A path forward for children's dental health

Alternatives to community water fluoridation in Multnomah County

Children's Dental Health Task Force

CITY CLUB of PORTLAND
CIVIC LABS

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City Club of Portland – Civic Labs

City Club of Portland brings together civic-minded people to help solve tough local problems. It has completed more than 1,000 fact-based, non-partisan research projects since 1916.

Civic Labs projects use City Club's research rigor to find solutions that will lead to lasting civic improvements, but they do not reflect the official position of City Club. For this project, City Club provided a facilitator, writer, and research and advocacy advisors to support the work of the Children's Dental Health Task Force.

The task force wishes to express its appreciation to the following City Club of Portland members for their active help and support:

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Children's Dental Health Task Force Funders

The task force wishes to thank its funders. Without their generous support and willingness to bring all voices to the table to find ways to improve children's dental health in our community, this report would not have been possible.

Northwest Health Foundation

Kaiser Permanente

Daniel Deutsch

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The Children's Dental Health Task Force

Too many of Multnomah County's children lack access to basic preventive dental care. Oregon fares about average when compared to national measures of dental health, but average is not good enough. Portland, Multnomah County and Oregon can do better for children.

We will not substantially reduce rates of tooth decay without new strategies to reach the populations that have the greatest need. Leaders and dental champions must embrace scientifically validated practices that have the support of the community.

In the spring of 2013, health advocates proposed adding fluoride to Portland's public water supply to improve dental health. It became one of the most contentious civic debates in recent memory. Ultimately, voters rejected water fluoridation 60.6 percent to 39.4 percent. Since 1957, voters have rejected fluoridation four times and approved it once.[*] Regardless of one's position on water fluoridation, Portland voters appear highly unlikely to approve it in the foreseeable future.

Representatives from the two sides of the issue therefore agreed in the fall of 2013 to find attainable, cost-effective measures that would improve the dental health of Multnomah County's children. They sought to develop compromise strategies that both proponents and opponents of water fluoridation could support.

They turned to the City Club of Portland – Civic Labs for help. For nearly a century, City Club has brought together diverse voices in the community to tackle controversial topics. It produces reports that bear the hallmarks of careful analysis and practical recommendations.

The Children's Dental Health Task Force arose from those meetings.

Major water fluoridation proponents – Northwest Health Foundation and Kaiser Permanente – and the largest in-state donor for the anti-water-fluoridation campaign – Daniel Deutsch – provided funding for the task force. City Club managed it and provided a facilitator, writing services and other assistance.

A note about fluoride

The Children's Dental Health Task Force came together out of the singular desire to improve the health of Portland's children. Members on both sides of the water fluoridation debate share that goal, and found many areas of agreement, including topical application of fluoride varnish as a best practice.

Some readers might find it surprising that the three task force members who opposed community water fluoridation now endorse a different fluoride application. It is a misconception that opposition to community water fluoridation implies opposition to all fluoride uses.

While the taskforce supports recommendations that include removing barriers to dental access and expanding dental education for families, it also agrees that fluoride is effective and has the least adverse risk when applied topically through fluoride varnish. This also allows individuals to choose how much fluoride they and their children receive.

[*] The lone voter approval was in 1978. Voters reversed their decision two years later, before any fluoride was added to the public water.

The task force itself was composed of six stakeholders – three who opposed community water fluoridation and three who supported it. A selection committee consisting of representatives from the funders and City Club chose them through an open application process.

The task force cannot emphasize enough one fundamental point about this report:[*]

The task force's recommendations have the support of both proponents and opponents of water fluoridation.

The task force met for the first time on Nov. 18, 2013. It interviewed 29 health and community experts over almost a year. After deliberation and additional follow-up research, members agreed to make the recommendations contained in this report. The task force urges medical and dental professionals, community organizations, school districts, and city, county and state leaders to implement them.

Public awareness of dental health remains high after the 2013 campaign. This is an opportune time to engage the community in a dialogue and to take action that improves the dental health of Multnomah County's children.

"The arena of agreement is larger than many people would imagine. We never set ourselves up as being experts, but we talked to the right people to find the best ideas for Portland's children."

— **Children's Dental Health Task Force member**

[*] **A note about presentation:** Throughout this report recommendations and sidebars are highlighted in blue. Important findings and key points are highlighted in green.

Executive summary

The Children's Dental Health Task Force formed in the aftermath of Portland's debate over community water fluoridation. Advocates for children's dental health on both sides put aside their disagreements to find effective services that all could agree on.

Too many children in Multnomah County have dental health problems. They face barriers to receiving preventive services that reduce the need for more expensive and invasive treatments when dental decay sets in.

The task force identified five fundamental barriers to children's dental health: diverse communities are not served well, workforce shortages, lack of integration between medical and dental services, inadequate metrics for success, and lack of leadership around dental health.

The task force spent almost a year studying options and interviewing experts in order to identify the most promising strategies to overcome those barriers. If Portland, Multnomah County and Oregon are willing to invest in innovative approaches to delivering services, progress is possible. Greater education, expanded preventive services and stronger leadership are the three cornerstones upon which city, county and state can build success. Health officials and providers can do many things for children's dental health that do not generate the same level of controversy as water fluoridation.

The greatest challenges exist in specific underserved communities. Any child can get a cavity, but dental decay and chronic problems arise with much greater frequency among communities of color, non-English speakers and low-income families. Successful strategies therefore will engage those communities.

Work to prevent decay must begin even before a child is born with prenatal conversations and education with parents about good dental health practices.

Once teeth come in, fluoride varnish is a best practice to help all children avoid decay. It should be applied twice annually to both baby and adult teeth. Meanwhile, sealants should be applied to both first and second molars when they emerge.

Public health officials and community leaders must maximize opportunities for children to receive preventive services in diverse settings, both clinical and non-clinical. Community-based organizations are willing partners, if the county collaborates with them to deliver services to underserved, culturally diverse communities.

School-based programs remain an ideal location to reach many children, but Multnomah County and Coordinated Care Organizations (CCOs) must allocate resources to expand existing services and implement new ones. The schools themselves should take steps to make programs more accessible.

At a higher level, state health officials should use strong metrics for children's dental health to encourage Coordinated Care Organizations and dental plans to adopt best practices including varnish, sealants and education. They also should work to gather data that will inform future research on what programs are effective.

The state dental director must play a significant role in implementing these measures. The director must provide needed leadership by prioritizing children's dental health and advocating measures to address workforce shortages.

This is a time of great opportunity. After the water fluoridation debate, residents are more aware than ever about the dental needs of children. Political, health and community leaders will do Multnomah County's children a great service if they capitalize on this opportunity.

> *"Tooth decay affects children in the United States more than any other chronic infectious disease. Untreated tooth decay causes pain and infections that may lead to problems; such as eating, speaking, playing, and learning."*
>
> — **Centers for Disease Control and Prevention**

Recommendations

Recommendation 1
Multnomah County government and health service providers should partner with community-based organizations and provide funding to deliver services to underserved, culturally diverse communities.

Recommendation 2
Multnomah County Health Department should partner with community-based organizations to provide culturally specific, integrated, dental health and nutrition education programs to pregnant women, children and families.

Recommendation 3
Public health officials at all levels should promote prenatal dental instruction that includes daily baby gum wipes to encourage brushing when teeth emerge and dietary recommendations to reduce sugar intake.

Recommendation 4
Multnomah County and the state should immediately negotiate with CCOs and dental plans to create a system of shared funding and responsibility for providing preventive services – including fluoride varnish and sealants – in a culturally competent manner in community settings. Key settings include schools, childcare centers, early childhood learning centers and community-based service providers.

Recommendation 5
In order to improve workforce shortage problems, Oregon state elected officials should support:

- Training traditional and non-traditional healthcare providers to apply varnish and perform dental screenings.
- Expanding the pool of providers eligible for Medicaid reimbursement for applying varnish and performing dental risk examinations to include a range of health and non-traditional service providers, including community health care workers.
- Diversity in the dental workforce with programs such as tuition reimbursement for dentists who provide services in underserved communities.
- Incentives such as enhanced reimbursement rates for dental screening and fluoride varnish application in order to encourage more dental and medical providers to accept Medicaid patients.

