21st Century Solutions for Dental Care Access

Report

Fall 2020

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A Message from Brad Hester, DMD, President of the Oregon Dental Association

At the core of dentistry is a desire to take care of people. Whether in a public health clinic, private practice, mobile dental van, senior living facility or school-based setting, dentists provide high-quality health care to Oregonians every day.

This work has become even more important during the pandemic. We know regular dental visits help to reduce the number of people seeking treatment in emergency and urgent care facilities, freeing our hospital systems to focus on diagnosing COVID-19 and saving lives.

Our confidence in the safety of dental care was recently affirmed with the release of the first large-scale report on national rates of COVID-19 and protection and control practices among dentists, which found that fewer than 1 percent of dentists were diagnosed with the novel coronavirus after clinics began reopening in spring 2020. This means our heightened infection controls, and attention to patient and dental team safety, are working.

Dentists have embraced new ways of connecting with patients, such as through teledentistry. And thanks to legislation the Oregon Dental Association proposed and won in 2019, dentists with appropriate training are now able to administer flu shots and other vaccines. Once an approved COVID vaccine is available, dentists will be able to help deploy it across the state.

We have expanded our abilities to meet Oregonians' needs in this challenging time, and yet, there's much more to be done.

At a time when access to health care is more critical than ever, our state faces funding cuts to Medicaid dental benefits, a crucial safety net for vulnerable Oregonians. With limited resources, our state leaders must focus on proven solutions providing Oregonians with high-quality care, such as integrated and school-based services, and support dentists who accept Medicaid patients or operate in remote, rural and other underserved communities. We must also take practical steps to ensure we remain eligible for federal dollars by funding our vacant state Dental Director position.

In all of our efforts, we must continue to center equity. We must raise the floor for underserved communities, not lower it. In past legislative sessions, the ODA supported legislation aiming to expand community dental health coordinators, enhancing ethnic, racial and linguistic diversity and inclusion in our field, and, in 2021, we are supporting a Tribal Scholarship for Equity in Dental and Medical Education. This exciting bill will allow members of Oregon Tribes to attend graduate programs at Oregon Health & Science University tuition-free and join the next generation of dentists and medical doctors in our state.

It's time to invest so all Oregonians have access to equitable health care when they need it most. Together we're making great strides in unprecedented times, and together dentists will continue working on solutions that truly help all Oregonians.

Executive Summary

Oral health is essential to overall health. Healthy teeth and gums are critical components of a person's overall physical health, well-being and quality of life. Good personal oral hygiene habits and regular visits to the dentist may also help people manage the severity of chronic health conditions like type 2 diabetes and kidney disease.

Understanding this, Oregon has consistently demonstrated strong public commitments and investments in oral health care access. Oregon's commitment to Oregon Health Plan (Medicaid) funding for preventative dental care has resulted in healthier lives and improved outcomes for patients, while the state itself has enjoyed decreased financial burdens as patients are better able to avoid the costlier treatments that arise following neglect. Oregon also has a unique, multi-tiered dental care delivery system that has helped to facilitate access for an increasingly diverse population. In Oregon, for example, patients may access dental care through a system that includes private clinics and offices, larger corporate facilities, public health centers and Coordinated Care Organizations. Coordinated care, relatively new in Oregon, is widely accepted as a critical tool to overcome gaps in access, affordability and quality of care.

Oregon's dentists have also been on the frontlines to deliver access solutions. In recent years, Oregon dentists have led advocacy efforts for community dental health coordinators, services for underserved children, school-based dental screenings, and promotion for access to vaccines and diabetes screenings. And when the COVID-19 crisis struck in 2020, Oregon's dentists led the way in donations of essential equipment to hospitals and frontline health workers, while ensuring statewide access to emergency and urgent dental care.

Yet despite Oregon's success in supporting dental care access, facilitating positive patient outcomes and providing quick action to alleviate burdens caused by the COVID pandemic, significant challenges remain. Oregon trails behind neighboring California and Washington in outcomes for seniors, for example. Also, Black children and other children of color, along with lower-income families, disproportionately endure poorer oral health outcomes and receive fewer preventive services. This is not acceptable. And despite efforts to alleviate access challenges, certain rural communities in Oregon continue to face access obstacles.

It must also be noted that affecting all of this for the next few years will be the extraordinary financial and state budget challenges caused by the COVID-19 crisis. Greater statewide needs and fewer available dollars mean that every challenge becomes more daunting. All parties will have to work harder, more creatively and more collaboratively to assure the access that Oregonians deserve and expect.

To do this, access barriers must be overcome. Barriers that include not only geographic or structural impediments, but also personal barriers like the avoidance of adequate dental care due to fear, inconvenience or cost. Part of the solution is structural. Dental offices must be convenient to access for every Oregonian. Part of the solution is also affordability. The state must continue dental care support for its Medicaid populations while also ensuring that provider reimbursements adequately cover the cost of care.

Finally, part of the solution is ingenuity and creativity. This may include everything from rural and Tribal scholarships for dental students, to expanded dental services in schools and community dental clinics in senior facilities, and even to renewed conversations about fluoridated water, so long as we focus on evidence-based solutions that improve health outcomes and access without lowering standards for any underserved community.

When planning for Oregon's oral health future (and to paraphrase a great American statesman), we must see that as the case is new, we must think anew and act anew. We must disenthrall ourselves.

Summary of Challenges

A brief summary of pressing dental care challenges faced by Oregonians includes:

- Medicaid is underfunded, resulting in access issues for Medicaid patients
- Private dental insurance does not pay enough for many services and has increasingly shifted the burden of cost to patients
- COVID-19 has increased the cost of delivering dental care
- COVID-19 has led to delays in patients receiving services, and practices now see fewer patients because of safety precautions and restrictions
- Coordination of physical, behavioral and dental care is critical for a patient's health and reduces overall health care costs, but dental care is still left out too often
- Too few dentists are located (or open at flexible/convenient times) in some rural areas
- Black children and other children of color disproportionally have poorer oral health outcomes
- Oregon Health Plan enrollment has increased 13 percent since the COVID-19 pandemic hit, resulting in more demand on the Medicaid system
- COVID- and unemployment-related budget constraints, along with budget cuts proposed by the Oregon Health Authority, suggest a dismantling of public oral health programs including school-based services, Medicaid and more — right when Oregonians need them the most

Summary of Recommendations

Full recommendations are available later in this report. In short, solutions include:

- Analyze and support programs that focus on convenience, such as school-based dental services, which have proven to dramatically expand access to care in rural counties that have focused resources to meet families where they are at
- Maintain and strengthen state programs that ensure dentists can locate in areas with lower patient volume such as rural and underserved communities
- Improve incentives that support diversity, equity and inclusion in dentistry that raise the floor to provide access and opportunity for BIPOC communities without reducing quality and care standards based on income, location or identity
- Improve Medicaid reimbursement rates to expand access to care, starting with a review process including relevant stakeholders on dental rates and capitation
- Consider cost-effective, widescale approaches to prevention
- Ensure Oregon does not fall behind on oral health or access to critical resources by funding the vacant state Dental Director position required by state statute

Oregon's Oral Health Landscape

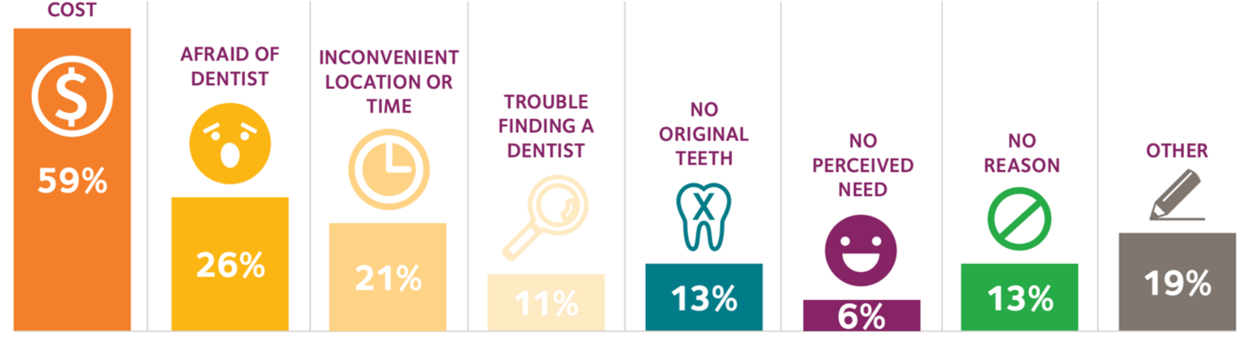
Oral health is an essential component of a person's overall health. Dental disease can result in chronic pain, poor nutrition, missed work or school days, poor academic or job performance, reduced quality of life and unnecessary, expensive trips to the emergency room. Long-term, complications from oral disease are linked to other health conditions such as diabetes, respiratory disease, cardiovascular disease and adverse pregnancy outcomes.[1] Regular dental care, on the other hand, can reduce the incidence of chronic disease, prevent pain, prevent emergency or urgent care visits and improve a person's quality of life.

Proper preventive care also provides critical savings for our health care system by avoiding more costly treatment down the line. A January 2020 report produced by Oregon Health & Science University and the Oregon Community Foundation found that investing in preventive care such as sealants and fluoride treatments to protect teeth, dental cleanings and oral hygiene education for Medicaid patients may generate significant savings for the state.

"Among children age 6-14, annual spending per child on non-preventive dental services was 73 percent higher than spending on preventive services," the report found. "This suggests that greater spending on preventive services that reduce the need for more intensive services to treat dental problems, such as fillings and root canals, could yield net savings for Oregon's Medicaid program."

