CENTER FOR PREVENTION AND HEALTH PROMOTION
Oral Health Program
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon St, Ste 825
Portland, Oregon 97232-2186
Office: 971-673-1563
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www.healthoregon.org/dpp

Quarterly Dental Pilot Project
Meeting: DPP 100
Meeting Minutes

Date: Monday, November 16, 2020
Time: 9:00 AM – 11:30 AM
Location: **Virtual -** OHA Public Health Division

Committee Members Present:
Rick Asai, Michael Costa, Bob Garcia, Jennifer Lewis-Goff, Jonathan Hall, Paula Hendrix, Kelli Swanson Jaecks, Jill Jones, Laura McKeane

Committee Members Absent: Leslee Huggins, Carolyn Muckerheide

OHA Staff & **Consultants to OHA**
Kelly Hansen, Fred King, Sarah Kowalski, Rose McPharlin, John, Putz, Cate Wilcox

Project Attendees and Invited Presenters:
Vicki Faciane, Marrisa Gardner, Naomie Petrie, Sarah Rodgers, Gita Yitta

Signed in Public Attendees:
Doug Barrett, Tanya Firemoon, Pam Johnson, Jamie Meyers, Christina Peters, Dove Spector, 11 additional attendees on phone.

Summary of Meeting

Agenda Item: Review of Meeting Agenda and Introductions

Topic: Review of meeting agenda.
Summary of Discussion: Meetings are recorded for note taking purposes. Reviewed agenda.
Decision: No decisions made. Move to next agenda item.
Action: Meeting started.

Agenda Item: Project Updates

Topic: Accreditation update, results of application to CODA (Commission on Dental Accreditation.) Review modification request submitted by project sponsor Northwest Portland Area Indian Health Board.

Summary of Discussion: Discuss results of CODA application submitted by Alaska Native Tribal Health Consortium (DHAT) program in Alaska.

- CODA granted initial accreditation to the Alaska Native Tribal Health Consortium (DHAT) program in Alaska. First dental therapy in the United States to receive accreditation.
- Current language under CODA states that student who graduated from the program prior to the granting of accreditation will not be considered graduates of a CODA accredited program which includes the trainees operating under DPP#100.
- Modification request submitted by Northwest Portland Area Indian Health Board (NPAIHB) on September 18, 2020.
    - The modification request allows trainees to provide services under a dental oral health outreach model to the following locations described in the request:

      •Daycare facilities including in-home and worksite daycare
      •Local/Tribal preschool and head start programs
      •Local/Tribal after school programs
      •Wellness fairs
      •Tribal events
- The outreach model described will provide oral healthcare to patients who are eligible for treatment at the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI) Dental Clinic.
- Advisory Committee was be asked to review modification request and submit feedback to OHA.
- OHA approved modification request on October 15, 2020.

Decision: No decision made. Will continue to monitor CODA actions.
Action: Move on to next agenda item.

Agenda Item: Oregon Administrative Rule Changes

Topic: OAR 333-010-0750 proposed rule changes.

Summary of Discussion: SB738 states: (a) Operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project;

- Current OAR 333-010-0750 states projects may operate from three to five years.
- Proposed language changes will read (d) The length of time the project can operate - from between three to five years or a sufficient amount of time to evaluate the validity of the project.
- OARS effective October 28, 2020

Decision: No decisions made.
Action: Move on to next agenda item.

Agenda Item: Advisory Committee Survey Results

Topic: Review survey results.
Summary of Discussion: Survey sent to the Advisory Committee for DPP#100.

- Survey Results: Meetings will continue to be held virtually. 64% of respondents indicate this as their preference.
- Survey Results: Advisory Committee members were asked what priorities should be focused on at future meetings.

(1) Evaluation of Quality of Care provided by the Dental Therapists

(2) Access to Care provided by the pilot project

(3) Cost-effectiveness of the DHAT Dental Therapy Model

(4) Implementation of the Dental Therapist Workforce Model in the Dental Clinic

(5) Implementation of the Dental Therapist workforce model, education programs & CODA approval of the Alaska Dental Therapy Program

(6) Impact of COVID-19 on Dental Pilot Project

- Majority indicated first priority was to review cost- effectiveness of the DHAT dental therapy model.
- Next meeting will focus on implementation of the dental therapist workforce model in a dental clinic.

Decision: No decisions made.
Action: Move on to next agenda item.

Agenda Item: Presentation, Cost-Effectiveness

Topic: Presentation on the Cost Effectiveness of Dental Therapy by Mark Schoenbaum, MSW
Summary of Discussion: Mr. Schoenbaum presented a “Review of Cost-Effectiveness of Dental Therapy” and overview of studies on the cost-effectiveness of dental therapy.

- Various approaches to reviewing the cost-effectiveness of the dental therapy workforce model. Different points of view, from provider, practice, patient, payer and society. Different goals and views on cost benefits.

- "Dental therapists in Alaska Native communities were associated with significantly higher rates of preventive care use and lower rates of extraction – for both children and adults." University of Washington study, Dr. Don Chi, 2017.
- Factors that influence cost-effectiveness and what aspects to measure.
- Many studies and reports measuring this measure. *(See meeting minutes for links, citation and/or copies of studies.)*
- Minnesota Department of Health published "Early Impacts of Dental Therapists in Minnesota, 2014"

  Findings:

  - Clinics with DTs seeing more new patients, most underserved: Study clinics served 6,338 new patients. 84% SPP average
  - Nearly 1/3 of patients saw a reduction in wait time.
  - Some patients saw a reduction in travel time.
  - Preliminary findings suggest expanded capacity may reduce ER use by vulnerable populations.
  - Clinics report additional impacts: Personnel cost savings, Increased dental team productivity, Improved patient satisfaction.
  - DTs appear to be practicing safely; clinics report improved quality.
  - Savings to clinics from lower costs of dental therapists are allowing clinics to expand capacity to serve more underserved and public program patients.

- Children's Dental Services in Minnesota, Data Review
  - (Advanced Dental Therapists) ADTs are vital to the financial viability of CDS

    The State of Minnesota has two mid-level dental provider types, a Dental Therapist and an Advance Dental Therapist.
  - Dentists cost $75.00, ADT cost $45 per hour. ADT provides restorative care to 1,500 low-income children and pregnant women per year.
  - *Cost-Benefit Analysis based on 1 ADT providing services covered under the ADT statute for 40 hours/week in a public health dental clinic. Total Cost Savings using ADT Public Health Model: $1,200/week or 62,400/year.*
  - *Review cases studies commissioned by Delta Dental of Minnesota and completed by Wilder Research.*

    Available at: https://www.wilder.org/articles/dental-therapy-increases-access-rural-minnesota and https://www.wilder.org/articles/improving-access-dental-care-minnesota

- *Apple Tree Dental Please see meeting minutes for copies of Apple Tree Dental Case Study.*

- Center of Health Workforce Studies
- Analyses showed addition of DTs has had positive outcomes for patients, providers, and the organization generally.
- Statistics demonstrate that currently dentists are seeing more patients, providing more services, and producing higher average RVUs and fees per treatment day.

A copy of the presentation was included in materials packet disseminated to the Advisory Committee and has been included the meeting minutes.

A document has been created with titles of studies mentioned in the presentation. Some articles have been included in the meeting minutes.

Studies Referenced in Presentation:

An Advanced Dental Therapist in Rural Minnesota: Jodi Hager's Case Study, February 2018

Children's Dental Services – Dental Therapy in Minnesota: A Study of Quality and Efficiency Outcome, Sarah Wovcha, JD, MPH, Executive Director, Emily Pietig, DDS, Dental Director,

Delta Dental of Minnesota & Wilder Research – Grand Marais Family Dentistry: Dental Therapist Case Study, May 2017

Delta Dental of Minnesota & Wilder Research – Midwest Dental: Dental Therapist Case Study, May 2017

Dental Therapy Toolkit: A Resource for Potential Employers, Minnesota Department of Health, Office of Rural Health and Primary Care, Minnesota Department of Human Services, Health Reform Minnesota, February 2017

Early Impacts of Dental Therapists in Minnesota, Minnesota Department of Health & Minnesota Board of Dentistry Report to the Minnesota Legislature 2014, February 2014

Economic Viability of Dental Therapists, Prepared by: Frances M. Kim, DDS, DrPH for Community Catalyst, May 2013

Minnesota's Dental Therapist Workforce, Dental Therapist Fact Sheet, September 2019. Minnesota Department of Health, Office of Rural Health and Primary Care. September 2019

Promising Practices in Improving Oral Health Care Service Delivery and Access, A Literature Review prepared for the Delta Dental of Minnesota Foundation, May 2019

Safety Net Care and Midlevel Dental Practitioners: A Case Study of the Portion of Care That Might Be Performed Under Various Setting and Scope-of-Practice Assumptions, September 2015

The Contributions of Dental Therapists and Advanced Dental Therapists in the Dental Centers of Apple Tree Dental in Minnesota, Center for Health Workforce Studies, School of Public Health, University at Albany, State University of New York, August 2020

Decision: No decisions made.
Action: Move on to next agenda item.

Agenda Item: Questions and comments from Advisory Committee

Topic: Questions, discussions
Summary of Discussion: Advisory Committee members asked clarifying comments during presentation. Materials will be made available in meeting minutes.
Decision: No decisions made.
Action: Move on to next agenda item.

Agenda Item: Presentation on Cost-Effectiveness by Confederate Tribes of Coos-Lower Umpqua-Siuslaw (CTCLUSI) Dental Clinic

Topic: Presentation "Dental Therapy and The Economic Impact For The Confederated Tribes of Coos, Lower Umpqua and Siuslaw Tribe" by Vicki Faciane, MBA, M.Ed, Health & Human Services Director at Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians
Summary of Discussion: Ms. Faciane presented an overview of the structure of the following:

- Goals of the Presentation:
    - Understanding history and economics of tribal health systems
    - Understanding current costs to community and individuals with barriers to oral health care
    - What we know about dental therapists ability to have positive economic impact
    - Assumptions and limitations of evaluating costs in Pilot Project #100
- Vision for future, Overview of the Tribal government system
    - "Tribal governments are separate sovereign nations with powers to protect the health, safety and welfare of their members and to govern their lands. This tribal sovereignty predates the existence of the U.S. government and the state of Oregon. The members residing in Oregon are citizens of their tribes, of Oregon and, since 1924, of the United States of America."
    - "Tribal sovereignty in the United States is the inherent authority of indigenous tribes to govern themselves within the borders of the United States of America. The U.S. federal government recognizes tribal nations as "domestic dependent nations" and has established a number of laws

attempting to clarify the relationship between the federal, state, and tribal governments."

- Review of Historical trauma
    - Historical trauma refers to cumulative emotional and psychological wounding, extending over an individual lifespan and across generations, caused by traumatic experiences.

- Indian Health Delivery System
    - Indian Health Programs can be grouped into 3 categories:

- Indian Health Service (IHS) Directly Operated - Warm Springs, Western Oregon Service Unit – Chemawa Indian School
- Tribally Operated (P.L. 93-638 Indian Self-Determination Act) 8 Oregon Tribes
- Urban Indian Health Care Program – NARA

- IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita, 2019
    - IHS spending per user was $3,943
    - Compared to Medicare which was $13,257 and Medicaid was $8,371
    - Chronically underfunded

- CTCLUSI Dental Clinic Revenue and Expenditures
    - Funding of healthcare is a treaty obligation between the Federal government and sovereign Tribal nations. This obligation is chronically underfunded and does not provide enough money to cover the health needs of our Tribal members.
    - Tribal dental clinic provides services to any American Indian/Alaska Native (AI/AN) who is a member of a federally recognized Tribe and seeks dental care, regardless of county of residence or Tribal affiliation. Rules for providing this care come from the IHS.
    - Amounts not paid by insurance are written-off. Patients are not balance billed. Clinic wrote-off $535,568.54 in 2019 for services provided in our clinic. This was 52% of gross charges.
- Costs to individuals and tribal communities facing barriers to routine and culturally relevant oral health care.
    - Increased use of emergency care

- Lost work time
- Missed school days
- Delayed preventive and restorative treatment
- Increases costs for higher levels of care
- Lost job opportunities
- Increased risk and costs of overall health impacts
- Higher use of and strains on all health services

- Frequency of Patient Visits and Access to Care
  - The Clinic saw a modest increase in the number of patients served each year – an increase of 13%from 2016 through 2019.
  - Patients were able to make more appointments during each year with the addition of the dental therapists.
  - The increase from 2017 to 2018 is 467% with another 48% from 2018 to 2019.

- Dental therapy is a cost-effective solution for Tribal Health Programs
  - DHATs cost only about $.30 for every dollar they generate. This allows dental teams to see more patients at existing reimbursement rates and put those cost savings into further expanding care.
  - DHATs, earning about half the salary of a dentist, can perform many routine procedures typically done by a dentist:
    - Swinomish Indian Tribal Community analyzed the procedures done at their dental clinic and found that a DHAT could perform 50% of the procedures being done by the dentist.
    - A published study of portion of care that could be performed by mid-level professionals at a series of safety net clinics found that DHATs could perform between 64 and 90% of the procedures, depending on clinic type.
    - DHATs have a select scope of practice that includes both preventive and restorative procedures and allows providers to work at the top of their scope. Team approach increases efficiency and supports the clinic's bottom line.
    - DHATs can decrease costly dental-related emergency room visits by increasing access to preventive dental services and continuity of care.
    - DHATs that stay in their community generate economic benefits for themselves and their Tribes. The accelerated, post-secondary degree training program offers a very realistic career pathway and results in a living-

wage job. Tribes benefit from those jobs coming from and staying in the community.

- Assumptions and limitations of evaluating cost in Pilot Project #100
    - 3 chairs for 4 providers
    - Dental assistant shortages
    - Clinic construction and closures
    - Staff leave
    - COVID-19
    - Evaluation and administration of pilot project, difficult to assess due to constraints of evaluation requirements.
    - Time spent on administration of pilot vs. patient care
    - Preceptorships taking longer than anticipated
    - Monitoring requirements impact productivity and cost

- Vision for Future
    - Less wait time for appointments and more routine preventive care from familiar providers decreasing need for emergency or more complex and costly care
    - Community outreach – care available in more locations, shortening or eliminating travel time
    - Dental Therapy Economic Benefits to Patients
        - Excellent care at lower cost
        - Dental Therapist currently paid 40% of Dentist salary
        - Return on investment of clinic building/expanding realized
        - DHAT salary an important budget factor
        - Dentist can focus on more complex procedures
        - Provider turnover decreased by hiring community members
- Dental Therapy Economic Benefits to Clinic
    - Excellent care at lower cost
    - Dental Therapist currently paid 40% of Dentist salary
    - Return on investment of clinic building/expanding realized
    - DHAT salary an important budget factor

- Dentist can focus on more complex procedures
- Provider turnover decreased by hiring community members

- Dental Therapy Economic Benefits to Community:
    - Living wage professional jobs for community members
    - Keeps funds spent within the community
    - Role models inspire the next generation of professionals
    - Increased oral and overall health increases economic health of communities

- Dental Therapy Economic Benefits to Outreach:
    - COVID-19 has presented us with challenges in conducting home visits
    - On October 13, 2020 OHA approved an amendment to the approved outreach modification to expand locations for our outreach model.
    - We currently are implementing these additional sites to our outreach protocols and will report our efforts in the months to come.

A copy of the presentation was included in materials packet disseminated to the Advisory Committee and has been included the meeting minutes.

A document has been created with titles of studies mentioned in the presentation. Some articles have been included in the meeting minutes.

Studies referenced in presentation:

- *Kim, Frances M. "Economic Viability of Dental Therapists." Community Catalyst. May 2013*
- *Phillips, Elizabeth, et. al. "Safety Net Care and Midlevel Dental Practitioners: A Case Study of the Portion of Care That Might Be Performed Under Various Setting and Scope-of-Practice Assumptions." American Journal of Public Health, September 2015*

- Questions and comments from Advisory Committee
    - Comments included appreciation for presenting. No further questions or comments.

Decision: No decisions made.
Action: Move on to discussion with Advisory Committee and NPAIHB project staff.

Agenda Item: Questions and comments from Advisory Committee

Topic: Questions, discussions
Summary of Discussion: Advisory Committee members asked clarifying comments during presentation. Materials will be made available in meeting minutes.
Decision: No decisions made.
Action: Move on to next agenda item.

Agenda Item: OHA Preliminary Chart Review Data,

Topic: Chart Review Methodology

Summary of Discussion: OHA Chart Methodology

- Chart Reviews conducted with each site visit
    - Chart reviewers attend calibration trainings
- OHA is responsible for monitoring and evaluating projects for patient health and safety
    - Reviews of patient records to monitor for patient safety, quality of care, minimum standard of care and compliance with the approved or amended application
    - Purpose: Opportunity to review trainee performance and quality in regards to patient safety
        - Lead to a greater understanding of the proposed workforce model
        - Use an iterative process to lead to quality improvement
        - Determine that a minimum standard of care is met
    - Not the purpose:
        - To “root out bad quality”
        - Judge things you can’t see
        - Prove or disprove the educational competency of the model
    - Domains of Review
        - Adverse Events
        - Intraoral Images and Radiographs
        - Anesthetic Notes
        - Diagnosis
        - Treatment

- Overall Impression of Procedure Quality
- Posterior Restorations
- Anterior Restorations
- Stainless Steel Crowns
- Extractions

- Adverse Events
  - No serious adverse events were reported.
  - Utilize Adverse Event process to categorize AE.

Decision: No decisions made. Move to next agenda item.
Action: No further agenda items.

A copy of the presentation was included in materials packet disseminated to the Advisory Committee and has been included the meeting minutes.

Agenda Item: Follow Up Items, Future Meeting Dates, Virtual Site Visit

Topic: Future dates
Summary of Discussion: OHA will continue to conduct Advisory Committee meetings and Site Visits virtually. Site Visit will be scheduled for late spring. OHA will send a doodle poll to determine next meeting date with the committee.
Decision: No decisions made.
Action: OHA will send information on dates to Advisory Committee.

Public Comment Period: There were no public comments.

• Next Meeting: To be determined via Doodle Poll.

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AGENDA

Dental Pilot Project #100 "Oregon Tribes Dental Health Aide Therapist Pilot Project"
Quarterly Dental Pilot Project Program Advisory Committee Meeting DPP #100
November 16th, 2020, 9:30am – 11:30am

Location: Remote meeting via Zoom.
Meeting ID: 161 667 8230
Passcode: 841320
Link: https://www.zoomgov.com/j/1616678230?pwd=OFUrRmVsK0xTQWhvRVhySzdQRURaUT09

Call in option: 669-254-5252, Meeting ID: 161 667 8230 **Passcode**: 841320

9:30-9:40	Official Introductions, Agenda Review, Survey Results, CODA,	Sarah Kowalski, MS, RDH Dental Pilot Project Program Oregon Health Authority
9:40-10:15	Presentation, Cost-Effectiveness,	Mark Schoenbaum, MSW Senior Advisor, New Americans Alliance for Development, Adjunct Health Policy Faculty, University of Minnesota-Crookston and Consultant to States on Health Workforce Issues.
10:15-10:25	*Questions and Answers*	Advisory Committee Northwest Portland Area Indian Health Board Oregon Health Authority
10:25-11:00	Dental Therapy and The Economic Impact For The Confederated Tribes of Coos, Lower Umpqua and Siuslaw Tribe	Vicki Faciane, MBA, M.Ed Director of Health & Family Support and Behaviorial Health Services, The Confederate Tribes of Coos Lower Umpqua Siuslaw Tribe
11:00-11:10	*Questions and Answers*	Advisory Committee Northwest Portland Area Indian Health Board Oregon Health Authority
11:10-11:20	DPP#100 Chart Review Results	Kelly Hansen, Research Analyst, Oral Health Program
11:20-11:25	Follow Up Items, Future Meeting Dates, Virtual Site Visit	Sarah Kowalski, MS, RDH
11:25-11:30	Public Comment Period	Public comments are limited to 2 minutes per individual; Public comments are accepted via in-person oral testimony or submission of written comments via email to oral.health@state.or.us or US Mail.