Recommendation 6

Local school districts should implement several changes no later than the 2015-16 school year to encourage children's dental health:

- Provide access to fluoride varnish for all children twice per year.
- PPS should follow through on plans to phase out its fluoride supplement program. Other school districts with supplement programs should replace them with a varnish program.
- Expand existing sealant programs and create sealant programs in school districts that do not now have them. Set a goal of reaching 75 percent of students and begin offering sealants no later than second grade.
- Consult with legal counsel to determine if students may participate in dental fluoride varnish programs through an opt-out policy instead of opt-in.
- If opt-out is not permissible, schools should present parents with multiple opportunities to sign the opt-in forms, and those forms should be valid until revoked, not just one academic year.
- Provide numerous additional opportunities to sign opt-in or opt-out forms such as at initial student enrollment, during parent-teacher conferences, and at school-organized community gatherings held during evening or weekend hours with translators available.

Recommendation 7

Multnomah Education Service District and all local school districts should pursue several measures to increase accessibility for children's dental services:

- Create a prioritized list of schools with children most in need of dental service and target top-priority schools.
- MESD, not PPS, should contract with the ViDA coordinator in order to eliminate HIPPA barriers to sharing information.
- Extend the hours of the Creston Clinic.
- Support plans to launch a dental clinic at Benson Polytechnic High School.

Recommendation 8

The Oregon Health Authority should immediately develop and adopt a tracking system that measures fluoride varnish, sealants, and basic preventive dental services during medical and dental visits. They should track data related to efficacy of those steps and any long-term health effects. If OHA fails to implement the tracking system, Multnomah County should implement a local version.

Recommendation 9

The Oregon Health Authority and the Metrics and Scoring Committee should adopt CCO metrics that explicitly include fluoride varnish and sealant applications, prenatal dental care visits and early childhood visits.

Recommendation 10

Oregon's state dental director should champion children's dental health and reform. Specifically, the director should:

- Collaborate with medical and health leaders, especially the State Public Health Director, to find opportunities for shared responsibility and ensuring that basic preventive dental care is standard practice in well child visits.
- Secure funding to expand training in fluoride varnish application and dental screenings, including all licensed childcare providers.
- Build partnerships with organizations that serve low-income families and communities of color and encourage them to play a more active role in implementing best practices and developing dental policies that work for their communities.
- Develop and advocate for innovative legislation to integrate medical and dental services, expand access to preventive services and increase the workforce.
- Seek out and develop partnerships with dental health leaders and local dental health coalitions that will vigorously advocate children's dental health in their communities.

Recommendation 11

Multnomah County and local CCOs should implement and fund a pilot ABCD-like program within two years. It should include:

- A medical home/dental home model that allows integration of dental services with primary care visits through WIC, pre-natal, child wellness and home health visits.
- Public/private partnerships that provide assistance navigating Medicaid billing and protocols similar to Washington Dental Service Foundation's services provided to the ABCD program.
- Programs to provide basic preventive services and screenings at licensed childcare centers and other suitable organization – such as HeadStart, Boys and Girls Clubs and Ys.

* * *

The state of children's dental health

Dental disease is common among Oregonians, especially the state's children.

The most recently available data show that slightly more than half (52 percent) of children aged 6 to 9 in Oregon have had a cavity, an improvement on previous years.* The rate was 64 percent in 2007 and 57 percent in 2002.[1]

The dental health of children in Multnomah County differs little from children statewide and nationally on such measures.

Oregonians should never be satisfied with being just average. Oregon's goal should be for residents of all ages to have the healthiest teeth in the nation.

Dental and oral health

For this report, the task force focused on children's *dental* health as opposed to *oral* health. Loosely speaking, dental health is a subset of oral health that deals with teeth, especially early stage decay and cavities. Oral health includes gum disease and other mouth conditions.

That is not to say that oral health is irrelevant to this report. Indeed, good dental health is an essential foundation to good oral health.

Dental problems are especially acute in particular populations. The Oregon Health Authority's 2012 "Oregon Smile Survey" found that rates of childhood tooth decay are much greater among lower-income households and racial and ethnic minorities. Sixty-three percent children from lower-income households had a cavity compared to 38 percent of those from higher-income. Meanwhile, 68 percent of Hispanic children had cavities compared to 47 percent of whites.†

Cavities can be filled, but often children do not receive the dental care they need and decay goes untreated. One-quarter of children from low-income households have untreated decay, and one-fifth have rampant decay.

"A lot of kids and even adults walk around with a mouth full of cavities. They don't really know what it's like to be pain-free," said Dr. Lisa Bozzetti, dental director at Virginia Garcia Memorial Health Center.[2]

If the community wishes to improve childhood dental health broadly, it must focus on groups that have the greatest problems. The task force believes every child deserves the best dental health services. Its recommendations apply broadly, but it gave special focus to measures that target groups most at risk.

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* Tooth decay and cavities are medically referred to as "caries." Per the Centers for Disease Control: "[Caries/Cavities] are caused by a breakdown of the tooth enamel. This breakdown is the result of bacteria on teeth that breakdown foods and produce acid that destroys tooth enamel and results in tooth decay." The task force chose to use the term "cavities" in this report because it is more commonly used colloquially. (See cdc.gov/healthywater/hygiene/disease/dental_caries.html)

† The Oregon Smile Survey counted as low-income households those in which children participated in the free or reduced lunch program. It did not directly measure income.

Tooth decay contributes to a host of other challenges. Chronic or acute pain in the mouth can cause significant disruptions in a child's life and well-being. Dental disease is a leading cause of missed school days and leads to social stigmatization caused by cosmetic issues.

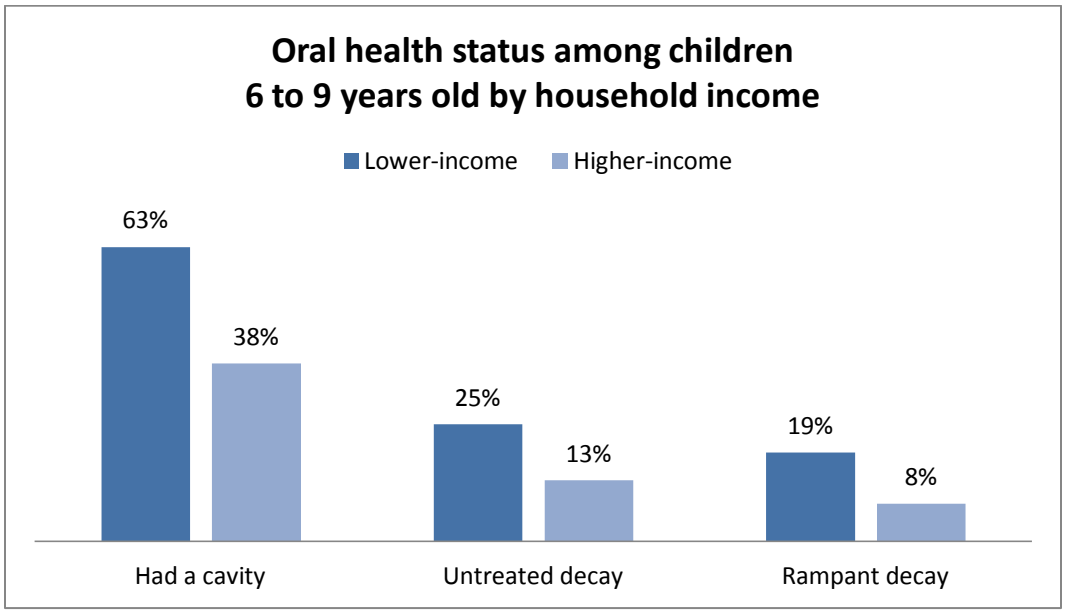
If children can make it to their teens without significant oral health problems, they likely will avoid them in adulthood. Decay is cumulative, and having avoided it that long typically means a young person has developed healthy practices and received preventive care.

