer drafted a new dental periodicity schedule that will be discussed in January 2012 before going out for advisory group review with dental provider participation leading to formal adoption. Regulation changes to age one dental visits are anticipated in calendar year 2012. This will assist efforts for age one dental visits, but it is expected the change will mostly be seen in first dental visit by 24 months. Medicaid reimbursement for medical providers to perform oral evaluations and apply fluoride varnish should assist in connecting medical homes to dental visits, but it is likely to be a slow incremental process. The Oral Health Program worked with the Alaska Dental Society, University of Alaska Anchorage, and Alaska Native Medical Center to offer a course to medical and dental providers on early childhood caries evaluation and fluoride varnish application in April 2011. The Oral Health Program will continue working with medical and dental providers, Medicaid and other stakeholders to continue increasing age one dental visits and other activities to reduce childhood caries. Additionally the program will work with Medicaid on a forthcoming initiative from CMS to increase preventive dental visits for all children enrolled in Medicaid.

Evaluation

It was not assured that EPSDT guidance would be changed to dental referral by age one during this grant period. However in fall 2011 an EPSDT workgroup adopted “Bright Futures” for EPSDT guidance, and the Dental Officer drafted a new dental periodicity schedule that will be discussed in January 2012 before going out for review. These activities are moving toward a more formal adoption of age one dental visits.

Objective 8: Increase preventive dental visits for pregnant women by 30% as measured by survey information from the Pregnancy Risk Assessment Monitoring System (PRAMS) from CY2004 to CY2010 (from 28% to 36%).

Year 1

- Results from PRAMS for CY2004 indicated 28% of pregnant women reporting a preventive dental visit (teeth cleaning) during their pregnancy. The Dental Officer worked with the PRAMS Coordinator to ensure the dental access question will be included in PRAMS through CY2010. Preventive and enhanced dental services for adult Medicaid took effect April 1, 2007 - - this includes preventive dental services, routine care and periodontal maintenance for pregnant women age 21 and older. Increased

access as a result of these services should begin to be reflected in 2007 PRAMS data (results likely available in early 2009). The Medicaid enhanced dental services sunset June 30, 2009 without legislative reauthorization – Oral Health Program staff and the Alaska Dental Action Coalition will be assisting the department with the reauthorization in the 2009 legislative session.

Year 2

- In CY2007 30.4% of pregnant women reported a preventive dental visit during their pregnancy. The Dental Officer worked with the PRAMS Coordinator to ensure the dental access question will be included in PRAMS through CY2010. The Dental Officer and case manager will continue to monitor PRAMS results as they become available.

Year 3

- In CY 2008 36.3% of pregnant women reported a preventive dental visit during their pregnancy (Objective 8 met for CY 2008). Preventive and enhanced dental services for adult Medicaid took effect April 1, 2007 including preventive dental services, routine care and periodontal maintenance for pregnant women age 21 and older. Increased access as a results of these services would only begin to be reflected in the CY2009 PRAMS.

Year 4

- Table 1 below shows the change in percentage of women reporting a preventive dental visit during their pregnancy from CY 2004 through CY 2009:

Table 1 – Teeth cleaned during pregnancy

	2004	2005	2006	2007	2008	2009
Yes	28.84	28.47	28.55	30.42	36.31	38.32
No	60.32	56.66	57.93	57.42	50.49	59.95
Skip	9.74	8.03	7.76	7.06	7.84	
Blank	1.10	6.84	5.76	5.10	5.36	1.73
Total Women	10002	10098	10746	10805	11164	11033

Source: Pregnancy Risk Assessment Monitoring System

- Any dental visits for pregnant women increased from 39.9% in CY2004 to 44.36 in CY2008. Reported discussion about dental care during pregnancy increased from 42.0% in CY2004 to 46.7% in CY2008.
- The Dental Officer has asked MCH Epidemiology to analyze the increase in teeth cleaning visits and dental visits during the pregnancy in the 2006-2008 period to see if data support the assumption the addition of adult dental preventive and routine restorative visits to Medicaid in April 2007 assisted with the increased dental access for pregnant women during this period.

