WEST VIRGINIA LEGISLATIVE AUDITOR

PERFORMANCE EVALUATION AND RESEARCH DIVISION

Preliminary Performance Review

Oral Health Program

The Three Projects Comprising the Oral Health Program Are Limited Either in the Scope of Their Activities or the Areas of the State That Receive Services

December 2004
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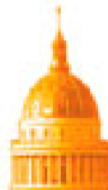

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December 5, 2004

The Honorable Edwin J. Bowman
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The Honorable J.D. Beane
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Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a Preliminary Performance Review of the *Oral Health Program*, which will be presented to the Joint Committee on Government Operations on Sunday, December 5, 2004. The issue covered herein is "The Three Projects Comprising the Oral Health Program Are Limited Either in the Scope of Their Activities or the Areas of the State That Receive Services."

We transmitted a draft copy of the report to the Bureau for Public Health on November 18, 2004. We held an exit conference with the Development Office on November 22, 2004. We received the agency response by email on November 24, 2004. We received the agency response in letter form on December 1, 2004

Let me know if you have any questions.

Sincerely,

John Sylvia

John Sylvia

JS/wsc

Joint Committee on Government and Finance

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Executive Summary

Issue 1: The Three Projects Comprising the Oral Health Program Are Limited Either in the Scope of Their Activities or the Areas of the State That Receive Services.

The Pre-Employment Dentistry Project, which has accounted for most of the Oral Health Program budget, provides dentures and other necessary related dental treatment to approximately 2,000 individuals annually in nearly all of the state.

In 2002, the Legislature passed the Oral Health Improvement Act (*West Virginia Code* Chapter 16, Article 41), which created the Oral Health Program. It is important to note that while the Oral Health Program has statutorily existed since 2002, and has existed organizationally since July 1, 2003, the three projects that constitute it (the Children's Dentistry Project, the Pre-Employment Dentistry Project and the Donated Dental Project) existed prior to its creation. The Oral Health Improvement Act combined all existing Bureau for Public Health (BPH) oral health-related programs into the newly-created Oral Health Program, under the Office of Maternal, Child and Family Health.

The OHP currently provides services on a limited scale, both in terms of services provided and the regions of the state that receive services. The Pre-Employment Dentistry Project, which has accounted for most of the OHP budget, provides dentures and other necessary related dental treatment to approximately 2,000 individuals annually in nearly all of the state. The federal Temporary Assistance to Needy Families program funds the project (nearly $2.5 million in FY 2004). Funding for the enrollment of new participants temporarily ceased at the end of FY 2004 but the previous funding level will resume beginning December 1, 2004.

Over 25,000 children in 28 counties received oral health education services through the Children's Dentistry Project during FY 2004.

The Children's Dentistry Project's main goal is to improve the oral health of children through oral health education, rather than the direct provision of dental services. Over 25,000 children in 28 counties received educational services during FY 2004. It existed for over 20 years prior to the statutory creation of the Oral Health Program. The Children's Dentistry Project has five basic components:

- ❏ Oral Health Education (available in 28 counties)
- ❏ School Fluoride Rinse
- ❏ School Brush-Ins
- ❏ Fluoride Supplements
- ❏ Dental Service Resource Directory

Another OHP project, the Donated Dental Project, utilizes dentists willing to donate their services to help a medically needy indigent patient. The OHP will only pay for laboratory costs up to $500, that are

associated with services provided. The goal of this project is to provide patients with full or partial dentures. The OHP does not reimburse dentists for any necessary fillings or extractions that take place prior to the construction of dentures. There are participating oral health providers available in eighteen (18) counties, however, only five individuals received donated dental services during FY 2004. The BPH was unable to provide data on the number of individuals assisted prior to FY 2004. This was due to difficulties related to the organization contracted to administer the program during previous years, the Foundation for Dentistry for the Handicapped. The foundation refused to provide records documenting services rendered to patients, as required by contract.

The Foundation for Dentistry for the Handicapped refused to provide records documenting services rendered to patients, as required by contract.

The Legislative Auditor is concerned that the OHP does not provide adequate contract supervision to oral health providers who provide educational services for the Children's Dentistry Project in order to evaluate the quality and extent of services provided. The OHP has also failed to select counties receiving services through the Children's Dentistry Project primarily on the basis of need.

The Legislative Auditor recognizes that state statistics on oral health suggest a need for an oral health program. The program has, however, not been as effective and efficient as possible, and has not provided statewide services. This conclusion is based on the following observations:

The Legislative Auditor is concerned that the Oral Health Program does not provide adequate contract supervision to oral health providers who provide educational services for the Children's Dentistry Project in order to evaluate the quality and extent of services provided.

1. The criteria for selecting counties for services as part of the Children's Dentistry Project were not based on need and funds could have been allocated in a manner in which counties with greater needs could have received services.
2. There is insufficient oversight of Children's Dentistry Project grants, in that there is insufficient knowledge of the extent and quality of services provided.
3. There is a lack of participating providers, particularly those who would have to donate their services as part of the Donated Dental Project.

Recommendations:

1. The Oral Health Program should begin collecting data on the numbers of students receiving oral health education for evaluation purposes.

2. The Oral Health Program should begin to supervise the performance of entities with oral health education contracts, establishing performance goals and measures for evaluation purposes, such as

specifying the schools to be visited and the number of visits annually, in order to allocate funds efficiently and coordinate educational efforts.

3. *The Oral Health Program should examine the possibility of expanding or reallocating resources for the Children's Dentistry Project, identifying counties with the greatest need for oral health education.*

4. *The Oral Health Program should seek to expand the number of oral health care providers participating in the Donated Dental Program.*

5. *The Oral Health Program should make further attempts to obtain records from the Foundation for Dentistry for the Handicapped that document whether or not the foundation actually provided the services for which it was contracted.*

6. *The Department of Health and Human Resources should determine if the Foundation for Dentistry for the Handicapped is currently receiving funds from the department itself or from any other state agency, for the purpose of discontinuing these funds as soon as possible.*

7. *The Legislative Auditor recommends continuing the Oral Health Program.*

Objective, Scope and Methodology

The Objective of the Preliminary Performance Review of the Oral Health Program is to determine the Oral Health Program's compliance with the objectives set forth in the Oral Health Improvement Act (*West Virginia Code* Chapter 16, Article 41), which specifies the functions of the Oral Health Program:

