PA: 161 - Public Dental Prevention Program Survey

Conducted by the Michigan Department of Health and Human Services-Oral Health Program and the Michigan Caries Prevention Program.

July 2015

Prepared by Altarum Institute

ACKNOWLEDGEMENTS

INTRODUCTION AND METHODS

In the spring of 2015, PA 161: Public Dental Prevention Programs (PA 161 programs) were invited to participate in a survey administered by both the Michigan Department of Health and Human Services (MDHHS) – Oral Health Program and the Michigan Caries Prevention Program (MCPP). The survey was designed to identify areas of need and barriers for Michigan's PA 161 programs.

An email was sent to 89 PA 161 program contacts on June 22, 2015 inviting them to participate in a survey. The email contained a web-link to the survey and a brief explanation of what the survey entailed, encouraging programs to participate. Two additional email reminders were sent to the contacts on July 6th and July 10th. The survey concluded on July 13, 2015.

Out of the 52 PA 161 programs in the state, a total of 38 unique programs responded. Six programs were excluded based on inclusion criteria, because they do not provide care to children ages 0-17, or had incomplete data. The overall response rate was 36%. The following analyses are based on the 32 responses that fulfilled the inclusion criteria.

This summary will report the findings of the July 2015 PA 161 survey. Table 1 provides a profile of the respondents and their corresponding credentials. The majority of respondents identified as Registered Dental Hygienists (RDH). The remaining results are listed as follows: Directors within their PA 161 program, Other (Community Outreach Coordinator, Oral Health Coordinator, Dental Assistant/Clerk, and Registered Dental Assistant); Master of Science in Education (MSEd); Registered Dental

Table 1. Profile of the Sample of Survey Respondents	
Credentials	**% Overall**
RDH	50
DDS/DMD	6
MSEd	9
RDH/RDA	9
Director	13
Other	13

Hygienists/Registered Dental Assistants (RDA); and Doctor of Dental Surgery (DDS)/Doctor of Dental Medicine (DMD).

## BACKGROUND: PA 161 Public Dental Prevention Program History

The 1978 PA 368 – Public Health Code was amended by PA 58 of 1991. Initially, it was changed to address a concern among local health departments regarding prevention programs, such as fluoride rinse programs in summer camps. In 2005, it was amended to include schools and

nursing homes. It also deleted a section on funding requirements. On October 5, 2005, legislation was passed by the State of Michigan 93rd Legislature and Governor Granholm signed Public Act 161 of 2005. This allowed public, non-profit entities, schools, and nursing homes the ability to administer a program of dental care to a dentally underserved population. A public entity may be a federal, state, or local health agency (commonly Health Departments). A non-profit entity may be an organization, who has non-profit status from the State of Michigan, or 501(c)3 status given by the Federal Government – Internal Revenue Service (IRS).

The public or non-profit entity shall apply to become a PA 161 program and may employ, or contract with at least one dentist and one dental hygienist. The PA 161 program is approved for a 2-year period. A dental hygienist may perform dental hygiene services under the supervision of a dentist. There is no change in licensure for the dental hygienist, only a change in the supervisions of the delegated dental procedures for a dental hygienist listed in the Administrative Rules of the Michigan Board of Dentistry. A dental hygienist may only perform preventive procedures to unassigned patients, limited to a dental assessment, dental prophylaxis, application of fluoride and/or dental sealants, nutritional counseling, patient education and tobacco cessation.

RESULTS: Length of PA 161 Operation

The majority of providers that responded indicated that their PA 161 program has been in operation for several years, with 7 or more years being the most frequent response. See Graph 1 for results in number of years PA 161 programs have been in operation. Nearly 38% of providers that responded indicated that their PA 161 program had been in operation 3 years or less, with the remaining 28% of providers' programs in operation 4 to 6 years.
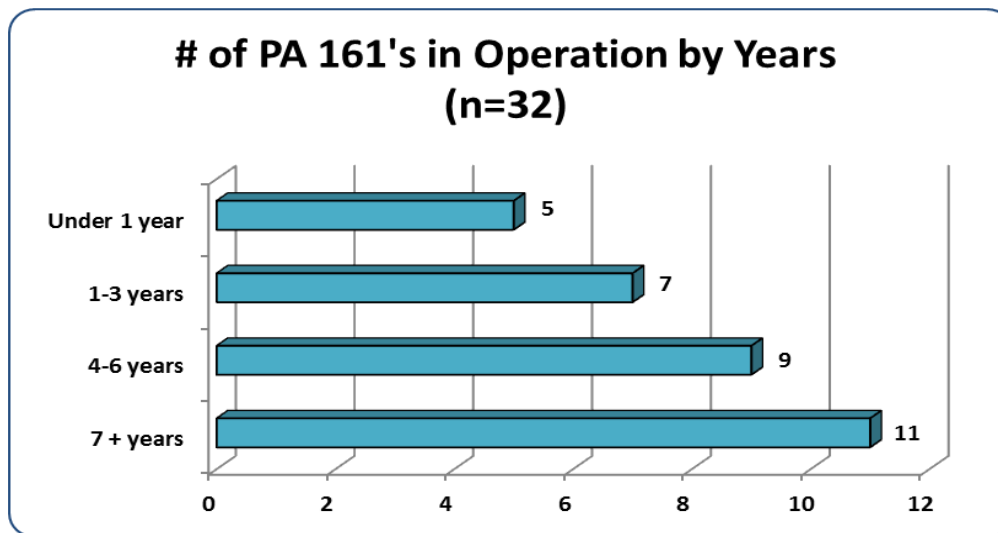
Graph 1. Length of PA 161 Program Operation

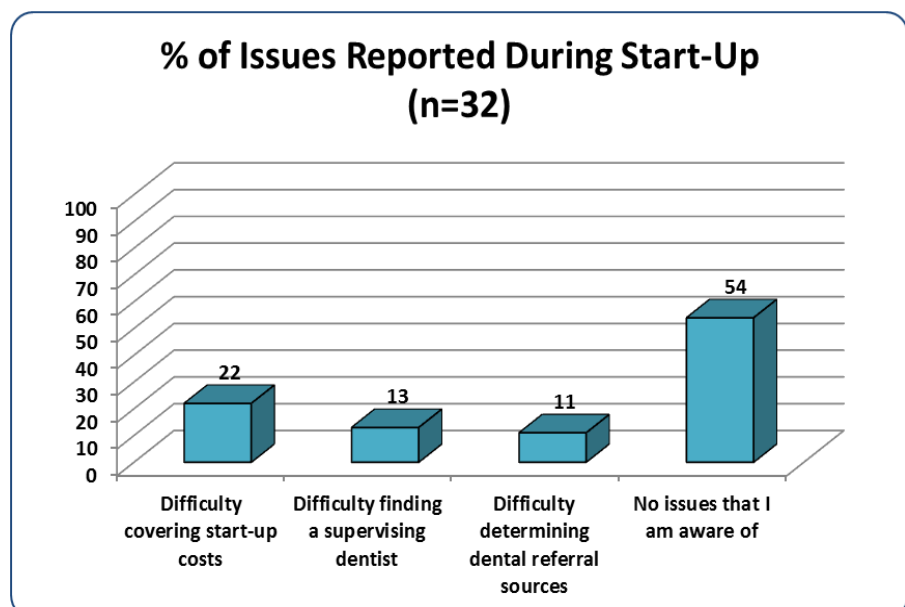## RESULTS: Number of Registered Dental Hygienists Employed

When asked how many Registered Dental Hygienists (RDH) are employed in each PA 161 program, Graph 2 displays the responses submitted by each participant. Although the amount of RDH's employed may be correlated with the size of the PA 161 program, the majority of participants indicated that they employ between 1 and 3 RDH's.

