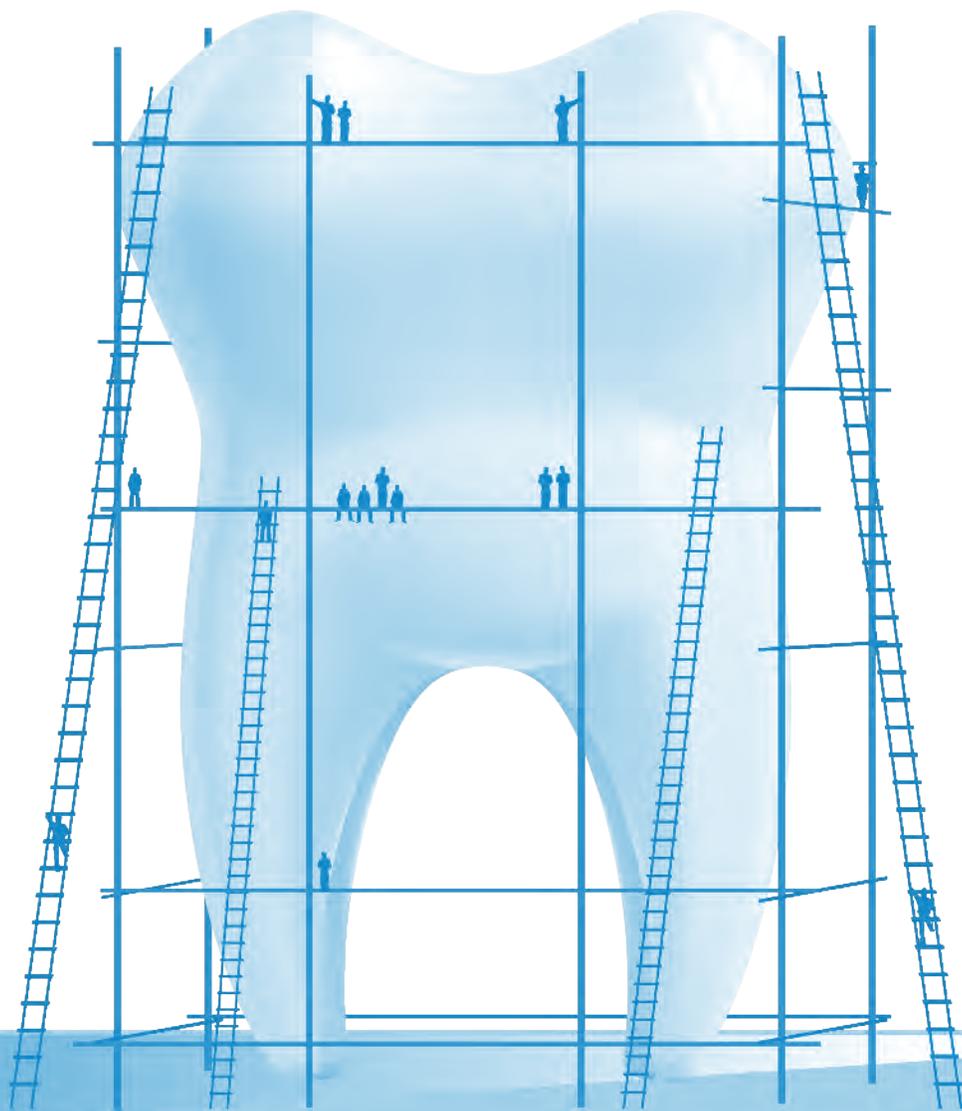




IDAHO ORAL HEALTH ACTION PLAN 2 0 1 0 – 2 0 1 5





CONTENTS

INTRODUCTION.....	3
THE IMPACT OF ORAL HEALTH.....	4
HOW BIG IS THE CHALLENGE?.....	5
BARRIERS TO CARE.....	6
PARTNERSHIPS FOR CHANGE.....	7
STATE PLAN GOALS.....	10
Goal 1: Prevention.....	10
Goal 2: Access to Care.....	21
Goal 3: Policy.....	30
GLOSSARY.....	36
SELECTED REFERENCES & RESOURCES.....	38



“WE MUST BUILD AN
EFFECTIVE HEALTH INFRASTRUCTURE
THAT MEETS THE ORAL HEALTH NEEDS
OF ALL AMERICANS AND INTEGRATES
ORAL HEALTH EFFECTIVELY INTO
OVERALL HEALTH. WE MUST WORK
TO CHANGE PERCEPTIONS ABOUT
ORAL HEALTH AMONG THE GENERAL PUBLIC,
AMONG POLICYMAKERS, AND
AMONG HEALTH PROVIDERS.
WE MUST REMOVE THE BARRIERS
BETWEEN PEOPLE AND ORAL
HEALTH SERVICES.”

David Satcher MD, PhD
Surgeon General – 2000

INTRODUCTION

PLAN: A method for making, doing or accomplishing something.

ACTION: The process of doing.

The Idaho Oral Health 5-Year State Plan is meant to be a plan of action, a roadmap to ensuring and improving the oral health of Idahoans. In November 2007, the Idaho Oral Health Alliance (IOHA) convened the Idaho Oral Health Summit to discuss the challenges and opportunities to improve oral health care in Idaho. That meeting was the first step in developing a course of action.

National Call to Action to Promote Oral Health:

“Advance the general health and well-being of all Americans by creating critical partnerships at all levels of society to engage programs to promote oral health and prevent disease.”

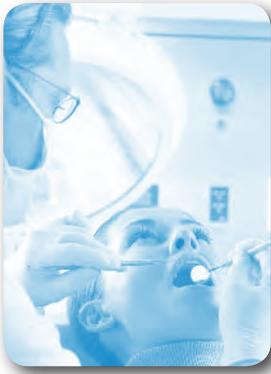
US Department of Health and Human Services 2003

No one individual, agency, or organization can improve oral health care. Collaboration among partners with common goals is essential to bring about the changes needed in the oral health arena. The IOHA represents this collaboration and defines itself as a non-profit organization of dental professionals, public health agencies, businesses, community health providers, and individuals dedicated to better oral health and overall health for all Idahoans. The vision of the IOHA is to promote good oral health and increase access to preventive and restorative care.

Everyone can be involved in working on parts of this plan. Going forward we will need to address the disparate burden faced by racial and ethnic minorities, children and the elderly, and people with limited incomes and no dental insurance. We will need to be teachers and coaches

helping people learn how to care for their own oral health. We will need to be oral health visionaries seeking funding to expand oral health care, developing policies that improve access to care, and linking oral health care to medical care.

The Idaho Oral Health Alliance and partners believe much of this 5-year plan is realistic and achievable. It will take commitment and passion to accomplish the goals set forth in the plan. Judging by outreach programs such as Give Kids a Smile organized by dentists and dental hygienists, oral health care given to participants in the Idaho sponsored Special Olympics World Winter Games 2009, and school dental sealant programs, the passion and drive is evident.



If a person earns less than \$25,000, he or she is 50% less likely to have an annual dental exam.

2008 Idaho Behavioral Risk Factor Surveillance Survey

THE IMPACT OF ORAL HEALTH

Idaho oral health data indicate many Idahoans are at risk for poor oral health outcomes. While there is slight improvement in many areas of oral health care, there is growing concern that people are avoiding preventive oral health care because they are losing dental insurance and facing unemployment. Economic hardship may reverse the gradual progress being made.

The Idaho Oral Health Plan Goals — Interconnected

This Plan defines three interconnected goals — Prevention, Access to Care, and Policy. The goals and priorities do not stand alone, but are linked together. Preventive care occurs with access to care. Both are more likely to occur with strong oral health policy in place. Accomplishing these goals and their accompanying priorities will take planning and collaboration. At the same time linking the goals extends the opportunity to strengthen program interventions and achieve the expected outcomes as outlined in the Plan.

GOAL 1

PREVENTION

Emphasizes strategies to provide oral health education messages, preventive care provided by oral health professionals, and community public health programs such as community water fluoridation and school-based fluoride and sealant programs.

GOAL 2

ACCESS TO CARE

Identifies the most common barriers to oral health care in Idaho and recommends solutions that will help to ensure effective care for pregnant women, children, adults, and seniors, as well as people who are at high risk for poor oral health.

GOAL 3

POLICY

Recognizes the importance of creating policies to ensure access to care and prevention, seeking funding and supporting oral health programs.

HOW BIG IS THE CHALLENGE?

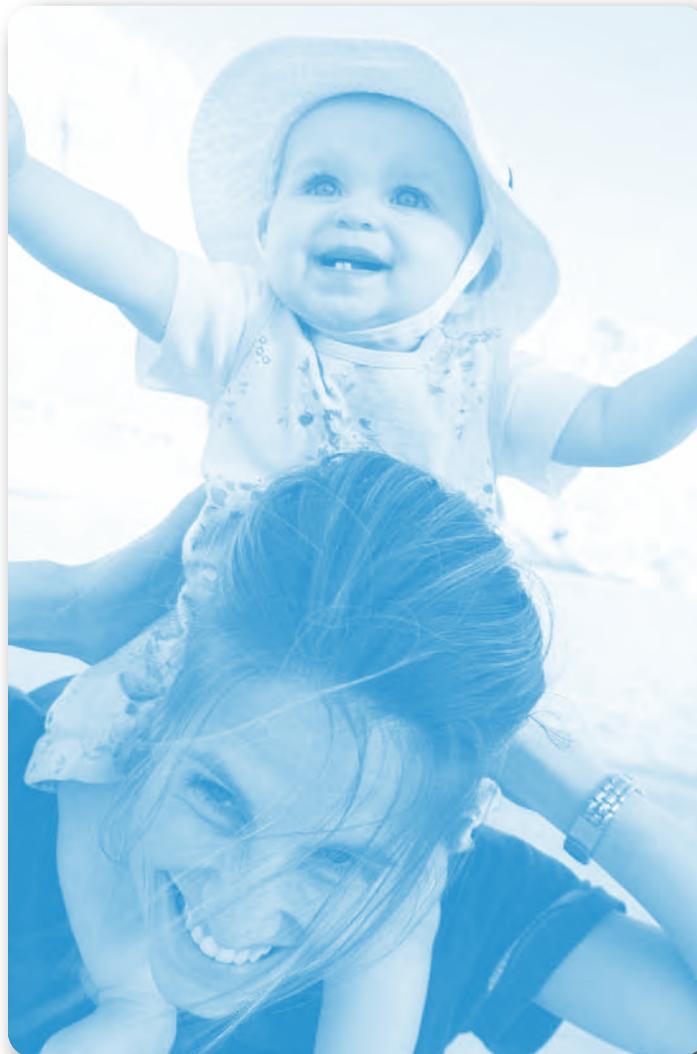


Idaho's Medicaid dental program spends \$38 million annually (2009) — mostly for costly restorative care or tooth extractions.

