Oral Health in Wisconsin: Community based efforts impact statewide success

Matt Crespin, MPH, RDH

Associate Director

Children's Health Alliance of Wisconsin

Welcome to Milwaukee

PRIDE.
OUR SECRET INGREDIENT.

MILWAUKEE
Summerfest
The World's Largest Music Festival

Milwaukee survival guide

Don’t: “Where is the water fountain?”

Do: “Where is the Bubbler?”

Where is the TYME machine?

Children's Health Alliance of Wisconsin

Wisconsin Asthma Coalition
Children's Health Alliance of Wisconsin

Infant Death Center
Children's Health Alliance of Wisconsin

Keeping Kids Alive in Wisconsin
Children's Health Alliance of Wisconsin

Childhood Injury Prevention Network
Children's Health Alliance of Wisconsin

Wisconsin Oral Health Coalition
Children's Health Alliance of Wisconsin

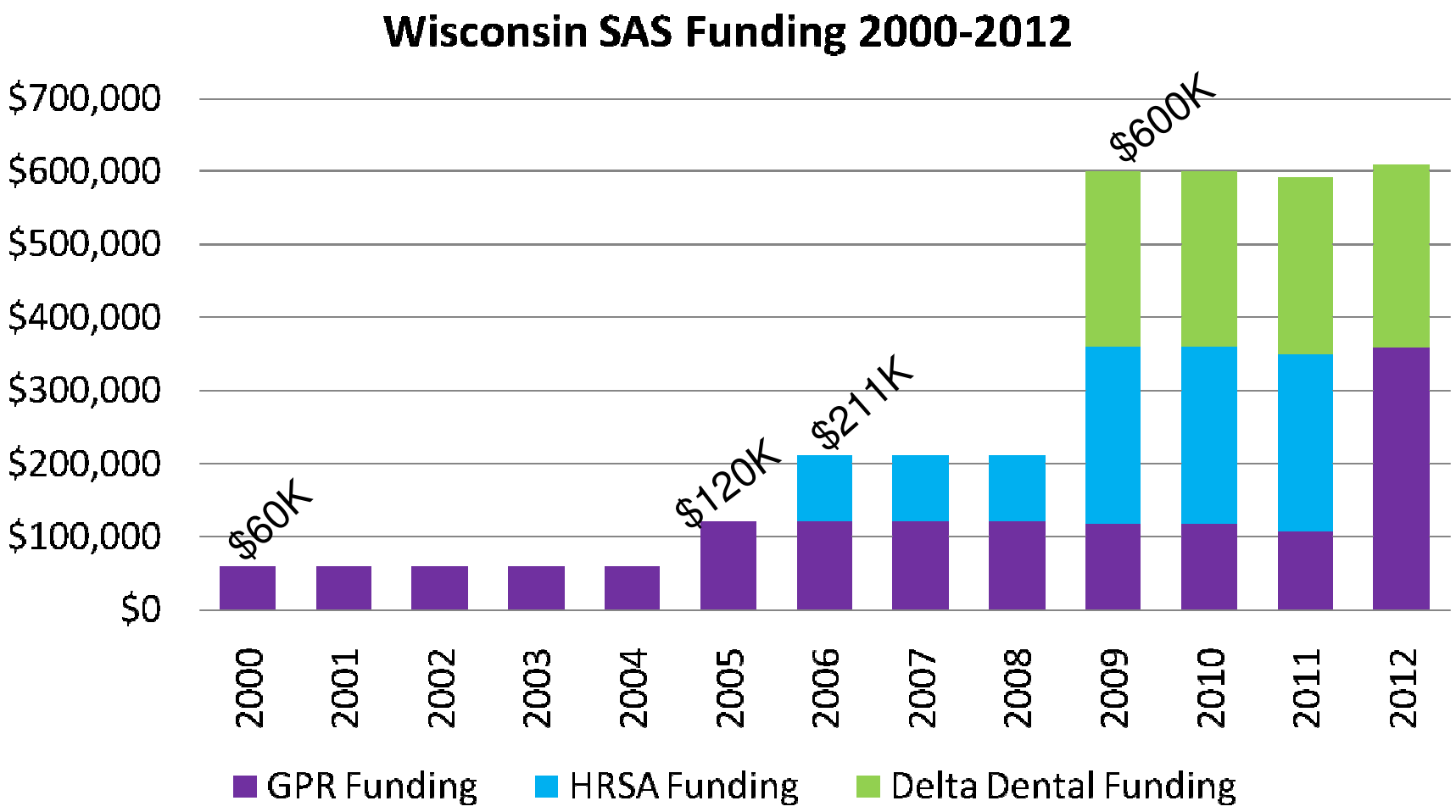
Reach Out and Read®

Wisconsin Seal-A-Smile Program Overview

- Program administered collaboratively by Children's Health Alliance of Wisconsin and WI Division of Public Health
- Mini-grants awarded annually for funding
- Provide grant administration and TA