"Untreated dental problems early on may manifest in the form of ED (Emergency Department) visits and increased costs later in life," the report continued. "Expanding access to comprehensive dental care — including dental cleanings, other preventive services, and oral health exams — may be a means to avoid ED visits and costs in the future."

Despite the critical importance of preventive care, not all Oregonians regularly visit a dentist. The reasons vary, with surveys finding that perceived cost, fear and inconvenience top the list. Of adult Oregonians, an estimated two-thirds see a dentist at least annually, although this may include non-preventive care such as trips for emergency services.[2] Of those who do not see a dentist at least yearly, the most common reasons are out-of-pocket cost, fear of the dentist or inconvenience.[3]



[1] "Improving Access to Oral Health Care for Vulnerable and Underserved Populations." Washington, D.C., Institute of Medicine and National Research Council, 2011.
[2] Oregon Behavioral Risk Factor Surveillance System Data. Oregon Health Authority, Public Health Division. Retrieved from https://www.oregon.gov/oha/PH/BirthDeathCertificates/Surveys/AdultBehaviorRisk/brfssresults/Documents/2016/Oralhealth16.pdf.
[3] "Oral Health and Well-being in Oregon." American Dental Association. Retrieved from https://www.ada.org/en/~/media/ADA/Science%20and%20Research/HPI/OralHealthWell-Being-StateFacts/Oregon-Oral-Health-Well-Being.pdf.

These findings were largely reaffirmed by listening sessions conducted in August 2020 for Oregon's Pediatric Oral Health Coalition. Results from three listening sessions conducted across the state, with one session in English, one in Spanish and one through an online survey, showed that children's caregivers recognized the value of dental care, but they continue to face barriers including fear based on traumatic past experiences, a lack of clarity about how to obtain interpretive services when needed, and convenience.

Especially in rural areas, families want flexible appointment times, including evenings and weekends, as well as more providers covered by the Oregon Health Plan within a 15- to 20-minute drive and with shorter wait times for appointments, the sessions found.[4] Cost concerns were another factor keeping some families from seeking dental care for their children, and financial concerns were exacerbated by unpredictable employment during the COVID-19 pandemic, the sessions found.

"When it comes to getting information about oral health, families trust schools, doctors, social services and other parents," according to the Oregon Pediatric Oral Health Coalition's report.[4]

Oregon Pediatric Oral Health Coalition Community Listening, Relevant Excerpts:

WHAT WE HEARD

When it comes to getting information about oral health, families trust schools, doctors, social services and other parents.

Spanish Session:
- **Schools**
- Clinics
- **Pediatrician**
- Dental offices
- Community programs shared by friends/family members
- **WIC**

English Session
- **Schools**
- CCOs
- **Pediatrician**
- Dental hygienist
- Email and mail from dentist
- Oregon WIC texting
- Head Start family advocate
- Tribal office
- **Facebook parent groups**
- Community events

"There are many reasons why children go without dental care, including systemic barriers like geographic isolation; families' concerns about cost and difficulty securing time off from work, especially from hourly jobs; and lack of reliable transportation or child care. In some places in Oregon, these barriers have existed for generations."

"In addition to social determinants, lack of knowledge and attitudinal barriers can prevent children from receiving dental care. In the United States, there is a general lack of knowledge or understanding about the importance of dental health and its relationship to overall health. … This lack of knowledge about the importance of dental care can also be coupled with apprehension about receiving it. Families or children may be fearful about visiting a dentist."

[4] "Dental care for kids during the pandemic, community listening findings." Healthy Teeth, Bright Futures, Pediatric Oral Health Coalition, 2020. See Appendix: Exhibit A.

Oregon's Dental Care Delivery System, Workforce & Coordinated Care

Oregon is frequently cited as a national leader in transforming its health care delivery system. Only eight other states have better dentist-to-population ratios.[5] Oregonians receive dental care through a system that includes private clinics, larger corporate facilities and health centers, as well as Coordinated Care Organizations (and affiliated Dental Care Organizations). Coordinated care is widely accepted as a critical path to overcome gaps in access, affordability and quality, and since 2012, the state has transitioned its Medicaid system to focus on Coordinated Care Organizations (CCOs), which aim to manage physical, behavioral and dental health benefits for their members to reduce health care costs and improve overall care.

While CCOs have been credited with advancing Oregon's health care delivery system in many ways, studies suggest they may be lacking when it comes to dental care. A 2016 OHSU report found that, in some cases, the development of CCOs was correlated with "moderate reductions" in all dental outcomes. Following initial statewide integration of health care, access to dental care for CCO members *decreased* moderately, the percentage of CCO members with a visit for any dental issue and the number of overall dental visits dropped slightly, and the percentage of children receiving dental sealants decreased moderately, the report found.[6]

Why did early attempts to coordinate care result in less consistent delivery of dental services? OHSU researchers found that CCOs may need more time to fully integrate dental care into their delivery systems, a surge in Oregonians on Medicaid able to receive dental services may have reduced availability of appointments with providers, and "faced with multiple priorities and limited capacity, CCOs may have chosen to focus on reforms other than dental integration."[6]

While the report cited anecdotal evidence that CCOs are still working to improve integration of dental care into their systems — diverting Oregonians from emergency rooms by intervening earlier, providing enhanced services to members with diabetes and offering teledentistry, placing care coordinators in dental clinics and incorporating dental health into care planning tools, for example — these efforts must continue and receive appropriate oversight and funding to ensure success.

Data from 2019 on Oregon's CCOs shows progress in some areas. For example, all regions in the state saw improvements in the number of children ages 6 to 14 receiving preventive dental services during the year. However, looking at CCO members of all ages across all regions, the percentage receiving at least one dental service over the year declined from 46.6 percent in 2018 to 44.8 percent in 2019. The state must continue to maintain metrics such as these as incentives to ensure progress across all demographics and a broad range of dental procedures.[7]

Demographic Disparities

Although Oregon has made great strides toward improving access, affordability and quality of care, additional work remains to address disparities experienced by specific populations and communities.

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[5] "Oral Health Integration in Oregon." Health Management Associates, 2016. Retrieved from https://static1.squarespace.com/static/554bd5a0e4b06ed592559a39/t/58e80478414fb5fb3ee50499/1491600521021/Oral+Health+Integration+in+Oregon-+Environmental+Scan+and+Recommendations.pdf.

[6] Young, Jenny, M.Sc., Kushner, Jonah, M.P.P, and McConnell, K. John, Ph.D. "The Impact of Dental Integration in Oregon's Medicaid Program." Center for Health Systems Effectiveness, Oregon Health & Science University, 2016. Retrieved from https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/The%20Impact%20of%20Dental%20Integration%20in%20Oregon%E2%80%99s%20Medicaid%20Program.PDF.

[7] Oregon Health System Transformation: CCO Metrics 2019 Final Report. Oregon Health Authority, September 2020.

Seniors face major challenges.
In Oregon, 32 percent of seniors age 65 and older have lost six or more teeth, compared to a national average of 37 percent. As many as 13 percent of Oregon seniors have lost all of their teeth, compared to 15 percent on average nationally. But while Oregon is faring better than the national average in these areas, it's trailing behind neighboring states: Only 9 percent of California seniors have lost all of their teeth, and only 11.5 percent in Washington.[8]

Black children and other children of color, along with lower-income families, disproportionately endure poorer oral health outcomes and receive fewer preventive services.
While 54 percent of Oregon's Medicaid-enrolled children received at least one preventive dental service during the year, less than half of those of American Indian or Alaskan Native descent, and less than half of Black children, received any preventive dental care, according to a January 2020 OHSU Center for Health Systems Effectiveness Issue Brief.[9]

Black children not only had the lowest rate of utilization of preventive care, but also the highest rate of emergency department visits for what could have been avoidable oral health problems.[9]

Low-income children see a dentist less often than higher-income peers, making policies to improve dental care access especially important for this population as well.[10] In Oregon, the single biggest risk factor for childhood tooth decay is poverty: 63 percent of children in poverty have experienced tooth decay, compared to 38 percent of those from higher-income families.[11]

Because systemic barriers such as families' concerns about cost, difficulty securing time off work, especially from hourly jobs, and lack of reliable transportation or childcare, school-based oral health programs offer promising opportunities to improve oral health for low-income families by meeting children where they spend much of their time: at school.[11]

Rural communities continue to face additional obstacles.
In addition to low-income families and families of color, rural communities experience higher rates of tooth decay.[11] Typically they also experience reduced access to care.

Dentists opening clinics in remote locations face challenges such as lower patient volume, lower incomes and greater travel times for patients to visit. Specialists such as orthodontists and oral surgeons are also less likely to be located in remote or rural parts of the state.

However, some rural and remote Oregon counties have much better access to care than their counterparts and offer case studies for consideration when working to expand access elsewhere in the state.

[8] Oregon Health Authority Oral Health Roadmap. Prepared by Health Management Associates and Artemis Consulting, December 2016. Retrieved from https://static1.squarespace.com/static/554bd5a0e4b06ed592559a39/t/58e80528e6f2e1de533177a1/1491600738031/Oregon+Health+Authority+Oral+Health+Roadmap.pdf
[9] Kusher J and Renfro S. "Dental Care for Oregon's Medicaid-enrolled children in 2018." Center for Health Systems Effectiveness, Oregon Health & Science University, 2020. Retrieved from https://static1.squarespace.com/static/5d97a4561a002c5b8061d827/t/5e334de678d5f55da08d8733/1580420589070/ocf_dental_brief_200122_FINAL.pdf.
[10] Soni, Anita. 2014. "Children's Dental Care: Advice and Visits, Ages 2-7, 2011." Medical Expenditure Panel Survey Statistical Brief 432. Agency for Healthcare Research and Quality. Retrieved from https://meps.ahrq.gov/data_files/publications/st432/stat432.pdf
[11] "Learning What Works for School-Based Dental Health Programs." The Oregon Children's Dental Health Initiative, Oregon Community Foundation, 2019. Retrieved from https://oregoncf.org/Templates/media/files/reports/childrensdentalhealth.pdf

One example is rural, high-poverty Malheur County, which enjoys relatively high rates of access to dental care, according to a study conducted by researchers at OHSU.

