



Children's Oral Health in the Forefront

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Introduction—Improving Children's Oral Health Takes Leadership!

The Surgeon General of the U.S. issued a major report on Oral Health in 2000 and a challenge to take oral health seriously as an indicator of overall health. That report called oral health "a silent epidemic" and it called for new policy initiatives to prevent oral diseases and to address the related problems of access and affordability that make screening and treatment difficult for many families.

Research shows that most people underestimate the importance of oral health, and few connect a child's oral health to their total health, social conditions, and achievement. Too often, citizens feel the issues are "merely cosmetic." Yet, statistics are shocking: In Washington state, moderate-to low-income families suffer disproportionately. Twenty percent of children suffer 84 percent of the overall tooth decay, yet only 20 percent of children aged 1–3 who are eligible for medical assistance actually receive dental care

Northwest Bulletin: Family and Child Health, with the generous financial and staff support of Washington Dental Service, is addressing this issue to help increase the awareness and involvement of professionals in improving oral health.

The state reports indicate that there is much being done and that there is increased understanding and willingness of health care providers and dental professionals to collaborate. Other articles point out the overall health impact of dental caries, which cause children considerable pain, affect their speech and nutrition, and affect the growth of permanent teeth.

Oral Health, A Regional Perspective

by Forrest Peebles, DDS

In a recent New York Times article discussing current trends in child health care, Dr. Marie C. McCormick, a researcher at the Harvard Center for Children's Health, reported one *surprising* [emphasis added] finding, "... that fewer than half of all children under 18 saw a dentist in 1996. ... Although dental care is covered by Medicaid, the families of many children either do not take advantage of it or cannot find a dentist who accepts Medicaid, experts say. The data for Black and Hispanic children were even more grim. ..." Those findings probably come as no surprise to anyone working with Head Start programs or serving low-income populations. Addressing the lack of access to oral health care was cited as a high priority in recent meetings with health care staff in the four states served by Region X.

To bring attention to the worsening trend, the Surgeon General presented a report* on oral health last year. The Health Resources and Services Administration (HRSA) and the Health Care Finance Administration (HCFA) have collaborated on their own Oral Health Initiative to direct resources of the agencies to develop federal activities that address the crisis. And, most important, state and local health departments and local organizations have developed strategies and coalitions to bring attention to the problem at the state and local levels. The HRSA/HCFA initiative has helped support several meetings of key decisions makers and those with a critical role in finding solutions.

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Contributions to the NW BULLETIN on news from throughout the Northwest, activities of state legislatures, upcoming meetings and events, as well as investigative articles and reviews are welcome; however materials submitted for publication are printed at the discretion of the Editorial Board. Notices for the Calendar should include a brief description of the event, the date, time and place, and the name of a contact person for further information. Submissions must be typewritten, double-spaced; illustrations and graphs should be in a form suitable for reproduction. Manuscripts and correspondence should be addressed to:

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Joint agency funding brought state Medicaid staff, state dental association representatives, state dental directors, federal staff, and others together both at a national level and at some state-specific meetings. If resources are available, one of the initiative's goals is to continue the individual state meetings. It is hoped that each state in our region will have support for a similar meeting in the next two years.

A major problem is a diminishing number of dentists. According to the American Dental Education Association, approximately 6000 dentists are retiring each year, while only 4000 are graduating from dental school. The number of dental hygienists has increased only slightly in the past twenty years. These trends are of particular concern in the Northwest as there are only two dental schools in the four states, and both have decreased class size as compared to the 1970s. To address this shortage, the National Health Service Corps has re-instituted the dental scholarship program to help increase the number of dentists available to underserved populations.

According to Dr. Burton Edelstein, Director of the Children's Dental Health Project, "dental disease speaks about more than teeth – it speaks volumes about a child's life environment, general health, and personal welfare. If oral health can be forgotten, kids can be forgotten." Expanding on Dr. Edelstein's comment, oral disease in adults should not be overlooked. Oral disease is a family problem and will only be resolved when everyone in the family has access to good oral health care. Recent studies have clearly demonstrated that oral disease is an infectious disease process, and the bacteria are passed from the primary care giver to the child at a very early age. Unfortunately, publicly financed adult dental care has little support. If adult Medicaid coverage exists, it is typically very limited. And, when state budgets are debated, adult dental care is often chosen as a "luxury" that can be eliminated.

There is some good news. Each of the four states in the region has a number of creative activities going on to address the problem. Most of the states have active local and state oral health coalitions. Washington has expanded its ABCD (Access to Baby and Child Dentistry) pilot program. Oregon was selected to participate in the National Governor's Association Policy Academy on Oral Health. Last year Idaho completed a "Seal Idaho" campaign. Alaska has successfully started new, and expanded existing, dental programs in the state's community health centers. Several foundations have provided financial support to various efforts in the states, including Washington Dental Service Foundation and the Northwest Health Foundation. The unprecedented attention to this problem is promising for improved oral health opportunities in the Northwest.

Forrest Peebles is the Regional Dental Consultant in the HRSA Seattle Field Office. Dr. Peebles practiced dentistry in rural communities and in community health programs before joining HRSA.

*Executive summary of the Surgeon General's Report can be found at www.nidcr.nih.gov/sgr/execsumm.htm.