Oral health in Idaho is a serious public health issue.

The incidence of oral disease is greater in children and adults who can least afford care. Oral disease contributes significantly to the impact and cost of overall health care and can contribute to cardiovascular disease, stroke, pre-term birth, poorly controlled diabetes and other systemic conditions.

Dental caries or tooth decay is communicable through bacterial infection such as streptococcus mutans which can be spread from parents to children. Young children and infants are especially vulnerable to early childhood caries, a severe and rapidly developing form of tooth decay also called "baby bottle tooth decay." Parents erroneously believe decay in primary teeth is not a concern because those teeth will be replaced by permanent teeth. They don't realize the stage has been set for poor oral health during the child's lifetime. Without regular preventive care, tooth decay can proceed without pain until damage is significant, resulting in pain and costly repair is needed to restore tooth structure.



BARRIERS TO CARE



Cultural and Income Disparities: People with lower incomes or of cultures less attuned to oral health self-care are at higher risk for poor oral health. At the same time, they do not have the resources or the education to seek treatment or help until it is too late. People may feel they have no control over their oral health. Often there is a sense of hopelessness — “I will lose my teeth anyway, like the rest of my family”, transference of blame — “I have soft teeth”, ignorance — “Brushing and flossing does no good”, and fear of cost — “Don’t go to the dentist — they will charge you a fortune.”

Access to Oral Health Providers: Most dentists graduate with a large debt for their education averaging over \$130,000. Loan forgiveness programs could help new dentists establish practices and retiring dentists leave the workforce. The natural inclination is to establish a practice in a larger community where more people may afford dental care. Consequently, rural and low income areas may have fewer dental providers. As of 2008, 96.7% of the geographic area of Idaho was designated as a dental Health Professional Shortage Area (HPSA).

Community Water Fluoridation: In 2006, Idaho ranked 45th among states in the percentage of population (31.3%) served by a community water system with optimal fluoride levels. This alone contributes greatly to the high incidence of caries for Idahoans.

Insufficient Safety-Net Care: Idaho has nine Federally Qualified Community Dental Centers providing treatment at reduced fees depending on income. Access to these centers is limited for those individuals who do not live near one of the nine centers. Demand for care far exceeds the resources of these centers leaving many without low cost options. Hospitals report oral pain is the most frequent reason patients visit their emergency rooms where definitive care is not provided. Oral health emergencies drive up the cost of health care.

SOLUTIONS



Education: Aggressively educate the public on how to care for teeth and gums and how to recognize early signs of disease.

Loan Forgiveness: Apply for programs that support loan forgiveness for people graduating from dental and dental hygiene school.

Dental Home: Educate the public and dental and medical providers about the importance of establishing a dental home, with emphasis on children by one year of age.

Community Water Fluoridation: Educate community leaders and policy makers about the value of water fluoridation and the health benefits that result.

School-Based Dental Programs: Develop and promote school-based programs that provide fluoride varnish, fluoride mouthrinse and dental sealants to children.

Medicaid: Enroll eligible children in Medicaid and increase Medicaid reimbursement for dentists.

Community Health Centers: Increase the number of dental clinics linked to CHC primary health care.

PARTNERSHIPS FOR CHANGE

Improving oral health care in Idaho is an enormous undertaking. The human and financial demands alone far exceed the capacity of any single group, community or public health entity, regardless of the level of commitment. Real success — something that is achievable and sustainable — can only be realized through a coordinated effort that brings together both traditional and non-traditional participants in a working partnership that is aligned with and guided by a central plan.

PARTNERS

Idaho Oral Health Alliance
 Idaho Dental Hygienists' Association
 Idaho State Board of Dentistry
 Idaho Area Health Education Center (AHEC) Mountain States Group
 Idaho Head Start Collaboration
 Idaho Oral Health Program
 Idaho Primary Care Association
 Idaho Public Health Association
 Idaho State University, Department of Dental Sciences
 Panhandle Health District
 Public Health Idaho — North Central District
 Southwest District Health Department
 Central District Health Department
 South Central Public Health District
 Southeastern District Health Department
 Eastern Idaho Public Health District
 Advantage Dental Plan
 Aspen Dental Care – John McMurray, DDS
 Bear Lake Dental Care, PLLC – Robert J. Timothy, DDS & Monty Westin, DDS
 College of Health Sciences – Boise State University
 Center for the Study of Aging – Boise State University
 DentaQuest
 Friends of Children and Families Head Start
 Medicaid
 Regence Caring Foundation
 Terry Reilly Health Services
 Allyson Vansteenbergen MD, Meridian Pediatrics
 Anita Herzog, BS, M.Ed, Professor Emeritus, Idaho State University Department of Dental Hygiene
 Jeffery Roth, DMD
 Lorraine Evans Clayton, M.Ed, State Early Childhood Comprehensive Systems Grant
 Misty D. Robertson, RDH
 Sally Kane, RDH-EA
 Sarah Toevs, RDH, PhD
 Shari Williams, BS, RDS-ER
 Virginia Reyna-Walling RDH-EA
 Idaho Voices for Children

STATE PLAN WORKGROUP

Much thanks and appreciation are owed to this group for their dedicated work toward making the Idaho Oral Health Action Plan 2010 – 2015 a reality.

Arthur R. Sacks
 Carolyn Brammer, RDH
 Dan L. Watt, DDS
 Janet Garlick, RDH, BS
 Linda Boyd, RDH, RD, EdD
 Mimi Hartman-Cunningham, MA, RD, CDE
 NaDene Palmer, MBA
 Omair Shamim MD, MHA
 Sally Kane, BSDH, RDH-EA
 Vanessa Hanser, RDH-ER, BSDH

A FEW IDAHO ORAL HEALTH



Special Smiles Idaho is indeed something special itself. When 2,000 athletes from 100 countries came to compete in the Special Olympic 2009 World Winter Games in Boise, Idaho, they were greeted by 262 Special Smiles Idaho dentists, dental hygienists, assistants and students as well as 25 dentists and hygienists from 20 other states and 15 dentists and hygienists from 15 other countries. Special Smiles Idaho introduced the “Miles for Smiles” mobile dental van to the world and offered any dental treatment necessary for Olympic athletes. Since 2001, each year Idaho dentists have opened their practices to provide dental cleanings, X-rays, and any necessary work for Special Olympic athletes at no cost. The Special Olympic Motto is: “Let me win, but if I cannot win, let me be brave in the attempt.” True enough words, especially if the contest is for us to reach out to those less fortunate.

Special Smiles Idaho Directors

Jennifer Clayton RDH

Amy Haugen RDH, MAOL



Delta Dental of Idaho Community Outreach to Idaho Schools

Studies show that children in low-income families experience the most decay. To help change this statistic for Idaho children, Delta Dental’s Community Outreach staff travels across Idaho to provide free dental sealant clinics on-site in Idaho elementary and middle schools. Proven to help prevent cavities, the dental sealant clinics are conducted at schools where 55% or more of the students qualify for free and reduced lunches. Since beginning the clinics in 2007, Delta Dental has seen over 8,000 children, placing over 14,000 sealants, and providing one-on-one dental education in a positive, child-friendly environment. In 2011, Delta Dental is looking forward to seeing 7th graders, who were first seen in their clinics as 3rd graders. It is hoped that these students will have significantly lower cavity rates than other middle school students. Because of this outreach, children who typically do not have a dental home are given access to long-term preventive care and education.

Delta Dental Community Outreach

Lisa Reed, Public Benefit Manager



Terry Reilly Boise and Canyon County Dental Clinics

Women who are pregnant and people with diabetes may not realize how important it is to practice good personal oral health care and see a dentist regularly. Through a special grant from the Women’s Health Foundation, dentists at Terry Reilly Dental Clinics provided free exams, risk assessments, personal care instruction and a dental home-care kit to these Terry Reilly patients. Individual treatment plans for caries and periodontal disease were provided to each patient. Why is preventive dental care important for pregnant women and people with diabetes? Mothers are considered the original source of bacteria for their child. Empowering mothers to understand the importance of their own oral health increases the chance they will have healthier children with a lower caries rate as they grow. People with diabetes are at higher risk for periodontal disease if their diabetes is poorly managed. Most do not know oral disease is a complication of diabetes. Of the people seen in the Terry Reilly program, 30% showed a marked improvement in their oral health and were enthusiastic about their progress. Preventive care works.

Terry Reilly Dental Director

Dan Watt, DDS

SUCCESSES TO SMILE ABOUT.



Idaho Dental Hygienists' Association (IDHA) Hygienists Go To School

Wilder, Idaho is a small rural town with low-income families and kids in need of preventive oral health care. With enthusiastic support from the Wilder School District, IDHA volunteer hygienists, the Regence Caring Foundation, and volunteer dentist, Dr. Allan Stevenson, provided free dental screenings and oral hygiene education to 343 children in kindergarten through 12th grade. About 10% of the students had urgent dental needs and were referred for treatment. The school nurse followed up to make sure treatment was obtained. Of the children seen, only 15% had preventive dental sealants. Fifty percent of the children, who did not have dental problems, had dental sealants.