# of RDH's Employed Per Practice (n=32)

- 0 RDH: 2
- 1-3 RDH: 22
- 4-6 RDH: 3
- 7+ RDH: 5
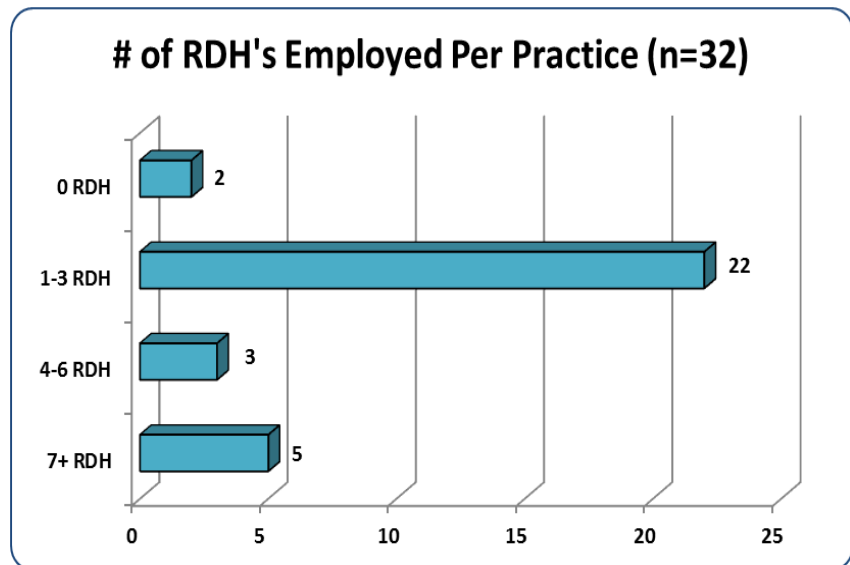
Graph 2. Number of Registered Dental Hygienists Employed within Each PA 161 Program

RESULTS: Issues Identified During PA 161 Program Start-Up

Participants were asked, "What issues, if any, did your PA 161 program have during start-up? Please select all that apply." Graph 3 displays that all 32 participants answered the question, with some selecting multiple responses. More than half (54%) indicated they were unaware of issues during the start-up of the PA 161 program. Two respondents indicated through open-ended responses that they were not part of the program when it started and they provided services prior to becoming a PA 161. This could be in part why such a large majority indicated they were unaware of any issues. Open ended responses from participants further detailing difficulties include:

% of Issues Reported During Start-Up (n=32)

- Difficulty covering start-up costs: 22
- Difficulty finding a supervising dentist: 13
- Difficulty determining dental referral sources: 11
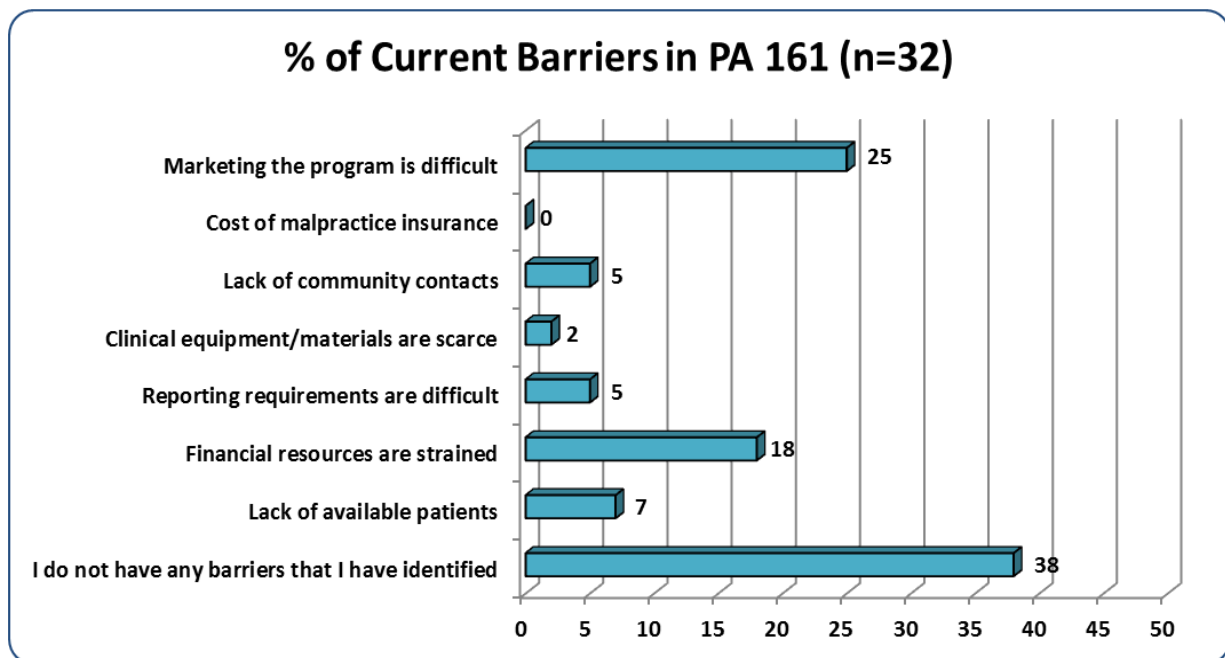- No issues that I am aware of: 54

Graph 3. Issues Identified During Start-Up of PA 161 Program

- Marketing to the community
- Obtaining support from community dentists
- Getting enrolled with insurance companies
- Purchasing dental software for billing
- Understanding basic rules and regulations for PA 161
- General confusion starting a new program
- Getting schools to participate and parents and caregivers to sign up children for services
- Equipment transportation
- No reimbursement with managed care agency for services provided, such as oral assessments

RESULTS: Current Barriers Identified Among PA 161 Programs

Graph 4 below shows the percentage of barriers that participants currently face within their PA 161 program. The main barriers indicated in Graph 4 include:
- Providers do not have any barriers they are currently aware of
- Marketing the PA 161 program is troublesome
- Financial resources are an issue

% of Current Barriers in PA 161 (n=32)

Barrier	Value
Marketing the program is difficult	25
Cost of malpractice insurance	0
Lack of community contacts	5
Clinical equipment/materials are scarce	2
Reporting requirements are difficult	5
Financial resources are strained	18
Lack of available patients	7
I do not have any barriers that I have identified	38

Graph 4. Current Barriers Identified by PA 161 Programs

Although 38% of responses indicated that they were not familiar with any current barriers, several open ended responses identified obstacles not provided as an option in the survey.

