

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

ORAL HEALTH FORUM

Friday • February 23, 2007

BP Energy Center • Anchorage, Alaska



Facilitated by

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Executive Summary

On February 23, 2007, the Children with Special Health Care Needs (CSHCN) Oral Health Issues forum was held at the BP Energy Center in Anchorage, Alaska. The forum's purpose was to bring together individual parents, foster parents, practitioners, dentists, dental hygienists, policy makers, and funders to share their knowledge, expertise, strategic insights, and contributions toward the oral health care of children with special health care needs (CSHCN). The CSHCN Oral Health Forum was sponsored by The Stone Soup Group, Anchorage, Alaska, with support from a grant from the Association of State and Territorial Dental Directors and collaboratively planned by the Department of Health and Social Services, Division of Public Health, Section of Women's, Children's and Family Health, Oral Health Program staff members.

The Morning Session

The forum was designed to be delivered in two sections; the morning session was structured so that individual experts were given ten to 15 minutes to share their Alaskan perspective on the oral health issues that exist for children with special health care needs and their families. These individuals provided either a Power Point presentation and/or documented studies/notes regarding the issues. While the experts were presenting, the facilitator documented the issues and solutions as they arose. The documentation then served as a platform for the day's work. The experts (in order of their appearance) are as follows.

Experts

Dr. Richard Mandsager
Stephanie Birch
Cindy Christensen

Perspectives

Children's Hospital at Providence
MCH and CSHCN Department of Health and Social Services
Medicaid Department of Health and Social Services

Panelists

John Cartwright	Parent
Bonnie Lange	Parent
April Tynan	Parent
Cheri Scott	Parent
Kathinka White	Parent
Dr. Singleton,	ANMC Dental Clinic
Dr. John Etter	ANMC Pediatric Residency Program
Sharon Schlicht	Specialty Clinics Department of Health and Social Services
Jeannette Gorda	Specialty Clinics Department of Health and Social Services
Steve William	Alaska Mental Health Trust Authority
Kathy Allely	Governor's Council on Disabilities and Special Ed.
Elizabeth Barnett	Home Visitor
Judy Oyler	Home Visitor
Brad Whistler	Approaches in other states

During the morning session key issues, ideas, and solutions were documented and categorized into seven specific areas of priority. These seven areas of priority were determined by previous study of the prevailing research and the current planning strategies that the Department of Health and Social Services, CSHCN Division had been drafting. The seven areas of priority are:

- 1) Preventative Services
- 2) Surveillance
- 3) Financial/Medicaid
- 4) Dental Services & Programs (Providing Services)
- 5) Dental Workforce/Training Issues
- 6) Education of Parents/Caregivers/Providers
- 7) Access to Dental Services

As the morning unfolded, clearly these seven categories were in line with the current status and issues as shared by the experts.

The Afternoon Session

During the working lunch hour, the participants reviewed the issues, and areas of priority discussed during the morning session and clarified each category's documentation. This process set the tone for the afternoon's work.

The afternoon session was structured for participants to work within individual mini-strategic planning groups. First as a larger group, the participants were asked to prioritize the seven categories down to three. (It was agreed upon that the four categories not selected would be secured for future development). The participants then determined which priority they wanted to independently work on throughout the afternoon; this small group then became the "working group" for each of the three priorities. The afternoon's outcome was the development of an action planning document per priority. The participants identified the following categories as the three most important priorities to focus on over the next three years.

- Priority #1: Financial/Medicaid Issues
- Priority #2: Access to Dental Services
- Priority #3: Education of Parent/Caregivers/Providers

As the first step to action planning, the participants were asked to identify and select no more than one to two specific issues as documented under the prioritized category. Next they brainstormed all the possible action steps that were needed to successfully address each issue. This step seemed to be the most time intensive; however, once the steps were listed the group

could then align the action steps in order of priority, timeline, and responsibility (who is responsible for getting the action started and accomplished).

Throughout the afternoon the participants had the opportunity to “check-in” with each of the other groups regarding direction on their strategies and timelines. Often, there were areas within each of the action steps that could be “cross-walked” over to another group’s action plan.

This proactive approach was a positive spin away from reacting to a crisis then putting together a patch-work plan. Rather, the forum participants were treated to thorough, deeply sensitive, and “real” practices, experiences, and concerns as expressed by the guest speakers and panelists alike. In the final analysis of the day, the participants were able to hear each of the three group’s strategies, action steps, and direction. It was determined at that time to establish follow-up on a regular basis in order to keep the action plans moving forward.

