



Summary Report **DRAFT**

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I. Overview and Background on the Summit

The purpose of the 2007 Oral Health Summit was to increase awareness about the oral health status and needs of Idaho's children and families, as well as to highlight the integral role of oral health to overall health and well-being. The Summit also provided the opportunity to present information on best practices and potential solutions to help create a shared vision for improving access to dental care and to inform the development of the next State Oral Health Plan.

The 2007 Summit, convened by the Idaho Oral Health Alliance (IOHA), expanded upon earlier efforts to improve oral health and access to dental care for Idaho children and adults. IOHA was formed in 1998 by a wide range of stakeholders from the public and private health, education, and business sectors. In 2001, IOHA convened the first Idaho Oral Health Summit to assess barriers to oral health care confronting Idaho and identify potential solutions in the areas of policy and funding, access to care, and prevention and education. A subset of the 2001 Summit attendees were invited to attend a series of follow-up meetings to identify priority goals and define short- and long-term strategies to increase access to primary dental care, reduce disease, and improve oral health. Recommendations from these follow-up meetings became the basis for the first Idaho Oral Health Plan, which was released in 2002.

II. Individual Presentations

Welcome and Opening Remarks: Call to Action

Dan Watt, DDS, Dental Director, Terry Reilly Health Services, and Chair, Idaho Oral Health Alliance

Dr. Watt opened the meeting by providing highlights from IOHA's oral health promotion activities, including the *Seal Idaho 2000* project which provided free dental sealants to elementary school children across the state, particularly high-risk children without regular access to preventive dental care. Dr. Watt also described the success of the first Idaho Oral Health Summit held in 2001 that culminated in the creation of a 5-year statewide oral health plan. He then stated that one of the major goals for the day's events would be to track progress on meeting goals set for the initial statewide oral health plan and to determine if these goals were still appropriate for the next 5 years of strategic planning for the state. Despite a growing understanding of the link between oral health and systemic health and increasing amount of money being spent to address oral health, the incidence of oral health disease has risen across Idaho since the first Summit was convened. Dr. Watt explained that a number of barriers to oral health promotion remain, including the rising cost of providing dental care, a dental insurance reimbursement system that is often frustrating for dental providers, and difficulty communicating oral health prevention messages that resonate with the public and address the social determinants of oral health status. Attendees will need to develop strategies to use resources better to overcome these challenges.

Making Oral Health a Priority

Congressman Mike Simpson, U.S. House of Representatives

Congressman Simpson provided an update of oral health-related legislative activity in Congress, which he mentioned has recently generated more interest than in the past due, in large part, to the high-profile death of Deamonte Driver, a 12-year-old boy residing in Prince George's County, MD, who died from an abscessed tooth because he was not able to access timely dental care. Key bills mentioned included the following:

- A labor, health, and human services appropriations bill has recently passed Congress, which includes increased funding for the Dental Health Improvement Act and the National Institute for Dental and Craniofacial Research. However, President Bush has threatened to veto this bill, which would have a major impact on publicly funded dental services.
- Reauthorization of the State Children's Health Insurance Program (SCHIP). A previous compromise bill was passed by the House and Senate in September that, for the first time, included a guarantee for the provision of dental services. However, this bill was later vetoed in October due to concerns that it expanded coverage to other groups outside the original scope of the program, including childless adults and illegal immigrants. Congress is currently drafting new bills that they hope will be able to meet President Bush's approval and increase coverage of children from 6 million to nearly 10 million once the program is reauthorized.
- Introduction of the Oral Health Act of 2007, which is being cosponsored by Congressman Simpson. This bill would allow states to access enhanced federal match fund rates for delivery of dental services, tax credits for dental providers who offer free or reduced cost dental care to underserved communities, among other programs designed to improve access to dental care.

Keynote: Insuring Bright Futures for Children – Improving Access to Oral Health Care

Kathleen Roth, DDS, Immediate Past-President, American Dental Association

Dr. Roth began her keynote address by also emphasizing the important role that Deamonte Driver's untimely and preventable death has played in putting a spotlight on the entire oral health care delivery system. This system is comprised of a variety of key players beyond just dental providers that have responsibility for increasing awareness of the importance of oral health and making dental care accessible to those in need. Dr. Roth suggested looking to some of the successful strategies implemented by the medical community, which has had a long history of providing care to underserved populations. The dental home, which is adopted from the successful medical home model, should be promoted as an early intervention to get children to see a dental provider by age 1 and as a strong foundation for a lifetime of dental care. In addition, providers should be regularly screening young children for oral health problems, providing basic preventive services such as fluoride varnish and sealants, and referring children for follow-up treatment when needed. Currently, many pediatric medical providers are missing the opportunity to identify oral health needs early in life during well-child visits, and many dental providers lack the experience and training necessary to treat very young children.

Dr. Roth highlighted a number of promising practices from the American Dental Association that attendees should look to that have been able to serve vulnerable populations. These practices include the following:

- The Community Dental Health Coordinator (CDHC) model. The CDHC is a new type of mid-level provider that is being piloted in four different settings. The CDHC brings both social work experience and clinical dental skills to a dedicated public health dentistry position that can help provide oral health education, increase access to care, and help form community partnerships to advance oral health promotion at the systems-level. This position has already been found to work well in public settings like community clinics, schools, and social welfare programs.
- The Oral Longevity Initiative, which is designed to increase awareness about the need to enhance and preserve the oral health of older Americans.
- Development of simple, consistent oral health messages that resonate well with the public.