Program Overview

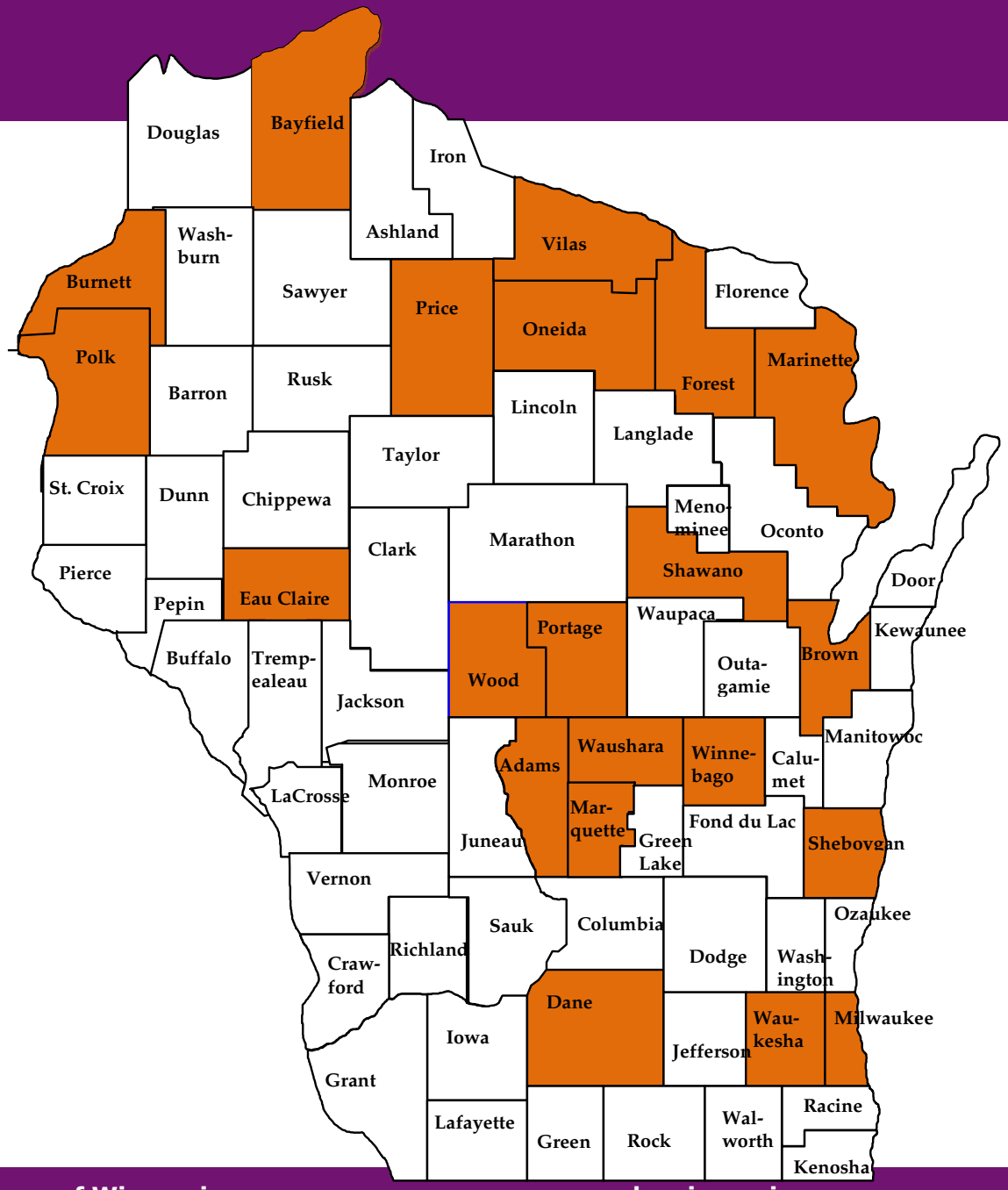
- Individualized approach
- Best practices/Evidence-based practices
- Targeting schools with FRL > 35%
- Medicaid billing


Wisconsin SAS Funding 2000-2012
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$0
$60K
$120K
$211K
$600K
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
GPR Funding
HRSA Funding
Delta Dental Funding

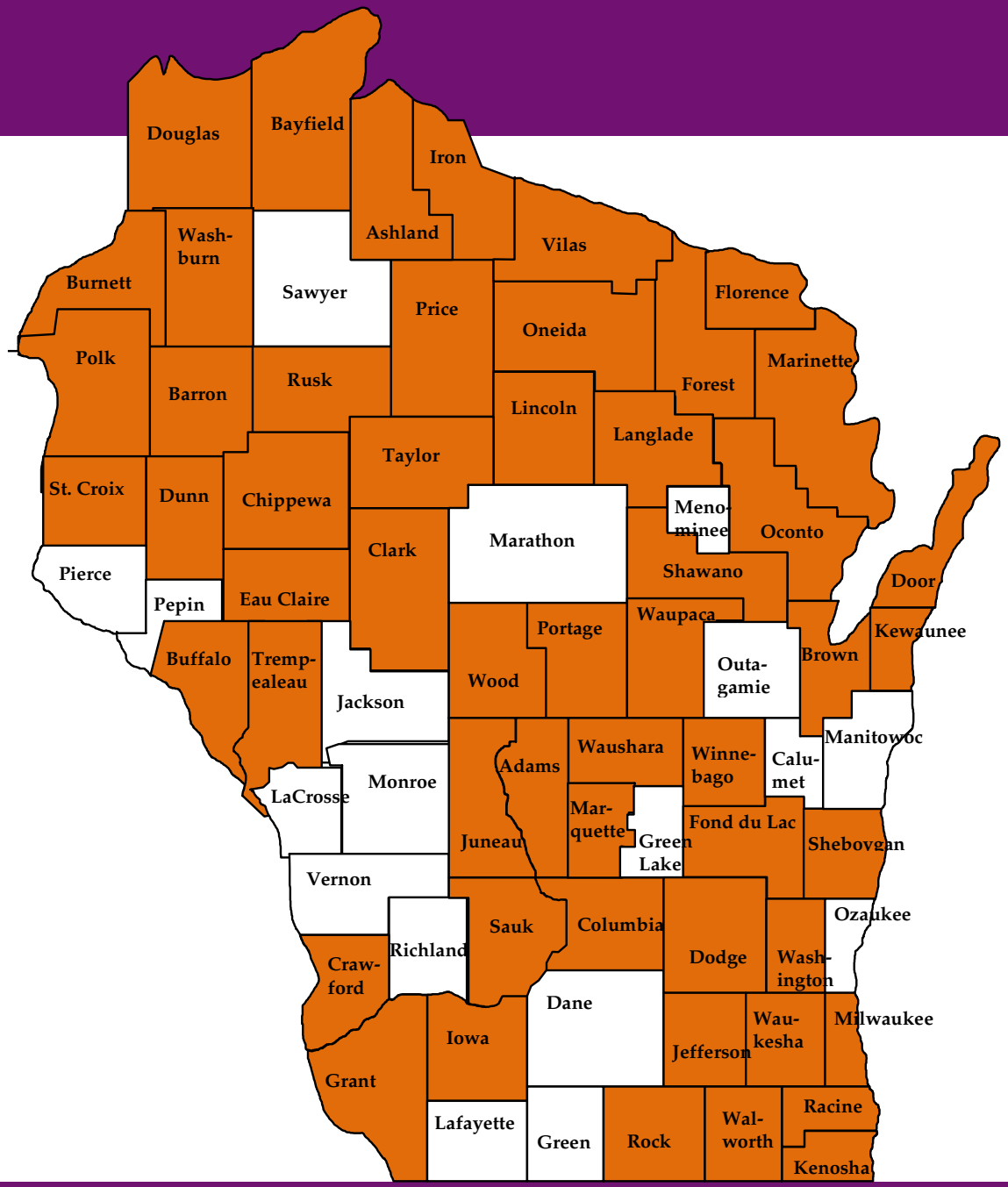
Statewide success due to community level work

- Local public health departments
- Community dental clinics
- Local dental providers
- Local foundations/civic organizations

