Smart Mouths, Healthy Bodies:  
An Action Plan to Improve  
The  
Oral Health of Coloradans

Five Year Evaluation of Progress  
July 31, 2011

Prepared for the Oral Health Colorado Coalition  
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This report is a review of progress made since initiation of Colorado’s “Smart Mouths, Healthy Bodies: An Action Plan to Improve the Oral Health of Coloradans.” In looking back over the five years the plan has been in place, significant progress forward has been made in Colorado to increase awareness of the importance of oral health, the relationship of oral disease to overall health, and the interest in improving the oral health workforce to increase access to oral health services for all of Colorado’s population. It is progress worth celebrating and provides incentives to continue to push even harder to realize the agreed upon goals in the next five years. To understand how the progress was made, it is useful to acknowledge the process used to devise the goals.

Colorado’s current “State Oral Health Plan” (COSOHP) was completed in the Fall 2005 by the Oral Health Plan Action Team, convened by the Oral Health Awareness Colorado! coalition in 2004. The plan followed a successful stakeholder summit on November 19, 2004 in which six primary focus areas were agreed upon as a framework:

**Financing of Oral Health** which pursues effective financing of both the system of oral health care and the activities of the state oral health plan.

**Promising Practices** directed at successful, evidence-based and research-based strategies, decision-making practices, and activities that can to replicated and applied to oral health problems.

**Policy and Advocacy** initiatives directed at public or private policies that need to be established or advocated for in order to positively impact access to or delivery of oral health care services.

**Health Promotion** outcomes directed at educating the public on the relationship between oral health and general health and on individuals’ roles and responsibilities for their own oral health.

**Systems of Care** to assure the coordination of systems of care for more efficient and effective application to oral health.

**Workforce** activities to assure both access to oral health care and the development of a diverse, competent, and representative-of-the-population oral health workforce.

This process closely aligned with the infrastructure development tool for state oral health plans developed by the Centers for Disease Control and Prevention’s (CDC) Division of Oral Health.

The CDC highlights the need for the state oral health plan to draw upon data regarding the

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burden of oral disease in the state population, proven prevention approaches such as community water fluoridation and school-based sealant programs, best practices as found in the ASTDD Best Practices website, and acknowledgement of barriers to implementing disease prevention programs (Fig. 1).

Within each of the six focus areas, “Priority Outcomes” and coinciding strategies were outlined. Within each strategy, suggested partners and action steps were identified as a means to move the plan forward. This analysis will evaluate the Priority Outcomes and strategies to showcase progress in the state in improving the oral health of Coloradans.

It should be noted that while Smart Mouths, Healthy Bodies: An Action Plan to Improve the Oral Health of Coloradans was the first oral health plan addressing all population groups, it was not the first state oral health plan. In 2000, under the leadership of Governor Owens, a Commission on Children’s Dental Health met for six months and identified three focus areas and nine strategies for improving the oral health of Colorado’s children. These in turn led to five legislative initiatives that have significantly altered the face of oral health in Colorado:

- Increase the investment in revention in order to reduce costly acute medical and dental care.

- Outline a dental benefit that meets the minimum oral health needs of children and increases the number of dental providers.
  
  HB01-1331 added a dental benefit to Colorado’s Child Health Plan Plus (the state SCHIP program for children authorized by Congress in 1997). Colorado was the second to the last state to add the dental benefit.

- Build and expand a network of dental professionals in order to increase the dental safety net for Colorado’s at-risk children.
  
  HB01-1282 added dental hygienists to the recognized provider list for Medicaid so that they could bill Medicaid directly.

  HB01-1257 added dentists and dental hygienists to state income tax credit for health professionals program. This allowed dental professionals living and working in identified rural shortage areas to receive a state income tax credit.

SB 01-164 created the state dental loan repayment program, which assisted dentists and dental hygienists with repayment of educational loans in exchange for serving underserved populations, including Medicaid, Child Health Plan Plus, low-income uninsured, and Old Age Pension seniors.
SB 01-212, the year’s Long Bill, created a $2M line item for the Department of Health Care Policy and Financing to administer a grant program to expand the infrastructure of safety-net dental clinics.

The Smart Mouths, Healthy Bodies: An Action Plan to Improve the Oral Health of Coloradans built upon the success of the Commission on Children’s Dental Health, with perhaps not quite the same successful outcomes. A discussion of “why” occurs in the discussion portion of this report.