Next Meeting: June 2021, Date to be determined

Resources and Articles Referenced in Advisory Committee Meeting: November 16, 2020

An Advanced Dental Therapist in Rural Minnesota: Jodi Hager's Case Study, February 2018 Available at: https://www.appletreedental.org/wp-content/uploads/2018/02/ADT-Rural-Jodi-Hagers-Case-Study-022118.pdf
The Contributions of Dental Therapists and Advanced Dental Therapists in the Dental Centers of Apple Tree Dental in Minnesota, Center for Health Workforce Studies, School of Public Health, University at Albany, State University of New York, August 2020 Available at: https://www.chwsny.org/our-work/reports-briefs/the-contributions-of-dental-therapists-and-advanced-dental-therapists-in-the-dental-centers-of-apple-tree-dental-in-minnesota/
Children's Dental Services – Dental Therapy in Minnesota: A Study of Quality and Efficiency Outcome, Sarah Wovcha, JD, MPH, Executive Director, Emily Pietig, DDS, Dental Director For more information contact: http://childrensdentalservices.org/
Delta Dental of Minnesota & Wilder Research – Grand Marais Family Dentistry: Dental Therapist Case Study, May 2017 Available at: https://www.wilder.org/wilder-research/research-library/grand-marais-family-dentistry-dental-therapist-case-study-and
Delta Dental of Minnesota & Wilder Research – Midwest Dental: Dental Therapist Case Study, May 2017 Available at: https://www.wilder.org/wilder-research/research-library/midwest-dental-dental-therapist-case-study-and-addendum-dental
Dental Therapy Toolkit: A Resource for Potential Employers, Minnesota Department of Health, Office of Rural Health and Primary Care, Minnesota Department of Human Services, Health Reform Minnesota, February 2017 Available at: https://www.health.state.mn.us/facilities/ruralhealth/emerging/dt/index.html
Early Impacts of Dental Therapists in Minnesota, Minnesota Department of Health & Minnesota Board of Dentistry Report to the Minnesota Legislature 2014, February 2014 Available at: https://www.ncsl.org/portals/1/documents/health/MNDentalReport0214.pdf
Economic Viability of Dental Therapists, Prepared by: Frances M. Kim, DDS, DrPH for Community Catalyst, May 2013 Available at: https://www.communitycatalyst.org/doc-store/publications/economic-viability-dental-therapists.pdf
Minnesota's Dental Therapist Workforce, Dental Therapist Fact Sheet, September 2019. Minnesota Department of Health, Office of Rural Health and Primary Care. September 2019 Available at: https://www.health.state.mn.us/data/workforce/oral/docs/2019dt.pdf
Promising Practices in Improving Oral Health Care Service Delivery and Access, A Literature Review prepared for the Delta Dental of Minnesota Foundation, May 2019 Available at: https://www.wilder.org/wilder-research/research-library/promising-practices-improving-oral-health-care-service-delivery
Safety Net Care and Midlevel Dental Practitioners: A Case Study of the Portion of Care That Might Be Performed Under Various Setting and Scope-of-Practice Assumptions, September 2015 Available at: https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2015.302715

Dental Pilot Project #100:
"Oregon Tribes Dental Health Aide Therapist Pilot Project"

Advisory Committee Meeting

9:30am-11:30am

November 16, 2020

Dental Pilot Project #100:
"Oregon Tribes Dental Health Aide Therapist Pilot Project"

- Agenda Review
- Introductions
- Project Updates
- Oregon Administrative Rule Changes
- Survey Results

- Agenda Review & Meeting Guidance
- Please turn on your video camera.
- Please use chat function to ask question.
- MUTE yourself.
- Only Committee Members and Invited Guests will actively participate in the meeting.
- Public Meeting: Public Comment Period at End of Meeting
- Meetings are recorded.

Dental Pilot Project #100:
"Oregon Tribes Dental Health Aide Therapist Pilot Project"

- Project Updates

CODA
Commission on Dental Accreditation

CODA
Commission on Dental Accreditation

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

education program has received accreditation from the Commission. Students who are enrolled in the program at the time accreditation is granted (August 6, 2020), and who successfully complete the program, will be considered graduates of a CODA-accredited program. Students who graduated from the program prior to the granting of accreditation will not be considered graduates of a CODA-accredited program.

The Commission on Dental Accreditation's mission is to serve the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs. The scope of dental therapy practice and licensure authority resides within the jurisdiction of each state licensing agency.

Students who graduated from the program prior to the granting of accreditation will not be considered graduates of a CODA-accredited program.

Oregon Health Authority

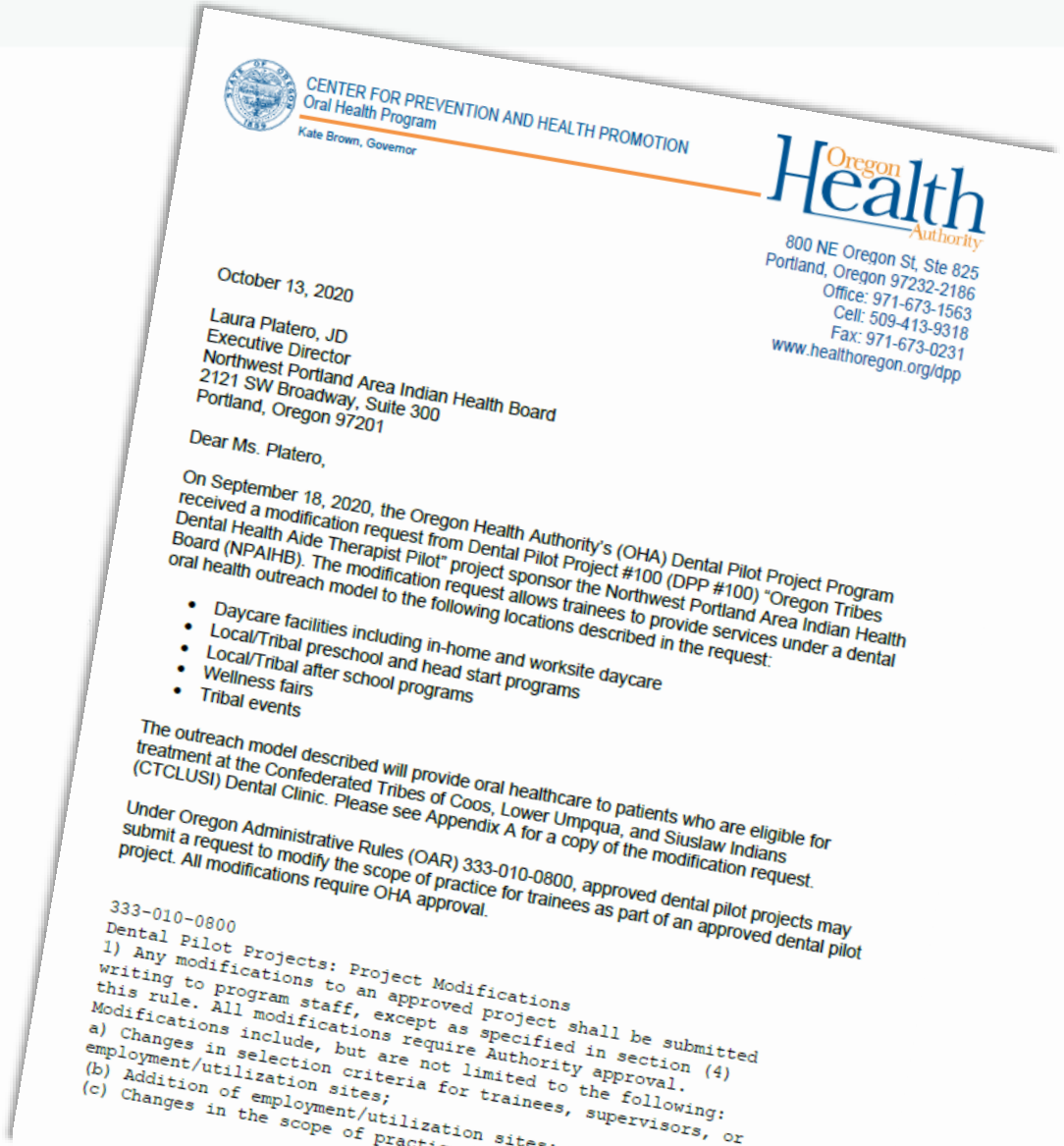
- Project Updates

The modification request allows trainees to provide services under a dental oral health outreach model to the following locations described in the request:

•Daycare facilities including in-home and worksite daycare
•Local/Tribal preschool and head start programs
•Local/Tribal after school programs
•Wellness fairs
•Tribal events

The outreach model described will provide oral healthcare to patients who are eligible for treatment at the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians

(CTCLUSI) Dental Clinic.



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October 13, 2020

Laura Platero, JD
Executive Director
Northwest Portland Area Indian Health Board
2121 SW Broadway, Suite 300
Portland, Oregon 97201

Dear Ms. Platero,

On September 18, 2020, the Oregon Health Authority's (OHA) Dental Pilot Project Program received a modification request from Dental Pilot Project #100 (DPP #100) "Oregon Tribes Dental Health Aide Therapist Pilot" project sponsor the Northwest Portland Area Indian Health Board (NPAIHB). The modification request allows trainees to provide services under a dental oral health outreach model to the following locations described in the request:

- Daycare facilities including in-home and worksite daycare
- Local/Tribal preschool and head start programs
- Local/Tribal after school programs
- Wellness fairs
- Tribal events

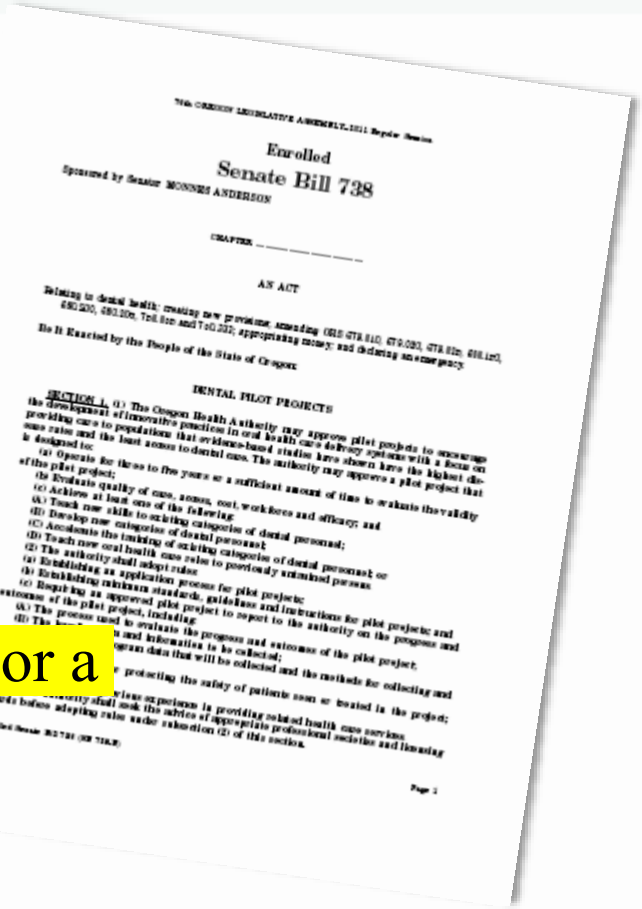
The outreach model described will provide oral healthcare to patients who are eligible for treatment at the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI) Dental Clinic. Please see Appendix A for a copy of the modification request.

Under Oregon Administrative Rules (OAR) 333-010-0800, approved dental pilot projects may submit a request to modify the scope of practice for trainees as part of an approved dental pilot project. All modifications require OHA approval.

333-010-0800
Dental Pilot Projects: Project Modifications
1) Any modifications to an approved project shall be submitted writing to program staff, except as specified in section (4) this rule. All modifications require Authority approval. Modifications include, but are not limited to the following:
a) Changes in selection criteria for trainees, supervisors, or employment/utilization sites;
(b) Addition of employment/utilization sites; and
(c) Changes in the scope of practice for trainees.

- Amended Oregon Administrative Rules

SB738 states: (a) Operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project;



Enrolled
Senate Bill 738

AN ACT

DENTAL PILOT PROJECTS

333-010-0750

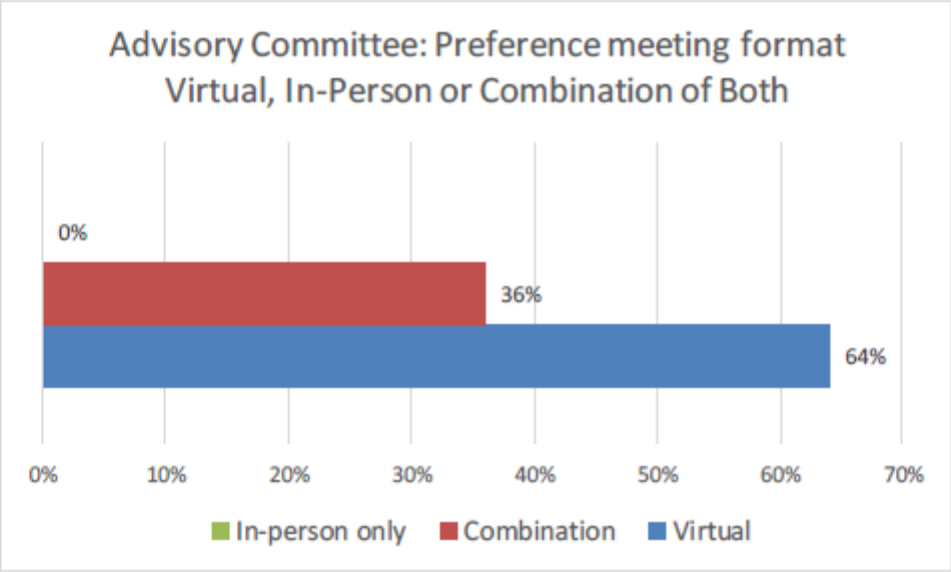
(3)(d) The length of time the project can operate from between three to five years or a sufficient amount of time to evaluate the validity of the project.

- Survey Results: Meetings will continue to be held virtually

This past Advisory Committee meeting held on June 8th, 2020, there were 36 individuals who attended the virtual meeting. Please indicate whether you would like to continue to hold committee meetings virtually or in person. Please note, that due to the ongoing pandemic, all meetings will be held virtually until further notice.

Please select only one option.

(1) Yes, I prefer that all future Advisory Committee meetings are held virtually. 64%
(2) I prefer a combination of in-person and virtual meetings. 36%
(3) No, I do not prefer to have meetings held virtually. 0%



- Survey Results: Advisory Committee members were asked what priorities should be focused on at future meetings.

DENTAL PILOT PROJECTS

SECTION ... the Oregon Health Authority may approve pilot projects to encourage the develop... innovative practices in oral health care delivery systems with a focus on provid... to populations that evidence-based studies have shown have the highest dise... and the least access to dental care. The authority may approve a pilot project th... ned to:

(a) ... for three to five years or a sufficient amount of time to evaluate the validity ... the pilot project;

(b) **Evaluate quality of care, access, cost, workforce and efficacy**; and

(c) Achieve at least one of the following:

(A) Teach new skills to existing categories of dental personnel;

(B) Develop new categories of dental personnel;

(C) Accelerate the training of existing categories of dental personnel; or

(D) Teach new oral health care roles to previously untrained persons.

- Survey Results: Advisory Committee members were asked what priorities should be focused on at future meetings.

Evaluate quality of care, access, cost, workforce and efficacy

(1) Evaluation of Quality of Care provided by the Dental Therapists

(2) Access to Care provided by the pilot project

(3) Cost-effectiveness of the DHAT Dental Therapy Model

(4) Implementation of the Dental Therapist Workforce Model in the Dental Clinic

(5) Implementation of the Dental Therapist workforce model, education programs & CODA approval of the Alaska Dental Therapy Program

(6) Impact of COVID-19 on Dental Pilot Project

Evaluation of Quality of Care provided by the Dental Therapists

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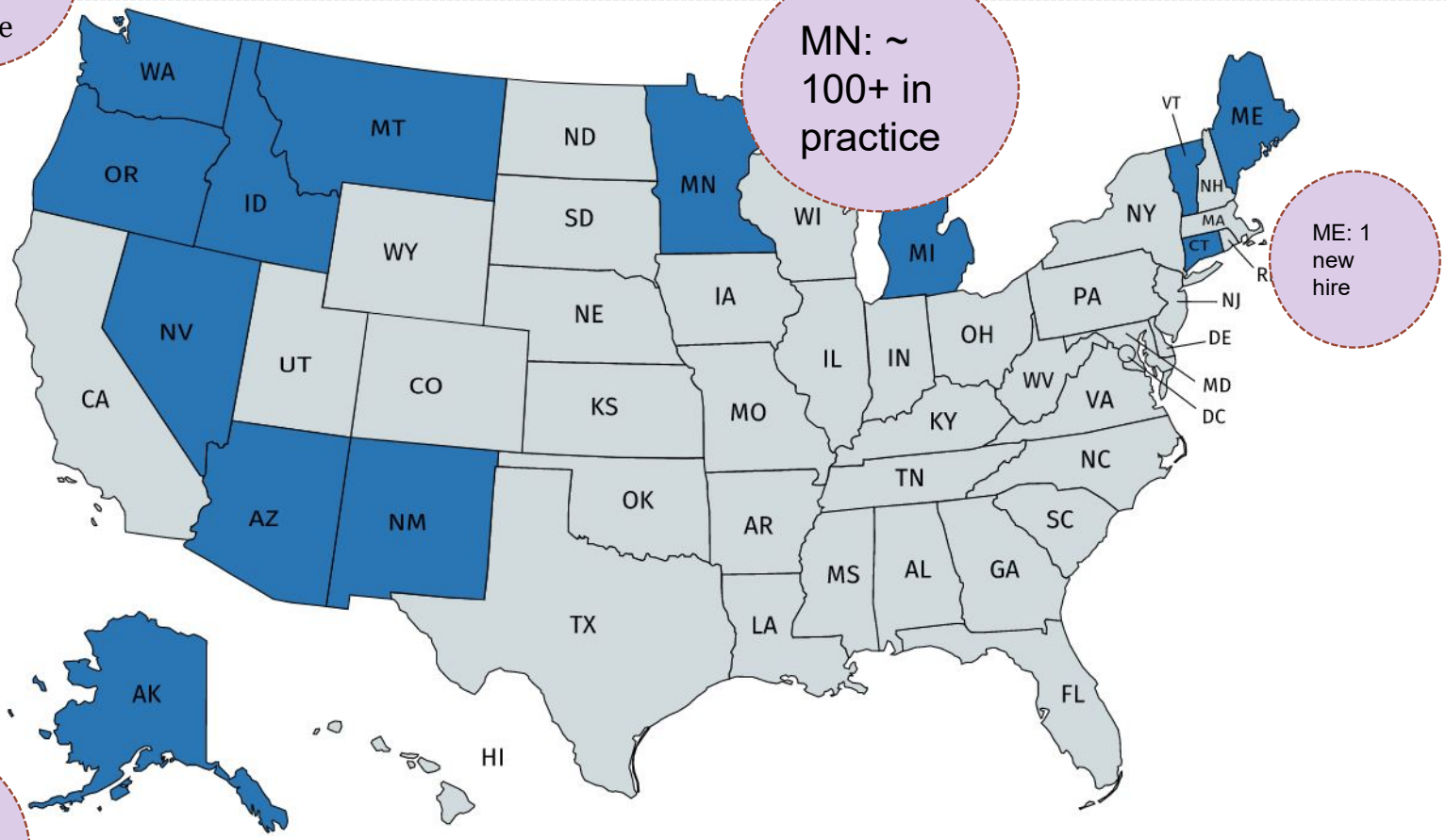
(6) Impact of COVID-19 on Dental Pilot Project

APPROACHES TO DENTAL THERAPY ECONOMIC ANALYSIS
What the Research Shows

WA, OR, ID: 10 – 12 in practice

MN: ~ 100+ in practice

ME: 1 new hire



AK: ~35 in practice

- Mark Schoenbaum
- Implementation Consultant
- Pew Dental Program
- November 16,2020

Types of Economic Evaluation Methods

Type of Economic Analysis	Results Are Expressed as:
Cost Analysis	Costs
Cost Effectiveness Analysis	Cost per unit of health or behavioral outcome improved or impacted
Cost Benefit Analysis	Benefit cost ratio (benefits expressed as dollars divided by costs expressed as dollars)
Cost Utility Analysis	Cost per quality-adjusted life year gained

Source:
Evaluation and Program Effectiveness Team
Centers for Disease Control and Prevention
2012

Cost Benefit Perspectives

Provider
- Earnings
- Job Satisfaction

Practice
- Bottom line/PL effects
- Productivity, employee satisfaction

Patient
- Pain & other health impacts
- Employability
- Time lost from work or school; sick leave used

Payer
- Access/customer satisfaction
- Reduced acute care costs/increased preventive care claims
- Avoidable ER visit costs

Society
- Population health outcomes
- Economic growth/productivity
- Equity

Both costs and benefits, financial and otherwise, could be calculated for these results

Dental Utilization for Communities Served by Dental Therapists in Alaska's Yukon Kuskokwim Delta: Findings from an Observational Quantitative Study

Final Report

August 11, 2017

Principal Investigator
Donald L. Chi, DDS, PhD
Associate Professor
University of Washington, School of Dentistry
dchi@uw.edu

Co-Investigators
Dane Lenaker, DMD, MPH; Lloyd Mancl, PhD; Matthew Dunbar, PhD; Michael Babb,

"Dental therapists in Alaska Native communities were associated with significantly higher rates of preventive care use and lower rates of extraction – for both children and adults."

Analyzed 2006 -16 data, N = 28,861

UNIVERSITY of WASHINGTON

Pilot Evaluation Questions: All influence cost effectiveness

- How do the new DHATs influence the average # of patients seen during a month and how do these averages change with therapist experience?
- How does access change in terms of wait time for appointments, and distance traveled to clinic?
- How does educational outreach increase and improve with the addition of DHATs?
- What are the numbers of procedures completed by provider over 3-month intervals including baseline and after therapists have joined the dental team?
- How does the addition of therapists influence the type of care provided by the dentist—does it increase number of more complicated procedures?
- How does completion of treatment plans change with the addition of a therapist as measured by the number of visits required in the treatment plan and duration of time to completion?
- How many new patients seek care at the clinic after addition of therapist, and what types of dental needs to they have?
- How do the clinic dentists assess the quality of the DHATs' work, including ensuring patient safety during the DHATs' preceptorship, and how does an independent dentist assess the quality of the DHATs' work through a review of random samples of the DHATs' work?
- What do oral health surveys of a random sample of adults and children indicate before and after the introduction of the therapists?
- How satisfied are a random sample of clients with the care they receive from the therapists?
- How does a purposeful sample of clinic patients describe their experiences with the therapists?
- How does a random sample of tribal members receiving care from outside providers perceive their care compared to those using tribal dental facilities?
- How does a random sample of clients view their comfort level with a provider who shares their same cultural and community background?
- How satisfied are clinic staff, therapists, tribal health administrators, and tribal council members with the progress/outcomes of the project?
- How does increased capacity in the dental clinic influence the percentage of tribal members served compared to their numbers in the 6-county area?
- What are the personnel costs for all providers and assistants providing care in relative value units prior to and over the course of the pilot project?
- What, if any, staff turnover occurred during the pilot project phase, and how did this change influence costs and performance?
- What effect has the project had on the number of referrals of community members to outside dentists for care?
- How has the addition of the therapists influenced the overall oral health budgets and billings for each of the tribal communities?