Editorials from a Dental and a Medical Professional Collaboration is Essential _____ Provider Involvement is Crucial__

by Bryan Williams, DDS, MSD

The nation's tertiary care children's hospitals are the refuge of last resort in the dental health safety net for children. Every day, as a full-time pediatric dentist in a tertiary care hospital, I see the devastating effects of dental disease on the well-being of children. Untreated dental disease causes pain, swelling and suffering for children. Their families turn in desperation to our emergency services department for care. Caries which could have been prevented or treated at an incipient stage can end up creating a facial cellulitis which can require an in-patient admission, intravenous antibiotics, and an operating room procedure for an incision and drainage.

Dental caries is the most prevalent chronic disease in childhood, yet access to care for children in need is a severe problem that is now considered a public health crisis. Many times the problem with dental caries begins well before the time most children visit a dentist. By age 6–8, more than half of all children experience dental decay. Additionally, since many children with caries are in economically disadvantaged families, funding support for their care either comes from the Medicaid program or is non-existent. Distribution of dentists is uneven, active participation by dental offices in the Medicaid program is limited, and there are fewer dentists. These factors place a significant burden on the community safety net.

This public health crisis requires a conceptual shift away from identifying dental problems as specifically owned by the dental profession. This problem is of a magnitude and scope beyond the dental profession's ability to manage it.

How the medical community can help

As a person involved in primary health care for children, your involvement can be invaluable. First, all primary care providers have an opportunity to influence public health policy. We need a common will to support access to preventive modalities as well as treatment for these children.

The most effective, universally beneficial, public health measure to reduce dental caries is community water fluoridation. Solid scientific data supports the efficacy and safety of fluoridation. It is also a very cost-effective public health measure, with each dollar spent in community water fluoridation saving approximately one hundred dollars in restorative dental costs. As a primary care provider, there is no question that your support for fluoridation and other dental public health initiatives will be of immense value.

Additionally, and unfortunately, many children are beyond the point where preventive modalities can alone fulfill their needs.

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by Danette Glassy, MD

Science tells us oral health is a part of total health. Dental caries is an infectious, transmissible disease. But our care systems have created a disconnect between primary care providers and dental providers, which has left some children's oral health at risk. As primary care providers, particularly because we see more young children more often than any other group of providers, we are in the position to start bridging the gap and preventing disease. We can begin by including a child's mouth as part of a child's body at each visit in our offices and creating an easy bridge for families between their primary health care and their dentist. From the point of view of a pediatrician, there are some basic steps we can take as physicians, pediatric nurse practitioners, public health nurses, WIC nurses, or others to lay the planks on that bridge.

Assess

Oral health should be a routine part of overall health assessments. When we see children for well child checkups, EPSDT exams, or when their parents bring them in when they are sick, we have an opportunity to assess by:

Doing "Lift the Lip" exams—lifting the child's lip and looking at the teeth. The earliest signs of decay appear as a general loss of translucency or reflectiveness of the enamel, much like looking at frosted glass or flat paint. Brown or yellow spots or carious lesions on the teeth are more obvious symptoms of early dental caries.*

Treat and Refer

Like any assessment, the next step is treatment or referral:

Encourage the first dental exam by age 1. The American Academy of Pediatric Dentistry recommends this, and the American Academy of Pediatrics recommends that dental evaluations as early as one year may be appropriate for some children. Start kids off with regular assessments and capture a health education "moment of opportunity" with parents.

Tell parents about fluoride supplements if the child does not routinely drink fluoridated water.

Recommend use of a "pea-sized" amount of fluoride toothpaste for children over 12 months of age.

Apply fluoride varnish for children at high risk.

Refer to dental providers for urgent care needs.

Refer families without insurance to agencies that help low income families find coverage and care.

Educate

Pediatricians, other primary care providers, and their staffs are trusted sources of information, and each office visit presents an opportunity. If you do not already deal with these topics,

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You can be of help in supporting public initiatives to improve access to treatment facilities for children.

As a primary care provider, you have the unique advantage of seeing the child early in life. In addition, you may be the first stop in a dental emergency. In recognizing oral health problems as overall child health problems, you can help by including basic dental disease evaluation and oral health counseling in your regular well-child visits. The caries process can be prevented or arrested with timely intervention if it is caught in its early stages. Counseling regarding diet and improved oral hygiene may be of major benefit in preventing or reversing this early stage caries. You have built a rapport and understanding with the parents so that communication from you about prevention has a good opportunity to be effective. In some children, timely and frequent intervention with topical fluorides may be beneficial in arresting the disease process. In those children who have active disease beyond the initial stages, referral to treatment resources can intercept the problem at a point where it can still be managed without complex and expensive treatment.

In your practice you, no doubt, get a surprising number of questions from parents about teeth, dental alignment, tooth eruption and other soft tissues of the mouth. Unfortunately, your training may have ill-prepared you for the nature and volume of these questions. A few simple clinical tips can provide answers and action plans for many of the common situations that present themselves. Dentistry is beginning to realize that it is our responsibility to provide clinically useful training for the primary care practitioner. I urge you to take advantage of the educational opportunities that are becoming available.

History has raised some artificial barriers between our professions. The well-being of children is at stake and we must work together to help solve the child health tragedy of dental disease.

Dr. Williams is the Director of the Department of Dental Medicine at Children's Hospital and Regional Medical Center.

NOHIC (National Oral Health Information Clearinghouse) is a service for the National Institute of Dental and Craniofacial Research. Free publications are provided on many oral health disorders including oral cancer.