Nearly 19% of participants expressed difficulties surrounding parent involvement with either paperwork (permission slips, information about program, follow-up, etc.), or investing in the importance of children's oral health treatment needs. Further, additional concerns about patient participation were:

- Difficulty getting children signed up for the program in schools
- Competing against other PA 161 programs in the area
- A decrease in patient numbers with Healthy Kids Dental
- Increased dental homes leading to a reduction in participation in school based oral health programs.

## RESULTS: Current Care Settings, Desired Care Settings, and Barriers Expanding

Participants were asked to indicate in which settings their PA 161 program provided preventive oral health services to children ages 0-17. Graph 5 below displays the responses, with schools (32%) and early head starts/head starts (28%) greatly outranking the other settings. Additional settings indicated in open-ended responses include:

- Salvation Army
- Day Care
- Health Fairs
- Facilities helping compromised females (girls, women, and children)
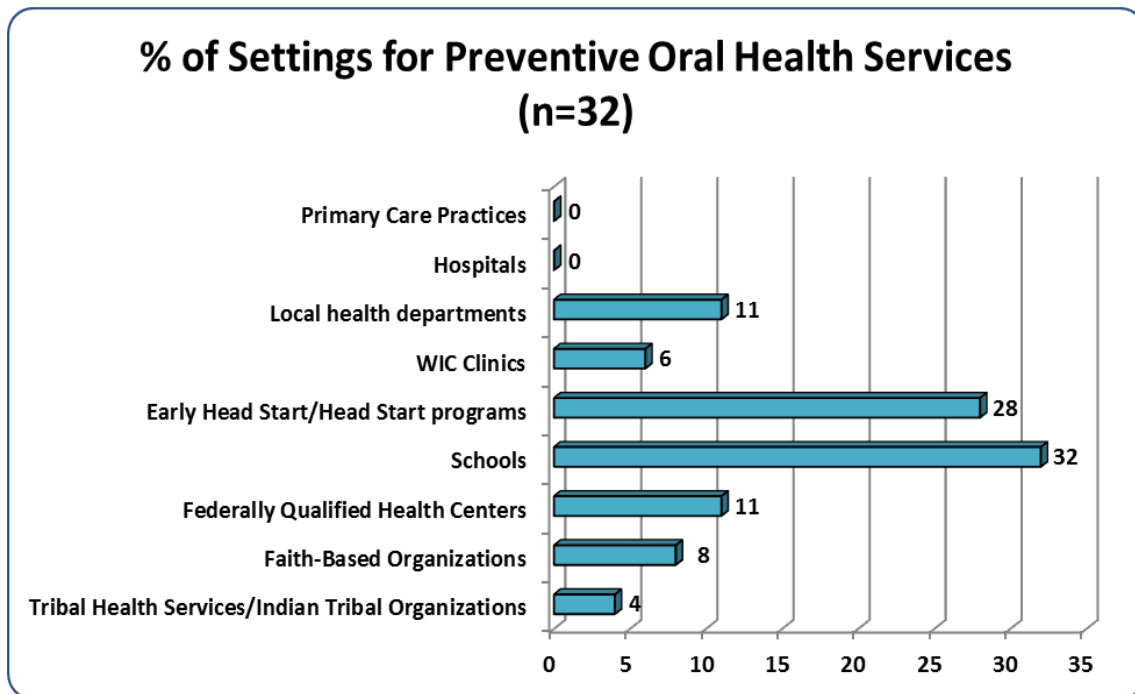
Graph 5. Settings where PA 161 Programs Provide Services

Survey respondents were asked which additional settings they would like to expand to. Nearly a third (27%) of participants specified that there were no additional care settings they wished to expand to at the time they took the survey. The previous question revealed that among the respondents, there were no PA 161 programs that currently provide care in primary care practices or hospitals, but several respondents expressed a desire to expand care into those settings (12% and 7% respectively). Graph 6 below details the percentage of additional care settings PA 161 providers would like to expand to.
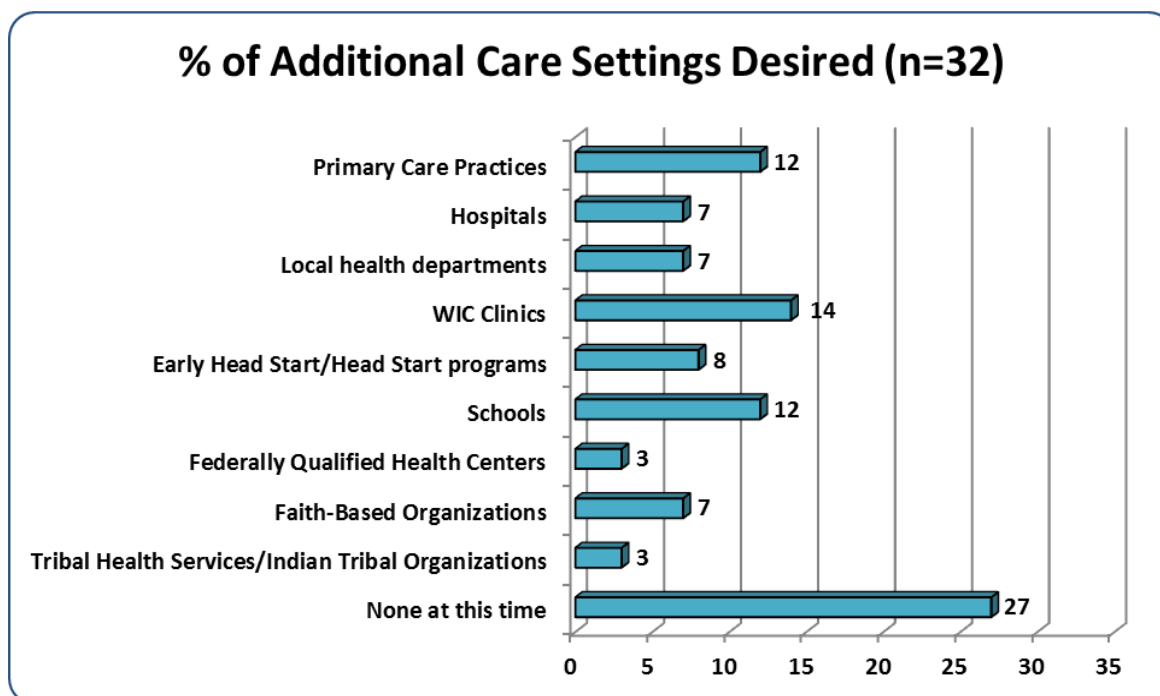
**Graph 6. Additional Care Settings Desired by PA 161 Programs**

Participants were asked to identify barriers, if any that may exist while trying to expand to additional settings (see Graph 6). Almost half (46%) of respondents selected, "Lack of connections in those settings" as the primary barrier in expanding current service settings. Open-ended responses included two additional obstacles:
- Language barriers
- A disconnect with knowledge of oral health as part of systemic health; making it difficult to expand in medical community settings

RESULTS: Preventive Oral Health Service Offerings, Desired Services, and Barriers Expanding