Idaho Dental Hygienists' Association
Susan Cameron, RDH-EA, BS,
Executive Director



Healthy Smiles Happy Children—Reaching Latino Children

Some of the highest risk kids in Idaho for poor oral health may be those in Latino communities in southwest Idaho. These children are less likely to see a dentist and are more likely to experience dental caries than other children. Southwest District Health's (SWDH) Oral Health Program works with SWDH's Women Infants and Children (WIC) clinics, the Regence Caring Foundation and Burkhart Dental to provide children and their parents with bi-lingual care, Spanish language educational materials, fluoride varnish, and self-care essentials such as toothbrushes, dental floss and brushing timers. Most importantly these children are referred to a "dental home" where they are more likely to receive regular preventive dental care. Since the program began in 2006, the number of children receiving care has doubled. In 2009, 945 children were served. Of those, over 400 were Latino children, two to three years old, who now have a better chance of good oral health.

Southwest District Health
Virginia Reyna-Walling, RDH, Oral
Health Program Coordinator



Give Kids a Smile

Partnerships get things done. Since 2003, every February the Eastern Idaho Public Health District Oral Health Program coordinates *Give Kids a Smile Day*, the American Dental Association's signature national dental access event. The event has grown. In 2009 the Upper Snake River Dental Society, the media, schools, parents, 50 volunteer dentists and 200 volunteer auxiliaries, donated approximately \$116,000 worth of dental services to 495 low income, high-risk children ages 2 to 18 years old who do not normally have access to dental care. Preventive services included exams, X-rays, cleaning, fluoride varnish and sealants. Restorative care included fillings, pulpotomies, and extractions. Delta Dental provided oral hygiene kits to the children. Over the six years, the dental community has provided \$546,000 in services. Partnerships matter.

Eastern Idaho Public Health District
Elyse Baird, RDH, Oral Health Program
Coordinator

GOAL 1 PREVENTION

Optimal oral health across the life span, in families, and throughout Idaho communities begins with prevention practices including personal oral health care practices and access to regular preventive dental care.

To meet oral health needs we must think beyond the status quo and assure that decisions are based on evidence and not simply tradition.

*Sarah Toevs, RHD, PhD,
Boise State University*

Prevention also begins with mothers having a healthy pregnancy, parents caring for “baby” teeth and teaching their children the importance of brushing and flossing and modeling proper self-care. Prevention involves communities deciding to fluoridate their water supplies and school systems supporting fluoride programs, oral self-care education and dental sealant programs. In senior centers and long-term care settings preventive care must be emphasized for the comfort and health of residents. Prevention also means working at the policy level to ensure access to oral health care is available and affordable to everyone. Evidence supports that the cost of oral health care is reduced when preventive care is emphasized. Optimally all people, regardless of age, income, race or ethnicity should have an accessible dental home. Good health is linked to good oral health.



Approximately 60% of Idaho third graders had dental sealants on one or more teeth. 22.5% of Idaho third graders had untreated tooth decay.
2009 Idaho Smile Survey

Priority 1**Population-Based Preventive Dental Measures**

To achieve optimal oral health for Idaho citizens across all ages, programs and policies need to be identified and recommended by oral health experts.

- Oral health experts must take the lead in establishing and implementing programs to benefit the public. For example, the science and evidence shows communities with adequate water fluoridation have a lower rate of tooth decay.¹
- Children and adults who have a dental home and a life-long practice of personal oral health care can expect better oral health and general health.^a
- Children with a dental home by age one have significantly fewer restorative dental needs throughout their lifespan.^{2,3}
- Children with dental sealants are less likely to experience tooth decay.⁴
- Using the school setting to teach good oral health habits and implement preventive programs, such as fluoride mouthrinse, fluoride varnish and dental sealant programs, ensures better oral health outcomes for kids.

“Community water fluoridation remains one of the great achievements of public health in the twentieth century — an inexpensive means of improving oral health that benefits all residents of a community, young and old, rich and poor alike.”
David Satcher MD, PhD
Surgeon General

Interventions

1.1 — Community Water Fluoridation: Promote optimal fluoridation in community water systems in Idaho. As of 2010, 31% of Idaho community water systems provide fluoridation.

- Inform and educate the public and policy makers about the importance of water fluoridation by linking tooth decay incidence to fluoridation status.⁵
- Create local fluoride policy examples for communities to adopt.

Expected Outcomes

- Increased number of communities with an optimally fluoridated water supply.
- Reduced amount of tooth decay in children and adults living in communities with fluoridated water.



^a The following definition of “dental home” is the official policy of the American Dental Association adopted October 2005. **Dental Home:** The ongoing relationship between the dentist who is the Primary Dental Care Provider and the patients, which includes comprehensive oral health care, beginning no later than age one, pursuant to ADA policy. **11**

Priority 1



The prevalence of four or more teeth with untreated decay for students in low-income schools was significantly higher (27.4%) than among high-income schools (14.4%).

2009 Idaho Smile Survey

Interventions

1.2 — School-based Oral Health Programs: Provide dental programs and education that promote healthy teeth and gums in the school setting. Good oral health supports academic achievement.⁶

School-based Tooth Decay Prevention Programs: Encourage partnerships between schools, local public health districts, and dental organizations to provide school-based dental programs such as sealant clinics, fluoride mouth rinse and fluoride varnish programs.

School-based Oral Health Education: Encourage and work with schools and school nurses to implement oral health programs that educate teachers, staff, parents and children about life-long oral health habits such as proper brushing and flossing, healthy eating, and regular dental checkups.

Basic Smile Survey: In collaboration with the Idaho Oral Health Program and Idaho State Department of Education, engage schools to conduct the Smile Survey every four years to measure and report on the oral health status of elementary school children.⁷

Expected Outcomes

- Increased number of schools with fluoride mouthrinse, fluoride varnish and sealant programs and oral health education provided to students.
- Increased number of school children with sealants on first and permanent molars.
- Decreased number of children with decay in primary and permanent teeth.
- Assurance the Basic Smile Survey, as an ongoing assessment of Idaho children's oral health status, is scheduled at a minimum of every four years.

Interventions

1.3 — Day Care and Pre-School Programs: Children may eat one to two meals a day during the week in pre-school or day care settings. The staff in these settings can establish oral health procedures for the children in their care with training and support from oral health professionals.

Day Care and Pre-School Settings: Implement programs that train staff in pre-school and day-care settings about oral health including tooth brushing, teaching children and parents about self-care and healthy eating. Programs should include modeling good oral health care by staff.

Expected Outcomes

- Increased number of pre-schools and day care programs with oral health programs that include trained staff and oral health care for children.

Priority 1



Less than half of Idaho mothers (46.9%) who gave birth had a dental visit during their pregnancy. Only 47.9% reported being counseled about the importance of dental care during pregnancy. 2007 Idaho Pregnancy Risk Assessment Tracking System (PRATS)

Interventions

1.4 — American Academy of Pediatric Dentistry (AAPD) Guidelines: The AAPD Clinical Guidelines provide recognized practice recommendations concerning direct patient care for children.⁸

AAPD Guidelines: Adopt and promote AAPD Guidelines for infant oral hygiene, counseling on harmful oral habits, preventing dental injuries, and promoting initial oral exams within six to twelve months of age or with the emergence of the first primary tooth.

AAPD Dental Home: Support adoption and promotion of the AAPD recommendation that children have a dental home by age one.^b

Expected Outcomes

- Increased awareness and adoption of AAPD Guidelines in oral health education programs targeting parents, families and pediatricians.
- Increased number of children who have a dental home by age one.

Interventions

1.5 — Oral Health Care for Mothers, Infants and Children: Proper dental care during the perinatal period may help prevent pre-term and low birth weight babies and is an important aspect of overall health for pregnant women.⁹ Research shows mothers often transmit oral pathogens to their infants setting the stage for oral disease in their child. Delivery of oral health care is not only safe during pregnancy, but also increases the likelihood children will begin life with good oral health. According to the American Academy of Pediatrics (AAP), every child should begin to receive oral health risk assessments by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional.¹⁰

Oral Health Care During Pregnancy: Partner with oral health professionals, physicians, allied health professionals, public health and community organizations to develop a strategy to ensure women in Idaho seek and have access to preventive dental care during pregnancy.

Education of Pregnant Women: Develop health messages and opportunities that promote and support pregnant women to seek dental care during pregnancy. Educate women about risk of transmission of dental disease to their children.

Education of Obstetricians and Primary Care Physicians: Educate physicians to educate pregnant patients about the importance of oral care and fluoride use.

Primary Medical Care: Educate and use family practice and pediatric medical settings for oral health risk assessments, for the use of topical fluoride at well-child visits and for ensuring children are referred to a dental home by age one.

Women Infants and Children (WIC) Program: Ensure local district health departments' oral health programs collaborate with WIC to provide oral health education to parents/caregivers starting during pregnancy and continuing after childbirth. This includes offering fluoride varnish to children enrolled in WIC.

^b AAPD definition of Dental Home: "The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and family-centered way."

Priority 1

First Teeth: Develop health messages encouraging appropriate topical and systemic fluoride as soon as teeth erupt. Messages should include age appropriate home care habits involving caregivers.

Head Start: Support Head Start to offer oral health services and education through Head Start settings that include:

- Providing oral healthcare training and education to Head Start staff and family advocates.
- Offering topical fluoride to Head Start children following evidence-based guidelines.
- Promoting the use of the Head Start dental program as the model for other pre-school programs.

Expected Outcomes

- Increased collaboration among oral health and medical professionals and community organizations to ensure pregnant women have access to preventive oral health care.
- Increased number of pregnant women who seek and receive oral health care during pregnancy.
- Increased knowledge and awareness of parents and caregivers about the importance of good oral health, proper oral health care habits, and transmissibility of dental disease between family members.
- Increased utilization of topical fluoride in multiple settings, such as physician offices and Head Start and other pre-school centers.
- Increased number of children who have a dental home by age one.