Idaho Dental Health Professional Shortage Area Designations

Laura Rowen, Program Manager, Office of Rural Health and Primary Care, Idaho Department of Health & Welfare

Ms. Rowen provided an overview of statewide data she helps pull together to apply for Health Professions Shortage Area (HPSA) designations, which describe oral health disparities and barriers to accessing oral health care. Overall, the large majority (92.4 percent) of Idaho's area is designated as a dental health professional shortage area. In rural areas of the state, dentists are much more likely to serve the low-income population (those living below 200 percent of the federal poverty line) by accepting Medicaid or offering a sliding fee schedule compared to urban areas. Ms. Rowen's office also collects data on dentists' ages as a factor in calculating full-time equivalents for the federal formula used in HPSA designations. Her team discovered that nearly one in five dentists is approaching or at retirement age. Moreover, Idaho's dentists are retiring or dying at a faster rate than they are graduating from dental schools.

Another major source of data on the status of oral health care in Idaho is an annual publication that the Office of Rural Health and Primary Care purchases called *Healthcare State Rankings* that is produced by Morgan Quito Press. The rankings for 2007 indicate that while Idaho only ranks 37th in the nation for total dental expenditures for dental services, it ranks 15th for per capita dental expenditures and second for the percent of personal health care expenditures spent on dental care. In terms of access to dental care and field strength for dentists, Idaho is about average for the rate of dentists per 100,000 persons with a rank of 22nd. However, Idaho ranks eighth in the nation for the percentage of the population lacking access to dental care with a rate that is twice the national average (18.6 percent in Idaho compared to 9.3 percent across the United States).

Oral Health and Access to Care: Idaho Legislative Perspectives

Senator John McGee and Representative Margaret Henbest, Idaho State Legislature

Senator McGee serves on the Health Care Task Force in the state legislature and also acts as Marketing Director at the West Valley Hospital. In these roles, he indicated that he has noticed a

higher level of need for timely and affordable oral health care. In the hospital, he has personally seen an increase in the number of individuals coming into the emergency department for nonemergency dental-related treatment. He then listed several of the largest barriers to oral health promotion in Idaho:

- The lack of awareness among the public and the state legislature about the importance of addressing oral health problems and the link between oral health and systemic health
- The lack of dental insurance among families
- The large number of children and adults that do not visit the dentist regularly for care

Representative Henbest works as a registered nurse and serves a large Medicaid pediatric population. She highlighted a number of issues that may impact oral health care in Idaho that should be discussed during the rest of the Oral Health Summit:

- Regarding public insurance, Idaho's Medicaid program has a new capitated payment contract called Idaho Smiles that is designed to improve access to oral health care and improve provider reimbursement. More dialogue is needed with the local dental community to see if this new contract is meeting these goals and accommodating the needs of the low-income population.
- The dental community also should monitor the pending federal legislation to expand SCHIP and role this insurance program plays in expanding children's access to dental services.
- Dental provider issues are cause for concern. Recent surveys indicate that a number of dental practices across Idaho are reporting that are not operating at full patient capacity, even though many consumers report difficulty getting dental appointments. More research is needed to explore what is driving this trend, such as the distribution of dentists relative to population density or how rising out-of-pocket expenses are impacting dental care utilization patterns. Lastly, we need to reevaluate opportunities for Idaho's students to attend nearby dental schools and the availability of loan repayment programs for dental students to ensure that Idaho continues to have an adequate supply of new dentists.

Following their presentations, Senator McGee and Representative Henbest engaged in a question and answer session with the audience. Several questions and comments addressed local dental providers' concerns about delays in receiving reimbursement payments and the challenges they face in covering high overhead costs and trying to remain profitable with the relatively low reimbursement rates under Idaho's Medicaid program. The Senator and Representative indicated that the state legislature is aware of these concerns and is hoping that the Idaho Smiles program, which is managed by Blue Cross and Doral Dental, will increase the timeliness of reimbursement payments. They added that increasing the level of Medicaid reimbursement rates is more challenging because such increases in the state budget are difficult to pass in the state legislature. However, the legislature will more be more likely to increase funding if there is more pressure from the dental community. The Senator and Representative also emphasized the critical role that Idaho's network of community health centers play in filling gaps in oral health care for underserved populations and noted that more public pressure is also needed push the state legislature to increase funding for these centers. Other questions asked about possibility of establishing a State Dental Director position in Idaho and getting representation for the dental

community on the Governor’s Health Task Force. While there is no current push to address these issues, the Senator and Representative were open to moving them forward.