Survey participants were asked, "What type of preventive oral health services does your program provide to children ages 0-17? Please select all that apply." There was a fairly even

distribution between the four preventive service option offerings as displayed in Graph 7 to the right. Two additional categories of services offered transpired in open-ended responses: oral health education and referrals.
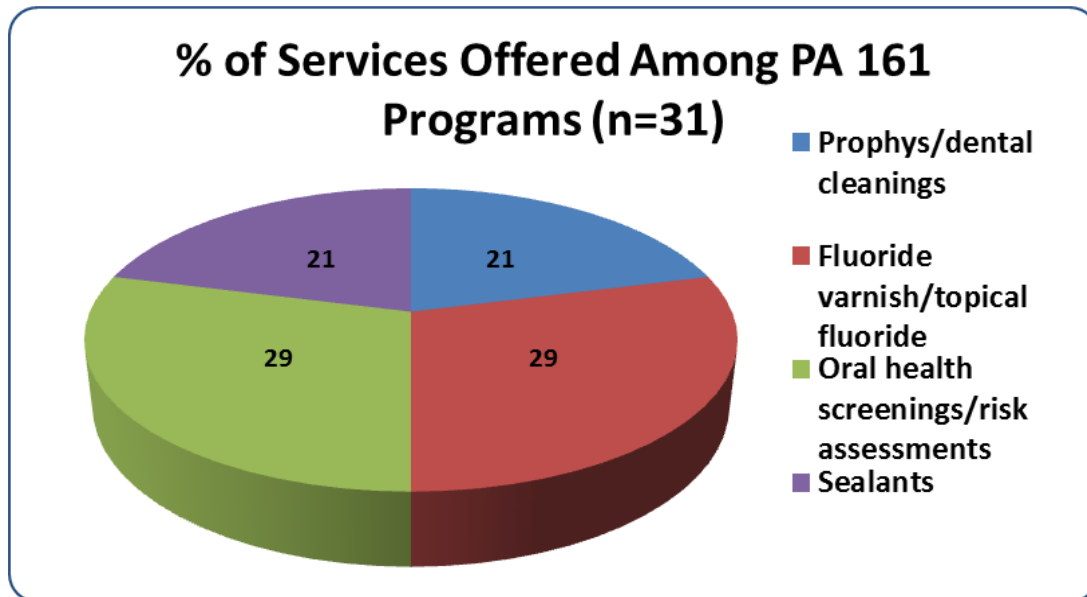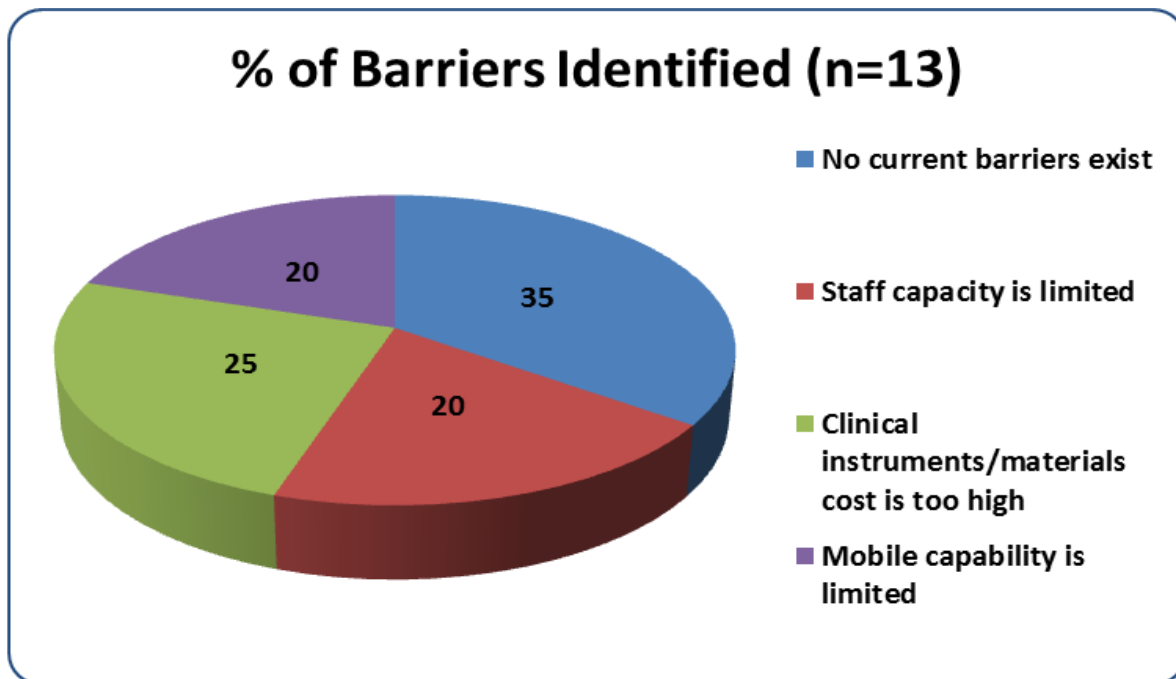

Graph 7. Percent of PA 161 Programs that Offer Identified Preventive Services

After indicating what services their PA 161 program provides, survey respondents were asked which additional services they would like to offer. More than half (58%) of participants expressed that their program already offers all preventive oral health services, while 29% did not wish to add any additional program services (see Graph 8). Although 13% wished to add sealants, there were no programs who chose prophys/dental cleanings, fluoride varnish/topical fluoride, or oral health screenings/risk assessments as services they would like to additionally offer.
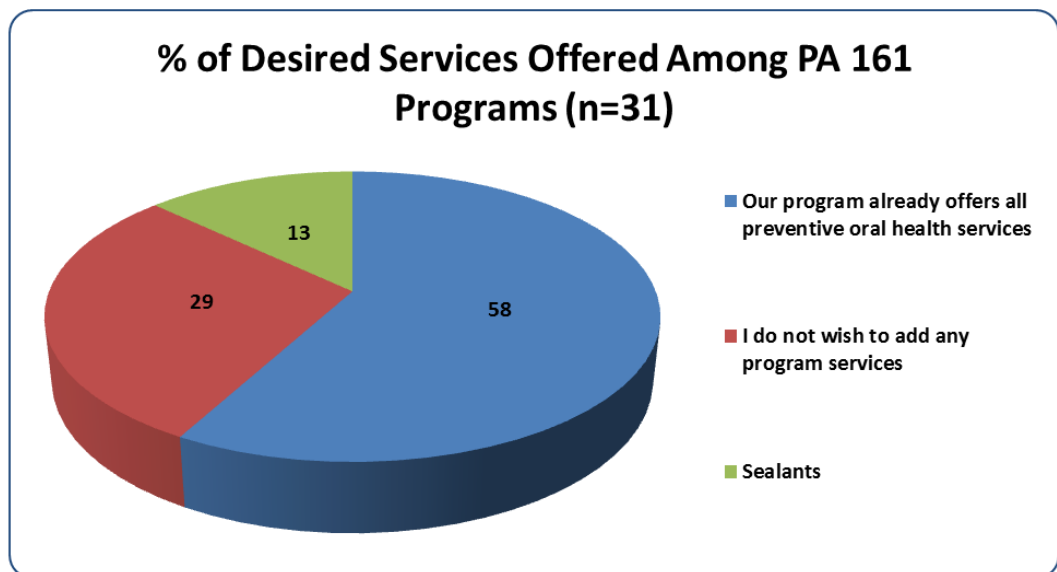
Graph 8. Percent of Desired Services Offering among PA 161 Programs

