Promising Practices to Improve Access to Oral Health Care in Rural Communities

Promising Practices to Improve Access to Oral Health Care in Rural Communities

Grantees also found that it was important to develop program evaluation strategies. The 330A Outreach Authority grantees reported that they needed to achieve their program goals and whether outcomes were being met. They also found that the importance of oral health and developments in knowledge and practice in this area, significant oral health disparities exist in rural communities related to access to care, utilization of services, and outcomes. These disparities result from a number of factors including provider shortages in rural areas, a lack of dentists who accept Medicaid or have dedicated areas in the program. Oral health status—occur over many years, and are more difficult to measure. The 330A Outreach Authority grantees’ experiences guide program development, implementation, and sustainability.

Program Evaluation Strategies
Program evaluations can be used to gain buy-in from community stakeholders, educate decision makers, mobilize resources, measure patient satisfaction, demonstrate program outcomes, and share success stories. Evaluation can also help to refine strategies as the needs in the community and diverse oral health in a community. One grantees noted that it is critical to "just demonstrating the need for oral health activity in the community—so the eyes of donators...they can understand what is going on.

Rural communities are conducting process and outcome evaluations to assess their programs. The 330A Outreach Authority grantees evaluated the success of their programs in the area of program outcome measures. For example, one grantees noted that their programs—induced cavities and birth extractions, changing attitudes and behaviors, improvements in oral health status—increase over many years, and are more difficult to measure.

The 330A Outreach Authority grantees’ experiences suggest several lessons learned for evaluating rural oral health programs. First, design data collection instruments to measure the impact of their programs, some noted that the benefits of their programs—induced cavities and birth extractions, changing attitudes and behaviors, improvements in oral health status—occur over many years, and are more difficult to measure. The 330A Outreach Authority grantees’ experiences guide program development, implementation, and sustainability.

This project identified rural oral health programs as programs of oral health programs. First, design data collection instruments to measure the impact of their programs. Second, consider the mobility of the population that is participating in the program evaluation because it will loss less impact on the numbers and success. For example, one grantees noted that their programs—induced cavities and birth extractions, changing attitudes and behaviors, improvements in oral health status—occur over many years, and are more difficult to measure.

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This study was funded under a contract with the Health Resources and Services Administration Federal Office of Rural Health Policy (ORHP, ORHP, Contract Number HHS/00024S/000027C). Under this contract, the NORC-Walsh Center for Rural Health Analysis and the University of Minnesota Rural Health Research Center are conducting evaluations of the grant programs established under the 330A Outreach Authority. The project described in this brief was conducted in the first year of the four-year evaluation project. The conclusions and opinions expressed in this report are the author’s alone, and no endorsement by NORC at the University of Chicago, the University of Minnesota, Health Resources and Services Administration, or Health Resources and Services Administration is intended or should be inferred. The Walsh Center for Rural Health Analysis is a part of NORC at the University of Chicago. For more information about the project or the Walsh Center and its publications, please contact Michael White at (503) 434-9212 or michael-white@norc.org.
While many communities have developed innovative approaches to increasing access to oral health care, there is a lack of research on the oral health models that are most effective in rural communities. The 330A Outreach Authority programs have successfully implemented a range of different oral health program models, and their experiences suggest promising practices that can be adapted and applied in other rural communities. Identifying evidence-based and promising practices for rural oral health programs and sharing this information widely will help to facilitate the replication of programs that are supported by research and practice.

Findings for this issue brief are based on a literature review of rural oral health programs and lessons learned from seven 330A Outreach Authority grantees that implemented rural oral health programs. This project collated for the development of a toolkit of rural oral health program resources and promising evidence-based practices. The toolkit is available on the Rural Assistance Center (RAC) website, www.raconline.org.

Purpose of the Project
The purpose of this project was to identify promising practices for rural oral health programs that help rural communities learn from the experiences of their peers and access tools and tested approaches. The study focuses on reviewing the experiences of rural oral health programs in the field to identify “model” programs—those that are frequently implemented in rural communities. We reviewed the grantee applications, which contained information about grantees’ strategies and approaches to increasing access tried and tested tools and approaches. The key themes that emerged from this study are included in the toolkit.