"When we start out without a lot of cavities as teenagers, we can actually keep our teeth from getting cavities as adults," said Dr. Eli Schwarz, professor and chair of the Oregon Health & Science University's Department of Community Dentistry.[3]

Without that foundation of good dental health, children face a lifetime of not only dental problems but also potentially other health issues. Dental disease often leads to gum disease and other oral health problems. The Mayo Clinic notes that research suggests links between the oral bacteria that cause decay and occurrence later in life of cardiovascular disease and other health problems.[4]

"We know disease is related to oral health of the individual," said Donalda Dodson, executive director of the Oregon Child Development Coalition.[5]

The relatively small cost of prevention pays large dividends over a lifetime. All Multnomah County children deserve resources, education and dental care necessary to experience optimal health. That will require delivering services in new places and engaging with diverse communities in ways that respect their unique characteristics.



Source: Oregon Smile Survey, 2012

Barriers to children's dental health

Children and families face many barriers to dental health in Multnomah County. The task force heard from diverse community members and health professionals who described the challenges they see on a daily basis. Some barriers are rooted in historic practices, events and community divisions. Others arise from economic, social and cultural realities.

Barriers also exist at the intersection of the medical and dental communities. How they interact and provide services bears tremendously on how effectively children can access services.

The status quo has failed too many residents. While current delivery models are adequate for some people, entire communities within the city are poorly served. Just as no one barrier to dental health affects everyone, no one solution will fix all of them.

The task force identified five barriers that are particularly important to address and consider openly:

1. **Diverse communities are not served well**
2. **Workforce shortages**
3. **Lack of integration between medical and dental services**
4. **Inadequate metrics for success**
5. **Lack of leadership at the state level around dental health**

Health and community leaders must adopt a multi-pronged approach that seeks to deliver preventive dental care and education in as many places as possible, especially in the environments in which members of historically underserved communities will be best served.

> *"A lot of kids and even adults walk around with a mouth full of cavities. They don't really know what it's like to be pain-free."*
>
> — **Dr. Lisa Bozzetti**

Diverse communities are not served well

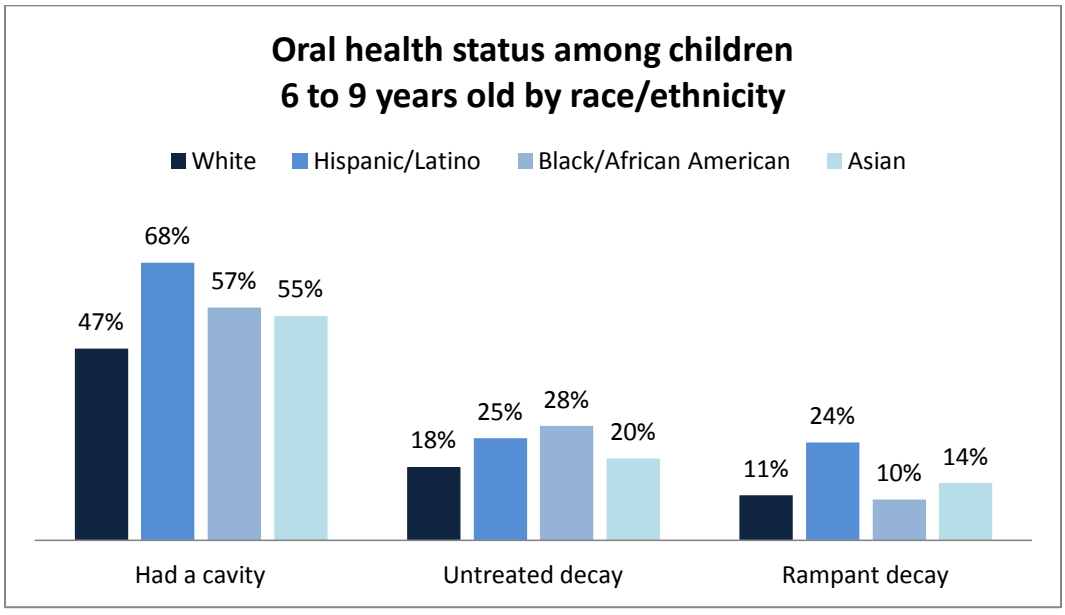
(Recommendations 1, 2, 4, 5, 10 and 11 address this barrier.)

Children of color, those from low-income families and those who speak English as a second language have higher rates of cavities and untreated dental decay than other children.

The racial and ethnic groups that have the greatest rates of childhood cavities each are unique communities with different characteristics and challenges. Although broad-based strategies have the potential to reach the most people, in order to engage with underserved populations, leaders also must tailor goals and strategies to specific communities. Often, cultural and historic forces work against their engagement with mainstream systems.

The task force spoke to representatives of several groups to understand better their particular challenges. Those representatives agreed that dental challenges are very real to their particular communities, and they clearly stated that they would welcome better access to dental preventive services. They recommended enhanced cultural awareness, cultural competence and trust as necessary components for successful outreach.

Tawna Sanchez, Director of Family Services with NAYA Family Center, traced skepticism about medical and dental services in the Native American community to historic wrongs committed against them. Forced sterilization and involuntary pulling of teeth still linger in the community's collective consciousness.



Source: Oregon Smile Survey, 2012

"It sits in our history. Like generational trauma, it rolls down into the next generation, so people have innate fear about those sorts of things," she said. "We have to get to a place where we move past those, but that takes work. It takes a lot more than somebody standing there with a toothbrush and toothpaste, saying, 'Well, this is what you've got to do every day.' It doesn't work like that."[6]

Those communities wish to become engaged and active participants in solutions that meet them on their own terms. Solutions created by state or county officials who are not as actively engaged in the day-to-day life and needs of these communities are less likely to succeed.

Dental strategies also must take into account the economic factors that affect personal health. "It is very time-consuming and expensive to be poor," Sanchez said.[7]

She described some of the specific challenges. Federal and state programs like Temporary Assistance for Needy Families (TANF) and Special Supplemental Nutrition Program for Women, Infants and Children (WIC) require meetings and paperwork. If people cannot afford gas for a car to get children to daycare, they take the bus. That can be very tiring and time-consuming.

"Because so many of the families were low-income, they just didn't get the dental care that the kids deserve. So they just went without it," said Patricia Bates-Sherman of Self Enhancement, Inc.[8]

Things only get worse with health care for children. Sometimes parents are so overwhelmed, they do not have time to take children to appointments without skipping some other important appointment.

These challenges are by no means unique to low-income households. Many working parents experience similar difficulties.

Nevertheless, poverty is a clear indicator of propensity for dental disease. It falls beyond the scope of this report to end poverty, but the task force acknowledges that measures to improve the economic wellbeing of the community will have far-reaching benefits including in the realm of children's dental health.

Mainstream health systems and dental services have proven ineffective at serving racially, culturally and economically diverse communities.

Workforce shortages

(Recommendation 5 addresses this barrier.)

The lack of access to dental care in Multnomah County and all of Oregon has many causes, but none is more fundamental than the shortage of trained providers. Children, especially those from low-income households, cannot go to the dentist or other provider if none is available.

The shortage has two primary elements:

- Dentists are unevenly distributed. As a result, regions of the state and county have inadequate workforce to serve community members.
- Too few dentists and medical providers accept Medicaid patients.

With regard to distribution, nearly a quarter of the state is underserved. Twenty-four percent of Oregonians live in federally designated dental health professional shortage areas. HPSAs are defined as areas with 5,000 or more people per dentist. In 2013, the U.S. Department of Health and Human Services ranked Oregon as the 10th worst state for dental shortages.[9]

Meanwhile, Oregon's recent health care transformation and the integration of dental plans under CCOs create an increased demand for dentists who accept Medicaid-eligible patients. This is especially true in urban settings. Medicaid enrollment statewide increased by 62 percent from Jan. 1 to Sept. 1, 2014.[10]

Workforce shortages have a cultural component as well. The dental workforce in Oregon lacks diversity and does not reflect the ethnic and racial makeup of the state.