1. Develop comprehensive dental health plans within the framework of the State Plan of Operation.
2. Provide consultation to coordinate federal, state, county and city agency dental health programs.
3. Encourage, support and augment efforts of local health departments in the implementation of the dental health component of their program plans.
4. Provide consultation and program information to, at a minimum, health professions, health professional educational institutions, school educators, extension specialists and volunteer agencies.
5. Provide programs aimed at preventing oral cancer with a focus on high-risk and under-served populations.
6. Oral heal education including:
    - A. Public health education to promote the prevention of oral disease through self-help methods, including the initiation and expansion of preschool, school age and adult education programs;
    - B. Organized continuing health education training programs for, at a minimum, health care providers, school educators and extension specialists;
    - C. Preventive health education information for the public.
7. Facilitation of access to oral health services, including:
    - A. The improvement of the existing oral health services delivery system for the provision of services to all West Virginia residents;
    - B. Outreach activities to inform the public of the type and availability of oral health services to increase the accessibility of oral health care for all West Virginia residents;
    - C. Assistance and cooperation in promoting better distribution of dentists and other oral health professionals throughout the state.
8. Providing programs specifically targeting prevention of tooth loss and the restoration of existing teeth to the extent that funds are available.
9. Providing oral or dental health services to individuals in need, to the extent funds are available for the services.
10. Provide evaluation of these programs in terms of preventive services.
11. In consultation with dental care providers, the commissioner shall develop and implement ongoing oral cancer educational programs in the state.

12. On or before the first day of December of each year, the commissioner shall submit a report on the commissioner’s findings and recommendations to the governor and theJoint Committee on Government and Finance on the oral health programs established under this article. The report shall include the identification of existing barriers to proper oral health care in the state and recommendations addressing the removal of the barriers.

The scope of this performance audit extended from FY 2000-2004. The West Virginia Department of Health and Human Resources, Bureau for Public Health supplied all data for the report. The method of analysis included measures of program activity and efficiency for each year of the period examined, such as:

1. The numbers of individuals provided services by each of the three Oral Health Program projects;
2. Expenditures on administrative costs;
3. Expenditures on patient services;
4. The availability of services in different geographic areas of the state.
5. The types of services provided.

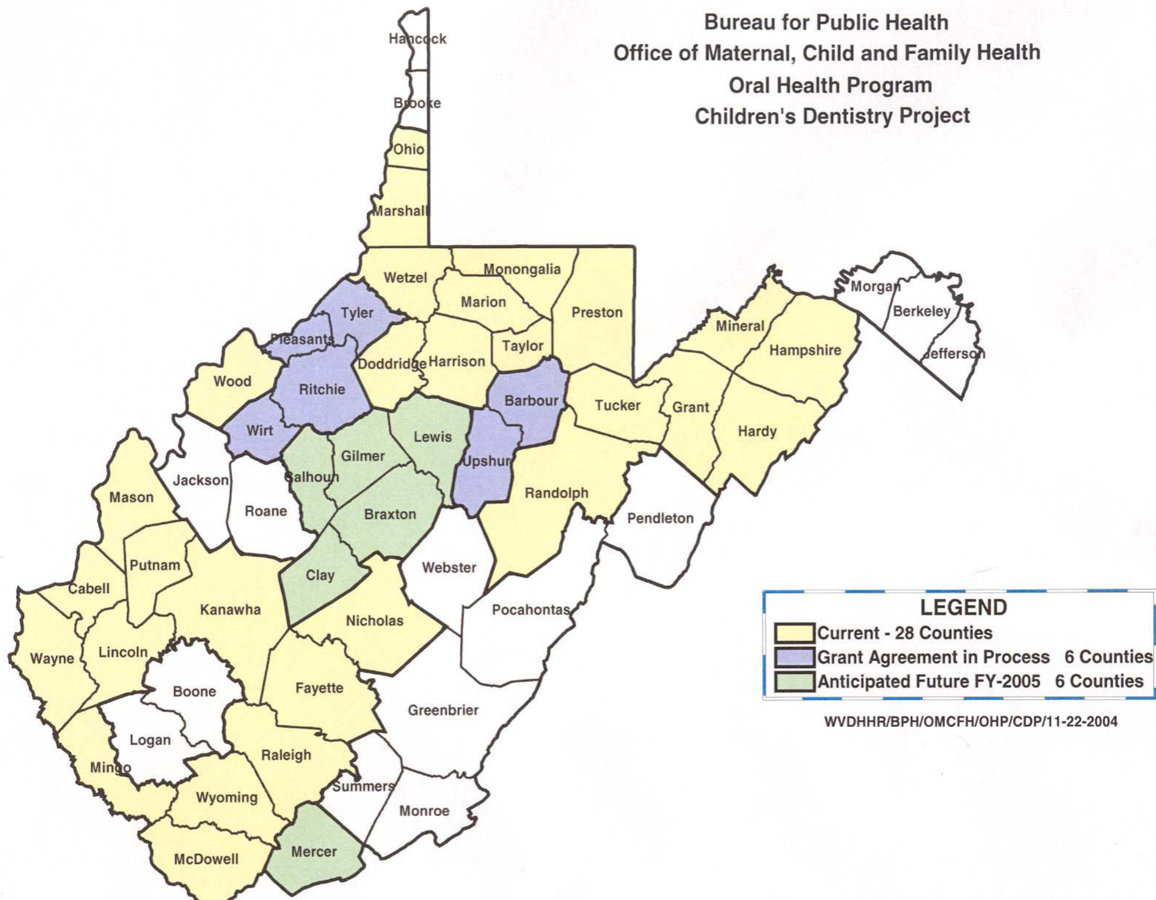
Issue 1

The Three Projects Comprising the Oral Health Program Are Limited Both in the Scope of Their Activities and the Areas of the State That Receive Services.

Issue Summary

The Oral Health Improvement Act combined all existing Bureau for Public Health (BPH) oral health-related programs into the newly-created Oral Health Program, under the Office of Maternal, Child and Family Health.

The Legislature passed House Bill 3017 in 2002. It is also known as the Oral Health Improvement Act (*West Virginia Code* Chapter 16, Article 41) and it created the Oral Health Program (OHP). It is important to note that while the Oral Health Program has statutorily existed since 2002, and has existed organizationally since July 1, 2003, the three projects that constitute it (the Children's Dentistry Project, the Pre-Employment Dentistry Project and the Donated Dental Project) existed prior to its creation. The Oral Health Improvement Act combined all existing Bureau for Public Health (BPH) oral health-related programs into the newly-created Oral Health Program, under the Office of Maternal, Child and Family Health.