Methodology
For the purpose of this project included: 1) a review of the literature on rural oral health programs; 2) a review of the applications for fourteen 330A Outreach Authority grantees that were funded in 2010 to implement an oral health program; and 3) a development of a toolkit that contains resources and promising practices that were identified by the grantees and the literature.

In the first phase of this project, ORHP staff identified fourteen 330A Outreach Authority grantees that were funded in 2010 to implement oral health programs in rural communities. We reviewed the grantees’ applications, which contained information about grantees’ strategies for developing rural oral health programs; conducted a review of the literature on rural oral health programs and developed a grantees’ interview protocol for developing a grantees’ interview protocol. The protocol included a range of topics such as the goals of the program, key activities, promising or evidence-based approaches used, implementation lessons learned, challenges, facilitations, evaluation activities, sustainability plans, and dissemination strategies. Of the fourteen grantees identified, seven grantees participated in an interview. Following the interview, some grantees provided resources for inclusion in the rural oral health toolkit. Interviews were completed between July and August 2012.

In the second stage of the project, we reviewed findings from the interviews and compiled written resources from the interviews and compiled toolkit resources. The toolkit is organized in eight sections: 1) introduction to rural oral health; 2) health programs models; 3) implementation of rural oral health programs; 4) sustainability; 5) measuring and evaluating rural oral health programs; 6) disseminating rural oral health resources and promising practices; and 7) rural oral health program clearhouse. The toolkit provides information about rural oral health programs and resources that may help to other communities developing similar programs. The toolkit is available on the RAC site at www.raconline.org.

This project represents the first effort to develop a toolkit that houses promising practices and resources for rural oral health programs. Findings from a review of the literature and discussions with the grantees illustrated that the approaches used by rural oral health programs are not rigorously evaluated because of a lack of time, funding, and resources. Additionally, there is not an existing body of literature on evidence-based oral health programs in rural communities. Thus, the toolkit is a compilation of promising practices rather than evidence-based practices and provides information and resources for rural communities that are interested in implementing a rural oral health program. Future research is needed to validate rural oral health program approaches. The key themes that emerged from this project are described in this issue brief.

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These rural oral health models are not mutually exclusive. Many of the models complement one another and can be implemented in the same program. For example, a rural oral health program may combine the oral health-primary care integration model and dental home model given the emphasis on communication and coordination across services. Similar, a rural community may implement the mobile dental services and school-based models by delivering care to children using portable dental clinics in school settings.

Staff and Resources Needed to Support Rural Oral Health Programs

The 330A Outreach Authority grantees reported that their programs would not have been successful without a combination of talented staff and expertise and contributions from a range of partner organizations. The grantees collaborated with dental clinics, hospitals, area health education centers, programs such as Head Start and WIC, and schools; faith-based organizations; tribal health programs; local health departments; and community and social service organizations. Many programs also worked with volunteers such as retired dentists and students from dental school residency programs to deliver services. Partnerships formed during funding, staff time, technical assistance, space for program activities, and supplies. For example, one grantee’s partner donated space for a dental clinic, while another grantee’s partner furnished a mobile dental van. Grantees also worked with partners to identify champions in the community to speak to primary providers, educators, and policy makers to participate in support the program. Grantees commented that the importance of gratitude acknowledging the contributions of their partners.

Implementation Lessons Learned

The 330A Outreach Authority grantees shared their experiences implementing different rural oral health programs. Grantees that implemented a dental home model reported that recruiting dentists to practice in rural areas was a challenge. One grantee who was implementing a dental clinic for underinsured residents said: "We had recruitment issues in the beginning. And it was as though you might expect in a rural community. We were unable to identify a dentist or even a dental director. The most successful dental clinics have a dentist at the helm and we weren’t able to find that person.” Another grantee reported that finding a dentist to staff a rural mobile unit was problematic. To address these challenges, grantees recruited retired dentists who volunteered their time as well as dentists who were paid to see patients one day each week in a rural dental clinic. One program established an agreement with a medical center to pay dental students to practice in the program’s rural site.