In Malheur County, a large proportion of Medicaid-enrolled children receive regular dental services, including preventive care, despite the transportation and provider availability challenges historically faced in remote areas.[12]

The study concluded that, “while transportation issues and dental provider shortages can create barriers to access in rural areas,” this is not always the case. “To help expand access to dental services,” the study found, the state should “investigate how these rural counties have surmounted potential challenges with access.”

In Malheur County, school-based health programs are a powerful tool likely driving the high rates of care, according to a February 2020 article in the Malheur Enterprise newspaper.[13]

Eastern Oregon Healthy Living Alliance’s Healthy, Happy Smiles program partners with Advantage Dental to place hands-on dental learning labs in schools county-wide, the article noted.

Expanded practice dental hygienists from Advantage Dental visit schools and provides free check-ups and other services to any student whose parent has signed a consent form.

The article quoted Mary Ann Wren, manager of community care for Advantage Dental, on the ability of this program to reach people who rely on Medicaid for health care coverage.

“In areas where we have a heavy presence we see higher rates of reaching our Medicaid population, and I think that’s very true in Malheur County,” Wren said.

Report: Malheur County leads state in access to dental care

Kids enrolled in Medicaid in Malheur County have the state's highest rate of access to care, according to a recent report.

By Yadira Lopez - The Enterprise, February 20, 2020

Students at Nyssa Elementary learn about oral health through Healthy, Happy Smiles, a school-based oral health program targeting eastern Oregon. A study on children’s oral health published last month by the Oregon Health and Science University determined that Medicaid-enrolled children in Malheur County had the highest rate of access to dental care in the state, according to data from 2018. (The Enterprise/Yadira Lopez)

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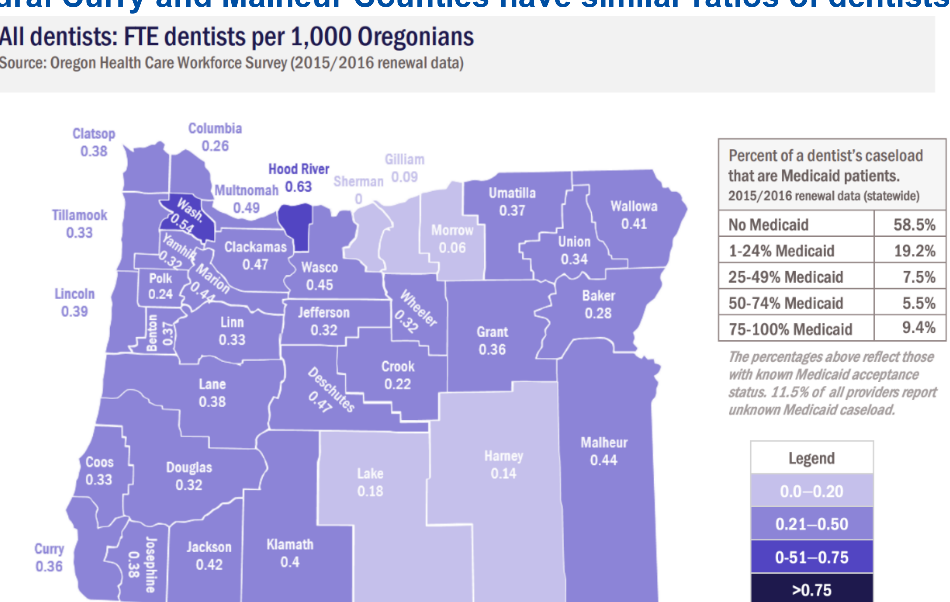
[12] Kusher J and Renfro S. “Dental Care for Oregon’s Medicaid-enrolled children in 2018.” Center for Health Systems Effectiveness, Oregon Health & Science University, 2020. Retrieved from https://static1.squarespace.com/static/5d97a4561a002c5b8061d827/t/5e334de678d5f55da08d8733/1580420589070/ocf_dental_brief_200122_FINAL.pdf.

[13] Lopez, Yadira (2020, Feb. 20). “Report: Malheur County leads state in access to dental care.” Malheur Enterprise newspaper. See Appendix, Exhibit B.

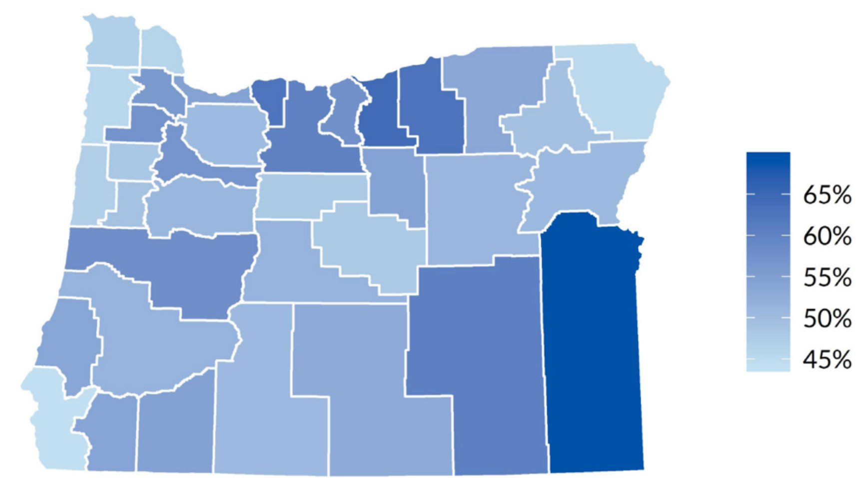
While the availability and distribution of dental care providers is a frequent topic when discussing access to care in rural areas, Malheur County is especially interesting in this regard. Malheur County has a similar ratio of dentists who accept Medicaid to residents as Curry County, another rural part of the state. But the percentage of Medicaid-enrolled children receiving dental care is drastically different between the two areas, with 69% of children receiving dental services in Malheur County, compared to 44% of kids in Curry County.[14]

For this reason, additional analysis is needed to better understand why two areas with roughly the same access to dentists accepting Medicaid patients could have such different outcomes in the proportion of Medicaid-enrolled children receiving care.

Rural Curry and Malheur Counties have similar ratios of dentists:



Malheur dwarfs Curry County in access to care for Medicaid-enrolled children:



[14] Kusher J and Renfro S. “Dental Care for Oregon’s Medicaid-enrolled children in 2018.” Center for Health Systems Effectiveness, Oregon Health & Science University, 2020.

Budget and Policy Constraints
Medicaid remains woefully underfunded in Oregon. The state ranks 30th nationwide on analyses comparing Medicaid reimbursement levels to the actual cost of care.[15] This is evident in the number of dentists able to accept Medicaid patients and the number whose Medicaid patients represent a large portion of their workload.

While Oregon has seen improvement — 60 percent of Medicaid-eligible children received dental services at least once during 2018,[16] up from 44 percent reported in 2015[17] — we must continue expanding access for Oregonians on Medicaid.

To accomplish this, Oregon can look to other states across the nation. Those that have increased their Medicaid reimbursement rates, such as in Connecticut, Maryland and Texas, have experienced a correlated increase in the number of Medicaid patients seen by providers.[15]

In Connecticut, increasing the Medicaid program's dental reimbursement rates to the 70th percentile of private dental insurance rates, combined with a new case management program to reduce missed appointments, led to an increase in the number of providers participating in the Medicaid program, an increase in access to dental care and an increase in utilization of dental care among Medicaid-enrolled children.[15]

Similarly, Maryland saw some of the largest improvements of any state in utilization of dental care for Medicaid-enrolled children after improving dental care reimbursement rates, carving Medicaid out of managed care, creating a missed appointment tracker and improving customer service, among other reforms.[15]

In Texas, when the Medicaid program increased dental reimbursement by more than 50 percent and the state implemented loan forgiveness for dentists practicing in underserved areas along with allocating more funds to clinics in those underserved communities, dental care use among Medicaid-enrolled children increased so much it eventually outpaced that of children with commercial dental insurance.[15]

It should be noted that fee-for-service rates, which set reimbursement amounts for specific services such as office visits or tests, are not the only way dentists are reimbursed. Increasingly in coordinated care models like those in Oregon, health care providers are instead reimbursed with a capitated rate, which is a contracted amount based on the number of eligible patients within the provider's service area. Because of Oregon's emphasis on coordinated care models, attention must be paid to all types of reimbursement compared to costs and anticipated impacts from the COVID-19 crisis.

The COVID-19 pandemic is expected to exacerbate existing challenges for a number of reasons, even as dentists have adapted and innovated to continue safely providing crucial care to patients.

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[15] Gupta, Niodita, M.D., M.P.H., Ph.D. et al. "Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for all States." Health Policy Institute, American Dental Association, 2016. Retrieved from https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0417_1.pdf.
[16] Kusher J and Renfro S. "Dental Care for Oregon's Medicaid-enrolled children in 2018." Center for Health Systems Effectiveness, Oregon Health & Science University, 2020.
[17] Oregon Oral Health Surveillance System. Oregon Health Authority, 2002-2016.

The pandemic has increased the cost of providing care due to requirements to purchase more personal protective equipment for patient and worker safety and a decrease in the volume of patients dentists can see due to the need for social distancing. At the same time, the pandemic has led many patients to delay care. Because regular dental treatment prevents more expensive trips to urgent care or the ER, there is great concern that trips for emergency dental care will increase. It is now even more important that the public is confident in dental clinics' abilities to safely prevent dental disease and treat it early when it occurs.