In 2008, a “midcourse” review was undertaken to assess progress on the state oral health plan. Smart Mouths, Healthy Bodies: Actions Toward Improving the Oral Health of Coloradans highlighted progress made to-date and assessed the policy climate in terms of how successful the plan was in changing policy, as well as how the political climate was affecting progress on the plan. In scanning national as well as state initiatives, it was noted that significant progress was being made in the focus areas of financing, health promotion, and policy & advocacy; but no detectable progress on systems of care strategies, and only a “perceived” improvement in the areas of workforce and the replication of promising practices. Specific examples were presented in each of the focus areas to capture the progress made and policy initiatives that may have been counter-productive. The report concluded with five primary recommendations:

- Utilize and disseminate currently available sources of information for promising oral health programs and practices.
- Increase understanding of Systems of Care applications for oral health care and develop broader strategies to evolve from a provider to a system focus.
- Combine the strategies for Policy and Advocacy with Financing into one Topic Area ‘Policy and Financing.
- Continue to commit resources to assessment, evaluation and research in the areas of epidemiology, practice, workforce, and systems of care.
- Continue to formulate and disseminate messages for target audiences, particularly legislators.

This review will note progress on these recommendations as well as document oral health activities throughout the state over the period of the COSOHP in preparation for another plan to be developed by the Oral Health Colorado coalition.
Development of a State Oral Health Plan

The CDC developed a “map” to outline the process of developing a state oral health plan (Fig. 2) Oral Health Colorado adhered to this fairly well, but choosing to conduct the regional-community meetings after the launch to garner feedback on becoming partners in the six identified focus areas.

The Oral Health Unit at the Colorado Department of Public Health and Environment and the statewide oral health coalition, Oral Health Colorado, convened a planning team to conduct the statewide summit and to finalize the plan. Once the plan was finalized, it was launched in a breakfast meeting with key stakeholders and accompanying press release. The plan was then presented to oral health and policy entities throughout the state for input and buy-in. Oral health entities included local dental component societies and policy entities included three non-metro regional policy action committees: Progressive 15 representing the NE part of the state; Action 22 representing the 22 counties in the SE part of the state; and Club 20, representing the counties on the Western Slope.

Comments received in these forums centered around two main themes: the aggressiveness and breadth of the plan to be completed in five years, and who was ultimately responsible for assuring progress on the plan. Oral Health Colorado reviewed the comments and agreed it was aggressive but wanted to retain the priorities and strategies it had. They also decided to take on the responsibility of assuring progress on the plan by developing “State Plan Implementation Teams” (SPIT) and assigning a lead person for each of the SPITs. At each coalition meeting, each SPIT would report on progress. The SPITs aligned with the six focus areas, and added a Communications team. A contract was established with Miles Consulting to gain a voice at the legislature as key policy initiatives were decided upon.

Other key milestones included the contracting of an evaluator by the state Oral Health Unit who within a year of the launch of the plan conducted a survey of key stakeholders immediately following the release of the plan. The results of this survey included:

1. Strong agreement that oral health is an important part of general health
2. Efforts are needed to improve capacity and to eliminate gaps in oral health services in Colorado
3. A plan is needed to improve policy and practice associated with oral health for all Coloradans
4. Partners are needed within and external to the dental community to implement the oral health improvement plan in Colorado

Survey respondents also agreed that the top three strategies in the plan that they personally were in favor of included:

- Health promotion education the public (e.g. parents and students) on the relationship between oral health and general health
- Increased oral health education in schools
- Making dental care part of medical home. Working on policy level to increase insurance assistance for dental care. Integrating dental hygiene into school personnel structure.

If any of the strategies were of concern, it was in the area of financing, only because of the hurdles to achieving success, not that the strategies should not be attempted.

Two years after the release of the plan, a second survey was conducted of key stakeholders to gauge awareness of OHAC! and the state oral health plan and how it was being used. Thirty-five stakeholders participated in the survey:

Thirteen respondents indicated they had used the oral health plan.
- The most common use of the report was a data resource and as a reference to write grants/reports for grantors, proposals or presentations. Examples include:
  - Used to prepare oral health information for The Colorado Promise, developed by Governor Bill Ritter.
  - Guided the development of a county-level oral health assessment where it was used to keep county activities in alignment with those of the state.
  - A non-profit organization staff person used the information to develop a proposal to bring safety-net oral health services to her community.
- One foundation staff person used it as an information resource when addressing oral health issues.
- One academic and two non-profit organizations used it as a strategic planning resource.
- A state employee used it to locate oral health resources.
- One state office and one non-profit organization shared the report internally with people who were in decision-making or planning positions.
- A professional organization used it to develop education materials and shared it with members.
- A non-profit organization had shared the oral health plan with their board to educate them about oral health issues.

Negative comments centered around the lack of specificity in the means to achieve the goals of the plan (which measurable objectives would have addressed).

Comparison of state oral health plans provides a bit of insight into the categories that should be included. The Children’s Dental Health Project (CDHP) provides a comparison of state oral health plans on their website. However, they use Colorado’s 2000 Children’s oral health plan as the comparison,
rather than the current one that is the subject of this evaluation. The categories for comparison include (in other words, does the state plan have in it):

- CDC Activities (Leadership, burden document/surveillance system, coalition/partnerships, evaluation, fluoridation, and sealants)
- Increasing policymakers’ and the publics’ awareness of oral health
- Workforce issues
- Education (dental and non-dental professionals)
- Case management/integration of health services/continuity of care
- School-Based/community-based programs
- Safety Net (Access to care, underserved areas, cultural competence of care)
- Special Needs populations (pregnant women, early childhood, tobacco and alcohol users/cancer prevention)
- Financing (Medicaid/SCHIP, state general fund)
- Miscellaneous

This is not to say that every state plan should necessarily include all of these categories as state oral health plans need to be response to the individual state priorities, but it does provide a reminder of categories to discuss in designing a plan that meets the oral health needs of the state’s population.