Grantees that implemented the mobile dental services program also face different issues. One program, a local health department, collaborated with a school district and a dental clinic to provide preventive care to underserved, low-income, elementary school children. This program provides oral health care to students in a school clinic and is designed to be functional to provide dental care to students using a small trailer rather than a recreational vehicle (RV).

"We know that we didn’t want an RV unit," the reason was because of all the concerns. We didn’t want that overtook the unit, having to have a special license to drive it, having to have a special support unit, and having to winterize a unit. That is why we went with a small trailer that would pull behind our company vehicle.”

In this mobile dental program, dentists serve students in the school clinic rather than a mobile unit. Therefore the grantee also works with the school to identify a power source for the unit and a source of water. In addition to deciding on the appropriate vehicle, grantees implementing the mobile dental services program model also established relationships with school dentists for referrals. Because mobile clinics cannot serve as a dental home to patients, and often are not used for more complex procedures like root canals, grantees established relationships with local dentists to refer patients with more complex needs.
Oral Health Program Models in Rural Communities

The literature review and 330A Outreach Authority grantee interviews identified oral health program models that are frequently implemented in rural communities and have contributed to positive outcomes.

**Workforce Model.** Recruiting and retaining dentists can be challenging in rural areas because of fewer local training programs, lower health insurance reimbursement rates for services, and fewer employment opportunities for the dentist’s spouse. Rural communities have implemented workforce programs that involve encouraging students from rural communities to choose dental careers; offering incentive programs to dental professionals who serve rural populations including tuition reimbursement and loan forgiveness programs; introducing students to dentists who practice in rural areas; and creating linkages between dental schools and rural dental clinics to increase the number of dental student graduates completing a portion of their training in a rural community.

**Mobile Dental Services Model.** Rural programs deliver oral health care to adults and children using the mobile dental services model. In this model, a mobile dental unit is used to conduct dental exams, deliver fluoride treatments and sealants, and take x-rays. Some programs deliver oral health education services. Mobile units may also be used to deliver portable dental equipment to schools, Head Start facilities, health centers, and community organizations where dentists can deliver oral health services. Mobile dental units may visit the same location several times each year.

**School-based Model.** In this model, dental professionals deliver services to children in school-based clinics. This program model may involve dentists, dental hygienists, dental students, and community health workers. Programs may offer fluoride varnish, dental sealants, and oral health education to students, and if needed, refer patients to local dentists that have agreed to treat more complex cases. Other programs provide with dental hygiene professionals and students who travel to schools to deliver care services. Community health workers may work alongside dental professionals to assist with screenings. The school-based model helps to reduce missed school time for children and can reach children in families that may not seek dental care due to a lack of resources.

**Dental Home Model.** The dental home model of care is a comprehensive approach to improving oral health access for vulnerable populations by providing a regular source of care. This model emphasizes an ongoing relationship between the dentist and the patient, increased collaboration among providers, and the promotion of oral health education. Rural communities are designing dental homes for adults and children.

**Oral Health-Primary Care Integration Model.** In this model, rural oral health programs improve communication between dental providers and primary care providers. Approaches include establishing referral partnerships between dental clinics and primary care practices and creating interdisciplinary teams where dental hygienists work alongside primary care physicians to provide services.

**Allied Health Worker Model.** Allied health professionals support oral and health programs by providing dental care, education, referrals, screening oral support services. Allied health professionals include dental hygienists, dental assistants, dental educators, and dental laboratory technicians. Some states have established an allied health professional training program for mid-level dental therapists who have more training than a dental hygienist but less than a dentist in order to increase access to care in rural areas.

**Community Outreach and Engagement Model.** Rural programs develop strategies to increase knowledge and awareness of the importance of oral health. Examples of activities include conducting outreach programs in hard-to-reach rural areas, providing oral health education at community events, and working with primary care providers to incorporate oral health into patient visits. 

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–330A Outreach Authority Grantee

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While many communities have developed innovative approaches to increasing access to oral health care, there is a lack of research on the oral health models that are most effective in rural communities. The 330A Outreach Authority grantees have successfully implemented a range of different oral health programs and they are eager to share promising practices that can be adapted and applied in other rural communities. Identifying evidence-based and promising practices for rural oral health programs and sharing this information widely will help to facilitate the replication of programs that are supported by research and experience.