Interventions

1.6 — Oral and Dental Aspects of Child Abuse and Neglect: Oral health professionals should be aware of and recognize cases of potential abuse and neglect in children. Guidance is provided by the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD).¹¹

P.A.N.D.A — Prevent Abuse and Neglect through Dental Awareness¹²

Through collaborative effort with oral health professionals, evaluate the opportunity to develop and implement a PANDA program in Idaho.

Expected Outcomes

- Increased awareness among oral health professionals and communities about abuse and neglect in children as well as adults.

Priority 2



71.4% of adults have never had permanent tooth extracted because of dental caries or periodontal disease. This surpasses the Healthy People 2010 goal of 42%. 2008 Idaho Behavioral Risk Factor Surveillance Survey

“No physician or other medical specialist I saw ever suggested I see a dentist.”
...a woman with diabetes

Oral Health Education

Most people are unaware of how important oral health care is to their overall good health. For many reasons people do not seek regular dental checkups and lack consistent routine preventive care.

People of other cultures and speaking other languages may not have information about oral health care and may not seek care. Most oral health diseases are preventable which may not be known to the public. Dental and medical professionals play an important role in educating people about healthy behaviors such as good nutrition, tobacco cessation as well as personal oral health care. Education should include cultural and language specific information.

Often neglected and not understood is the link between good oral health and successful management of chronic diseases such as diabetes and cardiovascular disease. Therefore oral health education must include helping people understand their risks.

Interventions

2.1 — Educating the Public: Oral health professionals should gather and develop key evidenced-based oral health messages. Messages should inform and motivate children, families and adults to practice personal oral health care, understand oral health and health risks associated with poor care, and encourage people to seek regular dental care. Oral health information should be consistent and accurate and help link people to care.

Oral Health Messages: Identify and promote preventive oral health information that is consistent with evidence-based care.

Message Delivery-Community Settings: Promote oral health messages in locations where people live, learn, work and play such as faith-based settings, schools, food pantries, worksites, and senior citizen agencies.

Message Delivery-Electronic: Promote oral health messages through web-sites and social networking sites.

Cultural and Language Specific Information: Develop and deliver oral health information that reaches people with culturally appropriate messages.

Oral Health Toolkits: Develop oral health toolkits for schools, pediatricians, primary health care settings to educate children and adults about basic oral health care.

Resource Center: Create a centralized web-based Idaho Oral Health Resource Center listing all available education materials such as print materials, power point presentations, and teaching outlines.

Expected Outcomes

- Increased number of opportunities for interdisciplinary sharing of medical and oral health issues to improve patient health outcomes.
- Increased number of non-medical settings where people can receive educational information about oral self-care.
- Increased number of culturally relevant oral health messages developed and delivered.
- Increased number of opportunities where the Oral Health Toolkits are requested and utilized.

Priority 3

Adults with heart disease (80.5%) or diabetes (72.6%) are more likely to have had one or more teeth removed due to periodontal disease than adults without disease (41.8%)
2007 Idaho Behavioral Risk Factor Surveillance Survey

Prevention of Periodontal Diseases

Periodontal disease is characterized by loss of connective tissue and bone supporting the teeth and begins with gingivitis characterized by inflammation, swelling and bleeding gums. Preventing periodontal disease ensures that people keep their teeth for a lifetime. People at high risk include those in racial or ethnic minority groups or who have a low income.

Interventions

3.1 — Prevention of Periodontal Disease: Periodontal disease is preventable with proper oral health self-care and regular visits to the dentist.

Education: Dentists and dental hygienists provide patient education in the dental office. Develop public health messages that encourage daily oral self-care and routine professional preventive care.

Expected Outcomes

- Increased proportion of adults who have never had a permanent tooth extracted because of dental caries or periodontal disease to meet the Healthy People 2010 goal of 42%.^c
- Reduce periodontal disease to the Healthy People 2010 target of 41% for gingivitis and 14% for destructive periodontal disease.



^c Healthy People (HP) 2020: This benchmark will be adjusted upon release of the new HP 2020 Oral Health Objectives.

Priority 4



For children tooth decay is five times more common than asthma.

Children's Oral Health – Surgeon General 2000

67% of third graders experienced caries and 22% had untreated decay. 2009 Idaho Smile Survey

Chronic Disease and Risk Behavior

The public and health professionals may not be fully aware of the link between having a chronic disease or engaging in risky health behaviors and how these factors can impact oral health.

Interventions

4.1 — Chronic Disease: Evidence suggests a link between oral infections, diabetes and cardiovascular events that could otherwise be prevented with prudent oral health care. In diabetes, poorly controlled blood sugar increases the risk for periodontal disease and tooth loss. Periodontal disease and the presence of infection can make managing diabetes more difficult.¹³

Public Education: Educate the public about the links between oral health and chronic disease, especially cardiovascular disease and diabetes.

Professional Education: Educate health professionals about oral health and chronic disease through continuing education and promoting standards of care.

Public Health: Include oral health as part of public health chronic disease state plans.

Expected Outcomes

- Increased number of people with cardiovascular disease and/or diabetes who are more aware of risks associated with poor oral health and who seek oral health care.
- Increased number of oral health professionals and health professionals receiving education about the risks of chronic disease and oral health.

Interventions

4.2 — Oral and Pharyngeal Cancer: From 1997-2006, 1,406 Idahoans were diagnosed with oral cavity and pharyngeal cancer resulting in 327 deaths. This is a preventable cancer most often caused by using tobacco products. The use of tobacco and alcohol substantially increases risk for these cancers. Other risk factors include prolonged exposure to sun, poor oral hygiene, and chronic irritation from rough teeth, dentures or fillings. Human Papilloma Virus (HPV) may be a factor in the development of 20% to 30% of oral and pharyngeal cancers.¹⁴

Screening: Promote screening in dental offices and teach patients about risks associated with oral and pharyngeal cancer.

Public Education: Educate patients and the public about risks associated with tobacco, alcohol and substance abuse and the link to poor oral health including oral cancer and rampant tooth decay.

Expected Outcomes

- Increased number of oral health professionals reporting oral and pharyngeal cancer screening is routinely done at office visits.
- Increased public awareness about oral and pharyngeal cancer and how to prevent it.
- Reduce late stage diagnoses of oral and pharyngeal cancers.

Priority 4



Northern Idaho and south central Idaho have the highest rates of both smoking prevalence and oral cancer incidence. Counties with higher rates of smokeless tobacco use had significantly higher rates of oral/pharyngeal cancer. <http://www.idcancer.org/special/CountyProfiles/CountyMap2006.htm>

Although the use of tobacco and alcohol are risk factors in developing oral cancer, approximately 25% of oral cancer patients have no known risk factors. *American Dental Association*

Interventions

4.3 — Tobacco Cessation: Avoiding tobacco products protects oral health and general health as well as prevents oral and pharyngeal cancer.¹⁵

Health Information: Promote tobacco cessation to dental patients following the recommendations of tobacco cessation guidelines promoted as best-practice from the U.S. Department of Health and Human Services, Treating Tobacco Use and Dependence: 2008 Update.¹⁶

Cessation Counseling: Refer patients to tobacco cessation counseling, use of nicotine replacement therapy and the Idaho Tobacco Prevention and Control Program-Project Filter's QuitLine and QuitNet.¹⁷

Health Messages: Develop and promote messages to inform people of other risks contributing to oral cancer such as sun exposure, Human Papilloma Virus, poor oral hygiene, poor diet, and chronic irritation from rough teeth, dentures or fillings.

Expected Outcomes

- Increased number of dental practices and public health hygienists referring patients to tobacco cessation programs.
- Reduced incidence and prevalence of oral and pharyngeal cancers.

Interventions

4.4 — Nutrition: Healthy eating habits during pregnancy, along with proper oral self-care, reduce the presence of harmful bacteria, such as *Streptococcus mutans*, when primary teeth are forming. From early childhood and throughout the life span good nutrition and avoidance of sugary snacks contribute to healthy teeth and gums.¹⁸

Public Education: Promote appropriate infant and child feeding habits to avoid early childhood caries such as "baby-bottle tooth decay." Provide nutritional guidelines to prevent dental caries. Provide information on the transfer of bacteria and prevention among family members.

Policy Support: Support initiatives that reduce high sugar snacks and drinks in children's diets.

Expected Outcomes

- Increased development and utilization of healthy eating messages provided to parents and children.
- Reduction in cases of early childhood caries.
- Increased awareness of the transmission of bacteria causing decay.
- Establishment of policies linked to healthy food choices.

Priority 4

Interventions

4.5 Sport Injury Prevention: School athletic programs should promote and facilitate use of mouth guards to prevent permanent injury to teeth and gums.

Sports Policy: Promote use of mouth guards and safety gear to prevent sport injuries. Target K-12 schools, and provide coaches and community sports teams with messages emphasizing importance of mouth protection.

Expected Outcomes

- Increased number of health promotion messages about mouth guards and safety gear delivered to schools.
- Reduction in sport-related dental injuries to children K-12.

**Interventions**

4.6 — Oral Piercings: Teens and young adults who obtain and wear oral piercings on the tongue and lips are at risk for pain, infection, tooth fractures, and airway obstruction. Unregulated piercing parlors and piercing techniques may expose an individual to communicable diseases such as hepatitis, tetanus, and tuberculosis as well as increase the risk for bacterial endocarditis in susceptible patients.¹⁹

Public Education: Develop and promote education messages describing the risk of oral piercings and proper oral health care.

Policy Support: Develop a policy position that advocates regulation of piercing parlors.

Expected Outcomes

- Reduced number of people seeking oral piercings.
- Regulations established for piercing parlors.



Priority 5

In 2008, only 17.3% of Idaho adults 65 and older had lost all of their teeth which exceeds the Healthy People 2010 goal of 20%.

2008 Idaho Behavioral Risk Factor Surveillance Survey

In Idaho, 1 in 640 births had a cleft lip or cleft palate (Bureau of Vital Records and Health Statistics, ID Dept. Health and Welfare 2007).