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now is the time to start:

Let parents know how to prevent early childhood caries (baby bottle tooth decay).

Help parents understand the importance of taking their baby to the dentist at age one whenever possible.

Provide nutrition counseling, especially avoidance of sweet, sticky snacks.

Recommend use of mouthguards for children participating in contact sports.

Know your community

Do you know if the community water supply is fluoridated? If it is not, and if there is a campaign for water fluoridation, get behind it!

Do you know the local pediatric dentists? Do you know general dentists skilled in caring for children and if they take kids on Medicaid? Are there community dental clinics?

Is there a program to increase children's access to dental care in your state? (e.g., Access to Baby and Child Dentistry [ABCD] is a program in Washington state.)

We can be the bridge, the link to improving children's oral health. We see more young kids than any other group of providers. Let's "watch *our* mouths," and speak up and work for kids' oral health!

Dr. Glassy is President, Washington Chapter of the American Academy of Pediatrics.

* *Bright Futures in Practice: Oral Health*, Guidelines for Oral Health Supervision for Health Care and Dental Professionals. National Center for Education in Maternal and Child Health, 1996. Available from National Maternal and Child Health Clearinghouse, 703-821-8955 or www.nmchc.org.

Preterm Births and Oral Health

New research is showing that there is an association between periodontal disease and preterm births. Preliminary results from a study of pregnant women show an eight-times higher rate of preterm births among those with serious gum disease. The findings were reported at the American Dental Association's National Media Conference, June 2000.

Healthy Mothers Healthy Babies indicates that severe gum disease may affect the births of as many as 45,000 babies each year in this country. Pregnant women are encouraged to have dental exams early in pregnancy, to brush and floss daily, and to eat nutritious foods.

Contact the ADA: www.ada.org

Contact Healthy Mothers Healthy Babies: www.hmhb.org

Reference: Marjorie K. Jeffcoat, DMD, Dept. of Periodontics, University of Alabama at Birmingham

The Face of a Child

Surgeon General Calls Oral Health a Silent Epidemic

by Wendy Mouradian, M.D.

Oral health is an important part of children's overall health and quality of life. *The Face of a Child: Surgeon General's Conference on Children and Oral Health*¹ was held June 12-13, 2000 in Washington, DC after the release of *Oral Health in America: A Report of the Surgeon General*.² Key findings from the report and conference follow.

The Problems

Caries is the most common chronic disease of childhood, affecting five–seven times as many children as asthma. Dental caries is initiated by pathogenic bacteria that can spread from mother to infant. Early childhood caries (baby bottle tooth decay) is a rampant form of the disease often associated with inappropriate feeding practices.

Children with neglected dental related illness miss an estimated 52 million hours of school per year, and as a result many suffer serious medical complications. Often such children are treated in emergency rooms and may require costly operative treatments.

Cleft lip/palate, one of the most common birth defects, has significant long-term consequences. Tobacco use among teens and oral and craniofacial injuries can also become important oral health problems.

Good oral health habits in young children need to be encouraged to avoid health concerns in later life. For example, pathogenic oral bacteria associated with periodontal disease have been associated with conditions ranging from preterm birth and low birth-weight babies to diabetes and heart disease in adults.

Access

A critical problem is the disparity in children's access to oral health care. Children at greatest risk for oral health and access problems are those from low-income and/or minority families, those in dental care shortage areas, and children with special health care needs. Among Medicaid-eligible children, fewer than one in five receive a single preventive dental visit in a year.³ Almost three times as many children lack dental insurance as lack medical insurance. Dental care is now the most prevalent unmet health need for children.⁴

Children with Special Health Care Needs

Dental care is also the most prevalent unmet health care need for children with special health care needs.⁵ Dentists may not be comfortable treating these children. Children with craniofacial conditions often have difficulty accessing needed dental and orthodontic care to move or replace congenitally abnormal

(or absent) teeth. Primary care providers need to be aware of the potential oral health complications of chronic medical conditions and their treatment.⁶

Some Solutions

Dental caries is preventable through a combination of community, professional, and individual measures—including water fluoridation, professional application of topical fluorides, and dental sealants, use of fluoride toothpastes, proper infant feeding practices, and diet. Dental caries may be reversed if diagnosed early before it results in frank cavities. Fluoride helps promote remineralization.

Oral health must become a part of primary care. A good starting point is *Bright Futures*⁷ guidelines for oral health promotion and disease prevention in primary care. These include risk assessment, anticipatory guidance, appropriate parental counseling, and dental referrals. Other resources are available.^{8,9} In some communities, pediatricians apply fluoride varnishes to teeth of high risk children. Primary care medical providers can advance children's oral health by working with their dental colleagues to establish referral networks and advocate for water fluoridation. There is a need for more dentists trained to treat infants and young children.

To be effective, efforts to improve children's oral health problems must be considered in the context of children's overall health and development, family needs, and cultural needs. Community sites such as WIC centers, Head Start, developmental centers, and schools are ideal for partnering with other professionals—including nutritionists, social workers, educators, and occupational/physical therapists. Because prevention must start early, all providers working with young children must be knowledgeable about oral health and its importance.