Perhaps more significant is whether the plan has the elements described in the CDC State Oral Health Plan Framework (Fig. 1).

- Measurable objectives that are data-driven
- Strategies that are science-driven
- Planning that is capacity-driven
- Evaluation that is evidence-driven

In the next revision of Colorado’s state oral health plan, a format that includes SMART objectives, references the science behind the selected strategies, keeps in the forefront the issues of capacity to carry out the strategies, and builds in an evaluation component from the start, will assure the plan is realistic and reflective of Colorado’s current environment.
**Topic Areas of Action Plan Focus**

While each “focus area” will be presented here separately as it appeared in the plan, there is significant overlap in successes. Many actions contributed to success in more than one focus area (e.g. the Cavity Free at Three initiative is successful in Health Promotion, Financing, Promising Practices, and Workforce) and will be highlighted under each. The “priority outcomes” were the desired end results, with the strategies only suggestions on how to achieve the outcomes with suggested partners and action steps. Each of the focus areas were referenced to one or more of the five action items in the Surgeon General’s Call to Action:

- Change Perceptions of Oral Health
- Overcome Barriers by Replicating Effective Programs and Proven Efforts
- Build the Science Base and Accelerate Science Transfer
- Increase Oral Health Workforce Diversity, Capacity, and Flexibility
- Increase Collaborations

**Financing**

In 2005, the same year as this state oral health plan was drafted, Colorado residents voted to suspend the revenue caps mandated by the Taxpayer Bill of Rights (TABOR) for five years. However, despite this potential easing of fiscal constraints in the state budget, the economic downturn in the latter part of the decade prevented significant progress in the goals identified in the plan:

| Priority Outcome #1: Increase proportionally the amount of dollars spent on oral health care relative to overall health care. |
| Priority Outcome #2: Increase the number of Coloradans who have access to dental insurance coverage. |

The possible strategies for achieving this included quantifying the financial impact of preventing oral disease, educating and encouraging legislators to prioritize oral health financing, assuring that Colorado is utilizing and maximizing all funding for oral health, identifying potential funding sources for adults as well as children, and investigating the addition of a dental benefit under CHP+ for pregnant women.

A great deal of work has been dedicated to this focus area over the past five years, with perhaps a slight gain despite the very visible losses.

- **Temporary loss of Old Age Pension Dental benefit in 2009.** (-)
  
  The OAP dental benefit was originally legislated in 1977, recognizing the oral health needs of low-income seniors who were often living in pain, without dentures and partials, and were at risk for losing their general health and independent living due to oral infections. The program was financed by state general fund of ~$600K/year, serving over 750 seniors yearly. As the state’s fiscal situation changed, these funds have been used to help balance the budget.
☐ Redefining of Medicaid dental benefit for pregnant women in 2008. (-)
   Many see this as a “loss” of a benefit which was not really there to begin with but had been functioning for many years. The redefining of the benefit clarified that certain oral health care procedures were a benefit during pregnancy with substantiation that the dental problem may be exacerbating the pregnancy complications (e.g. gestational diabetes). Routine preventive care during pregnancy was no longer allowed as Colorado has not had an adult dental benefit under Medicaid except emergency extractions.

☐ Elimination of “stairstep” eligibility in Medicaid for children 2011. (+)
   In Colorado prior to this legislation, children ages 0-5 living in families with incomes above 100% of the Federal Poverty Level (FPL) and below 133% of the FPL were eligible for Medicaid; but children 6-20 were only eligible for the CHP+ program, resulting in varying health coverage programs with different benefits in the same family, confusing parents and providers.

☐ Governor veto of legislation that would have added a monthly premium to CHP+ (rather than yearly) in 2011 (+)

☐ Medicaid “carve-out” legislation failed (-)
   This was a recommendation of the Colorado Legislative Council’s Health Care Task Force in 2009 with the intent of improving the administration of the Medicaid dental benefit to entice more providers to participate.

☐ Oral Health included in Blue Ribbon Commission report on health care reform in Colorado (+)
   Submitted to the Colorado General Assembly on January 31, 2008, the Commission recommended that dental benefits for both children and adults be part of the benefits included in a state-specific health care reform package.