Training, Collaboration and Education of Non-Dental Health Professionals

During medical training and through continuing education, health professionals in non-dental health disciplines should be educated about the link between good oral health and good overall health as well as the potential of poor oral health to exacerbate chronic diseases.

Interventions

5.1 — Professional Education:

Professional Education: Collaborate with higher education institutions who train health professionals, to encourage the inclusion of education about the importance of oral health, the oral-systemic link to chronic disease and need for preventive dental care. This should include programs in nursing, family practice residency, nutrition, pharmacy, physician assistant, and other allied health professions.

Continuing Education: Work with state and local health professional organizations to include CME programs about oral health and the oral-systemic link between chronic disease and dental disease.

Expected Outcomes

- Increased number of entry-level professional education programs reporting a unit or module on oral health.
- Increased number of CME or professional development programs including oral health as a topic.



GOAL 2 ACCESS TO CARE

People in Idaho experience challenges in obtaining access to preventive and restorative oral health care. Barriers to care include multiple factors such as not having a “dental home,” being a member of a racial or ethnic minority, and lacking ability to pay for care. Current economic challenges have caused people to lose their jobs and dental insurance. Medicare does not provide oral health care coverage leaving many people over the age of 65 struggling to afford to see a dentist. These barriers impact the ability of children and adults to access preventive and restorative care which may cause people to avoid care until a dental emergency occurs.

Access to preventive and restorative dental care starting with pregnancy and continuing through the life span is essential for people in Idaho to live healthy lives. This includes linking people to preventive services in community health clinics and ensuring children have a dental home by age one. At the local public health level, this means expanding Idaho district health department oral health programs serving schools. Developing and implementing oral health care policies establishes a better system of care.



Oral health care is an integral component of children’s overall health and well being and the most prevalent unmet health care need among children. Medicaid and the Children’s Health Insurance Program (CHIP) are major sources of dental coverage intended to reach eligible children, but not all eligible children are enrolled and served. Inadequate access to oral health care for these children remains a critical policy challenge.²⁰

While access may be an oral health system issue, there is a long held perception by the public that oral health is not as important as general health. Efforts to improve oral health literacy by the public should begin with policy makers, oral health professionals, health professionals, and public health working together.

Looking to the future, oral health professionals and partners need to embrace and use health information technology, ensure a sufficient workforce to meet oral health care needs, and build public health systems and social networks that direct people to needed oral health care. Access to care could be enhanced if medical and dental school programs cross-trained students to have a stronger knowledge of the link between primary health and dental health. In addition, oral health care could improve if medical and oral health professionals established integrated systems of care.

Priority 1**Pregnant Women**

Access to care leads to preventive oral health care for pregnant women. Oral health care is not only safe during pregnancy, but it can also increase the likelihood children will begin life with good oral health. In Idaho only 47% of mothers had a dental visit during pregnancy concluding that pregnant women may not be well informed about oral health care or able to access the oral health services they need.²¹

Interventions

1.1 — Women Infants and Children (WIC) and Early Head Start: Enroll eligible pregnant mothers in WIC and Early Head Start programs. Programs should educate pregnant mothers on the importance of good oral health care and encourage them to have dental checkups during pregnancy.

1.2 — Primary Medical Care Linking to Oral Health Care: Work with dental professionals to establish referral systems to oral health care. Partner with primary care to develop education messages for women about oral health care.

Action steps include:

- *assist women to establish a dental home*
- *provide information about oral self-care to patients*
- *refer women to WIC when appropriate*
- *refer women to Federally Qualified Health Center (FQHC) when appropriate*

1.3 — Idaho District Health Departments (DHD): Collaborate with Idaho district health department oral health programs and other health education settings to provide education to pregnant women.

1.4 — Federally Qualified Health Centers (FQHC): Encourage and educate medical providers in FQHCs to develop a system of referral for pregnant women to oral health care.

Expected Outcomes

- Increased number of women referred to and seen in FQHC dental clinics.
- Increased number of women enrolled in WIC and Early Head Start receiving oral health education.
- Increased number of women receiving perinatal oral health care.
- Increased number of all health professionals providing information about oral health care during pregnancy.

Priority 2



“Informed policymakers at the local, state, and federal levels are critical in ensuring the inclusion of oral health services in health promotion and disease prevention programs, care delivery systems, and reimbursement schedules.”

National Call to Action to Promote Oral Health, 2003

Children and Adolescents

The highest rate of caries experience and need for restorative treatment are concentrated among low-income and racial/ethnic minority children. An important task for pediatricians, primary care providers, dental practices, dental hygienists with extended access endorsements, and health professionals is to guide parents toward making sure children have a dental home by age one and dental care is part of well-child care. Increased access to care improves preventive care.

Interventions

2.1 — District Health Departments: Collaborate with Idaho district health department oral health programs to maintain and expand school-based programs providing fluoride treatments, sealants, and education to children, parents, and school staff.

2.2 — Community-Philanthropic Organizations: Collaborate with these organizations to provide oral health care to children who do not otherwise qualify for oral health preventive and restorative services.

2.3 — Private Dental Practices: Promote programs among private dental practices that provide preventive and restorative care for underserved children.

2.4 — Dental Home by Age One: Promote and provide a dental home by age one through pediatric and family practice offices, WIC, and FQHC clinics.

2.5 — Medicaid and Children’s Health Insurance Program (CHIP): Promote enrollment of eligible children in Medicaid and CHIP.

2.6 — School-Based Oral Health Clinics: Work with dentists, dental hygienists, schools and community partners to develop school-based clinics.

Expected Outcomes

- Increased number of children receiving fluoride treatments and sealants, in the school and public health settings.
- Increased number of children who receive preventive and restorative care.
- Increased number of dental practices providing philanthropic services to underserved children, such as office care or through community service programs.
- Increased numbers of children who have a dental home by age one.
- Increased number of school-based clinics with an increased number of children receiving preventive and restorative care.
- Increased involvement from community and philanthropic organizations to provide programs that improve access to care.

Priority 2

Intervention

2.7 – Children with Special Health Care Needs (CSHCN):^d Maintaining good oral health is difficult for CSHCN who face physical and cognitive challenges and for their families who may be emotionally and financially stressed and unable to devote adequate attention to oral health.²²

The Idaho Oral Health Action Plan proposes adopting the Association of State and Territorial Dental Directors' (ASTDD) Strategic Framework to Improve the Oral Health of Individuals with Special Health Care Needs (SHCN).²³

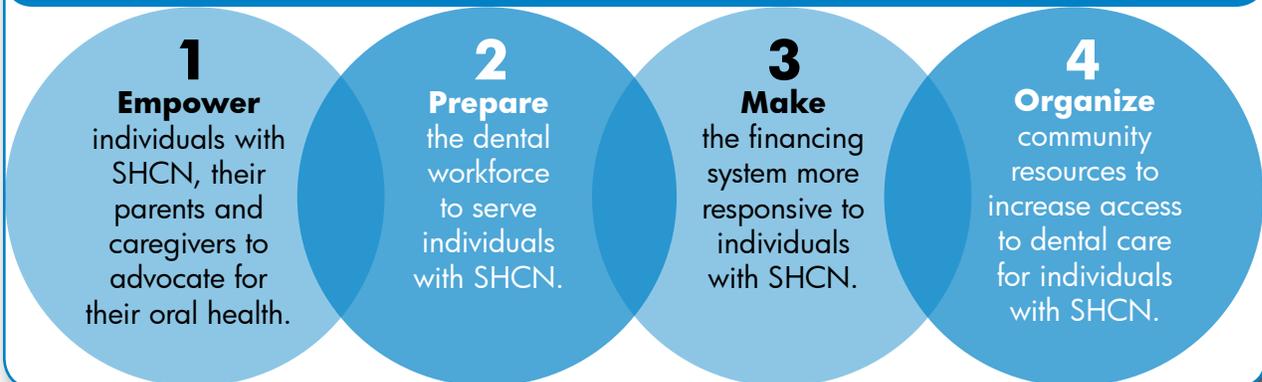
- Implementation of ASTDD Strategic Components: Establish a workgroup to assess the scope of the problem and define a collaborative approach to improving oral health care to CSHCN.

Expected Outcome

- Increased focus on oral health care for CSHCN.



ASTDD Strategic Components



^d The federal Maternal and Child Health Bureau's (MCHB) definition of children with special health care needs (CSHCN) is "...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

Priority 3**Adults and Older Adults**

During economic difficulties, adults may forego dental care, especially if they have lost dental coverage due to job loss or work for an employer without dental coverage. The ages least likely to seek dental care are people 18 to 34 years because they often lack dental insurance.²⁴ Those over 65 years old may not seek dental care except in emergency situations because of limited income and because Medicare does not cover oral health care. Dependent elderly, people in long-term care or the disabled may not be able to provide self-care or have access to care and must depend upon caregivers or others to provide their oral health care.

**Intervention**

3.1 — Dental Home: Adults without a dental home are less likely to receive preventive care than adults with dental insurance or adequate income. The challenge lies in linking these people to oral health services.

Oral Health Safety Net: Collaborate with medical and dental professionals to establish a plan to increase the capacity of community health center dental clinics and other dental services to link people to care.

Expected Outcome

- Increased capacity of community health center dental clinics to provide oral health care to high-risk adults.

Interventions

3.2 — Long-Term Care, Assisted Living, and the Homebound: Older adults suffer the cumulative toll of risk factors leading to poor oral health outcomes over their lifetime. Medicare does not provide dental coverage and most people lose their private dental insurance when they stop working. Lack of income, insurance coverage and logistics may delay or prevent this population from seeking routine dental care. The elderly often suffer from multiple chronic diseases, use medications that negatively affect oral health, and may have physical or cognitive disabilities that make taking care of their mouth difficult or impossible. Inadequate routine dental care may increase the risk of infection, decay and periodontal disease. Caregivers may not have training or time allocated to provide oral health care to dependent elders or residents of long-term care facilities.