The OHP currently provides services on a limited scale, both in terms of services provided and the regions of the state that receive services. The Pre-Employment Dentistry Project has accounted for most of the OHP budget, provided dentures and any related dental treatment to approximately 2,000 individuals annually in nearly all of the state. The federal Temporary Assistance to Needy Families (TANF) Program funds the project (nearly $2.5 million in FY 2004). Funding for new enrollees into the project temporarily ceased at the end of FY 2004. Additional funding later became available beginning December 1, 2004. The Children's Dentistry Project's main focus is educational in nature, rather than the direct provision of dental services. Over 25,000 children in 28 counties received educational services during FY 2004. The other remaining OHP project, the Donated Dental Project, assisted only five individuals with dental services donated by dentists, during FY 2004. There are, however, participating oral health providers in 18 counties.

The Children's Dentistry Project's main focus is educational in nature, rather than the direct provision of dental services.

The Legislative Auditor is concerned that the OHP does not provide adequate contract supervision or evaluation to oral health providers who provide educational services for the Children's Dentistry Project in order to evaluate the quality and extent of services provided. A similar problem with a lack of contract oversight with the Donated Dental Project, that occurred prior to the creation of the OHP, resulted in a lack of documentation to prove that the contractor who formerly operated the project provided any services.

The Legislative Auditor is concerned that the OHP does not provide adequate contract supervision or evaluation to oral health providers who provide educational services for the Children's Dentistry Project in order to evaluate the quality and extent of services provided.

The Legislative Auditor recognizes that an oral health program is necessary. The program has, however, not been as effective and efficient as possible, and has not provided statewide services. This conclusion is based on the following observations:

1. The criteria for selecting counties for services as part of the Children's Dentistry Project were not based on need and funds could have been allocated in a manner in which counties with greater needs could have received services.
2. There is insufficient oversight of Children's Dentistry Project grants, in that there is insufficient knowledge of the extent and quality of services provided.
3. There is a lack of participating providers, particularly those who would have to donate their services as part of the Donated Dental Project.

Overview of the Oral Health Program Budget

The Oral Health Program's budget totaled $3,266,899 during FY 2004. Expenditures on the Pre-Employment Dentistry Project accounted for the largest portion of the budget (77.8%). While the BPH initially informed the Legislative Auditor that federal funding for this project would no longer be available after FY 2004, additional funding has since been obtained. Funding for the project was interrupted from July 1, 2004 to December 1, 2004.

Table 1
The Oral Health Program Budget: FY 2000-2004

Fiscal Year	Children's Dentistry	Pre-Employment Dentistry	Donated Dental	Total Budget: Oral Health Program	Administrative Costs*	Administrative Costs as % of Total Budget
2000	$740,771	$362,966	$20,000	$1,123,737	$250,238	22.3
2001	$691,151	$1,619,648	$15,341	$2,326,140	$394,042	16.9
2002	$705,150	$2,453,424	$25,675	$3,184,249	$422,936	13.3
2003	$592,668	$2,306,602	$26,584	$2,925,854	$299,650	10.2
2004	$646,655	$2,540,244	$30,000	$3,266,899	$411,549	12.6

Source: Bureau for Public Health

**Administrative Costs are salaries, benefits and other staff-related costs, as well as other miscellaneous administrative expenses. Essentially, these are all expenditures not directly related to service provision.*

The Bureau for Public Health has temporarily discontinued enrolling new participants in the Pre-Employment Dentistry Project, which has historically formed the largest portion of the Oral Health Program's budget.

The Pre-Employment Dentistry Project has the goal of providing dentures to and other necessary dental care (such as exams, teeth cleaning, fillings and root canals) to indigent patients in order to improve their appearance and thereby their chances of obtaining employment. The TANF program funds the project through the DHHR's Bureau for Children and Families. The BPH informed the Legislative Auditor that federal funding for the project ended and the OHP ceased enrolling new people at the end of FY 2004. The BPH later obtained additional funding to continue the program, beginning December 1, 2004. The BPH anticipates the resumption of

funding at previous levels, approximately $3,000,000 annually. During the five (5) month interruption in funding, individuals who were in the process of completing necessary dental services were still being served, for example, those who had teeth extracted but were still waiting to receive dentures. The Pre-Employment Dentistry Project has historically formed the largest portion of the Oral Health Program's budget ($2,540,244 in FY 2004). It also served as the only Oral Health Program project to provide significant numbers of needy individuals with dental care services, which is a goal of the Oral Health Improvement Act. The Pre-Employment Dentistry Project assisted over 2,000 patients in FY 2004 (see Table 2).

The Pre-Employment Dentistry Project has historically formed the largest portion of the Oral Health Program's budget.

Table 2
Expenditures on Dental Services and Numbers of Patients Receiving Services from the Pre-Employment Dentistry Project: FY 2000-2004

Fiscal Year	Patient Services Expenditures	Number of Patients
2000	$506,578	659
2001	$1,338,100	1,531
2002	$1,853,613	1,922
2003	$1,639,368	1,814
2004	$1,931,740	2,120

Source: Bureau for Public Health

The Children's Dentistry Project provides oral health education to schools in 28 counties through contracts with local health departments but does not oversee contracts to ensure the quality and extent of services provided.

The primary goal of the Children's Dentistry Project (CDP) is to improve the oral health of children in West Virginia. It existed for over 20 years prior to the creation of the Oral Health Program. The CDP has five basic components:

- ❏ Oral Health Education (available in 28 counties)
- ❏ School Fluoride Rinse
- ❏ School Brush-Ins
- ❏ Fluoride Supplements
- ❏ Dental Service Resource Directory

The OHP literature on the project summarizes its functions:

> *All children who attend public schools in the 28 counties are eligible to receive education to promote good oral health habits. Topics include effective oral hygiene, the importance of fluoride in reducing cavities, the benefit of sealants, injury protection (e.g., use of mouth guards during contact sports), the role of proper nutrition, and abstinence from all forms of tobacco. In addition, CDP assists schools in conducting activities such as weekly fluoride rinse programs and brush-ins which teach and encourage proper brushing methods.*

Over 25,000 children received oral health education services during FY 2004.

> *The Children's Health Insurance Program (CHIP) and Medicaid cover a full range of dental services. For children with a Medicaid or CHIP card, we maintain a directory of dental health professionals who accept new patients. We can also help you find a dental health professional to care for your child. Children who are uninsured or under-insured for dental health services may qualify for free or reduced-cost care at select clinics throughout the state. These clinics are locally funded, demonstrating their additional commitment to the oral health of their communities.*

Table 3 provides data on the numbers of children who have received educational services and oral sealants through the OHP. Over 25,000 children received oral health education services during FY 2004.