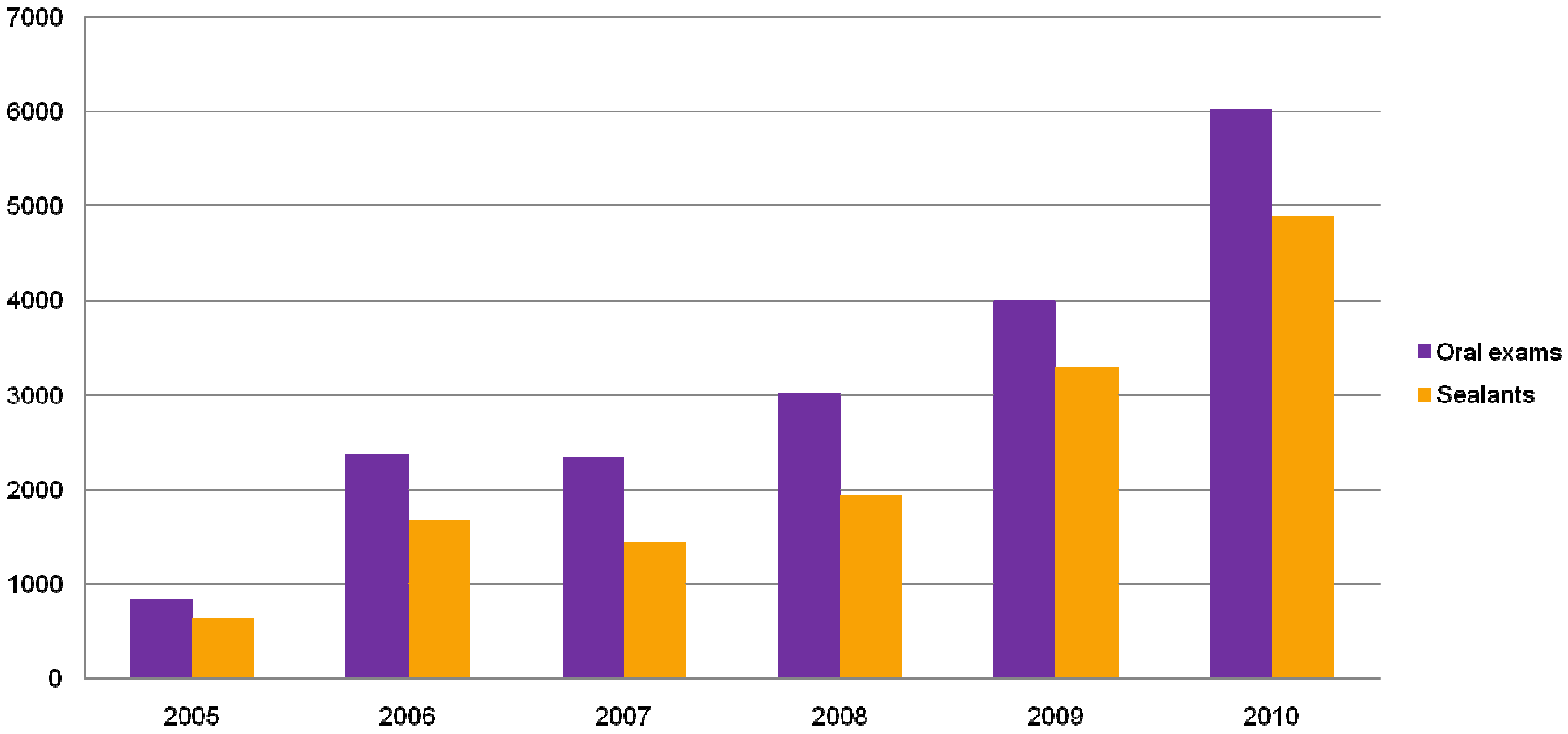
July 2009


Douglas
Bayfield
Iron
Ashland
Wash-
burn
Vilas
Florence
Burnett
Sawyer
Price
Oneida
Forest
Marinette
Polk
Barron
Rusk
Lincoln
Langlade
Taylor
St. Croix
Dunn
Chippewa
Meno-
minee
Oconto
Clark
Marathon
Shawano
Door
Pierce
Pepin
Eau Claire
Waupaca
Portage
Kewaunee
Buffalo
Tremp-
ealeau
Jackson
Wood
Outa-
gamie
Brown
Manitowoc
Adams
Waushara
Winne-
bago
Calu-
met
LaCrosse
Monroe
Mar-
quette
Fond du Lac
Juneau
Green
Lake
Sheboygan
Vernon
Ozaukee
Sauk
Columbia
Richland
Dodge
Wash-
ington
Craw-
ford
Dane
Milwaukee
Iowa
Jefferson
Wau-
kesha
Grant
Racine
Lafayette
Green
Rock
Wal-
worth
Kenosha

Current


Douglas
Bayfield
Iron
Ashland
Vilas
Florence
Wash-
burn
Burnett
Sawyer
Price
Oneida
Marinette
Polk
Barron
Rusk
Lincoln
Forest
Langlade
Taylor
St. Croix
Dunn
Chippewa
Meno-
minee
Oconto
Clark
Marathon
Shawano
Door
Pierce
Pepin
Eau Claire
Waupaca
Portage
Kewaunee
Buffalo
Tremp-
ealeau
Wood
Outa-
gamie
Brown
Jackson
Manitowoc
Waushara
Winne-
bago
Calu-
met
Adams
Monroe
LaCrosse
Mar-
quette
Green
Lake
Fond du Lac
Sheboygan
Juneau
Vernon
Ozaukee
Sauk
Columbia
Dodge
Wash-
ington
Richland
Craw-
ford
Dane
Iowa
Jefferson
Wau-
kesha
Milwaukee
Grant
Racine
Lafayette
Green
Rock
Wal-
worth
Kenosha

Localized Expansion – Milwaukee Smart Smiles



MAKING MILWAUKEE SMILE

A report on efforts to improve the oral health of Milwaukee children.

2011

Partners


Children's
Health
Alliance
of Wisconsin


Columbia St. Mary's
A Passion for Patient Care


MEDICAL
COLLEGE
OF WISCONSIN


MILWAUKEE
MILWAUKEE
HEALTH SERVICES, INC.


Children's Hospital
of Wisconsin


MARQUETTE
UNIVERSITY
School of Dentistry


SEDA
Southeast Dental Associates


Milwaukee Public Schools

Cause for concern

- Nationally: Children living in poverty are almost twice as likely to have decay.
- Wisconsin: 28% of children with decay in high FRL schools compared to 13% in low FRL schools.
- SE Region: 24% of third graders have decay (13.4% in Southern and 16.9% in Northern).
- Milwaukee: 50% have decay.

MMS Development

- Partners awarded development grant in 2006 ($50,000)
- Healthy Teeth = Healthy Kids (HT=HK) released by partners in 2007
- HT=HK four key objectives/recommendations
  1. Reduce the proportion of children in Milwaukee with urgent oral health needs.
  2. Increase the capacity of clinics and private practices to treat the uninsured and Medicaid population.
  3. Increase the number of children having access to school-based oral health prevention programs.
  4. Increase the role of health care providers in assessing the oral health of Milwaukee Children.