III. Panel Discussions

Panel 1: Best Practices and Promising Models for Improving Oral Health

Promoting the Importance of State Oral Health Programs

Steven J. Steed, DDS, Utah State Dental Director and President, Association of State and Territorial Dental Directors

Dr. Steed described the role of the Association of State and Territorial Dental Directors (ASTDD) as influencing policy at federal, state, territorial, and local levels to improve oral health, promoting evidence-based practice, enhancing state and territorial oral health program infrastructure, meeting the needs of ASTDD members, and building and strengthening partnerships with relevant organizations and agencies. ASTDD emphasizes four major areas that state oral health programs should be competent in the following:

1. **Clinical preventive services**, such as oral health exams, prophylaxis, and fluorides; oral cancer screening; and anticipatory guidance
2. **Access to care and health systems**, including facilities, oral health workforce, reimbursement for services, and health policy
3. **Community preventive services**, such as fluoridation, sealants, and school-based programs
4. **Evidence bases for services**, including the capacity to conduct surveillance, epidemiological analysis, biostatistics, and investigation of the determinants of health

Dr. Steed indicated that state oral health programs are responsible for linking different professions, including education, research, and evaluation, dentistry and dental hygiene, public health, and other health professions. These programs also act as the “go to” place in state government for oral health services, provide a range of services to support local communities such as training and education or building local- and state-level partnerships, and help leverage resources to increase access to oral health care from foundations, state funds, and other sources.

Vibrant state oral health programs are those that have the capacity and infrastructure to perform the three core health functions: (1) assessment, such as establishing a state oral health surveillance system, (2) policy development, such as developing a state oral health improvement plan, and (3) assurance, such as proving oral health communication and education to policymakers and the public. A vibrant state oral health program can do the following:

- Act as a “focal point” and provide oral health expertise for state action to improve oral health
- Provide continuity for moving a comprehensive oral health agenda forward
- Convene a broad array of stakeholders to improve oral health
- Promote legislation and policies to improve oral health
- Serve as an unbiased information “broker” to state officials and legislators

Dr. Steed concluded his presentation by indicating that each state's oral health program is unique and responds to community needs unique ways, while using many resources that have been developed by ASTDD and partner groups.

Strategic Approaches for Improving Children's Oral Health and Access to Care

James J. Crall, DDS, ScD, Professor and Chair of Pediatric Dentistry, UCLA School of Dentistry, and Director, Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB), National Oral Health Policy Center

Dr. Crall began his presentation by describing dental caries as a complex, chronic disease that may promote the demineralization (decay) of and cavities (holes) in teeth and may have significant consequences for general health and quality of life among children if left untreated. Caries is also infectious in nature and is caused by bacteria typically transmitted from mother to child before their teeth erupt and colonize on tooth surfaces shortly after initial eruption. The cariogenic process is a dynamic balance between risk factors, such as frequent exposure to refined sugars which promote cariogenic bacteria and tooth decay, and protective factors, such as fluorides and antimicrobials, which promote healthy teeth.

Dr. Crall noted that although children have greater access to some form of dental insurance than ever before, the prevalence of children's dental caries actually has increased nearly 15 percent in the past decade. Surveillance data indicate that severe tooth decay is not evenly distributed among all children but is concentrated in low-income and racial- and ethnic-minority populations. These trends reflect a poor understanding of the caries disease process and the failure of previous dental caries control paradigms that focused only on restorative treatment to deal with the consequences of disease and, later, a one-size-fits-all approach to caries prevention. Fortunately, Dr. Crall has found that the dental community is moving toward a more systematic, targeted approach to preventing and reducing dental caries. Key components of this new paradigm include the following:

- **Risk Assessment.** Categorize children into different caries-risk groups based on an assessment of their status on risk indicators. The American Academy of Pediatric Dentistry identifies three types of caries-risk indicators: (1) the presence of clinical conditions, such as previous caries experience and visible gingivitis; (2) environmental characteristics, such as level of exposure to topical fluoride and caregiver socioeconomic status; and (3) the existence of special health care needs, such as those impairing saliva composition and flow.
- **Early Intervention.** Initiate preventive dental visits upon initial tooth eruption or by age 1 and immediately providing restorative treatment when oral health problems are identified. Research indicates that the age at the first preventive dental visit has a significant positive effect on dental service expenditures.
- **Individualized Prevention and Disease Management.** Tailor oral health services to the individual risk levels of each child. Children in lower risk levels will require less monitoring and follow-up care than high risk children with advanced caries progression.
- **Anticipatory Guidance.** Provide guidance to families on how to promote their children's oral health as they age, such as the importance of good eating habits, oral hygiene practices in the home, and regular preventive and restorative dental care.

Dr. Crall concluded his presentation by highlighting two community-based initiatives that have achieved success in promoting children's oral health. The first initiative, the Early Childhood Caries (ECC) Prevention Program in Klamath, OR, seeks to develop community supported strategies to stop the transmission of caries between mothers and their children. The key components of the program include the following:

- Establishment of dental homes for enrolled mothers and children under age 2
- Home visits to provide parent oral health education and distribute tool kits with oral hygiene supplies
- Case management to reduce barriers to dental care
- Chlorhexidine rinses provided during pregnancy and xylitol gum provided for new mothers
- Fluoride varnish applications for children based on risk assessment

The second initiative, More Smiling Faces, based in South Carolina, has established a local advisory committee that has taken the lead in creating a more organized and dedicated system of oral health care, including the following features:

- An integrated network of dental and medical providers, faith-based organizations, schools, and other community resources
- Provision of pediatric oral health training to medical and dental providers
- Integration of oral health promotion into existing medical home models
- Establishment of patient navigators to help consumers link to community resources and dental providers to medical homes
- Consistent oral health messages disseminated to the public

Dr. Crall noted the medical providers that participated in this initiative have welcomed the development of stronger relationships with the local dental community and were very open to working with the patients navigators to address their patients' oral health needs.