Professional Education: Develop a curriculum and training materials to enhance the oral health knowledge and skills of professional staff in care facilities, hospice and home health agencies.

Oral Health Care Delivery: Explore opportunities and increase the number of programs where oral health professionals provide services to patients in long-term care facilities.

Expected Outcomes

- Increased number of facilities with trained staff providing adequate oral health care to patients.
- Decreased barriers to obtaining needed oral health services for persons 65 and older.
- Increased number of oral health professionals serving elderly patients and residents of long-term care facilities.

Priority 4

**Medicaid**

Eligible participants are enrolled in one of two dental plans: the Basic Plan covering low-income children and working age adults with Idaho Smiles dental insurance.^e Not all eligible Idaho children are enrolled in Medicaid and CHIP. As Idaho attempts to enroll all eligible children, Idaho dentists report Medicaid reimbursement is inadequate to cover the services they provide.^{f, g}

Interventions

4.1 — Coalitions: Collaborate with existing coalitions to promote enrollment for eligible children and adults, emphasizing outreach to disparate populations.

4.2 — Usual Customary Reimbursement (UCR): Promote raising the dental fee schedule to at least the 75th percentile of UCR (Issues Brief 2007).²⁵

4.3 — Dental Hygienists as Medicaid Providers-Extended Access: Promote recognition of dental hygienists as Medicaid providers to allow direct reimbursement in extended access settings such as in Idaho district health department settings and long-term care facilities.

Expected Outcomes

- Increased percentage of eligible children and adults covered under Medicaid's Basic Plan and Enhanced Plan (special needs population), with a greater number of disparate populations receiving benefits.
- Increased reimbursement which adequately covers the cost to provide oral health services.
- Increased percentage of Medicaid enrollees seen by a dentist.
- Dental hygienists receive Medicaid reimbursement for oral health services.



^e Medicaid: Medicaid contracts with Blue Cross of Idaho to provide Idaho Smiles, and Blue Cross subcontracts with DentaQuest to administer the program. The Enhanced Plan provides dental benefits to the elderly, disabled or special needs population, and is administered through Hewlett Packard.

^f Medicaid: Although the total number of children enrolled in Medicaid has increased nearly 79% from 2003 to 2009, it is estimated from the 2008 census that upwards of one-half of the 37,000 uninsured children, approximately 18,500 children are eligible but not currently enrolled in a Medicaid plan (Medicaid or CHIP).

^g Medicaid: As of September 2009, the Idaho State Board of Dentistry reports 980 active, licensed dentists in Idaho, of which 61% are participating in Idaho Smiles. Of the 638 total providers participating, an average of 78% (500) are submitting claims on a monthly basis and receiving reimbursement. Although the number of providers accepting Medicaid enrollees has increased 79%, providers indicate reimbursement is not adequate to cover costs.

Priority 5**Head Start**

Head Start and Early Head Start programs are mandated to ensure all enrolled children receive an oral health examination, follow-up treatment, oral health education, and a dental home with consistent, ongoing care by the end of the program year.

Interventions

5.1 — Head Start Partnerships: Increase partnerships between Head Start programs and local dentists, encouraging dentists to adopt a Head Start center to ensure children have a dental home.

5.2 — Family Assistance: Help families keep their dental appointments by facilitating transportation, sending appointment reminders, and educating parents on the importance of oral health care for their children.

5.3 — Pediatric Dentists: Give incentives to dentists and pediatric dentists to open their practices in rural areas to support Head Start programs.

Expected Outcomes

- Increased number of children with an established dental home.
- Increased number of children with dental exams and follow-up.
- Fewer children with decay at the start of kindergarten.
- Improved overall health and increased learning among children.



Priority 6**Oral Health Work Force**

In response to the call of the U.S. Surgeon General to increase access to oral health services for the Nation's underserved, it is important for Idaho to investigate and discuss new workforce models, establish entry-level competencies for those individuals entering the oral health profession and fully utilize the skills and demonstrated competencies of the current workforce.²⁶ By demonstration of certification and licensure, minimal standards and competency are established for each member of the oral health care team and quality care for the public safety may be assured. Idaho needs to continue to explore the development of accreditation and certification pathways for individuals in the oral health care workforce to assure standards and proficiency. Focus should be placed on promoting education opportunities to minorities to encourage a diverse workforce. According to the American Dental Association, the average educational debt for dentists is \$130,000.²⁷ Opportunities to expand education loan forgiveness and workforce distribution need to be explored.

Interventions

6.1 — Expanded Oral Health Provider Models: Convene a work group of educators, as well as public health and private practitioners, to investigate and monitor expanded oral health provider models. Make recommendations based on relevant scientific models, current initiatives, and consumer input. Identify gaps and barriers in access to oral health care in Idaho.

6.2 — Scope of Practice: Provide opportunities for greater dialogue about an expanded scope of practice for dental hygienists to ensure greater access to oral health care, particularly in the public health framework.

6.3 — Health Discipline Collaboration: Promote interdisciplinary collaboration between all oral health and medical health professionals, academia and community partners.

6.4 — Loan Forgiveness: Seek funding and programs providing loan forgiveness.

6.5 — Workforce Diversity: Promote early mentoring and education opportunities to minorities encouraging diversity in the oral health workforce.

Expected Outcomes

- Increased scope of practice for extended access dental hygienists.
- Increased collaboration among oral health and medical professionals.
- Increased capacity to provide loan forgiveness and therefore incentive for oral health professionals to enter public health service.
- Increased number of minorities entering academic dental programs resulting in an increase in the number of dental professionals representing diverse cultures.

Priority 7

Federally Qualified Health Clinics (FQHC) *Assistance to the Uninsured and Underinsured*

Access to oral health is especially limited among the near poor, typically defined as those whose incomes or financial resources exceed current federal guidelines defining poverty but who have very limited economic resources. Nine of Idaho's 13 FQHCs have dental clinics which serve as an oral health care safety net. Adding new dental clinics or expanding capacity of the current dental clinics would increase geographical access and increase the number of children and adults who could claim having a dental home.

Interventions

7.1 — FQHC Dental Clinics: Expand the number of FQHC dental clinics in Idaho.

7.2 — Expand Capacity: Expand capacity to provide more dental care within FQHC existing dental clinics.

7.3 — Mobile Dental Clinics: Establish mobile dental clinics where economically feasible.

Expected Outcomes

- Increased numbers of people who establish a dental home.
- Increased number of FQHC dental clinics.

Priority 8

Hospital Emergency Dental Care

Hospital emergency departments are treating an increased number of people with acute dental conditions that could be avoided with public education and by helping people establish a dental home. Costs for hospital emergency dental care are significantly higher than in a dental office. People who have a dental home are potentially less likely to need emergency dental care.

Interventions

8.1 — Collaborative Problem Solving: Encourage oral health professionals to work with local emergency departments, hospitals, and insurance companies to find solutions for emergency dental care.

8.2 — Community Education Campaigns: Develop health messages to increase the oral health knowledge of the public.

Expected Outcomes

- Decrease number of people seeking dental treatment in hospital emergency departments.

GOAL 3 POLICY

High quality oral health care for all people in Idaho begins at the policy level. Effective oral health policies should be designed to address access to care, preventive care, restorative care, and disease control.

Working together, oral health professionals and oral health advocates can educate policy and decision makers about the importance and value of dental care to overall health across the lifespan. Good policy decisions from a legislative or organizational level can produce positive and powerful effects on how oral health care is delivered. Sound policy enables people to access oral health care who might not otherwise receive adequate care as well as help communities develop strategies to support healthy personal behavior including oral health. Good oral health policy can positively change institutions, communities, and healthcare systems, as well as empower families and individuals to practice personal oral health care.

Priority 1



Public Health Leadership

To maintain a strong oral health program within Idaho State Government, it is recommended the state oral health program be managed by a full-time dental director, who ideally is a dentist with public health training.

Interventions

1.1 — State Dental Director: Establish and support the position.

1.2 — Funding: Ensure the Idaho Oral Health Program is adequately funded.

1.3 — Oral Health Programs Across the Lifespan: Provide leadership in coordinating oral health programs to link people of all ages to preventive and restorative care.

1.4 — Health Disparities: Assure health disparities are addressed and high-risk populations are linked to oral health care delivery systems.

1.5 — Policy Makers: Inform policy makers at the state and local level to ensure inclusion of oral health services in health promotion and disease prevention programs, care delivery systems, and reimbursement schedules. (*U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.*)

Expected Outcomes

- A strong state oral health program adequately staffed with a state dental director and supported by a program manager ensures integrity of the state oral health program.
- Increased leadership on oral health issues results in strong policy development.
- Increased funding of oral health programs and projects throughout Idaho.
- Increased number of programs and projects focused on reaching disparate populations and people across the lifespan.
- Increased number of oral health advocacy initiatives.

Priority 2**Data and Surveillance**

To monitor oral health status and needs of people of all ages in Idaho, it is essential to implement an oral health surveillance system to identify, investigate, and monitor oral health problems and health related risks. Data information supports the expansion of oral health programs, assists in seeking new funding, and evaluates progress toward improving the oral health status of people in Idaho. Data supports decisions for policy change and direction.

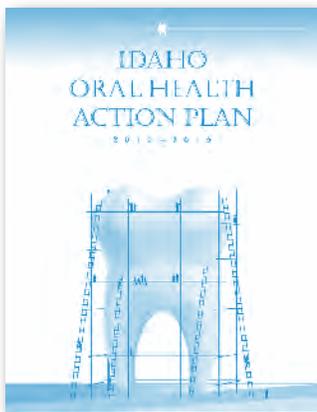
Interventions

2.1 — Data Gathering: Identify and maintain a systematic process for gathering and analyzing Idaho oral health data aligned with national oral health data measures and Healthy People 2020 health objectives. Establish data benchmarks to demonstrate progress toward improving the oral health of Idaho children and adults.