Integration of Medicine and Dentistry

The separation of medicine and dentistry has an additional impact on oral health care and access to care. Pediatricians may lack the knowledge to effectively promote children's oral health.¹⁰ Dentists may not recognize signs of systemic disease or abuse and neglect. They may not be comfortable providing care to young children or to those with special health care needs. Pediatric dentists see younger and more complex patients, but represent a small percentage of practitioners.¹¹

Community and local partnerships are also critical. The disparities in children's access to care cannot be solved by a single group. Partnerships are needed that involve providers of pediatric dental and medical care, professional associa-

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The Face of a Child

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tions, educators, researchers, parents, policymakers, and the private sector. The key will be sustaining the momentum created by the Surgeon General's report and the June 2000 conference.

Dr. Wendy Mouradian was the chair of "The Face of a Child: Surgeon General's Conference on Children and Oral Health." She is a general and developmental pediatrician and was formerly the Director of the Craniofacial Program at Children's Hospital and Regional Medical Center in Seattle. She is currently on loan to the National Institute of Dental and Craniofacial Research at NIH, and also works at the Center for Comprehensive Oral Health Research at the University of Washington.

¹ *The Face of a Child: Surgeon General's Conference on Children and Oral Health*, June 12-13, 2000, Washington, DC

² U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General-Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. p 1; 5-6.

³ U.S. Inspector General. *Children's Dental Services under Medicaid: Access and Utilization*. U.S.DHHS. San Francisco 1996. Publication OEI 09-93000240.

⁴ Newacheck, P., et al, "The Unmet Health Needs of America's Children." *Pediatrics*. 2000; 105 (4 parts 2): 989-997

⁵ Newacheck, P., et al, "Access to Health Care for Children with Special Health Care Needs." *Pediatrics*. 2000; 105: 760-766

⁶ Nowak, A.J., ed., *The Handbook*, 2nd ed. Chicago: American Academy of Pediatric Dentistry, 1999.

⁷ Cassamassimo, P., ed., *Bright Futures in Practice: Oral Health*, National Center for Education in Maternal and Child Health, Arlington, VA, 1996.

⁸ Edelstein, B.L., "Evidence-based Dental Care for Children and the Age One Dental Visit," *Pediatric Annals* 27:9; 569-574 1998.

⁹ Milgrom, P., and Weinstein, P., *Early Childhood Caries: A Team Approach to Prevention and Treatment*, University of Washington School of Dentistry, Seattle, 1999. Available from Continuing Dental Education, Box 357137, University of Washington. Telephone: (206) 543-5444; Fax: (206) 543-6465.

¹⁰ Lewis, C.W., Grossman, D.C., Domoto, P.K., Deyo, R.A., "Role of the Pediatrician in the Oral Health of Children: A National Survey," *Pediatrics*, 2000. Vol. 106. No.6 E84. www.pediatrics.org/cgi/content/full/106/6/e84

¹¹ Mouradian, W., Wehr, E., Crall, J.J., "Disparities in Children's Oral Health and Access to Care," *JAMA*. Vol 284 (20) 2625-2631, November 22/29, 2000.

Oral Health in Primary Health Centers

by Mark Koday, DDS, and Talibah Chiku

The Northwest Regional Primary Care Association (NWRPCA), a member of the *Northwest Bulletin* Editorial Board, received pilot dollars from HRSA to implement a Community Health Center (CHC) Group Mentoring Project. CHCs organized themselves to mentor leadership in new health centers. Oral health is one of the issues the 45 centers in this region have organized to take on. One way the CHCs mentor and share information is through a dental group list-serve led by Mark Koday. The following are two examples of how CHCs are starting to deal with the oral health issues and reach out to their communities.

Migrant/Community Health Centers (M/CHC)

Yakima Valley Farm Workers Clinic (YVFWC) serves low income and migrant farm workers and residents of Central and Southeastern Washington and Northeastern Oregon. To integrate dental and medical services, YVFWC dental programs have set up priority access to the dental clinic for specific medical referrals from medical clinics and WIC departments.

The YVFWC medical programs in the Washington clinics are now delivering direct dental preventative services. As part of a newly established project, the medical programs apply fluoride varnish to children's teeth at well-child checks and teach oral hygiene instructions. The goal is three to four fluoride applications by age 2. Children with specific dental problems are referred to dental programs for follow-up.

The YVFWC also has a comprehensive AIDS/HIV+ treatment program called the New Hope clinic. All New Hope clients are case managed and referred to dental department for comprehensive care. Referrals flow from the dental department to medical department as well. Blood pressures are taken on all dental patients, and those who have high blood pressure are referred to the medical department for care. It is important that services in C/MHCs are integrated if we are to achieve the health improvements that we have long fought for in our communities.

Klamath Oregon Clinic

For the past five years, Bonnie Lederman, dental director with the Oregon Klamath Open Door Family Practice Clinic, has advised dental hygiene students at Oregon Institute of Technology (OIT). The students organized a program to screen school children. The children receive exams including radiographs, oral hygiene instructions, exams by dentists, and sealants. The clinic has agreed to continue treatment even after the school term ends. This collaborative oral health and primary care learning opportunity links the health center with an academic institution to identify young dental patients and to foster access to dental hygiene students.

Mark Koday is Dental Director, Yakima Valley Farm Workers Clinic. Talibah Chiku is Clinical Program Manager, Northwest Regional Primary Care Association.

Reframing Oral Health for Lasting Change

by Richard Brandon, PhD, University of Washington, Human Services Policy Center

Policy change requires public understanding of the issues and a will to act. Research has demonstrated that citizens are not aware of oral health problems or their solutions. They view oral health as a personal responsibility without understanding how communities can play a role.