Studies & Reports for today

Both case studies & quantitative analysis

1. **2014** Early Impacts of Dental Therapists in Minnesota, Minnesota Department of Health and the Minnesota Board of Dentistry
2. **2015** Dental Therapy in Minnesota: A Study of Quality and Efficiency Outcomes, Children's Dental Service
3. **2017** An Advanced Dental Therapist in Rural Minnesota: Jodi Hager's Case Study, Apple Tree Dental
4. **2017** Two Dental Therapist Case Studies, Delta Dental of MN & Wilder Research
5. **2020** Case Study, Southside Community Health Services
6. **2020** COVID-19 & Minnesota Dental Therapist Employment, Member survey, MN Dental Therapy Association
7. **2020** The Contributions of Dental Therapists & Advanced Dental Therapists in the Dental Centers of Apple Tree Dental in Minnesota, Center for Health Workforce Studies, SUNY Albany

2014

Health Policy Division, Office of
Rural Health and Primary Care
PO Box 64882
St. Paul, MN 55164-0882
651-201-3838
www.health.state.mn.us

Minnesota Board of Dentistry
2829 University Avenue SE
Suite 450
Minneapolis, MN 55414-3246
612-617-2250
www.dentalboard.state.mn.us

Early Impacts of Dental Therapists in Minnesota

Minnesota Department of Health
Minnesota Board of Dentistry
Report to the Minnesota Legislature 2014

Methods

- Dental therapist licensing data
- Survey of 1,382 dental therapist patients
- Interviews with clinics employing dental therapists
- Clinic administrative data
- Oral health-related emergency room usage data

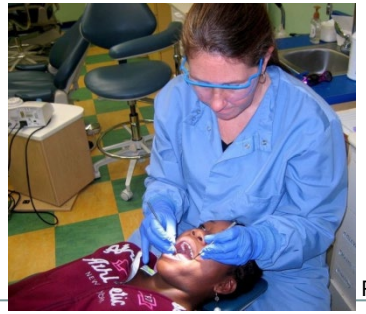
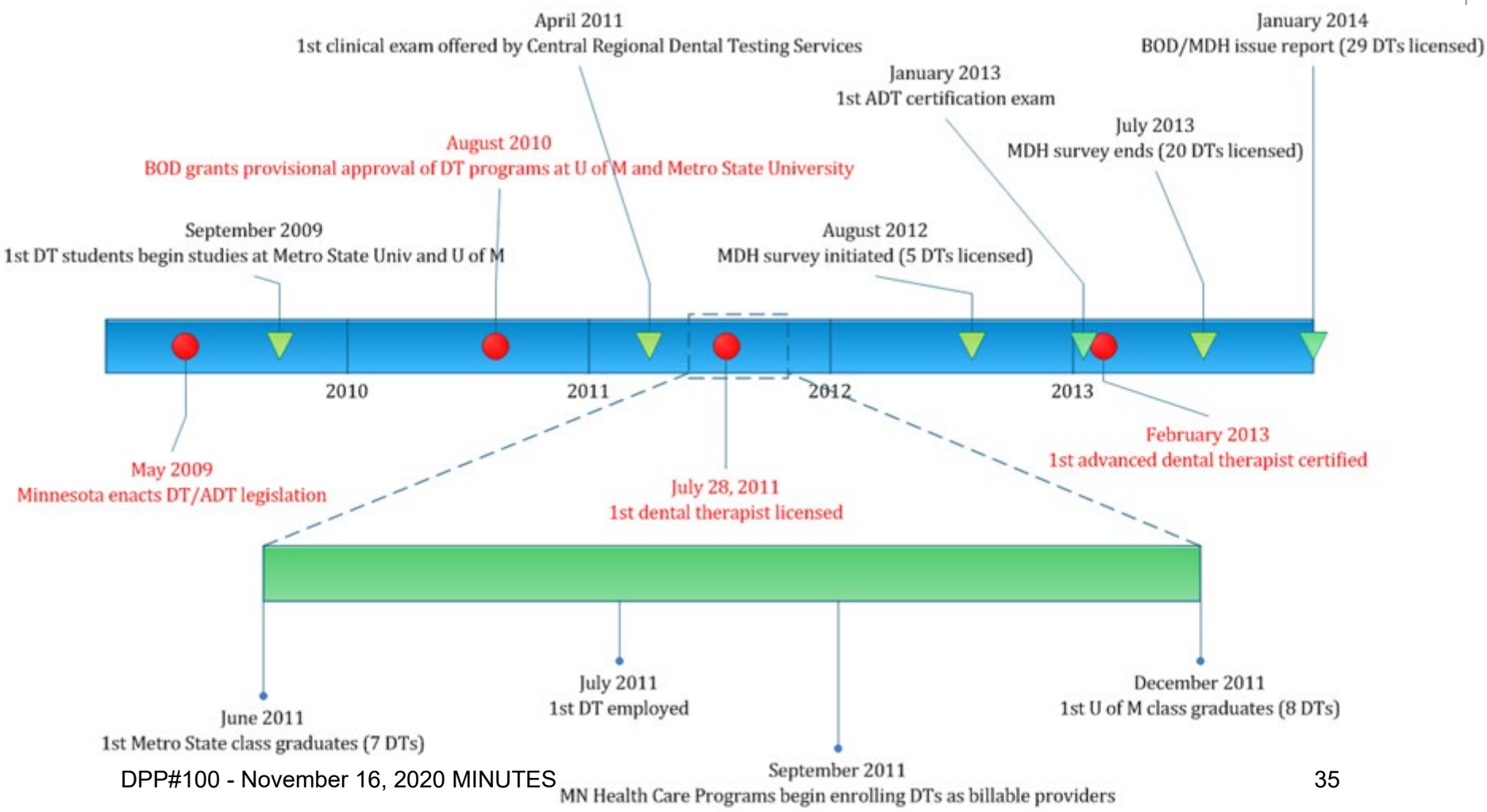


Photo: Thedailystar.net

Dental therapy timeline in Minnesota



Assessment of Impact

- Clinics with DTs seeing more new patients, most underserved: Study clinics served 6,338 new patients. 84% SPP average
- Nearly 1/3 of patients saw a reduction in wait time
- Some patients saw a reduction in travel time
- Preliminary findings suggest expanded capacity may reduce ER use by vulnerable populations.
- Clinics report additional impacts:
  - Personnel cost savings
  - Increased dental team productivity
  - Improved patient satisfaction.
  - DTs appear to be practicing safely; clinics report improved quality.
  - Savings to clinics from lower costs of dental therapists are allowing clinics to expand capacity to serve more underserved and public program patients.

2015 - excerpts

Children's Dental Services

Dental Therapy in Minnesota: A Study of Quality and Efficiency Outcomes

Sarah Wovcha, JD, MPH, Executive Director

Emily Pietig, DDS, Dental Director

Children's Dental Service History

- Children's Dental Services was established in 1919 and received non-profit status in 1954
- Minnesota's primary provider of portable dental care to low-income children
- First provider in the nation of on-site dental care in Head Start setting
- Serves entire state

Results: Production 2012

Production Summary August 2012 (*CDS began tracking ADT productivity in March. ADT productivity has consistently risen since that time.)*

Provider Code	Total Production Charges	Total Hours Worked	Total Production
DR11 Endo Provider	6,420	16	401.25
DR01	66,696	130.39	511.51
DR04	2,132	4.35	490.08
DR20	4,974	12	414.50
ADT01	66,508	171	388.94
DR12	43,978	150.66	291.90
DR36	43,562	162.35	268.32
DR43	22,946	85.95	266.97
DR44	43,219	174.65	247.46
DR38	27,094	111	244.09
DR42	20,757	85.94	241.53
DR24	23,861	110.2	216.52
ADT02	9,390	52	180.58
DR41	3,017	23.55	133.79

Results: Production 2013

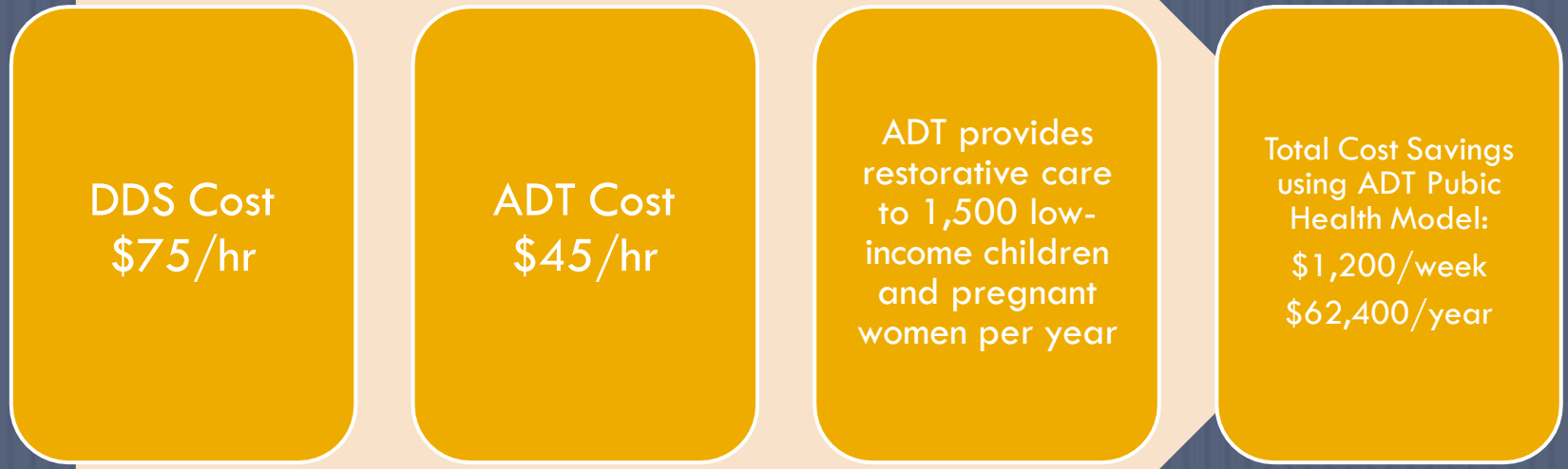
Production Summary August 2013

Provider Code	Total Production Charges	Total Hours Worked	Total Production
DR11 Endo Provider	8,516	16	$532.25
DR20	19,343	43.15	$448.27
DR44	53,555	138.05	$387.58
ADT01	46,755	123.5	$378.58
DR24	53,507	144.91	$361.45
DR36	42,304	140.05	$302.06
DR01	41,008	144.96	$299.66
DT01	4,277	16.3	$262.39
DR43	3,382	4.65	$207.48
DR12	57,856	171.87	$203.46
DR53	10,676	62.74	$170.16
DR04	487	3.05	$159.67

Summary of Dental team production results with integration of dental therapist (average salaries: dentist =$75/hr, dental therapist=$39/hr, advanced dental therapist=$45/hr)

- 2011: Average production of team is $280.72/hr
- 2012: Average production of team is $298.09/hr ($292.13 adjusting for fee increase); Average production of ADT is $340.35/hr
- 2013: Average production of team is $336.87 per hour ($326.76 adjusting for fee increase); Average production of ADT is $365.04/hr
- ADTs are vital to the financial viability of CDS

Results: Financial Impact



Cost-Benefit Analysis based on 1 ADT providing services covered under the ADT statute for 40 hours/week in a public health dental clinic.

MAY 2017

Delta Dental of Minnesota

Wilder Research

Information. Insight. Impact.

TWO DENTAL THERAPIST CASE STUDIES

Delta Dental of MN commissioned 2 case studies from Wilder Research, a long-established & respected nonprofit in St, Paul, MN

Wilder Research case studies of dental therapists in Minnesota found that clinics saw net benefits to their practices, as additional revenue outweighed costs for a net gain to the clinics' monthly revenue

Both in HPSAs

Limitations – brief study period (6 months) & small N (~450 – 1,000 DT visits)

Midwest Dental: Dental Therapist Case Study

Characteristics of patients seen by dental therapist

Median age:

26

Type of procedure seen for:

RESTORATIVE TREATMENT

83%

Type of insurance:

PUBLIC

71%

Renville, MN Pop. 1,200

- Changes in revenue: positive financial returns. Avg monthly revenue more than doubled after adding DT.
- Avg ~ 16% increase in personnel costs.
- Net benefit = 2.4 x avg monthly revenues prior to DT
- DDS generated avg $10,042 more revenue/month after DT added

MAY 2017

DELTA DENTAL

Delta Dental of Minnesota

Wilder Research

Information. Insight. Impact.

Grand Marais Family Dentistry: Population 1,400 Dental Therapist Case Study

Characteristics of patients seen by dental therapist

Average age (January – June 2015):

48

Type of procedure seen for:

RESTORATIVE TREATMENT

69%

Type of insurance (July 2014 – June 2015):

PUBLIC

36%

Dental Therapist generated positive returns.

- Revenues increased 19%/month during study period.
- Expenses dropped 9%/month largely due to reduction in hours for 2nd PT DDS
- Net benefit after hiring DT was 13% of avg. monthly revenue.
- Main factors impacting profitability - productivity of DT & reduced DDS hours
- DT generated ~$16,926 revenue/month

DENTAL THERAPY

MAY 2017

DELTA DENTAL

Delta Dental of Minnesota

Wilder Research

Information. Insight. Impact.

2017

APPLE TREE DENTAL
Access • Compassion • Excellence

An Advanced Dental Therapist in Rural Minnesota

Madelia, MN population 2,400

Study period 2014 – 2016. Data from Apple Tree Dental's electronic records system, Open Dental

- DT's average daily billing was 94 percent of dentists ($2,792 compared to $2,951).
- Billing per visit was close to the average for dentists—within 8 to 15%, the pay difference was significantly larger, making the dental therapist's role cost-effective.
- Working 4 day/wk, DT averaged over 185 clinic days/yr, providing 1,525 dental visits annually. Nearly 80% of DT patients insured by public programs.
- Nearly 2/3 of DT services were for restorative care.
- Over the three-year period, DT placed 60% of clinic's sealants (nearly 800 a year), providing one of the most effective therapies to prevent future decay.

Madelia Community Hospital and Clinics entrance

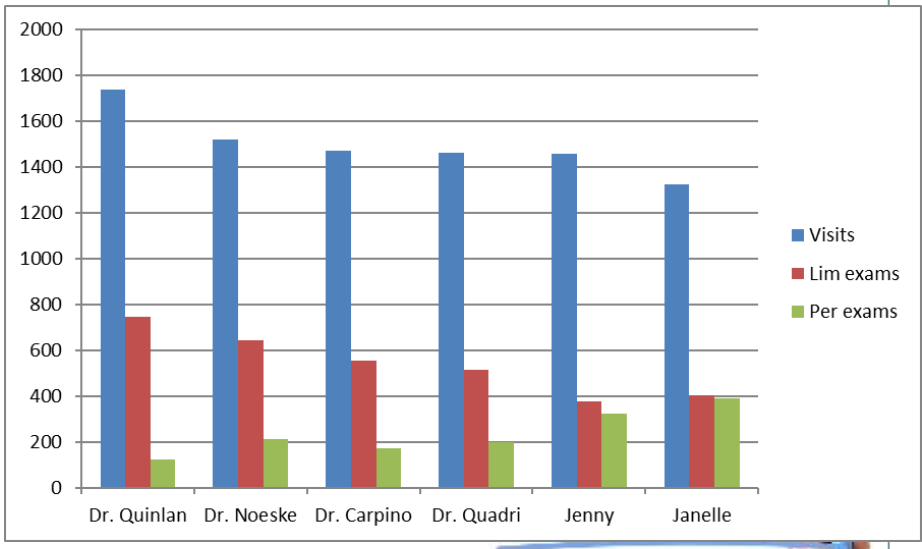
2020

Southside Community Health Services Case Study– Minneapolis FQHC

Brian Quinlan DDS Dental Director

- Value
  - Access for children: bigger workforce
  - Exams: walk ins, scheduled limiteds, hygiene exams, Local for 1 hygienist
  - DDS can work to top of license. My case: ext's and dentures. Younger docs: crowns and endo.
  - Emergencies: diagnose, set up, local
  - Utilizing for teledentistry now popularized by Covid.
  - Special skills: one in TMD, another w/ projects. For all the above-at less salary

Totals by Provider 2019			
	Total Visits	**Total D0140**	**Total D0120**
Quinlan	1739	746	123
Quadri	1461	513	199
Carpino	1472	556	172
Noeske	1521	645	214
Jenny	1456	375	322
Janelle	1324	405	391



DTs used their own column w/ asst.

COVID-19 & Minnesota Dental Therapist Employment
Member survey by MN Dental Therapy Association

- March – April

- 89% not working at all
- 12% working reduced hours
- 3% (1 person) working full time
- 58 responses of 101 licensees

- Mid-June

- 88 % Working
- Of those:
- 79% back to full pre-pandemic hours
- 18% working over 50% or pre-pandemic hours
- 3% working less then 50% of pre-pandemic hours
- 91% have no or neutral reluctance to return (Rikert 1-3 of 5)
- 9% have some reluctance (Rikert 4 of 5)
- 33 responses

August 2020

The Contributions of Dental Therapists and Advanced Dental Therapists in the Dental Centers of Apple Tree Dental in Minnesota

CHWS
Center for Health Workforce Studies

School of Public Health, University at Albany
State University of New York
1 University Place, Suite 220
Rensselaer, NY 12144-3445

Phone: (518) 402-0250
Web: www.chwsny.org
Email: info@chwsny.org

SUNY Albany CHWS Center for Health Workforce Studies

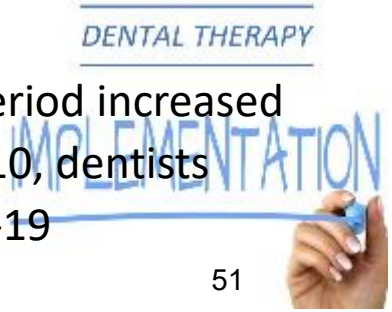
METHODOLOGY

- Study examined the quantity, type, and relative value of services provided before and after introduction of dental therapy practice at Apple Tree Dental.
- Study Period: February, 2009 – July, 2019
- Size: Over 250,000 encounters for 76,342 patients obtaining care in one of the 7 dental centers operated by Apple Tree Dental in Minnesota
- Over the study period, 15 DTs worked for Apple Tree along with DDS & DHs. Ten DTs also held DH licenses. Currently 10 dental therapists/advanced dental therapists at Apple Tree Dental.

SUNY Albany CHWS Center for Health Workforce Studies

RESULTS

- Fees for services by dentists increased in all years since the introduction of DTs.
    - Average daily fees per DDS increased from $3,604.52 in 2009-10 (adjusted to 2018 fee levels) to $4,194.01 in 2018- 19.
- Average fees for advanced dental therapists per treatment day were higher in 2018- 19 ($3,065.06) than in 2013-14 ($2,341.35), the first year in which advanced dental therapists were in the centers.
- Average daily fees for dental therapists per treatment day ($1,712.98) in 2018-19 were similar to those generated in the first year in which dental therapists were introduced to practice ($1,764.67 in 2012-13).
- The intensity, or relative value, of both DDS and DT services increased during the years when dental therapists were on the clinical team.
- The average daily number of procedures by dentists during the period increased from 21.69 in 2009-10 to 25.61 in 2018-19. Additionally, in 2009-10, dentists completed, on average, 10.9 patient visits per day & 13.8 in 2018-19



SUNY Albany CHWS Center for Health Workforce Studies

TAKE AWAYS

- Analyses showed addition of DTs has had positive outcomes for patients, providers, and the organization generally.
- Statistics demonstrate that currently dentists are seeing more patients, providing more services, and producing higher average RVUs and fees per treatment day.