Based on the evaluation (synopsis in appendix of report) of the day’s events, the participants were very satisfied with the CSHCN Oral Health Forum. They commented very positively on the organization of the forum, the productivity of the day, how the day’s time was prioritized, the direction of the facilitation, and the facility/location. Participation in the afternoon (in comparison to attendance in the morning) was a little more than half; and some participants noted they wished more had stayed for the afternoon. Ninety percent of the participants are interested in a follow-up meeting to work on the action plans. Participants acknowledged that by the end of the afternoon, “there was a direction for care and action steps to get us there” and that “this forum made us look at how discussion could become REAL.”

Priority Areas and Action Plans

WHERE DO WE WANT TO BE IN THREE YEARS?

Priority #1: Financing Issues

The following four strategies were determined by the participants after their thorough review of the issues, ideas, and solutions shared during the morning session:

Non-Kept Appointments or “No Shows”: Priority #1 as efforts are underway to address this issue. Regulation package for adult dental Medicaid services includes clarification that dentists can charge Medicaid recipients for non-kept appointments so long as it is the practice policy to charge all clients for missed appointments. Additionally, the department should explore a mechanism (e.g., use of D9999) to track non-kept appointments even though the Medicaid program would not be reimbursing providers for the missed appointments.

Increased Medicaid Dental Reimbursement: This is the highest priority identified of financing/Medicaid issues. It was felt that dentists and advocacy agencies need to encourage a Medicaid dental reimbursement increase. Medicaid reimbursement for most dental codes has not increased since 1999 using 1997 claim profiles. Historically, the department had tried to keep reimbursement at 80% of UCR (UCR = median charge). The current reimbursement level is typically 50-60% of median billed charges for dental procedures. It was also highlighted that the mechanism for dental reimbursement should be established in regulation (e.g., establishing new reimbursement rates every 3 years). Advocacy agencies that could work on building support for an increase include: Alaska Mental Health Trust Authority (AMHTA); Governor’s Council on Disabilities and Special Education; Alaska Chapter of the American Academy of Pediatrics, Alaska Chapter of American Academy of Pediatric Dentistry and Alaska Dental Society.

Liability Provisions in the Medicaid Provider Agreement: Some dentists and the Alaska Dental Society have expressed concerns with “hold harmless” language in the provider agreement. The provisions note the department is held harmless and that providers indemnify the department against any legal costs. Information from the Department of Law indicates this is standard language in state contracts and since the state is self-insured the Risk/Loss section would not support removing the language from the provider agreement. CSHCN Oral Health Forum participants felt it was worth the AMHTA and Governor’s Council to discuss with their legal consultants on any possibilities to change the hold harmless language – particularly the obligation for providers to be liable for any state legal costs should action be taken against the state in relation to the Medicaid program.

1115A Waiver: Several participants noted the Alaska Senate is contracting with Pacific Health Policy to draft an 1115A waiver for the Medicaid program. AMHTA and Governor’s Council could monitor the waiver and look at options in relation to dental services provided by Medicaid.

Additional issues, ideas, and solutions generated during the afternoon session:

- ✓ Medicaid reimbursement increase – update fee schedule.
- ✓ Federal law change to allow for co-pay (Title 19)
 - 1115A Waiver <AK Dental Society>
- ✓ Sliding fee scales (co-payment)
- ✓ Expansion of SCHIP – adding co-pay.
- ✓ Pressure needs to come from outside the state system to increase fee schedule.
- ✓ Regulations change to require a 2-3 year fee revision.
- ✓ SB Davis Bill: #3 W; Hollis French/#4 Dentists/AAPP/AAP, AMHTA/AAPP
- ✓ No show: take \$ as a fine from PFD.
- ✓ Charging clients for no-kept patient (need for surveillance on numbers – we need data). MMIS new system.
- ✓ Implement extended adult dental.
- ✓ Increase payment/incentives for preventative care.
- ✓ Liability clause in provider agreement - “changing this” ← AMHTA influence.
- ✓ MH Trust involved with oral health care issues.

Children with Special Health Care Needs (CSHCN) Oral Health Forum
Priority #1: Medicaid Financing

Issue	Proposed Activities/Description	Outcomes	Timeline Start/Finish	Responsibility	Follow-Up
1. Non-kept appointments	<ul style="list-style-type: none"> • Regulation clarification billing to bill • Track non-kept appointments 		<ul style="list-style-type: none"> • 3/2007 • 2-3 years: new system for Medicaid billing 		
2. Increase Medicaid Reimbursement	<ul style="list-style-type: none"> • Profile fees • Outside involvement - dentists • Legislative support budget issues 		<p>Done</p> <ul style="list-style-type: none"> • FY 2009 	<ul style="list-style-type: none"> • Pediatric Dentists • Alaska Dental Society • Trust/Beneficiaries/Medicaid Recipients 	
3. Liability clause in provider grant	<ul style="list-style-type: none"> • Review other state's liability • Dep't of Law input • Involve outside agency to visit Governor/Legislative/Law to change language 		<p>Done</p>	<p>Alaska Mental Health Trust</p>	
4. Allow for co-payment, increase eligibility with co-payee 1115 Waiver, sliding fee schedule	<ul style="list-style-type: none"> • Waiver – set co-payments • Federal approval • Implement waiver 			<ul style="list-style-type: none"> • Legislature – Senate HESS • Consultant- DHSS • Governor's Council on Disability and Special Ed. • Alaska Mental Health Trust Authority 	

Priority #2: Access to Dental Services

The following three strategies were determined by the participants after their thorough review of the issues, ideas, and solutions shared during the morning session.