- Oral health problems often begin early and grow bigger.
- Children's oral health is an important, overlooked component of overall health.
- If oral disease is not treated early, a child's health and achievement are at risk.
- Disease keeps kids out of school and, later, out of work.
- Sealants and fluorides are as important in protecting against disease as immunizations.
- Medical research has given us ways to protect children so they won't have to see a dentist as often, but we must get them into prevention and care early.
- Solutions languish in legislatures because children don't vote and most people don't understand the connection between oral health and a child's overall health.
- Children's oral disease is preventable, and
- Children's oral health is the entire community's concern.

Creating Lasting Change Through Policy Change

Most Americans favor the policy options that oral health experts tell us would make a difference for children. Among those policies currently under consideration by Washington's Citizen's Watch for Kids' Oral Health (see next column) are:

- fluoridation of public water supply systems serving more than 1,000 people
- incorporation of oral health components into comprehensive physical examinations
- expansion of community dental health clinics with attention to securing dentists to staff such clinics
- effective implementation of Medicaid guidelines providing for initial dental examination of children at age 1
- incentives (e.g., tax credits, reimbursement rates) to dentists serving Medicaid-covered and low-income children
- provision of continuing education for primary health care professionals on pediatric dentistry in the context of culturally diverse community needs
- expansion and streamlining student loan repayment program for dentists who agree to practice in areas of need

Advocacy requires the mobilization of community resources to accomplish a change of public understanding and behavior. On this and the following pages are many examples of how this is happening in Region X. To find out more, check <http://www.kidsoralhealth.org>

An Example of Advocacy:

To move policy, you need support. To increase support, you need awareness and understanding of the issues. To increase awareness, you need many hands to deliver the information. A coalition of Washington state health, business, labor, and children's groups has responded to the Surgeon's General call to improve children's oral health by gathering those hands. They have formed the "Citizen's Watch for Kids' Oral Health." The coalition kicked off a public awareness campaign in January, mobilizing member communications channels to reach a broad cross-section of the state's population.

Called "Watch Your Mouth," the campaign aims to increase understanding and support for children's oral health issues. It is important to let the community know a child's oral health impacts the child's overall health, and that there are things that can be done to improve children's oral health—but parents can't do many of them. The community has to do them.

The campaign is designed to create the needed community will to support future policy initiatives. It has four critical elements:

- a strategic communications and policy coalition,
- a research-based communications effort,
- momentum for policy change in Washington, and,
- templates with "lessons learned," developed for potential national deployment.

Research Driven Communications Strategies

The campaign is grounded in communications research conducted by the FrameWorks Institute. The campaign employs grassroots communication through the Citizen's Watch organizations along with mass media. Edgy, creative, and clear messages (such as "Watch Your Mouth!") are being used to communicate that overall health is the sum of its parts—and that oral health must be one of those parts.

To find out more, contact: Citizen's Watch for Kids' Oral Health, Washington Kids Count, Box 353060, University of Washington, Seattle, WA 98195, or 206/616-1833, or visit www.KidsOralHealthWatch.org.



State Reports: Alaska and Oregon

Alaska Focuses on Improving Access to Dental Care

by Brad Whistler, Chief, Medicaid Services Unit, Alaska Department of Health and Social Services

Alaska, like many states, has been working to increase access to dental services for low-income children and their families. Access to dental care for children enrolled in Medicaid is a long-standing concern in many areas of the state. In urban areas, most private dentists participate in Medicaid. However, many do not accept and/or limit children enrolled in Medicaid as new clients in their practices. While the recent Medicaid expansion under SCHIP has provided increased health coverage and significant increases to preventive health services, it has further strained the ability to find private dentists to see recently enrolled children in the program. In more remote areas of the state, dental services continue to be provided on an itinerant basis largely by the Alaska Native health corporations and tribal providers.

Staff in the Medicaid program convened meetings with the state dental association to improve access by increasing private dentists' participation in the program. Meetings held between February-May 2000 resulted in the following:

- Changing the claim processing system to pend claims with incomplete/inaccurate information, allowing staff to work with dental offices to promptly resolve claims.
- Removing service limits for teeth cleaning and oral exams for children, avoiding denying claims for preventive dental services that come into the system earlier than six months from the last dental exam.
- Streamlining claims processing: standardizing dental claim forms, accepting claims regardless of where the dental procedure code was located in CDT coding, and increasing availability of electronic billing.
- Adding new procedure codes for sedative fillings, analgesia, and therapeutic drug injection for treatment of adult dental emergencies.
- Revising/reformatting dental provider billing manuals, reformatting provider training, and developing a web site to make the program more provider friendly.
- Clarifying to providers that enrollment in Medicaid does not restrict the providers' ability to make practice decisions on the number of adult and/or children enrolled in Medicaid that they will accept into their practice.
- Changing compliance audits to encourage more communication between auditors and dentists to resolve concerns early in the audit process and provide timely feedback on audit findings.