MMS Development

- Added additional partners and applied for implementation in 2008
- Awarded three year HWPP impact award. ($450,000)
- Plan called to implement HT=HK objectives 1,3,4.
  - **MMS Objective 1: By June 30, 2011, reduce the proportion of children in Starms Schools with urgent oral health needs by 15 percent.**
  - **MMS Objective 2: By June 30, 2011, increase participation in Columbia St. Mary's school-based oral health programs by 30 percent.**
  - **MMS Objective 3: By June 30, 2011, increase the role of 100 health care providers in addressing oral disease.**

MMS Implementation

Two key interventions

1. Oral Health Care Coordinator (OHCC)

2. Primary care provider training

MMS Implementation

OHCC

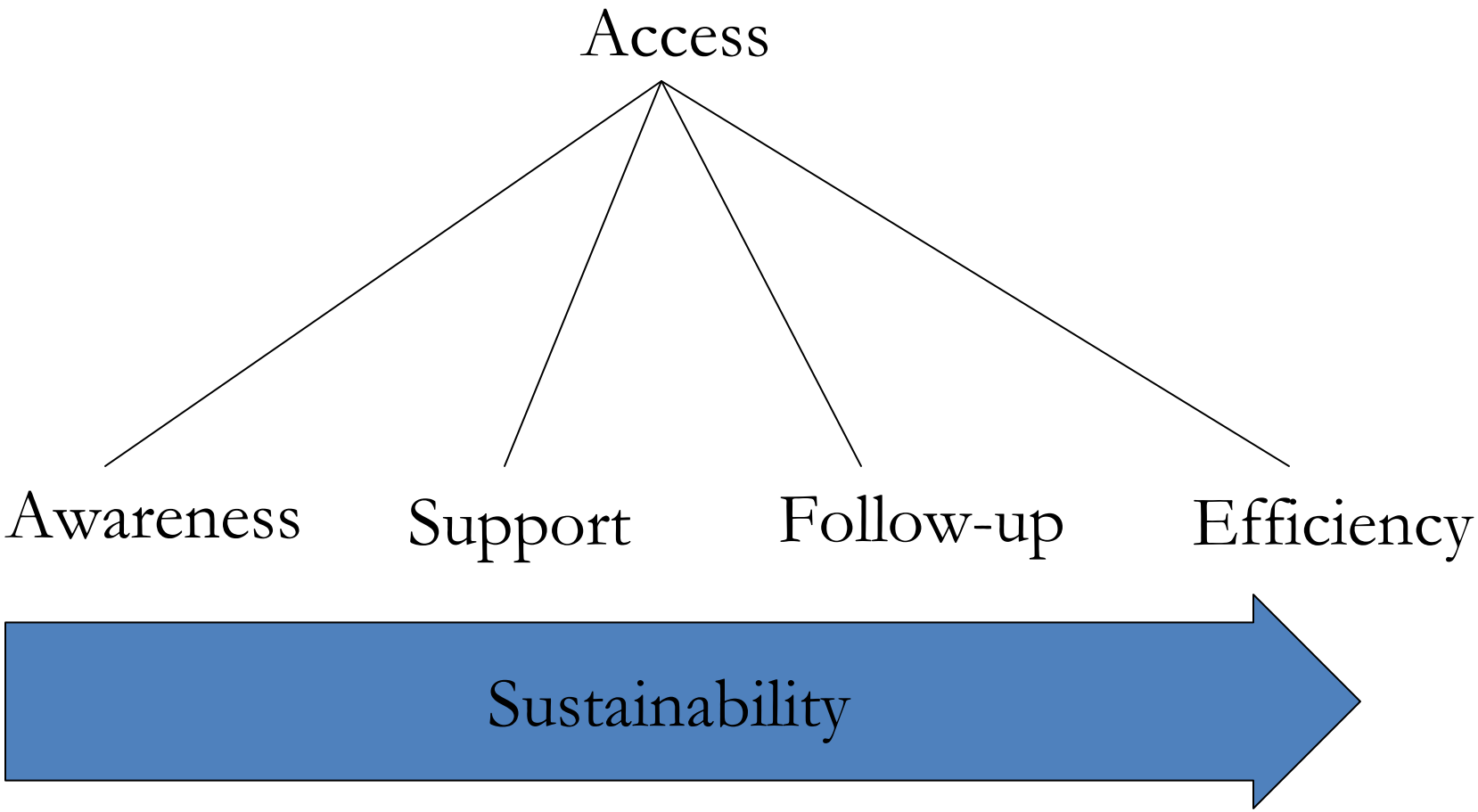
- Worked directly in two Milwaukee Public Schools

- Increase participation

- Educate

- Case management

Oral Health Care Coordinator:
Duties and Responsibilities



Goals of the OHCC

- Reach out to the children left behind.
- Become the resource for parents who have been searching for dental care for their children.
- Continue strengthening established relationships with providers, schools, families.