- 1: Attention to Fee Schedule
- 2: Medicaid Co-Pay
- 3: House Bill #136 Support and Passage

Additional issues, ideas, and solutions generated during the afternoon session:

- ✓ SN dental clinic
- ✓ Case management.
- ✓ Childcare for siblings during appointments.
- ✓ Services available in-state, increase in DEC reimbursement rate.
- ✓ Home visits prior to appointments.
- ✓ Appointments outside traditional hours
- ✓ SN clinics in rural areas.
- ✓ Access to public transportation.
- ✓ Improving quality of care (knowing your patients better).

Children with Special Health Care Needs (CSHCN) Oral Health Forum
 Priority #2: Access to Dental Services

Issue	Proposed Activities/Description	Outcomes	Timeline Start/Finish	Responsibility	Follow-Up
	<ul style="list-style-type: none"> Update fee schedule Review fees periodically 				
	<ul style="list-style-type: none"> Advocate federal law change to allow Medicaid co-pay 				
	<ul style="list-style-type: none"> Get rid of "hold harmless" clause. 				
Support HB 136 Passage	<ul style="list-style-type: none"> Gather info on Bill and disseminate 			Cheri Scott (SSG) Ray Ann (SCF)	
	<ul style="list-style-type: none"> Request the GCDSE track HB 136 	Advocates informed		Kathy Allely (GCDSE)	
	<ul style="list-style-type: none"> Distribute information to CSHCN OH Forum participants 				
	<ul style="list-style-type: none"> Additional training for hygienists to work with CSHCN 				

Priority #3: Education of Parents/Caregivers/Providers

The following three strategies were determined by the participants after their thorough review of the issues, ideas, and solutions shared during the morning session.

- 1: Parent/Caregiver Education
 - ∇ Advocacy
 - ∇ Oral health care
- 2: Design dental experience space
- 3: Promote continuity of care
- 4: Develop a guidebook

Additional issues, ideas, and solutions generated during the afternoon session:

- ✓ Fluoride varnish education.
- ✓ Information to parents on home care/tips that work.
- ✓ Information on recent technology.
- ✓ Parent friendly oral hygiene instruction.
- ✓ Culturally appropriate, respectful care.
- ✓ Parent and child will know what to expect from dentist and appointment and will be comfortable.
- ✓ Education that teeth can last a lifetime!!
- ✓ Parents will know there is a provider for their child.
- ✓ All parents know where to go.
- ✓ Providers adequately treat CSHCN (listen to parent).
- ✓ Education of providers on CSHCN.
- ✓ Advocacy training for parents.
- ✓ Outreach information will be available to all parents – “guidebook” access to oral health care.
- ✓ Education on questions to ask.
- ✓ Information to give providers.
- ✓ A space to experience dental office (Imaginarium)
- ✓ Health fair for CSHCN children and parents.
- ✓ Access to interpreters and educational materials in different languages.
- ✓ Transition from child to adult services – continuity of care.

Children with Special Health Care Needs (CSHCN) Oral Health Forum
 Priority #3: Education of Parents, Caregivers, and Providers of CSHCN (Page 1 of 4)
 Guiding Principle: Teeth **CAN** last a lifetime

Issue	Proposed Activities/Description	Outcomes	Timeline Start/Finish	Responsibility	Follow-Up
Parent/Caregiver Education <ul style="list-style-type: none"> • Advocacy • Oral health care • What to watch for 	<ul style="list-style-type: none"> • Pamphlets 	Parents will have materials (information) to make informed decision regarding care.		Thelia Wood – 269.3499	
	<ul style="list-style-type: none"> • Have a health fair for families with CSHCN 			• •	
	<ul style="list-style-type: none"> • DVD on oral hygiene instruction 				
	<ul style="list-style-type: none"> • Instruction on fluoride varnish 			•	
	<ul style="list-style-type: none"> • Access to interpreters and educational materials in different languages 			•	
	<ul style="list-style-type: none"> • Get materials to schools/ILP to distribute to parents 			•	

Children with Special Health Care Needs (CSHCN) Oral Health Forum
 Priority #3: Education of Parents, Caregivers, and Providers of CSHCN (Page 2 of 4)
*Guiding Principle: Teeth **CAN** last a lifetime*