Beyond the Medicaid program, Alaska's community health centers are looking at adding dental services in the clinics and/or expanding dental service in the one health center that offers these services currently (Anchorage Neighborhood Health

Center). Native health corporations and tribal providers are also looking at strategies to expand dental services including, in some circumstances, provision of services to non-Native children who have been unable to access dental services with private dental offices. While a lot of great work has been done to improve access to dental services, there remains much to do. Of dentists with active licenses in Alaska, 65% are age 45 and above and more than half of them have practiced in Alaska 15 years or longer. Access to private dental offices could get worse as older dentists reduce practice hours and/or retire without new dentists moving to the state.

For more information e-mail: Brad_Whistler@health.state.ak.us

Oregon Working to Close the Access Gap

by Dr. Whitney Payne, State Dental Director

The Dental Health Program (DHP) seeks to improve the oral health of Oregon's children and, to a lesser degree, adults. DHP works to decrease the number of children with decayed, filled, or missing teeth; increase the number of children with preventive dental sealants on their permanent molars; and increase the percent of people served by community fluoridated water systems.

Currently, DHP coordinates the state-wide, school-based King Fluoride Program, a volunteer program to bring fluoride rinses and supplementation to vulnerable populations. This program is an effort to overcome the tremendous lack of fluoridated water systems in Oregon. Only 24% of Oregon's population receives optimally fluoridated water. (Oregon is 45th in total optimally fluoridated water systems reaching populations of 10,000 or more.) Coalitions have formed and are promoting optimally fluoridated water in the most populous counties and communities in the state.

The Dental Program is also promoting an Early Childhood Caries education package intended for all health care personnel to identify and possibly treat rampant caries found in the very young. This packet was disseminated statewide to a variety of dental and medical practitioners.

Further, DHP provides technical assistance and partnership for dental sealant programs in operation in five counties. Assistance is provided to local health departments, public health programs, Head Start programs, and other partners in promoting preventive health activities/programs, providing education, and gathering, interpreting and disseminating current preventive dental health information and resources.

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Idaho Report

Advocacy to Eliminate Dental Disparities

by Lisa Penny, RDH, Oral Health Program Manager, Idaho Department of Health and Welfare

Advocacy - n. The act of pleading or arguing in favor of something, such as a cause.

Idaho's oral health advocacy efforts began in earnest in May 1998, with formation of the Idaho Oral Health Alliance (IOHA). IOHA works to improve the general health of Idahoans by promoting oral health and increasing access to preventive and restorative services. Members include representatives of state and district health departments, private and public dental insurers, dental and health professional associations, schools, educators, and others. Since its inception, IOHA has worked to increase awareness of dental needs, disparities, and evidence-based solutions. IOHA also facilitates collaborations and initiatives built around members' shared interests and resources.

next column

Oregon, continued

To encourage access for this population, an initiative is under way to reactivate the pediatric dentistry graduate program at the local dental school. Since vulnerable populations of children have more oral problems and less access to care, DHP wanted to educate a variety of health care providers who routinely provide care for pregnant women and children from birth to age 3. DHP is actively involved in seeking funding for this initiative. It is an attempt to close the access gap for Oregon's Medicaid-enrolled children, since the vast majority of Oregon's general dentists are uncomfortable seeing these patients.

Finally, the School-Based Dental Health Project is an exploratory effort to determine the feasibility to have state and/or federally-funded dental care, under appropriate statutory guidance, in accommodating schools.

The most significant oral health advocacy effort to come out of IOHA last year was *Seal Idaho 2000*. Sponsored by the Idaho State Dental Association (ISDA) in partnership with the Idaho Department of Health and Welfare, the project goal was to provide free sealants to all second grade children in need of them. Almost 19,000 Idaho second graders and their parents received information about the project, the benefits of sealants, and early preventive dental care. More than \$250,000 dollars in free sealants were donated to 2,804 children by volunteer dentists and their staffs.

A major outcome of the sealant project was the formation of new community partnerships. *Seal Idaho 2000* opened communication between the dental societies and school districts, health departments, and the Governor's Office. The governor promoted *Seal Idaho 2000* and the importance of children's dental health in his January 2000 *State of the State* address. A proclamation signing with the governor, attended by the media, legislators, key policy makers, administrators, and others resulted in extensive local news media coverage. Television and radio commercials that featured the governor promoting sealants and early preventive dental care were aired statewide. On several non-dental occasions, the governor highlighted the sealant project as an example of a successful public-private partnership. *Seal Idaho 2000* was a highly visible project and helped broaden public perception of oral health as an integral component of total health.

Notable oral health advocacy efforts have also resulted from strengthened collaboration between the State MCH Oral Health Program and the state dental association, leading to increased interest and understanding of how the

private dental sector and dental public health can partner. This Fall, ISDA hosted a seminar on evidence-based early childhood caries prevention for dental and medical health care providers and established a Public Health standing committee. ISDA leaders have engaged in ongoing meetings with the state health agency director to discuss public-private solutions to strengthen the dental public health infrastructure and to increase access to primary dental care. ISDA also asked the governor to establish an Oral Health Task Force.

Oral health advocacy efforts in Idaho utilize a variety of opportunities and venues. The state division of Medicaid is working to identify dental access issues. Data on children's oral health is published annually in the Idaho Kids Count Book. A fall 2000 presentation at the annual meeting of the Idaho Dental Hygienists' Association highlighted findings and recommendations of the Surgeon General's Report on Oral Health in America. The Coalition for a Healthy Idaho (CHI), a group of organizations advocating use of tobacco settlement dollars for health programs, requested funding from the 2000 Idaho legislature for a comprehensive early childhood caries prevention program. While not funded, the proposal heightened dental awareness and knowledge among CHI members and legislators. CHI recommendations to the 2001 Idaho legislature will request tobacco dollars to support dental provider tobacco interventions.