Accomplishments

PRAMS data for pregnant women reporting a preventive dental visit (teeth cleaning) during their pregnancy increased from 28.8% in CY 2004 to 38.3% in CY2009 surpassing the goal of 36% by CY2010. Any dental visit increased from 39.9% in CY 2004 to 44.4% in CY 2008, and reported discussion about dental care during pregnancy increased from 42.0% in CY 2004 to 46.7% in CY 2008. The Dental Officer has asked MCH Epidemiology to analyze the increases in the 2006-2008 period to determine if data support the assumption that the addition of adult dental preventive and routine restorative services to Medicaid in April 2007 assisted with increased dental access for pregnant women during this period. Meetings with public health nursing included discussions of Medicaid dental coverage for adults including pregnant women. The Oral Health Program continues to work with WIC, Health Start and medical groups for provision of education and referrals

Evaluation

PRAMS data from 2006-2008 show an increase in pregnant women reporting preventive dental visits during their pregnancies. The Dental Officer asked MCH Epidemiology to determine if data support the assumption that the addition of adult dental preventive and routine restorative services to Medicaid in 2007 assisted with increased dental services for pregnant women during this period. Enhanced adult Medicaid was scheduled to sunset in June 2009. The Oral Health Program worked with the Alaska Dental Access Coalition to assure adult Medicaid dental services were reauthorized in 2009. In meetings with public health nurses the Dental Officer educates on the importance of pregnant women visiting their dentists for preventive dental care. Additional work will be done with WIC, Head Start and medical groups.

Objective 9: Discuss and finalize an evaluation plan by June 2008 for the grant activities with input from the Alaska Dental Action Coalition and other key stakeholders.

Year 1

- The Oral Health Program application noted use of PRAMS, CUBS, Medicaid utilization to assess changes in dental access for pregnant women and age one dental visits. These changes in utilization may not solely be a result of grant activities as other variables cannot be controlled for (e.g., other program education) but clearly grant activities will play a role in utilization changes. Oral health resource materials will be developed for parents/caregivers of CSHCN (Objective 3). The Dental Officer will work with the case manager/coordinator and Stone Soup Group staff to finalize a more formal evaluation plan for the grant activities in June – August 2008.

Year 2

- Evaluation of resource materials for parents/caregivers of CSHCN is planned through key informant interviews. Initial focus group discussions indicated there was a great need for oral health information. The project that was originally limited to four pages expanded to more than 20 pages. Stone Soup Group will assist with tracking distribution of notebooks so parents/caregivers can be identified for the key informant interviews.

Years 3 and 4

- The CUBS (infant/toddler) survey is no longer being used to monitor trends in dental visits prior to 24 months as the survey is now collecting information on 3-year olds. Oral health resource materials for CSHCN were completed and distributed to participants in the Oral Health for CSHCN Forum, Project Officer and MCH Oral Health Resource Center.

Accomplishments

The grant application noted PRAMS, CUBS, and Medicaid utilization would be analyzed to assess changes in dental access for pregnant women and age one dental visits. CUBS (infant/toddler survey) is no longer monitoring trends in dental visits prior to 24 months as the survey is collecting data on three-year olds. Stone Soup Group conducted key informant interviews to evaluate oral health resource materials developed with the Oral Health Program for parents/caregivers of CSHCN. Focus groups indicated there was a great need for this information. This project, initially limited to four pages of information, grew to more than 20 pages and a DVD due to parent/caregiver demand. Final copies were distributed to participants in the forum on oral health for CSHCN, the Project Officer, and the MCH Oral Health Resource Center. These resource materials were also available by request to all families that received services from Stone Soup Group.

Evaluation

PRAMS, CUBS and Medicaid utilization data were reviewed to determine changes in dental access for pregnant women and age one dental visits. Although changes in utilization may not be due solely to grant activities, they played a role. By Year 3 of the grant CUBS (infant/toddler survey) was collecting data on three year olds and no longer monitored trends in dental visits prior to 24 months of age. Evaluation of resource materials for parents/caregivers of CSHCN was done through key informant interviews. The resource materials were completed and distributed.