☐ Economic impact of community water fluoridation report in Colorado completed (+)
   Published in the e-journal Preventing Chronic Disease, Costs and Savings Associated With Community Water Fluoridation Programs in Colorado by Dr. Joan O’Connell highlighted that Colorado would save $47 million annually in dental costs if “community water fluoridation programs were implemented in the 52 water systems without such programs and for which fluoridation is recommended.”
   http://www.cdc.gov/pcd/issues/2005/nov/05_0082.htm

☐ Funding for SB 97-208 was defeated again in 2008 that would have provided state general funds for school-based sealant programs (-)
   Existing legislation allowed the Colorado Department of Public Health and Environment the ability to seek grant funds for school-based sealant programs, which there had been significant success through the Health Resources and Services Administration (HRSA) through two grant programs. However, this was not sustainable for the long term.

☐ Reduction in Medicaid dental provider reimbursement rates and payment delays in 2009/2010 (-)
   Throughout the last decade, dental provider reimbursement rates have increased, decreased, but have not attained a level that covers the overhead costs of the majority of dental practices. A recent estimate found reimbursement rates at about 48%.
☐ Significant investment by local Colorado Foundations into oral health initiatives (+)
  Caring for Colorado is into its third $1 million oral health initiative; six foundations partnered to fund Cavity Free at Three; The Colorado Trust and the Colorado Health Foundation’s investment in oral health workforce activities; Delta Dental of Colorado Foundation’s investment in school-based sealant programs, interprofessional education, and public awareness campaigns; and El Pomar’s support of communities obtaining direct care for uninsured children.

☐ Legislation to add an adult dental benefit to Medicaid and CHP+ failed (-)
  This bill (SB 009) was the second recommendation coming from the Colorado Legislative Council’s Health Care Task Force in 2008. Although broadly supported by both dental and primary care health providers, as well as the majority of committee members, the issue was one of economics.

☐ Significant expansion of the dental components of the safety nets (+)

☐ Medicaid begins reimbursing physicians and other primary care providers for screening and fluoride varnish applications in 2009 (+)

☐ The Colorado Health Institute completes the Oral Health Environmental Scan in 2005, which quantified the rates of oral disease in Colorado, the specific initiatives to improve oral health and identified key promising practices [http://www.coloradohealthinstitute.org/~/media/Documents/OralHealthScan.ashx](http://www.coloradohealthinstitute.org/~/media/Documents/OralHealthScan.ashx)

While not a lot of progress was made on increasing the proportion of oral health dollars relative to overall health funding, the Blue Ribbon Commission on Health Care Reform documented a baseline from which to work from in its final report.

Figure 3: FY 2007-2008 Estimated Spending in Colorado by Type of Service and Source of Funding provided to the Commission by The Lewin Group.

Restoring the Old Age Pension benefit for low income seniors and/or adding an adult dental benefit to Medicaid, assuring dental benefits for pregnant women, and setting provider reimbursement rates at a level to assure participation would increase the proportion of dental expenditures in relation to total spending.
Health Promotion

The primary intent of this focus area was to raise public awareness on the relationship between oral health and general health and the personal responsibility individuals can take to improve their own health.

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<td>Priority Outcome #3: Educate consumers about their dental plans in order to maximize insurance utilization and third party reimbursement.</td>
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The possible strategies for these outcomes included increasing the knowledge and awareness of oral health issues among primary care providers; build a database of existing health promotion projects; develop a series of targeted health promotion/communication campaigns; increase oral health education in schools, medical centers and the community-at-large; and develop materials emphasizing prevention for use by third-party payers and HR departments.

These outcomes are difficult to measure concretely, but intuitively, significant progress has been made.

☐ Delta Dental Foundation launches media campaign (+)
   Working with GBSM (a communications, management consulting and public affairs firm), Delta launched a public awareness campaign in Metro Denver highlighting the importance of oral care during pregnancy and preventing the transmission of bacteria from mother to child. http://www.healthyteethhappybabies.com/

☐ Oral Health Awareness Colorado produces multiple op-ed pieces (+)
   www.besmartmouth.com

☐ Cavity Free at Three initiative trains primary care providers and general dentists (+)
   The program, now with the Colorado Area Health Education Center (AHEC), emphasizes the importance of seeing children as soon as the first tooth erupts and educating pregnant mothers through motivational interviewing techniques and fluoride varnish applications http://www.cavityfreeatthree.org/

☐ Oral health promotional materials developed by Univision for their market (+)
   OHAC! Communications Spit team provided technical expertise in the development of messages that ran on local radio and television Spanish language markets.

☐ Oral health “report cards” released by Pew Center on the States and the Colorado Health Foundation (+/-)
   The Pew Center on the States released two report cards, “The Cost of Delay” and “Dental Coverage Matters” (linked above). In both instances, Colorado received the letter grade “B” for meeting 5 of 8 recommended infrastructure indicators determined to assure improved oral health in the state. The three indicators Colorado did not meet...
included 1) no policies/legislation moving the alternative oral health care provider forward; 2) having less than 75% of residents on public water systems served by optimal levels of fluoride; and 3) low Medicaid dental reimbursement rates to providers.