MMS Implementation

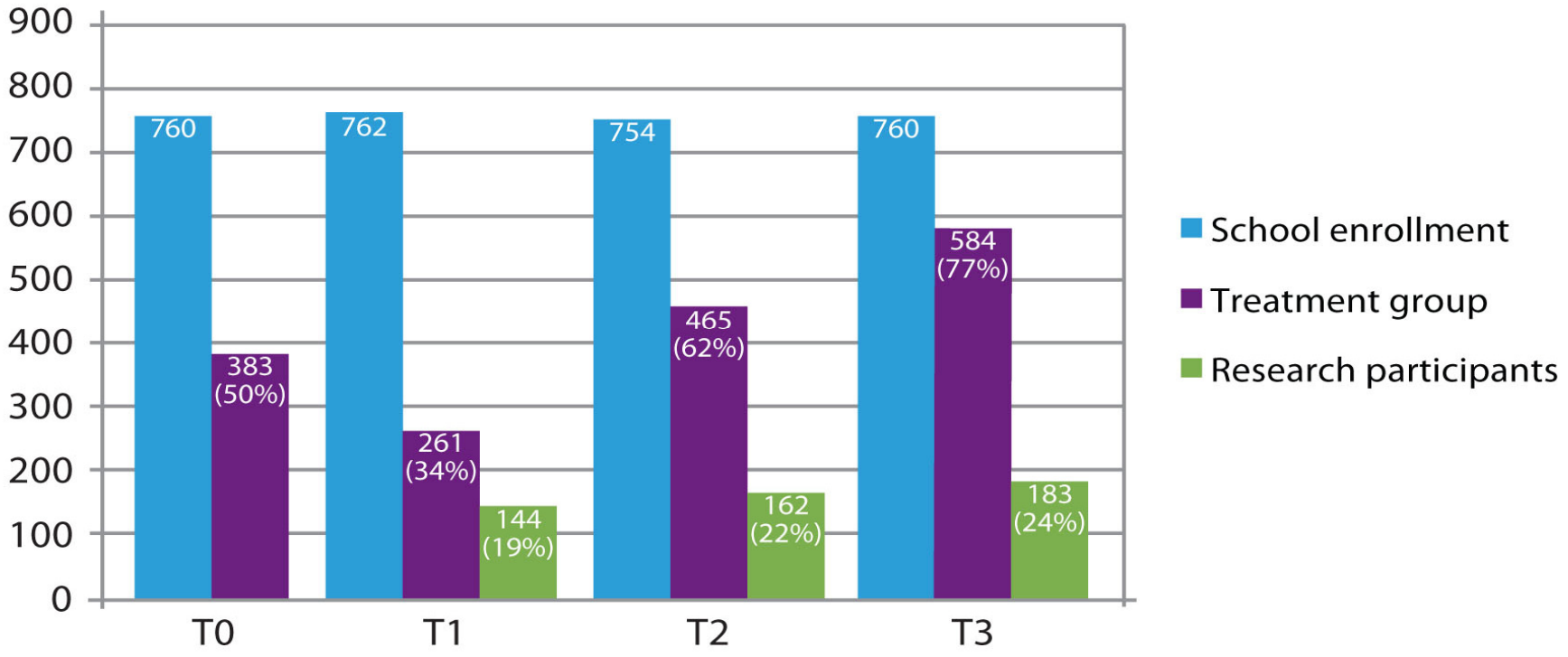
Primary Care Provider Training

- Developed in partnership with AAP
- CHW Grand Rounds
- Individual clinics

Key Finding #1

Implementation of an OHCC significantly increased access to preventive services.

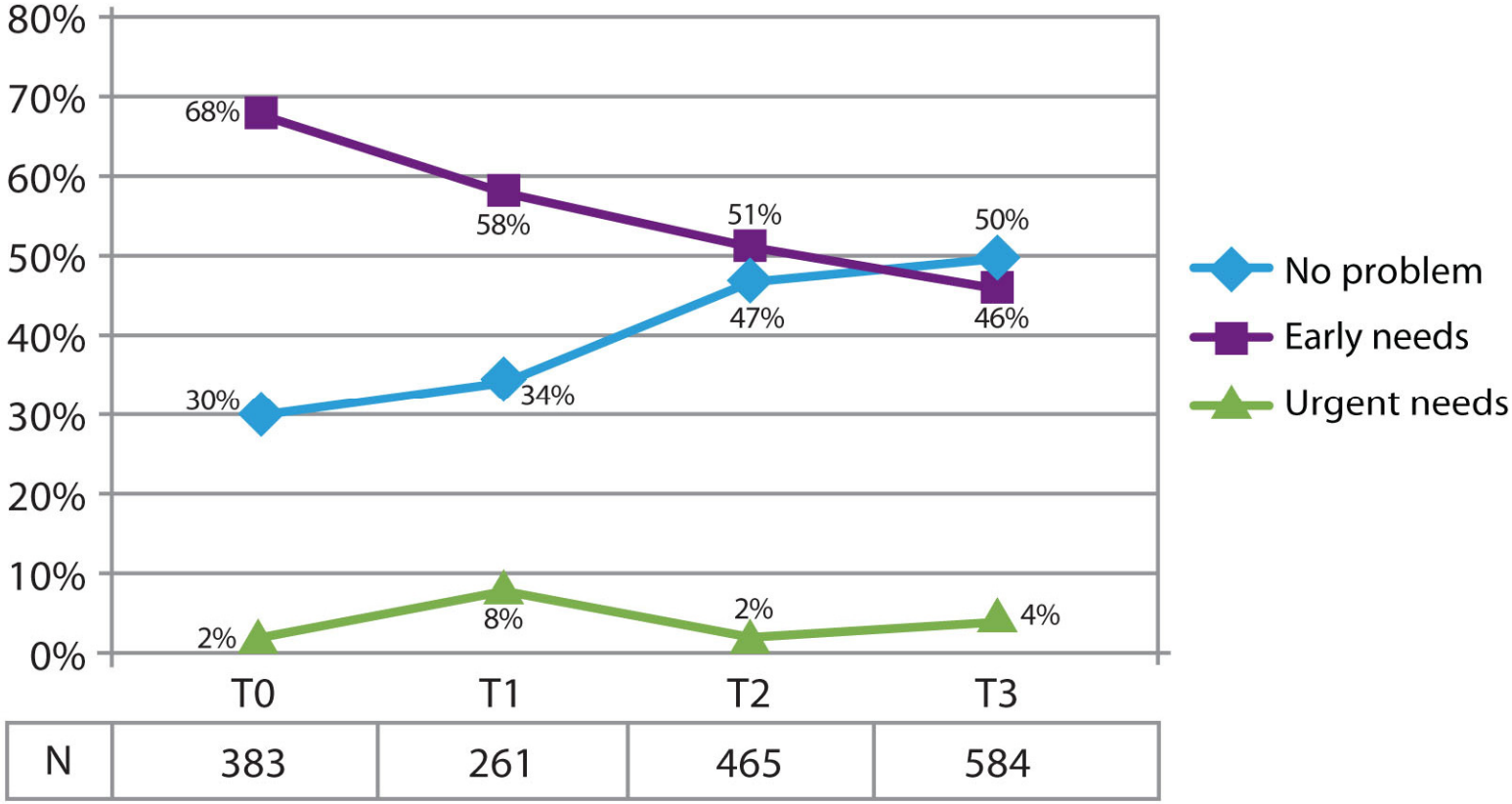
Table 1. Total school age groups distribution, 2007-11



Key Finding #2

Implementation of an OHCC had an impact on early and urgent disease rates.