Objective 10: Develop funding support for the dental case manager/coordinator position utilizing funding from other grants, MCH, Medicaid or state general funds beginning in FY2010 and with full funding by FY2012.

Years 1 and 2

- Dental Officer continues to assist the Medicaid/SCHIP programs with dental policy issues. This objective and activities are not scheduled for active discussion with Medicaid and MCH until FY2010.

Year 3

- Dental Officer continues to assist the Medicaid/SCHIP programs with dental policy issues. The Dental Officer and Alaska Dental Society have discussed the need for case management of some children in the Medicaid program – much of the focus has been on case management for families that chronically miss scheduled dental appointments. The Commissioner’s Office and Medicaid Director have been reluctant to commit to any form of dental case management at this time, thus utilizing Medicaid as a source for ongoing financial support of the dental case manager/coordinator position is speculative. At this

time funding for the position would need to be augmented with funds from the program's cooperative agreement with the CDC or discuss use of MCH Block Grant funding (as needed).

Year 4

- Dental Officer continues to assist the Medicaid/SCHIP programs with dental policy issues. In 2011 the Dental Officer requested an ASTDD State Oral Health Program review – conducted in August 2011 one aspect noted in the review was for the Medicaid program to develop internal capacity/infrastructure for dental/oral health. At this time there is no specific action on this recommendation and the Medicaid budget environment will likely preclude development of this infrastructure (including dental care coordination for CSHCN). Sharon Schlicht, RDH, MPH has been serving in this role and will be retained in the Oral Health Program under CDC funding in SFY2012-2013. Funding past July 2013 is uncertain for the program at this time. Sharon will continue to assist with increasing dental access for young children and CSHCN in addition to other duties with the CDC cooperative agreement.

Accomplishments

Throughout the course of this grant, the Dental Officer assisted Medicaid/SCHIP programs with dental policy issues. The Dental Officer and the Alaska Dental Society have discussed the need for case management for some children in the Medicaid program, especially those who chronically miss appointments. The Commissioners Office and Medical Director are reluctant to commit to dental case management at this time. At the request of the Dental Officer, the state Oral Health Program was reviewed by ASTDD in August 2011. One recommendation from the review was to develop internal capacity/infrastructure for dental/oral health. There is no specific action on this recommendation, and the Medicaid budget environment likely will preclude development of this infrastructure at this time. Sharon Schlicht, RDH, MPH will continue in her role with the Oral Health Program under CDC funding in SFY 2012-2013. She will also continue to assist with increasing dental access for young children and CSHCN along with other duties under the CDC cooperative agreement.

Evaluation

In 2010 the Alaska Dental Action Coalition discussed working to secure state general funds to support the State Oral Health Program. It was decided this is not a good time to move forward with a request because of the current budget environment. An ASTDD State Oral Health Program review conducted in August 2011 noted that the Medicaid program should develop internal capacity/infrastructure for dental/oral health. There is no specific action on this recommendation and the Medicaid budget environment will likely preclude development of this infrastructure (including dental care coordination for CSHCN).

Additional Objective: Another objective was added to the original ten. It was an objective to pilot a school-based dental sealant project. Although it was not a part of the original application, it was conducted with use of HRSA TOHSS carryover funds and CDC funding. The Oral Health Program collaborated with the Anchorage Neighborhood Health Center so that children had access to treatment for dental needs identified in the pilot project. The pilot was held at an Anchorage elementary school that serves “at-risk” children. Children are considered “at-risk” if

they attend a Title 1 school, come from a low-income family, and are from a racial/ethnic minority population. At the original event in February 2010 eighteen second-graders were screened and received sealants if indicated. The follow-up event was held in February 2011. Thirteen third-graders who participated in the 2010 event were seen again for retention checks. Additional sealants were placed as appropriate. Twenty-one second-graders were also screened and received sealants as appropriate. Eighty-three percent of children screened were subsequently sealed, and twenty eight of them were referred for dental care. Forty-three percent of them had untreated decay and 11 percent had urgent dental needs. One problem encountered with his project is the low rate of parent consent for children to participate. It is consistent with the school district's usual rate of about 40%. If funds become available for another school event, the school offered to set up a table at parent-teacher conferences where parents can have their questions answered and sign consent forms on site. The school principal suggested this would result in a better return than sending forms home with students.