TOPICS NOT DISCUSSED TODAY

- Team Dynamics
- Orientation & ramp-up to full productivity
- Supervision
- Patient Experience
- Wait times
- Health Outcomes
- Malpractice Ins. – Readily available in MN, ind. policy @ $93yr, group policy @ $600-900
- Disciplinary Action – No discipline or corrective action in MN,0n 7 complaints since 2011.
- Other studies and reports

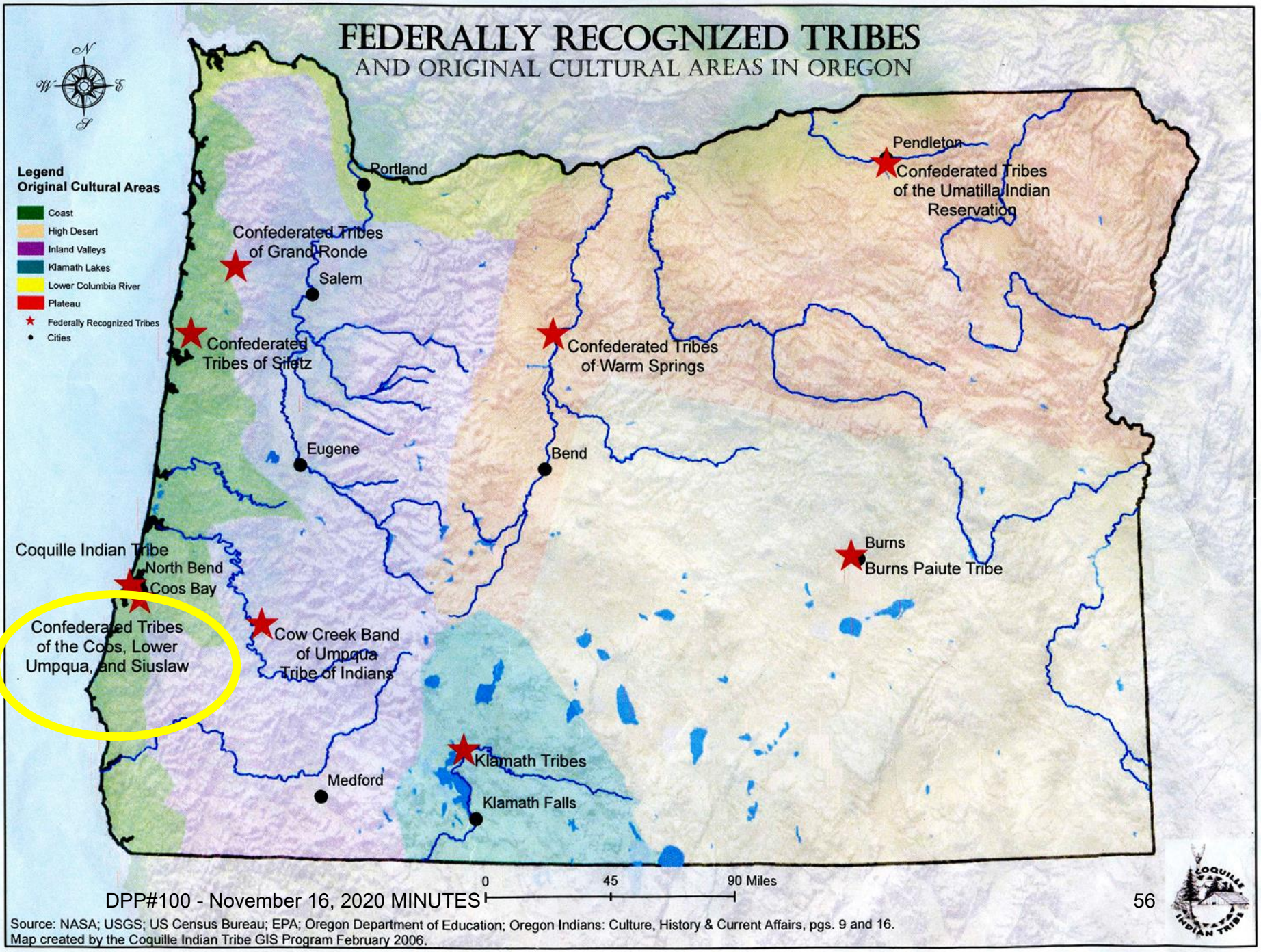
QUESTIONS?

Mark Schoenbaum

markschoenbaum@gmail.com

612.584.9802

Oregon Health Authority


FEDERALLY RECOGNIZED TRIBES
AND ORIGINAL CULTURAL AREAS IN OREGON
N
W
E
S
Legend
Original Cultural Areas
Coast
High Desert
Inland Valleys
Klamath Lakes
Lower Columbia River
Plateau
Federally Recognized Tribes
Cities
Portland
Pendleton
Confederated Tribes of the Umatilla Indian Reservation
Confederated Tribes of Grand Ronde
Salem
Confederated Tribes of Siletz
Confederated Tribes of Warm Springs
Eugene
Bend
Coquille Indian Tribe
North Bend
Coos Bay
Burns
Burns Paiute Tribe
Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw
Cow Creek Band of Umpqua Tribe of Indians
Klamath Tribes
Medford
Klamath Falls
0
45
90 Miles
Source: NASA; USGS; US Census Bureau; EPA; Oregon Department of Education; Oregon Indians: Culture, History & Current Affairs, pgs. 9 and 16.
Map created by the Coquille Indian Tribe GIS Program February 2006.

Oregon Indian Tribes

Tribal governments are separate sovereign nations with powers to protect the **health, safety and welfare** of their members and to govern their lands. This tribal sovereignty predates the existence of the U.S. government and the state of Oregon. The members residing in Oregon are citizens of their tribes, of Oregon and, since 1924, of the United States of America.

All Oregon tribal governments have reservation or trust lands created by treaties or federal acts.

Tribal Sovereignty

Tribal sovereignty in the United States is the inherent authority of indigenous tribes to govern themselves within the borders of the United States of America. The U.S. federal government recognizes tribal nations as "domestic dependent nations" and has established a number of laws attempting to clarify the relationship between the federal, state, and tribal governments.

Resources

- Legislative Commission on Indian Services-Government to Government annual reports, links of interest, approach to state tribal relations, tribal government websites and more.
- https://www.oregonlegislature.gov/cis
- Broken Treaties, An Oregon Experience
- http://www.opb.org/television/programs/oregonexperience/segment/broken-treaties-oregon-native-americans/

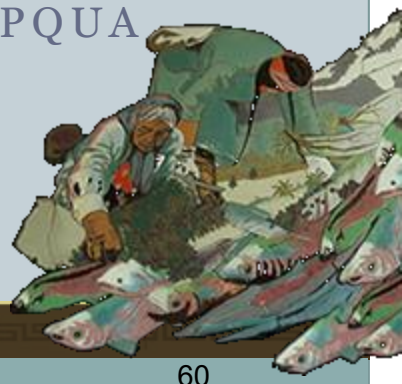
Dental Therapy and The Economic Impact For The Confederated Tribes of Coos, Lower Umpqua and Siuslaw Tribe

VICKI FACIANE, MBA, M.ED.

DIRECTOR OF HEALTH & FAMILY SUPPORT & BEHAVIORAL HEALTH SERVICES

THE CONFEDERATE TRIBES OF COOS LOWER UMPQUA SIUSLAW TRIBE

MONDAY, NOVEMBER 16TH



Presentation Goals

- Understanding history and economics of tribal health systems
- Understanding current costs to community and individuals with barriers to oral health care
- What we know about dental therapists ability to have positive economic impact
- Assumptions and limitations of evaluating costs in Pilot Project #100
- Vision for future

Oregon Indian Tribes

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Termination & Relocation

The Klamath Termination Act (PL 587) enacted in 1954 and terminated Federal supervision over land and members

The Western Oregon Indian Termination Act (PL 588) was passed in August 1954 as part of the United States Indian termination policy and affected ~60 Oregon Tribes (Siletz, Grand Ronde, Coquille, Coos, Lower Umpqua, Siuslaw, and other Oregon tribes) effective immediately

The Indian Relocation Act of 1956 encouraged Native Americans to leave Indian reservations, acquire vocational skills, and assimilate into the general population

Restoration 1977-1989

1977, the Siletz Tribe was recognized and restored

1982, the Cow Creek Band of the Umpqua Tribe was restored

1983, Grand Ronde Restoration Act (PL 98–165), creating the Confederated Tribes of Grand Ronde

1984, Coos, Lower Umpqua, and Siuslaw had trust status restored

1986, Klamath had their trust status restored

1989, Coquille Restoration Act to restore federal trust relationship

Historical Trauma

Historical trauma refers to cumulative emotional and psychological wounding, extending over an individual lifespan and across generations, caused by traumatic experiences.

- Loss of Land
- Loss of Culture
- Loss of Language
- Boarding Schools
- Relocation Act

Indian Health Delivery System

Indian Health Programs can be grouped into 3 categories:

- Indian Health Service (IHS) Directly Operated - Warm Springs, Western Oregon Service Unit – Chemawa Indian School
- Tribally Operated (P.L. 93-638 Indian Self-Determination Act) 8 Oregon Tribes
- Urban Indian Health Care Program - NARA

Types of Health Services that may be provided:

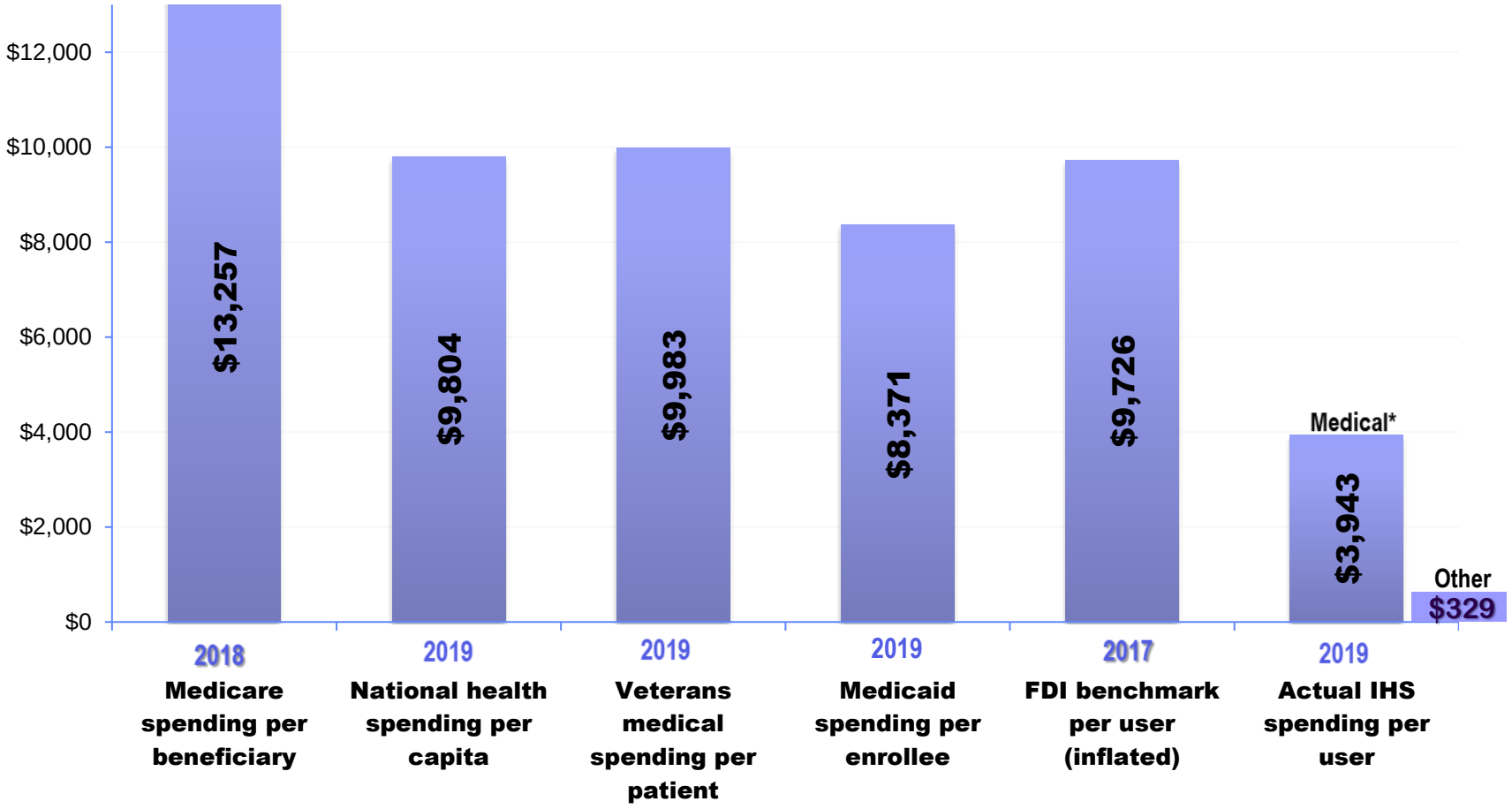
- Ambulatory Primary Care (outpatient care)
- Inpatient care - Hospitals
- Medical specialties
- Traditional healing practices
- Dental and Vision Care
- Behavioral Health Services
- Specialty Care Services (CHS)

A note on Service Areas

Each tribe's area of interest may extend far beyond its tribal governmental center or reservation location. The federal government acknowledges that many tribal members do not live on tribal lands and, therefore, allows for tribes to provide governmental programs in specified service areas to any AI/AN, regardless of tribal affiliation.

For example, the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians service area includes 5 Oregon counties: Coos, Curry, Douglans, Lane, and Lincoln.

2019 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



*See page 2 notes on reverse for sources. *Payments by other sources for medical services provided to AIANs outside IHS is unknown.*

CTCLUSI Dental Clinic Revenue and Expenditures

- The CTCLUSI Dental Clinic is Tribally-operated through a P.L. 638 compact with the Indian Health Service (IHS)
  - Funding of healthcare is a treaty obligation between the Federal government and sovereign Tribal nations. This obligation is chronically underfunded and does not provide enough money to cover the health needs of our Tribal members.
    - Tribal clinics rely heavily on the ability to bill third-party payers, such as private insurance and Medicare/Medicaid programs to remain open.
    - Any "revenues" that exceed the amount needed to cover the expenses of the clinic go back into the clinic and other health programs for Tribal members.
  - Our P.L. 638 compact gives us control over how we spend IHS dollars. This allows us to allocate our limited dollars to the area(s) of greatest need for our Tribal members rather than those "priorities" determined by federal officials.

CTCLUSI Dental Clinic Revenue and Expenditures

- Our Tribal dental clinic provides services to any American Indian/Alaska Native (AI/AN) who is a member of a federally-recognized Tribe and seeks dental care, regardless of county of residence or Tribal affiliation. Rules for providing this care come from the IHS.
  - AI/AN are not billed for professional services they receive in the clinic:
    - AI/AN are not required to purchase insurance; however, if they do have insurance or Medicaid/CHIP, we submit a claim for payment to the payer.
    - Amounts not paid by insurance are written-off. We do not balance bill AI/AN.
    - We wrote-off $535,568.54 in 2019 for services provided in our clinic. This is 52% of gross charges.
  - Budget for expenses: 59% from IHS AFA; **30% from 3rd party billing**; 3% from OHA-OSOW; and 8% from our DHAT grant.

CTCLUSI Dental Clinic Specialist Referrals

- Our dentist provides services to all ages in our clinic.
  - Patients are referred to specialists, such as endodontists, oral surgeons, etc., when the complexity is beyond our ability to provide the care in our clinic.
    - The dentist gives patients the option to choose treatment by a specialist.
    - Patients are given information to make an informed choice.
  - Referrals can be problematic because:
    - Many of our patients do not have insurance or Medicaid;
    - There is a shortage of specialty care in our area;
    - Transportation issues to get specialist care out of the area; and
    - Patient comfort issues – many patients are concerned with how they may be treated at a non-Tribal dental clinic.

CTCLUSI Tribal Dental Clinic

- The Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians dental clinic is an Indian Health Service clinic serving members of all federally recognized Tribes who live in the area, as well as non-Tribal members.

- Dentists: 1 (Vacant)
- Dental hygienists: 1
- Dental therapists: 2
- Dental assistants: 4
- Receptionist: 1
- Coordinator: 1

- Patients: 792 (2019)

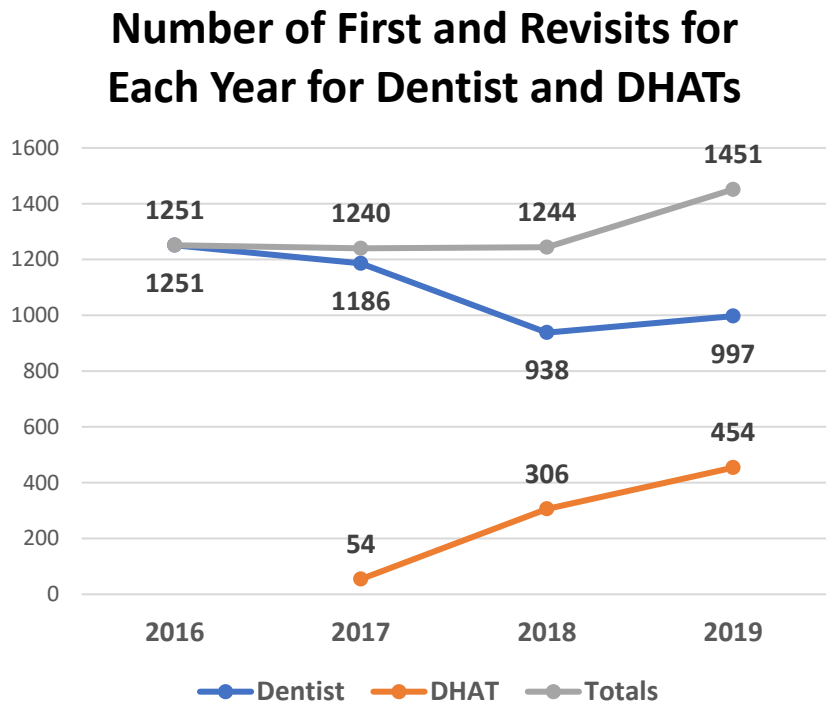
- Operatories: 7
  - (2020 expansion from 3 to 7)

Costs to individuals and tribal communities facing barriers to routine and culturally relevant oral health care

- Increased use of emergency care
- Lost work time
- Missed school days
- Delayed preventive and restorative treatment increases costs for higher levels of care
- Lost job opportunities
- Increased risk and costs of overall health impacts
- Higher use of and strains on all health services

Frequency of Patient Visits and Access to Care

- The Clinic saw a modest increase in the number of patients served each year – an increase of 13% from 2016 through 2019
- However, the patients were able to make more appointments during each year with the addition of the therapists
- The increase from 2017 to 2018 is 467% with another 48% from 2018 to 2019



Slide Provided By Mekinak Consulting, June 2020

Dental therapy is a cost-effective solution for Tribal Health Programs

DHATs cost only about $.30 for every dollar they generate[1] This allows dental teams to see more patients at existing reimbursement rates, and put those cost savings into further expanding care.

DHATs, earning about half the salary of a dentist, can perform many routine procedures typically done by a dentist:

- Swinomish Indian Tribal Community analyzed the procedures done at their dental clinic and found that a DHAT could perform 50% of the procedures being done by the dentist.
- A published study of portion of care that could be performed by mid-level professionals at a series of safety net clinics found that DHATs could perform between 64 and 90% of the procedures, depending on clinic type.[2]

1 *Kim, Frances M. "Economic Viability of Dental Therapists." Community Catalyst. May 2013*
2 *Phillips, Elizabeth, et. al. "Safety Net Care and Midlevel Dental Practitioners: A Case Study of the Portion of Care That Might Be Performed Under Various Setting and Scope-of-Practice Assumptions." American Journal of Public Health, September 2015*

Dental therapy is a cost-effective solution for Tribal Health Programs

DHATs have a select scope of practice that includes both preventive and restorative procedures and allows providers to work at the top of their scope. This team approach increases efficiency and supports the clinic's bottom line.

DHATs can decrease costly dental-related emergency room visits by increasing access to preventive dental services and continuity of care.

DHATs that stay in their community generate economic benefits for themselves and their Tribes. The accelerated, post-secondary degree training program offers a very realistic career pathway and results in a living-wage job. Tribes benefit from those jobs coming from and staying in the community.

Assumptions and limitations of evaluating cost in Pilot Project #100

3. How has the TDHATP impacted the productivity of the oral health team and the costs of dental care in the tribal communities?

Evaluation Question	Source of Data/Timing	Notes
a. What are the personnel costs for all providers and assistants providing care in relative value units prior to and over the course of the pilot project?	Tribal financial records regarding salaries of providers. Baseline data collected in 2016, and comparison data collected annually.	Formula for relative value units will be used for baseline and annual analysis.
b. What, if any, staff turnover occurred during the pilot project phase, and how did this change influence costs and performance?	Annual interviews with clinic administrators and tribal health administrators.	Interview guides for 2k will include questions about staff turnover.
c. What effect has the project had on the number of referrals of community members to outside dentists for care?	Tribal health billing records. Information collected in baseline period and at 6-month intervals after therapists placed.	Information collected for both tribes.
d. How has the addition of the therapists influenced the overall oral health budgets and billings for each of the tribal communities?	Interviews with tribal health administrators and review of annual budgets.	Interview guides for 2k will include questions about overall budgets and costs of care.

Assumptions and limitations of evaluating cost in Pilot Project #100

External to pilot, clinic factors impacting evaluation data:

- 3 chairs for 4 providers
- Dental assistant shortages
- Clinic construction and closures
- Staff leave
- COVID-19

Assumptions and limitations of evaluating cost in Pilot Project #100

Pilot specific factors impacting evaluation data:

- Changing rules and requirements over first 4 years of pilot
- Time spent on administration of pilot vs. patient care
- Preceptorships taking longer than anticipated
- Monitoring requirements impact productivity and cost

Monitoring Safety and Quality

Preceptorship:

- Preceptorship for trainees is 400+ hours of direct supervision and includes a checklist of 4-8 of every procedure in scope. As trainees complete procedures in checklist they can be moved into a practice plan under the level of supervision deemed appropriate by supervising dentist, or required by OHA.