A workforce shortage that includes professional shortages, insufficient acceptance of Medicaid, and a lack of diversity hinders many children from receiving dental care.

Oregon dentists and the population at large:
Select race and ethnicity

Race	Dentists	Oregon	Multnomah County
American Indian/Alaska Native	0.9%	2%	2%
Asian	8%	4%	7%
Black (not Hispanic)	0.4%	2%	6%
Hispanic	2%	12%	11%
White (Not Hispanic)	87%	76%	72%

Sources: Oregon Board of Dentistry and U.S. Census Bureau.

Note: Dentists rates reflect those who chose to answer a race/ethnicity question in an OBD survey. Only half of respondents did so.

Lack of integration between medical and dental services

(Recommendations 3, 8, 9 and 11 address this barrier.)

One of the challenges in addressing dental health is the historic accident that the mouth is typically treated separately from the rest of the body. The tradition goes back at least to the 19th century, and modern medical training, professionalization and insurance practices have reinforced it.[11]

The Institute of Medicine of the National Academies' Committee on an Oral Health Initiative noted the pervasiveness and some of the implications of this paradigm:

> *Oral health care is often excluded from our thinking about health. Taken together with vision care and mental health care, it seems that problems above the neck are commonly regarded as peripheral to health care and health care policy. This division is reinforced by the fact that dentists, dental hygienists, and dental assistants are separated from other health care professionals in virtually every way: where they are educated and trained, how their services are reimbursed, and where they provide oral health care. This separation is at odds with the fact that good oral health has been shown to directly affect a person's overall health.*[12]

Practical challenges related to this division arise as well. For example, electronic records are neither commonly shared nor even compatible between medical and dental providers.

Several of the witnesses to whom the task force spoke raised concerns that the separation does not serve patients well.

Dr. Cat Livingston, a family physician at OHSU Richmond Clinic, described the views of many doctors. "It's mostly just a lack of awareness or engagement. The mouth is somebody else's issue," she said. "A lot of it is thinking of it as, 'Oh, they can just see their dentist and get it taken care of there.' "

Donalda Dodson, Executive Director, Oregon Child Development Coalition put it succinctly. "We've got to put the mouth back into the body," she said.

While completely integrating dental and medical care into the systems that deliver health care services will likely take many years due to the long-standing differentiation between the professions, the task force concludes such an approach would reduce dental decay in all populations and potentially save overhead costs for providers as infrastructure and services become more collaborative.

Greater integration between dental and medical providers creates opportunities to improve dental health for patients.

Inadequate metrics for success

(Recommendations 4, 8 and 9 address this barrier.)

Historically, there has been a lack of standardized, coordinated metrics to gauge success in dental care and prevention. That is now changing due to the confluence of medical transformation taking place locally and nationally.

At the federal level, standardized dental metrics are coming online and best practices are being identified. Dental delivery systems within the state and county should capitalize on these changes by updating to a shared vision of success that incorporates best practices and embraces sound metrics.

"Despite some cynicism around metrics, the metrics are helping drive health reform right now," Tri-County Health Officer Dr. Paul Lewis said. "In the last year we watched CCOs flex to meet the first 17 metrics. Good oral health metrics are critical because that work gets prioritized."[13]

Oregon's health care transformation includes CCOs working with eight dental plans. So far, they have adopted just one shared metric: sealant rates.

A single metric is inadequate to judge the success of preventive measures and improved dental health in the community.

Without additional metrics, CCOs have little official or financial incentive to pursue many of the best practices and strategies that would benefit underserved children.

Deploying additional metrics also would generate missing data about the effectiveness of treatments and strategies. Better data would allow officials to fine tune programs to serve children of diverse backgrounds and ensure that public resources are expended in the most cost-effective manner.

Detailed dental metrics serve two useful purposes:

- **They provide an incentive for CCOs and dental plans to provide dental services specified in the metric.**
- **They are a mechanism to gather data that will allow accurate assessment of effectiveness and program performance.**

Lack of leadership at the state level around dental health

(Recommendations 5 and 10 address this barrier.)

The task force heard from many witnesses that a leadership deficit exists in Portland, Multnomah County and Oregon when it comes to dental health. Without strong leaders who actively advocate for change, the status quo will persist.

Champions must step forward throughout the system. They must come from community organizations, from the ranks of practicing dentists, and from government.

"It all stems back to lacking strong leadership in the state about oral health policy and practice," said Melissa Freeman, Director of Strategic Projects at Oregon Community Foundation.

"One of the more problematic things that I see is that there seems to be a lot of good work happening out there, but it's all disconnected," said Andre Jackson who oversees Portland Public Schools' Vision, Dental and Audiometric (ViDA) program. "We are a community. If we truly want to address dental health and leverage resources, we need to have a mechanism to coordinate programs and organizations."[14]

Strong leadership focused on politically feasible initiatives and best practices is needed to implement systems that will serve Oregon children.

"We have to provide preventive dental services and education through public health programs, through childcare centers, elementary schools, community centers and other areas, otherwise it's just not going to be effective."

— **Dr. Cat Livingston**

Partnerships to reach people where they live: Health and housing collaboration

Low-income families face tremendous barriers to accessing health care. Cost of care, proximity of care, and knowledge that care options exist can be major impediments to receiving service. Schedules of school age children, the multiple jobs required to earn a living wage, as well as lack of employer flexibility can reduce available time for care. Major barriers include cost, time and lack of transportation options. Further, a care organization's cultural competence and/or non-holistic approach to health management may be an impediment to providing adequate care services.

Human Solutions Inc. and Wallace Medical Concern have partnered to expand their low-income health services collaboration by introducing a low-income dental clinic on the bottom floor of a new affordable housing development in Gresham.

Rosewood Plaza is an example of how the affordable housing community is innovating to link housing and health services for better health outcomes, improved health access, and reduced healthcare costs for disadvantaged populations.

Rosewood Plaza will provide 45 affordable housing units and expands on Human Solutions' Rockwood housing development that includes 47 housing units over a multi-service center. The center is a one-stop shop for health and human services including supports from eight local service providers. The co-location of multiple providers allows a complementary suite of supports that is more accessible to low-income families. The location of the two projects on light rail and in close proximity to major bus lines reduces transportation barriers.

Wallace Medical Concern is a federally qualified health center that provides a patient-centered, medical-home model of care, including integrated dental health services. Wallace is partnering with Oregon Health and Science University's School of Dentistry. The school provides crucial technical advice, is donating some equipment, and will place dental students in rotations at the site, extending Wallace's medical supports and providing the dental students with invaluable training and experience in a community clinic setting.

The dental clinic will provide crucial access to an area that is characterized by high poverty levels, substandard housing, and rent-burdened residents. When completed, Wallace Medical Concern anticipates 3,000 dental patients annually with improved dental outcomes leading to improved health outcomes and a better quality of life for its clients. The new clinic will have seven dental exam rooms, labs, x-ray s and facilities for simple oral surgeries.

Rosewood Plaza demonstrates one innovative way that affordable housing and health care can be linked to increase services for low-income people.

Strategies for improving children's dental health

Just as the task force found many barriers to advancing children's dental health, it heard about many potential solutions.

Greater access to preventive services and better education of children and parents must flow from partnerships with the communities that face the highest rates of decay and the steepest barriers to service on their own terms. Existing mainstream systems, while serving many children, have not created the sort of dramatic shift in care that is needed. Providers and funders must better support preventive services that are provided beyond dental chairs and dental clinics.

Engage with diverse communities

The task force's most fundamental recommendation, the one from which all its other recommendations flow, is that Multnomah County – and Oregon – must find new ways to work with diverse racial, ethnic and economic communities. Dental leaders must embrace strategies that will provide multiple opportunities for children and parents to receive the services and education that will lead to dental health.

Dozens of community-based organizations in the county could host successful programs. Members of those communities already go to those organizations for services.