Issue	Proposed Activities/Description	Outcomes	Timeline Start/Finish	Responsibility	Follow-Up
Dental experience space	<ul style="list-style-type: none"> Develop a non-threatening space for children to experience the dental office 	Reduce anxiety for CSHCN and create a positive dental experience, reduction in parental stress			

Children with Special Health Care Needs (CSHCN) Oral Health Forum
 Priority #3: Education of Parents, Caregivers, and Providers of CSHCN (Page 3 of 4)
*Guiding Principle: Teeth **CAN** last a lifetime*

Issue	Proposed Activities/Description	Outcomes	Timeline Start/Finish	Responsibility	Follow-Up
Continuity of Care	<ul style="list-style-type: none"> • Promote ongoing education regarding transition to adult services • Parent education on requesting same provider for familiarity 	Parent/family satisfaction and decrease in complex dental problems.			

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Children with Special Health Care Needs (CSHCN) Oral Health Forum
 Priority #3: Education of Parents, Caregivers, and Providers of CSHCN (Page 4 of 4)
*Guiding Principle: Teeth **CAN** last a lifetime*

Issue	Proposed Activities/Description	Outcomes	Timeline Start/Finish	Responsibility	Follow-Up
Guide Book	<ul style="list-style-type: none"> • Develop materials (i.e. step-by-step resources book) 	Parent/family satisfaction, timely access to appropriate care.			

Notes From the Brainstorming Session

The following pages represent the brainstorming ideas and thoughts generated by the participants in the seven priority areas, (Preventative Services, Surveillance, Finance/Medicaid, Provision of Dental Services, Dental Workforce/Training Issues, Access to Dental Services, Education of Parents/Caregivers/Providers) as well as solutions mentioned during the morning session. It is the intention of the group that these notes are to be held for future work on the CSHCN Oral Health Plan.

An evaluation summary can be found at the end of this report.

Preventative Services

- Care coordination is an ongoing parental/caregiver need. (needs to be delegated).
- Combined dental with other procedures when children are under general anesthesia (noted concerns with long procedures, however Dr. Singleton noted some success with diagnostic procedures and dental)
- Coordination of medical and dental services for hospital-based care (e.g., under general anesthesia) is not always feasible but cases where it can be coordinated (See above).
- Need for a resource list for parents - updated and kept current.
- What can we do to get general dentists engaged?
- Ideally pediatricians seeing CSHCN should be working closely with the dentists seeing these children. Connection between medical providers and pediatric dentists is pretty good but some examples that indicate need for greater awareness of pediatric dentists in treating CSHCN (possible Grand Rounds topic.)
- Pediatric Dentists may not be the sole solution. Need to look for ways to inspire and encourage more general participation for children and adults with special health care needs/disabilities.
- Medical/dental home "on campus" assists coordination of care (e.g., tribal programs)
- Interaction between Pediatric Dentistry is improving, strengthening with time.
- Noted concerns with prescribing medicines with sugar content, however want medicines that child is cooperative in taking (taste good).
- Noted concerns with fluoride or chlorohexidine rinses if child swallows the rinses.
- Train parents/caregivers on application of fluoride varnish for caries prevention (simple to teach painting the fluoride varnish on teeth.)
- One stop for dental needs (CSHCN Clinic) is a model used in some states (e.g., Pennsylvania). Likely an expensive model to pursue in Alaska to address CSHCN or adults with disabilities oral health issues.
- Repetitive treatment/repetitive visits – parents noted long wait times for both the dental visit and often once they are in the dental office (this can conflict with days the child is cooperative for dental treatment.)
- Advocating for increased dental rates (Medicaid) – could be a significant factor for continued dental practice participation in Medicaid.
- Other potential advocates for dental care for CSHCN include speech therapists and language/OT.
- Advocacy in the form of Parent Navigation for Native families.
- How to be a responsible patient – importance of keeping appointments (although group thought this was less of an issue with CSHCN due to difficulty getting appointments – but noted times when other medical issues/emergencies result in problems keeping appointments.)
- Continuity of care – seeing the same dentist each time means not having to utilize the first appointment time explaining the child's condition, medications and history.
- The aging of dentists! – 25% of the workforce is age 55 and older and Dr. Singleton noted a similar distribution for pediatric dentists in Alaska (may be less access with retirements).
- Would like to hear what strategies work and what continues to be frustrations to help not only those that are highly motivated but others lacking these strategies.
- Private practitioner. Some private dental specialists are concerned about being promoted as the only specialist in his field who accepts Alaska specialists statewide for Medicaid patients and/or CSHCN (they feel they can handle their urban area but not statewide referrals.)

