Dental Public Health Activity Descriptive Report Submission Form

CONTACT PERSON PREPARING THE SUBMISSION AND TO ANSWER QUESTIONS

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PROVIDE CONTACT INFORMATION FOR ONE ADDITIONAL PERSON WHO COULD ANSWER QUESTIONS REGARDING THIS PROGRAM

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SECTION I: ACTIVITY OVERVIEW

Title of the dental public health activity:

Rhode Island Prenatal & Pediatric Dentistry Mini-Residency

Public Health Functions*: Check one or more categories related to the activity.

"X"	Assessment
	1. Assess oral health status and implement an oral health surveillance system.
	2. Analyze determinants of oral health and respond to health hazards in the community
	3. Assess public perceptions about oral health issues and educate/empower them to achieve and maintain optimal oral health
	Policy Development
	4. Mobilize community partners to leverage resources and advocate for/act on oral health issues
	5. Develop and implement policies and systematic plans that support state and community oral health efforts
	Assurance
X	6. Review, educate about and enforce laws and regulations that promote oral health and ensure safe oral health practices
X	7. Reduce barriers to care and assure utilization of personal and population-based oral health services
X	8. Assure an adequate and competent public and private oral health workforce
X	9. Evaluate effectiveness, accessibility and quality of personal and population-based oral health promotion activities and oral health services
	10. Conduct and review research for new insights and innovative solutions to oral health problems

***ASTDD Guidelines for State and Territorial Oral Health Programs that includes 10 Essential Public Health Services to Promote Oral Health**

Healthy People 2020 Objectives: Check one or more key objectives related to the activity. If appropriate, add other national or state HP 2020 Objectives, such as tobacco use or injury.

"X"	Healthy People 2020 Oral Health Objectives	
X	OH-1	Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth
X	OH-2	Reduce the proportion of children and adolescents with untreated dental decay
X	OH-3	Reduce the proportion of adults with untreated dental decay
	OH-4	Reduce the proportion of adults who have ever had a permanent tooth extracted because of dental caries or periodontal disease
	OH-5	Reduce the proportion of adults aged 45 to 74 years with moderate or severe periodontitis
	OH-6	Increase the proportion of oral and pharyngeal cancers detected at the earliest stage
X	OH-7	Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year
X	OH-8	Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year
	OH-9	Increase the proportion of school-based health centers with an oral health component

	OH-10	Increase the proportion of local health departments and Federally Qualified Health Centers (FQHCs) that have an oral health component
	OH-11	Increase the proportion of patients who receive oral health services at Federally Qualified Health Centers each year
	OH-12	Increase the proportion of children and adolescents who have received dental sealants on their molar teeth
	OH-13	Increase the proportion of the U.S. population served by community water systems with optimally fluoridated water
X	OH-14	Increase the proportion of adults who receive preventive interventions in dental offices
	OH-15	Increase the number of States and the District of Columbia that have a system for recording and referring infants and children with cleft lips and cleft palates to craniofacial anomaly rehabilitative teams
	OH-16	Increase the number of States and the District of Columbia that have an oral and craniofacial health surveillance system
	OH-17	Increase health agencies that have a dental public health program directed by a dental professional with public health training

"X"	**Other national or state Healthy People 2020 Objectives: (list objective number and topic)**	
X	MICH-10	Increase the proportion of pregnant women who receive early and adequate prenatal care

Provide 3-5 Key Words (e.g. fluoride, sealants, access to care, coalitions, policy, Medicaid, etc.) These will assist those looking for information on this topic:

Prenatal care, perinatal care, pediatric, provider education, continuing education, children's oral health, workforce, access to care, special health care needs, pregnant women

Executive Summary: Complete after Section II: Detailed Activity Description. Please limit to 300 words in one or two paragraphs.

Provide a brief description of the dental public health activity. Include information on: (1) what is being done; (2) who is doing it and why; (3) associated costs; (4) outcomes achieved (5) lessons learned, both positive and negative.

With grant funding from the Health Resources and Services Administration and the Centers for Disease Control and Prevention, the Oral Health Program, Rhode Island (RI) Department of Health established the RI Oral Health Mini-Residency series to address the specific challenges presented by a lack of education opportunities for RI oral health professionals and its impact on the oral health status of vulnerable populations.