- Supervising dentists evaluate and make comments as necessary on every procedure through an online patient encounter form, and that information is submitted to OHA every quarter.

- Consent forms to see a DHAT are currently being collected for every patient encounter.

Monitoring Safety and Quality

Post Preceptorship:

- Practice Agreement includes all procedures allowed by supervising dentist, including any restrictions on supervision and additional documentation required.
- If in the event a new supervising dentist is assigned, each procedure listed in the Practice Agreement must be successfully demonstrated once to the new supervising dentist under direct supervision for a minimum of 80 hours.
- Every two years the Practice Agreement must be reviewed, and each procedure listed in the practice agreement successfully demonstrated at least once to supervising dentist for a minimum of 80 hours.
- Weekly chart review by supervising dentist of irreversible procedures submitted to OHA every quarter.
- External Dentist reviews random sample of 10 charts and required images of irreversible procedures, submitted to OHA quarterly.

Monitoring Safety and Quality

Standing Operating Procedures:

- **Consent forms:** In compliance with OAR 333-010-0440, informed consent is required for each visit. The patient must sign and date the general DHAT treatment administration paper consent form indicating they understand the DHAT role. Before proceeding with treatment, the DHAT must obtain and document PARQ verbal consent which includes possible complications of treatment. For other procedures such as extractions and silver diamine fluoride procedures, a digital consent format is acceptable.

- **Photos**: Procedures requiring tooth preparation and final restoration require pre-op, mid-op, and post-op intraoral photos when appropriate. Images must be of high quality with no debris, blood, or excess restorative material present. Extractions: A recent radiograph of the tooth to be extracted is required including a pre-op intraoral photo. A post-op photo of the removed tooth must be taken including all residual coronal or root tip remnants. A post-op PA is not required.

Monitoring Safety and Quality

External/OHA Review and Monitoring

- Original Application reviewed by OHA Technical Review Board comprised of members of dental professional associations, Board of Dentistry, individual oral health providers.
- Reports submitted quarterly on all aspects of project, including evaluation data and monitoring and demographic data collected *per procedure.*
- OHA site visits to training and utilization sites, including interviews with pilot participants, tour of facilities and chart reviews drawn from random sample of all DHAT charts.
- OHA Advisory Committee reviews and offers opinions on modifications, documents, protocols, and participates in site visits and chart reviews.

Key Pilot Project #100 staff and consultants costs

Sponsor Project Director: Miranda Davis, DDS, MPH: 25% FTE
Sponsor Project Manager: Pam Johnson: 20% FTE
Sponsor Project Specialist: Dove Spector: 100% FTE
Project Dental Director: Gita Yitta, DMD: 42 hours/month
Consulting Dentist: Dane Lenaker, DMD, MPH: 11 hours/month
External Evaluating Dentist: Under contract,: 2 hours/month
Evaluators: Joan LaFrance, EdD; Janet Gordon, PhD, Mekinak Consulting: 42 hours/month

CTCLUSI Staff Time allocated to pilot:

Tribal Health Director: Vicki Faciane: 20% FTE
Supervising Dentist: Vacant: 50% FTE
DHATs: Naomi Petrie, Marissa Gardner: 100% FTE
DHAT coordinator: Jamie Meyers: 50% FTE

Looking Ahead

- In next year, hoping some external factors to data will decrease with full staffing, new operatories functioning, preceptorships done
- Outside of pilot constraints, we would expect productivity to increase and costs to clinic to decrease
- Vision for the future includes benefits to patients, clinic and community

Vision for Future

Dental Therapy Economic Benefits to Patients

- Less wait time for appointments and more routine preventive care from familiar providers decreasing need for emergency or more complex and costly care
- Community outreach – care available in more locations, shortening or eliminating travel time

Dental Therapy Economic Benefits to Clinic

- Excellent care at lower cost
  - Dental Therapist currently paid 40% of Dentist salary
- Return on investment of clinic building/expanding realized
  - DHAT salary an important budget factor
- Dentist can focus on more complex procedures
- Provider turnover decreased by hiring community members

Vision for Future

Dental Therapy Economic Benefits to Community:

- Living wage professional jobs for community members
  - Keeps funds spent within the community
- Role models inspire the next generation of professionals
- Increased oral and overall health increases economic health of communities

Dental Therapy Economic Benefits to Outreach:

- COVID-19 has presented us with challenges in conducting home visits
- On October 13, 2020 OHA approved an amendment to the approved outreach modification to expand locations for our outreach model
- We currently are implementing these additional sites to our outreach protocols and will report our efforts in the months to come


Questions?

DPP#100 Chart Review Results

Preliminary 2019 and 2020 Combined Results

ORAL HEALTH UNIT
Public Health Division

Chart Review Methods

1. Develop Rubric
2. Identify patient population
   - Patients seen by trainee
3. Determine sample size / pull sample
   - Stratified random sampling
4. Create audit tools
5. Calibrate screeners
6. Collect data
7. Analyze results
8. REPEAT

Monitor and evaluate for patient health and safety

- Reviews of patient records to monitor for patient safety, quality of care, minimum standard of care and compliance with the approved or amended application

- Purpose:
  - Opportunity to review trainee performance and quality in regards to patient safety
  - Lead to a greater understanding of the proposed workforce model
  - Use an *iterative* process to lead to quality improvement
  - Determine that a minimum standard of care is met

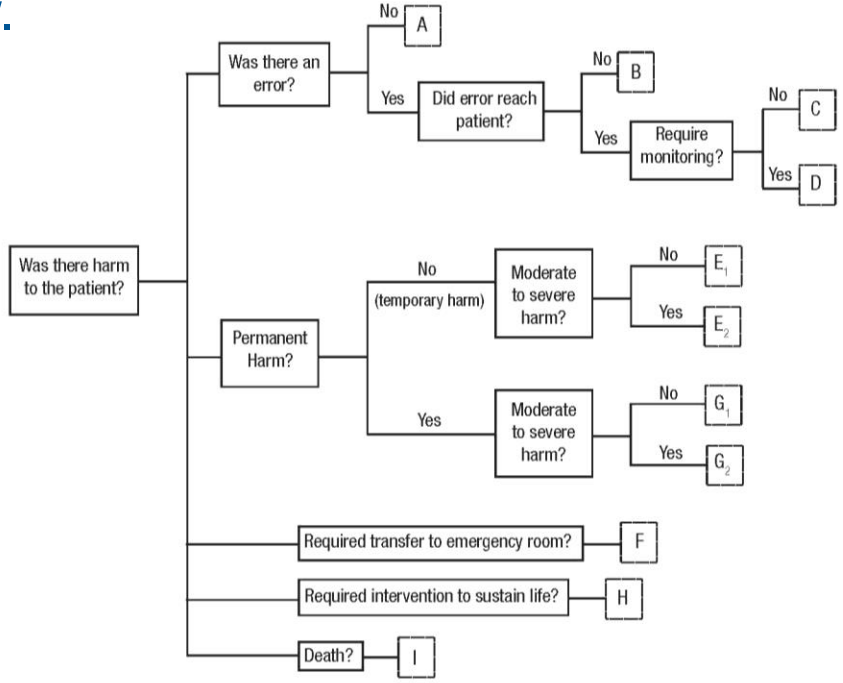
- Not the purpose:
  - To “root out bad quality”
  - Judge things you can’t see
  - Prove or disprove the educational competency of the model

Domains of Review

- Adverse Events
- Intraoral Images and Radiographs
- Anesthetic Notes
- Diagnosis
- Treatment
- Overall Impression of Procedure Quality
- Posterior Restorations
- Anterior Restorations
- Stainless Steel Crowns
- Extractions

Adverse Events

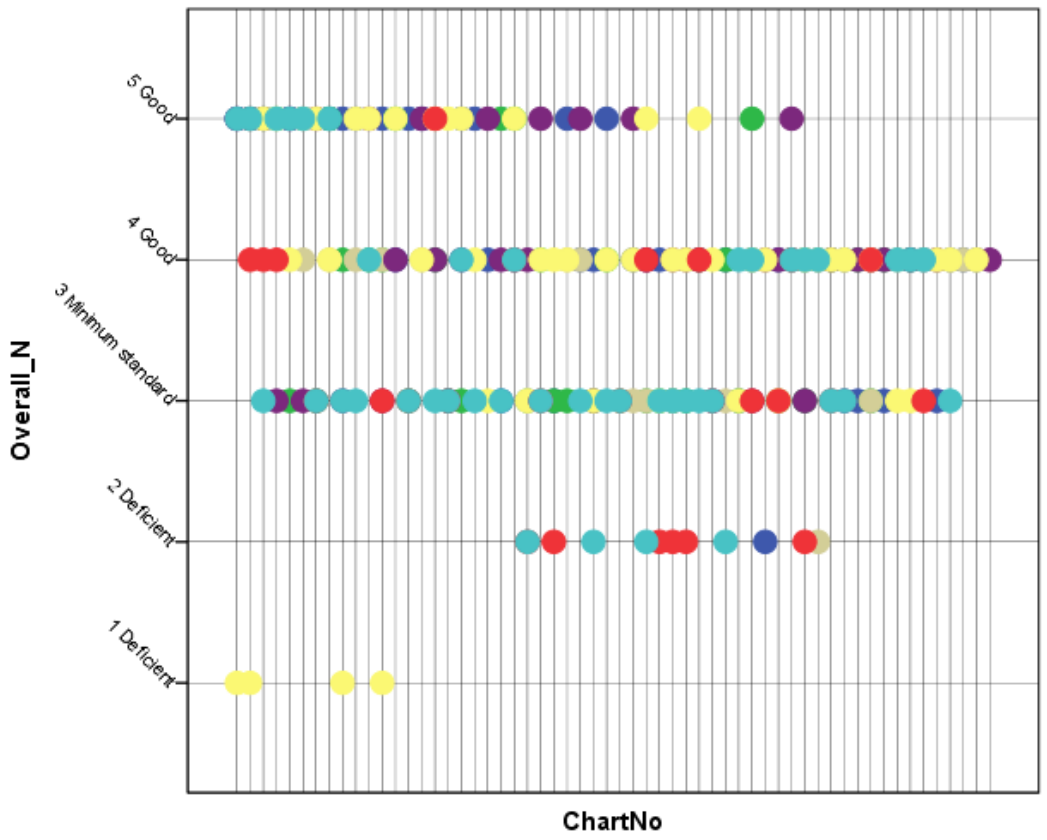
- There were no Serious Adverse Events identified in either chart review.



Category	Description of Dental Adverse Event Severity Categories using the Dental AE severity tree
A	No errors
B	Error with no impact on patient
C	Error with minimal/mild impact to patient; does not require monitoring
D	Error with moderate to severe impact to patient; requires monitoring
E_1	Temporary (reversible or transient) minimal/mild harm to the patient
E_2	Temporary (reversible or transient) moderate to severe harm to the patient
F	Harm to the patient that required transfer to emergency room and/or prolonged hospitalization
G_1	Permanent minimal/mild patient harm
G_2	Permanent moderate to severe patient harm
H	Intervention required to sustain life
I	Patient death

Adapted from: Kalenderian E, Obadan-Udoh E, Maramaldi P, et al. Classifying Adverse Events in the Dental Office [published online ahead of print, 2017 Jun 30]. J Patient Saf. 2017;10.1097/PTS.0000000000000407. doi:10.1097/PTS.0000000000000407

Overall impression of procedure quality



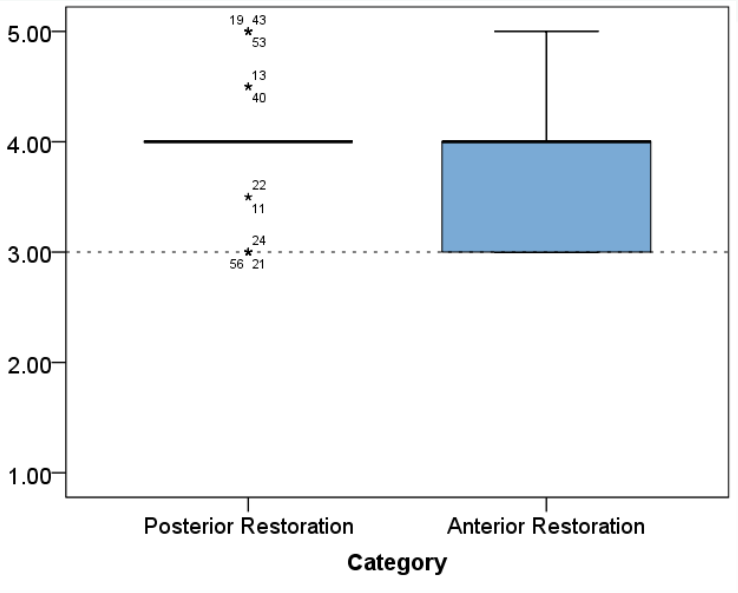
Overall impression of procedure quality
- Median Scores

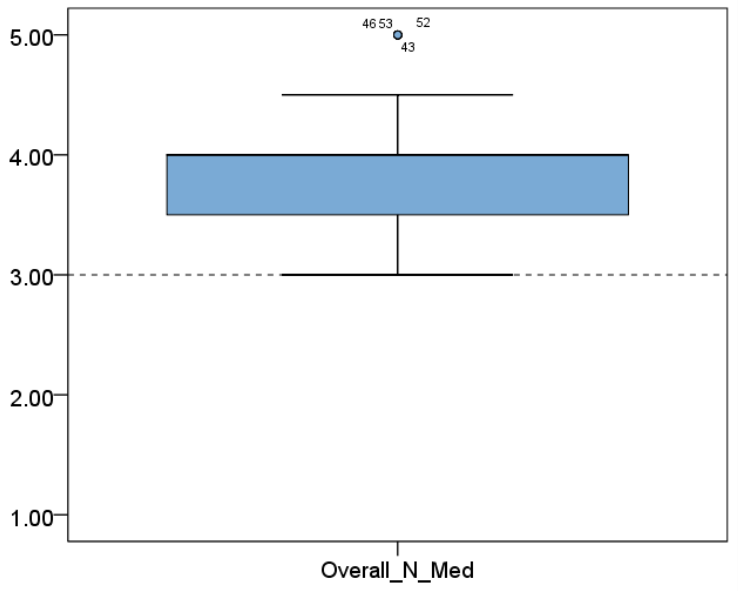
Descriptives

			Statistic	Std. Error
Overall_N_Med	Mean		3.9138	.07983
	95% Confidence Interval for Mean	Lower Bound	3.7539	
		Upper Bound	4.0737	
	5% Trimmed Mean		3.9042	
	Median		4.0000	
	Variance		.370	
	Std. Deviation		.60797	
	Minimum		3.00	
	Maximum		5.00	
	Range		2.00	
	Interquartile Range		.50	
	Skewness		-.021	.314
	Kurtosis		-.405	.618

Case Processing Summary

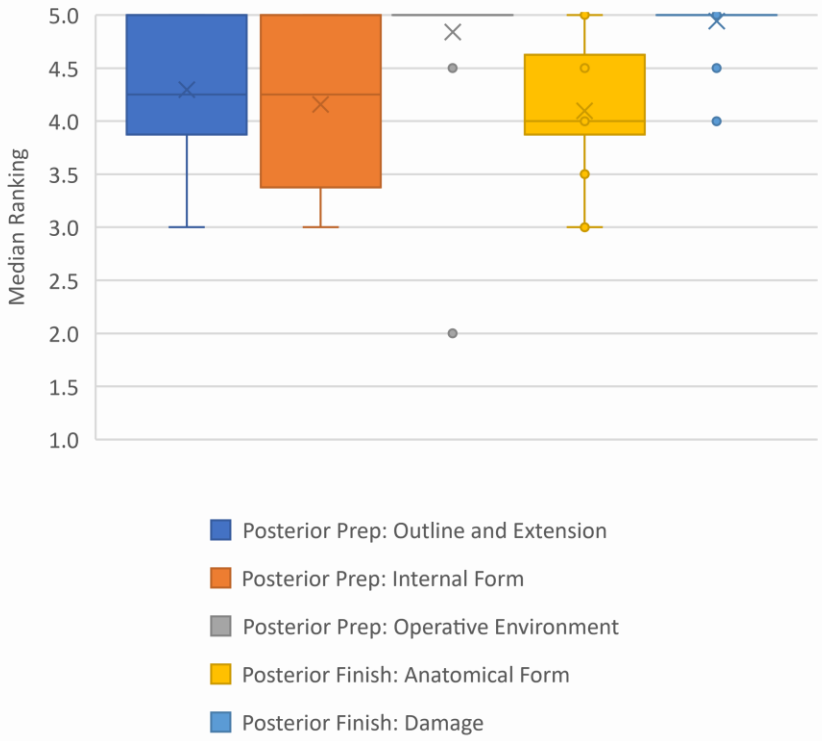
		Cases					
		Valid		Missing		Total	
	Category	N	Percent	N	Percent	N	Percent
Overall_N_Med	Posterior Restoration	42	100.0%	0	0.0%	42	100.0%
	Anterior Restoration	16	100.0%	0	0.0%	16	100.0%





Posterior Restorations

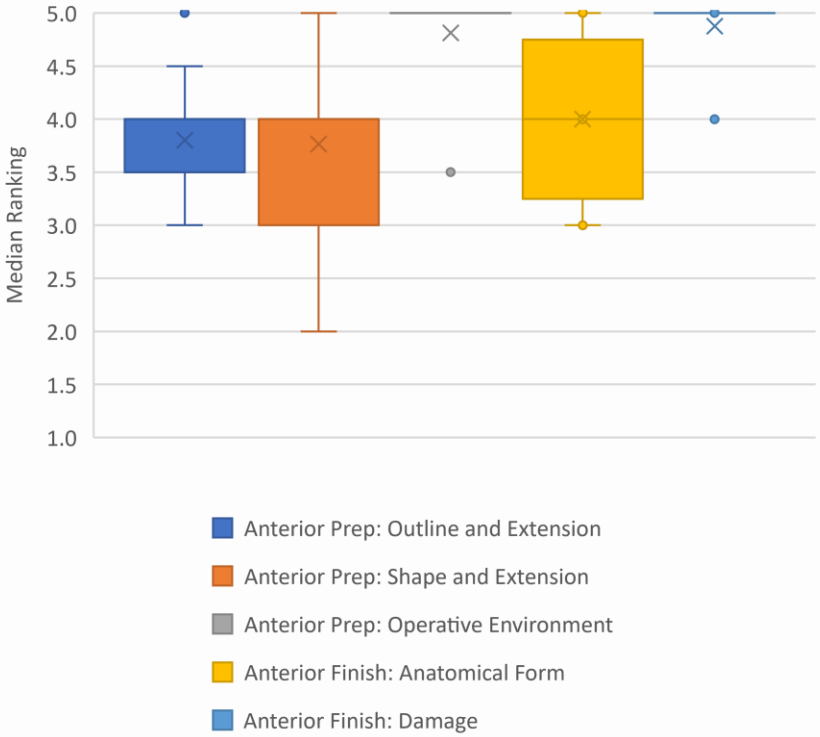
Figure 2: Median Ratings for Sub-Criteria in Posterior Amalgam/Composite Restorations



Posterior Restorations Sub-Criteria	Minimum standard of care (see Appendix A for the full rating criteria)
Preparation: Outline and Extension	• Outline moderately weakens marginal ridge or a cusp. Isthmus is too wide or too narrow for lesion. • Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough but will not adversely affect the final restoration.
Preparation: Internal Form	• Pulpal floor and/or axial wall is moderately shallow or deep.
Preparation: Operative Environment	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed. • Management of any damage is appropriate • Documentation of difficult behavior if necessary to explain excessive damage
Finish: Anatomical Form	• Moderate variation in normal anatomical form is present. Marginal ridge is improperly shaped. • There is moderate variation of proximal contour and shape.
Finish: Margins	• Moderate marginal excesses and/or deficiencies are present.
Finish: Damage	• Moderate damage to hard or soft tissue is evident.

Anterior Restorations

Figure 3: Median Ratings for Sub-Criteria in Anterior Composite Restorations



Anterior Restorations Sub-Criteria	Minimum standard of care (see Appendix A for the full rating criteria)
Preparation: Outline and Extension	• Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough but will not adversely affect the final restoration. • Cavosurface angles possibly compromise the integrity of the tooth or restoration.
Preparation: Shape and Extension	• Outline is moderately over or under extended. Outline is moderately irregular but does not weaken the tooth. • Gingival margin is moderately overextended. • Any overextension that severely weakens tooth is properly documented
Preparation: Operative Environment	• Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.
Finish: Anatomical Form	• Moderate variation in normal anatomical form is present. Marginal ridge is improperly shaped. • There is moderate variation of proximal contour and shape.
Finish: Margins	• Moderate marginal excesses and/or deficiencies are present.
Finish: Damage	• Moderate damage to hard or soft tissue is evident.