Surveillance

- Getting water fluoridation information to parents and providers.
- In sub-specialty and Neurodevelopmental mental clinic settings, start tracking incidence of dental cavities/hygiene issues. (Already noted in report – add to monthly report to WCF section.)
- Medicaid patient satisfaction survey.
- Parents of children utilizing a fluoride program without living in communities with fluoridated water.
- Survey percentage of children with healthy habits:
 - Tobacco
 - Soda pop
 - Candy
 - Bottle health
 - Nutrition



Finance/Medicaid

- Medicaid is working on a more quick turn-around time
- Medicaid problems have not changed much the last few years – still areas of the state with few private dentists participating in the program.
- No shows (non-kept appointments) are a huge loss to everyone. They cost provider's downtime, restrict access to orthodontia. None in private practice in Fairbanks that accept care when providers reduce Medicaid participation and the children don't get services.
- Tracking non-kept appointments in MMIS – Have discussed using a dental code to track "no-shows" in the claims processing system (e.g., use of D9999) without a reimbursement.
- Examples of practices with low "no show" rate with phone call reminders and other efforts to remind parents/caregivers and/or policies to discontinue seeing patients with repeated no shows. However, other examples of no show rates in tribal programs of 50-60%. No shows are likely a real (not just perceived) problem for dental offices.
- Shriner's Hospital in Portland: Some parents have found additional accesses and services they could not get in-state at Shriner's Hospital. Medicaid offers assistance with parent's travel – Shriner's assisting with other expenses. Noted services outside Shriner's hospital are usually charged for and can be expensive.
- Rotational dentists not willing to work with Medicaid.
- Access to orthodontia - None in private specialty practice in Fairbanks that accept Medicaid.
- Private insurance may not cover ortho care; Medicaid only covers in specific circumstances (with cleft palate or Class III malocclusion and orthognathic surgery.)
- Routine access to dental services – Medicaid.
- Delayed cleft palate treatment (Fairbanks). No orthodontists in Fairbanks participating in
- Eligibility month-to-month (Medicaid) – problems when by the time the child gets an appointment they are not eligible for Medicaid.
- Reasons given for not getting involved in Medicaid:
 - Non-kept appointment issue; resulting loss of productivity and practice revenue.
 - Reimbursement issue – Medicaid reimbursement typically at 40-50% of billed charges.
 - Liability concerns – language in the Medicaid provider agreement indicating provider is responsible for any state legal costs if the state brought into Medicaid related lawsuits
- Medicaid reimbursement for most dental services has not increased since 1999 using 1997 claims data (10 years from current rates).
- Some states (e.g., New Mexico) provide a case management fee in addition to dental Medicaid reimbursement to compensate providers for additional time treating CSHCN in their dental offices.
- Most dentists enrolled in Medicaid as the program has not dis-enrolled providers that are not active – about 50-70 private practices participate in Medicaid at a level of \$10,000 + in paid Medicaid claims (most pediatric dentists are high-end Medicaid providers)
- Bills to watch: increase in DKC with co-pay. 200-300% poverty.
- Excess Medicaid receipts (at \$10,000) most in Anchorage, 3 Fairbanks, 1 Bethel, 1 S.E., 2/3 from Anchorage.
- Confusion between Denali KidCare and Medicaid perception! Some providers indicate they accept DKC but not Medicaid (DKC is a higher income group under SCHIP but it is a Medicaid expansion)
- Review of DKC dental utilization indicates children in these higher income families have greater dental access than the traditional Medicaid program (Title XIX).

Medicaid.