Each 2-day forum seeks to strengthen the oral health workforce capacity in RI through enhanced evidence-based knowledge and skills for all members of the dental team (dentist, dental hygienist, dental assistant). The Mini-Residency series also seeks to assure improved oral health outcomes for targeted underserved populations: children ages 0-6, individuals with special health care needs, elders in nursing homes, adolescents, and pregnant women. Each event includes numerous nationally recognized oral health experts.

All training forums are held at a central location, and participating oral health professionals earn continuing education credits. Funding for the series comes from a variety of sources, including federal grants, corporate sponsorships, and revenue from participant registrations. The cost to hold the event averages about $33,000 including printing, space (including AV, food, etc.), binders, registration, and expenses for expert speakers.

The 2017 Prenatal and Pediatric Dentistry Mini-Residency goals included enhancing

providers' comfort level in treating pregnant patients and very young children, and increasing their awareness of best practices for delivering high quality prenatal and pediatric oral health services. The wide-range of speakers (from obstetricians to insurers to liability insurance representatives) allowed attendees to get a holistic view of treating these populations, but there was lower attendance (110 total) possibly due to topic "fatigue."

SECTION II: DETAILED ACTIVITY DESCRIPTION

Provide detailed narrative about the dental public health activity using the headings provided and answering the questions. Include specifics to help readers understand what you are doing and how it's being done. References and links to information may be included.

Rationale and History of the Activity:

1. What were the key issues that led to the initiation of this activity?

Ongoing education is the key to success of any health care provider. Increased knowledge of special populations and clinical/cultural competency of the oral health workforce are vital to meet the complex and diverse needs of the RI's racial/ethnic minority populations, underserved children, those with special health care needs, pregnant women, and the elderly. With no in-state dental school, the dentist shortage is expected to become more critical in the near-term given that a significant portion of the currently practicing dentist workforce is near retirement age. The dental hygiene and certified dental assistant training programs at the Community College of RI are the only accredited programs in the state. Such gaps in educational opportunities had led to concerns surrounding a potential shortage in supply of oral health professionals in RI.

Most importantly, these shortages impact the state's most vulnerable populations – children from families with low-income, children with special health care needs, disabled adults, elders in nursing facilities, and those of minority race/ethnicity. In 2011, the RI Oral Health Program reported half of the children in RI do not see a dentist until age 5, despite the recommendation of professional organizations that children visit a dentist by age one. Prenatal women comprise another important but often underserved population group. As noted in Oral Health in America: A Report of the Surgeon General, access to dental services and appropriate oral health guidance during pregnancy is essential to improve maternal health, fetal development, infant health, and birth outcomes.

Analysis of 2009 PRAMS data demonstrated the less than optimal access to oral health services among pregnant women in RI. Approximately half of RI women reported they had a dental visit during their pregnancy The proportion of pregnant women who visited a dentist or dental clinic was not uniform by age, marital status, educational attainment, household income level, or residential area. Women who were younger than 30 years of age, those who were not married, or women who lived in urban core cities were less likely to have a dental visit. Only 40.5% of women who had prenatal care coverage by Medicaid/RIte Care and 42.1%of women who participated in WIC were seen by a dentist or other oral health professional during their pregnancy.

There are challenges and barriers that keep women from obtaining oral health care during their pregnancy, such as financial barriers, lack of oral health care information during pregnancy, lack of appropriate counseling on oral health care needs from prenatal care providers (obstetricians, family physicians, and other prenatal care providers), and misperceptions of dental care providers on treatment for pregnant women.

In particular, oral health professionals must address unnecessary treatment delay or deferral. Dentists often postpone treatment for pregnant women because they may not fully understand

the physiological changes that occur during pregnancy and fetal development, or have misconceptions about the effect of dental treatments on pregnant women and their fetuses.