% of Barriers Identified (n=13)

- No current barriers exist
- Staff capacity is limited
- Clinical instruments/materials cost is too high
- Mobile capability is limited

35 · 20 · 25 · 20

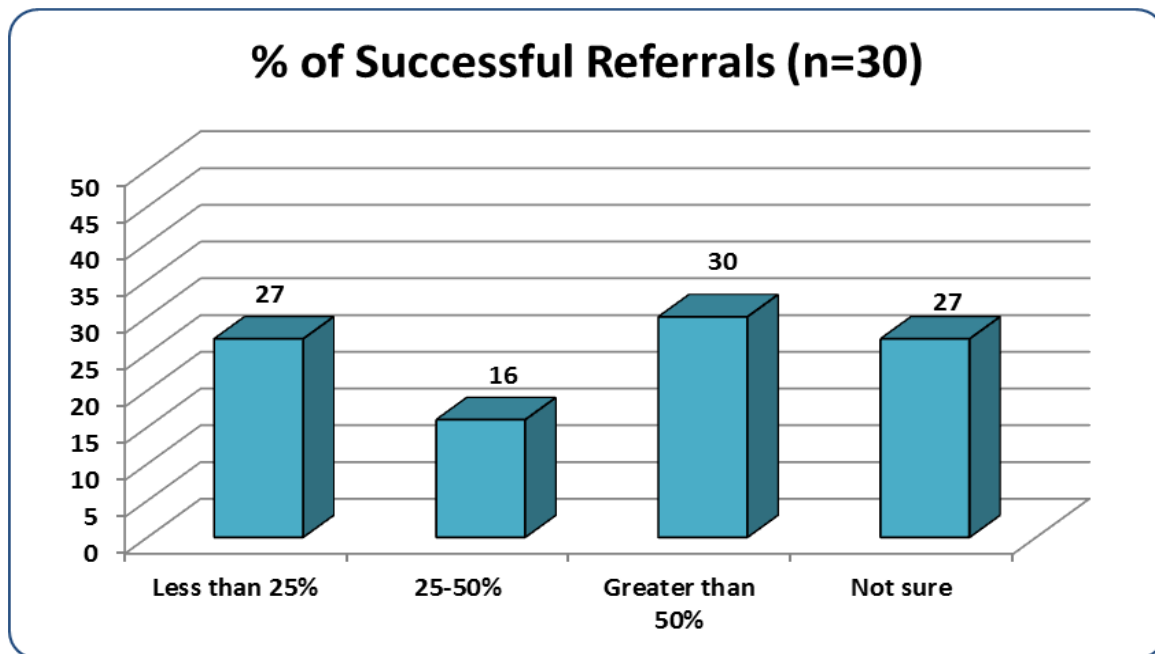**Graph 9. Percent of Barriers Identified by PA 161 Programs to Expanding Service Offerings**

Similar to barriers with expansion of service settings, barriers may exist while trying to expand the preventive services listed in the previous two questions. Respondents were asked to identify which barriers, if any would be a burden. The responses (shown in Graph 9) were fairly consistent, with "No current barriers exist" as the most common response (35%). The number one barrier identified by respondents was that clinical instruments and materials were financially burdensome. One participant also indicated in an open-ended response, two challenges to expanding preventive oral health services to their program were finding dentists who accept Healthy Kids Dental Insurance and are willing to support PA 161 programs as a supervising dentist.

RESULTS: Referral Completion, Barriers, Tracking Systems

Ensuring referred patients receive the treatment can be challenging. Participants were asked: "Looking at the total number of children (ages 0-17) that your PA 161 program serves over a 6 month time frame, approximately how many of the patients who are in need of dental treatment receive it once you make a referral?"
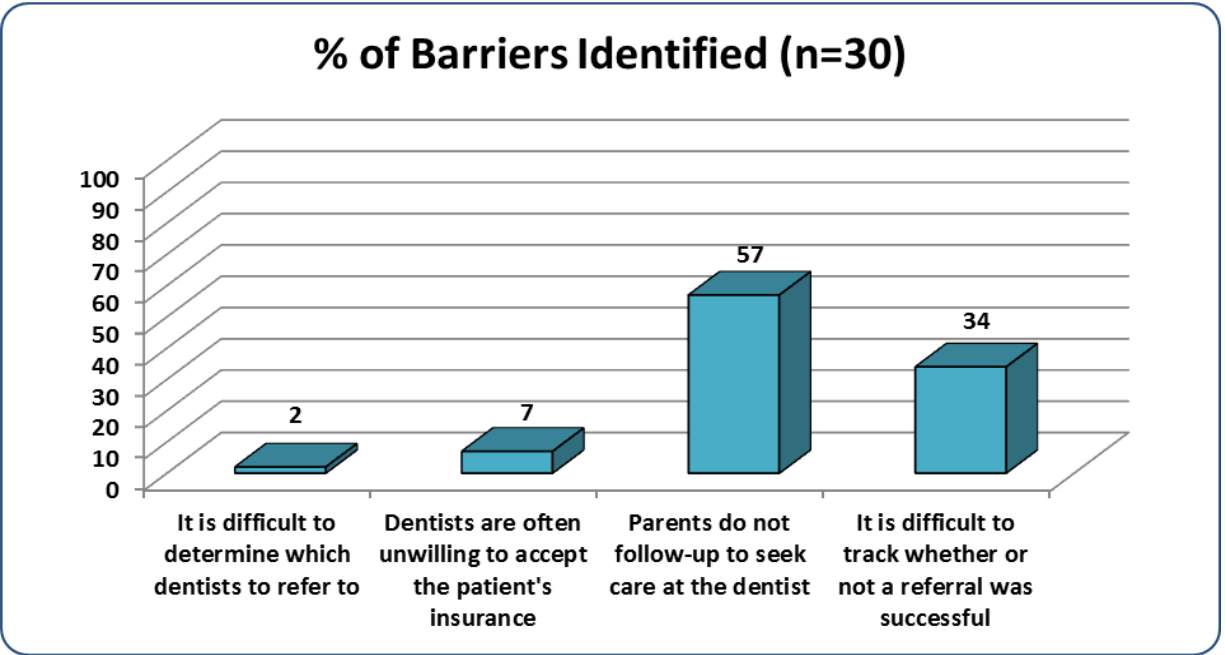
Responses (shown in Graph 10) were split with 27% reporting that less than a quarter of their referrals are successful and 30% indicating that over half of their referrals resulted in patients

receiving needed care post-referral. A notable 27% indicated that they were unsure as to whether or not their patients successfully received the treatment needed. Various reasons could explain the uncertainty, potentially due to a communication or technology gap between the PA 161 providers and the dental community (i.e., a reporting mechanism or platform to support communication and continuity of care).