Table 2: Making Milwaukee Smile reasons for oral health referrals, 2007-11

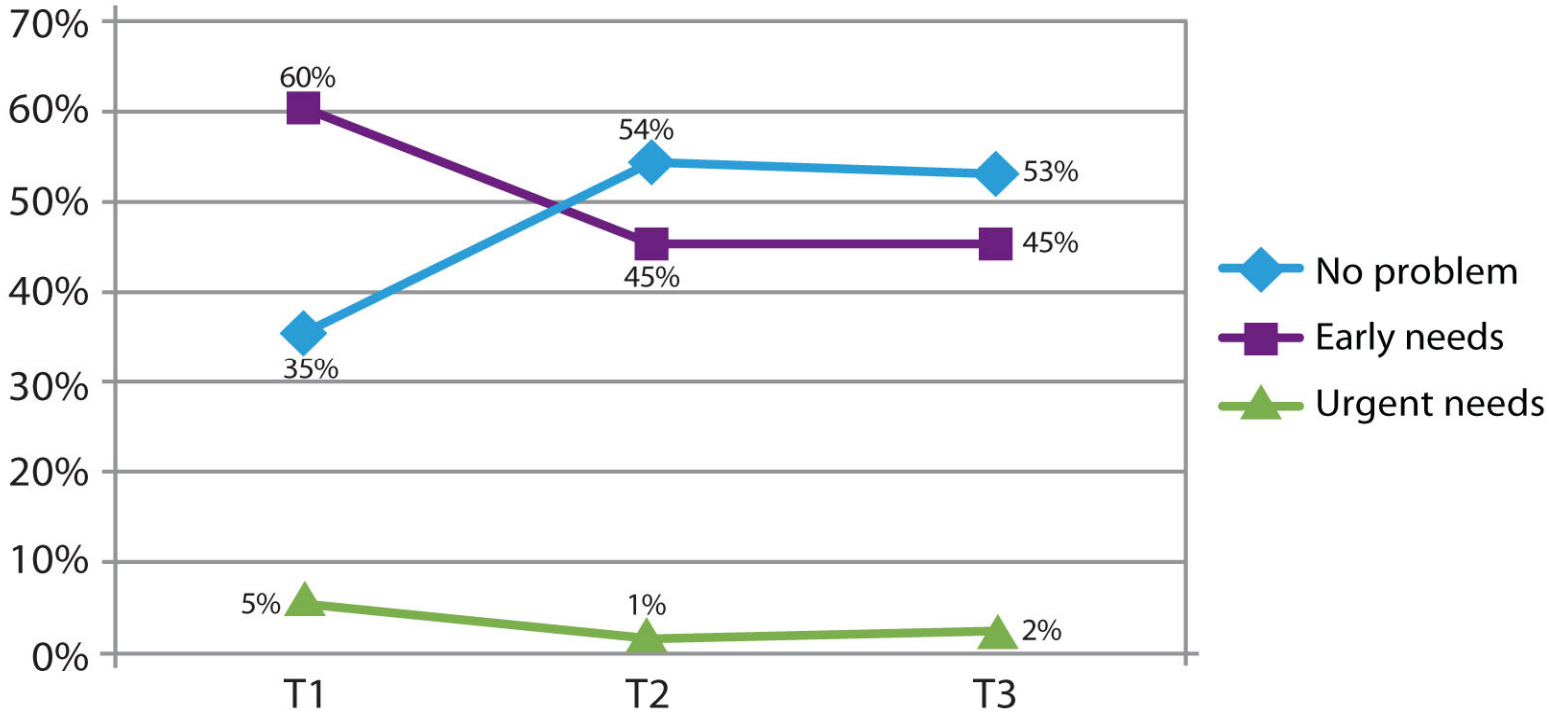


	T0	T1	T2	T3
N	383	261	465	584

Key Finding #3

Children with annual access to school-based oral health preventive services had lower untreated dental disease rates.

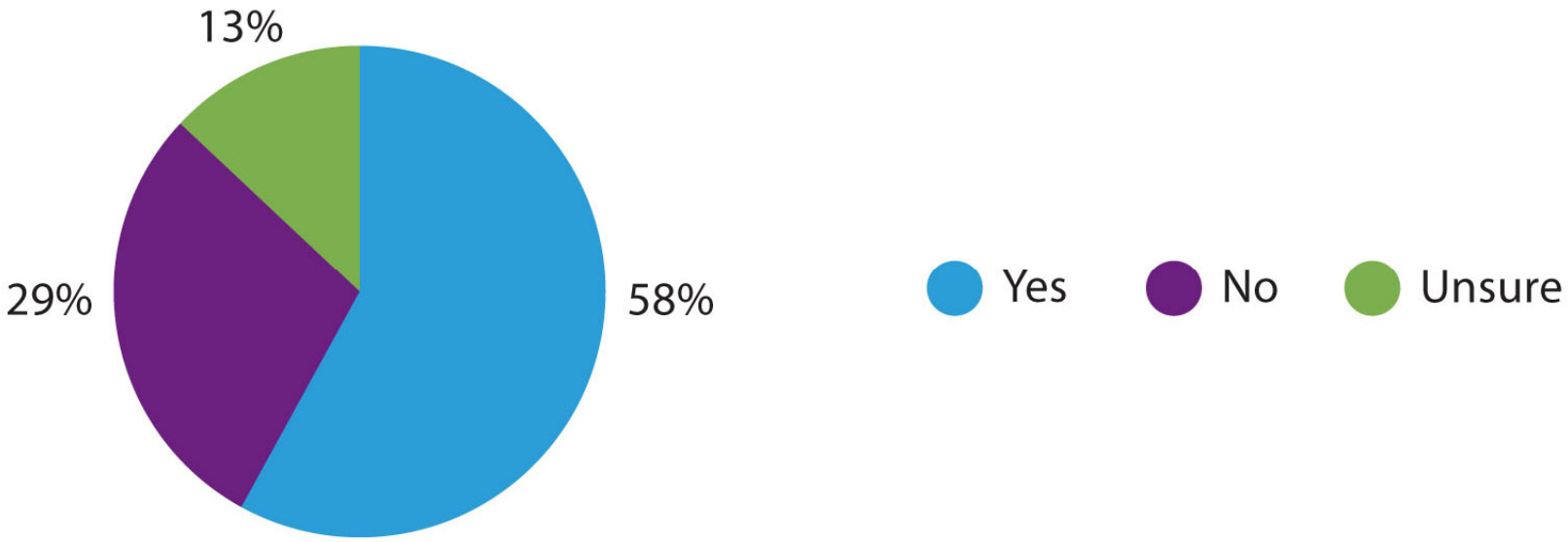
Figure 3. MMS reasons reported for oral health referrals for returning participants, N=112



Key Finding #4

Over half of Milwaukee primary care providers are aware that early oral health intervention is best.

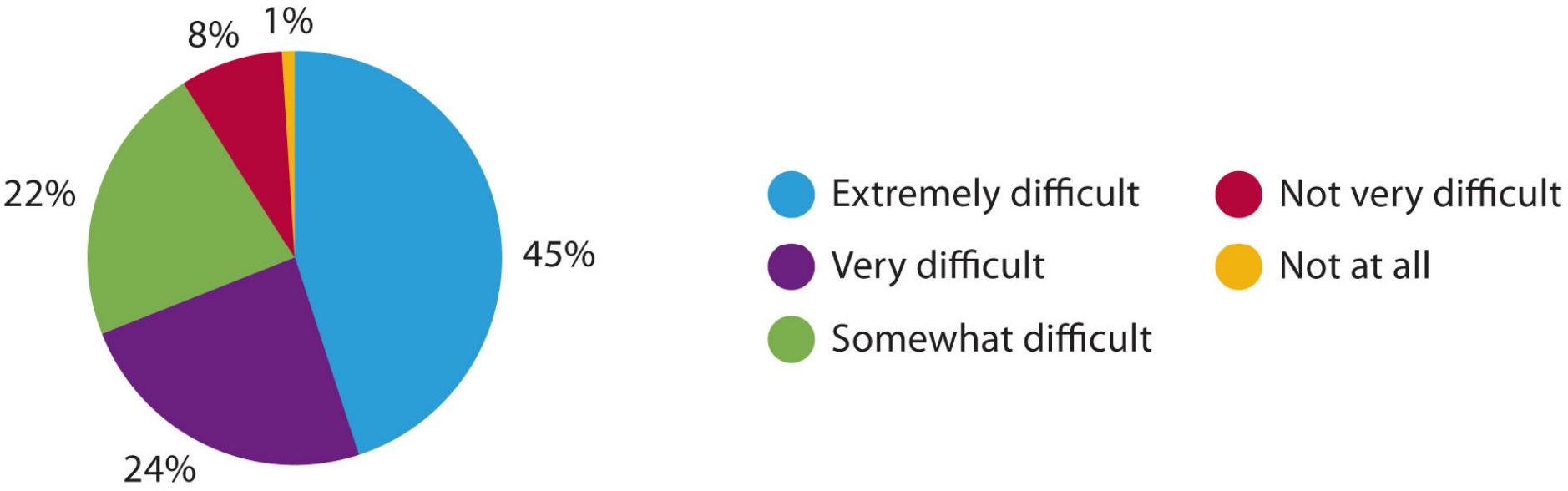
Figure 4: Primary care provider's awareness that they should perform oral health risk assessment on patients beginning at 6 months of age. N=101