Panel 2: Perspectives on Oral Health and Access to Care

PUBLIC HEALTH PERSPECTIVES

Idaho State and District Oral Health Programs

Debora James, RDH, Oral Health Program Manager, Bureau of Community and Environmental Health, Idaho Department of Health & Welfare

Ms. James began by highlighting Idaho's performance on the 2001 National Oral Health Report Card, which measures progress on oral health issues in relation to Healthy People 2010 goals. Idaho scored an overall grade of C-. Among individual categories, Idaho scored C's on access to care and children's oral health, D's on prevention and the state's oral health program, and an F on fluoridation. She then presented data on several specific statewide programs designed to improve access to preventive and restorative care among various populations. These programs include the following:

- **Children's Dental Sealants.** This program targets grades one to three at schools with 50 percent or higher enrollment in free or reduced-mean programs. The state average rate

for third-graders with sealants increased 2.1 percent over a 5-year period, from 53.6 percent in 2001 to 55.7 percent in 2005.

- **Perinatal Oral Health Program.** This program works with Women, Infants, and Children agencies to educate clients about the importance of dental care during the perinatal period and links them to a perinatal oral health referral network to access care. The percent of women in Idaho who received dental care during pregnancy significantly increased from 37.6 percent in 2001 to 43.6 percent in 2005.
- **Idaho Water Fluoridation & School Fluoride Mouthrinse Program.** Although 82 percent of wells in Idaho have some level of natural fluoride in them, only about 10 percent have optimal levels (0.7 to 1.2 ppm). The school fluoride mouthrinse program therefore serves as an important source of fluoride for children residing in areas with suboptimal water fluoride concentrations. From 2003 to 2006, there has been a 2.6 percent increase in the number of students enrolled in the program, for a total number of 34,812.

Ms. James indicated that these and other statewide oral health programs have helped to improve Idaho's performance on the recently released 2007 National Oral Health Report Card. The overall grade increased to a C+, and improvement was seen in individual categories as well, including B's for prevention and sealants and C's for fluoridation and the state oral health program, access to care, and children's oral health.

Despite the progress achieved by these statewide programs, a number of factors continue to act as barriers to oral health care in Idaho. While the number of clients enrolled in Medicaid increased nearly 50 percent from 2000 to 2006, the proportion of dentists participating in Medicaid has remained low. Even with these recent increases in Medicaid enrollment, one of four adults in Idaho is still without dental insurance coverage. In addition, oral health surveillance data indicate that the rate of caries among third graders has increased in all but one health district between 2001 and 2005. Ms. James concluded by stating that the state's oral health program would be soliciting participation from Summit attendees to help update and improve the Idaho Oral Health Plan, which plays a critical role in improving access to care for the people of Idaho.

Idaho Head Start Programs

Carolyn Kiefer, Director, Idaho Head Start Collaboration Project

Ms. Kiefer gave some background information on Head Start and Early Head Start (HS/EHS) programs in Idaho. There are 13 programs across the state, including some dedicated to migrant and seasonal farmworkers and American Indian and Alaska Native tribal communities, serving a total of 4,813 children. Ms. Kiefer noted that Idaho currently is serving only 34 percent of children eligible for these programs and that Idaho is one of the few states that do not contribute any additional state funds to HS/EHS. In addition, HS/EHS programs focus on the "whole child" and offer a comprehensive array of services that include oral health exams and the establishment of a dental home. Nearly 93 percent of enrolled children received a dental exam during the past program year, and more than 40 percent were diagnosed as needing dental treatment.

Ms. Kiefer then focused her presentation on the South Central HS/EHS Program, the only program in Idaho and one of only three programs in Region X (which includes Idaho, Washington, Oregon, and Alaska) to receive an Oral Health Initiative (OHI) Grant from the federal Head Start Office. The OHI Grant is designed to improve oral health education and access to care among enrolled clients. South Central was awarded \$75,000 per year for a total of 4 years to implement its OHI grant program, which offers enrolled clients the following:

- Two home visits for parents to conduct a family assessment and provide meal planning oral health education
- Development of a new oral health education curriculum called *Smiles Count*, which covers the importance of prevention, treatment, dental homes, and proper etiquette to follow at the dental office
- Children’s oral health education and practicing tooth brushing in the classroom
- Fluoride varnish applications for children three times per year
- The establishment of Memorandums of Understanding with 16 local dentists to provide dental services to HS/EHS children and families
- Use of a Family Health Services Mobile Dental Van that visits rural sites to offer basic preventive and treatment services, as well as referrals to pediatric dentists

South Central is currently in the second year of grant funding and has already seen some positive impacts from the program. Ms. Kiefer said that more children are getting examined by a dentist, more dentists in the service area are now willing to accept Medicaid-enrolled children, and parents have become more aware of the importance of dental care for “baby teeth” and been more active in getting their children in for treatment.