2. What rationale/evidence (may be anecdotal) did you use to support the implementation of this activity?

   With no in-state dental school, the dentist shortage is expected to become more critical in the near- term given that a significant portion (58%) of the currently practicing dentist workforce is of retirement age (50-59 y.o.= 26%; >70 y.o.= 32%) and the state has a less than optimal supply of dental hygienists, dental assistants, dental laboratory technicians and/or the expert faculty to train students seeking entry to these professions. Most importantly, these shortages impact the state's most vulnerable populations– children from families with low income, children with special health care needs, disabled adults, elders in nursing facilities, and those of minority race/ethnicity. In 2011, the RI Oral Health Program reported half of the children in Rhode Island do not see a dentist until age 5, despite the recommendation of professional organizations that children visit a dentist by age one. Prenatal women comprise another important but often underserved population group. As noted in *Oral Health in America: A Report of the Surgeon General*, access to dental services and appropriate oral health guidance during pregnancy is essential to improve maternal health, fetal development, infant health, and birth outcomes. The RI Oral Health Program raised concerns of less than optimal oral health access among RI pregnant women and disparities by women's socioeconomic status.

   The RI Oral Health Program reported concerns of less than optimal oral health access among RI pregnant women and disparities by women's socioeconomic status based on the 2009 PRAMS findings. The 2011 RI Prenatal and Pediatric Dental Mini-Residency training conference was established to address the specific challenges presented by a lack of education opportunities for RI oral health professionals and improve oral health care for the most vulnerable Rhode Islanders, including pregnant women. Increased knowledge of special populations and expanded clinical competency/skills of the oral health workforce are expected improve dental care utilization and meet the oral health needs of the RI's pregnant women.

3. What month and year did the activity begin and what milestones have occurred along the way? (May include a timeline.)

   Mini-Residency Program (in general) – 2006
   Milestones: 10th Anniversary 2016 (Topic: Adult Medicaid Collaborative); As of 2013, over 1,300 dental professionals have attended a Mini-Residency

The sections below follow a logic model format. For more information on logic models go to: W.K. Kellogg Foundation: Logic Model Development Guide

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	OUTCOMES

1. What resources were needed to carry out the activity? (e.g., staffing, volunteers, funding, partnerships, collaborations with various organizations, etc.)

   Topic areas were determined from recommendations of several key commissions/coalitions/workgroups comprised of a diverse group of oral health stakeholders and action plans associated with these key coalitions including, but not limited to: 1) 2006 and 2011-2016 RI Oral Health State Plans; 2) RI Oral Health Commission; 3) RI Early Childhood Oral Health Action Plan; 4) Special Report: The Dental Safety Net in RI; 5) Oral Health in Rhode Island Nursing Homes: The Crisis and Possible Solutions; and 6) Recommendations from the RI Oral Health Workforce Symposium.

RI Oral Health Program staff coordinated the program logistics, including contact/communication with speakers, meeting arrangements with the venue, fiscal management with Departmental grants staff, ordering of supplies/materials, development of program evaluation/analysis, and issuance of continuing education credits/certificates.

INPUTS	**PROGRAM ACTIVITIES**	OUTPUTS	OUTCOMES

2. Please provide a detailed description the key aspects of the activity, including the following aspects: administration, operations, and services.

The Oral Health Program, RI Department of Health oversees the annual Mini-Residency with support from the Office of Primary Care and Rural Health (RI Department of Health) and other interested parties depending on the topic. For example, RI KIDS COUNT was a member of the planning committee for the 2017 Mini-Residency due to their work on the *TeethFirst!* project that promotes the age one dental visit and prenatal oral health.

The topics for the event were:
Day 1
The Importance of Medical-Dental Connection
Recent Trends in Prenatal Oral Health
Periodontal Infection/Inflammation and Adverse Pregnancy
Addressing Concerns of Liability and Ethics of Treating Pregnant Women

Day 2
Connect the Dots RI! – The Age One Dental Visit
Health Disparities by the Numbers in RI
Practical Techniques for Management of Infant & Toddler Patients
Insurance Landscape in RI for Pregnant Women & Young Children

INPUTS	PROGRAM ACTIVITIES	**OUTPUTS**	OUTCOMES

3.What outputs or direct products resulted from program activities? (e.g., number of clients served, number of services units delivered, products developed, accomplishments, etc.)

Number served: between 100-150 dental providers each year
Products: Participants at each of the five mini-residency programs were provided with a binder, which included all lecture materials, supplemental handouts/articles, state and local resources, and other relevant documents/ publications. Considerable time was devoted to collecting materials, printing, and organizing/ creating the filled binders. Several stakeholder volunteers assisted with collating and putting the binders together.