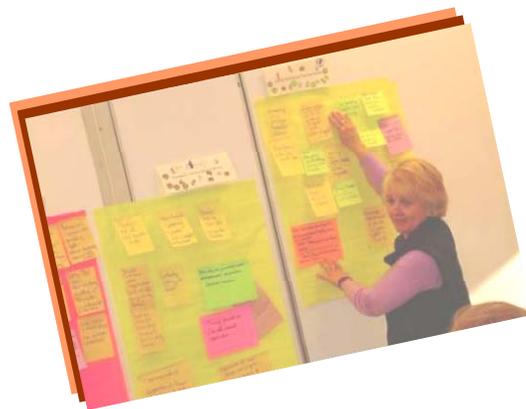
Provision of Dental Services

- Parents/caregivers feel like second class citizen in some provider offices – perception they are “taking from the system.”
- Some parents have experienced long wait times in provider offices – other children coming later that were seen first while they were kept waiting.
- Going out of state is a real burden. Locally who is available? Many doctors are booked way ahead.
- Getting a large wheel chair into a clinic environment – dental operatory can be a barrier to care.
- Rural issues: once they come to town, going to the appointment. No rural care.
- Rural issues: Services that are available in Anchorage are often not available in rural areas. Some rural families are unwilling to relocate family/child to Anchorage for long periods of time for surgeries (e.g., cleft palate cases).
- Challenging settings can create behavior problems and/or fearfulness - noise (drills, others crying, etc.)
- Dental care is one of many issues in the child’s life, yet they are all linked.
- Many schedules and situations have to line up to get care: provider scheduling, work, child care availability for other children, medical appointments and a day that behavior/compliance is not going to be an issue.
- Difficult to get all issues diagnosed. Costs are high.
- Need to have everything in order to receive treatment; paperwork, timing, schedules, and child’s temperament/willingness.
- Multitude of appointments for CSHCN – parents must prioritize children’s appointments.
- Dental access typically Monday through Friday services only – few dental providers have Saturday hours.
- Barriers: big systems, no routines and scheduling patterns.
- Don’t focus only on what is available in Anchorage. Rural areas have oral health issues.
- Poor water quality in some rural Alaskan communities - easy to drink soda or fruit drinks instead. Sugar → cavities.
- Pediatric Dentistry requires more training (additional time and debt for extra years training in this specialty.)
- Pediatric dentists are typically high-end Medicaid providers and the major source of dental care for CSHCN. ANMC-Southcentral Foundation, with support from Lutheran Health Systems, has started a hospital-based pediatric dental residency program that offers great potential for increasing the number of pediatric dentists in Alaska (currently 13- 14 pediatric dentists.)
- ANMC-Southcentral Pediatric Dental Residency Program trying to build a good foundation of education/training for treatment of CSHCN.
- Training of general dentists to see CSHCN and/or adults with disabilities may be the

issue limiting access to these providers.

Dental Workforce/Training Issues

- University clinic will have access for CSHCN.
- Free training: NMC Oral Health Association (or is this the MCH National Oral Health Resource Center training?).
- Use community based entities to raise awareness of dental issues and do screenings. Example – beautician trained about strokes.
 - Church BINGO, Daycares, Message on date stamp on photo
- Examinations: How do we do this on a regular basis? What is frequent? CSHCN need may need more frequent exams.
- Are there good textbooks that focus on CSHCN?
- Training for dental assistants and dental hygienists/hygienist also important. Expose students to CSHCN especially in the child’s home setting.
- Private specialty practice (orthodontists) do not want to take Medicaid cases outside of Anchorage hub clients (stated they can’t be the referral center for the entire state.)
- Knowledge has decreased with fluoride in water systems in rural Alaska.
- Start with easy first, and then move on to more complex!
- Training and expertise needed within state – look at services that CSHCN are having to go out-of-state for (e.g., Shriner’s Hospital).
- Instill in students the “service” belief skill set. Sense of responsibility.
- Community Health Aide training program (include dental). Possible to increase preventive services in rural Alaska – assist parents/caregivers.
- Educating providers: sensitivity training.
 - Are they ready to provide compassionate care?
 - Do they have the time?



Access to Dental Services

What action steps will be necessary to get there?

- ✓ Study other states' action plans (PA and NM) for SN Dental Clinic.
 - ✓ Explore the possibility of regional hubs.
 - ✓ Explore funding around case management.
 - ✓ Distribute information on HB 136 (rroyer@scf.cc)
 - ✓ Seek funding source.
- Mobile units: just imagine the potential – assist with home based dental services, topical fluorides, etc.
 - Home/house calls. More at ease at home, familiar and practical for child (children often fearful and leads to behavior difficulties in the dental office.)
 - University dental assisting/hygiene school is a good resource – could be used to assist more (e.g., appointments for cleanings.)
 - Engaging dental hygienists with CSHCN.
 - Move out into community.
 - Supporting HB 136 as a potential for dental help coming to you (bill to allow for more hygiene functions under general supervision in underserved settings.)
 - Goal: Blessing of dental society and/or Board of Dental Examiners to support traveling dental hygienists.
 - Someone to help – just to figure all this out (parent resource and/or case managers)
 - ANMC residency program has seen increase access to care. Months to 2-3 weeks.
 - Dental “presence” in the community is seen as extremely important.
 - Supports in place for families: assistance with Medicaid enrollment, getting to appointments, etc.
 - Surgeries/appointments on Saturdays, evenings would help.
 - Finding providers who take Medicaid and will see CSHCN.