Idaho Smiles Dental Program

NaDene Palmer, Executive Director, Doral Dental USA

Ms. Palmer described the Idaho Smiles program as a partnership between Blue Cross of Idaho and Doral Dental USA, a leading provider of Medicaid dental insurance programs. Idaho Smiles, which began on September 1, 2007, is intended to provide dental coverage for 140,000 low-income children and working-age adults. The goals of the program include the following:

- Improve access to a wider network of dental care providers
- Provide more information and support services
- Encourage preventive and restorative dental care
- Maximize use of technology
- Prevent fraud

Ms. Palmer then presented data on enrollment of consumers and providers in Idaho Smiles to date. From September 1 to October 31, 2007, a total of 110,432 consumers have been enrolled (100,785 children and 9,647 adults), 473 of 502 active Medicaid dental providers have been contracted, and at least one general or pediatric dentist has been contracted in 93 percent of Idaho’s counties.

Idaho Smiles offers a number of important benefits to both consumers and providers. Ms. Palmer categorized the major incentives of program participation into three main areas: (1) an increased competitive fee, (2) outreach programs, and (3) wellness programs. The enhanced reimbursement

rates are intended to attract providers into the program. The outreach program includes educational tools for consumers, such as information on finding participating dentists and the consequences of untreated dental problems, as well as for providers, such as an office reference manual and a Web site to help manage claims and other administrative functions. Examples of wellness programs include Healthy Beginnings, which seeks to reduce the incidence of ECC; and the Smiling Stork, which emphasizes access to perinatal dental care.

During the question and answer session that followed, Ms. Palmer fielded several questions from the audience regarding their personal experience with Idaho Smiles. Two questions concerned that challenge of obtaining preauthorization for extensive treatment services for participating patients. Ms. Palmer noted that Idaho Smiles is still a very new program and they still are trying to address preauthorization and other billing and coding issues. A couple of questions also addressed the lack of coverage for some preventive services, including additional dental sealants, anticipatory guidance, nutritional counseling, and oral bacteria tests. Ms. Palmer responded that there is a limited budget with which to cover dental services, but the program may be open to expanding benefits if there is substantial evidence of the cost-effectiveness of additional services.

PROVIDER PERSPECTIVES

Idaho State Dental Association **Tim Thompson, DDS, President**

Dr. Thompson began by asking the audience to consider what “access” to dental care really means. He explained that it does not mean having more dentists necessarily. Rather, it could encompass the provision of education and training for dentists to better meet the needs of different patient populations. Greater access to oral health care is also dependent on the ability to secure sufficient financial resources to cover the costs of care. Dr. Thompson offered that for too long, dentists have endured providing care under Medicaid at a significant financial loss because of low reimbursement rates. Idaho’s Medicaid program only pays about 40 percent of the cost of care, which is much lower than other states. Dr. Thompson noted that the Idaho State Dental Association (ISDA) is lobbying the legislature and Governor very hard this year to encourage increased funding for Medicaid to ensure that is viable for dentists to participate in and that they need much more public support to make this a priority issue. Another issue the ISDA is concerned about is the need to reestablish the state dental director position, which Dr. Thompson feels will play a major role in facilitating increased patient education about the importance of addressing oral health. In addition, ISDA is coordinating with the Idaho Smiles program to address concerns with denials of claims and the slowness of reimbursement payments. He added that ISDA also will be pushing for increased funding for Idaho Smiles as well. Dr. Thompson closed by remarking that Idaho’s dentists do care about their patients but that dentistry is also a business that cannot continue to provide care on a charitable basis. The state’s Medicaid program is operating as a broken system that is grossly underfunded and has not placed enough emphasis on prevention.

Oral Health Assessment and Preventative Dental Care in the Primary Care Setting
Perry Brown, MD, FAAP, American Academy of Pediatrics (AAP), Idaho Chapter

Dr. Brown opened by stating that the AAP has recognized that oral disease still poses a significant threat to many children and has responded by supporting measures to improve access to early oral health care, which has been shown to be critical in the early identification and prevention of disease. Dr. Brown then provided some background information on why it is important for primary care providers to address children's oral health. Primary care physicians (PCPs) are often more likely than dental providers to have regular, consistent contact with children. Children are nearly 2.5 times more likely to have medical insurance than dental insurance and are more likely to be enrolled in a well established medical home than a dental home. In addition, PCPs have frequent visits with children beginning soon after birth through required well-baby and well-child checkups. There is also strong evidence from the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention supporting many preventive oral health interventions, particularly those involving the use of fluorides, which can be implemented in primary care settings. These interventions include the following:

- Fluoridate toothpaste
- Topical fluoride gels
- Fluoride varnish on permanent teeth
- Fluoride supplements if suboptimal water fluoride concentrations
- Dietary counseling

Despite awareness of consequences of poor oral health and the increased need to integrate the use of evidence-based interventions, Dr. Brown highlighted that access to oral health care remains a major issue. Many patients do not have a dental home. Among the biggest drivers are lack of dental coverage, gaps in coverage, and physicians who are poorly trained in dental issues and do not promote dental care. National surveys have found although greater than 90 percent of physicians think oral health should be addressed at well visits, many reported feeling unprepared to discuss oral health with their patients or do not offer basic oral health clinical preventive services in their offices. Specifically, more than half of surveyed physicians had little or no oral health training and less than 30 percent discussed oral health during well visits. Moreover, data from Idaho's primary care system indicate that only 19 percent of children receive fluoride varnish applications during well visits.