NAYA's Tawna Sanchez said the Native American community would welcome greater engagement. "I would like dentists to come to our office. I'd like there to be a dental clinic because what I know about our community is if we had that capacity in NAYA, NARA* or any one of the major programs, people would trust it because they trust us," she said.

The task force heard similar sentiments from representatives of other racial and ethnic communities. Community-based organizations are willing to work with government agencies so long as they are approached in a culturally sensitive way.

Recommendation 1

Multnomah County government and health service providers should partner with community-based organizations and provide funding to deliver services to underserved, culturally diverse communities.

* The Native American Rehabilitation Association of the Northwest.

Oral hygiene and education

The most important thing for healthy teeth is personal action. Families and children who take care of their teeth will experience less decay and fewer cavities. With that goal in mind, the task force recommends investment in educational efforts.

Education and the will to put knowledge into practice is an essential element of lifetime dental health, and it should begin before birth with parents.

The task force acknowledges that nonprofits, schools and the county already engage in education efforts, but they must build upon and expand existing systems.

For Washington State's Access to Baby and Child Dentistry program, that has meant reaching out to parents early and often. "We wanted to emphasize that parents have an important role. Parents need to understand more about the importance of teeth to development, to social interaction, to success in school and to less absenteeism in school," ABCD Managing Director Kathy O'Meara-Wyman said.*

Dr. Lisa Bozzetti, dental director at Virginia Garcia Memorial Health Center, shared that view, "The pregnant woman is a really key starting point for even having this discussion. If you can help prevent dental disease in a pregnant woman and help to educate her about her own dental health and also give her some background, she will then know when the baby is born that it's important to bring the child in and have the child evaluated."

In order for education to be effective, it must be tailored to the needs of specific cultural groups. For example, in the Mexican and Native American communities, some common practices are detrimental to children's dental health and span generations of cultural practice. Going to bed with a sweet beverage in a bottle or sippy cup is common practice.

About one-quarter of Oregon toddlers use a baby bottle or sippy cup in bed, and 41 percent of those bottles have something other than water in them at night. Many preventive services aimed at reducing decay rates, including fluoride, are less successful under those circumstances.[15]

Daniel Ornelas, also at Virginia Garcia, said that infants often go to bed with a bottle of milk. That leaves them exposed to sugars for hours at a time. Many early childhood cavities are the result of such "baby bottle tooth decay" or "bottle rot."

As Mexican children grow up, they begin to consume a considerable amount of soda. "In our culture, drinking soda is like drinking water with your meals," Ornelas said.[16]

Mexico is second only to the United States in national per capita soda consumption.[17]

* See page 24 for more information about Washington's ABCD program.

"There's a huge opportunity for messaging on the medical end of things when it comes to obesity," Bozzetti said. "It would be a really easy message to include a piece about oral health because everything that causes obesity is pretty much the same as causes dental cavities."

Recommendation 2

Multnomah County Health Department should partner with community-based organizations to provide culturally specific, integrated, dental health and nutrition education programs to pregnant women, children and families.

Recommendation 3

Public health officials at all levels should promote prenatal dental instruction that includes daily baby gum wipes to encourage brushing when teeth emerge and dietary recommendations to reduce sugar intake.

Fluoride varnish and sealants

Fluoride varnish is a concentrated topical fluoride that is brushed onto teeth. That prolonged exposure has proven particularly effective at preventing cavities. A 2013 literature review found that varnish's effectiveness at preventing dental decay to be 43 percent.[18]

The U.S. Preventive Services Task Force, an independent panel of national medical experts, recommends fluoride varnish application to baby teeth in all infants and children as soon as they emerge from the gums. It also views a six-month interval between applications as suitable.[19]

The Centers for Disease Control also endorses fluoride varnish. It cites practical advantages such as ease of application, inoffensive taste and smaller quantity of total fluoride exposure compared to other delivery methods.[20]

Children who receive fluoride varnish applications twice per year experience significantly less decay than children without such treatment.

Schools are one of the best places to reach children with preventive dental services because almost all children must attend by law.* However, even under compulsory education requirements, students do not need to attend until age 7.[21] Therefore, programs must target children outside of school also.

Patricia Bates-Sherman of Self Enhancement, Inc. reinforced the importance of a broad-based approach to reaching diverse communities. SEI is a nonprofit organization supporting at-risk urban youth. It

* Home-schooled students are the notable exception.

collaborates with teachers and school administrators to identify at-risk youth. The majority of the young people whom the program serves are African-American.

“Synagogues, community centers, the Ys, the Boys and Girls Clubs, all of those places where kids and families gather, we need to make it convenient for them,” she said.[22]

Bates-Sherman described success that the organization has had when it directly engages with families in the home. When education and referrals for dental care came from SEI, they tended to be received well because the organization is known and trusted in the community.

Fluoride varnish is especially well suited for deployment in diverse settings including within community-based programs and licensed childcare centers. Anyone can learn to apply varnish to a child’s teeth. It does not require a medical professional.

Fluoride varnish is suitable for deployment in diverse settings by anyone with appropriate training in its application.

Dental sealants are another successful means of protecting teeth. Sealants are thin, plastic-like coatings applied to the chewing surfaces of molars to prevent food from being trapped inside pits and fissures. They thus deprive resident plaque bacteria of food and help prevent formation of cavities.

Sealants are most effective when applied to molars soon after eruption. The application process takes little time, and the sealants can last up to 10 years in the mouth. Sealants are generally applied in first, second or third grade, and secondary sealants are applied with eruption of second molars, generally during middle school years.

Both the CDC[23] and the American Dental Association[24] identify sealants as an effective means of protecting permanent molars in children. The literature review conducted by the ADA found incidence of cavities within the molars of children after sealants was reduced by 86 percent at one year and 59 percent at four years.

The Pew Charitable Trusts, in a report on the use of sealants in the states, found that Oregon does better than most, earning a B grade. The state’s main deficiency was inadequate deployment of sealant programs in high-need schools. Pew sets a goal of reaching 75 percent of such schools, but Oregon falls into the 50 percent to 74 percent range.[25]

Multnomah County historically has done very well providing sealants for children in schools that qualify for the program. However, disparities persist in delivering services to diverse racial, ethnic and linguistic groups. Greater success is possible by reaching more children and by providing funding to apply sealants to second molars.

The CDC concurs about the efficacy of school-based sealant programs. “School-based sealant programs are especially important for reaching children from low-income families who are less likely to receive private dental care. Programs generally target schools by using the percentage of children eligible for federal free or reduced-cost lunch programs,” the agency reports.[26]

Dental plans and CCOs are focusing on sealants because they are their lone metric of success.

All children should receive dental sealants on their first and second molars.

Varnish and sealant applications will reach the most children if they are be available in a wide range of settings, including through partnerships with culturally specific organizations and licensed childcare centers. One step to encourage deployment of fluoride varnish and sealants in more settings is to increase reimbursement rates.

Fluoride varnish is inexpensive. The cost of materials is $1 to $4 per application.[27] The 2014 Oregon Health Plan's varnish reimbursement rate is $12.97. However, reimbursements were restricted to dentists, dental hygienists, doctors, nurse practitioners, and physician assistants. Other people who apply varnish outside clinical environments are ineligible for reimbursement.

Expanding reimbursements to additional providers, both traditional and non-traditional, will require collaboration with the State Board of Dentistry and elected officials. The board, with support from local dental advocates and community-based organizations, should advocate for state changes that would allow additional providers to apply varnish and to receive reimbursement for their services.

If that proves politically impractical, partnerships with cultural organizations must include working with suitable providers to ensure proper reimbursement from the Oregon Health Plan.[28]

If OHP's sealant reimbursement rate of $19.31 per tooth ($77.24 for all four first or second molars) were augmented, it could encourage more dental providers to apply them.

Multnomah County Education Service District offers one example of innovative workforce deployment. It coordinates with school nurses in the David Douglas School District to send dental vans to each of the district's schools annually. Oregon Health & Science University Dental School students staff those vans. The district sends students with severe problems to Multnomah County school-based health centers for immediate, temporary services.