Education of Parents/Caregivers/Providers

- Parent's education of oral health needs.
 - Sugar in medications – are there alternatives that still taste good.
 - Recognition of enamel caries
 - Training on use of fluoride varnish
 - Monitor and assist with brushing
 - Use of battery operated toothbrush and/or floss aides
- Parental confidence with approaches – assisting brushing, fluoride varnish and other preventative measures.
- Transportation: more flexible appointment times, consideration of medications and behavior (am or pm better.)
- Non-English speaking parents.
 - What is available to help them?
- Constantly putting out fires – need assistance managing given medications, other medical appointments, transportation issues, etc. – case management assistance.
- Parents having skill sets.
 - We are the teachers.
- Some studies indicating CSHCN have two times more unmet oral health needs.
- Children often not seen prior to five to seven years old. No access for young – DKC issue (referral by age one) and provider issue with accepting younger children.
- Exams can be more difficult for children under three years old.
- Questions from health providers about compliance.
- Multiple developmental issues:
 - Swallowing
 - Choking
 - Gastroesophageal reflux
 - Gag reflex
 - Difficulty brushing/flossing
- Behavioral issues with brushing teeth: Where's the priority? Shoes on? Teeth
- Daily start over – battling with not wanting anything in their mouth. Parents often have to do what they can at the time – can't always get everything done especially on days when child is not cooperative. (Do what you can at the time.)
- More than one generation with developmental disabilities (parents and children) – complex issues in families with more than one child and/or adult with a disability.
- Education of new Medicaid eligible clients regarding value of appointments and physicians, dentists, AMP, etc. Importance of keeping appointments.
- Literacy programs for dental care include; Asian, Hmong, Alaska Native, Am. Indian, Hispanic, Hawaiian/Pacific Islanders, African American/Black, etc.
- Dental decay and relation to other chronic diseases (e.g., diabetes.)
- Medications – sugar content, decrease saliva flow and/or hypertrophy of gingival (dilantin seldom used anymore).
- Exposure to general anesthesia – sedation.
- Education and linkages: oral health issues can affect speech and language development. Also, may affect dietary choices.
- Parent housing/assisting children from rural Alaska has seen a number of children that have never had a toothbrush in their mouth. Hard to get them to start brushing if the habit hasn't been established – tries integrating them in with when other children are brushing.
- Risk issues:
 - Child safety
 - Provider safety
 - Environmental safety
- Oral issues and medications. Have adverse

brushed?

conditions.

Solutions – Mentioned in Morning Session

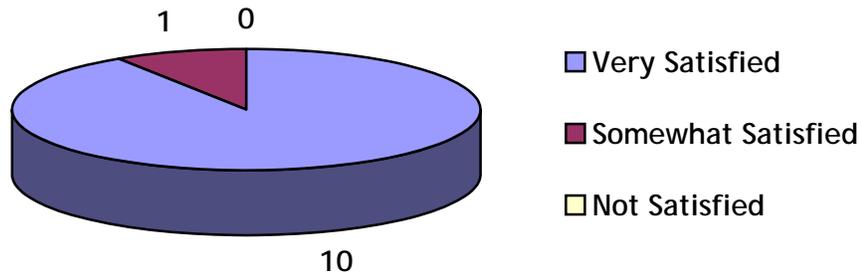
- Fluoride varnish – training of parents; done by medical providers; fluoride varnish is Medicaid reimbursable for dental providers but not medical providers at this time.
- Teeth should be a higher priority for CSHCN – often overwhelmed by medical concerns and medications!
- Mobile units: just imagine the potential.
- Governor’s Council is willing to work on dental care health issues.
- 13 Pediatric Dentists in Alaska.
- Asking parents on oral health practices – what has worked (e.g., fluoride rinses, battery-operated toothbrushes, etc.)
- Limited funding is available at federal level. Need for more research on products, what works, etc.
- Supporting House Bill 136 as a potential for dental help coming to you – bill authorizing more dental hygienist practice under general supervision.
- Streamlining takes time and patience.
- University dental assisting/hygiene school is a good resource – could be used to assist more (e.g., appointments for cleanings.)
- Dental “presence” in the community is seen as extremely important.
- Identify patients and help with community dental care needs as a community issue.
- Incentives for prevention.
- Supports in place for families, Medicaid, getting families to services on time; use of a navigator.
- Transition from child to adult dental services.
- Finding providers who take Medicaid. Donated dental program offers some access (includes donated lab fees in addition to treatment.)
- ANMC residency program has seen an increase access to care: months to 2-3 weeks.
- Dental health fair for CSHCN and their parents (families)
- MH Trust involved with oral health care issues.
- Surgeries and/or dental appointments on Saturdays or evenings would assist parents/families.
- Most dentists are enrolled in the Medicaid program – but only 50-60 private practices participate at a significant level in the program.
- Someone to help; just to figure this all out.
- Familiarity with the same provider. Assists in provider working with child, can assist in child cooperation/comfort with dental office and avoids repeating long medical histories.
- Coordination of services.
- Dedicated time from beginning to end of the process.
- Mobile dental care.
- Interpreters for families.
- A manual for dental health care for CSHCN
- Guardianship for adult CSHCN.
- Medicaid is key to supporting our adoptive children.
- Imaginarium has a pretend dental suite.
- Home/house calls. More at ease, familiar and practical for child.
- Getting dropped. I don’t know everything.
- A space to experience the dental office. Get children comfortable with the dental environment without using appointment time for that.
- Need more available resources to assist with home care, working with dental

- offices and parent information.
- Some solutions may be simple – Smiles say it all.