Dr. Brown then presented two examples of recent oral health initiatives sponsored by AAP. In May, 2003 the AAP developed a policy statement in May titled, "Oral Health Risk Assessment Timing and Establishment of the Dental Home". This policy states that every child should begin to receive an oral health risk assessment by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional. When performing an oral health risk assessment, child health professionals should do the following:

- Assess the mother's or caregiver's oral health
- Assess the oral health risk of infants and children
- Perform an oral health examination and recognize signs and symptoms of caries
- Assess the child's exposure to fluoride
- Provide the parent with education on oral hygiene and diet
- Make a timely referral to a dental home

In addition, the AAP recommends that all children have an identified dental home within 6 months after the first tooth erupts or by 1 year of age, whichever is earlier. The concept of the dental home is derived from the AAP concept of the medical home, which states that medical care should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. Pediatric primary dental care needs to be delivered in a similar manner. The dental home is a specialized primary dental care provider who supports the principles of a medical home. The role of the pediatric providers is to refer a child for an oral health examination by a dentist who provides care for infants and young children establishes the child's dental home and provides an opportunity to implement preventive dental health habits that meet each child's unique needs and keep the child free from oral disease. Dr. Brown also noted that contrary to popular belief, PCPs can get reimbursement for preventive oral health services such as fluoride varnish applications.

In addition, AAP has also secured funding from the MCHB to create a training program for pediatricians and child health professionals. The goal of this curriculum is to address this disconnect between providers' support for oral health interventions and their daily practices by training family physicians assist their patients in preventing oral disease and preparing them with a basic approach to frequently encountered oral problems.

Dental Hygienists' Perspective

Sally Kane, RDH, President, Idaho Dental Hygienists' Association

Ms. Kane began by providing background on the 1,035 currently active dental hygienists in Idaho. Basic qualification for entry level dental hygiene education programs include 2–4 years of college education. Typical curricular content includes instruction on the following:

- Basic sciences
- Dental hygiene sciences
- Clinical practice (exceeding 1,000 hours)
- Community health
- Restorative care (offered at selected programs, including the Idaho State University)

The second requirement is dental hygienist licensure. Students must first pass the written National Board Examination and then the Clinical or Practical Board Examination. Practicing dental hygienists must also receive continuing education throughout their career to meet requirement for re-licensure. Ms. Kane then indicated that after 2 years of experience, dental hygienists may apply for two types of license endorsements to expand their scope of practice:

- **Extended Access Dental Hygiene Endorsement.** Allows recipients to practice in extended access settings, such as community health centers, health departments, and schools with high proportions of low-income students, under general supervision of a dentist.
- **Extended Access Dental Hygiene Restorative Endorsement.** Allows recipients to perform specified restorative functions under the direct supervision of a dentist in an extended access oral health care program.

Ms. Kane proceeded to present several recommendations to respond to what she characterized as a crisis in access to care for child and elderly populations and with the diminishing number of dentists in the Idaho’s oral health workforce:

1. **Strengthen the public oral health program.** State and local health departments must have dental expertise and the capability to provide leadership to address the health needs of their communities. Right now the state pay scale is significantly below market and less than registered nurses. The State of Idaho saw the value of nurses and increased their salary. Dental hygienists can save taxpayer dollars through preventive dental programs, not to mention the preventable pain and discomfort to children they serve so the children can be healthy and ready to learn. Sufficient funding should be dedicated to fund a full cadre of licensed public health dental hygienists in district health departments. The state should also hire a public health dental director as well.
2. **Improve collaborative partnerships.** We should learn from existing successful partnerships and foster additional creative partnerships between public and private entities. Examples of recent partnerships follow:
 - **Eastern Idaho Give Kids a Smile Day.** This event was sponsored by a number of dental and public health partners, including the Southeaster Dental Society, Southeast District Health Department, and the ISU Department of Dental Hygiene. More than 100 children from low-income families will receive dental services at no cost ranging from dental exams to professional fluoride applications and fillings provided by dental hygiene students and practicing dental assistants, hygienists and dentists over the 2-day event.
 - **Dental Care Provided at the Van Buren Elementary School.** A local private dentist hired an Extended Access licensed dental hygienist to coordinate and deliver clinical preventive care on site and triage children into community resources based on unique needs. This program was sponsored by the Regence Caring Foundation, which not only covered costs for supplies and staff time but also helped establish dental homes for all participating children.
3. **Improve direct access to care by registered dental hygienists.** The American Dental Hygienists’ Association defines “direct access” as the ability of dental hygienists to initiate treatment based on dental hygienist’s assessment of patient’s needs without specific authorization from a dentist, treat the patient without the presence of a dentist, and maintain a provider-patient relationship. Ms. Kane explained that this definition is important because Idaho’s dental hygienists have a strong desire to be recognized as providers of care by third-party insurers. Hygienists could then approach various facilities, such as medical clinics and schools, with a plentiful oral health workforce and a cost-effective plan that could sustain a systematic and prevention-oriented approach to oral health promotion.