Finding the money for new preventive programs will not be easy in the current environment of tight government budgets. Oregon's health transformation says that CCOs should pay for all children eligible for Medicaid, which is slightly more than half of all children. CCOs have a moral and legal obligation to fund preventive services for those children and should work with schools to make it happen.

At the same time, the community must create a funding framework, so that all parties feel comfortable providing a fair amount of funding. This is critical to moving forward with key prevention strategies.

Funding for universal varnish and sealant programs will require collaboration between CCOs, government, community programs and other nonprofits.

Recommendation 4

Multnomah County and the state should immediately negotiate with CCOs and dental plans to create a system of shared funding and responsibility for providing preventive services – including fluoride varnish and sealants – in a culturally competent manner in community settings. Key settings include schools, childcare centers, early childhood learning centers and community-based service providers.

Recommendation 5

In order to improve workforce shortage problems, Oregon state elected officials should support:

- **Training traditional and non-traditional healthcare providers to apply varnish and perform dental screenings.**
- **Expanding the pool of providers eligible for Medicaid reimbursement for applying varnish and performing dental risk examinations to include a range of health and non-traditional service providers, including community health care workers.**
- **Diversity in the dental workforce with programs such as tuition reimbursement for dentists who provide services in underserved communities.**
- **Incentives such as enhanced reimbursement rates for dental screening and fluoride varnish application in order to encourage more dental and medical providers to accept Medicaid patients.**

While the taskforce recommends expansion of preventive services into many environments, schools remain the best place to reach the most children ages 7 and older. Meanwhile, licensed childcare centers, including Head Start, are the best places to reach children from birth to 6 years old, especially children from low-income families, but they are by no means points of universal access.

Multnomah County and Portland Public Schools currently operate a fluoride supplement program for students, but PPS has announced it will phase out the program in the fall of 2015.

Multnomah County operates a school sealant program in grades 2 and 3, with dental professionals applying the sealants. It also offers a more limited program in grades 7 and 8. Those periodic visits are important to ensure that sealants remain intact and replace them if not.

The problem is limited availability. Only schools that serve low-income families – defined as schools in which 50 percent of students qualify for free or reduced-price lunch – are eligible for the program.[29]

PPS will expand the sealant program with the phasing out of the supplement program. Resources that had gone to the supplement program will go to sealants. While the task force applauds this decision, it urges even greater investment in preventive dental health programs as described below.

In the David Douglas School District, all students are eligible to receive sealants in grades 2 and 3 under a program run through Multnomah County Health Department. David Douglas also provides a daily fluoride supplement program, but it faces the same inherent problems as all such programs.

Portland Public Schools Head Start does not offer fluoride varnish to students. It instead helps families identify dental homes for their children. Once connected with a dental home, a child's dentist makes the determination if that child is at high risk for cavities and applies fluoride varnish him or herself.

In ideal application situations, fluoride varnish and supplements have comparable success at preventing dental decay, 43 percent and 48 percent respectively.

In real world situations, especially in schools, the relative effectiveness of varnish is greater than fluoride supplements in large part because it does not require daily dosage that can easily be missed.

Local school districts might partner directly with CCOs and dental plans to implement a varnish program. Such collaboration could offer expertise and simplified administration.

Fluoride varnish and expanded sealant programs are each more effective than fluoride supplement programs.

One of the chief challenges for the fluoride program has been obtaining consent from parents. It will be a challenge for varnish and sealant programs.

Multnomah County's school-based fluoride supplement program requires a parent or guardian to sign an opt-in form. If the forms are not returned, children may not participate in the program.

For children in need of such preventive services, and for their families, tracking forms can be a complex and laborious process. Many families face social pressures or cultural history that distract from returning forms, if parents receive them at all. In addition, English is a second language in many households.

Removing this barrier to participation would increase access for all children and, in particular, vulnerable children most in need of dental preventive services. Schools cannot solve the underlying issues, but a different permission system could increase participation.

The task force concludes that an opt-out program would be more effective. However, the task force was unable to ascertain the full legal ramifications of this within the scope of its work. County and school legal counsel is better positioned to identify whether an opt-out program is feasible.

If schools cannot or will not adopt an opt-out model, they must work harder to overcome the inertia of unsigned paperwork. The more opportunities parents have to opt their children into preventive programs and the longer signatures are valid, the more likely it is that children will receive services.

Initial student enrollment, parent-teacher conferences and other events that engage parents are all appropriate opportunities to ask parents to allow their children to receive preventive dental services. Moreover, once granted, permission should last until revoked or until graduation rather than seeking new permission annually.

School-based preventive dental programs would be more effective if permission were opt-out rather than opt-in, or if parents and guardians were afforded more opportunities to sign a permission form that lasts until revoked.

Recommendation 6

Local school districts should implement several changes no later than the 2015-16 school year to encourage children's dental health:

- **Provide access to fluoride varnish for all children twice per year.**
- **PPS should follow through on plans to phase out its fluoride supplement program. Other school districts with supplement programs should replace them with a varnish program.**
- **Expand existing sealant programs and create sealant programs in school districts that do not now have them. Set a goal of reaching 75 percent of students and begin offering sealants no later than second grade.**
- **Consult with legal counsel to determine if students may participate in dental fluoride varnish programs through an opt-out policy instead of opt-in.**
- **If opt-out is not permissible, schools should present parents with multiple opportunities to sign the opt-in forms, and those forms should be valid until revoked, not just one academic year.**
- **Provide numerous additional opportunities to sign opt-in or opt-out forms such as at initial student enrollment, during parent-teacher conferences, and at school-organized community gatherings held during evening or weekend hours with translators available.**

Dental health in public schools

Given the importance of schools as an access point for almost all children, local school districts must ensure that their programs operate effectively. When the task force conducted interviews and site visits to learn how Portland Public Schools encourages dental health, it found a well-intentioned but complicated endeavor characterized by divided responsibility, insufficient staffing and inadequate resources that limit access.

The problems are most acute in K-8 schools dominated by low-income and minority students, the very students most in need of preventive dental health services.

For several years, PPS has operated the ViDA (Vision, Dental and Audiometric) Program. A dozen K-6 and K-8 schools are selected every other year at which a nurse screens students' visual, auditory and dental condition. Since 2008, more than 10,000 students have received screenings.[30]

Parental or guardian permission is not required for these screenings, but a signed permission form is required for any follow-up treatment. This model has several shortcomings.

Children must be in school on the day screenings are conducted. At least in the ViDA schools, a student who is absent on screening day in a given year will be seen the next year.

Even if a student is screened, the reported results are incorporated into materials sent home in student backpacks. That paperwork faces the same challenges as opt-in forms described above. Too often, parents never see it.

Staffing and funding issues also prevent schools from maximizing their services.

For example, Multnomah Education Service District (MESD), under contract with PPS, employs the nurses. At the same time, the ViDA coordinator is a PPS contractor not employed by MESD. Because they have different employers, federal health privacy regulations (HIPPA) prohibit the coordinator from contacting anyone until a signed permission form is returned. Jamie Stout, the ViDA coordinator, reports an average return rate of merely 20 percent. As a result, even if they had the workforce to contact every parent, it would be illegal under HIPPA.[31]

The task force is under no illusion that Congress will change HIPPA to address this problem. However, adding funds for the ViDA coordinator to PPS's contract with MESD would allow the coordinator and the nurses to have the same employer, thus eliminating the HIPPA barrier and enabling considerably more focused follow-up by the ViDA coordinator.

Accessing dental care once the need is known can be difficult given location of facilities relative to home address and their hours of operation. PPS also supports several school-based health and health/dental clinics, including a dental-only clinic at the Creston School. The Creston Dental Clinic is only open Monday through Friday until 4:30 due to constraints imposed by the host school. That is hardly readily available to adults with one or more jobs.