Findings for this issue brief are based on a literature review of rural oral health programs and lessons learned from seven 330A Outreach Authority grantees that were funded in 2010 and twelve grantees that were funded in 2012 to implement an oral health program. The project concluded with the development of a toolkit of rural oral health program resources and promising and evidence-based practices. The toolkit is available on the Rural Assistance Center (RAC) website, www.raconline.org.

Purpose of the Project

The purpose of this project was to identify promising practices for rural oral health programs that help rural communities learn from the experiences of their peers and access tried and tested tools and approaches. The study focuses on reviewing the experiences of rural oral health programs in the field to identify “model” programs—those that are frequently implemented in rural communities with positive outcomes—and promising practice resources that may benefit rural communities.

Methodology

The methods for this project included: 1) a review of the literature on rural oral health programs; 2) a review of the applications for fourteen 330A Outreach Authority grantees that were funded in 2010 and twelve grantees that were funded in 2012 to implement an oral health programs; 3) a review of the applications for fourteen 330A Outreach Authority grantees that were funded in 2012 to implement an oral health program; and 4) the development of a toolkit that contains resources and promising practices that were identified from the grantees and in the literature.

In the first phase of this project, ORHP staff identified fourteen 330A Outreach Authority grantees that were funded in 2010 to implement oral health programs and communities. We reviewed the grantee applications, which contained information about grantees’ strategies for developing rural oral health programs, conducted a review of the literature on oral health programs, and developed a grantees interview protocol. The protocol included a range of topics such as the goal of the program, key activities, promising or evidence-based approaches used, implementation lessons learned, challenges, facilitators, evaluation activities, sustainability plan, and dissemination strategies. Of the fourteen grantees identified, seven grantees participated in an interview. Following the interview, some grantees provided resources for inclusion in the rural oral health toolkit. Interviews were completed between July and August 2012.

In the second stage of the project, we reviewed findings from the interviews and compiled toolkit resources from the literature. The toolkit is organized in eight areas: 1) introduction to rural oral health; 2) oral health program models; 3) implementation of rural oral health programs; 4) sustainability; 5) measurement and evaluation of rural oral health programs; 6) disseminating rural oral health resources and promising practices; and 7) resources that may helpful to other communities developing similar programs. The toolkit is available on RAC at www.raconline.org.

This project represents the first effort to develop a toolkit that house promising practices and resources for rural oral health programs. Findings from a review of literature and discussions with the grantees illustrate that the approaches vary based on rural oral health programs are not rigorously evaluated because of a lack of time, funding, and resources. Additionally, there is not an existing body of literature on evidence-based and promising practices for rural oral health programs. Thus, the toolkit is a compilation of promising practices rather than evidence-based practices and provides information and resources for rural communities that are interested in implementing a rural oral health program. Future research is needed to validate rural oral health programs. The key themes from this project are described in this issue brief.

Implementation Lessons Learned

The 330A Outreach Authority grantees shared their experiences implementing different rural oral health programs. Grantees that implemented a dental home model reported that recruiting dentists to practice in a rural area was a challenge. One grantee commented that implementing a dental clinic for underserved residents was “the best outreach tool we’ve got because they see you as you might expect in a rural community.” We were unable to identify a dentist or even a dental director. Most successful dental access clinics have a dentist at the helm and we weren’t able to find that person. Another grantee reported that finding a dentist to staff their mobile unit was a problem. To address these challenges, grantees recruited retired dentists who volunteered their time as well as dentists who were paid to provide one day each week in a rural dental clinic. One program established an agreement with a medical center to pay dental students to practice in the program’s clinic.

Grantees that implemented the mobile dental services model faced different issues. One local health department, in collaboration with a school district and local dentists, provided services in a mobile dental van. The 330A Outreach Authority grantees reported that implementing the mobile dental services program model also established relationships with local dentists for referrals. Mobile dental clinics are often used to serve a dental home to patients, and often are used for more complex procedures like root canals, grantees established relationships with local dentists to refer patients to more complex needs.
Promising Practices to Improve Access to Oral Health Care in Rural Communities

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Purpose
This project and workbuild to knowledge about how to successfully implement the evidence-based approach to oral health care in rural communities. The 330A Outreach Authority program focuses on reducing health care disparities in underserved communities related to access to care, utilization of services, and outcomes. This requires a multi-faceted approach to include provider shortages in rural areas, a lack of clinics who accept Medicaid or Medicare, the disparities related to cultural and linguistic barriers, and other factors. This brief provides examples of promising practices that can be replicated in other rural communities across the country.