☐ “OHI Listserve” established to keep subscribers up-to-date on new oral health research, funding availability, and news of interest (+)
   Maintained by the Oral Health Unit at the Colorado Department of Public Health and Environment, subscribers are informed of news releases, new national publications, and funding opportunities.

☐ Colorado professor of Family Medicine at the University of Colorado School of Medicine is instrumental in the development of the Smiles for Life Curriculum (+), an on-line curriculum on oral health targeting non-dental health professionals. [www.smilesforlife.org](http://www.smilesforlife.org)
   The Smiles for Life Curriculum on a national level has spawned interest among non-dental providers to become educated about oral health issues. The National Interprofessional Initiative for Oral Health ([www.NIIOH.org](http://www.NIIOH.org)) has a vision that all dental disease can be eradicated and that primary care providers play a crucial role.

☐ Delta Dental of Colorado Foundation funds the CU Frontier Center at the School of Dental Medicine to support interprofessional education (+)
   In its sixth year, the Frontier Center has trained over 1,000 medical and physician assistant students in intra- and extra-oral exams and fluoride varnish application.

☐ The Denver Children’s Oral Health Partnership program is initiated (+)
   Through the Center for American Indian Health at the University of Colorado, School of Public Health, provides classroom education and fluoride varnish for ECE-1st grade at Denver Public Schools with “Native American Focus” (+)

☐ The School of Dental Medicine organizes the first Oral-systemic Symposium (+/-)
   In 2009, the School of Dental Medicine through its Frontier Center, brought together nationally recognized speakers to connect oral disease to systemic disease across the life cycle. Despite major advertising on campus, the event was poorly attended, which was a missed opportunity. However, national speakers included Dr. Caswell Evans (author of the Surgeon General’s Report), Dr. Paul Casamassimo from the National Children’s Center, Dr. Lonnie Johnson, Dr. Douglas Berkey, and Dr. John McDowell.
Policy and Advocacy

The purpose of this topic area was to address the five key actions in the “National Call to Action” of the U.S. Surgeon General, and the Healthy People 2010 Goals as they related to oral health. It was recognized that public and private policies needed to be established for advocated for in order to positively impact oral health in Colorado.

Priority Outcome #1: Advocate for changing the Dental Practice Act regarding licensing Registered Dental Hygienists and foreign-trained dentists.

Priority Outcome #2: Improve reimbursement to oral health care providers, from private and public-funded sectors, for all services.

Priority Outcome #3: Coordinate dental insurance plans with health insurance plans.

The suggested strategies includes examining best practices in other states, advocating for the inclusion of preventive benefits in all publicly provided dental coverage, and provide learning opportunities for health insurance plans to understand the oral health-general health connection.

This focus area is the one that generates the most interest, not only among coalition members, but key stakeholders as well.

☐ Oral health benefits for children and adults clearly advocated for in the Governor’s Blue Ribbon Commission on health care reform. (+)
http://www.colorado.gov/cs/Satellite/BlueRibbon/RIBB/1207055681539

The final report to Colorado’s General Assembly included a recommendation for an independent study to exam barriers for nurses and dental hygienists that prevent them from practicing to the full extent of their training; and to merge Medicaid and Child Health Plan Plus (CHP+) into one program, assuring dental coverage was included and increasing the maximum to $1,000. These recommendations were also reiterated by stakeholders in the community meetings throughout the state.

☐ Collaborative Scopes of Practice Advisory Group was commissioned under Executive Order B 003 08 (+)

The advisory group studied advanced practice nurses, physician assistants, and dental hygienists. Findings included a recommendation that “an evaluation be conducted and options recommended for reimbursement policies that would enhance the use of dental hygienists in areas of the state where oral health access is lacking.”

☐ SB 129 (2009) passed clarifying the scope of practice for dental hygienists and adding “dental hygiene diagnosis” to that scope (+)
☐ OHAC! supported the 2009 legislation creating the Hospital Provider Fee (+)
   The successful legislation allows Colorado to draw down matching federal funds to help fund uncompensated care as the state moves into health care reform.

☐ Oral health is included in the Early Childhood Colorado Framework (+)
   The Framework is a roadmap developed by the Early Childhood Leadership Commission in the Colorado Lieutenant Governor’s Office to develop a comprehensive, coordinated education and health delivery system for young children. http://www.colorado.gov/cs/Satellite/LtGovGarcia/CBON/1251592929261
   The framework adds increased knowledge of the importance of oral health for families, caregivers, educators, and policymakers; and increased numbers of dentists participating in Medicaid and CHP+ to the Commission’s commitment to improving the lives of young children in Colorado.