One promising development is shaping up at Benson Polytechnic High School. The school might soon house an after-hours dental clinic, according to Paul Anthony, father of a sophomore. Benson has a

dental health care program, five dental suites, an initial pair of retired dentists and a cadre of students eager to serve the underserved population, a true win-win proposition.[32]

Because access is so difficult, one effective approach has been to bring services to students. Dental buses, though expensive, provide a means for bringing a full-service dental facility to schools.

The David Douglas School District relies primarily on such buses provided by Medical Teams International. The Oregon Tooth Taxi – a project of the Dental Foundation of Oregon, Oregon Education Association's Choice Trust and Moda Health – also has been very successful. Staffed by volunteer and retired dentists, this eases the access problem – so long as parents have given permission for treatment.

Recommendation 7

Multnomah Education Service District and all local school districts should pursue several measures to increase accessibility for children's dental services:

- **Create a prioritized list of schools with children most in need of dental service and target top-priority schools.**
- **MESD, not PPS, should contract with the ViDA coordinator in order to eliminate HIPPA barriers to sharing information.**
- **Extend the hours of the Creston Clinic.**
- **Support plans to launch a dental clinic at Benson Polytechnic High School.**

Metrics for dental health

Shared vision and shared resources are necessary to achieve better dental health in the community, but the taskforce found such coordination lacking. A shared vision must grow from dental plans and CCOs collaboratively developing common goals and metrics.

In researching available dental metrics used for tracking dental outcomes, the task force learned that this area could be greatly improved. Providing secure streams of revenue for future data assessment is important to understand effectiveness of preventive measures. Currently, for example, no one tracks varnish application data with future outcome metrics.

Accurate data could allow future assessment of long-term success of programs and effectiveness of treatments, as well as monitoring for any now-unknown health challenges associated with preventive services.

"If medical had some sort of metric that would look at fluoride varnish rates or rates of referral into a dentist, I think you would be seeing much better relationships between medical and dental," said Dr. Lisa Bozzetti, dental director at Virginia Garcia Memorial Health Center.[33]

Health care transformation is a work in process, and the integration of dental care into the system is a complex issue. For all of the challenges it presents, however, it also creates a timely opportunity to improve dental health care for all members of the community.

CCOs can encourage progress by offering incentives to dental plans through contracts to achieve improved access and preventive strategies. Coordinated metrics will allow the groups involved as well as the public to assess success in meeting incentivized goals.

Recommendation 8

The Oregon Health Authority should immediately develop and adopt a tracking system that measures fluoride varnish, sealants, and basic preventive dental services during medical and dental visits. They should track data related to efficacy of those steps and any long-term health effects. If OHA fails to implement the tracking system, Multnomah County should implement a local version.

Recommendation 9

The Oregon Health Authority and the Metrics and Scoring Committee should adopt CCO metrics that explicitly include fluoride varnish and sealant applications, prenatal dental care visits and early childhood visits.

Leadership

Oregon's plan to hire a new dental director creates an exciting moment of opportunity. If the director embraces a new vision for dental health in the state, he can become a genuine change agent.

Leadership from the top must better engage with diverse communities. The dental director must be not only a champion for expanding services, but also for listening to the people on the ground who already work within those communities. They know better than anyone how to frame messages and convince people to seek preventive measures and take better care of their teeth. They should have a seat at the table when plans are first discussed, not simply be presented with them and told to implement something they had no hand in developing.

The director must advocate strongly for access to dental care in the broader medical community and should seek dental and medical champions across Oregon who can advocate best practices to their peers.

For example, the First Tooth program has a proven record of success training people to provide effective preventive dental services. It provides continuing medical education at no cost to providers and staff on how to integrate oral health preventive services into the practice. Among the topics covered in training are risk assessment and fluoride varnish application. Since 2010, First Tooth has trained more than 2,600

medical providers throughout Oregon. Eligible providers include primary care providers, medical assistants, nurse practitioners and physician assistants.

Many more people interact with young children and would welcome training. School personnel, community health workers, licensed childcare providers, social workers and anyone else who interacts with children in any volume should know what to look for and be trained to apply varnish.[34]

Non-medical providers in community cultural centers and other locations then could offer preventive services to members of those communities in an environment of trust.

Programs like First Tooth can only grow, however, if leaders advocate strongly for expansion and additional funding.

Several witnesses identified Medicaid reimbursement as an impediment to providing services in more diverse medical locations. Medicaid should add reimbursements for oral exams and fluoride varnish application provided by community health care workers.

Richmond Clinic: Team-based, integrated care

Oregon Health & Science University Family Medicine at Richmond is a highly functioning patient-centered, primary care medical home.

The clinic is divided into pods – or teams – that each have clinicians, nurse case managers, medical assistants, team coordinators, behavioral health staff, and front office staff. An interdisciplinary team allows coordination across patients' needs based on continuous, comprehensive care. This team-based approach to health care, is a model for how to better integrate all forms of health (dental, mental, physical) within one setting.

Richmond Clinic also has taken steps to integrate dental care by performing clinic-wide training in oral health assessment, distributing free toothbrushes and toothpastes to children, and applying fluoride varnish as part of the routine delivery of well child checks. The clinic subsidizes restorative dental care in some patients who have inadequate access to dental coverage.

The clinic's early and important efforts to address oral health should serve as a model for how other providers might integrate dental health into primary care.

The state dental director will be the ideal person to provide strong leadership advocating for that change. The director's job is not solely or primarily to serve dentists but to promote dental health for all Oregonians.

State and local leaders must be clear that medical-dental integration is a priority for Oregon. Strong leadership on this point will make all the difference. Health care transformation in the state and the recent inclusion of dental plans under Coordinated Care Organizations (CCOs) creates an opportune time to implement collaborative services and integrate care between medical and dental professionals.

"Oral health integration in the primary care setting is something that's been going on through baby steps across the nation for years, including in Oregon," said Heather Simmons, program supervisor of Multnomah County's School and Community Oral Health Programs. She cited the First Tooth program as an example of local progress on integration.[35]

"In the county we really value integration," she added. "It does take time and a lot of commitment from leadership and buy-in from staff."

The dental director also can play a role in developing programs that promote workforce expansion.

Recommendation 10

Oregon's state dental director should champion children's dental health and reform. Specifically, the director should:

- **Collaborate with medical and health leaders, especially the State Public Health Director, to find opportunities for shared responsibility and ensuring that basic preventive dental care is standard practice in well child visits.**
- **Secure funding to expand training in fluoride varnish application and dental screenings, including all licensed childcare providers.**
- **Build partnerships with organizations that serve low-income families and communities of color and encourage them to play a more active role in implementing best practices and developing dental policies that work for their communities.**
- **Develop and advocate for innovative legislation to integrate medical and dental services, expand access to preventive services and increase the workforce.**
- **Seek out and develop partnerships with dental health leaders and local dental health coalitions that will vigorously advocate children's dental health in their communities.**

Fresh ideas from Washington: The ABCD Program

Oregon's dental leaders should not shy away from emulating success in other states. They need only look across the Columbia River for some fresh ideas.

The rate of cavities occurrence among children in third grade is 58 percent in both Oregon and Washington. The difference between the two states is how many of those children with decay receive treatment. Untreated dental decay is a metric used to measure access to dental care. Cavities and rampant decay are metrics used to measure the success of preventive programs. In Washington third graders, untreated dental decay rates were 15 percent[36] compared to Oregon's 20 percent.

After interviews with Oregon and Washington experts, this task force concludes that much of the difference in untreated decay can be attributed to the fact that Washington embraces a coordinated system called Access to Baby and Child Dentistry program (ABCD).

Washington's ABCD (Access to Baby & Child Dentistry) is one example of an innovative program that ensures the youngest and most-vulnerable children have access to dental care.

In 1994 a group of concerned dentists, dental educators, public health agencies, the state dental association, and state Medicaid representatives came together to address the problem of severe lack of dental access among high-risk preschool children in Washington.

The first ABCD program opened for enrollment in Spokane, in February 1995. It was a collaborative effort between several partners in the public and private sectors, and its success has led other county and health districts in Washington to adopt the program, and states such as Montana have based their dental model on ABCD.