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	**OUTCOMES**

4.What outcomes did the program achieve? (e.g., health statuses, knowledge, behavior, care delivery system, impact on target population, etc.) Please include the following aspects:

a. How outcomes are measured

Evaluations are required to be completed after each presentation in order to receive the CEU credits for that session. There is also a final overall evaluation for the event.

For this particular topic: Looking at the number of attendees who became Age One Champions (agreed to take very children as patients) & the number of preventive dental visits for pregnant women & infants.

b. How often they are/were measured

The evaluations are collected at every mini-residency and the Age One Champion Directory is updated quarterly. The RIte Smiles (RI children's Medicaid dental benefit) data is reported twice a year and PRAMS is yearly.

c. Data sources used

Evaluation; Medicaid data; PRAMS

d. Whether intended to be short-term (attainable within 1-3 years), intermediate (achievable within 4-6 years), or long-term (impact achieved in 7-10 years)

Having more dentists agree to see very young children is a short-term goal that will have a long-term impact on the number of preventive dental visits.

Evaluations have a short-term impact in that they will influence the next mini-residency.

Increasing the number of preventive dental visits for pregnant women and infants is a long-term goal.

Budgetary Information:
NOTE: Charts and tables may be used to provide clarity.

1. What is the annual budget for this activity?

   $30,-35,000

2. What are the costs associated with the activity? (Including staffing, materials, equipment, etc.)

Estimated Expenses	Amount
Faculty Stipends and Travel	$7,000.00
Binders (leather-like, embossed)	$2,460.00
Office Supplies	$303.58
Room Rental	$3,000.00
Audio Video	$3,700.00
Printing: binder contents	$1,400.00
Printing: color registration brochure	$700.00
Postage: brochure	$674.00
Food, service charge	$14,500.00
TOTAL EXPENSES:	**$33,737.58**

The Oral Health Program staffs the event with help from the Office of Primary Care and Rural health and interns. Total numbers for each day are 8 staff.

3. How is the activity funded?
   Federal grants (HRSA/CDC), RIDOH programs sponsorship (especially the Office of Primary Care and Rural Health who provide scholarships to cover the registration costs for a limited number of rural providers), and registration costs.

4. What is the plan for sustainability?

   Individual participants have been tracked over time and show that a significant proportion of oral health professionals have attended multiple programs. The local dental societies have supported the promotion of the events, and assisted in dissemination of information to their members.

   Participant evaluations clearly demonstrate that these programs are a valuable educational resource and attendees are interested in future opportunities.

   Unfortunately, the mini-residency programs have relied primarily on grant support for funding. Large expenses, such as speaker honoraria and meeting facility rental are supported by grant resources. Private corporations/vendors have contributed to the programs in the past and will need to be accessed for future programs.

   The Oral Health Program also plans to coordinate with other RI Department of Health programs that are interested in reaching dental providers. The 2018 Mini-Residency topic is Communication Tools and Trends, and the speakers will include partners of the tobacco cessation program, immunization program, and overdose prevention. These programs are paying for the speakers, and helping with printing costs.

Lessons Learned and/or Plans for Addressing Challenges:

1. What important lessons were learned that would be useful for others looking to implement a similar activity? Was there anything you would do differently?

   Input from stakeholders important: focus area, specific lecture/session topics, suggestions for expert faculty/speakers, venue, time of year, length of program and time of year

   Participant evaluation essential: overall conference, opinions on topics and speakers, suggestions for improvement and future educational needs/topics for other conference.

2. What challenges did the activity encounter and how were those addressed?

   There was an issue with low registration numbers leading to the 2016 and 2017 event. The 2016 event was scheduled over the Easter holiday weekend (it was the only Friday/Saturday the event space had available), so that was easily resolved for the next year. The Oral Health Program attempted to increase registration for the 2017 event by doing a paper mailing of the registration and promoting the event more in dental provider settings (RI Department of Health newsletter to dental providers, RI Dental Association newsletter, discussing it at the Oral Health Commission full meetings, etc.).

Available Information Resources:

Share any models, tools, and/or guidelines developed by the program specifically for this activity that may be useful to others seeking additional information. Hyperlink resources if possible.

Mini-residency agendas and registration brochures are available to be shared as well as presentations.

TO BE COMPLETED BY ASTDD	
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