Future Oral Health Program Activities to Continue Work on the Objectives

Pregnant women's oral health and dental access: Continue work with MCH Program to develop educational information for resource materials and the program website on the importance of the mother's/caregiver's oral health during pregnancy and in relation to risks of early childhood caries (transmission of bacteria causing caries). This information will also integrate information on the need for early dental exams for children at-risk for development of caries (e.g., children enrolled in Medicaid and SCHIP programs). Additionally, the Oral Health Program will continue to work with stakeholders to maintain support for preventive and restorative dental services for adults enrolled in Medicaid.

Early (age one) dental visits: The Oral Health Program will work with stakeholders to encourage medical providers to integrate oral evaluation and fluoride varnish into well child visits. Additionally, the program will be working with Medicaid and other stakeholders to increase early dental visits with the recent adoption of "Bright Futures" as the guidelines for the EPSDT program. The program will look for funding to conduct other workshops on early childhood caries prevention for dental and medical providers. Finally, the program will be working with the Medicaid program on the Medicaid Action Plan to be requested by CMS to increase preventive services for children enrolled in Medicaid and continue monitoring CMS 416 reports for trends in child dental utilization.

CSHCN oral health and dental access: With funding for a "CSHCN Oral Health Forum" and follow-up meeting from ASTDD and activities conducted under this grant the Oral Health Program has established a good working relationship with Stone Soup Group (Family Voices agency) and the MCH CSHCN Coordinator. The Dental Officer will be meeting with the CSHCN workgroup in January 2012 for updates and to discuss new activities to improve the oral health and dental access for CSHCN. The Executive Director of Stone Soup Group is now a member of the Alaska Dental Action Coalition which will provide three additional times during the year there is interaction between these agencies.

The CSHCN Oral Health Forum and follow-up meeting noted a number of Medicaid activities to improve dental participation in Medicaid as also being priorities for dental access to CSHCN –

primarily the focus has been on increasing Medicaid dental reimbursement rates. Passage of preventive and routine restorative dental services for adults also offers an opportunity for dental services for CSHCN if they age into the adult Medicaid population.

The Alaska Dental Action Coalition identified improved oral health and dental access for CSHCN as one of the top five priorities for the coalition over the next two to three years. Specific areas discussed included providing training to dental professionals on dental treatment of CSHCN in the dental office and offering financial incentives for dental providers undertaking care of CSHCN in the dental office. For dental training there will need to be broader stakeholder involvement in identification of private dentists interested in the training – so there is more private dental involvement in the training than was obtained in the workshop offered by Dr. Paul Glassman. Financial incentives could include allowed use of the behavior management CDT code when CSHCN are treated in the dental office, however this will also need stakeholder involvement/support – Medicaid is likely reluctant to take on another dental reimbursement expenditure increase after coverage of the adult Medicaid population and coverage of medical providers for oral evaluation and fluoride varnish. Additionally, the behavior management code use is already over-utilized by some fee-for-service dental providers. It will take education and likely information showing how use of the behavior management code might reduce overall Medicaid expenditures by averting treatment as outpatient hospital services (dental treatment under general anesthesia).

Private dental participation in Medicaid: The Oral Health Program will continue to monitor trends in private dental participation in Medicaid. As noted above in this report, child dental utilization increased in FFY2010 – some of this could be the three new additional pediatric dentists in Alaska as a result of the Alaska Native Medical Center pediatric residency program and increased private dental participation. Private dental participation may have increased with recent dental reimbursement increases and the slowing U.S. economy (although Alaska has been largely insulated from the economic slowdown with high oil prices). There is now a process under regulation for annual department review of dental Medicaid reimbursement with respect to changes in Anchorage CPI – while Medicaid reimbursement remains lower than most private dental insurance reimbursement this still should assist with maintaining participating dental providers.