ABCD provides dental services for Medicaid enrolled children from birth to age six. The model is collaborative, and its success is due to the shared vision, and participation of diverse stakeholders from counties to state agencies.

The program's efforts include:

- Recruitment and training of dentists.
- Working closely with community organizations to identify young Medicaid-eligible children and remove barriers that prevent low-income families from receiving dental care for their young children.
- Engaging and training primary care medical providers to deliver oral health preventive services during well-child checks.
- Working with childcare centers to provide dental preventive services and education on site.

After ABCD's first five years, untreated dental decay among Washington's low-income preschool children declined by an astonishing 50 percent.

Oregon's ongoing transition to Coordinated Care Organizations (CCOs) and the implementation of the federal Affordable Care Act allow health and dental advocates, state and county representatives, and public and private stakeholders to develop new models of dental care. In particular, the recent integration of dental plans into CCOs is an opportunity to create a shared vision and practices that improve dental access for all children in the state.

Although Oregon almost certainly cannot replicate the entirety of the ABCD program, some elements are suitable for use here.

The cornerstone of ABCD is coordination and integration of services. The program works closely with community organizations to identify Medicaid-eligible children 0- to 6-years-old and to remove barriers that prevent low-income families from receiving dental care for young children. The ABCD model finds a dental home for all children, provides early family education, and offers varnish applications in diverse settings. Each of these is attainable in Oregon.

Integration of dental services occurs in primary care models and medical homes. Children receive varnish application as part of their child wellness visits, thereby reducing barriers to dental access.

One cannot overstate the importance of facilitating dental care and prevention in medical homes. Too many children rarely if ever see a dentist, but the vast majority of them see medical doctors and other providers.

In Multnomah County, more children access health care through primary medical visits than dental visits by a ratio of almost three-to-one.

"We've been able to go back in and do oral health education with primary medical providers. More than one-third of primary care medical providers, family physicians and pediatricians, are now trained in oral health techniques … and quite the percentage of staff is," Kathy O'Meara-Wyman, managing director for ABCD, told the task force.[37]

In addition, for newly enrolled Medicaid children, utilization rates were greater than for insured children in the state. O'Meara-Wyman attributed that success to a collaborative approach that includes family education about the importance of dental care during pre-natal visits, case management at the community level, and assistance for transportation to dental visits if needed.

"We've developed this whole workforce of people who are concerned about young children and who can talk about an awareness that oral health is an issue and who ultimately will do something about it," she said.

ABCD increases outreach by holding dental clinics located in communities where vulnerable children can receive care. For example, King County has a dental clinic located in the Boys and Girls Club. Some practices take all of their ABCD children on one day because they have language and transportation services available on that day. Some integrate it throughout.

If Oregon provided greater outreach where children are located, it could remove some barriers to dental care for vulnerable children. The key is bringing basic dental education, screening and prevention to the

places children and young families congregate, not expecting them to come to the services. Avenues for such outreach include:

- Funding Oregon Oral Health Coalition's First Tooth program that trains primary care providers and staff in dental risk screenings and varnish application,
- Working with licensed childcare centers that serve children from low-income families, including Head Start, Head Start waitlist sites and state-supported childcare centers.
- Working with Boys and Girls Clubs, faith-based organizations, and other community organizations that directly interact with children and families.

Multnomah County could become a test site for innovation and model for broader implementation of an ABCD-like program. The county could also go beyond the ABCD model by giving greater emphasis to medical/dental integration so that dental preventive services and oral exams are part of regular child wellness visits. At those visits, children with acute problems can be referred to dentists for more specialized care.

The work of implementing successful components of Washington's ABCD program would require dental champions, case managers, enhanced Medicaid reimbursement rates, and alignment among current dental plans. It could provide tangible improvements such as reduced rates of both dental decay and untreated dental decay for all children, as well as greater coordination between governments, medical and dental practices, and community groups that engage with children who are most in need of services.

Recommendation 11

Multnomah County and local CCOs should implement and fund a pilot ABCD-like program within two years. It should include:

- **A medical home/dental home model that allows integration of dental services with primary care visits through WIC, pre-natal, child wellness and home health visits.**
- **Public/private partnerships that provide assistance navigating Medicaid billing and protocols similar to Washington Dental Service Foundation's services provided to the ABCD program.**
- **Programs to provide basic preventive services and screenings at licensed childcare centers and other suitable organization – such as HeadStart, Boys and Girls Clubs and Ys.**

Concluding Remarks

The Children's Dental Health Task Force believes that healthy teeth are not only possible but also within reach if Portland, Multnomah County and Oregon adopt the recommendations in this report. It recognizes that some of these recommendations will challenge the status quo of how dental services are provided, but if there is one fundamental lesson the task force learned, it is that the status quo is not working well enough in Oregon.

The task force started with the premise that all Portland-area residents want to improve the dental health of children. The challenge was finding services and strategies about which most residents could agree. The task force reiterates that its recommendations have the support of both proponents and opponents of water fluoridation.

Lifetime dental health begins in childhood. If Multnomah County expands preventive services and engages with communities that historically have been underserved, it can help children avoid decay. The upfront investment will reduce pain and suffering and result in long-term savings.

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Witnesses*

Paul Anthony, parent of Benson High School student.

Malia Band, Clinic Manager, Creston Dental Clinic.

Dr. Len Barozzini, DDS, Dental Director, Multnomah County Health Department.

Patricia Bates-Sherman, Self Enhancement, Inc.

Dr. Lisa Bozzetti, DDS, Dental Director, Virginia Garcia Memorial Health Center.

Mary Daly, Tooth Taxi Program Manager, Dental Foundation of Oregon.

Donalda Dodson, Executive Director, Oregon Child Development Coalition; Board Member, Northwest Health Foundation.

Mitra Ebrahimi, Dental Operations Manager, Virginia Garcia Memorial Health Center.

Destin Ferdun, Director of Project Finance, Housing Development Center.

Kurt Ferré, President, Friends of Creston Children's Dental Clinic.

Melissa Freeman, Director of Strategic Projects, Oregon Community Foundation.

Rosa Foronda, Clinic Manager, Virginia Garcia Memorial Health Center.

Jessica Guernsey, Maternal Child Health Director, Multnomah County Health Department.

Brett Hamilton, Community Development Coordinator, FamilyCare Health Plans.

Andre Jackson, Senior Manager for Partnerships and Development, Portland Public Schools.

Barbara Kienle, Director of Student Services, David Douglas School District.

Charlie LaTourette, Executive Director, Dental Foundation of Oregon.

Dr. Paul Lewis, MD, Health Officer, Multnomah County Health Department, and Tri-County Health Officer, Clackamas, Multnomah and Washington counties.

Dr. Cat Livingston, MD, Family Physician, OHSU Richmond Clinic.

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* Because one goal of the task force was to bring together experts who are engaged in the community, some pre-existing relationships between task force members and witnesses were inevitable. In the interest of full disclosure, the task force notes:

- At least one witness is a City Club of Portland volunteer.
- One task force member is executive director of NAYA.
- One task force member is director of an organization that shares space with SEI.
- One witness is the spouse of a task force member.
- One witness is the partner of a task force member.

Rui Neves, Assistant Principal, Woodlawn Elementary School.

Kathy O'Meara-Wyman, Program Managing Director, Access to Baby and Child Dentistry (ABCD).

Daniel Ornelas, Dental Operations Manager, Virginia Garcia Memorial Health Center.

Dr. Mike Plunkett, DDS, Senior Director, Dental Care Delivery, Kaiser Permanente.

Tawna Sanchez, Director of Family Services, Native American Youth and Family Center.

Dr. Eli Schwarz, DDS, Professor and Chair, Department of Community Dentistry, Oregon Health & Science University.

Heather Simmons, Program Supervisor, Multnomah County Health Department.

Holly Spruance, Executive Director, OEA Choice Trust.

Jamie Stout, ViDA Program Coordinator, Portland Public Schools.

Ann Vrabel, School Health Services Coordinator, Multnomah Education Service District.

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