At the same time, enrollment in the Oregon Health Plan has skyrocketed since the pandemic began. Between the governor's State of Emergency Declaration March 8, 2020, and Nov. 16, 2020, Oregonians relying on the state's Medicaid program grew by 13.02 percent.[18]

Oregon now faces proposed budget cuts that could further reduce access to dental care at a time when our communities need it most. The Oregon Health Authority (OHA) has proposed eliminating funding for the state's Dental Director, a position responsible for working across the OHA to provide coordination and direction of oral health systems, ensuring all Oregonians have equitable access to good oral health. The Dental Director position was created statutorily in 2015 to ensure oral health leadership at the highest levels of OHA decision making. Without a Dental Director, Oregon misses out on access to federal grant dollars.

In addition, as of Jan. 1, 2021, OHA will enact 11 percent rate cuts to Medicaid dental rates — a crucial safety net that is already underfunded.[19] These reductions pose massive consequences for access to care in Oregon. Research has demonstrated that in states such as Connecticut, Maryland, Texas and elsewhere, adjusting Medicaid payment rates closer to market levels, especially in conjunction with other reforms, has yielded a positive effect on access to oral health care.[20] Cutting these rates in Oregon will undoubtedly produce the opposite result, harming access to care.

Meanwhile, OHA recently announced an end to the state's Fluoride Tablet and Rinse program, eliminating the program used by public school students statewide starting the 2020-21 school year.[21] While OHA also considered cuts to additional services such as the school-based sealant program — another layer of critical preventive care for children — the ODA is relieved that program was ultimately saved.

Our state must refocus efforts on coordination of care through our existing health system and oral health programs rather than dismantling them at a time when Oregonians need them most.

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[18] Oregon Health Authority. Oregon Health Plan Weekly Enrollment Report, Nov. 16, 2020. Retrieved from https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/snapshot111620.pdf.

[19] Oregon Health Authority. 2021-23 Agency Budget Request. Retrieved from https://www.oregon.gov/oha/Budget/OHA-2021-23-Agency-Request-Budget.pdf.

[20] Gupta, Niodita, M.D., M.P.H., Ph.D. et al. "Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for all States." Health Policy Institute, American Dental Association, 2016. Retrieved from https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0417_1.pdf.

[21] Wilcox, Cate. "Oregon Health Authority's Statewide School Fluoride Tablet and Rinse Program Discontinued." Oregon Health Authority memo, April 30, 2020. See Appendix, Exhibit C.

Action for Dental Health

Dentists have long fought for measures to remove barriers, strengthen the public-private safety net and improve health outcomes for all Oregonians. Following are some of the measures that have contributed to improvements in Oregon's oral health care access, affordability, quality and outcomes in recent years.

Rural access to providers: Dentists have advocated for and will continue to support state programs that improve access in rural areas by better supporting dentists who practice in these locations, including:

- Rural Health Practitioner tax credits, which have helped thousands of health care providers to practice in rural areas
- Loan forgiveness through Scholars for a Healthy Oregon, which encourages recent dental school graduates to work in public health in rural or underserved communities
- Oregon Medicaid Primary Care Loan Repayment and Forgiveness programs, which provide incentive to providers to treat underserved patient populations

Tribal care and representation: In 2017-19, dentists worked to improve access to scholarship opportunities for Tribal youths. This coincided with ongoing discussions with members of Oregon Tribes at a Tribal Summit focused on access to equitable dental care. While the bill did not advance in previous sessions, Oregon must continue exploring opportunities to increase the number of Tribal youths able to pursue careers in dentistry and provide equitable care in their communities.

Community Dental Health Coordinators: In 2019-20, the Oregon Dental Association co-sponsored a project in Washington County to improve oral health care through Community Dental Health Coordinators, or CDHCs, who are recruited from the communities where they will work to help eliminate language, cultural and trust barriers while supporting access to preventive care and helping patients navigate to clinics and specialists when necessary for additional treatment. The CDHC in Washington County demonstrated success in expanding access to culturally relevant and inclusive dental care for low-income and predominantly Latino children.[22]

Community Dental Health Coordinators have proven to improve patient outcomes elsewhere across the country. In New Mexico, a CDHC working with diabetes patients in a Tribal community health center eliminated missed appointments among the patients she worked with. In Arizona, a CDHC doubled a single-dentist practice's patient base and improved access to care in a remote and rural area. And in Wisconsin, a CDHC visited 30 schools to provide 1,200 oral health screenings, 1,300 dental cleanings and over 2,000 sealants.[23] In 2020, the ODA co-sponsored a grant request to fund four additional CDHCs in school-based settings.

Serving underserved children: The Tooth Taxi, funded by the Dental Foundation of Oregon, the ODA's charity arm, travels throughout the state to provide kids in undeserved remote and low-income areas with dental education and care. Since 2008, the Tooth Taxi has traveled over 75,000 miles, provided oral health screenings to more than 22,475 students and taught

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[22] "Oral Health Access Pilot Project: Year One Report." Washington County Community Health Improvement Plan, January 2020. See Appendix, Exhibit D.

[23] "Community Dental Health Coordinators Provide Solutions Now." Action for Dental Health, American Dental Association. Retrieved from https://www.ada.org/~/media/ADA/Public%20Programs/Files/ADA_CDHC_Flyer_Infographic_Jan2020.pdf?la=en.

oral hygiene classroom education to 23,945 students. This amounts to as much as $10 million in services over the Tooth Taxi's 12 years on the road.

School-based screenings: Dentists have advocated for and supported improvements to children's preventive care, including by ensuring as many children as possible receive screenings when entering school for the first time through the state's oral health screenings program. While limited data are currently available to understand the overall impact of these screenings, the ODA continues working with education leaders to improve data collection down the line.

Healthy Teeth, Bright Futures: While policies such as Cover All Kids have helped to ensure the youngest Oregonians have basic dental care coverage, children still may not receive the care they need. The Oregon Dental Association is part of a coalition working to provide dental services to children where they are at: in schools. Along with the Oregon Community Foundation, Children First for Oregon, Oregon Latino Health Coalition, Coalition of Communities of Color and other organizations, the Oregon Dental Association supports Healthy Teeth, Bright Futures, which is building on more than five years of work to provide services to children through school-based oral health programs.

Access to vaccines: In 2020, dentists won the ability to administer vaccines to patients. This will help to reduce the incidence of flu and slow the spread of human papillomavirus (HPV), ultimately reducing rates of oral and throat cancers. Dentists have also helped organizations such as the American Cancer Society to develop education programs around HPV to support comprehensive, integrated health care. Once a COVID-19 vaccine is approved and available, dentists who are certified to provide vaccinations will be able to help deploy this lifesaving immunization across the state.

Diabetes screenings: Dentists are now able to identify and offer screenings to patients at risk of diabetes. This early identification and awareness can potentially save millions of dollars in treatment costs down the line, as more than 1 million Oregonians are at risk of developing the disease. This type of screening also further integrates dentistry into overall physical health, with the dentist referring to a primary provider as needed.

Pilot Projects: The ODA has supported and contributed to the state's dental Pilot Projects program from the very beginning, helping to develop the plan for

Dental Care During the COVID Crisis

When the pandemic hit the United States in 2020, Oregon dentists sprang into action, leading the way to conserve and donate personal protective equipment needed by hospital workers diagnosing, treating and caring for Oregonians with COVID-19.

In a March 2020 press release, Gov. Kate Brown noted that Oregon dentists led a drive that resulted in more than 60,000 face masks, 600,000 gloves, gowns and shields donated to the state. And dentists' efforts didn't stop there.

Knowing that delays in obtaining regular treatment and preventive care could increase dental emergencies, which could create an additional burden on emergency rooms, the Oregon Dental Association also created a comprehensive database available to the public to help Oregonians find nearby dentists offering emergency and urgent care.

At the same time, dental clinics have taken extreme precautions to ensure safety of their entire dental teams while implementing and expanding tools such as teledentistry to continue providing critical care to Oregonians in these unprecedented times.

pilot initiatives in 2011. Oregon dentists remain strong supporters of the pilot project model and advocate for thoughtfully designed studies that produce meaningful data and ensure quality, safe care for Oregonians.

Tobacco 21: The ODA supported successful efforts to raise the age to purchase e-cigarettes and other tobacco products from 18 to 21 in 2018. The earlier people start smoking, the more at risk they are for chronic health conditions such as heart disease, asthma and cancer. This public health initiative was important as it is projected to reduce smoking rates and prevent tobacco-related death and disease. Similarly, the ODA supported Ballot Measure 108, passed in the 2020 November General Election, which will increase essential funds to Oregon’s Medicaid funding through tobacco and e-cigarette taxes.

Recommendations & Next Steps

Analyze and support programs that focus on convenience, such as school-based dental services

Recent research suggests that some of the greatest gains in access to care have taken place in communities with the strongest school-based services. As noted earlier in this report, while rural counties such as Curry County and Malheur County have similar dentist-to-population ratios, Malheur County leads the state in access to dental care.[24] School-based health programs are a likely factor driving Malheur County's high rates of care.[24]

School-based dental services have helped to remove many obstacles while breaking down cultural and attitudinal barriers as well. School-based and other programs that meet people where they are at offer tremendous promise for ensuring all Oregonians receive equitable dental care. We must continue providing and expanding access to care by offering it conveniently, such as through school-based programs and through integration and coordination of care.

Maintain and strengthen state programs that ensure dentists can locate in areas with lower patient volume such as rural and underserved communities

We know there is no single silver bullet to solve challenges with utilization, coordination and access to dental care, and so we must consider a diversity of research-based solutions.

Programs that offset the cost of locating in remote and rural areas can help to ensure historically underserved communities have better access to care. The state must protect and consider expanding these subsidies that have proven effective.