Table 3
Oral Health Education Contract and Sealant Expenditures by the Children's Dentistry Project: FY 2000-2004

Fiscal Year	Contract Expenditures	Number Educated**	Sealant Expenditures*	Number of Sealants**
2000	$419,687	--	$14,436	--
2001	$362,243	17,656	$14,518	686
2002	$326,800	22,085	$15,657	895
2003	$323,300	22,597	$8,631	332
2004	$330,270	25,438	$17,567	--

Source: Bureau for Public Health

**Includes only sealants paid for by the Oral Health Program. Does not include sealants paid for by CHIP or Medicaid. During the period from FY 1998-2003, Medicaid paid for 189,743 sealants for 39,590 children.*

***The BPH was unable to provide complete data for FY 2000 or FY 2004.*

The Oral Health Program has received federal funding to provide additional services to other counties.

Table 4 lists oral health care providers who are contracted to provided educational services for the CDP during FY 2005. The OHP has received federal funding to provide additional services to other counties. In 2004, the CDP began providing services in McDowell County. Recently obtained funding will enable the CDP to expand into Mercer County and possibly into parts of Wyoming County that do not currently receive services. The OHP has recently signed a contact with a hygienist who is willing to provide educational services in Pleasants, Ritchie, Tyler, and Wirt Counties. An additional $5,000 is available for this purpose during FY 2005.

Table 4
List of Current Children's Dentistry Project Oral Health Education Contracts

Provider	Grant	Supply Funds
Beckley-Raleigh County Health Department	$5,500	$3,584
Cabell Huntington Health Department	$25,800	$500
Gerald Dice, D.D.S., Huntington	$5,000	$0
Grant County Health Department	$4,000	$645
Kanawha County Dental Health Council	$72,600	$0
Marion County Health Department	$57,000	$0
Marshall County Health Department	$11,000	$2,122
Mineral County Health Department	$10,800	$500
Monongalia County Health Department	$43,025	$8,026
Ohio County Board of Education	$10,900	$0
Putnam County Dental Health Company	$14,300	$0
Rand-Elkins Health Department	$32,600	$500
Valley Health Systems, Incorporated, Huntington	$4,000	$0
Mary Beth Shea, Parkersburg	$5,000	$0
Jerry E. Bouquot, D.D.S., Morgantown	$5,000	$0
John Raese, D.D.S., Elkins	$5,000	$0
Totals*	**$311,525**	**$15,877**

Source: Bureau for Public Health

**FY 2005 budgeted expenditures*
Some grantees provide services to multiple counties. All together these grantees serve 28 counties as of April, 2004.

Staff of the Legislative Auditor's Office contacted the BPH to obtain information on the bureau's contract oversight procedures. The bureau's commissioner stated the following:

> *The local grantees, who are responsible for oral health education in community settings, work and report to their home agency. The grantee/Oral Health relationship exists between the local agency administrator and the Children's Dentistry Coordinator. In turn, all the effort is supervised by the Dental Director, Greg Black, D.D.S.*

The Oral Health Program does not collect data on such considerations as which schools receive visits or the frequency of visits to each school.

The commissioner continued:

> *BPH is respectful of local organizations' ability to determine the greatest needs in their service area. In addition, funding amounts are insufficient to allow delivery of education to all schools. Therefore, BPH has not mandated this. If more money were available for oral health there would be more oral health local grantees to assure statewide coverage.*
>
> *In addition, a funding formula would have to be devised to rectify funding inequalities that were in place before the current administration assumed responsibility of Children's Dentistry. The Oral Health Program (OHP) is considering an effort to devise such a formula in collaboration with the current contractors; even if it is successful, the formula will not go into effect before July 1, 2006.*

The limited amount of oral health funding in the state makes the careful monitoring of oral health education contracts essential.

The fact that educational services are delivered through county health departments does not mean that the OHP has no role in contract supervision. Reporting and performance requirements are not unusual when receiving government grant funding. Monthly reporting documents submitted by county health departments to the OHP contain only a count of the number of individuals of various age groups in the county who have received oral health education or assessments. The OHP does not collect data on such considerations as which schools receive visits or the frequency of visits to each school. The collection of additional data from grantees would facilitate the planning and supervision of services provided. **The limited amount of oral health funding in the state makes the careful monitoring of oral health education contracts essential.** As mentioned earlier, one requirement of the Oral Health Improvement Act is to:

Provide consultation to coordinate federal, state, county and city agency dental health programs.

By failing to collect more detailed data or evaluate county-level oral health education programs, the OHP fails to coordinate programs on different governmental levels to the fullest extent possible.

When the Legislative Auditor's staff requested data on the number of children who have received oral health education each year since 1999, the commissioner stated:

We have found data on oral health education and screening activities for previous years. However, it is in an electronic format which must be converted and compiled. Also, we must review a sample of the date to be sure that this process worked correctly. If we are successful, we will submit this to you as soon as possible.

By failing to maintain easily-accessible data, the commissioner has essentially stated that the bureau does not use the data to evaluate the quality and extent of services provided by local health departments.

By failing to maintain easily-accessible data, the commissioner has essentially stated that the bureau does not use the data to evaluate the quality and extent of services provided by local health departments. The BPH does not know which schools receive educational services nor the frequency of educational visits to schools. The fact that the available data were allowed to lapse into an unusable format demonstrates that the BPH has not made use of them. The *"evaluation of these programs in terms of preventive services"* is a requirement of the Oral Health Improvement Act. The lack of comprehensive data collected by BPH on services offered by the CDP through county health departments makes the evaluation of programs difficult. While the BPH did eventually provide most of the requested data, the data were clearly not maintained with the intention of using them for evaluation purposes. Some county health departments receive tens of thousands of dollars annually for oral health education, yet the BPH does not have a clear understanding of the quality and extent of services provided.

Some Counties With Serious Oral Health Needs Do Not Receive Oral Health Education Through the Children's Dentistry Project

There is evidence that some counties that need oral health services do not receive school-based oral health education through the CDP (Appendices B and C indicate CDP counties). Data obtained by the Legislative Auditor's staff indicate that three of the bottom ten counties, in terms of the percentage of the population under nineteen (19) years of age who have had at least one visit

to the dentist, do not receive oral health education in schools (see Appendix C. These counties are Morgan (52.5%), Summers (54.3%) and Wirt (48.9%). A total of nine counties out of the bottom twenty counties do not receive school-based oral health education. None of these nine counties have more than 57.5% of children under nineteen years of age who have been to a dentist. Clearly, the Oral Health Program does not target its educational services to children based primarily on the need for oral health services in a particular county.

Clearly, the Oral Health Program does not target its educational services to children based primarily on the need for oral health services in a particular county.