% of Successful Referrals (n=30)

Graph bars:
- Less than 25%: 27
- 25-50%: 16
- Greater than 50%: 30
- Not sure: 27

Graph 10. Percent of Successful Patient Referrals among PA 161 Programs

Participants indicated what they believed to be the barriers for their patients accessing necessary dental care. An overwhelming majority (57%) felt that the greatest barrier was that parents do not follow-up to seek needed care at the dentist (see Graph 11). One participant elaborated in an open-ended response that they have no way of knowing whether or not the parents made the appointment after a referral is made. Other participants may have selected this option for the same reason, similar to the 34% that expressed difficulty in tracking referrals made by PA 161 providers.

% of Barriers Identified (n=30)

Barrier	Percent
It is difficult to determine which dentists to refer to	2
Dentists are often unwilling to accept the patient's insurance	7
Parents do not follow-up to seek care at the dentist	57
It is difficult to track whether or not a referral was successful	34

Graph 11. Percent of Barriers Identified by PA 161 Programs to Successful Referrals

PA 161 providers that participated in the survey were also asked how they currently track patients to determine whether they received dental treatment after a referral was made.

% of Tracking Referral Systems (n=30)

Tracking System	Percent
Manually without use of an electronic dental record program	34
Electronic dental record program	18
Parent/guardian confirmation	37
I don't track	11
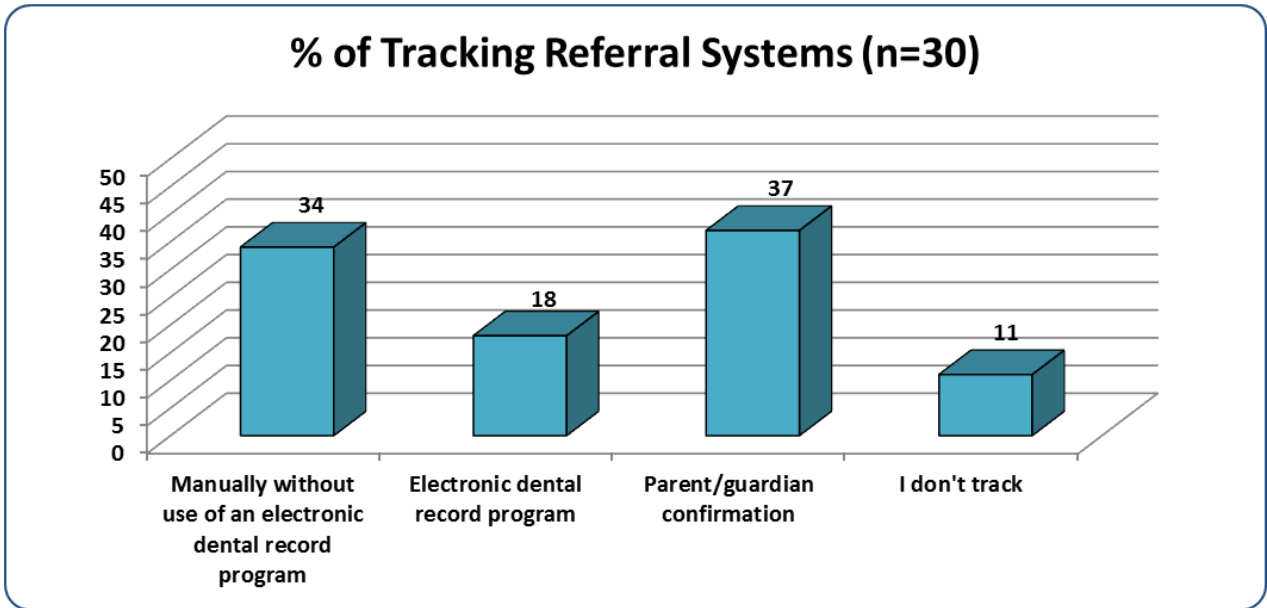
Graph 12. Current Patient and Referral Tracking Mechanisms

Nearly 40% of providers solely rely on parent/guardian confirmation, while 34% manually track referrals. Less than 20% of PA 161 programs use an electronic dental record program and 11% don't track referrals (see Graph 12). Additional responses identified other methods of tracking referrals:
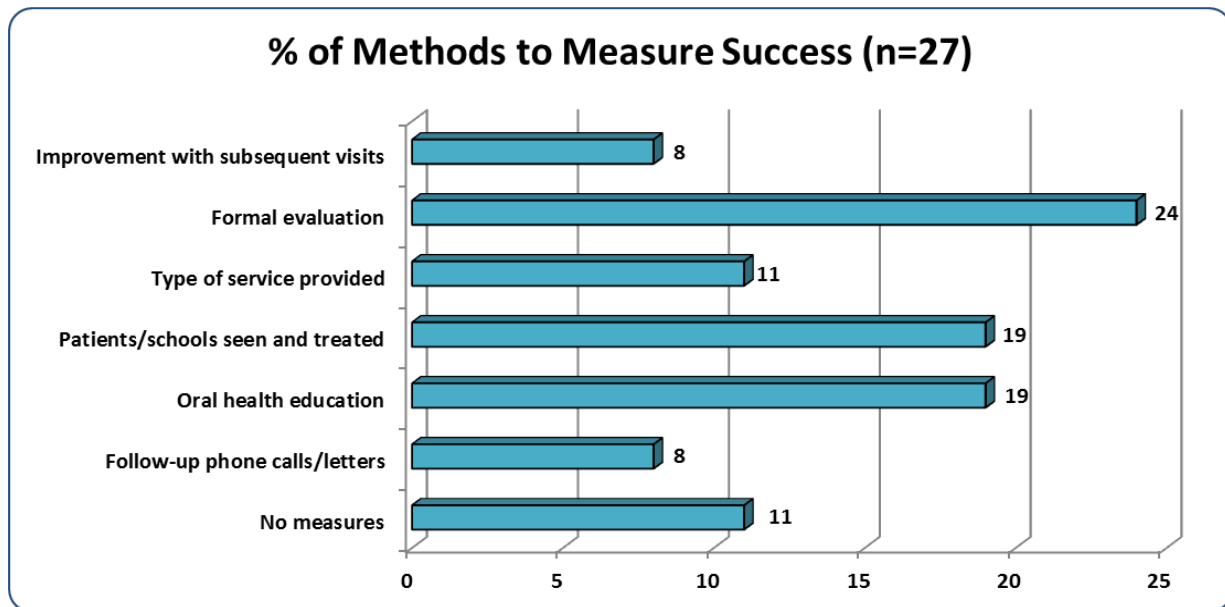
- Phone calls to the early head start/head start coordinator
- Phone call reminders for every child with treatment needs and urgent cases
- Some facilities provide assistance for follow-up care due to their own regulations and requirements
- Letters to the child's parents/caregivers

Two respondents identified issues with their current tracking systems:
- Difficult to assess whether follow-up was completed or not when the parent indicates they are going to their own dentist for care
- There is tracking who needed service, but no tracking once the patient comes to the fixed clinic for treatment

RESULTS: Reporting and Measuring

PA 161 providers that participated in the survey were asked how they measure the success of their program. Qualitative responses were coded into various categories to capture the responses as displayed in Graph 13.