CENTER FOR PREVENTION AND HEALTH PROMOTION
Oral Health Program
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon St, Ste 825
Portland, Oregon 97232-2186
Office: 971-673-1563
Cell: 509-413-9318
Fax: 971-673-0231
www.healthoregon.org/dpp

October 13, 2020

Laura Platero, JD
Executive Director
Northwest Portland Area Indian Health Board
2121 SW Broadway, Suite 300
Portland, Oregon 97201

Dear Ms. Platero,

On September 18, 2020, the Oregon Health Authority's (OHA) Dental Pilot Project Program received a modification request from Dental Pilot Project #100 (DPP #100) "Oregon Tribes Dental Health Aide Therapist Pilot" project sponsor the Northwest Portland Area Indian Health Board (NPAIHB). The modification request allows trainees to provide services under a dental oral health outreach model to the following locations described in the request:

- Daycare facilities including in-home and worksite daycare
- Local/Tribal preschool and head start programs
- Local/Tribal after school programs
- Wellness fairs
- Tribal events

The outreach model described will provide oral healthcare to patients who are eligible for treatment at the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI) Dental Clinic. Please see Appendix A for a copy of the modification request.

Under Oregon Administrative Rules (OAR) 333-010-0800, approved dental pilot projects may submit a request to modify the scope of practice for trainees as part of an approved dental pilot project. All modifications require OHA approval.

```
333-010-0800
Dental Pilot Projects: Project Modifications
1) Any modifications to an approved project shall be submitted
writing to program staff, except as specified in section (4)
this rule. All modifications require Authority approval.
Modifications include, but are not limited to the following:
a) Changes in selection criteria for trainees, supervisors, or
employment/utilization sites;
(b) Addition of employment/utilization sites; and
(c) Changes in the scope of practice for trainees.
```

(2) Upon receipt of a request for a modification approval, the Authority will inform the project sponsor in writing on the timeline for review of the request and decision response deadline.
(3) If the Authority has convened an advisory committee for an approved project, the Authority may confer with the advisory committee regarding the proposed modification.
(4) Changes in project staff or instructors are not considered a modification and do not require prior approval by program staff, but shall be reported to the program staff within two weeks after the change occurs along with the curriculum vitae for the new project staff and instructors.
(5) The Authority may approve or deny a request for modification. A modification may be denied if:
(a) It does not demonstrate that the project can meet the minimum standards or other provisions in these rules; or
(b) The modification would result in a substantial change to underlying purpose and scope of the pilot project as originally approved.
(6) Projects are not permitted to implement the proposed modification until approval has been rendered by the Authority.

OHA consulted the Advisory Committee for DPP #100 in addition to reviewing best practices and evidence-based approaches to oral health outreach programs. The committee was asked to review the modification request and associated materials and provide feedback to OHA by October 9, 2020. Please see Appendix B for materials consulted. After reviewing all recommendations and feedback, OHA has approved the request for modification to allow trainees to provide services under the outreach model described in the modification request.

The project is authorized to complete all aspects of the project as described in the approved application and addendum's. The project must continue to maintain compliance with OAR 333-010-0700 through 333-010-0820 and with the Amended Stipulated Agreement signed on April 27, 2020.

The modification request is effective as of October 15, 2020.

Sincerely,

Cate Wilcox, MPH
MCH Section Manager

Sarah Kowalski, RDH, MS
Dental Pilot Project Program

cc: Dental Pilot Project #100 Advisory Committee
Oregon Board of Dentistry

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

September 18, 2020

Sarah Kowalski, RDH, MS
Dental Pilot Project Program
Oregon Health Authority

RE: Oregon Pilot Project #100

Dear Ms. Kowalski:

The Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians (CTCLUSI) dental clinic's current outreach modification allows the Dental Therapists to conduct home visits for elders and new mothers. Recently the DHATs have faced significant challenges in conducting these home visits due to the global pandemic, COVID-19. As a result, additional outreach locations are needed to accommodate the health and safety restrictions while maintaining the overall goals and evaluation factors highlighted in the pilot project's original application.

At this time, **Pilot Project #100 requests a modification to add additional sites to the existing outreach modification.** There is no request for a modification regarding scope of practice. It is a continuation of currently approved treatment modalities. The patient population to benefit from the outreach will be community members who are eligible for treatment at the CTCLUSI Clinic. Address locations will not be included in this request to protect patient privacy. Patient records will be kept at the CTCLUSI clinic to ensure proper documentation and billing. There will be no changes in supervision as part of this outreach plan. Dental therapists who complete their preceptorship requirements and transition into general supervision will be allowed to provide treatment as part of the home visit.

Building relationships with patients in settings outside the clinic can result in connecting those patients to needed care at the clinic, as well as provide additional preventive care needed in the community. It would also provide greater access to tribal members who may find it challenging to physically come to the clinic at this time.

The dental therapist's educational curriculum is focused on improving dental care access to high risk patients. The addition of sites to the current outreach modification will greatly help the clinic to expand the utilization of preventive type services.

The additional community outreach sites we are requesting to add to the current outreach modification for CTCLUSI are:

- Daycare facilities including in-home and worksite daycare
- Local/Tribal preschool and head start programs
- Local/Tribal after school programs
- Wellness fairs
- Tribal events

Thank you for considering this modification request. Please contact me at 503-407-4082 or Dr. Miranda Davis if you have any questions. We look forward to your response.

Sincerely,

Laura Platero, JD
NPAIHB, Executive Director

Location Address Site Name	Target Population	Demographics of Site	Dental HPSA and Designation Type[1]	HRSA – Urban Area/Rural Area[2],[3],[4]	National Health Service Corps (NHSC) Approved Sites[5], [6],[7]
Location: Coquille **Site Name**: Coquille **Primary Site Location***	• Individuals who are tribal members of Confederated Tribes of Coos, Lower Umpqua & Siuslaw • Individuals who are tribal members of the Coquille Indian Tribe Individuals are who members of a federally recognized American Indian and/or Alaska Native tribe	**Site Name & Description:** Coquille **Clinic Patient/Payment Source Demographics: N/A** The Coquille Site was approved as part of the Dental Pilot Project #100 application. Coquille is in the process of building a dental clinic. Individuals who are tribal members of the Coquille Indian Tribe are eligible for services at the CTCLUSI Site.	**In a Dental Health HPSA: Yes** **HPSA Name:** Low Income - Coos County **ID:**6414318289 **Designation Type:** HPSA Population **Status:** Designated **Score:**17 **Designation Date:**04/10/2008 **Last Update Date:**10/28/2017	HRSA- Rural Designation – Yes Location: Qualifies as a location that would be eligible under HRSA requirements to apply for Rural Health Grants.	

* **Primary Site Location versus Secondary Site Location**: A majority of the trainee's services are provided at the primary site location. Secondary site locations are where services are occasionally provided by the trainee or may be provided at a future date in time by the trainee. All locations listed under each site must be approved by the Oregon Health Authority as required under OAR 333-010-0710.

[1] https://data.hrsa.gov/tools/shortage-area/hpsa-find
[2] List of Rural Counties and Designated Eligible Census Tracts in Metropolitan Counties, Updated Census 2010, HRSA
[3] https://www.hrsa.gov/rural-health/about-us/definition/index.html
[4] https://www.ohsu.edu/sites/default/files/2018-08/2018%20Area%20of%20Unmet%20Health%20Care%20Need%20Report.pdf
[5] https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_NHSC_SITE/NHSC_Appr_Site_List&rs:Format=PDF&theFilterType=region&theWhere=REGION_CD=%2710%27
[6] https://nhsc.hrsa.gov/downloads/nhsc-sites/nhsc-site-reference-guide.pdf
[7] https://datawarehouse.hrsa.gov/HGDWReports/OneClickRptFilter.aspx?rptName=NHSCAppSiteList

Location Address Site Name	Target Population	Demographics of Site	Dental HPSA and Designation Type[8]	HRSA – Urban Area/Rural Area[9],[10],[11]	National Health Service Corps (NHSC) Approved Sites[12], [13],[14]
Location: Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians Dental Clinic (CTCLUSI) Dental Clinic 1245 Fulton Ave Coos Bay, OR 97420 Primary Site Location **Site Name**: CTCLUSI Site	• Individuals who are tribal members of Confederated Tribes of Coos, Lower Umpqua & Siuslaw • Individuals who are tribal members of the Coquille Indian Tribe • Individuals are who members of a federally recognized American Indian and/or Alaska Native tribe • Individuals eligible to receive services from CTCLUSI Sites include CTCLUSI enrolled Tribal members spouses (must be legally married and currently residing with the Tribal member) and CTCLUSI widows/widowers. • Individuals eligible for services under Indian Health Services (IHS)[15]	**Site Name & Description:** CTCLUSI Dental Clinic Indian Health Service (IHS) Dental Clinic (CTCLUSI Site) **Clinic Patient/Payment Source Demographics**: • 22% of individuals who identify as CTCLUSI • 14% of individuals who identify at Coquille • 51% of individuals who identify as Other Tribe (AI/AN) • 33% of patients are Oregon Health Plan (Medicaid) recipients • 39% of patients are covered under Indian Health Services Contract Purchas of Care[16] • 6% of patients are spouses of AI/AN CTCLUSI or CIT members covered by tribal funds	**In a Dental Health HPSA: Yes** **HPSA Name:** Low Income - Coos County **ID:**6414318289 **Designation Type:** HPSA Population **Status:** Designated **Score:**17 **Designation Date:**04/10/2008 **Last Update Date:**10/28/2017	HRSA- Rural Designation – Yes Location: Qualifies as a location that would be eligible under HRSA requirements to apply for Rural Health Grants.	This is a National Health Service Corps (NHSC) site; the area is a Health Professional Shortage Areas (HPSA) shortage area for medical, mental health, and dental. The need is greater for dental and mental health than for medical.
Location: Home Visits: CTCLUSI Members (Elders) **Secondary Site Location** **Site Name:** CTCLUSI Site	• Individuals who are tribal members of Confederated Tribes of Coos, Lower Umpqua & Siuslaw • Members who are eligible to be seen at CTCLUSI Dental Clinic • Individuals are who members of a federally recognized American Indian and/or Alaska Native tribe • Individuals eligible for services under Indian Health Services (IHS)	**Site Name & Description:** CTCLUSI Dental Clinic Indian Health Service (IHS) Dental Clinic (CTCLUSI Site). **Clinic Patient/Payment Source Demographics**: • 22% of individuals who identify as CTCLUSI • 14% of individuals who identify at Coquille • 51% of individuals who identify as Other Tribe (AI/AN)	**Private residence home visit** **In a Dental Health HPSA: Yes** **HPSA Name:** Low Income - Coos County **ID:**6414318289 **Designation Type:** HPSA Population **Status:** Designated **Score:**17 **Designation Date:**04/10/2008 **Last Update Date:**10/28/2017	HRSA- Rural Designation – Yes Location: Qualifies as a location that would be eligible under HRSA requirements to apply for Rural Health Grants	

[8] https://data.hrsa.gov/tools/shortage-area/hpsa-find
[9] List of Rural Counties and Designated Eligible Census Tracts in Metropolitan Counties, Updated Census 2010, HRSA
[10] https://www.hrsa.gov/rural-health/about-us/definition/index.html
[11] https://www.ohsu.edu/sites/default/files/2018-08/2018%20Area%20of%20Unmet%20Health%20Care%20Need%20Report.pdf
[12] https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_NHSC_SITE/NHSC_Appr_Site_List&rs:Format=PDF&theFilterType=region&theWhere=REGION_CD=%2710%27
[13] https://nhsc.hrsa.gov/downloads/nhsc-sites/nhsc-site-reference-guide.pdf
[14] https://datawarehouse.hrsa.gov/HGDWReports/OneClickRptFilter.aspx?rptName=NHSCAppSiteList
[15] https://www.ihs.gov/aboutihs/eligibility/
[16] https://www.ihs.gov/aboutihs/eligibility/

		• 33% of patients are Oregon Health Plan (Medicaid) recipients • 39% of patients are covered under Indian Health Services Contract Purchas of Care 6% of patients are spouses of AI/AN CTCLUSI or CIT members covered by tribal funds			
Location: Private home visits of CTCLUSI Members (New Mothers) **Secondary Site Location** **Site Name: CTCLUSI Site**	• Individuals who are tribal members of Confederated Tribes of Coos, Lower Umpqua & Siuslaw • Members who are eligible to be seen at CTCLUSI Dental Clinic Individuals are who members of a federally recognized American Indian and/or Alaska Native tribe • Individuals eligible for services under Indian Health Services (IHS)[17]	**Site Name & Description:** CTCLUSI Dental Clinic Indian Health Service (IHS) Dental Clinic (CTCLUSI Site) **Clinic Patient/Payment Source Demographics**: • 22% of individuals who identify as CTCLUSI • 14% of individuals who identify at Coquille • 51% of individuals who identify as Other Tribe (AI/AN) • 33% of patients are Oregon Health Plan (Medicaid) recipients • 39% of patients are covered under Indian Health Services Contract Purchas of Care • 6% of patients are spouses of AI/AN CTCLUSI or CIT members covered by tribal funds	**Private residence home visit** **In a Dental Health HPSA: Yes** **HPSA Name:** Low Income - Coos County **ID:**6414318289 **Designation Type:** HPSA Population **Status:** Designated **Score:**17 **Designation Date:**04/10/2008 **Last Update Date:**10/28/2017	HRSA- Rural Designation – Yes Location: Qualifies as a location that would be eligible under HRSA requirements to apply for Rural Health Grants	
Location: **• Daycare facilities including in-home and worksite daycare** **• Local/Tribal preschool and head start programs** **• Local/Tribal after school programs** **• Wellness fairs** **• Tribal events** **Secondary Site Location(s)**	• Individuals who are tribal members of Confederated Tribes of Coos, Lower Umpqua & Siuslaw • Members who are eligible to be seen at CTCLUSI Dental Clinic Individuals are who members of a federally recognized American Indian and/or Alaska Native tribe • Individuals eligible for services under Indian Health Services (IHS)[18]	**Site Name & Description:** CTCLUSI Dental Clinic Indian Health Service (IHS) Dental Clinic (CTCLUSI Site) **Clinic Patient/Payment Source Demographics**: • 22% of individuals who identify as CTCLUSI • 14% of individuals who identify at Coquille • 51% of individuals who identify as Other Tribe (AI/AN)	**Private residence home visit** **In a Dental Health HPSA: Yes** **HPSA Name:** Low Income - Coos County **ID:**6414318289 **Designation Type:** HPSA Population **Status:** Designated **Score:**17 **Designation Date:**04/10/2008 **Last Update Date:**10/28/2017	HRSA- Rural Designation – Yes Location: Qualifies as a location that would be eligible under HRSA requirements to apply for Rural Health Grants	

[17] https://www.ihs.gov/aboutihs/eligibility/
[18] https://www.ihs.gov/aboutihs/eligibility/

Site Name: CTCLUSI Site		• 33% of patients are Oregon Health Plan (Medicaid) recipients • 39% of patients are covered under Indian Health Services Contract Purchas of Care • 6% of patients are spouses of AI/AN CTCLUSI or CIT members covered by tribal funds			

Location Address (Site Name)	Target Population	Demographics of Site	Dental HPSA and Designation Type[19]	HRSA – Urban Area/Rural Area[20],[21],[22]	National Health Service Corps (NHSC) Approved Sites[23], [24],[25]
NARA Dental Clinic* 12750 SE Stark St. Building E, Portland, OR 97233 **Primary Site Location** (Native American Rehabilitation Association Site) ***Primary location**	• Individuals who are members of a federally recognized American Indian and/or Alaskan Native tribe • Individuals on Medicaid (OHP) • Individuals who are uninsured and low-income and have a household income equal to or less than 200% of the published Federal Poverty Guidelines (FPG) who qualify for reduced fee under HRSA sliding fee scale[26] - Full discount to individuals at or below 100% FPG - Sliding fee discount to individuals above 100% FPG and below 200% FPG	**Site Name & Description:** NARA Clinic (NARA Site) **Clinic Patient/Payment Source Demographics**: • 60% of patients are Alaskan Native/American Indian 90% if patients are Oregon Health Plan (Medicaid) recipients or HRSA funding	**Primary** **In a Dental Health HPSA: Yes** **HPSA Name:** Low Income-North/Northeast Portland **ID:**6413534196 **Designation Type:** HPSA Population **Status:** Designated **Score:**20 **Designation Date:**07/23/2018 **Last Update Date:**07/23/2018		
Montessori Title 7 Preschool Program 9325 N Van Houten Portland, Oregon 97203 Secondary Site Location (Native American Rehabilitation Association Site)	• Individuals who are members of a federally recognized American Indian and/or Alaskan Native tribe • Individuals on Medicaid (OHP) • Individuals who are uninsured and low-income and have a household income equal to or less than 200% of the published Federal Poverty Guidelines (FPG) who qualify for reduced fee under HRSA sliding fee scale[27] - Full discount to individuals at or below 100% FPG - Sliding fee discount to individuals above 100% FPG and below 200% FPG	**Site Name & Description:** Montessori Title 7 Preschool Program (NARA Site) **Clinic Patient/Payment Source Demographics**: • 60% of patients are Alaskan Native/American Indian • 90% if patients are Oregon Health Plan (Medicaid) recipients or HRSA funding	**In a Dental Health HPSA: Yes** **HPSA Name:** Low Income-North/Northeast Portland **ID:**6413534196 **Designation Type:** HPSA Population **Status:** Designated **Score:**20 **Designation Date:**07/23/2018 **Last Update Date:**07/23/2018		
NARA Adult Residential Treatment Center	• Individuals who are members of a federally recognized American Indian and/or Alaskan Native tribe	**Site Name & Description:** NARA Adult Residential Treatment	**In a Dental Health HPSA: No**		

[19] https://data.hrsa.gov/tools/shortage-area/hpsa-find
[20] List of Rural Counties and Designated Eligible Census Tracts in Metropolitan Counties, Updated Census 2010, HRSA
[21] https://www.hrsa.gov/rural-health/about-us/definition/index.html
[22] https://www.ohsu.edu/sites/default/files/2018-08/2018%20Area%20of%20Unmet%20Health%20Care%20Need%20Report.pdf
[23] https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_NHSC_SITE/NHSC_Appr_Site_List&rs:Format=PDF&theFilterType=region&theWhere=REGION_CD=%2710%27
[24] https://nhsc.hrsa.gov/downloads/nhsc-sites/nhsc-site-reference-guide.pdf
[25] https://datawarehouse.hrsa.gov/HGDWReports/OneClickRptFilter.aspx?rptName=NHSCAppSiteList
[26] https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html
[27] https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html

17645 NW St. Helens Highway, Portland, Oregon Secondary Site Location (Native American Rehabilitation Association Site)	• Individuals on Medicaid (OHP) • Individuals who are uninsured and low-income and have a household income equal to or less than 200% of the published Federal Poverty Guidelines (FPG) who qualify for reduced fee under HRSA sliding fee scale[28] - Full discount to individuals at or below 100% FPG - Sliding fee discount to individuals above 100% FPG and below 200% FPG	Center (NARA Site) **Clinic Patient/Payment Source Demographics**: • 60% of patients are Alaskan Native/American Indian • 90% if patients are Oregon Health Plan (Medicaid) recipients or HRSA funding			
Native American Youth and Family Center 5135 NE Columbia Blvd Portland, Oregon 97218 Secondary Site Location (Native American Rehabilitation Association Site)	• Individuals who are members of a federally recognized American Indian and/or Alaskan Native tribe • Individuals on Medicaid (OHP) • Individuals who are uninsured and low-income and have a household income equal to or less than 200% of the published Federal Poverty Guidelines (FPG) who qualify for reduced fee under HRSA sliding fee scale[29] - Full discount to individuals at or below 100% FPG - Sliding fee discount to individuals above 100% FPG and below 200% FPG	**Site Name & Description:** Native American Youth and Family Center (NARA Site) **Clinic Patient/Payment Source Demographics**: • 60% of patients are Alaskan Native/American Indian • 90% if patients are Oregon Health Plan (Medicaid) recipients or HRSA funding	**In a Dental Health HPSA: Yes** **HPSA Name:** Low Income-North/Northeast Portland **ID:**6413534196 **Designation Type:** HPSA Population **Status:** Designated **Score:**20 **Designation Date:**07/23/2018 **Last Update Date:**07/23/2018		
NARA Indian Health Clinic 15 N Morris Street Portland, Oregon 97227 Secondary Site Location (Native American Rehabilitation Association Site)	• Individuals who are members of a federally recognized American Indian and/or Alaskan Native tribe • Individuals on Medicaid (OHP) • Individuals who are uninsured and low-income and have a household income equal to or less than 200% of the published Federal Poverty Guidelines (FPG) who qualify for reduced fee under HRSA sliding fee scale[30] - Full discount to individuals at or below 100% FPG - Sliding fee discount to individuals above 100% FPG and below 200% FPG	**Site Name & Description:** NARA Clinic (NARA Site) **Clinic Patient/Payment Source Demographics**: • 60% of patients are Alaskan Native/American Indian • 90% if patients are Oregon Health Plan (Medicaid) recipients or HRSA funding	**Secondary Site HPSA Score:** **In a Dental Health HPSA: Yes** **HPSA Name:** Low Income-North/Northeast Portland **ID:**6413534196 **Designation Type:** HPSA Population **Status:** Designated **Score:**20 **Designation Date:**07/23/2018 **Last Update Date:**07/23/2018		

[28] https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html
[29] https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html
[30] https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html

NARA Outpatient Addiction Treatment Center 1634 SW Columbia Street, Portland, Oregon 97201 Secondary Site Location (Native American Rehabilitation Association Site)	• Individuals who are members of a federally recognized American Indian and/or Alaskan Native tribe • Individuals on Medicaid (OHP) • Individuals who are uninsured and low-income and have a household income equal to or less than 200% of the published Federal Poverty Guidelines (FPG) who qualify for reduced fee under HRSA sliding fee scale[31] - Full discount to individuals at or below 100% FPG - Sliding fee discount to individuals above 100% FPG and below 200% FPG	**Site Name & Description:** NARA Outpatient Addiction Treatment Center (NARA Site) **Clinic Patient/Payment Source Demographics**: • 60% of patients are Alaskan Native/American Indian • 90% if patients are Oregon Health Plan (Medicaid) recipients or HRSA funding	**Secondary Site HPSA Score:** **In a Dental Health HPSA: Yes** **HPSA Name:** Low Income-North/Northeast Portland **ID:**6413534196 **Designation Type:** HPSA Population **Status:** Designated **Score:**20 **Designation Date:**07/23/2018 **Last Update Date:**07/23/2018		
NARA Wellness Center 12360 E. Burnside, 2nd Floor, Portland, Oregon 97233 Secondary Site Location (Native American Rehabilitation Association Site)	• Individuals who are members of a federally recognized American Indian and/or Alaskan Native tribe • Individuals on Medicaid (OHP) • Individuals who are uninsured and low-income and have a household income equal to or less than 200% of the published Federal Poverty Guidelines (FPG) who qualify for reduced fee under HRSA sliding fee scale[32] - Full discount to individuals at or below 100% FPG - Sliding fee discount to individuals above 100% FPG and below 200% FPG	**Site Name & Description:** NARA Wellness Center (NARA Site) **Clinic Patient/Payment Source Demographics**: • 60% of patients are Alaskan Native/American Indian • 90% if patients are Oregon Health Plan (Medicaid) recipients or HRSA funding	**Secondary Site HPSA Score:** **In a Dental Health HPSA: Yes** **HPSA Name:** Low Income - Mid-Multnomah **ID:**6414480423 **Designation Type:** HPSA Population **Status:** Designated **Score:**14 **Designation Date:**11/30/1999 **Last Update Date:**10/28/2017		

[31] https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html
[32] https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html

Healthy Mouth, Healthy Start

IMPROVING ORAL HEALTH FOR YOUNG CHILDREN AND FAMILIES THROUGH EARLY CHILDHOOD HOME VISITING

BY MATTHEW MARIANI, LILIANA VELÁZQUEZ, AND JENNY KATTLOVE

The Children's Partnership

CHILDRENSPARTNERSHIP.ORG

Introduction

Good oral health is critical to children's ability to grow up healthy and succeed in school and life. Yet, nationally and in California, tooth decay ranks as the most common chronic disease and unmet health care need of children.[1] Poor oral health can lead to unnecessary pain and suffering, diminished academic outcomes, and poorer overall health over a lifetime.[2] Further, good oral health is also critical to the health of pregnant women and potentially linked to healthy birth outcomes.[3]

Early childhood home visiting programs, focused on the health and development of pregnant women and young children, can play a critical role in getting children off to a good start when it comes to oral health. Home visiting programs link pregnant women, young children, and parents with trained home visitors who come into their homes and provide coaching, education, and resources to improve their health and well-being. By bringing care into the home, children and families are more likely to get the care they need. Home visiting programs—because of their goals and the close and consistent contact home visitors have with families—provide an ideal opportunity for providing early preventive oral health education and services, while also linking families to needed oral health care.