Ms. Kane finished her presentation by discussing the possibility of creating a new mid-level dental provider position in Idaho. She noted that Idaho was the first state to license such a position for medical care. As a result, nurse practitioners have played an important role in helping physicians meet the needs of medically underserved populations across the state. Ms.

Kane continued by explaining that there is an opportunity to utilize this successful model and for Idaho to become the first state to license the Advanced Dental Hygiene Practitioner (ADHP). Licensed ADHPs would be educated at the master's level and be responsible for the following:

- Providing preventive, therapeutic, and basic restorative care directly to underserved and unserved populations
- Collaborating with dentists and other types of providers as part of a dental team and identifying and referring those in need of more comprehensive dental care

Oral Health in Idaho: A Perspective from Community Health Centers
Denise Chuckovich, Executive Director, Idaho Primary Care Association

Ms. Chuckovich began by stating that Idaho's community health centers are an important source of oral health care for many vulnerable populations, because they are located in high-need areas, are open to all regardless of insurance status or ability to pay, and are able to tailor services to the unique needs of each community. There are currently 12 community health centers across the state, all of which offer some level of dental services. Over the past 5 years, the number of patients coming in for dental care has doubled. Dental visits now account for 20 percent all services offered.

Ms. Chuckovich then described the major challenges that community health centers have faced in addressing the oral health needs of patients. The centers are struggling to get patients to understand the importance of oral health and to act early to prevent oral disease. More than half (51 percent) of the patient population lives below the federal poverty line and has a number of other competing needs that make it difficult to prioritize oral health until faced with care needs. As a result, many patients do not often come in for care until they have intensive treatment needs. Centers see a lot of cases of severe ECC, premature tooth loss in young adults, and "meth mouth" among methamphetamine users. After patients come in for the initial visit to diagnose oral health problems, many often do not return for all necessary follow-up treatment. Out-of-pocket costs for extensive restorative procedures can be prohibitive even for those with insurance or access to sliding-scale fees. Community health centers often face challenges in recruiting and retaining providers, in large part because they are not able to offer salaries at levels competitive to private practice.

Idaho's policymakers and dental community, Ms Chuckovich explained, can help community health centers overcome these barriers by supporting policies and initiatives that value prevention and disease management approaches to care, increase recruitment and retention of providers, promote greater collaboration and partnership, and facilitate the integration of oral health with primary care.

IV. Facilitated Group Discussions

Following the conclusion of individual presentations, Dr. Watt announced that meeting attendees would then be organized into three groups addressing a different oral health topic based on each

person's background and personal interest, including (1) access to oral health care, (2) oral health policy and funding, and (3) oral disease prevention and oral health education. Dr. Watt provided the charge for the discussion groups during the afternoon as follows:

- Identify and define key issues regarding each discussion group topic area
- Select the top three priority issues
- Identify current promising approaches or efforts to address each of the three priority issues
- Identify, select, and prioritize three (large or small) collaborative actions that can be undertaken for each of the three issues
- Select the most strategically important action to undertake and identify “next steps”

It is important to note that the purpose of the discussion groups were to provide a forum where all participants could present what they saw as the key issues in oral health in Idaho. The fact that issues are listed here does not mean that the group as a whole agreed on proposed solutions.

DISCUSSION GROUP FINDINGS

Access to Oral Health Care

List of All Key Issues Identified:

Systems and Infrastructure:

- More effective utilization of the infrastructure we have right now, e.g., dentists, dental hygienists, Head Start staff, educators, etc., and more effective collaboration between all service sectors
- Utilization of a dental team model to delivery oral health care that includes representation from a variety of types of dental, medical, education, and social service providers
- Assuring an adequate supply of dentists and hygienists
- Lack of transportation to dental appointments
- Utilize all available expertise to address patients' complex oral health needs

Partnership Building

- Partnerships with dental offices and others to accept low-income and uninsured patients
- United front between hygienists, dentist, and other providers when approaching the state legislature on oral health issues
- Develop collaborations with educational partners, including teachers and school nurse associations

Financing for Oral Health Care

- Greater funding for public oral health dental programs
- Addressing the growing number of uninsured
- Lack of tax incentives for providers

Education and Training

- Enhancing public understanding of the importance of oral health literacy

- Lack of understanding among non-dental health care professionals about oral health
- Breaking down consumers' fear of dentists/dental offices

Research

- Review why a lot of dentists do not want to take Medicaid patients.
- Conduct additional research to clearly identify populations most at risk of lacking access to oral health and the major barriers they face.

Top Three Priority Issues:

1. Effectively utilizing current resources by improving collaboration between dental and medical professionals and educators and social service providers.
2. Enhancing public understanding of the importance of oral health literacy
3. United front between hygienists, dentist, and other providers when approaching the state legislature on oral health issues

Prior to the end of the session, the Access to Care Workgroup suggested a strategy for using current resources effectively by improving collaboration between dental and medical professionals and educators and social service providers. They listed specific action steps to implement this approach as:

- Holding meetings with all appropriate stakeholders
- Obtaining agreement on the overall goals and objectives
- Deciding how to address policy issues, such as the pressing need to revisit the curricula for health professionals to ensure that the needed oral health-related components are there, including issues related to licensure and the scope of practice

Oral Health Policy and Funding

List of All Key Issues Identified:

Disease Management

- A tendency to treat symptoms of oral disease, rather than the disease itself
- Many families are more likely to seek emergency treatment rather than preventive care.