Improve incentives that support diversity, equity and inclusion in dentistry

Scholarship programs offering incentives to underrepresented communities pursuing degrees in dentistry can improve representation while ensuring equitable, high-quality care for all Oregonians.

This is a critical path for our state toward equity, as all Oregonians should have access to the same level of high-quality care from providers. Any recommendations targeting equity should not simply target access in general; they must also provide equity in safety and quality for BIPOC communities.

Health equity, according to the Institute of Medicine, is defined as: "Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status."[25]

Improve Medicaid reimbursement rates to expand access to care

Research has demonstrated that improvements in Medicaid reimbursement rates are correlated with expanded access and utilization of dental services in other states. Oregon should consider making similar improvements to ensure lower-income and underserved families can obtain the care they need.

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[24] Lopez, Yadira (2020, Feb. 20). "Report: Malheur County leads state in access to dental care." Malheur Enterprise newspaper. See Appendix, Exhibit B.

[25] Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine (US) Committee on Quality of Health Care in America. Washington, D.C.: National Academies Press (US), 2001.

As a starting point, the state should undergo a rate-setting review process with relevant stakeholders on dental rates and capitation to provide future legislators with an understanding of how dental rates are set, how they compare to dental rates elsewhere in the country and how Medicaid reimbursement compares to private insurance rates.

State leaders should also consider additional ways to expand dentists' capacity to serve Oregonians on Medicaid such as by creating a student debt forgiveness program for dentists who treat Medicaid patients.

Consider cost-effective, widescale approaches to prevention
Rather than cutting Medicaid rates when Oregonians need stable health care the most, the state should target cost-effective, research-based approaches to dental disease prevention.

The Oregon Health Authority's 2016 Roadmap report highlighted that, unlike younger children in Oregon, youth ages 13 to 15 have higher rates of tooth decay than the national average.[26] This may be in part due to a lack of access to fluoride in the water, the report found.[26]

Water fluoridation is widely considered one of the most equitable, economical and efficient ways to prevent tooth decay for entire communities. Optimally fluoridated water (where the amount of fluoride, which is naturally occurring in water, is adjusted to a level that protects against tooth decay) is proven to reduce tooth decay in children by 18 percent to 40 percent. But fewer than 22 percent of Oregonians have access to optimally fluoridated water, and the city of Portland is the largest urban area in the country without fluoridated water.[27]

While fluoride has been a contentious topic at the state level, it may be fruitful to consider bringing together stakeholders and revisiting the discussion at this time.

Ensure Oregon does not fall behind on oral health and access to critical resources
In 2014, Oregon dentists participated in a coalition that successfully advocated for the state to hire a dental director to oversee state efforts to improve oral health, from oral health literacy and preventive health care services both in and outside of dental clinics, to creating incentives for providers to work in underserved locations and providing access to equitable care to address disparities. At the time, Oregon was one of only a handful of states without a full-time dental director, a position that also ensures the state is eligible for federal grant dollars.[28]

We are once again without a state dental director, and Oregon is currently missing out on federal grant money as a result. We need a dental director who will establish clinical, fiscal and policy priorities for oral disease prevention and care. Oral health leadership is especially critical for the Oregon Health Authority to ensure oral health access is maintained in the state as it responds to the COVID crisis. It is recommended the state fund this crucial position and that the Oregon Health Authority appoint someone to fill it, as required by statute.[29]

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[26] Oregon Health Authority Oral Health Roadmap. Health Management Associates and Artemis Consulting, December 2016. Retrieved from https://static1.squarespace.com/static/554bd5a0e4b06ed592559a39/t/58e80528e6f2e1de533177a1/1491600738031/Oregon+Health+Authority+Oral+Health+Roadmap.pdf.
[27] "Learning What Works for School-Based Dental Health Programs." The Oregon Children's Dental Health Initiative, Oregon Community Foundation, 2019. Retrieved from https://oregoncf.org/Templates/media/files/reports/childrensdentalhealth.pdf.
[28] Yoo, Saerom (2014, Oct. 2). "Report urges Oregon to hire dental director." Statesman Journal newspaper. Retrieved from https://www.statesmanjournal.com/story/news/health/2014/10/03/report-urges-oregon-hire-dental-director/16608907/.
[29] ORS 413.083.

Appendix

Exhibit A

Dental Care for Kids During the Pandemic

Community listening findings

Pediatric Oral Health Coalition

OCTOBER 8, 2020

OVERVIEW

We're here to share and reflect

- What we did
- What we heard
- What it means
- What's next

GOALS

Why community listening?

- Support the Pediatric Oral Health Coalition in community-centered policy development
- Address access barriers exacerbated and newly created by COVID-19

APPROACH

Community listening principles

- Center communities' expertise and resilience to own and co-create solutions
- Acknowledge historical traumas and inequities resurfacing during COVID
- Create and foster a safe and engaging process
- Reciprocity and compensation

INQUIRY EXERCISE

Questions

- Can anyone tell me about a time when you took your child to see a dentist, either for a toothache or a teeth cleaning?
- Has your child needed to get their teeth checked or treated during the pandemic?
- Do you have any concerns or worries — whether it's the cost of care, safety, or issues related to COVID-19 — about taking your child to the dentist's office?
- Are there things you have wanted to do for your child's teeth but haven't done?
- Where do you get information about keeping your child's teeth healthy and where to find care?
- Would you say it is generally pretty easy to get care for your child's teeth or not so easy?

What we did

ATTENDANCE

Listening session #1 (English)

- August 18, 2020
- 26 parents + caregivers
- 3 breakout sessions
- Multnomah, Columbia, Marion, Benton, Washington, Linn, Wallowa

ATTENDANCE

Listening session #2 (Spanish)

- August 26, 2020
- 17 parents + caregivers
- 3 breakout sessions
- Multnomah, Washington, Clackamas, Linn
- Registered folks from other counties did not attend

Online questionnaire

- Offered in English and Spanish
- Given to listening session participants who couldn't participate in virtual listening sessions
- Also shared on Facebook
- 11 total responses
- Clackamas, Lincoln, Multnomah

What we heard: Dental care experiences

Caregivers understand that oral health is important; they want children to have healthy teeth and positive experiences with dental care.

Caregivers:

- Believe it is their responsibility to ensure good oral health.
- Are familiar with and practice good oral health habits.
- Believe that some factors of oral health are genetic and out of their control.
- Aren't always familiar with local laws and practices related to oral health (standard of care, presence of fluoridated water, etc.).

"I feel your orthodontal care is just as important as a well-child exam, so I would absolutely make it a priority to get any one of my kids to a dentist if it was something that would be covered." –Michelle, St. Helens

"We all eat the same, we all do the same, but he's been the one who is always suffering." –Mimi, Portland

WHAT WE HEARD

At the same time, caregivers have general fear and anxiety about dental procedures because of traumatic past experiences.

- Many reported having negative experiences with dental care.
- They want to prevent trauma for their children.
- Experiences that cause the most anxiety included: anesthesia, removal of teeth, not understanding procedures in advance.

WHAT WE HEARD

"I heard so many horror stories about dentists. Myself, I had bad experiences with them." –Jose, Portland

"I feel like I delayed taking my daughter to the dentist at first because the one dentist who would take our insurance was really scary and I was more worried about her having a bad dental experience." –Jessie, Joseph

"When she came out of anesthesia, I was petrified. It was terrifying, the most excruciating feeling in my heart as a mom to watch my baby go out like this. I knew she needed it done but watching her go through that was absolutely excruciating." –Michelle, St. Helens

WHAT WE HEARD

When it comes to getting information about oral health, families trust schools, doctors, social services and other parents.

Spanish Session:

- **Schools**
- Clinics
- **Pediatrician**
- Dental offices
- Community programs shared by friends/family members
- **WIC**

English Session

- **Schools**
- CCOs
- **Pediatrician**
- Dental hygienist
- Email and mail from dentist
- Oregon WIC texting
- Head Start family advocate
- Tribal office
- **Facebook parent groups**
- Community events

WHAT WE HEARD

"I am just doing my own research online. I joined this Beaverton mom's group where you get to ask questions [and hear about] experiences from other moms. Based off that is what I'm trying to be taking care of her teeth at home." –Amy, Beaverton

"Pre-COVID we would get information at community events. Whenever there was a kid event happening, there would be a dental provider there with information about oral hygiene and things you could be doing." –Jessie, Joseph

"My dentist sends regular emails, reminders about cleanings and remember to brush your teeth and stuff like that." –Jose, Portland

WHAT WE HEARD

Above all, families want caring, child-focused relationships with their dental providers.

This includes:

- Playful, fun interactions with staff
- Kid-friendly ambience, prizes
- Family-friendly explanations of tools and procedures
- Speaking directly to children
- No shaming/blaming parents
- Flexible appointment times

WHAT WE HEARD

"When I lost insurance, and got new insurance, I had to look through the network and call around to see who would accept that insurance. So that was a little more difficult. Because I had been with someone a very long time and I trusted them."
–Shaniqwa, Gresham

"Not all dental clinics are equal… now we're at a clinic where they make an effort to make the child feel a bit more comfortable, they try to get the child's point of view, which is very important… compared to the first few years when we were in an OHP clinic where they just diagnose and they go about their ways…you feel like the energy in the room is not really inviting for questions." –Celia, Portland

WHAT WE HEARD

Families on OHP say it is difficult to find a provider they like and that they regularly experience scheduling delays when making appointments.

- Same-day appointments are needed, but difficult to get.
- Families want appointment times that fit their work schedule and are not during school hours.
- They experience long wait times for initial appointments, then again when making follow-up appointments.
- Long wait times for follow-up appointments to deal with specific problems were particularly frustrating for families.