However, the current role home visiting programs play in meeting the oral health needs of young children, pregnant women, and families is not well recognized. Nor are oral health elements of home visiting programs supported to the extent they could be. Drawing from interviews with leaders in the home visiting and oral health communities and a literature review, this issue brief examines how oral health is incorporated into the early childhood home visiting models that serve the largest number of young children in California: Healthy Families America, Nurse-Family Partnership, Parents as Teachers, Welcome Baby, and Early Head Start (home-based option). This brief makes the case for increasing efforts to promote oral health care in home visiting programs and strengthening the relationship between the home visiting community and the oral health community. Finally, it articulates recommendations for next steps for how home visiting programs can further address oral health disparities among young children and pregnant women.

The Oral Health Needs of California's Young Children and Pregnant Women

As mentioned, tooth decay is prevalent among California's children. The 2011 National Survey of Children's Health found that more than 22 percent of California's children had a dental problem in the last year, making California the 47th worst state in the nation for children's oral health status, with only four states performing worse.*[4] Further, 71 percent of children experience tooth decay by the time they reach the third grade, according to the most recent data available.[5]

Lack of access to oral health care is a major reason for poor oral health among children. While the utilization of oral health care is below optimal levels for many of California's children, certain groups, such as children enrolled in Medi-Cal and young children, face particular obstacles to getting needed oral health care services. In 2013, nearly 56 percent of children enrolled in Medi-Cal did not receive an oral health visit through the program.[6] Similarly, 57 percent of children, zero to three years old, in California had never been to a dentist.[7] In addition to there not being enough oral health care providers in communities where children enrolled in Medi-Cal live, many low-income families have trouble getting traditional office-based oral health care because they do not have affordable transportation, lose pay when they miss work, are juggling multiple jobs, and face other barriers to care.[8] Finally, many families

*The National Survey of Children's Health includes all 50 states and Washington, DC.

do not realize that their children have oral health care benefits or know how to use their coverage.[9]

Additionally, young children of color experience higher rates of dental decay and face additional obstacles in obtaining preventive oral health care. There is a lack of linguistically and culturally appropriate oral health care providers to serve communities of color as well as a lack of dentists working in areas that serve underserved and low-income communities of color.[10]

Poor oral health can disrupt normal childhood development and seriously damage overall health.[11] In addition, decay in primary teeth is a significant predictor of decay in permanent teeth, meaning that many children with poor oral health grow up to be adults with poor oral health.[12] Furthermore, dental disease impacts children's speech development and self-confidence, as well as their ability to eat, sleep, and learn and succeed in school.[13]

More than 22 percent of California's children had a dental problem in the last year, making California the 47th worst state in the nation for children's oral health status, with only four states performing worse.

Pregnant women in California also do not fare well when it comes to oral health. In one study, 52 percent of pregnant women revealed they experienced a dental problem, of which 62 percent were not receiving oral health care.[14] Poor oral health among pregnant women has been associated with low birth weights, stillbirths, and pre-term births. For example, periodontal disease can lead to premature labor.[15] Pregnancy may also result in increased dental decay because of the increased levels of acidity in the mouth, usually from morning sickness, along with the increased likeliness of teeth loosening due to increased hormone levels that affect the ligament and bone that support teeth.[16]

The primary reason many pregnant women do not get oral health care is that they do not perceive a need for the care. They are not aware of the importance of getting oral health care and, therefore, do not prioritize it. The second most common reason pregnant women do not get oral health care relates to financial barriers.[17]

Another leading factor causing pregnant women to not receive oral health care is the limited number of oral health providers available to treat pregnant women. Many dentists, for example, have not been trained to provide oral health care to pregnant women. While training programs have changed, many providers continue to hold on to the myth that they should not treat pregnant women because it is not safe.[18] In addition, many pregnant women enrolled in Medi-Cal do not realize that their coverage includes oral health benefits. The elimination of most adult oral health benefits from Medi-Cal in 2009 compounded this issue. Many oral health care providers were not aware that pregnant women continued to be eligible for oral health benefits under Medi-Cal, even while most other Medi-Cal-enrolled adults were ineligible for oral health benefits.[19] In short, an overall lack of understanding of the need for good oral health and care and the lack of providers willing to treat pregnant women, especially those enrolled in Medi-Cal, leads to too many pregnant women having poor oral health.

Maternal and child oral health problems are linked. Mothers with high levels of dental decay are more likely to pass on oral health disease to their children through saliva, which could easily occur through day-to-day activities.[20] Further, poor nutrition—such as drinking sugar-sweetened beverages and consuming sugary snacks—can also lead to dental decay concerns for both mother and child.[21]

The points outlined above highlight the critical need to focus attention on the oral health of young children and pregnant women to help ensure children start off right. Because early childhood home visiting programs target this population, they are a logical place to address this need.

What Is Home Visiting?

Early childhood home visiting programs are voluntary programs delivered by trained home visitors to support families and—in particular—pregnant women, parents, and young children. Home visiting programs are designed to serve specific demographic groups and high-need communities and/or to meet specific needs. Home visitors work with families in the home (or other community locations, as appropriate) and are trained to connect families to resources and help them develop the skills they need to raise children who are physically, socially, and emotionally healthy and ready to learn. In short, home visitors act as a social support, forming a strong relationship with the parent and helping to connect the parent and child with much-needed services.

There is a wide variety of early childhood home visiting models in existence, including the five models researched for this brief. Home visiting models often serve pregnant women, parents, and children with particular risk factors. Risk factors include, but are not limited to, domestic violence experience, low family income, lack of stable housing, low parental education, substance abuse in the family, a prevalence of depression or other mental health issues, first-time births among mothers, and/or living in communities selected by specific programs (e.g., First 5 LA's Best Start communities).[22] Families participate in home visiting programs voluntarily and are enrolled based on need and the child's age. The duration and frequency of home visits vary by model. Home visits can occur weekly or every other week, ranging from pregnancy through the child's fifth birthday, depending on the needs of the family and requirements of the model.

While home visiting programs have provided services to families for decades, they have recently enjoyed increased attention since the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program was established as part of the Affordable Care Act (ACA), committing $1.5 billion over five years to expand and improve state-administered home visitation.[23] MIECHV was reauthorized in March 2015, and funding will expire at the end of the 2017 federal fiscal year.

Home Visiting Programs in California

In California, various organizations implement a number of different early childhood home visiting programs to best meet the needs of the families in their communities, based on funding availability and the availability of program models in the community. Many of the programs implemented in California have demonstrated effectiveness in supporting child development and school readiness, improving positive parenting, decreasing child abuse and maltreatment, reducing low birth weights, and helping family functioning and economic self-sufficiency for California children.[24]

Home visiting programs in California are developed and funded through three primary sources:[*]

- Local First 5 Commissions[†] support services for 29,500 families across 42 counties;
- California Home Visiting Program (MIECHV) supports services for approximately 2,500 families in 24 counties; and
- Early Head Start supports about 1,998 families in 42 counties.[‡25]

The largest source of funding for home visiting programs in California is local First 5 Commissions, investing nearly $80 million in 2015.[26] Other sources of funding for home visiting, in addition to the ones listed above, include foundations, the Mental Health Services Act (MHSA), and local government funding.[27]

*We acknowledge the difficulty in obtaining exact numbers of families and children served per program given the various programs and funding streams in California and provide these numbers as an estimate.

[†] In 1998 California voters passed Proposition 10, adding a 50-cent tax to each pack of cigarettes sold to create First 5 California, also known as the California Children and Families Commission, to fund education, health services, child care, and other crucial programs for California's young children and their families. First 5 California distributes funds to local communities through the state's 58 individual counties, all of which have created their own local First 5 county commissions.

[‡] According to the California Head Start Association 2014–15 Program Statistics, 15,057 children ages 0 to 2 are served by Early Head Start (EHS), and 13.27 percent of all Head Start/EHS children are served in the home-based programs. We multiplied the total number of children served by EHS by the percent of all children served in the home-based program to estimate the number of children enrolled in EHS's home-based option (1,998).

Despite strong evidence of the long-term positive impacts of home visiting programs on children and families, funding limitations prevent these programs from reaching the hundreds of thousands of families in California that could benefit from such services. There are varying levels of access to home visiting programs in counties throughout California, and the estimated unmet need for home visiting programs is nearly 600,000 children, as indicated by their experience with one or more of the risk indicators.[28]

ORAL HEALTH ELEMENTS OF HOME VISITING PROGRAMS IN CALIFORNIA

Below are brief descriptions of the largest home visiting programs in California and how each incorporates oral health services.

Early Head Start

Early Head Start—a component of Head Start—is designed to serve pregnant mothers, newborns and children through age three who are at or below the federal poverty level or who are eligible for Part C services of the Individuals with Disabilities Education Act. Home visiting through Early Head Start consists of one 90-minute home visit per week and two group socializations per month with a trained professional who has an associate degree in infant-child development or comparable experience.[29]

Oral health care is a part of the early childhood health requirements of the Early Head Start program. For example, Early Head Start staff brush children's teeth or wipe the gums of infants under age one. In addition to providing oral health education to families, Early Head Start requires that programs track whether a child has oral health care insurance and a dental home as well as determine whether well-child exams are up to date (oral screening). They then connect families that need assistance to health coverage and oral health care. They also enter data indicating if pregnant women have had an oral health exam and if oral health treatment has started and has been completed. Finally, the program ensures that lesson plans include oral health.[30]

Healthy Families America

Healthy Families America (HFA) is designed to serve families with particular risk factors identified by local HFA sites. Families are enrolled prenatally or within the first three months of birth. Services are offered to families for a minimum of three years, and families can be enrolled in the program until the child is five years old. Providers trained in the HFA model visit families for an hour about once a week for the first six months after the child is born. Visits vary in frequency afterward.[31]

Healthy Families America addresses 12 critical elements, which are focused on the health and well-being of participating families. Based on these elements, implementing agencies can choose a curriculum that will best help their home visitors work toward these standards with the families they serve. Depending on the implementing agency and the curricular resources selected, the focus on oral health can vary. One of the elements relates to connecting families to health care and other services and includes standards for home visitors to provide information, referrals, and linkages to available health care and health care resources for all participating family members. This includes information on the importance of oral health care and referrals linking families to preventive services for oral health care, as appropriate.[32]

Nurse-Family Partnership

Nurse-Family Partnership (NFP) is designed for first-time, low-income mothers and enrolls mothers no later than their 28th week of pregnancy. Services are provided until the child turns two years old. Public health nurses conduct weekly home visits for the first month after enrollment and then every other week until the baby is born. Visits are then weekly for the first six weeks after the baby is born and then every other week until the baby is 20 months. The last four visits are monthly. Home visits typically last 60 to 90 minutes. The visit schedule may be adjusted to meet client needs.[33]

All NFP home visitors ask if families have had an oral health care visit, following guidance provided by the American Academy of Pediatrics (AAP). They are also trained to provide oral health education and services to families, as needed. NFP home visitors are all public health nurses with extensive training and health care knowledge, including the importance of good oral health practices. As such, they are able to assess any health care issues that a child or pregnant mother may have and, as nurses, are required to practice

to the full scope of their license.[34] Information is also collected if a child has seen a dentist at various points in the program, along with health records that track the outcome of any problems identified by the home visitor. [35]

Parents as Teachers

Parents as Teachers (PAT) is designed to serve families from pregnancy through kindergarten entry, with various eligibility criteria depending on the PAT program. The PAT model offers at least 12 home visits annually to families with high-need characteristics, as defined by the program. Families with two or more high-need characteristics—such as low income and history of child abuse in the family—receive at least 24 home visits annually. Home visits are with a provider trained in the PAT model and last approximately 60 minutes.[36]

Oral health is an essential element of the PAT model. PAT provides an evidence-informed curriculum for their home visitors, which addresses oral health care practices (frequency of brushing and flossing and type of toothbrush and toothpaste to use, as recommended by AAP). The parent educators provide easy-to-read parent handouts during visits, which are reviewed with the parents. These are in both English and Spanish. In addition, PAT-implementing agencies conduct ongoing health reviews with all families of which an oral health review is a part. From these reviews, home visitors make referrals to Medi-Cal enrollment and oral health care providers. Parent educators also address challenges that may impact the family getting to oral health care providers, such as transportation, distance, and oral care providers' office hours. The parent educator connects families to other resources to support the family and assists in problem solving the particular challenge.[37]

Welcome Baby

Welcome Baby is a locally developed program of First 5 LA that has expanded to 14 hospitals in Los Angeles County. All families delivering at a Welcome Baby-participating hospital in a Best Start community (14 communities where First 5 LA has focused community-building efforts) are offered up to nine visits: three Welcome Baby visits occurring prenatally, one at the hospital, and five offered at home, once the baby is born.[38] Families identified as needing more focused support are referred to First 5 LA-funded HFA or PAT programs for more intensive home visiting services.

One of the focus areas of the Welcome Baby model is facilitating connections to other services and resources, including connections to oral health coverage through Medi-Cal and oral health care providers. Beyond referral, home visitors are able to advocate on behalf of families. In the case of the implementing agency interviewed for this brief, an oral health advocate is able to step in to assist families that are facing particular barriers to accessing oral health care; however, not all Welcome Baby-implementing agencies have an oral health advocate as a resource. Welcome Baby visitors also ask families during their intake whether they have seen a dentist within the last 12 months and, during subsequent appointments, check with families to see if they have been to the dentist since the initial intake.[39]

The Role of Home Visiting in Meeting Oral Health Care Needs

Since early childhood home visiting programs are fundamentally concerned with the health and well-being of young children, when feasible, they are a logical place to increase a focus on oral health. Further, the strategies that are used to achieve results in home visiting programs—such as early intervention, anticipatory guidance, and education—can be effective in improving children's oral health. In fact, there is increased attention to the fact that early childhood caries (i.e., tooth decay) is, indeed, a chronic disease and should be treated using chronic disease management tools, including parent education, family engagement, adoption of beneficial behaviors, and community and health system support.[40]

In the United Kingdom, for example, a study of a home visiting program—focused specifically on oral health—showed a reduced level of dental disease in participating children as a result of the oral health education provided to mothers by home visitors.[41] Mothers in the study that were provided with basic oral health information, such as using fluoride toothpaste twice a day, along with being given the opportunity to ask questions of a trained home visitor, showed improved oral health for themselves, as well.[42]

Another study demonstrated that anticipatory guidance provided to first-time mothers during pregnancy and after the child's birth showed a lower incidence of dental caries in the women's young children.[43] Finally, a study of a Virginia program that provides in-home preventive dental services and oral health literacy education for parents found that Medicaid-enrolled children in the program were three times more likely to have at least one dental visit than Medicaid-enrolled children not in the program. This evidence suggests that increasing parents' oral health literacy and exposing them to preventive oral health practices played a role in encouraging families to seek care.[44]

Because of the unique role home visiting models play in reaching newborns and their mothers, they can play a vital role in oral health disease prevention.

Home visiting also helps address the issue that many families face socioeconomic barriers to getting critical oral health care services.[45] To address this, the Institute of Medicine recommends bringing oral health care services to families in the community—such as at their home.[46]

In addition, there is growing recognition that the dentist is not the only provider that can address children's oral health needs. A team approach is necessary to provide the comprehensive oral health education, care management, and treatment families need. Home visitors can and should be an integral member of the team.

Further, because of the unique role that many home visiting models play in reaching newborns and their mothers at a very early point in the child's development, they can play a vital role in oral health disease prevention, helping to set young children on a positive trajectory for good oral health later in life. Moreover, home visiting models have the added advantage of serving both the parent and child, meaning the benefits of improved oral health extend to two generations. Home visitors simply have a greater amount of contact with families than a traditional oral health care provider, giving time for more impactful lessons and reinforcement.

Finally, from a systems perspective, strengthening the role home visiting programs play as part of the oral health care delivery system makes sense. It is well known that California—as well as other states—has a severe lack of providers that treat children enrolled in Medi-Cal.[47] As mentioned above, not all oral health services are required to be provided by a dentist. By having home visitors (and other appropriate community-based providers) assess risk for oral health disease and provide education and preventive oral health services to children and families, dentists can focus on restorative and other services only they can provide. For example, in the San Mateo County Early Head Start program, the University of the Pacific has trained home visitors to assess oral health risk of young children and refer high-need children to an oral health provider. By maximizing the role of both oral health providers and home visitors, we can begin to build a system where each provider can work at the top of his or her expertise and education, making the most efficient use of our workforce and ensuring children and families get the appropriate care they need, when they need it.

It should be noted that, while the home visiting programs reviewed for this brief all recognize the important role good oral health plays in improved overall health and well-being for traditionally underserved families, each home visiting model is unique. Increasing the emphasis on oral health will depend on the requirements of each home visiting model, the needs of the target population, and the resources available. Additionally, any added emphasis on oral health care in home visiting models will need to take into account the importance of maintaining fidelity to the home visiting model. In other words, it is important to pay attention to the overall goals of each home visiting program and how oral health activities can be incorporated so as to not overburden home visitors or compromise the program's integrity.

The Opportunity Now to Strengthen Oral Health Care in Home Visiting Programs

Over the past several years, there has been increased recognition of the importance of good oral health care for children and adults in California. Additionally, a number of efforts have been implemented to address the fact that the utilization of oral health care services among California's underserved children is among the worst in the nation.[48]

For example, the 2016–17 State Budget restored funding to the California Children's Dental Disease Prevention Program (CCDDPP), which provides oral health education and prevention services to children in schools. In 2014, Governor Brown signed Virtual Dental Home legislation to allow dental hygienists and specified dental assistants to provide more care in community settings, such as school and Head Start sites, while requiring Medi-Cal to pay for teledentistry so providers can seamlessly collaborate with an off-site supervising dentist to provide care.

The State also included a Dental Transformation Initiative (DTI) in the most recent Medi-Cal Waiver* to improve the delivery of oral health care to children enrolled in Medi-Cal. The DTI aims to reward oral health care providers for providing preventive, risk-based, and continuous oral health care to children enrolled in Medi-Cal and to pilot innovative ways to bring oral health care to Medi-Cal-enrolled children in community settings.