References
3. Oral health is a critical component of general health and well-being. Poor oral health is related to a range of diseases and disorders, including cardiovascular disease, and respiratory disease. Routine oral health care examinations and services can help patients achieve and maintain oral health in their communities. This brief describes the importance of oral health and oral health care providers, including provider shortages in rural areas, the importance of oral health to overall health status—occur over many years, and are more difficult to measure. The Walsh Center for Rural Health Analysis is part of NORC at the University of Chicago, the University of Minnesota, HRSA, ORHP, and other sources of funding or grants, in-kind contributions from partners, local stakeholders, educators, and community outreach and engagement.

Rural Implications
The 330A Outreach Authority grantees commented that their programs are not a stand-alone initiative. Several grantees mentioned the importance of strong partnerships that exist in their rural communities and that providers, local agencies, and other organizations will work together and that the work being done is important.

Implementation
Improving access to oral health care in rural communities requires a multi-faceted approach to include provider shortages in rural areas, a lack of clinics who accept Medicaid or Medicare, the disparities related to cultural and linguistic barriers, and other factors. This brief provides examples of promising practices that can be replicated in other rural communities across the country.
Promising Practices to Improve Access to Oral Health Care in Rural Communities

Grantees also believed that their programs address cultural barriers in their communities, such as stigma associated with receiving “bad” oral health care. Some grantees offered free oral health services, but experienced low demand because individuals did not seek treatment. One grantee that implemented a school-based and health program noted, “We had a lot of folks excited, but we could get folks to sign up. We opened up the service to all students, it made the sign ups drop. The way we needed to serve was the ones signing up, but because [the program] was open to all, there was no pressure. We had very few people sign up who did not want the service.”

This grantee also noted that working with a professional marketing firm helped them to engage their population through social media outreach. In addition, other grantees leveraged community engagement and outreach activities to reach underserved populations, the need for oral health care, and the relationship between oral health and overall health. For example, grantees developed a brand identity for their programs by creating a dental mascot that represented the project.

Finally, grantees found that it was important to develop a project advisory committee comprised of local partners, such as the local dental school and hospital as well as members of the dental community. One grantee noted that the advisory committee helped to facilitate relationships with members of the local dental community who visited the rural health program as a component of their practice.

“We didn’t want to take away patients from the private sector. We had to communicate to them what we were doing. We are basically trying to take care of patients who [have] not been accessing care. We have the private community at the table as well, so they can understand the project and support the project.”

The grantee was successful in achieving buy-in from the local dental community. In fact, some local dentists volunteered their time to help with the project.

Program Evaluation Strategies

Program evaluations can be used to gain buy-in from stakeholders, educate decision makers and health care advocates about health care challenges in their communities. Thus, grantees are developing sustainable strategies to evaluate their work. Below are three examples of how the missions and mindset of oral health project leaders have evolved over time, and what programs and strategies have been successful because of their rural communities’ culture, resources, and pre-existing relationships with community members.

Sustainability Strategies

The 330A Outreach Authority grantees are striving to develop and implement strategies that will ensure sustainability and access to oral health care challenges in their communities. Thus, grantees are developing sustainable strategies to help them continue their work. We must also help grantees to develop the tools and skills to sustain their programs. For example, school-based programs that provide services and build relationships with schools—such as health and nutrition programs—can sustain programs in a more effective way than other programs. To help ensure sustainability, grantees must learn from their experience in the community.

While the 330A Outreach Authority has funded short-term projects, the grantees have a long-term view and strive for sustainability. What we are able to do in a rural area, since we do not have great population—resulted in a strong buy-in from our partners. The need to work in a collaborative fashion is absolutely essential. From that aspect, I think there are some advantages in a rural area.”

Viola Bayne, MPA, Alana Knudson, PhD, Arika Garg, BA, Malida Kassahun, BS

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