Idaho advocacy efforts to eliminate dental disparities through evidence-based solutions will continue in 2001.

For more information, call Lisa Penny at (208) 334-5966 or e-mail at pennyl@idhw.state.id.us.

Washington Report

Linking Oral Health with Public Health

by Beth Hines, RDH, MPH

Oral Health programs within the Office of Maternal and Child Health, Washington Department of Health, facilitate leadership, learning, and support for community-based oral health programs. Public health functions are integrated into oral health program planning by local health jurisdictions through ongoing training, technical assistance, and statewide initiatives. A number of activities took place in 2000.

The *Smile Survey 2000 – An Oral Health Assessment of Children* was implemented statewide. A random selection of 1- and 2-year-old children, Early Head Start and Head Start participants, and second- and third-grade students were surveyed. Analysis and reporting of the data is under way.

Preliminary findings point to challenges for both private and public health leadership. More than 14 percent of children ages 1 and 2 years, have already experienced tooth decay with almost 12 percent in need of dental treatment. Of children in Early Head Start and Head Start, 25 percent are in need of dental treatment. Of school children in second and third grades, 56 percent exhibited a history of cavities, with more than 21 percent having untreated decay.

When stratified by race and/or ethnic origin, significant differences in oral health status appeared. Tribal children screened were found to have significant levels of dental disease and need for dental treatment. Restorative dental treatment is needed by 51 percent of second and third grade students in tribal school.

The *Smile Survey 2000 Report* will be ready for distribution in early 2001. Assessment activities have also included integrating oral health indicators within other surveys such as Lead Poisoning Prevalence, Disability, Pregnancy Risk Assessment Management System (PRAMS), and Behavioral Risk Factor Surveillance System (BRFSS).

The Oral Health Program in Maternal and Child Health places a priority on providing practical tools for communities to use to prevent dental disease and to increase access to dental care for at-risk populations.

State-funded pilot projects have resulted in models that can easily be adapted to other programs.

Health education and promotion materials have been produced for Russian and Hispanic populations.

Guidelines are available for local dental sealant programs, integration of oral health and maternity support services, community assessment, oral health in child care and school curriculums.

Bright Futures – Oral Health is used as the standard for anticipatory guidance in children's oral health.

A federal grant has supported state and local oral health coalition development. Annual conferences, a list-serv, and web page support networking among communities working on oral health issues.

Community Roots – Guidelines for Successful Coalitions is a notebook available to groups seeking to initiate or build community-based action toward improved oral health.

Another successful public health initiative supported by the Oral Health Program in Maternal and Child Health is a community-based dental sealant program. The program targets low-income schools, giving second grade children the opportunity to have sealants placed on their first permanent molar teeth. In 1999, 7505 children received dental sealants through this effort. Promotion of sealants among the general population is also emphasized. As a result of this initiative, the number of children with one or more sealants visible on a permanent tooth has increased from 34% in 1994 to 47% in 2000 (*Smile Survey 2000* preliminary data).

Beth Hines managed the Oral Health Program in MCH. She changed positions to become the coordinator for Adolescent and Adult Immunizations earlier this year.

For Washington State Oral Health Information contact: Nancy Reid, Manager, Child and Adolescent Health and CHILD Profile – Maternal and Child Health, Office of Community and Family Health, Washington State Department of Health, nancy.reid@doh.wa.gov

Nancy Reid can also provide information about these materials:

- Sealants Work! Washington State Dental Sealant Guidelines, Tooth Tutor Curriculum grades K-6,
- Smile Survey Screening Guidelines for county-based oral health assessment in Washington state,
- Community Roots for Oral Health – Guidelines for Successful Coalitions,
- Assessment of Teeth for Community Based Sealant Programs video,
- Smile Survey 2000 – An Oral Health Assessment of Children (not available until Spring, 2001),
- Lift the Lip (video-4 minutes).

Fluoride varnish training available! In an effort to promote oral health in young children, Washington state's Medical Assistance Administration will provide information and training to medical practices on application of fluoride varnishes for Medicaid-insured children. Contact Margaret Wilson, ARNP, 360-725-1658.

Advocacy in Washington State

Children's oral health advocates create projects to increase access to care, to train dentists, dental hygienists, and assistants, to see young children, and to bring oral health education to the community. Here are some notable examples:

Washington State Oral Health Coalition (<http://www.childrensalliance.org/kidsteeth.htm>) The Coalition consists of 40+ organizations, promotes oral health at the state and local levels, and sponsors an annual conference for oral health advocates from around the state.

Access to Baby and Child Dentistry Program (ABCD) (<http://www.abcd-dental.org>) a partnership to increase access to dental services among Medicaid-eligible children from birth to age six.

Washington Dental Service and Washington Dental Service Foundation (http://www.deltadentalwa.com/oral_health/default.htm) work to improve oral health in Washington through prevention, community outreach, advocacy, and research programs. Programs include: the SmileMobile, Cavity Free Kids, and grants.