When asked by the Legislative Auditor's staff how the BPH selected counties participating in the CDP, the Commissioner of the BPH stated:

> *The Bureau for Public Health has had an oral health component for many years. Originally, local health departments received dollars for dental services to include examinations, cleanings and restorative procedures. None of the existing staff* [of the BPH] *were involved when the counties were selected, and we do not have records which explain the selection of counties or the amounts allotted to each county. These relationships may have been established based on the provider willingness to serve. When the transition from direct services to oral health education was made, OMCFH [Office of Maternal, Child and Family Health, within the BPH] continued the existing relationships and the funding allotments...*
>
> *During the transition from direct services to oral health education, the Bureau was repeatedly contacted by Legislators from counties which had been providers of oral health services supported by OMCFH. These contacts were for the purpose of assuring their home county would continue to receive funding without reduction. In addition, there was at least one instance of an amount being included in the Budget Digest for a specific county.*

The Oral Health Program should examine the possibility of expanding or reallocating resources for the Children's Dentistry Project, identifying counties with the greatest need for oral health education.

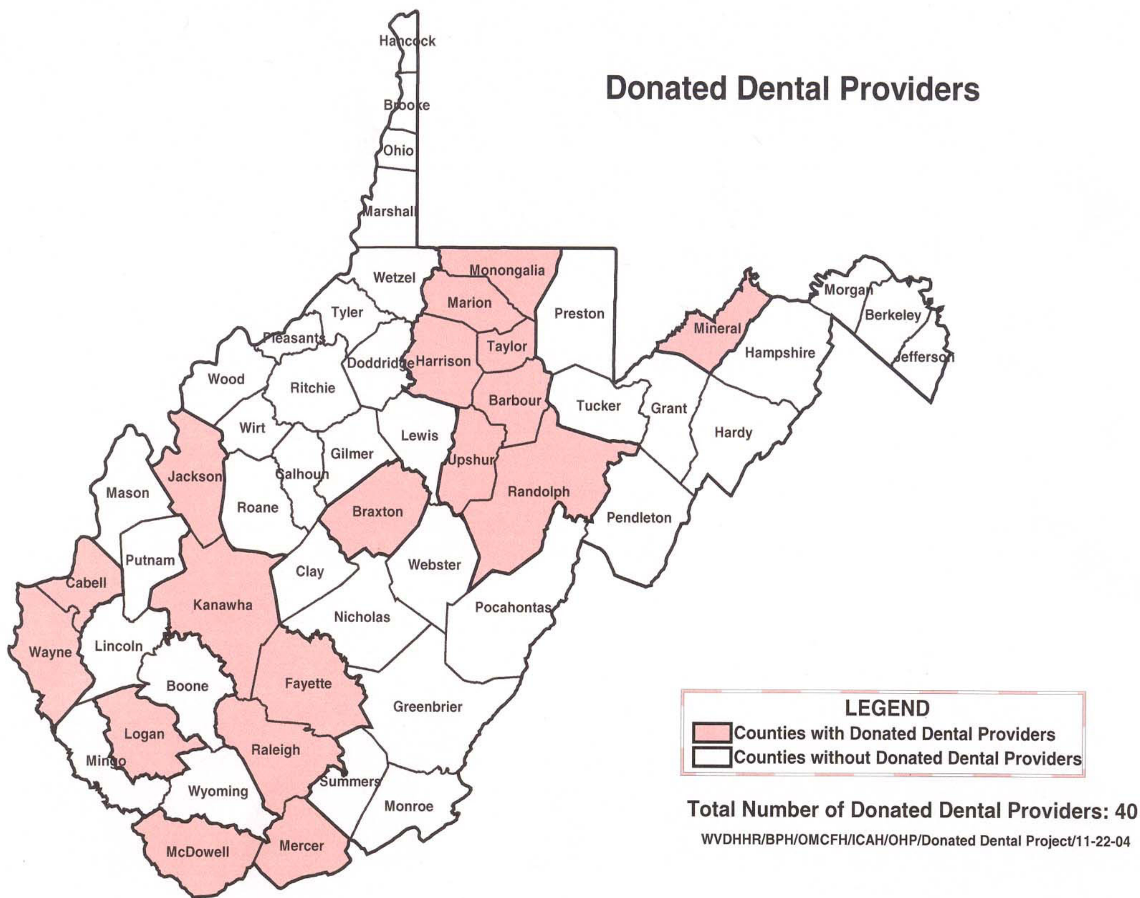
The OHP does not have a clear understanding of how participating counties were selected for the CDP. The OHP should begin to supervise the performance of entities with oral health education contracts, establishing performance measures and goals, such as specifying the schools to be visited and the number of visits annually, in order to allocate funds efficiently and coordinate educational efforts. The OHP should also examine the possibility of expanding or reallocating resources for the Children's Dentistry Project, identifying counties with the greatest need for oral health education.

The BPH has expressed the concern that the current CDP funding level for each county limits the extent of services available in each county. According to the BPH, the current county-level allocation of CDP funds was designed taking into consideration the input of members of the Legislature and the BPH feels limited in its ability to provide services in each county based solely on objective measures of oral health need.

The effectiveness of the Donated Dental Project, prior to the creation of the Oral Health Program, cannot be determined and the BPH possibly paid for services that were not provided.

Only five individuals received donated dental services during FY 2004.

The Donated Dental Project (DDP) utilizes dentists willing to donate their services to help a medically needy indigent patient. The OHP will only pay for laboratory costs up to $500, that are associated with services provided. The goal of this project is to provide patients with full or partial dentures. The OHP does not reimburse dentists for any necessary fillings or extractions that take place prior to the construction of dentures. There are forty (40) participating oral health providers available in eighteen (18) counties (Fayette County was added to the project during the course of this review), however, only five individuals received donated dental services during FY 2004. The importance of the DDP could increase as it is the only OHP project that could fill the gap in services created by the end of the Pre-Employment Dentistry Project. The BPH has stated, "...we are in the process of rebuilding the network of dental practitioners willing to donate their time." The small number of counties in which DDP services are available makes it clear that the BPH needs to expand the number of oral health care providers participating in the Donated Dental Program.



The Bureau for Public Health was unable to provide data on the number of individuals assisted through the Donated Dental program prior to FY 2004.

While the DDP provided services to five individuals during FY 2004, the BPH was unable to provide data on the number of individuals assisted prior to FY 2004. This was due to difficulties related to the organization contracted to administer the program during previous years, the Foundation for Dentistry for the Handicapped, according to the BPH:

> *Reports received from the foundation were narrative and basically the same from period to period. The reports did not list patient names or dental providers. The Foundation refused to provide that information.*

The FY 2003 contract with the foundation clearly stated that quarterly reports submitted to the Department of Health and Human Resources (DHHR) should have been more detailed and that it should have provided any information requested by the DHHR:

Report to the Department on a quarterly basis and such report shall contain, at a minimum, the number of patients requesting services, the number of patients referred, the number of patients served, and the dollar amount of services provided on a volunteer basis. The Grantee further agrees to provide such other information as the Department may deem necessary.