WHAT WE HEARD

"For me, the most difficult thing has been scheduling an appointment."
–Ana Luz, Albany

"It was a process of finding who our dentist was, then there was a long waiting period because of the limited amount of Medicaid patients they would take so we ended up waiting a couple of months." –Sarah, St. Helens

"Getting dental appointments is always difficult. One of my kids had a cavity, but the next appointment they could get was almost 4 months out. Then what? My kid's going to be back in pain, crying and going through this again? I just really wish they would make it a reasonable amount of time before the tooth is more damaged."
–Celia, Portland

WHAT WE HEARD

Families outside of Portland report long drive times to get to preferred dental providers that are covered by their insurance.

- Families with OHP are particularly limited when it comes to finding convenient providers.
- Driving time creates an extra burden for families.
- It is especially difficult for families in need of medical transportation.

WHAT WE HEARD

“We’re in a very inconvenient place—driving an hour to Portland or the other direction 45-50 minutes. Nothing is close and everything is somewhat of a burden to get to.”
–Sarah, St. Helens

“We have three dentists in Rainier but we aren’t allowed to go to them.”
–Cheryl, Rainier

“Right now we live in South Salem and there are quite a few places that do not take OHP. We have Native American insurance as well, but it’s supposed to be used as secondary. And a lot of places don’t take those.” –Martha, South Salem

WHAT WE HEARD

Cost of care is a concern for many families, particularly for those without consistent insurance coverage.

- These families said they rely more on school resources and are more likely to pay out of pocket for emergency care.
- In many cases, care was delayed or limited due to cost.
- Immigrants are unaccustomed to the limited and very costly dental care in the U.S.
- Unpredictable employment during COVID-19 exacerbated cost concerns.

WHAT WE HEARD

“I’m interested in how we can make dental access more affordable. It’s treated like a luxury and it should be more like healthcare.” –Jenny, Portland

“I would make sure they were able to see the school nurse and the school dentist...so at least if some problems do pop up you can take them. If they ever do need to go, I would pay cash out of my pocket. It’s very expensive.”
–Anjenette, East Portland

“There are lots of kids that [school] really is the only way they get some of those screenings. If that’s not happening at school, where is it happening? Or will it happen at all? That is kind of frightening for people.” –Jessie, Joseph

WHAT WE HEARD

Providers do not readily offer interpretive services, which heightens misunderstandings, creates distrust and affects quality of care.

- Few Spanish-speaking participants said they were aware of such services.
- Families have the most trouble communicating health issues, asking questions and understanding answers, securing follow-up appointments and understanding overall health trajectories.
- They often feel taken advantage of and misunderstood, but unsure how to advocate for themselves.

WHAT WE HEARD

“The first clinic we went to had a person who spoke Spanish but then they referred us to a different clinic to treat the infection and they didn’t speak Spanish there.” –Alda, Portland

WHAT WE HEARD

Families understand the connection between braces and oral health and mentioned frequently the need for OHP to cover braces.

- Many families wanted braces for their children.
- Most mentioned they couldn’t afford them or struggled to pay for them.
- They saw them as important for overall physical and mental health, not just cosmetic.

WHAT WE HEARD

“I know that OHP would pay for it if there’s issues—if it’s causing pain or headaches—but it’s just pushing her teeth forward.” –Michelle, St. Helens

“I ended up getting braces on my own because OHP didn’t cover that. So I had to go through steps of my own.” –Laura, Salem

“OHP can only do so much. Does not cover braces. I would take them to get it if it was fully covered.” –Orlisa, Portland

“My oldest son got braces. Pretty expensive. Dental does not cover it and you have to pay upfront. I learned how to save money. That was his wish before high school. Now he has beautiful teeth.” –Anjenette, East Portland

What we heard:
Dental care during COVID-19

WHAT WE HEARD

Most families believe that, during COVID-19, dental providers are open for emergency visits only.

- A majority have not visited the dentist and don't plan to unless there's an emergency.
- Some have heard directly from dental clinics that they are closed.
- Some are presuming that dentists' offices are closed.
- Others don't yet have a regular dentist and plan to wait until after COVID-19 to establish care.
- There is some confusion about what qualifies as an emergency.

WHAT WE HEARD

"He had an appointment for March and then COVID hit and we haven't been able to reschedule it since. Every time they say their clinic is being shut down and is not taking patients." –Cheryl, Rainier

"I'm not sure if they're making appointments. I honestly haven't called. But I understand that if it is urgent, they will see us but if not, then no. But I think that even though I want to do it, I'll have to do it since I need to take [my child]."
–Guadalupe, Clackamas

"Three of my kids have cavities and we can't get in anywhere because of the COVID-19. They said it has to be an emergency. I don't know what to think. Maybe I should call around a look to see a different dentist? I don't know." –Martha, South Salem

WHAT WE HEARD

At best, caregivers feel anxious about going to the dentist during the pandemic.

- Many are choosing to stay home to protect themselves and their families from COVID-19.
- Black parents were more likely to say that going to the dentist during COVID-19 poses a serious risk to their health.

WHAT WE HEARD

"Of course I'm scared for my kids. We don't know this disease. Unless it's super painful and needs to be dealt with, everything else can wait." –Celia, Portland

"I feel, as a Black person, I don't want to go to the dentist or the emergency room and not have COVID and then come out and have COVID… where if I never went to the doctor or dentist then I would have been fine." –Shaniqwa, Gresham

"I'm the only person that [my daughter] depends on financially, so I will not risk anything where I will have to opt out of work just because right now any job you have is important and you hold on to that. So, I'd rather do the safety route and stay home." –Amy, Beaverton

WHAT WE HEARD

Those who *have* gone to a dentist during COVID-19 say it's stressful.

Overall experiences:

- Precautions being taken, with a few exceptions
- Long wait times for appointments
- Having to wait in the car + not getting accurate follow-up information
- Crowded waiting rooms, at times

Precautions reported:

- Symptom check by phone
- Symptom/temperature check at entry
- One parent allowed in
- Hand sanitizing
- Masks required
- Quicker service/less waiting
- Plexiglass barriers

WHAT WE HEARD

"They were really safe and sanitary about everything. We were in and out of there actually pretty quick. It was really efficient and I felt really safe." –Laura, Salem

"I was incredibly overwhelmed with the amount of people coming in and out of the small waiting room. It really was overwhelming." –Sarah, Philomath

"My daughter was due for a cleaning after they had opened it up in May to Phase I. I did send her in by herself because they didn't want extra people, which is sort of nerve-wracking when your 9-year-old is retelling you what the dentist and hygienist said, it's not always very reliable. I don't think there were any problems… I actually still don't really know." –Jessie, Joseph

WHAT WE HEARD

Those who *haven't* yet gone to the dentist say they want to know more about precautions being taken before they visit.

- What is being done to keep people safe?
- What are the risks?
- What's an emergency?
- Dental office staff don't appear to be proactively reaching out to let patients know about precautions.

WHAT WE HEARD

“[It would be good to hear from dentists about what they are doing so] we can have some requirements and some base standards. In the midst of a pandemic you really have to ask particular questions and ask about training and who will be there and how many people they are allowing in… so many factors. If you care enough to take care of their teeth, you obviously don’t want to come home with COVID.”
–Anjenette, East Portland

“None of us has ever been through a pandemic. With so much information thrown at everybody with everything, it’s kind of hard to know what is truth and what is false and what precautions anybody is taking.” –Cheryl, Rainier

What it means

WHAT IT MEANS

During the pandemic—and after—families want proactive ways to learn about preventive care and common dental issues.

- School has been an important source for preventive care—even while dentists and pediatricians are the primary source for seeking care when problems arise.
- Parents need proactive communication from CCOs, doctors and dentists to support them with preventing and addressing common issues.
- Peer groups and community-based social media provide new opportunities for reaching caregivers.

WHAT IT MEANS

Families want a consistent standard of family-friendly dental care that includes cultural competence and more culturally specific providers.

- Families want strengths-based, non-judgmental communications with their providers.
- Families value relationship-building that is grounded in cultural understanding, which could lead to more consistent care and improved outcomes.

WHAT IT MEANS

Families want to understand their rights for accessing interpretive services and want providers to use them more freely and consistently.

- This is an equity issue that could be exacerbating health disparities.
- Families need access to interpretation so that they can better understand procedures, support their child's oral health and follow through with services.
- Families need more education and tools so they know how to request and access interpretive services.
- We need to understand the barriers to connecting families with interpretive services among dental providers to inform potential solutions in culture and practice.

WHAT IT MEANS

Families want more family-friendly dental provider options in their area.

Especially in rural areas, families need access to more providers that:

- Are covered by OHP
- Have flexible appointment times (evenings and weekends)
- Offer reasonable appointment wait times for appointments that address issues
- Are located within 15-20 minutes' drive of where they live

WHAT IT MEANS

Families want braces to be covered by OHP.

- They understand the connection between orthodontic intervention and other aspects of physical and mental health, particularly for adolescents.
- Their children need braces, but they feel they have few options when it comes to paying for them.
- They worry about the effects on their child's mental health and quality of life, the longer braces are delayed.

WHAT IT MEANS

Families want dental providers to proactively communicate about COVID-19 precautions.

Families need to know:

- If dentist offices are open and what kind of services they are offering.
- What is expected and what precautions are being taken, before, during and after the visit.
- How to prepare themselves and their child before the visit.
- How to speak up and advocate for themselves.

WHAT IT MEANS

Families who are reluctant to visit the dentist still need to know what they can do for their child's oral health during the pandemic.

- Many need support weighing the risks of being exposed to COVID-19 against the risks of delayed dental care.
- They want to understand what qualifies as a dental emergency to help make the best decision for their child and family.
- They need to know what they can do for their child's teeth if they can't or won't visit the dentist during the pandemic.