University of Washington School of Dentistry, Pediatric Dentistry. On-going collaboration with medical providers to create a new access pathway to help vulnerable families achieve good oral health. UW and community partnerships include: South Park Community Center/School of Nursing/Husky Smiles, Wonderland Birth to Three Developmental Center/DECOD/Reach Out and Read/American Academy of Pediatrics, Street Links Van Project/SPARKS. <http://www.dental.washington.edu/pedo/>

University of Washington Oral Health Collaborative, a component of the U W Dental Hygiene Degree Completion Program. Collaborative activities are linked to day care and preschool centers, among other agencies. Looking for help in planning or teaching about oral health or oral hygiene? Need tooth fairies? A puppet show? Ideas for parents, infants and toddlers? Contact University of Washington Oral Health Collaborative at <http://depts.washington.edu/dhyg/collaborative/>

Washington State Dental Association's advocacy programs include: Anti-Spit Tobacco program for junior high students; Take-A-Bite program promotes preventive dental care to the general public through radio spots and informational kits; 3-Point Play for Oral Health and Safety, an educational program for children; National Children's Dental Health Month activities.

Washington State Dental Hygiene Association (<http://www.wsdha.org>) in coordination with dental hygiene education programs, local component groups organize screenings, sealants, and restorative clinics each February and March.

Oral Health Resources

Oral Health Resource Center, Washington Dental Service, 206/729-5545, resourcecenter@ddpwa.com.

Provides information on free or low-cost education materials, including Pediatric Oral Health Reference Cards. The Oral Health Resource Center provides links to education materials, contacts to community efforts, and the Roots list-serve. To join the list-serve, e-mail resourcecenter@ddpwa.com

The American Dental Association
<http://www.ada.org/>

The American Dental Hygienists' Association
<http://www.adha.org/>
Includes Consumer Information.

CDC's Oral Health Program
<http://www.cdc.gov/nccdphp/oh/>
Includes Fluoridation Fact Sheet, Toothbrush Procedures for Schools, and other educational publications

Bright Futures in Practice: Oral Health
<http://www.brightfutures.org>

FluorideWorks
<http://www.fluorideworks.org>
A partnership of 20+ Washington organizations to provide information on water fluoridation.

Proctor and Gamble Dental ResourceNet
<http://www.dentalcare.com/>
It includes Patient Education and Library Online.

Colgate Oral Care
http://www.colgate.com/cp/corp.class/oral_care/index.jsp

Crest Family Care Center
<http://www.crestsmiles.com>

The Dental Zone
<http://www.saveyoursmile.com>

The World of Dentistry Online
<http://www.floss.com>

Healthy Mothers, Healthy Babies
"Baby Book," section on oral health. Available in English and Spanish. Call 1-800-322-2588.

Contacting Your State Dental Association

Dental Associations are a gold mine of information. Contact the dental society in your state to learn about local activities for National Children's Dental Health Month each February.

- Alaska State Dental Assoc. - <http://www.akdental.org/>
- Idaho State Dental Assoc. - <http://www.isdaweb.com/>
- Oregon State Dental Assoc. - <http://www.oregondental.org>
- Washington State Dental Assoc. - <http://www.wsdha.org>

Calendar

April 23-24, 2001, 26th Annual Adolescent Sexuality Conference Sponsored by Marion County Health Department, Seaside, OR
Contact Kristin Nelson at 503/373-3751 or e-mail knelson@open.org

April 29- May 2, 2001, AAPHD/ASTDD National Oral Health Conference, Portland, OR
503/226-7600
<http://www.pitt.edu/~aaphd>

May 3-5, 2001, Society for Public Health Education's Midyear Scientific Meeting "Celebrating Diversity in a Climate for Wellness," in Seattle, WA
Contact: www.sophe.org

May 4 - 8, 2001, Voice 2001: The National Conference on HIV/AIDS and Children, Youth & Families, Washington, DC, Contact: Chip Heath 202/785-3564 Email: cheath@aids-alliance.org

May 19-23, 2001, Spring Primary Care Association Conference, Anchorage, AK, Clinical and Dental travel support may be available.
Contact: cbyrne@nwrpca.org
www.nwrpca.org

May 21-23, 2001, Tenth Conference on International Safe Communities, Anchorage, AK, Injury Prevention Center, 907/929-3939,
Contact: HUDSON@HOTMAIL.COM Web: www.alaska-ipc.org/page_31.htm

May 23-25, 2001, 24th Annual NRHA Conference on Rural Health "2001: A Rural Health Odyssey: New Horizons, New Paths," Dallas, TX,
Contact: mail@NRHARural.org 816/756-3140

May 29-June 1, 2001, 35th National Immunization Conference, Atlanta, GA,
Contact: Rick Nelson 404/639-8211,
Email: RNelson@cdc.gov
<http://www.cdc.gov/nip/nic/>

June 20 - 23, 2001, 11th Annual Conference, Social Marketing in Public Health, Clearwater Beach, FL,
Contact: gphillip@hsc.usf.edu
Website: publichealth.usf.edu/conted/

June 18 to July 15, 2001 Summer Institute for Human Sexuality Studies at San Francisco State University (SFSU) For information, see web site:
<http://hmsx.sfsu.edu/summerinstitute1.htm>.

September 7, 2001, Washington State Oral Health Coalition, "Community Roots for Oral Health", Ellensburg,
Contact: driter@ddpwa.com

October 8-10, 2001, Washington State 8th Annual Joint Conference on Health, Yakima, WA, Contact: Kathy Kimsey 425/377-1477; Fax: 425/397-8309,
Email: kathy@wspha.org