Reviewing the files, OMCFH found that only one-sixth of funding was to be used to pay for dental care with the remainder used for administrative expenses.

If these records exist, they should still be available to the DHHR. The contract also required the foundation to:

Maintain financial records, supporting documents, statistical reports and all other records pertinent to the Grant for a period of five (5) years after the completion of this Grant. If audit findings, litigation or other legal action has not been resolved at the end of the five (5) year period, the records shall be retained until resolution.

The Commissioner of the BPH described the history of the contract:

The Foundation was asked to provide records listing patients served and providers who had donated their time. The Foundation refused the offer and refused to supply the requested information.

The state contracted slightly over three years, beginning on March 1, 2000. The decision to enter into this contract with the Foundation was made by the Secretary of DHHR. OMCFH was assigned responsibility for administering the contract. That responsibility, along with the records, was transferred to the Office of Community and Rural Health Services (OCRHS) in 2002.

The final contract ended June 30, 2003. To comply with HB 3017, OMCFH consolidated this project into the Oral Health Program it created on July 1, 2003. Reviewing the files, OMCFH found that only one-sixth of funding was to be used to pay for dental care with the remainder used for administrative expenses. Therefore, BPH and OMCFH leadership felt obligated to exercise improved stewardship of the funds and operate the program internally. The Foundation was asked to provide records listing patients served and providers who had donated their time. Realizing there would be some expense in gathering and copying records, OMCFH offered the Foundation a phase-out contract of $3,500. The Foundation refused the offer and refused to supply the requested information.

The Bureau for Public Health has no documentation to prove that anyone was actually assisted by this project prior to FY 2004 due to a lack of data from the vendor.

The BPH has no documentation to prove that anyone was actually assisted by this project prior to FY 2004 due to a lack of data from the vendor. Table 5 provides data on expenditures for the DDP from FY 2000-2004. Expenditures for FY 2000-2003 represent amounts paid to the Foundation for Dentistry for the Handicapped during the period it administered the project. Prior to the creation of the OHP, contract oversight was clearly a serious problem. This fact highlights the need for closer contract oversight of the Children's Dentistry Project, since similar situations could occur.

Table 5
Expenditures on the Donated Dental Project: FY 2000-2004

Fiscal Year	Donated Dental
2000	$20,000
2001	$15,341
2002	$25,675
2003	$26,584
2004	$30,000

Source: Bureau for Public Health

The Legislative Auditor recommends that the Bureau for Public Health make further efforts to obtain the information to which it is entitled by contract.

The BPH has not taken any legal steps to recover funds paid to the Foundation for Dentistry for the Handicapped or to obtain records of the foundation's activities during the period it managed the DDP:

> *We have not taken legal steps to recover the funds paid to the Foundation. Due to the nature of the organization and with the uncertainty and such a small amount of money in question, the effort may not be worthwhile.*

While the Legislative Auditor understands that the potential costs of legal action in this case may outweigh the possible financial returns, the foundation has clearly failed to meet its contractual reporting obligations and permitting a contractor to refuse to comply with the provisions of a contract sets a bad precedent for others to follow. The Legislative Auditor recommends that the BPH make further efforts to obtain the information to which it is entitled by contract. The Legislative Auditor further recommends that the DHHR determine if the foundation is currently receiving any funds from either the department itself or any other state agency, given its poor record of contract compliance.

Conclusion

The passage of the Oral Health Improvement Act essentially resulted in the transfer of existing BPH oral health-related programs under the control of the Oral Health Program, without enhancing the quality or extent of services provided. In the case of the Pre-Employment Dentistry Project, TANF funding was unavailable for the purpose of enrolling new participants for a period of five (5) months. When examining the other OHP projects from FY 2000-2004, it is clear that the Children's Dentistry Project continued to operate as it previously had, without focusing its efforts on some counties with serious oral health needs or evaluating the educational services provided by its contractors. The Donated Dental Project did not assist significant numbers of needy individuals and lacks participating oral health care providers in much of the state. Its expansion should be made a priority as the OHP identifies additional participating oral health providers .

The Legislative Auditor recognizes that an oral health program is necessary. The program has, however, not been as effective and efficient as possible, and has not provided statewide services. This conclusion is based on the following observations:

1. The criteria for selecting counties for services as part of the Children's Dentistry Project were not based on need and funds could have been allocated in a manner in which counties with greater needs could have received services.
2. There is insufficient oversight of Children's Dentistry Project grants, in that there is insufficient knowledge of the extent and quality of services provided.
3. There is a lack of participating providers, particularly those who would have to donate their services as part of the Donated Dental Project.

The Legislative Auditor recommends continuing the Oral Health Program, but makes the following recommendations:

1. The Oral Health Program should begin collecting data on the numbers of students receiving oral health education for evaluation purposes.

2. The Oral Health Program should begin to supervise the performance of entities with oral health education contracts, establishing performance goals and measures for evaluation purposes, such asspecifying the schools to be visited and the number of visits annually, in order to allocate funds efficiently and coordinate educational efforts.

3. *The Oral Health Program should examine the possibility of expanding or reallocating resources for the Children's Dentistry Project, identifying counties with the greatest need for oral health education.*

4. *The Oral Health Program should seek to expand the number of oral health care providers participating in the Donated Dental Program.*

5. *The Oral Health Program should make further attempts to obtain records from the Foundation for Dentistry for the Handicapped that document whether or not the foundation actually provided the services for which it was contracted.*

6. *The Department of Health and Human Resources should determine if the Foundation for Dentistry for the Handicapped is currently receiving funds from the department itself or from any other state agency, for the purpose of discontinuing these funds as soon as possible.*

7. *The Legislative Auditor recommends continuing the Oral Health Program.*

Appendix A: Transmittal Letter

WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

John Sylvia
Director

November 18, 2004

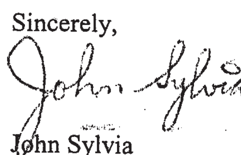
Chris Curtis, MPH, Acting Commissioner
Bureau for Public Health
350 Capitol Street, Room 702
Charleston, WV 25301-3712

Dear Commissioner Curtis:

This is to transmit a draft copy of the Preliminary Performance Review of the Oral Health Program. This report is scheduled to be presented during the December 5-7, 2004 interim meeting of the Joint Committee on Government Operations. We will inform you of the exact time and location once the information becomes available. A representative from your agency should be present at the meeting to orally respond to the report and answer any questions the committee may have.