Policy Development and Infrastructure Development

- Revisit the Dental Practice Act to allow direct access by dental hygienists and allow restorative endorsed hygienists to practice in all settings. Also consider expanding the scope of practice and need for supervision of dental assistants.
- Currently, there is no well-defined public oral health policy in Idaho, particularly one that addresses the new paradigm of treating dental disease
- Lack of infrastructure and leadership in Idaho and a resulting weak public oral health system, as well as a lack of education/knowledge/value among policymakers and the public for the fact that oral health is part of overall health
- The overburdening of pediatric dentists to treat Idaho's uninsured or Medicaid/Idaho Smiles-insured children
- Lack of consensus regarding how best to address access to oral health care.

Advocacy and Public Support for Oral Health

- A lack of a grass-roots effort to advocate for better dental health
- The challenge for dentists to advocate for increased reimbursement rates, they often come off as seeming self-serving
- There is limited public buy-in to address oral health issues, including a willingness to personally pay more for services
- Lack of dental health education in K-12 school system because it is not seen as a priority
- Dental health is not a priority for many parents.

Financing for Oral Health Care

- Insufficient reimbursement rates for Medicaid/Idaho Smiles
- Some services, such as the provision of family education, are not reimbursed under Medicaid/Idaho Smiles
- Funding being lost to paying for restorative when prevention costs less
- New dentists are emerging from school with large debts, which has made it challenging for them to accept Medicaid/Idaho Smiles or uninsured patients
- Insufficient funding for underserved and un-served populations
- Current reimbursement is too low and does not cover enough services to provide greater access to dental care or to address the prevention of oral disease.

Prior to the end of the session, the Oral Health Policy Workgroup was able to prioritize among the issues from this list and identify promising approaches for the first two priority issues.

Top Three Priority Issues:

1. Lack of infrastructure and leadership in Idaho and a resulting weak public oral health system, as well as a lack of education/knowledge/value among policymakers and the public for the fact that oral health is part of overall health.
 - Establish a state dental director
 - Develop a public oral health awareness campaign
 - Strengthen the public oral health system
 - Identify champions for oral health outside of the dental sector
 - Collaborate with other associations and health interests in oral health issues
 - Establish a state oral health advisory committee with representation from all relevant groups
 - Research and replicate successful oral health promotion models from other states
 - Support multiple practice systems.
2. Increase knowledge of the importance of oral health in overall health in order to increase how much oral health is valued among policymakers and the public.
3. Increase Medicaid reimbursement for providing dental care and preventive services

Oral Disease Prevention and Oral Health Education

List of All Key Issues Identified:

Screening and Early Access to Care

- Challenge of finding innovative and effective education and prevention strategies
- Need for adult oral cancer screening and early detection
- Emphasize need to see children in private practice beginning at age one

Provider Education and Outreach

- Need for distribution of maps displaying community access to fluoridated drinking water to providers
- Insufficient targeting of OB/GYN practitioners with oral health information
- Lack of provider education about preventive oral health services such as fluoride varnish and dental sealants

Consumer Education

- Coordination of effort on developing consistent oral health message
- Lack of time spent on educating patients about oral health promotion topics during dental and medical appointments
- Target pregnant women for preventive education
- Addressing poor oral health literacy and language barriers
- Making culturally appropriate information universally available
- Need for more education about the relationship between oral and systemic disease targeted at adults
- Failure to promote tobacco cessation as an oral health promotion strategy
- Lack of information on and prevention strategies targeted at “meth mouth”.
- Greater oral health literacy for elderly caregivers
- Inadequate nutritional information provided in schools for snack foods (vending machines)
- Greater emphasis on oral health education in high school health programs.

Prior to the end of the session, the Oral Disease Prevention and Oral Health Education Workgroup was able to prioritize among the issues from this list and identify promising approaches for all three priority issues.

Top Three Priority Issues:

1. Provider education and outreach
 - Mandate oral health continuing education for non-dental providers (e.g., physicians, nurses, etc.)
 - Educate providers about and obtain buy-in on the policy of having children seen by age one for an initial dental visit.

2. Preventive oral health services
 - Begin education about the importance of fluoride early during the prenatal period and provide follow-up education during well visits after children are born
 - Promote early, comprehensive intervention involving a community approach to prevention.
3. Consumer oral health education.
 - Develop a simple, consistent oral health message (i.e., tag line) about how oral health affects the body for use in public oral health education campaigns. One example tag line would be “healthy mouth, healthy body”.
 - Develop a public sector advertising campaign through various media outlets (e.g., radio, television, etc.), that would be directed toward all populations.

V. Closing Remarks

Dr. Watt concluded the meeting by indicating that an important next step to demonstrating commitment to action is for members of the audience to join the Idaho Oral Health Alliance and to participate in putting together the new 5-year state oral health plan. Elke Shaw-Tulloch, the Chief of the Bureau of Community and Environmental Health in the Idaho Department of Health and Welfare also said that although the Department will be playing the lead role in developing the next state oral health plan, it really will serve as a collective set of recommendations for the state so input from a wide range of stakeholders will be critical. The current planned release date for the plan is late spring 2008.