☐ OHAC! participates in pilot-testing the Policy Tool developed by the Children’s Dental Health Project and the Centers for Disease Control for the oral health funded states. (+)
   The top five policy areas selected (in terms of “opportunity” and “feasibility) included, in order:
   1) Supporting evidenced-based prevention interventions
   2) Assuring universal dental insurance coverage for all children
   3) Supporting school-based dental programs
   4) Adding adults to Medicaid dental coverage
   5) Increasing Medicaid dental reimbursement rates
Promising Practices

This topic area looks at successful, evidence-based and research-based strategies, decision-making practices, and activities that can be replicated and applied to oral health problems in Colorado.

Priority Outcome #1: All medical screenings and medical check-ups throughout the lifespan should include oral health.

Priority Outcome #2: Expand oral disease prevention and referral services into school health programs throughout the state.

Priority Outcome #3: Achieve greater than 90% of population on public water systems receiving optimal fluoridation.

Priority Outcome #4: Colorado children at greatest risk of dental disease receive dental sealants.

Suggested strategies included incorporating dental care into current medical schedules; work with health care providers to increase access to oral screenings; increase the number of pregnant women and children up to age one who receive an oral exam; develop a partnership to introduce oral disease prevention and referral into school health programs; duplicate successful fluoridation initiative strategies; expand sealant programs statewide; and work with the private dental community to increase sealant application.

This topic area contained a significant focus on the evidenced-based interventions of community water fluoridation and school-based sealant programs (www.thecommunityguide.org), and yet they are difficult to achieve for a variety of reasons.

☐ Several Colorado communities decided to discontinue adjusting the level of fluoride in their drinking water systems. (-)

These communities included Telluride, Pagosa Springs, Alamosa, Rifle, and Pueblo West. Communities who considered discontinuing (and the issue keeps coming around) include Aspen and Denver. For many, the argument is cost during tough economic times; for most, it is the influence of anti-fluoridation propaganda.

☐ The number of third grade children receiving sealants has increased (+)

A significant increase in the number of low income third grade children receiving sealants was found during the 2007 Basic Screening Survey. Among children in schools with at least 50% participating in the Free and Reduced Lunch Program, a nearly 10% increase was realized. The increase in school-based sealant programs most likely contributed.

☐ Several Colorado foundations support school-based oral health programs, including sealants (+)

Kids In Need of Dentistry (KIND), and Centennial AHEC are examples of organizations who received funds to begin and expand sealants for children from Delta Dental of Colorado Foundation and Caring for Colorado Foundation.

☐ Cavity Free at Three (CF3) launches effort to train general dentists and non-dental providers in
caries risk assessment, motivational interviewing, and fluoride varnish application (+)
To date, over 1,000 health care providers have been trained in CF3, and over 40,000 infants and families have received services through the trainings and after incorporation into practice

☐ University of Colorado School of Dental Medicine (SODM) offers diagnostic, preventive, and basic restorative care to low-income pregnant women referred from participating prenatal clinics in Metro Denver (+)
Supported by Caring for Colorado Foundation, SODM dental students are taught how best to provide oral health care to pregnant women through the Healthy Mothers Program

☐ The percentage of Colorado women who delivered in the past year recalling hearing about oral health from a health care provider has remained essentially unchanged for over 10 years at 40.5% (-)
Each year the Colorado Department of Public Health and Environment’s Data Unit randomly surveys new mothers via the Pregnancy Risk Assessment and Monitoring Survey (PRAMS). Of three oral health questions, the question “A dental or health care worker talked to me about how to care for my teeth and gums.”
http://www.cdphe.state.co.us/hs/mchdata/mchdata.html

☐ Dental Aid, in Boulder, targets pregnant women for dental care and documents improved birth outcomes (+)
“Improving Children’s Oral Health Through Perinatal Treatment and Education,” highlighting the program outcomes, was presented at the National Oral Health Conference in St. Louis in 2010.

☐ COHOP (Children’s Oral Health Outcomes Project) of the Colorado Community Health Network, documented a significant increase in children receiving their first oral health visit by age 1 in FQHC’s. (+)
“Through the Children’s Oral Health Outcomes Partnership (2003-2007), by 2006, 33% of one year olds and 43% of two year olds were referred to the dentist during their well child exams. This was a 20-30% increase over the baseline number of referrals measured in October 2003.”

☐ Oral health recommendations are included in the report to the Healthy Mothers Colorado Task Force (+)
Although the purpose of the final report “Comprehensive Prenatal Care Services in Colorado for Low-Income Pregnant Women: Access and Coordination Issues” was to better understand the barriers and gaps in policies and delivery systems that contribute to not meeting Healthy People 2010 goals in prenatal care, preterm low birth weight, and infant mortality, oral health was acknowledged as being an “enhanced service” with mental health, nutrition, substance abuse, and social service needs.
Systems of Care

This topic area looked at ways of finding efficiencies in coordinating systems of care that might apply to oral health.

| Priority Outcome #1: Integrate an oral check up with the standard physical exam. |
| Priority Outcome #2: Improve coordination and communication between the public and private sectors and systems of care. |
| Priority Outcome #3: Develop a collaborative workforce. |
| Priority Outcome #4: Reintroduce dental hygiene positions in school districts. |
| Priority Outcome #5: Develop alternative oral health care delivery systems as identified by communities’ needs. |