We would like to schedule an exit conference to discuss any concerns you may have with the report. We would prefer to meet on Monday, November, 22, 2004. We need your written response by noon on Monday, November 29, 2004, in order to included it in the final report. If your agency intends to distribute additional material to committee members at the meeting, please contact the House Government Organization staff at 340-3192 by Thursday, December 2, 2004, to make arrangements. Thank you for your cooperation.

Sincerely,



John Sylvia

c: Paul L. Nusbaum, Secretary
c: Greg Black, D.D.S., Dental Director

JS/rk

Joint Committee on Government and Finance

Appendix B

Percent of Persons with Dental Insurance by County and Age			
County	Age		
	<19	19-64	65+
Barbour+	55.5	23.4 - Low	7.2
Berkeley	75.2	54.7	36.6 - High
Boone	87.0 - High	25.4	5.2
Braxton+	64.3	25.4	5.2
Brooke	76.3	45.1	6.6
Cabell*+	66.9	47.9	21.6
Calhoun*	79.7	36.2	16.9
Clay	75.9	31.0	6.4
Doddridge*	73.2	39.1	9.8
Fayette*	69.4	39.7	18.1
Gilmer	65.9	34.6	7.4
Grant*	60.6	35.4	13.3
Greenbrier	72.6	40.2	4.3 - Low
Hampshire*	67.0	36.6	18.8
Hancock	69.2	52.9	9.2
Hardy*	59.2	46.4	9.0
Harrison*+	68.6	35.2	14.6
Jackson+	76.7	57.8 - High	12.2
Jefferson	74.7	56.8	24.0
Kanawha*+	79.9	51.0	18.9
Lewis	67.9	31.6	17.5
Lincoln*	75.5	32.5	18.2
Logan+	65.7	34.2	16.6

County	Age		
	<19	19-64	65+
McDowell*+	81.0	24.6	11.2
Marion*+	69.3	44.6	8.6
Marshall*	68.9	45.1	8.0
Mason*	72.1	54.0	11.5
Mercer+	75.4	42.0	12.5
Mineral*+	74.8	51.5	9.9
Mingo*	65.1	32.7	14.9
Monongalia*+	50.8 - Low	38.4	14.9
Monroe	67.0	39.8	9.9
Morgan	72.5	52.3	28.2
Nicholas*	76.4	42.0	17.5
Ohio*	67.5	50.7	15.3
Pendleton	68.2	37.9	19.6
Pleasants	78.0	53.4	17.7
Pocahontas	63.9	30.6	11.4
Preston*	64.7	34.8	8.0
Putnam*	70.6	50.0	21.1
Raleigh*+	78.9	43.1	14.1
Randolph*+	58.0	29.8	12.8
Ritchie	77.1	43.9	14.1
Roane	77.0	35.6	11.4
Summers	76.1	30.8	14.8
Taylor*+	67.5	40.8	14.3
Tucker*	65.9	37.8	9.0

County	Age		
	<19	**19-64**	**65+**
Tyler	78.8	46.5	8.8
Upshur+	62.6	34.6	10.7
Wayne*+	75.5	46.2	14.3
Webster	80.7	37.7	5.2
Wetzel*	66.8	49.7	11.1
Wirt	85.5	47.7	9.0
Wood*	73.3	57.2 - High	18.5
Wyoming*	76.1	40.8	5.9
State Average	**71.1**	**41.1**	**13.3**

Source: West Virginia University Institute for Health Policy Research

**Indicates Children's Dentistry Project county*
+Indicates Donated Dental Project county

Appendix C

Percent of Persons with One or More Visits to a Dentist by County and Age			
County	Age		
	<19	19-64	65+
Barbour+	59.5	42.5	17.4 - Low
Berkeley	54.4	54.9	37.1
Boone	64.5	43.5	20.5
Braxton+	59.3	34.3	30.2
Brooke	69.9 - High	56.3	27.9
Cabell*+	54.3	51.4	28.6
Calhoun*	50.8	34.2	27.6
Clay	65.5	35.4	21.7
Doddridge*	63.3	40.5	26.6
Fayette*	57.8	39.7	36.8
Gilmer	58.0	37.1	42.3
Grant*	56.6	56.8	48.2
Greenbrier	59.5	43.3	23.5
Hampshire*	54.6	46.2	41.7
Hancock	57.5	50.8	45.3
Hardy*	69.6 - High	50.9	39.8
Harrison*+	60.6	43.1	45.1
Jackson+	61.1	47.8	45.2
Jefferson	57.6	46.1	42.4
Kanawha*+	60.5	51.4	35.2
Lewis	62.9	44.3	30.0
Lincoln*	54.6	37.3	19.7
Logan+	55.0	28.5 - Low	19.1

County	Age		
	<19	19-64	65+
McDowell*+	48.9	37.1	25.8
Marion*+	63.9	46.3	36.1
Marshall*	60.2	44.9	34.5
Mason*	47.5 - Low	40.2	33.7
Mercer+	56.6	42.3	47.4
Mineral*+	51.8	52.4	42.1
Mingo*	52.7	27.7 - Low	17.7 - Low
Monongalia*+	66.9	53.9	63.7 - High
Monroe	66.1	45.9	38.0
Morgan	52.5	53.1	57.5
Nicholas*	60.8	46.4	30.8
Ohio*	63.9	59.8 - High	46.3
Pendleton	63.4	54.9	54.5
Pleasants	59.9	47.2	31.4
Pocahontas	66.9	48.0	45.4
Preston*	64.4	46.7	35.8
Putnam*	63.7	54.6	44.9
Raleigh*+	57.8	41.4	30.3
Randolph*+	64.6	47.8	44.7
Ritchie	55.2	39.7	35.5
Roane	60.5	41.6	21.6
Summers	54.3	51.2	33.9
Taylor*+	61.6	54.3	34.2
Tucker*	62.1	48.4	25.9

County	Age		
	<19	19-64	65+
Tyler	68.9	53.0	30.0
Upshur+	63.9	49.5	36.6
Wayne*+	56.7	48.6	26.7
Webster	56.0	37.3	18.7
Wetzel*	61.1	50.4	31.9
Wirt	48.9	35.6	20.3
Wood*	52.0	53.0	50.9
Wyoming*	61.6	34.6	21.2
State Average	**59.3**	**45.5**	**34.5**

Source: West Virginia University Institute for Health Policy Research

**Indicates Children's Dentistry Project county*
+Indicates Donated Dental Project county

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bob Wise
Governor

Paul L. Nusbaum
Secretary

November 24, 2004

RECEIVED
DEC 01 2004
PERFORMANCE EVALUATION AND RESEARCH DIVISION

Mr. John Sylvia
West Virginia Legislature
Performance Evaluation and Research Division
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610

Dear Mr. Sylvia,

My staff and I have reviewed the draft report of the PERD review of the DHHR/Bureau for Public Health/Oral Health Program. We commend your staff for the good job they have done with this review. This is a fair evaluation and we generally agree with the recommendations. However, there are a few things in the report we would like to clarify:

1. **Concern about oversight of contractors for oral health education**

   The Oral Health Program (OHP) acknowledges that it must strengthen its oversight of these contractors. That process has begun.