Key Finding #5

Primary care providers have a difficult time referring their patients with identified dental problems due to the lack of Medicaid dental providers.

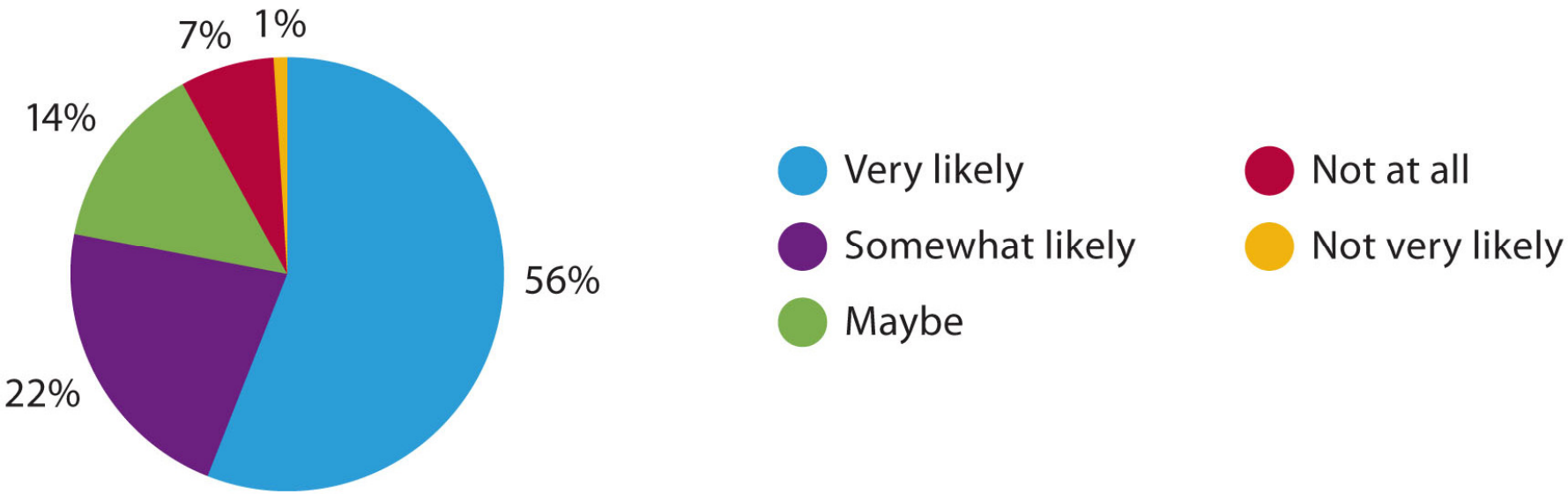
Figure 5: Primary care providers' reporting difficulty providing oral health risk assessments and anticipatory guidance. N=101



Key Finding #6

If reliable referral sources existed, more primary care providers would conduct pediatric oral health risk assessments.

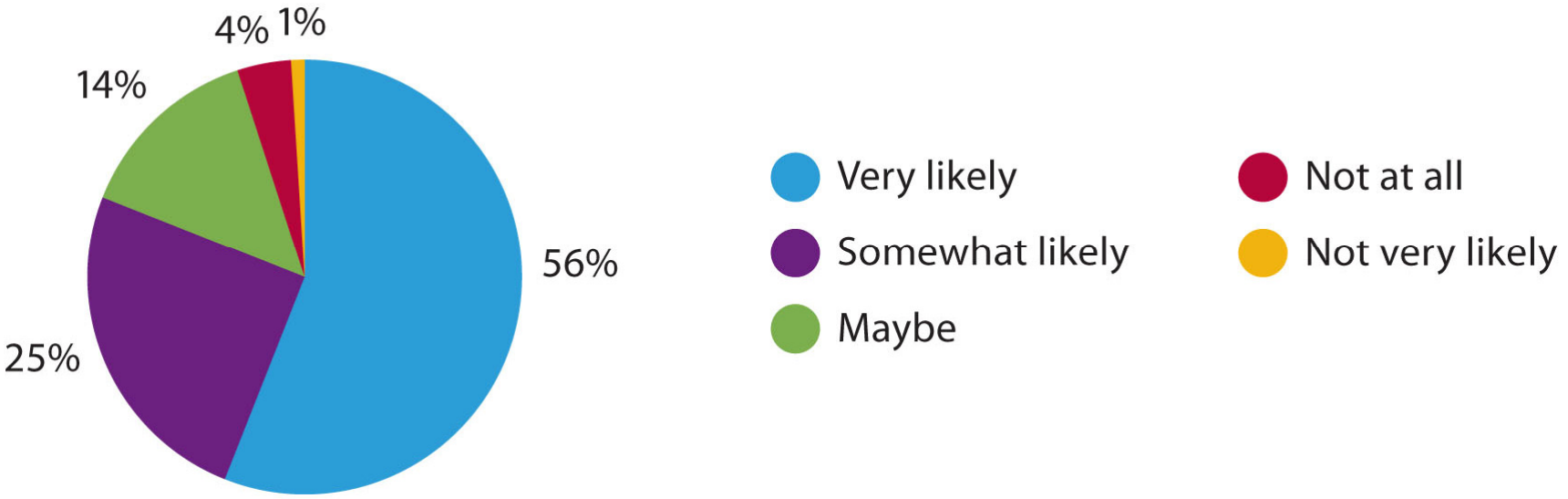
Figure 6: Primary care providers' inclination to perform oral health risk assessments if reliable referral resources were available. N=101



Key Finding #7

Medical providers are willing to implement oral health risk assessments and apply fluoride varnish with proper training.