The suggested strategies are as wide-reaching as the outcomes themselves. They include incorporating lifelong dental care into well-child visits and annual check-ups; work with all health care providers to increase access to oral screenings; collaborate and partner with primary care providers to institutionalize oral evaluation and care as part of medical health exams; engage health professional organizations to enhance collaboration and coordination; assure oral health is a visible part of medical home;” cross-train medical and dental staff to recognize comprehensive health programs and refer; provide curriculum to dental and dental hygiene students regarding infant/young child oral health care; investigate the feasibility of reintroducing dental hygienists into K-12 schools; explore and expand alternative fixed, mobile, and portable dental delivery systems.

This focus area was perhaps the most broad-reaching of all of the areas, but also where the most success was realized. Great strides have been made in Colorado on most of the strategies. While once again difficult to measure as written, success may be documented.

☐ Expansion of mobile van delivery systems (+/-)
   The first mobile dental clinic was the Miles For Smiles unit of Kids In Need of Dentistry. Since then, the Colorado Smilemakers Program with the School of Dental Medicine, the Ronald McDonald Charities’ units with Peak Vista Community Health Center and Rocky Mountain Youth, in addition to the joint medical/dental units in the San Luis Valley, Weld County, and San Juan Basin.

☐ Co-Location Project, where unsupervised dental hygienists are supported in high Medicaid volume pediatric practices, is underway (+)
   Funded by Delta Dental of Colorado Foundation, dental hygienists are working in five pediatric primary care offices in urban and rural settings with the goal to integrate preventive oral health with primary care and help raise awareness about the importance of oral health as part of overall health. As of October 2009, over 800 children had been seen, half of which were under the age of 3. Dental hygienists provide oral assessments, cleanings, oral hygiene and nutrition counseling, fluoride varnish, and referral to dentists for restorative care.
☐ New fixed dental clinic sites have arisen to meet the needs of underserved populations (+)

Several communities realized the unmet dental needs in their children as a result of mobile dental clinics visiting once a year and built fixed clinics for ongoing care (“dental homes”). This is true of Montrose and Craig; other communities have been working on fixed solutions for some time, including Summit County, the Healthy Smiles at The Children’s Hospital, and the expansion of dental clinics and dental sites with safety net dental providers.

☐ COMOM – collaboration between public and private providers (+)

In the four years that the Colorado Dental Association has sponsored a Mission of Mercy project, nearly 5,000 patients have received dental care in the communities of Alamosa, Loveland, Brighton, and Colorado Springs.

☐ Increased oral health services in school-based health centers (+)

Of the 47 school-based health centers in Colorado, some have varying aspects of oral health services from education, assessment and fluoride varnish, to application of sealants. Some have onsite clinic space; others contract with mobile and portable Programs to be able to provide restorative services as well.

☐ Oral health a component of Colorado’s Medical Home vision (+)

http://www.coloradomedicalhome.com/cmhi.html

SB 07-130 identifies oral health as a component of medical home: “’Medical Home’ means an appropriately qualified medical specialty, development, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care, and related services for a child.”

☐ Collaboration on data collection to gain a better picture of oral health in Colorado (+)

While not really a “system of care”, the collection of data helps to quantify the impact of various oral health systems. The Colorado Health Institute collaborated with Colorado’s safety net clinics to collect and analyze data regarding a variety of indicators. The Colorado Oral Health Network (COHN) provided data collectively showing over 120,000 patients received dental care through the safety net in 2007.

http://www.coloradohealthinstitute.org/~media/Documents/sn/snims.ashx
REACH initiative launched at Anschutz Medical Campus

REACH team is working to create a longitudinal, interprofessional curriculum that will integrate into the preclinical and clinical training for all of our health profession students, and will develop competencies in teamwork, communication, collaborative interprofessional practice, and quality and safety with an additional focus on vulnerable and underserved populations.

http://www.ucdenver.edu/academics/degrees/health/REACH/Pages/Default.aspx

Cavity Free at Three educates primary care and dental providers to provide preventive oral health interventions for very young children and counseling of pregnant women in the hopes of eradicating dental disease by age three. (+)

The system of care here is the integration of medical and dental homes and prevention of oral disease rather than restoring. What began as grants to communities to bring the training to their health care providers has evolved into training for health professional students, any practitioner desiring training, and technical assistance to practices wanting to integrate the CF3 philosophy into their daily routine.
Workforce

This final focus area targeted the development of a diverse workforce to ensure both access to oral health care and a workforce that is competent and representative of the populations it serves.

| Priority Outcome #1: Increase the number of providers willing to serve low-income and underserved clients. |
| Priority Outcome #2: Enhance access to care through recruitment of providers who are diverse, culturally competent and/or representative of the populations they serve. |
| Priority Outcome #3: Increase curriculum time for medical, dental, nursing students, and allied health professionals regarding oral health as a component of general health. |
| Priority Outcome #4: Active recruitment of non-traditional, ethnically and culturally diverse candidates into dental and dental hygiene programs. |

☐ REACH initiative (+)

“Realizing Educational Advancement for Collaborative Health” aims to prepare the health professional workforce for tomorrow. Funded by the Josiah Macy and Colorado Health foundations, the goal is interprofessional collaboration in which “a partnership exists between a team of health providers and a client in a participatory, collaborative, and coordinated approach to shared decision-making around health and social issues.”