% of Methods to Measure Success (n=27)

Method	Value
Improvement with subsequent visits	8
Formal evaluation	24
Type of service provided	11
Patients/schools seen and treated	19
Oral health education	19
Follow-up phone calls/letters	8
No measures	11

Graph 13. Methods to Measure Success among PA 161 Programs

Almost a quarter (24%) of participants measured the success of their program through some form of evaluation (i.e., summary/production/quarterly reports, evaluation/feedback forms, follow-up surveys), while nearly 20% measured success by the amount of oral health education provided or by the number of patients/schools served and patients treated. Several (11%) indicated that they capture the type of service provided as a measure (i.e., fluoride varnish,

sealants, prophys, and restorative care). Although 11% indicated that their program does not currently measure success, a couple of participants explained that their program has only been operational a short time period and that there is some inconsistency with the location and capacity that they serve in.

Participants were further asked what resources or support they would need in order to measure the success of their PA 161 program. The responses were also categorized to reflect the identified resources/support needed and are displayed in Graph 14 below.

% of Resources/Support Needed (n=27)

Category	Value
Other	11
Not sure	52
More Staff	11
A tracking system	26
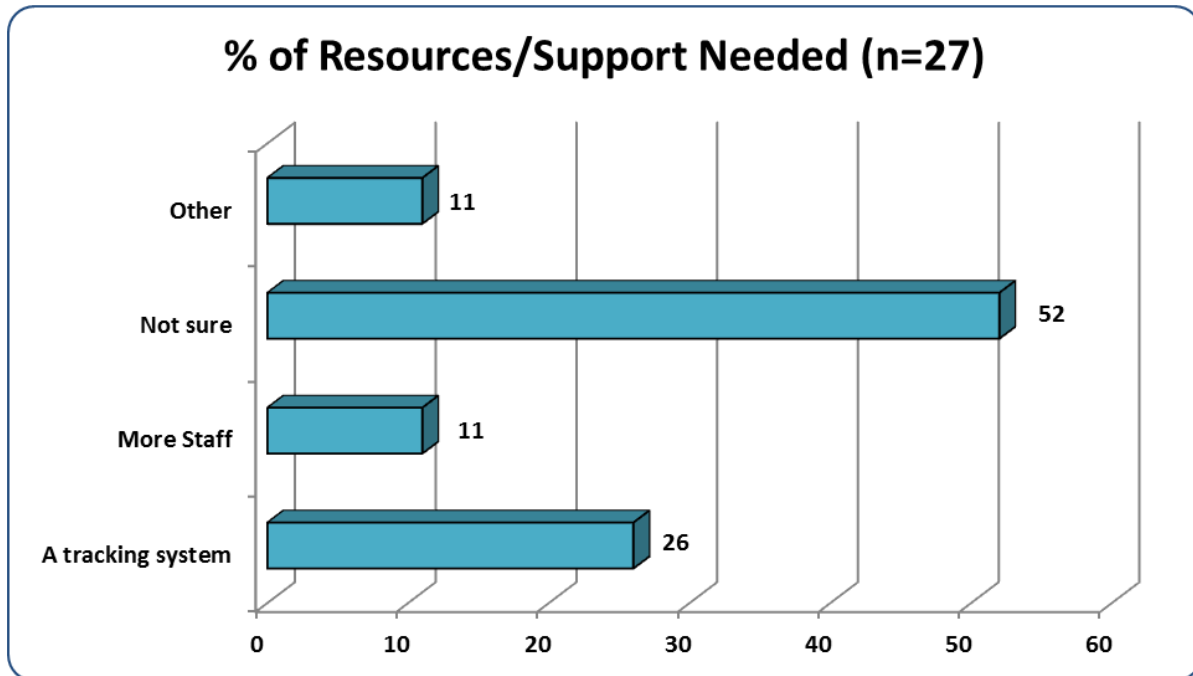
**Graph 14. Resources and Support Needed to Improve Ability to Measure Program Success**

More than half (52%) indicated that they were unsure, not aware of, or not needed, while 26% would like a better tracking system (preferably an online program) with some amount of technical support.

11% indicated the following responses:
- Information on other similar programs
- Ability to use passive consent on patients in specific settings, such as schools

Participants were asked: "If made available to Michigan PA 161 program staff, would you use a standardized reporting platform to input information and reporting data? This reporting platform would be used for patient tracking, communicating with health information systems, and streamlining MDHHS PA 161 program reports."

% of Participants that Would Use a Standardized Reporting Platform (n=27)

No — 7
Yes — 93
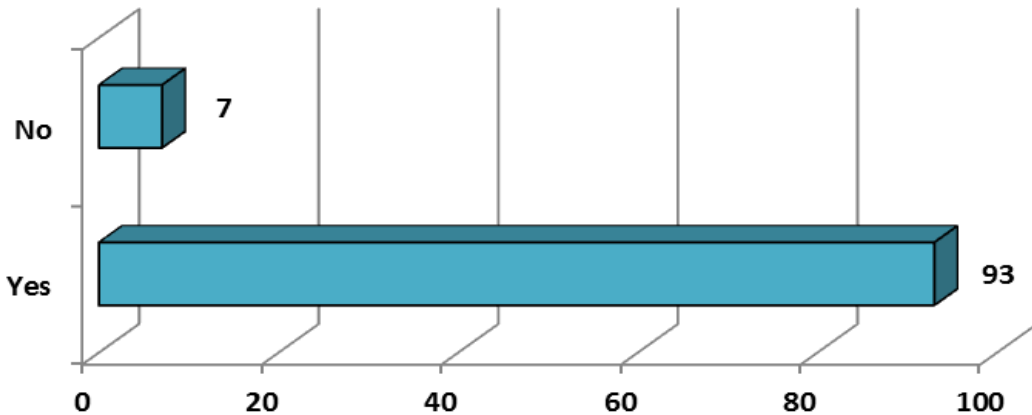
Graph 15. Percent of PA 161 Programs Who Would Utilize a Standardized Reporting Platform

Almost all PA 161 providers (93%) would use a standardized reporting platform to input information and reporting data if one were provided (see Graph 15).

RESULTS: Program Goals

PA 161 providers were asked to share some of their short and long term goals for their program. Some of the responses include:

- Expansion (into underserved areas, into schools and health fairs)
- Increase numbers (increased participation and client base)
- Provide additional preventive services (oral health education, sealants, fluoride varnish)
- Tracking (new patients, referrals)
- Increase oral health literacy among patients and families
- Create sustainability
- Have a dentist visit site to perform exams and restorative work
- Meeting the needs of the community
- Medicaid billing training
- Signing more children up for coverage
- Recruit more PA 161 hygienists

SUMMARY & LIMITATIONS

This report has summarized the key results of the PA 161: Public Dental Prevention Program 2015 survey. It is an overview of the results as opposed to an extensive statistical exploration of any specific topic. The focus of these analyses has been the frequency of various questions related to functionality and needs of PA 161 programs.

This survey was administered electronically & respondents received no incentive for participating. A reasonable amount of PA 161 providers responded to the survey (36% response rate) and the results can be used to inform programmatic changes, resource allocation, and areas of need; which is the goal of this report.