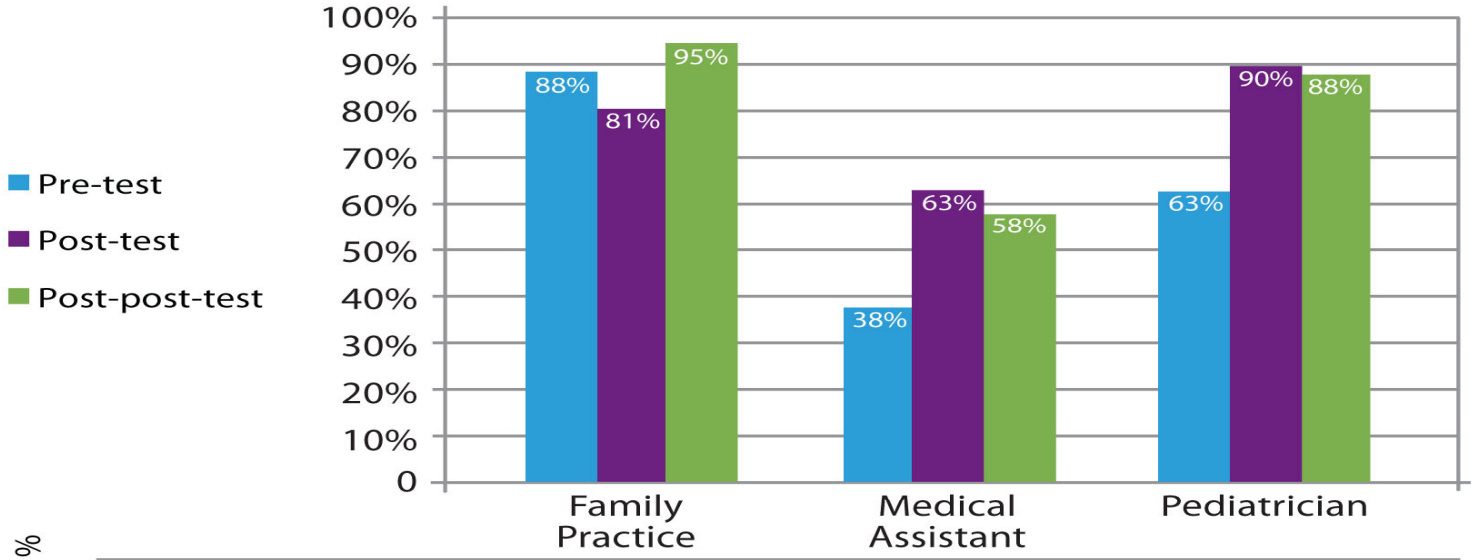
Figure 7: Primary care provider's willingness to implement oral health risk assessments into delivery of care if more training were provided. N=101



Key Finding #8

Training primary care providers increased their knowledge of oral health risk assessment.

Figure 8: Mean pre/post knowledge of oral health risk assessment by health professionals after training

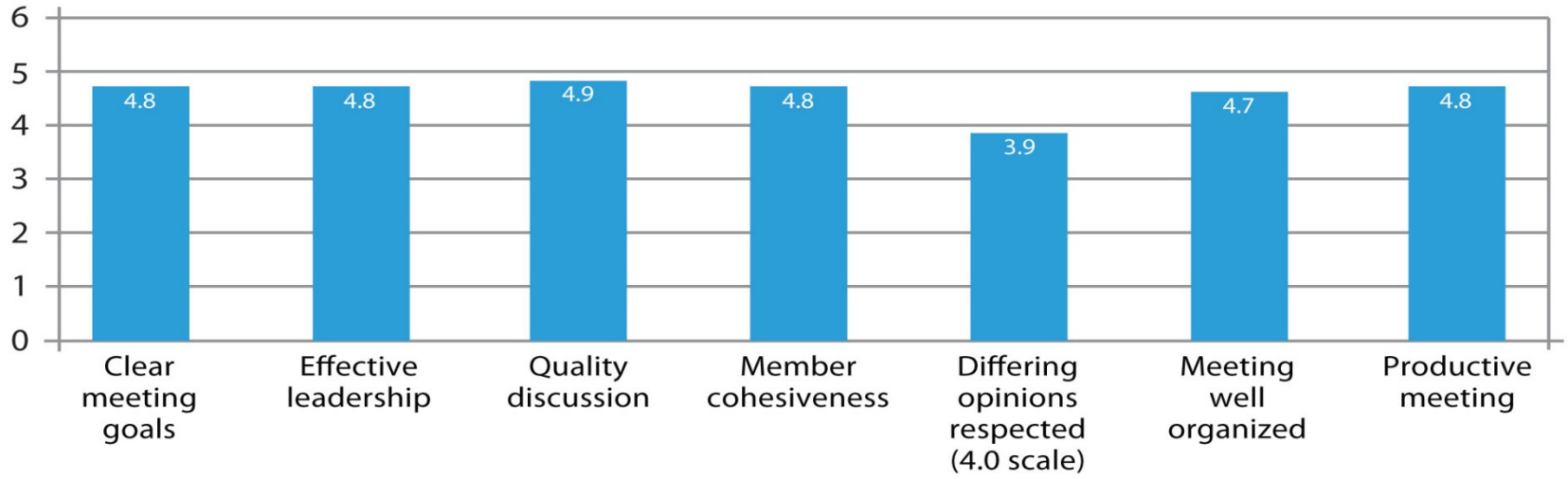


Median score % (range)	Family Practice	Medical Assistant	Pediatrician
Pre-test	83 (25-100)	38 (0-75)	75 (8-92)
Post-test	79 (75-92)	67 (33-92)	92 (83-92)
Post-post-test	96 (92-100)	58 (33-83)	92 (75-92)

Key Finding #9

Feedback from MMS partners revealed that effective and well-organized meetings with clear goals and quality discussions were held. In addition, partners reported that different opinions were respected and partnership meetings benefitted from effective leadership and facilitation.

Figure 9: Making Milwaukee Smile meeting evaluation summary. N=9 (Scale: 5=very well, 4=well, 3-neutral, 2=not well, 1=not at all, 0=N/A)



Conclusion

MMS Objective 1: By June 30, 2011, reduce the proportion of children in Starms Schools with urgent oral health needs by 15 percent.

Results:

- **Urgent needs decreased over 50% (5% to 2%)**
- **Disease rate decreased by 25% (58% to 46%)**

Conclusion

MMS Objective 2: By June 30, 2011, increase participation in Columbia St. Mary's school-based oral health programs by 15 percent.

Results:

- **Participation increased by 53% (50% to 77%)**

Conclusion

MMS Objective 3: By June 30, 2011, increase the role of 100 health care providers in addressing oral disease.

Results:

- **MMS Partners trained 151 medical providers**
- **New clinics implemented oral health programs**

Other outcomes

- Additional outcomes aligning with HT=HK recommendations and MMS objectives

- Funding of Earlier is Better (2012-2016)

Questions