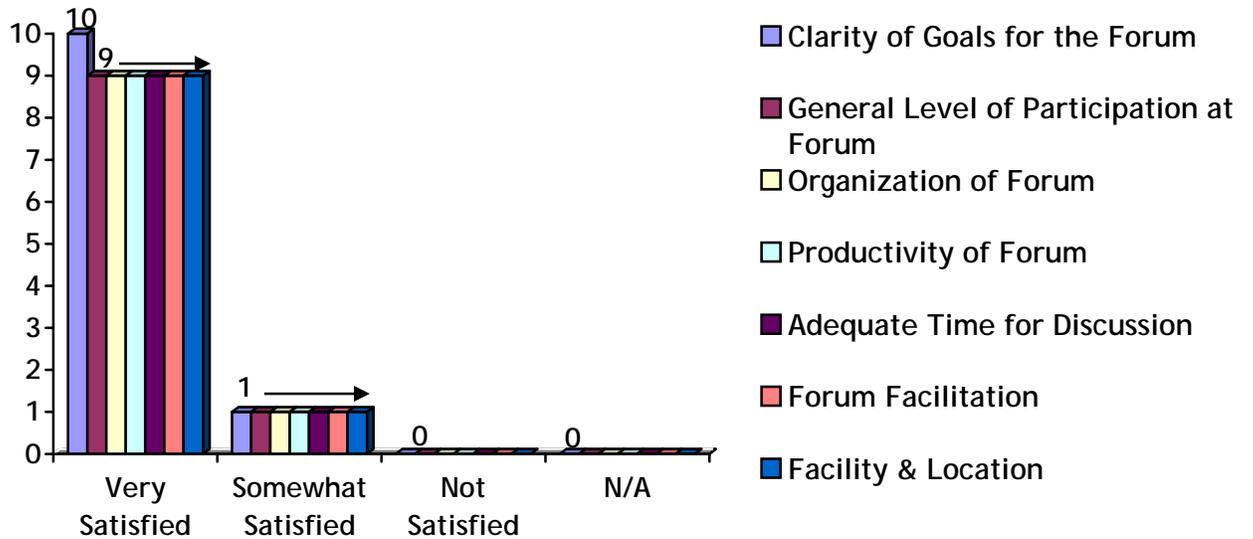
CSHCN Forum Evaluation

Total Evaluations Collected: 11

What was your overall reaction to the CSHCN Forum?



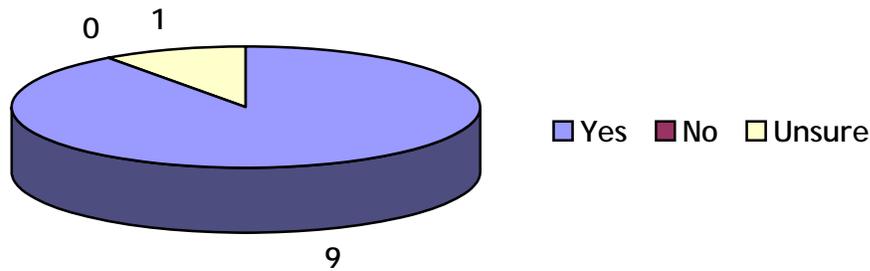
Please rate the following:



Comments:

- Creative and interesting; proactive discussion
- Rushed for a one-day meeting, but overall good participation and energy.
- Great job, Charlie!
- We covered a LOT of ground. Thanks for the great facilitation.
- Good location, but cool in the room.

Was an agenda provided before the meeting?



Were materials provided during the meeting?

Yes (10)

If yes, were they useful?

Yes (10)

Why/Why not?

- Fun!
- Survey information helpful
- Good overview of issues
- Made it easier to take notes
- Identified the issues
- Sticky notes 😊

Was the presentation(s) informative and useful?

Yes (10)

Why/Why not?

- Gave a good perspective
- As pertains to needs (real needs, at hand)

Was the afternoon discussion informative and useful?

Yes (9) No response (1)

Why/Why not?

- Round table should identify one facilitator and have more organization. May identify experienced facilitators to each group prior to the assignment.
- I wish we had stayed
- A little too much downtown
- Some dip in energy but okay
- But hard to narrow down a top priority
- It made us look at how discussion could become “real”

Would you be interested in a follow up meeting to work on an Action Plan?

Yes (9)

No response (1)

Suggestions for future meeting topics:

- Work on priorities and action plan as a group, not roundtable
- Successes and failures of action plans
- Need to get most of the same people back so didn't have to revisit issues
- Follow-up meeting to inform on progress

Other Comments/Suggestions

- Include rural area providers and community health aides and families; outside professional groups
- Thank you!