RECAP

Issues worth considering for prioritization

- Braces coverage for OHP families
- Rural and working family access needs
- Family-centered, culturally appropriate care, including meeting language access needs
- Better informing and addressing families' concerns about seeking care during COVID-19
- Others?

What's next

NEXT STEPS

What's next

- Discuss what issues the coalition would like to prioritize and advocate for

Thank you!

Appendix

Exhibit B

The Voice of Malheur County

MALHEUR COUNTY HEALTH

Report: Malheur County leads state in access to dental care

Kids enrolled in Medicaid in Malheur County have the state's highest rate of access to care, according to a recent report.

By Yadira Lopez - The Enterprise
February 20, 2020 at 11:17am

Students at Nyssa Elementary learn about oral health through Healthy, Happy Smiles, a school-based oral health program targeting eastern Oregon. A study on children's oral health published last month by the Oregon Health and Science University determined that Medicaid-enrolled children in Malheur County had the highest rate of access to dental care in the state, according to data from 2018. (The Enterprise/Yadira Lopez)

VALE – Malheur County led the state in access to dental services for children enrolled in federal health insurance in 2018, according to a recent report by the Oregon Health and Science University.

Nearly 73% of the county's kids who are in Medicaid, which covers services for low-income people, received at least one dental service in 2018.

The county's percentage of kids enrolled in Medicaid who received at least one preventive service – 69% – was also the highest in Oregon, according to the report.

Statewide, 60% of Medicaid-enrolled children received at least one dental service that year, and 54% received at least one preventive service.

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The study's conclusion noted that "while transportation issues and dental provider shortages can create barriers to access in rural areas," counties like Malheur had high percentages of care compared to other counties.

"To help expand access to dental services, Oregon could investigate how these rural counties have surmounted potential challenges with access," the study said.

Oregon is struggling from an oral disease epidemic, said Melissa Freeman, director of strategic projects at the Oregon Community Foundation, which funded the report.

Increasing access to dental care is vital to help keep kids healthy and successful in school, she added.

Oregon WIC is still open for business
malheurhealth.org

In office and telemed appointments availal
healthcarewithheartllc

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Freeman said school-based oral health programs are a powerful tool that could be driving Malheur County's high rates of care. She pointed to the Eastern Oregon Healthy Living Alliance's school-based program Healthy, Happy Smiles.

The program works in partnership with Advantage Dental to put on a hands-on dental learning lab at schools across the county.

Healthy, Happy Smiles provides the learning lab and Advantage Dental from DentaQuest provides the services.

The dental hygienist from Advantage Dental comes into schools and provides free check-ups and dental services to students whose parents have signed consent forms.

“In areas where we have a heavy presence we see higher rates of reaching our Medicaid population and I think that’s very true in Malheur County,” said Mary Ann Wren, manager of community care for Advantage Dental.

Advantage Dental currently serves 21 schools in Malheur County, from early head start to high school. It partners with Healthy, Happy Smiles in 11 county schools.

Wren said the hygienist her firm provides has developed a relationship with the schools.

“When we’re out in the community, any time she enters the services into our system we’re connected to a larger network and our case management team will follow up on kiddos who have elevated needs,” Wren added.

She said Advantage Dental will return to schools up to three times a year to follow up on kids found to be at risk for more serious dental issues.

The hygienist assesses students’ needs in a screening at school and then returns for preventive services.

“After every time we’re there [the kids] get a dental report card detailing what was done, what was seen and our recommendations,” Wren said. “Whenever that’s entered into the system if a child has urgent needs our case management team follows up to get them into care.”

The services, she added, are meant to be complementary; her team encourages parents to get a family dentist, and they help parents arrange that.

Wren said the goal is to get ahead of chronic diseases such as cavities.

The study also looked at the rate of emergency department visits that could have been prevented

through timely care at a dentist's office. The statewide number was 7.7 visits per every 1,000 Medicaid-enrolled children and young adults. In Malheur County, the rate was nine per 1,000.

"The research is clear. Poor oral health harms the well being of kids," said Chris Coughlin, legislative director of Children First for Oregon.

Coughlin said her organization often hears accounts of kids who end up in the emergency room with severe dental pain.

"Dental pain is a leading cause of absenteeism," she said. "Kids suffering from dental pain are more likely to miss school and have lower grades. Families are going into medical debt that with the right services could have been prevented."

"Here's the bottom line," she said. "All our kids need preventive dental care."

Have a news tip? Reporter Yadira Lopez: yadira@malheurenterprise.com or 541-473-3377

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Appendix

Exhibit C

800 NE Oregon St, Ste 825
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www.healthoregon.org/schooloralhealth

Memo

DATE: April 30, 2020

TO: School Fluoride Tablet and Rinse Program Coordinators

FROM: Cate Wilcox
Maternal and Child Health Manager, Title V Director
Public Health Division, Oregon Health Authority

RE: Oregon Health Authority's Statewide School Fluoride Tablet and Rinse Program Discontinued

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Oregon Health Authority's (OHA) school fluoride rinse and tablet program known as the "Swish and Swash" and "King Fluoride Program" respectively began in 1974. This program has been an important preventive intervention to reduce cavity rates of Oregon children since over three-fourths of our state's population does not have access to fluoridated community water systems.

OHA is grateful for your continued support and efforts to provide fluoride in Oregon elementary schools. We understand that with all that you do, it is an extra, albeit important, benefit for students.

As most of you are aware, there have been challenges in recent years to obtain and distribute fluoride rinse and tablets as part of the OHA program. The fluoride rinse used, both packets and individual dose cups, has been discontinued by the lone U.S. manufacturer. Nationally, there is only one fluoride tablet manufacturer and costs have significantly increased to unmanageable levels.

Due to the inability to obtain and sustain distribution of fluoride rinse and tablet products, OHA has decided to discontinue the statewide School Fluoride Tablet and Rinse Program at the end of this school year (2019-20). The decision to end the program is not related to the COVID-19 pandemic.

OHA has developed the enclosed FAQ sheet to help answer some initial questions. If you have any other questions, please contact Karen Phillips, OHA School Oral Health Programs Coordinator, at karen.phillips@dhsoha.state.or.us or (971) 673-0235.

Thank you again for your years of partnership in supporting school fluoride programs! OHA encourages you to ensure your school has access to a school dental sealant program, and if it does, potentially partner with them to provide fluoride varnish to students.

Frequently Asked Questions (FAQs)

Q. Can we use up our remaining tablets?

A. All of the tablets will expire either May 2020 of September 2020. DO NOT use tablets after their expiration dates. Please dispose of the tablets according to community waste disposal standards or return to Karen Phillips, OHA School Oral Health Programs Coordinator, at karen.phillips@dhsoha.state.or.us, 971-673-0235

Q. Can we use up our remaining individual dose cup rinse?

A. The unit dose rinse expires March 31, April 30 or June 30, 2020. DO NOT use this product beyond its expiration date. Please dispose of the dose cups according to community waste disposal standards or return to Karen Phillips at OHA.

Q. Can we use up our remaining fluoride rinse packets?

A. The packets have a variety of expirations dates from 2020 through 2021. Some schools may have enough rinse packets to complete the 2020-21 school year. Use only non-expired product. Please dispose of the expired rinse packets according to community waste disposal standards or return to Karen Phillips at OHA.

Q. Will OHA provide toothbrushes, parent permission forms, training and support for us if we have fluoride rinse packets to use for the 2020-21 school year?

A. Yes. OHA will provide you with rinse permission forms, technical assistance and training (including infection control guidance) for the 2020-21 school year. We will send you quantities of forms and toothbrushes based on your previous years' participation.

Q. What if we do not want to continue to use our remaining fluoride rinse packets?

A. Please return any unused expired or unexpired fluoride rinse packets and jugs to Karen Phillips at OHA. The jugs and unexpired product will be redistributed for use.

Q. Will we have to complete the data report reflecting our 2019-20 school year participation?

A. Yes, please! We rely on reported data to evaluate our program. We understand the challenges in reporting the 2019-20 school year's data. We will send a SurveyMonkey for you to complete when you are able.

Q. Who can we contact to see if our school participates in a school dental sealant program?

A. Contact Karen Phillips at OHA to receive a list of school dental sealant programs operating in your area.

Appendix

Exhibit D

Washington County Community Health Improvement Plan

Oral Health Access Pilot Project: Year One Report

1/22/2020

Project Background

There are significant inequities in access to oral health services in Washington County, especially for uninsured and Latinx communities. There is also limited access to culturally responsive care, significant gaps in connecting uninsured patients to a "dental home" and ensuring closed loop referral to other services. Oral health access is a recurring issue identified in local community health assessments.

As a result, oral health access was identified as a priority area in the 2017 Washington County Community Health Improvement Plan. The CHIP Access to Care Committee reviewed assessment data, determined priority areas, and created a pilot project as a strategy to address these issues. Washington County Public Health, Oregon Oral Health Coalition and Pacific University partnered to develop an innovative dental access program to determine if having a certified Community Dental Health Coordinator (CDHC) increases closed loop referrals, improves access to oral health care and increases donated community resources for the uninsured.

To test the impact of this model, a bilingual, bicultural CDHC was hired and placed in a community-based dental hygiene outreach program. This program is run by Pacific University and works closely with the Providence Health Promotores de Salud. Dora Sandoval, the first certified CDHC in Oregon, was hired for this role. Over the first year, the program increased closed loop referrals and supported important community partnerships to improve oral health access. This project has clearly demonstrated the need and positive impact of community-based navigation, education and care coordination as well as the value of the CDHC role.

Community Dental Health Coordinator Role

Tens of millions of Americans lack adequate access to dental care. Many of them suffer from untreated disease and preventable related complications because they don't have access to preventive dental health care and education. Difficulty finding a dentist, which is common, also makes the problem worse. Unfortunately, access to dental care and finding a dental home both have more to do with other community factors such as poverty, geography, language and cultural barriers, and availability of child care or transportation, rather than just the lack of dentists able to treat patients.