DISCUSSION

The goal of this survey was to identify barriers faced by the PA 161 programs to determine areas of need to strategically develop resource allocation and identify programmatic changes to address these barriers. Dental providers who work in public health setting face several challenges while trying to reduce the burden of dental disease to underserved children through-out Michigan. Providers within PA 161 programs face even greater challenges, as they are limited in the types of services they can provide. PA 161 programs are not able to provide the necessary comprehensive dental services many children urgently need and urgent referral resources (nearby dental safety net locations) commonly have long wait times for appointments or have limited availability to provide necessary dental treatment. PA 161 programs have identified common difficulties in determining local dentists with capacity/willingness to accept patient referrals, as well as ensuring necessary dental care has been completed for the children that were referred.

The majority of PA 161 programs operate in Head Start and school-based settings. Currently, there are no PA 161 programs that have expanded services into Primary Care settings, and very few work with WIC programs. Collaboration with medical providers and other early childhood organizations can help reach a greater amount of the underserved child population in Michigan. Given the population served in pediatric primary care and WIC program settings, these locations would be ideal to consider for program expansion among PA 161 programs.

Many PA 161 programs are small, staffed with three or fewer dental hygienists, and many programs are administered by a registered dental hygienist. This stretched capacity can create a

challenge when seeking to expand services or settings of their PA 161 program, due to financial and staff constraints.

One of the greatest barriers PA 161 programs face is in tracking the success of patient referrals. While many programs record the frequency of patient referrals given to patients, several are unsure if referrals are successful because of the lack of a feedback mechanism. Many programs rely specifically on parent/caregiver confirmation, and most programs do not have an electronic dental record program. This means tracking is manual, typically completed by sending out letters or making reminder phone calls regarding treatment needs to parents, caregivers, or Head Start and school dental coordinators. Almost unanimous among the respondents was interest in the use of a standardized reporting platform for PA 161 programs, which would allow for a more efficient reporting, patient tracking, and data capture system to monitor impact and quality improvement. This survey will help the Altarum Institute's Michigan Caries Prevention Program (MCPP) and the Michigan Department of Health and Human Services-Oral Health Program work together to optimize the efficiency and outreach of this skilled provider workforce to better help reduce the burden of childhood dental disease in Michigan.

This survey was conducted by the [Michigan Department of Health and Human Services](#) and the [Michigan Caries Prevention Program](#), and prepared by the [Altarum Institute](#).

APPENDIX: Survey Questions

Michigan PA 161 Program Survey

1. What is your name? (last name, first)
2. What are your credentials and/or title? (e.g., DDS, RDH)
3. What is the name/organization of your PA 161 program?
4. Does your PA 161 program provide care to children ages 0-17?
   a. Yes
   b. No
5. How long has your PA 161 program been in operation?
   a. Under 1 year
   b. 1-3 years
   c. 4-6 years
   d. 7+ years
6. How many registered dental hygienists does your program employ?
   a. Unsure
   b. 0
   c. 1-3
   d. 4-6
   e. 7+
7. What issues, if any, did your PA 161 program have during start-up? Please select all that apply.
   a. No issues that I am aware of
   b. Difficulty determining dental referral sources
   c. Difficulty finding a supervising dentist
   d. Difficulty covering start-up costs
   e. Other (please specify)
8. Which of the following barriers, if any, does your PA 161 program face currently? Please select all that apply.
   a. I do not have any barriers that I have identified
   b. Lack of available patients
   c. Financial resources are strained
   d. Reporting requirements are difficult
   e. Clinical equipment/materials are scarce
   f. Lack of community contacts
   g. Cost of malpractice insurance
   h. Marketing the program is difficult

       i. Other (please specify)

9. In what settings does your PA 161 program currently provide preventive oral health services to children ages 0-17? Please select all that apply.
   a. Tribal Health Services/Indian Tribal Organizations
   b. Faith-based organizations
   c. Federally Qualified Health Centers
   d. Schools
   e. Early Head Start/Head Start programs
   f. WIC clinics
   g. Local health departments
   h. Hospitals
   i. Primary care practices
   j. Other (please specify)

10. What additional settings would you like to expand your PA 161 program's child focused preventive oral health services to? Please select all that apply.
    a. None at this time
    b. Tribal Health Services/Indian Tribal Organizations
    c. Faith-based organizations
    d. Federally Qualified Health Centers
    e. Schools
    f. Early Head Start/Head Start programs
    g. WIC clinics
    h. Local health departments
    i. Hospitals
    j. Primary care practices
    k. Other (please specify)

11. What barriers, if any, would interfere with your ability to expand services to the additional areas listed above? Please select all that apply.
    a. Lack of connections in those settings
    b. Administrative burden when coordinating services
    c. Lack of additional materials/dental resources needed to serve additional settings
    d. Lack of staff capacity
    e. Other (please specify)

12. What type of preventive oral health services does your program provide to children ages 0-17? Please select all that apply.
    a. Prophys/dental cleanings
    b. Fluoride varnish/topical fluoride
    c. Oral health screenings/risk assessments

     d. Sealants

     e. Other (please specify)

13. Select a service that you don't provide but would like to add to your PA 161 program. Please select all that apply.

     a. Our program already offers all preventive oral health services

     b. I do not wish to add any program services

     c. Prophys/dental cleanings

     d. Fluoride varnish/topical fluoride

     e. Oral health screenings/risk assessments

     f. Sealants

     g. Other (please specify)

14. What barriers prevent your PA 161 program from providing additional preventive oral health services to children? Please select all that apply.

     a. No current barriers exist

     b. Staff capacity is limited

     c. Clinical instruments/materials cost is too high

     d. Mobile capability is limited

     e. Other (please specify)

15. Looking at the total number of children (ages 0-17) your PA 161 program serves over a 6 month time frame, approximately how many of the patients who are in need of dental treatment receive it once you make a referral?

     a. Less than 25%

     b. 25-50%

     c. Greater than 50%

     d. Not Sure

16. What do you believe to be the biggest barrier to accessing necessary dental treatment for the children your PA 161 program serves?

     a. It is difficult to determine which dentists to refer to

     b. Dentists are often unwilling to accept the patient's insurance

     c. Parents do not follow-up to seek care at the dentist

     d. It is difficult to track whether or not a referral was successful

     e. Other (please specify)

17. How does your PA 161 program track patients to ensure they received dental treatment?

     a. Manually without use of an electronic dental record program

     b. Electronic dental record program

     c. Parent/guardian confirmation

     d. I don't track

     e.   Other (please specify)

18. How do you measure the success of your PA 161 program (e.g., patient education, improvement throughout subsequent visits)? If you don't measure success, please state that.

19. What resources or support would help you in measuring the success of your PA 161 program?

20. What would better assist you in reporting PA 161 program data that is required by MDHHS?

21. If made available to Michigan PA 161 program staff, would you use a standardized reporting platform to input information and reporting data? This reporting platform would be used for patient tracking, communicating with health information systems, and streamlining MDHHS PA 161 program reports.
    a.   Yes
    b.   No

22. What are some of your short term and/or long term goals that you have set for your program? If you are not aware of any, please state that.

23. Can you think of a particular story to share that highlights a time when your program was successful?
    a.   Yes, please contact me to follow-up on sharing the story
    b.   Yes, but I do not want to share at this time
    c.   I do not have a story at this time
    d.   I don't know/unsure

24. Please provide either your phone number or email address and we will follow-up with you on your success story.