   For the current contract period, OHP requires all oral health education providers to file a plan showing the number of presentations to be given, the estimated number of children to hear those presentations, the total number of K-12 students in the catchment area and the percentage of K-12 students estimated to hear the presentations. The provider has to sign and date the plan. A sample plan is attached (see Attachment I).

   Regarding documentation of activity, obtaining data on oral education activity for previous years was somewhat difficult due to software incompatibility. However, current data is easily accessible. The OHP will use this data to strengthen its oversight of oral health education providers.

   Regarding the quality of oral health education activities, OHP has exercised a reasonable level of diligence. The OHP designed grade-specific oral health education modules that have been approved by the West Virginia Dental Association. These modules were distributed free of charge to all oral health

BUREAU FOR PUBLIC HEALTH
Commissioner's Office
350 Capitol Street, Room 702
Charleston, West Virginia 25301-3712
Telephone: (304) 558-2971 FAX: (304) 558-1035

educators and any other interested organizations (for example, schools and Head Starts). In addition, the Dental Director has frequent telephone contacts with the oral health educators. He meets with them semi-annually to discuss their activities, to apprise them of events at the State level and to offer guidance on State expectations.

2. **The temporary suspension of new enrollments for the Pre-Employment Dentistry Project**

This decision was not made by the Bureau for Public Health. Funding for this Project is from a DHHR sister Bureau, the Bureau for Children and Families (BCF). The BCF estimated that TANF funds, federal funds which were used to fund this Project, would not be sufficient to continue the project and notified OHP of their decision to discontinue Pre-Employment dental and vision services. New approvals for services (referrals) ceased on July 1, 2004. The BCF wisely and compassionately agreed to pay provider charges for previously-authorized patients to complete treatment plans.

Since that time, BCF has received additional information that indicates TANF funds are available and that Pre-Employment can be reinstated. New enrollments will begin effective December 1, 2004. The Bureau for Children and Families has indicated it plans to continue the project through State FY 2006. As in previous years, available funding will be capped at $3 million per year.

3. **Concern about data deficiencies**

While there were deficiencies in data collection before FY 2001, since then OHP has collected data which shows the number of children educated and the number evaluated (screened) for oral health problems. Data for recent years is easily accessible.

4. **Concern about coordination of programs**

As stated previously, OHP agrees that collecting and analyzing data for oral health education activities must improve, and that this can improve coordination with other services. However, there is currently a great deal of coordination with other programs.

The OHP is housed organizationally with HealthCheck (EPSDT), the Early Childhood Health Project, the Adolescent Health Initiative, Right From The

Start, Children with Special Health Care Needs, and Birth to Three. This organizational proximity has facilitated the following linkages:

The OHP has worked with HealthCheck to steadily increase the number of Medicaid-eligible children receiving dental services.

The OHP collaborated with the Early Childhood Health Project, the West Virginia Head Start Association and several other organizations to host an Oral Health Forum in October, 2004. The Forum included the participation of 73 private practicing dentists and 43 hygienists, gathering to improve access to care for young children and children with special health care needs.

The OHP regularly consults with staff of the Children with Special Health Care Needs and Birth to Three Programs in an effort to increase services to children served by these projects.

The OHP consults with Right From The Start on oral health issues affecting pregnant women. The two programs worked together to design an education pamphlet on dental care for pregnant women.

Community contacts established by the Adolescent Health Initiative are valuable in locating community partners for OHP and in gauging the effectiveness of oral health messages targeting adolescents.

The OMCFH Division Director responsible for the OHP is a member of the Executive Committee of Partners Implementing an Early Care and Education System (PIECES), a member of the School-Based Partnership of the Health Umbrella Group, a member of the Governor's Cabinet on Children and Families Workgroup on School-Based Health and a member of the Governor's Council on Transportation Coordination.

5. Expanding the Donated Dental Project

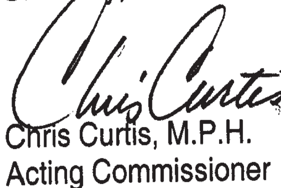
The forerunner to the current Donated Dental Project was known as Donated Dental Services (DDS) and was administered through a contract between another unit of BPH and a private foundation. To comply with HB 3017, OHP moved to consolidate DDS into the new Oral Health Program. A review of the budget for DDS showed that only a small percentage of the funds were used to pay for actual dental services. This prompted OHP's decision to administer the project internally with existing staff, using none of the available funding for administrative expenses.

The OHP notified the foundation of its intent to discontinue the contractual relationship and requested the records of patients served and providers rendering services. The OHP offered to pay for the compilation and copying of these records, and to allow the foundation to "phase out" its activities. The foundation refused to forward the records.

The OHP was faced with rebuilding the provider network for Donated Dental. The OHP began this process by discussing the project with Pre-Employment Services dental providers. Many of them had never heard of the concept of donated dental services and wanted time to consider it. As time has passed, we have enrolled forty providers in eighteen counties and linked 32 patients to services. In addition, we have contacted organizations which should enable us to increase providers and identify eligible patients. These organizations include the West Virginia University School of Dentistry, the Susan Dew Hoff Memorial Clinic in Harrison County (serves surrounding counties including Doddridge, a county with no resident dentist), the Developmental Disabilities Council and the West Virginia Bureau for Senior Services. We expect this project to continue to grow to the extent funds are available.

Again, we commend your staff and if you have questions concerning this matter, please call me at 558-2971.

Sincerely,



Chris Curtis, M.P.H.
Acting Commissioner

CC/dse

Attachment

cc: John Law
Pat Moss
Greg Black
Phil Edwards

Attachment I

Sample Plan

Supplement to the Statement of Work

Grantee:

Grant Number: G#
Grant Period: July 1, 2004 through June 30, 2005

By October 1, 2005, the Grantee must submit the following information, to supplement The Work Plan, to the Department:

#1. What is the number of presentations to be given during the grant period?
___________________Presentations

#2. What is the estimated number of children to be reached with these presentations?
___________________Children

#3. What is the total K-12 student enrollment in the catchment area?
__________________Students

#4. What is the percentage of K-12 students in the catchment area that #2 above represents?
________________Percentage (Divide #2 by #3)

____
Signature of Grantee Representative

____
Date