In response to these challenges, the American Dental Association launched the Community Dental Health Coordinator (CDHC) program in 2006 to provide community-based prevention, care coordination, and patient navigation to connect people who typically do not receive care from a dentist.

CDHCs are typically recruited from the same communities in which they will serve to eliminate cultural and language barriers that might otherwise reduce the effectiveness of these CDHCs. The CDHCs' connections to the communities also help establish trust and comfort level and, in turn, increase participation in provided services.

By focusing on oral health education and disease prevention, the CDHC can empower people in underserved communities to manage their own oral health. The CDHC refers patients to dentists who can provide other needed services in cases that require further evaluation, treatment and follow-up. Additionally, the CDHC also helps patients obtain other services beyond dental care — such as child care or transportation — they may need to receive care. (American Dental Association)

Project population of focus

For this project, the focus was on the Latinx population within Washington County, particularly uninsured community members because they are known to experiences significant barriers to accessing the health care they need.

Project overview and evaluation

The CDHC worked for all of 2019, following up on referrals for patients receiving dental hygiene care at the Pacific University Dental Hygiene Van outreach sites. The CDHC also made improvements to a community dental services database with patient resources and a directory of dentists and dental care providers who offer low-cost and accessible dental health services. The CDHC provided ongoing oral health education, support and training to the community at large as well as community health professionals and volunteers on oral disease prevention and basic dental hygiene.

To measure the impact and contributions of the project to the priority community, the following evaluation measures were identified:

1. Increased access to oral health education and prevention services for uninsured population in Washington County
2. Evidence of successful closed-loop referrals for follow-up care for patients as recommended during hygiene appointments
3. Reduced no-show rate for care donated by dental health providers
4. Establishment of additional dental health providers donating care
5. Increased number of patients who have established a dental home

EXAMPLE OF CLOSED LOOP REFERRALS

In February 2019, a patient visited the dental hygiene van and was provided multiple services including dental health screening, OHI, gross debridement and fluoride varnish. The CDHC referred the patient to Pacific University for a full set of radiographs, comprehensive examination, deep cleaning and fillings. The CDHC also provided a referral to Medical Teams International (MTI) for additional fillings and extractions. The patient had deep cleaning and some fillings at Pacific University. The CDHC called MTI and scheduled the patient for remaining treatment. All services were completed by April 2019. The patient was seen again for recare at the Pacific University dental hygiene van in July 2019. This was a great example of closed loop referral for all services.

This was the first time a program of this kind has been implemented in Oregon to improve access to dental care services and education for those in dire need of these services but unable to afford or have access to it. There were numerous success stories over the course of this implementation as well as some lesson learned and opportunities for improvement. The following outlines some of these successes and lessons in each of the evaluation categories.

Evaluation Question 1: Did the CDHC increase completion of referrals (closed loop referrals) for follow-up care and return to hygiene appointments?

Services offered by the CDHC during patient appointments provided a level of care, education and follow-up that was not available to patients not seen by the CDHC. The CDHC served 124 patients during the first year of this project. Over half of all patients (57%) required referrals for fillings, extractions or deep cleanings. More than one in three (38%) successfully completed the referral by attending the appointment and "closed the loop" by having their dental needs met for fillings or extractions. Approximately, one third (31%) completed the referral for deep cleanings. Another third of patients (31%) seen by the CDHC did not require referrals for more intensive dentistry but were counseled about preventive dental hygiene practices and reminded of their six-month cleaning appointment. Of these patients, eight (about 20%) successfully returned for preventive dentistry during the CDHC project year. In addition to completing recare at the van, seven patients established dental homes. Achieving these results over the short period of this project is a clear representation of the benefit and tangible impact of this program and services offered by the CDHC.

The CDHC also referred patients for other health concerns identified during their intake interview. Examples of these referrals include 14 patients who were referred to a provider due to high blood pressure, high blood glucose or other social services/resource need. See Table 1 below for more details on each type of referral and percent completion.

The Value of a CDHC

In April 2019, an inebriated patient came to the dental hygiene van with his wife. The patient's wife wanted her husband to get dental care, so she gave up her appointment on the van so he could get support. The next patient did not show up, so both were able to be seen. In talking with the patient's wife, the CDHC found out that he misuses alcohol. The CDHC was able to refer him to a behavioral health specialist and to Alcoholics Anonymous (AA). The patient's wife had increased blood glucose levels and the CDHC gave her a referral to a physician to address possible diabetes.

Table 1. Counts and completion of referrals by type, 2019 project year

Referral Type	Number of referrals*	Number of closed loop referrals	Percent closed
Fillings or extractions at safety net providers (Medical Teams International or Virginia Garcia Memorial Health Center van/clinics)	34	8	38%
Deep cleanings or fillings at Pacific University	67	21	31%
High blood glucose levels	9	5	55%
High blood pressure	2	1	50%
Private dentists for follow-up care	6	3	50%
Diabetic referral to primary care	9	5	55%

*Note: patients may have had more than one referral

Evaluation Question 2: Did the CDHC increase the number of patients receiving oral health education?

The CDHC provided oral health education to each patient seen at the dental hygiene van. She provided education on periodontal disease and overall health, correlation between diabetes and periodontal disease, pregnancy gingivitis, diet and nutritional counseling, and oral hygiene instruction.

Patients were asked to complete a satisfaction survey at the end of each visit and included questions on timeliness of service and quality of care. During the CDHC project year, two questions were added to capture the provision of oral health education. Of the 20 patients who completed the post-visit survey, 90% said that their understanding of diet and nutrition had improved, and 100% stated that their understanding of oral hygiene improved.

In addition to the survey results, the patients who established dental homes and the patients who were seen for preventive dentistry in six months at the van are evidence of increased oral health education.

Evaluation Question 3: Did the CDHC increase the reach, efficacy and the knowledge base of the Promotores?

As part of the year one pilot, the CDHC collaborated with the Promotores de Salud program of Providence Health. The Promotores are trained volunteers who build healthier communities through parish-based health promotion in the Latinx community. The Promotores disseminate information on health and health services and serve as liaisons between the community and the health delivery system to build relationships between the Latinx community, local churches and health care providers. The

CDHC worked closely with the Promotores and provided the Promotores with a greater level of understanding of oral health issues to help them to continue to support their communities. The CDHC will continue to work with the Promotores de Salud in year two and we have planned to participate in a Promotores meeting to gather feedback to inform year two of the program.

Initial feedback from the Promotores included the following:

- the CDHC being bilingual and bicultural made it easy to connect and build a relationship; there was a high level of trust between the patients and the CDHC that made patients feel more comfortable asking questions about the dental cleanings;
- the CDHC played an important role in following up with patients that needed further dental services and assistance;
- the CDHC opened new channels for referral for additional services such as crowns, extractions, and fillings.

The Promotores program recommended a CDHC with a flexible schedule, or additional CDHC capacity, to meet patient scheduling needs in the future.

Evaluation Question 4: Did the CDHC improve and enhance the use of donated dental care in the community?

Project partners identified a need for more donated dental care in the Washington County community. The CDHC presented to the Washington County Dental Society and developed communication materials on the need for donated care intended for dental providers. Oral health partners identified that Washington County dentists would like a more formal approach to donated dental care in the county, including standard hours, a tracking process, and support for community members to decrease no-shows. Better coordination of donated dental care to ensure the best use of the providers' time and resources and ensuring we are meeting patients' needs would be a beneficial CDHC role. While this part of the project has been gaining momentum, it is in the early stages and there is the opportunity to continue this work in year two.

Evaluation Question 5: Did the CDHC enhance community connections and alignment of resources related to oral health?

In 2019, the CDHC developed a comprehensive dental health resource guide with updated contact and eligibility information. This tool has been posted on the Washington County website, and was provided to Washington County health care partners, WIC clinics, Maternal and Child Health field team nurses, and the Washington County health care resource line.

The CDHC also provided community oral health education through training community health workers from the Immigration and Refugee Community Organization (IRCO) Africa House as part of their certification requirements.

The CDHC also presented on this project and important role of a CDHC at the Council on Advocacy for Access and Prevention (CAAP) of the American Dental Association, The Oregon Public Health Association Annual Conference, and to the Washington County Access to Care Committee. There was positive feedback from community partners as a result of these sharing opportunities.

The CDHC took a lead role in identifying and working to address referral barriers for urgent dental care needs. She provided information on the issue at a Washington County Access to Care meeting. As a result, the leadership from a Washington County federally qualified health center, Virginia Garcia Memorial Health Center (VGMHC), connected her with the appropriate staff to address the issue. The CDHC collaborated with Pacific University and VGMHC to hold appointment slots for uninsured patients with urgent care needs. This collaboration was a significant success of the project.

Conclusions and Next Steps

The closed loop referrals and success for connecting patients to care, the improved partner collaboration and coordination, and the impact on oral health access are clear across the results of year one. The project resulted in exciting new collaborations for oral health access partners across Washington County. Partners are excited to use the learnings from year one to support continuous improvement in year two of the project.

As the project moves into the next phase, some key learnings are offered from the successes in year one. These include:

1. Improved data collection and referral coordination
2. Expansion of populations reached by CDHC
3. Role of CDHC in developing systems and connections for dental providers and oral health access partners

Thank you to the following partners for their contributions and partnership:
Dora Sandoval, BSDH, EPDH, CDHC
Oregon Dental Association
Pacific University Dental Hygiene School
Oregon Oral Health Coalition
Providence Health and the Promotores de Salud
Washington County Health and Human Services and Public Health Division
Washington County Community Health Improvement Plan partners and the Washington County Access to Care Committee