☐ Number of participating dentists and dental hygienists in Medicaid as declined significantly (-)

In some ways, it depends on how the numbers are crunched, but any way it is cut, the number of licensed Colorado dentists and dental hygienists participating in Medicaid continues to decline. In a recent 2010 data analysis, of 3,400 licensed Colorado dentists, only 671 participated in Medicaid actively, with only 300 (less than 10% of dentists providing on-going care for 25 patients. Dental hygienist participation is open to unsupervised dental hygienists, and while the number who signed up for participation after the legislation designating them as recognized providers passed in 2001, the number participating in Medicaid has significantly decreased as well.

☐ Colorado hosts first Multicultural Oral Health Alliance (MOHA) meeting

MOHA is comprised of four national organizations: CDHP, Hispanic Dental Association, National Dental Association and the Society of American Indian Dentists. MOHA “works together with a united voice to address issues faced by vulnerable populations through advocacy and policy for the disparately affected in our respective communities.”

http://www.cdhp.org/multicultural_oral_health_alliance/multicultural_oral_health_alliance
☐ Interprofessional activities through the SODM Frontier Center (+)

☐ Oral Health representation on the Colorado Health Professions Workforce Collaborative (+)

The Collaborative is a multidisciplinary group from more than 30 organizations committed to ensuring a high quality health care workforce to provide all Colorado residents with access to quality health care. Oral health has been at the table through membership by the University of Colorado School of Dental Medicine, the Colorado Dental Association, and the Colorado Dental Hygienists’ Association. Public policy efforts center in increasing data collection about the whereabouts and practices of health care providers, optimizing loan repayment programs, increasing funding for health professional training programs, supporting adequate reimbursement for providers, and expanding the availability of rotational experiences for health professional students.

http://www.coruralhealth.org/programs/collaborative/

☐ Community health center expansion of dental clinics (+/-)

Through ARRA (American Recovery and Reinvestment Act), some community health centers (CHC’s) received funding to expand their operations to be able to serve an increased number of underserved and uninsured patients. CHC’s expanded to new sites and expanded the capacity of existing sites. The Patient Protection and Affordable Care Act (Health Care Reform) also earmarked an $11 Billion increase to CHC’s. In the 2011 state legislative process, all safety net clinics (CHC’s and Community Funded Safety-Net Clinics) rallied to prevent the elimination of the Primary Care Fund. Due to budget constraints at the state and national level, the potential for these expansions being realized is dwindling.
Conclusion and Recommendations

While many key stakeholders were initially concerned about the breadth of this first, comprehensive, statewide oral health plan, it is truly remarkable to look back over the past five years and recount the tremendous strides that have been made. There is evidence of collaboration among funders, providers, policy makers, and the public to increase awareness of the importance of oral health. While in most cases exact progress in terms of percentage increase/decrease is not available, there is no doubt the issue of oral health disparities is being tackled from a wide array of directions.

The Oral Health Colorado coalition has expressed an interest in updating this state oral health plan for another extended period, which is appropriate. There may be a few things the coalition should consider in developing that plan.

• Follow the framework for state oral health plans outlined by the Centers for Disease Control. With the new structure of the coalition, gaining broad stakeholder input will vary from this original plan, but will remain a key component.

• Consider tying the Priority Outcomes to Healthy People 2020 Objectives and writing state-specific objectives that are “SMART” (Specific, measurable, achievable, realistic, and time-related).

• Design the implementation strategy and evaluation plan into the oral health plan from the beginning. The “SPIT” team concept did not fully materialize. Consider how best to document successes and setbacks from as many key stakeholders as possible (e.g. An on-line database for stakeholders to enter data into for regular/yearly assessments of progress)

• Discuss whether the topic/focus areas in this plan are still reasonable, worth building on, too vague, too broad, etc. Consider the effects that health care reform will have on oral health in the state.

• Consider the timing of the new plan in relation to the new “burden” document being drafted by the Oral Health Unit at the Colorado Department of Public Health and Environment. The Impact of Oral Disease on the Health of Coloradans was a part of the basis for the state oral health plan.

• Devise a dissemination plan early on to get broad stakeholder support and buy-in. Consider targeting policy makers for the release of the new plan.

• Identify key policy initiatives that have not included oral health sufficiently for possible focus (e.g. the State Public Health Restructuring Act (C.R.S. 25-1-501 et seq.)