2.2 — Data Reporting: Publish reports on the oral health status of people in Idaho and disseminate these reports to policy makers, administrators, medical and oral health professionals, health organizations, community organizations, the media and the public.

Expected Outcomes

- Idaho oral health data are current, reportable, and available to health professionals, the public and policy makers.
- Increased number of opportunities to apply for funding to improve oral health care supported by data.
- Increased number of policies established to address oral health care issues in Idaho.

Priority 3**The Idaho Oral Health Plan 2010 - 2015**

To effectively plan and implement oral health initiatives, it is essential to have a framework that strategically guides and supports efforts to improve oral health and provides access to care.

Interventions

3.1 Plan Dissemination: Disseminate the plan to oral health professionals, health professionals, the public, and policy makers.

3.2 Plan Assessment: Review, evaluate and assess progress of the plan on an annual schedule.

Expected Outcomes

- Increased number of programs and policies to improve access to oral health care across the life span.
- Improved oral health status for all Idaho children and adults.

Priority 4**Public-Private Partnerships**

Oral health partnerships, both public and private, should be established and maintained to jointly work on issues related to oral health.

Partnerships enable a wise distribution of resources, prioritization of need, and bring diverse partners to the table to collaboratively solve problems. The Idaho Oral Health Alliance (IOHA) represents this cooperative effort of public and private oral health partnerships.

Interventions

4.1 — Advocacy Training: Plan and implement advocacy training.

4.2 — Advocacy Planning: Develop and promote advocacy plans to achieve goals and objectives.

4.3 — Health Care Reform: Ensure oral health professionals are represented in health care reform discussions at state and federal level.

4.4 — Information Sharing: Develop and implement plans for disseminating oral health information promoting education of the public, health professionals, policy and decision makers.

4.5 — Community Fluoridation: Advocate for an increased number of communities with fluoridated water systems.

Expected Outcomes

- Increased number of oral health professionals who receive advocacy training.
- Increased number of advocacy objectives initiated or accomplished including promoting community fluoridation.
- Increased evidence that oral health is integrated in health care reform initiatives.
- Increased amount of oral health information provided to the public, health professionals, and policy/decision makers.

Priority 5**Funding Idaho Oral Health Programs**

Funding to improve oral health care in Idaho is limited. Increased funding through grants, both private and public, could improve oral health care by:

- Linking high-risk groups of people to preventive and restorative care.
- Ensuring a well-trained oral health workforce through loan forgiveness and ongoing skills-based training.
- Disseminating health messages and programs to help people develop stronger personal oral health habits.
- Linking oral health care to medical care.

Intervention

5.1 — Grant Development: Select and apply for government and private grants to increase funding for oral health programs.

Expected Outcomes

- Increased funding to support and expand oral health programs which improve access to preventive and restorative care and provides oral health education.

Priority 6

“A more robust dental public health infrastructure will provide improvements in oral health for all Americans while increasing access to care for underserved groups.”

Association of State and Territorial Dental Directors 2009

Oral Health Work Force

In response to the call of the U.S. Surgeon General (2001) to increase access to oral health services for the Nation’s underserved, it is important to investigate and discuss new workforce models. These models must assure the highest quality of care for the public and demonstrate provider competency.

Interventions

6.1 — Dental Access Advisory Task Force: Appoint a dental access advisory task force to:

- Evaluate potential workforce models for use in Idaho.
- Investigate a mid-level provider model, identified through a needs assessment and based on relevant scientific models.
- Recommend credentialing for all oral health team members to ensure consistent public health, safety and welfare in Idaho.

6.2 — Work Force Models: Advocate for funding and program development to educate emerging work force models that sustain professional core competencies at all levels.

Expected Outcomes

- An appropriate mid-level oral health care provider model would be identified for use in Idaho.
- Standardized competency requirements for all oral health team members are established and recognized.

Priority 7



Science and Evidenced Based Approaches to Care

Ensure oral health professionals at all levels are practicing evidenced-based dentistry.

Intervention

7.1 Continuing Education: Promote continuing education opportunities for oral health professionals.

Expected Outcome

- Increased competency in the Idaho dental workforce.

Priority 8



Health Information Technology (HIT)

Information technology, including the Internet and social networking, is demonstrating enormous potential to transform the health care delivery system as well as dental care delivery. As medical care moves closer to electronic health and medical records and health registry systems, it is an ideal time for dental care to move in the same direction. Integrating oral health care into medical care creates an ideal health delivery system that is secure, seamless, time-sensitive, and actively involves patients in their own self-care. Teledentistry systems allow instant exchange of information assisting in patient care and diagnosis.

According to the National Oral Health Policy Center at the Children's Dental Health Project, HIT opportunities for oral health include:²⁸

Implementing electronic dental records

Linking dental offices into virtual networks for patient care

Linking dental services to primary care medical services in virtual networks

Improving the public's access to oral health information, raising awareness and informing consumers about appropriate care

Improving the quality of dental care through the exchange of research information and sharing information on treatment norms

Interventions

8.1 — Create a task force to assess opportunities to implement HIT in oral health care and link with primary care.

8.2 — Advocate for the inclusion of oral health care in the building of HIT capacity.

Expected Outcomes

- Increased quality of oral health care across the life span. (Long-term outcome)
- Increased number of oral health and medical systems of care electronically connected. (Long-term outcome)

Priority 9**Publicly Funded Dental Insurance**

The high level of enrollment in Medicaid by Idaho’s private dentists is evidence of their interest in serving low-income people. However, their active participation in this critical public program has been severely hindered by noncompetitive Medicaid reimbursement rates, which have historically ranked among the lowest in the nation. The current state Medicaid program, launched in 2007, was designed to address this issue by offering enhanced reimbursement rates for participating dentists. Yet these enhanced rates represent only a nominal increase, an average of just six percent across most included services, and are still too low to adequately cover the direct cost of care and to help cover overhead costs. Idaho’s Medicaid fee schedule should be increased to the 75th usual and customary rate (UCR) fee percentile or higher to ensure more active participation in Medicaid. To reduce barriers to care, a more liberal dental procedure authorization policy including shortened approval and adequate reimbursement is recommended.

Interventions

9.1 — Legislation: Advocate for legislation to increase income guidelines to 200% of federal poverty level in order to expand Medicaid coverage.

9.2 — Oral Health Assessment for Children Entering School: Propose legislation to mandate oral health assessment and identification of a dental home prior to entering elementary school.

9.3 — Medicaid Oral Health Advisory Board: Propose the development of an advisory board composed of oral health professionals who provide recommendations on the allocation of fees and services to improve the effectiveness of oral health care.

Expected Outcomes

- Increased number of people with access to dental insurance, especially children.
- Increased early detection of oral disease and treatment resulting in decreased long term costs.
- Increased number of children who receive preventive care prior to entering school.
- Expansion of opportunities for access to underserved populations such as children and the elderly.
- Increased oral health care to underserved, high risk populations such as geriatric and special needs populations who have complex oral health considerations.

GLOSSARY



Bacteria: Microorganisms commonly referred to as “germs” capable of producing disease under the right conditions.

Behavioral Risk Factor Surveillance

System (BRFSS): An ongoing national surveillance program developed by the Centers for Disease Control and Prevention and conducted annually in Idaho. It is a random telephone survey of the non-institutionalized adult population.

Best Evidence: The highest level of evidence available represents the current best evidence for a specific clinical question. Based on a hierarchy of levels of evidence, systematic reviews of randomized controlled trials constitute the highest level of current best evidence, and expert opinion is lower-level evidence. (*American Dental Association*)

Caries: Commonly used term for tooth decay.

Cavity: Known as missing tooth structure. A cavity may be due to decay, erosion or abrasion. If caused by caries, it is also referred to as a carious lesion.

Clinical Protocol: A step-by-step decision-making tool that describes how a health condition is diagnosed and managed. (*American Dental Association*)

Early Childhood Caries (ECC): A severe, rapidly developing form of tooth decay in infants and young children (affecting the primary “baby” teeth). It has also been referred to as Baby Bottle Tooth Decay and Nursing Caries.

Evidence-Based Clinical

Recommendations: Recommendations developed through critical evaluation of the collective body of evidence on a particular topic. The recommendations provide practical applications of scientific information that can assist dentists in clinical decision-making. The strength of the recommendation is classified according to the existing level of evidence. An example of evidence-based clinical recommendations is the ADA Evidence-Based Clinical Recommendations on Professionally Applied Topical Fluoride. (*American Dental Association*)

Cochrane Collaboration: An international nonprofit organization that develops evidence-based systematic reviews on health care interventions. (*American Dental Association*)

Fluoride: Fluoride, a mineral, is used in dentistry to promote a stronger tooth structure and help prevent decay.

Systemic Fluoride: Fluoride ingested from dietary sources such as food, beverages and drinking water and dietary supplement.

Topical Fluoride: Fluoride from non-dietary sources and usually found in dental products such as toothpaste, mouthrinse or gels, varnish, or foams. (*Source: Decision Support Matrix developed by MCHB Expert Panel on Topical Fluoride, October 2007. Appendix A: Decision Support Matrix Topical Fluoride Recommendations*)

Fluoride Varnish: A lacquer containing 5 percent sodium fluoride painted on teeth, which appears to reduce bacterial activity.

Gingivitis: The mildest form of periodontal disease. It causes the gums to become red, swollen, and bleed easily. There is usually little or no discomfort at this stage. Gingivitis is often caused by inadequate oral hygiene. Gingivitis is reversible with professional treatment and good oral home care.

Head Start: Created in 1965, Head Start is the most successful, longest-running, national school readiness program in the United States. It provides comprehensive education, health, nutrition, and parent involvement services to low-income children and their families.

Early Head Start: Focuses on pregnant women and children birth to age 3.

High Risk Children: There were two groups of children identified by the expert panel as high-risk populations. These groups are described below.

- **Low-Income Children:** Includes children who are enrolled in programs where they must meet income eligibility requirements. This category includes children enrolled in Early Head Start, Head Start, WIC, National School Lunch

Program, Medicaid, and the State Children's Health Insurance Program (SCHIP).