To improve the oral health of pregnant women, the California Department of Public Health was recently awarded a federal Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Expansion Grant. Focused on Sonoma County, the goal of this project is to reduce the prevalence of oral disease in high-risk pregnant women and infants through improved access to quality oral health care.[49]

Finally and critically, for the first time in decades, California has a state Dental Director. The Dental Director is charged with developing and implementing a statewide oral health plan, establishing prevention and oral health education projects, and working to secure funding for prevention-focused oral health programs, particularly for children.

Home visiting programs have similarly seen increased attention through the inclusion of MIECHV in the ACA and First 5 County Commissions' investment in home visiting programs locally. And, as mentioned, these programs recognize the importance of good oral health to improve the health and lives of pregnant women, children, and families.

These events provide us with a window of opportunity now to identify how the oral health and home visiting fields can come together and better reach children at the earliest point possible with preventive oral health care through home visiting programs.

Recommendations for Next Steps

As this brief suggests, home visiting programs are engaged in efforts to improve the oral health of pregnant women, young children, and families. However, representatives from programs reviewed for this brief also recognized that more could be done. At the same time, each home visiting program is tailored to meet the unique needs of the families they serve, and the importance of such tailoring should be recognized. Therefore, recommendations for improvements must allow for flexibility so that home visiting programs can remain true to their core principles.

Provide home visitors with the training and resources they need to incorporate oral health practices into their activities.

While most home visiting programs offer curricula related to oral health, it is also important that home visitors have access to resources to help them better

*The 1115 Waiver Renewal is also called the Medi-Cal 2020 Waiver.

understand oral health care practices and policies. For example, one way to expose home visitors to the basics of preventive oral health care, including what activities are appropriate for various ages of children and pregnant women, is to incorporate oral health education into other educational opportunities, materials, and training curricula offered to home visitors.

Further, home visitors need assistance in connecting children, pregnant women, and families to appropriate care. For example, one of the implementing agencies of the Welcome Baby program engages additional staff to help to address individual families' barriers to care in emergency or more complicated cases as well as connect home visitors to up-to-date resources related to oral health care.[50] Early Head Start programs, as a part of Head Start, have access to resources secured by the Head Start program, such as local dentists that may have an agreement to serve the children in the Head Start program and nurses or health coordinators that serve the broader Head Start program.[51]

In addition, just like the other services home visitors connect to, home visitors need relationships with oral health care providers to which they can make referrals. This can be especially difficult, given the lack of oral health care providers that treat women and young children enrolled in Medi-Cal. Many low-income families do not have the time or resources to follow up on referrals, especially if those referrals are not welcoming. Therefore, home visiting programs need support in building and maintaining ongoing relationships with linguistically, culturally, and otherwise appropriate oral health care providers to whom home visitors can connect families.

Collect oral health data.

Better collection of both process data (e.g., referrals to an oral health care provider) and outcomes data (e.g., caries in children over the course of their time in the program) will allow for models to better understand how they are impacting the oral health of pregnant women and young children and to refine their methods over time. And data collection helps to build the evidence base for home visiting models in addressing oral health issues as well as secure funding sources to incorporate oral health practices into home visiting programs. Data will also help to establish how home visiting programs fit into the larger community system of meeting the oral health care needs of underserved families.

Home visiting programs should come together with oral health data experts, state and federal decision-makers, and other relevant stakeholders to create recommendations for standardized data measures to implement across programs, as appropriate; identify financial and technical support for such data collection; and identify systems for using such data to inform continuous quality improvement by home visiting programs.

Create stable funding streams for home visiting.

While a broader recommendation not specific to oral health, if home visiting programs are not sustainable and cannot reach the number of families that could benefit, there will be a huge missed opportunity for California families to reap the long-term benefits that home visiting programs have proven to deliver, including in oral health care. California should consider the use of General Fund revenues, as other states have already done for home visiting programs, to support current programs and increase the number of home visiting spots available to families.[52]

California should also seek more sustainable financing of home visiting by maximizing Medicaid dollars. For instance, South Carolina recently received permission from the Centers for Medicare and Medicaid Services to conduct a pilot program, using section 1915(b) waiver authority, to pay for home visiting using the NFP model.[53] In addition, recent federal changes to Medicaid regulations clarify that states can reimburse for preventive services "recommended by a physician or other licensed practitioner…within the scope of their practice under State law."[54] This change creates an opportunity to provide Medicaid reimbursement for preventive services staffed by a broad array of health professionals, including home visiting program staff.[55] Innovative uses of Medicaid and state financing are key to increasing the number of home visiting spaces available and to reaching more children with these proven home visiting models.[56]

Community-based oral health programs can also be a source of funding to contribute to the funding of home visiting programs to pay for an oral health component. In other words, if a community is seeking funding to address the oral health needs of pregnant women and children, they can dedicate funds to home visiting programs to support the oral heath activities of those programs.

Conclusion

As California looks to transform its oral health care delivery system for underserved children through the statewide oral health plan as well as changes to the Medi-Cal program, we have a moment of opportunity to make sure early childhood home visiting is part of the solution. The activities home visitors engage in with families mirror those needed to help improve the oral health of young children and pregnant women. In addition, delivering preventive oral health education and care early on in life is critical to preventing oral health problems later in life. As such, home visitors are in an ideal position to make a real difference in the oral health of California's most vulnerable children. With investment and support from California leaders, this potential can become a reality.

The Children's Partnership is a California-based nonprofit children's advocacy organization committed to improving the lives of children where they live, learn, and play. Our mission is to better the health and well-being of underserved children through strong community partnerships, forward-looking research, and informed policy. We build meaningful partnerships with communities and decision-makers to provide a powerful voice for children and champion programs and policies that break down barriers to advancement. Since 1993, TCP has been a leading voice for children and a critical resource for communities across California, working every day to provide all children with the resources and opportunities they need to thrive.

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- LA Best Babies Network
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- Parents as Teachers

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Why Oral Health Matters

Oral health is an important part of a person’s overall health and well-being. Pain caused by tooth decay (cavities) and other oral health problems can dramatically affect an individual’s everyday activities and reduce their quality of life. Further, evidence-based studies have shown the link between oral health and various health conditions, including diabetes and heart disease. Although oral disease is one of the most common and preventable health problems, achieving oral health requires effective prevention measures and access to treatment. In the United States, cost and limited access to dental care heavily impact the poor and other underserved populations. It also underscores the “silent epidemic” of oral health problems affecting these vulnerable populations.[i

Migrant and seasonal farmworkers (MSFWs) are a medically underserved population with limited access to dental care.[ii Oral health is ranked as one of the major health problems of the farmworker community; yet, it is also one of the unmet needs in farmworker health services.[iii The lack of access and cost of dental services are reported to be the primary barriers to oral health care for farmworkers. These barriers often result in farmworkers seeking care for emergencies, rather than prevention services. Since oral health education is not normally provided during emergency care, opportunities are being missed where information on prevention could be shared such as those given during a routine visit with a dental provider.[iv Thus, more efforts to promote oral health and prevent oral disease are needed for the farmworker community.

Given the scope of community health centers reach within communities, their outreach programs, especially the outreach workers, can play a crucial role in providing prevention information on oral health and linking farmworkers and their families to dental services. Outreach workers are viewed as a trusted resource in the community. An outreach program that integrates oral health into its clinical model can serve to encourage oral hygiene and other healthy lifestyle behaviors, increase the use of prevention services, and lessen the risk of oral disease among the farmworker population.

Oral Health

Oral health allows us to eat, speak, swallow, smile, and engage in other daily activities and social interactions that are important to our overall well-being and quality of life. According to the U.S. Surgeon General’s Report: Oral Health in America, oral health means more than having healthy teeth, and includes being free of pain in the mouth and face, tooth decay, tooth loss, oral infections, sores and cancers, and other diseases and disorders. Additionally, research has shown the link between oral health and other chronic diseases, such as heart disease and diabetes.[v As a result, the World Health Organization (WHO) integrated oral health into its prevention efforts for chronic diseases. Oral exams can also help to detect nutritional deficiencies, microbial infections, and some cancers.[vi

Prevention is one of the most important strategies to achieve oral health. By adding fluoride to the public water supply, the U.S. saw a significant decrease in the rates of cavities in the general population. Individuals can also take preventive measures such as: maintaining daily oral hygiene, including brushing and flossing; engaging in healthy lifestyle behaviors, such as reducing the amount of sugar intake and stopping smoking; and getting routine dental exams and cleanings. Health providers can provide oral health education and work to ensure that patients have access to dental services.

Oral Health Disparities

Public health efforts in the United States have resulted in improving the oral health of the general population. However, disparities in oral health still remain a major public health problem today, especially for poor and underserved populations. Although 73.9% of the U.S. population receives fluoridated water, there are still about 104 million people who do not.[vii More than 40% of poor adults (20 years and older) have at least one untreated decayed tooth compared to 16% of non-poor adults.[viii Data from the National Health and Nutrition Examination Survey, 2009-2010 (NHANES) show that approximately one in four children aged 3-9 years living in poverty had untreated dental caries (tooth decay or cavities). For every adult 19 years or older with medical insurance, there are three without dental insurance.[ix 40% of Latino adults reported not seeing a dentist within the last year, and Latino adults are less likely to have visited a dentist within the past five years than White and African American adults.[x

For migrant and seasonal farmworkers, research shows worse oral health outcomes than compared to the general population. In the U.S., 31% of all adults (18 years and older) reported not seeing a dentist in the last year. Of farmworkers surveyed in North Carolina, 80% reported not receiving dental services within the last year; yet various oral health problems were frequently reported such as tooth decay (52.3%), sensitivity (40.4%) and missing teeth (32.5%).[xi In a study of farmworkers in southern Illinois, the majority of farmworkers have never or inconsistently received oral care.[xii From the collective data about farmworkers and oral

health, the barriers most cited have been cost, time, transportation and limited access to dental services. Additionally, there are not enough comprehensive oral health services available to serve the needs of farmworkers. Often times, migrant health centers that offer some type of dental services may not be adequately staffed, have limited clinic hours, and/or long waiting lists for care.[xiii Emergency care was identified as the most typical response to oral health problems. Thus, farmworkers are seeking care only when they have pain or other severe symptoms. Children of farmworkers generally have better oral health than their parents, but in comparison to the U.S. child population, they suffer from worse oral health outcomes.[xiv In many cases, oral health problems remain untreated, which results in chronic pain and in some cases, lead to severe health outcomes in the future. Further, the adverse effects of oral health problems can also impact farmworkers' ability to work, which results in the loss of hours of work.

The role of outreach in promoting oral health

For community health centers, outreach workers can play an important role in providing health education on oral health and linking farmworkers and their families to dental services. In Salinas, CA, Clínica de Salud del Valle de Salinas developed an integrated clinical outreach model where three full-time staff members provide health education classes, chronic disease management, oral health screenings, and vaccinations in outreach settings. Through this expanded clinical outreach model, farmworkers and their families receive much-needed oral health care in addition to other preventive health services in the fields, at schools, and during community events. Further, many oral health problems can be addressed by basic prevention measures, such as daily brushing and flossing, maintaining a healthy diet, and getting routine check-ups with the dentist. As outreach workers are viewed as a trusted resource in the community, they are in a good position to promote prevention. Finally, studies show that farmworkers will utilize oral health services when they are affordable and available. In one study, the availability of comprehensive dental services showed better oral health for farmworker children.[xv The outreach program of Cherry Street Health Center in Grand Rapids, MI worked with the health center to develop an affordable after-hours dental clinic, including extended emergency dental walk-in hours during the weekdays. By expanding dental clinic hours, Cherry Street responded to the needs of the farmworker community and ensured that oral health services are available. Outreach is integral in ensuring that oral health services can be accessed by farmworkers and their families, and outreach workers can encourage healthy lifestyle behaviors, increase the use of prevention services, and lessen the risk of oral disease among the farmworker population.

Conclusion

Although oral diseases are a major public health problem, oral health often gets overlooked when setting health priorities. Even at the individual level, oral health may not be seen as important as other health or daily life needs. However, evidence continues to grow showing the impact of oral health on the overall health and well-being of the population. In fact, the Department of Health and Human Services (HHS) has selected oral health as one of the 12 Leading Health Indicators (LHIs) for Healthy People 2020, the 10-year national objectives for improving the health of all Americans. Thus, oral health needs to be continually included in health promotion and prevention efforts with particular attention to underserved populations, such as migrant and seasonal farmworkers. Outreach workers can help to bridge the gap and increase the use of prevention measures and oral health services.

HOP Tip: For more details on the outreach practices mentioned in the article, please visit HOP’s website for our resources on Innovative Outreach Practices available at: http://web.outreach-partners.org/resources/iop .

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[ii Quandt, S.A., Hiott, A.E., et al. (2007). Oral Health and Quality of Life of Migrant and Seasonal Farmworkers in North Carolina. Journal of Agricultural Safety and Health. 13(1): 45-55.

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[iv Lombardi, G.R. (2002). Dental/Oral Health Services. Migrant Health Issues, Monograph Series, 1, 1-8.

[v Petersen, P.E., Bourgeois, D. , et al. (2005). The global burden of oral diseases and risks to oral health. Bulletin of the World Health Organization. September 2005, 83 (9).

[vi U.S. DHHS. 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. Available at: http://silk.nih.gov/public/hck1ocv.@www.surgeon.fullrpt.pdf . [Accessed September 11, 2012].

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[viii Centers for Disease Control. (2006). Oral Health for Adults. Available at: http://www.cdc.gov/oralhealth/publications/factsheets/adult.htm . [Accessed September 11, 2012].

[ix National Center for Farmworker Health, Inc. (2009). Oral Health. Available at: http://www.ncfh.org/docs/fs-ORAL%20HEALTH%20FACT%20SHEET.pdf . [Accessed August 30, 2012].

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[xi Quandt, S.A., Hiott, A.E., et al. (2007). Oral Health and Quality of Life of Migrant and Seasonal Farmworkers in North Carolina. Journal of Agricultural Safety and Health. 13(1): 45-55.

[xii Lukes, S.M., Miller, F.Y. (2002). Oral Health Issues among Migrant Farmworkers. The Journal of Dental Hygiene. 76(2): 134-40.

[xiii Lombardi, G.R. (2002). Dental/Oral Health Services. Migrant Health Issues, Monograph Series, 1, 1-8.

[xiv Quandt, S.A., Hiott, A.E., et al. (2007). Oral Health and Quality of Life of Migrant and Seasonal Farmworkers in North Carolina. Journal of Agricultural Safety and Health. 13(1): 45-55.

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Outreach and Education Model

Rural communities are developing outreach and education programs that use curricula, tools, and media to increase community member knowledge and awareness of oral health. Community outreach and education programs may also occur in dental clinics (see Dental Clinic Model (/toolkits/oral-health/2/dental-clinic-model)). Examples of rural oral health outreach and education activities include:

- Hosting a dental booth at a community health fair
- Identifying champions providers in peer groups to increase awareness of oral healthcare challenges in their communities
- Working with community health workers to conduct education on oral health self-care and preventive care in order to reduce emergency department visits
- Providing teachers with access to ongoing technical assistance on pediatric oral health issues
- Educating providers about the importance of oral examinations of infants and toddlers
- Conducting outreach to hard-to-reach populations such as migrant farm workers
- Working with the Women, Infants, and Children and Head Start programs (https://www.acf.hhs.gov/ohs/about/head-start) to include a dental education component

Rural oral health programs that focus on outreach and education may partner with Area Health Education Centers (/resources/3614), local health departments, schools, day care centers, tribes, and Head Start programs (https://www.acf.hhs.gov/ohs/about/head-start).

Implementation considerations

Rural oral health programs use culturally appropriate outreach and education strategies. Educational materials may be translated into different languages. Outreach may occur at churches, stores, and community centers.

Resources to Learn More

Community Health Access Project Pathways Model (https://innovations.ahrq.gov/profiles/program-uses-pathways-confirm-those-risk-connect-community-based-health-and-social-services)
Website
This website describes the Pathways Model, implemented by Community Health Access Project, for community-based outreach. The program focused on low birth weight babies but could be adapted to focus on oral health.
Organization(s): Community Health Access Project

Into the Mouths of Babes Toolkit (https://publichealth.nc.gov/oralhealth/partners/IMB-toolkit.htm)
Website
The *Into the Mouths of Babes* program trains medical providers to deliver preventive oral health services to high-risk children.
Organization(s): North Carolina Department of Health and Human Services

Oral Health Education Materials for Children (http://dphhs.mt.gov/publichealth/oralhealth/OHSchool-based.aspx)
Website

This website provides oral health education materials for children in first through fifth grade.
Organization(s): Montana Department of Public Health and Human Services - Oral Health Program

Smiles for Life: A National Oral Health Curriculum (http://www.smilesforlifeoralhealth.org/)
Tutorial/Training
Smiles for Life is a national comprehensive oral health curriculum. This curriculum is designed to enhance the role of primary care clinicians in the promotion of oral health for all age groups through the development and dissemination of high-quality educational resources. The curriculum contains educational modules for physicians, nurses, and physician assistants.
Organization(s): Society of Teachers of Family Medicine Group on Oral Health, DentaQuest Foundation, Washington Dental Service Foundation, Connecticut Health Foundation

Previous Page: Access to Medicaid Model (/toolkits/oral-health/2/access-to-medicaid-model)

Next Page: Oral Health-Primary Care Integration Model (/toolkits/oral-health/2/primary-care-integration-model)

RELATED RHIhub CONTENT

- Oral Health in Rural Communities Topic Guide (/topics/oral-health)

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Module 1: Oral Health in Rural Communities

Oral health is an integral component of an individual's health and well-being. Research demonstrates that poor oral health is related to a range of diseases. Access to oral healthcare services and having routine examinations can help to prevent disease and identify other related conditions. Rural communities experience disparities related to access to care, utilization of services, and outcomes in oral health. This module provides an overview of oral health in rural America.

In this module:

Previous Page: Rural Oral Health Toolkit (/toolkits/oral-health)

Next Page: Current State (/toolkits/oral-health/1/rural-oral-health-overview)

RELATED RHIhub CONTENT

- Oral Health in Rural Communities Topic Guide (/topics/oral-health)

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Module 2: Rural Oral Health Program Models

This section provides information and resources about different rural oral health program models.

To learn how to identify and adapt interventions, see Developing a Rural Community Health Program (/toolkits/rural-toolkit/2/developing-programs) in the Rural Community Health Toolkit.

Rural communities are implementing different oral health program models. The program models are not mutually exclusive. Some programs may apply a combination of these approaches.

- Workforce Model (/toolkits/oral-health/2/workforce-model)
  Workforce models focus on recruiting and retaining dental professionals in rural areas.
- Allied Health Professional Model (/toolkits/oral-health/2/allied-health-model)
  The allied health professionals model focuses on the different roles that these professionals play such as providing dental care, education services, and referral, screening, and support services.
- Access to Medicaid Model (/toolkits/oral-health/2/access-to-medicaid-model)
  The access to Medicaid model focuses on expanding access to Medicaid through community-based strategies.
- Outreach and Education Model (/toolkits/oral-health/2/outreach-and-education-model)
  Rural communities are developing community-based outreach and education programs to expand access to oral healthcare.
- Oral Health Primary Care Integration Model (/toolkits/oral-health/2/primary-care-integration-model)
  Rural communities are using different strategies to integrate oral health and primary care.
- School-Based Model (/toolkits/oral-health/2/school-based-model)
  Rural communities are implementing school-based oral health programs that provide fluoride varnish and dental sealants.
- Dental Clinic Model (/toolkits/oral-health/2/dental-clinic-model)
  Rural oral health programs are developing dental clinics that provide safety net care to individuals in order to increase access to care and reduce reliance on emergency services.
- Mobile Dental Services Model (/toolkits/oral-health/2/mobile-dental-services-model)
  The mobile dental services model focuses on providing access to dental care, preventive healthcare, and chronic disease screening and management services.
- Dental Home Model (/toolkits/oral-health/2/dental-home-model)
  The dental home model emphasizes wellness through improved oral health status, increased collaboration among providers, and the promotion of health education for adults and children.
- Eligibility and Enrollment Model (/toolkits/oral-health/2/eligibility-and-enrollment-model)
  Rural communities are using eligibility and enrollment models to expand access to oral health services.
- Community Fluoridation Model (/toolkits/oral-health/2/community-water-fluoridation-model)
  Community water fluoridation is a model public health intervention used to prevent tooth decay.

Also in this module:

- Guidelines for Rural Oral Health Programs (/toolkits/oral-health/2/program-guidelines)
- Populations Served (/toolkits/oral-health/2/populations-served)
- Adapting Programs to Serve Your Community (/toolkits/oral-health/2/adapting-programs-to-your-community)

Previous Page: Program Partners (/toolkits/oral-health/1/program-partners)

Next Page: Workforce Model (/toolkits/oral-health/2/workforce-model)

RELATED RHIhub CONTENT

- Oral Health in Rural Communities Topic Guide (/topics/oral-health)

This website provides oral health education materials for children in first through fifth grade.
Organization(s): Montana Department of Public Health and Human Services - Oral Health Program

Smiles for Life: A National Oral Health Curriculum (http://www.smilesforlifeoralhealth.org/)
Tutorial/Training
Smiles for Life is a national comprehensive oral health curriculum. This curriculum is designed to enhance the role of primary care clinicians in the promotion of oral health for all age groups through the development and dissemination of high-quality educational resources. The curriculum contains educational modules for physicians, nurses, and physician assistants.
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RELATED RHIhub CONTENT

- Oral Health in Rural Communities Topic Guide (/topics/oral-health)