• **Children with Special Health Care Needs (CSHCN):** *MCHB defines CSHCN as children and adolescents: who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that required by children generally. (Recommendations from MCHB Expert Panel, October 22–23, 2007, Altarum Institute, Washington, DC)*

Idaho Oral Health Alliance (IOHA): Idaho Oral Health Alliance (IOHA) is a non-profit organization of dental professionals, public health agencies, businesses, community health providers, and individuals dedicated to better oral health and overall health for all Idahoans. IOHA is open to all who have an interest in promoting good oral health and increasing access to preventive and restorative dental care.

Modeling: Providing an example or demonstrating a technique.

Optimal Fluoridation: Optimal fluoride levels recommended by the U.S. Public Health Service and Centers for Disease Control (CDC) for drinking water range from 0.7 parts per million (ppm) for warmer climates to 1.2 ppm for cooler climates to account for the tendency for people to drink more water in warmer climates.

Pathogens: The term pathogen most commonly is used to refer to infectious organisms. These include bacteria (such as staph), viruses (such as HIV), and fungi (such as yeast). Less commonly, pathogen refers to a noninfectious agent of disease such as a chemical.

Periodontal Disease: Periodontal (gum) diseases, including gingivitis and periodontitis, are serious infections that, left untreated, can lead to tooth loss. The word periodontal literally means "around the tooth." Periodontal disease is a chronic bacterial infection that affects the gums and bone supporting the teeth. Periodontal disease can affect one tooth or many teeth. It begins when the bacteria in plaque (the sticky, colorless film that constantly forms on your teeth) causes the gums to become inflamed. *(American Academy of Periodontology)*

Periodontitis: Untreated gingivitis can advance to periodontitis. With time, plaque can spread and grow below the gum line. Toxins produced by the bacteria in plaque irritate the gums. The toxins stimulate a chronic inflammatory response in which the body in essence turns on itself and the tissues and bone that support the teeth are broken down and destroyed. Gums separate from the teeth, forming pockets (abnormal spaces between the teeth and gums) that become infected. As the disease progresses, the pockets deepen and more gum tissue and bone are destroyed. Often, this destructive process has very mild symptoms. Eventually, teeth can become loose and may have to be removed.

Permanent Dentition: Teeth replacing primary dentition. These teeth usually erupt between the ages of 6 and 21. These teeth should last a lifetime.

Plaque (Biofilm): A soft sticky substance accumulating on teeth composed largely of bacteria and bacterial derivatives.

Primary Dentition: Teeth erupting approx 6 months of age to 2 and ½ years. These teeth will be lost as the permanent teeth emerge. Also known as baby teeth.

Sealants: Plastic resin placed on the chewing surfaces of molars to prevent bacteria from attacking the enamel and causing dental caries. *(American Dental Association)*

Streptococcus Mutans: A type of bacteria found in the mouth that is primarily responsible for tooth decay.

Systemic: Of, relating to, or common to a system; affecting the body generally.

Tooth Decay: An active process of tooth destruction resulting from interactions between teeth, food, and bacteria. It occurs when foods containing carbohydrates (sugars and starches) such as milk, pop, raisins, cakes or candy are frequently left on the teeth. Bacteria that live in the mouth thrive on these foods, producing acids as a result. Over a period of time, these acids destroy tooth enamel, resulting in tooth decay. *(American Dental Association)*

WIC – Women, Infants and Children: A federally funded nutrition education program and food vouchers for low income pregnant and nursing mothers, infants and children to age 5.

REFERENCES



¹Association of State and Territorial Health Officials. (2009). Community water fluoridation. Position Statement.

Retrieved from <http://www.astho.org/Advocacy/Policy-and-Position-Statements/Flouridation-Position-Statement/>

²(2009). Policy on the Dental Home. *Pediatric Dentistry*, 31(6), 22-23.

Retrieved from http://www.aapd.org/media/Policies_Guidelines/P_DentalHome.pdf

³(2003). Oral Health Risk Assessment Timing and Establishment of the Dental Home. *Pediatrics*, 111 (5), 1113-1116.

Retrieved from <http://aappolicy.aapublications.org/cgi/content/full/pediatrics;111/5/1113>.

⁴Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion. (2009). School-based dental sealant programs.

Retrieved from http://www.cdc.gov/ORALHEALTH/topics/dental_sealant_programs.htm.

⁵Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion. (2010). Community water fluoridation.

Retrieved from <http://www.cdc.gov/fluoridation/index.htm>.

⁶US Department of Health and Human Services. (2000). *Oral health in America: A report of the surgeon general*. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

Retrieved from <http://www.surgeongeneral.gov/library/oralhealth/>

⁷Malvitz D.M., Barker, L.K., & Phipps K.R. (2009). Development and status of the national oral health surveillance system. *Prev Chronic Dis*, 6(2).

Retrieved from http://www.cdc.gov/pcd/issues/2009/apr/08_0108.htm.

⁸(2009). Overview. *Pediatric Dentistry*, 31(6), 1-2.

⁹(2009). Guideline on Perinatal Oral Health Care. *Pediatric Dentistry*, 31(6), 90-94.

Retrieved from http://www.aapd.org/media/Policies_Guidelines/G_PerinatalOralHealthCare.pdf

¹⁰(2009). Guideline on Perinatal Oral Health Care. *Pediatric Dentistry*, 31(6), 90-94.

Retrieved from http://www.aapd.org/media/Policies_Guidelines/G_PerinatalOralHealthCare.pdf

¹¹American Academy of Pediatric Dentistry. (2005). *Guideline on oral and dental aspects of child abuse and neglect*. Chicago: American Academy of Pediatric Dentistry, 4.

¹²Office of Oral Health, Arkansas Department of Health and Human Services. (2006). *Prevent abuse and neglect through dental awareness (P.A.N.D.A.). Dental Public Health Activities & Practices, Practice #05002*.

Retrieved from <http://www.astdd.org/bestpractices/pdf/DES05002ARpanda.pdf>

¹³Taylor, G.W. (2003). The effects of periodontal treatment on diabetes. *Journal of the American Dental Association*, 134, 11-15.

¹⁴Comprehensive Cancer Alliance for Idaho. (nd). *Oral and pharyngeal cancer: Idaho and the U.S. key facts*.

Retrieved from <http://www.ccaidaho.org/docs/Oral%20Cancer%20Key%20Facts.pdf>

¹⁵American Academy of Family Physicians. (nd). *Ask and act: A tobacco cessation program*.

Retrieved from <http://www.aafp.org/online/en/home/clinical/publichealth/tobacco/askandact.html>

¹⁶U.S. Department of Health and Human Services. (2008). Treating tobacco use and dependence: 2008 update. *Clinical Practice Guideline*.

Retrieved from http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf.

¹⁷Idaho Department of Health and Welfare. (nd). Project Filter QuitLine and QuitNet Programs.

Retrieved from <http://www.projectfilter.org/quit.htm>

¹⁸Fitzsimons, D., Dwyer, J.T., Palmer, C., & Boyd, L.D. (1998). Nutrition and oral health guidelines for pregnant women, infants, and children. *Journal of the American Dietetics Association*, 98 (2), 182-189.

¹⁹American Academy of Pediatric Dentistry. (2007). Policy on intraoral and perioral piercing. Chicago: American Academy of Pediatric Dentistry, 31 (6), 54-55.

Retrieved from http://www.aapd.org/media/Policies_Guidelines/P_Pierce.pdf

²⁰Kaiser Commission on Medicaid and the Uninsured. (2009). Oral health coverage and care for low-income children: The role of Medicaid and CHIP.

Retrieved from <http://www.kff.org/medicaid/upload/7681-03.pdf>

²¹Idaho Department of Health and Welfare. (2007). 2007 PRATS annual report: Results from the pregnancy risk assessment tracking system.

Retrieved from <http://healthandwelfare.idaho.gov/Portals/0/Health/Statistics/PRATS%20Annual%20Report,%202007.pdf>

²²US Department of Health and Human Services, Health Resources and Services Administration. (nd). Achieving and measuring success: a national agenda for children with special health care needs. *Maternal and Child Health Bureau*.

Retrieved from <http://mchb.hrsa.gov/programs/specialneeds/measuresuccess.htm>

²³Association of State and Territorial Dental Directors. (2007). Oral health of children, adolescents, and adults with special health care needs. *Best Practice Approaches for State and Community Oral Health Programs*.

Retrieved from <http://www.astdd.org/docs/BPASpecialNeeds.pdf>

²⁴Idaho Department of Health and Welfare, Idaho Oral Health Program. (nd). (2008) Behavioral risk factor surveillance system. Unpublished Report.

²⁵Idaho Dental Hygienists Association. (2007). Issue brief: Expanding access to oral health care in Idaho.

Retrieved from <http://www.idha.org/IOHA%20Idaho%20Issue%20Brief.pdf>

²⁶Evans, C.A., & Kleinman, D.V. (2000) The surgeon general's report on America's oral health: Opportunities for the dental profession. *Journal of American Dental Association*, 131, 1721-1728.

Retrieved from <http://jada.ada.org/cgi/reprint/131/12/1721>

²⁷American Dental Association. (2009). Be a dentist: Financial information.

Retrieved from <http://www.ada.org/public/careers/beadentist/financia.asp>

²⁸Edelstein, B. (2008). Environmental factors in implementing the dental home for all young children. *National Oral Health Policy at Children's Dental Health Project*.

Retrieved from <http://www.cdhp.org/system/files/1.%20Implementing%20the%20Dental%20Home.pdf>



For more information about this plan
visit the Idaho Oral Health Program website at:
www.healthy.idaho.gov

This publication was supported by Grant No. B04MC17033 Award No. 6 B04MC17033-01-02 from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA. Costs are available from the Idaho Department of Health and Welfare, IDHW/400-16584-04/10 Cost per unit: \$9.87